Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

January 16, 2025

Virtual meeting held on Zoom
2-4:30 p.m.

Note: This meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission are available on the **FTAC webpage**. Additionally, votes made by the committee during this meeting are highlighted below in blue.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle
Kai Yeung

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:04 p.m.

Agenda items

I. Welcoming remarks

Beginning with a land acknowledgement, MacEwan welcomed members of FTAC to the thirteenth meeting and provided an overview of the agenda.

MacEwan notified members that this would be her last meeting facilitating as the FTAC liaison to the Universal Health Care Commission (Commission) and that David DiGiuseppe will now be filling this role. MacEwan will

remain an FTAC member, while DiGiuseppe will assume responsibilities to facilitate FTAC meetings and the back-and-forth work with the Commission.

II. Meeting summary

Committee members voted by consensus to accept the November 2024 meeting summary.

III. Public comment

Peter Markus provided comment on behalf of Whole Washington. Markus thanked FTAC for their report and analysis of the Washington Health Trust bill and reminded members that their report committed to continued review. The latest version of the bill is Senate Bill 5233, which includes several updates. Markus requested that FTAC include review of this bill in the 2025 workplan, as the resulting analysis may inform Whole Washington's advocacy in the Legislature.

Cris Currie summarized written comments he submitted to the Commission, which outline how a state-based single-payer system may contain costs by reducing the incidence of unnecessary medical procedures. Currie advocated for a cost containment approach which includes mandatory global budgets, enhanced transparency to determine motivations behind unnecessary care, practitioner education and best practices, integrated data systems which aid in determining best practices, and a governance and enforcement structure free from industry bias. Currie urged FTAC to recommend that the Commission adopt the single-payer structure as a guiding principle to achieve cost containment most efficiently.

Aaron Katz summarized his written comments provided to FTAC and the Commission. Katz recommends that the Commission and FTAC revise the workplan and focus on the design of the governance structure first. Katz states that this is the most important step in designing a unified system that contains costs and assures equity and access for all.

Aruna Bhuta spoke in support of a state-based single payer system as a matter of cost containment and access to affordable care. Bhuta advocated for a state-administered single payer system to minimize administrative costs and thanked FTAC for their work.

IV. Progress update: 2025 workplan and Milliman analysis

Mary Franzen, Health Care Authority (HCA)

Mary Franzen presented the Commission's 2025 workplan, starting with the foundational legislative charge to prepare the state for a unified health care system and propose interim solutions. Franzen presented the milestone tracker document which includes the Commission's work products toward these goals.

The Commission's 2025 workplan focuses on benefits and services and cost containment design during the first half of the year. Provider reimbursement and participation design will be addressed in the second half of the year. The Commission's intent is to focus on universal design in the first half of the year and add transitional solutions back into the agendas in the second half of 2025. This will allow time for members to consider activities related to the legislative session.

Franzen provided a brief update on the Milliman benefit design cost analysis. FTAC liaisons have been meeting with Milliman actuaries throughout this process. The interim report will be shared with the Health Care Authority (HCA) in February, with a final report being available for FTAC in March.

V. Health Care Cost Transparency Board benchmark report update

Sheryll Namingit, HCA

Sheryll Namingit, Health Economics Research Manager at HCA, provided background on total health care spending data and the health care cost growth benchmark for Washington. Namingit briefly outlined the data and analytic initiatives that are the responsibility of the Health Care Cost Transparency Board (Cost Board). Setting an annual cost growth benchmark and measuring performance is one of several data and analytical responsibilities of the Cost Board.

The Cost Board's first data call occurred in 2022, collecting Washington state carrier and non-carrier data from 2017-2019. The most recent data call occurred in 2024 when the Cost Board collected 2020-2022 data. Namingit explained the Cost Boad's calculation for total health care expenditure (THCE). The calculation includes the sum of total medical expenses (TME) including claims and non-claims expenditures, non-claims and private insurance administrative costs, and other spending. TME is broken down by markets, particularly commercial, Medicare, and Medicaid. The analysis is also broken down by carrier, and an attribution calculation for large provider organization spending.

In 2021, the Cost Board set five years of cost growth targets from 2022-2026. The targets are based on economic indicators including nominal gross domestic product (GDP) as well as the nominal wage growth in Washington. The recent benchmark report and data compares performance against the 2022 target of 3.2%. In 2022 cost growth was 3.6%, slightly above the target of 3.2%. Excluding 2020, this was the slowest year of growth measured since 2018. Medicare was the only market to exceed the 2022 benchmark and spending on Veterans Affairs members also contributed to growth. A broader look at data from 2019-2022 shows growth driven by commercial and Medicare markets with prescription drugs, non-claims spending driven by Medicare capitation payments, and hospital outpatient services representing the top three categories of spending, respectively.

Incarcerated individuals incur a high per member per month (PMPM) cost, but the population is relatively small and amounts to 0.5 percent of total spending, Medicare spending accounts for nearly one third of all spending with a PMPM of $13,070 in 2022. Commercial market members accounted for 36.1 percent of spending, with a PMPM of $6400. Medicaid members represent 20.3 percent of spending at a PMPM rate of $5012.

Spending from 2019-2022 was reported by market, with the commercial market growing by 11.5 percent and Medicare growing by 7.7 percent during this time. Medicaid enrollment and total spending increased, but PMPM slightly decreased by 0.1 percent from 2019-2022. This was not the case in 2017 – 2019 when Medicaid growth ranged between 11.9 and13.8 percent. Washington's growth rate is similar to the median cost growth of other states participating in cost growth benchmark activities. The growth rate in commercial, Medicare, and Medicaid spending was also similar to other states. The final brief on the benchmark performance will be made public later this year.

In the Q&A FTAC members discussed the analysis, specifically regarding incarcerated populations, Veterans Affairs (VA) spending, and Medicare growth. They also discussed the Cost Board's opportunities to further identify cost drivers at the provider level. FTAC members expressed interest in continued updates on the Cost Board's work.

VI. Universal Health Care Commission update

Pam MacEwan, FTAC Liaison

MacEwan provided a brief update on the Commission's December 5th meeting.

MacEwan reported on the Commission's preview and discussion of proposed reference-based pricing bill for the public employee and school employee health plans (more information here). MacEwan shared FTAC's support for the proposal and following the presentation, the Commission voted to "support the principle of reference-based pricing, not only to contain costs, but to rebalance resources." The Commission also noted that the current proposed bills may change during the legislative process but agreed with supporting reference-based pricing as a strategy.

FTAC members discussed the potential of recommending that the Commission specifically endorse the reference-based pricing bill that has been introduced in the Legislature. Gary Cohen from Health Management Associates (HMA) affirmed that the Commission supports the reference-based pricing strategy and will be watching the progress in the Legislature. Cohen noted that the Commission may choose to take a stronger position in the future. FTAC members deliberated the appropriate level of recommendation back to the Commission. DiGiuseppe agreed to relay FTAC's endorsement of the bill at the February Commission meeting.

The Commission requested that FTAC continue to explore cost containment strategies such as out-of-network price caps and hospital global budgeting. The Commission also approved revisions to its 2025 workplan focusing on universal design during the first half of the year and continuing to consider transitional solutions in the second half of the year.

VII. Hospital global budgeting, presentation and Q&A

Robert Murray, FTAC member

Robert Murray presented an overview of hospital global budgeting (HGB), starting with his professional background, experience working in Maryland, and research into various models. Murray's presentation covered the general characteristics of HGB models, a simplified example of an HGB, past state approaches with HGB, policy objectives and incentives, advantages, disadvantages, modifications to address weaknesses, as well as governance and oversight considerations.

Murray shared his background and personal assertions regarding cost containment, including the risk that any expansion in services requires a well-regulated cost control system. Failure to develop effective models may hamper expansion efforts, which may have been the case in Vermont's single payer initiative. In Murray's estimation the Affordable Care Act may also be at risk due to a lack of substantive cost containment initiatives. States may be best situated to contain excess health care spending through rate setting. Murray advocates for a state-based rate setting model, as these types of price control measures

are common throughout developed nations. Murray further recommends that states utilize low intensity measures and simple models to avoid regulatory failures. The model Murray recommends is for states to start with price caps in state employee benefit plans, then consider out-of-network rate caps, as this will influence in-network pricing as well. Eventually states can more broadly contain costs through HGB.

Murray briefly described the prevalence of HGB approaches in Canada and European countries. France and Germany initially utilized fixed budgets and then opted for more flexible models. Murray advocates for flexible models which account for a provider's marginal costs. Several states have utilized HGB including Maryland's original flexible HGB model from 1976-1992 and the current Advancing All-Payer Health Equity Approaches and Development (Link: AHEAD) model advancing in several states in partnership with the United States Center for Medicare and Medicaid Services (CMS).

Murray outlined several general characteristics of HGB including mandated participation covering all hospitals and potentially other services. Murray stressed the importance of including all hospitals to avoid ineffectiveness and distortion between HGB and fee-for-service incentives and utilization across providers. Per Murray, a state-based HGB system would ideally be governed by a regulatory body, utilizing a public utility model. Services covered by HGB models generally include acute inpatient and outpatient hospital services, but states may opt to cover a variety of services such as post-acute care and home health services. HGB models are more comprehensive than rate caps but can remain simple and less complex than setting prices for individual services. Flexible aggregate budgets offer a simple, low-intensity regional rate setting model which focuses on one number and addresses both price and volume.

Murray described potential policy goals that might be achieved with HGB approaches, including constraining price and volume, removal or reduction of fee-for-service incentives for volume, and potential reduction in need for prior authorization. Other goals include investment in reducing unnecessary care, improvements to population health, predictability and stability for hospitals, and built-in incentives to constrain costs, which can improve hospital profitability. Hospitals that are struggling could be identified for increased funding and highly profitable hospitals could be identified for potential reductions. Through such a model, the system may achieve better payment equity, though Murray notes this will take time. The HGB model can be modified to support other value-based payment initiatives and quality incentive programs. HGB models do pose a risk of hospitals limiting care and therefore quality incentives are a potential mechanism for ensuring quality of care over time. Through the success of a simple and flexible HGB model, states may opt to undertake more complex population-based reimbursement approaches.

Murray provided a simplified example for HGB models with budgets increasing annually, considering inflationary measures and demographics. This model provides a strong incentive for hospitals to control operating costs and unnecessary volume increases. This strategy can increase profitability when successful, as Murry notes in Maryland's experience. If hospitals are incentivized to reinvest savings into population health and preventative care, this can help perpetuate the model.

Weaknesses of HGB models were also presented, including potential inequities if the model is not mandated, the risk of providers limiting care, increased wait times, and risk of shifting care out of hospitals to clinics, thereby collecting double payment. Fixed HGB are not responsive to volume shifts or changes in community needs and may pose significant financial risk. Both flexible and fixed HGB models face risks of regulatory capture and failure.

The requirements Murray listed for HGB models included state regulation of mandatory budget compliance and significant fining authority for non-compliance. The model should include a regulatory commission with broad power to collect data and the legal authority to set budgets. The regulatory commission should include governor appointed volunteers and be supported with professional staff. Murray noted that regulatory and rate setting commissions have been effective in the past and can help avoid regulatory capture or failure.

Murray recommended flexible HGB models to equally emphasize cost containment and hospital financial stability. Flexible global budgets models can provide revenue to cover marginal or variable costs of production and can also help cover fixed costs if volume declines. This may be a particular advantage for small and rural hospitals. This model is a middle ground between a fee-for-service model which may drive unnecessary care, and a fixed global budget model which risks excessive limits on care.

Murray provided a simplified example calculation of how a HGB model might address variable costs, based on an assumed 50 percent margin. A 1 percent increase in utilization would result in a 0.5 percent increase to the budget, to cover variable costs. A 1percent decrease in utilization would result in a 0.5 percent decrease to the budget and fixed costs remain funded. Hospitals would report data to the public commission monthly and adjust rates to remain in compliance with the approved HGB. Annually, the public commission would adjust the HGB depending on whether volume went up or down. This mandated model would include large fines for non-compliance, but the system can become nearly self-regulated with hospitals adjusting prices throughout the year to meet their approved HGB. Murray contends this model adds financial stability for hospitals and particularly small rural hospitals with limited population and volume of services.

The key steps to devising an HGB model include developing a rate base using historical volume and revenue data to set base year budgets, followed by defining which services are included. Next, there may be adjustments to the rate-base, such as funding for uncompensated care and case management. Whether choosing a fixed or flexible HGB, provider payment could remain consistent with all payers. The HGB model utilizes formula-based prospective budgeting which accounts for hospital input cost inflation and demographic changes. States could then choose to improve pricing and budget equity with tiered measures which limit high price updates and augment low priced hospital updates. Finally, Murray emphasized that the regulatory commission must exercise their legal authority to mandate compliance.

Murray's final observations on HGB models included their ability to redirect incentives toward improving hospital's operating cost efficiency, reducing levels of low value or unnecessary care and making investments to improve population health. Murray argued that the health care industry faces challenges which require rate regulation to improve market function. Avoiding complexity and providing the governance structure to avoid regulatory capture from the hospital industry is ultimately how Murray suggests these models will be successful.

Murray addressed questions from FTAC members following the presentation.

FTAC member Roger Gantz asked about the level of staffing required and Murray noted that a public commission could be staffed by as few as 20 professional staff. Though Maryland may employ twice as many staff for their rate setting commission, Murray contends that this is not necessary. Gantz was also

curious about payment methodologies and Murray reaffirmed that payment models should remain consistent with the status quo to avoid complexity.

FTAC member Christine Eibner inquired about risk related to hospitals refusing to provide some services that are deemed too costly. Murray noted that in some global systems with fixed models there may be issues with wait-times and other delays in care. Murray has not observed or heard about this phenomenon in the state-based models he has studied.

FTAC member Eddy Rauser asked what actions might be taken if hospitals were not able to meet their targets. Under a flexible HGB model, Murray reiterated the aim is to constrain cost and hospitals would need to adjust volume of unnecessary care and unit cost. The profit incentive would be enough to drive hospitals to make these adjustments, according to Murray, and it would be counterproductive for the state to bail them out. If the regulatory authority identified unique circumstances which threatened access, and required raising a hospital's budget temporarily, this could be built into the system.

FTAC Liaison DiGiuseppe inquired about various perspectives the Commission might need to consider if they were to make a recommendation on HGB. Murray suggested that payers and consumers will likely support this model, while hospitals will be more resistant to adoption. Murray expressed his knowledge of previous efforts in Washington to consider HGB models and that he had ideas on why the effort failed. He expressed his willingness to present his flexible HGB model to the Commission in the future.

VIII. Cost containment discussion and future direction

Todd Bratton, HCA and Gary Cohen, HMA

Todd Bratton from HCA presented a plan for helping FTAC develop cost containment recommendations to UHCC. Over the next several meetings, FTAC will review and draft recommendations on cost containment strategies and principles for universal design. Drafts and references will be sent to FTAC members for review between meetings.

Gary Cohen from HMA led a discussion on this process within context of the Commission's workplan. FTAC Liaison DiGiuseppe inquired whether FTAC's recommendations might include cost containment approaches for controlling trends moving forward or realizing cost reductions compared to the current system. DiGiuseppe noted the suggestions of the workgroup which preceded the Commission and the savings they estimated based on a unified fee schedule. DiGiuseppe noted that recommending an HGB model seems to be aligned with approaches for managing current costs. Based on Cohen's understanding and experience with the Commission, the workgroup's estimated savings come from administrative reduction and improved efficiency rather than reductions to the price of care.

Mary Franzen from HCA noted that due to meeting time constraints, staff will be able to send out drafts and incorporate FTAC member suggestions for discussion at the next meeting. FTAC member Pam MacEwan requested that staff incorporate the work that FTAC has already completed as the starting point for this effort.

FTAC member Gantz expressed interest in considering HGB models as one strategy, however noting that its application is best suited to hospital facilities and not necessarily the entire system. Gantz suspects reference-based pricing could apply to a broader set of services. Gantz also reiterated his understanding

of savings estimated by the workgroup, which include administrative savings associated with a single payer system, plus the system's ability to address trends. Gantz suggests FTAC continues to engage with the Health Care Cost Transparency Board and recommended that FTAC member Murray present on HGB. Gantz also recommended that FTAC encourage the Commission to more strongly support the reference based pricing legislation for the public employee and school employee plans.

Cohen inquired how reference-based pricing and HGB models might intertwine. FTAC member Murray estimates that an HGB model would reduce the need for price caps, as it addresses both volume and price. A regulatory commission would need to review whether the system is functioning as expected, and Murray notes that the HGB model does appear to reduce administrative costs in the studies he has reviewed.

FTAC member Christine Eibner expressed interest in more fully investigating which strategies make sense as transitional solutions or universal design. FTAC member MacEwan agreed that some of the strategies make more sense to include in universal design than others.

IX. Benefits and services prioritization model

Due to time constraints, FTAC was not able to spend time discussing prioritization of benefits and services. Mary Franzen, HCA, reminded FTAC the Milliman analysis will likely be presented at the March FTAC meeting. This report will inform benefits and services design work for the next several meetings.

Adjournment

Meeting adjourned at 4:31 p.m.

Next meeting

Thursday, March 13, 2025 from 2-4:30 p.m.
Meeting to be held on Zoom