Washington State Health Care Authority

Advisory Committee on Data Issues

January 31, 2022

Washington State Health Care Authority

Advisory Committee on Data Issues
Meeting Materials Book

January 31, 2022
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

Topical Material

Resources

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Advisory Committee on Data Issues
AGENDA

January 31, 2022
10:00 a.m. – 12:00 p.m.
Zoom Meeting

Committee Members:					
☐	Megan Atkinson	☐	Jason Brown	☐	David Mancuso
☐	Amanda Avalos	☐	Jerome Dugan	☐	Ana Morales
☐	Allison Bailey	☐	Leah Hole-Marshall	☐	Hunter Plumer
☐	Jonathan Bennett	☐	Scott Juergens	☐	Mark Pregler
☐	Purav Bhatt	☐	Lichiou Lee	☐	Julie Sylvester
☐	Bruce Brazier	☐	Josh Liao	☐	

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00 – 10:05 (5 min)	Welcome, call to order, and roll call		AnnaLisa Gellermann Health Care Authority
10:05 – 10:10 (5 min)	Approval of October meeting minutes	2	AnnaLisa Gellermann Health Care Authority
10:10 – 10:15 (5 min)	Topics for today	3	January Angeles and Michael Bailit Bailit Health
10:15 – 10:20 (5 min)	Review meeting plan for Year 2	4	January Angeles and Michael Bailit Bailit Health
10:20 – 11:05 (45 min)	Discussion of analyses of cost and cost growth drivers	5	January Angeles and Michael Bailit Bailit Health
11:05 – 11:15 (10 min)	Public comment		AnnaLisa Gellermann Health Care Authority
11:15 – 11:30 (15 min)	Review pre-benchmark data collection process and timeline	6	Ross McCool Health Care Authority
11:30 – 11:35 (5 min)	Review payer survey of provider entity contracts	7	Ross McCool Health Care Authority
11:35 – 11:55 (20 min)	Wrap-up discussion on benchmark performance assessment	8	January Angeles and Michael Bailit Bailit Health

11:55 – 12:00 (5 min)	Wrap-up and adjournment		AnnaLisa Gellermann 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 Advisory Committee of Providers and Carriers will be conducted virtually.

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October meeting minutes

TAB 2

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.

Advisory Committee on Data Issues

January 31, 2022

Washington State Health Care Authority

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Topics for today

TAB 3

Topics for today

- Review meeting plan for Year 2.
- Discuss analyses of cost and cost growth drivers.
- Review pre-benchmark data collection plan and timeline.
- Review payer survey of provider entity contracts.
- Wrap-up discussion on benchmark performance assessment.

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Meeting plan for Year 2

TAB 4

Meeting plan for Year 2

Meeting plan for Year 2

Meeting Date	Meeting Topic

January 31, 2022	- Cost driver analysis strategy
	  ▪ Recommended areas for prioritization
	  ▪ Plan, process and timeline for supporting the work
	- Review of pre-benchmark data collection process and timeline
	- Wrap-up discussion of benchmark performance assessment

March 1, 2022	- Review of existing data on Washington cost growth drivers
May 5, 2022	- Feedback on benchmark performance data collection specifications

Meeting plan for Year 2

Meeting Date	Meeting Topic
July 8, 2022	- Review of initial cost driver analysis
September 8, 2022	- Discussion of in-depth, follow-up analyses on cost growth drivers
November 11, 2022	- Continued discussion of in-depth, follow-up analyses on cost growth drivers

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Analyses of cost and cost growth drivers

TAB 5

Analyses of cost and cost growth drivers

Cost growth benchmark analysis

- **What:** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data type:** Aggregate data that allow for assessment of benchmark achievement at multiple levels.
- **Data source:** Insurers and public payers.

vs.

Cost driver analysis

- **What:** A plan to analyze cost and cost growth drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data type:** Granular data (e.g., claims and encounters).
- **Data source:** Primarily, the all-payer claims database.

Peterson-Milbank framework for cost growth driver analyses

Where is spending problematic?

- High spending
- Growing spending
- Variation in spending
- Spending compared to benchmarks

What is causing the problem?

- Price
- Volume
- Intensity
- Population characteristics

Who is accountable?

- State
- Market
- Payer
- Provider organization

Jennifer Sayles, Deepti Kanneganti and Michael Bailit, "A Data Use Strategy for State Action to Address Health Care Cost Growth", June 24, 2021.

Phased implementation of cost growth driver analyses

Phase 1

What: Standard analytic reports produced on an annual basis at the state and market levels.

Purpose: Inform, track, and monitor the impact of the cost growth benchmark.

Phase 2

What: Supplemental in-depth analyses developed based on results from standard reports, plus ad-hoc drill-down analyses.

Purpose: Supplement Washington's ability to identify opportunities for actions to reduce cost growth.

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Jennifer Sayles, Deepti Kanneganti and Michael Bailit, "A Data Use Strategy for State Action to Address Health Care Cost Growth", June 24, 2021.

Recommended Phase 1 analyses

- Start with standard analyses, produced annually, that:
  - Examine the effects of price, volume, service intensity, and population characteristics on changes to spending and spending growth.
  - Use at least two years of data.
  - Are produced on a total and per capita spending basis.
  - Are released concurrently with public reporting of performance relative to the cost growth benchmark.

Jennifer Sayles, Deepti Kanneganti and Michael Bailit, "A Data Use Strategy for State Action to Address Health Care Cost Growth", June 24, 2021.

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HCA's proposed plan for Phase 1 analyses

- HCA has reviewed the recommended Peterson-Milbank standard analyses.
- The following slides walk through analyses HCA proposes to implement in this year for initial reporting.
- HCA also recommends including these analyses in *ongoing* annual reporting.

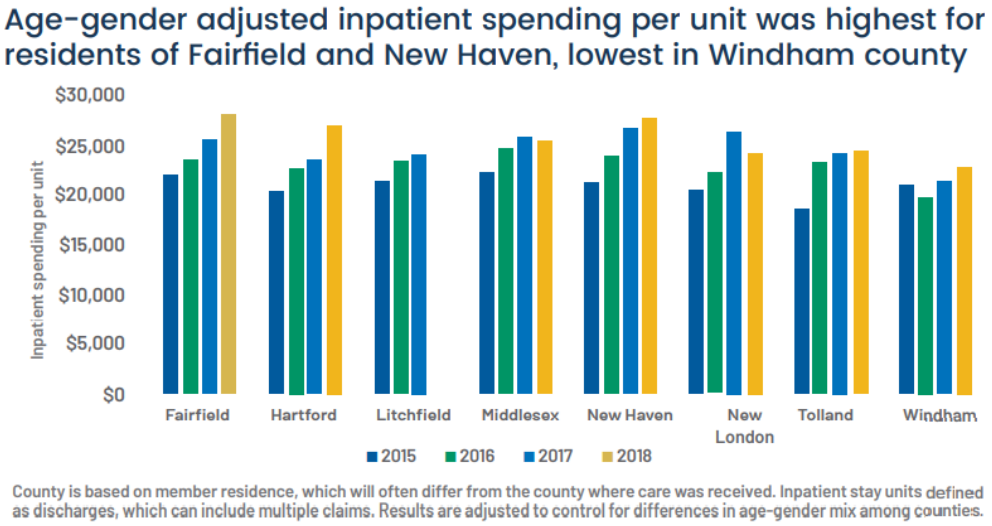
All-Payer Claims Database (APCD) as the primary source of data

Strengths	Limitations
• Includes claims and enrollment data from most payers for fully insured products. • Data include charged, allowed, and paid amounts. • Can be analyzed at a very granular level (by payer, region, provider type, provider, patient segment, service type, diagnosis, etc.). • Updated quarterly.	• Except for Public Employees Benefits and School Employees Benefits programs, does not capture self-insured data. • Does not contain non-claims costs (e.g., shared savings, capitated payments made outside the claims system, etc.). • Limited clinical data. • Significant lag times related to loading claims into the APCD and ensuring sufficient claims runout.

Spend and trend by geography

What	•	Spend and trend, stratified by geographic rating area.
Data Source	•	APCD
Notes	•	HB2457 requires analyses by geographic rating area.

Example from Connecticut



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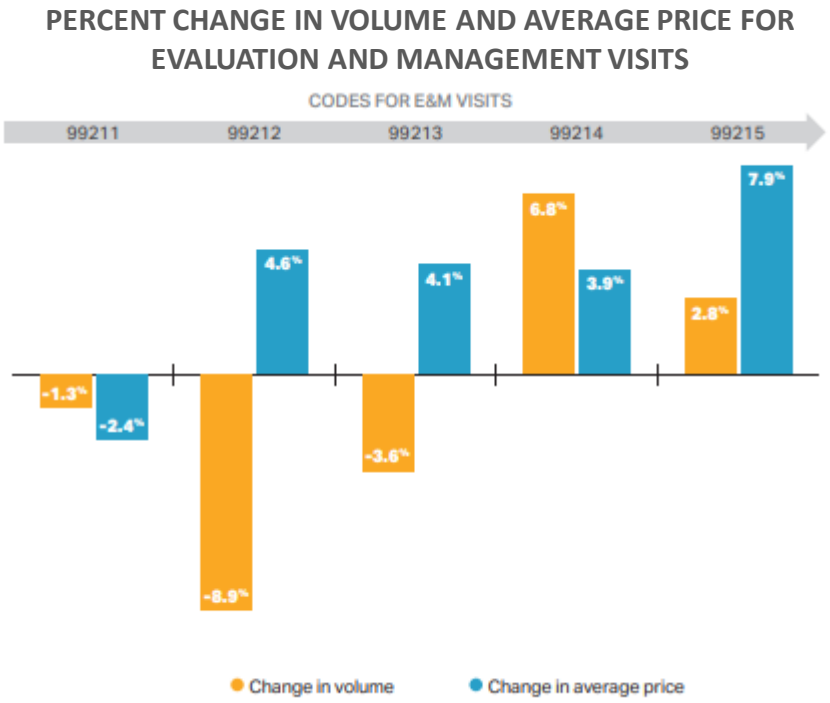
Trends in price and utilization

What	•	Analysis of spending the impact of price and utilization on spending on services.
Data Source	•	APCD
Notes	•	Work will be needed to identify the services.

Example from Massachusetts



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Spend and trend by health condition

What	• Analyses to detect whether and how health conditions influence service utilization and spend.
Data Source	• APCD
Notes	• Work will be needed to determine the conditions to analyze.

Example from Connecticut

Condition	2018		
	Members with condition	%	PMPY for members with this condition
All members	**455,780**	**100.0**	**$6,151**
Hyperlipidemia	73,081	16.0	$11,842
Hypertension	70,419	15.5	$13,739
Rheumatoid Arthritis/Osteoarthritis	67,943	14.9	$13,866
Depression	50,979	11.2	$13,501
Diabetes	28,608	6.3	$14,197
Anemia	26,723	5.9	$25,355
Acquired Hypothyroidism	25,918	5.7	$12,911
Glaucoma	18,035	4.0	$9,004
Chronic Kidney Disease	17,732	3.9	$24,029
Asthma	17,500	3.8	$16,887
One or more of 27 chronic conditions	218,698	48.0	$10,536
Two or more of 27 chronic conditions	115,855	25.4	$14,379

Spend and trend by demographics

What	• Analysis of how trends differ among communities with different demographic characteristics.
Data Source	• APCD • Census Bureau survey data.
Notes	• Need to determine demographic variables.

Example from Connecticut

Decile	Percentage white	Median family income	PMPM (adj.)
All	**0 – 100**	**$97,310**	**$526.69**
1	0 – 31	$45,663	$545.33
2	31 – 50	$68,060	$561.26
3	50 – 61	$82,466	$562.29
4	61 – 71	$105,442	$494.28
5	71 – 77	$103,407	$497.68
6	77 – 82	$122,067	$499.30
7	83 – 87	$149,181	$506.68
8	87 – 91	$127,302	$481.19
9	91 – 94	$118,223	$484.70
10	94 – 100	$112,875	$526.69
Ratio of 1st to 10th decile		0.40	1.09

Monitoring of potential unintended adverse consequences

What	• Selected indicators to monitor for potential negative impacts of the cost growth benchmark.
Data Source	• To be determined
Notes	• Need to determine what areas to prioritize.

- Potential analyses include:
  - Quality measures assessing utilization of preventive and chronic illness care.
  - Patient self-reported access to care, including but not limited to access to specialty care.
  - Changes in provider entity patient panel composition.
  - Stratified analyses to assess specific and disparate impact of the benchmark on economically and socially marginalized groups.

Connecticut's strategy for measuring unintended adverse consequences

- Connecticut has developed a measurement plan focused on three main domains of analyses:
  1. Underutilization
  2. Consumer out-of-pocket spending.
  3. Impact on marginalized populations.

- For each domain, Connecticut's plan identifies:
  - Potential measures that can be implemented immediately.
  - Potential measures that require further development.
  - Level of analysis (e.g., market, provider organization, etc.).
  - Data source(s)
  - Accountability for data collection and analysis.

Proposed analyses to include in the annual report

Analysis	State	Market
Spend / trend by geography	X	X
Trends in price and utilization	X	X
Spend / trend by health condition	X	X
Spend / trend by demographics	X	X
Potential unintended adverse consequences	X	X

Committee discussion: Phase 1 analyses

- Does the Committee support, including the following analyses in HCA's regular reporting?
  - Spend and trend by geography.
  - Trends in price and utilization.
  - Spend and trend by health condition.
  - Spend and trend by demographics.
  - Monitoring of potential unintended adverse consequences.

Committee discussion: Phase 1 analyses

- Are there other analyses that the Committee believes should be included in regular reporting?
  - If so, what types of analyses would you recommend?
- How should HCA prioritize the Phase 1 analyses that are conducted on a regular basis?
  - What types of analyses should HCA seek to measure immediately?

Recommended Phase 2 analyses

- Once a regular cadence for the recommended standard reports has been established, develop supplemental ad hoc reports to enhance ability to identify opportunities for action to reduce cost growth. Reports might include:
  - Trends in service intensity.
  - Supply as a cost driver.
  - Market consolidation as a cost driver.
  - Pharmacy cost drivers.
  - Changes in out-of-pocket spending.
  - Influence of site-of-care.
  - Professional spending analysis.

Proposed process for conducting and vetting cost growth driver analyses

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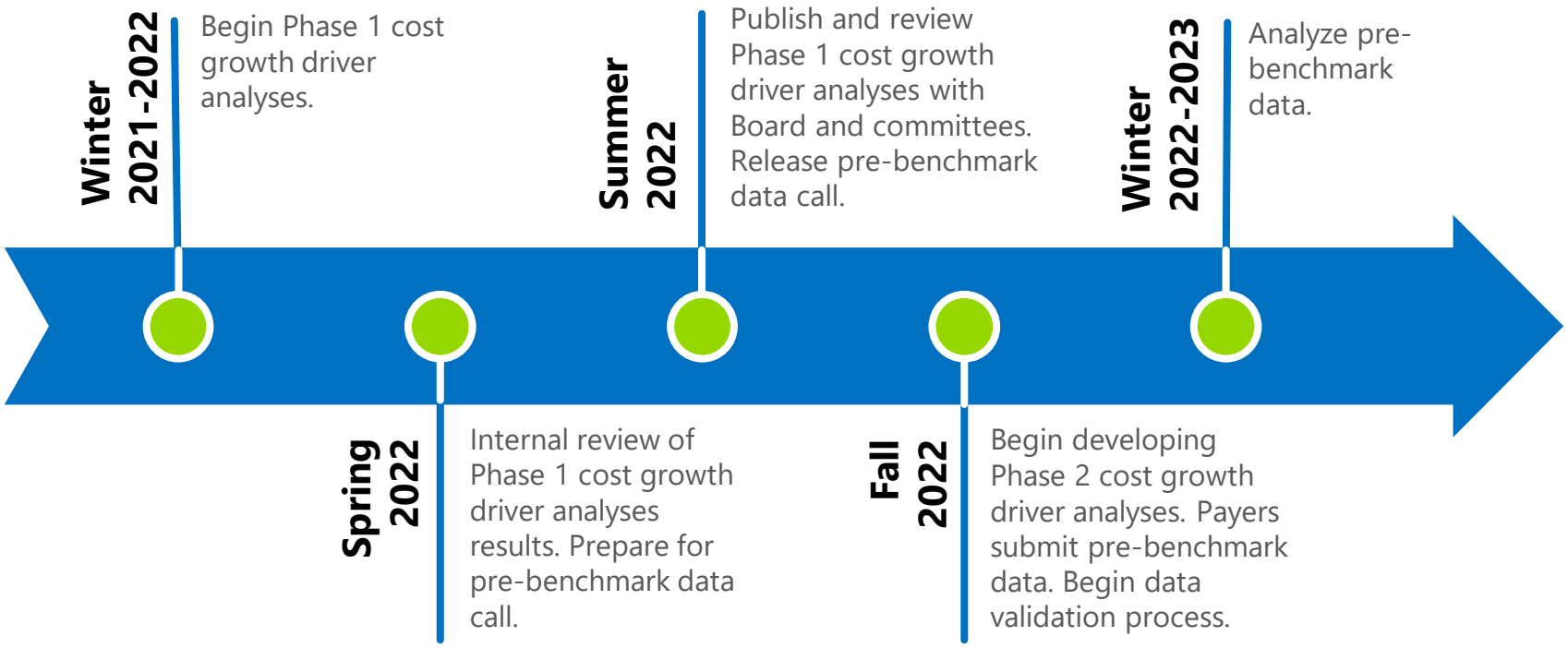
Proposed timeline for conducting cost growth driver and pre-benchmark analyses



Committee discussion: Plan, process, and timeline

- What feedback does the Committee wish to provide on the proposed plan, process. and timeline for analyzing costs and cost growth drivers?

Public comment

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Pre-benchmark data collection process and timeline

TAB 6

Pre-benchmark data collection process and timeline

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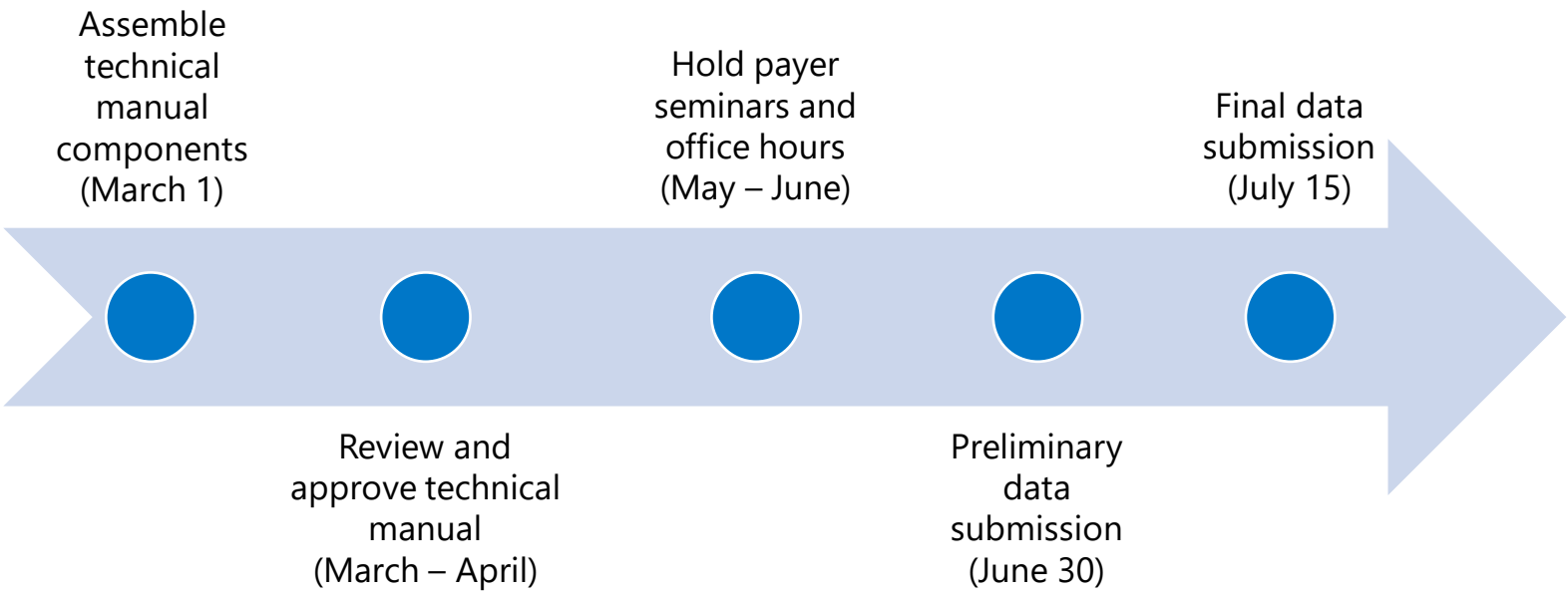
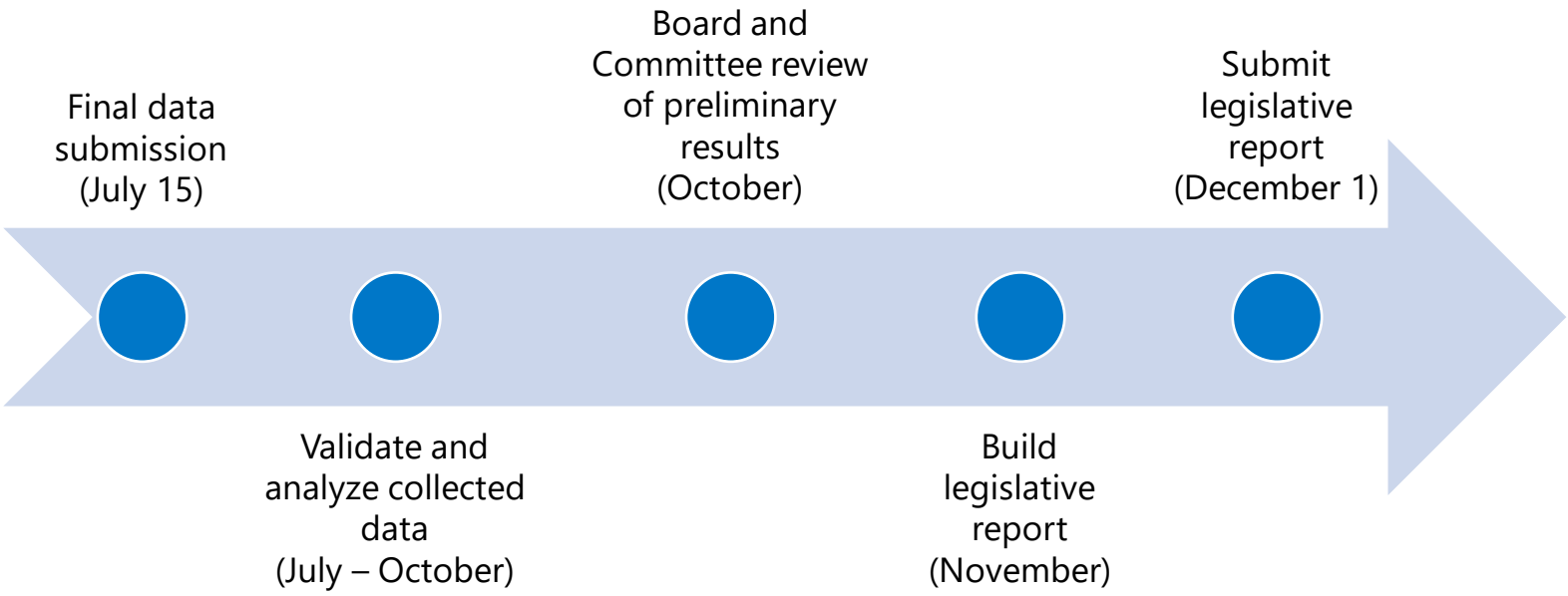
Overall timeline – data collection



Technical manual review

- The Board will be adopting the technical manual using its statute authority to collect data.
- The Board expects the Committee will have the opportunity to comment on the technical manual prior to adoption.
- Two possible approaches:
  - Small workgroup
  - Post for a period and request comments.

Overall timeline – report on findings



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Payer survey of provider entity contracts

TAB 7

Payer survey of provider entity contracts

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Payer survey

- For purposes of reporting, we want to capture the larger provider entities in the state that can influence the total cost of care.
- Following example of other states, we have created a list of larger provider entities that employ primary care providers. That list has been internally vetted.
- Next step is to confirm with payers that the list contains all the larger entities.
- We are asking payers to identify every provider entity that has a total cost of care contract with, which markets those contracts are in, and the total number of lives for each contract.
- HCA staff will use these responses to confirm which provider entities will be subject to reporting.

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Benchmark performance assessment

TAB 8

Benchmark performance assessment

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Truncating spending on high-cost outliers

- For measurement of insurer and provider entity performance against the cost growth benchmark, the Board decided to truncate spending on high-cost outliers at a to-be-determined threshold.
- The threshold could vary based on market (e.g., commercial, Medicaid, Medicare).
- Truncation would not be applied to measurement at the state and market levels.

Potential truncation thresholds

- Rhode Island was the first cost growth target state to implement truncation in its measurement of target performance.
- Rhode Island varied the truncation thresholds by market as follows:
  - Commercial: $150,000
  - Medicaid: $250,000
  - Medicare: $100,000
- Rhode Island payers indicated that these thresholds removed between 5-7 percent of total spending.

Potential truncation thresholds

- Other research on possible truncation points found the following:
  - Two commercial insurers in Rhode Island use $150K as the truncation point in risk-based contracts.
  - An analysis by Massachusetts found that a truncation point between $100K and $200K significantly reduced the impact of high cost-outliers for a commercial population.
  - Medicaid ACO programs in Maine and Minnesota vary the thresholds based on Accountable Care Organizations (ACO) size, with a threshold of $200,000 for ACOs with more than 5,000 attributed lives.

Committee discussion: Truncation thresholds

- HCA proposes to use the following truncation thresholds by market, consistent with Rhode Island's approach:

Market	Truncation Threshold
Commercial	$150,000
Medicaid	$250,000
Medicare	$100,000

- Does the Committee have any concerns with the proposed truncation thresholds? Do members of the Committee have analyses that would support different thresholds?

Risk-adjustment

- For future measurement of carriers and large provider entity performance against the cost growth target, spending will be risk-adjusted using standard age/sex factors.
- To implement this, carriers will need to submit aggregate spending and member months data by age/sex cells.
- HCA proposes to use eight age bands for all markets.

Proposed Age Bands for All Markets	
0-1	55-64
2-18	65-74
19-39	75-84
40-54	85+

Committee discussion: Risk-adjustment

- Do the proposed age bands seem reasonable?

Proposed Age Bands for All Markets	
0-1	55-64
2-18	65-74
19-39	75-84
40-54	85+

- Members should only fall into one age/sex cell per year.
  - Is there a preference for which point in the year is used to set the age? (e.g., January 1, July 1, December 31?)

Washington State Health Care Authority

Topical material

TAB 9

The Forest for the Trees: National Health Expenditures and Healthcare Reform

It is no secret that the United States spends more on health care than any other nation and yet, has poorer health outcomes compared to its peer countries.[i] Fixing the paradox of high costs and poor outcomes has been the impetus for health reform efforts for decades. From Diagnosis-Related Groups and health maintenance organizations to the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015, policymakers have made numerous attempts to rein in spending and improve quality. Rather than taking on the task of reducing absolute spending year-over-year, policymakers have focused on the less herculean – though still ambitious – goal of reducing the rate of cost growth (better known as "bending the cost curve"). While the concept of bending the cost curve appears simple enough, evaluating individual reform efforts and developing consensus on what success looks like has been far more elusive. We contend that recent trends in national health expenditures (NHE) show the cost curve is bending, that payment reform efforts are a likely contributing factor to this change, and that policymakers would benefit from incorporating broad indicators like NHE trends alongside granular evaluations of individual reform models when planning future reforms.

The Trees: Payment Models and Evaluation

Many of the nation's most recent payment reform efforts are a direct result of the ACA. Passed in 2010, the ACA dedicated funding to establish the Center for Medicare and Medicaid Innovation (CMMI), focused on testing reforms such as alternative payment models intended to reduce health spending and improve the quality of care, and the Medicare Shared Savings Program (MSSP), a voluntary nationwide program that allows providers to form Accountable Care Organizations. As of 2019, over 40 percent (~580,000) of Medicare providers have participated in either MSSP or a payment reform model operated by CMMI.[ii] While the pace and scope of these reform efforts is evident, determining their impact on spending has been a challenge, spurring much debate.

Evaluators have the unenviable job of navigating a health care market rife with overlapping reform efforts (and subsequent spillover effects) and numerous other confounding variables. Consequently, efforts to quantify the cost and quality impacts of individual models have yielded mixed results, causing some to reasonably question the efficacy of these reform efforts. Conversely, researchers have found evidence that these payment reform models can create positive spillover effects in the wider market. Researchers have also noted that, as a result

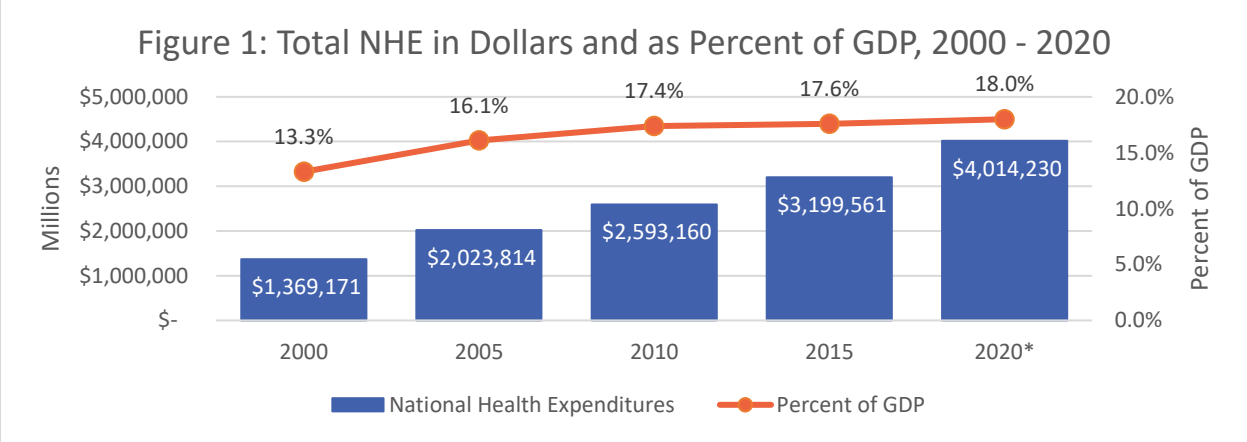
[i] R. Tikkanen, M.K. Abrams, U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?, The Commonwealth Fund, January 2020

[ii] MedPAC, Chapter 2: Streamlining CMS's Portfolio of Alternative Payment Models, Report to the Congress: Medicare and the Health Care Delivery System, June 2021

of these factors, evaluations likely underestimate the true benefits of these models.[iii,iv] While evaluating the impacts of individual models is essential, we believe that examining broader changes in national health expenditures offers a much-needed perspective on progress toward the larger policy goal of bending the cost curve.

The Forest: Trends in National Health Expenditures

In a recent paper, the Health Care Transformation Task Force (HCTTF or Task Force) explored the broader trends in health spending using NHE data produced by the Center for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) from 1960 to 2020.[v] The analysis focused on the actual and projected expenditures from 2000 to 2020 to identify trends in total spending, spending as a percentage of GDP (a measure of health care spending growth compared to the wider economy) and actual vs. forecasted spending (a measure of the relationship between the government's expectations for spending vs. real spending). The analysis found that while total national health expenditures have grown steadily, NHE growth as a percentage of GDP has leveled off in recent years (Figure 1). The annual NHE growth rate has also slowed over the last decade and currently sits at a historic low, 2 percentage points below the 2000-2010 average and over 8 percentage points below the historic peak from 1970-1980 (Figure 2). Finally, and perhaps most important to the discussion of bending the cost curve, actual expenditures over the last decade have consistently fallen below CMS projections, a notable departure from prior trends (figures 3 and 4).

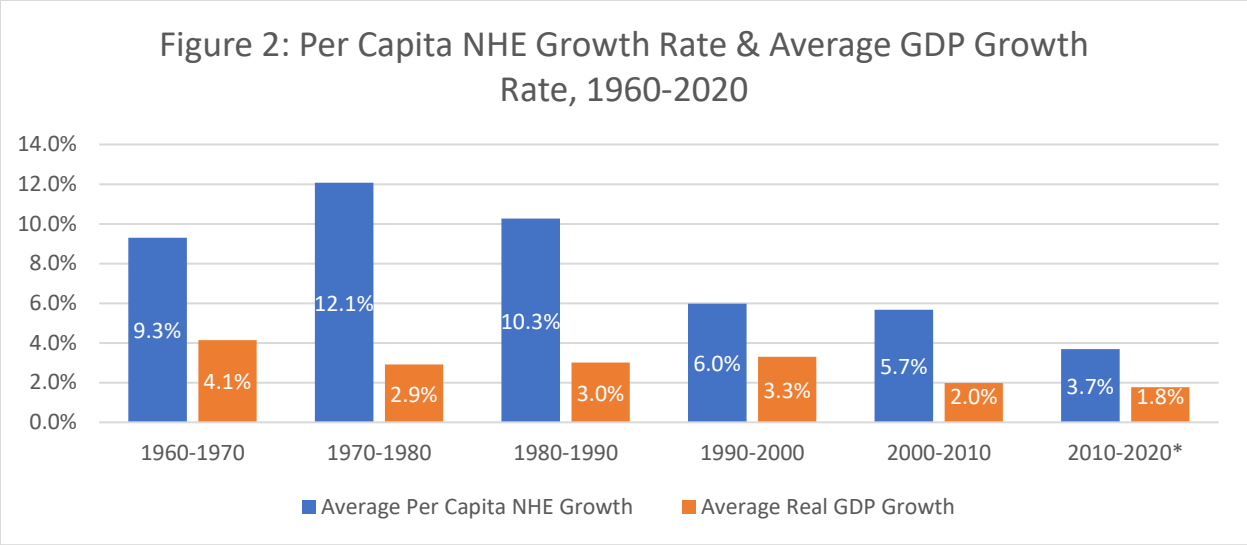


*Estimated based on 2019 NHE projections.

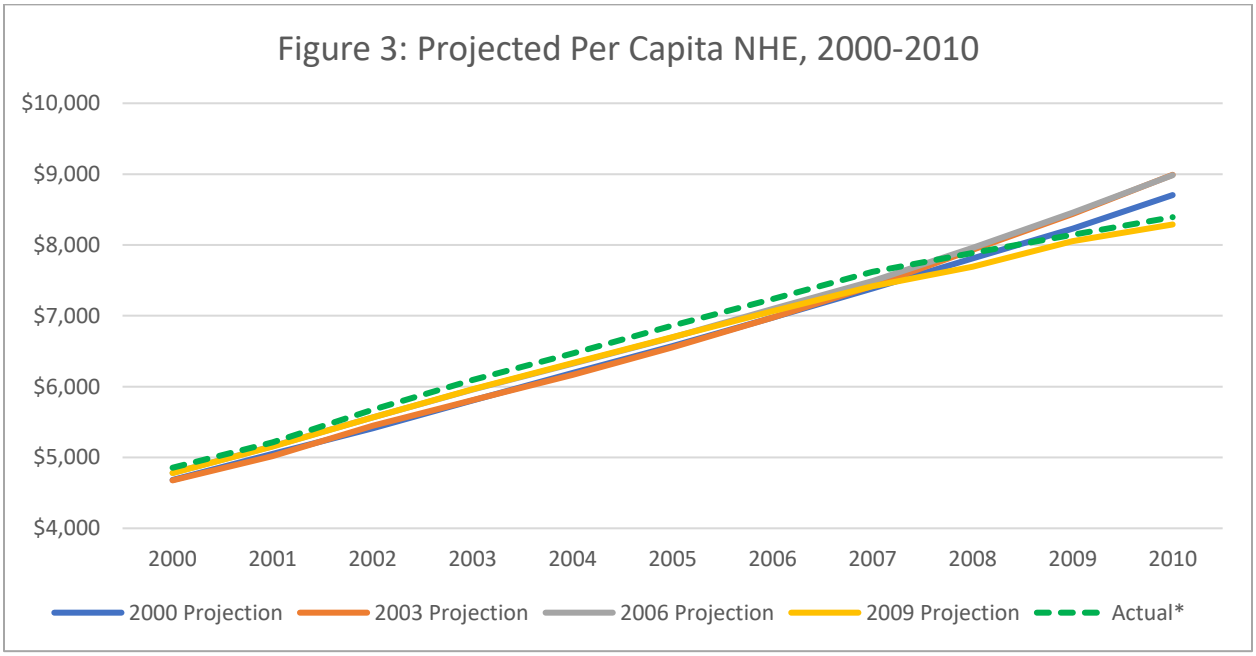
[iii] L. Einav et. al. Randomized trial shows healthcare payment reform has equal-sized spillover effects on patients not targeted by reform, PNAS, August 2020

[iv] A.S. Navathe et. al., Alternative Payment Models—Victims of Their Own Success?, JAMA, June 2020

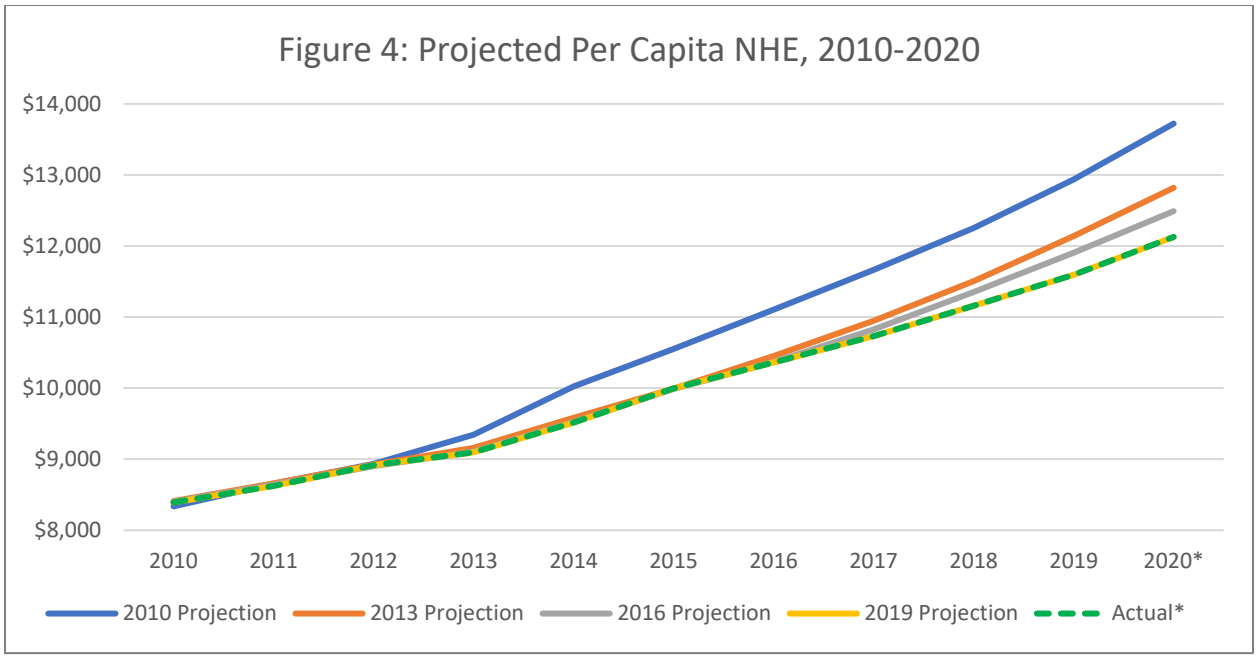
[v] The Health Care Transformation Task Force, Getting Warmer: Health Expenditure Trends and Health System Reform, August 2021



*Estimated based on 2019 NHE projections.



*Based on 2019 NHE data



*Based on 2019 NHE data.

Factors Bending the Curve?

The key questions for policymakers are: 1) what is driving the deceleration in cost growth, and 2) is there anything that can be done to further slow growth while improving access and outcomes. Initially, this slowdown was largely assumed to be a consequence of the Great Recession, with health spending growth expected to return to pre-recession levels as the economy recovered. Yet, growth rates remained near historic lows throughout the economic recovery and the period of full employment leading to the COVID-19 pandemic. So, if the economic impact of the Great Recession does not explain the enduring slowdown in spending growth, what other factors may be at play?

Myriad variables influence spending and create differences between projected and actual NHE. In 2020, OACT issued a report categorizing the main factors impacting NHE projections: exogenous and endogenous assumptions (factors outside and inside the health care system, respectively), changes in law, historical data revisions, and unforeseen developments in the health care industry.[vi]

Exogenous and endogenous assumptions impact NHE projections by altering the expected pricing and utilization of services. The forecast of real disposable personal income is a primary variable for NHE forecasts and economic shocks (*e.g.*, the 2008 Great Recession) can significantly alter actual health care spending compared to projections. Changes in law also impact expectations for health spending and service utilization (*e.g.*, the ACA caused projected expenditures to rise in Medicaid, Medicare, and Private Health Insurance). OACT periodically revises data sets to incorporate new and better information (*e.g.*, a 2019 methodology change accounted for higher prescription drug rebates, decreasing historical drug spending estimates).

The most interesting category of factors for policymaker consideration is that of "unforeseen developments" in the health care industry. This category captures variables including unexpected market responses to legislation and changes in standards of care that impact spending and utilization. The OACT report notes two unforeseen developments which we believe are directly connected to the last decade of payment reform efforts. First, hospital care experienced lower than expected growth in the volume and intensity of inpatient services (especially for Medicare beneficiaries), a drop in readmission rates, and increased use of outpatient services. Second, physician and clinical services saw slower than forecasted price growth likely driven by changes in practice patterns and shifts in workforce, specifically the use of more coordinated care teams.

While we believe there is a credible argument for attributing some portion of the slowing NHE growth to

Notable Events Impacting NHE

December 2003 The Medicare Prescription Drug, Improvement, and Modernization Act is passed creating Medicare Part D

January 2006 Medicare Part D goes into effect

December 2007 – June 2009 the Great Recession

March 2010 The Patient Protection and Affordable Care Act (ACA) is passed

June 2012 The U.S. Supreme Court finds the ACA's Medicaid expansion coercive of states, making Medicaid expansion optional

January 2014 The ACA is fully implemented

April 2015 The Medicare Access and CHIP Reauthorization Act (MACRA) is passed, repealing the Sustainable Growth Rate formula, and creating the Quality Payment Program

January 2017 MACRA goes into effect

December 2017 Repeal of ACA's individual mandate penalty

January 2019 Repeal of ACA's individual mandate penalty goes into effect

[vi] Centers for Medicare and Medicaid Services: Office of the Actuary, Analysis of National Health Expenditure Projections Accuracy, November 2020

payment reform efforts, we acknowledge that quantifying the magnitude of these impacts is challenging and requires further study.

Lessons for the Policy Road Ahead

Controlling health spending is a prerequisite for attaining an affordable, efficient, equitable, and high-quality health care system. While health expenditures in the U.S. continue to outpace other high-income peer nations, the slowdown in average NHE growth offers reason for optimism. Despite this progress, more work needs to be done. Employer and employee spending on health care continues to increase faster than GDP and wages. Bending the cost curve must translate to affordable care for consumers. To achieve this, health care reform efforts must transition from slowing spending growth to actually decreasing spending. The most obvious targets for such an effort are reducing the utilization of low-value care and lowering the unit price of services; two areas that alternative payment models are particularly well suited to impact.

While it may not be feasible to measure all the factors influencing NHE with certainty, it is noteworthy that the deceleration in spending growth coincides with the decade long effort by both the public and private sectors to reform the health care delivery system. We believe that reform efforts like the CMS Hospital Readmission Reduction Program, and alternative payment models like the Medicare Shared Savings Program and models launched by CMMI and several private payers are all likely contributing to the pattern of actual spending consistently falling below projections. In short, while model-specific evaluations are invaluable for refining model concepts, monitoring overall NHE may be a more useful indicator of the cumulative impact of health reform efforts on bending the cost curve. We should not lose sight of the forest for the trees.

Washington State Health Care Authority

Resources

TAB 10

2022 HCCT Board Meetings and Committees

Washington State Health Care Authority

	Date	Time	Location
Board Meeting (January)	January 19	2-4	Zoom
Advisory Committee on Data Issues	January 31	10-12	Zoom
Board Meeting (February)	February 16	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	February 1	9-11	Zoom
Board Meeting (March)	March 16	2-4	Zoom
Advisory Committee on Data Issues	March 1	10-12	Zoom
Board Meeting (April)	April 20	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	April 6	2-4	Zoom
Board Meeting (May)	May 18	2-4	Zoom
Advisory Committee on Data Issues	May 5	10-12	Zoom
Board Meeting (June)	June 15	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	June 2	3-5	Zoom
Board Meeting (July)	July 20	2-4	Zoom
Advisory Committee on Data Issues	July 8	10-12	Zoom
Board Meeting (August)	August 17	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	August 3	2-4	Zoom
Board Meeting (September)	September 21	2-4	Zoom
Advisory Committee on Data Issues	September 8	10-12	Zoom
Board Meeting (October)	October 19	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	October 5	2-4	Zoom
Board Meeting (November)	November 16	2-4	Zoom
Advisory Committee on Data Issues	November 1	19-11	Zoom
Board Meeting (December)	December 14	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	December 1	2-4	Zoom