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.

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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.