

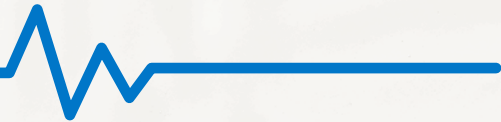
Beyond Hospital Transparency

GETTING TO FAIR PRICE



A Playbook for Employers/Purchasers and Regional Business Coalitions on Health

Thank you for reading
***Beyond Hospital
Transparency:
Getting to Fair Price***



This playbook offers...

- ▶ An understanding of how to use the latest hospital price transparency tools
- ▶ Insight into employer fiduciary rights and responsibilities
- ▶ Actionable market- and policy-based strategies to drive value-based care

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Employers Need to Stop Paying Indefensible Hospital Prices

Hospital costs are one of the fastest growing expenditures in the US economy with employers and employees paying the highest prices in the world. These costs have been further exacerbated by market consolidation where health systems increasingly operate with little or no competition or market constraints. This has allowed indefensible hospital pricing and minimal constraint on cost growth, further “investment” in market consolidation, and bloated overhead costs.

We’re entering a new era of transparency and the curtain of secrecy is lifting. While the battle to curb healthcare costs has been going on for decades, it wasn’t until recently that employers and other purchasers had access to the data to truly understand just how non-responsive the system has been. Employer-led studies from RAND Corporation show that **employers routinely pay two to five times what is charged by Medicare for hospital care**. And most recently the National Academy for State Health Policy (NASHP) released a tool to help employers better understand the indefensible hospital profit margins even after accounting for high underlying cost structures and subsidies of other markets.

Clearly prices cannot be evaluated independently of quality and the complexity of patients and services provided but the data is reinforcing that better quality and higher prices do not go hand-in-hand. This has been an eye-opener in many markets, debunking the claim that current hospital prices can be justified based on inadequate public sector payments, uncompensated care, charitable donations, higher quality care, or even current hospital costs.

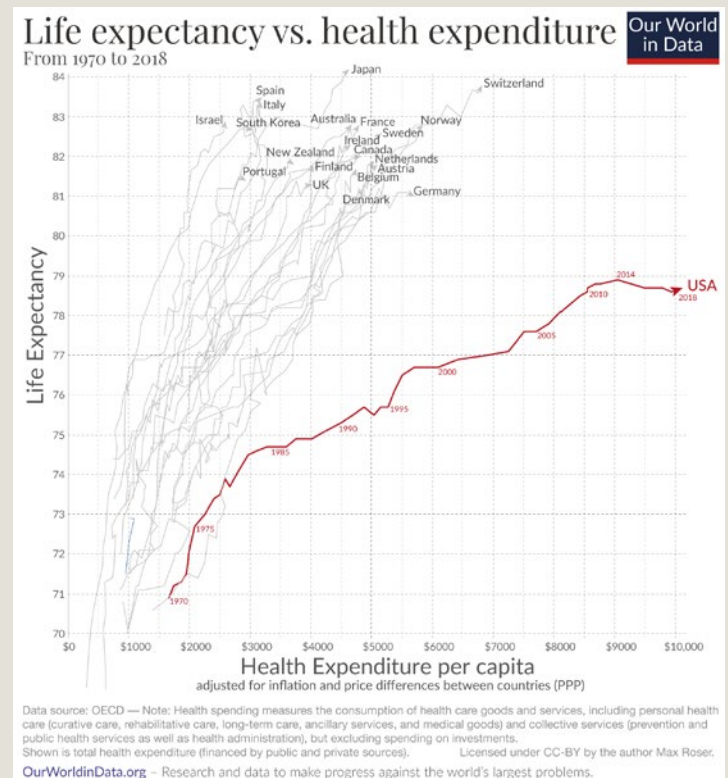
[Sage Transparency](#) is helping synthesize multiple sources of data to bring greater focus to the current state of hospital prices

in the commercial market (plan sponsors, not Medicare, Medicaid or other government programs). This Playbook will help purchasers navigate the data, understand rights and responsibilities as a plan sponsor fiduciary, determine what a fair price is for hospital services in specific marketplaces, and offer guidance about options available individually and collectively to achieve fair pricing for hospital services.

Employers not only have the right, but also the responsibility as plan fiduciaries, to ensure they are paying fair prices for the services provided. The

US Healthcare Costs Exceed Those of Other Developed Countries with No Clear Benefit

The US spends far more on health than any other country, yet the life expectancy of the American population is shorter than in other countries that spend far less. Learn more at <https://ourworldindata.org/us-life-expectancy-low>.



Consolidated Appropriations Act (CAA) not only enabled greater transparency in healthcare but also reinforced the fiduciary responsibility to understand the reasonability of what is being paid for that service. No plan services are greater in magnitude than hospital care and now, with transparency, we know we are often not being charged a fair price. In addition, while transparency can be illuminating, there can also be unintended consequences if employers and purchasers don't act promptly and decisively. As some

“Regional purchaser coalitions, with the active support and engagement of their members, can play a major role in driving and leveraging transparency data to improve quality and value. In fact, much of the transparency on quality and price achieved to date is directly attributable to the work of regional coalitions operating in the interest of employer-members.”

healthcare providers have learned that they are charging less than their competitors or are being challenged by payers to level the pricing landscape among different payers, they are seeking to raise prices further!

The data make it clear that the market has not controlled hospital costs and especially hospital pricing.

Through market and policy reform, we can and must act—individually as plan sponsors and collectively as a purchaser community—to demand value and fairness in the biggest segment of the healthcare industry.

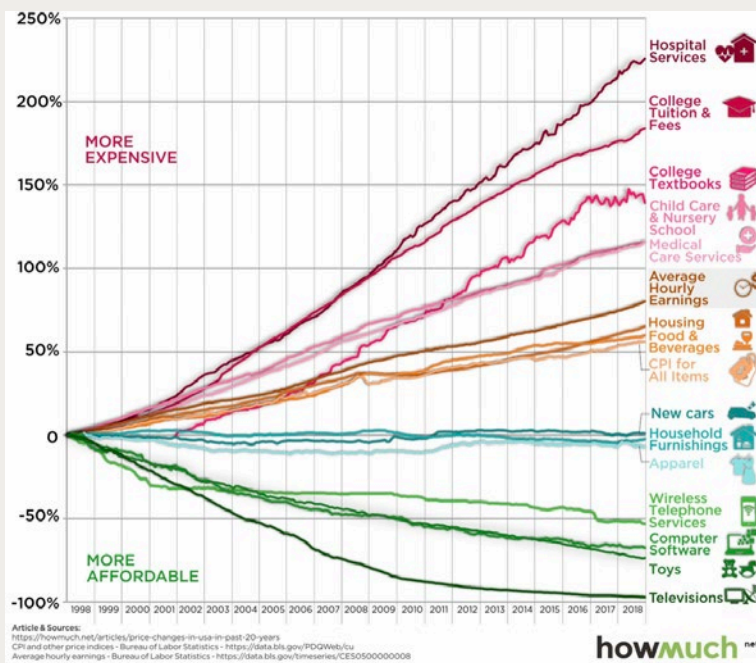
Michael Thompson

President and CEO

National Alliance of Healthcare Purchaser Coalitions

Hospital Price Increases Have Outpaced Every Major Segment of the Economy

Selected Consumer Goods & Services, Wages (January 1998 to December 2018)



Source: https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx

Hospital Price Transparency 101

Understanding the Basics



How we got here

- ▶ US employers and employees pay the highest healthcare prices in the world. High health benefit costs come **at the expense of core business investments, hold down wages, dampen business growth, squeeze family budgets**, and are the primary cause of **personal bankruptcies**.
- ▶ Hospital mergers increase the average price of hospital services by 6%–18%.
- ▶ Health plans and hospitals have relied on gag clauses to prevent employers and consumers from seeing the negotiated prices. For employers that means they don't know what they are paying for at the individual hospital level, and they have often been forced to accept how fees are negotiated and bills are paid by their intermediaries.
- ▶ As unsustainable healthcare costs continue to rise, regional coalitions, employers and other healthcare purchasers have begun to demand price transparency to be able to contract for hospital provider services that offer the greatest value—best quality care at a fair price.
- ▶ Until recently, there has been no way for employers to calculate value because there was little transparency on price. This has led to a national movement to increase transparency.

Age of transparency—what the data show

- ▶ Now in its fourth round, the [RAND National Hospital Price Transparency Report](#) incorporates claims data from employers, private insurers, and 11 state all-payer claims databases for more than 4,000 hospitals and 4,000 additional ambulatory surgical centers across 49 states and the District of Columbia (Maryland is excluded due to their all-payer rate-setting model, which sets a hospital's reimbursement level constant across payers). The study found:
 - In 2020, across all hospital inpatient and outpatient services (including both facility and related professional charges), employers and private insurers paid **224%** of what Medicare would have paid for the same services at the same facilities.
 - Some states (Hawaii, Arkansas, and Washington) had relative prices below 175% of Medicare prices, while other states (Florida, West Virginia, and South Carolina) had relative prices that were at or above **310%** of Medicare prices.
- ▶ In a complementary analysis, the National Academy for State Health Policy (NASHP) released a [Hospital Cost Tool](#) that indicated a hospital's commercial breakeven averaged 127% nationally and varied widely by both state and health system. This amount would not only cover the costs of employer-related admissions, but any subsidies required for Medicare, Medicaid and uncompensated care as well expenses not recognized as eligible under Medicare. For much of the hospital market, the gap between actual Hospital Facility Commercial Prices and Commercial Breakeven Prices as defined by NASHP appears indefensible given all factors considered in the analysis.
- ▶ [MedPAC has reached similar conclusions](#), finding that low margins on Medicare patients result

from high-cost structures that have developed in reaction to high private payer rates which have largely not been constrained by the commercial payers. They also concluded that relatively efficient hospitals can be financially viable with prices close to Medicare payment levels.

- ▶ Taken together, all the data collectively demonstrates that many hospitals are charging too much to employers and other plan sponsors and that such charges **cannot be justified** by uncompensated care, subsidies required for public program shortfalls, case mix, quality performance or even their current cost infrastructure. There have been many parties that have contributed to these conclusions including RAND, Rice University, Mathematica, NASHP, and MEDPAC.

Where do we go from here?

- ▶ Now is the time to have an honest discourse on what is reasonable for employers to pay for services. Despite the industry's effort to poke holes, the growing number of credible studies and tools only reinforce the need for purchasers to stand up to an industry that has long gone unchecked and out of control.
- ▶ Employers, as plan sponsor fiduciaries, have both a right and responsibility to understand and demand fair prices for services provided to plan beneficiaries. As such, they must act quickly and decisively to use this information to exert pressure on health plans and hospitals to negotiate reasonable prices, and with legislators to drive policy changes.

- ▶ Employers must expect health plans and hospitals to shift from the current hospital payment system to one that is based on a reasonable multiple of Medicare or another similar benchmark. This should be the foundation for payment upon which value-based strategies can be built, including population-based payments, bundled payments for episodes of care, accountable care organizations, centers of excellence, and high-performing networks. The more we can standardize, the more effective will be the framework for change.
- ▶ If market pressures cannot bring this in line, then policy-based corrections (regulations) should be considered. This is especially the case in which monopolies or providers with market power have raised prices above a reasonable level. Stronger oversight of proposed mergers and acquisitions is needed to ensure that they will not result in higher prices, and prohibitions on anti-competitive practices such as gag clauses should be put in place.



Plan Sponsor Fiduciary Rights and Responsibilities

Using the Latest Hospital Price Transparency Tools Helps Plan Sponsors Fulfill Fiduciary Rights and Responsibilities

The Consolidated Appropriations Act of 2021, enacted in 2020, raises the bar for employer-sponsored health plans, which, as fiduciaries, requires them to pay fair prices for services provided. The law—along with the transparency in coverage rule issued in November 2020—requires health plans to make their negotiated rates public starting July 1, 2022, and hospitals were required to do the same in 2021.

That means employers that do not know whether they're paying reasonable prices could face a heightened risk of lawsuits and considerable fines. According to a RAND Corp. report, employers and health insurers paid hospitals more than double what Medicare would have paid in 2020, on average, and sometimes much more. The data suggest that these prices are often indefensible and not reflective of a fair price for services rendered.



Who is a fiduciary?

- ▶ Anyone who exercises discretion over plan assets (e.g., CEOs, CFOs, COOs, board members, benefits committees, HR executives, benefits administrators, benefits consultants, benefit trusts)
- ▶ Almost always the plan sponsor
- ▶ Claims administrators

What does it mean to be a fiduciary?

ERISA requires fiduciaries to discharge their duties:

- ▶ For the EXCLUSIVE BENEFIT of the plan and participants
- ▶ Using the skills of a prudent person
- ▶ In accordance with the plan's documents

What are the consequences of breaching fiduciary responsibility?

As important, a plan sponsor that does not manage the plan assets prudently could be subject to civil or class action suits particularly when the prudent person standard is breached. Market transparency has the potential to escalate these risks, the same as it did for plan sponsors of retirement plans years ago. Personal liability to restore any losses to the plan resulting from their actions or inaction:

- ▶ 20% penalty assessed by the DOL
- ▶ Removal from fiduciary status
- ▶ Possible criminal penalties

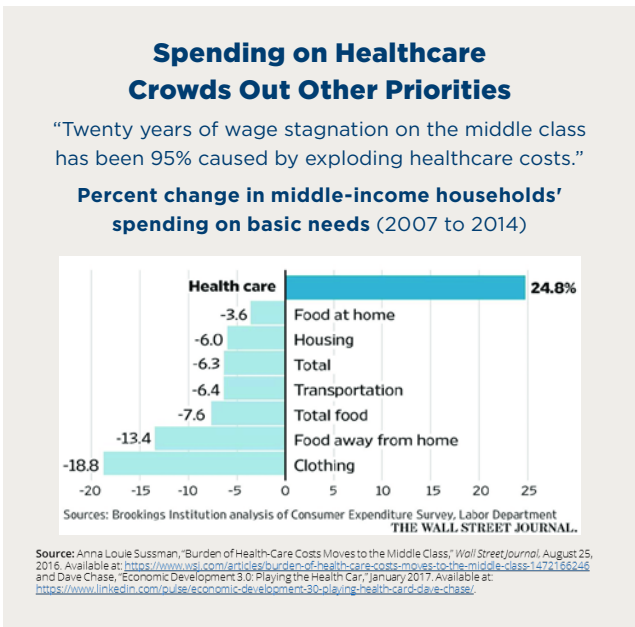
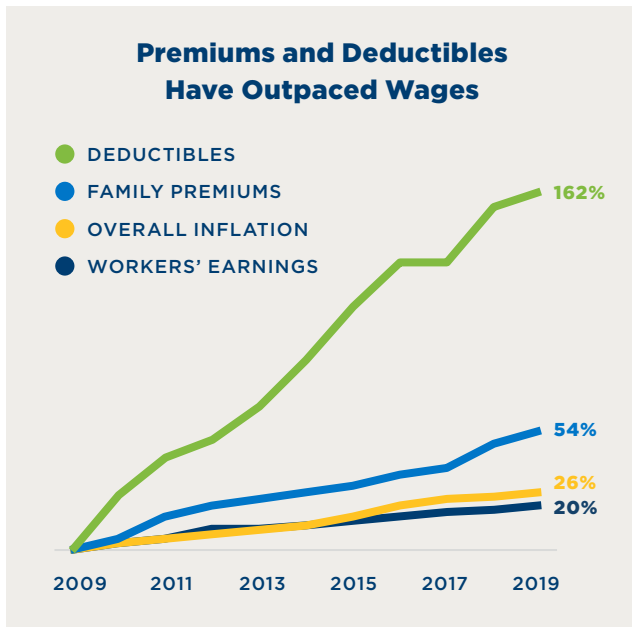
Plan Sponsor Requirements

- ▶ Act *solely* and *exclusively* in the best interest on benefit plan sponsors
- ▶ Pay only *reasonable* plan expenses
- ▶ Abide closely by *plan documents*
- ▶ Carry out duties *prudently*, which means with expertise and a thoroughly documented process
- ▶ Hold plan assets in trust

The Fiduciary Dilemma

- ▶ CAA requires fiduciaries to pay a fair price for services provided
- ▶ RAND and NASHP data suggest some health systems are charging well beyond “fair price,” driven largely by hospital costs

- ▶ Key contributors to hospital costs:
 - Consolidation leading to less or no competition
 - Lack of transparency
 - Anti-competitive practices



“Plan sponsors—both as fiduciaries and under the Consolidated Appropriations Act—have a responsibility to pay a fair and reasonable price for services rendered. However, determining a fair price across hundreds of different services requires homework on the part of the plan sponsor as well as collaboration with the plan administrator or intermediary. Additionally, in consolidated markets where suppliers (regardless of tax status or mission statements) are apt to exhibit oligopolistic or monopolistic behaviors, plan sponsors will likely want to engage policy makers and legislators as well. Actions can take many forms, both market-based and policy-based, and may come with limitations on their impact. Different plan sponsors may reach different conclusions on how to approach this, but a common approach to assessing reasonable hospital pricing—such as referencing to Medicare and benchmarking to either MedPAC’s “Payment Adequacy Analysis” and/or NASHP’s Hospital Cost Tool—is essential.”

—BOB SMITH
 Executive Director
 Colorado Business Group on Health

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Leveraging the New Hospital Price Transparency Tools

Understanding Quality Ratings and Costs



CMS Hospital Quality Star Ratings

Star ratings are based on a five-star scale and compare hospital performance to other hospitals in their peer group. Ratings are constructed from an average of around 37 measures across five quality categories: Mortality, safety of care, readmission, patient experience, and timely and effective care. Each measure category accounts for 22% of the score except for timely and effective care which is 12%. CMS evaluates approximately 4,500 hospitals and publicly reports ratings on the Care Compare website.

Healthcare Bluebook

CareCheck by Quantros evaluates almost 40 different clinical categories such as heart failure treatment, joint replacement, pneumonia care, and others. The measures fall into five equally weighted categories: Mortality, complications, readmissions, patient safety, and inpatient quality. It's widely known that quality varies not just across hospitals but within hospitals. Therefore, the Quantros quality is extremely helpful to evaluate quality at the procedure level.

Leapfrog Hospital Safety Grades

The Safety Grade is comprised of 22 measures from CMS, the Leapfrog Hospital Survey, and other sources to measure patient safety in hospitals. Measures fall

into two categories, process/structural measures and outcome measures. Each category accounts for 50% of the overall score. The methodology has been peer reviewed and published in the Journal of Patient Safety. Nearly 3,000 hospitals are graded twice a year and publicly reported at <https://www.hospitalsafetygrade.org>.

National Academy for State Health Policy (NASHP)

The NASHP Hospital Cost Tool (HCT) dashboard aims to provide state policymakers and researchers with analytical insights into how much hospitals spend on patient care services, and how such costs relate to the hospital charges (list prices) and actual prices paid by health plans. The dashboard reports on a range of measures for hospital revenue, costs, profitability, and breakeven points across over 4,600 hospitals nationwide for the period from 2011 through 2019. The dashboard offers options to view data at the hospital, state and health system levels. The underlying HCT dataset includes approximately 60 variables extracted and calculated using data from the national Healthcare Cost Report Information System (HCRIS) as the main data source. Hospitals in this dataset represent approximately 70 million patient discharges and \$49 billion hospital net income in the most recent reporting year.

RAND

Published by the RAND Corporation in May 2022, the [RAND 4.0 study](#) reported on 2018-2020 medical claims data from a large population of privately insured individuals. In 2020, across all hospital inpatient and outpatient services (including both facility and related professional charges), employers and private insurers paid **224% of what Medicare would have paid** for the same services at the same facilities.

Turquoise Health

Turquoise Health is a price transparency platform that brings together healthcare provider rates and procedure data. The Turquoise Health limited research dataset is built using publicly available data disclosed by hospitals

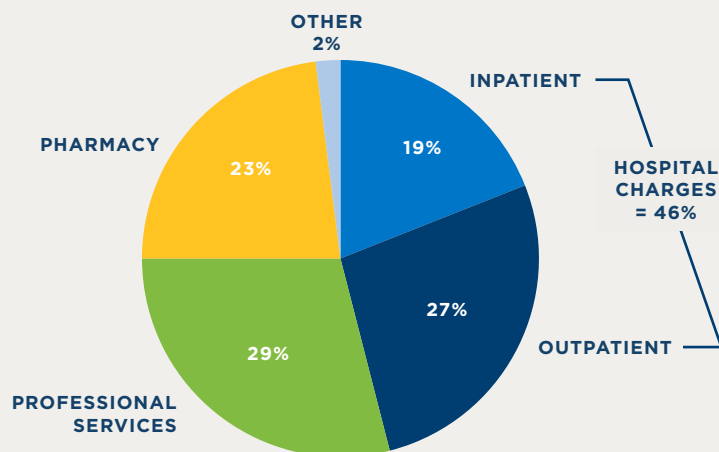
across the US in compliance with the machine-readable file requirement of the CMS Hospital Price Transparency Regulation (45 CFR §180.50). Included in this dataset is the facility fee portion for a curated list of shoppable services mandated for disclosure by CMS.

There are several ways to achieve the best value. The goal to achieving the highest quality care for the lowest cost is to identify which hospitals in your market are performing better than other hospitals at lower costs. One way to achieve this is to plot hospitals based on price and quality, identifying the best-value hospitals. You can plot any of the quality metrics against RAND price metrics and/or the NASHP breakeven cost metrics.

- ▶ A relatively efficient hospital can manage at or close to the Medicare price levels overall

- ▶ NASHP defines the current breakeven for a hospital as a percentage of Medicare (even if they have higher overhead spending)
- ▶ Some of the “other considerations” are considered in the NASHP Commercial Breakeven (see “NASHP Commercial Breakeven Covers More than you Think” on page 8):
 - Reasonable margins
 - Existing margins and market share of Medicare and Medicaid
 - Capital investments
 - Market dynamics (e.g., nursing salaries, personnel shortages)
 - Relative quality and safety metrics

Hospital Costs Contribute to 46% of Plan Sponsor Healthcare Spend in 2022



Source: [2022 Milliman Medical Index, May 2022](#)

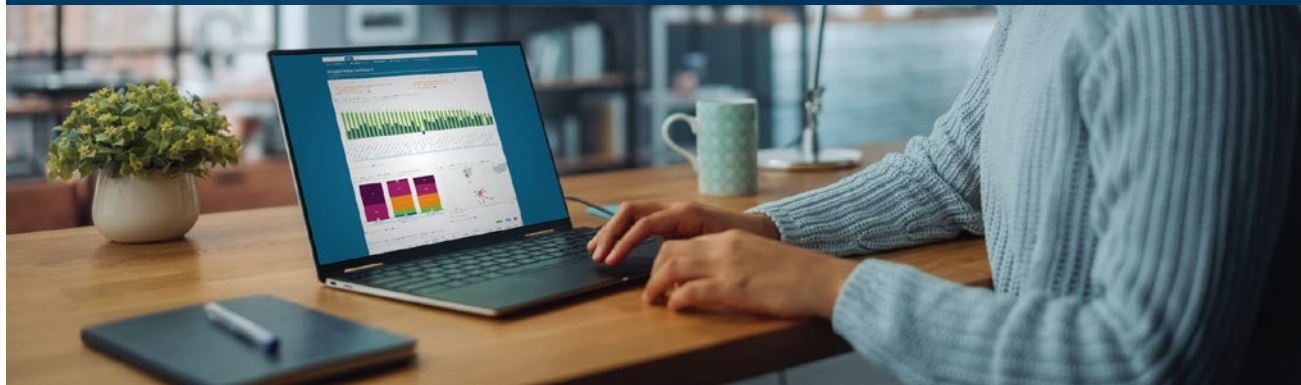


Breakthrough Hospital Price Transparency Tools Equip Employers to set Price and Quality Expectations

Sage Transparency Hospital Value Dashboard (<https://employerptp.org/sage-transparency/>)

Employers’ Forum of Indiana has developed a first-of-its kind tool that brings together public and proprietary data on hospital pricing and quality. [Sage Transparency](#), its hospital value dashboard, gives users access to price

and quality data for thousands of hospitals across the US. It’s not uncommon for the highest quality hospitals to have the lowest price—or for the lowest quality hospitals to have the highest price.



Sage Transparency’s Data Sources : A Powerhouse for Changing Healthcare

PUBLIC	<p>RAND 4.0 Prices paid by employers & insurers Claims data from employers, insurers, and APCDs</p>	<p>NASHP Hospital Cost Tool Commercial breakeven price Federal government data submitted by hospital</p>	<p>CMS Hospital Star Rating Quality ratings Posted by the federal government</p>
	<p>Turquoise Health Prices posted by payer Hospitals’ own websites aggregated by Turquoise Health into clinical categories</p>	<p>Quantros/ Healthcare Bluebook Quality ratings Determined by Quantros</p>	
	<p>PROPRIETARY</p>		

NASHP Commercial Breakeven Covers More than You Think

[Sage Transparency](#) includes access to the 2022 [Hospital Cost Tool](#) developed by the National Academy for State Health Policy (NASHP) in partnership with the Rice University Baker Institute for Public Policy and Mathematica Policy Research. This tool reveals hospital profit margins even after accounting for high underlying cost structures and subsidies of other markets. The NASHP Commercial Breakeven is how much a hospital needs to be reimbursed by commercial payers to cover its expenses and other shortfalls. NASHP Commercial Breakeven includes:



- 1. Commercial patient hospital “operating costs”** — derived from the Medicare Cost Reports based on the Cost to Charge Ratio for that hospital (includes overhead costs).
- 2. Shortfall or overage from public health programs** — Medicare Cost Report includes the detailed costs for Medicare. All other public health programs are calculated by the Cost to Charge Ratio **reported by the hospital**.
- 3. Charity and uninsured patient hospital costs** — based on actual operating costs rather than being shown at charge master rates. The hospital is required to report the actual COST of uncompensated care.
- 4. Medicare disallowed costs** — any costs not associated with direct patient care, so will include **research, meals to non-patients, unrelated home office costs, physician direct patient services**.
- 5. Hospital other income** — any COVID-19 funds, investment earnings, joint venture earnings, **340B profits**, facility fees, grants, contributions, etc.
- 6. Hospital other expense** — besides expenses described above, there may be expenses incurred for joint ventures, hospital owned and rented property, penalties and fines, etc.

“Sage Transparency brings together multiple sources of high-quality data on hospital price, cost, and quality of care. In the past, if you wanted to see how one local hospital group performed relative to another it would take hours poring through spreadsheets—not to mention subscription costs paid to data providers—to track down all the relevant information. Employers’ Forum of Indiana developed Sage Transparency as a free, publicly-accessible tool that any user can customize to their needs in a few clicks. As more information is made available through implementation of new price transparency laws, data in the tool will update and evolve.”

—GLORIA SACHDEV
CEO
Employers’ Forum of Indiana

Hospital
Information



Getting to Fair Price

Getting to Fair Price

The recent increased availability of hospital price data gives employers the ability to make comparisons not only by hospital system but health plan, procedure, and Medicare benchmarking. Employers now have the ability to use this data to determine if they are being charged a fair price for services under their health plans. This chapter contains specific and actionable strategies for determining a fair price. Recognizing that there isn't a one-size-fits-all approach, variations such as quality sources and ways to identify the best value are identified.

We know from MedPAC, that reasonably efficient hospitals can break even across all their business at Medicare prices. However, it is clear from the NASHP data that most hospitals have not felt the market pressure to operate at a reasonably efficient level.

While hospitals may need to charge more than Medicare for their commercial business to make up for losses on Medicaid and any charity care, the volumes of this care come nowhere near justifying the magnitude of hospital prices on the commercial segment. In fact, the national average NASHP commercial break even as a percentage of Medicare is 127% but there is wide variation across the country and within markets. Consequently, we have determined that a fair price for higher cost hospitals (NASHP Commercial Break Even over 130% of Medicare) should anticipate lower margins over current cost levels recognizing that some of the margin should be achieved through cost reduction or containment. Hospitals whose cost structures are closer to being “reasonably efficient” may reasonably expect a higher margin on those cost structures.

PROCESS TO ACHIEVE A FAIR PRICE

1 Comparison to costs



Determine what hospitals need to charge commercial customers to break even overall using the NASHP commercial breakeven calculation (considering all other incomes and expenses)



If hospital(s) commercial breakeven is greater than 130% of Medicare it's likely the hospital is operating overall materially above Medicare cost levels. MedPAC indicates that relatively efficient run hospitals can operate at or near Medicare cost levels

C

IF COMMERCIAL
BREAKEVEN IS
**GREATER THAN
130%**
OF MEDICARE
THEN **ADD A
10%**
MARGIN
TO THE
COMMERCIAL
BREAKEVEN
(CBE% X 1.1)

IF COMMERCIAL
BREAKEVEN IS
**LESS THAN
130%**
OF MEDICARE
THEN **ADD A
20%**
MARGIN
TO THE
COMMERCIAL
BREAKEVEN
(CBE% X 1.2)

If commercial breakeven (CBE) is over 130%, then add 10% margin (CBE x 1.1) to the commercial breakeven and assume that's reasonable; if it's under 130% of Medicare add 20% to the commercial breakeven (CBE x 1.2) and assume that's reasonable

2 Comparison to peers



Determine how hospital charges compare to similar (peer group) hospital charges. Consider hospitals whose services are comparable, and quality is at least as good as the comparison hospital.



If peer group hospitals in your market are more than two times Medicare, also compare to other states and the national average to make sure the market isn't a outlier (higher than it should be).

3 Fair market price

It's reasonable to assume the fair market price is in the range between 1C and 2B

Medicare price plus 10% to 20%
reasonable margin

Peer pricing

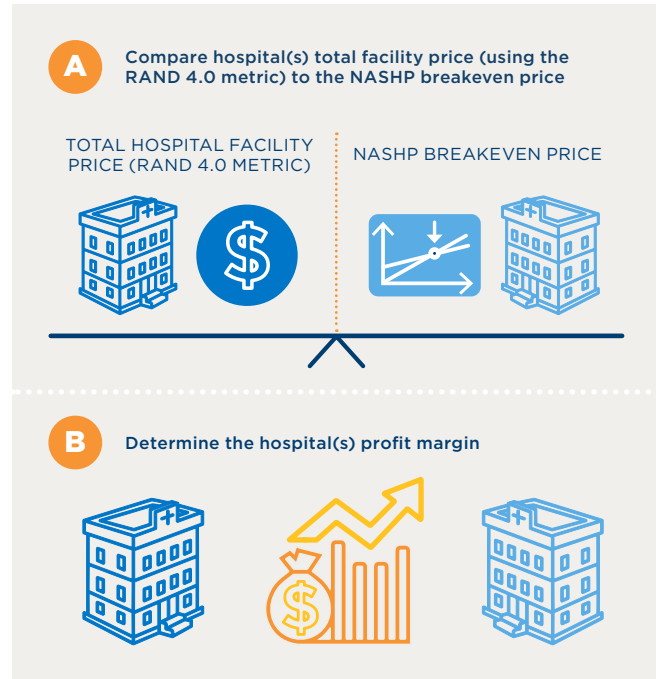


Determining what the hospital needs to charge

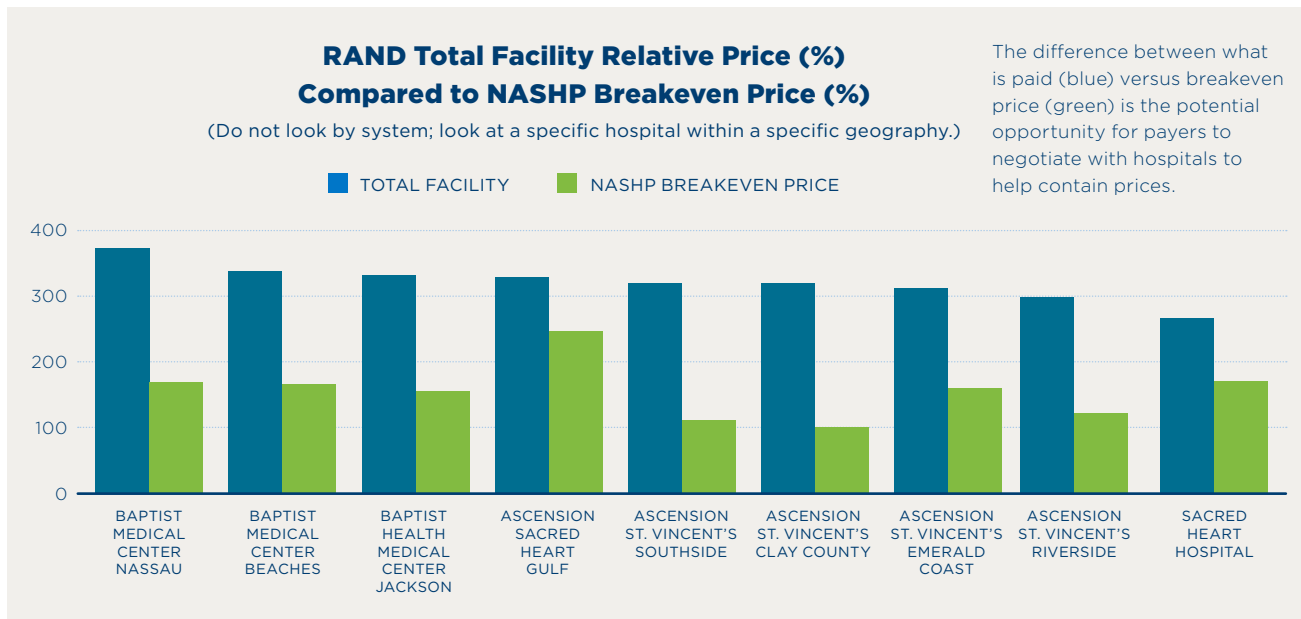
Determining a fair price relative to Medicare is a helpful benchmark because it uses an objective approach by adjusting for factors, including cost of living, teaching hospital, and uncompensated care, among others. Accordingly, NASHP developed a commercial breakeven calculation that accounts for revenue vs. expenses for charity care, uncompensated care, and other payers such as Medicare and Medicaid.

NASHP’s commercial breakeven metric is comprehensive, representing what hospitals need to charge commercial payers as a ratio of their Medicare reimbursement rate in order to break even. The metric acknowledges that there is a low reimbursement for Medicare and is generous in its computation, even including non-allowed Medicare expenses. The 2019 national average, median US breakeven point, is 127% of Medicare.

To use a specific example, the picture below shows the total facility metric (RAND 4.0) compared to the NASHP breakeven price for a health system in Florida. These hospitals charge between 32%–212% of Medicare more than required to break even.



MedPAC suggests relatively efficiently run hospitals should be able to operate relatively close to Medicare prices. Therefore, strive for a reasonable markup on their costs based on what the hospital needs to charge; 10%–20% is a reasonable markup from the Medicare price, depending on their current cost levels.

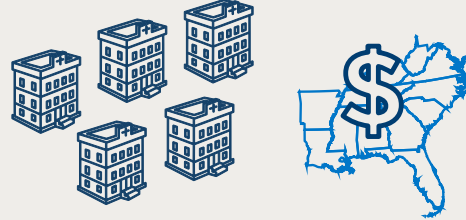


Determine if hospital prices are in line with competitors

ACTION STEPS

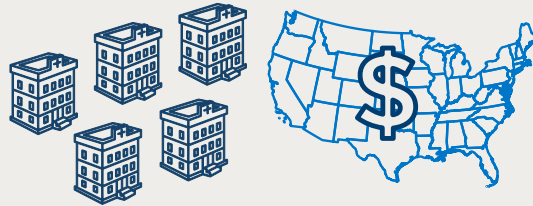
1 Consider regional peer group

Consider a regional peer-grouping of similar hospitals to develop a regional pricing benchmark. Peer groups should be hospitals with similar characteristics such as quality scores and regional/geographic region.



2 If no regional peers, develop national peer group

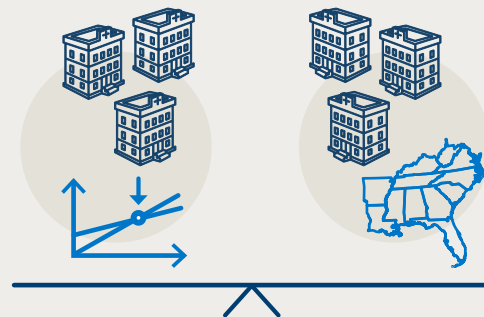
If you can't identify similar hospitals within the region, consider developing a national peer group by identifying like hospitals nationally such as grouping with other clinics within the system that are in different geographic areas.



3 Compare hospitals to commercial breakeven and to peer-group hospitals

If peer hospitals are more than two times Medicare, consider comparing to other states and the national average to see if your market is an outlier with significantly higher costs. The national average could be considered a reasonable benchmark for outlier markets.

- If the hospital price is significantly above the commercial breakeven for that hospital (above the recommended margin described above), it is reasonable to expect that a fair price should be no higher than the low end of peer-group hospitals.
- If the hospital price is lower than commercial breakeven and a reasonable margin, a fair price might be capped by the cutoff of the best third of prices for peer-group hospitals.
- If the low end of the peer-group hospital prices is above the national average, the national average should be considered the high end of the fair price range.



Compare prices not only within the market but across markets. If hospital pricing within your market is significantly above the national average, it may not be a fair price and likely should be lower.

Determine if there is a justifiable reason for significantly higher prices compared to peer groups or Medicare

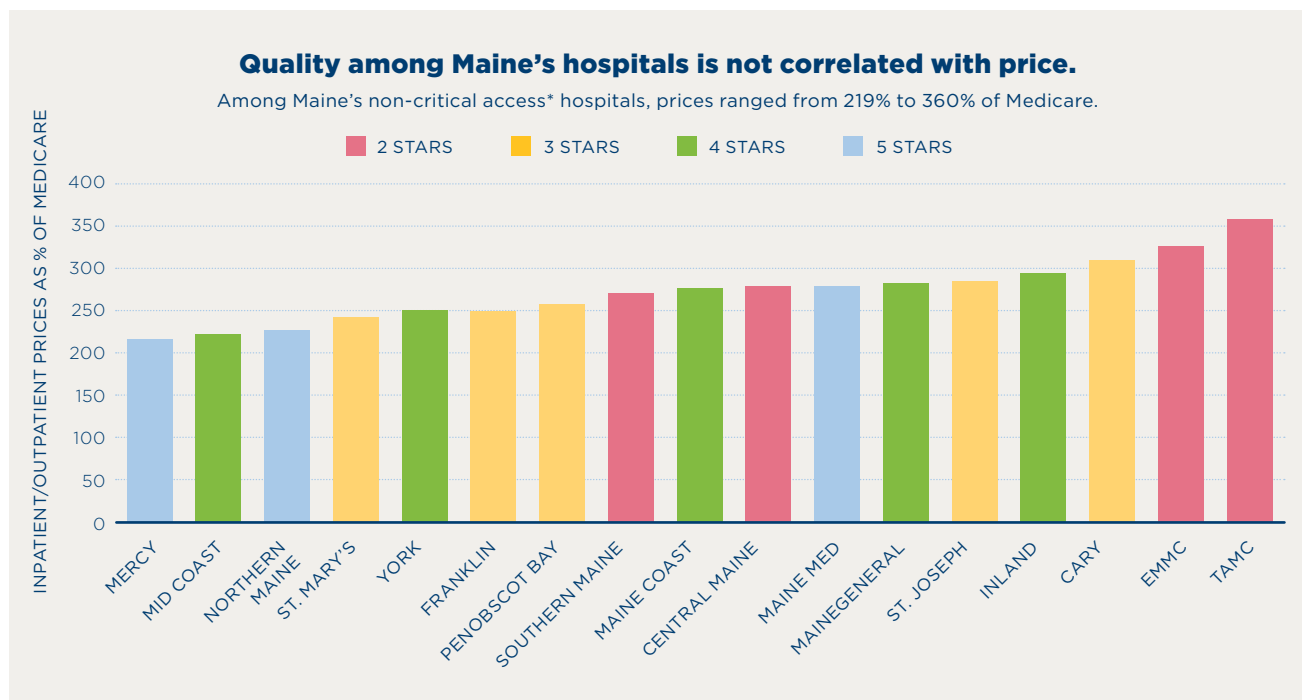
The goal to achieving the highest quality care for the lowest cost is to identify which hospitals in your market are performing better than other hospitals at lower costs. Ideally, your hospital's lower-right quadrant in the graph to the right (the blue star), provides the highest quality care for the lowest price.



The chart below shows what commercial payers are paying as a percent of Medicare with the quality scores. This shows there isn't a relationship between better quality and higher costs.

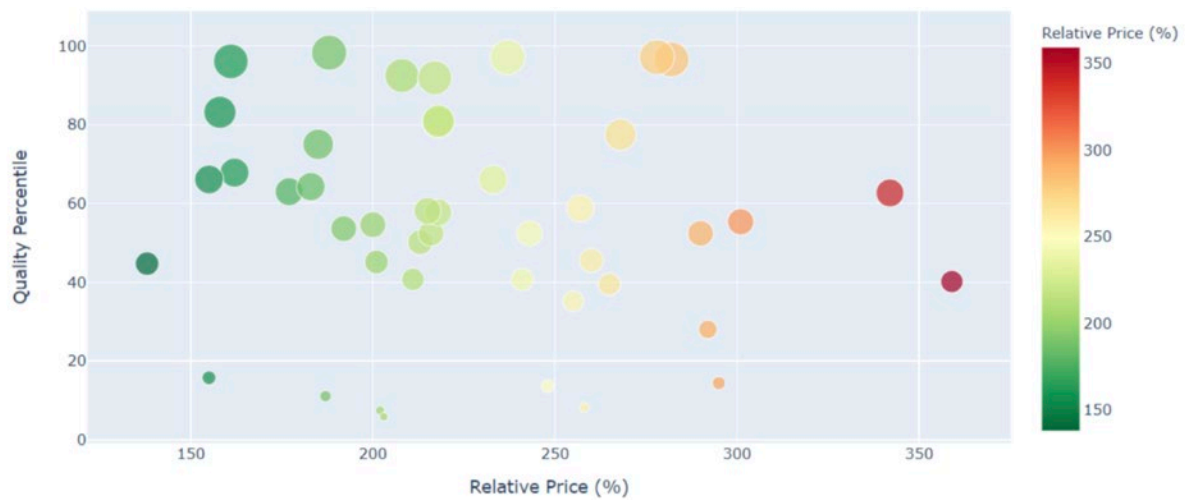
In the example below, which represents a peer grouping comparing cost and

quality, it's clear that some of the worst performing quality hospitals charging the most, represented by the red circles on the right of the screen. The green circles in the upper left of the chart represent the highest quality hospitals with the lowest relative price. When comparing market-based peer groups, the goal is to be on the lower of the price and as close to Medicare costs as possible.



Variations in Value Across Colorado Hospitals

This chart illustrates how some of the lowest-quality hospitals are charging the highest price



The Power of Transparency: Using Data to Get to a Fair Price and a Better Bottom Line

After analyzing and better understanding the economics of hospitals in the state (commercial breakeven), Montana's State Employee Health Plan used [reference-based pricing](#) agreements to limit the prices paid for care and reduce the variation in prices paid at all hospitals in the state.



AS A RESULT OF REFERENCE-BASED PRICING

MONTANA'S STATE EMPLOYEE HEALTH PLAN
SAVED AN ESTIMATED

\$47.8 MILLION

FROM 2017-2019.

A fair price generally should be between a reasonable markup from costs and a competitive market price for peer hospitals. If there is normal market competition

conditions or effective regulatory oversight, it is reasonable to expect a price close to a reasonable markup on costs.

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Evaluating Current Options/Strategies

Examining Market-Based and Policy-Based Strategies Considering Fair Pricing for Hospital Services

Plan fiduciaries should expect to pay a fair price for services rendered; however, achieving a fair price requires action by plan sponsors, intermediaries and, potentially, policymakers. This is particularly true in markets that have consolidated horizontally and vertically and exhibit monopolistic or oligopolistic anti-competitive behaviors. Actions can take many forms, both market-based and policy-based and may come with limitations on their impact. Plan sponsors choose difference approaches, ***but a common voice on fair hospital pricing is of utmost importance.***

Market-Based Strategies

At its core, market-based strategies require markets with multiple viable competitors that compete fairly based on value and performance: Cost, quality and patient experience.

Reference-Based Pricing

One approach to ensure the plan is paying a fair price for hospital services is to limit reimbursement under the health plan to a reference-based price that is deemed to be a fair price. This could be a percentage of Medicare or consider multiple factors that are deemed appropriate to ensure reasonable accommodation of diverse circumstances.

Limitations: While this approach would most directly achieve the intended result of paying a fair price for services, there is some potential for conflict and confusion for members. If hospitals either deny services or balance bill patients, this will cause significant concerns for plan sponsors and the affected patients. Any such approach would need to be applied with care and support to mitigate any such conflict. It could also be limited to out-of-network or a plan option that would be available.

“The key question is whether and how employers will be willing to assert their purchasing power to open conversations with health plans, hospitals, health systems, and other stakeholders, begin using the data to drive continuous value improvement, and drive employees through education and incentives to higher-value facilities.”

—NEIL GOLDFARB
President & CEO

Greater Philadelphia Business Coalition on Health





Contract or establish performance guarantees as a percentage of Medicare

Contracts based on discounts off charges tend to be non-constraining when hospitals have been able to escalate charge masters with no constraint on their relationship to reality (what things cost) or affordability. Contracts based on “per diems” or DRGs can make increases more explicit but have lost connection to what is reasonable and responsible. Furthermore, provisions that revert to discount on charges for outlier claims are loopholes that get exploited by unconstrained charge masters. Employers who contract directly or hold their intermediaries accountable to contract can help constrain the growth in charges. Using a percentage of Medicare itself. Using a percentage of Medicare as a charge basis also creates a universal framing that can help health plans and purchasers better understand, evaluate and negotiate the reasonability of charges relative to what is needed to break even and what services should cost. This is particularly true since:

- ▶ Medicare already adjusts for differences in salaries, uncompensated care, servicing of the underserved, and educational hospitals
- ▶ MedPAC has stated that a reasonably efficient hospital should be able to run close to Medicare fee schedule overall.
- ▶ NASHP Commercial Breakeven provides a percentage of Medicare that any given hospital can run at given its current cost structure and other economics (uncompensated care, subsidies for public programs, etc.).

Most employers and other plan sponsors rely heavily on intermediaries to negotiate a fair price on their behalf. Those intermediaries are rarely overseen with a level of accountability that rewards performance in achieving a fair price. A performance guarantee that aligns contracting performance with pricing targets as a percentage of Medicare may help create additional market focus and market pressure.

Limitations: Restructuring to a percentage of Medicare alone will not ensure a fair price for hospital services unless the negotiated percentage is a reasonable one. The same market dynamics may cause this to be a frustrating exercise of market power vs. rational dialogue. This is particularly true where there is limited health system choice or where purchasers collectively insist that all existing health systems in an area be included in the network (essentially guaranteeing that market power).

Tiered Networks/Centers of Excellence/Episodes of Care

One of the key factors in driving fair pricing is developing more direct market dynamics. When a plan sponsor offers a network that includes all major providers in the network, without any differentiation on value (cost, quality), they reinforce that there is no need for the provider to compete on value. Tiered networks or centers of excellence can encourage employees and their families to choose high-performing/higher-value providers while also changing market dynamics to compete at a fair price in order to be offered on a preferred basis to members. In a center of excellence strategy, reimbursement can be structured not only on a fair price basis but also on a more accountable basis, including a bundled approach with appropriate incentives and warranties. Savings can arise both from fairer pricing but also the achievement of more appropriate and high-quality care.

Limitations: Not all services lend themselves to being offered on a center of excellence basis. Where it is feasible to do so, this can help to negotiate a fair price, but purchasers will not buy in to any tiering toward

providers that are not first screened for high quality. Additionally, the challenge with tiering is that carriers often do not allow it unless you are a jumbo employer and/or you have a benefits advisor with the skills and experience to challenge carriers.

Advanced Primary Care/Site of Care/ Unaffiliated Providers

One strategy for avoiding unfair pricing is to take actions that will mitigate the use of services in those facilities. Strategies that invest in advanced primary care encourage use of other sites of care (e.g., ambulatory surgical centers) or contracting with unaffiliated providers who are not compromised by health system ownership, can help to mitigate the use of services that are either not high value or not fairly priced.

Limitations: Not all services lend themselves to mitigation outside of the hospital setting. This may have no impact on hospital pricing practices particularly since the economics will likely be the same to encourage alternatives sites of care where possible.

Health System Engagement

A variation on transparency is having local business leaders meet with local health system leadership. Multi-stakeholder collaboration on developing a system of value and performance benefits the entire community and supports broader community economic health and vitality. This can encourage voluntary actions that support greater alignment and promotes constraint.

Limitations: Local business leaders often are not informed about the magnitude of the issues and tend to

defer to health system leadership. Health systems may still attack the integrity of the data and use their market positioning to hold firm on strategies that maximize pricing at the expense of the local employer community, and employees and their families. It will also likely be difficult for purchasers to meet with every health system employees use. This is particularly true for national employers.

Transparency

Transparency alone can have some impact on value. By publishing relative price and quality performance, analysis of the reasonability of prices and margins, and examination of relationships between prices and benchmarks such as Medicare or cash price, we bring a level of awareness and a potential threat of public embarrassment and, potentially, more restrictive policy ramifications.

Limitations: The hospital industry and health systems, in general, have been very effective at deflection of facts and the data. Press coverage and local chambers of commerce have tended to be empathetic to the hospital point of view as one of the largest local employers, most influential political entities, and significant local patron. There is also little evidence that price and quality transparency alone can influence consumer discretionary use of higher value institutions.

Policy-Based Strategies

Rate Regulation

When there is limited functioning hospital competition in a region, the hospital “market” may be functioning more like a “utility” than a market. Hospital consolidation has resulted in more regions being non-competitive and as a result it may be necessary to create a formal oversight regulatory environment around hospital pricing. Regulatory approaches may be across all institutions or triggered based on certain circumstances (e.g., prices above X% of Medicare). Rate regulation may also have an impact on hospital cost growth over time.





Limitations: Regulation, by its nature, can be a politically charged process. Overseeing the complicated nature of diverse hospitalizations and hospital pricing would require regulatory infrastructure and clear guidance on rate regulation considerations. Benchmarking tools such as those described here could be a core part of such oversight.

Global Budgets

In a limited number of markets, regulators have stepped in to establish global hospital budgets to constrain cost growth. To date, Maryland is the only state to have fully established a global hospital budget system. Under hospital all-payer global budgets, hospitals are not paid on a fee-for-service basis. Instead, hospital budgets are paid a prospectively determined amount for all inpatient and outpatient services provided to a patient population in a given year. Global budgets counteract the volume-inducing characteristics of itemized payment systems by expanding the bundle of services. This approach is intended to provide hospitals an orientation to operate within a budget constraint and support of affordability.

Limitations: Global budgets may be more geared to costs than prices. They may or may not address the issue whether current prices are fair or unwarranted. Establishing the budgets may be a negotiated process and should consider both current state of expenses and reasonability of pricing. This requires a waiver from CMS if Medicare and Medicaid are included, is an incredibly complex and complicated process, and is a heavy lift politically.

Healthcare Cost Growth Caps

In some markets, regulators have developed frameworks for capping overall prices for healthcare costs. Price growth caps may constrain how much provider prices can increase over a defined period. Generally, these caps are pegged to measures of economic or price growth, such as gross domestic product (GDP), the consumer price index (CPI), or a medical price inflation index. The price growth caps could look at service-by-service, or on a more aggregated basis. This approach is intended to provide hospitals an orientation to operate within a budget constraint and support of affordability.

Limitations: Price growth caps may help stem the tide of unbridled cost growth but there is an underlying assumption that current prices are fair which may be unwarranted. It is sometimes unclear how the healthcare cost growth caps may be gamed or enforced. Establishing the growth rates may be a negotiated process and should consider the current state of pricing vs. fair prices.

Public Option

One policy approach that has been floated at the federal and at the state level is the offering of a “public option.” While design details could vary, a likely part of the public option is to include standardized rate setting established by the public sector. These rate levels may not be at Medicare or Medicaid levels (some have suggested 150% of Medicare) but would likely be based on a more rational calculation than most current “market rates.” A key detail is who would be eligible to access such a public option—individual market, public exchanges, employers and other plan sponsors? Also, would there be the ability to supplement the public option with other coverage (similar to Medicare). The threat of a public option has also been used as a lever to push the private market to meet certain pricing thresholds over time.

Limitations: Regardless of the design, it is unlikely that the commercial market will move to a public option overnight. However, the threat to move in that direction will, in itself, provide a check on what are otherwise

unchecked markets. This threat will only be valid if employers and other plan sponsors have the opportunity to offer such a plan. If they do not, then this could further exacerbate untenable market dynamics where only employers and other plan sponsors are left fighting for a fair price in a consolidated, monopolistic environment.

Anti-Competitive Practices/Anti-Trust Enforcement

Recent hospital consolidation and consolidation of provider practices have led to changing market dynamics and higher costs for patients and plan sponsors. This has led to aggressive anti-competitive practices by health systems. While some anti-competitive practices can be challenged based on existing antitrust laws, some legislation is being targeted to specific language commonly used by large health care providers in their contracts with insurance companies. One example includes contract terms like so-called “all-or-nothing” clauses, in which the provider refuses to contract with an insurer if that insurer doesn’t also contract with all the system’s affiliated providers across all markets. Another would prohibit what are known as “anti-tiering” or “anti-steering” clauses, which prohibit any incentives or benefit plan steerage within the networks (e.g., to higher-quality, more-efficient providers). Still others may place restrictions on how a health plan can negotiate contracts with other providers who are not a party to the contract.

Limitations: While many of these practices are likely prohibited by anti-trust law today, the tendency

to enforce the prohibitions against anti-trust behavior has been uneven at best. The fact that so many hospitals were allowed, without appropriate anti-trust consideration, to merge or acquire either other hospitals or other practices has given rise to these abuses today. With so much of the market now consolidated, it is unclear how impactful banning anti-competitive practices and enforcing anti-trust will be in many markets.

Surprise Billing Oversight

There is a particular need for overseeing pricing that occurs outside the control of either the purchaser or the patient. This happens when care is provided, even in-network, and then services are then charged on a basis that is outside of network negotiated fee structure. Without a pre-defined price, the purchaser is put in the position of either picking up whatever is charged (regardless of whether it is a fair price) or the patient being subject to a balance bill. Regulations are currently being discussed and proposed to establish a reasonable approach to establish a benchmark for surprise bill pricing oversight.

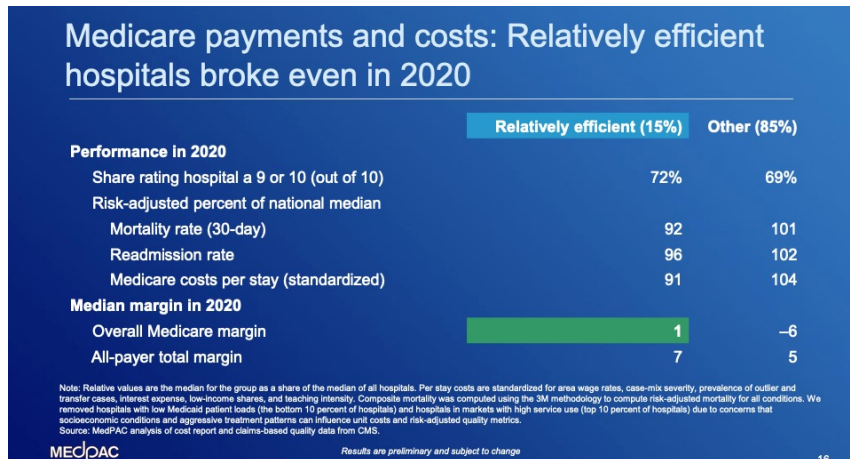
Limitations: While surprise bills can be the most egregious and uncontrolled pricing practices, they still represent a small minority of bills. Negotiated fees provide some level of pre-determination, but it is clear that in some hospitals and regions, not all negotiated fees are fair prices.

MYTH

The pandemic wiped out US hospital profitability

FACT

Relatively efficient hospitals broke even in 2020



ADDENDUM:

Additional Resources for Action

24 Understanding Sage Transparency Dashboard Tabs

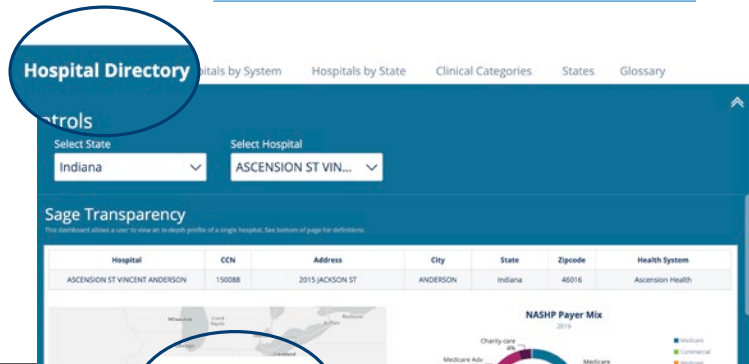
27 About the Consolidated Appropriations Act (CAA)

28 Hospital Myths and Facts

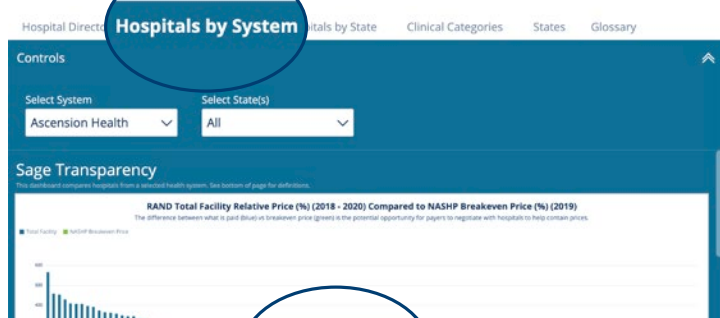
29 Additional Tools and Resources

Sage Transparency Dashboard Tabs [\(https://employerptp.org/sage-transparency/\)](https://employerptp.org/sage-transparency/)

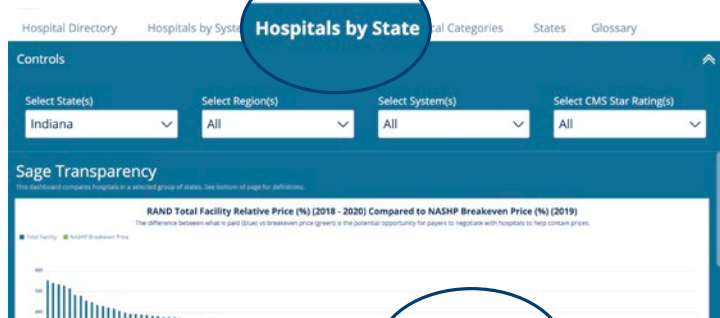
Hospital Directory: View an in-depth profile of a single hospital, bringing together hospital quality scores from CMS and Quantros, RAND relative prices, and outpatient and inpatient clinical category relative prices from Turquoise Health.



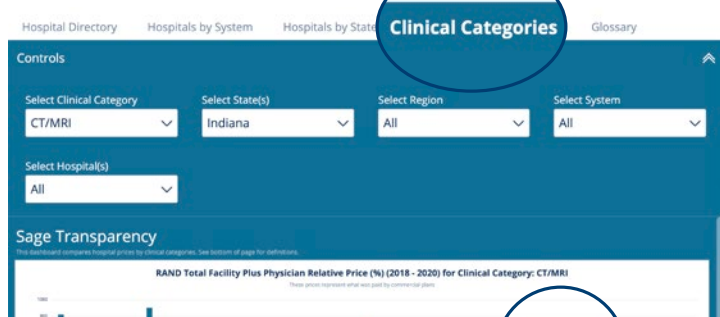
Hospitals by System: Compare a group of hospitals' quality scores and relative prices within a selected health system.



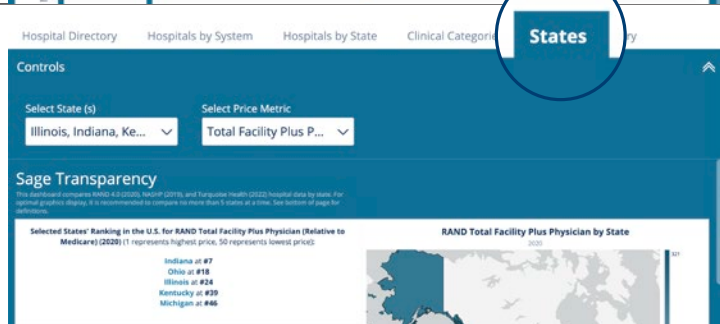
Hospitals by State: Compare a group of hospitals' quality scores and relative prices within selected states.



Clinical Categories: Compare a group of hospitals' quality scores and clinical category relative prices. You can select one clinical category and compare hospitals' relative prices.



States: This dashboard provides hospital price, cost, and quality data at the state level. You can explore price differences among selected states, and how these states compare to each other based on selecting one of the nine price metric options available.



Within the [Sage Transparency](#) tool, go to the “Hospitals by System” tab to compare the Total Facility Price to the NASHP breakeven Price. Use the filters to customize the selection to your desired state, region or hospital system. We compare the NASHP Breakeven calculation to the “Total Facility” (not Total Facility with Physician) because NASHP does not include physician costs.

The screenshot shows the Sage Transparency tool interface. At the top, there are navigation tabs: Hospital Directory, **Hospitals by System**, Hospitals by State, Clinical Categories, States, and Glossary. Below the tabs is a 'Controls' section with two dropdown menus: 'Select System' (set to 'Ascension Health') and 'Select State(s)' (set to 'All'). The main content area is titled 'Sage Transparency' and features a bar chart titled 'RAND Total Facility Relative Price (%) (2018 - 2020) Compared to NASHP Breakeven Price (%) (2019)'. The chart compares 'Total Facility' prices (blue bars) against 'NASHP Breakeven Price' (green bars) for various hospitals. Callouts point to the 'Hospitals by System' tab, the 'Select State(s)' dropdown, and the 'Select System' dropdown.

- ▶ 8+ year trend
- ▶ Hospital breakeven by market
- ▶ % Medicare breakeven
- ▶ Commercial breakeven

This screenshot shows the Sage Transparency tool on a laptop screen with several callouts highlighting user interface features:

- Reset all your selected filters:** Points to a circular refresh icon in the top left of the dashboard.
- Filter using intuitive controls:** Points to the 'Select State' and 'Select Hospital' dropdown menus.
- Move between dashboards by selecting tabs:** Points to the navigation tabs at the top of the page.
- Print or export to PDF:** Points to a printer icon in the top right corner.
- Expand the visualization to full screen:** Points to a full-screen icon in the top right corner.
- Click on title to sort:** Points to the 'Sort by' dropdown menu in the 'Outpatient Clinical Category Relative Prices' table.
- Leave feedback on your experience:** Points to a 'Feedback' button in the bottom right corner.

 The dashboard content includes:

- Hospital Metrics: ASCENSION ST VINCENT ANDERSON:** A bar chart comparing 'Total Facility Price' (blue), 'Medicare Breakeven' (green), 'Commercial Breakeven' (orange), and 'NASHP Breakeven' (purple).
- State Benchmarks: Indiana:** A bar chart comparing 'Total Facility Price' (blue), 'Medicare Breakeven' (green), 'Commercial Breakeven' (orange), and 'NASHP Breakeven' (purple).
- National Benchmarks: Median of All States:** A bar chart comparing 'Total Facility Price' (blue), 'Medicare Breakeven' (green), 'Commercial Breakeven' (orange), and 'NASHP Breakeven' (purple).
- Outpatient Clinical Category Relative Prices: ASCENSION ST VINCENT ANDERSON (2020):** A table with columns for 'Clinical Category', 'Turquoise Health Commercial (%)', 'Turquoise Health Medicare (%)', and 'Turquoise Health Cash (%)'.

Clinical Category	Turquoise Health Commercial (%)	Turquoise Health Medicare (%)	Turquoise Health Cash (%)
OT/AN	101	119	104
Cardiovascular Care	111	104	104
Emergency Services	34	34	315
Medical Services	137	65	121
Laboratory Services	84	89	
- Inpatient Clinical Category Relative Prices: ASCENSION ST VINCENT ANDERSON (2020):** A table with columns for 'Clinical Category', 'Turquoise Health Commercial (%)', 'Turquoise Health Medicare (%)', and 'Turquoise Health Cash (%)'.

Clinical Category	Turquoise Health Commercial (%)	Turquoise Health Medicare (%)	Turquoise Health Cash (%)
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Medical Services	137	65	121
Laboratory Services	84	89	

About the Consolidated Appropriations Act (CAA)

Group health provisions of the CAA

Why was the legislation created?

- ▶ Lack of clarity in the role of plan fiduciary under ERISA/PHSA and specific responsibilities
- ▶ Contracts that restrict plan sponsors from full access to their data
- ▶ Lack of transparency in pricing and benefit plan administration
- ▶ Accountability for services provided
- ▶ Need for more aggressive enforcement of the federal Mental Health Parity and Addiction Equity Act of 2008

Four key areas of CAA

- ▶ Remove gag clauses from service provider contracts on price and quality information (TPA contracts often include gag clauses)
- ▶ Establishes reporting requirements
- ▶ Requires the disclosure of direct and indirect compensation from all service providers
- ▶ Requires parity in substance abuse and mental health benefits



Be Prepared for Hospital Pushback: Know the Facts

The National Alliance has created a helpful “Myths and Facts” document to enable purchasers to respond to common myths about hospital pricing, such as:

- ▶ Hospitals are doing their part to control costs
- ▶ Health insurance shields patients from financial loss
- ▶ Hospital consolidation leads to greater efficiency and lower costs
- ▶ Hospital consolidation leads to better patient outcomes
- ▶ Hospitals suffered huge losses during COVID-19
- ▶ Higher costs mean higher quality
- ▶ Hospitals are underpaid by Medicare and Medicaid
- ▶ Hospitals charge payers/plans sponsors prices that are reasonably higher than Medicare
- ▶ Higher hospital prices are needed when there is lower public health funding
- ▶ Higher hospital prices are needed when state public health ranking is lower, meaning patients are more unhealthy
- ▶ Nonprofit hospitals provide significant amounts of charity care, necessitating cost shifting

Employer Action to (Re)Build a Better Healthcare System

MYTHS AND FACTS

Revealing Hospital Price Transparency Truths



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Driving Health, Equity and Value
nationalalliancehealth.org

10/21

Click on the image to view “Myths and Facts: Revealing Hospital Price Transparency Truths.”

Additional Tools and Resources

- ▶ [Presentations from Employers' Forum of Indiana May 2022 National Hospital Price Transparency Conference](#)
- ▶ [Assessing Payment Adequacy and Updating Payments: Hospital Inpatient and Outpatient Services and Mandated Report on Bipartisan Budget Action of 2018 Changes to the Low-volume Hospital Payment Adjustment](#) (PPT December 9, 2021)
- ▶ [Assessing Payment Adequacy and Updating Payments in Fee-for-Service Medicare](#) (MedPAC report December 16, 2021)
- ▶ [MedPAC Votes on Updates to Hospital Base Payment Rates and Physician Payments](#) (January 14, 2022)
- ▶ [Hospital Prices: Unsustainable and Unjustifiable](#)
- ▶ [Colorado Hospital Prices Continue to be Among the Nation's Highest: New Transparency Reports Identify Opportunities to Help Consumers, Employers, Emergency Preparedness](#)



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