Universal Health Care Commission's
Finance Technical Advisory Committee meeting

January 16, 2025

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

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

Agenda

Thursday, January 16, 2025
Zoom meeting 2:00 – 4:30 PM

FTAC members:		
☐ Pam MacEwan, FTAC Liaison	☐ Eddy Rauser	☐ Kai Yeung
☐ Christine Eibner	☐ Esther Lucero	☐ Robert Murray
☐ David DiGiuseppe	☐ Ian Doyle	☐ Roger Gantz

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome & call to order	1	Pam MacEwan, FTAC Liaison
2:05 – 2:08 (3 min)	Roll call	1	Mary Franzen, HCA
2:08 – 2:10 (2 min)	Approval of meeting summary from 11/14/2024	2	Pam MacEwan, FTAC Liaison
2:10 – 2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25 – 2:35 (10 min)	Progress update 2025 Workplan & Milliman analysis	4	Mary Franzen, HCA Liz Arjun, HMA
2:35 – 2:45 (10 min)	Health Care Cost Transparency Board benchmark report update	5	Sheryll Namingit, HCA
2:45 – 2:55 (10 min)	Universal Health Care Commission update	6	Pam MacEwan, FTAC Liaison
2:55 – 3:40 (45 min)	Hospital global budgeting, presentation and Q&A	7	Bob Murray, FTAC member
3:40 – 3:50 (10 min)	BREAK		
3:50 – 4:20 (30 min)	Cost containment discussion and future direction	8	Todd Bratton, HCA Liz Arjun, HMA
4:20 – 4:30 (10 min)	Benefits and services prioritization model	9	Liz Arjun, HMA
4:30	Adjournment		

Tab 2

Washington State Health Care Authority

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

November 14, 2024
Virtual meeting held electronically (Zoom)
2–4:30 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 **FTAC webpage**.

Members present

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

Members absent

Esther Lucero
Ian Doyle

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

Committee members voted by consensus to adopt the September 2024 meeting summary.

Public comment

Raleigh Watts commented on the topic of prior authorization and shared a personal story and his conclusion that prior authorization, required by a change in carriers, was responsible for his partner's medical emergency and corresponding medical bills. Watts urged FTAC to address prior authorization with patients in mind.

Kathryn Lewandowski with Whole Washington shared concerns about the results and potential impacts of the federal election and hopes that the work being done in Washington provides stability for patients and providers. Lewandowski requested FTAC review of Whole Washington's updated finance proposal.

Workplan updates & goals for today:

Liz Arjun, Health Management Associates (HMA) gave a brief recap of the Commission's workplan and progress on universal design and transitional solutions. From the Commission's workplan, the topic of prior authorization has been sent to FTAC for input on universal design and transitional solutions.

Commission Update:

Pam MacEwan, FTAC Liaison to the Commission, provided an update from the last Commission meeting in October. Topics of discussion at the meeting included administrative simplification and engaging FTAC on prior authorization. The Commission also voted to support Apple Health Expansion efforts, approved the 2024 report to the Legislature, revised and adopted FTAC's cost sharing principles, and were presented an overview of the affordability report from the Office of the Insurance Commissioner (OIC). Commissioners expressed interest in learning more about reference-based pricing and cost growth targets after discussion of the OIC report

The Commission reviewed and revised cost sharing principles that were developed and proposed by FTAC. In September, FTAC discussed available information and considerations on cost sharing. HCA staff summarized the discussion into a set of principles and revised with individual FTAC members via email. The draft principles were then presented to the Commission at their October meeting, and they adopted the principles with revisions. The principles are to be used as guidance in modeling benefits and services alternatives.

On the horizon, the Commission will continue to address Phase 1 design topics of benefits and services and cost containment. There is also interest in exploring transitional solutions around small business affordability and starting to explore provider reimbursement, primary care, and access.

Milliman Affordability Analysis Update:

Peter Hallum provided an update on the analysis, having met with the FTAC liaisons on three occasions as the parameters were developed. FTAC liaisons have provided input for various modeling scenarios, reimbursement rates, population clarifications, and provider network assumptions. Milliman is using a lot of publicly available data to provide a transparent approach to modeling. The required data-use agreement between Milliman and HCA has taken longer than originally anticipated, but is nearing approval. The data-use agreement is necessary to move forward with the analysis as planned. Timelines have been extended for Milliman's reports.

The model populations and cost sharing scenarios were reviewed for the selected model plans, and FTAC was offered a preview of how the data may be presented in the final analysis. Please note that any data included in Milliman's November presentation do not reflect actual analysis or results and were intended for illustrative purposes only. Next steps include completing the data request and analysis and compiling drafts of the report for internal review.

FTAC members asked several questions about the eventual presentation of the data, including opportunities for comparative analysis to status quo, sensitivity testing for medically managed plans, estimates and their ranges, and potential cost sharing comparisons.

Cost Containment

Liz Arjun provided a background on today's topic of cost containment. In October, the Commission heard results from OIC's Affordability Report to the Legislature. Two cost containment policy options in the OIC report appeared to show significant potential for savings. The Commission expressed interest in learning more about reference-based pricing and the cost growth benchmark.

Washington State Health Care Authority

Reference Based Pricing Presentation plus Q&A:

(For data and references, please start on page 51 of the meeting materials located here.)

FTAC member Robert Murray gave a presentation on rate setting models, including an overview of Oregon's current law which caps prices in their public employee and teachers benefit plan at 200% of Medicare rates (Find Oregon's law here).

Constraining health care costs and improving patient affordability are persistent challenges. Murray noted that state authority may be the best option to address cost issues, as federal anti-trust laws and voluntary efforts with providers and carriers have not effectively constrained cost growth. Countries around the globe utilize effective rate setting systems, and Murray pointed to Oregon's adoption of rate-setting measures alongside its broader efforts to balance the state budget.

Oregon, like Washington, began this effort by setting health care cost growth benchmarks and gathering data to provide rationale for price caps. Setting price caps at 200% of Medicare was considered sufficient to prevent negative impacts on the system. Research has shown hospital marginal costs, on average, to be below this level.

Initially, a misinterpretation of Oregon's law resulted in lower prices moving up to the cap, but Oregon re-enforced previous established rates and prices came down. This was addressed and clarified by administrative rule. Most of the savings were achieved in outpatient services where prices were previously well above 200% of Medicare. According to Murray, the caps produced roughly $100 million in savings in 27 months.

Murray cited benefits of this model: budget savings coverage of 15% total market and administrative simplicity. In addition, it met Oregon's budget requirements.

Murray cited possible negative impacts as well: providers may misinterpret and bring costs up to caps, and fee-for-service reimbursement always has potential for overutilization for purposes of revenue generation. Murray noted the latter does not appear to be the case in Oregon. Finally, providers could opt not to serve public employees in states with price caps, but this has not been the case in Oregon, likely due to the level of the rate caps. Setting prices above marginal hospital costs may alleviate concern from providers.

States may only use this model for public employee benefit programs, including local governments. The state cannot currently set rate caps for other commercial and self-funded plans. Once a state gains experience with setting rates, a similar approach could be applied to out-of-network hospital prices, according to Murray. This could temper provider interest in abandoning the network and might also help constrain prices in network.

Finally, Murray noted that states could take rate-setting approaches further and adopt hospital global budgeting.. Global budgets explicitly constrain cost growth by setting a fixed budget. This approach can constrain costs, as well as provide revenue stability and decrease over-utilization. According to Murray, rigid hospital global budgets may compel providers to move services out of the hospital setting, which could increase costs by essentially billing twice for the service intended to be covered by the global budget. Other countries have experienced issues with fixed global budgets, including possible stinting of care and longer wait-times. A flexible global budget, as adopted in Vermont, may avoid this and other issues. Further details on flexible global budgets for hospitals can be presented in the future.

A regulatory commission would be necessary to apply different models and policies to constrain costs through global budgeting. Ideally, a public utility commission would include volunteer commissioners appointed by the governor and not include hospital representation. This model has been implemented in Maryland, where costs have been constrained to about 3.5% since 2014.

Committee members clarified the following in Q&A:

- Discussed estimates that 140-150% of Medicare rates may be close to break even for hospitals. The National Academy for State Health Policy (NASHP) has provided estimates within this range. The goal should be a generous and gradual rate cap, which does not negatively impact the system.

- Remains to be seen if there is cost shifting or price increases in markets not subjected to price caps. It will be important to monitor cost shifting and volume increases that may occur, but generous rate setting may reduce these issues.
- Oregon rate-caps narrowly passed their legislature, but potentially some of the opposition and concerns have been moderated by early results.
- Bringing in commercial and federal payers into a global budget system requires significantly more resources and oversight than the lower intensity rate setting efforts like reference-based price caps.
- Prior to Oregon's rate cap, nearly all outpatient services were priced well above 200% of Medicare, and around 50% of inpatient services were as well.
- States may not be able to cap rates for some commercial plans subject to the Employee Retirement Income Security Act (ERISA), though Rhode Island has implemented broad rate setting without challenge from the ERISA governed carriers.
- Future potential to use Medicaid or Tricare as a reference, as it has a set of benefits which may be more comparable to commercial plans.
- Actuarial conversions would likely be needed to verify that managed care plan prices are compliant with the rate cap.
- Payment reform can also help shift care into preferred areas such as primary care and behavioral health.
- Discussed Washington's proposed legislation to set rate caps in public and school employees benefit plans, similar to Oregon's law.

Discussion: FTAC and cost containment

Committee members discussed reference-based pricing as a transitional solution and need for addressing cost containment in coordination with designing a unified system. The state has various cost containment efforts under way, including work being done by the Health Care Cost Transparency Board. The Commission and FTAC benefit from being informed of these transitional efforts, as work on unified design continues. FTAC does not have the resources to fully develop a rate setting system for the state but can support statewide efforts when prudent. The Commission will be presented with Washington's proposed legislation in December, and FTAC members were encouraged to attend. FTAC members clarified that discussions and decisions on cost-containment and other topics will not influence the results of Milliman's cost analysis, but will inform the interpretation of the results. Members discussed addressing this topic with Milliman during liaison meetings to inquire whether results could allow for drawing conclusions about rate caps.

FTAC agreed by consensus to support reference-based pricing as a transitional solution and to consider it as one of several potential cost containment strategies in universal design.

Prior Authorization and Discussion:

Mary Franzen from HCA presented an overview of prior authorization information previously presented to the Commission. The Commission's discussion originated from the topic of administrative simplification and was covered at several meetings in 2024. In June, the Commission heard from a panel of providers, and 3 of 4 described prior authorization as the #1 priority for administrative simplification. In August, the Commission was presented with research from KFF on prior authorization and state efforts. They also were presented with information on Washington's prior authorization modernization efforts from OIC. In October, the Commission discussed potential recommendations on gold carding and standardized forms, but ultimately decided to pause on transitional solutions and ask FTAC for feedback.

Prior to this meeting, FTAC members were provided with Commission meeting materials covering prior authorization and these materials were briefly reviewed. This material includes information from KFF and OIC presentations. The OIC now has four years of data to look for patterns. Prescription drug reporting is a new requirement and will provide more data going forward.

FTAC prior authorization discussion included the following thoughts:

- Gold carding might have potential to be a transitional solution, but standardized forms could be more complicated
- Universal system may see reduced need, potential for smaller list of items (Medicare-like)
- A maturing unified system may provide data opportunities and potential for automation
- Fee-for-service system provides opportunity for over-utilization – struggle between this and carrier incentive to moderate spending. In a universal design, perhaps medical management and utilization could be moderated by entity without financial interest.
- Potential to identify outlier provider entities within a relative system. Could move to exempt some services and monitor whether utilization data shows spikes or waves.
- Evidence of prior authorization having negative impacts on patients, and also evidence of overuse having negative health impacts.
- Potential for unified system to eliminate specific "pinch points" like when switching carriers, etc.
- Prior authorization reform can be situated alongside payment model reform, as shift from fee for service would limit over-utilization opportunities.

FTAC will continue to discuss prior authorization and consider options for universal design. FTAC members are encouraged to share thoughts with HCA staff between meetings as this work moves forward.

Adjournment

The meeting adjourned at 4:30 p.m.

Next meeting

January 16, 2025
Meeting to be held on Zoom
2–4:30 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

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Universal Health Care Commission's

Finance Technical Advisory Committee

Written Comments

Received from October 31, 2024

Written Comments Submitted by Email

Additional Comments Received at the November FTAC Meeting

- The recording is available here: https://www.youtube.com/watch?v=1-Tb9XirgeM&feature=youtu.be

From: jmhilde
To: HCA Universal FTAC
Subject: Public comment submission to FTAC
Date: Friday, November 8, 2024 12:40:50 PM

External Email

Thank you, all, for your dedication and hard work! It's imperative, especially in light of the recent presidential election, that Washington State protect its citizens by providing a reliable, affordable health care system. The sooner, the better! :-)

Jean Hilde
Shoreline, WA, USA

From: Kathryn Lewandowsky
To: HCA Universal FTAC
Subject: Full Written Comments for FTAC
Date: Thursday, November 14, 2024 2:17:39 PM

External Email

Here are Hello members of the FTAC committee. My name is Kathryn Lewandowsky, I am a Retired Registered Nurse and Vice Chair of Whole Washington.

We at Whole Washington of course have been very saddened and perplexed at the results of the recent election results and are very fearful at what the possible economic repercussions of upcoming federal administrative changes may have on the personal economic health of Washington's residents. Although there is a lot of angst, we also have a lot of hope that through our shared work we can deliver some real economic relief into the pockets of our residents and also help to create a stable source of funding for our current healthcare providers around the state.

We have also taken very seriously the issues and problems we have heard around the state from business owners and residents alike. We have done a lot of brainstorming to try and resolve their issues with providing healthcare to their employees in the most equitable and affordable way possible and we would like to ask for your expertise in evaluating the funding scheme we have recently revised.

The funding scheme consists of 3 legs that include;

1. Business Employee Healthcare Assessment- a graduated Healthcare assessment of 10.5%, 6.5% and 4.5% of each employee's payroll of which 2% of that could be passed onto the employee; with the rate based on the net revenue of the business.

2. A Sole Proprietorship self employment contribution of 2% of net revenues.

3.

And a Capital Gains tax of 8.5% after the first $100,000 of capital gains earned.

a. This capital gains tax does include some additional exemptions from our previous WHT capital gains exemptions that I will include in my written comments after this meeting.

I apologize for not having this completed in time for it to be included in your packet. But I will submit it to you today for your consideration.

We are hopeful that you might be able to take on this task of evaluating this revised funding scheme and offer your best recommendations for improvement if necessary.

Thank you for your time and we look forward to hearing your response in the coming months.

2025 Legislative bill language proposed changes include;

Sec. 202 (1) (b) The standard assessment rate shall be equal to 10.5 percent of an employee's aggregate adjusted quarterly payroll or wages and less the employer's health care expenditures for that employee during the same reporting period.

(c) A minibusiness operating within the state of Washington shall pay an assessment rate of 6.5 percent of an employee's aggregate adjusted quarterly payroll or wages and

(d) a microbusiness operating within the state of Washington shall pay an assessment rate of 4.5 percent of an employee's aggregate adjusted quarterly payroll or wages and less the employer's health care expenditures for that employee during the same reporting period less the employer's health care expenditures for that employee during the same reporting period.

(e) An employer may deduct up to two percent of the required health care expenditure

from an employee's wages.

(f) An employer may elect to pay all or any portion of the employee deduction.

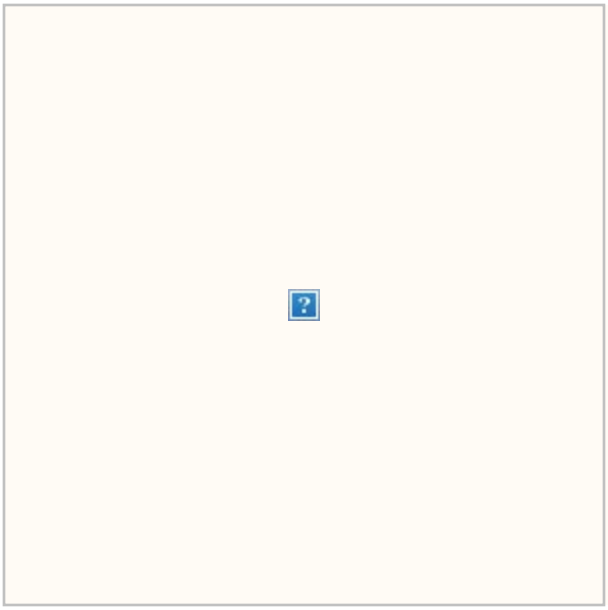
Sole Proprietorship self employment contribution

Sec. 203 (3) Beginning January 1, 2028, residents operating as sole proprietors must pay a self-employment contribution in annual installments to the department of two percent on adjusted net earnings from self-employment.

Long Term Capital Gains Excise Tax

Sec. 302. LONG-TERM CAPITAL GAINS TAX. (1) Beginning January 1, 2026, an excise tax is imposed on all individuals for the privilege of selling or exchanging long-term capital assets, or receiving Washington capital gains. The tax equals eight and one-half percent multiplied by the individual's Washington capital gains.

Kathryn Lewandowsky, BSN, RN
Whole Washington- Board Vice-Chair
One Payer States- Treasurer



SB 5335 establishes the Washington Health Trust and outlines funding, benefits coverage, provider reimbursements, and implementation. Whole Washington works to build legislative support for the Washington Health Trust, requiring majority support in the House, Senate, and from the Governor. Read more about SB 5335. We also work through the Ballot Initiative process when our legislative process fails us.

Together we can all have healthcare free at the point of service; that is comprehensive with no copays or deductibles and that puts billions of dollars of savings into the pockets of regular people just like you and me!. Healthcare that will take care of all of our people from Cradle to Grave! Please go to WholeWashington.org and donate today! It will take all of us demanding these basic human rights from the global elite! Together we can do this!

"Never believe that a few caring people can't change the world, For indeed that's all who ever have" Margaret Mead

From: Cris
To: HCA Universal HCC; HCA Universal FTAC
Subject: Public comment
Date: Saturday, November 23, 2024 4:46:18 PM

External Email

UHCC and FTAC:

I'm Cris Currie, retired RN from Spokane and Health Care for All-WA policy committee member.

Avoiding unnecessary health care is a complex issue that insurance companies have historically manipulated to their advantage. By erecting barriers to getting care, such as prior authorization and frequent denials, copayments and deductibles, limited provider networks, and value-based payments, they have reduced utilization in the U.S. to one of the lowest rates in the developed world. While denying care has dramatically increased insurance company profits, it has also contributed to some of the worst health outcomes in the developed world. The theory has always been that doctors cannot be trusted to order only what is medically necessary, so there must be an independent third party to oversee their decisions and deny care when it is unnecessary. Clearly, this strategy has been a colossal failure, such that the "treatment" is worse than the "disease."

Numerous studies have been done on unnecessary care, particularly diagnostic testing. Many suggest that about one-third to one-half of the testing is unnecessary, and one survey found that most physicians still see it as a serious problem. However, it is not always easy to decide what is necessary and what isn't. For example, simply having a negative test result does not mean it was unnecessary if it ruled out some serious conditions, especially if it was part of a triage protocol. Having a surgery that didn't help might not have been unnecessary if it was a last resort for treating a debilitating condition for which all other remedies had failed. However, prescribing an antibiotic for a viral infection because the patient demands a medical treatment is definitely unnecessary, expensive and counterproductive.

The Choosing Wisely Campaign sponsored by the American Board of Internal Medicine Foundation, was an 11 year program, ending in 2023, that sought to promote conversations between clinicians and patients in choosing care that is supported by evidence, does not duplicate other tests or procedures already received, is free from harm, and is truly necessary. According to its website, "Choosing Wisely" generated countless conversations in the exam room and across the health system, stimulated thousands of journal articles, inspired more than two dozen similar campaigns in other countries, and influenced many projects that explored ways to reduce overuse and unnecessary services and improve patient outcomes." It also resulted in lists of over 700 likely unnecessary tests and procedures for very specific situations by over 80 specialty medical societies. A brochure was also produced for patients with five questions they should ask before agreeing to a test or procedure.

Of course, conversations in the exam room will not be very effective if the physician is not educated as to the latest evidence-based recommendations. In a very interesting 2021 study in Poland, researchers selected 617 physicians who generated above average referrals to

diagnostic tests and sent them printed practice recommendations for each of the studied diagnoses. This intervention decreased the use of MRI and CT scans by 26% in neurology and 42% in orthopedics without decreasing patient satisfaction. It decreased the number of laboratory tests by 68%, especially in gynecology. These results are comparable to other studies where education was emphasized showing a 25-55% decrease in testing. This study was only possible because in Poland, an electronic medical records system is used that easily shows all medical events undertaken by doctors and the results, so comparisons can be made between individual physicians. Apparently, faculty at UVMC have figured out how to compare broad data with individual use as well.

But what are some other reasons why unnecessary testing is ordered? According to one survey of physicians, the top reason was malpractice concerns, followed by a need to be sure everything was considered, and wanting to please patients who insist on the test. Not having enough time with patients was also frequently mentioned. Other studies list such extrinsic influences as intense industry marketing, pressure to utilize technological advances and the promotion of questionable screening programs, competing corporate priorities particularly with respect to time spent with patients, ambiguous practice guidelines, discomfort with uncertainty, and inadequate access to medical records.

So might this research help inform the design of a system which could minimize unnecessary care without compromising the delivery of needed care, and not tied to financial outcomes or lead to moral injury? I believe a single-payer system definitely has this capability.

A single-payer has the authority to establish and enforce uniform regulations for all providers participating in the system. Therefore, there would be no need to get resistant, profit-first providers and carriers to agree on a cooperative, patient-first approach. It could restructure or eliminate the administrative burden of preauthorization requirements which second-guess practitioner judgment; it could severely limit denials of care, establish a completely open network, eliminate or greatly reduce cost sharing requirements, and make sure providers incur no unreimbursed patient contact by paying them based on their time, training, and expertise rather than the "value" of each patient's diagnosis or outcome. It could design an electronic medical record that is truly interoperable and reflects genuine clinical needs rather than corporate carrier needs, so that every patient experience can contribute to the research on evidence-based practice, and every practitioner's ordering habits can be compared. It could then design a uniform system of recommending and disseminating that information to all practitioners as well as patients, including warnings embedded in the EMR. It could even offer "decision aids" to help promote efficient exam room discussions. The EMR could also be designed to better keep patient medical histories up to date and easily accessed via an electronic ID card. A single-payer could eliminate the transparency problems of proprietary financial data maintained by hospitals and carriers, thereby making it possible to eliminate the financial incentives to over-testing. And finally, a single-payer system would greatly reduce claims for special compensatory damages in malpractice litigation since a defendant would no longer need to cover present or future medical bills for the plaintiff.

Each of these measures to reduce unnecessary medical care is far more effective than anything the private insurance industry has ever devised, but implementing them all will require a major shift to a unified, single-payer financial system.

Tab 4

Washington State Health Care Authority

Finance Technical Advisory Committee 2025 planning and updates

Universal Health Care Commission charge

As directed by the Legislature, the Commission must:

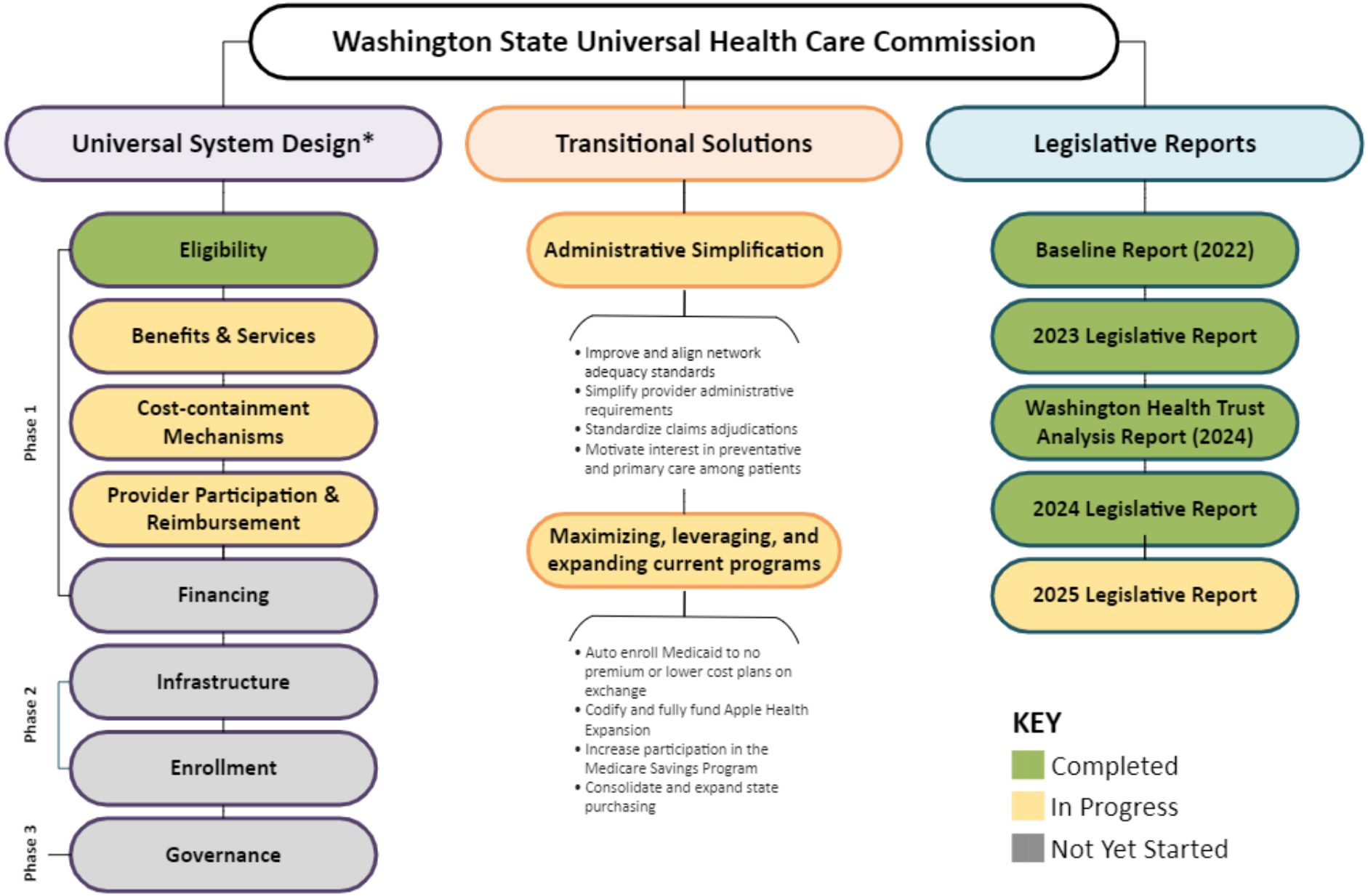
Transitional Solutions

"…create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available." (RCW 41.05.840)

Universal System Design

Milestone Tracker

Last updated: 11/21/2024



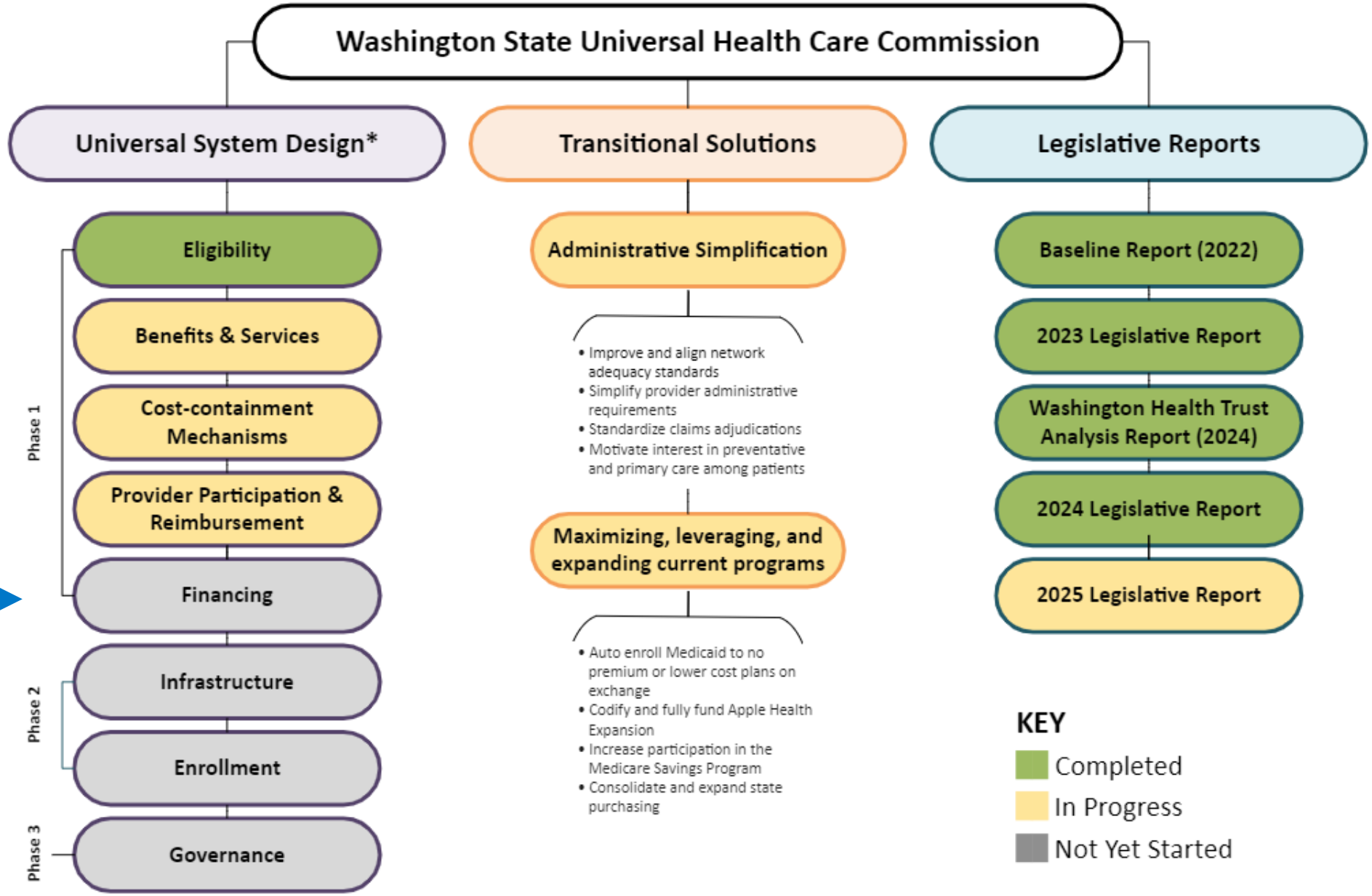
**Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.*

2025 proposed goals: universal design

- Complete analysis of benefits and services and determine prioritization
- Develop set of recommendations for cost containment mechanisms
- Develop set of recommendations for provider reimbursement and participation

Milestone Tracker

Last updated: 11/21/2024



early 2026 →

**Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.*

Commission feedback in December

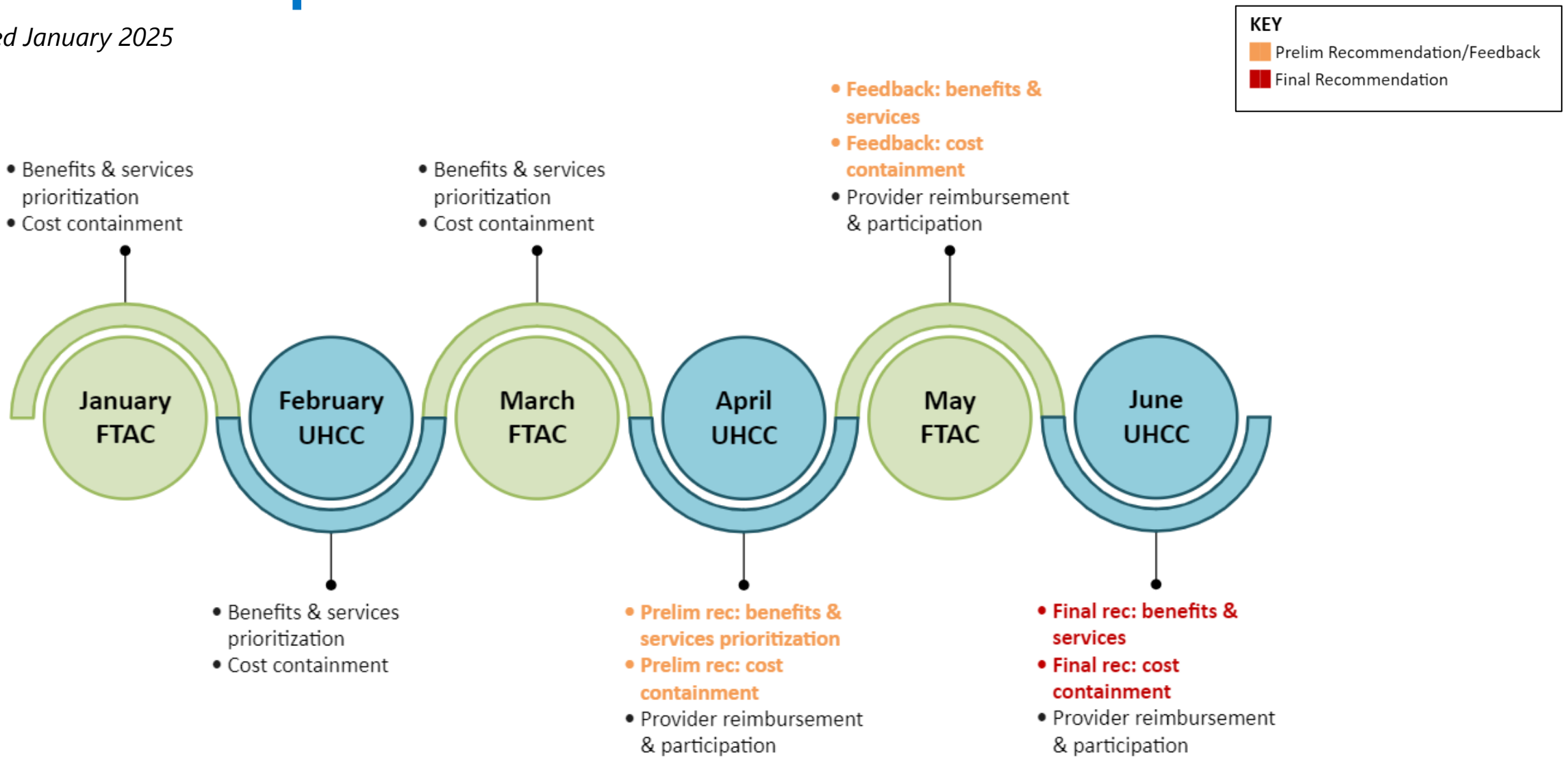
- Endorsed three goals for universal design
- Expressed preference for timing of topics
  - Universal design
    January – June 2025
  - Transitional solutions
    July – December 2025

2025 FTAC meeting schedule

- January 16
- March 13
- May 15
- July 17
- September 18
- November 6

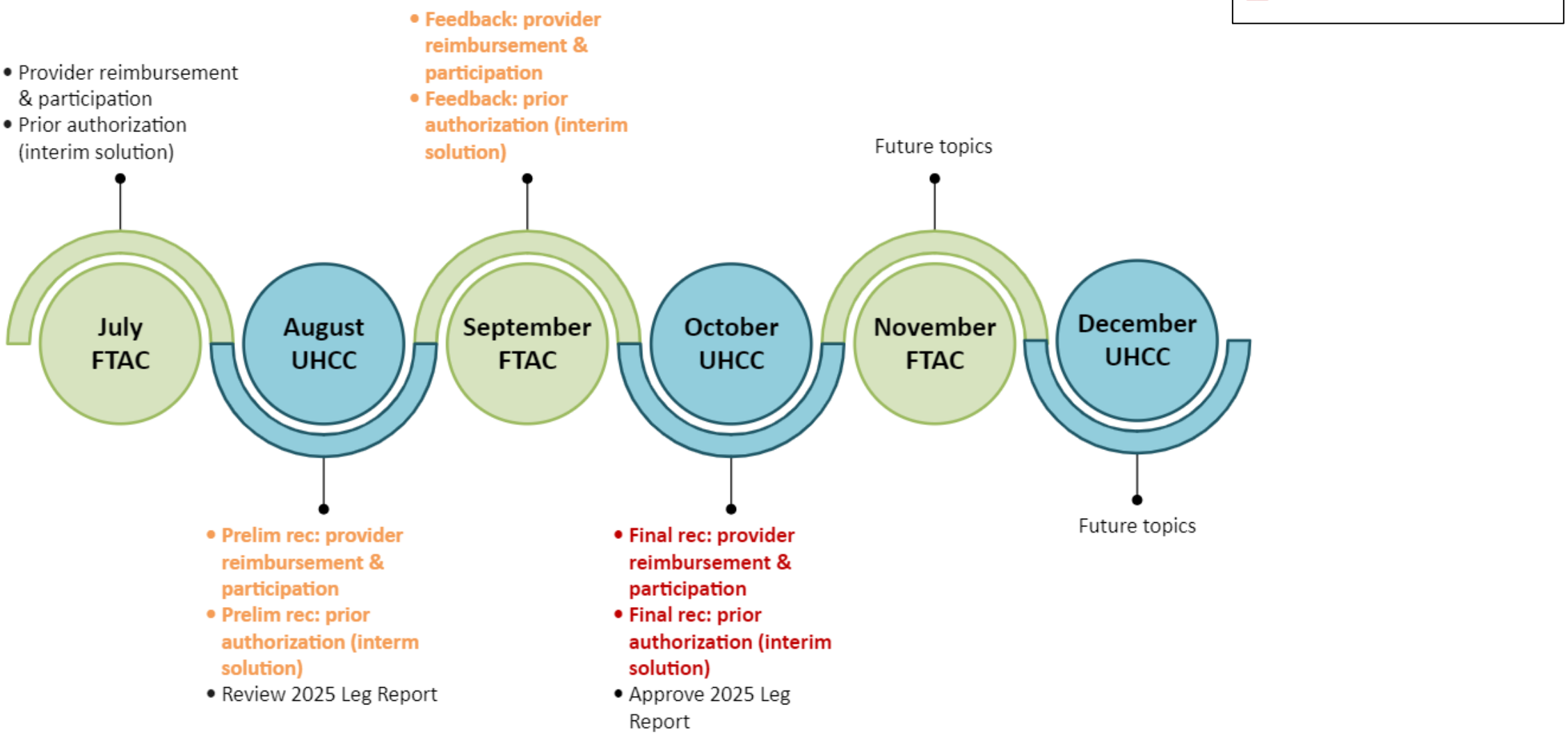
2025 workplan

Updated January 2025



2025 workplan

Updated January 2025



Milliman analysis

- Ongoing meetings with FTAC liaisons
- Revised timeline of analysis and reports
  - Interim report to HCA only in February
  - Final report to FTAC in March

Tab 5

Washington State Health Care Authority

Health Care Cost Growth Trends in Washington

January 16, 2025

Washington State Health Care Authority

Background

- During November FTAC meeting, discussion of cost containment
  - Reference-based pricing
  - Health care cost benchmarks
- Washington's Health Care Cost Transparency Board held a public hearing on Dec. 12 to discuss its upcoming benchmark report
- Sheryll Namingit, Health Economics Research Manager, HCA

Outline

- Background on total health care spending data & health care cost growth benchmark
- Highlights
- 2022 spending
  - Per-member spending cost growth vs. benchmark

Cost Board data and analytic initiatives

Cost growth benchmark

The goal for the growth of spending on health care year over year.

Data sources: Based on WA's economic indicators

Performance against benchmark

Assessment of cost growth against the growth benchmark .

Data sources: WA Health Care Cost Transparency Board Data Calls

Cost driver analysis/cost experience

Assessment of key drivers of cost growth.

Data sources: Washington All Payer Claims Database (WA-APCD)

Primary care spend measurement

Expenditure on primary care in relation to overall health care expenditure

Data sources: WA-APCD

Hospital cost, profit, and price analysis

Hospital financial analysis to identify cost, price and profit trends.

Data sources: Medicare hospital cost reports

Analytic support initiative

Analysis of cost growth by UW's IHME[a/].

Data sources: WA-APCD, public and private claims databases, public health data

Consumer affordability

The ability for a consumer to afford their health care insurance.

Data sources: Survey data

Source: Health Care Authority
Notes: a/University of Washington's Institute for Health Metrics and Evaluation

Washington State Health Care Authority

Health care cost data overview

Overall expenditure:

Total health care expenditure (THCE)

Components:

- Total medical expense (TME) = Claims + Non-claims
  - by Market
    - Commercial
    - Medicaid
    - Medicare
  - by Carrier
  - by Large Provider Organization → **Attribution applied**
- NCPHI
- Other spending
  - Veterans Affairs
  - Dept. of Corrections (DOC)
  - Labor & Industries (L&I) → **Workers' compensation**

Data Sources:

- *Commercial & non-FFS from carriers*
- *FFS data from WA HCA & CMS*

- *CMS Medical Loss Ratio Data & System*
- *OIC WA filings*

- *Agency's data*

NCPHI: Net Cost of Private Health Insurance; FFS: Fee-for-service; Non-FFS refers to Medicaid Managed Care and Medicare Advantage Plans; HCA: Health Care Authority; CMS: Centers for Medicare & Medicaid Services; OIC: Office of the Insurance Commissioner
For more details on data collection and submission, please see the Cost Board's Data Call Technical Manual.

Washington State Health Care Authority

2022: First year with health care cost growth benchmark

Calendar Year	Benchmark value
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Source: Health Care Cost Transparency Board

Per-member spending cost growth vs. benchmark:

- Statewide
- Markets

Cost growth performance metrics

Aggregation level:	Performance is based on:
Statewide	THCE PMPY growth rate
Markets	TME PMPY growth rate
Carriers	Confidence interval of age-sex risk-adjusted truncated TME PMPY growth rate
Large Provider Organizations	

Source: Health Care Cost Transparency Board

Links explaining the following methods:

- Attribution
- Truncation
- Age-sex risk adjustment
- Confidence interval calculation

are in the appendix

Highlights

- 2022 statewide per-member cost growth at 3.6% is slightly above the 3.2% growth benchmark and (excluding 2020) is the slowest growth since 2018.
  - Marketwise, only the Medicare market exceeded the benchmark.
  - Spending for Veterans Affairs (VA) members also pushed growth
- But one-year analysis on 2022 year-over-year growth may not fully capture developments during the pandemic period….

Highlights

- Per-member spending growth from 2019–2022 is driven by growth in:
  - Commercial and Medicare markets
  - VA spending
- Per capita spending growth from 2019–2022 led by these top contributors to growth:

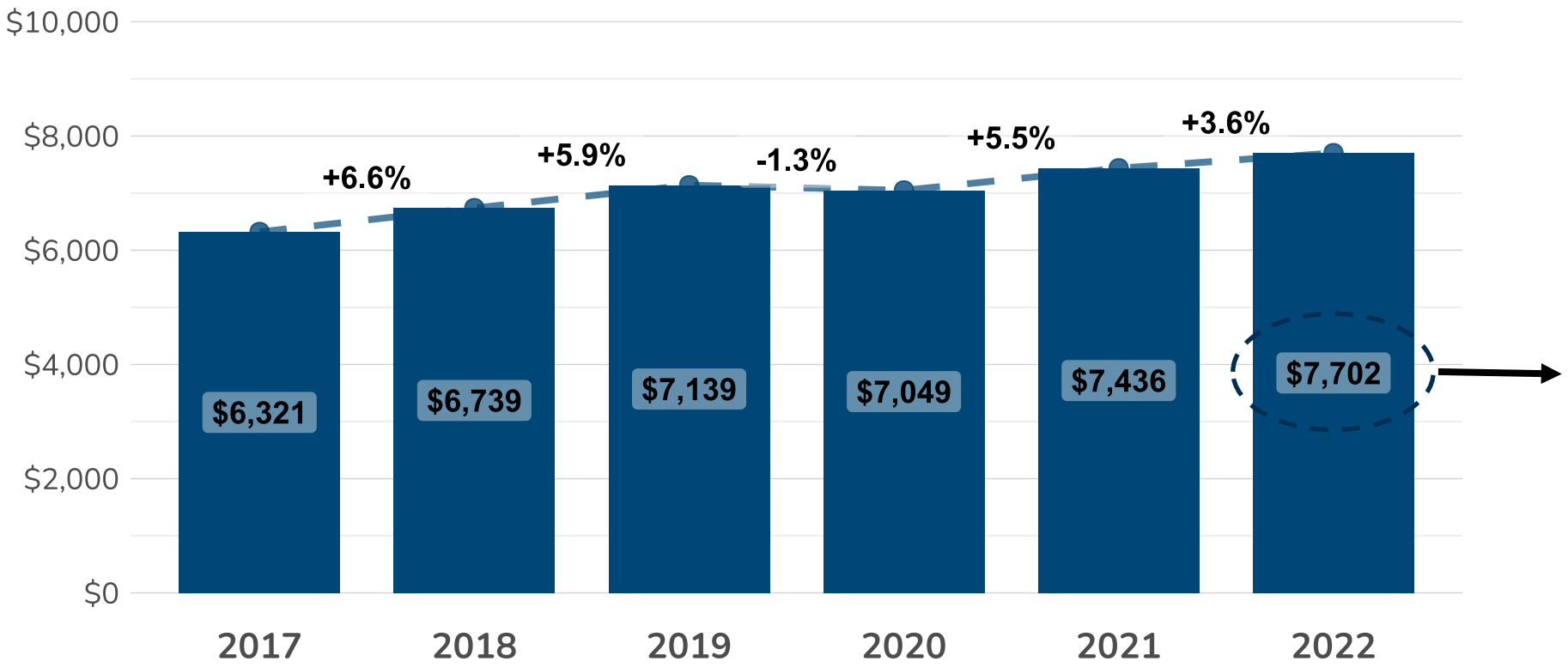
Top	Category	Market sources
1	Prescription drugs	Medicare, Commercial
2	Non-claims	Medicare
3	Hospital outpatient	Medicare, Commercial

- Per-capita Medicaid spending decreased from 2019–2022 due to a decline in Other Claims that more than offset an uptick in prescription drug spending.

2022 performance comparison against the benchmark

Statewide per-member spending

Total health care expenditure (THCE)
Per member per year



Source: WA Health Care Cost Transparency Board Data Calls

- Overall, per-member spending increased by 3.6%, reaching $7,702 in 2022
- Equivalent to ¼ of a minimum wage earner's annual 2022 income in WA.

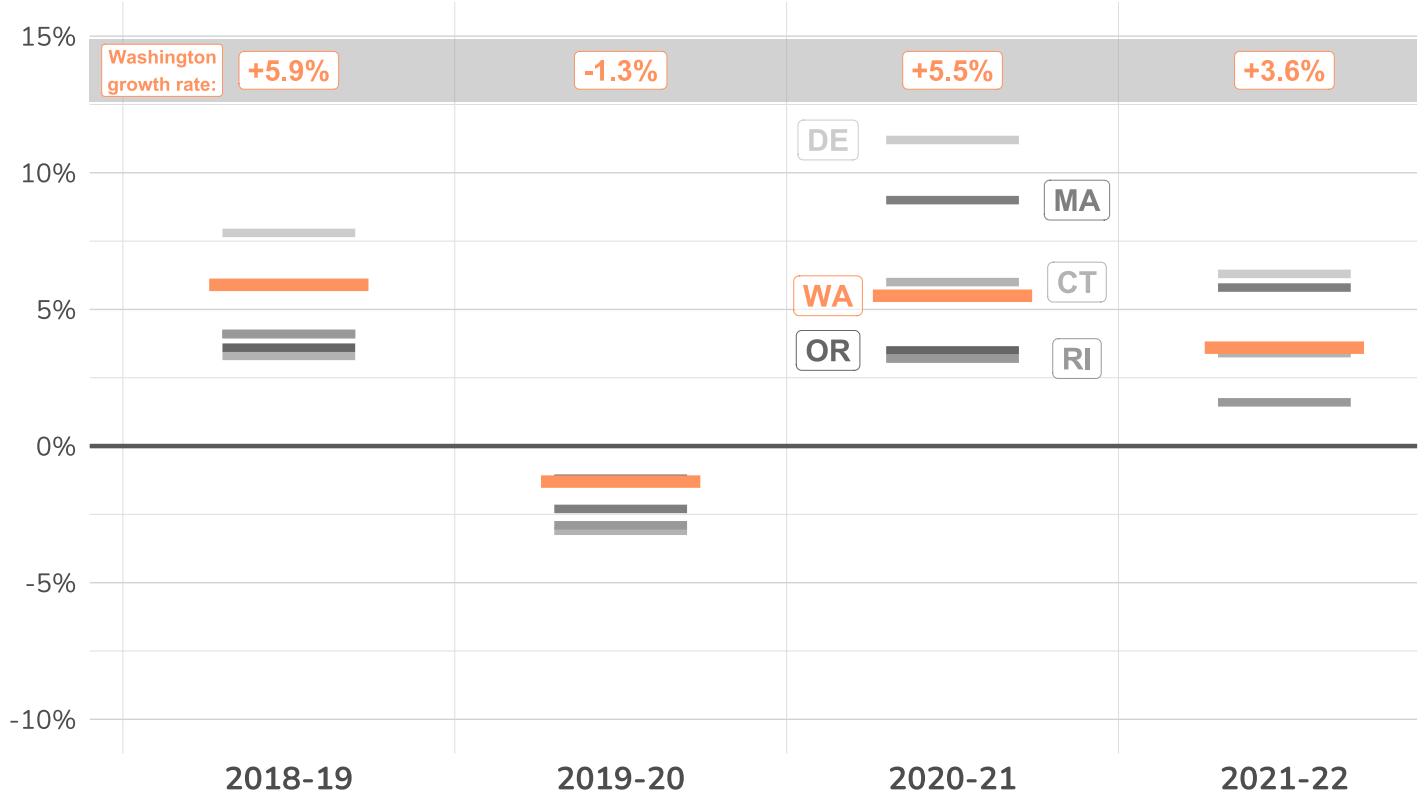
Washington State Health Care Authority

Overall growth across states

- Compared to other states, WA's annual growth is close to the median rate from 2018 to 2022

Total health care expenditure per member per year growth

Washington and five other benchmark states



Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

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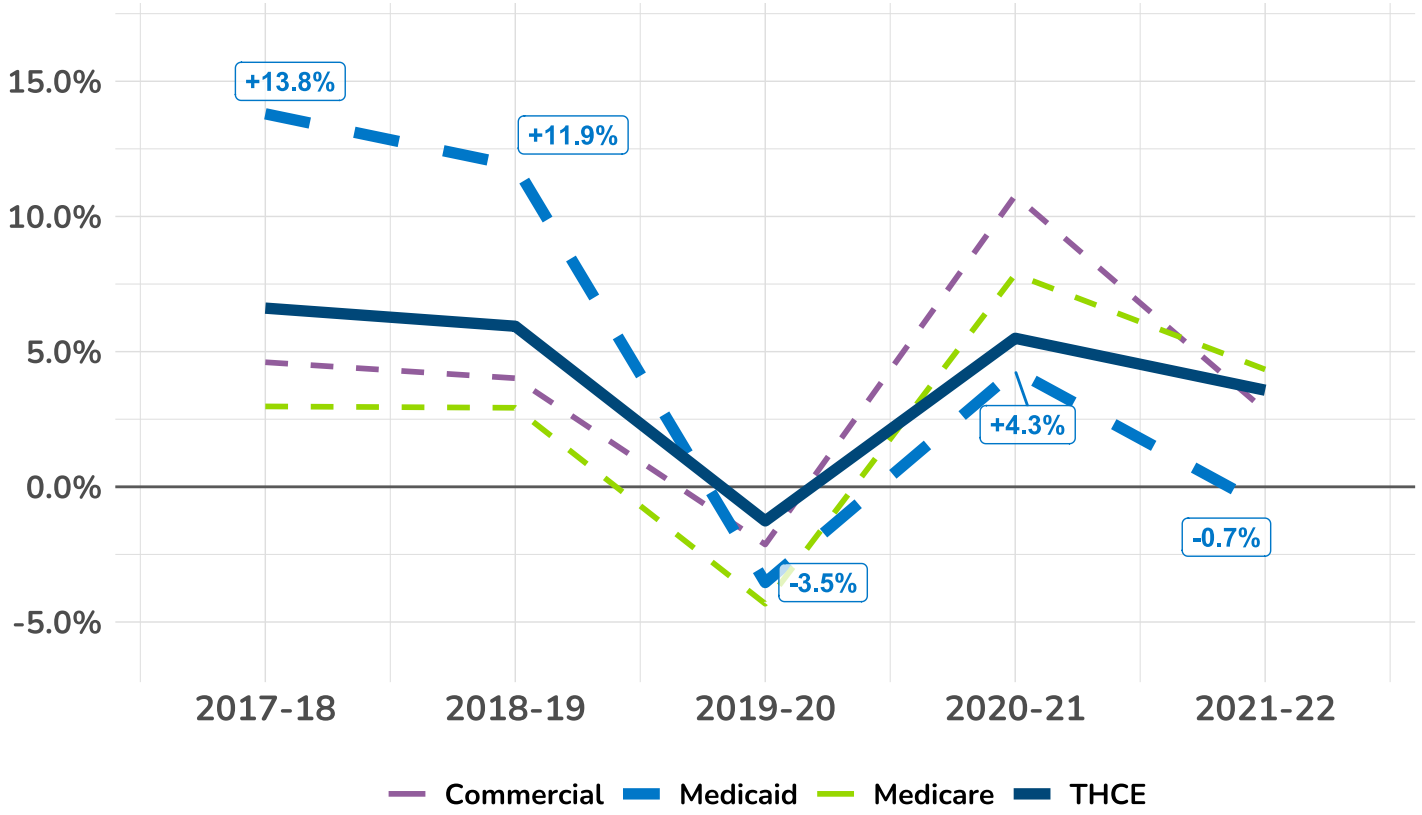
Spending patterns, 2019–2022

Market growth shifted during the pandemic

Overall per member per year growth by market



- Medicaid's growth is no longer above other markets.
- Commercial growth outpaced all other markets.

Source: WA Health Care Cost Transparency Board Data Calls

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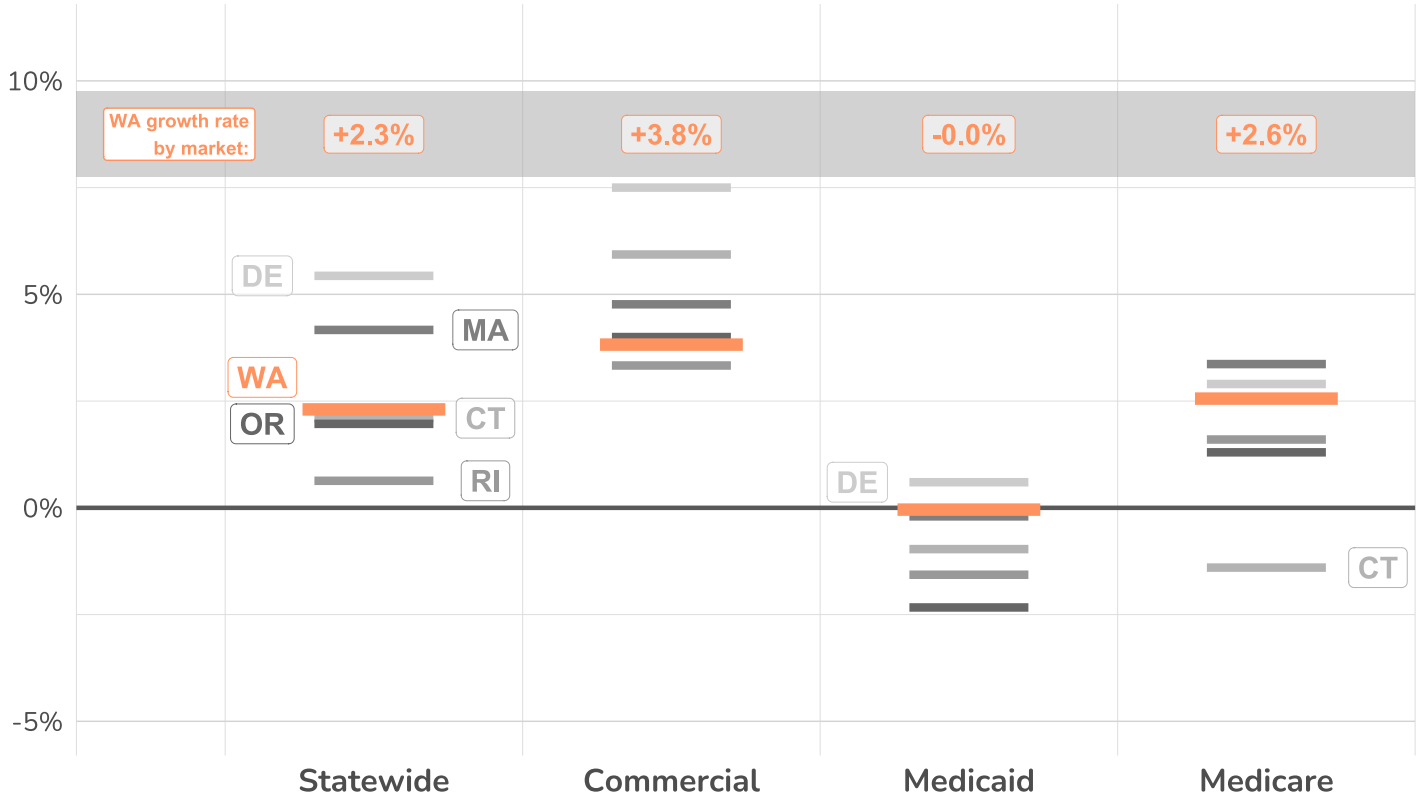
Average growth across states, by market

- Like other states, Commercial market registered the fastest growth during the pandemic.

Average total medical expense per member per year growth rate, 2019-2022
Washington and five other benchmark states



Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

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Questions?

Contact:

- HCACostBoardData@hca.wa.gov (for data-related questions)
- HCAHCCTBoard@hca.wa.gov (for all other questions).

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Appendix

Appendix – notes on data, continued

- There were revisions for 2017–2019 data due to data resubmissions from few carriers and revisions of NCPHI data.
- Member months data from DOC includes prison population and Rent-a-bed program population. The latter is limited to members with claims as existing data systems make it challenging to get information on those without claims.
- Federal Employee Health Benefit Plan (FEP) that have benefits split between two carriers are included only in the statewide and Commercial market spending. Split FEP was removed from provider/carrier benchmarking.
- L&I member months are estimates and rounded off at the 100,000th level.
- Methodologies (i.e., risk adjustment, standard deviation pooling, and confidence interval calculation) used in large provider organization and carrier reporting are documented in:
  - Attribution (pages A3-A4 of the Cost Board's Data Call Technical Manual)
  - Truncation (pages A11-A15 of the Cost Board's Data Call Technical Manual)
  - Cost growth calculations - demographic risk adjustment, pooled variance, and confidence interval (provider organizations)
  - Cost growth calculations - demographic risk adjustment, pooled variance, and confidence interval (carriers)

Tab 6

Washington State Health Care Authority

Commission Update

The Universal Health Care Commission last met: December 5th, 2024

Watch the meeting: here

See the meeting materials: here

Commission Update

The December Universal Health Care Commission meeting included a presentation about a potential bill to support reference-based pricing in Washington's public and school employees' benefit programs

- Following the presentation, the Commission voted to "support the principle of reference-based pricing, not only to contain costs, but to rebalance resources, recognizing that over the course of the upcoming legislative session there will likely be revisions to the language of the bill."

Commission Update

During the December meeting, Commission activity also included:

- Direction to FTAC to continue exploring cost containment strategies, such as out of network price caps and hospital global budgeting.
- Approved revisions to the 2025 workplan, looking to focus on universal system design during the first half of the calendar year, followed by transitional solutions during the second half of the year.

Up Next for UHCC

Next Commission Meeting is:

2 – 5 pm, Thursday, February 13th, 2025

Zoom and in-person at the HCA offices in Olympia

Tab 7

Washington State Health Care Authority

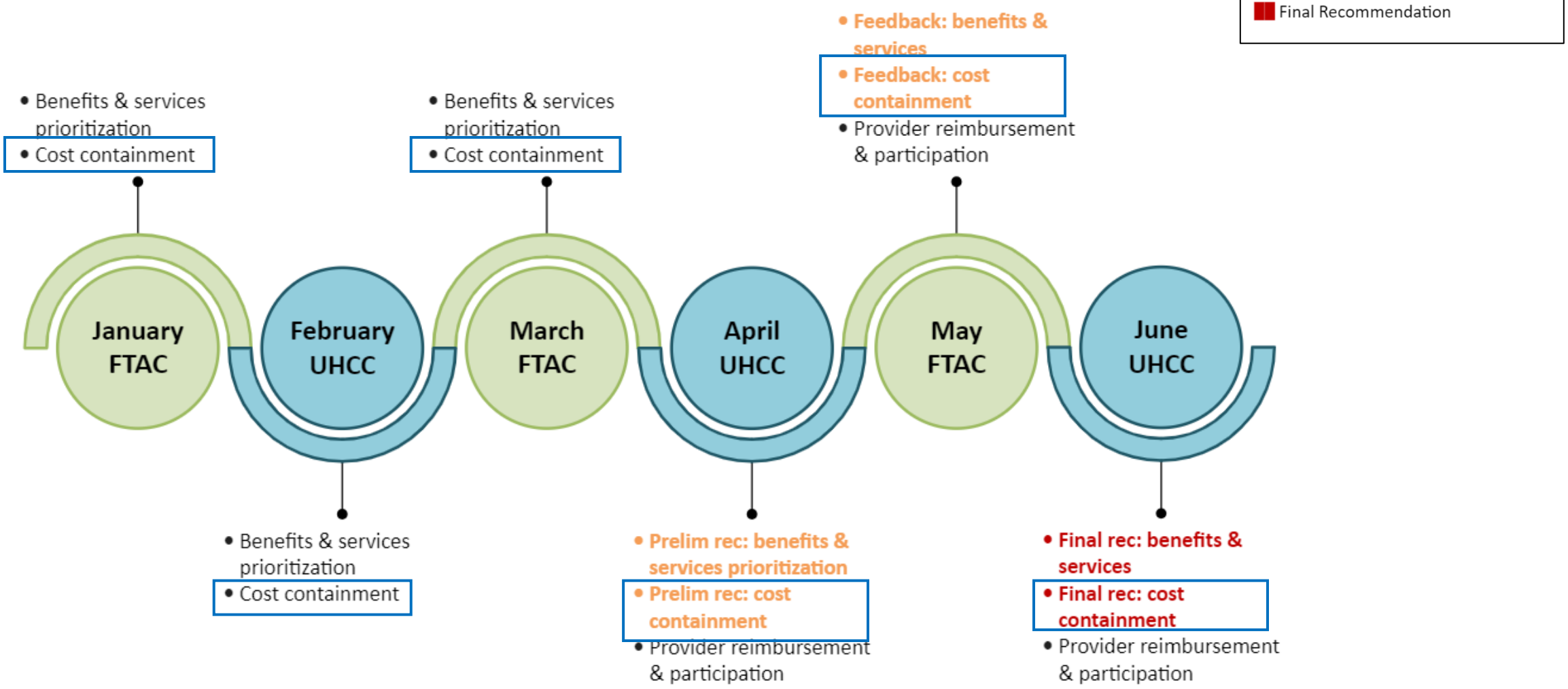
Cost containment mechanisms

2025 UHCC goals: universal design

- Complete analysis of benefits and services and determine prioritization
- **Develop set of recommendations for cost containment mechanisms**
- Develop set of recommendations for provider reimbursement and participation

2025 workplan

Updated January 2025



Overview of an All-Payer Hospital Global Budget Payment Model

Presentation for the Financial Technical Advisory Committee

Robert Murray, President, Global Health Payment LLC
January 16, 2025

Agenda

- My Background
- Description and General Characteristics of a Hospital Global Budget Rate Setting model
- Simplified Example of a Hospital Global Budget (HGB)
- Past Hospital Global Budget Model Applications
- Policy Objectives and Key Incentives of HGB Payment Model
- Advantages and Disadvantages of Hospital Global Budgets
- Modifications to address Model Weaknesses
- Governance and Oversight Considerations
- Conclusions, Questions/Answers and Discussion

My Background

- BA and MA in Economics and MBA from Stanford University
- Management Consultant for Amherst Associates, Ernst and Young
- Deputy Director and Executive Director, Maryland Health Services Cost Review Commission (HSCRC) 1993-2011
- During my time with HSCRC implemented several new payment initiatives:
  - A P4P quality-based incentive system to improve hospital quality of care
  - The Implementation of a pilot Hospital Global Budget (HGB) model for 10 more isolated rural hospitals
- Since leaving the HSCRC – served as a Consultant to the World Bank and various States (Vermont, Oregon, Rhode Island, Massachusetts) on Payment Reform and published a number of articles on Regulated Payment Models for states

Personal Biases

- Development of an expanded system of insurance access (i.e., expanded social insurance, single-payer/universal system), must first be accompanied by a regulated cost control system
- Failure to develop effective cost-control models will undermine health insurance expansion
  - Examples: Vermont Single Payer Initiative & The Affordable Care Act (ACA)
- Private payers and Antitrust activity have been unable to contain excess health spending
- Researchers at RAND, CBO and the Urban Institute have all concluded that State Rate Regulatory strategies have the best potential to constrain provider prices and spending
- All other Developed Countries have some form of governmental rate controls to ensure the affordability of their universal or near-universal coverage systems
- States should implement lower-intensity rate models to control health care spending
- Advocate an incremental rate setting approach, starting with Price Caps for State Benefits programs and Out-of-Network hospital care, and eventually all-payer HGBs to contain costs

Global Budget Applications

- Used widely in Canada and Europe – different iterations
  - France and Germany initially implemented Fixed Global Budgets but found these models too restrictive and moved to a more "Flexible" Budgeting model
- Maryland's original payment system employed a system of "Flexible" Hospital Global Budgets 1976-92
- Rochester and Finger Lakes Area hospitals (New York 1980s)
- Maryland 2009 (10 rural hospitals) and 2014-present (CMM), Vermont All-Payer ACO model & Pennsylvania Rural Health Model (CMMI) implemented Fixed Global budgets
- CMS/CMMI AHEAD Demonstration (2024-2033)
  - Currently, Maryland, Vermont, Hawaii, Connecticut, Rhode Island and several "down state" counties in New York have been approved to participate

Hospital Global Budgets General Characteristics – A Regulatory Model

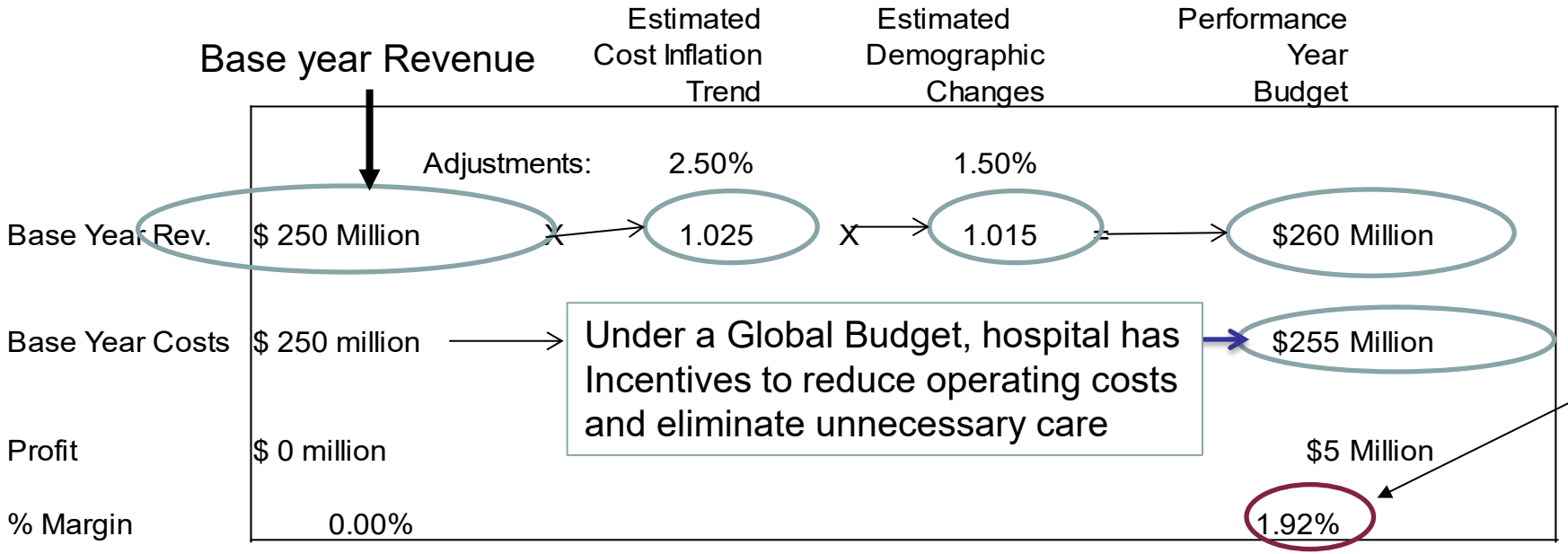
- Establishment of a fixed or semi-variable budget covering all hospital and potentially other services
- Initial budgets are based on hospital historical revenues in a recent Year < Eases Transition to HGBs
- HGBs established and enforced by a regulatory authority based on a Public Utility regulatory model
- The State has Legal Authority to control the growth of budgets to meet state affordability goals
- Best if HBG model applicable to all payers and all or most hospitals in a state
  - Medicare & Medicaid participation requires negotiation of Medicare Waiver with CMMI
  - Commercial/Self Funded payer participation must be mandated by state law
- HGBs generally cover all acute inpatient and outpatient hospital services, but may also include some physician services, post-acute and home health services
- HGBs are a more comprehensive cost containment model but still a "Lower Intensity" model: Regulating aggregate budgets - less complex than regulating individual service prices
- There are different HGB approaches: fixed budgets or semi-variable ("Flexible" Global Budgets)

Simplified Example of a "Fixed" Hospital Global Budget

- Washington County Hospital
  - Community hospital in a rural part of the State
  - Separated by distance and mountain ranges
  - Serves 148,000 population in Washington County
  - Limited "in-migration" from other parts of the State
  - Budget in Prior year = $250,000,000

This illustrates what is referred to as a "Fixed" Global Budget structure. Maryland and Rochester New York, implemented a more Flexible Global Budget model allowing additional payment for the Marginal Costs associated with new Volume

Updating the HGB from a Base Year
To future Performance Years



HGBs provide strong incentives for hospitals to control operating costs and unnecessary volume increases

If the hospital can control its cost growth and reduce unnecessary utilization, it can improve its profitability

Hospital Global Budgets can Achieve the Following Policy Goals:

- Constrain both price and total hospital spending (both price & volume) growth
- Remove or reduce FFS incentives hospitals currently face that promotes increased and unnecessary volume of care
  - Reducing the incentive to provide unneeded care will reduce the need for pre-authorization/denial of care
- Encourage investments in initiatives by using savings generated by reducing unnecessary use/cost and redeploying them to invest in/improve Population Health
- Provide financial predictability & stability for hospitals, (especially small/rural facilities)
  - Facilitate transition of small/rural hospitals to reduced service capacity
- Improve overall payment equity (reduce high prices and raise low prices)
- Support other Value Based Care initiatives such as ACOs
- Be modified to include Quality Incentive programs, funding of Uncompensated Care & Graduate Medical Education
- Be the basis of a future and broader Population-Based payment system

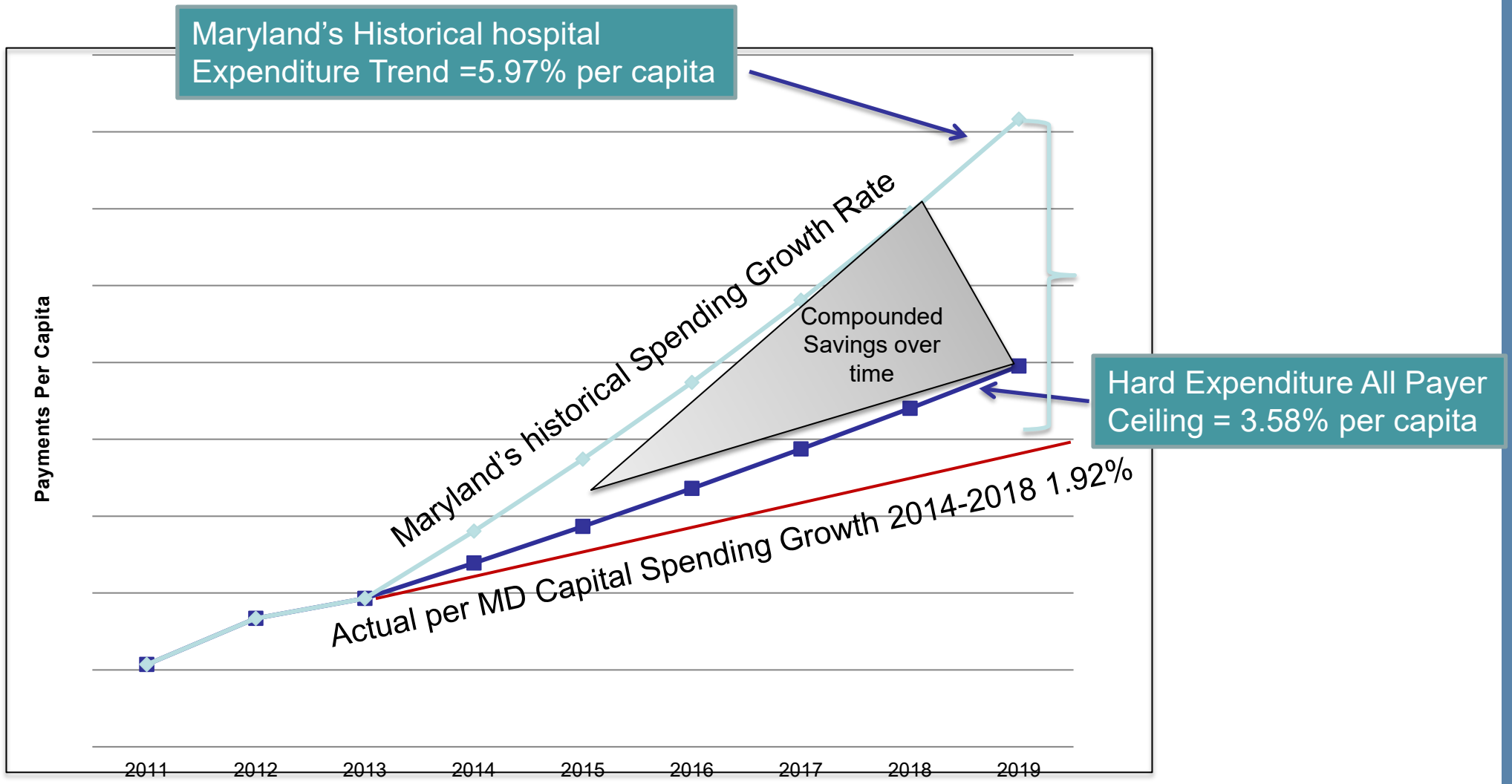
Weaknesses of Global Budgets include:

- Inequities and conflicting financial incentives if some payer categories and hospitals are not participating in the Global Budget Model
- Fixed budgets may also have too strong a set of incentives to reduce service provision: e.g., to shed patients/services or stint on care
  - Resulting in increased wait times for elective and ED care (experience in Europe and Maryland)
  - And shifts of care from acute hospitals to non-hospital and "unregulated" ASCs, imaging etc.
- Shifting of services away from the hospital may result in "double payment" for care (once under the HGB and once when care shifts)
- Fixed budgets are less responsive to shifts in volume (payer induced or other shifts) or service augmentation needs by communities/AMCs
- Fixed budgets also present a hospital with significant financial risk which may result in insolvencies for smaller hospitals
- As with all rate models, subject to "regulatory failure" particularly if model is too complex and "regulatory capture" by powerful provider interests

Absolute Requirements of a Regulated HGB Model

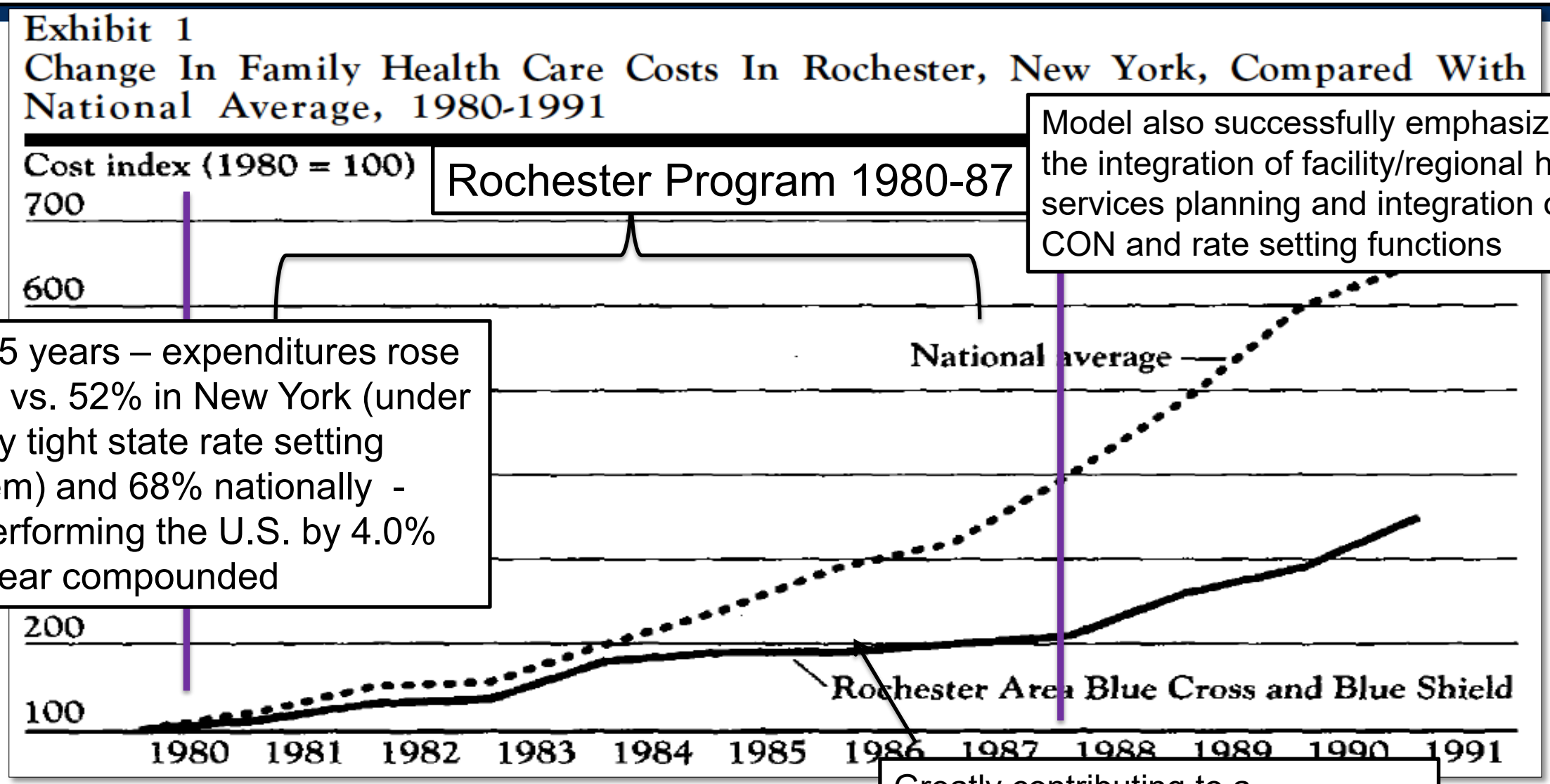
- HGB Model requires broad participation by hospitals and payer categories
- Must be overseen and operated by a State Regulatory Agency (enforcing participation & budget compliance) Past and current "voluntary" payment models have not been effective
- Compliance with established Budgets/Performance targets should be mandated by state law and regulation with significant fining authority for "non-compliance"
- Regulatory Commission should have broad powers of data collection and the legal authority to initially establish and annually update hospital rates/budgets
- Regulatory Commission should be governed by a board (volunteers appointed by the Governor) and staffed by a highly trained and sufficiently paid professional staff
- A Public Utility model of rate oversight and regulation has been effective in the past and can help avoid key pitfalls of "regulatory failure" and "regulatory capture"

Key Objective of HGBs: Meet State Affordability Goals



HGB models can help reduce the use of marginal/unnecessary services, improve hospital pricing equity, promote improved quality of care, improve hospital financial stability and equitably fund hospital uncompensated care

Global Budget Experience from Rochester NY



Rochester Program 1980-87

Model also successfully emphasized the integration of facility/regional health services planning and integration of CON and rate setting functions

First 5 years – expenditures rose 46% vs. 52% in New York (under a very tight state rate setting system) and 68% nationally - outperforming the U.S. by 4.0% per year compounded

Greatly contributing to a stabilization of commercial insurance premiums in the region

Hall and Griner et al. Health Affairs 1993

Global Budget Experience from Rochester NY

Table 1.—Cumulative Operating Profit (Loss) of Hospitals in Various Regions of New York State, 1980 Through 1984

Region	Operating Profit/(Loss), Millions of Dollars
New York City	(693.7)
Northern metropolitan (downstate)	(150.1)
Nassau/Suffolk	(180.7)
Abany	(41.7)
Utica	(33.7)
Syracuse	(77.7)
Rochester	11.9
Buffalo	(122.3)

Table 2.—Hospital Admissions to General Hospitals in New England, New York State, and Rochester, NY

	Admissions/1000		
Year	New England	New York State	Rochester
1979	148	149	135
1980	149	149	133
1981	147	150	132
1982	146	149	126
1983	146	148	124
1984	141	148	124
Net change, 1979-1984	−7	−1	−11

Profitability and cash flow of Rochester hospitals was significantly better than other New York hospitals 1980-84

System also experienced larger drops in use rates than other nearby areas (NY and NE)

Block JAMA 1987

HGBs – Two Versions: 1) Fixed Budgets

- First pioneered in Europe and Canada & used currently in Maryland
- Hospital receive a set, pre-determined amount of revenue regardless of patient volume
- Very strong incentives to manage care, restrict volumes and shift services out of hospital
- Budgets adjusted for patient demographic changes and annual approved inflation update
- Fixed budgets protected Maryland hospitals from revenue drops during the Pandemic
- However, evidence from Europe and Canada shows that Fixed Budgets also increased wait times for elective services and emergency room treatments
- Under Fixed Budgets, Maryland met its waiver tests but saw significant shifting of services to non-hospital providers < Causing double payment
- Academic Medical Centers complained about the rigidity of Fixed Budgets which constrained their ability to fund new drugs and technology

HGBs – Two Versions: 2) Flexible Budgets

- Flexible budget concept based on Rochester and Finger Lake Hospital Demos in 1980s and early Maryland rate setting system 1976-1992
- Flexible budgets are a “middle ground” approach – less severe than 100% fixed budgets but still corrects the flawed incentives of FFS payment that encourages over-use
- Flexible budgets provide additional revenue for hospitals as volumes increase – to cover their marginal or variable costs of production
  - Flexible budgets also provide hospitals with funding to cover fixed costs if volume decline
- Areas where implemented – (Rochester and Early Maryland system) performed well on both cost per case and cost per capita growth
- Flexible Budgets also allowed for adequate funding for new technology and provided sufficient increases in global budgets for increased service use
- Flexible Budgets didn’t encourage shifts of services to non-hospital providers or care
- Also believe that Flexible Budgets are more ”pro-competitive” – allowing hospitals to compete more on the basis of service delivery and quality - to attract patients

Weaknesses of FFS Payment

- Fee-for-Service (FFS) payment systems have an unfortunate weakness – they provide incentives for hospitals to produce unnecessary services
- This is because under FFS payment, hospitals are paid 100 cents on the dollar for each new service
- However, hospitals have both Fixed and Variable Costs
  - Fixed costs are covered in their base payments and are funded as long as volumes remain steady or increase
  - Variable costs vary by service, but are generally 50-60% of average costs
- The excess of marginal (variable) revenue (100 cents on the $) earned by new hospital services over hospital marginal cost of these services (50 cents on the $), adds to hospitals' profit margins
- It is this excess of Marginal Revenue earned over Marginal Cost of Production – that induces providers to generate large amounts of unnecessary and low-value services
- Thus, under FFS payment hospital, are over-rewarded for providing/promoting the use of more services – resulting in substantial over provision of care Excess/ unnecessary care = $600-900bill./year
- A Volume Adjustment System used in Flexible HGBs can correct this distortion

Incentives Under Different Bases of Payment

100% Variable 0% Fixed	Middle Ground	0%Variable 100% Fixed
FFS Payment	**Flexible Global Budget**	**Fixed Global Budget**
▪ Hospital is paid 100 cents on the dollar for each new service, even though cost to produce the service (i.e., variable costs) are 50-60 cents	▪ Hospital receives revenue for volume growth, but only for variable cost of new volumes	▪ Hospitals do not receive additional revenue for volume growth
▪ Excess of marginal revenue earned under FFS over hospital marginal cost results in increased profits with volume increases (and vice versa)	▪ Provides a predictable revenue source, but reduces incentive to decrease volume to increase profits and eliminates current excess FFS incentives to grow volumes	▪ May encourage stinting of care as hospital earns substantial rewards if volumes decline
This dynamic is the primary driver of excess low value & unnecessary care – leading to need for pre-Authorization and denials by payers		▪ May encourage hospitals to shift care to non-hospital providers – resulting in ”double payment”

Mechanics of Flexible Global Budgets

- Assume hospital Fixed Costs = 50% and Variable Costs = 50%
- Under these assumptions, hospital experiencing a 1% increase in volume realize a 0.5% increase in their Global Budget Revenue To Fund the Variable Costs of New Services
- Hospital experiencing a 1% volume decline only has only 0.5% revenue removed from HGB (but hospital keeps its fixed cost funding)
  - Retention of funding to cover fixed costs provides financial stability for hospitals – particularly for small and rural facilities that are experiencing reduced population and reduce volumes
- Hospitals report monthly data to the Commission and adjust their rates to remain in compliance with their "approved" HGB
  - Large fines for non-compliance
  - Settlements for each hospital at the end of a rate year
- The system can be "self-regulated" by the hospitals – with hospitals adjusting their prices up or down during the year as volume fluctuates – to meet their approved HGB

Key Steps in Devising a Hospital Global Budget Model

- Develop the Rate Base for hospitals

Best to use actual Historical Volumes/Revenues to set Base Year Budgets

- Define the Services and Populations subject to the Global Budget
- Determine Adjustments to the Rate Base

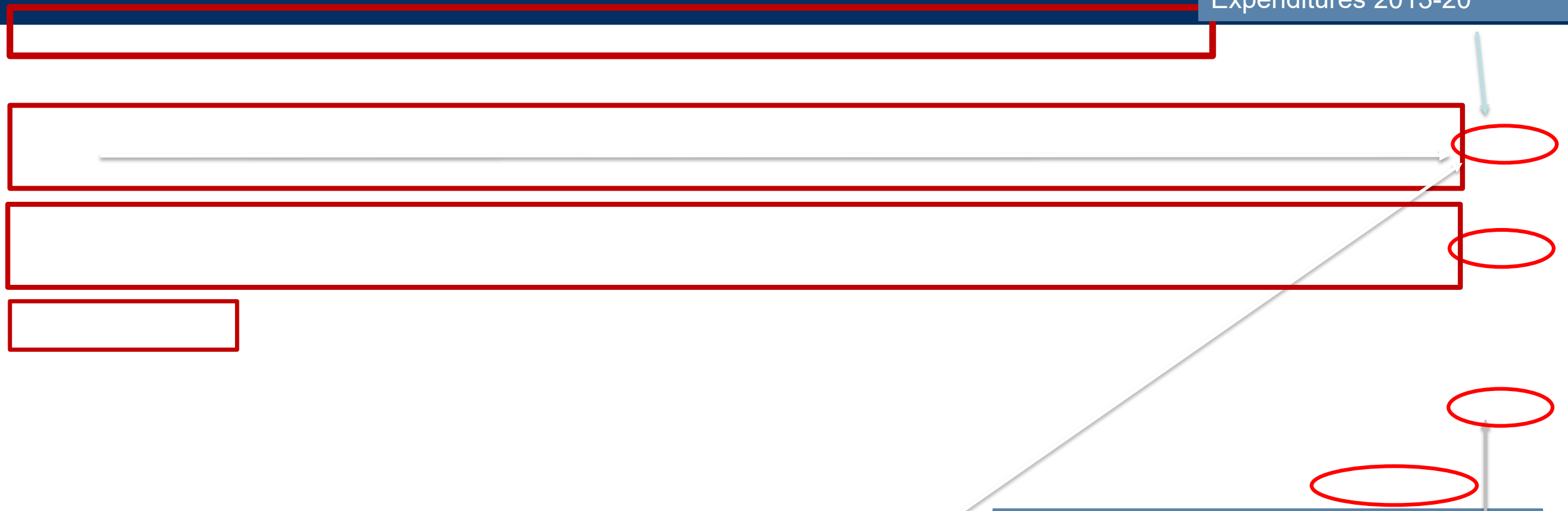
Ability to add funding for hospital Uncompensated Care & "Seed" Funding to promote better care management and primary care

- Choose between a Fixed HGB model and a "Flexible" HGB using a **Volume Adjustment**
- Determine how hospitals are paid for the services they deliver < Two basic Options
- Develop a Formula-based "prospective" method of Updating Budgets annually
  - As shown, Update must account for Hospital Input Cost inflation and Service Area Demographic changes
  - **States may wish to "Tier" their annual budget updates to improve pricing & budget equity** (i.e., limit high priced updates and augment low priced hospitals updates)
- Regulatory Agency/Commission must exercise its legal authority to mandate compliance with approved Global Budget and approved annual updates to Global Budgets

This is a government mandated, and state regulated model – not a voluntary model

Modeling of a Flexible HGB Model for Washington – Based

Actual Washington Hospital Expenditures 2013-20



HGB Model can Produce Hospital Price/Volume increases of 2.5% or less

Key Points:

(1) Actual Washington CAGR 2013 – 2020 for hospital expenditures = 2.93%
(2) Washington CAGR 2013 – 2020 for non-hospital expenditures = 4.20%
(3) Modeled Per capita (all-payer) hospital expenditure growth = 2.5% per year under Flexible HGB model
(4) Flexible HGB model **will not induce shifts to non-hospital sector** as is the case in Maryland currently
(5) 2.5% growth is well below Washington Gross State Product (total incomes) growth and below Spending target of 2.8%
(6) Washington projected hospital savings from implementing an All Payer Flexible HGB model 7 years 2014-20 = $1.7 bil.

Final Observations

- HGBs redirect hospital incentives toward improving their operating cost efficiency, reducing levels of low value or unnecessary care and making investments to improve population health
  - Maryland Commissioners noted: “Under HGBs, improved efficiency and reductions in Low Value Care now become sources of financial viability for the hospital under a HGB”
- My bias – the commercial health care market is replete with Market Failure – causing market-power oriented strategies by hospitals and payers, resulting in many pricing distortions
- Rate regulation is needed to improve market function (address market failures) but rate agencies should avoid unnecessary intrusions into hospital decision-making (HSCRC philosophy)
- Rate setting systems are still vulnerable to “regulatory failure” and “regulatory capture” – a Public Service Commission approach and other structural features can help prevent these problems
- Thus, the need to keep the rate setting process simple and well-understood and avoid excess complexity in methodology development
- And the need to develop governance structures that help prevent regulatory cppture by the hospital industry

Governance Considerations

- There are large advantages to using a Public Utility Model of Rate Setting (public deliberations and independent governance) and formula-based rate setting to operate a successful system
- Regulatory focus is on correcting market failures, setting clear and attainable targets/goals for hospitals, but avoiding unnecessary intervention & complexity
- Emphasis on keeping the rate system well understood & as simple as possible
- Public Utility approach based on a large body of case law with the ability to keep hospitals, payers and the regulatory body accountable to the public for performance
- Model retains “Appeal Rights” by Hospital as a Fail Safe to address untoward circumstances
- “Achilles Heel” of Rate Setting: Regulatory Failure (New York) and Regulatory Capture (all states) although these can be avoided with strong leadership and structural remedies

Advantages and Characteristics of a Public Utility Model of Governance

- Extensive case law and strong regulatory authority (i.e., a mandatory system) to collect necessary data, establish rates and perform key regulatory functions
- History of transparent, effective decision-making and due process protections
- Flexibility in application of different rate setting approaches
- State-based as opposed to federal implementation (more responsive to state needs)
- Governance by a board or Commission of appointed individuals with an interest in health care and backgrounds salient to the operation and governance of the regulatory system
  - Best if Commissioners are prominent “volunteers” with key expertise and backgrounds
  - Labor, Business, Consumer, Academic, Insurance and Hospital representatives
  - Hospital representation should be limited to a minority position
- Commission conducts most of its operations in public during monthly meetings inviting participation and testimony by interested and affected parties
- Commission employes a full-time professional staff that serves at the pleasure of the Commission

Additional reading

- Hospital Global Budgeting section (pg. 65-72) of the Washington Office of the Insurance Commissioner final report on Health Care Affordability

Finance Technical Advisory Committee

We are currently on a short break

Washington State Health Care Authority

Tab 8

Washington State Health Care Authority

Cost containment discussion

Discussion

- FTAC goal:
  - Develop set of cost containment recommendations to inform Commission decisions about universal design
- Today's topics:
  - Discovery and design process
  - Cost containment guiding principles
  - Next steps

Cost Containment: design process

- Discovery – HCA develops comprehensive list of cost containment strategies, measures and policies used by states and in global universal systems
- March FTAC meeting:
  - HCA sends resources prior to meeting
  - FTAC discussion/select topics for deeper analysis
- May FTAC meeting:
  - HCA provides further literature and information as requested
  - FTAC prioritizes list of strategies, measures and policies to recommend to Commission for consideration in universal design.

Commission will receive updates on this work

Cost containment: guiding principles

- Commission interest in this topic as part of universal design and interim solution
- Today: Discussion/brainstorming of guiding principles
- March FTAC meeting:
  - HCA staff will distill and organize information from today's discussion
  - Draft to be circulated to FTAC members before meeting
  - FTAC discussion/further refinement during meeting
- May FTAC meeting:
  - Further revision if necessary
  - Revised draft, if necessary, to be circulated to FTAC members before meeting
  - Formal adoption during May FTAC meeting

Guiding principles development ideas

For example:

1. Cost containment models should be administered and regulated by the state, not by provider organizations or carriers.
2. Cost containment mechanisms should be mandatory, not voluntary.
3. Cost containment mechanisms will preserve and promote access to quality, equitable health care.

Cost containment: Notes

Cost containment: next steps

- What are the next steps?
  - HCA sends FTAC members resources and references prior to March meeting
  - HCA sends FTAC members working draft: cost containment principles
    - FTAC Members individually respond to HCA with edits, suggestions.
  - FTAC discuss/revise cost containment principles at March meeting

Tab 9

Washington State Health Care Authority

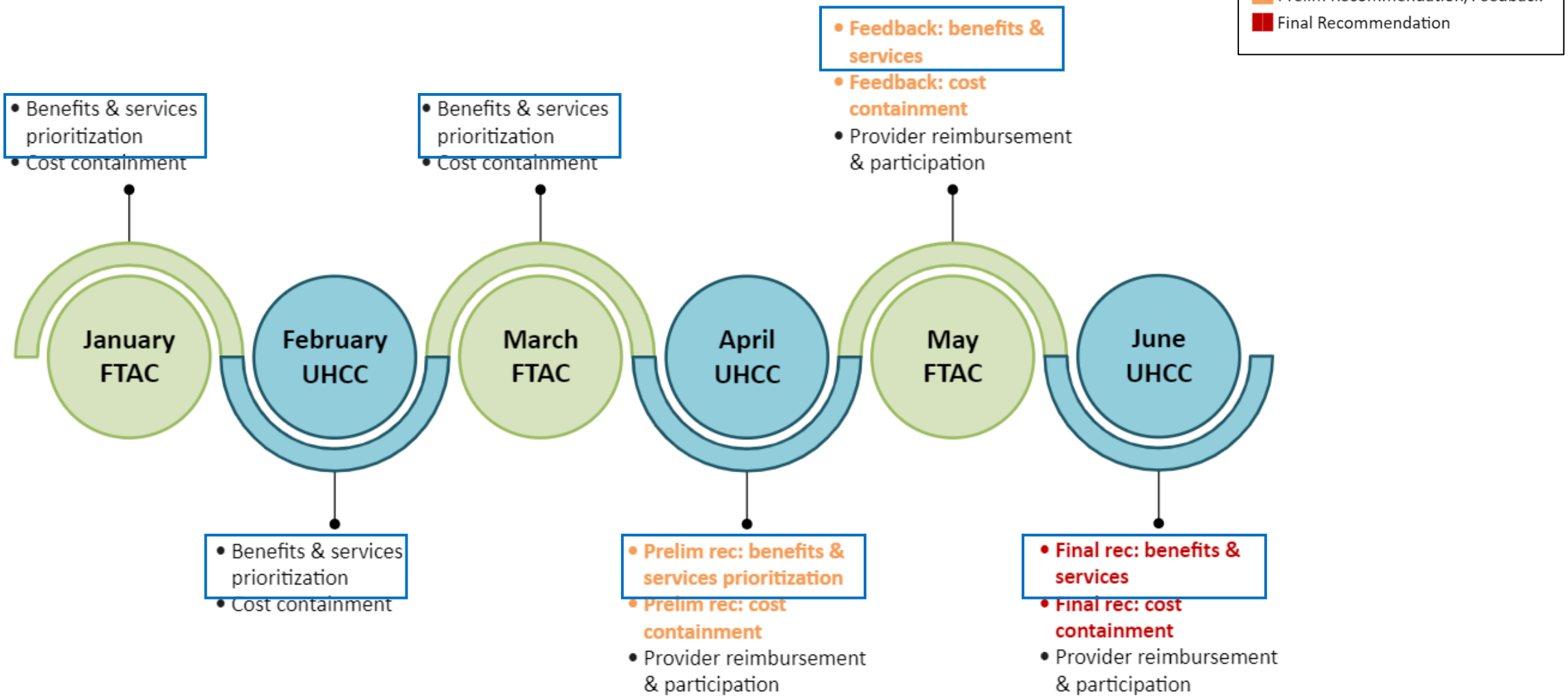
Benefits & services discussion

2025 UHCC goals: universal design

- **Complete analysis of benefits and services and determine prioritization**
- Develop set of recommendations for cost containment mechanisms
- Develop set of recommendations for provider reimbursement and participation

2025 workplan

Updated January 2025



UHCC guidance

- In the Universal Health Care Work Group's (UHCWG) final report, both Model A (state administered) & Model B (administered by managed care plans) included the same set of benefits:
  - Essential health benefits as defined by the ACA
  - Dental for Medicaid-eligible only (dental for other populations priced separately)
  - Vision
  - Long-term care for Medicaid-eligible only

Milliman analysis

- Milliman cost modeling looks at three existing benefit designs:
  - PEBB/SEBB
  - Medicaid
  - Cascade Care Silver
- Final reported expected March 2024

Appendix

ACA essential health benefits

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care (both before and after birth)
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

Source: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/, accessed 11/13/2024.

Washington state essential health benefits

Health benefit	Description	Plan type
Abortion coverage limitations (effective 1/1/2019)	Voluntary abortion or terminating a pregnancy **may be** included in a health plan's essential health benefits package. However, if a health plan provides maternity care or services, it must also provide coverage to allow	Individual/family Group
Anesthesia for dental services	General anesthesia and related facility charges for dental procedures performed in a hospital or ambulatory surgical center must be covered for children under age seven and other specified individuals.	Group
Cancer chemotherapy medications	Health plans covering cancer chemotherapy treatment must provide coverage for self-administered anticancer medication comparable to chemotherapy medications administered by a health care provider.	Individual/family Group (effective Jan. 1, 2012)
Chemical dependency	Treatment of chemical dependency must be covered in an approved treatment facility program.	Group
Colorectal cancer exams and lab tests	Colorectal cancer examinations and lab tests consistent with the recommendation of the U.S. Preventive Services Task Force or the federal Centers for Disease Control and Prevention must be covered.	Individual/family Group
Congenital anomalies in children and newborns	Newborn infants must be covered from birth. The coverage must include treatment of congenital anomalies.	Individual/family Group
Contraceptive coverage	Health plans with comprehensive prescription coverage must cover contraceptives the same as other prescription drugs/and or devices. Effective Jan. 1, 2019, health plans must provide coverage for all prescription and over-the-counter contraceptive drugs, devices and products approved by the FDA without requiring copayments, deductibles or cost sharing.	Individual/family Group
Diabetes coverage	Health plans must cover medically necessary diabetes equipment, supplies, education and training.	Individual/family Group
Donor human milk	Health plans must provide coverage for medically necessary donor human milk for inpatient use when a licensed health care provider or board-certified lactation consultant prescribes and orders it under certain circumstances.	Group (Effective Jan. 1, 2023)

Washington state essential health benefits

Health benefit	Description	Plan type
Emergency medical services in an emergency department	Emergency services must be covered by health plans if a medical provider believes a patient is having an emergency.	Individual/family Group
Gender affirming care	Health insurers generally cannot exclude, deny or limit medically-necessary gender-affirming treatment.	Individual/family Group
Injury caused by intoxication or narcotics	Health plans cannot deny coverage of an injury only because it was sustained while intoxicated or under the influence of a narcotic.	Individual/family Group
Mammograms	Health plans must cover screening or diagnostic mammography services if recommended by a physician or advanced registered nurse practitioner.	Individual/family Group
Maternity and drug coverage	All individual health plans must include coverage for maternity services and prescription drug coverage.	Individual
Mental health parity	Health plans must cover mental health services the same way they cover medical and surgical services.	Individual/family Group
Neurodevelopmental therapies	Health plans must cover neurodevelopmental therapies (occupational therapy, speech therapy, physical therapy) for enrollees age six or younger.	Group
Phenylketonuria (PKU)	Health plans must cover the formulas necessary to treat PKU.	Individual/family Group
Prostate cancer screening	Health plans must cover prostate cancer screenings recommend by the patient's physician, advanced registered nurse practitioner or physician assistant.	Individual/family Group
Temporomandibular joint disorder (TMJ)	Offer employers optional coverage for TMJ, a condition that causes jaw joint and muscle pain. (Employers are not required to include this benefit in the plan.)	Group
Voluntary sterilization (effective 1/1/2019)	Health plans must provide coverage for voluntary sterilization without requiring copayments, deductibles or cost sharing.	Individual/family Group
Women's health care services	Health plans must provide access to women's health services through in-network providers. Services include: maternity, reproductive health, gynecological care, general exams and preventive services.	Individual/family Group

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority