

Health Care Cost Transparency Board

June 16, 2021

Health Care Cost Transparency Board Board Book

June 16, 2021
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Agenda	1
May Meeting Minutes	2
Topics for Today’s Discussion.....	3
Snapshot of Historical Health Care Cost Growth in WA.....	4
Economic Indicators and the use of Historical vs. Forecasted Growth to Derive	5
Adjustments to the Cost Growth Benchmark	6
Review of Feedback from the Advisory Committee of Health Care Providers and	7

Agenda

TAB 1

Health Care Cost Transparency Board

June 16, 2021
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Board Members:

<input type="checkbox"/>	Susan E. Birch, Chair	<input type="checkbox"/>	Sonja Kellen	<input type="checkbox"/>	Kim Wallace
<input type="checkbox"/>	Lois C. Cook	<input type="checkbox"/>	Pam MacEwan	<input type="checkbox"/>	Carol Wilmes
<input type="checkbox"/>	John Doyle	<input type="checkbox"/>	Molly Nollette	<input type="checkbox"/>	Edwin Wong
<input type="checkbox"/>	Bianca Frogner	<input type="checkbox"/>	Mark Siegel	<input type="checkbox"/>	Laura Kate Zaichkin
<input type="checkbox"/>	Jodi Joyce	<input type="checkbox"/>	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:05-2:10 (5 min)	Approval of May meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10-2:15 (5 min)	Discussion and appointments: Additional member proposed for Advisory Committee on Data Issues		JD Fischer Health Care Authority
2:15-2:20 (5 min)	Topics for today's discussion	3	Michael Bailit and January Angeles Bailit Health
2:20-2:35 (15 min)	Snapshot of historical health care cost growth in Washington	4	Michael Bailit and January Angeles Bailit Health
2:35-2:50 (15 min)	Economic indicators and the use of historical vs. forecasted growth to derive the benchmark	5	Michael Bailit and January Angeles Bailit Health
2:50-3:05 (15 min)	Adjustments to the cost growth benchmark	6	Michael Bailit and January Angeles Bailit Health
3:05-3:35 (30 min)	Review of feedback from the Advisory Committee of Health Care Providers and Carriers	7	Michael Bailit and January Angeles Bailit Health
3:35-3:45 (10 min)	Public comment		Susan E. Birch, Chair, Director Health Care Authority
3:45-3:55 (10 min)	Next steps		Michael Bailit and January Angeles Bailit Health
3:55- 4:00 (5 min)	Adjournment		Susan E. Birch, Chair, Director 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 Health Care Cost Transparency Board meeting will be conducted virtually.

May Meeting Minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

May 13, 2021
Health Care Authority
Meeting held electronically (Zoom) and telephonically
9:00 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

Sue Birch, chair
Lois Cook
John Doyle
Bianca Frogner
Sonja Kellen
Pam MacEwan
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong
Laura Kate Zaichkin

Members absent

Molly Nollette

Call to order and welcome remarks

Sue Birch, chair, called the meeting to order at 9:03 a.m.

Agenda items

Welcoming remarks

Sue Birch

Ms. Birch welcomed the Board and informed them of the passage of SB 5377. She emphasized that the Board has a role to play in the state's public option, including a report when enrollment in public option plans reaches 10,000. She stated her observation that the Board is viewed by the legislature as bipartisan, objective, and a trustworthy source of data and analysis. She encouraged the Board to stay focused on the goals of the statute, as a market-wide intervention on cost inflation. Finally, she reminded the Board of the process for working with advisory committees, emphasizing that the Board will make final decisions only after receiving feedback on recommendations from the committee.



Adoption of Minutes

The April 13, minutes were adopted unanimously, and consensus was put on the record.

Discussion and appointments: Non-voting board member from the Advisory Committee of Health Care Providers and Carriers

The Board's enabling statute requires the addition of a non-voting member from the Advisory Committee of Health Care Providers and Carriers to sit on the Board. Interested Committee members were solicited to apply for the position, and the Board received interest from Jodi Joyce and Dr. Bob Crittenden. Staff recommended the selection of Jodi Joyce, based on her current role with a large market participant. The Board voted unanimously to approve Jodi Joyce.

Discussion and appointments: Proposed additional members for the Advisory Committee of Health Care Providers and Carriers

Following the Board's recommendation to seek additional members representing carriers, Managed Care Organizations and consumers, staff proposed the addition of four members to the committee: Paul Fishman, Stacy Kessel, Dorothy Teeter, and Wes Waters. The Board voted unanimously to approve the four additional committee members.

Discussion and appointment: Advisory Committee on Data Issues

The Board heard from J.D. Fischer, Health Care Authority staff and facilitator of the Advisory Committee on Data Issues, who presented staffs proposed list of experts for the committee. The Board received biographic materials from the candidates, and all applicants were included on the proposed list. The Board discussion included confirming the presence of expertise in Medicare data, and social determinants of health. The Board voted unanimously to approve all recommended members.

Presentation: Recap of preliminary recommendations (from 4/13 board meeting)

The Board's desire in general is to be as comprehensive as is feasible in defining health care spending that is measured against the cost growth benchmark.

Bailit Health presented a recap of recommendations as follows:

Total Health Care Expenditures (THCE) should be defined as the allowed amount of claims-based spending from payer to provider, all non-claims-based spending from payer to provider, and the net cost of private health insurance.

The Board reached general consensus on this issue. Defining it this way allows us to capture insurance payments, out-of-pocket costs, and administrative expenses. There was general recognition that consumer's out-of-pocket spending would not be captured because there are no good sources of data to capture it.

Total Medical Expenses (TME) should be reported as net of pharmacy rebates.

TME should not include dental or vision services unless they are covered under a comprehensive medical benefit.

The Board had a robust discussion about including dental benefits. There was recognition that capturing this cost would require a separate data call that would add to administrative expenses. The Board may in the future add



stand-alone dental plan payments to the definition of THCE as that allows for measurement of this spending as it becomes available and accessible.

The Board questioned how Medicaid waiver funds would be captured as part of THCE. Staff were directed to capture these funds in the claims and non-claims categories of spending used by other cost growth benchmark states.

Presentation: Defining the population for whom total medical expenses are being measured.

Design Recommendations: Sources of coverage to include, and state of residence and care location.

Sources of coverage to include

Bailit consulting prefaced the presentation by clarifying that the effort is to define who will be measured based on sources of coverage with data that is accessible, comparable, and reliable. Data access on health care spending can be a challenge to an effort to measure comprehensively.

The Board's general desire is to be as comprehensive as possible and include all feasible populations, in part to support the future ability to perform analyses of cost drivers related to social determinants of health. Staff was generally directed to discover the feasibility of data sources and bring back information about what is available and accessible. To the extent that the sources are too difficult or unwieldy, the Board will discuss removing them from consideration.

Sources of coverage will include Medicare, Medicaid, and commercial (fully and self-insured). Staff were further directed to follow up on the feasibility of including spending data for the Veteran's Administration, workers compensation, personal health services in public health, Indian Health Services data (in consultation with the tribal representative on the Advisory Committee of Health Care Providers and Carriers), and correctional health spending.

State of residence and care location

The Board recommended that THCE include health care spending on Washington residents incurred both in and out of state.

On the topic of spending in Washington for non-residents, the Board expressed concerns about the influence of non-residents impact on provider cost and state spend on health care. The Board recommended not including these costs, in part based on the difficulty of getting data from carriers not licensed in Washington but determined to consider the issue at a later date in the context of evaluating cost-drivers.

The Board will not include spending on out of state residents by out of state providers. The Board acknowledged that Public Employees Benefits/School Employee Benefits retirees and workers compensation do incur costs in this category.

Public Comment

Ms. Birch called for comments from the public.

Abby Cook from CNSI asked whether as currently defined out-of-pocket costs paid by uninsured individuals and families are captured in this proposed set of data? And do we know the magnitude of those costs? In response, it was stated that this expense is not captured as part of THCE, as the data is not available. Bailit Health is working



with Connecticut to develop a rough estimate of this spend, but other states find no reliable means to track it. Ms. Birch indicated the Board would reserve the issue for future consideration.

There were no further public comments.

Presentation: Establishing criteria for choosing an economic indicator

Design recommendation: Economic indicator criteria

The Board agreed with the 3 selection criteria presented to them, after inquiring as to the practice in other states and a discussion related to potential acceleration of cost if indicated by the other indicators, e.g., inflation.

Presentation: Economic indicators for the cost growth benchmark

The Board was presented with several options for an economic indicator without values, to keep the discussion based on principles rather than specific trends.

Presentation: Discussion of options for establishing a cost growth benchmark

Design Recommendation: Economic indicator for the benchmark

The Board determined that a hybrid approach was appropriate. The Board's goal is to have the indicator be specific to Washington, and to consider the impact of cost growth on "average consumers." Staff was directed to explore use of median wage rather than mean wage, to avoid potential skewing from urban high wage occupations. The Board has some discussion of weighing of different indicators in the hybrid approach. The Board will be presented with modeling of two different hybrids, one including implicit price deflator, median wage, and gross state product equally weighted, and the other including gross state product and median wage. The Board also requested information regarding the cost of obtaining the median wage value.

Presentation: Calculating an indicator to derive a cost growth benchmark and potential benchmark values

Design Recommendation: Historical vs. Forecasted values

The Board expressed interest in a hybrid approach that would combine long held trends while incorporating a forecast that could predict known future shocks. At the next meeting, the Board will review historical and forecasted values modelled by Bailit Health. The Board did not arrive at a specific recommendation.

Note: The remainder of the presentations scheduled for this meeting were deferred until the next Board meeting.

Next meeting

Wednesday, June 16, 2021

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.

Meeting adjourned at 11:56 a.m.

Topics for today's discussion

TAB 3

Topics for today's discussion

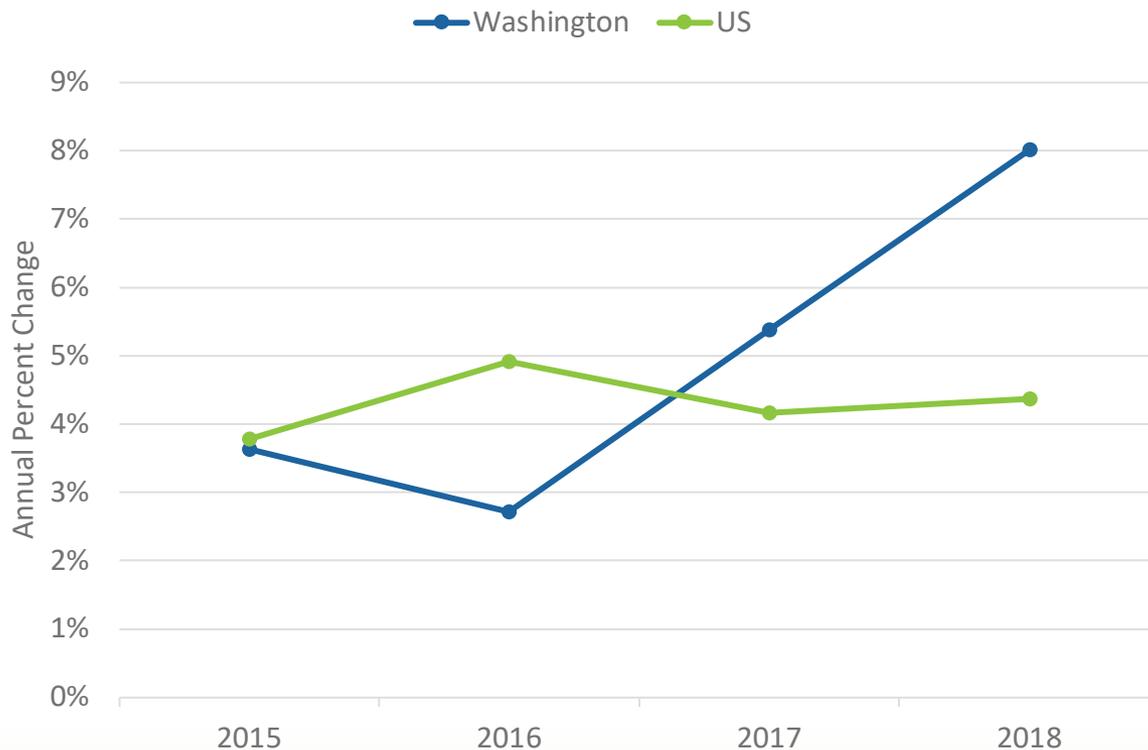
1. Review health care costs and cost growth in Washington.
2. Continue discussion on economic indices to use for setting the benchmark, and on using historical vs. forecasted values.
3. Discuss potential adjustments to the benchmark.
4. Review input from the Advisory Committee of Health Care Providers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

Snapshot of historical health care cost growth in Washington

TAB 4

Snapshot of historical health care cost growth in Washington

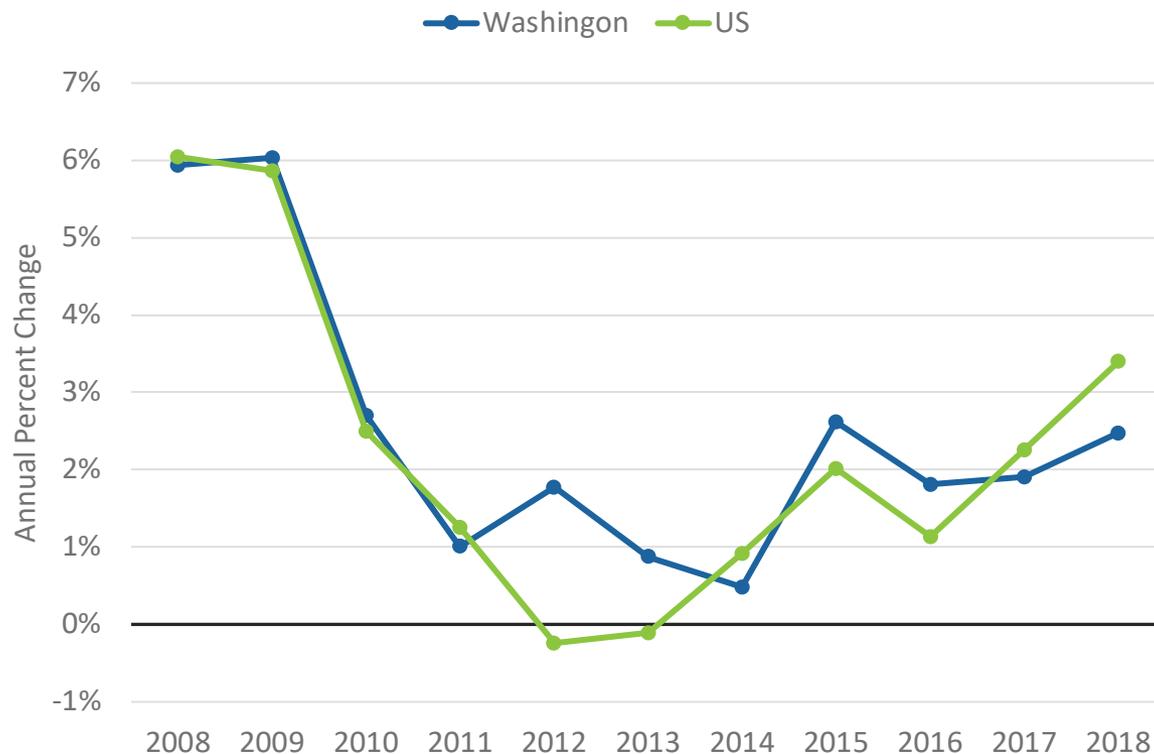
Growth in per person spending on employer-sponsored insurance



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."

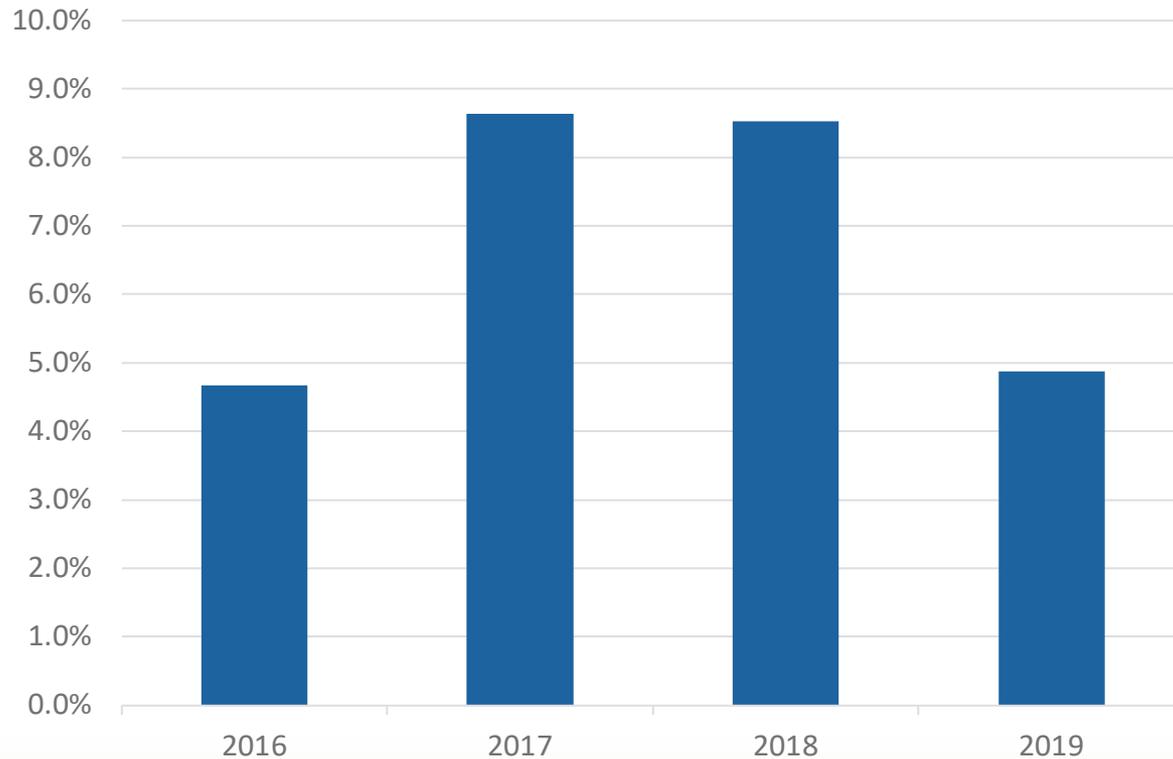
Growth in per person spending on Medicare



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."

Growth in per person spending on Medicaid



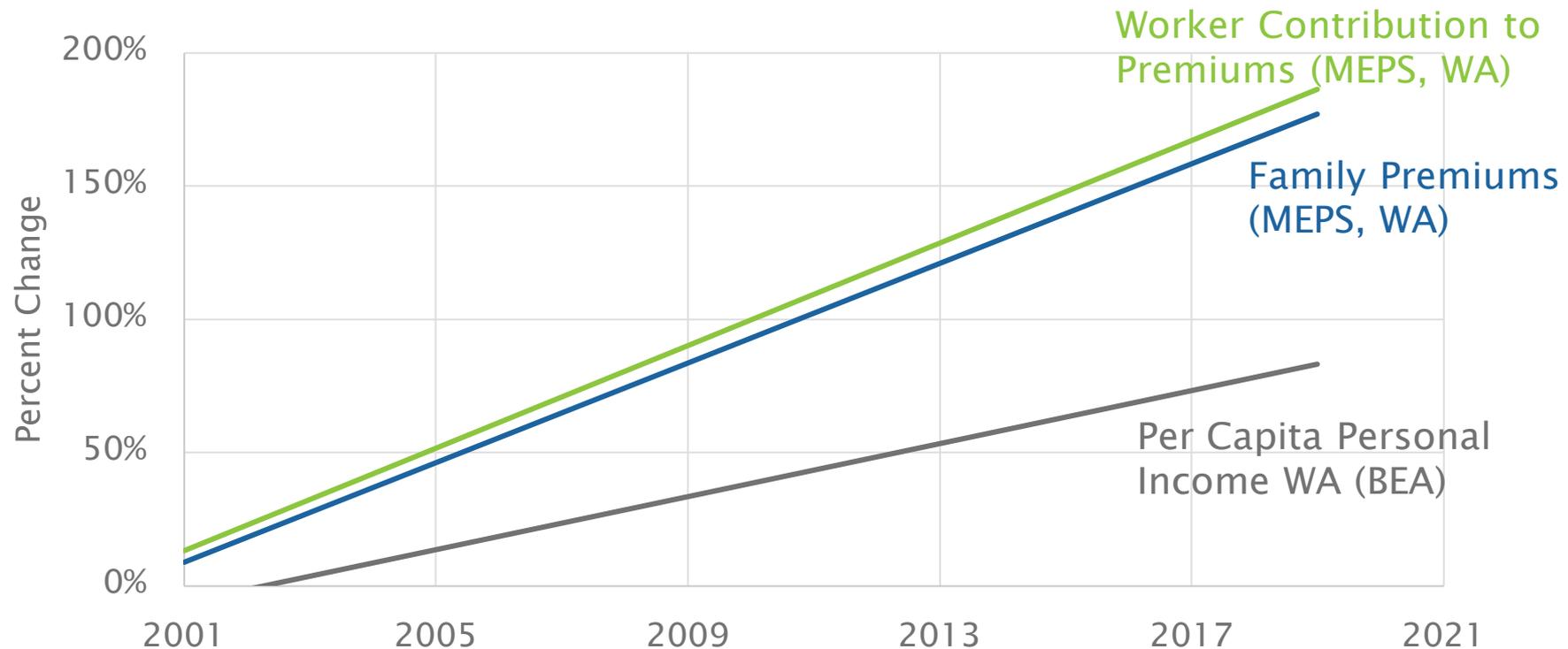
From 2015-2019, Washington's average annual growth in per capita Medicaid spending was 6.7%.

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

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%

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.



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

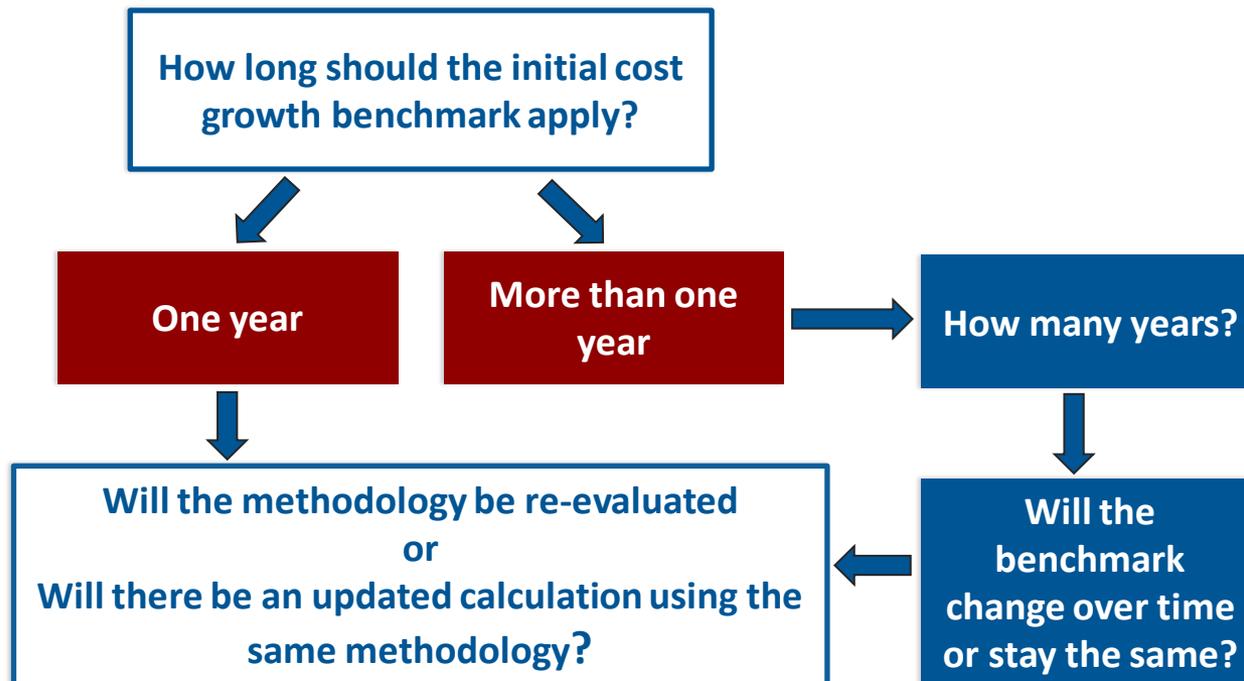
TAB 6

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.

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



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?

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.



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

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.

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?

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