Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

February 15, 2023
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 are available on the Health Care Cost Transparency Board webpage.

Members present

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

Members absent

Jodi Joyce
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. Chair Birch introduced new board member, Eileen Cody.

Approval of November meeting summary

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

Topics for Today

The main topics were: Board's analysis of the Cascade Select Public Option: Planning for the Legislative Report; Primary Care Committee recommendation – Primary Care Definition, Discussion, and Vote; Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark Discussion and Vote; and Washington's Cost Growth Driver Analysis: Discussion.

Board's Analysis of Cascade Select Public Option: Planning for the Legislative Report

Mandy Weeks-Green, Coverage and Marketing Strategies Manager, Health Care Authority
Laura Kate Zaichkin, Senior Policy Advisor, Health Benefits Exchange

Mandy Weeks-Green presented an introduction to the Board's required report on Cascade Select Plans (CSPs) due in August 2023. CSPs are the public option individual plans available on the Exchange. They have the same standard benefit design as Cascade Care Plans, but also have additional standards and requirements, such as quality measurements and an aggregate reimbursement plan. The goal is to increase availability of quality, affordable health care coverage available to Washington residents. Cascade Select is a three-agency effort with the Health Care Authority (HCA), the Health Benefits Exchange (HBE), and the Office of the Insurance Commissioner (OIC). HBE is the lead agency for benefit design. HCA is responsible for procurement and monitoring. OIC ensures rate review and network access requirements are met. The legislature has required three analyses of Cascade Select Plans: 1) HBE must analyze public option plan rates paid to hospitals for in-network services to see whether they have impacted hospital financial sustainability, 2) the Health Care Cost Transparency Board (Board) must report on the effect of enrollment in the public option on consumers, and 3) HBE must provide recommendations to the legislature on both HBE and the Board's two analyses, with final recommendations due December 1, 2023. The Board's analysis of enrollment in public option plans will include an examination of benefits, premiums paid, and cost-sharing amounts paid. The Board's report won't include general recommendations on the public option or recommendations on procurement, or standard plan design. For the development of the report, HCA and HBE will begin by identifying questions and data. After gathering data and performing initial analyses, HCA and HBE will present their findings at the June Board meeting for review and feedback. In July, HCA and HBE will present the final report.

Laura Kate Zaichkin reviewed anticipated data and analysis necessary for the Board's report on Cascade Select Plans' effect on consumers. The analysis will include Cascade Select premiums from 2021 through 2023; Cascade Care plan design and cost sharing, compared to non-Cascade plans on the Exchange from 2021 through 2023; a description of Cascade Select quality and value contractual requirements and aggregate results; Cascade Select enrollment from 2021 through 2023; and Cascade Select availability from 2021 through 2023. Most of the data will come from the data acquired by the Exchange since the launch of the public option in 2021. There was limited availability across counties in 2021 and only about 1,000 people enrolled. In 2023, there is widespread availability except for five counties. Enrollees total almost 27,000, which is more than 10 percent of the Exchange's total enrollment. HCA and HBE are interested in the Board's reaction to and feedback on data that the Board would like to see included or explored in the report to evaluate the effect enrollment in the public option has had on consumers.

Primary Care Committee Recommendation – Primary Care Definition, Discussion, and Vote

Dr. Emily Transue, Associate Medical Director, Health Care Authority

Dr. Transue updated the Board on the Advisory Committee on Primary Care's (Committee) finalized recommendation for a definition of primary care. The work of the Committee is different from but related to the work done by HCA on the Primary Care Transformation Model (PCTM). Both initiatives share the goal of increasing primary care expenditures while decreasing total health care spending. Dr. Transue reviewed the four main primary care recommendations: 1) a definition of primary care, 2) measurement methodologies to assess claims-based spending, 3) measurement methodology to assess non-claims-based spending, and 4) reporting on barriers to access and use of primary care data and how to overcome them. In October and November 2022, the Committee heard presentations on claims-based measurement from the Primary Care Collaborative and subject matter experts from the University of Washington. At their January 2023 meeting, the Committee made progress

discussing provider codes and facilities. The definition developed by the Committee represents a hybrid of concepts from the Bree Collaborative and the National Academy of Sciences, Engineering, and Medicine (NASEM). The definition is meant to be functional. Both the Advisory Committee of Health Care Providers and Carriers and the Committee on Data Issues provided feedback on the definition. Feedback centered on how the definition will be codified, reconciliation of different reporting requirements, and the connection between the definition and measurement. Additionally, there was a suggestion to emphasize Social Determinants of Health (SDOH). The final definition will serve as a guide for the Board for measurement but will not be codified as a statute.

Board member Eileen Cody moved to approve the definition, which was seconded by Board member Lois Cook. Board member Margaret Stanley asked for clarification on the term "equitable" in the definition. Dr. Transue clarified that equitable refers to whole-person health provision where all populations are able to achieve their respective health goals.

Board member Edwin Wong inquired about the Committee's future work on the methodology to assess non-claims-based spending and asked how that work will affect the definition. Dr. Transue responded that the non-claims-based work hasn't been conducted yet but that the Committee is analyzing work done across the country and should be looking at population-based care in greater depth in the coming months. Edwin Wong asked about how adaptable the definition is. Chair Birch responded that further questions/clarifications would be referred back to the Committee.

Board member Kim Wallace expressed support for the definition and its functional approach. However, the definition doesn't state "to what end" or what the aim is of primary care. There could be a piece added like "supports or promotes a person's experience of their health outcomes" that speaks to the effect of receiving primary care. The current definition says that the point is creating and maintaining a relationship, but there could be language added about health and the benefit a patient receives or experiences because of primary care. Dr. Transue responded that the group could ask the Committee to reexamine the addition of language speaking more directly to health outcomes.

Board member Bianca Frogner noted that the Bree Collaborative initially struggled to distinguish between what was measurable versus what was aspirational. It's hard to connect health outcomes, e.g., quality of life, back to providers, and it's easier to connect processes of care. The Bree Collaborative report on primary care provides background on each concept included. The Office of Financial Management (OFM) discussed other billing codes that might capture coordinated care or SDOH. Have there been increases in those codes? Is there discussion on the committee regarding OFM's approach to team-based care? Dr. Transue noted that there has been an uptick in the use of some SDOH, but most people aren't reimbursing for them yet. As value-based models continue, there may be greater uptake. Uptake is similarly low for collaborative care. The group will discuss this topic when they discuss non-claims-based spending.

Chair Birch noted three pieces of feedback from the Board to bring back to the Committee for consideration: 1) measurable components, 2) what outcomes are being sought, and 3) how the evolution into value-based payment (VBP) expands the definition.

Chair Birch called for a vote to approve the definition and the motion passed.

Public Comment

Sue Birch, Chair

There were no public comments.

Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark Discussion and Vote

January Angeles, Bailit Health

January Angeles provided an overview of inflation's impact on health care spending. The impact is lagged because rising prices in the general economy don't impact health prices immediately for several reasons: 1) Medicare prices for most services are updated annually based on projected growth in input costs, 2) commercial prices are often defined within multi-year contracts, and 3) Medicaid prices change infrequently and are not specifically linked to input costs. In 2021, the price for goods increased significantly, the price for services increased somewhat, and the price for health care services remained flat. In 2022, the prices for medical care increased at a significantly slower rate than other goods and services. Another analysis by Altarum showed that health care inflation was flat through the end of 2022 despite high and sustained inflation overall.

All six Peterson-Milbank cost growth target states have based target values on economic indicators that are affected by inflation. Washington looks at median wages and income, which are indirectly impacted by inflation. Household income tends to grow when inflation grows. These methodologies were developed under the assumption that inflation would increase at low levels. For a limited time, states should consider whether to allow performance to exceed the cost growth benchmark due to inflation and/or increased labor costs. Making these adjustments would not necessarily mean restating the benchmark, rather, a state could create a temporary allowance when assessing performance against the benchmark. Arguments for adjusting for inflation are: 1) states could lose support from providers and insurers who feel the benchmark value was set using inputs that are completely different from actual experience, 2) the benchmark could be viewed as unrealistic and unfair, leading to lost credibility as a meaningful state policy and a rejection of the benchmark for contract negotiations. Arguments against adjustment for inflation: 1) the benchmark value was purposely set using a methodology intended to provide long-term stability, 2) it is unlikely that the benchmark value or performance against the benchmark would be adjusted if providers were posting record profits or if deflation occurred, and 3) any adjustment could open the door to future calls for benchmark changes. Benchmarks matter because "payers routinely invoke cost growth benchmark values at the negotiating table." They have practical value in constraining spending growth, particularly in the commercial market. Some key policy considerations are: 1) how the state should balance protecting consumers who face slower income growth and a potential recession with being fair to provider organizations and insurers in light of increased costs 2) the precedent that might be set if the state chooses to modify benchmark values, and 3) the basis on which any modification should be made, and for what duration. Several states have their own responses to the rise in inflation. Massachusetts adjusted the 2023 target up by .5 percent, Oregon and Nevada decided to make no adjustment, and Rhode Island adjusted their 2023 through 2025 targets up by 2.7, 1.8, and .2 percentage points, respectively.

Bianca Frogner asked for more discussion of the evidence that inflation influenced healthcare costs. January Angeles clarified that there is a two-year lag and effects from 2020 and 2021 won't show up until 2023. Bianca Frogner also asked for elaboration on goods versus services. Providers are more concerned about wage inflation and the cost of labor. Is inflation happening across the board for all health care labor, or specific occupations? There is very poor data available.

Margaret Stanley noted that the Board received three letters regarding the impact of inflation on consumers, especially those with high deductibles. The Board should also look at unnecessary administrative burden placed on consumers by insurers. There isn't enough data to make a decision on inflation right now and the Board should

wait for the lag to end. There is no enforcement or accountability methodology available. The benchmark should remain the same while acknowledging the effects of an inflationary period. An adjustment could be made later with more data. January Angeles responded that providers need to know the benchmark as a prospective tool, so retroactive adjustment is difficult. Chair Birch asked whether HCA has already captured some inflation. January concurred that two percent had been captured in the current benchmark.

Board member Leah Hole-Marshall emphasized distinguishing between inflation that's been captured already and unexpected inflation. Before an adjustment, it is important to know how the Board will interpret the data and share its context. January Angeles replied that acknowledging inflation upfront suffices for context and used context of Covid as a further example of background information included in reporting. Leah Hole-Marshall expressed that it would be important to use multiple examples.

Board member Eileen Cody asked by what date would the Board need to decide to make a change? Has the Board looked back at past trends to analyze wage increases? January Angeles replied that research hasn't been done yet. For how far ahead to decide, it depends on how the Board views the benchmark e.g., as a point of negotiation for payers and providers. If it is a negotiation tool, it would be best to set it as far ahead as possible.

Bianca Frogner noted that a major challenge is the aggregation of data across many different places. Wages have gone up at other points in time but get lost in the aggregate. While some groups' wages may have gone up, other groups' didn't.

Eileen Cody made a motion to maintain the Board's current benchmark but monitor the need for a change in the future. Bianca seconded. Chair Birch proposed not changing the benchmark now to account for additional inflation not already built into the methodology. Lois Cook expressed agreement with the motion but also felt concerned from a small business owner perspective and shouldn't reduce health care resources in the state. Board member Carol Wilmes also expressed a preference for not making a change after looking after state responses. Those states who decided to make changes have been doing this work longer than Washington. Edwin Wong expressed agreement with the consensus but requested Washington specific measures on Consumer Price Unit (CPU) categories. Margaret Stanley stated the need to acknowledge lack of data to make an adjustment. Eileen Cody amended the motion to say that the benchmark remains unchanged to account for additional inflation as the Board awaits further data. Chair Birch called for a vote on the motion. Bianca Frogner seconded. The motion passed by unanimous approval.

Washington's Cost Growth Driver Analysis

January Angeles, Bailit Health

OnPoint presented its Phase 1 cost driver analysis at the previous Board meeting. OnPoint looked at cost growth from 2017 to 2021 and found that per member per month (PMPM) spending for medical and pharmacy services increased by 25 percent. There were also shifts in relative spending by category with outpatient, "other" professional, and "other" medical spending increasing while inpatient, specialist, long-term care, and primary care decreased as a percentage of total health care expenditures. Hospital outpatient services, pharmacy, and hospital inpatient services were the key cost drivers of commercial spending. Growth in outpatient services was driven by increased utilization, while pharmacy and inpatient were due to price increases. There was significant variation in medical PMPM spending at the individual Washington county level. Across all markers, high-cost members comprise less than one percent of the membership but account for 15 to 21 percent of total spending.

OnPoint also looked at other states' analyses. Connecticut's annual hospital outpatient and pharmacy growth averaged over seven percent in the commercial market between 2015 and 2019. Oregon's commercial cost growth from 2013 to 2019 was driven by professional services. Rhode Island's annual hospital outpatient trend in the commercial market averaged five percent, and pharmacy trend averaged over six percent between 2017 and 2019. Chair Birch asked about Oregon's professional services growth: Was it specialty, primary care, or other? Was this disaggregated? January Angeles clarified it was aggregate.

Kim Wallace asked for clarification on Washington's 25 percent growth. Was this over four years, as opposed to annually? This is in contrast to the annual trends from other states. January Angeles affirmed that the growth occurred over four years. Washington's results are generally consistent with other states, particularly with hospital and pharmacy services as key drivers in overall health care spending growth.

For Phase II analysis, there are two types of analyses that could be done for hospital spending: 1) analysis of hospital price growth – overall and by hospital to assess whether price increase is concentrated among specific facilities 2) analysis of procedure and service code movement between inpatient and outpatient settings to determine if inpatient procedures and services shifting to outpatient settings could be driving increases in outpatient utilization and spending.

January Angeles reviewed some of Massachusetts' analyses. Between 2013 and 2018, Massachusetts observed a decline in inpatient stays among commercially insured patients. This was while spending grew about five percent per year during that timeframe. The Health Policy Commission (HPC) looked at procedures commonly performed in either inpatient or outpatient settings. There were 11 surgical procedures that accounted for 21.3 percent of the overall decline in commercial inpatient admissions. Among the 11, HPC narrowed the analysis to spinal fusion, mastectomies, and hysterectomies. Lois Cook noted the lack of placements for people to be discharged. Oregon has a similar issue. How does Washington compare to other states in this regard? January Angeles clarified that proper discharging is an issue in all states. For all three procedures, the percentage of procedures done in inpatient settings declined. Community hospitals showed a greater loss of inpatient volume. HPC looked at the change in inpatient and outpatient volume by hospital system for mastectomies, which showed cross-provider shifts in outpatient care. Most systems experienced declines, but some were able to make up for it more easily with an increase in services in the outpatient setting. Systems that lost volume tended to be lower priced community hospitals. Those that didn't lose volume were higher-priced, academic centers. Eileen Cody asked whether it's correct to assume that outpatient costs less. Outpatient procedures are conducted more often by higher-cost academic centers. It's not just shift in settings, but cross-provider shifts.

The other area of spending to conduct a phase II analysis on is pharmacy. Washington could conduct two analyses: 1) analysis of retail pharmacy spending overall and broken down by generic vs. brand-name drugs and 2) analysis of retail pharmacy spending by drug class or drug category. Rhode Island developed an internal dashboard that shows medical and pharmacy spending PMPM and annual changes in that spending payment per unit and utilization per thousand. Seven categories accounted for almost all 2021 spending. Spending on immunological agents was the top driver, accounting for $152 million. There were very high prices per unit for a handful of drugs. There were high annual price increases, especially for drugs with growing market share.

January Angeles concluded with a review of other potential phase II analyses identified by HCA and OnPoint. OnPoint would like to know which analyses to prioritize and conduct for the next phase. Margaret Stanley recommended focusing on areas where Washington can have a state impact compared to the federal level. These are areas where purchasers or legislators could effect change. Eileen Cody requested more information about the change in hospital inpatient setting and where it differs e.g., ambulatory surgical centers (ASCs). Bianca Frogner

suggested a paired analysis of the decline in inpatient procedures along with the increase in outpatient procedures. For pharmacy fees, it would be helpful to compare baskets of goods around other states and would also be good to examine the role of Pharmacy Benefit Managers (PBMs). Chair Birch noted the existence of two HCA-led pharmacy groups: the drug price transparency workgroup and the drug affordability board. Work from these groups could be shared with the Board to avoid duplication of efforts.

Leah Hole-Marshall asked when there would be a definition of primary care and primary care spending. It was clarified that there are three more recommendations to go and there is no implementation plan yet. Carol Wilmes emphasized capturing instances of outpatient utilization to see how these affect overall utilization changes in spending impacts.

Chair Birch noted the Board's apparent consensus to focus on outpatient costs and major procedures that have shifted from inpatient to outpatient. Chair Birch also recommended considering high-cost clients for further analysis. OnPoint could look more into chronic conditions and length of stay. January Angeles responded that it's important to focus on what the state has the capacity to address and change. High-cost clients don't have as many policy levers to work with at the state level. Eileen asked whether the high-cost pool is included in the data. Vishal Chaudhry affirmed that if the claims were submitted to the All-Payer Claims Database (APCD), they were included. Bianca Frogner suggested looking at the length of stay. It would be good to look at year by year rather than grouped years due to events like Covid.

Chair Birch identified outpatient services as the first priority and suggested that the second could be high-cost or regional variation. What would the Board like to be its second topic of focus for OnPoint's Phase II analysis? Margaret Stanley suggested looking at PMPM rather than total cost.

Chair Birch summarized that the Board would look at outpatient services and will direct staff to look at existing pharmacy work. Leah Hole-Marshall suggested looking at high-cost patients and the top ten conditions they exhibit to better understand outliers. OnPoint could group patients by condition and spend to see the spread in the one percent group.

AnnaLisa Gellermann announced her departure from the Board and the search for her replacement.

Adjournment

Chair Birch adjourned the meeting at 4:00 p.m.

Next meeting

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