Health Care Cost Transparency Board meeting summary

October 19, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2 p.m.-4 p.m.

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

Members present

Bianca Frogner
Edwin Wong
Kim Wallace
Leah Hole-Marshall
Lois Cook
Margaret Stanley
Sonja Kellen
Sue Birch

Members absent

Jodi Joyce
Molly Nolette
Mark Siegel
Carol Wilmes

Agenda items

Welcome, Roll call, Agenda Review

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Approval of Minutes

The committee approved the minutes with two adjustments to be made by AnnaLisa Gellermann.

Topics for Today

Topics were listed as approval of a purchaser representative for the primary care committee; The Cost of Administrative Burden; and An Update on Cost Growth Benchmark Activities in Other States.

Approval of new member (purchaser representative): Primary Care Committee

Sue Birch, Washington State Health Care Authority

Sue reminded the board that at the previous meeting, the board asked for purchaser representation to be added to the newly formed primary care committee. After calling for a vote, the board approved Greg Marchand as a new primary care committee member.

The Cost of Administrative Burden

Dr. Mika Sinanan, MD, PhD, Medical Director for Contracting and Value-Based Specialty Care, Professor of Surgery, University of Washington
Jeb Shepard, Director of Policy, Washington State Medical Association

Dr. Mika Sinanan and Jeb Shepard delivered a joint presentation on administrative costs in healthcare using data from the Washington State Medical Association (WSMA), the American Medical Association (AMA) and Health Affairs. Jeb provided an overview of WSMA's size and membership and gave a brief history of healthcare, noting the healthcare system's evolution from house calls to modern-day conference calls. The relationship between patients and clinicians has changed and administrative work has increased compared to clinical work. A study in the Annals of Internal Medicine determined physicians only spend 27 percent of their total time with patients compared to 49 percent spent completing administrative work, e.g., work with electronic health records (EHRs). The same study found that clinicians, on average, spend one to two hours of personal time each day doing additional clerical work, e.g., responding to patient emails, etc., which has contributed to burnout, both before and during the pandemic. WSMA Advocacy surveys from 2022 ranked administrative burden as the top priority out of 30 issues. The 2021 WSMA survey results contained many anecdotes expressing frustration with time spent on prior authorization (PA) requests.
Mika provided examples of administrative burden in the healthcare system, e.g., insurance approvals, PA requests, coding and billing, and practice management. There are several negative consequences associated with administrative costs, including a more complicated coding system, variable contractual agreements, and non-standard authorization processes. Time spent on administrative work has resulted in less time spent with patients, reduced access to care, poorer clinical outcomes, and increased practice and treatment costs. Data from a 2022 Health Affairs study that compared billing and insurance-related costs across six countries found that coding costs were significantly higher in the U.S. compared to the other countries. The same cross-national analysis found that administrative costs consumed 25 to 31 percent of total health care spending in the U.S. A 2018 JAMA study found that there were twice as many administrative staff as physicians and nurses. Data from the Bureau of Labor Statistics showed the projected growth in medical and health service managers between 2021 and 2031.
Data from the AMA illustrates issues associated with PA, including PA's annual cost, the average cost of PA to primary care physicians relative to their total income, time spent on PAs per week, and the number of staff exclusively devoted to PA work. AMA data also highlights PA's high redo and abandonment rates, which have led to treatment delays and poorer patient health outcomes.
Jeb provided an overview of 2021 data from the Office of the Insurance Commissioner (OIC) about PA. Mika summarized the impacts of administrative burden on the healthcare system, including increased consolidation, burnout, and workforce shortages. Jeb proposed several possible solutions to address PA in 2023 legislation. Some of these solutions included: development of standardized timelines and processes, electronic submission and approval, increased transparency requirements, and sunsetting PA's for certain services. Jeb also noted that ERISA limits the state legislature's ability to regulate administrative costs.
Mika summarized possible solutions to address administrative burdens, including a simplification of the U.S. health care financial system, elimination or improvement of excessive administrative processes, and increased attention given to how initiatives impact patient access to care, particularly for small and rural, or underserved practices. Jeb concluded the presentation with an overview of state and federal entities that impact health care costs through

their mandates, e.g., the Legislature, the Department of Health, HCA, Labor & Industries, Congress, Center for Medicare, and Medicaid Services (CMS).
Margaret Stanley expressed her admiration for and agreement with the conclusions of Mika and Jeb's presentation. Margaret encouraged environmental impact statements for new requirements under consideration to account for total costs. Margaret also expressed a preference for eliminating PA's and using insurance providers' systems to identify any outliers.
Lois Cook highlighted how the service tax mentioned in the presentation affects small business' costs. Lois concurred with Margaret's recommendation to analyze outliers.
Leah Hole-Marshall observed that the board's role is to reduce cost growth which may not directly connect to the administrative costs outlined in WSMA's presentation. Leah also noted that the 2022 Health Affairs study comparing billing and insurance costs across countries was limited in scope.
Mika responded that the growth of practice management administrators cited in the presentation came from credible sources that covered a wide historical range. Mika also noted that the board's role encompasses more than cost growth, including addressing the drivers of underlying costs to reallocate resources in a wiser manner.
Jeb acknowledged the limitations of the Health Affairs study and offered to follow up with more data.
Sue asked Michael Bailit and January Angeles for information on other states' efforts to address administrative costs.
Michael responded that there hasn't been much prioritization of administrative costs with other states. Michael agreed with Jeb that there is a large research base that concludes administrative spending is waste, however, eliminating the waste won't necessarily affect cost growth. Michael asserted that analyzing administrative costs is still important because some of it is truly waste and administrative costs negatively impact primary care providers by increasing burnout.

Public comment

Katerina LaMarch, representing the Washington State Hospital Association (WSHA), began public comment. Katerina noted that hospitals, health systems, and outpatient care providers feel the weight of administrative processes and regulations, diverting time and effort which increase costs and impact access to care. Administrative costs contribute to physicians' drive to become part of larger systems. The board will look at cost growth benchmark in other states, including how to adjust for inflation, something WSHA has raised repeatedly over the years. It will be difficult to offset the significant increases in labor supply and drugs while limiting growth to the benchmark. The action plan from Mass General outlined in the board packet emphasizes moving post-acute patients out of the hospital, something which WSHA has requested assistance with. Addressing difficult discharges would reduce unnecessary costs by discharging patients to more appropriate care settings.
Sue noted that AnnaLisa would schedule time for the board to discuss inflation and difficult discharges.
Marcia Stedman, member of the board of directors for Health Care for All Washington, discussed the importance of simplifying health care to increase access and equity across the state for all residents. Marcia noted that simplifying administrative burden is key to achieving these goals. From a patient standpoint, Marcia questioned the validity of having PA's when so many are ultimately approved. Marcia also noted a shortage of providers and expressed hope for equalization of work effort across the healthcare spectrum. Sue responded that staff would gather more internal data on PA's.

Update on Cost Growth Benchmark Activities in Other States

January Angeles, Bailit Health

January gave a presentation on cost growth benchmark activities in other states which included an overview of California's legislation to establish cost growth benchmarks, the latest developments around benchmark data collection for Peterson Milbank states, an update on some states' approach to the impact of inflation on cost

growth, the development and implementation of accountability mechanisms in other states, and cost growth mitigation activities in other cost growth benchmark states.

January discussed California's creation of the Office of Health Care Affordability (OHCA) and its scope, mainly focused on three areas 1) managing cost growth targets or benchmarks 2) measuring system performance 3) assessing market consolidation. OHCA is modeled off Massachusetts and is the equivalent of the Massachusetts Health Policy Commission (HPC), just bigger and with greater flexibility. It will be built out over the next two years with an operating budget of almost $32 million and over 140 staff. January described OHCA's compliance mechanisms, including the establishment of benchmarks by 2025; annual reports and public meetings to assess performance; and enforcement, starting with technical assistance, and evolving over time to include public testimony, performance improvement plans (PIPs), and the assessment of escalating financial penalties.

Sue pointed out that California's large population is the equivalent of five Washingtons. Washington has five Managed Care Organizations (MCOs) and California has 28 in their Medicaid environment. January noted that there is a range of states doing this work, small states like Connecticut and Rhode Island, medium states like Washington and Massachusetts, and larger states like California. Mich'l Needham agreed that Washington's program is significantly different in size compared to other states.

January turned next to states' approaches to data collection. Connecticut, Oregon, and Rhode Island all collected and are now validating cost growth data for 2021. Nevada and Washington are in the process of collecting pre-benchmark data. New Jersey is finalizing decisions around cost growth measurement. Both Connecticut and Rhode Island have implemented the collection of quality data for commercial, Medicaid, and Medicare Advantage to complement the collection of cost growth data.

Sue asked January to elaborate on the collection of quality data in Connecticut and Rhode Island and noted HCA's partnership with the Washington Health Care Alliance on quality work. January responded that the quality data collection process occurred at the same time as the data call for cost data. Both quality and cost data are being analyzed at the same levels for the same provider entities and payers. January asked Michael what the metrics are. Michael explained that both Connecticut and Rhode Island have aligned measure sets like Washington which they are leveraging. Sue suggested that in Washington the Alliance has compiled cost and quality data using their proprietary data tool, but that this data is only for Alliance members, not for the entire state. Michael added that Massachusetts is doing similar work with quality as Connecticut and Rhode Island.

January transitioned to a discussion of the impacts of inflation on state benchmarks. All states had benchmarks set before a significant rise in inflation was observed. Inflation was discussed with the board previously, and at the time of that discussion, states weren't planning to adjust, but rather to interpret performance and results in the context of COVID and high inflation. Since that discussion, there have been some developments. January highlighted Rhode Island and Connecticut's approaches to inflation. Rhode Island is in the process of finalizing a methodology for 2023 through 2027 that will incorporate consumers' experience of costs and create a time-limited allowance to account for the current spike in inflation. Connecticut created new legislation which requires its Office of Health Strategy to review the current and projected inflation rate on an annual basis. A determination will be made to see whether the cost growth benchmark and primary care spending targets should be modified to account for the inflation rate. Connecticut will consider inflation at their October meeting.

Michael clarified that as of October 19, Connecticut reached an agreement to present options to their cost board to provide an allowance for inflation like Rhode Island's approach. The methodology won't be the same as Rhode Island's, but the concept will be similar. While Massachusetts is not a Peterson Milbank state, they have also adjusted upwards for inflation.

Sue asked when it would be prudent for Washington's cost board to begin discussions for possible inflation adjustments given that the data collection process is currently underway.

Michael responded that Washington could begin adjusting for inflation at any time but that the current data being collected comes from a period prior to the inflation spike.

Leah asked about next steps for the board to review inflation to adjust the current standard. January responded

that the board could decide that at any time. AnnaLisa noted there is not a built-in timeframe for reviewing the benchmark, but rather a standard for reviewing inflation. Sue acknowledged that Washington has more time before the data call in 2023 to monitor other states' approaches to inflation adjustments.

January's presentation shifted to a discussion of accountability issues, beginning with Massachusetts' Health Policy Commission's (HPC's) use of its first PIP to assess Mass General Brigham (MGB). MGB's commercial contracts contributed significantly to state spending growth with price and service mix driving costs more significantly than utilization. January provided details of MGB's PIP to address multiple dimensions of care delivery and pricing. MGB plans to reduce health care spending by $70 million annually by December 31, 2023. January also discussed Oregon's phased approach to implementing accountability mechanisms, including public identification of payers/providers, the application of PIPs, and the use of fiscal penalties. Oregon is in the process of finalizing its use of PIPs as a primary accountability measure with limited exceptions made for exceeding the benchmark. January outlined the conditions under which Oregon would employ PIPs and noted that the Oregon Health Authority (OHA) plans to engage organizations that exceed the benchmark in ongoing conversations to exchange data and allow for appeals when appropriate.

Finally, January presented a summary of other states' cost growth mitigation strategies. Some of these strategies include pharmacy price growth limits, accelerated multi-payer adoption of advanced VBP models, expanded regulatory constraints on market consolidation, and caps on commercial price growth and/or prices. January described Oregon and Rhode Island's pursuits of advanced VBP models.

Sue noted how small Rhode Island is (the equivalent of one of Seattle's neighborhoods) and that it's hard to compare Washington to Rhode Island because of the size differential. January acknowledged this discrepancy and pointed out that the same cost mitigation strategy will look different in different states.

Oregon also launched its health care market oversight program in 2022. Connecticut has focused on strategies to limit pharmacy price growth. Delaware is implementing a cap on price growth in commercial hospital contracts.

Adjournment

Meeting adjourned at 3:59 p.m.

Next meeting

November 16, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.