Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

June 21, 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 Nollette
Margaret Stanley
Kim Wallace
Edwin Wong

Members absent

Jodi Joyce
Mark Siegel
Carol Wilmes

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 April meeting summary

The board approved the Meeting Summary from the April 2023 meeting.

Topics for Today

The main topics were a presentation on the new analytic support initiative, an overview of the board's current legislative reports, and a presentation on primary care claims-based measurement recommendations.

Analytic Support Initiative Presentation

Joseph L. Dieleman, Associate Professor for Health Metrics and Evaluation, University of Washington

Joseph Dieleman introduced the Institute for Health Metrics and Evaluation (IHME) and the analytical support initiative. IHME is charged with completing work related to measurements and health. IHME's previous projects connect closely with the report, *A Data Use Strategy for State Action to Address Health Care Cost Growth*, funded by the Peterson Center on Healthcare and Milbank Memorial Fund. The report posed the question of what data is needed and how it should be used to curve cost growth. The first part of the analytic initiative describes all the health care spending in Washington using ten key metrics and the second part uses a trends analysis to compare Washington's growth to other states and counties. The analysis reviews which geographic units, health conditions, markets, and service categories have the most growth and how changes in population, disease prevalence, service utilization, and prices contribute to spending growth. The project is externally funded by the Peterson Center on Healthcare and Gates Ventures and is a partnership between the Health Care Authority (HCA) and IHME, with IHME supplying analytical support to HCA. The project is expected to last from June 2023 to July 2025. Joseph Dieleman provided a brief overview of key deliverables and respective due dates.

Next, the committee heard an overview of the Disease Expenditure (DEX) research project and its findings, which include proportions of national personal health care spending for 161 health conditions and their growth rates over time. IHME conducted an analysis to understand why health care spending has been increasing. At the national level, the analysis reviewed all health care spending, diseases, and age groups and attributed cost growth to one of five categories. The analysis identified the factors driving the increases in spending (such as ambulatory care, pharmaceuticals, nursing facility care, and emergency departments) for specific health conditions. For its work with HCA, IHME will take a similar approach to its earlier analyses but with a focus on Washington. The initiative will access the Washington All Payer Claims Database (APCD), begin data landscaping (finding and understanding data sources unique to Washington), learn and receive feedback, and form an analytical strategy to act as a guide for the first year on the project.

Questions from board members:

One board member asked how IHME's work relates to and complements other current cost work e.g., OnPoint and hospital cost work. Chair Birch responded that IHME gives the board an additional perspective and supplements current efforts to better understand cost drivers and appropriate policy solutions. Joe Dieleman added that IHME's work is meant to be complementary with OnPoint and not contradictory.

Another board member asked if spending on diagnostic work and testing is included when a diagnosis is unknown. Joe Dieleman confirmed undiagnosed conditions and testing would be included.

Another board member asked about pharmacy spending and specialty drugs. Would specialty drugs be lumped into the service price, utilization, in inpatient and ambulatory care? Joe Dieleman affirmed specialty drugs would be integrated. There's a dedicated member on the IHME team responsible for tracking prescription drug costs.

Public Comment

Katerina LaMarche, Policy Director of the Washington State Hospital Association (WSHA), provided comments on behalf of Allison Bailey and on behalf of herself. Receiving meeting agendas close to the meeting time makes it difficult to prepare for public comment but the joint meeting materials were supplied well in advance. Allison is the Associate Vice President of revenue cycle at Multi-Care Health Care Health System and a member of the Advisory Committee on Data Issues. At the last board meeting, the state's consultants presented an overview of how performance for providers would be assessed against the benchmark. Which providers will be considered in what networks and what information will be provided to providers if they exceed the benchmark? Will there be data at the provider specific level on how to verify that information is correct, and will the data be detailed enough to

understand what changes need to be made to improve? The data must be specific, verifiable, and actionable. It is important that there is enough information for providers to know where and how to make changes if they exceed the benchmark. Not providing enough information and not providing specific verified data will set providers up to fail. On behalf of WSHA, Katerina asked two questions about the annual legislative report. Based on the agenda, the board will be voting to adopt the report and board and stakeholder feedback will be incorporated into the final draft. Will advisory committees have a chance to review and provide feedback to the board? Will the board have a chance to review the final draft with the incorporated feedback before submission? Chair Birch responded that there will be opportunities to provide feedback through public comment periods. As HCA gains more definitive information, updates will come through the committees to the board.

Jonathan Bennett, Vice President of Data Analytics and IT services at WSHA and a member of the Advisory Committee on Data Issues noted that during the April board meeting, an overview of how provider performance against benchmark was shared. This left the board and committee members with a lot of general and specific questions. It is unclear which providers will be measured against the benchmark. To improve the understanding of the performance measurement process by the board and providers, WSHA requests that HCA staff provide a follow-up presentation to provide additional clarity. Advisory committee members introduced a motion at the June combined meeting but due to timing, members were unable to act on this motion. WSHA urges the board not to wait for a formal motion but to move ahead with HCA staff and consultants to provide requested clarification. It's important for the board to have a comprehensive understanding of the benchmark method including both its strengths and weaknesses since it's one of the primary tools to control cost growth. It is imperative for providers to understand how they're being measured and what resources they can expect to receive throughout the process. HCA needs to build engagement with providers to provide information and resources to the board and its committees to understand how providers will be measured. Is there a clear path for providers to take if they exceed the benchmark? Chair Birch noted that the board and its committees have discussed methodologies many times at multiple committee and board meetings. These discussions will continue. HCA is currently working on the establishment of the baseline of the benchmark, which will not include a report on providers and carriers initially. In future years following the baseline report, RCW 70.390 requires the board to report annually on performance relative to the baseline benchmark at the state, health insurance market, individual payer, and large provider entity levels, but not for small or individual providers. Initially, HCA and the board are collecting only aggregate information.

Jim Freeburg, Patient Coalition of Washington expressed support for the board's deep dive on cost drivers and urged the board to proceed as quickly as possible on policy solutions. Consumers continue to be hurt by high health care spending with no relief on the horizon. Many may be aware of the recent premium increases proposed by the Office of the Insurance Commissioner (OIC), with more significant increases expected in future years. There is incredible variation in care, cost, and quality and significant room for improvement. The board shouldn't get stuck on methodology but should move forward with real action items. IHME's work will help the board achieve its goals sooner rather than later.

Ronnie Sure, President of Healthcare for All Washington voiced support for the board's partnership with IHME to look at comprehensive data.

One board member asked how letters received from WSHA and the Washington State Medical Association (WSMA) are processed by HCA staff and relayed to the board for input. Chair Birch responded that HCA would provide more information on the process later.

HCCTB's Legislative Reports: Cascade Select and Annual Update Report

Mandy Weeks-Green, Board Director, HCA
Laura Kate Zaichkin and Kristin Villas, Health Benefit Exchange (HBE)

Mandy Weeks-Green, Laura Kate Zaichkin, and Kristin Villas provided an overview of the draft Cascade Select Report. A Word version of the report was provided to the board for feedback. This report is part of a series of reports. HBE is currently analyzing public option plan rates paid to hospitals for in-network services and analyzing rates' potential impacts on hospital financial sustainability. The board's report analyzes the effect of enrollment in public option plans on consumers, including benefits, premiums, and cost-sharing amounts. HBE will provide recommendations to the Legislature based on both sets of analyses and will submit recommendations by December 1, 2023. The board's Cascade Select report doesn't include general recommendations on the public option or recommendations on procurement or standard plan design. Based on board member feedback, members highly ranked access to care, broad issues of affordability, premiums, and cost-sharing as areas of interest. Additional areas of interest included drivers of enrollment in public option plans, qualitative data from consumers, and drivers of variability in public option premium affordability. The board's report uses data from a variety of sources, including Exchange data from 2021 to 2023 spring enrollment reports, carrier rate filings from 2021 to 2023 from the OIC, other Cascade Care analyses, and qualitative information from reviews of Exchange surveys, reports, and enrollment partner feedback.

Laura Kate Zaichkin provided a brief overview of Cascade Care and reviewed some of the feedback received in the report. Cascade Care exists to increase access to high-quality, affordable health coverage on a healthy individual market. Cascade Care plans differ from non-standard plans which are designed by carriers and vary in deductibles and co-pays. Cascade Care plans have uniform benefits and offer more coverage. Cascade Care plans are high quality, low-cost, standard benefit plans available exclusively to Washington Healthplanfinder customers. Some plans are called Select Plans and are part of the public option. Public option plans provide the same predictable benefits as all other Cascade Care plans; however, public option plans include narrower provider networks and lower premiums in many counties. In addition to standard benefits, carriers in public option plans are required to meet higher quality standards and state defined reimbursement rates for providers. As of 2023, hospitals are required to contract with at least one public option plan. The goals are affordability, statewide access, and quality and equity, each of which are associated with a set of policy levers.

Kristin Villas provided an overview of the analysis of public option premiums and cost sharing. At the end of the latest open enrollment, 11 percent of Exchange customers were enrolled in public option plans, with new enrollees being more likely to enroll in the public option. Public option enrollees tend to be younger than non-public option enrollees and, in 2021 and 2023, had lower incomes. Lower premiums drive enrollment in the public option. The informal target for lower premiums in public plans is 10 percent lower than the next premium cost plan. While initially higher, public option plan premiums have consistently trended downward. The average public option premiums across all levels are lower than non-Cascade Care premiums for the first time in plan year 2023. Public option plans are the lowest-cost silver premium qualified health plans in 25 counties in 2023, up from 13 counties in 2022. Public option enrollees pay less out of pocket when using their benefits. Cost sharing is lower for high-value services like primary care. Deductibles are an average of $1,000 less than non-Cascade plan deductibles. The introduction of Cascade Care plans to the marketplace decreased deductibles across Exchange plans. Public option plan enrollees select plans with more generous coverage but with narrower networks and access. Early affordability analysis suggests that current provider reimbursement targets may not be enough to meaningfully reduce premiums. While enrollment has increased, public option plans are still not available statewide.

Board member questions:

One board member asked about the percentage of people buying non-standardized plans, and whether this can be broken down by income level. For counties that still don't have the public option, did plans indicate the problem, e.g., lack of providers? HCA and HBE are currently investigating counties that don't have the public option. HBE is also conducting an analysis of the effect of elimination of non-standard plans on the market that could address plan demographics.

Another board member asked for more information on networks and how they differ between standard and non-standard plans. So far, analysis has shown that networks are the same between standard and non-standard, but that public option plans are narrower.

Chair Birch asked for a motion to adopt the public option report with the understanding that additional feedback from the board and other stakeholders would be incorporated into the final draft. The motion passed unanimously.

Mandy Weeks-Green noted the inclusion of the draft of the board's annual cost report in the meeting materials. The board will receive a Word version for further review and feedback. Board members and other stakeholders have until July 6 to provide feedback. One board member requested that for future reports, the board receive a copy that includes final edits to vote on before submission to the Legislature. Chair Birch asked for a motion to adopt the final report, with the understanding that final edits will be incorporated into the final draft and, if there are concerns, that the report be brought back for an additional vote. The motion passed unanimously.

Primary Care Claims-Based Measurement Recommendations: Discussion and Vote

Dr. Judy Zerzan-Thul, Medical Director, HCA

Dr. Zerzan-Thul provided an update on the Advisory Committee on Primary Care's recommendations. So far, the committee has voted on a high-level definition and is in the process of finalizing measurement methods for assessing claims and non-claims-based spending. The committee hasn't settled yet on a broad versus narrow definition. To measure claims, the committee is looking at the who (providers), the what (services) and the where (location). Reviewing sample data will allow the committee to refine the codes. In the board's report to the Legislature, the committee previewed several possible data strategies to align with primary care committee members' preliminary interests. The committee is developing recommendations on how to achieve the 12 percent target. The committee will review non-claims-based data collection policies and general data barriers at the end of June. In July, the committee will review a sample data analysis to finalize the code set and primary care definition and will continue the discussions of policies to advance primary care spending. The committee will use the remainder of the year to develop a measurement implementation plan.

Chair Birch made a motion to adopt the draft recommendation for claims-based measurement. The motion was approved unanimously.

Adjournment

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

Next meeting

October 18, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.