

WA OIC Preliminary Report on Health Care Affordability

November 29, 2023

Prepared By
Health Management Associates

With an Introduction From
The Office of the Insurance Commissioner

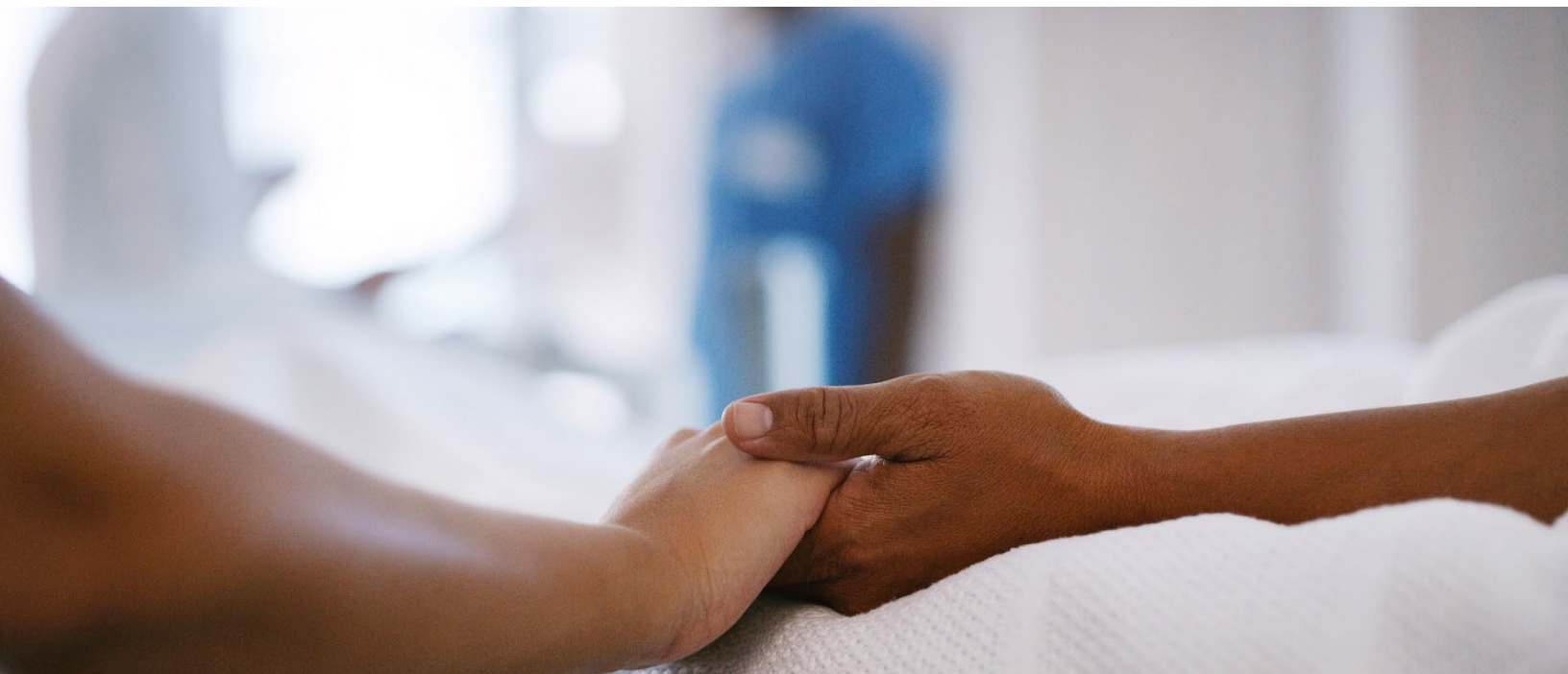


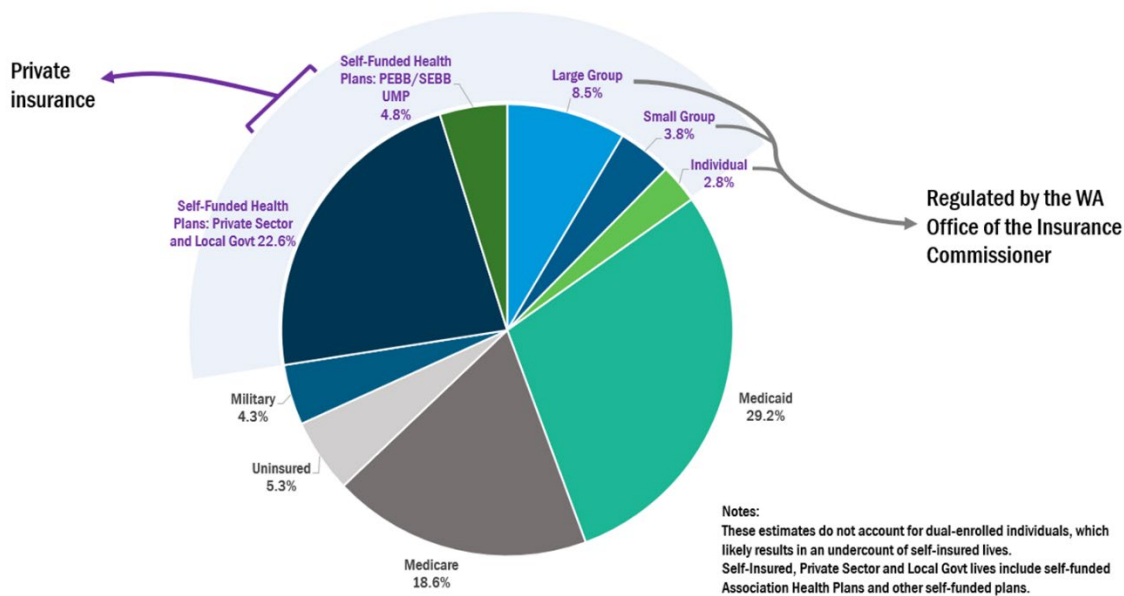
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INTRODUCTION FROM THE OFFICE OF THE INSURANCE COMMISSIONER

Despite having one of the lowest uninsured rates in the country and seeing Washington state’s uninsured rate stay under 6%, rising health care costs have created a growing and persistent health care affordability challenge for individuals, families, employers, and taxpayers in Washington state.¹ Health care expenditures now account for over 20% of Washington’s general fund budget.²

Source of Health Coverage for Washington Residents 2022



Challenges with health care affordability are not limited to individuals with lower incomes or those without health insurance. A survey of 1,300 Washingtonians in November 2022 found that 62% of respondents had experienced at least one health care affordability burden in the past year – including rationing medication, delaying or going without care, and depleting savings – and that 81% worried about affording health care in the future.³

¹ Washington State Office of Financial Management. <https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief108.pdf>

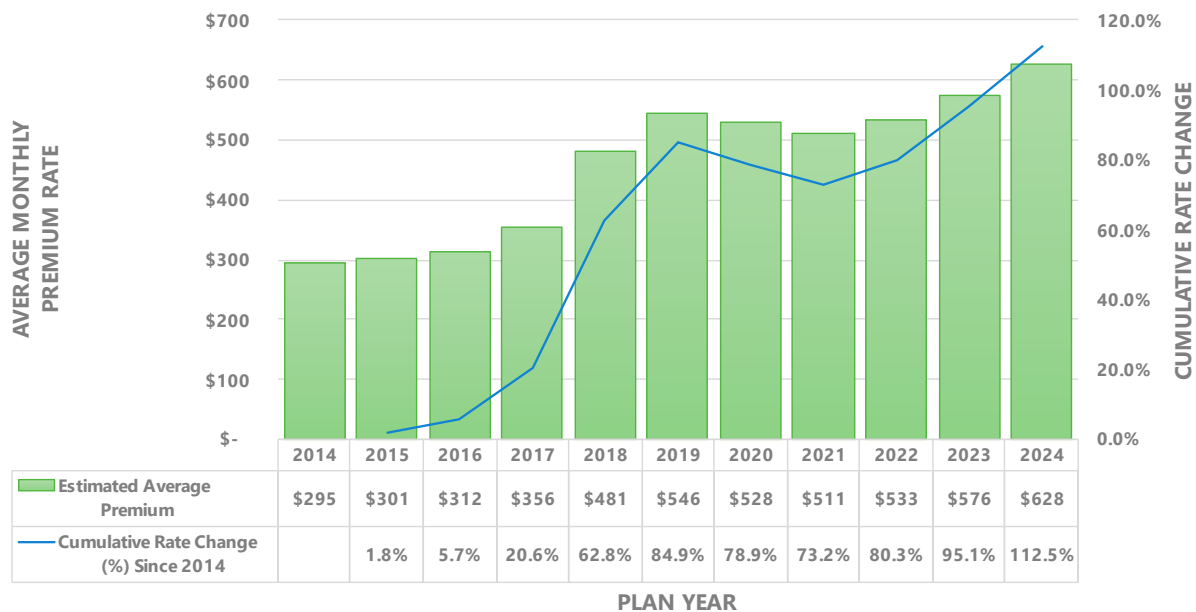
² Retrieved from <https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/budget-drivers/change-medical-costs>

³ Retrieved from <https://www.healthcarevaluehub.org/advocate-resources/consumer-healthcare-experience-state-survey>.

This year, the Commonwealth Fund surveyed individuals with all types of health coverage about their ability to afford health care. Across all of the groups surveyed, insured working-age adults said it was “very” or “somewhat difficult” to afford their health care including 43% of those with employer coverage, 57% with individual health plans, 45% with Medicaid, and 51% with Medicare.⁴

In Washington state specifically, workers and businesses have experienced double-digit increases over the last decade, with the total average premium for a single worker rising by 49% and the deductible rising by 78.5% from 2010 through 2020.⁵ From 2014 to 2024, premiums for health plans purchased on the Washington state Health Benefits Exchange more than doubled – from \$295 per month to \$628 per month.

Individual Healthplan Cumulative Rate Change Impact on Premium



⁴ “Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer.” Retrieved from <https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey>. November 7, 2023.

⁵ “State Trends in Employer Premiums and Deductibles, 2010 - 2020”. Retrieved from <https://www.commonwealthfund.org/publications/fund-reports/2022/jan/state-trends-employer-premiums-deductibles-2010-2020> November 7, 2023.

An analysis of the commercial health insurance market commissioned by the Office of the Insurance Commissioner (OIC) in 2022 found health care costs for the commercial health insurance market in Washington increased by 13%, nearly double the rate of inflation of 7%, between 2016 and 2019.⁶

Health care costs are driven by two factors – the type and number of health services people use and the price paid for those services. Employers and Washington state have tried to address health care costs through changes in health plan design, such as encouraging use of generic drugs, offering high deductible health plans and encouraging use of higher quality, lower cost health care providers and facilities. Yet, due to changes in the structure of Washington’s health care system, moderating the price of health care services has been a substantial challenge. Consolidation in the healthcare industry is a key factor driving up prices.⁷ Generally, consolidations do not improve quality of care, but rather, drive up prices and impact access to care for patients and working conditions for providers.⁸

Given the affordability challenges for Washington consumers, employers, and taxpayers, policymakers in Washington state have made several efforts to increase health care cost transparency and oversight, which are described further in this preliminary report. At the same time, it has become clear that this problem is one that pervades all types of health insurance coverage and likely will require an overlapping set of policies to address underlying health care costs while maintaining access to quality care for Washingtonians.

This year, the Legislature recognized the need to better understand policy options designed to improve affordability for consumers, their employers and taxpayers. Sec. 144(13)(a) of the 2023 biennial operating budget⁹ directed the OIC and the Attorney General’s Office (AGO) to conduct an analysis of a range of policy approaches to improve health care affordability, focusing on other states that have adopted the affordability policy, any impacts of the policy and whether any components of the option have been adopted in Washington state. A final report on affordability policy options will be delivered in August 2024 and will include in-depth actuarial and economic analysis of a subset of the policy options presented in this report and the companion report issued by the AGO. The subset of options to be analyzed will be determined after consultation with interested organizations and legislators.

⁶ Retrieved from <https://public.tableau.com/app/profile/onpointhealthdata/viz/WashingtonStateCommercialTrendsInCost2016-2019/TotalTrends?publish=yes>

⁷ See e.g., Karyn Schwartz et al., *What We Know About Provider Consolidation*, Kaiser Fam. Found. (Sept. 2, 2020) (citing to other relevant articles).

⁸ Samuel M. Chang et al., *Examining the Authority of California’s Attorney General in Health Care Merger*, California Healthcare Found., (Apr. 2020). Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals* (Washington Cntr. for Equitable Growth, Working Paper, 2018) (finding evidence of negative wage growth among skilled workers following recent hospital mergers). Carley Thornell, *Physicians report that organizational and technology changes are among the biggest burnout factors*, athenahealth, (July 2, 2021) (reporting on findings from 799 physician respondents between October and December 2020).

⁹ State of Washington. Sec. 144(13)(a) of Engrossed Substitute Senate Bill 5187: Washington State 2023–2025 Biennial Operating Budget. Effective May 16, 2023. Available at: <https://lawfilesexxt.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20231117085318>. Accessed November 25, 2023.)

This preliminary report includes:

- A detailed description of Washington’s existing health care insurance and care delivery structure, with a focus on available information regarding vertical and horizontal consolidation among health insurers, hospitals, and providers and an overview of private equity health care investment trends in the state. This information is included to provide a shared baseline understanding of the health care system in Washington state as the legislature considers cost and affordability challenges and the potential impact of health policy interventions designed to address affordability.
- An overview of potential policy options to address underlying health care costs, some of which have already been adopted in Washington.
- A description of the proposed economic model that will be used during the final report—along with actuarial analysis—to evaluate the impacts of a selected set of policy options.

An accompanying report from the AGO provides a detailed analysis of antitrust law and policy options related to health care merger and acquisition oversight and provisions of health insurer/health care provider contracts that impair market competition.

EXECUTIVE SUMMARY

Horizontal Consolidation and Vertical Integration in the Washington Health Care System

Washington State's health care system has changed significantly because of horizontal consolidation and vertical integration across health care providers, facilities, and insurers. For example, in the last three decades, hospital resources and care in Washington have become more concentrated as hospitals have closed or become part of multi-hospital systems. The percentage of hospitals in systems grew to nearly 50% in 2017 from 10% in 1986, according to a study from Washington's Office of Financial Management.¹⁰ The number and percentage have increased since. According to a July 20, 2022, Washington State Health Authority presentation to the Health Care Transparency Board, 40 of the 101 hospitals in Washington are affiliated with the five largest hospital systems: Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth. Another 15 belong to smaller multi-hospital systems.¹¹ These systems control a substantial portion of available beds and hospital-employed physicians in the state.

- Eight multi-hospital systems¹² have more than 90% of the licensed and more than 65% of the staffed beds at hospitals in the state.
- Eight multi-hospital systems employ more than 65% of the physicians and physician assistants that hospitals employ in the state.
- Most multi-hospital systems own and operate hospital-affiliated clinics, and many own freestanding clinics and other health care facilities.¹³

Similar to the consolidation of hospital systems and their operation of clinical services outside of the hospital, health insurers have purchased, either directly or through their holding companies, physician practices and other parts of the health care delivery system. For example, United HealthGroup, through its Optum subsidiary, is reportedly the largest employer of physicians in the country, with more than 70,000 employed or aligned physicians across more than 2,200 locations in 2023.¹⁴

¹⁰ Bolton D. Hospital Mergers in Washington 1986-2017. Washington State Health Services Research Project Research Brief No. 105. Office of Financial Management. March 2022. Available at: <https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief105.pdf>. Accessed November 25, 2023.

¹¹ Washington State Health Authority to Report to Health Care Cost Transparency Board. Washington State Hospitals: A Primer on Washington Hospital Costs, Tab 5. July 20, 2022. Available at: <https://www.hca.wa.gov/assets/program/hcctb-board-book-20220720.pdf>. Accessed November 25, 2023.

¹² A multi-hospital system has more than one hospital. In Washington, these include: Astria, Evergreen, LifePoint, MultiCare, PeaceHealth, Providence, Skagit, University of Washington, Virginia Mason Franciscan, and Confluence. Kaiser Permanente, which is a fully-integrated health care system consisting of a health plan, one hospital, medical clinics, physicians and other health care providers, with facilities throughout the state, is considered a health insurer for purposes of this report.

¹³ Washington State Health Authority to Report to Health Care Cost Transparency Board. Tab 5. Washington State Hospitals: A Primer on Washington Hospital Costs. July 20, 2022. Available at: <https://www.hca.wa.gov/assets/program/hcctb-board-book-20220720.pdf>. Accessed November 25, 2023.

¹⁴ Emerson J. Meet America's Largest Employer of Physicians: UnitedHealth Group. Becker's Payer Issues. Updated February 16, 2023. Available at: <https://www.beckerspayers.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html#:~:text=Meet%20America's%20largest%20employer%20of%20physicians%20UnitedHealth%20Group>. Accessed November 25, 2023.

With its acquisition of home health provider Signify Health in 2023, CVS Health added 10,000 physicians and other clinicians to the estimated 40,000 physicians and nurses it employs in its MinuteClinics and HealthHUBs.¹⁵

Health insurers have also integrated with a number of other sectors of the health care industry. The three largest pharmacy benefit managers (PBMs), which collectively account for 89% of the market, are Express Scripts (Cigna), CVS Caremark (Aetna), and Optum Rx (United Health Group).¹⁶

Washington's experience is consistent with national trends. Through their holding companies and subsidiaries, among the five insurers with the largest market share in Washington:¹⁷

- Four own companies that provide pharmacy services (retail, specialty and/or pharmacy benefit managers).
- Four own and operate clinical facilities, including medical clinics, home health agencies, lab services, and so on.
- All function as third-party administrators (TPAs) for self-funded employer plans under administrative services only (ASO) contracts.¹⁸

Table 6, page 27 lists ownership by the five largest health insurers in the state of pharmacy services, health care benefit managers, clinical services, and other health care sectors. This table illustrates the extent to which each of these companies provides health care services to Washingtonians, in addition to their role as health insurers.¹⁹

An additional recent trend is the investment in health care facilities and services by private equity firms. Private equity firms pool funds from investors to invest in a variety of industries. Private equity investment in various sectors of the health care economy has been growing nationwide over the past two decades. For example, one national study found that private equity purchases of physician practices across a number of specialties grew from 75 deals in 2012 to 484 deals in 2021.²⁰

¹⁵ American Hospital Association. CVS Health Adds Home Health Services. What's Next? Available at:

[https://www.aha.org/aha-center-health-innovation-market-scan/2022-09-13-cvs-health-adds-home-health-services-whats-next#:~:text=With percent20the percent20Signify percent20purchase percent2C percent20CVS,soon percent20to percent20be percent201 percent2C500 percent20HealthHUBs](https://www.aha.org/aha-center-health-innovation-market-scan/2022-09-13-cvs-health-adds-home-health-services-whats-next#:~:text=With%20the%20Signify%20purchase%2C%20CVS,soon%20to%20be%201%20percent2C500%20HealthHUBs). Accessed November 25, 2023.

¹⁶ National Association of Insurance Commissioners. Pharmacy Benefit Managers. Updated June 1, 2023. Available at: <https://content.naic.org/cipr-topics/pharmacy-benefit-managers>. Accessed November 25, 2023.

¹⁷ Premera Blue Cross, Cambia, Kaiser, CVS/Aetna and United HealthCare.

¹⁸ See Table 6, p. 27

¹⁹ These data are based on information found on insurer websites and financial reports filed by the insurers with the Office of the Insurance Commissioner pursuant to the Insurer Holding Company Act, 48.31B RCW. For details, go to: <https://app.leg.wa.gov/rcw/default.aspx?cite=48.31B>.

²⁰ Scheffler R, Alexander L, Fulton B, Arnold D, Abdelhadi O. Monetizing Medicine: Private Equity and Competition in Physician Practice Markets. American Antitrust Institute. July 10, 2023. Available at: https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG-Private-Equity-I-Physician-Practice-Report_FINAL.pdf. Accessed November 25, 2023.

This report includes data showing that four acquisitions occurred in 2014. By 2023, the total number of acquisitions has grown to 97. Since 2014, private equity firms have made acquisitions in the following categories of clinical services, among others in Washington:

- Physical therapy (12)
- Home care/hospice (10)
- Behavioral health/substance use disorder (SUD)—8
- Ophthalmic/optometric (7)
- Non-specialty medical (4)
- Gastroenterology (3)
- Other (9)²¹

Private equity firms also own physician staffing companies. TeamHealth, one of the six largest emergency medicine staffing companies in the country,²² employs physicians and other providers of emergency medicine and post-acute care services at hospitals and clinics throughout the state.²³ US Anesthesia Partners, a single-specialty anesthesia practice, provides services at Swedish medical centers and other ambulatory surgery centers (ASCs) in the Seattle area.²⁴

Policy Options to Address Health Care Affordability

This report describes policy options that other states have pursued to address health care affordability and, where applicable, compares the Washington experience with that of other states. These policies include:

- Set Health care cost growth benchmarks
- Establish prescription drug pricing regulation
- Enhance health insurance rate review
- Increase health insurer medical loss ratio requirements
- Implement a reinsurance program
- Use reference-based pricing
- Implement facility fee reform (e.g., site-neutral payment requirements)
- Offer public option health plans
- Implement exchange subsidies
- Enact a state individual mandate
- Create an all-payer model, as in Maryland

²¹ Data obtained from PitchBook, October 2023.

²² [Monetizing Medicine: Private Equity and Competition in Physician Practice Markets.](#)

²³ TEAMHealth. Locations. Available at: <https://www.teamhealth.com/locations/?r=1>. Accessed November 25, 2023.

²⁴ US Anesthesia Partners. USAP--Washington. Available at: <https://www.usap.com/locations/usap-washington>. Accessed November 25, 2023.

Economic Model

The final report will include actuarial analysis and economic modeling to project the likely impact of adopting policies to address health care affordability. This preliminary report describes the analytic framework of the economic model, which will be used to estimate the impact of the policy options selected for further analysis. The model will examine both direct benefits, such as the effect on health care spending by major purchasers of health insurance and indirect benefits, including increases in wages and reduced spending on means-tested programs. The model also will estimate the multiplier effect, which will reflect the positive ripple effect on Washington's economy as various parties experience savings from lower health care costs, which can be spent on wages, new business investments, etc. The model also will examine the costs that probably would be incurred to develop, implement, and manage the new policies.

The final outputs of the model will be a calculation of the ratio of total benefits to total costs, and the ROI from adopting the policies examined.

PART I: HORIZONTAL CONSOLIDATION AND VERTICAL INTEGRATION IN THE WASHINGTON STATE HEALTH CARE SYSTEM

This part describes the structure of the health care insurance and delivery system in Washington. It first looks at the various settings where physicians are employed in the state, providing data on the percentage of physicians working in hospitals or clinics, single or multi-specialty practice groups, state or federal government, or solo practice.

It then provides data on the percentage of physicians and physician assistants employed by hospitals who work in multi-hospital systems, as well as the percentage of hospital beds in the state that are available within those systems.

Next, it provides data on the extent to which hospitals or health systems own or control other hospitals, clinics and other types of providers.

It then examines the extent to which health insurers in the state, either directly or through their holding companies, own or control entities that provide a variety of health care services in addition to insurance coverage.

Finally, it describes private equity investment in health care companies in the state.

Caveat Related to Data Limitations

The data below were obtained from publicly available sources. Health Management Associates (HMA) is grateful for invaluable assistance from: the Washington State Hospital Association, the Washington State Medical Association, and the staff and subject matter experts at the Health Care Authority, the Department of Health, and the Health Benefit Exchange.

No public, single source was found for several categories of data that the legislature requested in the budget proviso. For example, to determine the medical facilities that hospitals own and operate, HMA had to consult their websites, which contained helpful but incomplete information. In addition, HMA was unable to find public sources to determine the number of providers, other than physicians and physician assistants, employed in each sector of the system.

Under the Insurer Holding Company Act, 48.31B RCW, insurance companies must file financial reports that include Schedule Y, which describes the holding company structure and lists all entities in which the holding company or its subsidiaries have an ownership interest. To the extent that lawmakers are interested in fully understanding the structure of the health care system in Washington and, in particular, the impacts of horizontal consolidation and vertical integration, HMA recommends that the legislature grant additional authority to the appropriate state agencies to collect data on the ownership of health care facilities in the state and the number and types of providers they employ.

For example, the 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.²⁵

Physician Employment in Washington State

It has been widely reported that the number of physicians working in independent practices has been declining. A report by Avalere Health for the Physician's Advocacy Institute found that as of January 1, 2022, almost 50% of physicians nationwide were employed by hospitals or health systems, and 20% were employed by other corporate entities.²⁶ This trend accelerated during the COVID-19 pandemic.

HMA has not found any single source for current, accurate data on the settings where physicians in Washington work. The Washington Medical Commission surveyed physicians and physician assistants in the state from October 2021–September 2023; 40% of practicing physicians reported being employed by a hospital or clinic.^{27, 28}

Tables 1 and 2 (on the following page) show the responses from physicians to the Medical Commission's survey question about their employment settings:²⁹

²⁵ States have required disclosure of ownership of health care entities in connection with review of proposed acquisitions or change of control. These policies are discussed in the companion report that the Office of the Attorney General is submitting. HMA has not found any state law that broadly requires disclosure of ownership outside of this context.

²⁶ Physician's Advocacy Institute. COVID-19's Impact on Acquisition of Physician Practices and Physician Employment 2019–2022. June 2022. Available at: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkqjKXB_vZflmFdXlvGg%3d%3d. Accessed November 25, 2023.

²⁷ Washington Medical Commission. Physician Demographic Census Aggregate Report. October 2023. Available at: <https://wmc.wa.gov/sites/default/files/public/MD%20Report%20Oct%202023.pdf>.

October 2023. Physicians in Washington must submit the data in this report to attain license renewal. <https://wmc.wa.gov/licensing/renewals/demographic-census>. Ten percent of the respondents stated that they were retired from clinical practice.

Washington Medical Commission. Physician Assistant Demographic Census Aggregate Report. October 2023. Available at: <https://wmc.wa.gov/sites/default/files/public/PA%20Report%20Apr%202022.pdf>. Only 2% of physician assistant reported that they have retired from clinical practice.

²⁹ Respondents were asked: "For patient related activities, indicate your practice arrangement and size of group." T²⁹ his response includes only physicians who were active; 75% of active physicians responding stated that they were practicing in Washington state. A "single specialty group" is a group of two or more physicians, providing patients with one specific type of care, such as primary care or a specific subspecialty like anesthesiology. A "multi-specialty group" practice is defined as offering various types of medical specialty care within one organization. American College of Physicians, Medical Practice Types, <https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/medical-practice-types>. Accessed November 25, 2023.

Table 1. Employment Setting Reported by Physicians

Single Specialty Group	5,259	24%
Multi-Specialty Group	4,745	21%
Solo Practitioner	1,622	7%
Employee of a Hospital or Clinic	8,883	40%
State or Federal Employer	2,399	11%
Other	1,827	8%

Table 2. Group Practice Size reported by Physicians

Group size	Single	Single %	Multi	Multi %
501 +	39	1%	1,067	22%
101 - 500	544	10%	1,273	27%
51 - 100	614	12%	486	10%
21 - 50	1,103	21%	505	11%
1 - 20	2,770	53%	830	17%
Unknown	189	4%	584	12%
Total	5,259	100%	4,745	100%

Data from the Washington State Hospital Association and the Washington State Medical Association reflect a higher percentage of physicians working for hospitals in the state—figures that are closer to the national trend. The Office of Financial Management reported that in 2021, a total of 21,332 physicians provided direct patient care in Washington state.³⁰ HMA estimates that 10,636, approximately 50%, are employed by hospitals. Of these, 65.6% are employed by multi-hospital systems. (See Table 5 on page 25).³¹

³⁰ Yen W. 2020-21 Physician Supply: Estimates for Washington. Health Care Research Center, Office of Financial Management. October 2021. Available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2020-21_washington.pdf. Accessed November 25, 2023.

³¹ These figures are estimates and are based on data from different sources reporting on different time periods.

Multi-Hospital Health System

In the past three decades, hospital resources and care in Washington have become more concentrated as hospitals have closed or become part of multi-hospital systems. The percentage of hospitals in systems grew to nearly 50% in 2017 from 10% in 1986, according to a study that the state Office of Financial Management (OFM) conducted.³² The number and percentage has increased since then. According to a July 2022 presentation to the Health Care Transparency Board, of 101 hospitals in Washington state, 40 are part of the five largest hospital systems: Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth. Another 15 are part of smaller multi-hospital systems.³³

These changes had a significant impact on the settings in which Washingtonians receive care. In 1986, three multi-hospital systems accounted for 20% of admissions; by 2017, that figure had nearly quadrupled, to 79%. From 1986 to 2017, the number of available hospital beds decreased from 298 per 100,000 population to 170, while the percentage of beds in hospital systems increased to 73% from 19%. As the OFM reported, “a decreasing resource became increasingly concentrated in systems.”³⁴

Table 3 (page 15) includes data that the Washington State Hospital Association (WSHA) reported to the Washington Department of Health. It lists the number of staff and licensed beds for all hospitals statewide and all multisystem hospitals.

Table 4 (page 17) provides data for each hospital in 10 multi-hospital systems: Astria Health, Confluence, EvergreenHealth, LIfePoint MultiCare, PeaceHealth, Providence, Skagit, University of Washington Medicine, and Virginia Mason Franciscan. The data include:

- Number and list of hospitals in the system
- Number and category of beds in the system
- Percent of all beds in the state, and
- Number of physicians and physician assistants employed by the system.

As noted above, 40%–50% of active physicians in Washington work at hospitals or clinics. Based on data from the Washington State Medical Association (WSMA), HMA estimates that 65.6% of physicians who work at hospitals in the state are employed by multi-hospital systems. With respect to physician assistants who work at hospitals, 68.8% are at multi-hospital systems.³⁵ (See Table 5, page 25.)

³² [Hospital Mergers in Washington 1986-2017](#).

³³ [Health Care Cost Transparency Board Report](#), p. 15.

³⁴ [Hospital Mergers in Washington, 1986-2017](#). The report notes, “some of the change is attributable to the growing number of procedures performed in ambulatory surgical centers. The decrease in numbers, however, raises questions about hospitals’ ability to provide effective care when high demands are placed on resources.”

³⁵ Data obtained from Washington State Medical Association, October 20, 2023.

In addition to employing a significant percentage of physicians, hospital systems in Washington typically own and operate other types of health care facilities. As WSHA reported in 2022, 9% of hospital systems owned skilled nursing facilities (SNFs), 82% owned hospital-affiliated clinics, 28% owned freestanding clinics, and 13% own a home health agency.³⁶ Table 4 (page 17) lists non-hospital services owned by or affiliated with multi-hospital systems in the state.

Table 3: Washington State Hospital Beds Landscape^{37,38}

Bed Type	ICU	Acute Care	Psychiatric	Skilled Nursing Facilities (SNF)	Alcohol Treatment (AT)	Other	Staffed Beds	Licensed Beds
All Washington Hospitals	1,734	9,164	1,257	218	94	291	12,758	15,427
Multi-Hospital Systems	1,418 (81.78% of all ICU beds)	7,703 (84.06% of all acute care beds)	607 (48.3% of all psychiatric beds)	75 (34.4% of all SNF beds)	78 (83.0% of all AT beds)	276 (94.8% of all other beds)	10,157 (79.61% of all staffed beds)	12,028 (79.51% of all un)

³⁶Health Care Cost Transparency Board Meeting, July 20, 2022, p. 11.

³⁷ Based on data from the Department of Health Hospital Reporting, October 11, 2023. HMA also reviewed this information against data from the Washington Hospital Association received October 27, 2023. When data were unaligned, HMA defaulted to Department of Health information. The data by bed type are from the Washington Department of Health Hospital. They may not yield total beds in system because of classification of swing beds, etc.

³⁸ Excludes data from Kaiser, a fully-integrated health care system.

Table 4: Multi-Hospital Systems Bed Detail³⁹

Based on all WA State hospitals (not solely multi-hospital data), hospitals associated with health systems include acute care, psychiatric, and critical access hospitals. Unless otherwise indicated, the hospital is an acute care facility. Of the state's total hospitals, the Department of Health identifies 39 as critical access hospitals (CAHs), which are small facilities with less than 25 beds in rural areas.⁴⁰

Details about each of the multi-hospital systems is available in Appendix A.

ACRONYMS

AUD: Alcohol Use Disorder
ALF: Assisted living facility
ASC: Ambulatory surgical center
BH: Behavioral health
CAH: Critical access hospital⁴¹
CH: Community hospital⁴²
ICU: Intensive care unit
SNF: Skilled nursing facility
Psych: Psychiatric

³⁹ The American Hospital Association (AHA) defines a multi-hospital system as two or more hospitals owned, leased, sponsored, or contract managed by a central organization. See Fast Facts on U.S. Hospitals, 2023, at <https://www.aha.org/statistics/fast-facts-us-hospitals>.

⁴⁰ Washington State Department of Health. Critical Access Hospital (CAH) Program Washington State Rural Health Plan. June 2020. Available at: <https://doh.wa.gov/sites/default/files/legacy/Documents/2900/609012-CAHlist-RuralHealth.pdf>. Accessed November 26, 2023.

⁴¹ Critical Access Hospital is a federal designation under the Rural Hospital Flexibility Program (Flex Program), administered by the federal Office of Rural Health Policy. The purpose of the program is to ensure people enrolled in Medicare have access to healthcare services in rural areas, particularly hospital care. Critical Access Hospitals (CAHs) are small hospitals with fewer than 25 beds in rural areas. There are 39 CAHs in Washington. Most CAHs are operated by public hospital districts. Available at [https://doh.wa.gov/public-health-healthcare-providers/rural-health/rural-healthsystems#:~:text=Critical%20Access%20Hospitals%20\(CAHs\)%20are,operated%20by%20public%20hospital%20districts](https://doh.wa.gov/public-health-healthcare-providers/rural-health/rural-healthsystems#:~:text=Critical%20Access%20Hospitals%20(CAHs)%20are,operated%20by%20public%20hospital%20districts).

⁴² AHA defines a community hospitals as all nonfederal, short-term general, and other special hospitals. These facilities include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals that are inaccessible to the general public, such as prison hospitals or college infirmaries. AHA *Fast Facts*, *Op. cit.*

Table 4: Multi-Hospital Systems Bed Detail

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System ⁴³	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System ⁴⁴	Number of Physicians and Physician Assistants Employed/ Affiliated with System ⁴⁵
Astria Health System (not-for-profit)	<p>Astria Sunnyside Hospital, Sunnyside (CAH) (78 licensed, 47 staffed beds) Yakima County</p> <p>Astria Toppenish Hospital, Toppenish (community hospital) (38 licensed, 25 staffed beds) Yakima County</p>	<ul style="list-style-type: none"> • 14 ICU • 44 acute care • 72 staffed • 116 licensed 	<ul style="list-style-type: none"> • <i>ICU: 0.81%</i> • <i>Acute: 0.5%</i> • <i>Psych: 1.11%</i> • <i>SNF: 6.88%</i> • <i>AUD: N/A</i> • <i>Other: N/A</i> • Staffed: 0.6% • Licensed: 0.8% 	<ul style="list-style-type: none"> • Primary care/rural health clinics (9) • Astria Ambulatory Surgical Center • Astria Sunnyside Hosp. Specialty Surgical Group • Astria Hearing & Speech • Astria Plastic Surgery Ctr • Astria Home Health & Hospital • Astria Health Center Multispecialty & Diagnostics • Telehealth 	<ul style="list-style-type: none"> • Physicians: 58 • Physician assistants: 13

⁴³ As identified by the Washington Department of Health Hospital Reporting data October 11, 2023.

⁴⁴ If number of sites for each non-hospital service was available, it is given in ().

⁴⁵ Based on data received from the Washington State Medical Association on October 20, 2023.

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
Confluence (not-for-profit)	Confluence Health Hospital DBA Central Washington Hospital (176 staffed, 176 licensed Beds) Chelan County	<ul style="list-style-type: none"> • 26 ICU • 150 acute care • 176 staffed • 176 licensed 	<ul style="list-style-type: none"> • ICU: 1.50% • Acute: 1.64% • <i>Psych: N/A</i> • <i>SNF: N/A</i> • <i>Alcohol: N/A</i> • <i>Other: N/A</i> • Staffed: 1.16% • Licensed: 1.38% 		<ul style="list-style-type: none"> • Physicians: 277 • Physician assistants: 78
EvergreenHealth (community-owned/ independent)	<p>EvergreenHealth Kirkland, Kirkland (318 licensed, 317 staffed Beds) King County</p> <p>EvergreenHealth Monroe, Monroe (112 licensed, 66 staffed Beds) Snohomish</p>	<ul style="list-style-type: none"> • 24 ICU • 281 acute care • 36 AUD • 42 other • 383 staffed • 430 licensed 	<ul style="list-style-type: none"> • ICU: 1.38% • Acute: 3.1% • <i>Psych: N/A</i> • <i>SNF: N/A</i> • Alcohol: 38.30% • Other: 14% • Staffed: 3.00% • Licensed: 2.84% 	<ul style="list-style-type: none"> • Primary care (13) • Urgent care (8) <p>Emergency care (3)</p>	<ul style="list-style-type: none"> • Physicians: 265 • Physician assistants: 22

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
<p>LifePoint (National Presence) Private <i>*Acquired by private equity firm in 2018</i></p>	<p>LifePoint Lourdes Medical Center, Pasco (CAH) (95 licensed, 35 staffed beds) Franklin County</p> <p>LifePoint Trios Health, Kennewick (111 licensed, 111 staffed beds) Benton County</p> <p>LifePoint Lourdes Counseling Center (32 licensed, 20 staffed beds)</p>	<ul style="list-style-type: none"> • 20 ICU • 116 acute care • 20 psych • 10 other • 166 staffed • 238 licensed 	<ul style="list-style-type: none"> • ICU: 1.15% • Acute: 1.27% • Psych: 1.59% • SNF: N/A • Alcohol: N/A • Other: 3.44% • Staffed: 1.10% • Licensed: 1.57% 	<ul style="list-style-type: none"> • Primary care • Specialty care • Acute care rehab units • Outpatient centers (imaging, freestanding emergency departments, cancer centers, ASC, urgent care) • Post acute service providers (SNFs, assisted living facilities, swing bed programs) • Telehealth 	<ul style="list-style-type: none"> • Physicians: 109 • Physician assistants: 15

MultiCare (MC) (not-for-profit)	<p>MC Auburn MC, Auburn (195 licensed, 165 staffed Beds) Pierce County</p> <p>MC Capital MC Olympia (107 licensed, 88 staffed beds) Thurston County</p> <p>MC Covington MC (58 licensed/56 staffed beds) King County</p> <p>MC Deaconess Hospital, Spokane (388 licensed, 279 staffed beds) Spokane County</p> <p>MC Good Samaritan Hospital, Puyallup (425 licensed, 394 staffed beds) Pierce County</p> <p>MC Mary Bridge Children’s Hospital (Childrens), Tacoma (82 licensed, 82 staffed beds) Pierce County</p> <p>MC Tacoma General/Allenmore Hospital, Tacoma (581 licensed, 451 staffed beds) Pierce County</p> <p>MC Valley Hospital, Spokane Valley (123 licensed, 123 staffed beds) Spokane County</p> <p>MC Yakima Memorial, Spokane Valley (226 licensed, 226 staffed beds) Yakima County</p> <p>MC Navos BH Hospital (Navos West Seattle Campus), Seattle (psych) (70 licensed, 70 staffed beds) King County</p> <p>Wellfound BH Hospital,⁴⁶ Tacoma (psych)⁴⁷ (120 licensed, 120 staffed Beds) Pierce County</p>	<ul style="list-style-type: none"> • 341 ICU • 1,342 acute care • 293 psych • 109 other • 2,085 staffed • 2,344 licensed 	<ul style="list-style-type: none"> • ICU: 19.67% • Acute: 14.64% • Psych: 23.31% • <i>SNF: N/A</i> • <i>Alcohol: N/A</i> • Other: 37.46% • Staffed: 16.34% • Licensed: 15.50% 	<ul style="list-style-type: none"> • Primary care • Urgent care • Pediatric care • Specialty services including MC BH Network; MC Indigo, Mary Bridge Health Network, Pulse Heart Institute, MC Rockwood Clinic (multi-specialty) • Telehealth 	<ul style="list-style-type: none"> • Physicians: 1,072 • Physician assistants: 161
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⁴⁷ Navos Behavioral Health Hospital in West Seattle is an independently operated affiliate. Wellfound Behavioral Health Hospital is an independently operated joint venture of MultiCare and CHI Franciscan Health.

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
PeaceHealth (not-for-profit Catholic)	<p>PeaceHealth Peace Island Medical Center, Friday Harbor (CAH) (10 licensed, 10 staffed beds) San Juan, County</p> <p>PeaceHealth Southwest Medical Center, Vancouver (450 licensed, 429 staffed beds) Clark County</p> <p>PeaceHealth St John Medical Center, Longview (346 licensed, 172 staffed beds) Cowlitz County</p> <p>PeaceHealth St. Joseph Medical Center, Bellingham (265 licensed, 265 staffed beds) Whatcom County</p> <p>PeaceHealth United General Medical Center, Sedro-Woolley (CAH) (35 licensed, 35 staffed beds) Skagit County</p>	<ul style="list-style-type: none"> • 120 ICU • 757 acute care • 34 psych • 911 staffed • 1,106 licensed 	<ul style="list-style-type: none"> • ICU: 6.92% • Acute: 8.26% • Psych: 2.70% • SNF: N/A • Alcohol: N/A • Other: N/A • Staffed: 7.146% • Licensed: 7.31.% 	<ul style="list-style-type: none"> • Primary care • Cancer care • Heart and vascular • Ob/Gyn • Orthopedics • Pediatric primary and specialty care • Telehealth 	<ul style="list-style-type: none"> • Physicians: 455 • Physician assistants: 80 •

Providence (not-for-profit Catholic)	<p>Providence – Kadlec Regional Medical Center, Richland (337 Licensed, 254 Staffed Beds) Benton County</p> <p>Providence Centralia Hospital, Centralia (128 licensed, 101 staffed beds) Lewis County</p> <p>Providence Holy Family Hospital, Spokane, Spokane (197 licensed, 182 staffed beds) Spokane County</p> <p>Providence Mount Carmel Hospital, Colville (CAH) (55 licensed, 25 staffed beds) Stevens County</p> <p>Providence Regional Medical Center Everett, Everett (595 licensed, 530 staffed beds) Snohomish</p> <p>Providence Sacred Heart Medical Center & Children's Hospital, Spokane (691 licensed, 684 staffed beds) Spokane County</p> <p>Providence St. Joseph's Hospital, Chewelah (CAH) (55 licensed/25 staffed beds⁴⁸) Stevens County</p> <p>Providence St. Mary Medical Center, Walla Walla (142 licensed, 92 staffed beds)</p> <p>Providence St. Peter Hospital, Olympia (372 licensed, 330 staffed beds) Thurston County</p> <p>Providence St. Luke's Rehab Medical Center, Spokane (102 licensed, 72 staffed beds) Spokane County</p>	<ul style="list-style-type: none"> • 453 ICU • 2,802 Acute • 147 Psych • 40 SNF • 42 alcohol • 57 other • 3,541 staffed • 4,215 licensed 	<ul style="list-style-type: none"> • ICU: 26.12% • Acute: 30.58% • Psych: 11.69% • SNF: 18.35% • Alcohol: 44.68% • Other: 19.59% • Staffed: 23.41% • Licensed: 33.04% 	<ul style="list-style-type: none"> • Urgent and same day care • Primary care clinics (~15) • Senior care centers • Hospice (Providence Hospice of Seattle) • Home health services and home care, including SNFs • Providence Medical Group – WA offers primary and specialty care 	<ul style="list-style-type: none"> • Physicians: 1,684 • Physician assistants: 210
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⁴⁸ According to the Department of Health Data, St. Joseph has “25 Licensed and 55 Staffed Beds)

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/Affiliated with System
Providence (not-for-profit Catholic) Continued from previous page	Affiliates Providence Swedish Edmonds, Edmonds (217 licensed, 186 staffed beds) Snohomish County Providence Swedish Medical Center, Cherry Hill, Seattle (349 licensed, 227 staffed beds) Swedish First Hill/Ballard (830 licensed, 659 staffed beds) King County Providence Swedish Medical Center – Issaquah (175 licensed, 144 staffed beds) King County				
Skagit Non-Profit	Skagit Regional Health, Mount Vernon (137 licensed, 137 staffed beds) Skagit County Skagit Regional Health Cascade Valley Hospital, Arlington (48 licensed, 48 staffed beds) Snohomish	<ul style="list-style-type: none"> • 18 ICU • 152 acute care • 15 psych • 185 staffed • 185 licensed 185 staffed	<ul style="list-style-type: none"> • ICU: 1.04% • Acute: 1.66% • Psych: 1.93% • SNF: N/A • Alcohol: N/A • Other: N/A • Staffed: 1.072% • Licensed: 915% 	<ul style="list-style-type: none"> • Urgent care (2) Clinics (specialty and primary care) (9) • Surgical center (1) • Telehealth 	<ul style="list-style-type: none"> • Physicians: 174 • Physician assistants: 32
University of Washington (UW) Medicine Private Non-Profit and Public	UW Medicine/Harborview Medical Center, Seattle (413 Licensed, 412 Staffed Beds) King County US Medicine/Valley Medical Center, Renton (341 Licensed, 330 Staffed Beds) King County UW Medicine/UW Medical Center, Seattle (810 licensed, 476 staffed beds) King County	<ul style="list-style-type: none"> • 248 ICU • 883 acute care • 84 psych • 3 other • 1,218 staffed • 1,564 licensed 	<ul style="list-style-type: none"> • ICU: 14.30% • Acute: 9.64% • Psych: 6.68% • SNF: N/A • Alcohol: N/A • Other: 1.03% • Staffed: 9.55.05% • Licensed: 10.3.02% 	<ul style="list-style-type: none"> • Primary care (25) • Urgent care (5) • Telehealth 	<ul style="list-style-type: none"> • Physicians: 1,741 • Physician assistants: 120

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
Virginia Mason Franciscan (VMF) (not-for-profit) CHI: Catholic	<p>VMF Health St Anne Medical Center, Burien (133 licensed, 115 staffed beds) King County</p> <p>VMF Health St. Anthony Hospital, Gig Harbor (112 licensed, 112 staffed beds) Pierce County</p> <p>VMF Health St. Clare Hospital, Lakewood (106 licensed, 102 staffed beds) Pierce County</p> <p>VMF Health St. Elizabeth Hospital, Enumclaw (38 licensed, 25 staffed beds) King County</p> <p>VMF Health St. Francis Community Hospital, Federal Way (124 licensed, 124 staffed beds) King County</p> <p>VMF Health St. Joseph Medical Ctr, Seattle (374 licensed, 362 staffed beds) King County</p> <p>VMF Health St. Michael Medical Center, Silverdale (336 licensed, 248 staffed beds) Kitsap County</p> <p>Virginia Mason Franciscan Health/Virginia Mason Franciscan Health Rehabilitation (60 licensed, 60 staffed beds) Pierce County</p> <p>Virginia Mason Medical Center, Seattle (371 licensed, 272 staffed beds) King County</p>	<ul style="list-style-type: none"> • 154 ICU • 1,176 acute care • 35 SNF • 55 other • 1,420 staffed • 1,654 licensed 	<ul style="list-style-type: none"> • ICU: 8.88% • Acute: 12.83% • <i>Psych: N/A</i> • SNF: 16.06% • <i>Alcohol: N/A</i> • Other: 18.90% • Staffed: 11.13% • Licensed: 10.93% 	<ul style="list-style-type: none"> • Primary care, • Cardio-vascular health • Digestive health, Neuro spine, etc. • Telehealth 	<ul style="list-style-type: none"> • Physicians: 1,142 • Physician assistants: 194

Table 5: Physicians, Physician Assistants, and Nurses (ARNPs) in all Washington State Hospitals and in Multi-Hospital Systems

Provider	Physicians ⁴⁹	Physician Assistants ⁵⁰	Nurse (ARNP) ⁵¹ N = 9,334
All Washington Hospitals	10,636	1,475	3,650 or 39.1%
Multi-Hospital System	6,977 (65.6% of Physicians)	985 (66.8% of Physician Assistants)	Unknown

Vertical Integration by Health Insurers in Washington

Similar to the trends in hospital consolidation, US health insurers or their holding companies have been purchasing physician practices and other providers of clinical care. For example, United HealthGroup, through its Optum subsidiary, is reportedly the largest employer of physicians in the nation, with more than 70,000 employed or aligned physicians across more than 2,200 locations in 2023.⁵² And, with its acquisition of home health provider Signify Health in 2023, CVS Health added 10,000 physicians and other clinicians to the estimated 40,000 physicians and nurses it employs in its MinuteClinics and HealthHUBs.⁵³

In addition, health insurers or their holding companies have integrated with a number of other sectors of the health care industry, including pharmacy benefit managers (PBMs), which administer prescription drug insurance benefits. Their key functions include negotiating prescription drug prices with manufacturers and pharmacies, establishing prescription drug formularies and pharmacy networks, and processing prescription drug claims.

⁴⁹ Data obtained from Washington State Medical Association, October 20, 2023.

⁵⁰ Ibid.

⁵¹ Washington Center for Nursing. Washington 2021 Nursing Workforce Supply Data Report: Characteristics of LPNs, RNs, and ARNPs. May 2022. Available at: https://www.wcnursing.org/wp-content/uploads/2022/05/WCN-WA-2021-Nursing-Workforce-Supply-Data-Report-Characteristics-of-LPNs-RNs-and-ARNPs_FINAL.pdf (wcnursing.org). Accessed November 23, 2023.

⁵² Jakob Emerson.

⁵³ American Hospital Association. CVS Health Adds Home Health Services. What's Next? Available at:

<https://www.aha.org/aha-center-health-innovation-market-scan/2022-09-13-cvs-health-adds-home-health-services-whats-next#:~:text=With%20the%20Signify%20purchase%20of%20CVS,soon%20to%20be%20a%20HealthHUBs>. Accessed November 26, 2023.

The three largest PBMs, which collectively account for 89% of the market, are owned by insurer holding companies: Express Scripts (owned by Cigna), CVS Caremark (owned by CVS/Aetna), and Optum Rx (owned by UnitedHealth Group).⁵⁴ The role of PBMs and their impact on the price of pharmaceuticals, and consumer cost sharing is the subject of considerable debate, as is the fact that PBMs often operate their own pharmacies, as do CVS and Optum in Washington State.⁵⁵

Table 6 (page 27) lists ownership among the five health insurers with the largest market share of pharmacy services, health care benefit managers, third-party administrators, clinical services, and other sectors of the Washington health care system. Beyond acting as health insurers for large portions of the state's population, each of these companies is extensively involved in the health care that Washingtonians receive.⁵⁶

⁵⁴ National Association of Insurance Commissioners. Pharmacy Benefit Managers. June 1, 2023. Available at: <https://content.naic.org/cipr-topics/pharmacy-benefit-managers>. Accessed November 26, 2023.

⁵⁵ Fiedler M, Adler L, Frank R. A Brief Look at Current Debates about Pharmacy Benefit Managers. Brookings. September 7, 2023. Available at: <https://www.brookings.edu/articles/a-brief-look-at-current-debates-about-pharmacy-benefit-managers/#:~:text=Today%2C%20PBMs%20have%20become%20increasingly,is%20a%20relatively%20recent%20development>. Accessed November 26, 2023.

⁵⁶ As required by the Insurer Holding Company Act, RCW 48.31B, <https://app.leg.wa.gov/rcw/default.aspx?cite=48.31B>, health insurers file quarterly reports that describe their holding company structure and list other health care companies in which the holding company or its subsidiaries have an ownership interest. These reports are available publicly through the "Consumer Tools" section of the OIC website, <https://fortress.wa.gov/oic/consumertoolkit/Search.aspx>, by searching for the insurer's name under the "Company Search" tab and then clicking on "View Financial Statements." The holding company data are reported in Schedule Y to the quarterly financial reports. A complete description of all of the ownership interests of each of these holding company systems is beyond the scope of this report.

Table 6: Health Plan Affiliations

Holding Company		Health Plan	Pharmacy Care Services	Health Care Benefits Manager	Data/Analytics/Clinical Guidelines	Third-Party Administrator	Clinical Services	Other Affiliates
Cambia Health Solutions	<i>Check if applicable</i>	✓	✓		✓	✓		✓
	<i>If yes, subsidiary name(s)</i>	Regence BlueShield Asuris Northwest Health BridgeSpan Health Company	Prime therapeutics (collectively owned by several Blues) includes Magellan Rx		Partnering with MultiCare on IT and other innovations	Regence Group Administrators (administers self-funded employer plans) Parent of Health Management Administrators (health plan administrator for self-funded plans)		Cambia Health Foundation (philanthropic arm) Acquired real estate assets of Capital Medical Center
CVS Health Corporation	<i>Check if applicable</i>	✓	✓			✓	✓	✓
	<i>If yes, subsidiary name(s)</i>	Aetna	CVS Pharmacies Longs Drugs Navarro Discount Pharmacies Omnicare Aetna Pharmacy CVS Specialty Rx CVS Caremark (PBM)			Aetna	Accordant (disease management) CVS Minute Clinics Signify Health (home health) Coram (home infusion services) HealthHUB	Gold Emblem products Partnership with Microsoft: digital health

Holding Company		Health Plan	Pharmacy Care Services	Health Care Benefits Manager	Data/Analytics/Clinical Guidelines	Third-Party Administrator	Clinical Services	Other Affiliates
Kaiser Foundation Group	<i>Check if applicable</i>	✓	✓			✓	✓	
	<i>If yes, subsidiary name(s)</i>	Kaiser Foundation Health Plan of Washington	Operates its own pharmacy and PBM, with MedImpact & Optum acting as a PBM in some states (varies by product line)			Kaiser Permanente	Permanente Medical Groups (including acquiring Group Health Cooperative of Puget Sound Kaiser Permanente Central Hospital Clinics and offices throughout the state Lab services)	
Premera	<i>Check if applicable</i>	✓		✓			✓	✓
	<i>If yes, subsidiary name(s)</i>	Premera Blue Cross		Calypso Healthcare Solutions			Kinwell Medical Group	Vivacity (Wellness solutions for employers)
UnitedHealth Group	<i>Check if applicable</i>	✓	✓	✓	✓	✓	✓	✓
	<i>If yes, subsidiary name(s)</i>	UnitedHealthcare of Washington United Healthcare Insurance Company	Optum Rx Optum Specialty Diplomat (specialty Rx provider)	United Behavioral Health OptumHealth Care Solutions, LLC OrthoNet LLC Spectera	Optum Change Healthcare InterQual	UMR	Optum Health: Polyclinic Northwest Physicians Networks Everett Clinic* Monarch Health Refresh MH Prospero (home health agency) Landmark (home health agency) LHC (aging in place services)	VA Mason Franciscan Health partnered with Optum to be the preferred medical center for Polyclinic patients

Private Equity in Washington's Health Care System

Background

In addition to the consolidation among publicly held health plans and companies, Washington's health care system, like that of many other states, has been the focal point of other investment activities, including a growing number of private equity transactions. Unlike the transactions and consolidations that involve publicly traded companies, far less information is publicly available about the status of private equity acquisitions. There are fewer reporting requirements compared with what is required of publicly held companies.

Private equity firms pool money from investors to make investments in a variety of industries. Nationwide, private equity investment in various sectors of the health care economy has been growing over the past two decades. For example, one study showed that private equity purchases of physician practices across a number of specialties grew from 75 transactions in 2012 to 484 transactions in 2021.⁵⁷ As the report stated:

A common strategy that private firms employ is to acquire a large physician practice—referred to as the “platform” practice—and then acquire smaller practices in the same specialty that have less infrastructure, potentially creating economies of scale and scope, providing managerial expertise, adding ancillary services, and increasing bargaining power with payers.⁵⁸

Certain specialties have been a particular focus for this type of investment: dermatology, ophthalmology, gastroenterology, primary care, obstetrics/gynecology, radiology, orthopedics, and more recently, oncology, urology, and cardiology.⁵⁹ In addition to physician practices, private equity firms also have acquired other health care facilities and services.

The impact of private equity investment in health care is controversial and has been the subject of much debate. Recent studies and reports have raised concerns about the impact of these acquisitions on the price and quality of health care services. Critics argue that by prioritizing profits and overburdening health care companies with debt, private equity investment may jeopardize patient safety. On the other hand, proponents argue that in addition to providing an infusion of capital, private equity ownership may bring valuable management expertise, reduce inefficiency, and leverage economies of scale.

⁵⁷ Scheffler et al, p. 4.

⁵⁸ *Ibid.*, p. 8.

⁵⁹ *Ibid.*, p. 11.

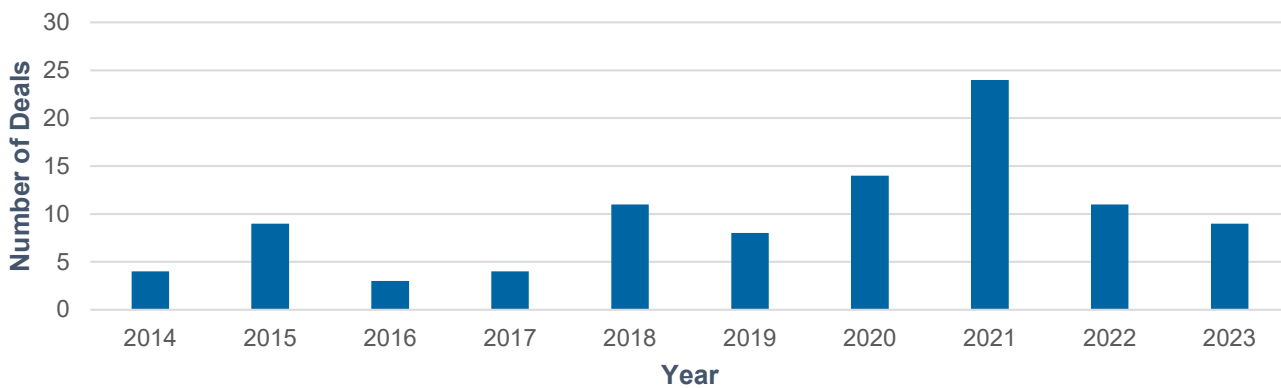
One recent review of 55 studies found that private equity ownership was most consistently associated with increased cost to patients or payers and with mixed to harmful impacts on quality.⁶⁰

The information presented in this report is derived from a comprehensive analysis of health care private equity activity in Washington, sourced from PitchBook, a provider of financial data, research, and analytics.⁶¹

Summary of Recent Private Equity Activity

Over the span of 10 years, 2014–2023, a total of 97 acquisitions within the health care sector have been documented in Washington State, all of which fall under the private equity deal classification. Figure 1 (below) offers an historical snapshot that reflects year-to-year fluctuations in deals, illustrating the changing nature of the health care private equity market.

Figure 1: Private Equity Deals by Year



Acquisitions by Industry

Figure 2 (on the following page) offers a breakdown of health care transactions by their primary industry group. Most acquisitions have been concentrated in health care services, offering insight into what has drawn the attention of private equity investors. In addition to health care services, health care technology systems, health care devices and supplies, pharmaceuticals and biotechnology, have garnered interest, underscoring the wide variety of potential targets within Washington’s health care sector. Many investments are in companies that provide software and other business services to the various sectors of the health care industry.

⁶⁰ Borsa A, Bejarano G, Ellen M, Bruch J D. Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review. *BMJ*. 2023;382:e075244. doi:10.1136/bmj-2023-075244.

⁶¹ [Pitchbook.com](https://pitchbook.com)

Figure 2: Primary Industries

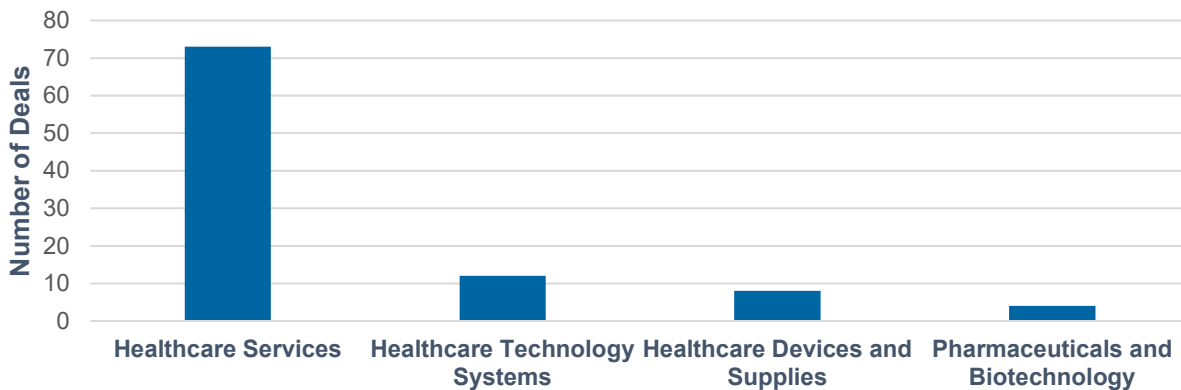


Figure 3 (on the following page) identifies the subcategories of health care clinical services that have been acquired. The greatest number of transactions have occurred in physical therapy, hospice and home health care, behavioral health/substance use disorder (SUD), ophthalmic/optometric, primary care/urgent care, and gastroenterology.⁶²

Private equity firms also acquire physician staffing companies. For example, private equity-owned TeamHealth was one of the six largest emergency medicine staffing companies in the United States as of 2022.⁶³ According to its website, TeamHealth employs physicians who provide emergency medicine and post-acute care in a number of hospitals and clinics in Washington, including St. Elizabeth Hospital, St. Joseph Medical Center–Tacoma, PeaceHealth St. Joseph Medical Center, Island Hospital, St. Anthony Hospital, Providence Centralia Hospital, and Trios Southridge Hospital.⁶⁴

Similarly, US Anesthesia Partners (USAP) is a private equity-owned single-specialty anesthesia practice that operates in eight states, including Washington. According to its website:

USAP Washington is the largest majority physician-owned + led anesthesia group in the Pacific Northwest, consisting of over 120 physicians and 15 CRNAs. We provide high-quality anesthesia services to the renowned Swedish Medical Center at First Hill (FH), Cherry Hill (CH), Issaquah, and Ballard, as well as prominent ambulatory surgery centers in the greater Seattle area.⁶⁵

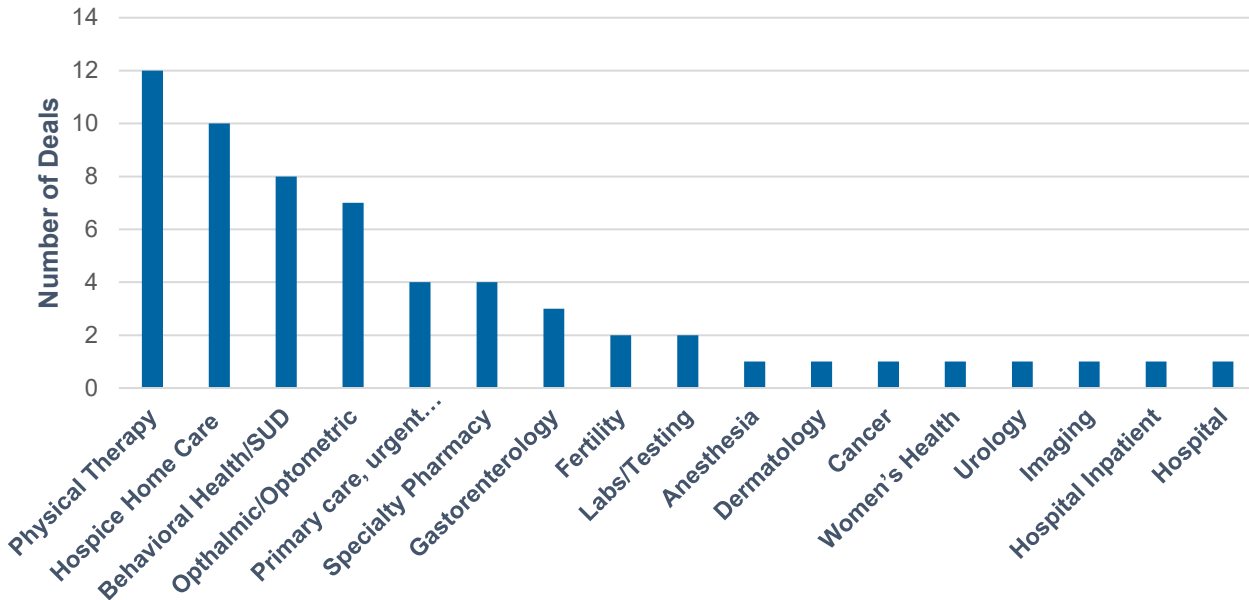
⁶² Data obtained from PitchBook, October 2023.

⁶³ *Ibid.*, at p. 8.

⁶⁴ TeamHealth.

⁶⁵ USAP describes itself as majority physician-owned, it is listed as one [Welsh, Carson, Anderson & Stowe's](#) private equity health care companies, a [complaint filed in September 2023](#), the Federal Trade Commission (FTC) alleges that Welsh Carson “created” USAP in 2012 in a scheme to monopolize the market for anesthesia services in Texas.

Figure 3: Subcategories of Clinical Services that Have Been Acquired

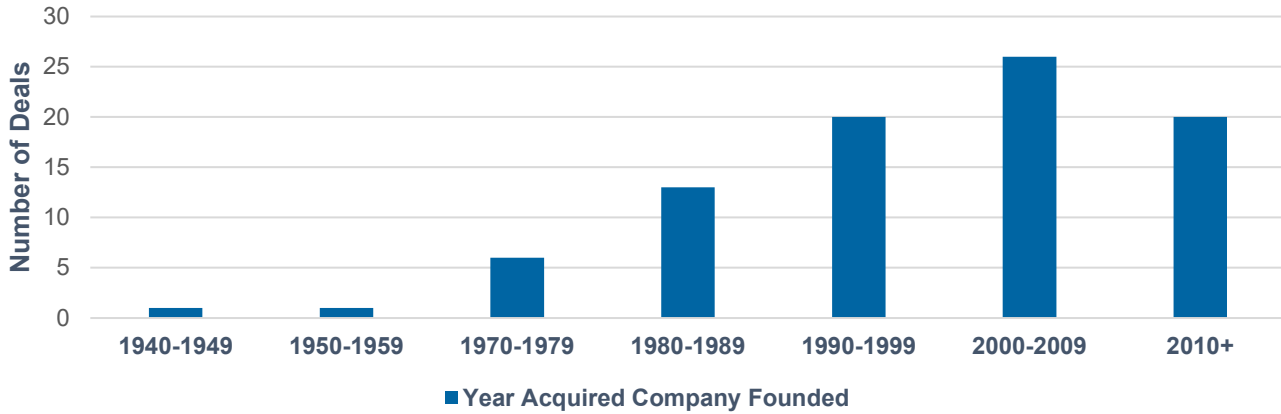


Location and Year Founded

Most of the acquisitions have been in Seattle and Bellevue, which is unsurprising given the high percentage of the state's population residing in those communities.

Figure 4 (on the following page) offers a breakdown of the year when the acquired companies were founded, categorized by the decades in which the companies were initially established. This analysis provides insights into the developmental stages of the companies that have become acquisition targets, offering a glimpse into the evolution of Washington's health care sector. The data illustrate the varying ages of the acquired companies, reflecting both long-established institutions and newer, innovative enterprises.

Figure 4: Years Acquired Companies Were Founded



Duration of Investment and Resale Transactions

One category that HMA did not explore because it is unidentifiable with the available data, is the extent to which resale transactions are occurring in the market. Private equity investments often are part of an investment strategy with predetermined entrance and exit strategies and timelines focused on realizing efficiencies and profits for the acquired entities. An area worth further examination is the impact of the timing of investments and divestures associated with Private Equity on patient affordability.

PART II: POLICY OPTIONS TO ADDRESS HEALTH CARE AFFORDABILITY

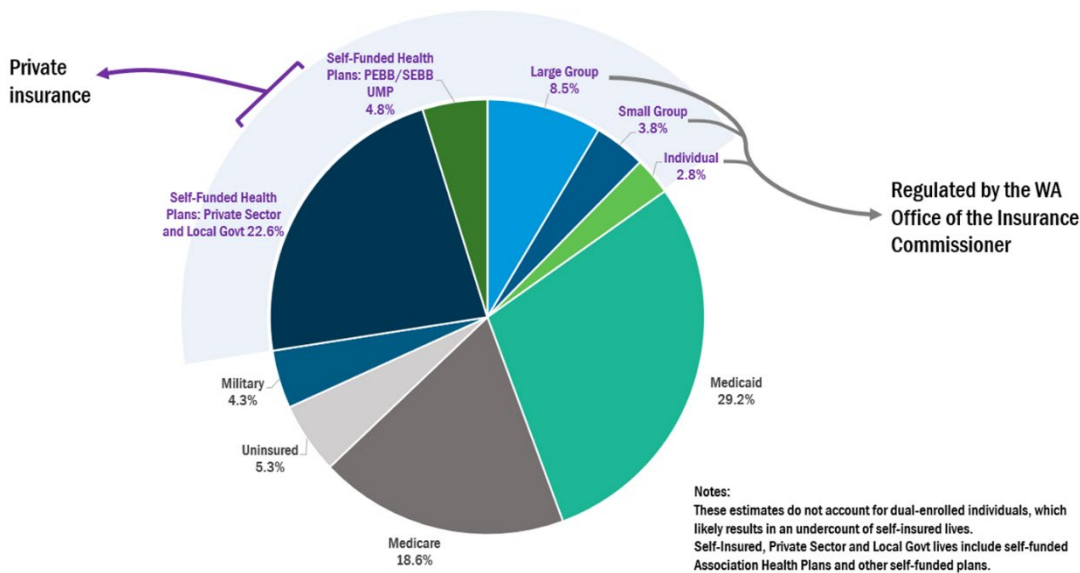
This part reviews several health policy options that have been proposed or implemented in Washington and other states to address the challenges of health care affordability for consumers, employers, and state government. It describes the purpose and features of each policy and provides information on its adoption and impact on the states where it has been implemented. This part of the report then describes any experience Washington State has had with the policy and compares it with that of other states, noting how Washington’s law could be changed based on the results that other states have achieved.

As Figure 5 (below) indicates, Washingtonians receive their health coverage from several different sources in different markets, each subject to different laws and regulations, with oversight from different state and federal authorities.

The policy options described in this report apply differently, or not at all, to these markets. Addressing affordability across these markets may, therefore, require a combination of these policy options.

Figure 5: Source of Health Coverage for Washington Residents

Source of Health Coverage for Washington Residents 2022



Health Care Cost Growth Benchmarks

Cost growth benchmarks establish targets for how much health care spending should grow each year. States set statewide benchmarks; some also apply these benchmarks to providers and payers.

Have been established in nine states and shown mixed results; the most mature program (Massachusetts) recently issued recommendations for improvement including a need to focus on constraining provider prices.

Washington's HCCTB, established in 2020, will issue its first report on baseline health care expenditures in Fall 2023. It lacks the authority to take any action against a provider or payer that exceeds the benchmarks such as requiring Performance Improvement Plans that are part of some other states' programs.



Set Health Care Cost Growth Benchmarks

A cost growth benchmark program establishes a target for a state's annual growth in health care spending. Nine states, including Washington, have established independent commissions or have increased the authority of an existing regulatory body to set targets for increasing health care costs. States have used a variety of methods to set cost growth targets, using somewhat different economic metrics such as expected state gross domestic product, wage growth, or growth in consumer prices and have given these factors somewhat different weights. Eight of these states—Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Rhode Island, and Washington—have set cost growth targets. California recently created a cost containment commission but has yet to set targets.⁶⁶

Other States' Programs

Appendix B (page 92) is a table from the National Academy for State Health Policy (NASHP) and last updated on January 18, 2023, lists the states that have established cost growth benchmark programs and describes a number of features of each program, including authority, collecting and reporting agency, cost growth benchmark level, total cost of care measurement, quality benchmark measures, and enforcement.

States have set benchmarks using a variety of methods and metrics; however, these targets have fallen within a fairly narrow range (see Appendix B, page 92).⁶⁷

The cost growth benchmark programs in several states include a number of features that distinguish them from Washington State's Health Care Cost Transparency Board (HCCTB). For example, in California, Connecticut, Delaware, Massachusetts, New Jersey, and Oregon, measurement and consideration of health care quality is expressly part of the program. Following is a comparison of key differences in the approach three states—Massachusetts, Oregon, California—and Washington's HCCTB have taken.⁶⁸

⁶⁶ During its 2023 legislative session, the Indiana General Assembly passed House Enrolled Act 1004, which the governor signed into law (P.L. 203) in May. The legislation creates a Health Care Cost Oversight Task Force, consisting of members of the state House and Senate, who are tasked with reviewing and making recommendations on a broad list of issues related to health care affordability. Data are to be provided to the task force by the Office of the Secretary of Family and Social Services, Department of Health, and Department of Insurance. The law also requires certain hospital systems to file reports containing extensive, detailed financial information, including revenue from a range of sources.

⁶⁷ Milbank Memorial Fund. Health Care Cost Growth Target Values. Available at: <https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/health-care-cost-growth-benchmarks-by-state/>. Accessed November 26, 2023.

⁶⁸ Massachusetts was chosen because it has the longest and deepest experience with a cost growth benchmark program. Oregon was selected because it is a neighboring state, and its health care market has some similarities to Washington's. California was chosen because, as the state to most recently establish a program, it has the benefit of learning from the experience of other states.

Massachusetts

Massachusetts has the longest and deepest experience with setting cost growth benchmarks, having established its Health Policy Commission (HPC) in 2012. The HPC has broader responsibilities and authorities than the HCCTB. In addition to setting the cost growth benchmark and setting and monitoring provider and payer performance relative to the benchmark, other key activities include:

- Creating standards for care delivery systems that are accountable to better meet patients' medical, behavioral, and social needs.
- Analyzing the impact of health care market transactions on cost, quality, and access.
- Investing in community health care delivery and innovations.
- Safeguarding the rights of health insurance consumers and patients regarding coverage and care decisions by health plans and certain provider organizations.⁶⁹

Massachusetts has established a separate state agency, the Center for Health Information and Analysis, which collects data and reports out to the HPC and the public.⁷⁰ The HPC has authority to enforce the provisions of its program and is permitted to require that a health care entity⁷¹ file a performance improvement plan (PIP) if it exceeds the cost growth benchmark. The commission also has authority to impose a civil penalty of up to \$500,000 as a last resort, if an entity that has been ordered to submit a PIP fails to file an acceptable PIP or fails to implement a PIP in good faith.⁷²

In January 2022, the HPC voted to require Mass General Brigham to implement a PIP; this was the first time it had ordered a PIP, and at present it is the only PIP nationwide pertaining to a cost growth benchmark program. The commission approved Mass General Brigham's PIP in September 2022; it proposed an annual savings target of \$176.3 million over the PIP's 18-month implementation period.⁷³ Mass General Brigham's most recent public report states that it is on track to meet its savings target.⁷⁴

⁶⁹ Massachusetts Health Policy Commission. 2023 Annual Health Care Cost Trends Annual Report. September 2023. Available at: <https://www.mass.gov/doc/2023-health-care-cost-trends-report/download>. Accessed November 26, 2023.

⁷⁰ Massachusetts Center for Health Information and Analysis. About the Agency. Available at: <https://www.chiamass.gov/about-the-agency/>. Accessed November 26, 2023.

⁷¹ A Health care entity is defined as a clinic, hospital, ASC, physician organization, accountable care organization or payer. Physician contracting units with a patient panel of 15,000 or fewer or who collectively receive less than \$25,000,000 in annual net patient service revenue are exempted, under [Massachusetts General Law, Title I, Chapter 6D, Section 10](#).

⁷²[Ibid.](#)

⁷³ Massachusetts Health Policy Commission Board Meeting. Extract of Presentation. September 27, 2022. Available at: <https://www.mass.gov/doc/extract-of-board-presentation-september-27-2022/download>. Accessed November 26, 2023.

⁷⁴ Mass General Brigham Performance Improvement Plan. March 2023 Update. Available at: <https://www.mass.gov/doc/mass-general-brigham-pip-public-6-month-report/download>. Accessed November 26, 2023.

Massachusetts Health Policy Commission Board Meeting. Mass General Brigham Performance Improvement Plan March 2023. Extract of Presentation. July 12, 2023. Available at: <https://www.mass.gov/doc/mass-general-brigham-pip-public-6-month-report/download>. Accessed November 26, 2023.

Oregon

Oregon's Health Authority may require PIPs from any payer or provider organization that unreasonably exceeds the benchmark during any year. Fines may be assessed for late or incomplete submission of data and/or PIPs. Payers or provider organizations that exceed the benchmark in any three out of five years are subject to a financial penalty that varies based on the amount of excessive spending and other factors.⁷⁵ Oregon has not yet required any entity to file a PIP. In January 2023, after consideration of macroeconomic factors including inflation and labor market trends, Oregon delayed implementation of the PIP program until 2024.⁷⁶

California

California enacted legislation in 2022 to create an Office of Health Care Affordability (OHCA). In addition to its cost growth benchmark program, OHCA will promote high value system performance by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health and workforce stability. OHCA will also analyze market 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 will coordinate with other state agencies to address consolidation as appropriate.⁷⁷

The Director of the OHCA may take the following progressive enforcement actions commensurate with the health care entity's failure to meet its cost growth target:

- Provide technical assistance to the entity to assist it in coming into compliance.
- Require or compel public testimony from the health care entity regarding its failure to comply with the target.
- Require submission and implementation of a performance improvement plan.
- Assess penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

California is in the process of setting cost growth targets and, therefore, has not yet required any PIPs.

⁷⁵ Oregon Legislative Assembly. Enrolled House Bill 2081. Available at: <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled>. Accessed November 26, 2023.

⁷⁶ Oregon Health Care Authority. Sustainable Health Care Cost Growth Target Program Update to Accountability Timeline. Revised August 2023. Available at: [https://www.oregon.gov/oha/HPA/HP/Cost percent20Growth percent20Target percent20documents/CGT-accountability-update_August-2023.pdf](https://www.oregon.gov/oha/HPA/HP/Cost%20percent20Growth%20percent20Target%20documents/CGT-accountability-update_August-2023.pdf). Accessed November 26, 2023.

⁷⁷ California Office of Health Care Affordability. Introduction to OHCA. Available at: <https://hcai.ca.gov/ohca/>. Accessed November 26, 2023.

State Experiences in Meeting Cost Growth Targets

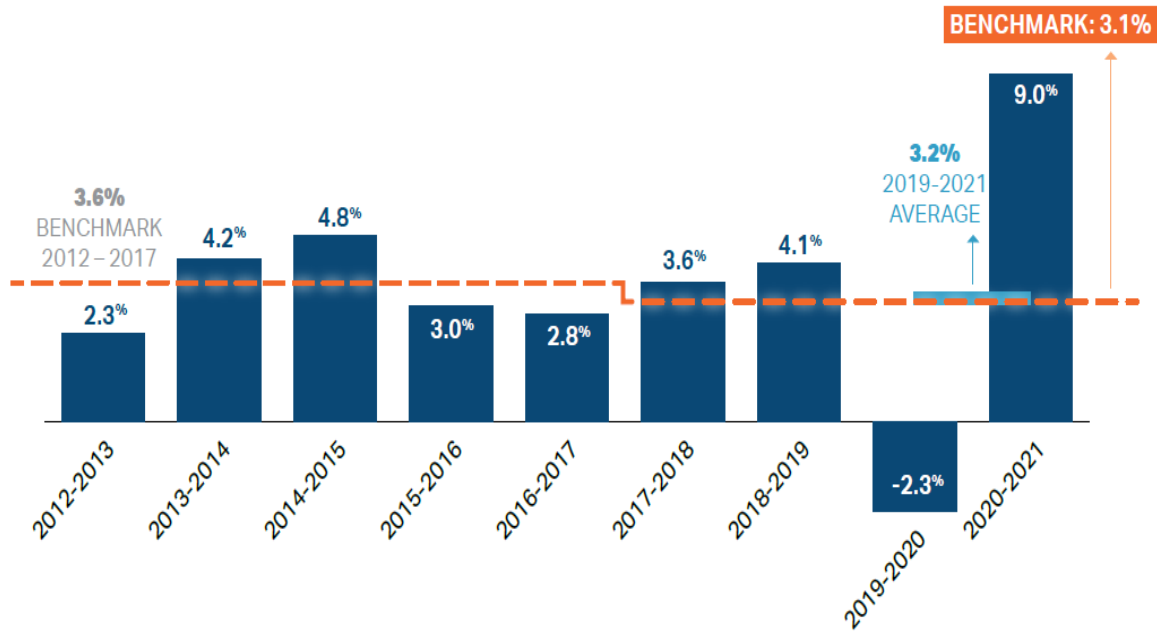
States that have reported on whether cost growth benchmarks have yielded mixed results.

Massachusetts

In Massachusetts, HPC set the benchmark for 2012–2017 at 3.6%; per capita total health care expenditure growth was below the target for three years and exceeded the benchmark for two years. For 2018–2021, the benchmark was set at 3.2%. Costs were below the target one year but exceeded the benchmark three years. For the nine years in which total health care expenditure growth has been evaluated, average annual per capita spending growth has been 3.5%.⁷⁸

The COVID-19 pandemic and the return of higher rates of inflation clearly have had a significant impact on health care cost expenditure growth. Though expenditures declined by 2.3% in 2019–2020, they rose by 9% in 2020–2021, the last year reported.⁷⁹

Figure 6: Annual Growth in Total Health Care Expenditures Per Capita in Massachusetts



Sources: Center for Health Information and Analysis, Annual Reports 2013-2023

⁷⁸ Massachusetts Health Policy Commission.

⁷⁹ Ibid.

Oregon

Oregon set cost growth targets for 10 years, at 3.4% for 2021–2025 and 3% for 2026–2030, to be adjusted in 2024 if necessary. The target was set using economic data such as historic and projected gross state product, wages, and income. The Medicaid and state employee programs had previously been subject to a 3.4% cost growth target.⁸⁰ The state employee program is described in detail in the reference pricing policy part of this report, (page 61).

In its 2023 Sustainable Health Care Cost Growth Target Annual Report, the Oregon Health Authority reported that annual per capita health care spending in 2020–2021 increased by 3.5%, just above the target of 3.4%. A large disparity was evident among markets: total health care expenditures in the commercial market increased 12.1%, compared with 6.5% for Medicare and 2.1% for Medicaid—the only payer that met the target.⁸¹

Oregon’s report included data on which payers and providers met or exceeded the cost growth target. A total of 29 Oregon payers were included in cost growth target reporting for 2020–2021; overall cost growth for payers was 4.7%. Cost growth for commercial payers was 11.5%, compared with 6.0% for Medicare Advantage (MA) and Medicaid plans at 3.0%. Of the 29 payers, 11 met the target for at least one market. Seven commercial payers and eight Medicare Advantage payers exceeded the target with statistical certainty.⁸²

A total of 51 provider organizations were included; overall cost growth was 4.9%. Provider organization cost growth in the commercial market was 11.8% versus 6.3% for MA and (3.0%) for Medicaid, and 26 provider organizations met the target for at least one market. In all, 16 commercial provider organizations and 10 Medicare organizations exceeded the target with statistical certainty.⁸³

Massachusetts HPC Policy Recommendations

Based on its experience to date, the Massachusetts HPC has made policy recommendations for ways to improve its cost growth benchmark program. Some of these policies were reflected in the legislation that established the OHCA program in California.

⁸⁰Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2018-2020. May 2, 2023. Available at: <https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Cost-Growth-Target-Annual-Report-FINAL.pdf>. Accessed November 26, 2023.

⁸¹ Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2020-2021. Available at: <https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf>. Accessed November 26, 2023.

⁸² Ibid, p. 5.

⁸³ Ibid.

In its 10th annual report in September 2023, HPC has set forth nine policy recommendations to address what it describes as “alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses.” Several of those recommendations are relevant to the HCCTB’s work and this report, including.⁸⁴

- Strengthen the Health Care Cost Growth Benchmark by using metrics in addition to health status adjusted total medical expense to refer entities for review and a potential PIP so that entities other than payers and providers with primary care networks are subject to review.
- Strengthen the PIP process to allow the HCP to set savings target expectations and identify the types of strategies that should be included in a PIP. This strategy would give the HCP more oversight authority and allow the HCP to apply tougher, escalating financial penalties for above-benchmark spending or noncompliance.
- Establish a new affordability index to be measured annually in a benchmark-like process in recognition of the fact that health insurance premiums and cost-sharing often have increased in excess of the health care cost growth benchmark. The index would track the differential impact of health care premiums and out-of-pocket spending by income, geography, market segment, and other factors.
- Establish new equity benchmark(s) to identify high-priority areas of health inequities, set measurable goals for improvement, and develop a framework for accountability. Require providers to provide annual progress reports.
- Constrain excessive provider prices in recognition that past market initiatives (e.g., tiered and narrow network products, price transparency efforts, risk contracting) have failed to meaningfully restrain provider price growth or reduce unwarranted variation in provider charges. Many states (e.g., Rhode Island, Oregon, Colorado and Maryland) are similarly recognizing that some level of price regulation, rather than market initiatives alone, may be necessary to ensure an equitable and affordable health care system. The HPC recommends:
 - Limiting excessive provider charges in excessive of reasonable benchmark amounts, which HPC defines as more than 200% of what Medicare fee-for-service pays for the relevant service. These price limits could target costs with the greatest impact on spending as well as annual price growth and would be directed at the highest-priced providers and those services for which competitive forces are least likely to contain prices.
 - Require site-neutral payment for certain ambulatory services that are commonly provided in office settings (e.g., office visits, lab tests, basic imaging and diagnostic services, and clinician-administered drugs) to limit hospital “facility fee” charges.)

The recommendations related to constraining excessive provider prices are discussed in the reference-based pricing and facility fees parts of this report.

⁸⁴ HCP 2023 Annual Health Care Cost Trends Annual Report, <https://www.mass.gov/doc/2023-health-care-cost-trends-report/download> at pp. 51-58. Several of the policy recommendations in the report relate to functions of the HPC which are not part of HCCTB’s responsibility.

Washington Law and Experience with the Health Care Cost Transparency Board

The Washington State Legislature created the Health Care Cost Transparency Board (HCCTB) in 2020 to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs.⁸⁵ HCCTB also was also charged with increasing price transparency.

In September 2021, the HCCTB approved a cost growth benchmark of 3.2% for 2022–2023, 3% for 2024–2025, and 2.8% by 2026. The benchmark is based on a blend of 70% historical median wage and 30% potential gross state product.⁸⁶ The data sources for calculating the benchmark value are set forth in the Board’s Technical Manual published in July 2022.⁸⁷ In the event of extraordinary circumstances, including drastic changes in the economy or the health care system, the board may consider revising the benchmark or the benchmark methodology.⁸⁸ Washington’s benchmark generally aligns with other states’ cost-growth benchmarks, although the metrics used to arrive at the benchmarks vary.⁸⁹

The HCCTB is collecting data from a variety of sources to evaluate the overall system’s performance against the benchmark. To make that measurement, the Board will calculate total health care expenditures (THCE), which include:

- Total Medical Expense (TME): Claim payments made to providers as reimbursement for health care provided, other payments to providers and all cost-sharing paid by consumers, including deductibles, co-payments and co-insurance, and
- Costs to state residents associated with the administration of private health insurance (for example, health plan administrative costs and profit).⁹⁰

The Board has issued data calls to insurers⁹¹ and state agencies and has completed its data validation process. Its first historical baseline benchmark report is expected in fall 2023.

HCCTB also is directed to study and report on the drivers of health care costs. Preliminary findings from this analysis were released and made public at the board’s December 14, 2022, meeting.⁹²

⁸⁵ Washington State Legislature. Second Substitute House Bill 2457 Chapter 340, Laws of 2020. February 11, 2020. Available at: <https://lawfilesexet.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2457-S2.pdf?q=20231126165319>. Accessed November 26, 2023.

⁸⁶ Washington State Health Care Authority. Health Care Cost Transparency Board Meeting Minutes. September 14, 2021. Available at: <https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf>. Accessed November 26, 2023.

⁸⁷ Washington State Health Care Authority. Washington’s Health Care Cost Growth Benchmark Program Technical Manual. July 7, 2022. Available at: <https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf>. Accessed November 26, 2023.

⁸⁸ Ibid.

⁸⁹ Melnick G. Health Care Cost Commissions: How Eight States Address Cost Growth. California Health Care Foundation. Available at: <https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf>. Accessed November 26, 2023.

⁹⁰ Washington State Health Care Authority. Health Care Cost Transparency Board Meeting Materials Book. October 18, 2023. Available at: <https://www.hca.wa.gov/assets/program/hcctb-meeting-materials-20231018.pdf>. Accessed November 26, 2023.

⁹¹ In the context of this report, the term “insurer” has the same meaning as “carrier,” as defined in Washington law. [RCW 48.43.005](#)

⁹² Washington State Health Care Authority. Health Care Cost Transparency Board Meeting Materials Book. December 14, 2022. Available at: <https://www.hca.wa.gov/assets/program/hcctb-board-book-20221214.pdf>. Accessed November 26, 2023.

These results are discussed in HCCTB's 2023 report to the legislature.⁹³ Beginning in 2024, HCCTB will be responsible for identifying providers and payers with cost growth that exceeds the benchmark, focusing on the state's largest health care systems and provider groups.⁹⁴

In 2022, Washington enacted legislation directing the HCCTB to also measure and report on primary care expenditures in Washington and on progress toward increasing it to 12% of total health care expenditures.⁹⁵ The HCCTB formed a primary care advisory committee to develop primary care expenditure measures.

The structure of the HCCTB, its methodology for determining cost growth benchmarks, the sources of the data it collects, and its plans for monitoring whether the benchmarks have been met are similar to what other states with similar programs have done and will do in the future. There are, however, some important differences. Perhaps the most significant is that though the HCCTB has no authority to take any enforcement action against a provider or payer that exceeds the benchmark, three states—Massachusetts, Oregon, and California—do have such authority.⁹⁶ Furthermore, in some states the entity that administers the cost growth benchmark program is responsible for a broader scope of issues related to the health care system, such as mandating an increase in primary care spending or promoting efforts to improve health care quality.

Summary of State Cost Control Benchmark Experience

The HCCTB's experience, along with the experience of other states, demonstrates that cost growth benchmark programs are valuable in focusing attention on growth in health care costs, providing data and making public the drivers of the cost of health care, and beginning to hold accountable those entities that are causing excessive cost growth. Some modifications could be made to Washington's program to align with other states' programs, notably by providing it with the authority to require PIPs and financial penalties, when appropriate, of entities that surpass the benchmark. Washington State also could adopt other policies to address affordability, as discussed elsewhere in this report.

⁹³ Washington State Health Care Authority. Health Care Cost Transparency Board Annual Report. August 1, 2023. Available at: <https://www.hca.wa.gov/assets/program/leg-report-hcctb-20230905.pdf>. Accessed November 26, 2023.

⁹⁴ Ibid.

⁹⁵ Washington State Legislature. Substitute Senate Bill 5589. Available at: <https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5589-S.S.L.pdf#page=1>. Similarly, In Connecticut, the Office of Health Strategy is directed to set targets by 2025 for increased primary care spending as a percentage of total health care expenditures. Available at: <https://portal.ct.gov/OHS/Content/Cost-Growth-Benchmark>. Accessed November 26, 2023.

⁹⁶ During the 2023 Washington State legislative session, lawmakers considered a bill that would have authorized the HCCTB to require a PIP from payers and providers that have "substantially exceeded the health care cost growth benchmark without reasonable justification or meaningful improvement for two of the previous three calendar years." The House passed the bill, but it did not come to a vote in the Senate. For details, go to: <https://lawfilesexternal.wa.gov/biennium/2023-24/Pdf/Bills/House%20Bills/1508-S.E.pdf?q=20231103110712>

Prescription Drug Pricing Regulation

Programs to increase transparency, cap out of pocket costs for prescription drugs and oversee Pharmacy Benefit Managers.

Eight states have implemented programs to oversee and regulate prescription drug prices; there is not enough information available yet to determine the effectiveness.

Washington's Prescription Drug Affordability Board was established in 2022 and has the authority to conduct up to 24 affordability reviews of drugs that have been on the market for 7 years. The PDAB had its first meeting in October 2023.



Establish Prescription Drug Pricing Regulation

High prescription drug costs caused 9 million American adults younger than age 65 (8.2% of people taking prescription drugs) to stop taking their medications as prescribed in 2021, according to a report from the CDC. Out-of-pocket costs for retail prescription drugs totaled \$63 billion that year.⁹⁷ Some estimates of the impact of these high costs are even more disconcerting. The Kaiser Family Foundation reported that in 2021, 29% of all adults reported not taking their medication as prescribed, and 24% of people taking prescription drugs and 23% of older adults say it is difficult for them to afford their medications.⁹⁸

States have pursued a variety of policies to address the high cost of prescription drugs. The most common approaches include:

- Increasing price transparency
- Capping out-of-pocket costs for certain medications, in particular insulin
- Limiting certain PBM practices

Some states have recently passed legislation establishing programs to regulate prescription drug prices. Eight states have enacted legislation creating Prescription Drug Affordability Boards (PDABs) since 2019: Colorado, Maine, Maryland, Minnesota, New Hampshire, Ohio, Oregon, and Washington.⁹⁹

Under state PDAB laws, the boards conduct affordability reviews on selected prescription drugs based on criteria established by statute or regulation. They are tasked with making recommendations to state officials regarding ways to make these drugs more affordable for residents. These recommendations typically apply to commercial health plans (self-funded employer plans are excluded but may participate voluntarily), state employee health plans and Medicaid plans, although some states limit their scope to publicly funded health plans. Laws Colorado, Maryland, Minnesota, Oregon and Washington, give their PDABs authority to establish upper price limitations (UPLs) after conducting affordability reviews. Colorado is furthest along in this process, having recently chosen five prescription drugs for review.¹⁰⁰

⁹⁷ Mykyta L, Cohen RA. Characteristics of Adults Aged 18–64 Who Did Not Take Medication as Prescribed to Reduce Costs. National Center for Health Statistics. June 2, 2023. Available at: <https://stacks.cdc.gov/view/cdc/127680>. Accessed November 26, 2023.

⁹⁸ Kaiser Family Foundation. Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age.

Available at: <https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/>. Accessed November 26, 2023.

⁹⁹ National Academy for State Health Policy (NASHP). State Laws to Lower Prescription Drug Costs: 2017-2023. Updated October 13, 2023. Available at: <https://nashp.org/state-drug-pricing-laws-2017-2023/>. The NASHP web page contains a comprehensive list of state laws addressing prescription drug prices.

¹⁰⁰ Colorado Department of Regulatory Agencies. Colorado Prescription Drug Affordability Review Board and Advisory Council. August 4, 2023. Available at: <https://doi.colorado.gov/insurance-products/health-insurance/prescription-drug-affordability-review-board>. Accessed November 26, 2023.

Washington Law and Experience with Prescription Drug Transparency and Price Regulation

Washington has sought to address affordability by establishing policies focused on addressing rising prescription drug costs. The approach has been applied in two phases: 1) increased transparency and 2) greater oversight and enforcement.

In 2019, the Washington State Legislature established the Prescription Drug Price Transparency Program (PDPTP) to understand of the drivers and impacts of drug costs.¹⁰¹ Under this program, HCA gathers prescription drug cost information from insurers, PBMs, manufacturers, and other entities to create an annual report on how prescription drugs affect health care costs.

In the first annual report, based on data from 2020 and reported in 2021, HCA identified that drug price increases may affect health care premiums. The extent of the impact, however, could not be identified, in some part because of limitations in HCA's ability to analyze this relationship without a comprehensive set of claims data for all health plans in Washington.¹⁰²

The report suggested several statutory changes, including requiring health insurers, PBMs, manufacturers, and other entities to provide additional data to HCA. HCA noted that these changes would improve the program's ability to understand the impact of prescription drugs on rising health care premiums. Many of these recommendations, including these additional reporting requirements, were included in the legislation that passed in 2022. This legislation also created the Prescription Drug Affordability Board (PDAB), which has additional oversight and enforcement authority over the cost of prescription drugs.¹⁰³

Beginning in 2023, the PDAB is empowered to conduct up to 24 affordability reviews of drugs that have been on the market for at least seven years, including drugs dispensed at a retail, specialty, or mail-order pharmacies, exclusive of that FDA has designated solely for the treatment of a rare disease or condition. These drugs also meet the following benchmarks to be considered for an affordability review:

- Brand name prescription drugs that have a:
 - Wholesale acquisition cost of \$60,000 or more per year or for course of treatment lasting less than one year
 - Price increase of 15% or more in any 12-month period or for a course of treatment lasting less than 12 months
 - 50% cumulative increase over three years
- Biosimilar products with an initial wholesale acquisition cost that is not at least 15% lower than the referenced biological product

¹⁰¹ [Engrossed Second Substitute House Bill 1224 Chapter 334, Laws of 2019.](#)

¹⁰² Washington State Health Care Authority. Drug Price Transparency (DPT) program Annual Report 2022. January 2022. Available at: <https://www.hca.wa.gov/assets/program/hca-dpt-annual-report-2022.pdf>. Accessed November 26, 2023.

¹⁰³ [Second Substitute Senate Bill 5532 Chapter 153, Laws of 2022.](#)

- Generic drugs with a wholesale acquisition cost of \$100 or more for a 30-day supply or less that has increased in price by 200% or more in the previous 12 months

The legislation included additional parameters for affordability reviews including establishment of advisory panels. The advisory panels include stakeholders such as patients, patient advocates, and a representative from the pharmaceutical industry. Affordability reviews will be focused on determining if the drug led to or will lead to excess costs or are not sustainable to the health care system over a ten-year period. PDAB will have the authority to set an upper payment limit for up to 12 prescription drugs annually beginning in January 2027.¹⁰⁴

The HCA proposed legislation in 2023 to strengthen the PDAB. It would have:

- Made all prescription drugs subject to eligibility reviews, rather than limiting it to 24
- Lowered the threshold criteria from \$60,000 to \$25,000 per year or course of treatment or price increases of 10% or more in any 12-month period or 25% over three years
- Begun the affordability reviews in 2026 rather than 2027
- Eliminated the upper payment limits¹⁰⁵

This legislation did not pass; hence, the parameters included in the original legislation creating the PDAB remain in place. The PDAB held its first meeting in October 2023.¹⁰⁶

¹⁰⁴ Ibid.

¹⁰⁵ State of Washington House Bill 1269. 2022–2023 legislative session. First read January 12, 2023. Available at: <https://lawfilesexternal.wa.gov/biennium/2023-24/Pdf/Bills/House%20Bills/1269.pdf?q=20231107061920>. Accessed November 26, 2023.

¹⁰⁶ Washington State Health Care Authority. Prescription Drug Affordability Board. October 20, 2023. Available at: <https://www.hca.wa.gov/about-hca/programs-and-initiatives/clinical-collaboration-and-initiatives/prescription-drug-affordability-board>. Accessed November 26, 2023.

Health Insurance Rate Review

Rate review is a process where state Insurance Departments (OIC in Washington), review proposed health plan rate increases and must approve them prior to their going into effect.

43 states have prior rate approval over the individual market, 38 states have prior rate approval over the small group market. States are pre-empted by ERISA from requiring rate review for self-funded health plans. Rhode Island has leveraged its authority to impose a cap on the amount hospitals can increase their prices each year and has a process for large group health plan rate prior approval.

Washington requires prior rate approval only in the individual and small group markets.



Enhance Health Insurance Rate Review

Through a process known as prior rate approval, Departments of Insurance (DOI) independently review and assess a health plan's proposed changes and associated documentation. These reviews may include assumptions about medical trend and utilization, changes in enrollment volume and health status of enrollees, and compliance with state and federal changes to policies, regulations, or law. DOIs require insurers to submit their rate requests and provide documentation justifying the proposed increase or, in limited cases, decrease to demonstrate they are adequate, reasonable, and non-discriminatory. A total of 43 states have prior rate approval authority over their individual market rates, and 38 states have prior rate approval in the small group market.¹⁰⁷ All but two states administer their own rate review programs in the individual and small group markets, including states that do not conduct prior rate approval.¹⁰⁸

The rate review process may include public hearings during which interested parties may comment on the proposed rates. At the conclusion of this process, the DOI makes a final determination as to how much of the proposed rate change is justified and directs the insurer to finalize its rates based on this determination. Typically, final rates wind up being lower than proposed, although in some instances a DOI has determined rates to be inadequately priced and at risk of not covering all the plan's potential health care and administrative costs. In these cases, the DOI has directed insurers to increase their rates. Most states use the rate review process, typically for the fully insured individual and small group markets, although some states have extended this approach to the large group market as well. In addition, the Employee Retirement Income Security Act of 1974 (ERISA) preempts some states from requiring rate review of self-funded health plans.

States have leveraged their rate review authority and capabilities to address affordability through a variety of specific policies applying to different coverage markets, including limitations on hospital price increases and large group health plan rate prior approval as described below.

Rhode Island Hospital Price Caps

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has leveraged its authority to limit the amount that hospitals can increase their prices for inpatient and outpatient services. This cap is part of a broader set of affordability standards¹⁰⁹ that OHIC enforces through its rate review process, which requires prior approval of fully-insured commercial rates.

¹⁰⁷ Corlette S, Raimugia V. Looking Under the Hood: "Enhanced" Health Insurance Rate Review to Improve Affordability. Georgetown University Center on Health Insurance Reforms. Available at: <https://georgetown.app.box.com/v/looking-under-the-hood>. Accessed November 26, 2023.

¹⁰⁸ Centers for Medicare & Medicaid Services. State Effective Rate Review Programs. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet. Accessed November 26, 2023.

¹⁰⁹ State of Rhode Island Office of The Health Insurance Commissioner. Affordability Standards. Available at: <https://ohic.ri.gov/policy-reform/affordability-standards>. Accessed November 26, 2023.

Though not applicable to the self-funded group health plans, the impact of these standards would extend to contract negotiations if an insurer uses a common contractual fee schedule across its fully insured and self-funded health plan markets.¹¹⁰ Rhode Island's affordability standards also require an annual 1% increase in spending on primary care in 2010–2014 without any corresponding increase in premiums.

OHIC's regulatory authority¹¹¹ gives the Health Insurance Commissioner considerable authority over commercial insurance pricing, including the ability to "consider whether the health insurer's products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products." It is from this broad authority that the affordability standards, including the hospital price cap, are established. The cap was designed to align health care cost increases with measures of price changes.

OHIC selected the Consumer Price Index for All Urban Consumers Less Food and Energy (CPI-U) as the benchmark and set the allowable price increase at no more than 1% above it, which means that the price for inpatient and outpatient services can increase only up to 1% above CPI-U. Though not implemented initially, in recognition of price disparities that existed across the hospital industry before the provider rate cap, OHIC revised the regulations to allow outlier, lower-cost hospitals to increase their rates above CPI-U +1% to bring their pricing in line with the rest of the industry. Once these pricing disparities were addressed, the provider rate cap was applied to these facilities as well.

OHIC assesses insurers' compliance with the hospital rate cap through the rate review process for the individual, small group, and large group markets. As part of the review, OHIC assesses the annual trend assumptions for inpatient and outpatient costs against the rate increase the insurer has requested to determine whether the combined average increase exceeds CPI-U +1%. If so, OHIC requests more information to determine the source of the non-compliant increase. If the discrepancy is the result of a filing issue, the insurer is directed to update its filing. If the discrepancy is because the average cost increase exceeds the provider price cap, the insurer is directed to re-engage with hospitals to secure lower reimbursement levels to bring the average increase into compliance with the cap. Unit of services payment methodologies, such as diagnosis-related groups (DRGs), must be used to calculate pricing adjustments. Requests for increases of more than CPI-U +1% must go to OHIC for review, and exception requests must be justified. OHIC has the authority to approve or disapprove exception requests.

The impact of this price control was significant, resulting in an immediate reduction in cost growth shortly after the provider rate cap was implemented in 2010. A *Health Affairs* study and report¹¹² on the effectiveness of the affordability standards, including the hospital rate cap, declared, "State regulators in Rhode Island achieved among the largest total health care spending changes observed from payment reforms to date."

¹¹⁰ This would be commercial insurers who also perform third party administrator services for self-insured employers, negotiating with hospitals on their behalf and leveraging their established fully-insured contractual fee schedule.

¹¹¹ State of Rhode Island Legislature. Powers and Duties of the Office of the Health Insurance Commissioner. Available at: <https://ohic.ri.gov/sites/g/files/xkqbur736/files/2023-08/230-RICR-20-30-4%20Effective%20August%202020%202023.pdf>. Accessed November 26, 2023.

¹¹² Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. 2019;38(2):237–245. doi: 10.1377/hlthaff.2018.05164.

When comparing the impact of the rate cap to spending in a control group from before and after the policy went into effect, the authors determined that, “quarterly FFS spending among the Rhode Island group decreased by \$76 per enrollee after implementation of the policy, or a decline of 8.1% from 2009 spending.”

Rhode Island Large Group Rate Review

Because large group premiums are experience-rated, OHIC determined that a review and approval process like individual and small group prior rate approval was infeasible. To apply the regulatory requirements described above to all fully insured health plans, including large group plans, OHIC developed a unique approach to reviewing large group health plan rates.

Because each large employer’s group membership has a different experience, replication of the review process for individual and small group would require an employer-by-employer review, something no state regulatory agency, including OHIC, has the capacity to accomplish. Given this reality, OHIC designed a large group rate review process aimed at protecting employers and their employees from unreasonable and unfair rate increases, without needing to go line by line through each employer’s membership. Instead, OHIC’s large group rate approval approach involves reviewing fully insured large group filings at the aggregate level for each participating insurer.

Insurers that request increases are required to submit the following information for OHIC’s consideration: anticipated medical expenses, administrative costs, and profits/contributions to reserves to inform their weighted average increase across their entire large group book of business. OHIC reviews these requests and, as with individual and small group rate review, will direct insurers to remove unjustified factors and assumptions from the proposed rate change. This process concludes with a final determination and approval of an overall, weighted average increase (or decrease) within which the insurer is required to keep overall spending. This methodology effectively results in an overall, insurer-specific, large group spending cap.

Throughout the year, OHIC monitors each insurers’ progress against this annual target through quarterly reviews and an end of year audit to ensure total spending stays within the approved increase. OHIC’s enforcement authority for insurers that exceed the annual approved increase ranges from penalties to member refunds and decertification from participation in the large group market. Requests for exceptions or good cause waivers must be justified, are subject to OHIC’s approval and are rare.

Final approval of large group rates is not reported on a market-wide basis and is instead published individually by insurer. Proposed and final rates for plan years 2021 through 2024 are listed below. Additional information and historical data can be found on the OHIC website.¹¹³

¹¹³ State of Rhode Island Office of the Insurance Commissioner. All Previous Years Health Plan Review Documents. Available at: <https://ohic.ri.gov/ohic-formandraterreview-olddocs.php>. Accessed November 26, 2023.

Table 7: Rhode Island Large Group Rates

Year	Requested Rate Changes	Approved Rate Changes
PY2021	-0.3% to 10.7%	-0.3% to 9.6%
PY2022	7.4% to 14.1%	4.6% to 7.7%
PY2023	7.0% to 13.4%	5.4% to 8.9%
PY2024	5.9% to 12.4%	0.3% to 10.4%

Washington State Law and Experience with Rate Review

Current state law in Washington requires prior rate approval by the OIC in the individual and small group markets.¹¹⁴ Large group health plan rates are negotiated between the insurer and the employer or association without prior approval by OIC. For the prior rate approval process, insurers must demonstrate that their rates are actuarially sound, that they are reasonable in relation to the covered benefits, and that they meet all state and federal regulatory requirements, including the ACA’s rating rules. Insurers must comply with the single risk pool requirements of each market, meaning they must rate for and treat the consumers of the individual and small group markets uniformly, and should account for the experience of the entire market (i.e., the pool), when setting rates. The only allowable individual adjustments to rates are age, family size, tobacco use, and geographic area.

To inform their annual rate proposals and projections, insurers must submit to the OIC their prediction of future premium components, including medical trend, administrative costs, and profit/contribution to surplus. Surplus funding is considered as part of the overall review process, but OIC is unauthorized to direct a company with excessive surplus levels to use it to lower rates. For 2024, OIC approved an 8.94% average rate increase over 2023 in the individual market, a decrease from the proposed average of 9.11%.¹¹⁵ In the small group market, rates increased on average by 8%.¹¹⁶

¹¹⁴ Washington Office of the Insurance Commissioner. Title 284. [RCW 48.18.110\(2\)](#), [RCW 48.44.020\(3\)](#), [RCW 48.46.060\(4\)](#), [48.19.010\(2\)](#), [RCW 48.44.040](#), [RCW 48.46.060\(6\)](#). Accessed November 26, 2023.

¹¹⁵ Washington State Office of the Insurance Commissioner. Average Rate Increase of 8.9% Approved for 2024 Individual Health Insurance Market. Available at: <https://www.insurance.wa.gov/news/average-rate-increase-89-approved-2024-individual-health-insurance-market>. Accessed November 26, 2023.

¹¹⁶ Washington State Office of the Insurance Commissioner. 13 Insurers Approved to Sell Health Insurance to Small Businesses in 2024. Available at: <https://www.insurance.wa.gov/news/13-insurers-approved-sell-health-insurance-small-businesses-2024>. Accessed November 27, 2023.

Medical Loss Ratio Requirements

The ACA requires insurers in the individual and small group markets to pay 80% and insurers in the large group market pay 85% of the premium collected towards medical care or quality improvement efforts.

This can be seen as a tool to reduce premiums by limiting administrative expenses and profits. Massachusetts has adopted a higher MLR of 88%.

Washington uses the minimum MLR requirements established by the ACA.



Increase Health Insurer Medical Loss Ratio Requirements

The Affordable Care Act (ACA) requires fully-insured commercial market insurers to pay a minimum amount of the premium collected towards medical care or quality improvement initiatives. In the individual and small group markets, this threshold is 80% or higher; in the large group market it is 85%. Consequently, individual and small group insurers cannot allocate more than 20% of premium collected to profit or administrative expenses, such as staff costs and marketing. Large group insurers cannot allocate more than 15% of premium to profit and administrative costs. If expenses and profit exceed these thresholds, the difference must be returned to customers as refunds or rebates.

When the ACA was enacted, the medical loss ratio (MLR) was seen as a consumer protection lever to improve the value of individual and employer-based health insurance, ensuring consumers got the most out of their premium contributions while also incentivizing efficient insurer operations and limiting profit potential. Starting with plan year 2011, insurers nationwide were required to meet the MLR standards or pay consumer rebates, with a few exceptions granted by CMS on a case-by-case basis. Except for Massachusetts, which set its MLR at 88% for their merged individual and small group market, no states have adopted MLRs higher than the federal requirements.

In 2012, more than \$500 million in rebates were issued nationwide across all three markets, only 0.2% of which were issued in Washington. The highest aggregate rebates ever issued were for plan year 2019,¹¹⁷ the year after insurance departments responded to the federal government eliminating cost-sharing reduction payments to health insurers. States allowed health insurers to account for the lost federal revenue by increasing prices on Silver Plans offered through the Exchange marketplaces only, often referred to as “silver-loading.” This mechanism was a major driver of MLRs that dipped below 80% in the individual market, resulting in nearly \$2.5 billion in rebates to consumers, and \$45.5 million, or just under 2% in Washington. Washington’s highest rebate year was in 2020, when rebates totaled nearly \$49 million—2.4% of total rebates nationally.¹¹⁸

The primary goal of this policy was to increase the value of the health plans that consumers and employers enroll in, but MLR also was viewed as an affordability tool that could serve to reduce premium rates through limits on administrative expenses and profits. Though the policy has served to increase the amount of spending on medical care and has resulted in billions of dollars in refunds to consumers, it is less clear how well it has served to reduce costs and premiums. Some policy even suggest that MLR incentivizes insurers and providers to work together to navigate compliance with the requirement by increasing claims costs.¹¹⁹

¹¹⁷ Ortaliza J, Krutika A, Cox C. 2023 Medical Loss Ratio Rebates. Kaiser Family Foundation. May 17, 2023. Available at: <https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/>. Accessed November 27, 2023.

¹¹⁸ Kaiser Family Foundation. Total Medical Loss Ratio (MLR) Rebates in All Markets for Consumers and Families. Available at: <https://www.kff.org/health-reform/state-indicator/mlr-rebates-total/?activeTab=graph¤tTimeframe=0&startTimeframe=9&selectedDistributions=total-rebates&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed November 6, 2023.

¹¹⁹ Livingston S. The Medical Loss Ratio's Mixed Record. *Modern Healthcare*. March 14, 2020. Available at: <https://www.modernhealthcare.com/insurance/medical-loss-ratios-mixed-record>. Accessed November 27, 2023.

It is possible that MLR requirements in combination with policies targeting health care service pricing could lessen this incentive.

Washington State Law and Experience with MLR minimums

Washington State has not enacted legislation requiring higher MLR minimums. The state uses the ACA MLR requirements described above.

Reinsurance

Reinsurance programs lower premiums for consumers in the individual market by paying a portion of high-cost claims incurred by health insurers.

17 states have reinsurance programs that lowered premiums from 5% to 38% in 2022.

Washington considered reinsurance in 2018, but did not enact it due to the potential cost to the state.



Implement a Reinsurance Program

Reinsurance is a risk stabilization program used in many states to limit premium increases and to promote financial stability and predictability in health insurance markets impacted by high-cost and volatile claims activity. These programs are federal-state partnerships enabled and partially funded by the federal government through 1332 state innovation waivers.¹²⁰ The ACA provides that states may apply for state innovation waivers under section 1332 of the act. The waivers permit a state to find alternatives to certain ACA provisions to implement innovative, state-specific approaches. CMS must approve these waivers, and the states must satisfy certain guardrails intended to protect consumers and federal expenditures on the program.¹²¹ States must contribute to the cost of these programs and through premium assessments, individual mandate revenues,¹²² other fees, and general appropriations. All states that have implemented these programs have done so in the individual market only, except Maine, which has extended the program to small employers through a pooled individual and small group market.¹²³

Reinsurance programs help mitigate uncertainty by providing a financial backstop to health insurers by paying for some or all high-cost claims, based upon either specific costly conditions or aggregate claim costs. The conditions-based model pays for specific conditions, either in total or partially. The claims-based model generally pays a portion of the eligible claims, known as the coinsurance rate, between the threshold, called the attachment point and the ceiling, known as the cap, above which the insurer resumes paying the full cost. At present, 17 states¹²⁴ have 1332 waivers for reinsurance, and of those, only Alaska and Idaho use the claims-based model.

In the individual market, reinsurance has the greatest impact on customers who are ineligible for ACA premium tax credits and are therefore responsible for paying the full monthly price of their plan. These unsubsidized customers bear the full brunt of yearly premium increases, unlike subsidized customers who are shielded, in part or entirely, from paying premium increases because of the corresponding increase in the ACA advanced premium tax credit value.

¹²⁰ Centers for Medicare & Medicaid Services. Section 1332: State Innovation Waivers. Available at: <https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers>. Accessed November 27, 2023.

¹²¹ Ibid.

¹²² Rhode Island has a state-based individual mandate requiring residents to have health insurance or pay a penalty on their state taxes. Individual mandate penalties fund the state's share of their 1332 state innovation waiver for reinsurance in the individual market.

¹²³ <https://www.maine.gov/governor/mills/news/federal-government-approves-maines-plan-improve-health-insurance-small-businesses-2022-07-15>

¹²⁴ State of Maine Office of the Governor. Federal Government Approves Maine's Plan to Improve Health Insurance for Small Businesses. July 15, 2022. Available at: <https://www.ncsl.org/health/state-roles-using-1332-health-waivers>. Accessed November 27, 2023.

In 2022, the impact of reinsurance programs across the country ranged from a 5% premium reduction to 38%. The average premium reduction impact across all reinsurance programs was 14.5%.¹²⁵ In 2023, the first year Maine's reinsurance was extended to small employers, the projected premium reduction impact was 8% for individuals and 6% for small employers.¹²⁶

Washington State Law and Experience with Reinsurance

Washington state considered reinsurance legislation in 2018, but it was not enacted because of concerns related to funding the state share of program costs. Generally, federal and state contributions to reinsurance are split similarly to the percentage of individual market consumers receiving premium tax credits and those who are not. The federal funding is generated by how much the program will reduce premium tax credits, so the generosity is dependent on the number of consumers receiving tax credits.

In 2018, approximately 50% of consumers covered through the Washington Health Benefit Exchange were receiving ACA advance premium tax credits. As a result of enhancements to the premium tax credits that Congress created, the share of unsubsidized customers has decreased in recent years, to approximately 30%, which would likely reduce the state's share of the cost of a 1332 reinsurance program. The impact of a reinsurance program is likely to have dropped as well, as fewer unsubsidized customers are able to reap the program benefits. Alternatively, the amount of available passthrough funding could increase because a greater portion of individual market enrollees are receiving subsidies through the American Rescue Plan¹²⁷ and the Inflation Reduction Act.¹²⁸

¹²⁵ Centers for Medicare & Medicaid Services. Data Brief on State Innovation Waivers: State-Based Reinsurance Programs. December 2022. Available at: <https://www.cms.gov/ccio/programs-and-initiatives/state-innovation-waivers/downloads/1332-data-brief-dec2022.pdf>. Accessed November 27, 2023.

¹²⁶ State of Maine Bureau of Insurance. State of Maine – Section 1332 State Innovation Waiver. February 10, 2022. Available at: <https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr/insurance/files/inline-files/maine-section-1332%20waiver-complete-application-02-10-2022.pdf>. Accessed November 27, 2023.

¹²⁷ US Congress. American Rescue Plan Act of 2021. Government Printing Office. Available at: <https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf>. Accessed November 27, 2023.

¹²⁸ US Congress. H.R.5376 - Inflation Reduction Act of 2022. Congress.gov. August 16, 2022. Available at: <https://www.congress.gov/bill/117th-congress/house-bill/5376>. Accessed November 27, 2023.

Reference-Based Pricing

Establishes standard reimbursement rates that are tied to an already defined pricing level, such as a percentage above what Medicare pays, for a set of health care services.

Montana and Oregon have established this for their state employee programs (and school employees in Oregon) and have realized significant savings as a result.

Washington has implemented reference-based pricing for its public option plan, Cascade Select. Provider reimbursement is limited to 160% of Medicare in the aggregate. To date, premium increases have been lower than other plans on the Exchange



Use Reference-Based Pricing

Reference-based pricing requires health care purchasers or health plans to establish standard reimbursement levels that they will pay for a set of health care services, such as hospital care. The reference point, or price, is tied to already defined and established pricing levels, such as Medicare reimbursement rates, and is usually set as a percentage of the reference rate. Prices cannot exceed the reference-based price. Medicare-based reference pricing ties reimbursement levels and growth to an established and transparent payment methodology that includes adjustments for cost growth over time. Reference pricing is a policy lever states are looking to more often as a mechanism for managing costs and predicting cost growth over time.

Montana's State Employee Plan

In the early 2010s, Montana turned to reference-based pricing to address uncontrolled and unsustainable state employee health plan cost increases and program reserves that were projected to be fully depleted by the end of 2017. The state employee health plan is self-insured and the state contracts with a third-party administrator to support the benefit plan serving approximately 29,000 members. Through contract negotiations with the hospital industry, the Montana Health Care and Benefits Division modified and standardized reimbursement levels for hospital inpatient and outpatient services to achieve pricing predictability and contain costs.

Prior to reference-based pricing, the Montana Health Care and Benefits Division (HCBD) paid each hospital negotiated discounts off their respective chargemaster,¹²⁹ which resulted in reimbursement ranging from 191% to 322% of Medicare for inpatient and 239% to 611% for outpatient services to the state's 11 acute care hospitals.

¹²⁹ A hospital chargemaster is the collection of standard list prices for hospital services. Chargemaster rates are essentially the health care market equivalent of a manufacturer's suggested retail price (MSRP) in the car buying market. What is a Chargemaster? <https://nashp.org/can-we-please-stop-fixating-on-hospital-chargemasters/#:~:text=What%20is%20a%20Chargemaster%3F,in%20the%20car%20buying%20market>.

NASHP commissioned a study to analyze the impact of the program estimated that from state fiscal year (SFY) 2017–2019, the program saved nearly \$48 million.¹³⁰ The state saved more than \$30 million on inpatient services, which resulted in approximately \$60 per employee per month (PEPM) in savings. Outpatient services were \$17.5 million lower, which resulted in \$32 PEPM in savings over three years. The study also found “no evidence of hospital closure or induced utilization to offset lower rates.”

In addition, according to a HCBD presentation given to the Maine legislature in November 2019, state health plan reserves were approximately \$60 million prior to December 2014 and were projected to be fully depleted and in the negative by the end of 2017. After the implementation of reference pricing, reserves instead grew and by the end of 2017 were at more than \$112 million.¹³¹

Despite the program’s success, Montana has indicated a willingness to move away from reference pricing. HCBD recently reprocured the state employee plan administrative services and is allowing flexibility to the awarded vendor (BCBS of Montana) in the resulting contract, setting financial targets but giving the health plan flexibility to achieve those targets through contracting mechanisms other than referencing pricing. “The contract calls for using Medicare’s rates as a baseline to set overall targets for the amounts the plan will reimburse hospitals. It gives Blue Cross the ability to meet those goals with reference-based pricing — but also by negotiating deals with individual health care providers using a mix of reimbursement models.”¹³²

¹³⁰Starting in July 2016 with reference-based pricing, payments for hospital services were capped at a multiplier of Medicare. Reimbursement for applicable hospital services had to stay within could not exceed those amounts. The price levels were set at 220–225% of Medicare for inpatient services and 230–250% for outpatient services. All 11 acute care hospitals were subject to these payment requirements. CAHs were exempted. Lower cost hospitals were able to implement the change most efficiently without disruption or material change to revenues, whereas higher costs hospitals were given a three-year grace period to come into compliance with the reference-based pricing requirements. For more information, go to: Starting in July of 2016 with reference-based pricing, payments for hospital services were capped at a multiplier of Medicare. Reimbursement for applicable hospital services could not exceed those amounts. The price levels were set at 220-225% of Medicare for inpatient services and 230-250% for outpatient services. All eleven acute care hospitals were subject to these payment requirements. Critical access hospitals were exempted. Lower cost hospitals were able to implement the change most efficiently without disruption or material change to revenues while higher costs hospitals were given a three-year grace period to come into compliance with the reference-based pricing requirements. For details, go to:

<https://leg.mt.gov/content/publications/fiscal/2023-Interim/March-2022/MARA-NASHP.pdf>

¹³¹ Bartlett M. Benchmarking Hospital Pricing. November 2019. Available at: <https://legislature.maine.gov/doc/3522>. Accessed November 27, 2023.

¹³² Houghton K. Montana’s Tax-Exempt Hospitals Oppose Increased Oversight by State Officials. Kaiser Family Foundation. February 13, 2023. <https://kffhealthnews.org/news/article/montanas-tax-exempt-hospitals-oppose-increased-oversight-by-state-officials/>. Accessed November 27, 2023.

Oregon State Employee Health Plan

In response to out-of-control spending for Oregon's state and public employee health plans, the legislature established reference pricing, requiring payments for applicable hospital services to not exceed 200% of Medicare prices for in-network services and 185% for out-of-network services.¹³³ The law requires in-network and out-of-network (OON) payments for inpatient and outpatient hospital services to be at or below a multiplier of Medicare pricing, establishing a standard ceiling or reference point that hospital services cannot exceed. The intent behind the lower reference-based price for OON services was to provide an incentive to hospitals to stay at the bargaining table with health plans. The legislature also established a budget growth cap, limiting the amount per-member expenditures in self-insured plans and premium growth in fully insured plans at no more than 3.4% annually.

If the insurer or third-party administrator (TPA) contract has a payment methodology that is an alternative to FFS and uses value-based payments, capitation, bundled payments, or some other payment methodology, the reference-based pricing limits must be incorporated into the insurer's or TPA's payment methodology. It must be documented annually through plan design submissions. Reference-based pricing requirements do not apply to certain small hospitals,¹³⁴ rural CAHs, hospitals in counties with fewer than 70,000 people, sole community hospitals or hospitals with Medicare payments totaling 40% or more of their payments.

Lastly, to prevent providers from increasing prices up to the payment limit for services below the newly established reference-based price, clarifying regulations¹³⁵ were issued to ensure that applicable reimbursement was the lesser of billed charges, the contracted rate, or the reference-based price.

This reference-based pricing requirement applies to employee health plans administered by the Oregon Educators Benefit Board (OEBB) and the Public Employees Benefit Board (PEBB), which were recently merged and are jointly administered. According to an Oregon Health Authority presentation to a legislative committee in March 2023, OEBB and PEBB together serve nearly 300,000 Oregonians, 147,000 through OEBB and approximately 141,000 through PEBB.¹³⁶ OEBB is self-insured and PEBB offers fully insured and self-insured plans, with over 80% of members enrolled in self-insured plans as of July 2023.¹³⁷

¹³³ Oregon Legislature. Enrolled Senate Bill 1067. Available at:

<https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB1067/Enrolled>. Accessed November 27, 2023.

¹³⁴ Type A hospitals are small hospitals (with 50 or fewer beds) that are located more than 30 miles from another hospital; Type B hospitals are small hospitals that are located within 30 miles of another hospital.

<https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/Hospital%20Type%20Document.pdf>. Accessed November 2023

¹³⁵ https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=pl7k9ex2qwwQs0-O7TqeZV0_9uZCmTeX8QLLDO0ETKCC8tGP2ryY!739320507?ruleVrsnRsn=275541

¹³⁶ <https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/265527>

¹³⁷ <https://www.oregon.gov/oha/PEBB/MeetingDocuments/PEBB-Board-Agenda-Attachments-20230718.pdf>

A Willis Towers Audit presented to the OEPP/PEBB Board of Directors in October 2022 estimated the savings created by reference pricing to be \$59m in 2020 and almost \$113m in 2021.¹³⁸ A NASHP article analyzing the results of the program highlighted that the average Medicare reimbursement level declined from 215% of Medicare pre-limit to 163% of Medicare in 2021.¹³⁹

Nevada Public Option Plan

Nevada enacted legislation¹⁴⁰ in 2021 to create a public option plan on its state-based exchange by 2026 to improve affordability and access to quality health plans for individuals and families purchasing health insurance in the individual market. The legislation mandated that premiums be reduced by 15% over four years from a 2024 reference-based price.¹⁴¹ It allowed the state to require Medicaid managed care organizations to propose a good faith offer of a public option plan achieving these premium reductions on the exchange.¹⁴² The legislation authorized the state to submit a 1332 state innovation waiver to implement the program and to use passthrough funds generated by the public option premium reductions to further reduce consumer affordability barriers. Actuarial analysis studying the impact of the public option as well as the potential passthrough funding created by it found “these reforms could bring in up to \$344 million to the state and decrease the uninsured rate among people currently eligible for but not enrolled in subsidized marketplace coverage by up to 12% over five years.”¹⁴³

The initial waiver application is due January 1, 2024. The governor and his administration recently announced¹⁴⁴ a change in strategy and approach. They intend to leverage the public option created passthrough savings to fund a market stabilization program to bring “...greater stability to Nevada’s individual market for health insurance by reinvesting 1332 waiver funds back into the marketplace and provider system.”¹⁴⁵ As proposed, the marketplace stabilization program will create and fund:

- A reinsurance program in the individual market
- A quality incentive program to reward insurers offering the public option who meet quality and access measures and to prevent cost-shifting the financial burden of the premium reduction requirements to providers; and
- A provider workforce loan repayment and scholarship program to grow the health care workforce in Nevada

¹³⁸ <https://www.oregon.gov/oha/PEBB/MeetingDocuments/PEBB-Board-Agenda-Attachments-20221018.pdf>

¹³⁹ <https://nashp.org/oregon-saves-millions-using-reference-based-pricing/>

¹⁴⁰ <https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Text>

¹⁴¹ Defined as “...the average second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity.”

¹⁴² <https://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Resources/PublicOption/NV%20Public%20Option%20Fact%20Sheet%2010-14-2022.pdf>

¹⁴³ <https://chirblog.org/nevada-actuarial-study-projects-significant-savings-public-option-plans/>

¹⁴⁴ <https://thenevadaindependent.com/article/lombardo-to-move-forward-with-public-option-with-a-new-twist-reinsurance>

¹⁴⁵ Nevada Department of Health and Human Services. Transforming the Nevada Public Option into a Market Stabilization Program. October 11, 2023. Available at: https://gov.nv.gov/Newsroom/PRs/2023/2023-10-11_nv-public-option/ Accessed November 27, 2023.

Actuarial analysis studying this change in 1332 waiver approach has not been released.

Washington State Law and Experience with Public Option Plan Cap on Provider Reimbursement

Washington's public option, Cascade Select¹⁴⁶, leverages reference pricing to mandate aggregate provider reimbursement levels. It requires public option plan reimbursement to not exceed 160% of Medicare in the aggregate. To achieve this aggregate cap, insurers can negotiate different reimbursement levels across broad categories of services, such as inpatient and outpatient services, as long as reimbursement levels for primary care providers is not lower than 135% of Medicare and critical access hospital reimbursement is not lower than 101% of their costs. Cascade Select plans are only available through Washington Healthplanfinder and are actively selected and administered by the Health Care Authority.¹⁴⁷

The public option was created to improve affordability and access to quality health plans for individuals and families purchasing health insurance in the individual market. Through the provider reimbursement cap, standard plan design requirements covering more services before the deductible, and state premium assistance to lower income consumers,¹⁴⁸ consumers have access to higher value plans at a lower cost than the non-public option plans offered on the Exchange.

Cascade Select plan enrollment tripled in 2023, and now makes up more than 11% of Washington Healthplanfinder individual market enrollment.¹⁴⁹ Premium increases in public option plans have been lower than for other plans offered on the Exchange. In 2024, Cascade Select will be the lowest cost Silver in 31 of 39 counties, up from 13 counties in 2023.¹⁵⁰

The legislature has tasked the Washington Health Benefits Exchange (WAHBE) with submitting an actuarial study by December 1, 2023, that analyzes strategies to change the public option plan in ways that could generate federal pass-through funding through a revision to the state's existing 1332 state innovation waiver. Additional pass-through funds would be invested in affordability programs designed to reduce consumer out-of-pocket spending on premiums and cost-sharing.

¹⁴⁶ Washington State Health Care Authority. Cascade Select (Public Option). Available at:

<https://www.hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option>. Accessed November 27, 2023.

¹⁴⁷ Washington State Legislature. Engrossed Substitute Senate Bill 5526. Available at: <https://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf?q=20220203164635>. Accessed November 27, 2023.

¹⁴⁸ Washington Health Plan Finder. Cascade Care Savings. Available at: <https://www.wahealthplanfinder.org/us/en/my-account/savings-options/cascade-care-savings.html>. Accessed November 27, 2023.

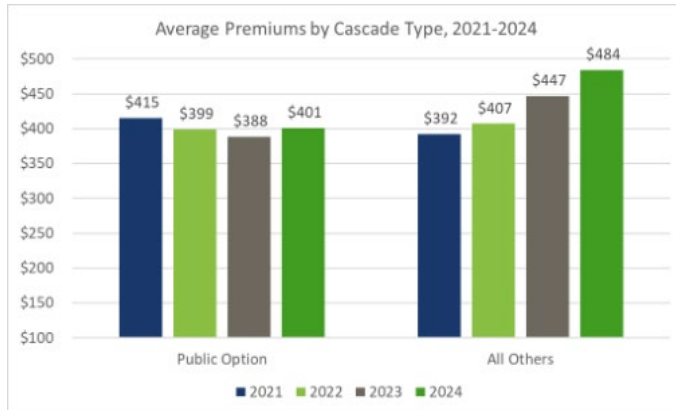
¹⁴⁹ Washington State Health Care Authority. Enrollment Triples in Washington's Cascade Select Public Option. Available at: <https://content.govdelivery.com/accounts/WAHC/bulletins/3482512>. Accessed November 27, 2023.

¹⁵⁰ Washington State Health Care Authority. In 2024, Cascade Select Plans Will Be Available in 37 Out of 39 Washington State Counties. Available at: <https://www.hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option>. Accessed November 27, 2023.

Figure 7: Status of Washington's Public Option 2023

Public Option Shows Promise, But Needs Strengthening

Public option plans supporting customer affordability compared to other Exchange plans, but premiums still not meaningfully lower.



Rates for 40-year-old nonsmoker, inclusive of all counties, and are not weighted for enrollment. Rates are before any available state or federal subsidy.

Source: 2021 -2024 OIC Carrier Rate Filings

Plan Type	Last Year	This Year	2022-2024
Cascade Public Option	-3%	3%	0.5%
All Others	10%	8%	19%



Facility Fee Reform

Additional oversight and limitation of "facility fees" for care received in outpatient and physician office settings that are part of hospital system.

State efforts have been few and focus on limitations about when and where fees can be charged and additional reporting and transparency; Connecticut has been the most aggressive.

Washington requires that provider-base clinics charging these fees disclose that the clinic is part of a hospital system and that the patient may be charged a separate fee that could result in additional out-of-pocket expenses.



Implement Facility Fee Reform

Hospitals charge facility fees for care provided in outpatient and physician office settings that are hospital-owned or controlled. These charges ostensibly reflect hospital overhead expenses. However, the facility fees are not necessarily intended to cover costs specific to the setting where care is being provided or the patient being charged the fee. Federal and state governments, health plans and consumer, have been raising concerns about the use and cost of hospital facility fees for services provided in outpatient settings and physician practices.

The expanded use and increasing price tag of facility fees have created affordability and cost control issues for both Medicare and commercial insurers. Some hospital administrators argue that primary care and other outpatient services generally cost more in hospital-based settings, including off-campus facilities, because of the overhead costs associated with running the facility and providing around-the-clock care. The fees merely reflect these additional costs. Conversely, critics of this practice argue that facility fees are a mechanism for increasing hospital revenues and profits and that the expense contributes neither to the care being delivered in off-campus settings nor the upkeep or maintenance of those facilities.¹⁵¹

Hospital purchases of independent outpatient and physician practices resulting in new hospital facility fees that increase costs and in many cases cause higher consumer cost-sharing, are driving widespread concerns about facility fees. According to a Georgetown University Center on Health Insurance Reforms (CHIR) report,¹⁵² health insurers “face higher prices for outpatient services as a result of vertical integration, with estimates ranging from a 14.1% increase for all services provided by acquired physician practices, to a 5% increase in outpatient primary care prices.” Facility fees for health insurance are generally unregulated and are set through contract negotiations, giving large hospital systems with dominant market position considerable leverage over pricing. This dynamic has resulted in growing fees and considerable variation in pricing across hospitals and markets.

Regulating or limiting facility fees for hospital-owned outpatient and physician practices is seen as a tool for combating vertical integration, as the facility fee financial incentive associated with owning these outpatient settings could be reduced. The Medicare Payment Advisory Commission has studied this issue extensively and has made recommendations¹⁵³ on moving toward a site-neutral approach to Medicare payments for outpatient and physician-based services. These recommendations are currently being considered by Congress.

¹⁵¹ For a comprehensive discussion of facility fees and the ongoing debate over whether and how to regulate them, [see go to https://www.healthaffairs.org/content/forefront/facility-fees-101-all-fuss](https://www.healthaffairs.org/content/forefront/facility-fees-101-all-fuss).

¹⁵² Monahan CH, Davenport K, Swindle R. Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform. July 2023. Available at: <https://georgetown.app.box.com/v/statefacilityfeereport>. Accessed November 27, 2023.

¹⁵³ Goldman M. MedPAC Wades Back into Outpatient Site-Neutral Payments. *Modern Healthcare*. November 9, 2021. Available at: <https://www.modernhealthcare.com/payment/medpac-wades-back-outpatient-site-neutral-payments>. Accessed November 27, 2023.

NASHP has also studied the issue, providing research and technical assistance to states, and has developed model legislation designed to give states authority and tools necessary to regulate and limit facility fees.¹⁵⁴

Facility Fee Regulation State Initiatives

In recent years, states have increased efforts to regulate facility fees and foster transparency around the issue in the interest of limiting facility fee charges, curbing price growth, and educating consumers. These steps include:

- Regulating or outlawing facility fees at off-campus hospital owned outpatient settings and physician offices
- Limiting facility fees for some on-campus services
- Limiting or prohibiting consumer cost-sharing for facility fees
- Requiring hospital owned facilities to disclose to patients their affiliations and potential for a facility fee charge on their bill
- Requiring hospitals to report facility fee activity to a state agency

To date, state efforts to limit and regulate facility fees have been limited. Connecticut has been the most aggressive state. Current law prohibits facility fees for certain off-site outpatient services as well as telehealth services. Starting July 1, 2024, hospitals will be prohibited from charging facility fees for on-campus services, with limited exceptions. Civil penalties of up to \$1,000 will be issued for violations of this law.¹⁵⁵ This law was and is still opposed by the hospital industry, which argued that facility fees are critical to covering the costs of providing adequate and quality care in outpatient settings, which in turn saves everyone money by preventing more costly inpatient and emergency care.¹⁵⁶ Indiana recently enacted a limitation on facility fees charges for outpatient services in off-campus office settings by certain non-profit hospitals¹⁵⁷ on. Facility fees for for-profit hospital systems as well as for on-campus non-profit outpatient services will still be allowed.¹⁵⁸ Indiana's law goes into effect on January 1, 2025.

The State of Maine recently enacted legislation creating a task force charged with studying and reporting on the impact of facility fees on consumers and costs and to make recommendations to the legislature on solutions for addressing or limiting their impact on affordability.¹⁵⁹ A table summarizing other state efforts to evaluate, limit and address facility fees from the above referenced CHIR report can be found in Table 8.

¹⁵⁴ National Academy for State Health Policy. NASHP Model State Legislation to Prohibit Unwarranted Facility Fees. August 24, 2020. Available at: <https://nashp.org/nashp-model-state-legislation-to-prohibit-unwarranted-facility-fees/>. Accessed November 27, 2023.

¹⁵⁵ <https://www.cga.ct.gov/2023/rpt/pdf/2023-R-0152.pdf>

¹⁵⁶ <https://ctmirror.org/2023/10/26/hospital-outpatient-facility-fee-charge-care/>

¹⁵⁷ Defined as non-profit hospitals with patient revenue of at least \$2 billion on the hospital system's audited 2021 financial statements.

¹⁵⁸ Indiana General Assembly. House Enrolled Act No. 1004. Available at: <https://iga.in.gov/pdf-documents/123/2023/house/bills/HB1004/HB1004.07.ENRS.pdf>. Accessed November 27, 2023.

¹⁵⁹ State of Maine. An Act to Create Greater Transparency for Facility Fees Charged by Health Care Providers and to Establish the Task Force to Evaluate the Impact of Facility Fees on Patients. P.L. 410. Approved by the Governor July 10, 2023. Available at: <https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0720&item=3&snum=131>. Accessed November 27, 2023.

Table 8: State Facility Fee Requirements

Table 1. Outpatient Facility Fee Requirements in 11 Study States

STUDY STATE	Regulatory Reform				
	1. Prohibition on Facility Fees	2. Out-of-Pocket Cost Protections	3. Consumer Disclosure Requirements	4. Hospital Reporting Requirements	5. Provider Transparency Requirements
COLORADO	State prohibits providers from charging facility fees for specified procedures and/or care settings	State limits consumers' financial exposure to outpatient facility fees in specified circumstances	State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No balance billing for facility fees for preventive services*	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study
FLORIDA			Hospitals and hospital-owned facilities, insurers		Annual reporting
INDIANA	Off-campus office settings owned by non-profit hospitals*		Hospitals and hospital-owned facilities, freestanding EDs		
MAINE**	On- and off-campus office settings				Annual reporting
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities		Annual reporting
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities		Annual reporting

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

Washington State Law and Experience Related to Facility Fees

Washington State law requires provider-based clinics that charge a facility fee to post and disclose to patients that the clinic is licensed as part of a hospital and that the patient may be charged a separate facility fee that could result in additional out-of-pocket expenses.¹⁶⁰ Washington also requires hospitals with provider-based clinics to include in their year-end financial reports to the Department of Health (DOH) information about facility fees. These reports are available on the DOH website,¹⁶¹ and information for 2022 is summarized in Table 9, page 69.

¹⁶⁰ Washington State Legislature. RCW 70.01.040: Provider-Based Clinics that Charge a Facility Fee—Posting of Required Notice—Reporting Requirements. Available at: <https://app.leg.wa.gov/RCW/default.aspx?cite=70.01.040&pdf=true>. Accessed November 27, 2023.

¹⁶¹ Washington State Department of Health. 2022 Facility Fees. Available at:

Table 9: 2022 Hospital Facility Fees

Name	Number of Clinics	Annual Patient Visits	Annual Facility Fee Revenue	Lowest Facility Fee	Highest Facility Fee
EvergreenHealth	2	19,925	\$ 4,115,576	\$ 100	\$ 233
Inland Hosptial	1	2,462	\$ 209,490	\$ -	\$ 255
Kadlec Regional Medical Center	15	197,376	\$ 16,305,430	\$ 1	\$ 704
Olympic Medical Center	18	173,474	\$ 43,904,378	N/A	N/A
Overlake Hospital Medical Center	3	19,472	\$ 2,244,469	\$ -	\$ 349
Providence Centralia Hospital	4	6,102	\$ 832,634	\$ 45	\$ 658
Providence Regional Medical Center Everett	1	19,492	\$ 2,560,631	\$ 28	\$ 830
Providence Sacred Heart Medical Center	1	5,341	\$ 525,758	\$ 33	\$ 678
Seattle Cancer Care Alliance	7	127,254	\$ 18,089,720	\$ 67	\$ 502
Seattle Children's Hospital	8	92,739	\$ 6,011,663	\$ 25	\$ 180
Skagit Valley Hosptial	4	104,315	\$ 4,377,149	\$ -	\$ 2,900
Swedish Medical Center - First Hill	4	34,494	\$ 4,234,684	\$ 5	\$ 608
University of Washington Medical Center	20	126,122	\$ 10,344,460	\$ -	\$ 253
UW Medicine/Harborview Medical Center	6	7,548	\$ 506,742	\$ -	\$ 253
UW Medicine/Valley Medical Center	5	281,954	\$ 13,243,390	\$ 0.4	\$ 3,860
Yakima Valley Memorial	13	88,958	\$ 4,723,220	\$ -	\$ 618

<https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-financial-data/hospital-facility-fees/2022-facility-fees>. Accessed November 27, 2023.

Public Option Plans

Public Option plans are designed to be the most affordable plans in the individual and small group markets.

Colorado has established a public option plan that is intended to decrease premiums by 15% over three years. It is not clear that this goal will be met.

Enrollment in Washington's public option (Cascade Select) now makes up more than 11% of Washington Healthplanfinder individual market enrollment. Premium increases in public option plans have been lower than for other plans offered on the Exchange; in 2024, Cascade Select will be the lowest cost silver in 31 of 39 counties.



Offer Public Option Health Plans

Colorado's Public Option Premium Reduction Enforcement

The Colorado Option,¹⁶² is intended to improve access to care, affordability, and to reduce racial health care disparities for consumers in the individual and small group markets through standard plan designs and premium reduction requirements. Starting in 2023, insurers are required to offer public option plans in any county in which insurers offer individual or small group plans. They also must decrease premiums for their public option plans by 15% over three years (5% annually) from a 2021 baseline. In addition, public option plans must adhere to standard plan designs that limit out-of-pocket spending and barriers to care.

The plans also have provider network requirements prohibiting networks narrower than non-public option plans and mandate contracting with 50% or more of Essential Community Providers¹⁶³ in the plan's service area, up from the federal standard of 35%. The Colorado Division of Insurance has estimated that the Colorado Option will save Coloradans \$14.7 million in 2023.¹⁶⁴ Not all insurers were able to meet the premium reduction requirement of 5% in 2023.¹⁶⁵

Starting in plan year 2024, insurers that cannot meet the annual premium decrease or network participation requirements for their Colorado Option plans will be subject to a public hearing process with the Colorado Division of Insurance to determine the cause of the failure to meet the requirements and to identify corrective actions. The hearing process is intended to create transparency. Once the hearing process begins, insurers and providers have the opportunity to negotiate and reach agreement. If the parties have reached an impasse, the hearing process is designed to find the root cause of the non-compliance. Through a final agency order, the commissioner can set lower provider reimbursement rates if they are the cause of the insurer's inability to meet the premium target and to direct the insurer to use those rates in their plan filings. Hearings were initially scheduled for plans filed in 2023 for the 2024 plan year, but none were held.¹⁶⁶

Nevada's and Washington state's public option plans are reviewed on pages 62 and 63.

¹⁶² Colorado Division of Insurance. Colorado Option 2023 Standard Plans Quality and Affordable Health Insurance Coverage. Available at: <https://drive.google.com/file/d/1HcCxoBi76XCHEwVN3O3qKbPUa6vdkFAk/view>. Accessed November 27, 2023.

¹⁶³ CMS defines "Essential Community Providers" (ECPs) as providers that predominantly serve low-income, medically underserved individuals. Details available at: <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/ecp-faq-20130513.pdf>. CMS regulations set forth the requirements for plans to contract with ECPs. See 45 CFR 156.235, [https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.235#p-156.235\(a\)\(2\)\(ii\)\(B\)](https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.235#p-156.235(a)(2)(ii)(B)).

¹⁶⁴ Ingold J. Colorado Health Insurance Rates Are Set to Rise Next Year—But Some People Could Still Pay Less <https://coloradosun.com/2022/10/26/colorado-option-health-insurance-prices-2023/>. *Colorado Sun*. Available at: <https://coloradosun.com/2022/10/26/colorado-option-health-insurance-prices-2023/>. Accessed November 27, 2023.

¹⁶⁵ Hawryluk M. Colorado Option's Big Test: Open Enrollment. *KFF Health News*. December 7, 2022. Available at: <https://kffhealthnews.org/news/article/colorado-public-option-test-open-enrollment/>. Accessed November 27, 2023.

¹⁶⁶ Ingold J. Why Every Public Rate Hearing for the Colorado Option Health Insurance Plans Got Canceled. *Colorado Sun*. Available at: <https://coloradosun.com/2023/07/05/colorado-option-health-insurance-hearings-canceled/>. Accessed November 27, 2023.

State Exchange Subsidies

State funds are used to lower premiums and provide cost sharing assistance for consumers enrolled in Exchange plans.

Eight states have implemented some form of state-based premium or cost-sharing assistance.

Washington has a state-funded premium subsidy to Exchange consumers who enroll in Cascade Care silver or gold plans.



Implement Exchange Subsidies

The ACA originally provided financial assistance through state Exchanges in the form of premium tax credits and cost-sharing reductions (CSRs), available to consumers without access to affordable, qualified coverage through some other means and who met the income eligibility requirements. Qualified consumers with incomes of 100%–400% of the federal poverty level (FPL) could receive premium tax credits to reduce monthly premiums, which were most generous at the lowest income levels, declining in value as income increased. Qualified consumers at 100%–250% of FPL were also eligible to receive cost-sharing reductions, if they enrolled in Silver plans. CSRs decline in generosity as income increases. Select populations, such as lawfully present immigrants under 100% of FPL not qualified for Medicaid¹⁶⁷ and Native American and Alaska Native¹⁶⁸ populations qualify for additional financial assistance opportunities.

The ARPA¹⁶⁹ changed the ACA premium tax credits, enhancing their value and expanding their availability to populations earning more than 400% of FPL. These enhanced premium tax credits are authorized through 2025. Though these changes have improved affordability for millions of people enrolling in exchanges across the country, cost of coverage and care affordability gaps remain.

State Initiatives

To address affordability gaps, states have created targeted premium and cost sharing assistance programs in the form of income-based subsidy and cost-sharing wraps as well as population specific programs. California,¹⁷⁰ Colorado,¹⁷¹ Connecticut,¹⁷² New Mexico,¹⁷³ and Vermont¹⁷⁴ all provide qualified exchange customers with additional premium and cost-sharing subsidies. Maryland¹⁷⁵ provides additional premium subsidies to qualified adults ages 18–37 and with income up to 400%, Massachusetts provides premium

¹⁶⁷ HealthCare.gov. Coverage for Lawfully Present Immigrants. Available at: <https://www.healthcare.gov/immigrants/lawfully-present-immigrants/>. Accessed November 27, 2023.

¹⁶⁸ Centers for Medicare & Medicaid Services. Information for American Indians and Alaska Natives Applying for Coverage. Available at: <https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/downloads/information-for-aians-applying-for-coverage2017.pdf>. Accessed November 27, 2023.

¹⁶⁹ US Congress. American Rescue Plan Act of 2021. P.L.117–2. March 11, 2021. Available at: <https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf>. Accessed November 27, 2023.

¹⁷⁰ Covered California. Covered California to Launch State-Enhanced Cost-Sharing Reduction Program in 2024 to Improve Health Care Affordability for Enrollees. Available at: <https://www.coveredca.com/newsroom/news-releases/2023/07/20/covered-california-to-launch-state-enhanced-cost-sharing-reduction-program/>. Accessed November 27, 2023.

¹⁷¹ Connect for Health Discounts. Healthcare Discounts. Available at: <https://connectforhealthco.com/financial-help/healthcare-discounts/>. Accessed November 27, 2023.

¹⁷² Access Health CT. Financial Help. Available at: <https://www.accesshealthct.com/financial-help/>. Accessed November 27, 2023.

¹⁷³ New Mexico Office of Superintendent of Insurance. 2024 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual. April 13, 2023. Available at: https://a.storyblok.com/f/132761/x/9707cfc6bb/final_2024-health-insurance-marketplace-affordability-program-policy-and-procedures-manual_230412.pdf. Accessed November 27, 2023.

¹⁷⁴ Department of Vermont Health Access. Vermont Health Connect. Available at: <https://info.healthconnect.vermont.gov/financial-help>. Accessed November 27, 2023.

¹⁷⁵ Maryland Health Connection. Young Adult Subsidy Program Expands Age Range. Available at: <https://www.marylandhealthconnection.gov/young-adult-subsidy-program-expands-age-range/>. Accessed November 27, 2023.

subsidies to qualified individuals up to 500%,¹⁷⁶ and New Jersey provides premium subsidies to qualified customers up to 600% of FPL.¹⁷⁷

Washington State Law and Experience Related to Additional Individual Market Premium Subsidies

Washington provides state-funded premium subsidies to Washington Healthplanfinder customers with incomes up to 250% FPL who enroll in Cascade Care Silver or Gold plans. Starting in 2024, all Washingtonians regardless of immigration status who are ineligible for the ACA premium tax credits may also receive these premium subsidies.

¹⁷⁶ <https://www.mahealthconnector.org/learn/plan-information/connectorcare-plans>

¹⁷⁷ <https://nj.gov/getcoverednj/financialhelp/gethelp/>

Individual Mandate

Requires individuals to participate in health insurance coverage to promote universal enrollment and a larger risk pool- penalties could be used to support affordability provisions.

Five states have enacted individual mandates.

Washington enacted an individual mandate as part of the 1993 Health Services Act which was repealed in 1995.



Enact a State Individual Mandate

The individual mandate, also known as the individual shared responsibility provision,¹⁷⁸ was included in the ACA based on the assumption that the pathway to universal coverage would be achieved through a combination of financial incentives, consumer protections, and penalties for not participating. The incentive came in the form of federal funding for the expansion of Medicaid to childless adults as well as the premium tax credits and corporate social responsibilities (CSRs) described earlier. Consumer protections included the elimination of preexisting condition denials, removal of annual and lifetime benefit caps, essential health benefit requirements, among many others. The penalties for failing to offer or enroll in coverage were fines assessed through the federal tax filing process on employers that didn't offer comprehensive and affordable health insurance and on individuals who choose to be uninsured. The latter is known as the individual mandate penalty. The individual mandate penalty was set as either a specific dollar amount or a percentage of family income, whichever was greater. The penalty was phased in beginning in 2014 and reached a maximum of the greater of \$2,085 per family or 2.5% of household income above the income tax filing threshold. The penalty was reduced to \$0 by Congress, effective in 2019.¹⁷⁹ In tax year 2017, 4.6 million returns reported penalties totaling approximately \$3.6 billion.¹⁸⁰

Other States

Massachusetts implemented an individual mandate¹⁸¹ and other access and affordability reforms in 2006, which was superseded by the ACA's individual mandate and then reinstated after its elimination. California,¹⁸² the District of Columbia,¹⁸³ New Jersey,¹⁸⁴ and Rhode Island¹⁸⁵ all enacted their own state-based individual mandates which largely mirrored the ACA individual mandate and were effective in 2019 or 2020. The advocacy for enacting state-based individual mandates was generally similar across these states and DC, arguing that achieving universal coverage is dependent on incentives, penalties, and full participation in the health care system. A related argument used during legislative advocacy for the individual mandate was that associated penalty revenues could be invested into affordability programs, such as state subsidies or reinsurance, utilizing these fines to improve access and affordability.

¹⁷⁸ <https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision>

¹⁷⁹ <https://www.kff.org/interactive/penalty-calculator/>

¹⁸⁰ <https://sfp.fas.org/crs/misc/R44438.pdf>

¹⁸¹ <https://www.mass.gov/regulations/830-CMR-111m21-health-insurance-individual-mandate-personal-income-tax-return-requirements>

¹⁸² <https://www.coveredca.com/marketing-blog/why-are-californians-required-by-law-to-have-health-insurance/>

¹⁸³ <https://code.dccouncil.gov/us/dc/council/code/titles/47/chapters/51>

¹⁸⁴ <https://nj.gov/treasury/njhealthinsurancemandate/>

¹⁸⁵ <https://tax.ri.gov/guidance/health-insurance-mandate>

Washington State Law and Experience with the Individual Mandate

In 1993, the Washington state Legislature enacted the Health Services Act, a comprehensive health care reform measure. The law included a requirement for individuals to enroll in coverage that would have been effective as of January 1, 1999.¹⁸⁶ The individual mandate was repealed in 1995.

¹⁸⁶ Formerly RCW 43.72.210 (Sec. 463 of Chap. 492, Laws of 1993)

All-Payer Model

An All-Payer Model establishes rates for hospitals which are the same for all payers and sets budgets for hospital revenue.

Maryland's model has changed over time to a Total Cost of Care Model that expands all-payer rate setting to primary care and specialty providers and provides support and incentives to reduce.

Washington had a hospital rate-setting statute like Maryland's in the 1970's and '80s. It was repealed in 1989.



Create an All-Payer Model Like Maryland's Original Hospital Rate-Setting

Starting in the 1970s, Maryland established a hospital rate-setting system that was authorized through an agreement with CMS which exempted the state from Medicare's Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). The agreement was based on the understanding that Maryland would keep Medicare inpatient payments per admission below the national growth rate. To accomplish this, all Maryland payers were required to pay the same rate for the same service at the same hospital.

In 2010, Maryland implemented a global budget program for rural acute care hospitals. Under the model, the state provided eight participating rural hospitals with an annual budget for all inpatient, emergency department, and outpatient services from all payers (Medicare, Medicaid, commercial, and self-pay). The state extended the global budget program to include urban and suburban hospitals with the Maryland APM in 2014. Maryland made this transition away from the rate-setting system because cost per admission had been increasing faster than the national average and state officials worried they would lose their CMS exemption. In addition, "...the focus on cost per admission was poorly aligned with other health care delivery system reforms under way in Maryland and nationally that focused on comprehensive, coordinated care across delivery settings."¹⁸⁷

All-Payer Model

In 2014, the Maryland Health Services Cost Review Commission (HSCRC) fully implemented the all-payer, global hospital budget cost containment initiative created by a CMS waiver. This All-Payer Model (APM) allowed the state to set nearly all inpatient and outpatient hospital rates, included a hospital revenue growth target and incentivized efforts to deliver high-quality services and improve population health. The APM was built upon the hospital rate-setting model and included commitments to limit hospital revenue growth over the 5-year waiver period to less than 3.58% and to create more than \$330m in Medicare savings.¹⁸⁸

The APM established an annual global budget for each hospital which was baselined in 2013 and adjusted annually based on several factors including inflation, population changes, and utilization. All regulated acute care hospitals participated in the program. HRSRC set the hospital's rates for all payers based on their global budget and allowed Medicaid and Medicare payers a 6% discount. The global budget included a hospital specific revenue ceiling and hospitals were penalized for overages as well as underspending exceeding 0.5% of revenue. Due to fluctuations in expected utilization, hospitals were allowed to adjust their rates mid-year in the interest of hitting their global budgets and could independently increase or decrease their rates by up to 5%, above which they would need approval from HSCRC. Adjustments above 10% were not allowed except under exceptional circumstances.¹⁸⁹

¹⁸⁷ <https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf>

¹⁸⁸ Maryland HSCRC, *Maryland's Total Cost of Care Model: Background and Summary*, <https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%205%2023%2018%20.pdf>

¹⁸⁹ *Ibid.*

For the five-year waiver period HSCRC reported that they met or exceeded all the originally set performance targets.¹⁹⁰ Annual hospital revenue growth per capita from 2014-2018 was 1.92%, well below the target of less than or equal to 3.58%. Medicare savings were \$1.4 billion over the waiver period, exceeding the original target of \$330 million or more. A CMS final evaluation report highlighted that total Medicare expenditures in Maryland "...declined by 2.8% and hospital expenditures declined by 4.1% without shifting costs to other parts of the health care system. A 17.2% reduction in outpatient department service expenditures drove Medicare hospital savings."¹⁹¹ Table 10 is a table from HSCRC that includes additional results and outcomes from the 5-year APM performance period.

Table 10: Outcomes from Maryland's All-Payer Model

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ \$330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	\$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	\$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

* \$273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate vs. 2013 base

¹⁹⁰[https://hscrc.maryland.gov/Documents/Maternal percent20Task percent20Force/HSCRC percent20All percent20Payer percent20Model percent20PY5 percent20Results.pdf](https://hscrc.maryland.gov/Documents/Maternal%20Task%20Force/HSCRC%20All%20Payer%20Model%20PY5%20Results.pdf)

¹⁹¹ <https://www.cms.gov/priorities/innovation/files/reports/md-allpayer-finalevalrpt-fg.pdf>

Total Cost of Care Model

In January 2019, Maryland implemented the total cost of care model (TCOC), which builds on global budgets tested in the alternative payment model (APM), and moves beyond hospitals to accept responsibility for limiting the growth in total cost of care for Maryland Medicare beneficiaries.¹⁹² The model creates incentives and supports for hospitals, primary care practices, and other providers that seek to reduce spending, enhance quality, improve population health and health equity, and achieve care transformation targets. The TCOC model also establishes multi-payer pricing for medical services that hospitals, primary care providers, and specialists deliver; sets each hospital's annual revenue from all payers; and supports improved care coordination and the provision of patient-centered care.

The TCOC model covers hospital payments, care redesign, and the state's primary care patient management services to reduce overall spending.

- The Hospital Payment Program is mandatory and allows participating hospitals to receive population-based compensation for all services they provide throughout the year.
- The Care Redesign Program is voluntary and allows participating hospitals to offer incentive payments to nonhospital health care providers who collaborate with the hospital to conduct care redesign activities. Participating hospitals can earn incentive payments only if they achieve savings under their global budget.
- The Maryland Primary Care Program (MDPCP) is voluntary and open to all Maryland qualifying primary care providers, including federally qualified health centers (FQHCs). Under this arrangement, CMS pays participating providers risk- and deprivation-adjusted care management fees, as well as performance-based incentive payments for providing comprehensive primary care. The program focuses on five comprehensive primary care functions: access to care, care management, comprehensiveness and coordination, patient and caregiver experience, and planned care and population health.

Under TCOC, Maryland accepts accountability for growth in Medicare spending per enrollee, and each hospital is subject to a Medicare performance adjustment (MPA) based on total per capita spending increases in its service area relative to a target growth level. Through TCOC, Maryland aims to save on Medicare per capita total cost of care during each model year (2019–2023). The state's goal is to achieve more than \$1 billion in Medicare total cost of care savings by the fifth model year, 2023.¹⁹³

¹⁹² Maryland HSCRC, *Maryland's Total Cost of Care Model: Background and Summary*, <https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%205%2023%2018%20.pdf>

¹⁹² *Ibid.*

¹⁹³ [https://hscrc.maryland.gov/Documents/Modernization/7-30-18 percent20Announced percent20Terms FINAL.pdf](https://hscrc.maryland.gov/Documents/Modernization/7-30-18%20percent20Announced%20Terms%20FINAL.pdf)

Washington State Law and Experience with Hospital Rate-setting

In the 1970s and 1980s, Washington had hospital rate-setting authority similar to Maryland's. One study assessing the impact of hospital rate setting during this time period noted it was "successful at controlling the rate of increase in hospital costs in most of the states that implemented this type of regulation."¹⁹⁴ The same study noted that Washington was one of two states in which it proved to be less successful, with hospital costs increasing faster than the nationwide average. Another study¹⁹⁵ found that Washington's rate setting commission's approach to regulating hospitals varied from that employed by Maryland and other states, which set growth targets and established compliance incentives but deferred the work of achieving these goals to the hospital administrators.

Washington's approach was more hands-on and received an unenthusiastic welcome from the hospital industry. "Despite the very large annual hospital allowances afforded by the Washington commission and despite an enabling statute that was nearly identical to Maryland's, Washington's system proved unpopular with hospitals and was terminated in 1989."¹⁹⁶

¹⁹⁴ <https://www.issuelab.org/resources/11206/11206.pdf>

¹⁹⁵ <https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf>

¹⁹⁶ Ibid.

PART III: ECONOMIC MODEL TO REVIEW THE IMPACT OF SELECTED POLICY OPTIONS

Background

This part describes several policies Washington policymakers might consider adopting or amending to reduce the growth in the total cost of health care. Part III describes how HMA will determine the potential impact of the selected policies on Washington's health care system. The results of this analysis will be included in the final report, which will be available in July 2024.

This analysis will include several inputs including the costs to the state of developing and managing the new policy initiatives and the direct and indirect benefits of adopting new policies or amending existing policies to reduce health care spending and improve health care affordability in Washington. The cost-benefit analysis will estimate the direct and indirect benefits to the state, to employers and Washington residents, and compare total benefits to total costs, resulting in a benefit-to-cost ratio and an ROI on the state's investment.

The analysis also will show to what extent the policy initiatives selected are likely to meet or exceed the benchmarks established by the Washington HCCTB (described in Part II on page 41). Finally, the analysis will include what is likely to happen if none of the policy reforms selected for modeling are adopted and implemented.

Key Assumptions

The National Bureau of Economic Research published an important report on key factors driving the growth in health care spending in December 2022.¹⁹⁷ This study identifies five factors driving increased health care spending:

1. Technological change
2. Income growth and macroeconomic change
3. Population demographics
4. Health insurance generosity
5. Unit prices of medical care goods and services

This report concluded that the growth in income—and its interaction with technology—is the dominant driver of medical spending growth. CMS recently released the federal government's forecast for national health expenditures. CMS projects that in 2022–2031, average annual growth in national health expenditures will be 5.4%. It is expected to outpace the average annual growth in gross domestic product (GDP), which is projected to be 4.6%.¹⁹⁸

¹⁹⁷ Smith SD, Newhouse JP, Cuckler GA. Health Care Spending Growth Has Slowed: Will the Bend in the Curve Continue? National Bureau of Economic Research. Working Paper 30782. Cambridge, MA. December 2022. <http://www.nber.org/papers/ww30782>.

¹⁹⁸ CMS Office of the Actuary Releases 2022-2031 National Health Expenditure Projections. June 14, 2023. [CMS Office of the Actuary Releases 2022-2031 National Health Expenditure Projections | CMS](#)

The following table, based on the CMS data, shows the long-term average annual growth of health expenditures over 40 years in Washington and it with the projected spending increases in United States. This table shows where the spending growth is coming from as broken down in terms of the various sectors of the health care system.

Table 11: Average Annual Percent Growth 1980 - 2020¹⁹⁹

Category	Washington	United States	Variance
Home Health Care	10.4%	9.4%	1.00%
Other Professional Services	9.2%	9.6%	-0.40%
Prescription Drugs	8.8%	7.8%	1.00%
Other Health, Residential, and Personal Care	8.4%	9.8%	-1.40%
Physician & Clinical Services	7.3%	7.8%	-0.50%
Personal Health Care	7.1%	7.6%	-0.50%
Durable Medical Products	6.7%	7%	-0.30%
Nursing Home Care	6.6%	6%	0.60%
Hospital Care	6.5%	7.7%	-1.20%
Other Non-durable Medical Products	6.4%	6.4%	0.00%
Dental Services	6.1%	6.3%	-0.20%
Total Health Expenditures	7.6%	7.1%	0.50%

As noted, the underlying assumption of this analysis is the extent to which the selected policy interventions are aimed at the major drivers of increases in Washington health care costs. HMA will use a combination of existing research complimented by quantitative data and qualitative experience from other states that have implemented comparable policy reforms.

¹⁹⁹ <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-provider>

This information will help determine the expected magnitude of the reduction in total health spending in Washington. If no other states have tested one or more policy option(s), HMA will use gather information from the existing research and key expert interviews.

The baseline is determined based on two factors: the expected growth in total health spending if the status quo is maintained and the overall performance of the economy. For example, if the United States experiences a significant and prolonged recession in 2024, perhaps extending into 2025, the baseline growth in total health care spending would decline. The opposite is also true. An unexpectedly strong economic performance will increase the baseline growth of total health spending.

The estimated gap between the expected growth in total health care spending in Washington in the absence of policy reforms and the expected growth in total health care spending if all the policies modeled are successfully implemented, will illustrate the extent to which the state benchmarks will be met and any remaining gaps.

Benefits and Costs

Following this determination, the analysis will then evaluate the benefits and costs of potential reductions in the growth of total health spending to the overall economy in Washington (see Figure 8 below).

Figure 8: Summary of Benefits and Costs of the Analysis

Direct Benefits	Indirect Benefits	Costs
<ul style="list-style-type: none"> • Publicly Funded Programs <ul style="list-style-type: none"> • Medicaid • PEBB/SEBB • Medicare • Private Sector Employers and Employees <ul style="list-style-type: none"> • Self-Funded • Fully Insured 	<ul style="list-style-type: none"> • Increased Wages and Salaries • Increased Hiring • State savings to means-tested programs • Tax Revenue • Multiplier Effect 	<ul style="list-style-type: none"> • Reduced revenue for providers • State cost to implement policies

Direct Benefits

Reducing the growth of health care spending could have direct benefits for health care purchasers and individual Washingtonians. These anticipated enhancements are described below.

Publicly-Funded Programs

Washington purchases health care for a significant portion of the population, including people who are enrolled in Medicaid and public and school employees. In addition, the state offers state-funded subsidies for some Washingtonians who purchase coverage through the Exchange.

- **Medicaid:** More than 2 million Washingtonians are enrolled in the state’s Apple Health (Medicaid) Program.²⁰⁰ HMA will estimate the reduction in expenditures to the Medicaid program and any reductions to health care spending for Medicaid will be split with the federal government using the 50% matching rate.
- **Public and school employees through the PEBB and SEBB programs:** As of October 2023, the Washington Health Care Authority reported that 609,896 individuals are enrolled in the state’s School or Public Employee Benefits programs.²⁰¹ Reductions in the growth of health care spending will manifest in reduced premiums that the state pays to the health plans serving state and school employees and reduced cost sharing for the employees and their families. Impacts on covered individual’s premiums can vary based on the exact plan in which the person is enrolled and how the plan’s costs compares with the significant state contribution, which covers the most premium costs.
- **Medicare:** A total of 18 percent of Washingtonians are enrolled in Medicare, about 45% of whom are in MA plans.²⁰² It is expected that policies will result in reduced growth in Medicare spending. However, because Medicare is 100% federally funded, unless the state chooses to negotiate with CMS to obtain expected savings, which is unlikely, no estimates will be made.

Private Sector Employers and Employees

- **Self-Insured Employers:** Slower growth in health care spending will result in lower-cost large, self-insured employer health benefits, including employers like Amazon, Starbucks, Deloitte Digital, Costco, and Microsoft. Self-insured firms are exempt from most state health insurance regulations under ERISA. Employees of such businesses also could receive savings in the form of lower premium sharing and lower out-of-pocket costs. Employers could choose to funnel savings from lower health care costs into other forms of compensation such as salary.
- **Fully-Insured:** The slowdown in the growth of total health spending should also lead to lower premiums for the entire fully insured market. HMA will estimate the savings to these purchasers including:
 - Large group market
 - Small-group market
 - Individual markets and health plans participating in the ACA Marketplace in Washington.

²⁰⁰Figure as of July 2023. Lousie Norris, Healthinsurance.org, <https://www.healthinsurance.org/medicaid/washington/>

²⁰¹ <https://www.hca.wa.gov/assets/pebb/pebb-enrollment-202310.pdf>.

²⁰² Louise Norris. Healthinsurance.org. July 5, 2023, <https://www.healthinsurance.org/medicare/washington/>

HMA will consider and include a brief discussion about any potential impact of the reduction or slowing of total health care spending on access to care and quality of care based on existing research.

Indirect Benefits

The reduction in the growth of total health care spending could produce a variety of indirect benefits, which will be included in the analysis. Examples include:

Increased Wages and Salaries

Some portion of the lower employer costs could lead to increases in wages and salaries for employees or a reduction in the share of employee health care premium contributions, deductibles and copayments. Because virtually all the literature related to this topic focuses on the reverse—how much will wages fall if employer health care costs keep spiking—it is difficult to foresee the outcome because we cannot just assume that the opposite effect would be commensurate in size.

Increased Hiring

It is also possible that as a result of savings to employers some degree of increased hiring may occur. This effect is likely to be relatively small but will be taken into account. The increase in jobs may lead to at least a small decrease in Medicaid enrollment, adding a bit to the State's savings.

State Savings from Reduced Spending on Means-Tested Programs

Washington should also experience some savings from reductions in the state's contributions to means-tested government programs.

- HMA will estimate the reduction in **Temporary Assistance for Needy Families (TANF)** spending that could accompany the projected health spending reductions as the favorable impact on the Washington economy draws some TANF recipients into employment, or improved earnings, which will reduce their TANF benefits or move them out of TANF. This move is a potential indirect benefit.
- **Washington State Social and Economic Services** operates a State Food Assistance Program (FAP) for legal immigrants who are ineligible for SNAP and the Pregnant Women Assistance Program for low-income pregnant women who are ineligible for TANF.²⁰³ HMA will consider the likelihood that spending under these programs could edge down as employment increases as a result of the reforms that slow the growth of total health spending.

²⁰³ Washington Department of Social and Health Services, Economic Services Administration. [State Food Assistance Program \(FAP\) | DSHS \(wa.gov\)](https://www.dshs.wa.gov)

Tax Revenue

HMA will estimate the increase in tax revenue Washington could realize from the reduction in the growth of total health care spending. Washington has a state sales tax rate of 6.50%. The maximum local sales tax rate is 4.10% and the average combined state and local sales tax rate is 8.86%.²⁰⁴ Washington does not have a personal or business income tax but does have a business and occupation tax (B&O) and/or a public utility tax. The increased tax revenue would emerge from the higher wages and salaries and the possibility of some new hiring.

The Multiplier Effect

In addition to all the benefits explained above, favorable ripple effects are likely to emerge as people who benefit begin to spend a large portion of their new income (i.e., the multiplier effect). The multiplier effect is the change in final income emerging from a new injection of spending into the economy.

Costs

Implementation and Operating Costs

New policies will require staffing and administrative overhead costs. HMA will work with OIC and other state agencies to obtain estimates for these costs. This would involve both initial implementation and ongoing, “steady state” costs. There may also be costs associated with bringing a contractor on board to help develop and manage the policy initiatives. In addition, there could be contracting costs for particular types of expertise (e.g., actuarial analysis and data analysis).

Benefit-to-Cost Ratio and ROI

Each of these benefits and costs will be used to calculate the ratio of total benefits to total costs and the ROI—the net gain from the original investment divided by the cost of the original investment. The original cost of the investment will be the cost to the state of implementing and managing the set of policies chosen to reduce the growth in total health care spending. The net gain will be the total benefits (direct and indirect, including the multiplier effect less the costs imposed on certain groups in the private sector) minus the cost as just described. Next, the net gain is divided by the total cost to arrive at the ROI. That amount will first be described as a ratio and next as a percentage gain.

The benefit-cost and ROI analysis will be conveyed in the following modalities:

- An in-depth report that fully explains the economic model, with an Executive Summary
- A concise (2-3 page) Summary paper
- A PowerPoint presentation.

²⁰⁴ Tax Foundation. Taxes in Washington. [Washington Tax Rates & Rankings | State Tax Data Explorer \(taxfoundation.org\)](https://taxfoundation.org/washington-tax-rates-rankings)

APPENDIX A: NOTES FOR MULTI-HOSPITAL SYSTEMS BED DETAIL (TABLE 4)²⁰⁵

- **Astria Health:** Non-profit health care system based in Eastern Washington. Astria Health is parent of two community-focused hospitals - Astria Sunnyside Hospital and Astria Toppenish Hospital.
 - Includes inpatient hospital care, emergency services, and outpatient services in Yakima Valley
 - *Information sourced from at astria.health*
 - *Community Health Needs Assessment at https://www.astria.health/site/files/file_manager/page/shared/2021-Astria-Community-Health-Needs-Assessment.pdf*
- **Evergreen Health:** Community-owned independent Hospital system.
 - Includes 13 Primary Care sites and eight Urgent Care centers, two emergency care units
 - Evergreen Health Medical Group (EHMG) is a physician led group of 350+ PCPs and specialists who are employed by EvergreenHealth; EHMg includes 12 or 13 primary care practices, 48 specialty practices and teams of hospitalists and intensivists.
 - *Information sourced from evergreenhealth.com*
- **LifePoint Health:** Headquartered in Tennessee with locations nationwide, including acute care hospitals, rehab facilities, and BH facilities (in 2018, 89 hospital campuses in 31 states)
 - Physician practices (primary and specialty care), acute care rehab units, outpatient centers (imaging, free standing emergency departments (EDs), cancer centers, ambulatory care centers (ASCs), urgent care, post-acute service providers (SNFs, ALF, Swing bed programs)
 - 2018: Acquired by private equity firm Apollo Global Management and merged with RCCH Healthcare Partners; 2021 – acquired Kindred Health (renamed Scion Health)
 - *Information sourced from <https://lifepointhealth.net>*
- **MultiCare:** Not-for-profit, community-based, locally-owned health system in Washington State.
 - Includes acute care and BH hospitals and one acute-care pediatric hospital in Tacoma, as well as urgent care, pediatric care, and specialty service, and 256+ primary, urgent, specialty clinics in Pierce, King, Kitsap, Thurston, Snohomish, Spokane and Yakima counties; 1,800 staff providers, 22,000 employees
 - Joint venture with Virginia Mason Franciscan Health, Wellfound BH Hospital
 - Navos BH Hospital in West Seattle is an independently operated affiliate; Wellfound BH is an independently operated joint venture with Multi-Care and CHI Franciscan
 - Nationwide imprint: 11 hospitals, 260+ primary, urgent, and specialty care clinics; 2,099 beds, 19,767 employees, 1,560 employed providers
 - *Information sourced from <https://www.multicare.org/>; annual report: [Annual Report 2022 - MultiCare](#)*

²⁰⁵ The AHA defines a multi-hospital system as two or more hospitals owned, leased, sponsored, or contract managed by a central organization.

- **PeaceHealth.** Not-for-profit health care system.
 - Includes medical centers, CAHs, and medical clinics in WA, OR, AK
 - Nine clinics/sites all offering primary care, cancer care, heart and vascular, Ob/Gyn, orthopedics, pediatric primary and specialty care
 - *Information sourced from <https://www.peacehealth.org/>*

- **Providence:** Largest health care provider in Washington State.
 - Providence serves five areas: North (WA Puget Sound, AK), Central (Eastern WA, Western MT, OR, West TX/Eastern NM), and South (So. Cal and No Cal)
 - Hospitals, urgent and same day care and primary care clinics (~15 clinics), senior care centers, hospice (Providence Hospice of Seattle), and home health services and home care, including SNFs
 - Affiliated with Swedish Health Services and Pacific Medical Centers in Western WA, and Kadlec in Eastern WA
 - Providence Medical Group operates 250 clinics in AK, CA, MT, OR, WA with over 34,000 physicians, 36,000 nurses, 1000 clinics, 1 health plan
 - Providence WA: Puget sound area, according to financial statement, eight hospitals in King, Snohomish, Lewis, and Thurston Counties, and a network of over 200 primary and specialty care clinics in Puget Sound area. For Central division, nine hospitals in Eastern WA and Western MT
 - *Information sourced from <https://www.providence.org/about/washington>*
 - *Annual Report at <https://www.providence.org/about/annual-report/reports/providence>*

- **Skagit Regional Health:**
 - Includes 2 hospitals, 12 clinics, a wound care center, hospice, primary and specialty care practices, cardiology, family medicine, etc. as well as two urgent care clinics; a surgical center is set to open in December 2024. According to press release, clinics located at Anacortes, Arlington, Camano Island, Darrington, Granite Falls, Mount Vernon, Oak Harbor, Smokey Point and Stanwood
 - *Information sourced from <https://www.skagitregionalhealth.org/home/location-landing/skagit-valley-hospital>*

- **UW Medicine.** University of Washington Medical Center, teaching hospital, multiple service lines. Family of organizations – some private nonprofit organizations and some public).
 - UW Medicine is a family of public and private nonprofit organizations operated or managed care, part of an integrated health system including:
 - Harborview MC (Acute Care partnership with King County, which owns the hospital, and UW, through which UW Medicine manages the hospital), Valley MC (acute care community hospital in South King County; operates more than 48 primary, urgent, and specialty care clinics), UW MC (acute care with two Seattle Campuses – Montlake and Northwest; owned by UW), UW Medicine Primary Care (network of community-based primary and urgent care clinics throughout Puget Sound regions), UW Physicians (2,600 providers and health care professionals associated with UW medicine) , UW School of Medicine , Airlift Northwest (air medical transport); Fred Hutchinson Cancer Center (Independent non-profit which is UW Medicine’s cancer program).
 - Key Affiliates: Bloodworks Northwest, Hall Health Center, MultiCare Health System, Northwest Kidney Centers, PeaceHealth, Seattle Children's, Skagit Regional Health, VA Puget Sound/Boise/American Lake.
 - Integrated Networks:
 - Wholly Owned: UW Medicine Choice Care LLC.
 - Partially Owned: Embright – Pacific NW Clinically Integrated Network (with Multi-Care and LifePoint).
 - Contractual: UW Medicine Accountable Care Network, UW Medicine Post-Acute Care Network.
 - UW Medicine Accountable Care Network includes access to: 1000+ PCPs, 5000+ specialists, 1000+ clinics, 18 hospitals, 70+ urgent care clinics, 19 Eds.
 - Partially Owned Networks: Children's University Medical Group (with Seattle Children's), LifePoint - UW Medicine LLC, Trios Health, a UW Medicine Community Health Partner.
 - *Information sourced from <https://www.uwmedicine.org/practitioner-resources>; Fact Book Aug2023 v4.pdf (uwmedicine.org)*

- **Virginia Mason Franciscan.** Health system formed by integration of CHI Franciscan and Virginia Mason.
 - Hospital, clinic, care locations - 10 hospitals and 300 care sites in Puget Sound.
 - Owned by Common Spirit (Chicago-based parent company – acquired in 2020). CommonSpirit represents a \$29 billion merger of Dignity Health and Catholic Health Initiatives (2019). Combined organization operates 12 hospitals and more than 250 sites. CHI Franciscan and Virginia Mason employ more than 21,000 people, including nearly 5,000 employed and affiliated Providers.²⁰⁶
 - *Information sourced from <https://www.vmfh.org/>*

²⁰⁶ <https://www.fiercehealthcare.com/hospitals/virginia-mason-acquisition-talks-commonspirit-s-chi-franciscan>

APPENDIX B: COMPARISON OF STATE BENCHMARK PROGRAMS

State	Authority	Collecting and Reporting Agency	Cost-Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
California	AB 1130 (2021–2022)	AB 1130 establishes the Department of Health Care Access and Information (HCAI) Office of Health Care Affordability (OHCA) to, among other responsibilities, set and enforce cost targets under the Health Care Affordability Board.	The Board will set the first statewide target, for 2025, by June 1, 2024. The Board also may develop targets that apply to specific sectors, such as geographic regions, as well as targets specific to fully integrated delivery systems, types of health care entities and individual health care entities. The Board will define sectors by October 1, 2027, and set sector-specific targets by June 1, 2028.	Total health care expenditures” is defined as all health care spending in the state by public and private sources, including all of the following: (1) All claims-based payments and encounters for covered health care benefits. (2) All non-claims based payments for covered health care benefits such as capitation, salary, global budget, or other alternative payment methods. (3) All cost-sharing for health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles. (4) The net cost of health coverage. (5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.	While quality benchmarks were not established in statute, the office will adopt a single set of standard measures for assessing health care quality and equity across health care service plans, health insurers, hospitals, and physician organizations. Health care entity performance will be included in the annual public report. The measures will use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations. They also consider available means for reliable measurement of disparities in health care, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.	Commensurate with the health care entity’s offense or violation, the director may take the following progressive enforcement actions: (1) Provide technical assistance to the entity to assist it to come into compliance. (2) Require or compel public testimony by the health care entity regarding its failure to comply with the target. (3) Require submission and implementation of performance improvement plans, including review and input from the board prior to approval. (4) Assess penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Connecticut	Executive Order No. 5 (2020)	Office of Health Strategy	<p>The Office of Health Strategy (OHS) recommended benchmarks of:</p> <ul style="list-style-type: none"> • 3.4% for Calendar Year 2021 • 3.2% for CY 2022 • 2.9% for CYs 2023, 2024, and 2025 <p>All payers and populations are to reach a primary care spending target of 10% by 2025, with OHS having set a conservative target of 5.0% for 2021 and convening a work group to make recommendations for 2022–2024.</p>	To be determined by the technical team and advisory board along with the Office of Health Strategy.	<p>Office of Health Strategy's Quality Council will develop quality benchmarks across all public and private payers, including:</p> <ul style="list-style-type: none"> • Clinical quality measures; • Under-utilization measures; • Patient safety measures. <p>Measures under consideration include:</p> <ul style="list-style-type: none"> • Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home (PCMH) Survey • Plan all-cause readmission • Breast Cancer Screening 	Enforcement not discussed.
Delaware	Executive Order 25 (2018)	<p>The Delaware Economic and Financial Advisory Committee sets the health care spending benchmark. The Delaware Health Care Commission is responsible for collecting information and analyzing performance against the benchmark.</p>	<p>Benchmark set in Executive Order at:</p> <ul style="list-style-type: none"> • Calendar Year (CY) 2019: 3.8% per capita spending growth • CY 2020: 3.5% + 0.5% (transitional market adjustment) • CY 2021: 3.25% + 0.25% (transitional market adjustment) • CY 2022: 3% + 0% (transitional market adjustment) • CY 2023: 3% + 0% (transitional market adjustment) 	<p>Total health care expenditures (THCE) in aggregate = commercial total medical expenses (TME) + Medicare Advantage TME + Medicare fee-for-service (FFS) TME + Medicaid Children's Health Insurance Program (CHIP) Managed Care Organization (MCO) TME + Medicaid Fee-for-Service TME + Veterans Affairs (VA) TME + insurer net cost private health insurance (NCPHI) THCE (per capita) = THCE in aggregate/population This measurement excludes payment on behalf of out-of-state residents and generally excludes payment on vision and dental. Reported amounts represent the total allowed amount (payer paid + copay and deductible associated, but premiums are not included).</p>	<ul style="list-style-type: none"> • Emergency department utilization rates • Opioid- related overdose deaths • Residents per 1,000 with overlapping opioid and benzodiazepine prescriptions • Adult obesity • Adult tobacco use • High school students who were physically active • Statin therapy for patients with cardiovascular disease, with adherence of 80% • Persistence of beta-blocker treatment after a heart attack 	<p>Silent on enforcement. Public information is not yet available on recourse if/when benchmark is exceeded. Performance against the benchmark will be reported publicly, as per member per year costs, and made at the statewide level with drill-down analyses.</p>

Massachusetts	MA Chapter 224 of the Acts of 2012	Center for Health Information and Analysis and Health Policy Commission	<p>Benchmark codified in MA Chapter 224 of the Acts of 2012:</p> <ul style="list-style-type: none"> • 2013-2017: 3.6% <p>Equal to growth rate of potential gross state product (PGSP).</p> <ul style="list-style-type: none"> • 2018-2022: PGSP minus 0.5% (3.1% in 2018), but the Health Policy Commission has the authority to vote it back up to the PGSP or 3.6%, and voted to maintain the benchmark at 3.1%. • 2023 and beyond: The PGSP growth rate 	<p>The Center for Health Information and Analysis - the state's all-payer claims database - measures the total health care expenditures and compares them against growth of the state's economy. The Health Policy Commission is charged with monitoring health care costs trends, price variation, cost growth at individual health care entities, and scrutinizing health care market power.</p>	<ul style="list-style-type: none"> • Patient-reported experience during acute hospital admission • Primary care patient-reported experiences for adults • Primary care patient-reported experiences for pediatrics • Trends in statewide, all-payer adult acute hospital readmission rate, discharges, and readmissions • All-payer readmissions among frequently hospitalized patients • Rates of maternity-related procedures relative to performance targets • Number of hospitals meeting Leapfrog standards for implementing interventions to improve medication safety • Incidence of health care-associated infections 	<p>If the Health Policy Commission (HPC) determines that an entity has an unwarranted pattern of contributing to excessive health care spending in the Commonwealth, it can vote to require the entity to submit a Performance Improvement Plan (PIP) to achieve meaningful, specified cost-savings. The PIP must be submitted within 45 days of the entity receiving the PIP notice. If the entity's PIP is approved by the HPC, it is implemented over 18 months. The HPC will monitor the implementation and ultimately determine if the outcome is sufficient to address the underlying causes of the entity's spending growth, or if additional action is needed. A fine of \$500,000 can be assessed for non-compliance.</p>
Nevada	Executive Order 2021-2029	The Nevada Department of Health and Human Services Patient Protection Commission (PPC) was designated the sole state agency responsible under AB 348 (2021), enacted prior to the governor's December 2021 executive order.	<p>CY 2022: 3.19% CY 2023: 2.98% CY 2024: 2.78% CY 2025: 2.58% CY 2026: 2.37%</p> <p>By October 1, 2026, the PPC shall recommend to the Governor appropriate benchmarks for 2027 and beyond</p>	<p>THCE has three components:</p> <ul style="list-style-type: none"> • All medical expenses paid to providers by private and public payers, including Medicare and Medicaid • All patient cost-sharing amounts (e.g., deductibles and co-payments) • The net cost of private health insurance (e.g., administrative expenses and operating margins for commercial payers) 	<p>Quality measures are not discussed in Executive Order 2021-29 or AB 348.</p>	<p>The PPC advanced a bill draft request to codify Executive Order 2021-29. The proposed legislation, AB 6 (2023), includes public reporting and an annual informational public hearing on health care cost trends and the factors contributing to such costs and expenditures. The PPC is considering additional enforcement mechanisms such as performance improvement plans and financial penalties.</p>

New Jersey	Executive Order 217 (2021)	The Governor's Office of Health Care Affordability and Transparency is leading an Interagency Working Group.	<p>The target growth rate is 3.2%, based on a 25% potential gross state product and 75% median household income blend Calendar Year 2022: Initiate data collection and reporting CY 2023: 3.5% CY 2024: 3.2% CY 2025: 3.0% CY 2026: 2.8% CY 2027: 2.8%</p>	<p>Total health care expenditures includes: • All payments on providers claims for reimbursement of the cost of health care provided • All other payments not included on providers' claims • All cost-sharing paid by members including but not limited to copayments, deductibles, and coinsurance • Net cost of private health insurance Expenditures include claims for: hospital inpatient and outpatient spending; primary care; specialty care and other professional spending; long-term care; pharmacy; and all other claims-based spending. Also included are non-claims payments (like incentive and value-based payments to providers), patient cost-sharing, and the cost of administering health insurance.</p>	<p>Quality will be a component of New Jersey's Cost Driver Analysis as part of the benchmark effort. Other key components include equity, access, and affordability. Reports will be released annually with further details to help point to the "whys" behind cost increases and specific areas driving spending growth.</p>	Enforcement not discussed.
Oregon	SB 889/Chapter 560 (2019)	Collection responsibilities are to be determined by the Health Care Cost Growth Benchmark Implementation Committee. The following entities are responsible for the cost growth target program: • Oregon Health Authority • Department of Consumer and Business Services • Oregon Health Policy Board	<p>The Implementation Committee recommended a benchmark of 3.4% for 2021–2025 and then 3.0% for 2026–2030 (to be adjusted in 2024 if needed). State programs (Medicaid/State Employee Health Plan) are already subject to a 3.4% growth target.</p>	<p>Total Health Care Expenditures should be defined as the "allowed amount" of claims-based spending from an insurer to a provider, all non-claims-based spending from an insurer to a provider, pharmacy rebates, and the net cost of private health insurance.</p>	<p>The Implementation Committee recommended that The Health Plan Quality Metrics Committee should identify a subset of its existing menu of quality measures for reporting as part of the Sustainable Health Care Cost Growth Program, while aligning with the Coordinate Care Organizations, Public Employees' Benefit Board, and Oregon Educators Benefit Board contractual measure sets as much as possible.</p>	<p>Oregon HB 2081 (2021) requires performance improvement plans from any payer or provider organization that unreasonably exceeds the benchmark during any year. Fines are assessed for late or incomplete submission of data and/or performance improvement plans. Additionally, payer or provider organizations that exceed the benchmark in any three out of five years are subject to a financial penalty that varies based on the amount of excessive spending.</p>

<p>Rhode Island</p>	<p>Executive Order 19-03 (2019)</p>	<p>Office of Health Insurance Commissioner and Executive Office of Health and Human Services</p>	<p>Benchmark set in executive order at 3.2% for 2019–2022, which is equal to Rhode Island's per capita gross state product.</p> <ul style="list-style-type: none"> • During 2022, target will be reassessed and maintained or replaced for 2023. Health care cost-growth target is expressed as the percentage growth from the prior year's per capita spending. 	<p>Office of Health Insurance Commissioner will lead efforts to perform a series of data collection activities and calculations. Total health care expenditures (THCE) in aggregate = Commercial total medical expenses (TME) + Medicare Advantage TME + Medicare fee-for-service (FSS) TME + Medicaid managed care organization TME + RI Executive Office of Health and Human Services FFS TME + Insurer net cost of private health insurance THCE (per capita) = THCE in aggregate/RI Population This measurement includes all the same qualifiers as Delaware. In addition, provider resources applied in the delivery of care for uninsured individuals are not included as they are not technically spending.</p>	<p>Quality measures are not discussed.</p>	<p>Silent on enforcement. Office of Health Insurance Commissioner will publicly report on performance against the target at a statewide level, with several drill-down analyses. Silent as to what action should be taken if benchmark is exceeded.</p>
<p>Washington</p>	<p>HB 2457/Chapter 340 (2020)</p>	<p>The Health Care Authority established the Health Care Cost Transparency Board</p>	<p>Calendar Year 2022: 3.2% CY 2023: 3.2% CY 2024: 3.0% CY 2025: 3.0% CY 2026: 2.8%</p>	<p>"Total health care expenditures" means all health care expenditures in the state by public and private sources, including: All payments on health care providers' claims for reimbursement for the cost of health care provided</p> <ul style="list-style-type: none"> • All payments to health care providers other than the aforementioned payments • All cost sharing paid by residents of this state, including copayments, deductibles, and coinsurance <p>The net cost of private health care coverage</p>	<p>Quality measures are not discussed in the establishing legislation for Washington's benchmark program.</p>	<p>Enforcement not discussed.</p>