

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.