Advisory Committee on Data Issues meeting minutes

October 28, 2021
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

Allison Bailey
Ana Morales
David Mancuso
Hunter Plumer
Jason Brown
Jerome Dugan
Jonathan Bennett
Josh Liao
Julie Sylvester
Leah Hole-Marshall
Lichiou Lee
Mark Pregler
Purav Bhatt
Scott Juergens

Agenda items

Welcome, Roll Call, Agenda Review

J.D. Fischer, committee facilitator, called the meeting to order at 2:02 p.m.

Approval of Minutes

Mr. Fischer provided a recap of the September Committee meeting, and the Committee approved the September meeting minutes.

Topics for Discussion

Topics relating to the cost growth benchmark measurement, reporting, and analysis presented to the Committee included the following:

- Recap of the Committee's September discussion.
- Board responses to Committee recommendations.
- Identification of carriers to report benchmark spending.
- Identification of large providers for whom carriers will report benchmark spending.
- Analysis of risk adjustment options.

Recap of the Committee's September discussion

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented a summary of the Committee's discussion on patient to clinician attribution methodology and attributing clinicians to large provider entities.

Board responses to Advisory Committee recommendations

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented a summary of Board responses to Committee recommendations relating to strategies to strengthen benchmark performance assessments. The Board unanimously supported the use of confidence intervals to determine carrier and provider performance against the benchmark and truncation to mitigate the impact of high-cost outliers.

- One Committee member requested that the Committee hear updates on these decisions as more information and analysis is presented to the Board. Ms. Angeles confirmed that those discussions and any decisions will be shared with the Committee.

Identification of carriers to report benchmark spending

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented to the Committee information pertaining to approaches to identifying carriers that will report total health expenditures to the Board. In the previous Committee meeting, members requested additional information prior to making a recommendation to the Board. Staff produced information to further inform the discussion, including the following:

- Reviewed enrollment data from the state of Washington Office of Insurance Commissioner's "2020 market Information Report." Enrollment data are not available for all plans and staff could not determine enrollment by market.
- Staff developed a list of carriers with at least 10,000 enrolled insured lives, and several for which enrollment data were unavailable but known to be major market players, that would be required to report to HCA and vetted the list with other state staff.

Ms. Angeles recommended not including standalone third-party administrators (TPAs) not affiliated with a licensed insurer and health care benefit managers (HCBMs) at this time. The Committee discussed the significance of the self-funded market in Washington State. One member shared a concern about missing out on a sizeable portion of the market given some large, self-insured employers and union groups (e.g., Boeing, Carpenters Union) not utilizing TPAs affiliated with Washington carriers. Another member shared that the Washington Health Alliance has some information that could be useful in assessing the market share of self-funded employers within the statewide commercial market. Ms. January affirmed the need to conduct additional research on large self-funded employers in the state that contract with non-Washington carrier TPAs.

Ms. Angeles shared the staff recommendation of including 12 carriers with major market share, which collectively account for 96 percent of covered lives in the fully insured individual and group markets. In reviewing the list of

carriers provided to the Committee, one member noted that some of the health plans included were dental-only and/or stop-loss coverage carriers. The Committee discussed the challenge of discerning which plans are dental-only or stop-loss coverage only and discussed the desire to be overly inclusive rather than under-inclusive at this stage. One member recommended requiring carriers to specify enrollment by type of benefit which would allow staff and the Board to identify dental-only type plans.

Ms. Angeles asked the Committee if members believed carriers with major market share were not reflected in the preliminary list. One member asked about the inclusion of Medicare Supplemental coverage, and Ms. Angeles explained the rationale behind excluding this segment due to potential double counting because of the data capture focusing on allowed amounts. One member shared that while the list should provide sufficient representation, there is a concern that self-funded employers may exhibit significant control over what data can be shared and reported, and that some TPAs might need to request permission from the employer to report the self-funded data. Ms. Angeles shared that this has not been a significant issue in other states. In further discussion, one member shared that he estimated that self-funded enrollment in the statewide commercial market exceeds one million lives. In discussing the inclusion of pharmacy data, one member noted that some TPAs may not have pharmacy data from pharmacy benefit managers (PBMs). Ms. Angeles affirmed that this is not unique to Washington and that other states have asked TPAs to estimate the amount of pharmacy spend in their reporting.

Ms. Angeles affirmed that staff would continue to refine the list.

Identification of large providers for whom carriers will report benchmark spending

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented to the Committee information pertaining to methodologies for attributing clinicians to large provider entities. Staff developed an initial list of potential providers for whom carriers will report spending and vetted the list with staff from other state agencies. The list identified 50 entities, comprising 24 Community Health Centers (CHCs), 22 health systems, and four medical groups and independent practice associations (IPAs). One member shared the concern about ensuring sufficient capture of covered lives in rural areas. The Committee discussed various provider thresholds used in other states:

- Delaware and Rhode Island publicly report providers with more than 10,000 Medicaid or commercial lives or 5,000 Medicare lives
- Massachusetts has not published their standard for public reporting
- Oregon will report on entities with at least 10,000 attributed lives across all markets, or 5,000 attributed lives in each market

One member noted a specific provider in King County that was missing from the list. Ms. Angeles acknowledged that the list may not capture all providers whose performance would be reported and added that we won't fully know the complete listing until the first data reporting is complete.

One member asked about how the Board will address accountability of large specialty groups that may not provide primary care, but may, through carrier contracts, have attributed patients. Mr. Bailit offered that the concept of accountability may be applied more broadly than just in terms of benchmark performance measurement, and that supplemental analyses of the benchmark performance data may include an assessment of specialty groups and hospitals and their respective influence on cost growth. One member raised the plausible regional impact on cost

growth of factors including labor costs and other operational expenses and asked if the Board had considered regional approaches to the benchmark. Ms. Angeles reiterated the Board's recommendation to institute one benchmark for all markets across the state. No other state has taken a regional approach, although the cost driver analysis could consider regional experience. One member offered that more discussion would be helpful to understand what the minimum size is for providers to have reliable data reported. Mr. Bailit indicated that there is currently research to inform this but that we will know more once we can review the data from other states, and that is best to be over-inclusive at this stage.

Analysis of risk adjustment options

Michael Bailit, Bailit Health
PowerPoint presentation

Mr. Bailit presented to the Committee information pertaining to options for risk adjustment to strengthen benchmark performance measurement. Mr. Bailit recapped information and experience from other states previously reviewed by the Committee. The Committee had discussed and expressed support for adjusting data by age and sex alone. Some members requested additional input from actuaries within their own organizations and some noted the concern that a significant shift in a payer or provider entity's population could yield inaccurate results.

Mr. Bailit shared four options for risk-adjustment developed by staff through additional research and consideration:

1. Age/sex adjustment performed by carriers.
2. Age/sex adjustment performed by the state.
3. Clinical risk adjustment normalization performed by payers.
4. Clinical risk adjustment normalization performed by the state.

Several members voiced support for option 2. One member added that building the capacity for option 4 would be important as part of a larger set of objectives: to build analytical capacity, better conduct cost trend analyses, and assist policy makers and the public discern difference across carriers and benefit plans. One member who supported option 2 recommended option 1 as a back-up and added that the strongest factor influencing health spending increases is price, followed by population growth and age, while disease prevalence and utilization have a minimal impact. Another member who supported option 2 added that options 1 and 3 are difficult to validate and that option 4 would be too costly at this time and may not capture all the requisite data. One member voiced concern for option 2, adding that actuaries and the public health experts at her organization are strongly opposed to age/sex risk-adjustment due to the potential negative impacts on access. One member recommended option 4, adding that while none of the options are perfect, option 4 takes more work but would provide more information on all the moving pieces that contribute to cost growth.

Public Comment

There was no public comment.

Wrap Up and Adjournment

Meeting adjourned at 3:40 p.m.

Next meeting

Thursday, January 27, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.