Washington State Health Care Authority

# HCA Market Assessment:

## A Snapshot of U.S. Health Care Costs, Health System Trends, and Washington State Public Purchasing Health Care Strategies

### A Report to Washington Legislators

August 11, 2017

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## A Snapshot of U.S. Health Care Costs, Health System Trends, and Washington State Public Purchasing Health Care Strategies

Washington State Health Care Authority

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# Table of Contents

# Executive Summary

The purpose of this market assessment is to provide a high-level view of relevant Washington State health care trends to complement monthly finance and utilization reports for state-purchased healthcare programs. Published semi-annually, each market assessment presents an overview of the latest trends in health care expenditures nationally and for Washington's state-financed health care programs, Apple Health and Public Employees Benefit Program. Additionally, it includes purchasing strategies implemented nationally and in Washington to incentivize smarter spending and increase the quality of care delivered. Each market assessment also features health care market and health system-related news released since the last market assessment, as well as a "deep dive" on a pertinent health care issue. This report explores the impact of health care costs patients face nationally and in Washington State.

In 2015, total health care costs in the United States grew 5.8 percent as more individuals gained coverage, utilization of services increased, and spending on pharmaceuticals grew**.** The Centers for Medicare & Medicaid Services (CMS) projects health expenditures will increase 5.6 percent annually from 2016-2025, eventually representing 19.9 percent of the Gross Domestic Product (GDP) in 2025; this increase is mainly attributable to rising medical prices, including pharmaceutical costs.

Washington State-financed programs—Public Employee Benefits Board (PEBB) and Apple Health—mirrored national trends, albeit with slower increases in health care expenditures and cost growth trends. Total PEBB non-Medicare health expenditures were $1.4 billion in Fiscal Year (FY) 2015 and $1.5 billion in FY 2016—a spending increase of 5 percent. PEBB non-Medicare per capita expenditures increased 4.4 percent, from $5,129 in FY 2015 to $5,356 in FY 2016. Medicaid (Apple Health) covered 1.8 million lives in Washington; total Medicaid spending by the Health Care Authority (HCA) increased 9.3 percent, from $6.3 billion in FY 2015 to $6.8 billion in FY 2016.[1] By comparison, national Medicaid spending increased 9.6 percent from Calendar Year (CY) 2014 to CY 2015. HCA's Medicaid per capita annual expenditures increased 2.4 percent from $3,634 to $3,772. Federal funds supported 69 percent of HCA's Medicaid spending in FY 2016.[2]

Increasing health care expenditures represent a growing burden on the federal government, states, and, especially, families. A middle-income family spends 25 percent more on health care in 2014 than they did in 2007. Roughly 29 percent of workers in 2016 were enrolled in a high-deductible plan that contains a deductible of $1,000 or more, up from 20 percent in 2014. In 2015, Washington families with employer coverage faced a deductible of $2,785 on average compared to the national average of $2,915. Individuals purchasing coverage on the individual market experienced highly

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[1] Note that Medicaid expenditure figures do not include non-forecasted expenditures such as disproportionate share hospital payments, hospital safety net assessment payments, provider access payments, and services paid for by DSHS.

[2] Apple Health spending data includes medical costs only; administrative costs and Medicaid disproportionate share payments (made to hospitals that serve a large number of individuals who are covered by Medicaid or are uninsured) are excluded.

variable premiums, though the Washington market was more stable than in other states. The Washington State Health Benefit Exchange (HBE) saw a premium increase of 13 percent from 2016 to 2017.

To control and reduce expenditures, Washington State, the federal government, and other states continue to develop and implement innovative value-based payment and purchasing strategies to increase the quality and value of health care and slow health care spending.

In addition to actively pursuing strategies to manage health care costs and expenditures, Washington State's health care system is among the best performing in the nation, making the biggest jump in the Commonwealth Fund rankings, according to a national study released in 2017.[3] Indicators of health care system performance include health care access, quality, avoidable hospital use and costs, health outcomes, and health care equity.

### A Note on Efforts to Repeal and Replace the ACA

Information regarding the efforts to Repeal and Replace the Affordable Care Act (ACA) have been intentionally excluded from this report. Any descriptions or analysis of legislation would be difficult to capture and present timely information in a semi-annual report. However, HCA continues to closely monitor national developments with the Governor's Office and other Washington agencies.

### A Note on Data

Given the nature of health care claims and billing, available data—especially aggregated expenditure data—can have a one to two year lag. This report contains the most recent data possible, however, in reviewing this information, readers should note the year and also how the year is defined (calendar year versus fiscal year). CMS will release National Health Expenditure 2016 data in December 2017.

# Background and Overview

The purpose of this market assessment is to provide a high-level view of relevant Washington State health care trends to complement monthly finance and utilization reports on state-purchased healthcare programs. Published semi-annually, each market assessment presents an overview of the latest trends in health care expenditures nationally and for state-financed health care programs (Apple Health and Public Employee Benefit Program) and purchasing strategies implemented nationally and in Washington to incentivize smarter spending and increase the quality of care and value delivered. Each market assessment also features health care market and health system-related news (e.g., relevant information about health insurance, health care quality, and other topics) released since the last market assessment (within the last six months), as well as a "deep

[3] Radley, David C., Douglas McCarthy, and Susan L. Hayes. (2017). Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance, 2017 Edition. The Commonwealth Fund.

dive" on a pertinent health care issue. This report explores the impact of health care costs patients face nationally and in Washington State.

The goal of these market assessments is to present the newest and latest information on different health care topics and influencers in the national and Washington State health care markets, rather than a compendium on all health care market topics and related news.

# Market Level Trends in Health Care Spending

## Trends in Health Care Spending

***Key Takeaways***

**National:** In 2015, total health care costs in the United States grew 5.8 percent as more individuals gained coverage and there was greater utilization of services and higher spend on pharmaceuticals.

**Public Employee Benefits (PEBB):** Total PEBB non-Medicare health expenditures were $1.4 billion in FY 2015 and $1.5 billion in FY 2016, a spending increase of 5 percent. Per capita annual expenditures increased 4.4 percent from $5,129 in FY 2015 to $5,356 in FY 2016.

**Medicaid (Apple Health**): Medicaid covered roughly 1.8 million lives in Washington in FY 2016; total HCA Medicaid spending (not inclusive of DSHS Medicaid spending) increased 9.3 percent from $6.3 billion in FY 2015 to $6.8 billion in FY 2016. HCA per capita annual expenditures increased 2.4 percent from $3,634 to $3,772.

**Future:** CMS projects health expenditures will increase 5.6 percent annually from 2016-2025, representing 19.9 percent of the GDP in 2025; this increase is due in large part to rising medical prices.

## National

*CMS: National Health Expenditure Trends*[4]

In 2015, total health care costs in the United States grew 5.8 percent and made up 17.8 percent of GDP compared to 2014 when health care cost increases were closer to 5.3 percent. U.S. health care spending totaled $3.2 trillion dollars ($9,900 per person). As more individuals gained coverage through the Medicaid expansion, new individual market subsidies, and traditional employer-sponsored plans, use of hospital and physician clinical services increased. The rising cost and use of pharmaceuticals has also contributed to the recent increase in spending.

[4] Centers for Medicare & Medicaid Services (2016, December 6). National Health Expenditures 2015 Highlights. Retrieved on February 16, 2017 from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html and Martin, A.B., Hartman, M., Washington, B., Catlin, A., (2016, December 2). National Health Spending: Faster Growth in 2015 As Coverage Expands and Utilization Increases. *Health Affairs* 36, no. 1: 1-11. Retrieved on February 16, 2017 from: http://content.healthaffairs.org/content/early/2016/11/22/hlthaff.2016.1330.full.pdf+html.

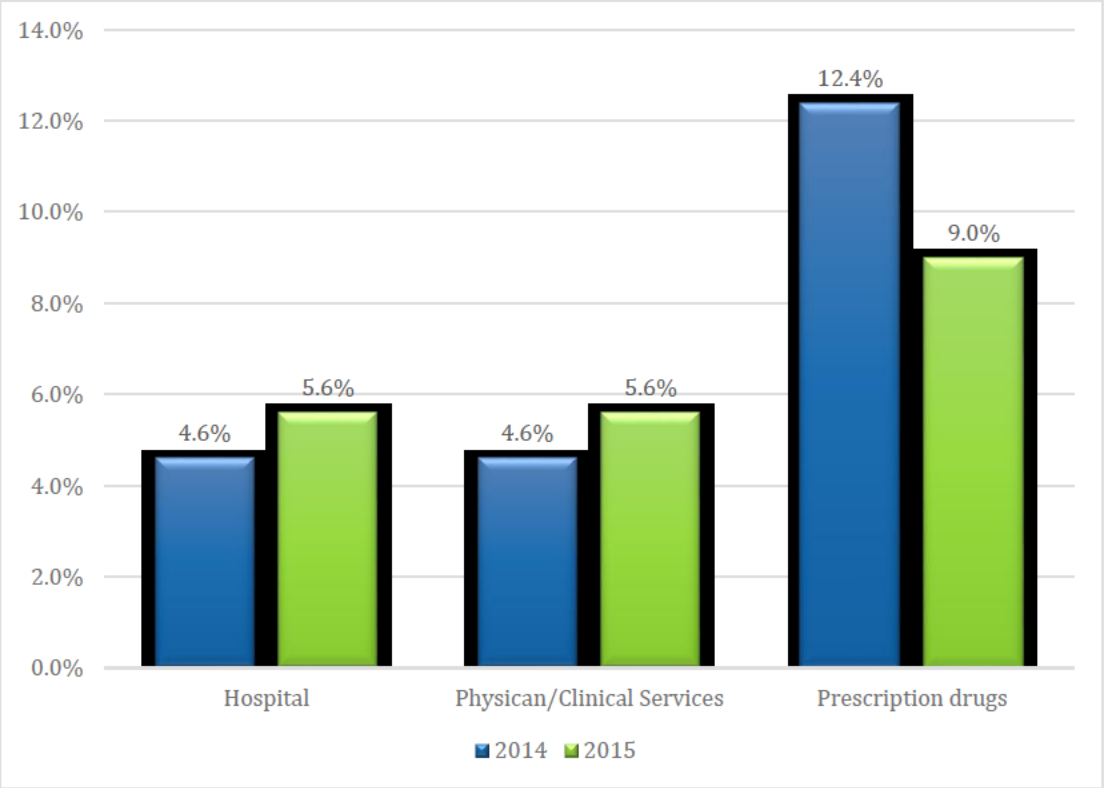
## Hospital, Physician and Clinical Services[5,6]

Nationally, hospital expenditures increased at a faster rate in 2015 than in 2014—5.6 percent versus 4.6 percent (see chart below). Increased use and the provision of higher-intensity services were both associated with the continued increase in hospital spending. Similarly, inpatient length of stay and the number of hospital admissions have grown for the last two years in a row, which is the first time these measures have moved in tandem in the past decade.

National expenditures for physician and clinical services also increased 5.6 percent in 2015 compared to 2014 when these expenditures grew 4.6 percent. Once again, the associated increased use that accompanied expanded insurance coverage drove higher expenditures.

Conversely, the growth in spending on prescription drugs slowed in 2015 compared to 2014 (9.0 percent versus 12.4 percent); still, prescription drug spending has remained the fastest growing service category of health expenditures. All payers continue to struggle with the cost of specialty drugs, such as those that treat hepatitis C and cancer.

**Chart 1: National Annual Percentage Growth by Service Category**




Data source: Centers for Medicare & Medicaid Services (2016, Dec. 6). National Health Expenditures 2015 Highlights.

[5] Ibid.

[6] National expenditure trend categories are not available for Washington State entire insurance market, PEBB, or Apple Health. However, we will explore analyzing and presenting Apple Health data per national trend categories in future Market Assessment reports.

## Payers – Medicare, Medicaid and Private Health Insurers[7]

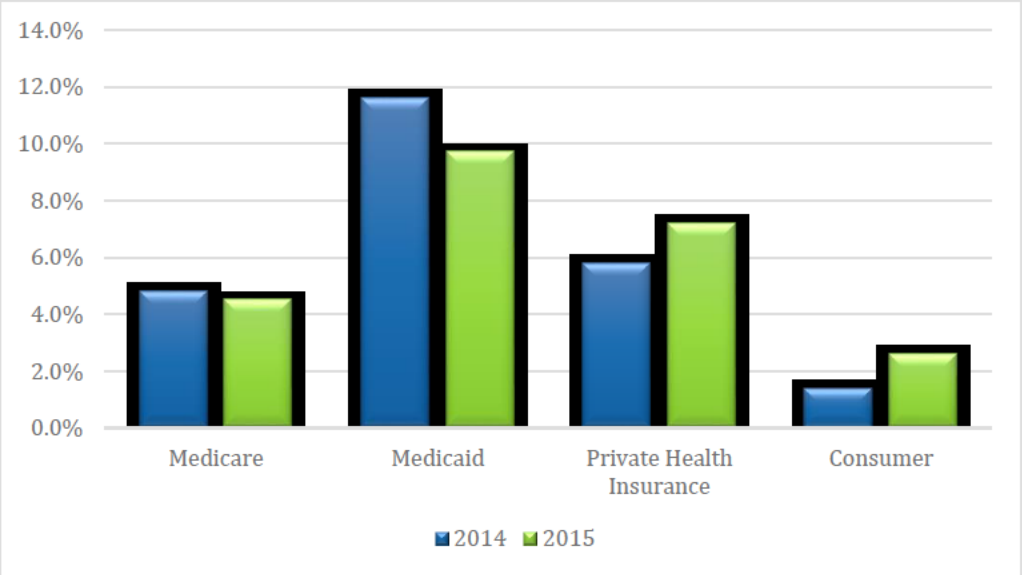
Nationally, Medicare accounted for 20 percent of total health expenditures, increasing 4.5 percent in 2015, slightly slower than the 4.8 percent increase in 2014. While the growth in Medicare enrollees for 2015 was slower than 2014, the growth in spending per enrollee remained constant in both years.

Medicaid expenditures represented another 17 percent of national health expenditures in 2015 and increased only 9.7 percent compared to an 11.6 percent increase in 2014. Although Medicaid enrollment slowed between 2015 and 2014, new Medicaid expansion enrollees under the Affordable Care Act (ACA) and new specialty drugs like hepatitis C treatments drove the continued increase in spending. Medicaid enrollment increased 5.7 percent from 2014 to 2015. CMS projects that Medicaid expenditures will grow 3.7 percent and enrollment will increase 2.6 percent in 2016. CMS anticipates per enrollee expenditures will grow 1.1 percent from 2015 to 2016.

Private health insurance coverage comprised roughly 33 percent of national health spending in 2015 and grew 7.2 percent from the previous year, as enrollment in private health insurance increased in both the newly expanded individual exchange market and employer-sponsored insurance (the result of stronger job growth).

Consumer out-of-pocket spending accounted for 11 percent of total health care spending. Consumers spent 2.6 percent more on health care out-of-pocket expenditures in 2015 than they did in 2014. These increases were fueled by more individuals gaining health care coverage, new enrollees using more health care, and the greater number of people enrolled in high-deductible health plans through the exchanges and through their employers.

**Chart 2: National Annual Health Expenditures – Percentage Growth by Payer**




Data source: Centers for Medicare & Medicaid Services (2016, Dec. 6). National Health Expenditures 2015 Highlights.

[7] Ibid.

## Washington State

Total PEBB non-Medicare health expenditures were $1.4 billion in FY 2015 and $1.5 billion in FY 2016, a spending increase of 5 percent. PEBB per capita non-Medicare health expenditures increased 4.4 percent, from $5,129 in FY 2015 to $5,356 in FY 2016. Non-Medicare PEBB enrollment increased 0.5 percent during this time.[8]

PEBB non-Medicare per subscriber per year medical benefit expenditures, which include the employee and their covered family members, were $10,068 in FY 2015, increasing 3.2 percent to $10,392 in FY 2016.[9]

**Chart 3: PEBB Non-Medicare Annual Expenditures – FY 2014-FY 2016 (in billions)**

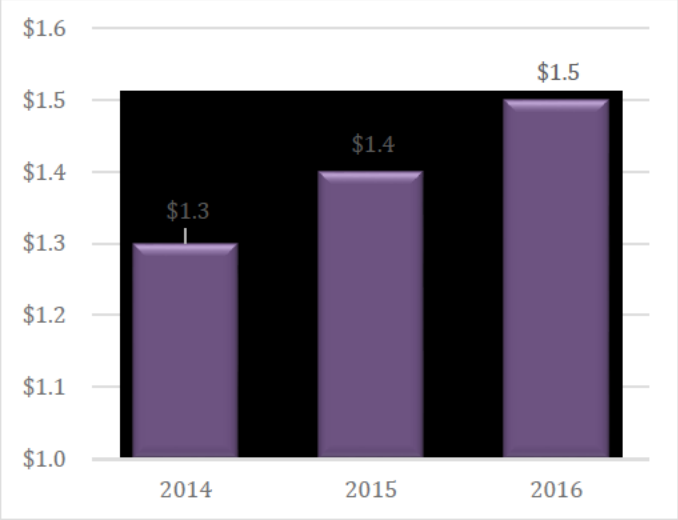
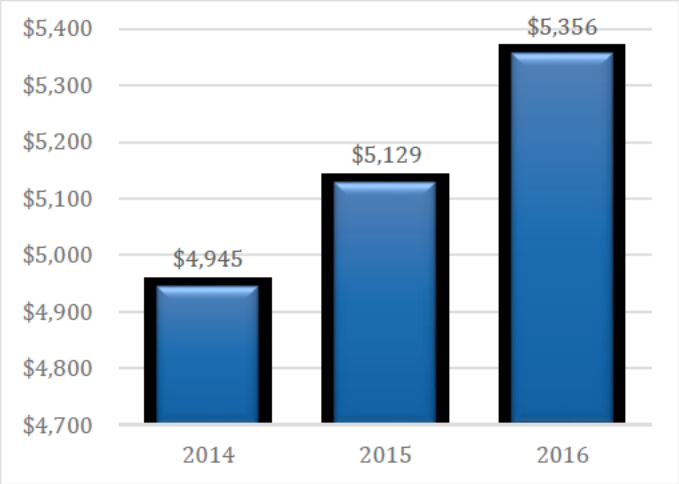



**Chart 4: PEBB Per Capita Annual Expenditures**

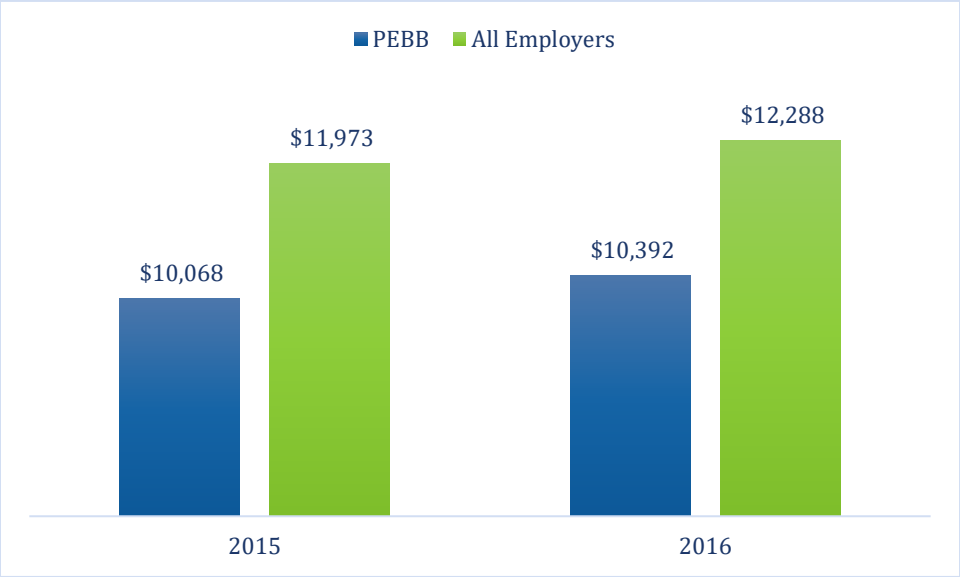



[8] A subscriber is defined as an employee.

[9] Washington State Health Care Authority (2017, February 14). Financial Projection Model: Exhibit 3a: PEBB Expenditures and Revenue by Risk Pool, Scenario 6.0 FY2017 2nd Quarter Projection.

To put this in context, large public and private employers reported that their spending per employee on health care benefits grew 2.6 percent from 2015 to 2016 after adjusting for annual plan changes, and rose from $11,973 per employee to $12,288.[10] Not taking into account annual plan changes, employee spending on health care increased 6.3 percent. Studies have shown that public employees are, on average, older and are more likely to have chronic health conditions compared to their private sector counterparts.[11]

**Chart 5: Annual Spending – PEBB vs. All Large Employers**




PEBB data is calculated for fiscal year (July to June); national data on large employers is calculated for calendar year (January to June). The PEBB increase is based on expenditures only and has not been adjusted for plan changes.

Data sources: Mercer Survey: Health Benefit Cost Growth Slows to 2.4% in 2016 As Enrollment in High-Deductible Plans Climbs. Retrieved on March 22, 2017 from: https://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html and: Washington State Health Care Authority (2017, February 14). Financial Projection Model: Exhibit 3a: PEBB Expenditures and Revenue by Risk Pool, Scenario 6.0 FY2017 2nd Quarter Projection.

In February 2017, PEBB had approximately 370,000 members; 280,000 were not eligible for Medicare. Approximately 161,000, or 58 percent, of those members enrolled in Uniform Medical Plan (UMP) Classic, which has the largest enrollment of any PEBB plan.[12]

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[10] Note: This figure is for employers with 500+ employees. PEBB data is calculated for fiscal year, while national survey data is calculated for calendar year. Source: Mercer (2016, October 2016). Mercer Survey: Health Benefit Cost Growth Slows to 2.4% in 2016 As Enrollment in High-Deductible Plans Climbs. Retrieved on March 22, 2017 from: https://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html.

[11] Pew Charitable Trusts and MacArthur Foundation. (2014, August). State Employee Health Plan Spending: An Examination of Premiums, Cost Drivers, and Policy Approaches. Retrieved March 17, 2017 from: http://www.pewtrusts.org/~/media/assets/2014/08/stateemployeehealthcarereportseptemberupdate.pdf.

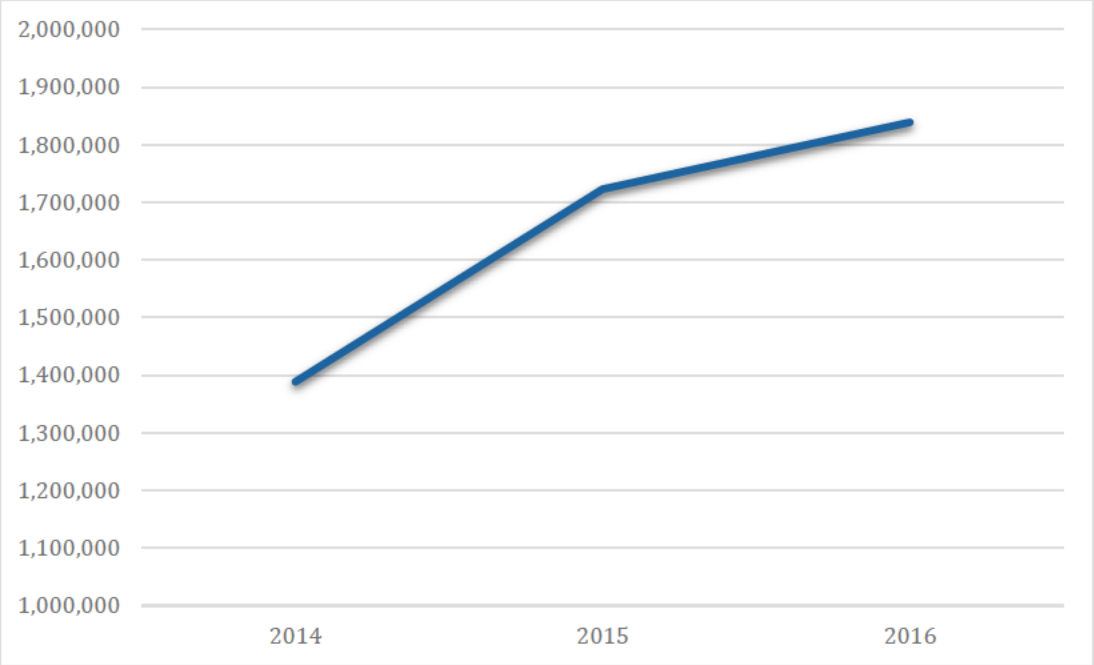
[12] Health Care Authority (2017, March 3). ACP Strategy Data Set.xls.

As HCA outlined in its November, 2016 Review of Prescription Drug Costs and Summary of Potential Purchasing Strategies (https://www.hca.wa.gov/assets/drug-price-and-purchasing.pdf), PEBB pharmacy expenditures, after rebates, were $379 million in Calendar Year (CY 15), compared to $334 million in CY 2014, a 14 percent increase. The high prices of new specialty drugs that cure hepatitis C as well as drugs that treat cancer, hemophilia, and rheumatoid arthritis led to the significant spending increase for the PEBB population.

## Apple Health Enrollment and Expenditures

This report focuses on Medicaid enrollment and expenditure trends starting in FY 2014, so it includes the Medicaid expansion coverage for adults up to 138 percent of the federal poverty level (FPL) under the ACA.[13] From FY 2014 to FY 2016, Apple Health enrollment grew from 1.4 million covered lives to 1.8 million covered lives—a 32 percent increase.

**Chart 6: Number of Apple Health Enrollees, FY 2014 – FY 2016**




It is important to note that, beginning in January 2017, the federal government's share of funding for newly eligible adults under the ACA decreased from 100 percent to 95 percent, with Washington State responsible for the other 5 percent. Total HCA Medicaid spending increased 9.3 percent from $6.3 billion in FY 2015 to $6.8 billion in FY 2016.[14]

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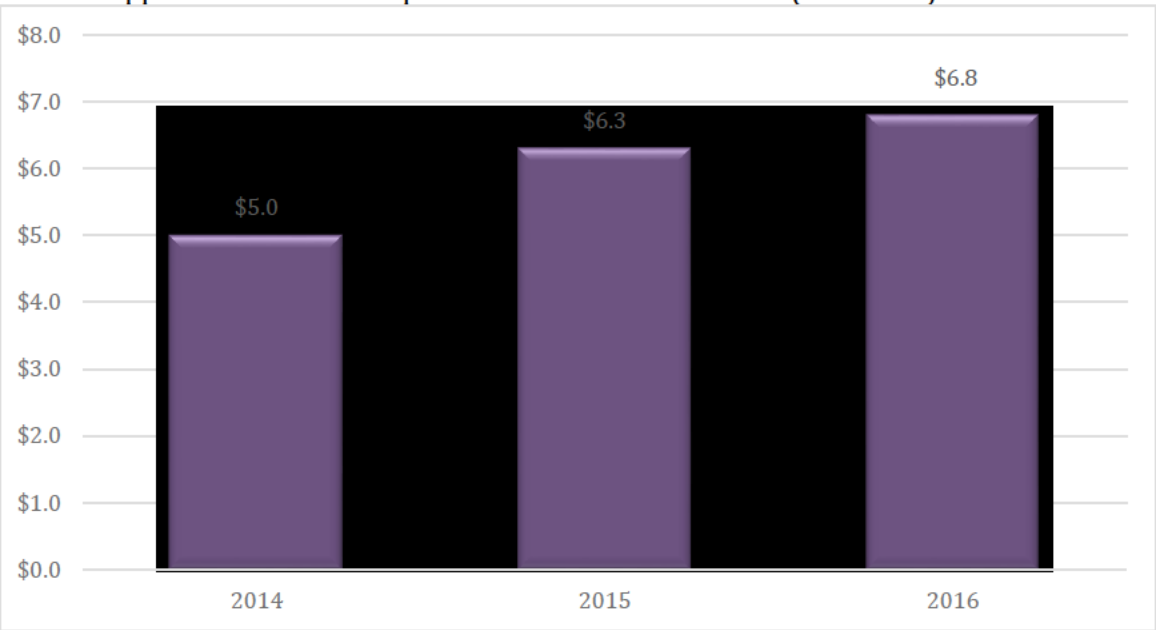
[13] Yen, Wei and Thea Mounts. (2016, April). Medicaid Growth Under the ACA: A Game-Changer in Reducing Washington's Uninsured in 2014. Washington State Office of Financial Management. Retrieved April 27, 2017 from: http://www.ofm.wa.gov/researchbriefs/2016/brief076.pdf.

[14] Health Care Authority. (2017, February). MPA Medical Assistance Forecast Summary Report, February 2017 Version D06.

Chart 7: Apple Health Annual Expenditures – FY 2014-FY 2016 (in billions)




During FY 2014-FY 2016, Apple Health has trended below national average annual growth rates for Medicaid among the newly eligible, family, and aged/blind/disabled populations.

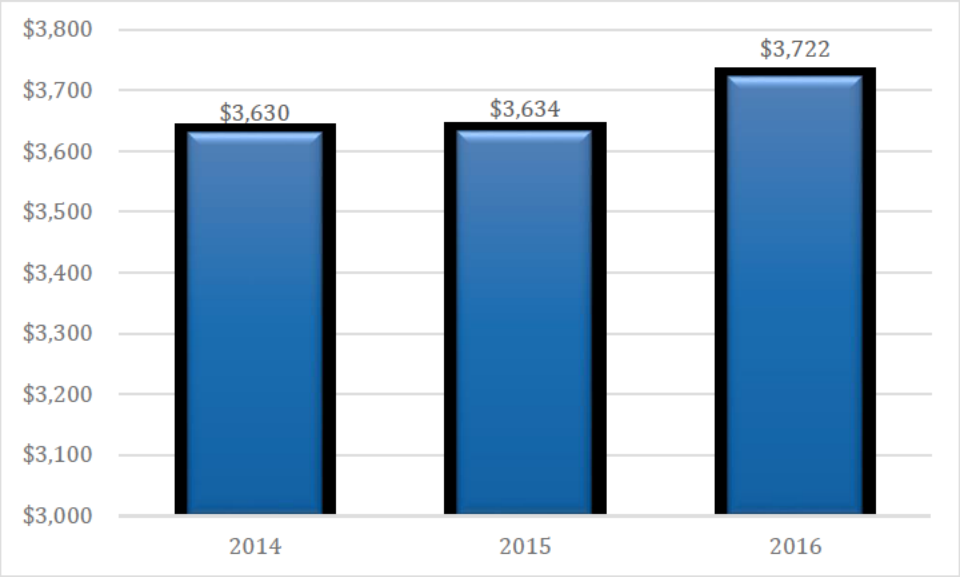
**Table 1: Average Annual Growth Rates for Medicaid**

| Population | HCA Average Annual Growth Rate | National Average Annual Growth Rate | Time Frame |
|---|---|---|---|
| **Newly Eligible (Adults under 138% FPL)** | -2.81% | 2.03% | FY 2014-2016 |
| **Family (SCHIP and Medicaid Eligible Adults with Children under 18)** | -0.69% | 3.69% | FY 2011-2016 |
| **Aged/Blind/Disabled** | 0.10% | 0.58% | FY 2011-2016 |

At the same time, per capita expenditures increased 2.4 percent from $3,634 in FY 2015 to $3,722 in FY 2016.[15]

[15]Health Care Authority. (2017, February). MPA Medical Assistance Forecast Summary Report, February 2017, Version D06.

**Chart 8: Medicaid Per Capita Expenditures – FY 2014-FY 2016**




Among the 1.8 million Apple Health clients, approximately 1.6 million are enrolled in a managed care organization (MCO), which receives a per-member-per-month (PMPM) rate to coordinate and pay for the majority of health care services.[16] This mirrors national trends in which 77 percent of Medicaid clients were enrolled in an MCO in 2014.[17] HCA has worked to transition more Medicaid health care purchasing from fee-for-service (FFS) to managed care to better coordinate client care and to manage costs. As part of this effort, HCA transitioned its foster care clients to managed care in April 2016.[18]

Overall, managed care costs represented 76.8 percent of Washington State's total Medicaid spending in FY 2016, compared to 67.4 percent in 2014, with the remaining 23.2 percent of costs in FFS.[19] FFS expenses include hospitals, licensed health care professional fees, pharmacy, and durable medical equipment.

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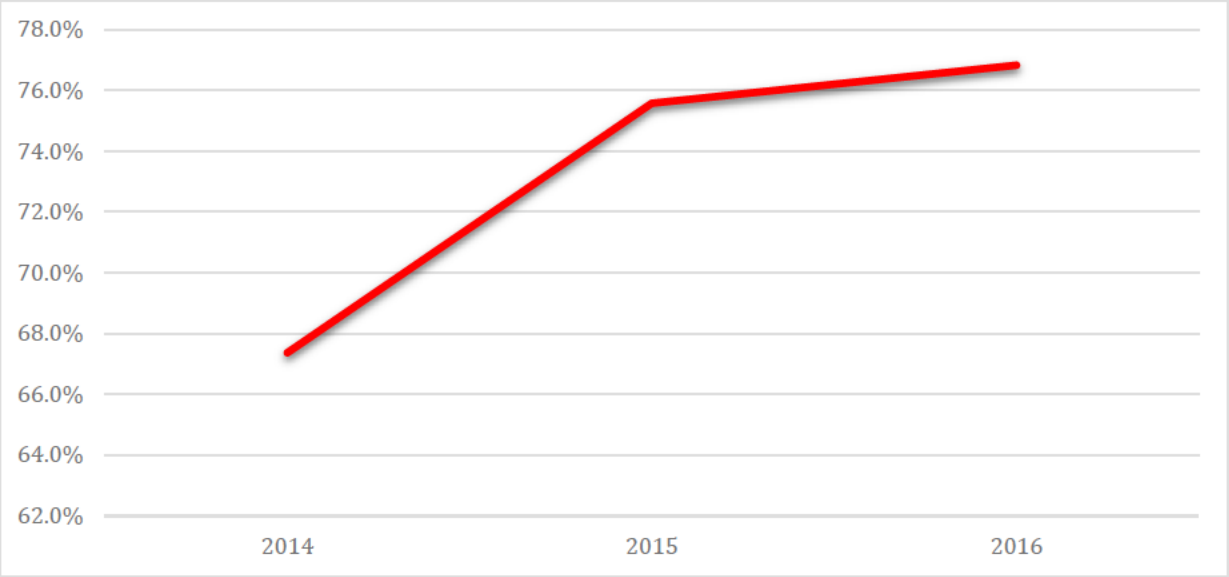
[16] Note: Calculated average MCO enrollment from July 2016-November 2016. Source: Health Care Authority. (2017, March 6). Summary of Apple Health Managed Care Enrollment for the Past 12 Months by Plan and County. Retrieved March 20, 2017 from: http://www.hca.wa.gov/about-hca/apple-health-medicaid-reports.

[17] Centers for Medicaid and Medicare Services, (2016) Actuarial Report on the Financial Outlook for Medicaid. Retrieved on May 1, 2016 from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf.

[18] Note: Community Health Plan of Washington (CHPW) is the MCO that covers foster care clients.

[19] Health Care Authority, Medical Program Assistance (MPA) Forecast.

**Chart 9: Managed Care Costs as a Proportion of Total Apple Health Expenditures, FY 2014-FY 2016**



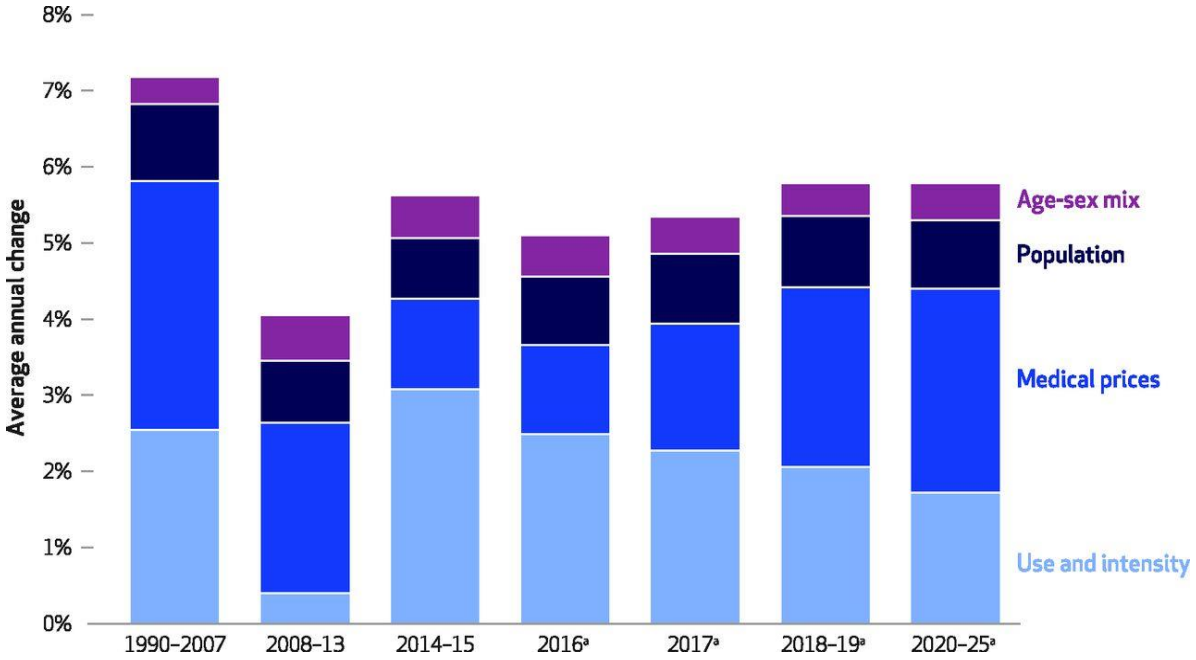

## National and State Health Expenditure Predictions[20]

National health spending forecasts assume that all provisions of the ACA will remain law. The following projections reflect this scenario and are subject to change pending new decisions by the federal administration along with any potential federal legislation. CMS analysts forecast that total national health expenditures will increase 5.6 percent annually from 2016 to 2025, rising from 17.8 percent of GDP in 2015 to 19.9 percent of GDP in 2025. Increases in medical prices account for a significant portion of rising expenditures rather than the use (volume) or intensity (type) of care, which drove increased expenditures at the onset of the ACA.[21] Individuals are likely to face greater cost sharing from private health insurance and more individuals will have higher deductibles for their health plan coverage as rising expenditures are passed onto consumers.

[20]Centers for Medicare & Medicaid Services (2017). National Health Expenditure Projections 2016-2025 Forecast Summary. Retrieved on March 5, 2017 from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf and Keehan, S.P. et Al. (2017, February 14). National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy. Retrieved on March 5, 2017 from: http://content.healthaffairs.org/content/early/2017/02/14/hlthaff.2016.1627.full.

[21] Definition of use and intensity of services is from: Health Care Cost Institute (2012 May). Health Care Cost and Utilization Report 2010. Retrieved on April 28, 2017 from: http://www.healthcostinstitute.org/files/HCCI_HCCUR2010.pdf.

**Chart 10: Factors Accounting for Growth in Personal Health Care Expenditures, Calendar Years 1990–2025**




Source: Keehan, S.P. et al. (2017, Feb 2014). National Expenditure Projections 2016-25, Price Increases, Aging Push Sector to 20 Percent of Economy. Health Affairs.

Private health insurance expenditures are projected to grow at a consistent 5.7 percent annual rate from 2017-2019 because fewer drugs have patents expiring, which means less generic lower-cost alternatives will be available. After 2019, private health insurance expenditures slow to 4.8 percent as disposable income for health care costs falls and the proposed tax on high cost health plans (e.g. "Cadillac Tax") is implemented.

From 2016 to 2025, Medicare costs are projected to increase 7.1 percent annually because, as the U.S. population ages, more individuals are likely to have complex health needs that require a greater quantity and intensity of services. Analysts anticipate Medicaid spending will increase 6 percent annually from 2018-2025 as Medicaid enrollees grow older and develop disabilities.

HCA forecasting data show similar increases. HCA projects PEBB's FY 2017 non-Medicare medical expenditures will be $1.6 billion and Apple Health FY 2017 expenditures will be $7.4 billion.[22]

[22] Figure does not include Disproportionate Share Hospital Programs (DSH), Safety Net Assessment Fund (SNAF), or DSHS Medicaid expenditures.

# Spotlight on Consumer-Level Health Care Costs

## Employer-Sponsored Insurance Marketplace Trends

***Key Takeaways***

**Healthcare consumes a growing portion of families' budgets:** Middle-income families spend 25 percent more on health care in 2014 than they did in 2007.

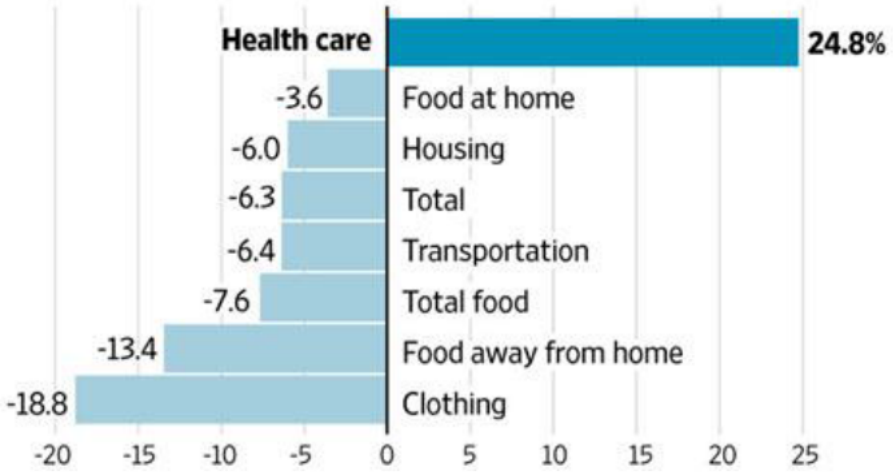
**Rising deductibles:** The average deductible increased 12 percent from 2015 to 2016, averaging $1,319 to $1,478 for subscriber-only coverage.

**Rise in health savings accounts (HSAs):** In 2016, one in five people (19 percent) were enrolled in a high-deductible health plan ($1,300/individual or $2,600/family) with an HSA option—twice as many (9 percent) as in in 2011.

## Consumer Health Care Costs[23]

Middle income families in the U.S. are spending a significantly greater proportion of their take-home income on health expenses. A middle-income family typically spent 25 percent more on health care in 2014 than they did seven years before. The burden of health care costs can vary depending on a variety of factors specific to an individual's medical situation. Although health care expenses can be highly variable, here are some overall trends on the relative impact of health care costs on household consumption between 2007 and 2014.

**Chart 11: Percent Change in Middle-income Households' Spending on Basic Needs (2007-2014)**




Sources: Wall Street Journal, Brookings Institution analysis of Consumer Expenditure Survey, Labor Department.

[23] Sussman, Anna Louie. (2016, August 25). Burden of Health-Care Costs Moves to the Middle Class: Rising Out-of-pocket Health Care Costs 'Means Less Money for Other Things'. Retrieved on February 6, 2017 from: https://www.wsj.com/articles/burden-of-health-care-costs-moves-to-the-middle-class-1472166246.

## Consumers with Employer-Sponsored Insurance

Roughly half of Washington State residents received employer-sponsored health insurance coverage in 2015; this aligns with national statistics.[24] Individuals with employer-sponsored insurance experienced a 3 percent increase in *premiums* from 2015 to 2016 with an average premium (employer share plus individual share) that totals $18,142 per family. The average employee with employee-sponsored insurance in the U.S. spent $5,277 for their portion of the family premium contribution in 2016, which is in line with their contribution from the previous year but 20 percent higher than what they paid in 2011.[25] In the West, the average family premium in 2016 totaled $18,145, with employees paying, on average, $5,372 for their portion of the premiums.[26]

The largest burden, however, is the steep rise in *cost sharing and deductibles* for individuals with employer-sponsored coverage. Among the 83 percent of workers with employer-sponsored coverage who have a health plan with a deductible, the average deductible individuals paid for subscriber-only coverage in 2016 was $1,478. This is a 12 percent increase from 2015.[27] In 2015, Washington families faced a deductible of $2,785 on average compared to the national average of $2,915.[28]

The increase from 2015 to 2016 represents part of a larger historical trend: employees are facing growing deductibles as employers respond to rising health care costs by shifting costs to their employees (see chart on following page).[29]

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[24] Kaiser Family Foundation (2016). State Health Facts: Health Insurance Coverage of the Total Population. Timeframe: 2015. Retrieved On February 6, 2017 from: http://kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[25] Kaiser Family Foundation and Health Research and Educational Trust (2016). Employer Health Benefits 2016 Annual Survey Retrieved February 6, 2017 from: http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey.

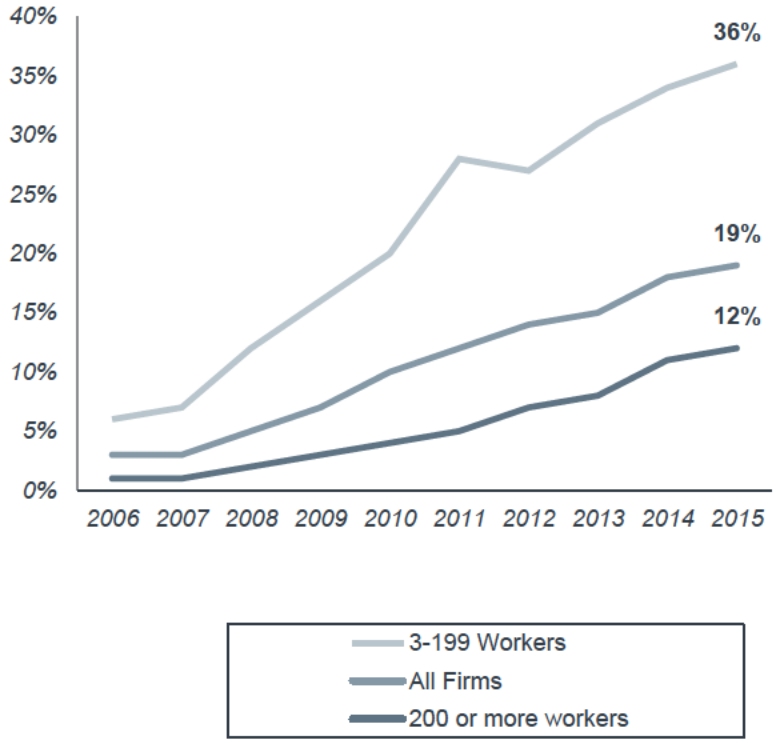
[26] Ibid. Note that the West is defined as: AZ, CO, ID, MT, NV, NM, UT, WY, AK, CA, HI, OR, and WA in this survey.

[27] Kaiser Family Foundation. (2016, September 14). Average Annual Workplace Family Health Premiums Rise Modest 3% to $18,142 in 2016; More Workers Enroll in High-Deductible Health Plans with Savings Option over Past Two Years. Retrieved on February 6, 2017 from: http://kff.org/health-costs/press-release/average-annual-workplace-family-health-premiums-rise-modest-3-to-18142-in-2016-more-workers-enroll-in-high-deductible-plans-with-savings-option-over-past-two-years/.

[28] This is the most recent data available for Washington State averages. Source: Agency for Healthcare Research and Quality (2016). Table II.F.3. Average Family Deductible (in dollars) per employee enrolled with family coverage in a health insurance plan that had a deductible at private sector establishments by firm size and state: United States, 2015. Retrieved February 6, 2017 from: https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2015/tiif3.pdf. Note 2015 is the most recently published data broken down at the state level.

[29] The Advisory Board (2017). Health Care Industry Trends 2017 Ready-to-Use Presentation Slides.

**Chart 12: Percentage of Covered Workers with Annual Deductible of $2,000 or More By Firm Size, 2006-2015**




Source: The Advisory Board. (2016) Health Care Industry Trends 2017.

## Rise in Health Savings Accounts

As employees face rising deductibles, more employers are offering Health Savings Accounts (HSAs) as a way for employees to manage their growing health care costs. A health savings account allows employees with high-deductible health plans—deductibles above $1,300 for individuals and $2,600 for families—to save money tax-free for medical expenses. The funds are not taxed when deposited into the account or if the employee withdraws them for health expenses, and any leftover funds carry over into the next year. Funds employees contribute to an HSA reduce their taxable income; the maximum annual contribution is $3,400 for individuals and $6,750 for families.[30] In 2016, 19 percent of people who had employer-sponsored health insurance were enrolled in an HSA-qualified high-deductible health plan (HDHP), compared to 9 percent in 2011.[31]

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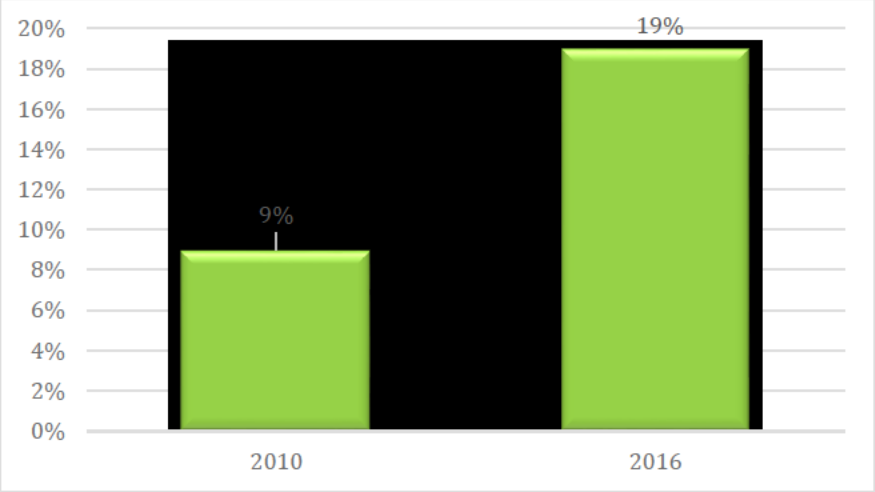
[30] Appleby, Julie. (2017, February 3). HSAs: 'Tax-Break Trifecta', or Insurance Gimmick Benefiting the Wealthy? *Kaiser Health News.* Retrieved February 6, 2017 from: http://khn.org/news/hsas-tax-break-trifecta-or-insurance-gimmick-benefiting-the-wealthy/.

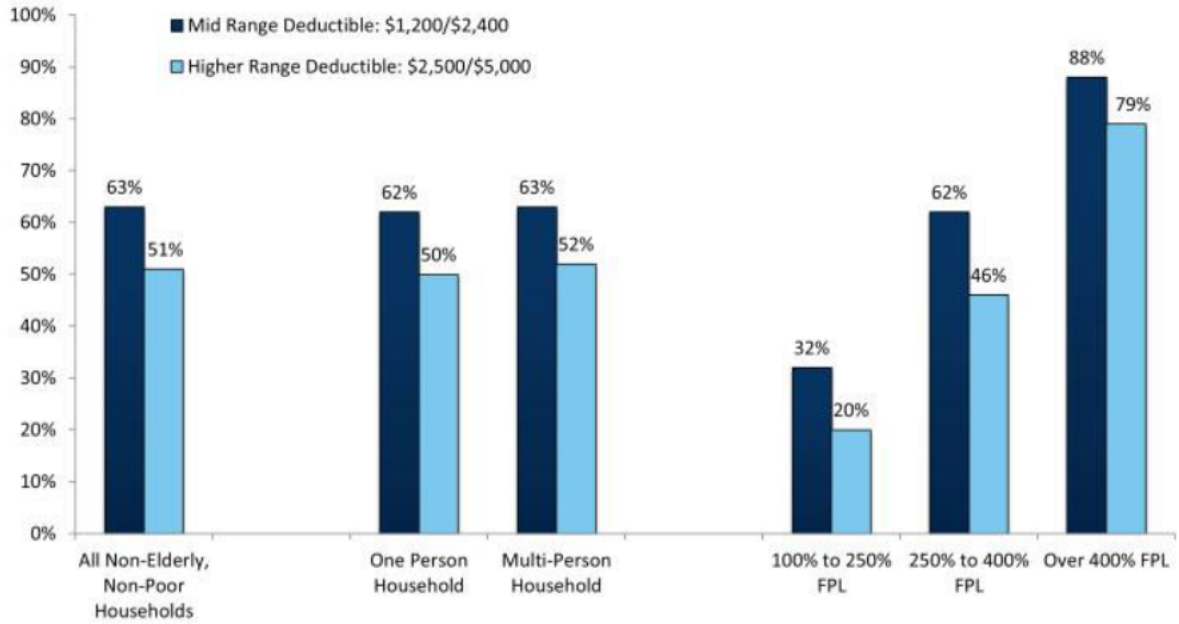
[31] Kaiser Family Foundation, Employer Health Benefits 2016 Annual Survey.

**Chart 13: Proportion of Individuals with Employer-sponsored Insurances with High-deductible Health Plans with Health Savings Accounts**




Although studies indicate that HDHPs and HSAs reduce employer health care costs, they also report that the higher deductibles are not affordable for some families.[32]

**Chart 14: Percent of Households with Liquid Financial Assets Greater than Specified Deductibles, Among all Non-elderly, Non-poor Households**




Source: Kaiser Family Foundation analysis of 2013 Survey of Consumer Finance data.

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[32]Brot-Goldberg, Zarek C. et al. (2015 October). What Does the Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. *Harvard Kennedy School Faculty Research Working Paper Series*. Retrieved on June 20, 2017 from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwiN-oWHws3UAhVM82MKHcfJDtIQFggoMAE&url=https%3A%2F%2Fresearch.hks.harvard.edu%2Fpublications%2FgetFile.aspx%3FId%3D1265&usg=AFQjCNH_o8VeAAHjHG8NNSsxvDs1B3AlJA.

A Kaiser Foundation Family study found that only 63 percent of non-poor households had enough liquid assets to meet a mid-range deductible of $1,200 and 51 percent had enough liquid assets to meet a higher range deductible of $2,500.[33] Moreover, a Federal Reserve Board study reported that 46 percent of individuals did not have $400 of cash on hand to pay for an unexpected expense without using a credit card or borrowing money from a friend or family member.[34] Another important consideration is that higher-income individuals are more likely to benefit from HSAs than low-income individuals. Employees who earn below the filing threshold of $10,000/person or $20,000/family do not pay federal income taxes, so they do not receive any tax benefits. Only those employees with disposable income are able to make contributions to an HSA.[35]

## Individual Marketplace Insurance Trends

***Key Takeaways***

**High variability in price:** Individuals who were the same age and made the same income had a $229 pre-subsidy premium in Louisville, Kentucky compared to $904 in Anchorage, Alaska for the same coverage.

**Moderate increases in Washington:** The Washington State Health Benefit Exchange found an average premium increase of 13 percent from 2016 to 2017.

**Harder-to-obtain coverage:** In 2017, 60 percent of individuals surveyed nationally responded that "it was difficult or nearly impossible to get affordable coverage," compared to 34 percent in 2016.

## Individual Health Insurance – National Trends

In 2015, a record 16.3 percent of individuals in the U.S. received coverage by purchasing an individual health plan. Nationally, individuals purchasing insurance in 2016 on the individual market witnessed great variability among policy premium prices before subtracting the ACA subsidies, depending on their age, income, tobacco use, number of dependents, and where they lived. The ACA mandates that premiums may not vary by more than 3:1—a person in the oldest age bracket cannot pay more than three times the amount that an individual in the youngest age bracket pays. Subsidies are available for households up to 400 percent of the Federal Poverty Level

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[33]Claxton, Gary, Matthew Rae, and Nirmita Panchal (2015, March 11). Consumer Assets and Patient Cost Sharing. *Kaiser Family Foundation.* Retrieved on June 20th 2017 from: http://www.kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/.

[34] Federal Reserve (2016 May). Report on the Economic Well-Being of U.S. Households in 2015. Retrieved on April 27 from: https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf.

[35] Andrews, Michelle. (2016, December 6). HSA Balances Climb but Benefits Reward Wealthier Consumers Most. *Kaiser Health News.* Retrieved on February 6, 2017 from: http://khn.org/news/hsas-benefits-reward-wealthier-consumers-most/.

(FPL), which is $47,080 for an individual and $97,000 for a family of four.[36] Any changes in family size, age, income, tobacco use, and place of residence could lead to premium changes for an individual purchasing insurance on the individual market.[37]

The individual health care market varies significantly based on geography, both in terms of the number of available plans by county and average premium costs in an area. One benchmark analysts use to assess average healthcare costs on the individual market is to calculate the monthly premium for a 40-year old non-smoker with no dependents and an income of $30,000 seeking the second lowest silver plan. As an example, individuals matching this description had a $229 pre-subsidy premium in Louisville, Kentucky compared to $904 in Anchorage, Alaska for the same coverage. The percentage increase in premiums from 2016 to 2017 also varied significantly by geography. An extreme case is that monthly premiums for the Benchmark plan in Phoenix, Arizona grew by 145 percent ($207 to $507) from 2016 to 2017.[38]

A number of factors influence rate-setting in the individual health insurance market. Insurers set premiums using informed predictions of the health needs of those who enroll. Below are a few explanations for the fluctuations in insurance premiums different individuals may have experienced that do not directly relate to changes in their household:

- Insurers over- or under-estimated the cost of care for the risk pool of individuals and have to adjust premiums accordingly the next year. Changes in underlying prices (for example, the cost for a particular medical procedure) and the utilization mix (the types of services people are seeking) also affect the accuracy of insurers' estimates.[39]

- The ACA included risk adjustment, reinsurance, and risk corridors programs meant to minimize destabilizing impacts of adverse selection and risk selection in the expanded individual market. The federal reinsurance and risk corridors programs were temporary and ended in 2016; the risk adjustment program is ongoing. All three programs were funded by payments from certain insurers and paid out to other insurers with the intent of spreading financial risk across the individual market and stabilizing premiums. Accuracy of insurers' expectations about the impact of these programs on their risk and the temporary

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[36] Internal Revenue Service. (2017, March 15). Eligibility for the Premium Tax Credit. Retrieved on February 6, 2017 from: https://www.irs.gov/affordable-care-act/individuals-and-families/eligibility-for-the-premium-tax-credit and Centers for Medicare & Medicaid Services (2016). How Health Insurance Companies Set Health Premiums. Retrieved February 6, 2017 from: https://www.healthcare.gov/how-plans-set-your-premiums/.

[37] American Academy of Actuaries (2016, May). Issue Brief: Drivers of 2017 Health Insurance Premium Changes (1-9). Retrieved February 6, 2017 from: http://www.actuary.org/files/publications/IB.Drivers5.15.pdf.

[38] Cox, Cynthia et.al. (2016, November 1) 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces. *Kaiser Family Foundation.* Retrieved February 6, 2017 from: http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/.

[39] American Academy of Actuaries. (June 2016). *Issue Brief Drivers of 2017 Health Insurance Premiums*.

nature of two of the three programs have affected premium growth trends in the individual market.[40]

- The number of enrollees who select an individual plan has an impact on pricing because a greater number of enrollees helps to spread risk in the insurance pool. If the uptake rate of people is higher, then more healthy individuals likely are entering the insurance risk pool and can help bring down per capita costs of care. About 46 percent of people who were eligible for an individual plan selected one in 2016.[41]

In 2016, approximately 6 percent of people in Washington received coverage by purchasing an individual plan. By metal level, 6 percent of enrollees selected a Gold plan, 62 percent of enrollees selected a Silver plan, 30 percent selected a Bronze plan, and the remainder selected a catastrophic plan.[42] The Washington State Health Benefit Exchange found an average premium increase of 13 percent from 2016 to 2017.[43] The benchmark example, a 40-year-old non-smoker who selected the second lowest-cost silver plan, experienced an average premium increase of $9 per month from 2016 to 2017. Individuals purchasing insurance on the Washington State Health Benefit Exchange faced a 5 percent increase in average deductibles for bronze plans and an 8 percent increase in average annual deductibles when they purchased a silver plan.[44]

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[40] Cox, Cynthia et. al. (2016, August 17). Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. *Kaiser Family Foundation*. Retrieved on February 6, 2017 from: http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

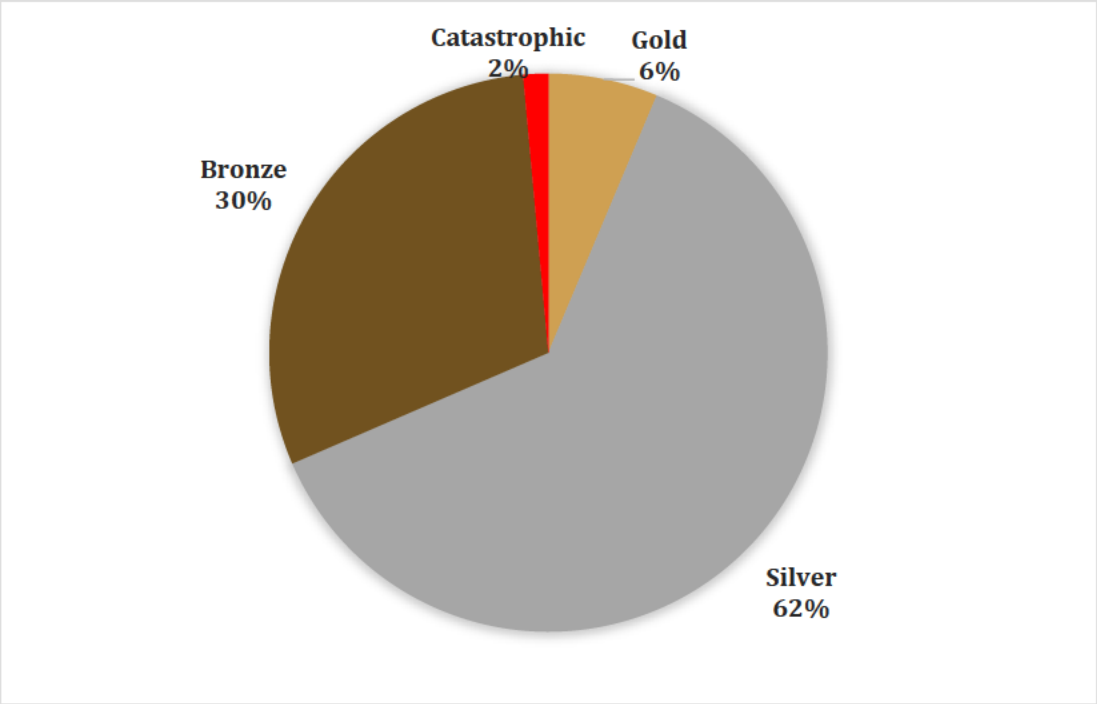
[41] American Academy of Actuaries. (June 2016), *Issue Brief: Drivers of 2017 Health Insurance Premiums*.

[42]Wakely Consulting Group. (2016, November). Washington State Benefit Exchange: Washington State Health Insurance Market Analysis. Retrieved on February 6, 2017 from: http://www.wahbexchange.org/wp-content/uploads/2013/05/HBE_LEG_161201_Wakely_Market_Analysis.pdf http://kff.org/other/state-indicator/total-population/?currentTimeframe=0.

[43] Washington Health Benefit Exchange. (2016, October 21). Washington Healthplanfinder Bucks National Rate Trends; Customers Will See Changes in Costs, Savings and Coverage Options in 2017. Retrieved on June 19, 2017 from: https://www.wahbexchange.org/washington-healthplanfinder-bucks-national-rate-trends-customers-will-see-changes-costs-savings-coverage-options-2017/.

[44] Washington Health Benefit Exchange. (2017, January 16). *Senate Health Care Committee*. Retrieved on February 6, 2017 from: https://www.wahbexchange.org/wp-content/uploads/2013/05/HBE_LEG_170116_Exchange_Overview_SHC.pdf.

**Chart 15: Individual Health Plan Selection, Washington Open Enrollment 2016**




Approximately 62 percent of individuals purchasing a qualified health plan (non-Medicaid) for 2017 on the market received a subsidy to help cover their premiums.[45] Once again, an individual in Washington may have faced significantly greater or lower premium and deductible increases but, as an aggregate, Washington State residents did not experience the dramatic increases in premiums that residents in other regions in the United States did from 2016 to 2017.[46]

**Table 2: Average Deductibles in the Washington State Individual Market**

| Metal Level | 2016 Average Deductible | 2017 Average Deductible | Change in Deductible |
|---|---|---|---|
| Bronze | $5,693 | $5,977 | $284 |
| Silver* | $3,343 | $3,620 | $277 |
| Gold | $1,148 | $1,223 | $75 |

Source: Washington Health Benefit Exchange

[45]Washington Health Benefit Exchange (2017, January 11). *Health Care & Wellness Committee*. Retrieved on February 6, 2017 from: https://www.wahbexchange.org/wp-content/uploads/2013/05/HBE_LEG_170116_Exchange_Overview_SHC.pdf.

[46] Aleccia, JoNel. (2016, October 16). Health-Insurance Premiums Rise in Washington, but Not As Much As Elsewhere. *The Seattle Times.* Retrieved on February 6, 2017 from: http://www.seattletimes.com/seattle-news/health/health-insurance-premiums-rise-here-in-state-but-not-as-high-as-elsewhere/.

## Impact of Exchanges on Health Insurance Reform

Research indicates that 29 million individuals who were seeking to purchase an individual health insurance plan were able to obtain coverage in 2016 compared to 12 million in 2010. The Commonwealth Fund, in its 2010 bi-annual national survey, found that 60 percent of individuals surveyed responded that "it was difficult or nearly impossible to get affordable coverage," while only 34 percent of individuals reported this experience in 2016.[47] With the implementation of the ACA in 2014, Washington expanded Medicaid and established the Washington Health Benefit Exchange. Washington's uninsured rate dropped by more than half from 14 percent in 2013 to 5.8 percent in 2015.[48] Prior to the ACA implementation, 5 percent of non-elderly individuals in Washington purchased an individual plan and 17 percent received Medicaid.[49] In 2015, 6 percent of individuals purchased an individual plan and 22 percent of Washington residents received Medicaid.[50]

**Table 3: Impact of ACA on People's Ability to Buy Insurance**

| | Total | | Health problem | | < 200% FPL | | 200%+ FPL | |
|---|---|---|---|---|---|---|---|---|
| | 2010 | 2016 | 2010 | 2016 | 2010 | 2016 | 2010 | 2016 |
| **Adults ages 19-64 with individual coverage or who tried to buy it in past three years who:** | **26 million** | **44 million** | | | | | | |
| Found it very difficult or impossible to find affordable coverage | 60% | 34% | 70% | 42% | 64% | 35% | 54% | 32% |
| Found it very difficult or impossible to find coverage they needed | 43% | 25% | 53% | 31% | 49% | 26% | 35% | 23% |
| Has individual coverage or ended up buying a health insurance plan | 46% **12 million** | 66% **29 million** | 36% | 60% | 34% | 63% | 57% | 71% |

Source: Commonwealth Fund Biennial Health Insurance Survey, 2016.

Subsidies for individual health plans and HSAs help ease the burden patients face paying for health care costs out-of-pocket. However, these options do not change or control the actual cost of a given procedure, service, or prescription because patients and providers are part of a large health care delivery system. A complex set of factors drive health care expenditures, such as individual

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[47] Collins, S.R., Gunja, M.Z., Doty, M.M., and Beutel, S. (2017, February 1) How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own. *The Commonwealth Fund.* Retrieved on February 6, 2017 from: http://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance?omnicid=1166533&mid=.

[48] Washington Health Benefit Exchange, *Senate Health Care Committee January 16, 2017.*

[49] Kaiser Family Foundation (2014, June 3). The Washington State Health Care Landscape. Retrieved on February 6, 2017 from: http://kff.org/health-reform/fact-sheet/the-washington-state-health-care-landscape/.

[50] Kaiser Family Foundation (2016). Health Insurance Coverage of the Total Population. Timeframe: 2015. Retrieved on February 6, 2017 from: http://kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

provider practice patterns and how payers finance health care—still largely an FFS system where the quality of a service is unrelated to outcomes.

As patients become responsible for a growing proportion of health care costs, it is important to support and reward delivery system efforts that improve quality of care as a way to lower overall costs.

# Value-based Payment and Purchasing, and Delivery System Reform Strategies

Under the fee-for-service (FFS) reimbursement system, providers are rewarded for more care (volume) rather than high quality, high value care. There is no incentive for coordinated and efficient care; this often leads to duplicative tests and procedures, and more costly care. The basic goals of value-based payment are to reward quality and value in the health care system and incentivize delivery system reform strategies that promote quality and value in our health care system such as primary care, team-based care, care coordination, patient engagement in care decisions, and care that adheres to best practices or what evidence shows works. Care delivery cannot be reformed or transformed without re-aligning payment incentives with better patient outcomes and higher value.

## Value-based Payment Adoption, Nationally and in Washington State

Several national surveys administered in 2016 show that more healthcare providers and payers are implementing value-based care reimbursement contracts and moving away from traditional fee-for-service payment models. An ORC International and McKesson survey found that, by the end of 2015, 58 percent of payers and hospitals were incorporating value-based care reimbursement protocols in their practice or moving toward that goal.[51] Additionally, according to the Health Care Transformation Task Force (HCTTF), of which HCA is an active member, as many as 42 percent of member providers used value-based care reimbursement arrangements and 38 percent of payers used an alternative, value-based payment model in 2015.[52]

In May 2016 HCA surveyed Washington State providers and payers on value-based payment (VBP) adoption status as of the end of 2015. According to survey responses, approximately 25 percent of payers and 20 percent of providers self-reported they were in engaged in VBP arrangements. HCA is administering its annual VBP survey to providers and payers to gauge VBP adoption again in June 2017.

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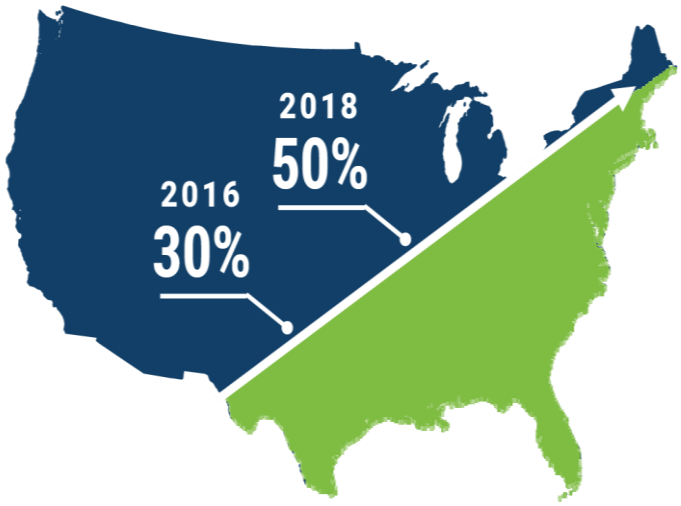
[51] Health Payer Intelligence. (2016, September 27). 58% of Payers, Providers Adapt Value-Based Care Reimbursement. Retrieved on June 26, 2017 from https://healthpayerintelligence.com/news/58-of-payers-providers-adapt-value-based-care-reimbursement.

[52] Williamson, Jennifer. (2016 April 12). Health Care Transformation Task Force Reports Increase in Value-Based Payments. Retrieved on May 15, 2017 from: http://hcttf.org/releases/2016/4/12/healthcare-transformation-task-force-reports-increase-in-value-based-payments.

## Federal Value-Based Payment Strategies

The federal government has set ambitious VBP goals: By 2018, 50 percent of Medicare FFS payments are to be in Alternative Payment Models (APMs).[53] In 2016, the federal government announced that 30 percent of their payments were in APMs.[54] (The federal government uses the LAN Framework [http://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf] to categorize different types of health care payment arrangements starting with fee-for-service and moving to advance value-based models.)




The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare's most significant VBP legislation, ends the Medicare Sustainable Growth Rate (SGR) formula payment method which adjusted Medicare reimbursement rates based on GDP growth, and creates the Quality Payment Program (QPP), a new framework for rewarding providers for delivering high quality care. Starting in 2017, physicians and others providing care for at least 100 Medicare Part B recipients (outpatient physician services) can choose to enroll in one of two tracks for payment under the QPP:

- Merit-based Incentive Payment System (MIPS), or
- Advanced Alternative Payment Models (AAPMs).[55]

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[53] Centers for Medicare and Medicaid Services. Health Care Payment Learning and Action Network. Retrieved on May 15, 2017 from: https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/.

[54] Shatto, John D. (2016 March 3). Center for Medicare and Medicaid Innovation's Methodology and Calculations for the 2016 Estimate of Fee-for-Service Payments to Alternative Payment Models. Retrieved on May 15, 2017 from: https://innovation.cms.gov/Files/x/ffs-apm-goalmemo.pdf.

[55] Centers for Medicare and Medicaid Services. Innovation Formula. (2017). Retrieved on April 29, 2017 from: https://innovation.cms.gov/initiatives/index.html#views=models. Advisory Board, (2017 April) Medicare Risk Strategy. Retrieved on April 29, 2017 from: https://www.advisory.com/-/media/Advisory-

The *MIPS* program consolidates three existing quality reporting programs: Physician Quality Reporting (PQRS), Value-based Payment Modifier (VBPM) and meaningful use (MU). Under MIPS, providers will earn a performance-based payment adjustment based on their quality and cost performance/metrics, implementation of care improvement activities (e.g., care coordination strategies), and adoption of health information technology.

Providers that choose to participate in the *advanced APM* track are eligible to earn incentive payments. Qualifying alternative payment models (APMs) are defined as any of the following:

- An innovative payment model expanded under the Center for Medicare & Medicaid Innovation (CMMI), with the exception of Health Care Innovation Award recipients;
- A Medicare Shared Savings Program (MSSP) accountable care organization (ACO);
- A Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration Program; or
- Another demonstration program initiated by CMS.

The amount that providers receive in 2019 Medicare payments will be determined according to their 2017 QPP performance, with providers receiving incentive payments for good performance or withholds for poor performance. In 2021, providers will also receive incentives for their participations in risk-based contracts with other payers including private health insurers and Medicaid.

## Washington State Value-Based Purchasing Strategies

To achieve HCA's goal of having 90 percent of state-financed health care in VBP arrangements by 2021, HCA is already using several VBP strategies in Medicaid and PEB, and plans to continue to design new models.

New VBP arrangements and activities that are currently being designed or implemented in 2017 include:

- **Tying Medicaid Transformation Demonstration incentive payments to Accountable Communities of Health (ACHs) and MCOs to attainment of VBP arrangements.** Under Initiative 1 of the Medicaid Transformation Demonstration, funds are available to reward MCO and ACH partnering providers for attainment of annual VBP targets. The VBP incentives are based on the LAN framework, with progressive targets throughout the demonstration.[56]

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com/Microsite/Research/2016/2016-HCAB-National-Meeting/Presentation%20PDFs/DC-APRIL/B-Final.pdf.

[56]Centers for Medicare and Medicaid Services. (2017, January 9). Washington State Medicaid Transformation Project. Retrieved on June 20, 2017 from: https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf.

- **Apple Health 1 percent VBP Withhold.** Starting in January 2017, HCA instituted a major change in Apple Health contracts. As part of HCA's Value Based Purchasing strategies to drive transformation in the marketplace, 1 percent of the capitation payments to Medicaid MCOs have been withheld. To receive the 1 percent withhold, MCOs must show that 0.75 percent of overall payments are paid out to providers to improve the quality of care delivered: 30 percent of their payment arrangements are in 2c-4b of the LAN Framework (http://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf); and attain quality improvement across seven different quality measures.[57]

- **Payment Model 2: Encounter to Value.** HCA has been working with the federal government, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), the Washington Hospital Association, and other stakeholders to reform FQHC and RHC payments by linking payment to quality. In April, 16 FQHCs and one RHC agreed to participate in an innovative new payment model, Payment Model 2: Encounter to Value. Payment Model 2 will reward clinics that deliver high quality care to patients by linking payment to improvement and attainment against quality measures. Payment Model 2 promotes greater access to care through increased flexibility by allowing providers to deliver care in new and innovative ways that improve patient care, incentivize care coordination, and encourage robust primary care teams.[58] Payment Model 2 is regarded as a national value-based model for FQHCs, receiving the attention of other states seeking to transform FQHC payments.

- **Payment Model 4: Multi-Payer.** Under Heathier Washington's Payment Model 4, aimed at fostering VBP approaches in commercial markets, two provider organizations have agreed to participate in regional multi-payer demonstrations where they are incentivized to spread and scale value-based payment adoption and reform activities. This includes reporting on a subset of quality measures (similar to the set used in HCA contracts), accelerating value-based payment implementation, and recruiting additional payers to participate in the demonstration each year. HCA is providing financial assistance and data extracts on attributable UMP members and Apple Health clients to assist these providers in managing their patient populations. The two participating provider organizations are Northwest Physicians Network (NPN) in Tacoma and Summit Pacific Medical Center in Elma.[59]

- **Bundled Episodes of Care Request for Information.** In late April, HCA issued a Request for Information (RFI) to gather information on providers' experience and feedback on bundled payment episodes of care. The results of the RFI will inform HCA's future episodes

[57]The LAN Framework categorizes different types of health care payment arrangements starting with fee-for-service and moving to advance value-based models.

[58] Health Care Authority, (2016, November 21) Request for Letter of Intent, FQHC and RHC APM4 and Health Care Authority, (2017 May 12). Clinics agree to new Medicaid payment model to expand access, improve care.

[59] Health Care Authority, *Greater Washington Multi-Payer* and Request for Letter of Intent.

of care bundle strategies for PEB and Medicaid. Bundle strategies will be designed in 2018 and implemented in 2019.

- **Application for Certification of HCA's payment models as advanced Alternative Payment Models.** HCA intends to apply to the federal government for its VBP payment models to be certified as advanced alternative payment models. By applying for advanced APM certification, participating providers who use HCA's models would quality for extra incentive payments under the APM track starting in 2019. HCA is waiting for the federal government to release more information on the certification process.

## Drug Cost Solutions

Most of the models listed above are total-cost-of-care models, meaning the plan and/or provider is accountable for both medical and drug costs. HCA is exploring additional strategies to curb drug growth in PEBB and Medicaid, many of which were identified at the two HCA-convened drug-purchasing summits held in 2016. These include:

- Alternative payment models connecting state drug purchasing payments to patient clinical outcomes and insurance plan financial results;
- An expanded preferred drug list (PDL) to increase supplemental drug rebates from manufacturers and a single PDL that includes both FFS and the Medicaid MCOs (now required through legislative direction in the 2017-19 biennial appropriations act); and
- Having Washington Medicaid join the NW Prescription Drug Consortium, a group of Washington and Oregon state entities that negotiate drug pricing contracts and services.[60]

## Other States and Initiatives

Like Washington, other states are actively implementing value-based payment models in their Medicaid and other state-purchased programs, aided by federal support like the State Innovation Models (SIM) grant, aimed at assisting states in implementing value-based purchasing and APMs across a variety of healthcare payers.

SIM launched in April 2013 and six states (Arkansas, Massachusetts, Maine, Minnesota, Oregon, and Vermont) initially received test grants. Seven additional states, including Washington, received test grant funds in 2015. Of the six states participating in the first phase of the SIM Initiative, two have been able to link more than half of their population to a value-based care model.[61]

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[60] Health Care Authority. (2016, November 15). Review of Prescription Drug Costs and Summary of Potential Purchasing Strategies: A Report to Washington Legislators. Retrieved February 16, 2017 from: http://www.hca.wa.gov/assets/drug-price-and-purchasing.pdf.

[61] RevCycle Intelligence. (2016, September 8). CMS Touts Progress of State-Led Alternative Payment Model. Retrieved on June 26, 2017 from: http://revcycleintelligence.com/news/cms-touts-progress-of-state-led-alternative-payment-model.

Medicaid Delivery System Reform Incentive Payment (DSRIP) programs also provide federal support to states to reinvest savings to test innovative value-based payment and delivery system strategies. In addition to Washington, eight states currently have approved DSRIP initiatives: California, Texas, Massachusetts, New Jersey, New Mexico, New York, New Hampshire, and Kansas – and other states are in the process of negotiating their DSRIP program with federal partners.[62]

# Other Relevant Heath Care Market Updates and News

Changing the way health care is paid for is critical to incentivizing the right care and improving population health. At the same time, health insurance coverage is also key to improving population health, as health insurance directly influences a person's access to care and, consequently, their health.

## Washington State Health Care System Performance[63]

Washington State's health care system is among the strongest in the nation, making the biggest jump in the rankings, according to a Commonwealth Fund national study released in spring 2017. The latest Commonwealth Scorecard on State Health System Performance ranked Washington tenth out of 50 states, making it the highest–ranked state in the West. Washington had one of the largest improvements in the rankings from the prior year, moving from a ranking of 16 to 10. The areas where Washington scored favorably include:

- Vaccination rates among children/adults,
- Numbers of adults who went without care,
- The uninsured rate for adults/children,
- The proportion of adults with a usual source of care,
- Infant mortality,
- The number of colorectal cancer deaths, and
- Multiple long term care (LTC) quality measures.

Washington State scores declined in two areas: breast cancer deaths for females and risk-adjusted 30-day mortality among Medicare beneficiaries hospitalized for heart attack, stroke, COPD, heart failure, or pneumonia both increased.

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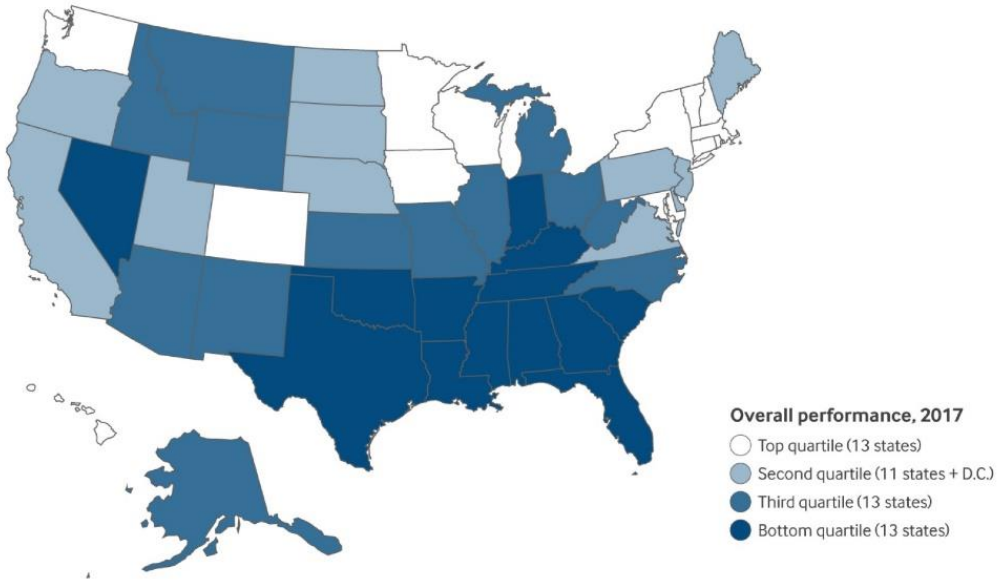
[62] Heflin, Katherine. (2016, October 20). Driving Health Care Innovation through DSRIP: State of the States. Center for Health Care Strategies, Inc. Retrieved on June 26, 2017 from: http://www.chcs.org/driving-health-care-innovation-through-dsrip/.

[63] Radley, D.C., McCarthy, D., and Hayes, S.L. (2017 March). Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance 2017 Edition. Retrieved on March 16, 2017 from: http://www.commonwealthfund.org/interactives/2017/mar/state-scorecard/#chapter6.

Overall, the 2017 Scorecard finds that nearly all state health systems improved on a broad range of health indicators between 2013 and 2015. The scorecard found that Washington and other states that expanded Medicaid under the ACA saw greater gains in access to care.

Washington State has made significant strides in improving health system performance, but there is still room for improvement.

## Overall State Health System Performance: Scorecard Ranking, 2017




Source: D. C. Radley, D. McCarthy, and S. L. Hayes, *Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance 2017 Edition*, The Commonwealth Fund, March 2017.

# Appendix A

## Monthly Silver Premiums and Financial Assistance for a 40-Year-Old Non-Smoker Making $30,000/Year

| State | Major City | 2nd Lowest Cost Silver Before Tax Credit | | | 2nd Lowest Cost Silver After Tax Credit | | | Amount of Premium Tax Credit | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2016 | 2017 | % Change | 2016 | 2017 | % Change | 2016 | 2017 | % Change |
| *Alabama* | Birmingham | $288 | $492 | 71% | $208 | $207 | 0% | $80 | $285 | 256% |
| *Alaska* | Anchorage | $719 | $904 | 26% | $164 | $163 | -1% | $555 | $741 | 33% |
| *Arizona* | Phoenix | $207 | $507 | 145% | $207 | $207 | 0% | $0 | $300 | N/A |
| *Arkansas* | Little Rock | $310 | $314 | 1% | $208 | $207 | 0% | $102 | $107 | 4% |
| *California* | Los Angeles | $245 | $258 | 5% | $208 | $207 | 0% | $37 | $51 | 38% |
| *Colorado* | Denver | $278 | $313 | 12% | $208 | $207 | 0% | $70 | $106 | 51% |
| *Connecticut`* | Hartford | $318 | $404 | 27% | $208 | $207 | 0% | $110 | $196 | 79% |
| *Delaware* | Wilmington | $356 | $423 | 19% | $208 | $207 | 0% | $148 | $216 | 46% |
| *District of Columbia* | Washington | $244 | $298 | 22% | $208 | $207 | 0% | $36 | $91 | 153% |
| *Florida* | Miami | $262 | $306 | 17% | $208 | $207 | 0% | $54 | $99 | 84% |
| *Georgia* | Atlanta | $254 | $286 | 13% | $208 | $207 | 0% | $46 | $79 | 72% |
| *Hawaii* | Honolulu | $262 | $347 | 32% | $179 | $178 | -1% | $83 | $169 | 104% |
| *Idaho* | Boise | $273 | $348 | 27% | $208 | $207 | 0% | $65 | $141 | 117% |
| *Illinois* | Chicago | $198 | $291 | 48% | $198 | $207 | 5% | $0 | $84 | N/A |
| *Indiana* | Indianapolis | $298 | $286 | -4% | $208 | $207 | 0% | $90 | $79 | -12% |
| *Iowa* | Cedar Rapids | $284 | $301 | 6% | $208 | $207 | 0% | $76 | $94 | 25% |
| *Kansas* | Wichita | $248 | $361 | 46% | $208 | $207 | 0% | $40 | $154 | 287% |
| *Kentucky* | Louisville | $223 | $229 | 3% | $208 | $207 | 0% | $15 | $22 | 47% |
| *Louisiana* | New Orleans | $332 | $373 | 13% | $208 | $207 | 0% | $124 | $166 | 34% |
| *Maine* | Portland | $288 | $341 | 19% | $208 | $207 | 0% | $80 | $134 | 68% |
| *Maryland* | Baltimore | $249 | $309 | 24% | $208 | $207 | 0% | $41 | $102 | 152% |
| *Massachusetts* | Boston | $250 | $247 | -1% | $208 | $207 | 0% | $42 | $40 | -5% |
| *Michigan* | Detroit | $226 | $237 | 5% | $208 | $207 | 0% | $18 | $29 | 65% |
| *Minnesota* | Minneapolis | $235 | $366 | 55% | $208 | $207 | 0% | $27 | $159 | 481% |
| *Mississippi* | Jackson | $283 | $352 | 25% | $208 | $207 | 0% | $75 | $145 | 95% |
| *Missouri* | St Louis | $287 | $310 | 8% | $208 | $207 | 0% | $79 | $103 | 31% |

| State | Major City | 2nd Lowest Cost Silver Before Tax Credit | | | 2nd Lowest Cost Silver After Tax Credit | | | Amount of Premium Tax Credit | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2016 | 2017 | % Change | 2016 | 2017 | % Change | 2016 | 2017 | % Change |
| *Montana* | Billings | $322 | $425 | 32% | $208 | $207 | 0% | $114 | $218 | 92% |
| *Nebraska* | Omaha | $313 | $368 | 18% | $208 | $207 | 0% | $105 | $161 | 54% |
| *Nevada* | Las Vegas | $261 | $282 | 8% | $208 | $207 | 0% | $53 | $75 | 41% |
| *New Hampshire* | Manchester | $261 | $267 | 2% | $208 | $207 | 0% | $53 | $60 | 14% |
| *New Jersey* | Newark | $330 | $353 | 7% | $208 | $207 | 0% | $122 | $146 | 19% |
| *New Mexico* | Albuquerque | $186 | $258 | 39% | $186 | $207 | 11% | $0 | $51 | N/A |
| *New York* | New York City | $369 | $456 | 24% | $208 | $207 | 0% | $161 | $249 | 55% |
| *North Carolina* | Charlotte | $409 | $572 | 40% | $208 | $207 | 0% | $201 | $364 | 82% |
| *North Dakota* | Fargo | $304 | $331 | 9% | $208 | $207 | 0% | $96 | $124 | 29% |
| *Ohio* | Cleveland | $234 | $229 | -2% | $208 | $207 | 0% | $26 | $22 | -17% |
| *Oklahoma* | Okla. City | $295 | $493 | 67% | $208 | $207 | 0% | $87 | $286 | 230% |
| *Oregon* | Portland | $261 | $312 | 20% | $208 | $207 | 0% | $53 | $105 | 98% |
| *Pennsylvania* | Philadelphia | $276 | $418 | 51% | $208 | $207 | 0% | $68 | $211 | 209% |
| *Rhode Island* | Providence | $263 | $261 | -1% | $208 | $207 | 0% | $55 | $54 | -2% |
| *South Carolina* | Columbia | $314 | $404 | 29% | $208 | $207 | 0% | $106 | $197 | 85% |
| *South Dakota* | Sioux Falls | $309 | $448 | 45% | $208 | $207 | 0% | $101 | $241 | 138% |
| *Tennessee* | Nashville | $281 | $419 | 49% | $208 | $207 | 0% | $73 | $212 | 192% |
| *Texas* | Houston | $256 | $288 | 13% | $208 | $207 | 0% | $48 | $81 | 69% |
| *Utah* | Salt Lake City | $244 | $292 | 20% | $208 | $207 | 0% | $36 | $85 | 139% |
| *Vermont* | Burlington | $468 | $492 | 5% | $208 | $207 | 0% | $260 | $285 | 9% |
| *Virginia* | Richmond | $276 | $296 | 7% | $208 | $207 | 0% | $68 | $89 | 31% |
| *Washington* | Seattle | $227 | $238 | 5% | $208 | $207 | 0% | $19 | $31 | 62% |
| *West Virginia* | Huntington | $341 | $419 | 23% | $208 | $207 | 0% | $132 | $212 | 60% |
| *Wisconsin* | Milwaukee | $326 | $379 | 16% | $208 | $207 | 0% | $117 | $172 | 46% |
| *Wyoming* | Cheyenne | $426 | $464 | 9% | $208 | $207 | 0% | $218 | $257 | 18% |