Health Care Cost Transparency Board meeting minutes

July 20, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 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

Sue Birch, chair
Lois Cook
Bianca Frogner
Jodi Joyce
Leah Hole-Marshall
Molly Nollette
Mark Seigel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Sonja Kellen

Call to order

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

Agenda items

Welcoming remarks

Approval of minutes

Ms. Gellermann shared that the June minutes contained in the Board materials were submitted in error, and had not contained a record of public comments,
Chair Birch directed that the June minutes be corrected and resubmitted for approval at the August meeting.

Advisory Committee Nomination and Vote

A candidate for the Advisory Committee of Health Care Providers and Carriers was, based on application materials included in the materials and staff recommendation. Justin Evander was nominated to replace departing member Bill Ely. Mr. Evander is the Executive Director for Care Delivery Finance for Kaiser Permanente Washington.

The application was approved.

Presentation: Washington Hospital Costs, Price, and Profit Analysis: First Look at a High Level

John Bartholomew and Tom Nash, Consultants

Mr. Bartholomew presented initial findings from his review of 2020 Medicare cost reports submitted by Washington hospitals. Mr. Bartholomew concluded that Washington hospitals, when ranked on price and cost against all other states, are higher than the median in both price and cost per patient. He also pointed out that Washington hospitals rank lower than the median in profit, as a measure of margin. He presented data over time demonstrating that hospital costs are increasing nationally and in the state. Mr. Bartholomew stated that Washington, based on its admission rate, was a relatively healthy state with lower admission rates. He shared that his review of trends in some key cost metrics show that trends increase from 2009 to 2014 that largely track national trends. He then pointed out that Washington metrics appear to trend higher beginning in 2014 to the present and suggested that further investigation and analysis might be pursued to verify and identify potential causes. He concluded that identifying hospitals of higher should lead to inquiry about what might be driving that cost, which could be a variety of factors.

One Board member asked if the information presented was adjusted for patient population, including considerations of acuity and/or health conditions and services sought. Mr. Bartholomew responded that Medicare reports contain information on the inpatient case mix, in which Washington is ranked in the middle third of the country on overall healthiness. In Colorado, Mr. Bartholomew was able to obtain additional information from their claims data base, and that this information could also be obtained from the Washington APCD.

One Board member asked for clarification of hospital cost per patient vs. cost per patient. Mr. Bartholomew explained that hospital only cost is based on what Medicare allows, while total cost per patient would include other sources of cost and revenue including investment income, and costs that vary from hospital to hospital. Mr. Nash shared that hospital only costs were generally 75-80% of total cost.

One Board member asked if they had performed an evaluation and done adjustments on Washington labor costs, and/or cost of living. Mr. Bartholomew responded that he could break down hospital costs into overhead (including salary) and medical costs, which might be interesting, but that he had not done it here. Mr. Nash responded that they had used the "C2ER" cost of living index, which was widely used.

One Board member asked why 2020 had been chosen as the data year, as it was a statistical outlier, and whether they had considered the impact of the lack of elective procedures which would be expected to have an outsize impact on cost and profit. Mr. Bartholomew responded that it was the most recent data set, and self-reported data. He recommended looking at more years and additional data sources in further study.

One Board member asked if more detail could be provided under consolidated line items, including on-patient income and cost lines and operating expense lines to better point to what drivers might be to the relatively high Washington operating expenses as reflected in the relatively low profit. Mr. Bartholomew said he could investigate and provide more information if that was of interest to the Board.

One Board member questioned whether the Board, charged with looking at overall trend and year over year increases should appropriately be focused on profit margin as a measure, especially when most Washington hospitals are non-profit. Mr., Bartholomew responded that profit could be a useful benchmark to prompt additional and deeper dives into information, agreeing that there are many reasons for variance in profit including size, geography, market power, and others.

Presentation: Washington State Hospitals: A Primer on Washington Hospital Costs

Johnathan Bennett, Vice President of Data and Analytic Services, Washington State Hospital Association
Bruce Deal, Economic Expert for the Washington State Hospital Association

Mr. Bennet began the presentation by stating that he and his team were eager to partner with the Board and payers in controlling health care costs while maintaining access to quality health care. He also wanted to provide information about Washington hospitals and the role they play in the health care ecosystem, and the challenges currently facing them.

Mr. Deal provided an overview of medical cost growth. Mr. Deal described medical cost growth as driven by three primary factors: overall inflation, cost growth beyond inflation, and increased use of care. Discussing historic trends reported by Kaiser Family Foundation, he indicated that in the last decade spending growth on hospital, physicians and prescriptions has slowed from historic growth levels, with hospital spending growing at 4.6% in the 2010s. Mr. Deal then focused on hospital spending as representing 31% of overall healthcare spending, compared to drugs at 8%, physicians and clinics at 20%, and other healthcare at 27 percent. He also contrasted Washington's benchmark values with projected estimates of health care expense increase and inflation.

Mr. Deal reviewed the Washington hospital system, including information about ownership of non-hospital services. size and location, type, and affiliation. 2/3 of patient days in the hospital are provided by 19 larger hospitals of 250 plus beds and he described this as a system driven state represented by 5 large systems and several smaller ones.

He then turned to the topic of hospital cost both generally and in Washington, relating cost to payors and individuals and its relationship to revenue, which is driven the volume of patients, services used per patient, and price per service. Mr. Deal described Washington hospital admission, utilization, and length of stay as very low compared to national standards. Washington hospital spending per beneficiary in the Medicare market is also comparatively lower. Mr. Deal cited the 2022 Rand study and pointed out that Washington hospital price levels in the Medicare market are also comparatively low, averaging in the bottom 3 of all states. He emphasized that based on the Rand results, Washington is not a particularly high-priced hospital state on a price per service basis.

He then pivoted to the cost of running a hospital, with four "buckets" of costs: employee cost, supply cost, purchased services (including travelling nurses) and facility/equipment cost. To provide a sense of where dollars are spent, he estimated that a 300-bed hospital with 50+ departments cost approximately 500M per year in costs. Salaries and benefits represent about 60% of the cost, with an average of 125,000 per FTE in salary and benefits. He detailed percentages of other costs also.

Mr. Deal emphasized that Washington hospitals are currently having a major financial at this time. Specifically, per WSHA survey data hospital employee cost increased 10% in 2021-2022. He also focused on the issue of increased utilization of travelling nurses at a large increase in cost. He shared an analysis of net income of Washington hospitals showing it is historically a low profit state, with substantial variation between individual hospitals. He pointed out that hospital systems created a "portfolio effect", with hospitals in the system having varied profit levels. This resulted in some protective subsidy between hospitals in a system. He emphasized that hospital margins are deteriorating real time, and all large hospitals in the Washington state are losing money, and an average of a negative 10%. From a big picture economic perspective, he shared that while there may be a cost problem in Washington hospitals there is currently a major crisis and hospitals were highly motivated to keep cost down. But they cannot control the current rise in labor costs, and many hospitals are at risk.

One Board member shared a patient experience at the two hospitals in the region, and reported that they were very different, wondering if it could be based on a difference in prices, charges, or financial management. Mr. Deal responded that many researchers were looking at the question of variation in quality as related to cost. It was also indicated that acuity and number of patients can impact the quality of services.

One Board member queried whether profit margin was the appropriate measure for the Board to consider but appreciated the information in the presentation. She encouraged the Board to look at quality measures as well.

Public Comment

Ms. Birch called for comments from the public.

Parnian Karimi, Washington Public Interest Research Group (WashPIRG) Students, UW and Evergreen chapters. Ms. Karimi's dream is to become a doctor, but a degree is not enough when many people cannot afford or access care. She recently shadowed a neurosurgeon who had a patient with a spinal tumor and rapidly worsening condition who was told that her surgeon was out of network, resulting in a bill that they could never afford. The insurance company could not be contacted by the surgeon, and the patient was eventually forced to go to the emergency room where she luckily received treatment. No patient in her condition should have to worry about cost. As a future doctor I urge you to make sure patients are better protected and better represented on this Board.

Joelle Craft, member of Washington Community Action Network (Washington CAN). The patient experience should be centered in the work of this Board. Diagnosed with multiple sclerosis at 16, I have carried the burden of high medical debt due to unaffordable drugs and costs of care I need to survive. The high medical costs have impacted my life- I have had to live with my family due to medical bankruptcy, I live in a crowded home with more people than is comfortable all because of the cost of my necessary care. Exorbitant profits are balanced on the backs of the sick and disabled. I am calling on the Board to provide equal access and time for patients, including patient advocates who can propose solutions. Washington CAN will be submitting a formal request on this topic.

Noreen Light, member of Washington CAN. I've advocated for many friends and family, recently including a nephew who has substance use disorder and a serious accident. It was so difficult to find out available services and cost for his necessary treatment. He was released from the hospital with no home, no transportation, no prescription. I've advocated for my senior parents, and incarcerated people-trying to get them appropriate medical care. I am privileged, I have insurance, and it is still difficult for me to access care. This Board needs to center the voice of people and patients in their discussions.

Joselito Lopez, member of Washington CAN. I'm here to follow up on my comments from last month, and I'd like to hear the Board's perspective on increasing the power of patient perspectives. The mistaken June minutes were unfortunate and emphasized the point I am making that patient voices are not an afterthought but an essential stakeholder in this process. We need to hear how patients will have a more robust representation on the Board, and how consumer advocates can share sound policy solutions for the benefits of state residents. It would be the right thing to have patients on the Board, so you know how real life is affecting us. As a Latino, I see how it impacts us and I see how people cannot afford care because they are undocumented, or don't have insurance, or can't afford it. We need patient voices on the Board.

Consuela Echeverria, member of Washington CAN. I'm at a loss to understand when we're talking about excessive cost of health care why the excessive cost of billing and insurance related expenses are not being shown. I think we are still under the impression that value-based payments and the private insurance model is the only option we have. But the 2017 paper by Wollenhandler and Hammerstein, that I recommend reading, puts the total cost of administration at 1.1 trillion dollars. Moreover, per the Center of American Progress, US health care payers and providers spend almost 500,000 billion dollars on billing and insurance related costs. To truly understand the drivers of hospital loss of profit and the high cost of care, BIR needs to be included.

Presentation: Pharmacy Pricing, Purchasing and Access

Ryan Pistoresi, Assistant Chief Pharmacy Office, Health Care Authority

Due to length of the prior presentations, this presentation did not occur.

Adjournment

Meeting adjourned at 4:00p.m.

Next meeting

Wednesday August 17, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.