Washington State Health Care Authority

# Health Care Cost Transparency Board

**May 13, 2021**

Washington State Health Care Authority

# Health Care Cost Transparency Board
# Board Book

**May 13, 2021**
**9:00 a.m. – 12:00 p.m.**

**(Zoom Attendance Only)**

Washington State Health Care Authority

# Agenda

# TAB 1

Washington State Health Care Authority

# Health Care Cost Transparency Board

**May 13, 2021**
**9:00 a.m. – 12:00 p.m.**
**Zoom Meeting**

## AGENDA

| Board Members: | | | | | |
|---|---|---|---|---|---|
| ☐ | Susan E. Birch, Chair | ☐ | Pam MacEwan | ☐ | Carol Wilmes |
| ☐ | Lois C. Cook | ☐ | Molly Nollette | ☐ | Edwin Wong |
| ☐ | John Doyle | ☐ | Mark Siegel | ☐ | Laura Kate Zaichkin |
| ☐ | Bianca Frogner | ☐ | Margaret Stanley | | |
| ☐ | Sonja Kellen | ☐ | Kim Wallace | | |

| Time | Agenda Items | Tab | Lead |
|---|---|---|---|
| 9:00-9:10 (10 min) | Welcome, roll call, and agenda review | 1 | Susan E. Birch, Chair, Director Health Care Authority |
| 9:10-9:15 (5 min) | Approval of April meeting minutes | 2 | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 9:15-9:25 (10 min) | Discussion and appointments: Non-voting board member from the Advisory Committee of Health Care Providers and Carriers and proposed additional committee members. | 3 | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 9:25-9:40 (15 min) | Discussion and appointment: Advisory Committee on Data Issues | 4 | JD Fischer, VPB Project Manager, Cost Transparency Team Member Health Care Authority |
| 9:40-9:45 (5 min) | Recap of preliminary recommendations (from 4/13 board meeting) | 5 | Michael Bailit and January Angeles Bailit Health |
| 9:45-9:50 | Topics for today's discussion | 6 | Michael Bailit and January Angeles Bailit Health |
| 9:50-10:05 (15 min) | Defining the population for whom total medical expenses are being measured.<br>**Design recommendations:**<br>**Sources of coverage to include, and**<br>**state of residence and care location** | 7 | Michael Bailit and January Angeles Bailit Health |
| **Time** | **Agenda Items** | **Tab** | **Lead** |
| 10:05-10:15 (10 min) | Establishing criteria for choosing an economic indicator | 8 | Michael Bailit and January Angeles Bailit Health |

| | | | |
|---|---|---|---|
| | **Design recommendation:**<br>**Economic indicator criteria** | | |
| 10:15-10:25<br>(10 min) | Public Comment | | Susan E. Birch, Chair, Director<br>Health Care Authority |
| 10:25-10:35<br>(10 min) | Break | | |
| 10:35-11:05<br>(30 min) | Economic indicators for the cost growth benchmark | 9 | Michael Bailit and January Angeles<br>Bailit Health |
| 11:05-11:35<br>(30 min) | Discussion of options for establishing a cost growth benchmark<br>**Design Recommendation:**<br>**Economic indicator for the benchmark** | 10 | Michael Bailit and January Angeles<br>Bailit Health |
| 11:35-11:50<br>(15 min) | Calculating an indicator to derive a cost growth benchmark and potential benchmark values<br>**Design Recommendation:**<br>**Historical vs. Forecasted values** | 11 | Michael Bailit and January Angeles<br>Bailit Health |
| Time permitting | Snapshot of historical health care cost growth in Washington<br>**Design Recommendation:**<br>**Benchmark methodology and value** | 12 | Michael Bailit and January Angeles<br>Bailit Health |
| 11:50-11:55<br>(5 min) | Wrap-up and next steps | | AnnaLisa Gellermann, Board Manager<br>Health Care Authority |
| 11:55-12:00<br>(5 min) | Adjournment | | Susan E. Birch, Chair, Director<br>Health Care Authority |

*In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.*

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# April Meeting Minutes

# TAB 2

# Health Care Cost Transparency Board meeting minutes

April 13, 2021
Health Care Authority
Meeting held electronically (Zoom) and telephonically
10:00 a.m. – 12:00 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
John Doyle
Bianca Frogner
Sonja Kellen
Pam MacEwan
Molly Nollette
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong
Laura Kate Zaichkin

## Call to order and welcome remarks

Sue Birch, chair, called the meeting to order at 10:02 a.m.

## Agenda items

### Welcoming remarks

Sue Birch
Ms. Birch welcomed the Board to the second meeting. She shared her perception of public confusion about the work of the Board and pointed out a role for Board members in public outreach. She discussed the difference between the data call to carriers, and the role of the state All Payer Claims Database in determining cost drivers.

### Adoption of March 15 minutes

The March 15 minutes were adopted unanimously, and consensus was put on the record.

### Discussion and Adoption of Proposed Charter and Operating Procedures

The Board reviewed the proposed changes to the charter proposed in the materials. An additional motion was brought by Laura Kate Zaichkin to amend the vision statement. In the Board discussion, it was determined to keep some "flavor" of the stricken purpose statement related to the impact of the Board's work on negotiations between

providers and carriers and new language was developed. Laura Kate Zaichkin moved to adopt a new vision statement, seconded by Molly Nollette. The Board approved the new vision statement. After thorough discussion of the strike out language, Margaret Stanley proposed a revised statement to be inserted into the purpose section. A motion was made by Margaret Stanley and seconded by Carol Wilmes to adopt the new statement. The Board voted affirmatively to adopt the changes to the statement. Laura Kate Zaichkin moved to adopt the amended document with submitted changes, and this motion was seconded by Carol Wilmes. The Board unanimously approved the motion.

### Discussion and Appointment: Advisory Committee of Health Care Providers and Carriers

The Board reviewed the list of nominations received from nominating entities, and the proposed slate recommended by HCA staff. The Board requested additional representation from the Eastern region of the state, and representation from large provider and hospital systems. Laura Kate Zaichkin moved to approve the recommended slate and Molly Nollette seconded the motion. The motion was unanimously approved. AnnaLisa Gellermann was directed to look for the additional representation requested by the Board.

### Presentation: Beginning the process of defining the benchmark methodology and decisions we will cover today

Michael Bailit, Bailit Health

### Presentation: Defining total health care expenditures

January Angeles, Bailit Health
Discussion of programs in Massachusetts, Delaware, Rhode Island, Oregon, and Connecticut.

**Note:** due to time, the remainder of the presentations scheduled for this meeting were deferred until the next Board meeting.

### Public comment

There was no public comment.

## Next meeting

Thursday, May 13, 2021
Meeting to be held on Zoom
9:00 a.m. – 11:00 a.m.

Meeting adjourned at 11:58 a.m.

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# Non-voting board member from Advisory Committee of Health Care Providers and Carriers and Proposed Additional Committee Members

# TAB 3

# Health Care Cost Transparency Board

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## Non-voting member of the board for consideration:

| Name | Title | Place of Business |
|---|---|---|
| Bob Crittenden | Physician and Consultant | Empire Health Foundation |
| Jodi Joyce | Chief Executive Officer | Unity Care NW |

| Name | Title | Place of Business |
|---|---|---|
| Patricia Auerbach | Market Chief Medical Officer | United Healthcare |
| Mark Barnhart | Chief Executive Officer | Proliance Surgeons, Inc., P.S. |
| Bob Crittenden | Physician and Consultant | Empire Health Foundation |
| Bill Ely | Vice President of Actuarial Services | Kaiser Permanente |
| Jodi Joyce | Chief Executive Officer | Unity Care NW |
| Louise Kaplan | Associate Professor, Vancouver | WSU College of Nursing |
| Ross Laursen | Vice President of Healthcare Economics | Premera Blue Cross |
| Todd Lovshin | Vice President and WA State Executive | PacificSource Health Plans |
| Vicki Lowe | Executive Director | American Indian Health Commission |
| Mike Marsh | President and Chief Executive Officer | Overlake Hospital and Medical Center |
| Natalia Martinez-Kohler | Vice President of Finance and CFO | MultiCare Behavioral Health |
| Megan McIntyre | Pharmacy Director, Business Services | Virginia Mason |
| Byron Okutsu | AVP Network Management, Pacific NW | Cigna |
| Mika Sinanan | Surgeon and Medical Director | UW Medical Center |

## Additional members for consideration:

| Name | Title | Place of Business |
|---|---|---|
| Paul Fishman | Professor, Dept. of Health Services | University of Washington |
| Stacy Kessel | Chief Finance and Strategy Officer | Community Health Plan of Washington |
| Dorothy Teeter | Consultant | Teeter Health Strategies |
| Wes Waters | Chief Financial Officer | Molina HealthCare of Washington |

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# Advisory Committee on Data Issues

# TAB 4

# Advisory Committee of Data Issues

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## Members for consideration:

| Name | Title | Place of Business |
|---|---|---|
| Megan Atkinson | Chief Financial Officer | Health Care Authority |
| Amanda Avalos | Deputy, Enterprise Analytics, Research, and Reporting | Health Care Authority |
| Allison Bailey | Executive Director, Revenue Strategy and Analysis | MultiCare Health System |
| Jonathan Bennett | Vice President, Data Analytics, and IT Services | Washington State Hospital Association |
| Purav Bhatt | Regional VP Operations, Management, and Innovation | OptumCare Washington |
| Bruce Brazier | Administrative Services Director | Peninsula Community Health Services |
| Jason Brown | Budget Assistant | Office of Financial Management |
| Jerome Dugan | Assistant Professor, Department of Health Services | University of Washington |
| Leah Hole-Marshall | General Counsel and Chief Strategist | Health Benefit Exchange |
| Karen Johnson | Director, Performance Improvement, and Innovation | Washington Health Alliance |
| Scott Juergens | Division Director, Payer Analytics and Economics | Virginia Mason Franciscan Health |
| Lichiou Lee | Chief Actuary | Office of the Insurance Commissioner |
| Josh Liao | Medical Director of Payment Strategy | University of Washington |
| Dave Mancuso | Director, Research and Data Analysis Division | DSHS, Research and Data Analysis |
| Ana Morales | National Director, APM Program | United Healthcare |
| Thea Mounts | Senior Forecast Coordinator | Office of Financial Management |
| Hunter Plumer | Senior Consultant | HealthTrends |
| Mark Pregler | Director, Data Management and Analytics | Washington Health Alliance |

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# Recap of Preliminary Recommendations

(from 4/13 board meeting)

# TAB 5

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# Recap of Preliminary Recommendations

May 13, 2021

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# Recap of preliminary recommendations

- Total Health Care Expenditures (THCE) should be defined as the allowed amount of claims-based spending from payer to provider, all non-claims-based spending from payer to provider, and the net cost of private health insurance.
- Total Medical Expenses (TME) should be reported as net of pharmacy rebates.
- TME should not include dental or vision services unless they are covered under a comprehensive medical benefit.

# Recap of preliminary recommendations

- Project staff should ensure that waiver services are appropriately captured in the claims and non-claims-based categories of spending used by other cost growth benchmark states.
- The final recommendations report should document the Board's desire to be as comprehensive as is feasible in defining health care spending that is being measured against the cost growth benchmark.
  - The Board may in the future add standalone dental plan payments to the definition of THCE as data that allow for measurement of spending become available and accessible.

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# Topics for Today's Discussion

# TAB 6

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# Topics for Today's Discussion

1. Determine whose costs to measure
2. Establish criteria for selecting an economic indicator
3. Review options for economic indicators to use as a basis for establishing the cost growth benchmark
4. Compare methodological options for the cost growth benchmark
5. Review options for calculating an indicator to derive a cost growth benchmark
6. Discuss potential benchmark values

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# Defining the Population for Whom Total Medical Expenses are being Measured

# TAB 7

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# Defining the population for whom total medical expenses are being measured

May 13, 2021

# Determine whose total medical expense to measure

- HB 2457 does not provide highly specific guidance on whose costs to measure. It states only that total medical expense include "all health care expenditures in this state by public and private sources."
- Therefore, we needed to determine:
  - the population whose total medical expense should be measured
  - the sources of insurance coverage for that population

# Total medical expense for whom?

- We need to be specific with the definition of “for whom.” We will walk through a series of questions to help define the coverage status of individuals whose health care spending is being measured.
- Data access may play a role in which coverage groups can be included.

# Primary sources of health care coverage

- Medicare
  - Fee-for-service
  - Medicare Advantage
- Medicaid
  - Fee-for-service
  - Managed care
- Medicare & Medicaid “Duals”
- Commercial
  - Fully-insured
  - Self-insured

All cost growth benchmark states include these sources of coverage.

HB 2457 requires all public and private sources of coverage to be included, which we assume to be those listed.

# Other sources of health care coverage

- Veterans Health Administration (VHA)
- State Correctional Health System
- Indian Health Services (IHS)

States vary on inclusion of these sources of coverage.

We will review the considerations of including each of these sources.

Note: TRICARE is not presented for separate consideration as we assume that spending will be captured in the data request to commercial carriers.

# Total medical expense for which sources of coverage?

| | Advantages of Including | Disadvantages of Including |
|---|---|---|
| Veterans Health Administration (*MA, DE and CT*) | • Including VHA would make WA's definition comprehensive. (In 2019 1.8% of WA residents were covered through the VHA or TRICARE.) | • Data are limited and not "apples-to-apples." |
| State Correctional Health System *(OR and CT)* | • Including state correctional health system health care spending would make WA's definition more comprehensive. (In 2018, 17,845 individuals were incarcerated in WA, which is approximately 0.2% of the state population.) | • Some inpatient costs are already included under Medicaid (in certain circumstances).<br>• Data are limited and not "apples-to-apples." |
| Indian Health Service *(OR)* | • Including spending by the Indian Health Service would make WA's definition more comprehensive. (In 2020 1.8% of WA's population was Native American/Alaskan Native, though likely not all were served by the HIS.) | • Data are extremely difficult to collect and require consent from all tribes. |

# Design recommendation: Sources of coverage to include

Per HB 2457, THCE will include the following sources of coverage:

- Medicare (FFS and Medicare Advantage)
- Medicaid (FFS and managed care)
- Commercial (fully and self-insured)

# Design recommendation: Sources of coverage to include

Does the Board wish to include any additional sources f coverage?

- Veterans Health Administration
- State Correctional Health System
- Indian Health Service

Are there any other sources of coverage to consider for inclusion?

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# Whose THCE is being measured?


For the services covered by the recommended payers, what should be the:

- **Residence** of the **individual**?
- **Location** of the **provider**?

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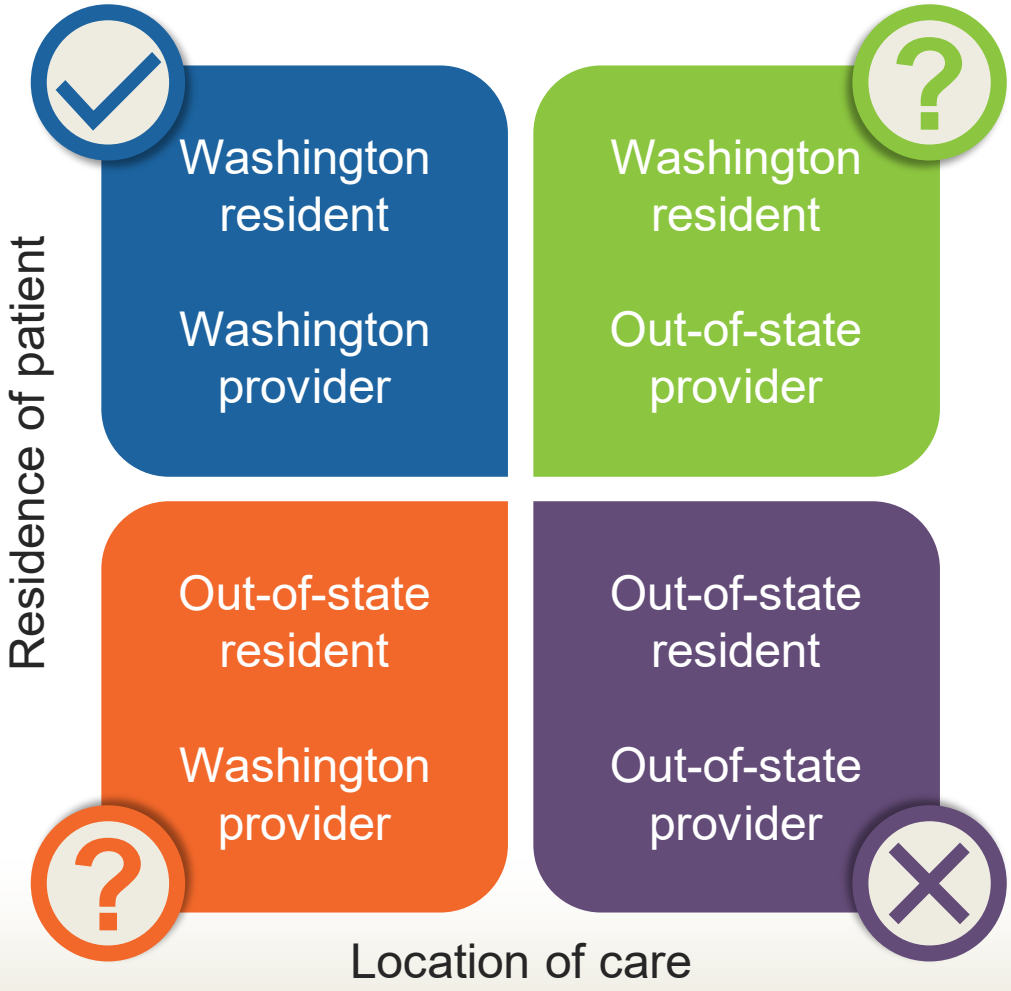
# State of residence and care location




It's clear that we should:

- *Include* Washington residents who received care from Washington providers
- *Exclude* out-of-state residents who received care from out-of-state providers

# Considerations around spending on care received by state residents from out-of-state providers

- Some health systems and ACOs have affiliated or employed physicians who practice in bordering states.
- Some residents split their time between Washington and other states, e.g., community across the border, wintering in a southern state.
- MA, DE, RI, OR and CT include spending by state residents with out-of-state providers in the numerator for their cost growth benchmarks.

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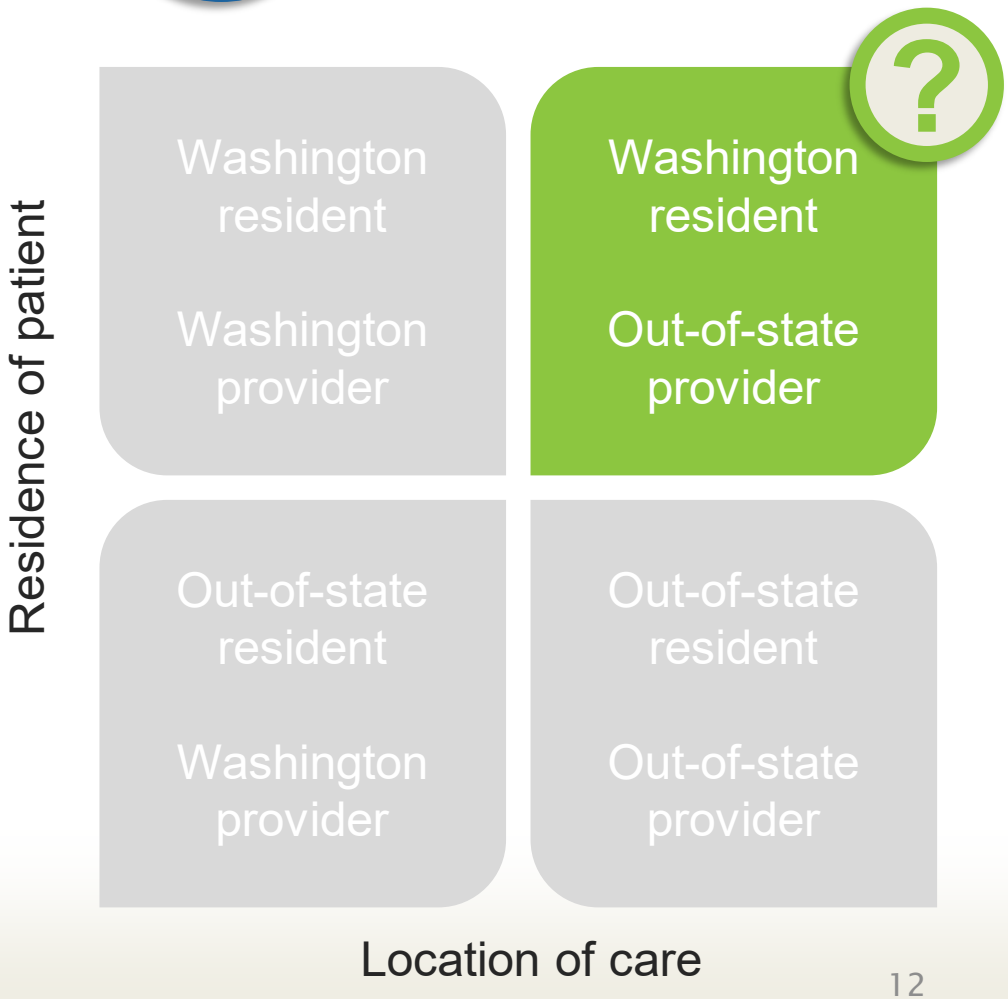
# Design recommendation: State of residence and care location




Should we include health care spending on Washington residents that were incurred out-of-state?

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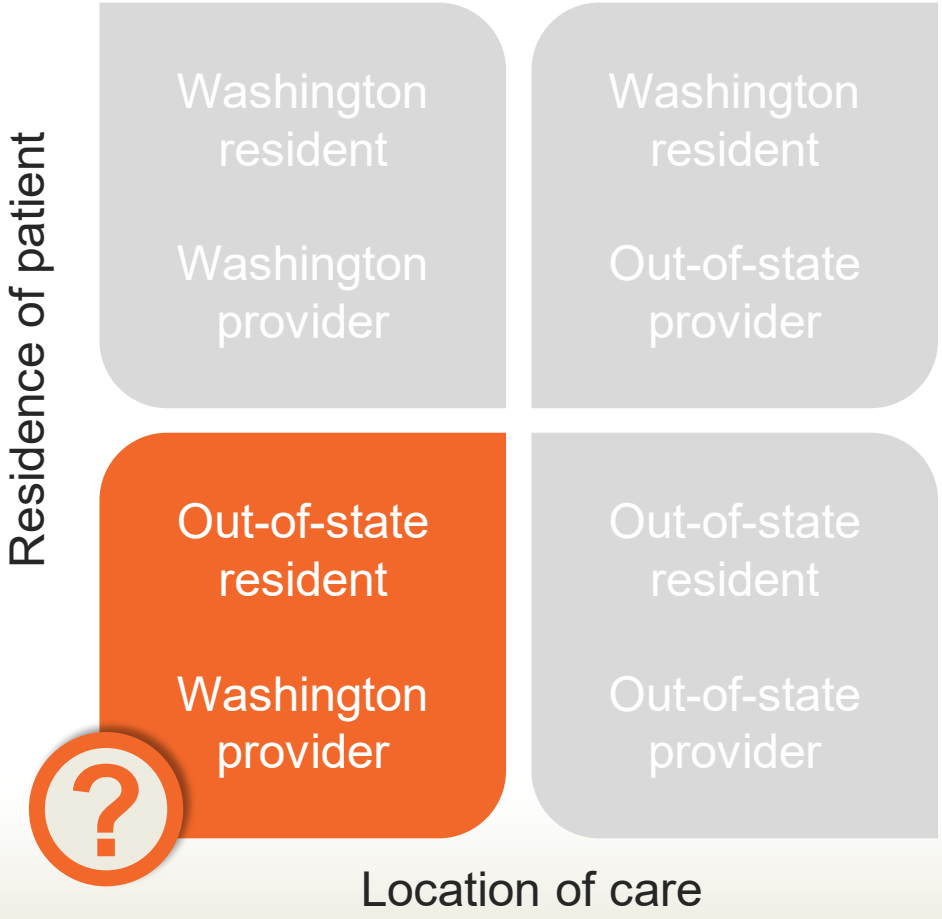
# Considerations around spending on care for non-state residents by in-state providers

- Advisory bodies in other states have debated whether to include spending associated with non-state residents.
  - State employees and other workers may commute into the state for work and receive their health care in the state. This spending represents an expense for Washington employers.
- These dollars can only be captured from those licensed insurers required to report; insurers not licensed in the state are less likely to report.
- Do we care about this spending since it is not spending on behalf of Washington residents?
- MA, DE, RI, OR and CT do not include these expenditures.

# Design recommendation: State of residence and care location




Should we include non-state residents who receive care from in-state providers?

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# Establishing Criteria for Choosing and Economic Indicator

# TAB 8

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# Establishing Criteria for Choosing an Economic Indicator to Inform the Benchmark Value

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# Why use an economic indicator?

- The primary reason for establishing a health care cost benchmark is that high and rising health care costs have been having a harmful impact on consumers and the non-health care economy.
- Using an economic indicator as the basis of the benchmark would link health care spending growth to consumer or state economic wellbeing.
- HB 2457 requires the Board to "select an appropriate economic indicator to use when establishing the health care cost growth benchmark."

# Establishing criteria for choosing the economic indicator

- Later in the meeting we will share economic indicator options to inform the value of the cost growth benchmark.
- Determining which indicator is a matter of preference – there is no objectively right or wrong answer.
- Identifying decision-making criteria may help facilitate the process, however. We therefore offer three criteria suggestions.

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# Suggested criteria

1. Provide a stable, and therefore, predictable benchmark.
2. Rely on independent, objective data sources with transparent calculations.
3. Lower health care spending growth.

# Design recommendation: Economic indicator criteria

Does the board wish to adopt the following criteria for choosing an economic indicator for the benchmark?

1. Provide a stable, and therefore, predictable benchmark.
2. Rely on independent, objective data sources with transparent calculations.
3. Lower health care spending growth.

Does the board wish to modify the above criteria or add other criteria for consideration?

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# Economic Indicators for the Cost Growth Benchmark

# TAB 9

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# Economic Indicators for the Cost Growth Benchmark

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# Options for the cost growth benchmark

- Annual growth in Washington's Gross State Product
- Annual growth in the personal income of Washington residents
- Annual growth in average wages of Washington workers
- Annual inflation rate, as measured by the Consumer Price Index
- Annual inflation rate, as measured by the Implicit Price Deflator for Personal Consumption Expenditures

# What Will We Learn About Each of the Indicators?

**What each of these indicators measures in the real world**

**What the "message" would be if the target was pegged to one of these indicators**

**What the annual rate of change has been over the last 20 years (for informational purposes only)**

# Option 1: Rate of growth in Washington's Gross State Product

- **Gross State Product (GSP)** is the total value of goods produced and services provided in a state during a defined time period.
- This is the state counterpart to Gross Domestic Product (GDP), which is measured at the national level, with a few methodological differences in how the figures are calculated.

# What it means to use the rate of growth in Washington's economy

GSP is often considered the main measure and key target of economic policy at all levels of government. The growth in GSP tells us how fast the state's economy is growing.

By tying the benchmark to GSP, we would be recommending an expectation that health care spending should not grow faster than the economy.

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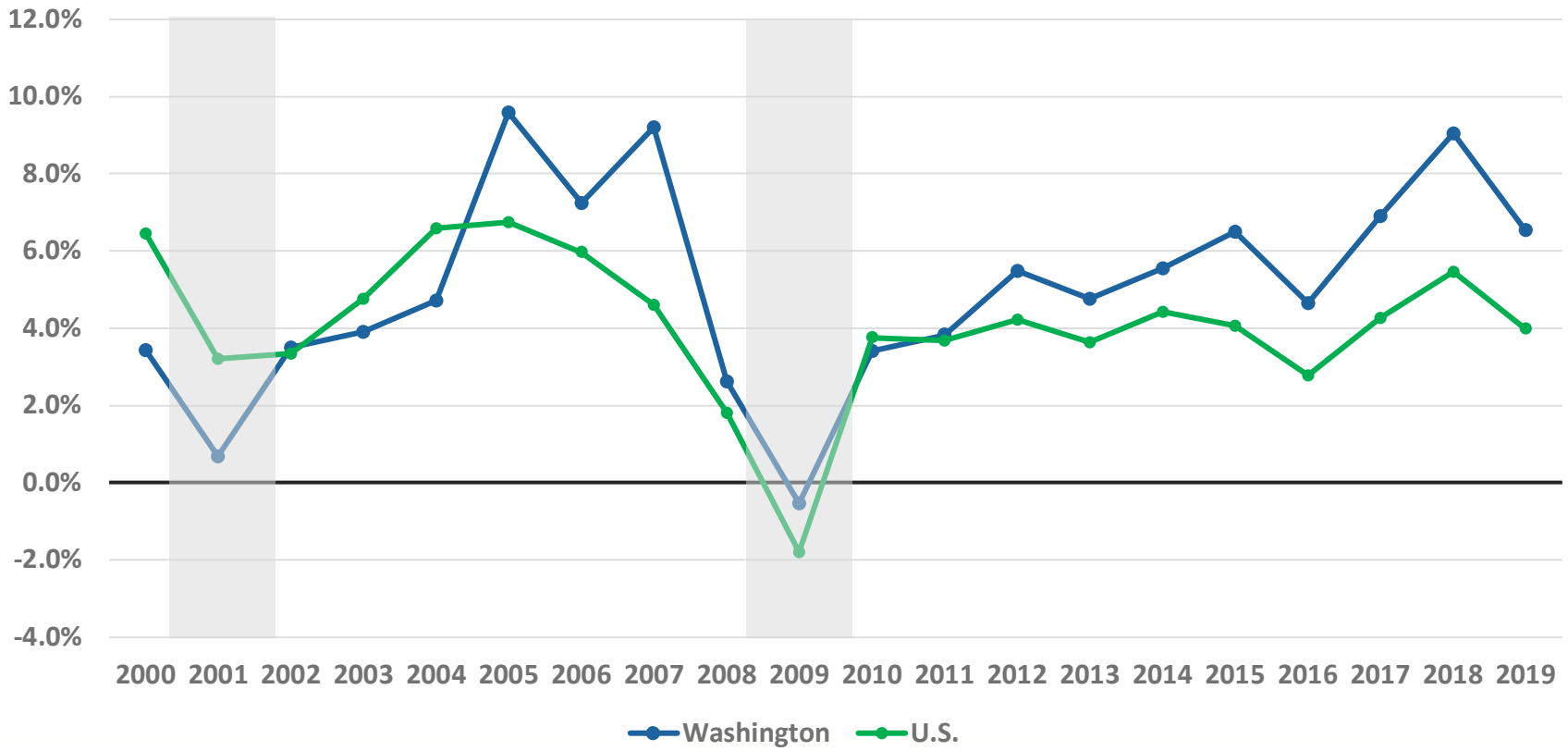
# Growth in the Washington and U.S. gross state/domestic product, 2000-2019




Shaded areas indicate U.S. recessions.

SOURCE: U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/GDP, March 22, 2020.

# Option 2: Rate of growth in personal income of Washington residents

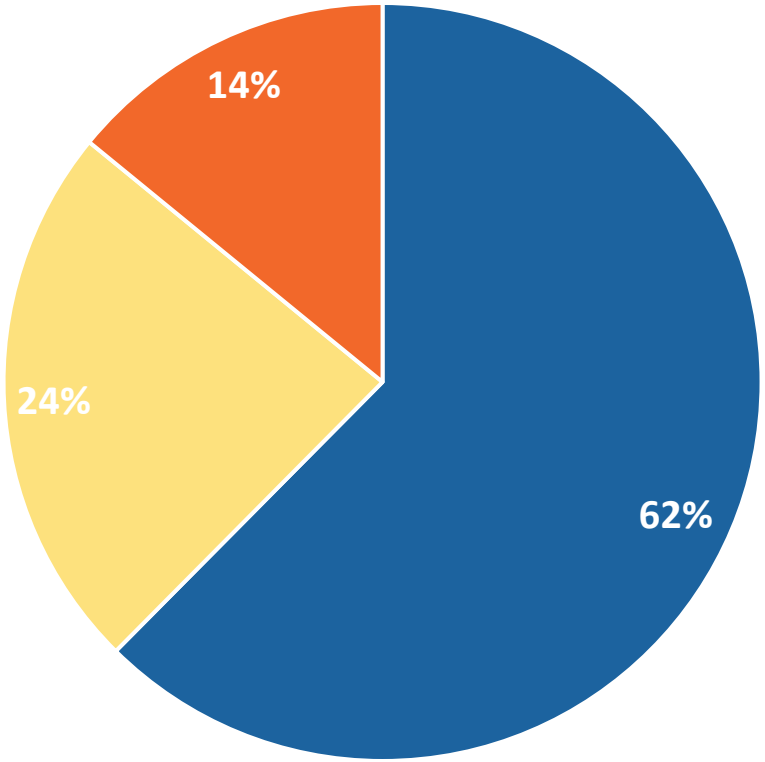
- **Personal income** is the sum of all payments received by individuals within the state.
- It includes:
  - Earnings such as wages and salaries, proprietor's income (farm and non-farm), and other income (employee benefits)
  - Property income (dividends, rent ,and interest)
  - Transfer payments (pensions, Social Security, and other government benefits)
- It does not include some other sources of income, such as capital gains.

# What it means to use rate of growth in Washington residents' personal income

State revenue and spending on government assistance programs depends on personal income. Personal income growth can offer clues to the financial health of Washington residents and future consumer spending.

By tying the benchmark to personal income growth, we would be recommending health care not grow faster than a measure of consumer financial wellbeing.

# Personal income in Washington by Type




- Net earnings (wages, supplement to wages, and proprietor's income less contributions to social insurance)
- Property income (dividends, interest, and rent)
- Transfer payments (pensions, Social Security, and other government benefits)

SOURCE: Washington State Office of Financial Management, "Personal Income by Component," https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-state-data-book, accessed March 22, 2020.

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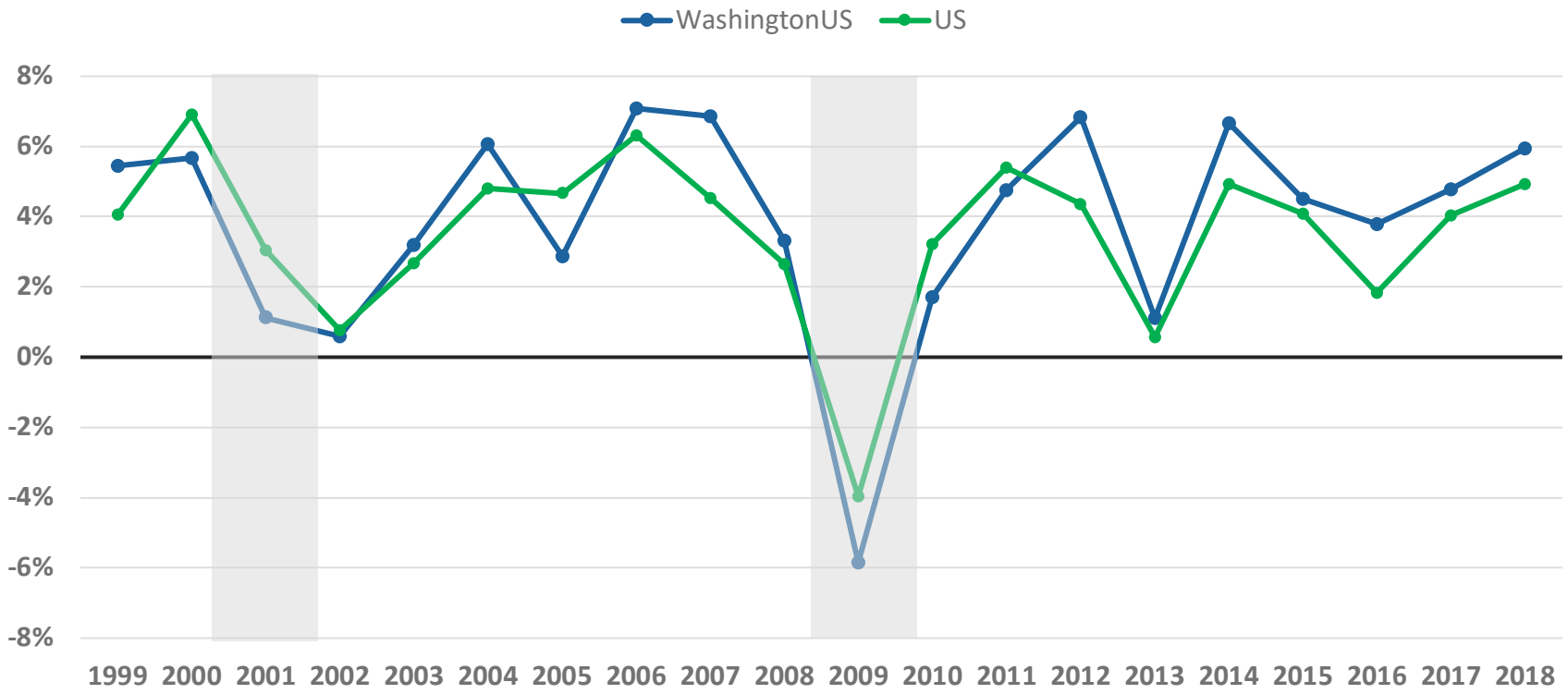
# Growth in per capita personal income in Washington and the U.S., 1999-2018




Shaded areas indicate U.S. recessions.

SOURCE: Washington State Office of Financial Management, Per Capita Personal Income in Washington using nominal dollars, Table CT02, https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-state-data-book, March 22, 2020

# Option 3: Rate of growth in wages of Washington residents

- **Wages and salaries (wages)** is compensation received by individuals for work as an employee or as a contractor with an employer.
- It does not capture income that typically accrues to higher income earners, such as capital gains, dividends, rents and interest.
- Wages have grown slower than personal income due to the boost in non-wage income, including the value of health insurance benefits, in the recent past.

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# What it means to use rate of growth in Washington residents' average wage

Wage growth is a more tangible indicator for most individuals than personal income growth as it more closely represents "take-home pay."

Setting the benchmark to the growth in Washington residents' wages implies that health care should not grow faster than Washington residents' "paychecks."

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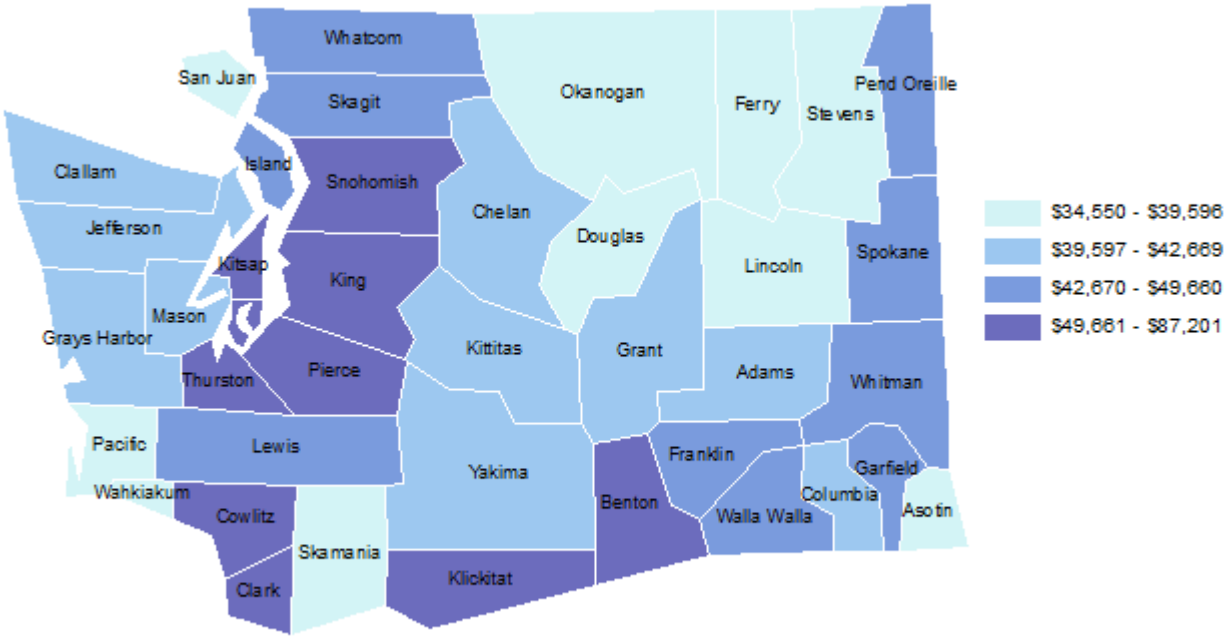
# Average wage by county, 2018

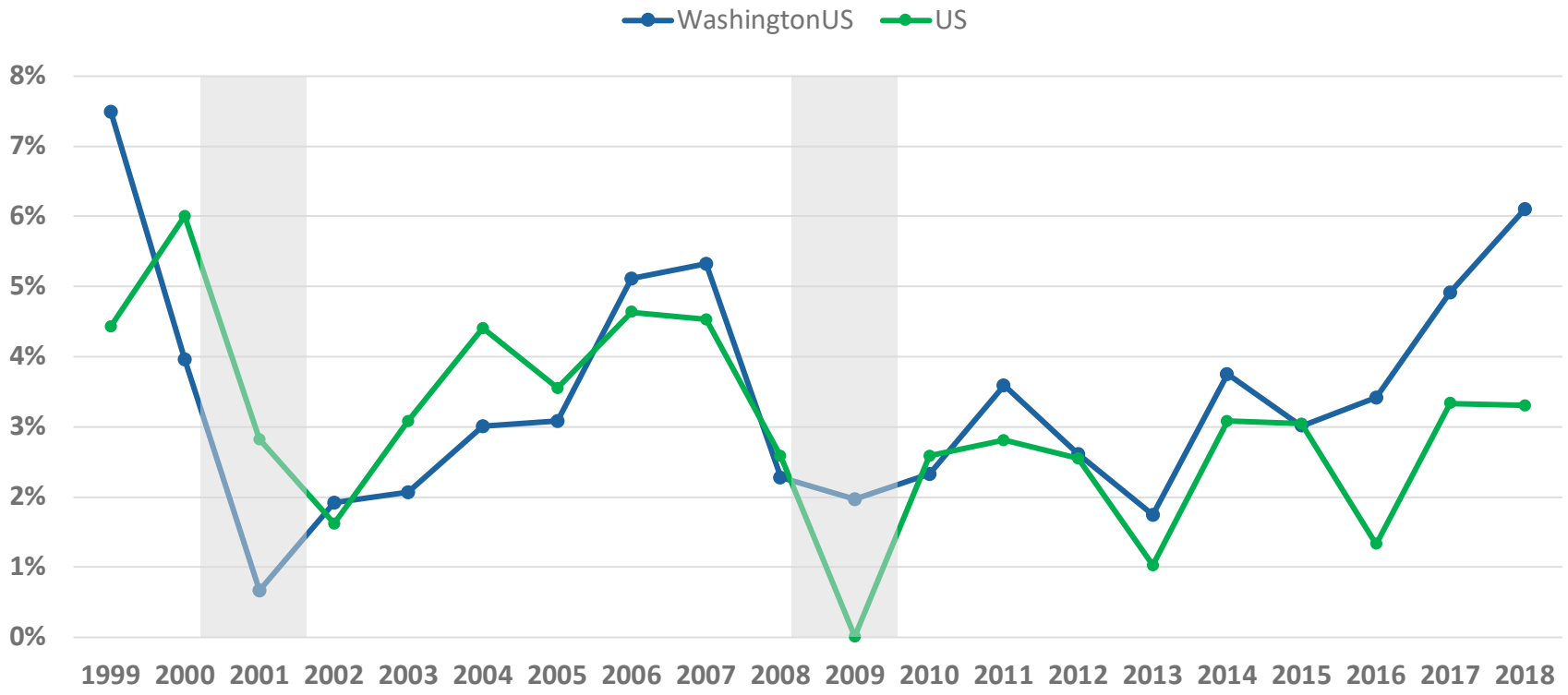
In 2018, average wage in Washington was **$65,640**.

Washington ranked **6th** highest among the states in average wage.




SOURCE: Washington State Office of Financial Management, "Average Wages, 2018," https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/economic-trends/washington-and-us-average-wages/average-wages-county-map, March 22, 2020.

# Average per worker wage growth in Washington and the U.S., 1999-2018




Shaded areas indicate U.S. recessions.

SOURCE: Washington State Office of Financial Management, Average Wages, using nominal dollars, Table CT09, https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-state-data-book, March 22, 2020

# Options 4 and 5: Rate of inflation

- Inflation is the process of rising prices that causes the buying power of a dollar to decrease over time.
- Various indices exist to measure different aspects of inflation. Two commonly used indexes are the:
  - Consumer Price Index (CPI)
  - U.S. Implicit Price Deflator for Personal Consumption (IPD)

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# What is the Consumer Price Index (CPI)?

- The **Consumer Price Index** measures price changes for a "market basket" of retail goods and services purchased out of pocket by consumers.
  - It is most often measured using "CPI All Urban or CPI-U," which captures the experience of 94% of Americans.
- CPI measures inflation as experienced by consumers in their day-to-day living expenses.

# What is the Implicit Price Deflator for Personal Consumption (IPD)?

- The **Implicit Price Deflator** measures personal consumption of goods and services measured in today's prices compared to current personal consumption at prices from a base year.
  - It is the ratio of the nominal value of a series, such as GDP, to its corresponding chained-dollar value, multiplied by 100.
- The IPD measures the prices of a much wider group of goods and services than the CPI.
- Washington's state expenditure limit and inflation adjustments in the biennial budget are based on the IPD.

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# What it means to use inflation

Measures of inflation give a sense of how prices have risen over time, and of consumers' purchasing power.

Setting the benchmark to the rate of inflation signals that health care should not grow faster than the rise in consumer prices.

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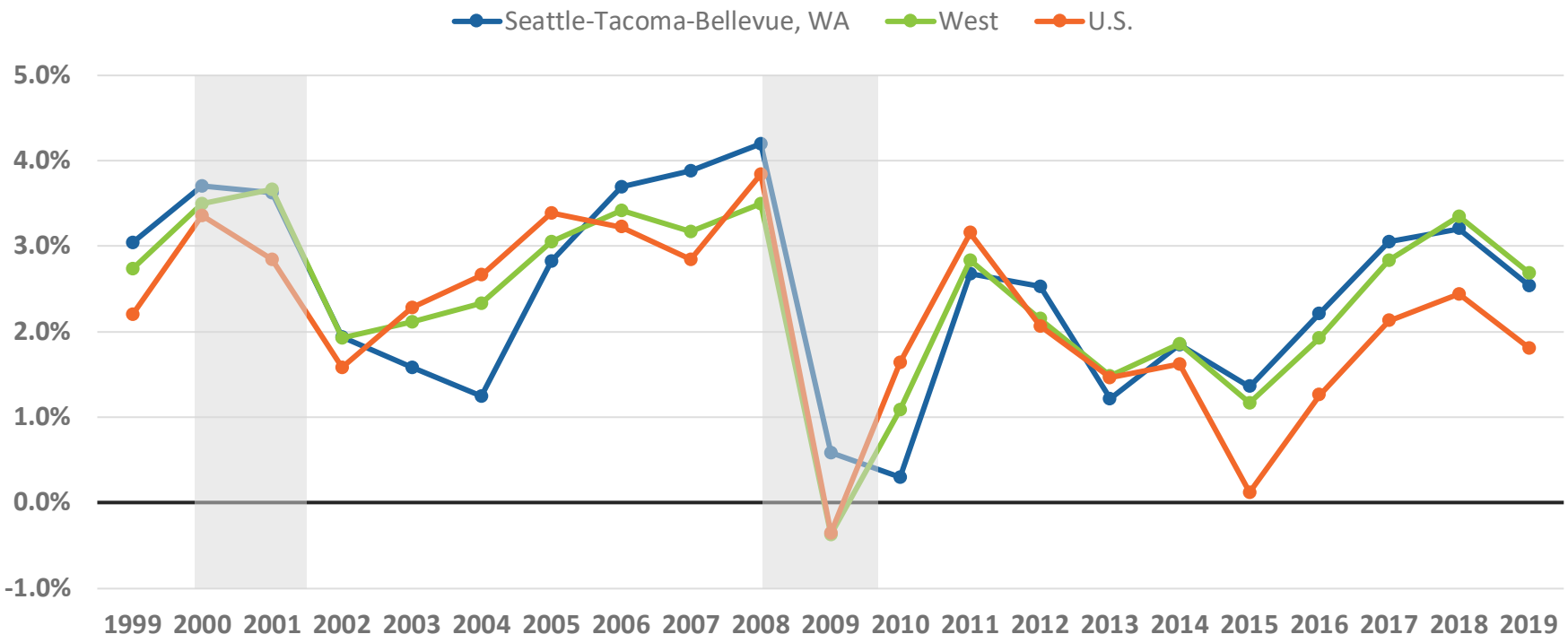
# Annual Growth in CPI-U, 2000-2019




Shaded areas indicate U.S. recessions.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Retrieved from: https://www.bls.gov/regions/west/data/cpi_tables.pdf, March 22, 2021.

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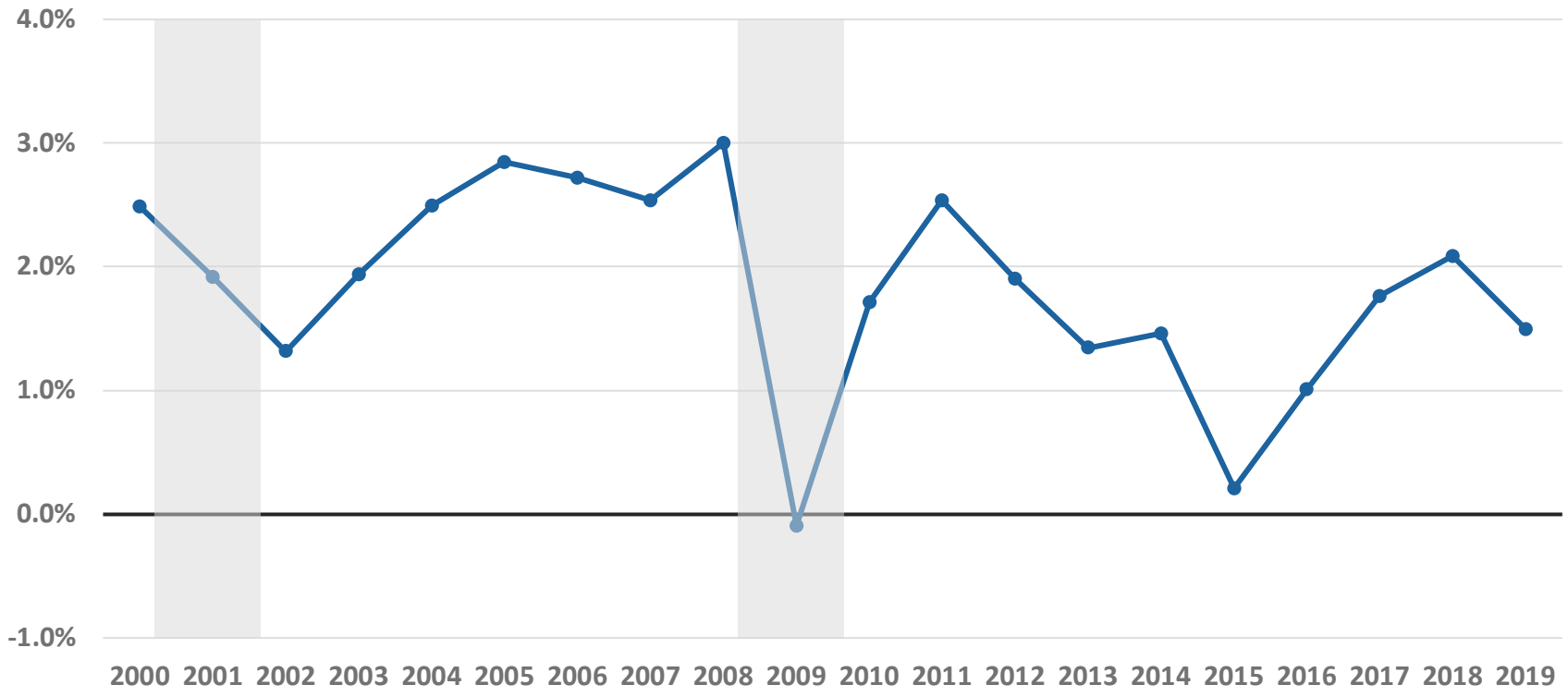
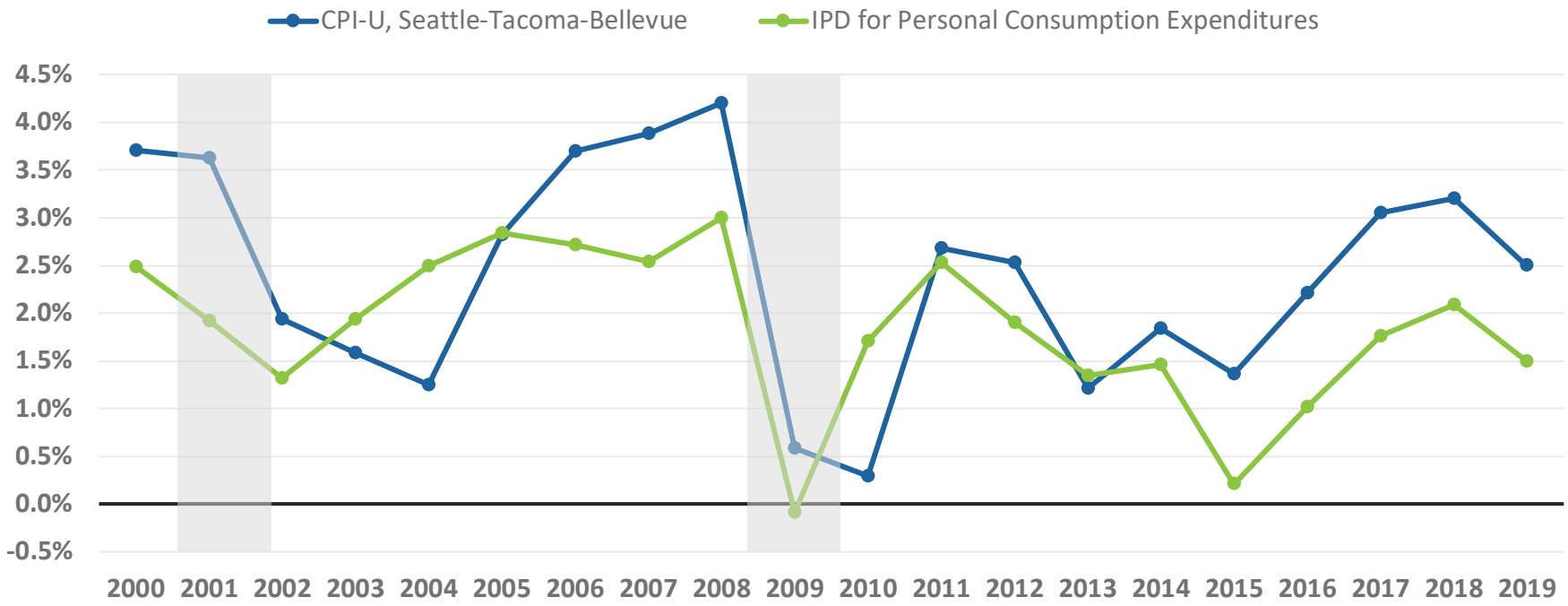
# Growth in the Implicit Price Deflator for Personal Consumption, 2000-2019




Shaded areas indicate U.S. recessions.

SOURCE: Washington Office of Financial Management, 2019 Data Book, https://ofm.wa.gov/washington-data-research/statewide-data/washington-state-data-book, accessed March 22, 2021.

# Annual Growth in the CPI-U, Seattle vs IPD, 2000-2019




Shaded areas indicate U.S. recessions.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, and U.S. Bureau of Economic Analysis, accessed March 22, 2021.

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# Discussion of Options for Establishing a Cost Growth Benchmark

# TAB 10

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# Discussion of Options for Establishing a Cost Growth Benchmark

May 13, 2021

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# Approach to discussion of options

- We have presented five options for your consideration. Next, we will provide you with pros and cons to each option to help you answer these questions:
  - Do you want to tie the health care cost growth benchmark to any of the aforementioned economic indicators?
  - If so, which one(s), and why?
- We will proceed with the discussion first on a more theoretical basis, focusing on the rationale for tying the benchmark to one of the indicators.

# Approach to discussion of options (cont'd)

- How can we make a decision if applying the criterion of "lowering growth in health care spending" requires us to know the value of historical sending growth?
  - After this discussion we will walk you through options for how these economic indicators can be calculated.
  - We will then share a table with the values of each economic indicator, and also information on historical health care spending growth in Washington.
  - We will conclude with a discussion about ways in which the benchmark value could be adjusted, should the Board wish to do so.

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# Discussion of options: A reminder of other state approaches

- DE, MA and RI tied their health care cost growth targets to Potential Gross State Product.
- OR based its decision on historical Gross State Product and median wage data, and in consideration of the growth cap in OR's Medicaid and publicly purchased programs – but did not specifically "tie" the target to an indicator.
- CT based its benchmark on a 20/80 blend of Potential Gross State Product and median income.

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# Comparison of options for establishing the benchmark

| | Advantages | Disadvantages |
|---|---|---|
| **1. Gross State Product** | Used by most other states with cost growth targets; there is value to having consistent policies. | Abstract economic concept that may not resonate with citizens. |
| **2. Personal Income** | Recognizes that income is more than just wages. | Measure grows faster than wages because it accounts for higher earner non-wage income. |
| **3. Average Wage** | More consumer-oriented reference to "take-home pay." | Does not reflect relationship of health care spending growth vis-a-vis the larger economy. |
| **4. Inflation – Consumer Price Index-Urban, Seattle** | Treats health care as another consumer household expense, much as consumers do. | There is no longer a Washington-specific measure of CPI-U so may not be reflective of Washington's experience. Captures only price & not volume. |
| **5. Inflation – Implicit Price Deflator for Personal Consumption** | Methodology used to adjust the State's economic and revenue data. | Not well-known among the broader public. No Washington-specific measure so may not be reflective of Washington's experience. |

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# Design recommendation: Economic indicator for the benchmark

Does the Board wish to tie the health care cost growth benchmark to any of the aforementioned economic indicators?

If so, to which one, and why?

- Gross State Product
- Personal income
- Average wage
- Inflation – CPI-U
- Inflation – IPD

Does the Board wish to consider other indicators not listed above?

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# Calculating an Indicator to Derive a Cost Growth Benchmark and Potential Benchmark Values

# TAB 11

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# Calculating an Indicator to Derive a Cost Growth Benchmark and Potential Benchmark Values

May 13, 2021

# Calculating an indicator to derive a cost growth benchmark

- Now that we have discussed the options, we need to discuss how to calculate an economic indicator to derive a cost growth benchmark.
- There are two ways to calculate an economic indicator:
  - Based on historical experience
  - Based on a forecasted projection
- We will weigh each of these options and ask your preferences. Then, we will review a table with the options for continued discussion.

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# Calculating a benchmark based on historical experience

- A benchmark figure could be calculated based on the historical experience of a given economic indicator.
  - 5 years, 10 years, 20 years, etc.
- Using historical data would reflect to varying degrees the volatility of year-over-year changes, including booms and busts.
- Historical figures are a relatively easy mathematical calculation (straight average of growth over prior time periods).

# Calculating a benchmark based on a forecast

- A benchmark figure could also be calculated based on forecasts, which are designed to predict stable future figures.
- There are government forecasts (e.g., Washington Office of Financial Management, Congressional Budget Office) and private forecasts (e.g., Moody's, HIS Markit).
  - The figures and methods of calculation vary.
  - Typically, private forecast methodologies are not available for scrutiny and can vary by the philosophy and outlook of the chief economists at each organization.

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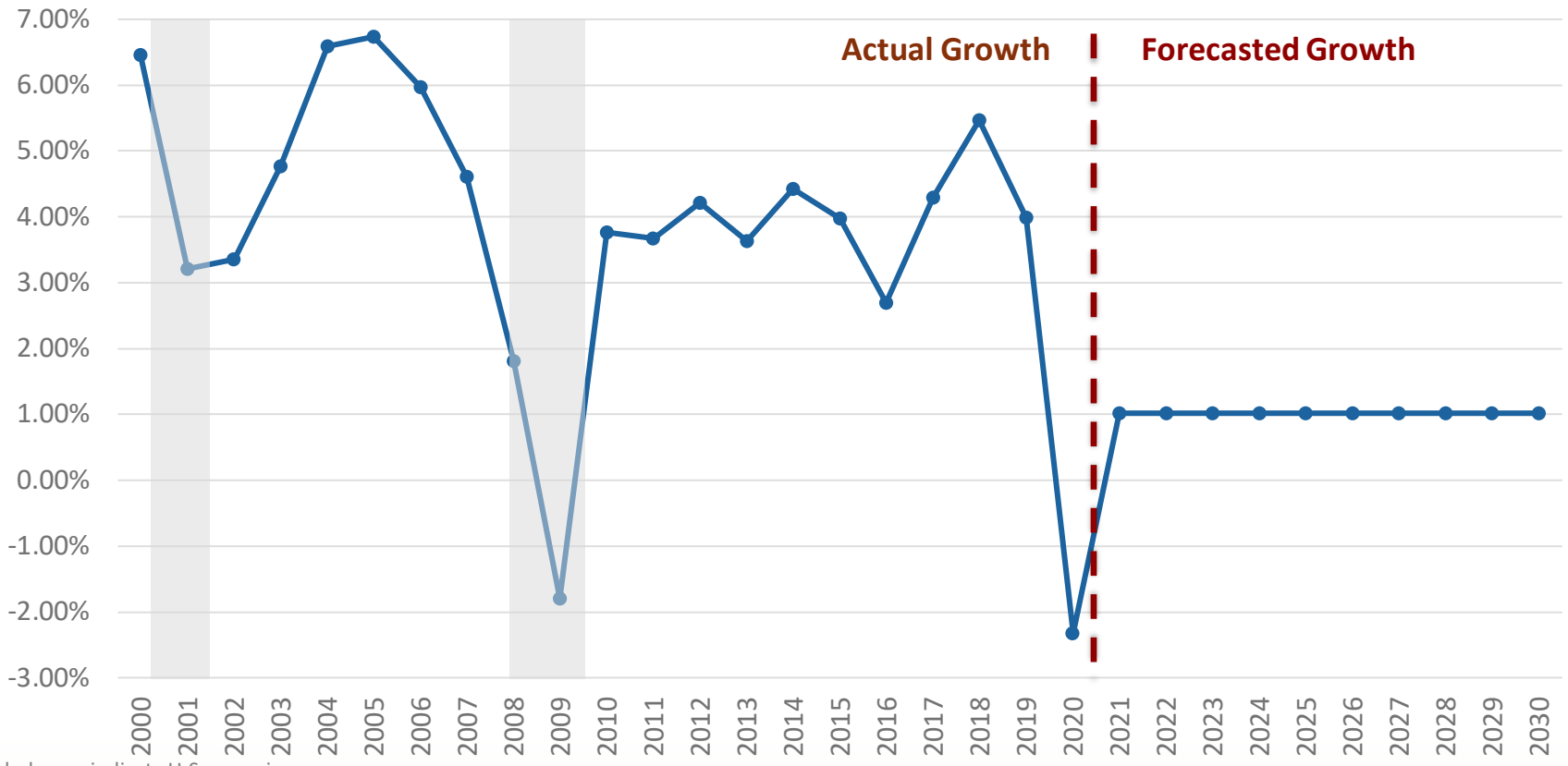
# Comparison of historical vs. forecast for *real* U.S. GDP, 2000-2030




Shaded areas indicate U.S. recessions.

SOURCE: U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/GDP, April 6, 2021; and OECD (2020), Real GDP Long-Term Forecast, https://data.oecd.org/gdp/real-gdp-long-term-forecast.htm#indicator-chart, April 6, 2021.

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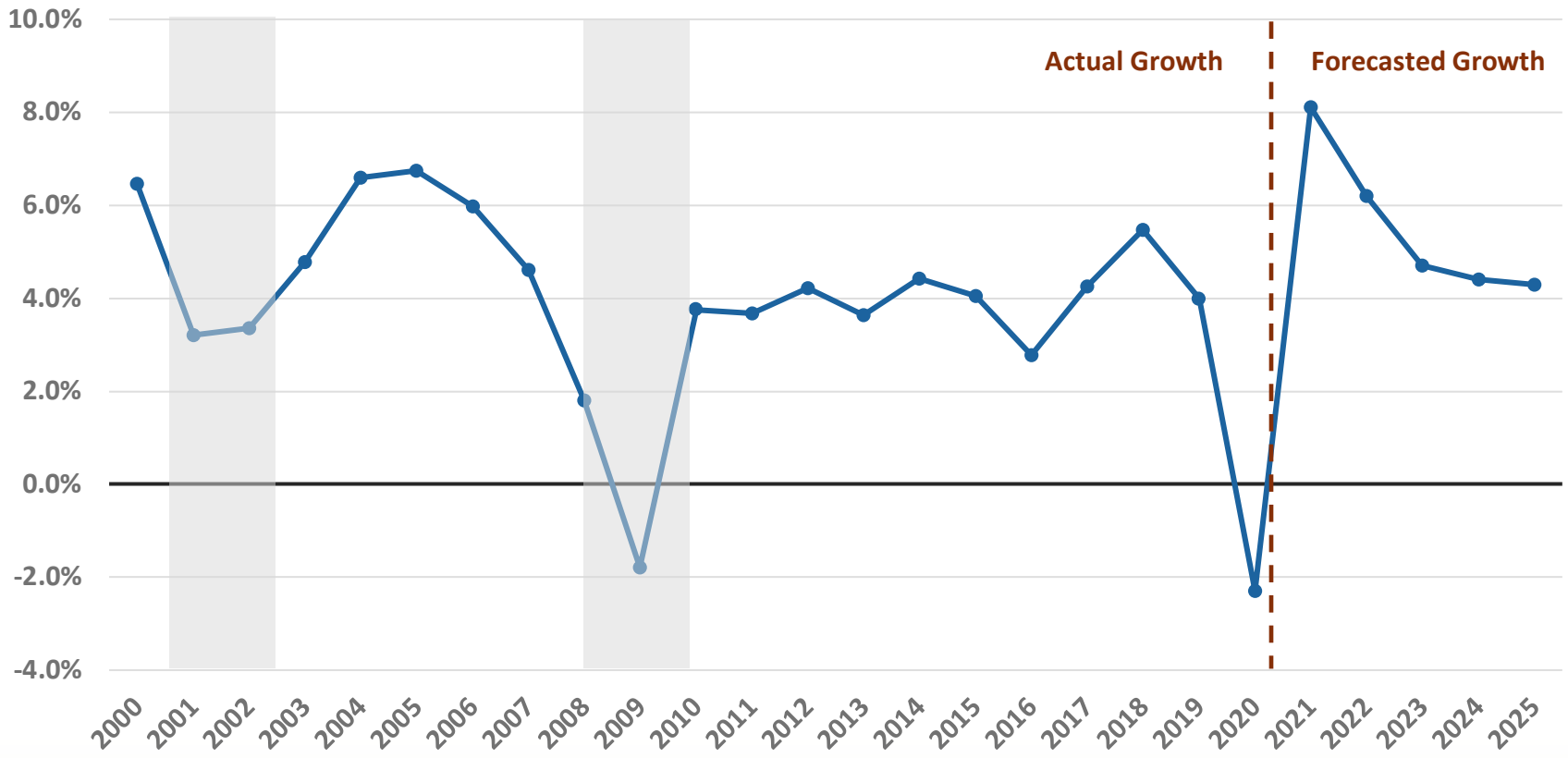
# Comparison of historical vs. forecast for U.S. GDP, 2000-2025 (*nominal*)




Shaded areas indicate U.S. recessions.

SOURCE: U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/GDP, April 6, 2021; and Washington State Economic and Revenue Forecast Council, "Economic Forecast Calendar Year Summary Tables," March 12, 2021.

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# Forecasting Gross State Product

- DE, MA, RI, and CT (in part) all use a forecasted measure of nominal Potential Gross State Product (PGSP).
- PGSP measures the long-run average growth rate of a state economy, excluding fluctuations that may occur due to the business cycle. It is forecasted for year 5 to year 10 in the future and is calculated on a per capita basis.
- This is the only economic indicator discussed that has a publicly available forecasted calculation, but is not forecasted Gross State Product, per se.

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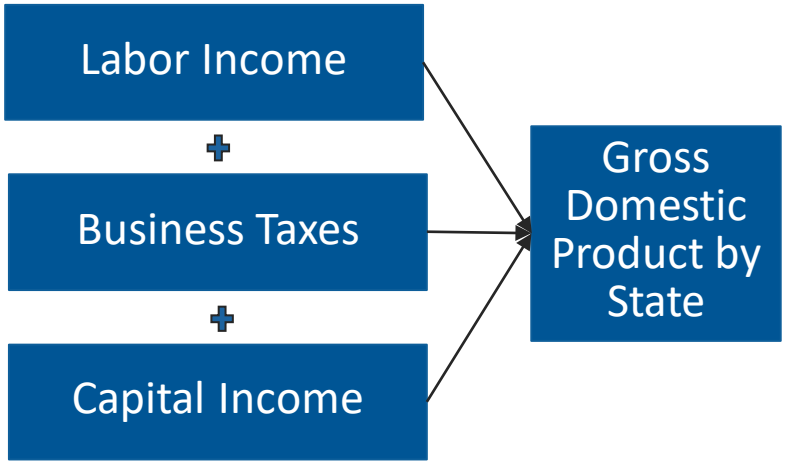
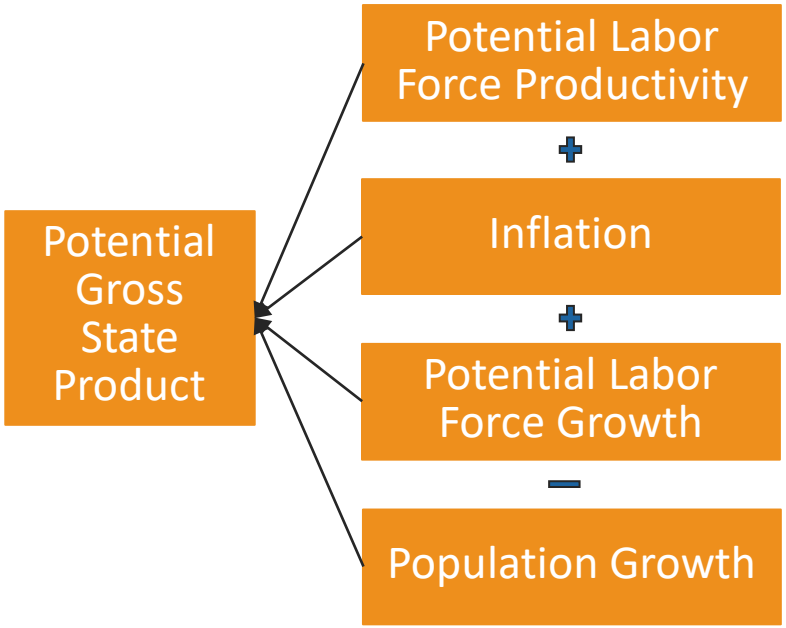
# GSP and PGSP are different measures and therefore forecasts will be different




GSP can be calculated using historical averages or forecasted. If GSP is forecasted, it will not equal PGSP.




By definition, PGSP is a forecast.

# Advantages and disadvantages of using historical vs. forecasted values

| | Historical | Forecasted |
|---|---|---|
| **Advantages** | • Easy to calculate.<br>• Reflects actual experience. | • Smooths out historical variability and provides more stability and predictability. |
| **Disadvantages** | • Highly variable, reflecting economic booms and busts.<br>• Unclear rationale for which time period to choose. | • Forecasts are predictions and may be incorrect.<br>• WA state forecasts are only available through 5 years out.<br>• Longer-term forecasts will need to rely on data from forecasting organizations whose methodologies are opaque. |
| **State Use** | • OR | • CT, DE, MA and RI |

# Design recommendation: Historical vs. forecasted values

Does the Board wish to use historical or forecasted values of the selected economic indicator to derive benchmark values?

# Potential Benchmark Values

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# Historical and Forecasted Values

- Historical averages were calculated by taking 20-year straight averages of annual percent growth.
  - 20 years includes a sufficient number of business cycles to reduce the influence of any one particular boom or bust period.
  - Using the 10-year average would have overvalued the Great Recession.
  - Data to calculate the 20-year historical average are only available to 2018 or 2019 and don't yet reflect the COVID-19 pandemic's effects.
- The forecasted values for all but PGSP were obtained from the Washington Economic and Revenue Forecast Council.
- PGSP was calculated by project staff using the aforementioned formula.

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# Comparison of historical and forecasted values of potential indicators

| Economic Indicator | Historical (20-year lookback) | Forecast (2021-2025) |
|---|---|---|
| Gross State Product and Potential Gross State Product | **5.0%** (2000-2019) | **3.8%** (2021-2025) |
| Personal Income | **3.8%** (1999-2018) | **3.2%** (2021-2025) |
| Average Wage | **3.4%** (1999-2018) | **3.3%** (2021-2025) |
| Consumer Price Index-Urban, Seattle | **2.4%** (2000-2019) | **1.9%** (2021-2025) |
| Implicit Price Deflator for Personal Consumption | **1.8%** (2000-2019) | **1.9%** (2021-2025) |

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# Snapshot of Historical Health Care Cost Growth in Washington

# TAB 12

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# Snapshot of Historical Health Care Cost Growth in Washington

May 13, 2021

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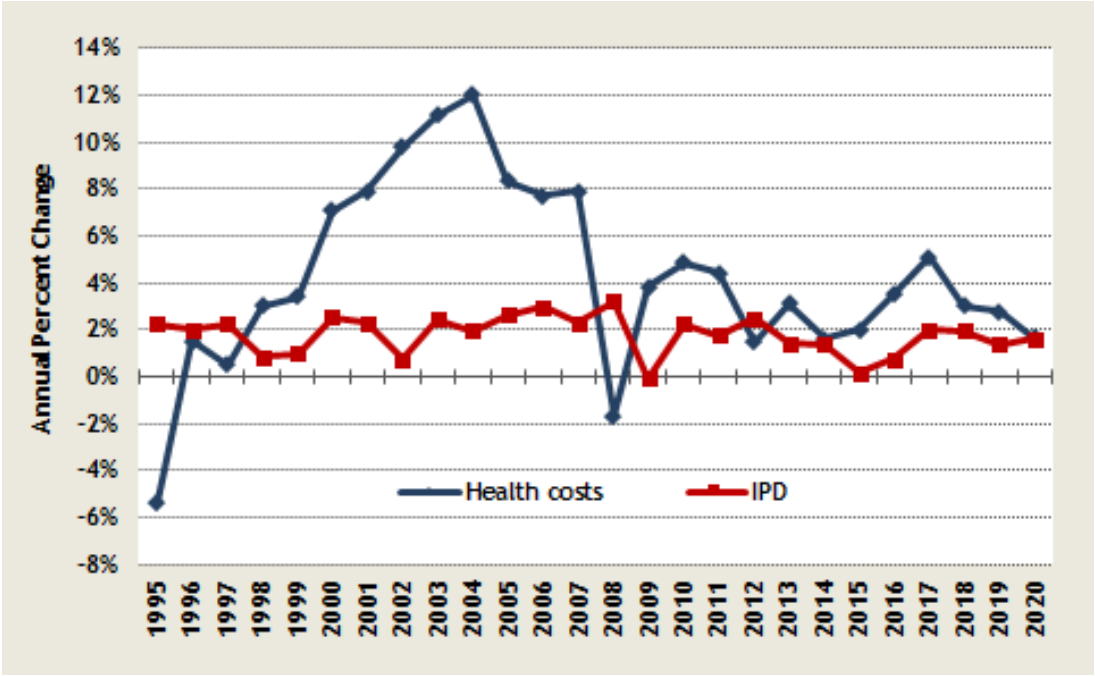
# Health care costs in Washington have grown much faster than inflation




From 2000 to 2020, annual growth in health care costs averaged 5.14%. Health care cost growth has slowed since 2010 but remains higher than inflation.

Source: Washington Office of Financial Management, "Change in Medical Costs."

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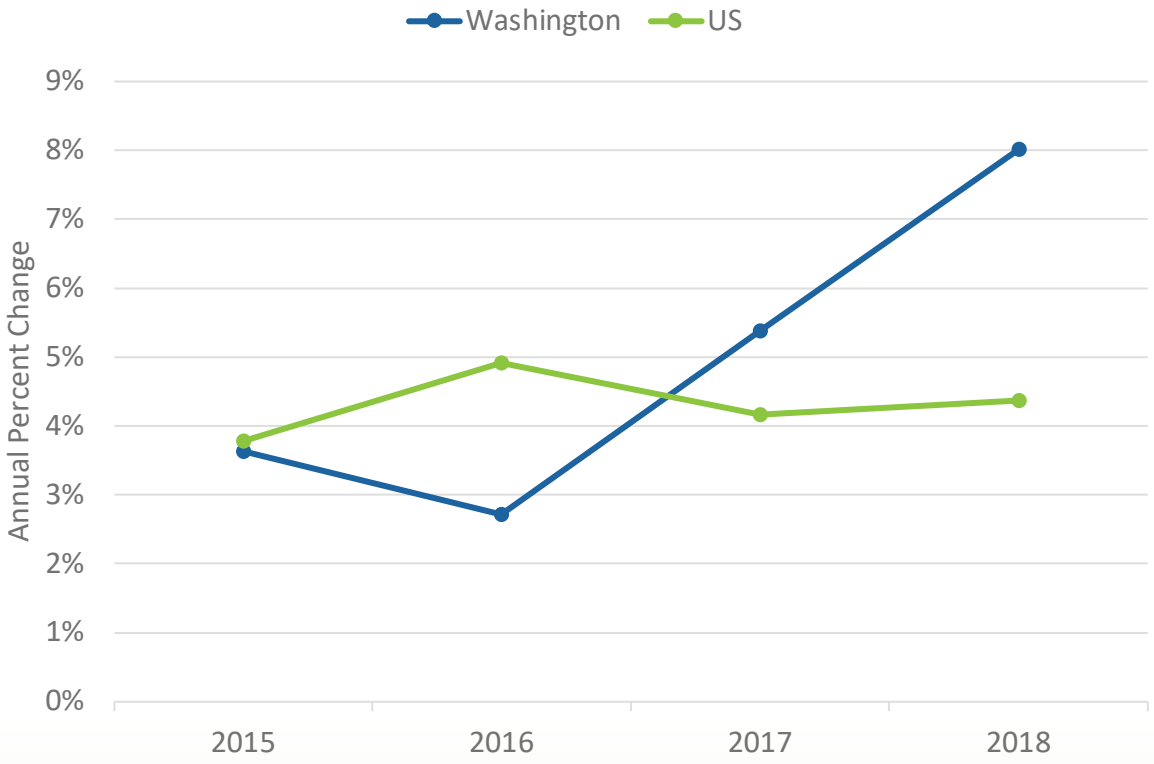
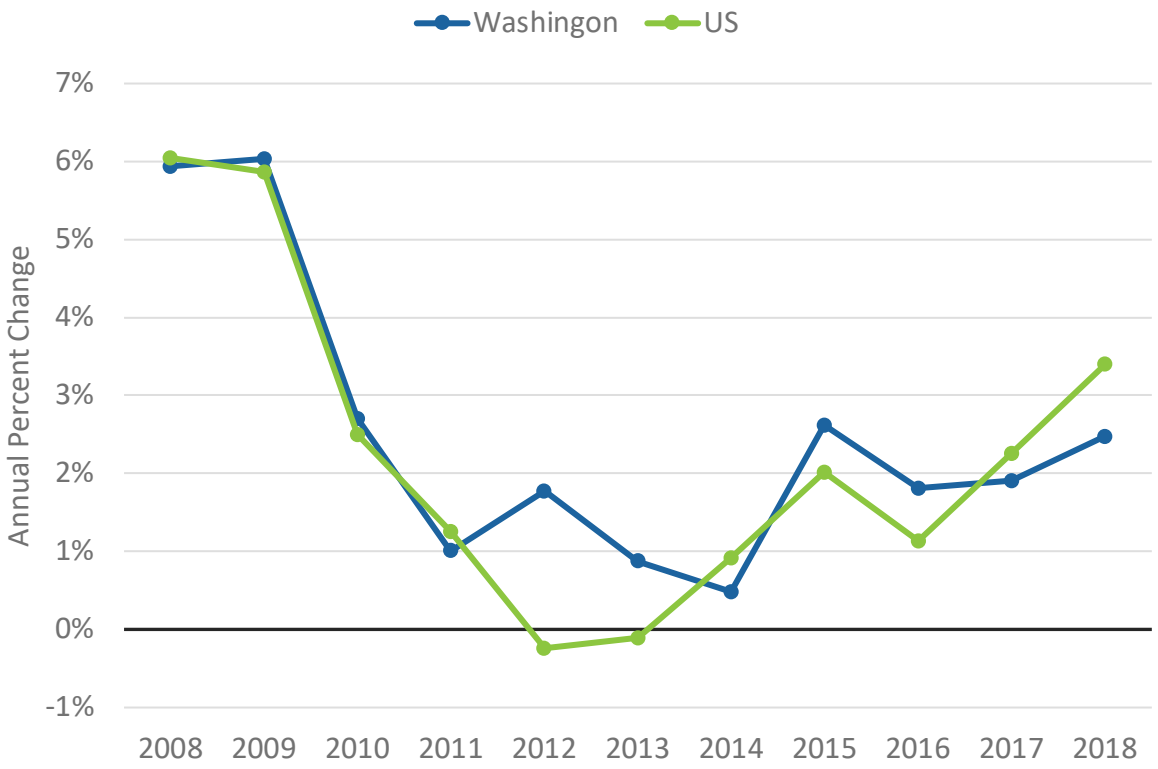
# Growth in per person spending on employer-sponsored insurance




From 2014-2018, Washington's average annual growth in per person spending on employer-sponsored insurance (4.9%) was higher than the national average (4.3%).

Source: Health Care Cost Institute. "2018 Health Care Cost and Utilization Report."

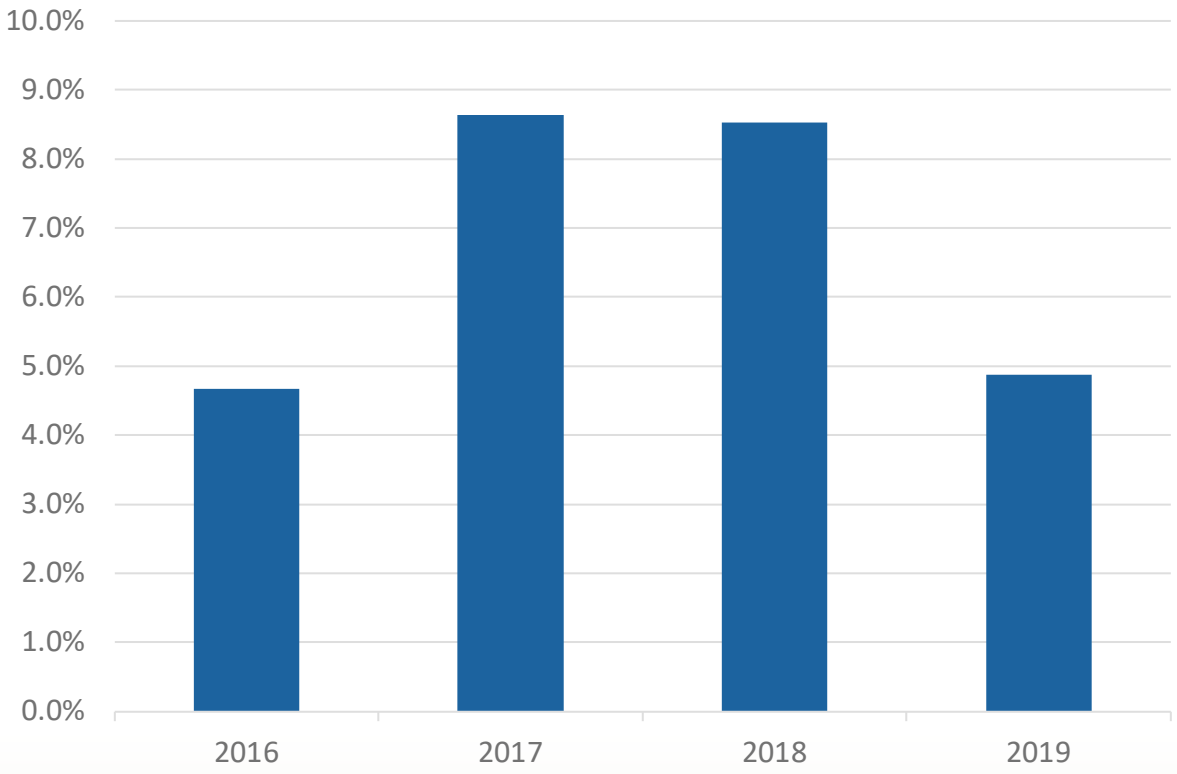
# Growth in per person spending on Medicare




From 2008-2018, Washington's average annual growth in Medicare per capita cost was 2.4%, slightly higher than the national average of 2.1%.

Source: Centers for Medicare & Medicaid Services Office of Enterprise Data and Analytics, "State/County Report - All Beneficiaries."

# Growth in per person spending on Medicaid




From 2016-2019, Washington's average annual growth in per capita Medicaid spending was 6.7%.

Source: Washington Health Care Authority, "Apple Health Per Capita Expenditure Trend: 2015-2019," March 12, 2021.

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# Design recommendation: Benchmark methodology and value

## What benchmark value and methodology(ies) does the Board wish to use?

| Economic Indicator | Historical (20-year lookback) | Forecast (2021-2025) |
|---|---|---|
| Gross State Product and Potential Gross State Product | **5.0%** (2000-2019) | **3.8%** (2021-2025) |
| Personal Income | **3.8%** (1999-2018) | **3.2%** (2021-2025) |
| Average Wage | **3.4%** (1999-2018) | **3.3%** (2021-2025) |
| Consumer Price Index-Urban, Seattle | **2.4%** (2000-2019) | **1.9%** (2021-2025) |
| Implicit Price Deflator for Personal Consumption | **1.8%** (2000-2019) | **1.9%** (2021-2025) |