Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

December 14, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Sue Birch, Chair
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Jodi Joyce
Molly Nolette
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Mark Siegel

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

Chair Birch called the meeting to order and reviewed the agenda.

Approval of November meeting summary

The Board approved the Meeting Summary from the November 2022 meeting.

Topics for Today

The main topic was an introduction to the 2022 Cost Growth Drivers Study.

Introduction to 2022 Cost Growth Drivers Study

Amy Kinner, OnPoint
Amy Kinner presented an overview of OnPoint's study of cost growth drivers. The study looked at cost trends and drivers of cost growth in the health care system by market, geography, health conditions and other demographics, and examined potential unintended consequences to inform the Board on how to curb spending growth.

Topics covered in the presentation included: changes in insurance enrollment over the last five years, changes in spending on a total and per-member basis, spending changes for different products (commercial, Medicaid, Medicare Advantage), spending variation by category of service (inpatient, outpatient, professional, primary care, and specialty care), variation by region, variation by age and gender, and how high-cost members impact spending. In quarter one of 2023, OnPoint will begin to examine chronic conditions.

The presentation began with a summary of methods used. There were five years of data, from 2017 through 2021, to align with the cost-benchmarking period. Products analyzed included commercial (limited data from self-insured plans), Medicaid (managed care only), Medicare Fee-For-Service (FFS) (only available through 2019), Medicare Advantage (MA)(covered by commercial plans), Public Employees Benefits Board (PEBB) (commercial and MA), Washington Health Benefit Exchange (HBE) (commercial), and dual-eligibles (not broken out separately due to missing FFS data beyond 2019). Categories of service are aligned with the benchmarking initiative and include hospital inpatient, hospital outpatient, a narrow definition of primary care providers, non-primary care specialty providers, other providers like physician assistants (PAs) and nurse practitioners (NPs), etc., long-term care, retail pharmacy, and all other spending (ambulances, durable medical equipment, etc.).

Board member Kim Wallace asked whether data will be broken out for PAs and NPs functioning as primary care providers. Would any service provided by these groups be referenced under the "other" category? Amy Kinner clarified that the Office of Financial Management (OFM) definition allocates a certain percentage of care based on survey data. There are some PAs and NPs included. The narrow definition requires that they be a Primary Care Provider (PCP) and that the provider bills something as primary care. The OFM workgroup developed a list of codes. There is a new definition coming out. Kim Wallace noted that for the large bucket of "other" those people typically act as a PCP providing primary care. Vishal Chaudhry clarified that OnPoint is using the same definition of primary care that OFM reported on in 2019. The Advisory Committee on Primary Care is working to refine the definition and conduct primary care spending analysis. These categories are in the context of what has been done in the broader spending analysis.

The following are limitations of the study: lack of data for self-insured individuals, no Alternative Payment Model (APM) data, no uninsured data, no Medicare Fee-for-Service (FFS) data, and no Medicaid FFS data. Long-term care data for Medicaid is not reported but is a significant contributor to spending.

Chair Sue Birch asked what percentage of the population is represented by the good/available data OnPoint has? Amy Kinner clarified that the All-Payer Claims Database (APCD) data represent about 4 out of 7 million (the total state population). Between 2017 and 2021, enrollment increased from 3.5 to 4 million (not including Medicare FFS). There would have been an even greater increase if Medicare FFS had been included - about 500,000. There isn't data for the full 12 months for every enrollee and there are changes between insurance types. In this study, six months is half a person, and a whole year is a full person – this is average membership - member months of eligibility divided by 12. The study looked at population growth compared to membership growth. Population growth was relatively stable around 1.6 percent, with a marked shift in membership in 2020, almost 6.3 percent.

The next slides showed enrollment by product: Medicare FFS (only 2017 and 2019), with all other products ranging from 2017 through 2021. There was significant growth in Medicaid, from 1.5 million to 1.7 million. Commercial remained steady. Nationwide, MA plans became more popular due to higher marketing. Medicaid lost membership in 2018 and 2019 and then increased during the COVID-19 emergency. The COVID-19 emergency also prompted some growth in the HBE population.

The next slide showed changes in total medical expenditures, claims, in billions. Medicare FFS was broken out separately and stayed stable. There was high growth in expenditures for other plans.

For spending by categories of care, inpatient was the highest category of spending in 2017 and continued to be highest in 2021 with outpatient catching up. There was more growth in outpatient than inpatient. There was no significant growth in primary care.

For the percent of medical spending by category between 2017 and 2021, inpatient spending decreased relative to other spending, as did specialist, long-term care, and primary care. Categories shifted relative to one another. Pharmacy claims increased from 4.6 to 6 percent for all APCD submitted data.
Board member Jodi Joyce asked how primary care was differentiated from outpatient. Amy Kinner clarified that outpatient means outpatient facility claims – bills from a facility and within those, providers. Specialists could also be billing in outpatient setting.
The next slide showed how spending changed on a per member per month (PMPM) basis. The PMPM calculation is total expenditures divided by member months in a group. PMPMs increased from $271 to $340 between 2017 and 2021. The aggregate growth was $69 per month, $800 per year, per person. There was an aggregate change of 25 percent over time – mostly focused in 2021. This includes commercial, Medicaid, Medicare Advantage (as a combined rate across all products) and does not include Medicare FFS. Pharmacy PMPMs showed the same aggregate percent increase of 25 percent over 5 years with an increase of $21 per month. Different products experienced different growth rates, for medical only. MA has the highest PMPMs because there are higher health needs than commercial patients. There was growth across the board, but slightly lower in MA.
The next category was pharmacy spending by product (not including MA due to Part D coverage). Spending was slightly higher under the HBE. All products increased between 21 and 29 percent.
The study also analyzed PMPM by category. Most spending was on inpatient and outpatient. Other professional and other medical, while lower than inpatient and outpatient, still saw significant growth.
The next slide showed inpatient PMPM spending by product. Inpatient spending for MA was much higher than other plans. Bianca Frogner asked whether OnPoint used inpatient for PMPM when looking across all people. Does OnPoint know the percentage that had inpatient care? Amy Kinner said that OnPoint hasn't looked at that. For the study, OnPoint took the entire eligible population and summed up the total spent. People were included in the study even if they didn't have a claim for the year because it was necessary to include everyone in the denominator. Bianca Frogner asked if inpatient usage has increased over time. Amy Kinner responded that there will be more work to analyze utilization and price and how they drive PMPMs. In general, there was low growth overall, only 5 percent growth for commercial.
The next slide showed outpatient PMPM spending by product. MA grew almost 50 percent. HBE spending growth was also high, with 47 percent growth. Commercial showed steadier growth. Medicaid growth remained low. The study also analyzed changes in professional PMPM spending by product. There was high spending for specialty, especially for MA. OnPoint looked at changes in PMPMs over time from a baseline which is also how other states look at it.
The next slide showed inpatient, outpatient, and total pharmacy PMPM spending. Outpatient PMPM growth was driven by a utilization increase of 32 percent despite no pricing increases. For pharmacy, people had the same number of prescriptions, but prices increased by 25 percent. Price was more important for pharmacy than for outpatient. Inpatient saw a decrease in utilization, but an increase in average allowed amount per service. OnPoint will look more at utilization and the average allowed amount in the future.
Leah Hole-Marshall asked whether ambulatory surgical centers (ASCs) are in the "other" category." Amy Kinner affirmed that ASCs were included in other. Leah Hole-Marshall noted that it would be interesting to track ASCs along with inpatient and outpatient to see where services shift. Bianca Frogner suggested breaking outpatient out with Emergency Departments (EDs) and diagnostic labs. EDs may be important to break out given the pandemic.
Next, Amy Kinner showed OnPoint's analysis of regional variations in spending. Sue Birch asked if OnPoint can analyze outliers for consistency. Amy Kinner responded that OnPoint could do that eventually, but didn't want to include them initially, and instead wanted to show general variation by county. Medical PMPMs ranged from $150 to $1,200. Utilization is an important aspect but not fully explored yet and will be part of the next phase of analysis. PMPM spreads expenditures over the entire enrollment base. Using utilization as the denominator would be a different level of analysis. Amy Kinner reminded that this is the first phase of analysis. A county of residence is just a proxy and isn't necessarily where a service takes place. It would be helpful to look price variation by county. This

variation could be outlier patients, or health systems in places with higher pricing, or people receiving more expensive services, or risk demographic differences. There is a wide range in geographic variation in Medicaid and MA.
The next slide showed commercial medical PMPM spending by Accountable Community of Health (ACH) of patient residence. There was a significant increase in spending growth for the Southwest ACH and great variation between ACHs. There may be outlier patients, or differences in care delivery.
The next slide showed medical PMPMs by age and gender. There was higher spending for infants (high needs for newborns) and higher spending for men in every category. There was spending growth across ages for both men and women.
The next slide showed commercial PMPM spending by age from 2017 to 2021. Spending increased at every age. This analysis did not include individuals over 65 as most are covered under Medicare.
The final slide looked at the impact of high-needs members on spending growth. There will be a different strategy if most spending growth is driven by high health needs, e.g., chronic conditions. OnPoint will perform additional analysis in the future. High-cost members were defined as those with greater than $125,000 in total medical spending. High-cost members comprised less than 1 percent of membership but 15 to 21 percent of total spending. High-cost members tend to have $20,000 or more in PMPM. Cost containment needs to account for high-cost, high-health needs.

Public Comment

Emil Chang from Health Care for All Washington shared a personal experience with drug costs in the U.S. Emil was covered under an employer-sponsored silver plan and was prescribed a better prescription for diabetes, Farxiga. Emil's insurance turned down coverage after an appeal. Emil's family in Taiwan made it possible to obtain the new drug. Good Rx is $530 per month in the U.S., in Taiwan, it is $30 per month – 17 times the price for the same drug in the U.S. versus Taiwan. There are drugs manufactured in the U.S. and shipped to Taiwan which are offered at 10 to 15 times a cheaper price. In doing the benchmark work, the Board should look internationally with respect to drug pricing.
Albert Froling, from the Washington State Hospital Association (WSHA), offered comments on the data methodology used by the Board to analyze costs. There were two comparisons the Board was directed to analyze by legislative statute. One point of comparison was provider case mix, and the other was provider input prices – these comparisons haven't been analyzed yet. Some examples of provider input prices include salaries and wages. Puget Sound is one of the most competitive markets for healthcare in the state and the nation. The cost of salaries, wages, and benefits, accounts for 50 percent of hospital spending. At earlier meetings, WSHA asked the Board to use the Centers for Medicaid and Medicare (CMS) wage index to adjust for these cost differences. The OnPoint cost growth drivers study showed growth in outpatient due to utilization and transitioning patients with complex needs from inpatient to outpatient. Hospitals use EDs and ASCs to treat the most vulnerable patients, e.g., Medicaid, and these settings are the safety net for people who can't be seen elsewhere. The Board should dig into input prices. Retail pharmacy isn't contributing to medical spending, supplies, or devices.
Consuelo Echeverria requested that the Board post meeting materials in advance of meetings. AnnaLisa Gellermann responded that materials will be posted immediately after the meeting. Consuelo Echeverria asked if HCA and consultants could dig into data the way Optimus did for the Oregon Universal Task Force on administrative burdens associated with Value-Based Purchasing (VBP) and VBP contracts. That study found administrative costs of close to $1 billion. Sue Birch noted that HCA is on a journey of discovery and will take these comments and weave them into future work.

Cost Driver Discussion

Amy Kinner, OnPoint

Amy Kinner summarized the key takeaways from the OnPoint study. The insured population has grown. There have been shifts between plans driving changes in spending. It's not clear what will happen when the public health emergency (PHE) ends but there will be impacts. Total and per capita expenditures have grown. There has also been professional spending growth in mostly specialty and other categories. There are some differences in how outpatient, inpatient, and pharmacy spending growth has occurred due to pricing and utilization and variation by geography, age, and gender. Members with high-cost needs pose unique challenges. OnPoint's phase two analysis will analyze: 1) spending growth by product, region, etc. 2) the impact of chronic conditions on spending and spending growth 3) variation in spending on primary care and behavioral health across the state 4) how out-of-pocket spending has changed 5) relationships between spending and quality/access to care 6) how utilization impacts spending and 7) how price changes impact spending.

Edwin Wong noted that the outpatient category saw the most marked increases, particularly in 2021. In future calls, it would be helpful to learn more about the growth and see how certain subcategories have increased. There should be analyses to tease out increased care that occurred due to disrupted care during the pandemic. It would be helpful to know to what extent 2021 was an outlier. Amy Kinner noted that OnPoint is close to adding 2022 data. Screenings dipped in 2020 and came back in 2021 for many Healthcare Effectiveness Data and Information Set (HEDIS) measures. Edwin Wong suggested that OnPoint analyze elective surgeries that dipped in 2020.

Margaret Stanley noted that it's important to remember that some payers have fixed rates while others don't. Commercial payers enter multi-year contracts. Medicaid pays below costs and hasn't increased its rates in decades. This causes a cost-shift and inflationary pressure on other payers. Sue Birch pointed out that many articles say there isn't a cost-shift. There is more detailed information about Diagnosis Related Groups (DRGs) being reset. There was an article released today that alluded to the lack of increase in Medicaid rates in decades. Amy Kinner noted that when the PHE ends, and people move from Medicaid to commercial, there could be spending growth.

Bianca Frogner emphasized the need to further break down spending in the outpatient setting. It would be helpful to break out labs for cost and utilization. It would also be helpful to analyze community health centers (CHCs), because CHCs change in a different way due to reliance on Medicaid and uninsured individuals. Amy Kinner clarified that it would be possible to further analyze outpatient spending to see what procedures and areas are driving change.

Kim Wallace noted that it was encouraging to see that the phase two analysis would include aspects of quality and access. What are the Board's plans to capture access, quality, and health? Amy Kinner noted that for phase two, OnPoint will provide data that relates to HEDIS measures e.g., well-child, breast cancer screening, etc., showing primary or basic care as well as all plan-cause readmissions. There are 8 or 9 measures that will be analyzed by geography, relationship to total cost, relationship to percent primary care spending, and relationship to percent spent on behavioral health care. The data has been built but not analyzed or visualized.

Leah Hole-Marshall noted that there are existing sources to examine the alleged cost-shift theory. The National Academy for State Health Policy (NASHP) has done work on break-even rates and Research and Development (RAND) studies address hospital specific costs.

Sue Birch asked how Washington compares to other states in cost containment work. Amy Kinner noted that the pattern of growth in inpatient spending showing less growth than outpatient is evident in other states. Commercial PMPM rates, Medicaid, and Medicare FFS are lower in Washington compared to other places.

Kim Wallace asked about when someone resides in a county, e.g., rural in Eastern Washington and receives intense high-cost care in Seattle, whether that cost is assigned to their county of residence, or King County. Amy Kinner clarified that the cost was assigned to the patient's county of residence. OnPoint could look at costs of specific surgeries in different areas. Kim Wallace noted that there is significant price variation across the state. A $20,000 procedure or episode of care may be twice that in another area. What is known about the variation? Is that next? Amy Kinner agreed that this would be a great next step. Vishal Chaudhry noted that provider pricing analysis hasn't been reached. The APCD will be only one source. HCA is analyzing the factors that contribute to health care expenditures. Right now, it's purely claims-based and a passive analysis.

Lois Cook asked about the large increase in the number of insured individuals in 2020. Sue Birch clarified that there was a federal requirement that all those that came onto Medicaid during the PHE stay enrolled. There will be disruption after the unwinding of the PHE. Vishal Chaudhry noted that all data provided today was sourced from the APCD. The APCD doesn't have self-funded insurance plans. Many people who lost jobs at the beginning of the pandemic would have been self-insured. HCA has retained Medicaid coverage for everyone, which has inflated the number of enrollees in the APCD. Lois Cook asked how many are covered by private insurers that aren't covered. Vishal Chaudhry responded that there are estimates, somewhere in the 2 to 3 million figures. Sue Birch noted that the Washington Health Alliance has self-insured data. There may be a true-up occurring from Milliman which the Board can look at in the future. There is a recent Health Affairs article titled, "National Health Care Spending in 2021: Decline in Federal Spending Outweighs Greater Use of Health Care." Healthcare spending in the U.S. grew 2.7 percent to reach $4.3 trillion in 2021 at a much slower rate than the increase of 10.3 percent seen in 2020. Slower spending growth was driven by a 3.5 percent decline in federal spending for healthcare after a spike in 2020, largely in response to the pandemic. The share of the economy for healthcare fell from 19.7 percent to 18.3 percent in 2021, which was still higher than the 17.6 percent share in 2019.
Edwin Wong noted the lack of FFS data in the presentation. Amy Kinner responded that there isn't a definite timeline for when this would be included in the APCD, but hopefully within the next 6 months.
Bianca Frogner noted that one of the public comments was around adjustments that account for the wage index. There is some concern that wage inputs have had a higher impact. The wage index isn't updated for 2017 to 2021. Due to lag time in data acquisition, available data couldn't capture what WSHA is concerned about e.g., high contracting costs. Data wouldn't reflect current or more recent year changes in wages or contracting costs. It is difficult to disentangle the hourly wage rate from contracting costs. It's also difficult to find contracting costs using public sources.

Adjournment
Sue Birch adjourned the meeting at 3:40 p.m.

Next meeting
February 15, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.