Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

November 7, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2:00 – 5:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **Health Care Cost Transparency Board webpage**.

Members present

Sue Birch, Chair
Jane Beyer
Eileen Cody
Lois Cook
Bianca Frogner
Mark Siegel
Ingrid Ulrey
Kim Wallace
Carol Wilmes
Greg Marchand

Members absent

Jodi Joyce
Margaret Stanley
Edwin Wong

Call to order

Sue Birch, Chair, called the meeting of the Health Care Cost Transparency Board (Cost Board) to order at 2:02 p.m.

Agenda items

Welcome and Roll Call

Chair Sue Birch welcomed members of the Cost Board, gave an overview of the agenda, and shared updates about a recent University of Washington meeting about health care trends in Washington and nationally with major journal articles. Chair Birch then proceeded to do a roll call.

Approval of September Meeting Summary

A Cost Board member asked to have the word Medicare removed from “without facility fee… Medicare” and be replaced with MultiCare.

Another board member noted that the Advisory Committee on Data Issues meeting summary was included in the meeting packet.

The Cost Board **voted to adopt** the September 19, 2024, meeting summary.

Public Comment

Chair Sue Birch called for comments from the public.

Jeb Shepard representing the Washington Medical Association congratulated the Cost Board and Health Care Authority for distributing the benchmark reports and completing the annual legislative report. Jeb highlighted that Medicare data is incomplete, covering only 30-35% of the total Medicare population and excluding significant Medicare Advantage partners. Jeb added that there is a need for a process to allow physician groups to verify data accuracy, that the process to verify data is currently burdensome, and encouraged a more robust collaborative system. Jeb recommended including context for cost data indicating that costs attributed to physician groups reflect contracted hospital rates beyond their control. Finally, he advocated for inclusion of utilization data to provide a more comprehensive review.

Katerina LaMarche representing the Washington State Hospital Association. Katerina highlighted the critical role of facility fees in sustaining hospitals by funding staff, supplies, and essential costs. Katerina emphasized that hospitals, especially safety-net providers are already in financial distress due to underpayment from government programs like Medicare and Medicaid for outpatient care. Katerina indicated that reducing or eliminating facility fees could severely impact patient access to care particularly in rural areas. Katerina requested that the Cost Board carefully vet any recommendations regarding facility fees to fully understand their impact on access and services for vulnerable populations.

Zocia Stanley Vice President and Associate General Counsel of the Washington State Hospital Association. Zocia provided comments regarding the Cost Board’s discussion and vote regarding business oversight. She mentioned that it is important to consider Washington’s specific data and laws. She said that the state already requires pre-transaction notice for health care transactions involving seven or more providers with a 60-day review period by the Attorney General’s Office. Zocia also mentioned that Washington’s corporate practice of medicine doctrine exists in case law rather than statute and that hospitals already report ownership and control through annual reporting. She indicated the National Academy for State Health Policy model legislation doesn’t align with these existing reporting practices. Lastly, Zocia advised the Cost Board to account for Washington’s existing laws and frameworks in their decision-making process.

Best Practices Report

Gary Cohen and Jeanene Smith, Health Management Associates

Presenters discussed the State Health Care Cost Growth Programs' Infrastructure: Study of Best Practices report requested by the Washington State Legislature. The study focused on program structures, scopes, financing and staffing in eight states with active cost growth programs. The eight states studied were Massachusetts, Delaware, Oregon, Connecticut, Washington, New Jersey, Rhode Island and California. Some of the common features of the programs were: Authority to collect and use data to monitor health system spending trends, growth target against which to measure spending trends, spending measurement to collect and track health care expenditures, data and analytic capacity to support data analysis, reporting and use cases among others.

The presenters also offered a breakdown of some examples such as Massachusetts, which is the oldest program established in 2012 operating through an independent Health Policy Commission. Some of their program components are comprehensive data collection, and progressive enforcement including performance improvement plans. On the other hand, Oregon combines growth targets and markets within the Oregon Health Authority focused on affordability with hospital payments caps tied to Medicare rates. Rhode Island for example,

uses insurance commissioner oversight with a voluntary compact of stakeholders and it caps hospital price increases based on Medicare price index and inflation. Finally, California, recently launched their program in 2022, with a focus on growth, market oversight and value- based payment. Additionally, they have significant funding with plans to transition from consultants to permanent staff. A full report with all the insights on this study is included in the meeting packet as well as this year's legislative report.

Introduction: Business Oversight of Mergers and Acquisitions

Liz Arjun, Gary Cohen, and Jeanene Smith, Health Management Associates

Jeanene reminded the Cost Board that the purpose of the board is to develop benchmarks and understanding the underlying drivers of growing health care costs in response to the growing impact on health care consumers, employers and the state budget. Jeanene showed a breakdown of strategies which included long-term which would target health care costs, medium term which would look at consumer health care affordability and short-term actions focused on mitigating consumer medical debt.

Regarding consolidation and oversight what stood out was that consolidation both horizonal and vertical has been linked to higher prices and increased medical debt. Also, private equity investments in health care raise concerns about increased costs and potentially harmful impacts on care quality. Data from Washington state shows significant consolidation across the health care market, prompting concerns about reduced competition and higher costs. Another topic discussed this year was transparency and facility fees, the focus on this topic is about improving -consumer affordability by addressing the lack of transparency in health care pricing and facility fees.

The presenters shared that Washington's health care market is highly consolidated, with ongoing mergers and acquisitions. They mentioned that consolidation and private equity involvement have contributed to rising health care prices and medical debt.

The Cost Board's discussions and proposed strategies highlight the critical need to balance health care affordability with robust market oversight to prevent unchecked consolidation and its negative impact on costs, quality and consumer access.

National Academy for State Health Policy (NASHP) Model Policy to Address Consolidation and Closures in Health Care

Maureen Hensley-Quinn, MPA, NASHP
Hayden Rooke-Ley, JD, Brown University School of Public Health

NASHP presented a model policy to help states improve oversight and regulation in three areas. The first is health care transaction oversight, which strengthens the requirements for reviewing, approving, or denying health care mergers and acquisitions, especially those involving private equity or large-scale consolidations. Also, corporate practice of medicine which focuses on preventing management services organizations and private equity from exerting undue control over physician practices.

Ownership and transparency require annual or transactional reporting of ownership changes, covering various entities like hospitals, insurers, and long-term care facilities. States like Oregon, Massachusetts, and California have implemented transaction oversight models and shared feedback on best practices. The focus is on enhancing state agencies' authority to monitor transactions, assess long term impacts, and ensure transparency in health care ownership.

Health care market consolidation and private equity investments often lead to reduced access, higher costs and reduced quality of care. Private equity often employs strategies like management services organizations to bypass corporate practice of medicine laws. The NASHP model has transaction oversight which includes mandatory notification, review, and monitoring of health care transactions. Corporate practice of medicine reforms prohibit restrictive contracting and ensure that health care practices retain clinical autonomy. Ownership transparency enhances reporting requirements to help states understand the health care market better.

Washington state has made strides in health care market data collection, making it potentially well-positioned to adopt these reforms incrementally. The Cost Board was encouraged to evaluate the feasibility and scope of such legislative changes considering existing state resources and market dynamics.

Discussion and Recommendations Regarding Business Oversight

Sue Birch, Chair

The Cost Board discussed recommendations for addressing health care consolidation, improving oversight and harmonizing data collection and policy implementation efforts. Health market consolidation increases prices, raises consumer costs and jeopardizes access. A way to solve this is to strengthen state oversight of mergers and acquisitions and harmonize reporting. The NASHP model was proposed as a guiding framework for state oversight of health care mergers to improve transparency and ensure public benefit.

A recommendation was discussed to mandate health care entities to report ownership structures, including private equity involvement. This would improve transparency and aid policy decisions. The need for better coordination of data collection and reporting among state agencies was emphasized. It was suggested to consolidate reporting efforts into a single, streamlined process for efficiency and better outcomes.

The Cost Board **approved the following recommendations**:

> Recommendation 1: Given the evidence that market consolidation increases prices, raises consumer costs, and jeopardizes access the Board proposes the legislature use the "NASHP Model Act for State Oversight of Proposed Health Care Mergers" to draft legislation to increase Washington state's oversight of mergers and acquisitions.
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> Recommendation 2: The legislature should require all carriers, health systems, hospitals, and other health care facilities such as ambulatory surgery and dialysis centers to report ownership structures and legal affiliations. Reporting should include any acquisition or ownership stake by a private equity firm and be designed to provide transparency into any private equity or corporate affiliations with a system, facility or provider.

Concerns were raised about limited resources for new initiatives leading to a focus on practical, phased approaches rather than large, resource intensive recommendations. Oregon's model of using existing resources to create an integrated data and policy framework was highlighted as potential example. Reference based pricing was noted as an immediate opportunity to apply downward pressure on health care costs. It was suggested as a key area to highlight in the report to the legislature.

The Cost Board discussed aligning recommendations with legislative priorities and the upcoming legislative session to maximize impact. It was also suggested to use the NASHP model to guide Washington's oversight of health care mergers and acquisitions adapting it to fit local needs and limitations. Requiring health care entities to report ownership, private equity involvement, and legal affiliations, will make it essential to include specific reporting elements such as National Provider Identifier and Tax Identification number for better data consistency.

Furthermore, it was suggested to coordinate data collection and analysis across agencies and establish a consolidated office or framework in the future to enhance data sharing and policy alignment. The Cost Board is asking the Data Issues Advisory committee to review reporting gaps, analyze existing data sources and align them with the NASHP model recommendations.

Staff and consultants will integrate these recommendations into the legislative report, ensuring they are actionable and aligned with current resources. The Advisory Committee on Data Issues will begin cross-referencing existing data and identifying opportunity gaps. The Cost Board will consider how to effectively communicate the need for better agency coordination and harmonization in the legislative report.

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Analytic Support Initiative (ASI) Report

Joe Dieleman, PhD, Institute for Health Metrics and Evaluation (IHME)

Joe Dieleman gave an update on health care spending trends in the state through 2022 using the All-Payer Claims Data Base (APCD). Joe discussed the following topics: Washington ranks low nationally in per capita health care spending, however, the growth rate in spending (2010-2022) is slightly above the median at approximately 4.5% annually. Total health care spending in 2022 is estimated at $60.1 billion. Private insurance accounts for approximately 50% (26.4B), Medicare $16B, Medicaid $10.4B and ambulatory care makes up about 50% of spending. Some of the drivers are service, price and intensity. Utilization is declining especially for inpatient and ambulatory care.

Medicare has the highest per beneficiary growth driven by an aging population and more complex care needs. Home health and nursing facilities are seeing high growth, often aligned with care shifts from hospitals. High spending and growth are concentrated in King, Lewis and Pierce counties. The fast growth is in Chelan and the San Juan Islands. Regional disparities exist even after adjusting for population and beneficiary metrics.

The top spending categories are musculoskeletal disorders, cancers, and cardiovascular diseases at about $6-7B each in 2022. Behavioral health conditions show the fastest growth with mental health disorders at about 6.9% and substance use disorders at about 9.4%. A significant portion of spending in ambulatory care includes drugs administered in clinical settings, for example cancer treatments.

Board members emphasized price and intensity as the primary drivers of spending increases, citing Gerard Anderson's "It's the Prices, Stupid" argument as still relevant[1]. Another topic of discussion was how utilization per capita is decreasing, countering assumptions that increased health care use is driving costs. Board members also discussed distinguishing between necessary growth areas such as home health, versus excessive pricing. Proposed legislation such as reference-based pricing was mentioned as expected to address pricing disparities and inform targeted interventions. There were recommendations to analyze spending alongside health status indicators such as life expectancy and population age to uncover disparities and inform targeted interventions.

Board members also questioned how spending trends vary across demographics, such as older populations and Medicaid beneficiaries in regions with high birth rates. Board members also proposed using models to project the impact of cost-control strategies on overall expenditure growth. There was also a discussion about the need for insights into proportional impacts of commercial versus public payer spending.

As final discussion suggested exploring overlays of health care spending with population health metrics and demographics, also model potential scenarios for reducing growth in health care spending with a focus on pricing reforms.

<u>Reference:</u>

[1] "It's The Prices, Stupid: Why the United States is So Different from Other Countries", Health Affairs May/June 2003, Vol. 22, No.3.

Facility Fees

Gary Cohen and Jeanene Smith, Health Management Associates

The board revisited the topic of facility fees, recapping prior discussions and decisions. Facility fees charged by hospitals and clinics in addition to service fees, have increased with health care consolidation, but lack comprehensive reporting or transparency on their consumer impact. Current reporting requirements in Washington capture only a subset of entities charging facility fees and lack detailed data on services and consumer impact. There are concerns about facility fee prohibitions or caps leading to cost-shifting in commercial markets through alternative revenue streams.

2024 Legislative Report

Sue Birch, Chair

There was a high level overview of the draft report which provides a comprehensive summary of the Cost Board's 2024 activities. The following were highlighed during the Cost Board Meeting: Facility fees and primary care expenditure recommendations **have been approved.** Data activities include the benchmark and performance targets, cost driver analysis, primary care spend measurement, hospital spend assesment and Analytic Support Initiative (ASI). Market Oversight was pending consideration.

Comments to the report:

Comments are to be accepted until November 18, and thus integrated into the report.

A Cost Board member suggested adding the recommendations to the executive summary, which would strengthen it for legislative review.

Another comment emphasized framing the report within the broader context of health care cost control.

The Cost Board expressed strong support for the proposed bill to increase affordability by capping prices for public employee benefits (PEBB) enrollees through reference-based pricing. There was a clarification to emphasize a shift in expenditures toward primary care without increasing overall health care spending. There were also recommendations to include voted-on actions in the summary for clear and concise communication to the legislature.

The Cost Board **approved the draft legislative report**, indicating the need to incorporate the discussed changes, with final adjustments delegated to staff.

Next Steps:

Staff will refine the executive summary and align it with the Cost Board's priorities, ensuring the report communicates key recommendations effectively.

The finalized report will be submitted to the governor's office and legislature by December, with further public comments and Cost Board edits addressed beforehand.

At future meetings, the Cost Board will revist discussions on key issues, such as facility fee prohibitions to ensure comprehensive exploration and concensus.

Adjournment

The next meeting is Thursday, December 12, 2024, at 1:30 p.m. Meeting adjourned at 5:00 p.m.