Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers

June 29, 2021

Agenda

TAB 1

Washington State Health Care Authority

Advisory Committee of the Health Care Providers and Carriers

June 29, 2021
10:00 a.m. – 12:00 p.m.
Zoom Meeting

AGENDA

Committee Members:					
☐	Patricia Auerbach	☐	Louise Kaplan	☐	Natalia Martinez-Kohler
☐	Mark Barnhart	☐	Stacy Kessel	☐	Megan McIntyre
☐	Bob Crittenden	☐	Ross Laursen	☐	Byron Okutsu
☐	Bill Ely	☐	Todd Lovshin	☐	Mika Sinanan
☐	Paul Fishman	☐	Vicki Lowe	☐	Dorothy Teeter
☐	Jodi Joyce	☐	Mike Marsh	☐	Wes Waters

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00-10:05 (5 min)	Welcome, roll call, and agenda review	1	AnnaLisa Gellerman, Board Manager Health Care Authority
10:05-10:10 (5 min)	Approval of meeting minutes	2	AnnaLisa Gellermann
10:10-10:15 (5 min)	Topics for today's discussion	3	AnnaLisa Gellermann
10:15-10:30 (15 min)	Snapshot of historical health care cost growth in Washington	4	AnnaLisa Gellermann
10:30-11:00 (30 min)	Economic indicators and the use of historical vs. forecasted growth to derive the benchmark	5	AnnaLisa Gellermann
11:00-11:10 (10 min)	Public Comment		AnnaLisa Gellermann
11:10-11:30 (20 min)	Adjustments to the cost growth benchmark	6	AnnaLisa Gellermann
11:30-11:55 (25 min)	Discussion and Feedback to the Board	7	AnnaLisa Gellermann
11:55-12:00 (5 min)	Wrap-up and adjournment		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.

Washington State Health Care Authority

May Meeting Minutes

TAB 2

Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers meeting minutes

May 25, 2021
Health Care Authority
Meeting held electronically (Zoom) and telephonically
1:30 p.m. – 3:30 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

Patricia Auerbach
Mark Barnhart
Bob Crittenden
Bill Ely
Paul Fishman
Jodi Joyce
Louise Kaplan
Stacy Kessel
Ross Laursen
Todd Lovshin
Mike Marsh
Natalia Martinez-Kohler
Byron Okutsu
Mike Sinanan
Dorothy Teeter
Wes Waters

Agenda items

Welcome, Call to Order, Approval of meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 1:32 p.m. Minutes from April 27 were approved.

Committee Appointments

Ms. Gellermann presented the Board's selection of members for the Advisory Committee on Data Issues.

Recap and Overview of Recommendations to Review

Bailit Health presented a summary of the Board's recommendations for presentation to and feedback from the Committee. The recommendations were on the following topics:

- What spending should be included in the measurement of health care cost growth?
- Whose health care costs to measure?

- Residence of individual and location of rendering provider.
  - Sources of coverage.
- Criteria for choosing an economic indicator to inform the value.
- Economic indicator options.
- Using historical versus forecasted data to calculate the benchmark.

Defining Total Health Care Expenditures

Bailit Health presented the Board's preliminary recommendations on defining total health care expenditures (THCE) to the Committee. The Board recommended defining THCE in the same way that other cost growth benchmark states have defined it, which includes three components:

- Total medical expense (TME) spending on all medical services, including non-claims-based payments to providers.
- Patient cost-sharing; and
- Net cost of private health insurance.

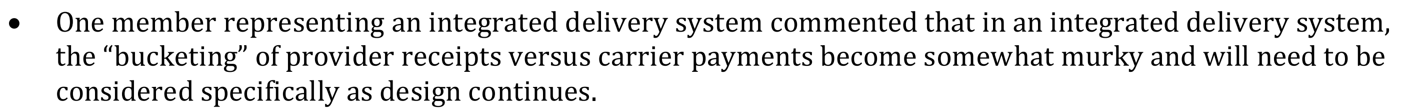
Other specific recommendations included directing staff to ensure that Medicaid waiver services are appropriately captured in spending categories used by other states, that TME would include dental and vision services only as covered under a comprehensive medical benefit (reserving stand-alone dental for future consideration), and that TME should be reported net of pharmacy rebates.

Committee members shared the following feedback:

- Some members representing providers noted that THCE should include data regarding bad debt and charity, in fairness to providers who see more low-income patients and rely on cost-shifting as part of the social safety net. Some members also wished to measure out-of-pocket spending incurred by uninsured residents. Bailit Health shared that in other states, THCE measures payments made to provider organizations, and that bad-debt and charity care are not included since they are an *expense* to providers, and that uninsured payments are difficult to track comprehensively and accurately. In response, a Committee member pointed out that provider expenses are a "cost" to the health care system that must be considered to avoid the unintended consequence of damaging the social safety net.

- Several members expressed a desire to capture spending to address social determinants of health (SDOH), such as transitional housing, transportation, etc. Bailit Health shared that to the extent services are a covered benefit, they would be captured in the measurement of TME. Spending to address SDOH that is not a covered benefit should be included in carriers' administrative expenses and would be captured as part of the net cost of private health insurance. Committee members expressed that these expenses related to SDOH have a critical role in preserving health and will likely increase in the future, and that simply capturing them as administrative expenses does not accurately reflect their importance to medical care. Bailit Health shared that these expenses have not been a major source of spending identified in other states, so there is no example to follow. Bailit Health clarified that in other states, the cost growth benchmark is intended to capture payments from payers to providers, but not costs incurred by providers.

- One member commented that the recommended measure does not include consumer out-of-pocket spend, which is often made at a full rate, and a higher level than covered costs and may increase more quickly. The member suggested looking for ways to reflect this cost, such as through estimates.



- One member representing an integrated delivery system commented that in an integrated delivery system, the "bucketing" of provider receipts versus carrier payments become somewhat murky and will need to be considered specifically as design continues.

Determining Whose Total Medical Expenses to Measure

Bailit Health presented the Board's recommendations to measure spending for all Washington residents, regardless of where they received their care, and to include spending for Medicare, Medicaid, commercial insurance, the Veteran's Health Administration, worker's compensation medical spending, state correctional health system, Indian Health Services (IHS), and public health spending on personal health services.

The Committee generally agreed with the Board's recommendations. However, many members expressed that spending by IHS will likely be difficult to obtain. They also noted the complexities of disentangling IHS spending from spending by Medicaid, and the potential for double counting this spending. The Committee requested follow up with Vickie Lowe to discuss collection of tribal data. Tribal expenditure or IHS funding would take separate requests and likely tribal permission.

Economic Indicators Considered for the Cost Growth Methodology and Calculating an Indicator to Derive a Cost Growth Benchmark: Historic vs. Forecasted Data

Bailit Health presented information on the various indicators considered by the Board, which included annual growth in:

- Washington's gross state product.
- Personal income of Washington residents;
- Average wages of Washington workers;
- Inflation, as measured by the consumer price index; and
- Inflation, as measured by the implicit price deflator for personal consumption expenditures.

Committee members generally preferred using forecasted values over historical values. There appeared to be even support for two economic indicators.

- Some supported potential gross state product (PGSP) as a stable measure that applied evenly across the state, avoiding regional winners and losers. It allows comparison with other states, and internationally gross domestic product. Some also thought it would yield a benchmark value that is most realistic or achievable. However, some that did not support PGSP were concerned about the impact that the exit of large, multi-national employers may have on the estimates.

- Some supported use of median wage, either on its own or in combination with inflation. Committee members liked median as it reflects the impact of increasing cost on people. The use of median wage over average wage would correct any skew of data for high wage occupations. Bailit Health indicated that forecasts of median wage are not available and committee members felt that the use of median wage is important enough that relying on historic data should be considered, despite a preference for forecasting. One Committee member suggested consideration of the consumer price index all urban (CPI-U) in Bellevue as a pertinent metric, it appears to closely tracks the West, and could be used as part of a combination with a wage indicator.

Finally, Committee members shared some statements of principle:

- Control of cost must avoid degrading quality and access.
- Costs are being shifted from employers to people at an increasing rate.

Public Comment

There was no public comment.

Next meeting

Tuesday, June 29, 2021
Meeting to be held on Zoom
10:00 a.m. – 12:00 p.m.

Meeting adjourned at 3:00 p.m.

Topics for today's discussion

TAB 3

Washington State Health Care Authority

Topics for today's discussion

1. Review health care costs and cost growth in Washington.
2. Continue discussion on economic indices to use for setting the benchmark, and on using historical vs. forecasted values.
3. Discuss potential adjustments to the benchmark.
4. Review input from the Advisory Committee of Health Care Providers and Carriers.

Washington State Health Care Authority

Snapshot of historical health care cost growth in Washington

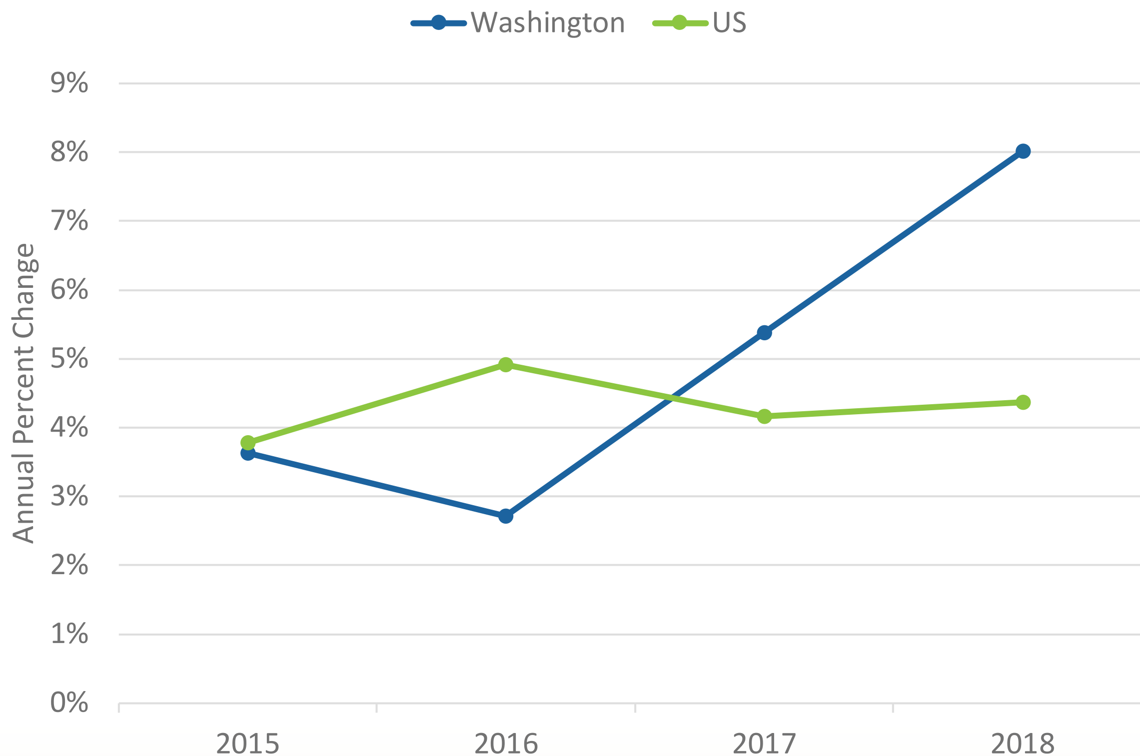
TAB 4

Washington State Health Care Authority

Snapshot of historical health care cost growth in Washington

Washington State Health Care Authority

Growth in per person spending on employer-sponsored insurance

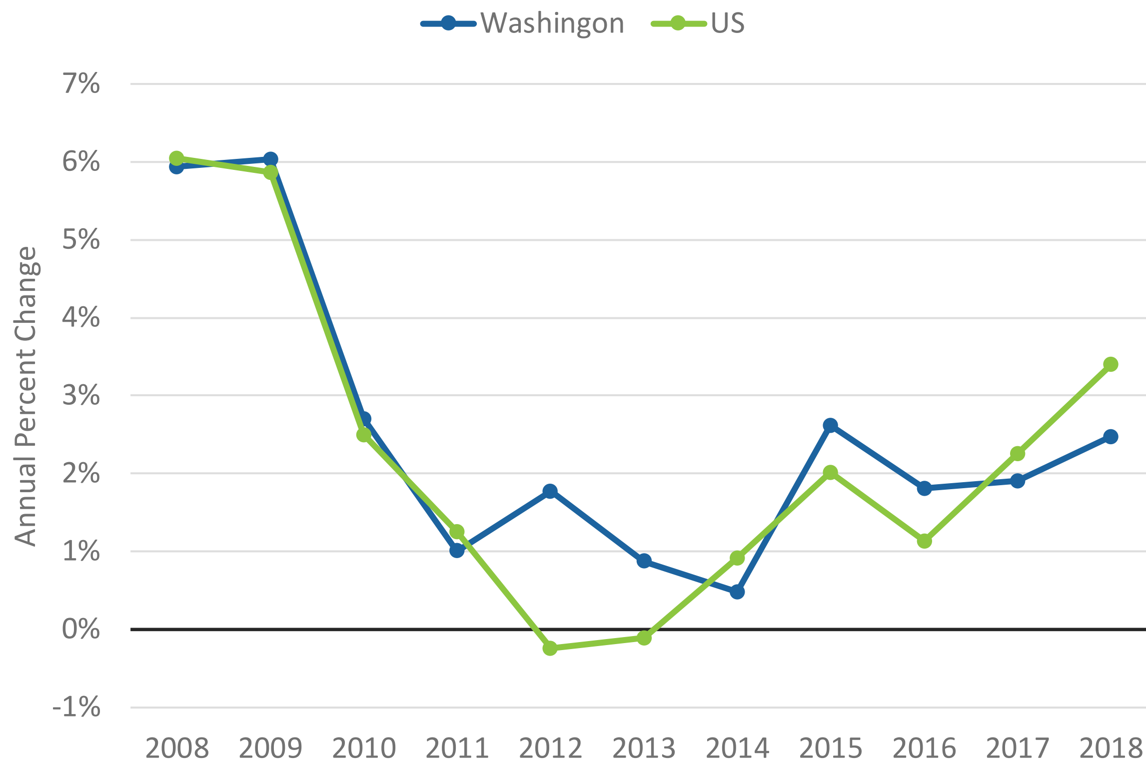


From 2014-2018, Washington's average annual growth in per person spending on employer-sponsored insurance (4.9%) was higher than the national average (4.3%).

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

Washington State Health Care Authority

Growth in per person spending on Medicare



From 2007-2018, Washington's average annual growth in Medicare per capita cost was 2.4%, slightly higher than the national average of 2.1%.

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

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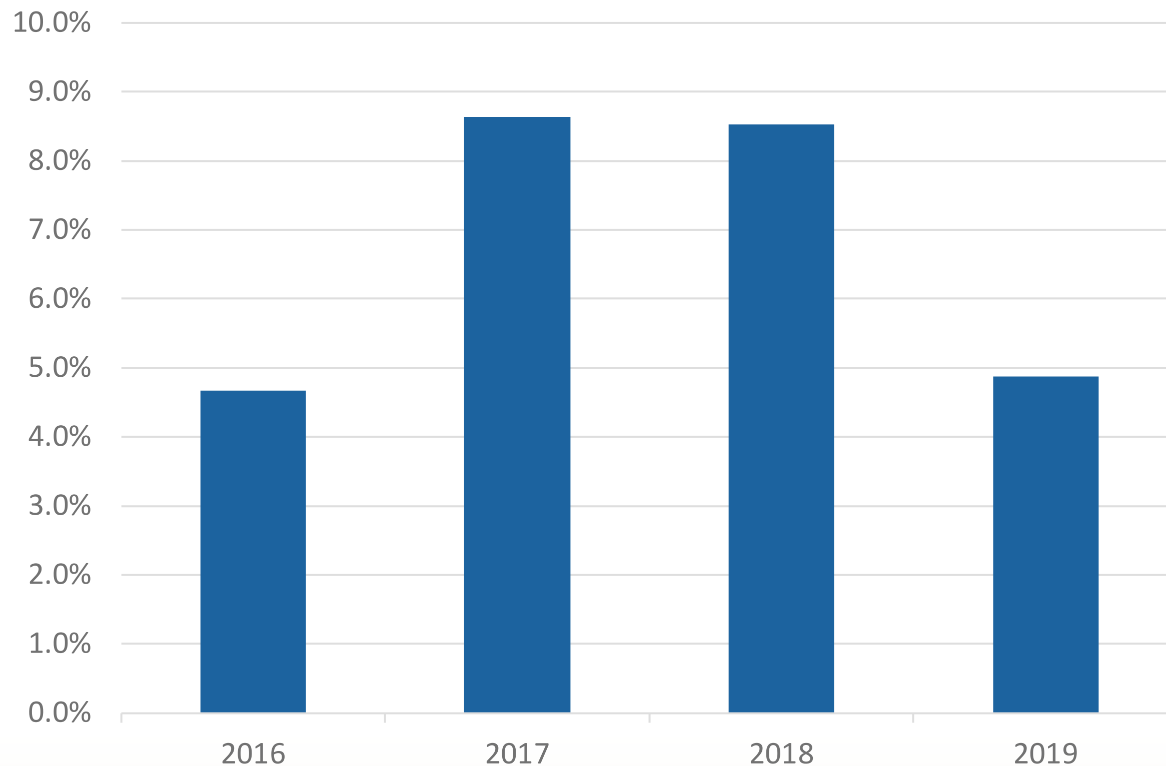
Growth in per person spending on Medicaid



From 2015-2019, Washington’s average annual growth in per capita Medicaid spending was 6.7%.

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

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Average annual growth rate for commercial, Medicaid, and Medicare

Payer Type	Average Annual Growth	Since 2016
Commercial	4.9% (2014-2018)	6.7%
Medicare	2.4% (2008-2018)	2.1%
Medicaid	6.7% (2015-2019)	7.3%

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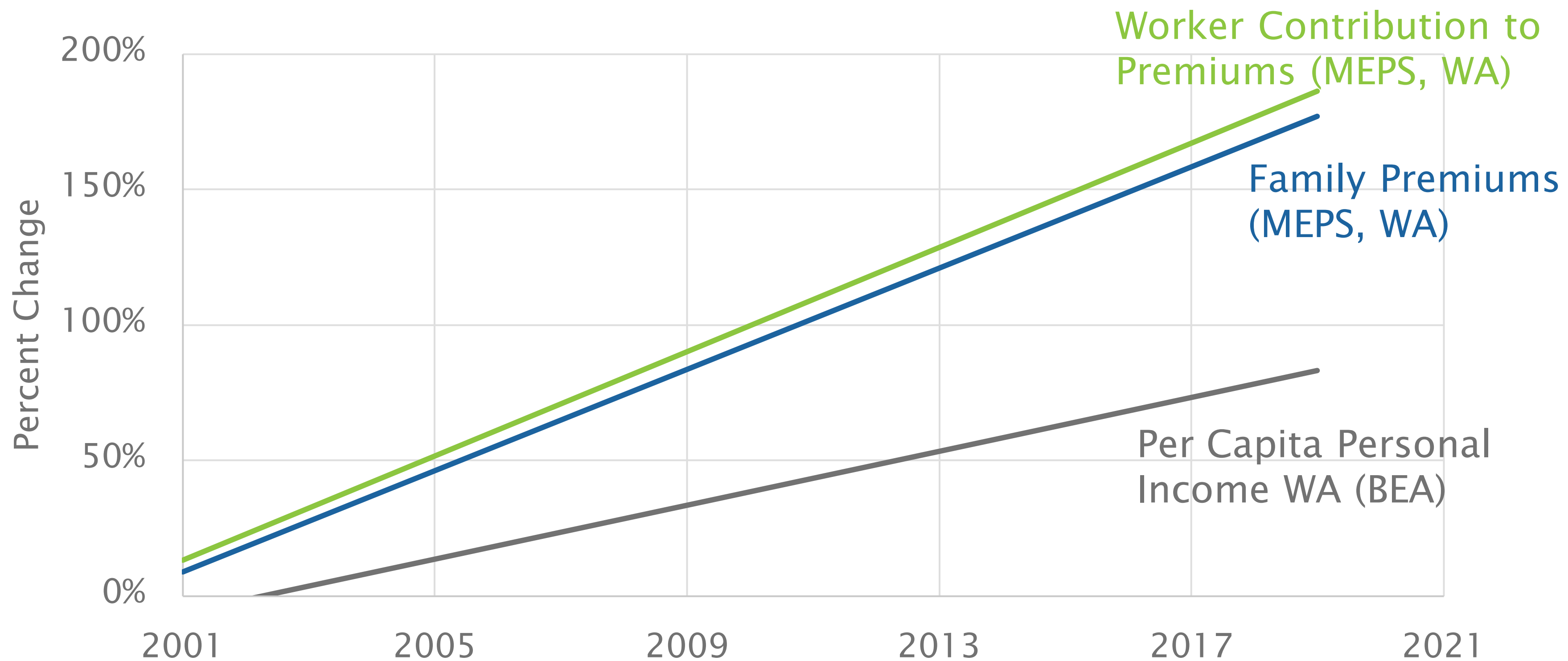
Health Care Premium Spending is Outpacing Income



*Graphs are linear trendlines of the data
Sources: AHRG's Medical Expenditure Survey, Tables D.1 and D.2 for 2001-2019 and Bureau of Economic Analysis

Economic indicators and the use of historical vs. forecasted growth to derive the benchmark value

TAB 5

Economic indicators and the use of historical vs. forecasted growth to derive the benchmark value

Recap of previous Board discussions on the benchmark methodology

- The Board previously did not come to a recommendation on which economic indicator(s) to use.
- There was support voiced for most indicator options.
- Some Board members expressed a desire for using a measure of median wage, as opposed to average wage.
- Many members preferred a hybrid approach based on a blend of:
  - Median wage and inflation; or
  - Median wage, gross state product and inflation.

Summary of Committee's discussion on potential indicators

- Committee members generally preferred using projections over historical estimates.
- Support for the following indicators was generally evenly split:
  - Potential gross state product.
  - Wage, sometimes in combination with inflation.

Summary of Committee's discussion on potential indicators

- Discussions on potential gross state product included the following:
  - Members that supported this measure felt it best represented the diversity of the state economy and liked that it offers comparability to other states.
  - Some members felt it would be the most realistic/ achievable.
  - Those who did not support this measure were concerned that the departure of a large employer could significantly affect the estimates.

Summary of Committee's discussion on potential indicators

- Perspectives on wage, alone or in combination with inflation, included the following:
  - Some members felt the combination of wage and inflation gets at drivers of provider cost structure changes.
  - Some members believed that wage best reflects what consumers experience.
  - Those who supported use of wage preferred using median wage over average wage.

Historical growth in health care expenditures in other states with cost growth benchmarks

	5-Year Average (2010-2014)	10-Year Average (2005-2014)	20-Year Average (1995-2014)	Cost Growth Benchmark
Massachusetts	3.0%	4.7%	5.1%	3.6% for 2013-2017 3.1% for 2018-2022
Delaware	5.1%	5.7%	5.6%	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023
Rhode Island	2.6%	3.7%	5.3%	3.2% for 2019-2022
Oregon	5.3%	5.9%	5.7%	3.4% for 2021-2025 3.0% for 2026-2030
Connecticut	2.4%	3.9%	4.8%	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025
Washington	**4.1%**	**5.8%**	**6.7%**	**TBD**

- States started with benchmark values that were **59-70%** of their 20-year growth, and dropped those values over time to **52-60%**, except for RI which kept a steady benchmark at **60%** of the state's 20-year growth.
- Averages reflect data not available to MA when it set its benchmarks.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: National Health Expenditures by State of Residence, June 2017.

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Design recommendation: Benchmark methodology and value

What benchmark value and methodology does the Board wish to use?

Economic Indicator	Historical (20-year lookback)	Forecast (2021-2025)
Gross State Product and Potential Gross State Product	**5.0%** (2000-2019)	**3.8%** (2021-2025)
Median Wage	**3.0%** (2000-2019)	Not available
Consumer Price Index-Urban, Seattle	**2.4%** (2000-2019)	**1.9%** (2021-2025)
Median Wage and GSP/PGSP (split evenly)	**4.0%** (2000-2019)	**3.4%*** (2021-2025)
Median Wage, CPI and GSP/PGSP (split evenly)	**3.5%** (2000-2019)	**2.9%*** (2021-2025)

* These estimates use historical median wage since forecasted median wage is not available.

Adjustments to the cost growth benchmark

TAB 6

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Adjustments to the cost growth benchmark

Adjusting the health care cost growth benchmark

- The benchmark *could* be adjusted over the period it is set, both in terms of value and methodology.
- In this discussion, we will walk you through potential options as well as remind you of the decisions made in the four other cost growth benchmark states.

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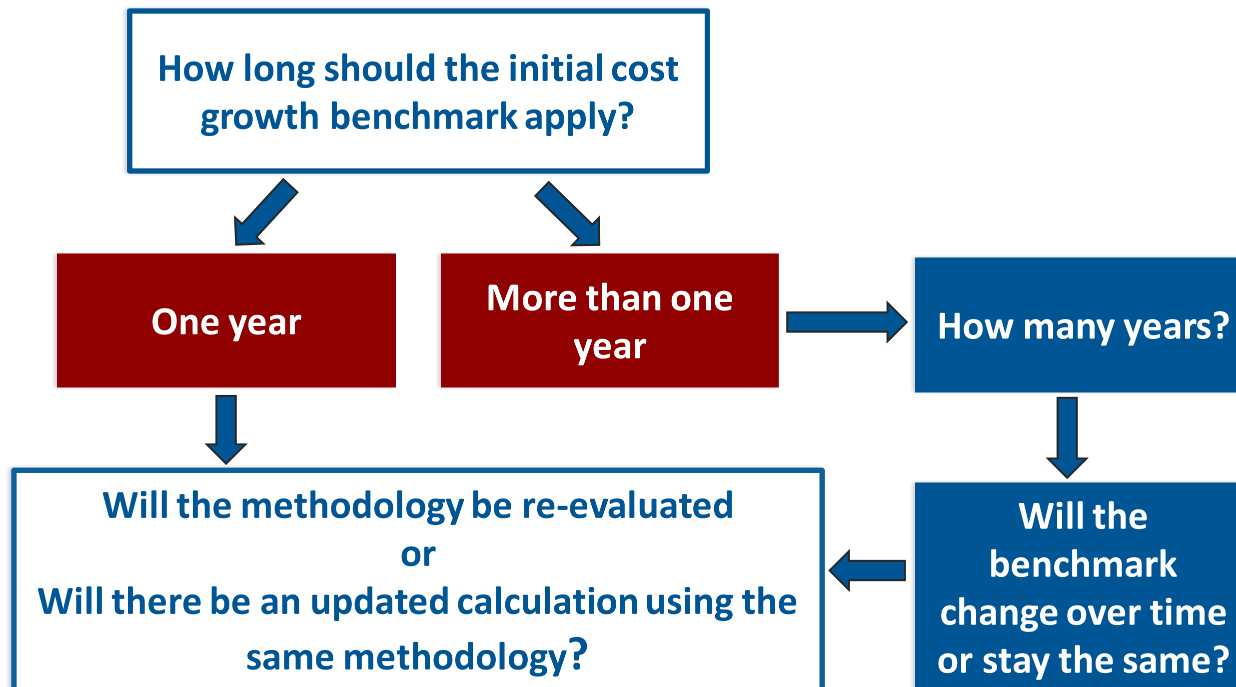
Key questions related to making benchmark adjustments



How long should the initial cost growth benchmark apply?

- Benchmark values could be set one year at a time or for multiple years.
- Other states have set multiple years' worth of benchmark values so payers and providers can know what the benchmark value will be well ahead of time.
- The length of time for which states have set benchmark values range from 4 years to 20 years.
  - Massachusetts – 20 years
  - Delaware – 5 years
  - Rhode Island – 4 years
  - Oregon – 10 years
  - Connecticut – 5 years

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Design recommendation: How long should the initial cost growth benchmark apply?

- Does the Board wish to set benchmark values one year at a time, or for multiple years?
  - If for multiple years, for how long?

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Will the benchmark change over time or stay the same?

- When setting benchmark values over multiple years, states can make adjustments. For example:
  - Massachusetts' benchmark values were set to PGSP but were adjusted down by .5% in years 6-10.
  - Delaware's target is based on PGSP with a "transitional market adjustment" for the first three years.
  - Oregon set target values at 3.4% for the first five years and 3.0% for the next five years.
  - Connecticut's benchmark is a 20/80 blend of PGSP and median income but has an "add-on factor" during the first two years.
- Rhode Island is the only state thus far to set multi-year target values at a flat rate.

Design recommendation: Will the benchmark change over time or stay the same?

- Does the Board wish to make any adjustments to the benchmark value?
  - If so, *how?*

Will the methodology be re-evaluated?

- States can also revisit the benchmark methodology at some future time.
- All cost growth benchmark states have set some process or criteria that would allow for the benchmark methodology to be revisited in the future.

Other states' criteria for changing the benchmark methodology

- Massachusetts set the benchmark in statute, but there is a process for the Health Policy Commission to modify it, subject to legislative review.
- Delaware's State's Finance Committee annually reviews the target methodology and can change the target if the PGSP forecast changes in a "material way."
- In Rhode Island, "highly significant" changes in the economy can trigger re-visiting of the target methodology.
- Connecticut may revisit the methodology and calculation should there be a sharp rise in inflation between 2021 and 2025.

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Design recommendation: Will the benchmark methodology be re-evaluated?

- Does the Board wish to identify circumstances or criteria for changing the benchmark methodology in the future?
  - If so, what criteria would the Board like to use?

Review of feedback from the Advisory Committee of Health Care Providers and Carriers

TAB 7

Washington State Health Care Authority

Review of feedback from the Advisory Committee of Health Care Providers and Carriers

Feedback on defining total health care expenditure and total medical expense

- Many members wanted to be able to capture spending addressing social determinants of health (SDOH) separately from general administration costs.
  - Spending to address SDOH is generally considered to be an administrative cost because it does not constitute medical spending.
- Some provider representatives expressed belief that total health care expenditures should also capture unreimbursed costs to providers, such as bad debt and charity care.
  - It does not do so because it does not represent spending by payers.

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Feedback on defining total health care expenditure and total medical expense

- One member suggested looking at estimates of out-of-pocket spending not captured by payers, including spending on non-covered services and spending by uninsured individuals.
- One member suggested that further discussion is needed to determine whether an integrated delivery system is a payer vs. a provider for measurement purposes.
- There was a suggestion to have a process to reflect back on what is not being captured and periodically re-evaluate whether new data is available.

Design decision: Defining THCE and TME

- Does the Board wish to make adjustments to its recommendations for measuring total health care expenditures and total medical expense based on any of the Committee's feedback?

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Feedback on whose health care spending to include

- Committee members agreed with the Board's recommendation to include Medicaid, Medicare, and commercial spending for all Washington residents, regardless of where they receive their care.
- There was also agreement with the recommendation to try and capture the following sources spending:
  - Veteran's Health Administration.
  - State correctional health system.
  - Public health spending on personal services.
  - Worker's compensation medical spending.
- Some committee members expressed doubt in HCA's ability to obtain Indian Health Services spending data.

Next steps