

Advisory Committee of Health Care Providers and Carriers

February 1, 2022

Advisory Committee of Health Care Providers and Carriers Meeting Materials Book

February 1, 2022
9:00 a.m. – 10:00 a.m.

(Zoom attendance only)

Agenda and Presentations

Agenda.....	1
September meeting minutes.....	2
Topics we will discuss today.....	3
Meeting plan for Year 2	4
Analyses of cost and cost growth drivers	5
Pre-benchmark data collection process and timeline	6
Payer survey of provider entity contracts	7
Accountability	8

Topical Material

The Forest for the Trees: National Health Expenditures and Healthcare Reform.....	9
---	---

Resources

2022 Schedule of the Board and Advisory Committees.....	10
---	----

Agenda

TAB 1

Advisory Committee of the Health Care Providers and Carriers

February 1, 2022
9:00 a.m. – 11:00 a.m.
Zoom Meeting

AGENDA

Committee Members:

<input type="checkbox"/>	Mark Barnhart	<input type="checkbox"/>	Stacy Kessel	<input type="checkbox"/>	Megan McIntyre
<input type="checkbox"/>	Bob Crittenden	<input type="checkbox"/>	Ross Laursen	<input type="checkbox"/>	Mika Sinanan
<input type="checkbox"/>	Bill Ely	<input type="checkbox"/>	Todd Lovshin	<input type="checkbox"/>	Dorothy Teeter
<input type="checkbox"/>	Paul Fishman	<input type="checkbox"/>	Vicki Lowe	<input type="checkbox"/>	Wes Waters
<input type="checkbox"/>	Jodi Joyce	<input type="checkbox"/>	Mike Marsh		
<input type="checkbox"/>	Louise Kaplan	<input type="checkbox"/>	Natalia Martinez-Kohler		

Committee Facilitator:

AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00 – 10:05 (5 min)	Welcome and roll call		AnnaLisa Gellerman, Board Manager Health Care Authority
10:05 – 10:08 (3 min)	Approval of September meeting minutes	2	AnnaLisa Gellermann
10:08 – 10:10 (2 min)	Topics we will discuss today	3	AnnaLisa Gellermann
10:10 – 10:20 (10 min)	Review meeting plan for Year 2	4	AnnaLisa Gellermann
10:20 – 11:00 (40 min)	Analyses of cost and cost growth drivers Discussion: Phase 1 and Phase 2 proposed analyses	5	AnnaLisa Gellermann
11:00 – 11:10 (10 min)	Public comment		AnnaLisa Gellermann
11:10 – 11:20 (10 min)	Review pre-benchmark data collection process and timeline	6	Ross McCool Health Care Authority
11:20 – 11:25 (5 min)	Review payer survey of provider entity contracts	7	Ross McCool

11:25 – 12:00 (35 min)	Accountability Discussion: Activities and principles	8	
12:00	Adjourn		AnnaLisa Gellerman

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.

September meeting minutes

TAB 2

Advisory Committee of Health Care Providers and Carriers meeting minutes

September 30, 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

Bill Ely
Bob Crittenden
Dorothy Teeter
Jodi Joyce
Louise Kaplan
Mika Sinanan
Natalia Martinez-Kohler
Patricia Auerbach
Ross Laursen
Stacy Kessel
Todd Lovshin
Wes Waters

Members absent

Mark Barnhart
Megan McIntyre
Mike Marsh
Paul Fishman
Vicki Lowe

Agenda items

Welcome, call to order, approval of meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m. Minutes from July were approved.

Topics we will discuss today

Ms. Gellermann shared that the group would hear a recap of the Board's September meeting and adoption of benchmark methodology and value, discuss the impacts of the benchmark to pursue and avoid, get an introduction to reporting against the cost growth benchmark, and statistical methods to ensure the accuracy and reliability of benchmark performance measurement.

DRAFT
Advisory Committee of Health Care Providers and Carriers meeting minutes
09/30/2021



Review of Board's decision: Benchmark methodology and value

Ms. Gellermann reminded Committee members of key decisions at the prior Board meeting and were informed of Board decisions related to trigger and review language and the selection of the cost benchmark.

The Committee was provided the Board-adopted language for review of the benchmark as follows: “the Board will annually review performance against the benchmark and may consider any impact of the cost benchmark on the overall health system, including access to care, quality of care, and impact on the specific populations, providers, or market sectors.” One Committee member shared concerns that the purpose of the Board’s consideration was not clear and requested clarification and additional language.

The Committee was also provided the Board-adopted language to trigger consider of changes to the benchmark as follows: “in the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the benchmark or to the benchmark methodology.” One Committee member asked for clarification of whether “highly significant changes” were limited to those related to the effect of the benchmark. Another committee member asked whether extraordinary circumstances that a positive effect on the health care market would trigger a consideration of change, and perhaps reduction of the benchmark.

Ms. Gellermann responded that the language was intended to broadly encompass highly significant changes of any kind, and that the Board’s intent was to set the circumstance as broadly as possible. Clearer language was requested for both statements.

The Committee then reviewed information presented to the Board projecting savings under three selected benchmark scenarios. The projection was created by actuaries at Bailit Health, based on national data. Estimated savings over the 5-year period of the benchmark ranged between \$10.8 billion in avoided cost, to \$11.8 billion. Ms. Gellermann shared that the Board reviewed the information but did not seem strongly focused on the differences in cost avoidance between the three in the initiation 5-year period of the benchmark.

The Committee discussed the link between cost avoidance and affordability for consumers. Ms. Gellermann stated that the two were not directly linked, although it was likely that employer savings would be redirected to employee benefits and salary. One member pointed out that commercial plans are subject to rate review, and that as a result savings would likely be realized in monthly premium costs, and that overall lower trends would influence premiums lower. One member shared a concern that the two would be linked, pointing out that the last year of Covid had seen large reductions in utilization that did not translate to reduction in premium. A member raised the concerns related to the Covid pandemic, anticipating increased utilization and labor costs, and the pending finalization of contracts in 2022, raising the question of whether it was appropriate to begin measuring the benchmark in these extraordinary times.

Ms. Gellermann responded that the Board was aware of the issues, and that they posed important topics for future consideration. She informed the Committee that the Board selected the benchmark, but that it was not by consensus.


Impacts to pursue and to avoid-developing baseline recommendations

Ms. Gellermann led the Committee in a discussion of things to be careful about as we consider the impact of the benchmark on our health care delivery systems and on the issues of access, quality, and cost. Considerations

DRAFT

Advisory Committee of Health Care Providers and Carriers meeting minutes

09/30/2021



identified as important considerations are likely to become the subject of future analyses, reports, or other efforts. One member provided the broad perspective of the importance of using the anticipated cost driver analysis to identify where the impacts are and where action can be taken, and that a failure to think creatively and change practices at a systemic level would result in continued increased cost.

Members identified the following issues:

- Disproportionate impact on historically disadvantaged people. Concerns include decreased access for patients and reduced supportive spending that will result in less care and increased disadvantage (equity issues). One member stressed the importance of impacting population health by incentivizing increased investments in supportive spending like peer counselors and community health workers, perhaps increasing near-term cost but perhaps resulting in long term savings.
- Tracking whether we are cutting costs, or cutting services, potentially will be cut from the most fragile systems including rural providers and primary care.
- The danger of thoughtless cuts in cost “across the board”, to the detriment of services and consumers. The example provided was long-term care.
- Reductions in primary care reimbursement and utilization, which would have a substantial impact on health and health care cost.
- Adverse impact on smaller regional practices with lower market share and less leverage. One committee member shared that many of those practices have been strongly impacted by Covid.
- Impact of Covid that create impacts on spend that will influence benchmark results, including the impact of rising labor costs, changes in utilization, and analysis of data that is not representative of normal patterns.
- Impact of losing jobs at lower ends of the pay scale such as homebased workforce (equity for the workforce).
- Slimming in benefit design that does not benefit consumers.
- Rising cost must be connected to a problem, rather than just assuming that all increased cost is negative.
- The challenge of measuring across the whole health care ecosystem and learning from the data at a population and total investment level. One member suggested the creation of a “learning community” to support this.

Public Comment

There was no public comment.



Introduction to reporting against the cost growth benchmark

Ms. Gellermann shared a presentation previously reviewed by the Board related to how benchmark data will be reported. States typically report at four levels: state, market, payer, and large provider entity. Reporting on provider entities is limited to those that are large enough to influence the total cost of care. The Committee reviewed reporting at each level issued by other states.

One Committee member expressed a concern that the size of a provider should not be assessed by the number of patients in the group, but rather by the number covered by total cost of care contracts. One member stated that the reporting lens shown did not inform on whether the right services were given to the right person at the right time by the right professions, which is key to understanding opportunities for improvement.

Methods selected to ensure the accuracy and reliability of benchmark performance measurement

Ms. Gellermann shared with the group the Board's activities related to development and design of the benchmark data call. The Board's intent is to use best practices to ensure accurate, valid, and consistent data to support confidence in the results. Larger decisions will be made by the Board with recommendations from the Advisory Committee on Data Issues, and some decisions will be made by staff. September design decisions will be related to confidence intervals and truncation of high-cost outliers.

Ms. Gellermann presented information about other states' use of confidence intervals, including Oregon, Connecticut, and Rhode Island. The Advisory Committee on Data Issues supported use of confidence intervals and recommended clear documentation on how the intervals were constructed. She reported that the Board approved use of confidence intervals. Staff would prepare a proposal for the Advisory Committee on Data Issues. One member asked whether Oregon's use of intervals was based on the use of population sampling. Sarah Bartelmann of the Oregon cost benchmark team was monitoring the meeting, and upon request responded that Oregon was not using population sampling and offered a full write-up of the Oregon methodology.

Ms. Gellermann shared information about mitigating the impact of high-cost outliers on per capita spending. The common solution is truncation, which involved capping individual spending at a high level. Ms. Gellermann shared some documented experience in other states related to the use of truncation and lessons learned. The Advisory Committee on Data Issues supported the use of truncation and had different opinions on how to set the levels. The Advisory Committee on Data Issues will be asked to make a recommendation regarding specific truncation levels at a future meeting.

Adjourn

Meeting adjourned at 12:04 p.m.

Next meeting

To be determined.

DRAFT

Advisory Committee of Health Care Providers and Carriers meeting minutes
09/30/2021

Advisory Committee of Health Care Providers and Carriers

February 1, 2022

Topics we will discuss today

TAB 3

Topics for today

- ▶ Review meeting plan for 2022.
- ▶ Introduction to cost growth driver process and priorities.
- ▶ Review of benchmark data collection process and timeline: Carrier survey presentation.
- ▶ Accountability discussion.

Meeting plan for Year 2

TAB 4

Meeting plan for Year 2

Meeting plan for Year 2

Meeting Date	Meeting Topic
February 1, 2022	<ul style="list-style-type: none">- Cost driver analysis strategy<ul style="list-style-type: none">▪ 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
April 6, 2022	<ul style="list-style-type: none">- Review of existing data on Washington cost growth drivers
June 2, 2022	<ul style="list-style-type: none">- Accountability recommendation to Board- Cost growth mitigation strategies of interest

Meeting plan for Year 2

Meeting Date	Meeting Topic
August 3, 2022	- Review of initial cost driver analysis
October 5, 2022	- Discussion of in-depth, follow-up analyses on cost growth drivers - Update on benchmark data analysis
December 1, 2022	- Continued discussion of in-depth, follow-up analyses on cost growth drivers

Analyses of cost and cost growth drivers

TAB 5

Analyses of cost and cost growth drivers

Cost growth benchmark analysis

vs.

Cost driver 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.

- ▶ **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

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.

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.

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.

Spend and trend by geography

What	<ul style="list-style-type: none"> Spend and trend, stratified by geographic rating area.
Data Source	<ul style="list-style-type: none"> APCD
Notes	<ul style="list-style-type: none"> HB2457 requires analyses by geographic rating area.

Example from Connecticut

Age-gender adjusted inpatient spending per unit was highest for residents of Fairfield and New Haven, lowest in Windham county



County is based on member residence, which will often differ from the county where care was received. Inpatient stay units defined as discharges, which can include multiple claims. Results are adjusted to control for differences in age-gender mix among counties.

Trends in price and utilization

What

- Analysis of spending the impact of price and utilization on spending on services.

Data Source

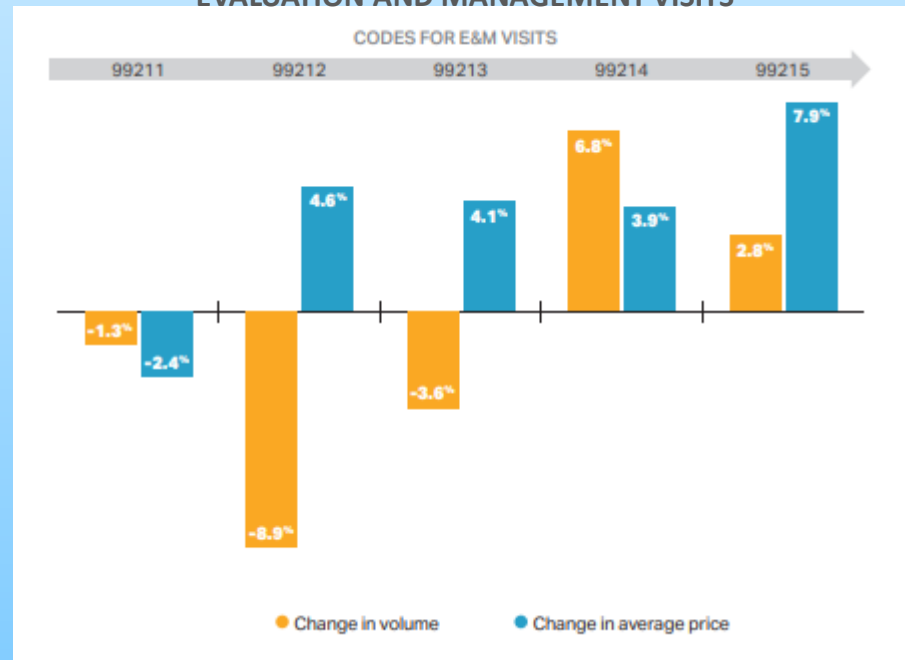
- APCD

Notes

- Work will be needed to identify the services.

Example from Massachusetts

PERCENT CHANGE IN VOLUME AND AVERAGE PRICE FOR EVALUATION AND MANAGEMENT VISITS



Spend and trend by health condition

Example from Connecticut

What	<ul style="list-style-type: none"> Analyses to detect whether and how health conditions influence service utilization and spend.
Data Source	<ul style="list-style-type: none"> APCD
Notes	<ul style="list-style-type: none"> Work will be needed to determine the conditions to analyze.

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	218,598	48.0	\$10,556
Two or more of 27 chronic conditions	115,855	25.4	\$14,379

Spend and trend by demographics

Example from Connecticut

What	<ul style="list-style-type: none">• Analysis of how trends differ among communities with different demographic characteristics.
Data Source	<ul style="list-style-type: none">• APCD• Census Bureau survey data.
Notes	<ul style="list-style-type: none">• Need to determine demographic variables.

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	<ul style="list-style-type: none">Selected indicators to monitor for potential negative impacts of the cost growth benchmark.
Data Source	<ul style="list-style-type: none">To be determined
Notes	<ul style="list-style-type: none">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.
- ▶ 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

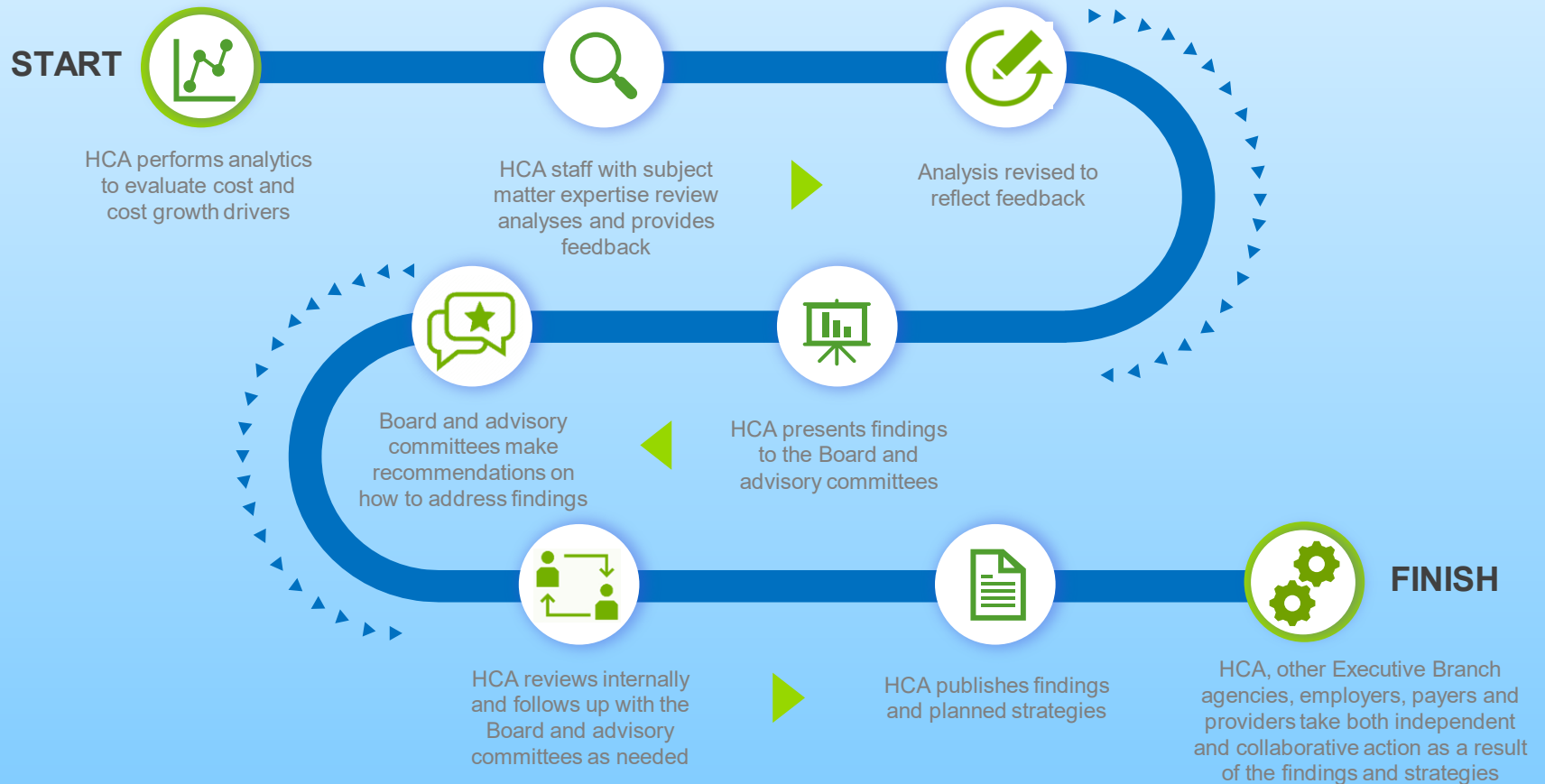
- ▶ Once a regular cadence for the recommended standard reports has been established, develop supplemental ad hoc reports to enhance ability to identify opportunities for action to reduce cost growth.
- ▶ Legislative suggestions include:
 - ▶ Labor (wages, benefits, salaries).
 - ▶ Capital costs (including new technology).
 - ▶ Supply costs.
 - ▶ Uncompensated care.
 - ▶ Administrative and compliance costs.
 - ▶ Federal state and local taxes.
 - ▶ Capacity, funding and access to post acute care, long-term services and supports and housing.
 - ▶ Regional differences in input prices.



Committee discussion: Phase 2 analyses

- ▶ Are there other analyses that the Committee believes should be considered in Phase 2 analyses?
 - ▶ If so, what types of analyses would you recommend?
- ▶ How should the Board prioritize these analyses?

Proposed process for conducting and vetting cost growth driver 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?

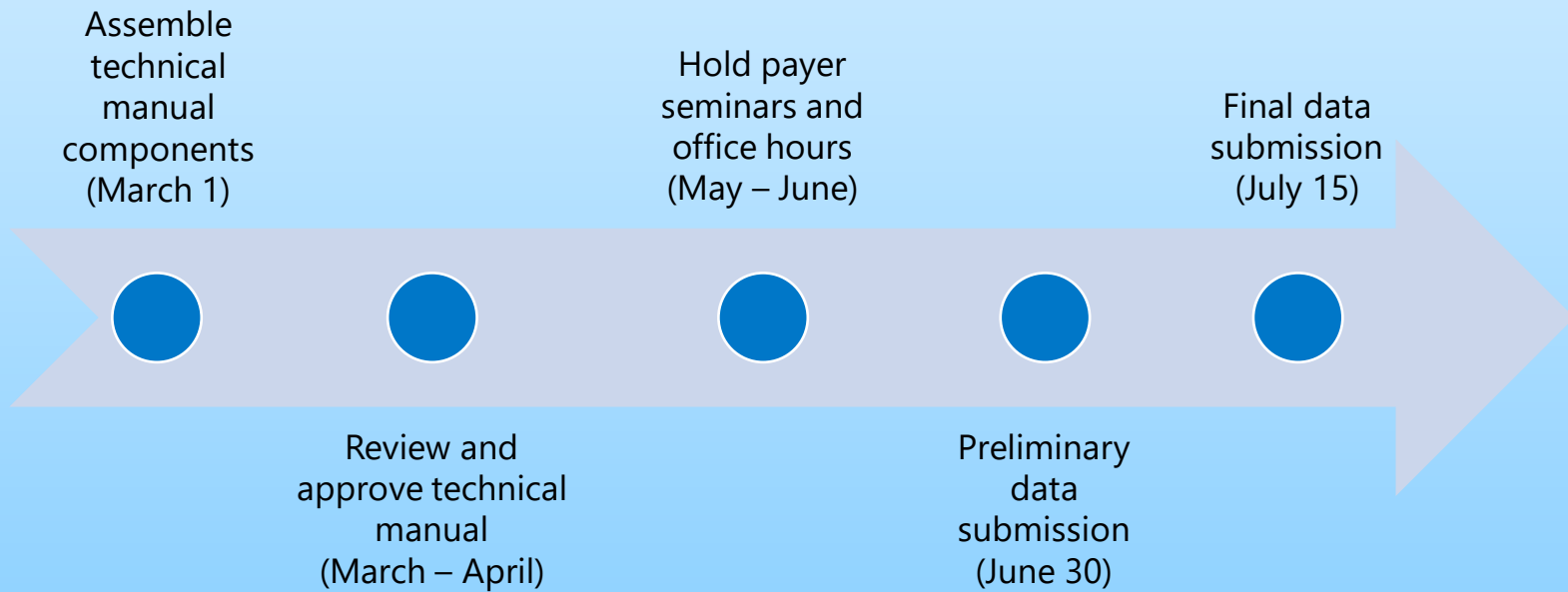
Public comment

Pre-benchmark data collection process and timeline

TAB 6

Pre-benchmark data collection process and timeline

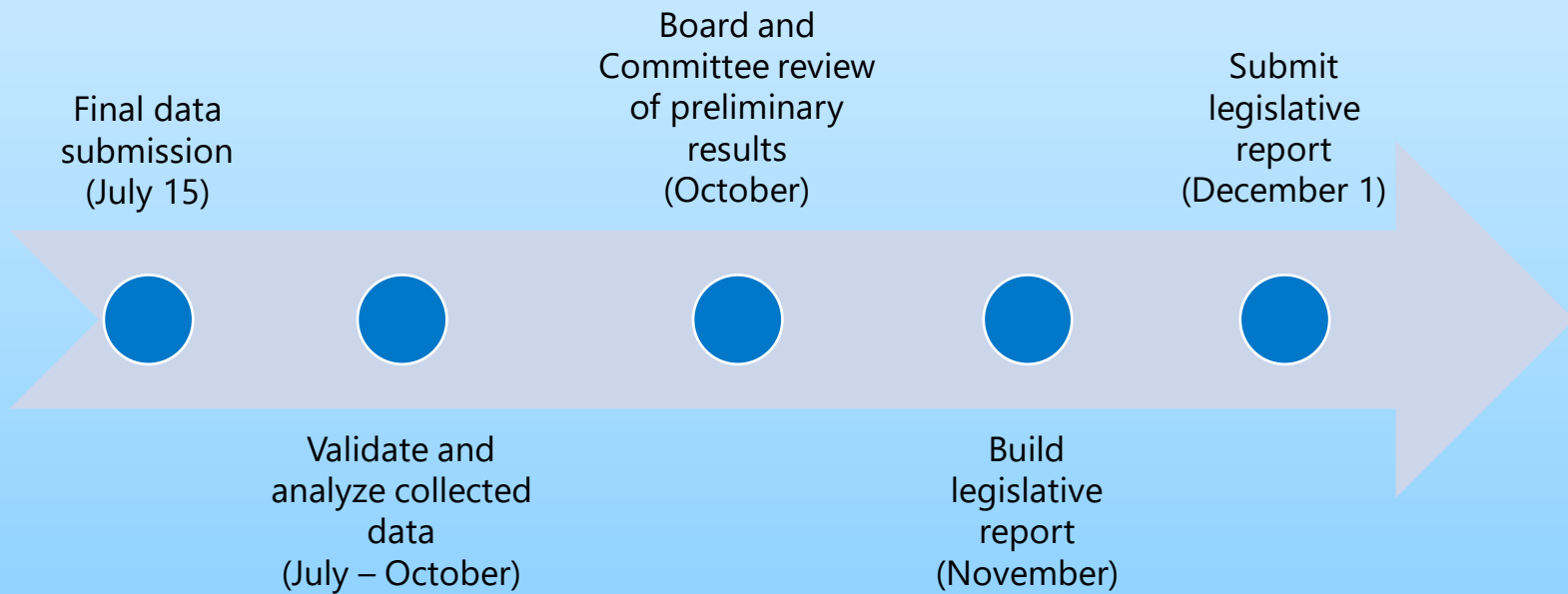
Overall timeline – data collection



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



Payer survey of provider entity contracts

TAB 7

Payer survey of provider entity contracts

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.

Accountability

TAB 8

Accountability

Accountability design

- ▶ The Board will receive baseline data in 2022, and in 2023 will receive trend data at 4 levels: state, market, carrier and provider.
- ▶ This Board “shall” identify those health care providers and payers that are exceeding the health care cost growth benchmark.
- ▶ After review and consultation with identified entities.

Accountability activities (2023)

- ▶ Preparation of analyses
 - ▶ Identification of providers and payers exceeding the benchmark.
 - ▶ Identification of cost drivers.
- ▶ Review and consultation with identified entities.
- ▶ Reporting and recommendations.

Accountability processes: Other states

▶ Massachusetts:

- ▶ On an annual basis, Center for Health Information and Analysis (CHIA) publicly reports performance at four levels (state, market, payer, insurer).
- ▶ Annual public hearing on benchmark (including stakeholder participation).
- ▶ Annual written report of performance (all identified).
- ▶ Providers whose cost growth exceeds the benchmark can be required to implement a performance improvement plan (PIP) and be penalized up to \$500,000 for noncompliance with the PIP.

Accountability processes: Other states

- ▶ Other states (CT, RI, DE) largely based on Massachusetts:
 - ▶ All
 - ▶ All states intend to publish performance at the state, market, insurer, and provider entity levels for the purposes of transparency.
 - ▶ Oregon will apply an “escalating accountability mechanism” for payers or provider organizations who exceed the target without a reasonable basis.
 - Initially payers or provider organizations that don’t meet the target will be subject to PIPs.
 - Those that don’t meet the target in 3 out of 5 years (on a rolling basis) or do not participate in the program will be subject to financial penalty.

Accountability: Draft principles

- ▶ The Board's accountability process (including preparation, review, reporting, and recommendations) will be transparent and predictable.
 - ▶ The Board's benchmark report will identify the entities who are reported on, permitting comparison between them.
- ▶ The effect of Board reports are served by public awareness and understanding.
- ▶ Effective recommendations to consider context and include objective and fair-minded analysis.



Committee discussion: Accountability activities and principles

- ▶ What feedback does the Committee wish to provide related to the timeline and content of accountability activities? What is reasonable and fair?
- ▶ What comments do you have on the draft principles? Will they be helpful in guiding the Board's accountability design?
- ▶ What else would you like the Board to hear about accountability?

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

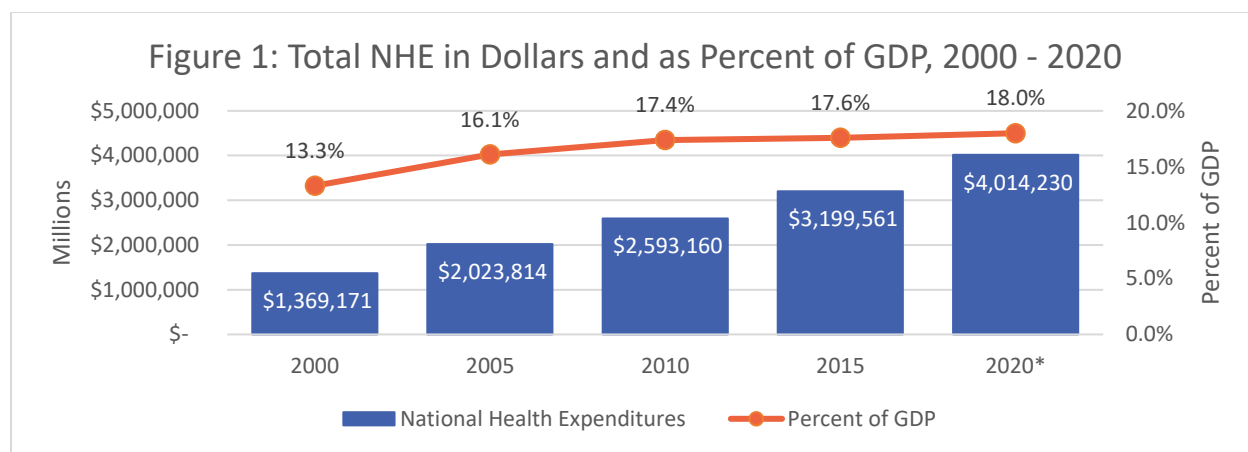
ⁱ R. Tikkanen, M.K. Abrams, U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?, The Commonwealth Fund, January 2020

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).



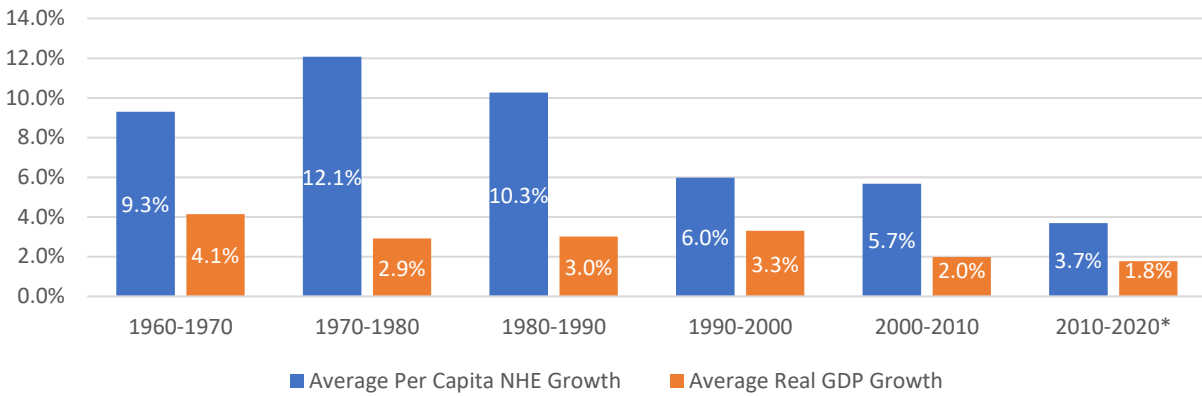
*Estimated based on 2019 NHE projections.

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

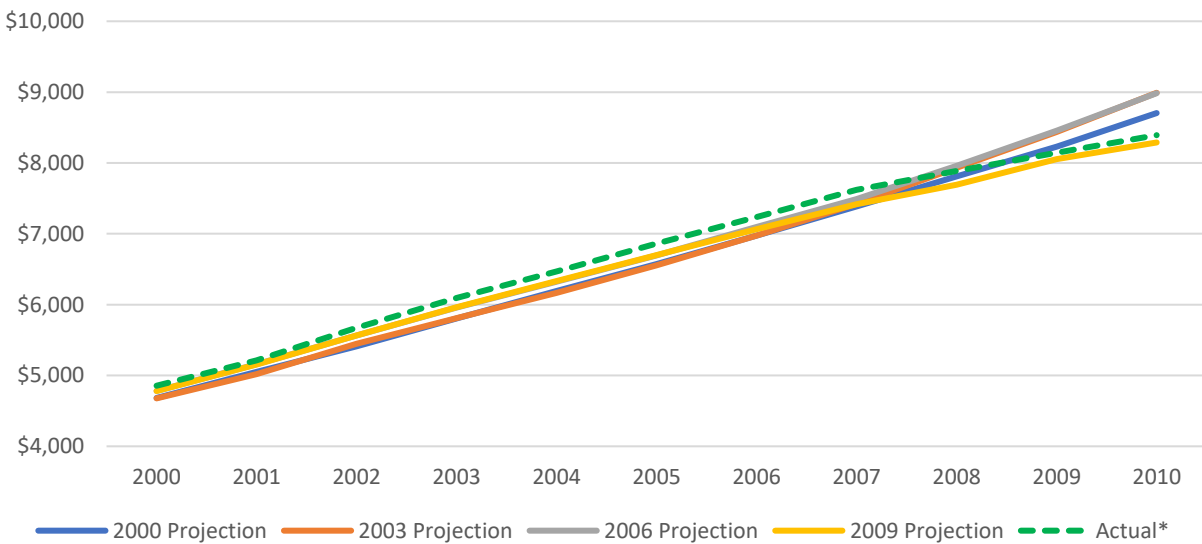
^v The Health Care Transformation Task Force, Getting Warmer: Health Expenditure Trends and Health System Reform, August 2021

Figure 2: Per Capita NHE Growth Rate & Average GDP Growth Rate, 1960-2020

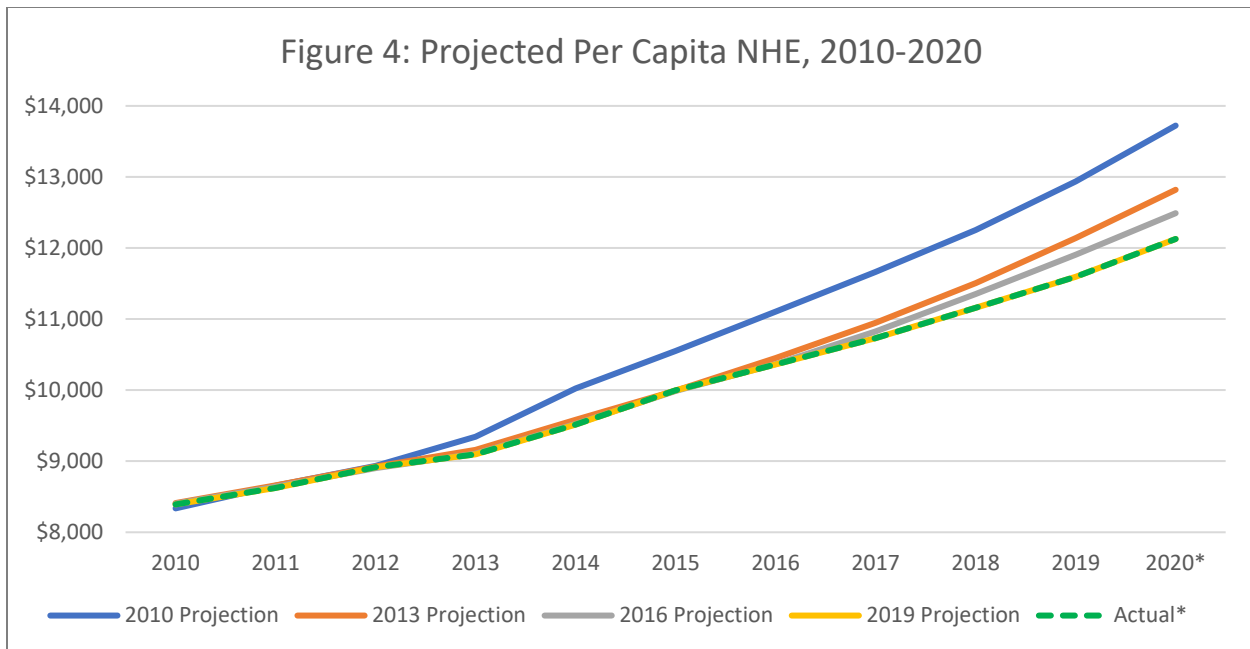


*Estimated based on 2019 NHE projections.

Figure 3: Projected Per Capita NHE, 2000-2010



*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.

Resources

TAB 10

2022 HCCT Board Meetings and Committees

	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