Welcome to the 2023 Fall Forum!

Jon Rankin

CEO/President
NCBCH

WELCOME!!

NCBGH Spring FORUM

Forum.NCBCH.net

- ✓ Agenda
- ✓ Speaker Information
- ✓ Sponsor Information
- ✓ Grandover Info

Today's Agenda

*(details available online at **forum.ncbch.net**)*

"Getting to Fair Price for Employers"

7:30 AM – Networking Breakfast

8:45 AM – Welcome and Introductions

9:00 AM – NC Attorney General Josh Stein

9:15 AM – Legal Update

10:15 AM - Break

10:25 AM – Hospital and Healthcare Fair Pricing at State and Employer Levels

11:15 AM – Using Data for Market Decisions and Policy Changes

12:00 PM – Innovations in Employer Benefits

12:15 PM – Networking Lunch

1:15 PM – A View Inside the Black Box of Pharmacy

2:45 PM – Fair Price Initiative

3:00 PM – Wrap-up

Link to presentation slides
will be sent to all attendees following the Forum

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5.5 recertification credits available for attending today

Activity codes available at registration desk

NORTH CAROLINA BUSINESS GROUP ON HEALTH

Our Members

Employer Members

All sizes

(at least 25 employees based in North Carolina)

All Industries

Affiliate Members

Vetted benefit/HR service providers and consultants

Advisory Council Members

Key Healthcare Stakeholders dedicated to furthering our mission

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ABOUT NCBCH

Formed in 2011 as a coalition of employers using their collective voice to influence decisions that impact the quality and cost of healthcare delivery systems in North Carolina.

Mission:

Advocate – Create a business community with a shared vision and message on matters of healthcare policy, regulation, and legislation based on sound fiscal principles and quality standards.

Innovate – Seek creative, common sense solutions to improve the overall cost and quality of our healthcare delivery system.

Educate – Promote health and wellness education. Advocate for provider performance disclosure of both quality and outcomes to help employees become better consumers of healthcare services.

Our National Presence...

The North Carolina Business Group on Health is a member of the National Alliance of Healthcare Purchaser Coalitions,
the *only* nonprofit, purchaser-led organization with a *national and regional structure*
dedicated to driving health and healthcare value across the country

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

For NC Hospital Safety, Quality and Transparency

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Giant Leaps for Patient Safety

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NORTH CAROLINA BUSINESS GROUP ON HEALTH

Fair Pricing in NC

Josh Stein

North Carolina Attorney General

Legislative and Legal Update for Employers

Chris Deacon, J.D.

Principal
Versan Consulting

Legal Update: What Employers Need to Know

Key Legislation Impacting Employers

CAA Section 201

"A group health plan... may not enter into an agreement with a ... [TPA].. that would directly or indirectly restrict a group health plan... from - (B) electronically accessing de-identified claims and encounter information... on a per claim basis [including] ...financial information... or any other claim-related financial obligations included in the provider contract... service codes... or any other data element included in claim or encounter transactions...

CAA Section 202

Requires brokers, agents, and consultants to disclose any direct or indirect compensation related to brokerage services or consulting to group health plan sponsors.Health plans are required to disclose compensation information to enrollees and the Department of Health and Human Services (HHS) for individual health coverage and short-term or limited-duration coverage.

Transparency in Coverage

Require group plans to disclose their rates and other price information for all covered billable services. (If fully-insured, the carrier is responsible for posting. If self-funded, the employer is responsible for posting.)

Insurance carriers and/or employers must post information about the cost to participants, beneficiaries, and enrollees for in-network and out-of-network healthcare services through machine-readable files (MRF) on a public website.

Hospital Price Transparency Rule

The Hospital Price Transparency regulations require hospitals to make public a list of the standard charges the hospital has established for the items and services it provides and to make these data elements available in a single machine-readable file as applicable.

Updates to Key Legislation Impacting Employers

CAA Section 201

- Employers struggling to access data and comply with attestation requirement
- TPAs and Carriers' are able to submit attestation on Employers' behalf
- Conflict over what data is required, who owns data and with whom it can be shared with.
- Recently Released House Bill would clarify what is a "reasonable restriction" on use and gives HHS Secretary Power to Determine ownership of Data

Transparency in Coverage

- Carriers and Plans largely compliant, but size of files has rendered them unreadable and difficult to use
- TiC File and Hospital Price Files do Not Match
- Legislation Released by House would significantly change TiC data elements, require $$$ figures, limit size of files and attempt to make them more useable

Hospital Price Transparency Rule

- Limited and lack of uniform compliance has rendered the information difficult to use
- Enforcement has been sparse with the largest and most out of compliance systems not being forced to disclose
- Legislation Released by House would codify Hospital Price Transparency Rule AND Require Disclosure of PE Ownership, apply rule to ACS, Site Neutral Payments, and Data Specification Updates

PBM Updates Impacting Employers

PATIENT ACT of 2023 (HR 3561)

Establish reporting requirements for prescription drugs and PBMs, as well as disclosure requirements for rebates, fees, alternative discounts or other payment from pharmaceutical companies struggling to access data and comply with attestation requirement

Pharmacy Benefit Manager Transparency Act of 2023 (S.127)

Eliminate spread pricing and pharmacy clawbacks.

Requires PBMs to pass 100% of the rebate to the plan or payer and to disclose the cost and reimbursement of drugs, as well as any fees or discounts the PBM charges.

State Legislation

North Carolina House Bill 246 (HB 246) – passed 114-0 vote in House

Prohibit PBM from reimbursing pharmacies less than the national average cost of a drug or less than the pharmacy benefits manager would reimburse itself.

Prohibited from assessing certain fees and restricting the right of pharmacies to dispense specialty drugs.

Key Litigation Impacting Employers

2021

Mass Labors vs. BCBS Mass - Ruling

Dec 2022

Bricklayers et al. vs. Elevance, Anthem and Empire - in process

Dec 2022

O&M vs. Anthem - Settled

July 2023

Kraft Heinz Co. vs. Aetna - no answer yet filed

“"The riskiest thing we can do is just maintain the status quo."”

BOB IGER

Hospital and Healthcare Fair Pricing at State and Employer Levels

Maureen Hensley-Quinn

Senior Program Director
National Academy for State Health Policy (NASHP)

Hospital Cost Overview: Cost Data to Policy Options

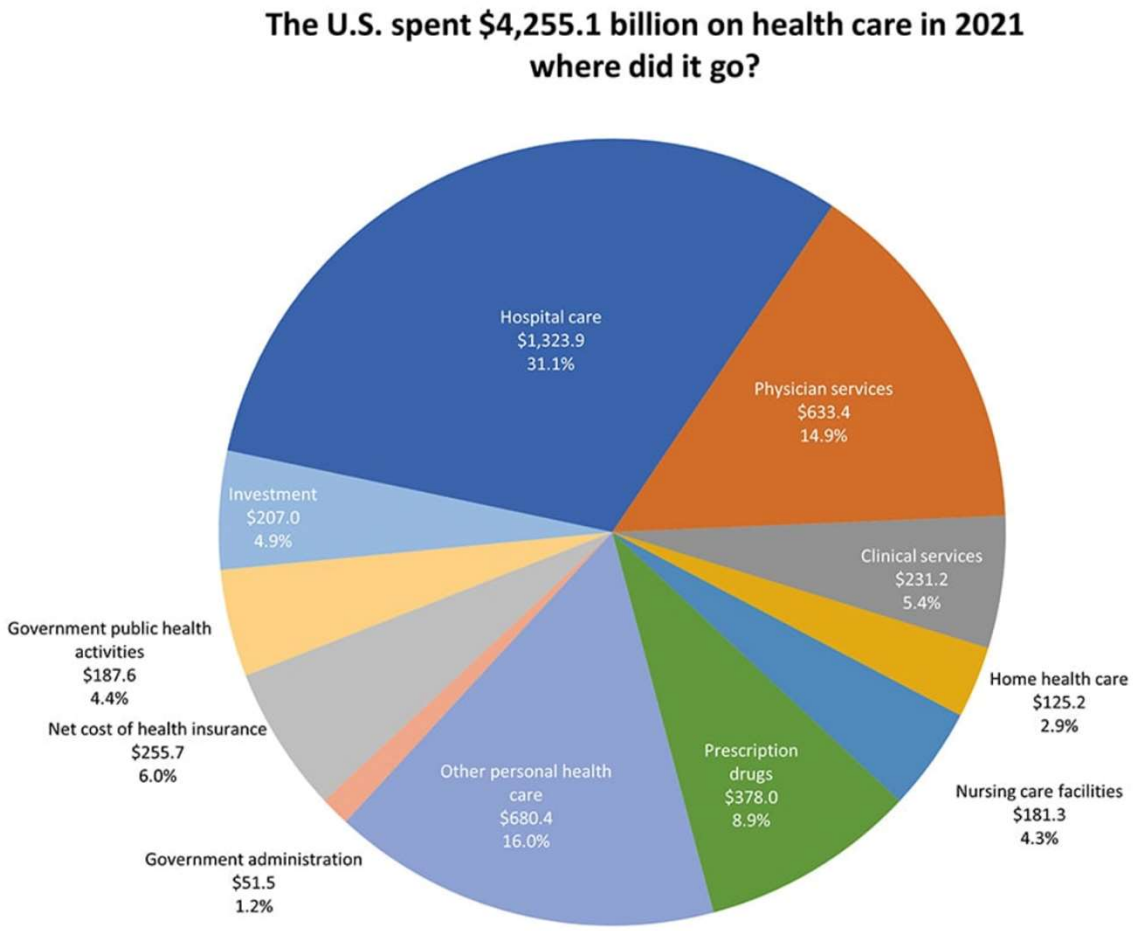
September 15, 2023

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

nashp.org

About NASHP

- A national, nonpartisan organization committed to developing and advancing state health policy innovations and solutions to improve the health and well-being of all people.
- NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.
- To accomplish our mission, we:
- **Advance** innovation in developing new policies and programs
- **Surface** and support implementation and spread of best practices
- **Ensure** availability of info, data, tools
- **Encourage** sustainable cross sector solutions by strengthening partnerships
- **Elevate** the state perspective



Source: Trends in Health Care Spending, AMA, March 2023 from the National Health Expenditure Data


NASHP HOSPITAL COST TOOL
Hospital Revenue Streams
NON-PATIENT SERVICES
INCOME TAX AND PROPERTY TAX EXEMPTIONS (FEDERAL AND STATE)
FEDERAL GOVERNMENT
STATE GOVERNMENT AND MUNICIPAL BONDING
GROUP PURCHASING OPERATIONS
INVESTMENTS
340B DRUG PROGRAM
GRANTS, DONATIONS, AND FOUNDATION FUNDING
DRUG MANUFACTURERS
PATIENT CARE REVENUES
HOSPITAL-OWNED MEDICAL PRACTICES
HOSPITAL-OWNED BUSINESSES AND JOINT VENTURES

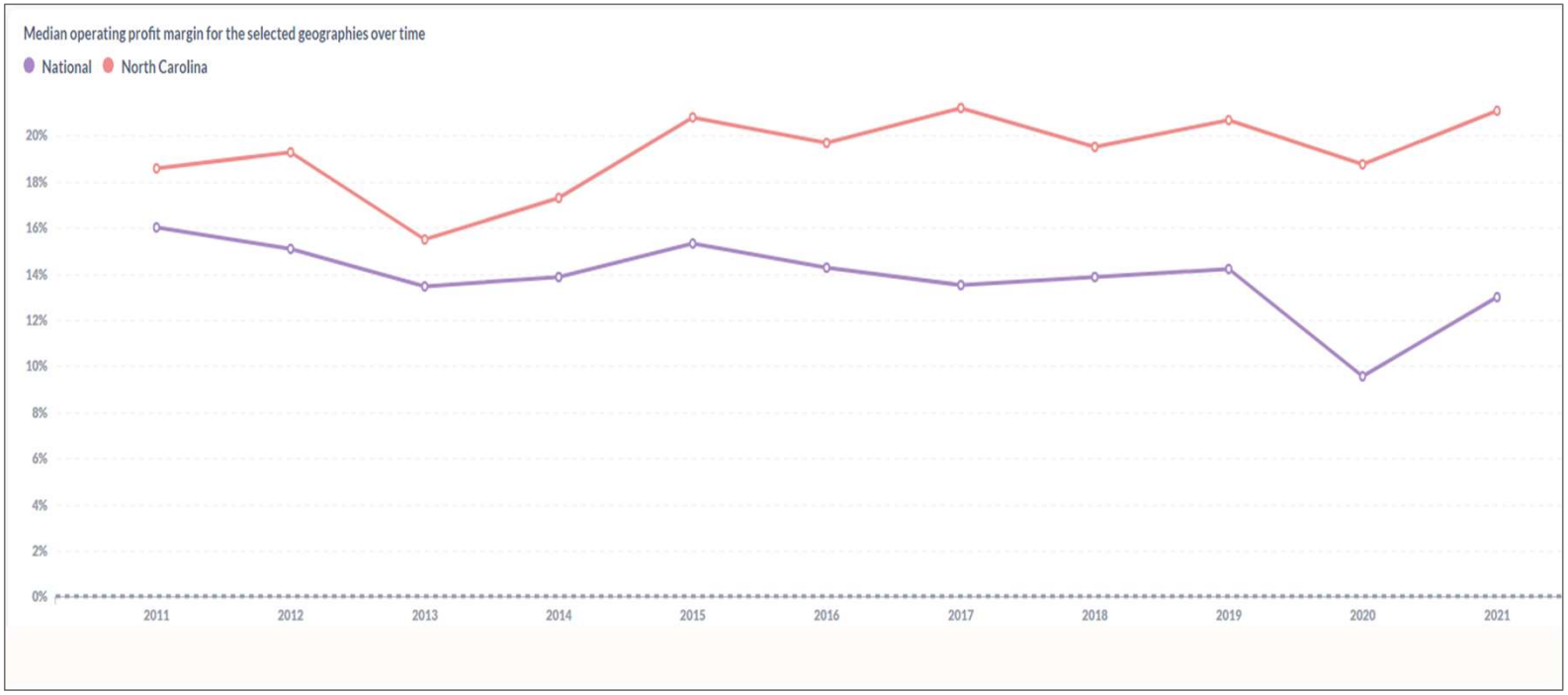
What is NASHP's Hospital Cost Tool?

- **An online tool that purchasers and regulators can use to better understand and address hospital *costs***
  - For example, the tool can help inform hospital rate negotiations or demonstrate hospital finances pre- and post- merger/ acquisition
- **Identifies costs using data that hospitals report annually to the federal government**
  - Each hospital that serves Medicare patients must annually submit, and verify the accuracy of, a Medicare Cost Report (MCR) to the Centers for Medicare & Medicaid Services (CMS)
  - MCRs provide hospital level data and are the only national, public source of hospital costs
- **Developed by the NASHP, alongside Rice University and Mathematica, with support from Arnold Ventures**

Key Data Metrics Include:

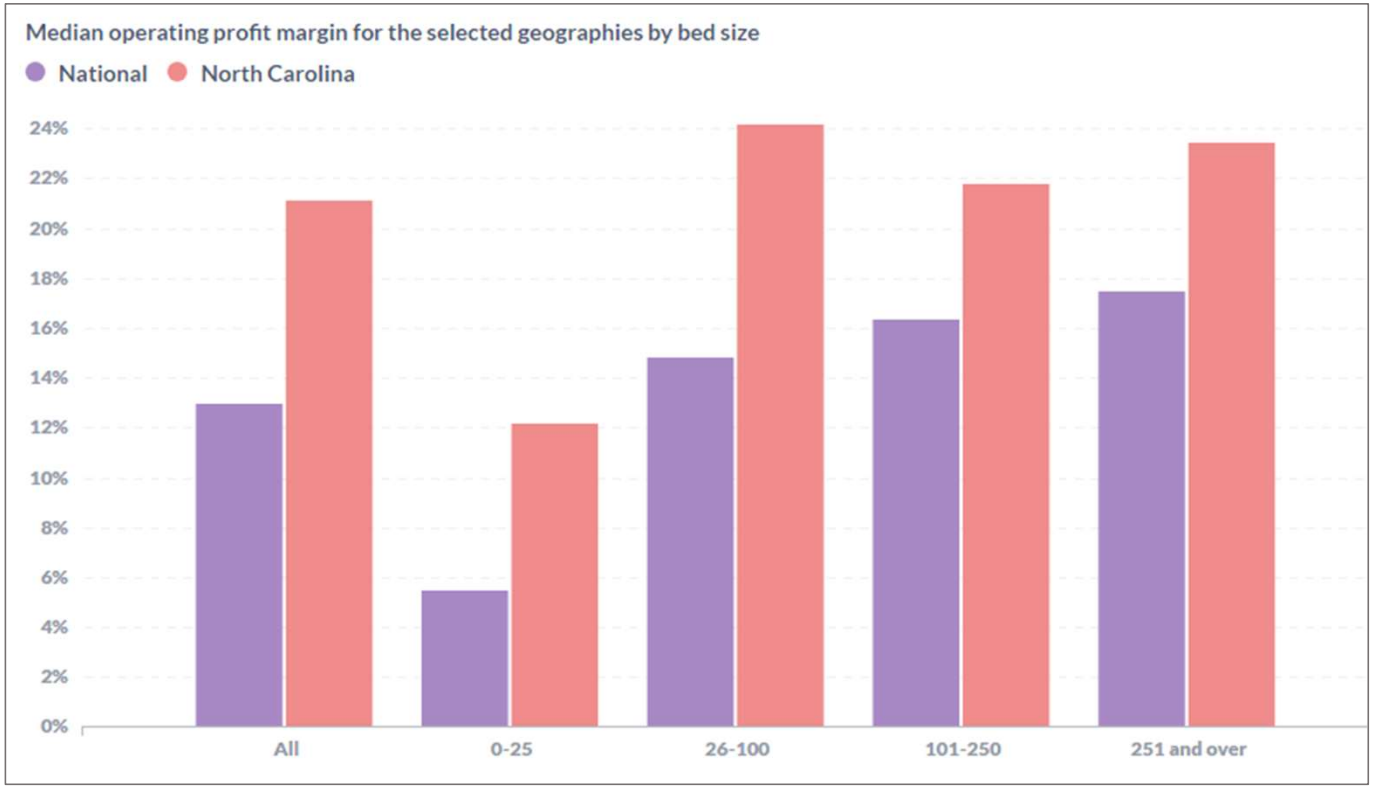
- **Costs vs Charges (**aka "sticker prices")
- **Commercial Breakeven vs Commercial Price –** the reimbursement rate needed to cover expenses vs the reimbursement rate received by the hospital
- **Operating Profit Margin –** earnings on hospital patient services
- **Net Profit Margin –** earnings retained by hospital, *includes* non-patient related income and costs
- **Charity Care and Uninsured/ Bad Debt Costs**
- **Payer Mix Metrics**, including payer-mix adjusted profit on each payer
- **Labor Costs, Patient Volume, and more**

Operating Margin: North Carolina and National



https://www.nashp.org/hospital-cost-tool/

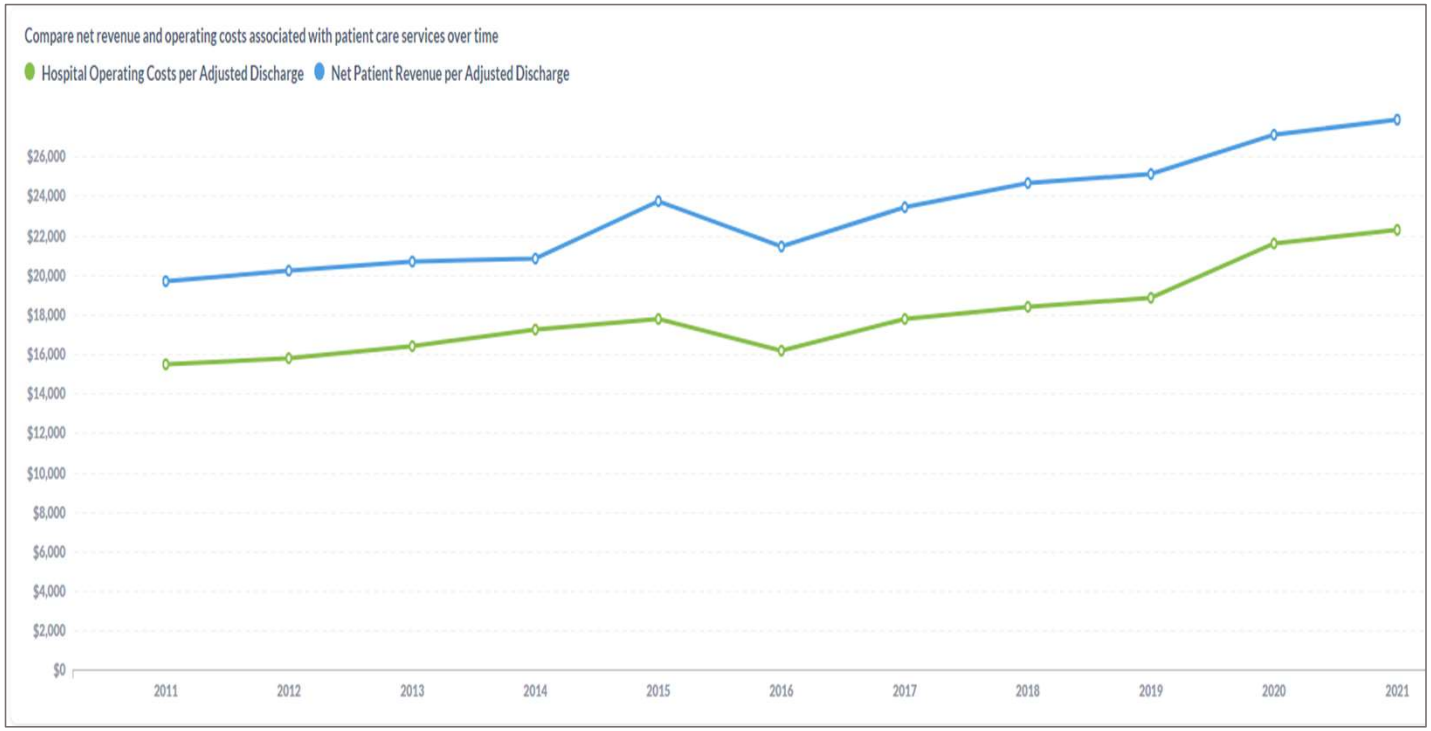
Operating Margin by Bed Size: National and North Carolina



https://www.nashp.org/hospital-cost-tool/

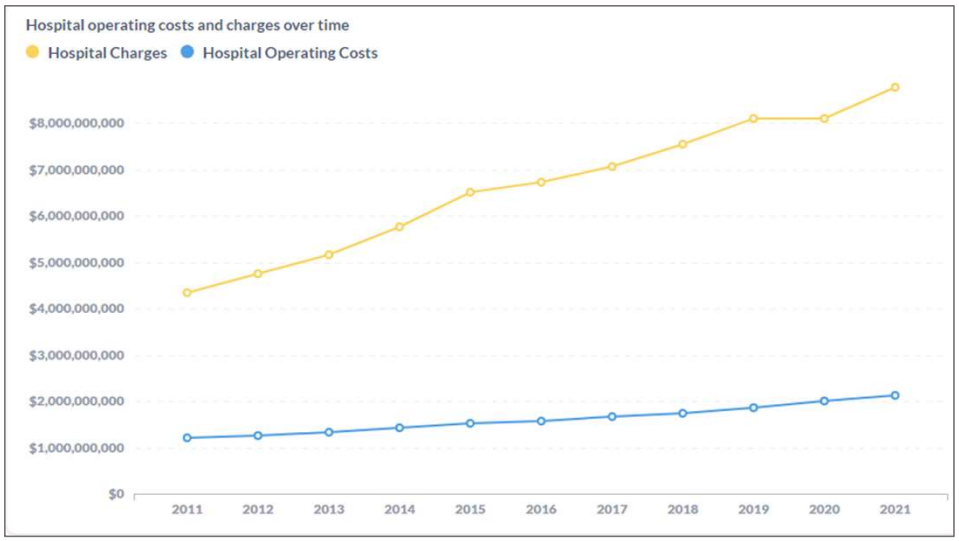
Hospital Level View: Revenue vs Operating Costs

Duke University Hospital



https://www.nashp.org/hospital-cost-tool/

Hospital View: Charges vs Costs Analysis

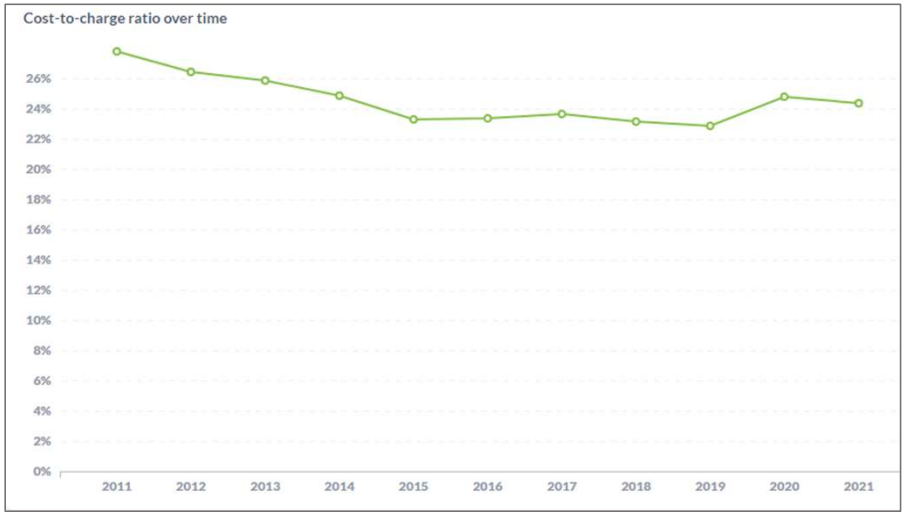


Charges: the '[sticker price]' set by the hospital for services

Costs:

- Salaries & benefits;
- Contracted services;
- Equipment and supplies;
- Rent, interest, depreciation, etc.
- Other hospital services

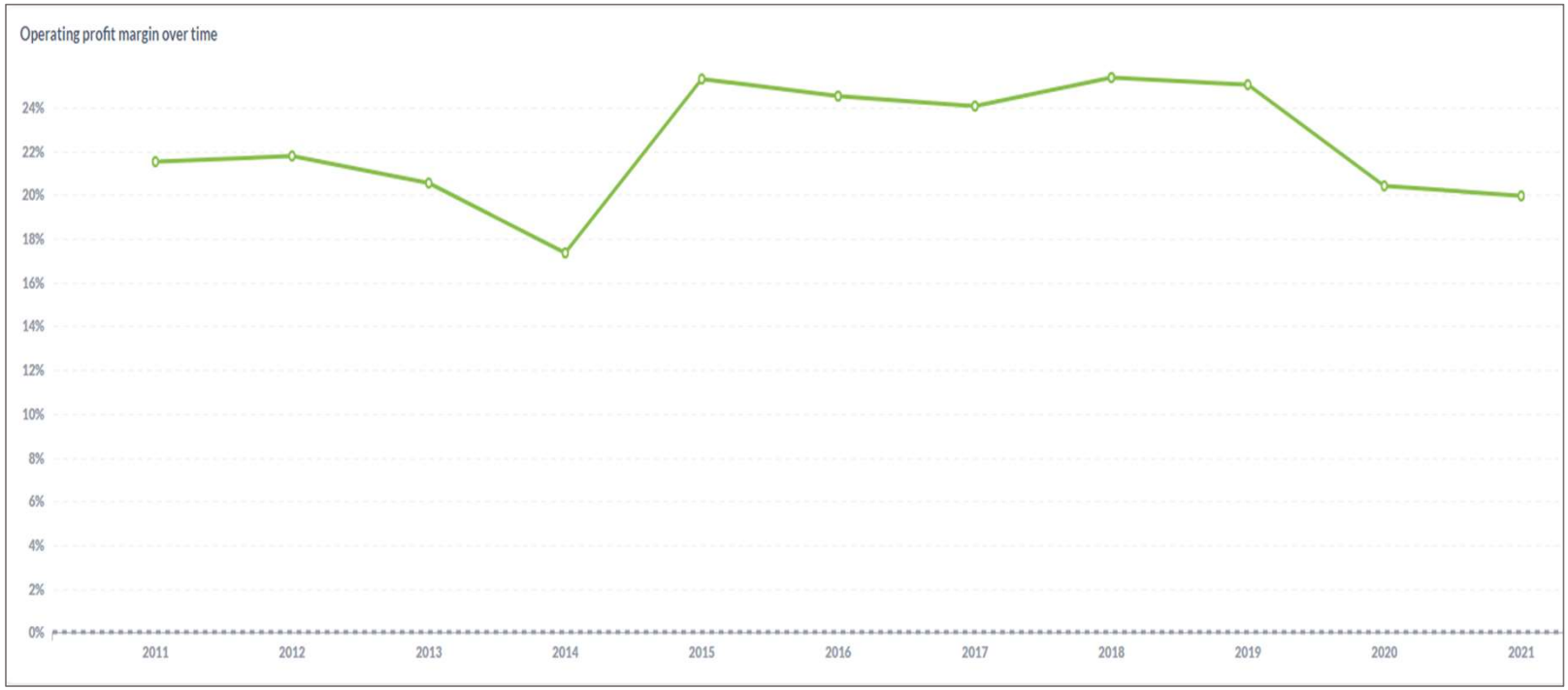
Duke University Hospital



https://www.nashp.org/hospital-cost-tool/

Hospital View: Operating Margin

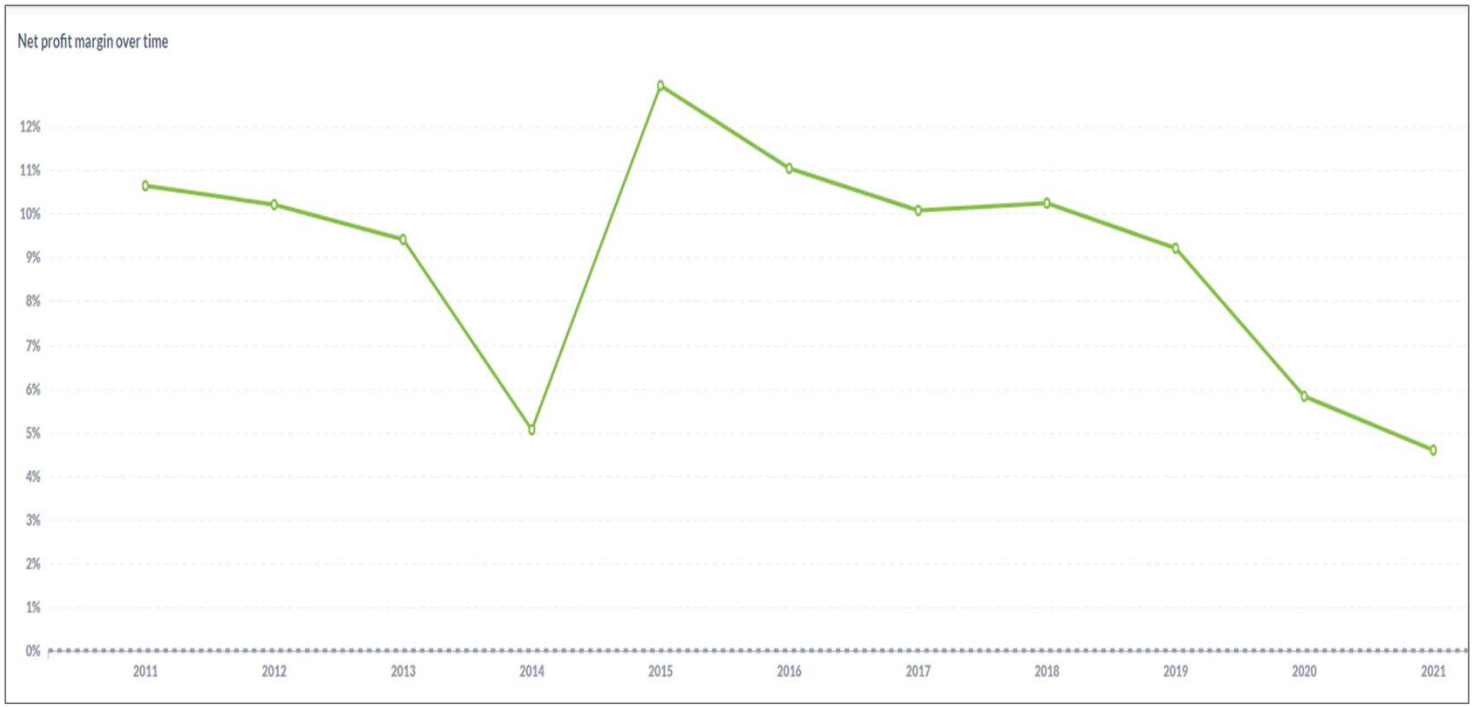
Duke University Hospital



https://www.nashp.org/hospital-cost-tool/

Hospital View: Net Profit Margin

Duke University Hospital

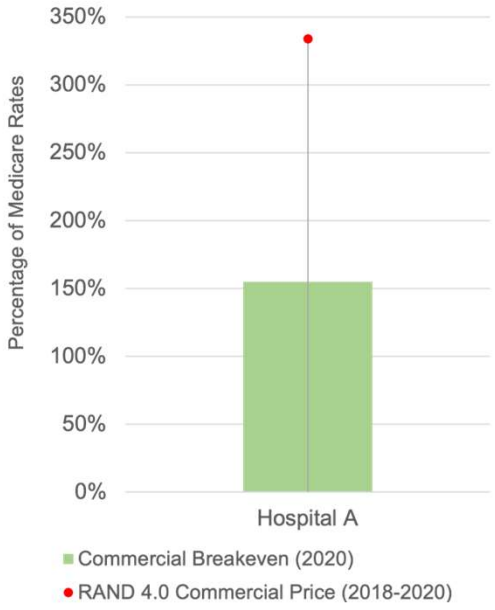


https://www.nashp.org/hospital-cost-tool/

Breakeven Analysis

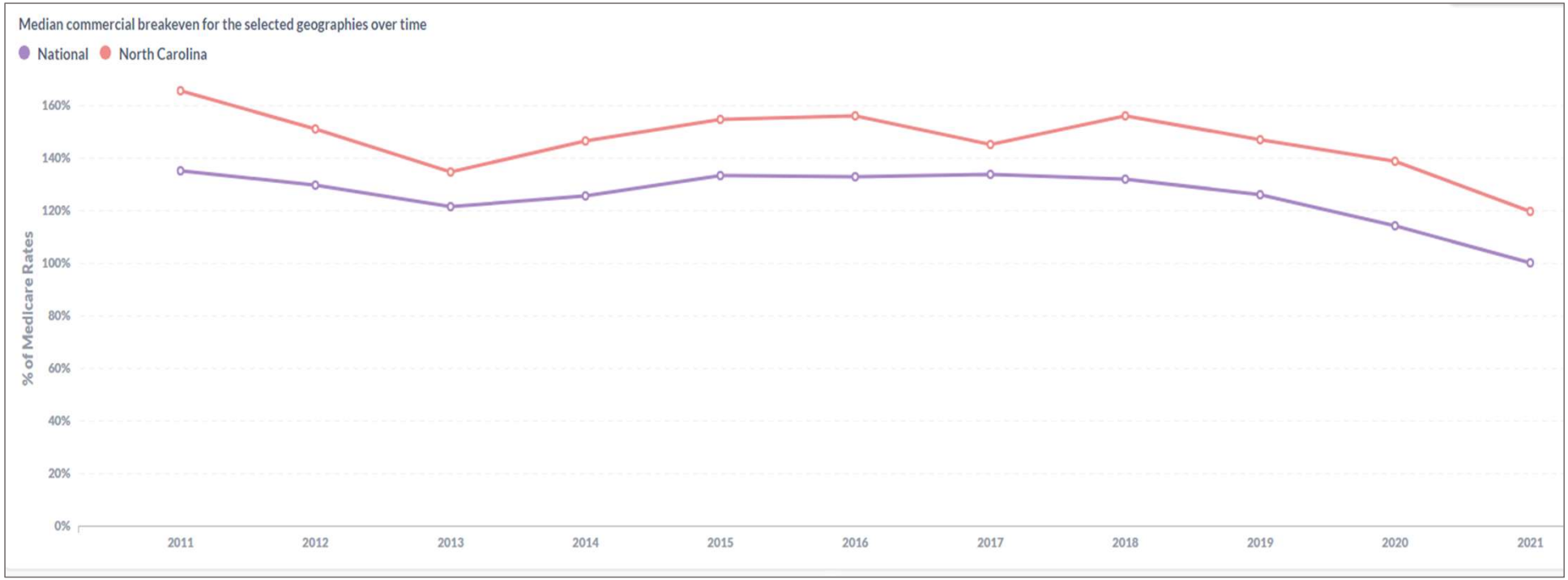
- **NASHP's Hospital Cost Tool calculates a hospital's breakeven point: Revenue = Expenses**
  - Revenue includes payments from all sources. Expenses include hospital operations, administration, ancillary services, & non-operating expenses.
- **NASHP Commercial Breakeven –** how much a hospital needs to be reimbursed by commercial payers in order to cover its expenses
  - **Factors that impact breakeven:** Medicare payment rate, hospital other income, reimbursement from other payers, reporting error
- **RAND 4.0 Commercial Price –** how much a hospital was reimbursed by commercial payers in aggregate from 2018 to 2020
  - Includes claims from participating self-insured employers, health plans, and APCDs (AR, CO, CT, DE, ME, NH, OR, RI, UT, WA) at over 4,000 hospitals
- Breakeven and Price expressed as multiples of the individual hospital's Medicare rates for comparability purchases

Example: Hospital A could cover its expenses if reimbursed by commercial payers at **155 percent** of Medicare rates. However, it was paid **334 percent** of Medicare (in aggregate from 2018 to 2020).



Source: NASHP Hospital Cost Tool, 2020 Data; price from RAND Corporation, 2018-2020 Data

Breakeven: North Carolina Median compared to National Median



https://www.nashp.org/hospital-cost-tool/

A Hospital View: Breakeven

Duke University Hospital

Quick Stats

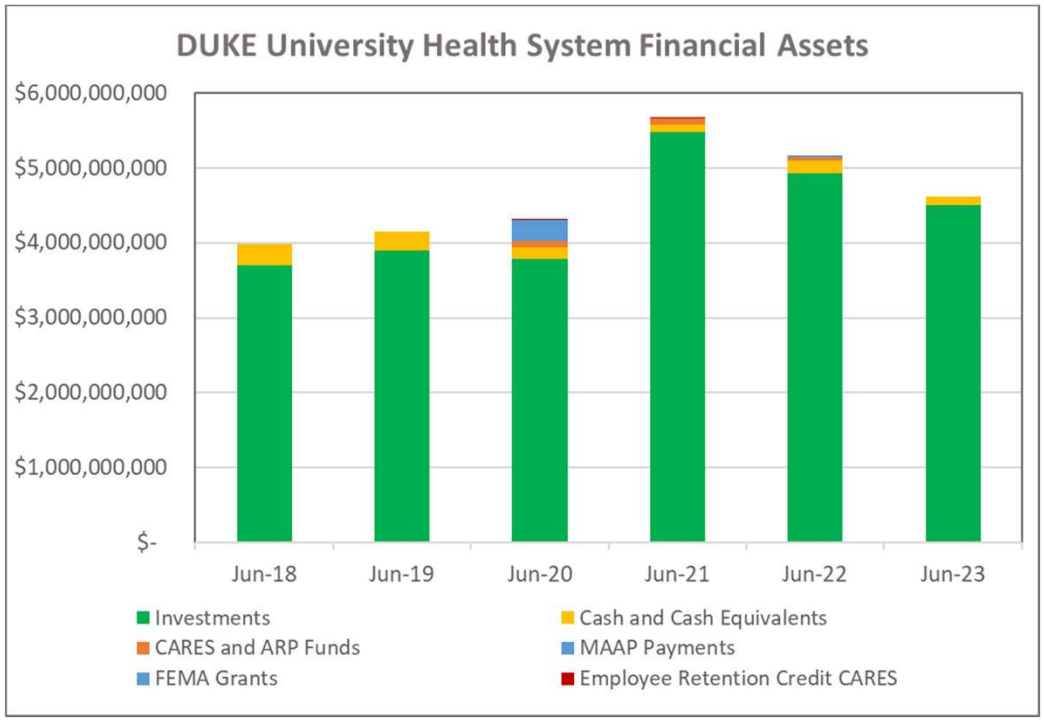
Breakeven
2018: 156% of Medicare
2019: 163% of Medicare
2020: 173% of Medicare
2021: 178% of Medicare

Compared to

RAND Analysis = What Commercial Payers Paid 2018-2021: 247% of Medicare

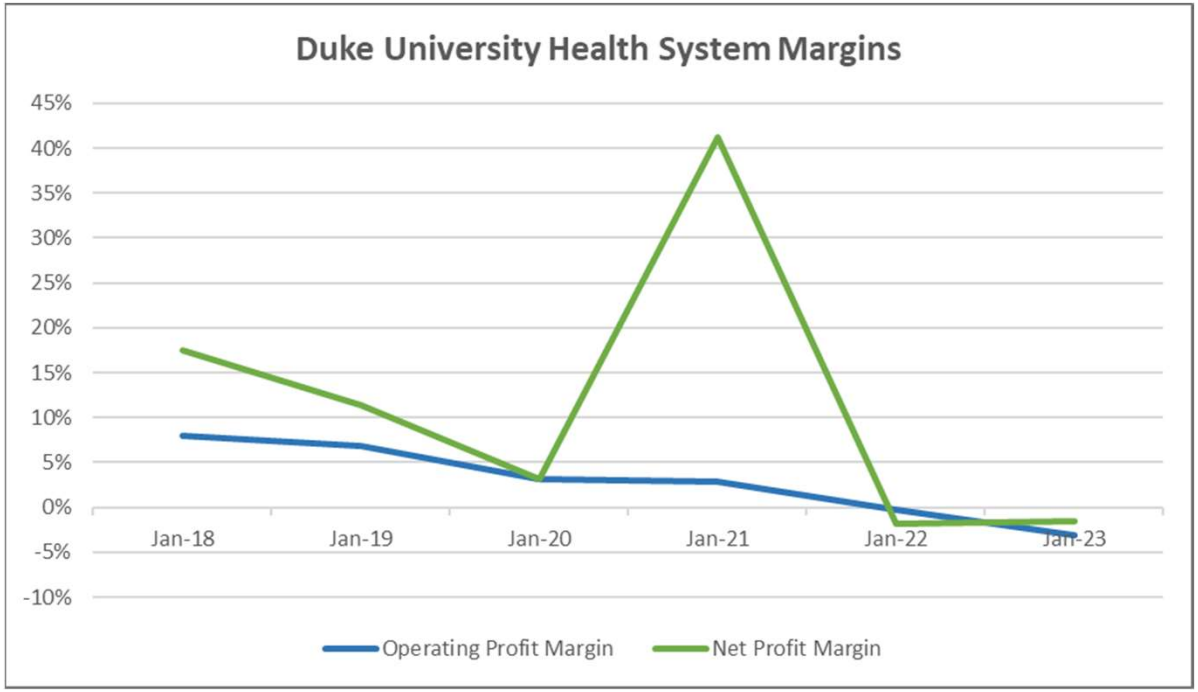
Digging Deeper: Financial Health of Health Systems

Duke Health System: Financial Assets



Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

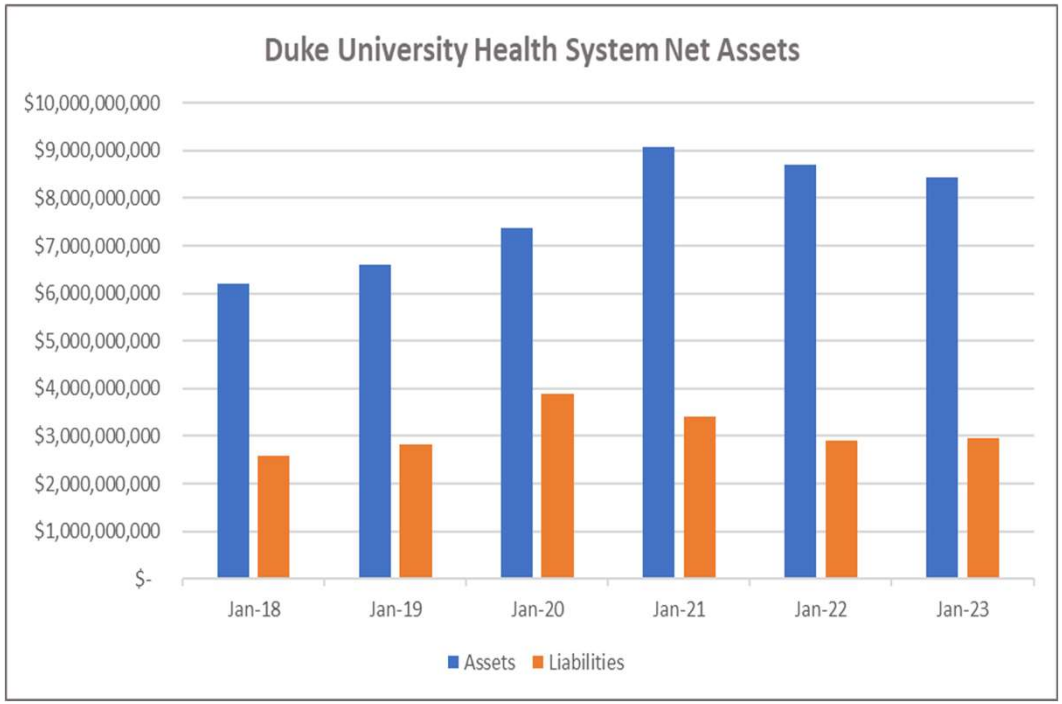
Duke Health System: Margins



Unrealized Gains (Losses)
2020: $1.6 billion
2021: ($90 million)
2022: $40 million

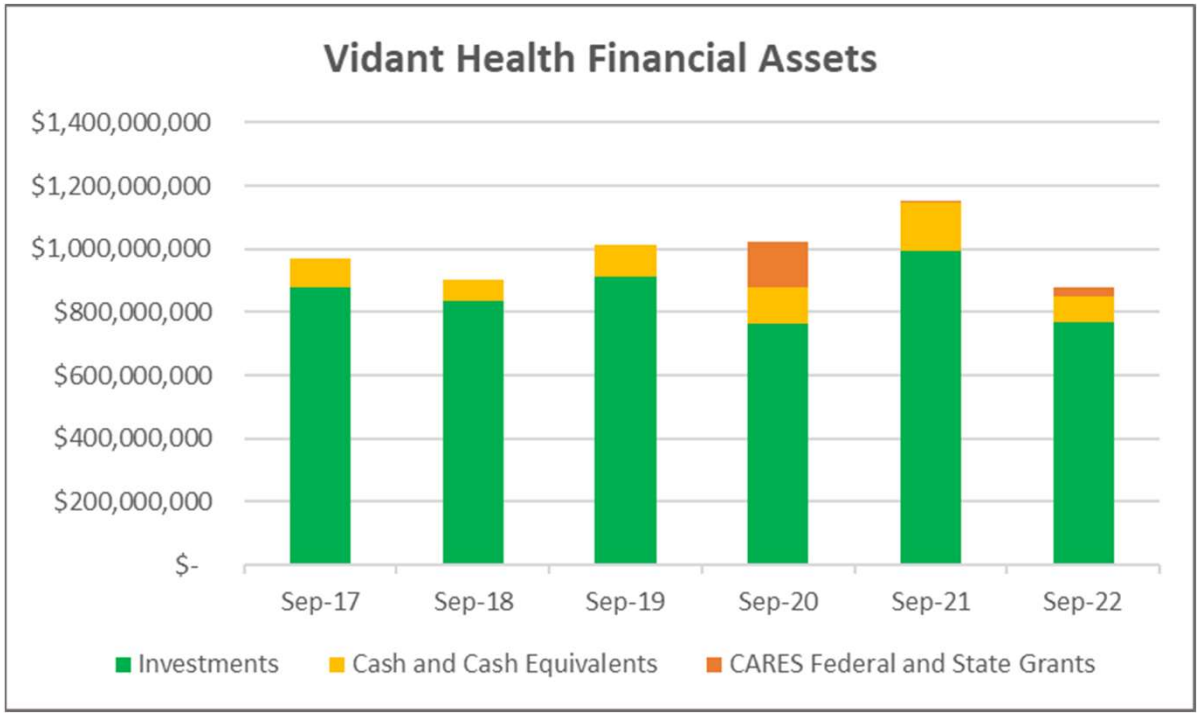
Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

Duke Health System: Net Assets



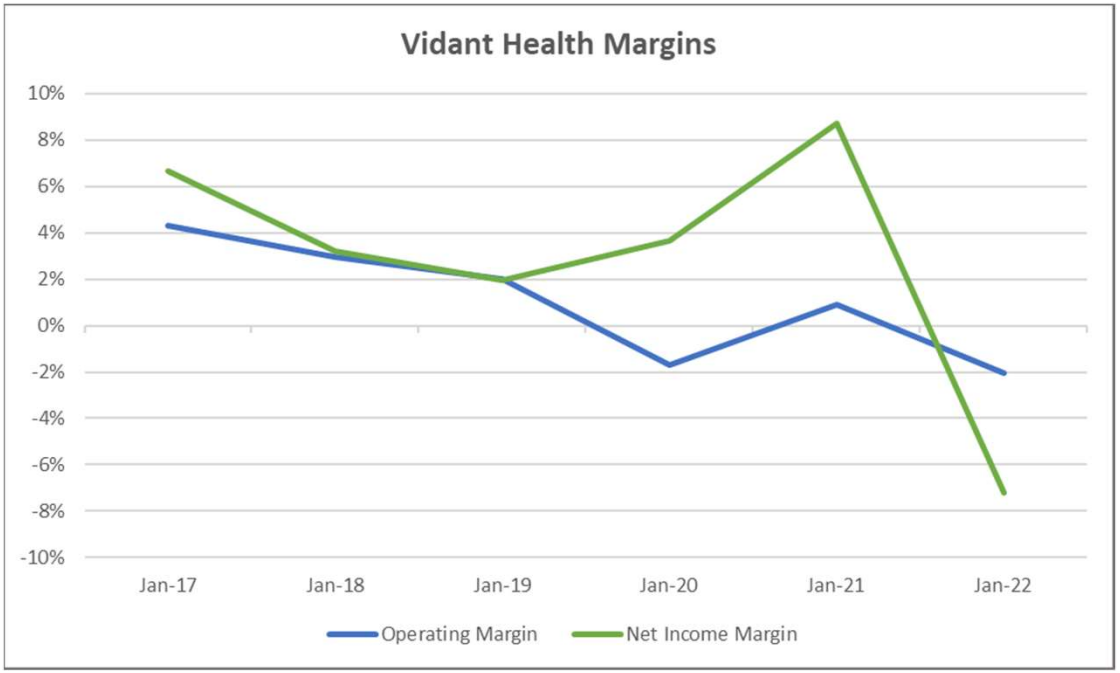
Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

Vidant Health System: Financial Assets



Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

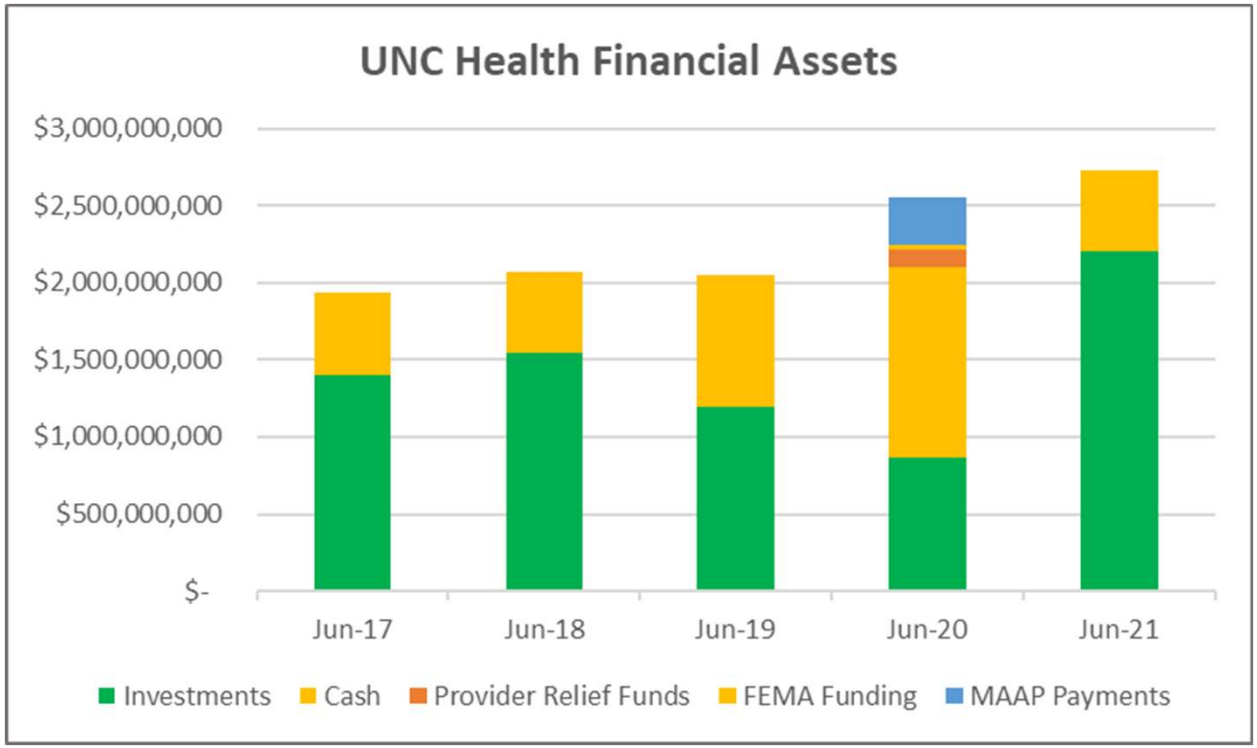
Vidant Health System: Margins



Unrealized Gains (Losses)
2021: $54 million
2022: (153 million)

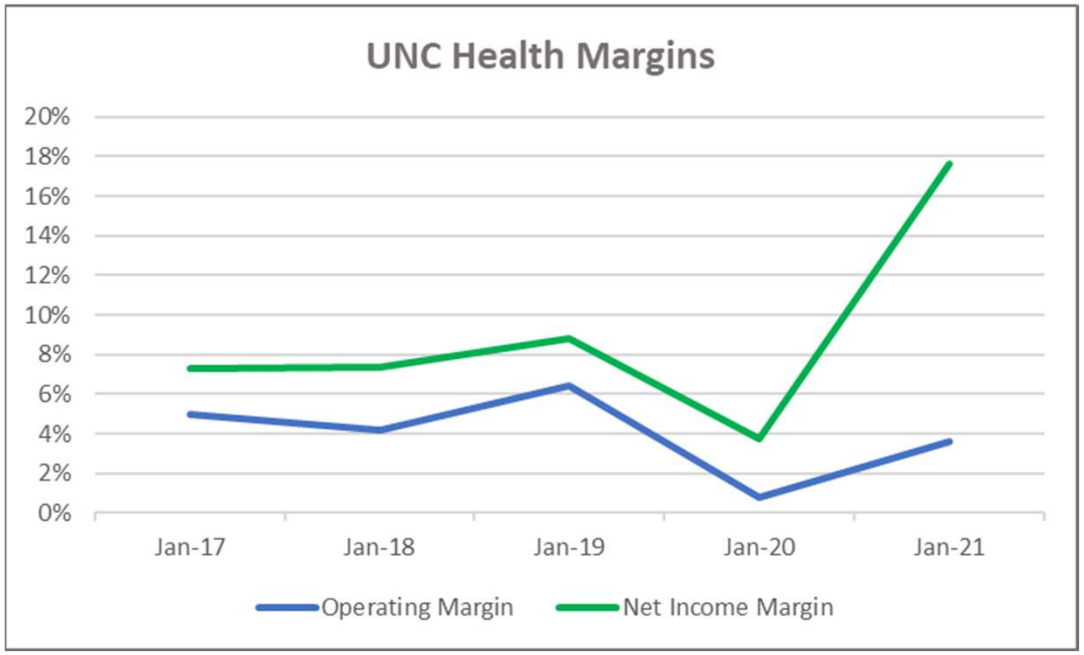
Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

UNC Health System: Financial Assets



Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

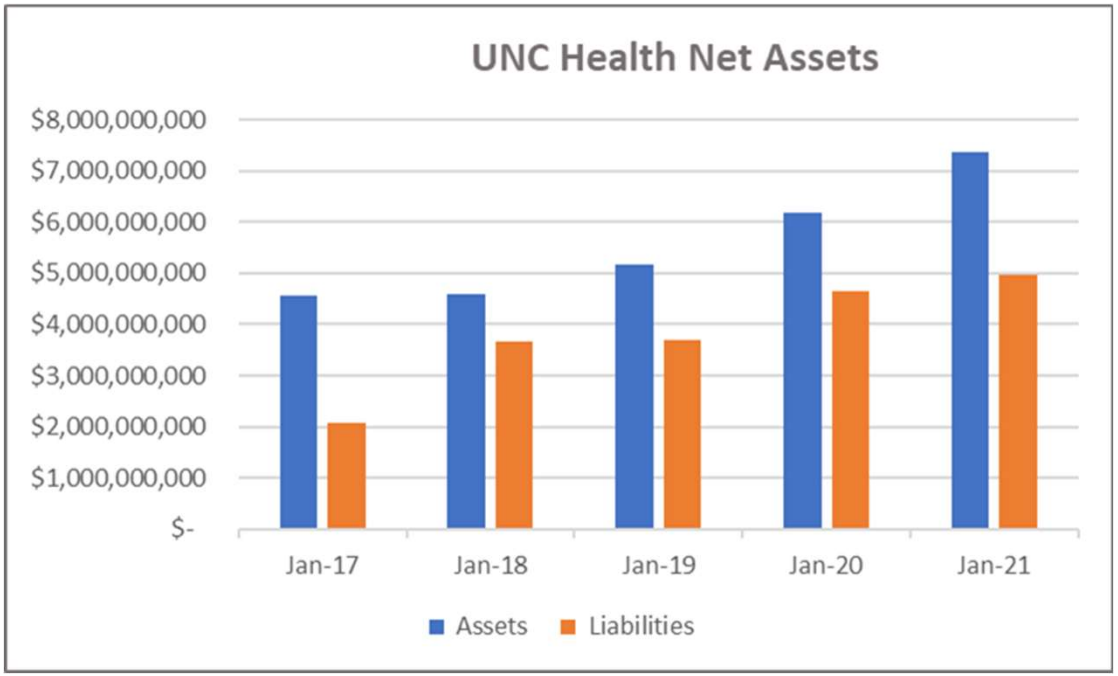
UNC Health System: Margins



Unrealized Gains (Losses)
2021: $1.0 billion

Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

UNC Health System: Net Assets



Source: Audited Financial Statements. Municipal Securities Rulemaking Board::EMMA (msrb.org)

Policy Options to Address High and Rising Health Care Costs

Policy Tools

What do you want to address?

Lack of Transparency

- All payer claims databases
- Enhanced hospital financial reporting
- NASHP's Hospital Cost Tool

Consolidation

- Pre-transaction review and approval of proposed transactions
- Banning anticompetitive contract terms between providers and physicians

Rising Spending

- Health care cost growth benchmarks
- Health insurance rate review – affordability standards

High Prices

- Reference-based pricing state employee health plans
- Limit outpatient facility fees
- Public option
- Establish maximum payment limits for out-of-network services
- All-payer model, global budgets

https://www.nashp.org/policy/health-system-costs/model-legislation-and-resources/

What State Can Do To Address High Provider Costs

Prohibiting anti-competitive contracting terms

NASHP's model act is designed to help address high-cost drivers **within a consolidated health market** by prohibiting common anti-competitive contracting practices.

All-or-nothing contracting	Health systems leverage the status of their "must-have" providers and require plans to contract with all providers in the system or none of them. This forces insurers to face a difficult choice — include all of the systems' providers (even if they are low-value or high-cost) or lose them all.
Anti-tiering or Anti-steering Clauses	Dominant systems may require a health plan to place all physicians, hospitals, and other facilities associated with a hospital system in the most favorable tier of providers (i.e., anti-tiering) or at the lowest cost-sharing rate to avoid steering patients away from that network (i.e., anti-steering). These clauses undercut a plan's ability to direct patients to high-value providers.
Most-favored-nation (MFN) clauses	Typically used by a dominant insurer in combination with a dominant health system, MFN clauses are contractual agreements in which a health system agrees not to offer lower prices to any other insurer. For a dominant insurer, this ensures they are getting the best price and that no rival insurer can negotiate to offer a novel product at lower rates. MFNs may also allow insurers and providers to collude to raise prices.
Gag clauses	Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. The lack of transparency from gag clauses and the mistaken notion that prices are trade secrets undermines price transparency tools for consumers and decreases plan sponsors' ability to push back on rising prices.

Resources:

Model Act to Address Anticompetitive Terms in Health Insurance Contracts

Policy Brief: A Tool for States to Address Health Care Consolidation

Policy Brief: Weighing Policy Trade-offs: Overview of NASHP's Model Prohibiting Anticompetitive Contracting

What State Can Do To Address High Provider Costs

Prohibiting unwarranted facility fees

Prohibiting certain facility fees 	• **Site-specific facility fees:** services rendered at physician practices and clinics located more than 250 yards from a hospital campus. • **Service-specific facility fees:** typical outpatient services that are billed using evaluation and management codes, even if those services are provided on a hospital campus.
Reporting 	• Requires annual reporting of facility fees charged or billed by health care providers.
Authority 	• Delegates implementation authority to a relevant state agency
Enforcement Mechanisms 	• An annual facility fee audit by the relevant state agency; • A private right of action for consumers; and • Administrative financial penalties against health care providers for violations.

Resources:

Model State Legislation to Prohibit Unwarranted Facility Fees Reporting Requirements

Report: State Policies to Address Vertical Consolidation in Health Care

Blog: Combat Rising Health Care Costs by Limiting Facility Fees with New NASHP Model Law

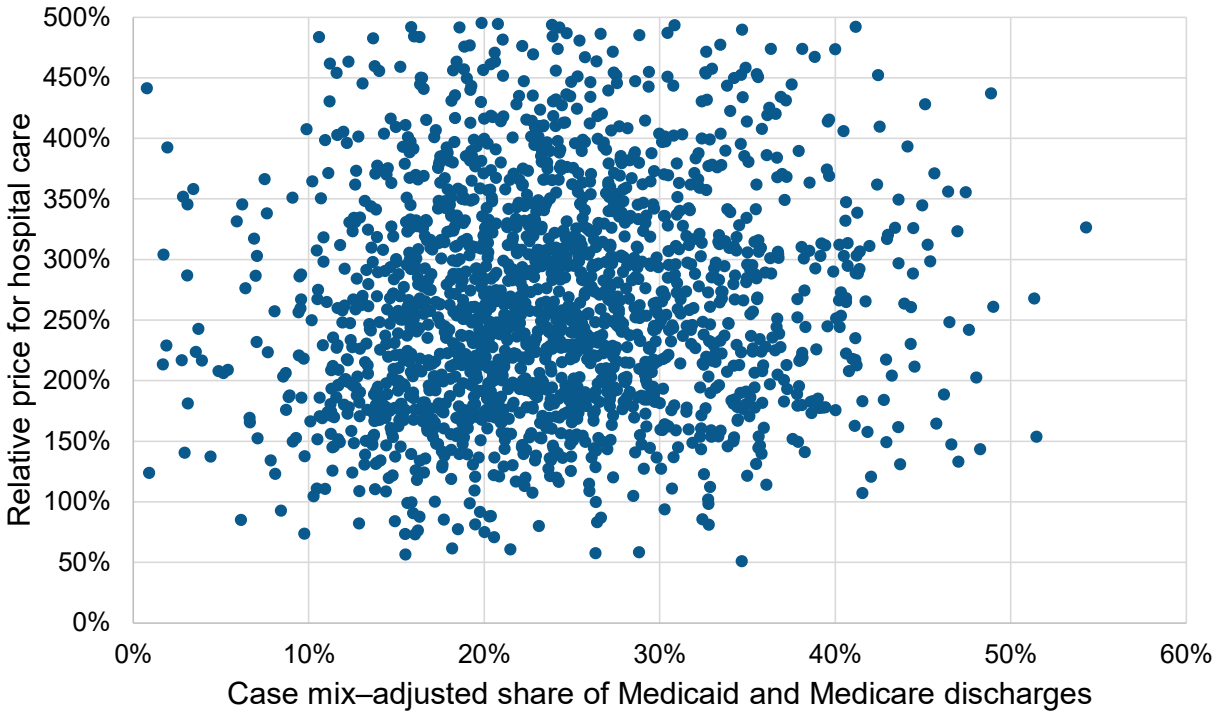
Out-of-Network (OON) Limit Exceptions

Smaller, rural, and/or critical access hospitals (CAHs) are often not the primary drivers of high hospital prices, so could be exempted from state policies limiting out-of-network rates.

- **Option 1**: Fully exempt certain hospital types. Exemption language in NASHP Model Act to Limit Out-of-Network Provider Rates:
  - (D) *Exceptions.* This section shall not apply to:
    I. [A rural critical access hospital as defined by [code citation]]
    II. [A federally qualified health center as defined by [code citation]]
    III. [Any other exceptions that the state may want to include, such as rural health clinics, or other types of safety net hospitals or facilities]
  - State example: OR SB 1067: SECTION 29.(5)

- **Option 2:** Set an OON payment limit across the state but establish higher bases for certain hospital types.
- For example, a statewide minimum OON limit of 205% of Medicare for all hospitals, but +30% for CAHs, +20% for independent hospitals
  - A non-CAH hospital within a health system would have an OON payment limit of 205%
  - A CAH hospital within a health system would have an OON payment limit of 235%
  - An independent non-CAH would have an OON payment limit of 225%
  - An independent CAH would have an OON payment limit of 255%
- State example: Colorado HB 21-1232 Section 10-16-1306 4(a)

No correlation nationally between a hospital's public insurance reliance and its private insurance prices[1]



- If the cost-shifting argument were true, one would expect a positive correlation between these two variables.
- "The share of providers' patients who are covered by Medicare and Medicaid is not related to higher prices paid by commercial insurers. That finding suggests that providers do not raise the prices they negotiate with commercial insurers to offset lower prices paid by government programs (a concept known as cost shifting)." – Congressional Budget Office, 2022
- Additionally, The National Bureau of Economic Research found that when hospitals received an unexpected 10 percent increase in Medicare payment rates, they did not reduce their private prices.[2]
- Instead, they:
  - Added new technology;
  - Increased nursing staff;
  - Increased payroll by one-third

1. Whaley et al., RAND Corporation, 2020.
2. Skinner et al., National Bureau of Economic Research, *JAMA*. 2018

Thank you!

NASHP's Health System Costs Resources:

- Written research and analysis & state legislative tracking
- Model legislation & regulation to address consolidation and more
- Hospital Cost Calculator & hospital financial transparency reporting template
- Available Now! Interactive Hospital Cost Tool
- https://www.nashp.org/policy/health-system-costs/

Maureen Hensley-Quinn
Senior Director
National Academy for State Health Policy
mhq@nashp.org

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

nashp.org @NASHPhealth @NASHP

Using Data for Market Decisions and Policy Changes

Gloria Sachdev

President/CEO
Employers' Forum of Indiana

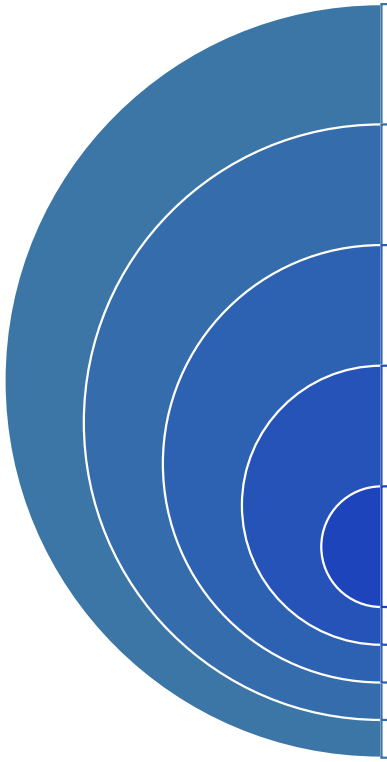
EMPLOYERS' FORUM OF INDIANA
Addressing the challenges of the local healthcare marketplace

How the Employers' Forum of Indiana is Using Data to Inform Honest Conversations

Gloria Sachdev, Pharm.D.
President and CEO, Employers' Forum Of Indiana
gloria@employersforumindiana.org

North Carolina Business Coalition on Health
Greensboro, NC
September 15, 2023

ABOUT THE EMPLOYERS' FORUM OF INDIANA



Employer-Led Healthcare Coalition Founded in 2001
Executive Committee Comprised of non-provider employers
Non-Profit 501(c)(3)
Aim: To improve the value employers and patients receive for their healthcare expenditures
https://employersforumindiana.org/

Employers' Forum of Indiana Members

*Executive Committee Members

Updated August 14, 2023

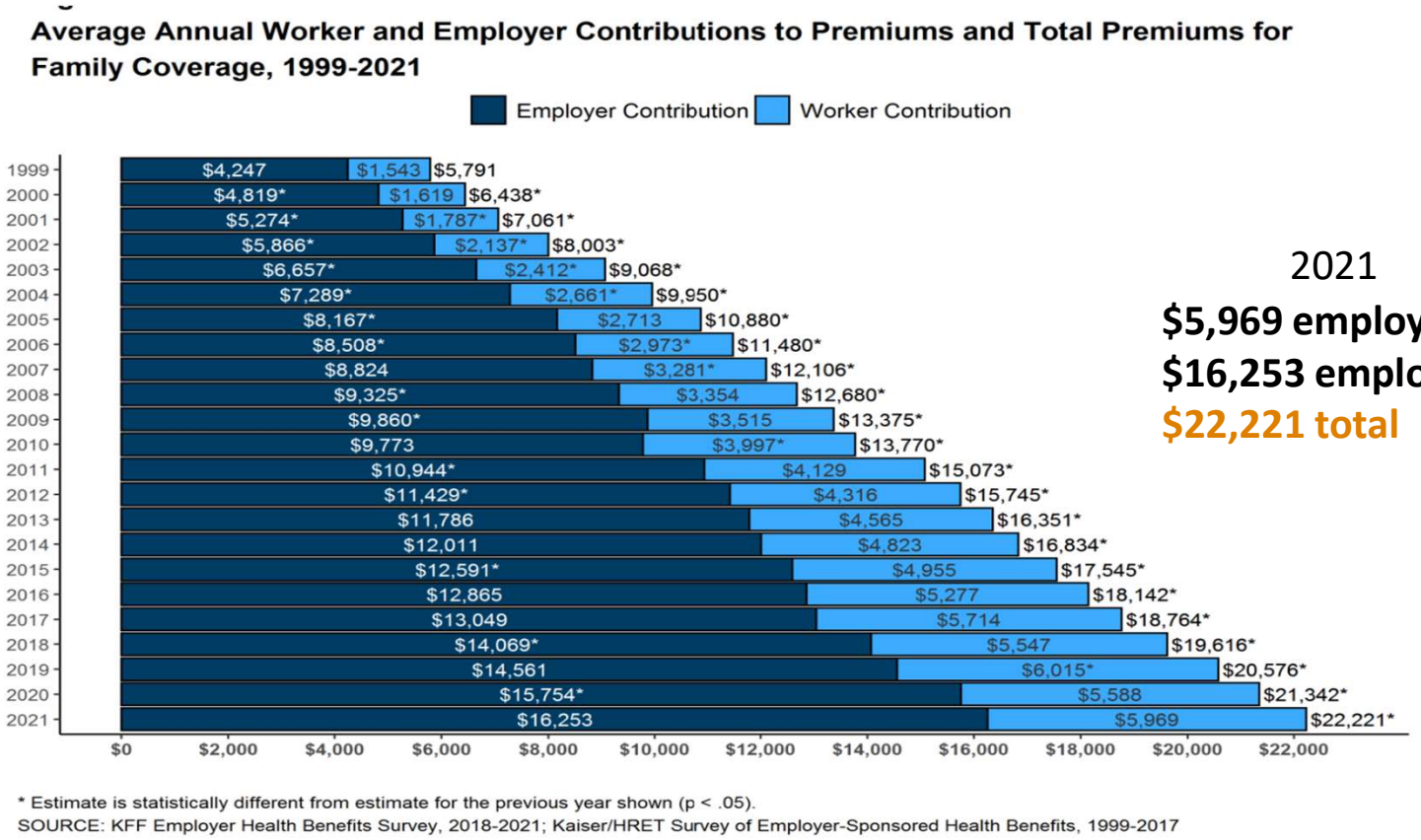
Individual Members

1. Allison Transmission*
2. American Health Network
3. Anthem BCBS
4. Aon
5. ApexBenefits
6. Apollo Pain Center
7. Ashley Industrial Molding*
8. Barnes & Thornburg*
9. Cameron Memorial Community Hospital
10. Capital RX (affiliate member)
11. Carrum Health (affiliate member)
12. Central Noble Schools*
13. Certus Management Group
14. Chris Magiera, MD
15. Clear Healthcare Advocacy
16. Conner Insurance
17. Cummins*
18. Danzer Veneer Americas, Inc*
19. Deaconess Hospital
20. Delta Dental of Indiana (affiliate member)
21. Eli Lilly and Co.*
22. Encore Health Network
23. Eskenazi Health
24. Everside Health
25. Express Scripts/Cigna
26. Fiat Chrysler Automobiles (Stellantis)*
26. Fort Wayne Medical Oncology & Hematology
27. Gibson
28. Goodman Campbell Brain and Spine
29. Gregory & Appel Insurance
30. Haynes International*
31. Healthcare Options*
32. Hylant
33. Indiana Health Information Exchange
34. Indiana Spine Group
35. Indiana State Teachers Association*
36. Indiana University*
37. Ivy Tech*
38. JA Benefits
39. LHD Benefit Advisors
40. Lutheran Health
41. Managed Health Services
42. Marathon Health
43. Merck (affiliate member)
44. Meridian Medical Services
45. Metro Plastics*
46. MJ Insurance
47. Northwest Cancer Center
48. Northwest Radiology
49. OneBridge*
50. Ortho Indy
51. PatientMD (affiliate member)
52. Physicians Health Plan of Northern Indiana
53. Purdue University*
55. Qsource
56. Red Gold*
57. RE Sutton and Associates
58. Roche & Genentech*
59. Roman Catholic Archdiocese of Indianapolis*
60. Sacred Roots Birth & Wellness Center
61. Sandoz (affiliate member)
62. Sanofi Genzyme (affiliate member)
63. Schweitzer Engineering Laboratories*
64. Shery Roussarie, MHA/MBA
65. Suburban Health Organization
66. The Alliance
67. The DeHayes Group
68. TrueRx
69. UnitedHealthcare
70. University of Notre Dame*
71. VeriVitae (affiliate member)
72. Weaver Popcorn*
73. Wellbridge Surgical

Group Members

74. American Physical Therapy Association, Indiana Chapter
75. Bartholomew Consolidated School Corp*
76. Fort Wayne Community School Corporation*
77. Indiana Manufacturers Association
78. Indiana Pharmacists Association
79. Patoka Valley Healthcare Cooperative*
80. South Central Indiana School Trust*

PROBLEM: U.S. EMPLOYEES & EMPLOYERS ARE PAYING A LOT MORE $$$ FOR HEALTH INSURANCE PREMIUMS: FAMILY COVERAGE, TREND 1999-2021



2021

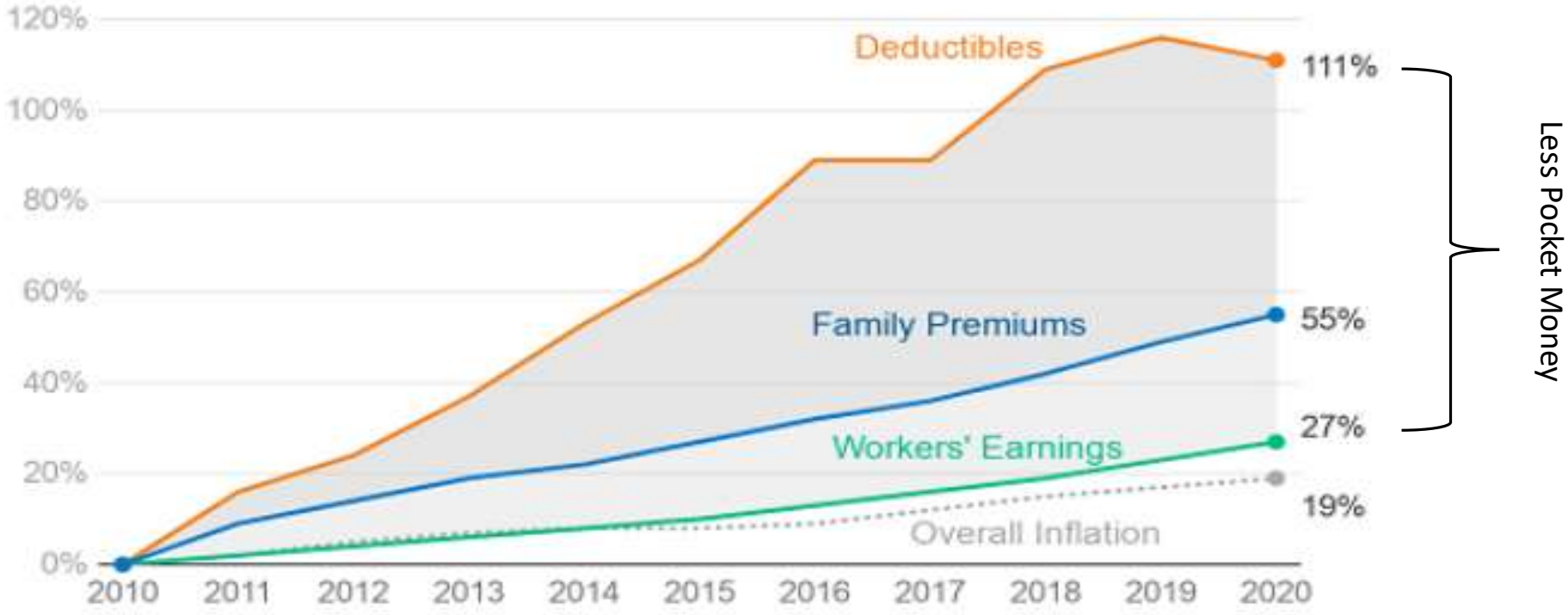
$5,969 employee +

$16,253 employer =

$22,221 total

https://www.kff.org/report-section/ehbs-2021-section-6-worker-and-employer-contributions-for-premiums/

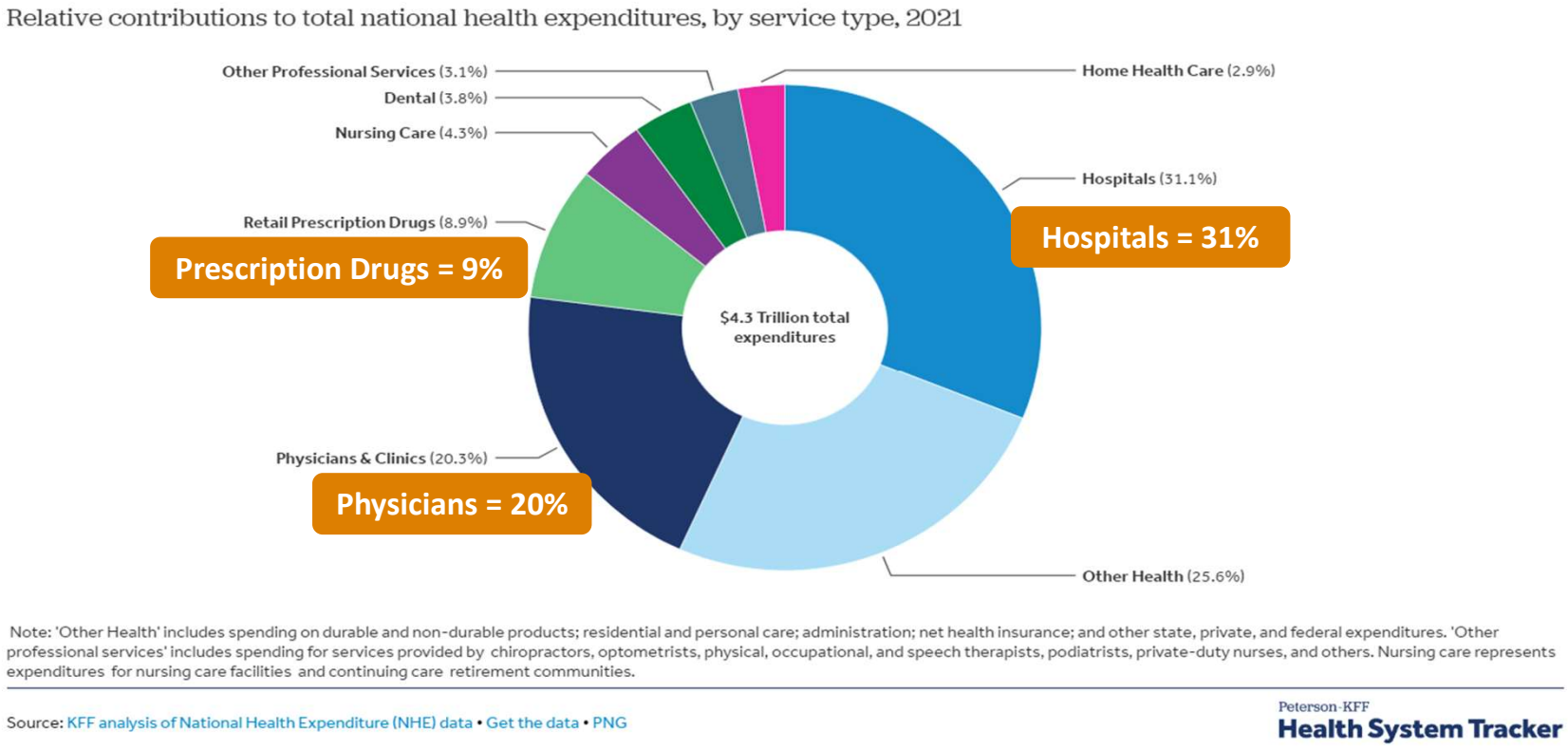
PROBLEM: EMPLOYEE DEDUCTIBLES & PREMIUMS HAVE RISEN MUCH FASTER THAN WAGES, 2010-2020



NOTE: Average general annual deductibles are for single coverage. Workers in plans without a general annual deductible for in-network services are assigned a value of zero. Source: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010 and 2015: https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/

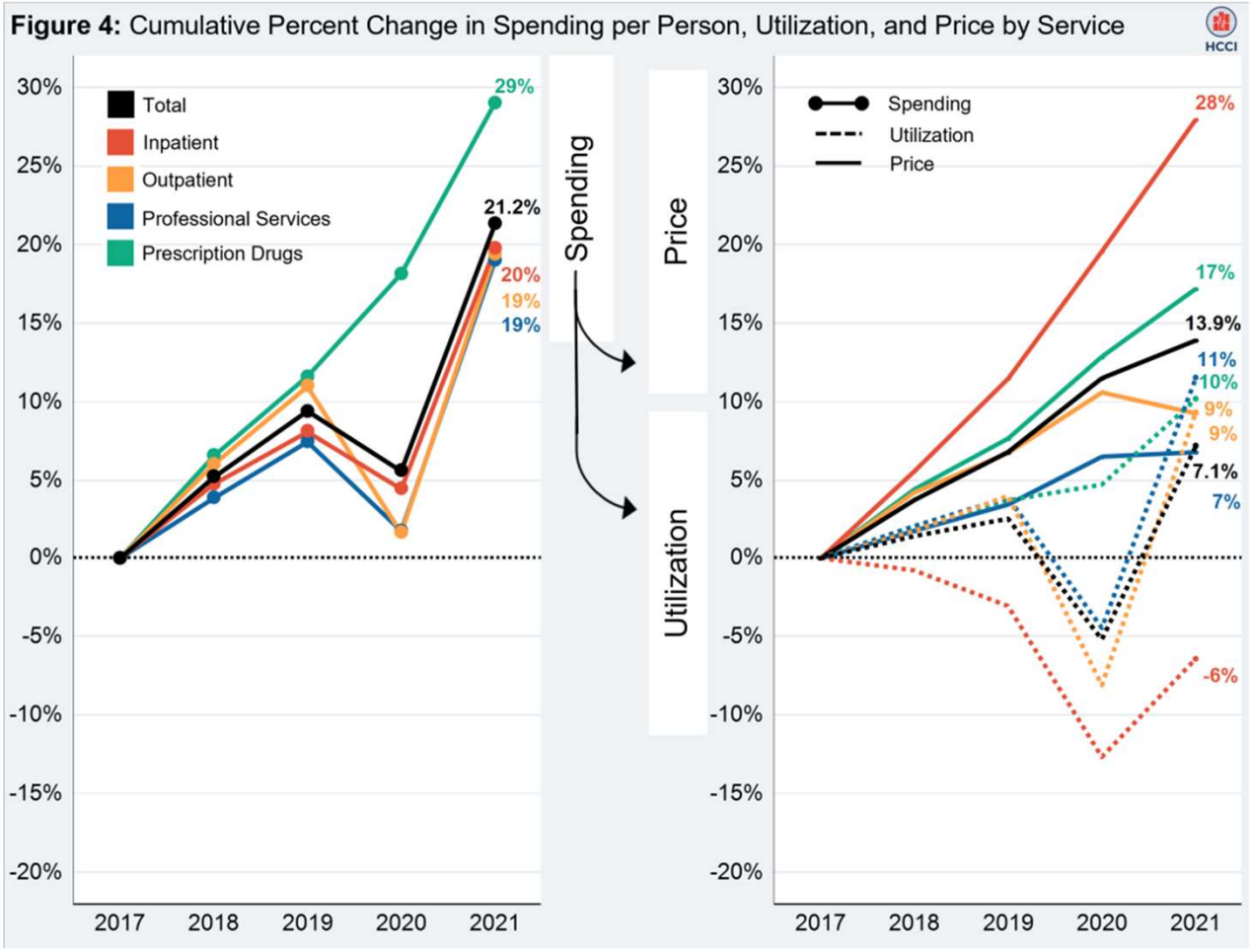
Where are We Spending Healthcare Dollars?

Hospital & Physician Services Represent Half of Total Spend, 2021



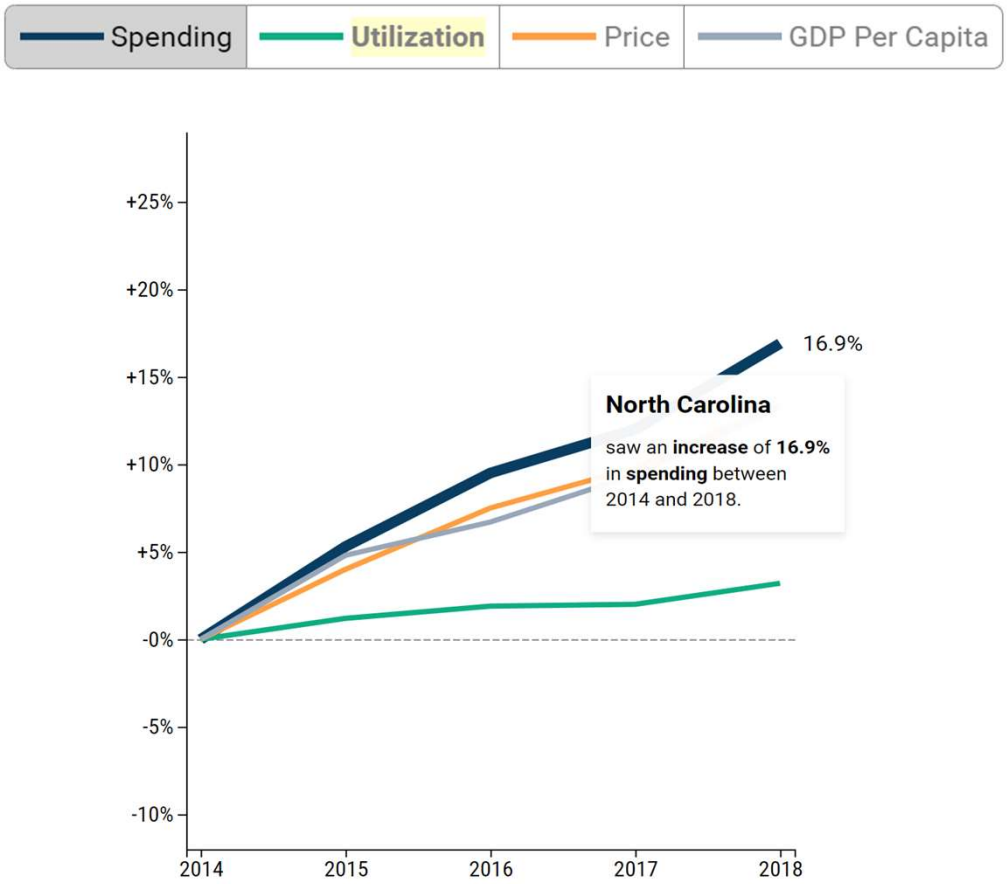
https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Relative%20contributions%20to%20total%20national%20health%20expenditures,%20by%20service%20type,%202021

Total Cost of Care = Total Spending = Price X Utilization



https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports

PRICE in North Carolina is Driving Up Spending, Not Utilization



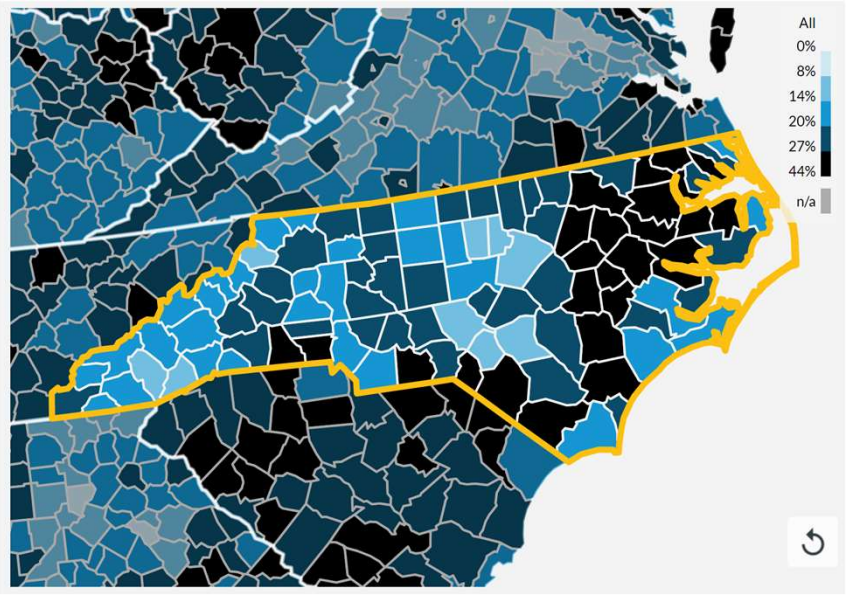
https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report?highlight=WyJ1dGlsaXphdGlvbiJd

DEBT IN AMERICA: AN INTERACTIVE MAP

Last updated June 23, 2022; credit data from February 2022

Interactive map noting **"Share of medical debt in collections"** and Median amount in collections per country, state, national levels

- Conducted by Urban Institute, non-profit research organization
- Includes 10 million lives
- Provides demographic information at county level including: white vs communities of color, share without insurance, avg household income
- Downloadable Excel Spreadsheets for country, state, and national level data available



https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=medcoll

DEBT IN AMERICA: PEOPLE IN COLLECTIONS

North Carolina

- **20% of population have medical debt in collections. RANGE = 9% to 44%**
- Includes data for all 100 North Carolina counties with highest counties as follows:
  - Lenoir = 44%, Greene = 44%, Anson = 43%, Tyrrell = 40%, Hertford = 38% of adult population

OTHER STATES percent of population with medical debt in collections:

- Virginia = 14%
- Georgia = 17%
- Tennessee = 18%
- South Carolina = 22%

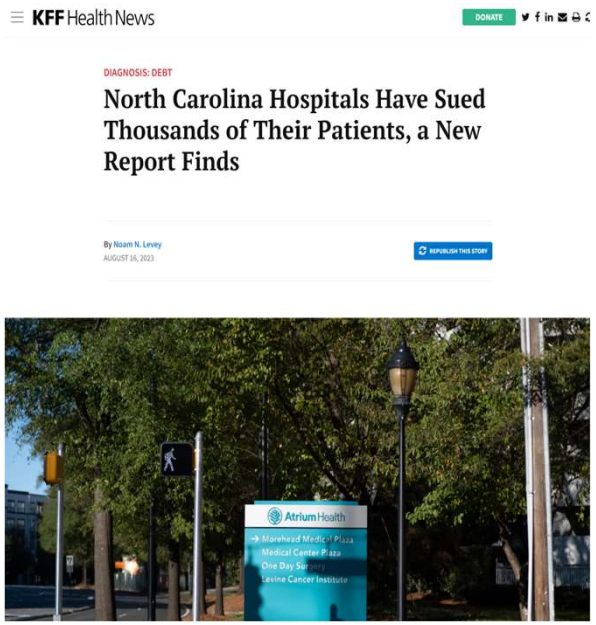
NATIONAL AVERAGE percent of population with medical debt = 13%

https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=medcoll

New Report: NC Hospitals Suing Patients

North Carolina hospitals sued ~ 6000 patients between 2017-2022, according to an August report by the state treasurer and researchers at Duke University School of Law.

- 3,449 judgments for hospitals totaling $57.3 million, or an average of $16,623 per judgment
- nonprofit hospitals initiated 90.6% of the lawsuits against patients
- Under North Carolina law, a judgment automatically triggers a lien against real property



"Hospitals Suing Patients: How Hospitals Use N.C. Courts to Collect Med" by Barak Richman, Sara Sternberg Greene et al. (duke.edu)

https://kffhealthnews.org/news/article/north-carolina-hospitals-patient-debt-lawsuits/

Solution: Need More Transparency to Inform Purchasing and Policy Decisions

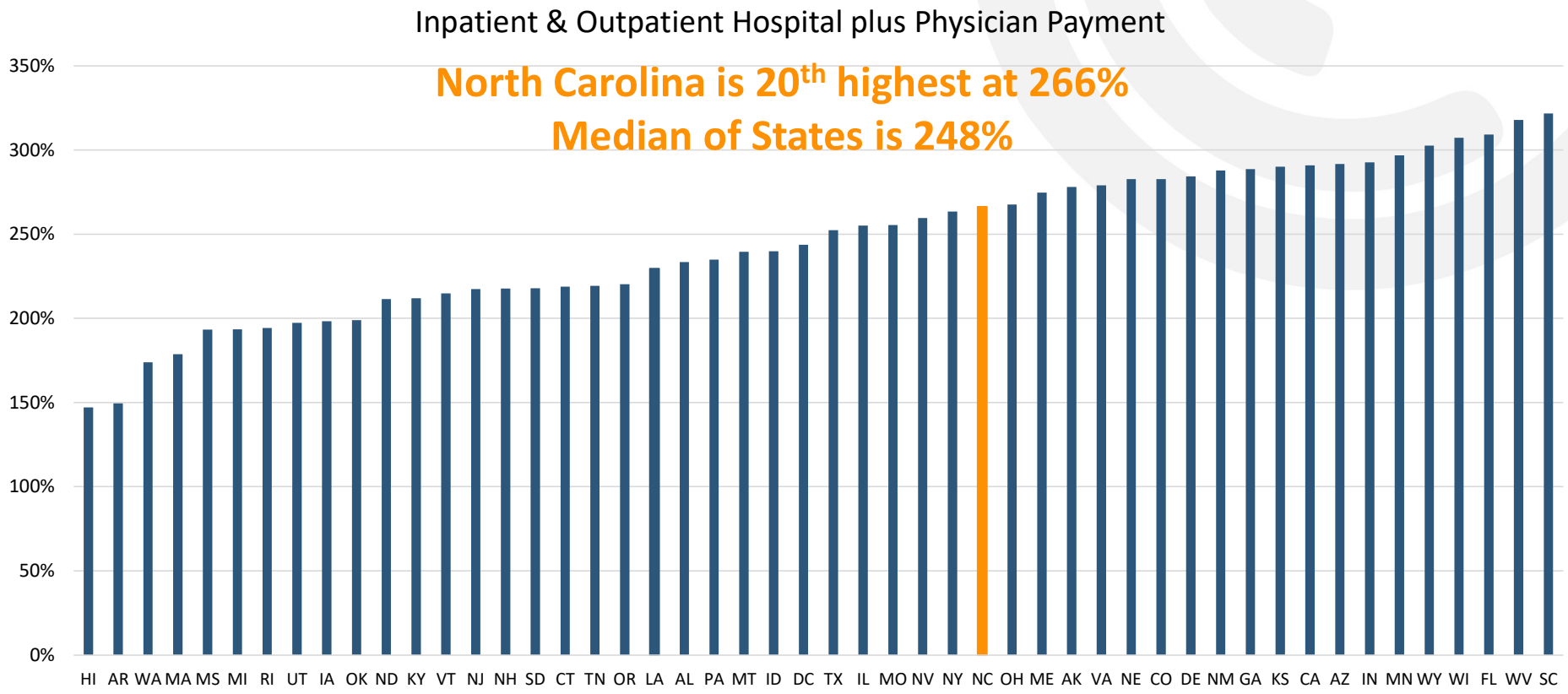
RAND HOSPITAL PRICE TRANSPARENCY STUDIES

- First of its kind study in the country to **publish negotiated prices by hospitals name**, noted as Percent of Medicare & Standardized Prices
- Conceived and commissioned by the Employers' Forum of Indiana
- Analysis and published report conducted independently by RAND Corporation
- Funded by Employers, Robert Wood Johnson Foundation, & Arnold Ventures (no funding accepted from insurers or hospitals)
- Does not include Rx drug prices

OVERVIEW: RAND HOSPITAL PRICE TRANSPARENCY STUDIES

	RAND 1.0 2017	RAND 2.0 2019	RAND 3.0 2020	RAND 4.0 2022
Services	Hospital Inpt & Outpt	Hospital Inpt & Outpt	Hospital Inpt & Outpt Fees Professional Inpt & Outpt Fees	Hospital Inpt & Outpt Fees Professional Inpt & Outpt Fees
States	IN	25 States	49 States (excludes Maryland)	49 states and the District of Columbia (excludes Maryland)
Years	2013 - 2016	2015 –2017	2016 – 2018	2018 - 2020
Hospitals	120	1,598	3,112	4,102
Claims	14,000 inpt facility stays 275,000 outpatient facility services	330,000 inpt facility stays 14.2 million outpt facility services	750,000 inpt facility stays (and professional fees) 40.2 million outpt services (and professional fees)	1.3 million inpt facility stays (and professional fees) 12.2 million outpt services (and professional fees)
Allowed Amounts (Hosp)	$695,000 million faciltiy total: $336 million inpt $359 million outpt	$12.9 billion total: $6.3 billion inpatient $6.6 billion outpatient	$33.8 billion total: $15.7 billion inpatient $14.8 billion outpatient $3.3 billion professional	$78.8 billion total $36.5 billion inpatient facilities, $34.7 billion outpatient facilities $7.6 billion professional
Data Sources	Participating self-funded employers	Self-funded employers, 2 all payer claims databases, and health plans	Self-insured employers, 6 state all-payer claims databases, & health plans across the US	Employers, health plans and 11 APCDs

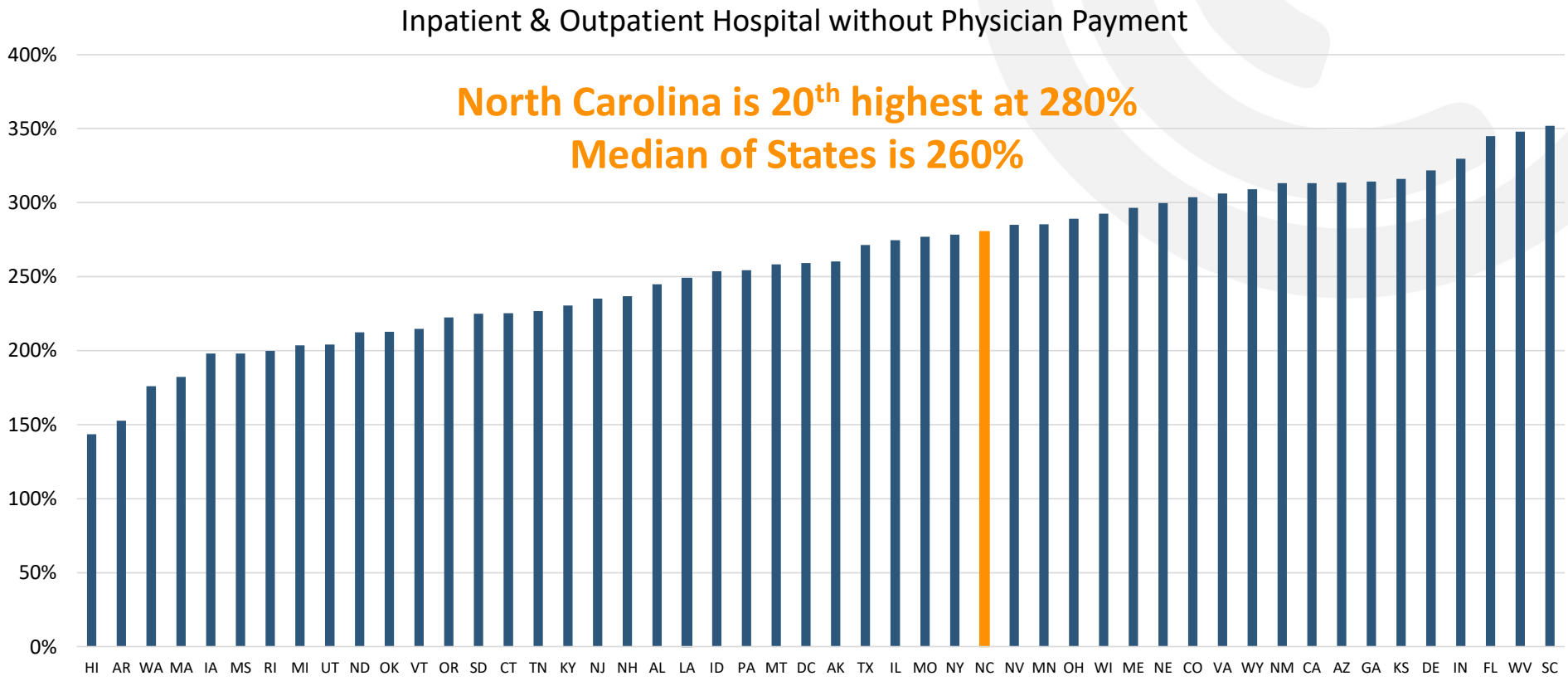
TOTAL HOSPITAL COMMERCIAL PRICES RELATIVE TO MEDICARE



EMPLOYERS' FORUM OF INDIANA
Addressing the challenges of the local healthcare marketplace

RAND 4.0 study, C. Whaley et al. https://employerptp.org/rand/4-0/

HOSPITAL FACILITY PRICES RELATIVE TO MEDICARE



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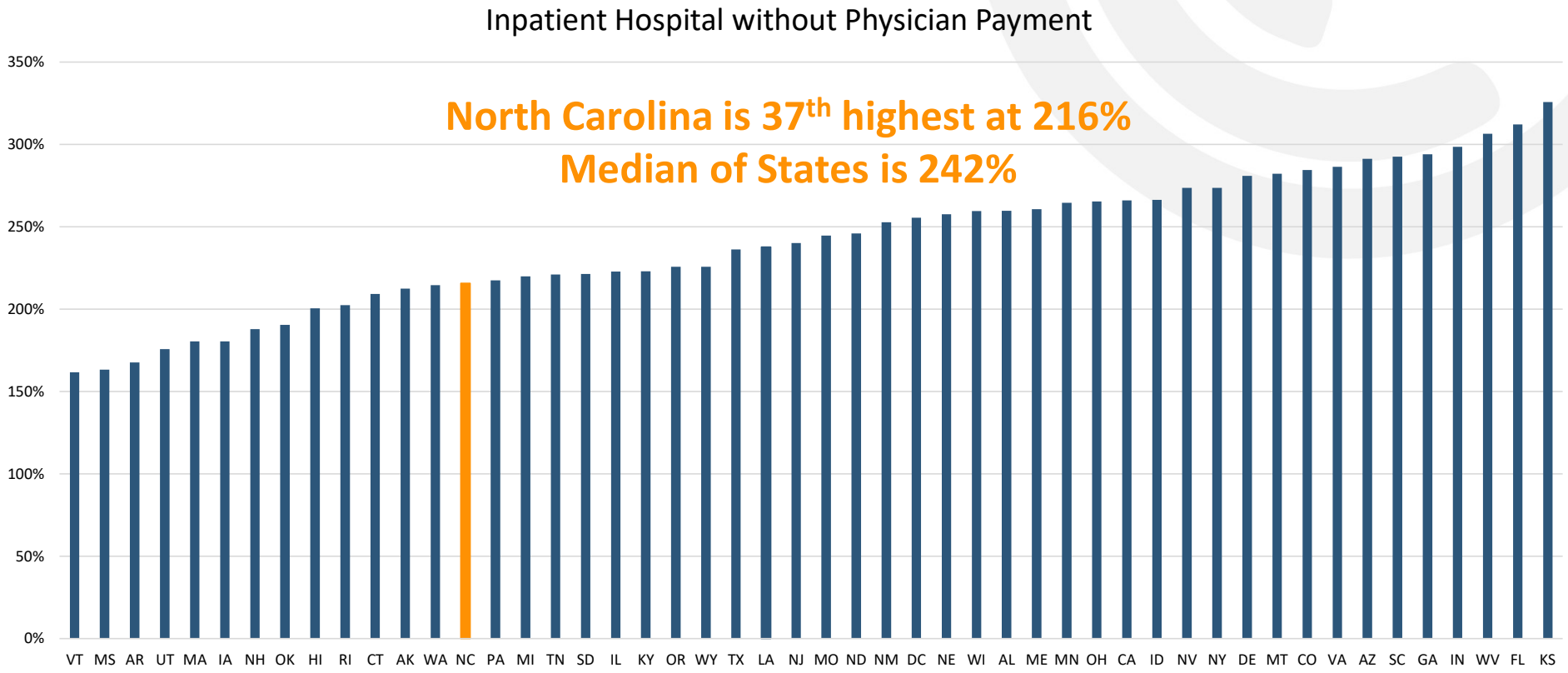
HOSPITAL INPATIENT FACILITY PRICES RELATIVE TO MEDICARE



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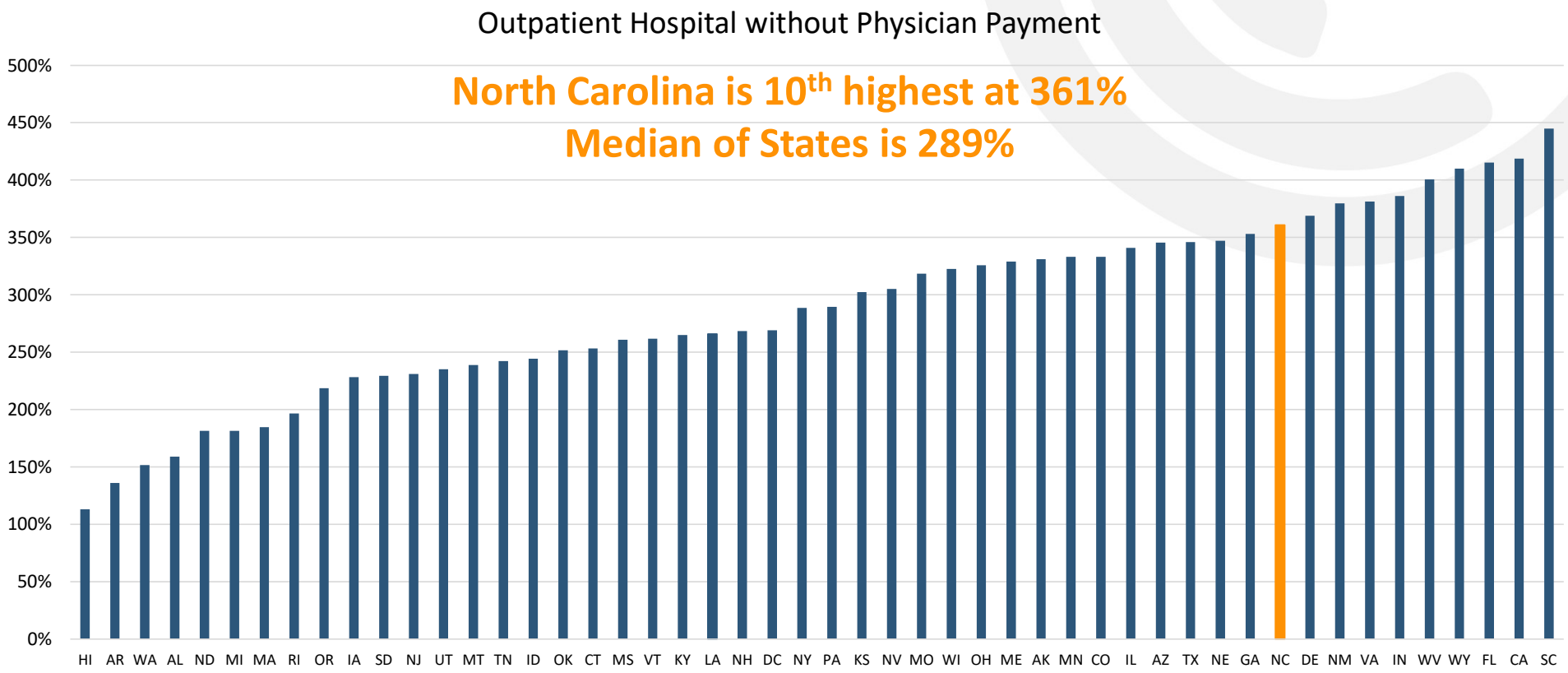
HOSPITAL OUTPATIENT FACILITY PRICES RELATIVE TO MEDICARE



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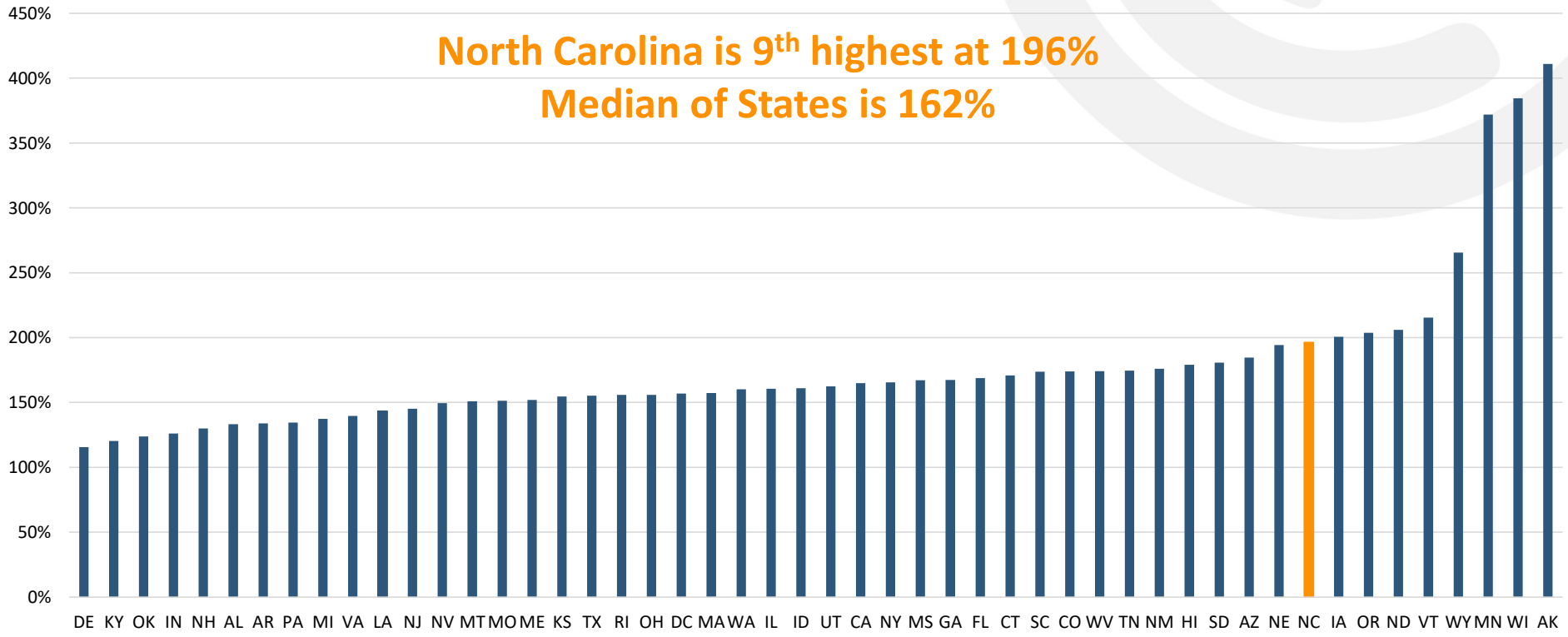
HOSPITAL PROFESSIONAL FEES RELATIVE TO MEDICARE

Inpatient & Outpatient Physician Payment without Hospital Facility Payment



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RAND 4.0 study, C. Whaley et al. https://employerptp.org/rand/4-0/

Employers' Forum of Indiana (EFI) Response

Legislative Policy Solutions

Market Solutions

2023 Indiana Legislation: Two Bills that Passed into Law

HEA 1004

- Sets a price benchmark of 285% of Medicare against which Indiana's five largest hospital systems will be compared.
- Eliminates hospital facility fees at off-campus labs, imaging centers, physician offices, etc. (there are numerous exceptions).
- IGA | House Bill 1004 - Health care matters (in.gov)

SEA 7

- Bans new primary care physician non-compete agreements and notes non-competes are unenforceable in certain circumstances.
- Prevents non-compete agreements from applying to any physicians after the terms of their employment contract have been fulfilled.
- IGA | Senate Bill 7 - Physician noncompete agreements (in.gov)

Indiana HEA 1004 Details - Rep. Donna Schaibley (R)

HEA 1004 passed with bipartisan support, 45-5 in the Senate and 90-7 in the House of Representatives. This bill establishes the following:

1. Effective 1-1-25, prohibits 5 nonprofit health systems from charging facility fees for off-campus services provided in an "office setting" including hospital, medical, surgical, and pharmaceutical services or products. Requires bills for healthcare services to be submitted on an individual provider form and prohibits payers' acceptance of institutional provider forms. Several exceptions are noted.
2. Requires 5 nonprofit health systems to submit their hospital price data annually to the Department of Insurance (DOI). Requires DOI to contract with a third party to calculate Indiana nonprofit hospital systems' prices for self-funded, fully-funded, individual market health plans, and total. *"Prices" means allowables that are paid for patient care services."*
    - By 3-1-24, and by March 1 annually thereafter, requires these hospital systems to submit price data for 2021-2023 to DOI or DOI's third party contractor, to analyze data required, as well as provide hospital price transparency data required to be made public by CMS.
    - By 12-1-24, and annually thereafter, require the DOI contractor to compare hospital system commercial inpatient, outpatient, and "practitioner" prices per hospital and per health system to 285% of Medicare, and provide a report to DOI, the Health Care Cost Oversight Task Force, and the Budget Committee.
3. Effective 7-1-23, and annually thereafter, requires hospitals to report net patient revenue and total number of paid claims by payer to Indiana State Department of Health as part of their annual financial reports.
    - The first report is due by 12-1-23.
    - Establishes a $1,000/day late submission fine which goes into the payer affordability penalty fund.
4. By 11-1-23, requires FSSA to do a one-time analysis on Medicaid hospital and professional reimbursement rates for Indiana, all other states and determine a national reimbursement rate average. By 12-1-23, this report is to be submitted to Health Care Oversight Task Force and General Assembly.

Continued HEA 1004

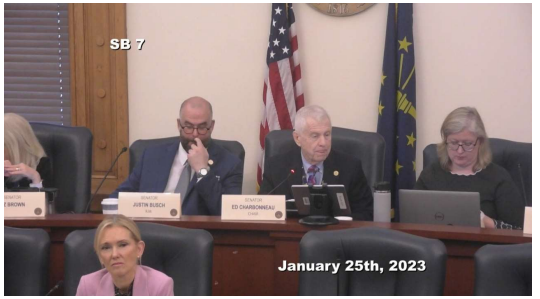
5. Effective 7-1-23, Requires that *"Not more than twice annually",* Third Party Administrators (TPA), insurers, and HMO's contracted with self-funded or fully-insured group plan provide any requested information to health plans within 15 business days. Minimum reporting shall include timing of paid claims, information on individual claims more than $50,000, and more.
    - DOI *may* assess a $1,000 per day fine to TPAs, insurers, and HMOs if claims data is provided after 15 business days. Fines to be deposited into the payer affordability penalty fund.
6. Effective 1-1-24, provides a tax credit for employers with < 50 employees if they adopt a health reimbursement arrangement (HRA) in lieu of traditional employer provided health insurance plan. The tax credit is up to $400 for the first year and $200 for second year. The amount of tax credit granted may not exceed $10 million per year.
7. Effective 1-1-24, allows for primary care providers to be eligible to receive a tax credit of $20,000 x 3 years, if they meet certain criteria. Qualifying providers include those in family medicine, general pediatrics, internal medicine, and general practitioners (GPs).
8. Effective 7-1-23, allows physicians who were credentialed by Medicaid in prior 12 months to be provisional credentialed to establish or join an independent primary care practice. This allows for expediated credentialing while insurers continue their own credentialing process.
9. Effective 7-1-23, Establishes that providers who enter into a value based health care reimbursement agreement and an electronic medical records access agreement with a health plan may qualify to participate in a program established by the health plan to reduce or eliminate Prior Authorization requirements.

Continued HEA 1004

10. Effective immediately, establishes the Health Care Cost Oversight Task Force
    - Consist of six legislators whose duties are defined
    - Indiana State Department of Health, the Family and Social Services Administration, and DOI are required to provide data, documents an information deemed necessary to the task force.
    - Charges this task force to assess and monitor Indiana's healthcare costs across industries.

11. Repeals Public Forum requirement for Hospitals and Insurance Companies.

IT TAKES A TEAM!



House and Senate Republican leadership held a press conference to updated House Bill 1001, and the two-year state budget bill, on Wednesday, April 26, 2023, at the Indiana State House in Indianapolis. From left, Speaker of the House, Todd Huston, (R-Fishers,) House Ways and Means Chair Jeff Thompson (R-Lizton,) Senate President Pro Tem Rodric Bray (R-Martinsville.)

EMPLOYERS' FORUM OF INDIANA
Addressing the challenges of the local healthcare marketplace

Our Team Approach

INTERNAL

Employers' Forum of Indiana: analyze, explain, provide understandable and usable data to legislators; meet with legislative leadership routinely; build relationship with potential bill authors & legislative leadership; edit bill language; testify / coordinate testimony with members; respond to data requests from legislative leadership (responses must be timely within hours of request); educate & engage employers; establish grassroots activism of employers, benefit consultants & independent physicians to support bills; communicate with ally organizations; be a trusted and data driven stakeholder

Employer Consultant: draft bill language, review policy topics, create one-pager policy topic summary, sound board to CEO

PR Consultant: manage social media; draft op-eds; coordinate with reporters; advise on crisis management

Government Affairs / Lobbying Consultant: schedule meetings with legislative leadership; explain policy priorities to leadership; monitor / lobby legislators on key bills; weekly updates to Employers' Forum of Indiana policy committee

Our Team Approach

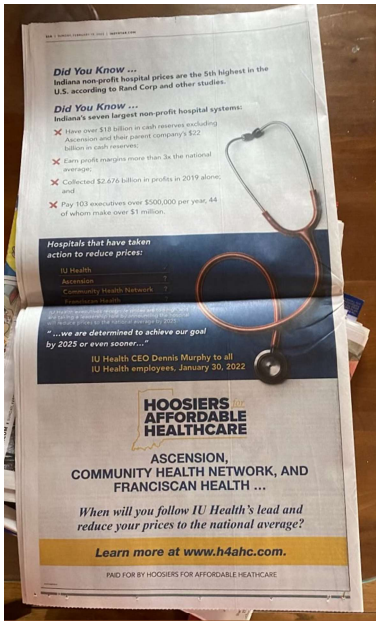
EXTERNAL

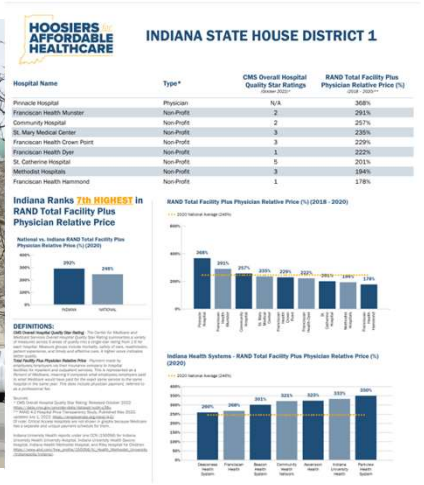
Legislative Leadership: IN State Speaker of the House Todd Huston & Senate President Pro Tem Rod Bray. Representative Donna Schaibley who was lead bill author and championed healthcare affordability

Brain Trust Subject Matter Experts: RAND healthcare economist, NASHP forensic accountant, Healthcare Options Inc. local financial expert; and resources from Georgetown Univ, The Source on Healthcare Price & Competition, APCD Council, Berkely Petris Center, etc

Hoosiers for Affordable Healthcare (critical political Influencer with deep connections to legislative leadership): meet with leadership to explain data findings, lobby political campaign-style external communications (stats on mobile ad truck, community grassroots effort with email/text/patch through), op-eds, and interviews with reporters

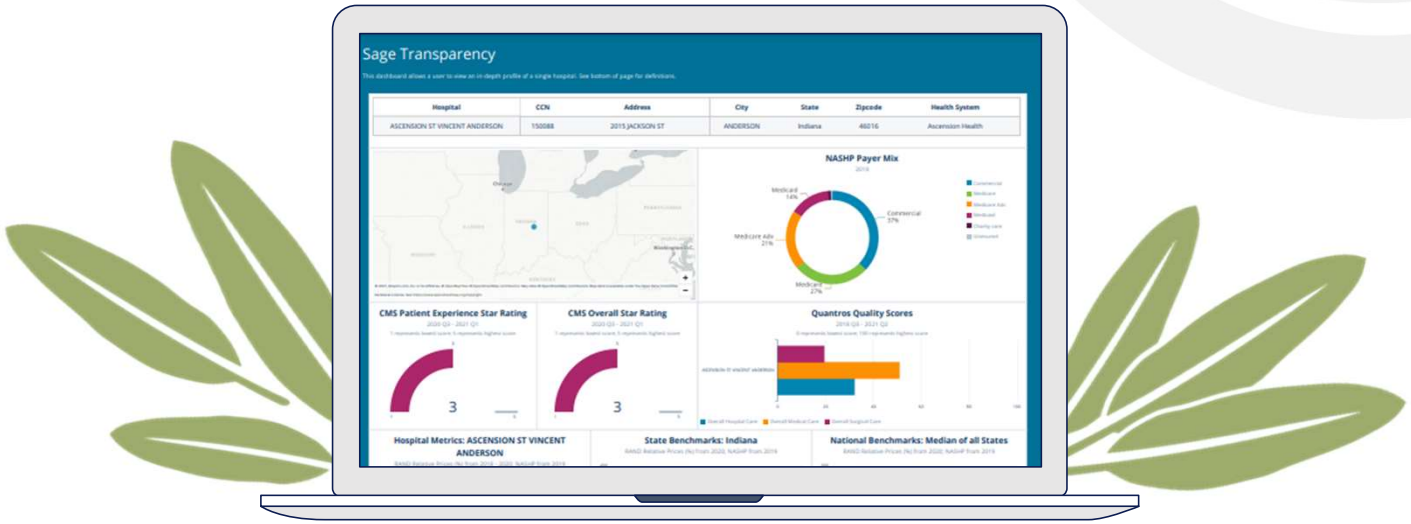
Hoosiers for Affordable Healthcare Advocacy Efforts





LAUNCHED ON MAY 5, 2022!

SageTransparency.com



FREE ONLINE TOOL: Use sage transparency to look at hospital price, quality, cost data. Sources include:

PUBLIC

RAND 4.0

Prices paid by employers & insurers

Claims data from employers, insurers, and APCDs

NASHP Hospital Cost Tool

Commercial breakeven price

Federal government data submitted by hospital

CMS Hospital Star Rating

Quality ratings

Posted by the federal government

PROPRIETARY

Turquoise Health

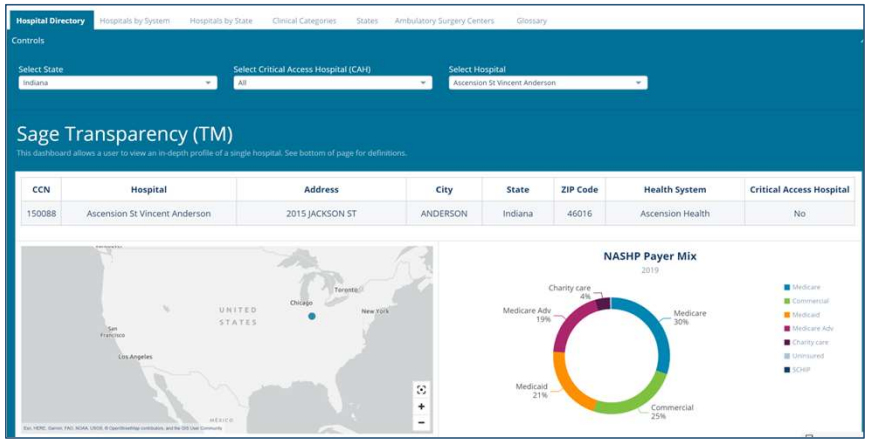
Prices posted by payer

Hospitals' own websites aggregated by Turquoise Health into clinical categories

Quantros/Healthcare Bluebook

Quality ratings

Determined by Quantros

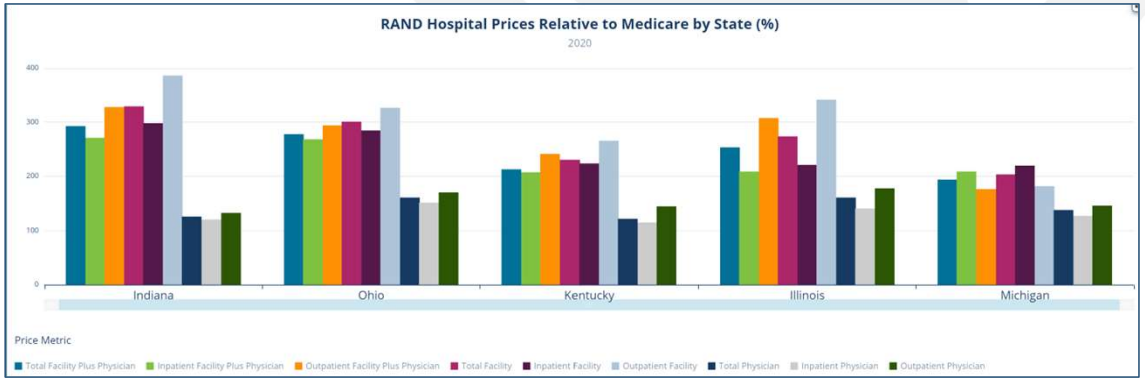


Quantros Hospital Quality Reliability Scores (2019 Q1 - 2021 Q4)

For each Quantros category, 0 represents lowest score and 100 represents highest score.

Dark purple represents the bottom quartile (0-24), orange represents the middle half (25-74), and green represents the top quartile (75-100)

Hospital	Overall Hospital Care Quality Score	Overall Medical Care Quality Score	Overall Surgical Care Quality Score
Alexian Brothers Medical Center 1	79	20	78
Amita Health Resurrection Medical Center	96	98	84
Ascension All Saints Hospital	42	88	27
Ascension Borgess Lee Hospital	56	65	42
Ascension Calumet Hospital	71	69	44
Ascension Columbia St Mary's Hospital Milwaukee	45	18	50
Ascension Columbia St Mary's Hospital Ozaukee	86	81	77
Ascension Eagle River Hospital	57	53	
Ascension Genesys Hospital	17	84	5
Ascension Good Samaritan Hospital	79	78	
Ascension Macomb Oakland Hosp-warren Campus	1	9	1
Ascension Ne Wisconsin - St Elizabeth Campus	25	24	46
Ascension Our Lady Of Victory Hospital	49	39	



Inpatient Clinical Category Relative Prices: Columbus Regional Hospital

2022

These prices represent what is posted by hospitals on their own websites as required by federal law. If no data is shown, information was not provided on the hospital website.

Clinical Category	Turquoise Health Commercial (%)	Turquoise Health Medicaid (%)	Turquoise Health Cash (%)
Circulatory System	210	126	213
Digestive System	199	146	189
Ear, Nose, Throat	197	117	194
Eye			
Infectious and parasitic diseases	228	126	224
Kidney and Urinary Tract	208	144	200
Mental diseases and disorders	107	94	116
Newborns and Neonates	59	46	44
Orthopedics	226	148	240
Pregnancy and Childbirth	187	124	179
Respiratory System	231	126	225

Outpatient Clinical Category Relative Prices: Columbus Regional Hospital

2022

These prices represent what is posted by hospitals on their own websites as required by federal law. If no data is shown, information was not provided on the hospital website.

Clinical Category	Turquoise Health Commercial (%)	Turquoise Health Medicaid (%)	Turquoise Health Cash (%)
CT/MRI	394	244	421
Cardiovascular Care	125	66	122
Emergency Department	330	129	359
GI Procedures	164	129	155
Laparoscopic Surgery	123	133	111

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THANK YOU!

Gloria Sachdev
gloria@employersforumindiana.org

Innovations in Employer Health/Wellness Benefits

Quick Rounds

2 Innovators for Employer Health

Format

Each speaker will have *only* 5 minutes
to convey their innovative product/service

(We don't have a "stage hook",

so instead, microphone will cut off when time runs out!)

Innovator #1: Coherus

Biosimilars Offer Patients High-quality Treatment While Reducing Costs

Chris Slavinsky, Chief Business & Legal Officer, Coherus Biosciences

Coherus BIOSCIENCES

Coherus is focused on expanding patient access to important, cost-effective medicines and delivering significant savings to the U.S. healthcare system

Every member of the Coherus team is dedicated, motivated, and passionate about expanding patient access to lifesaving therapeutics.

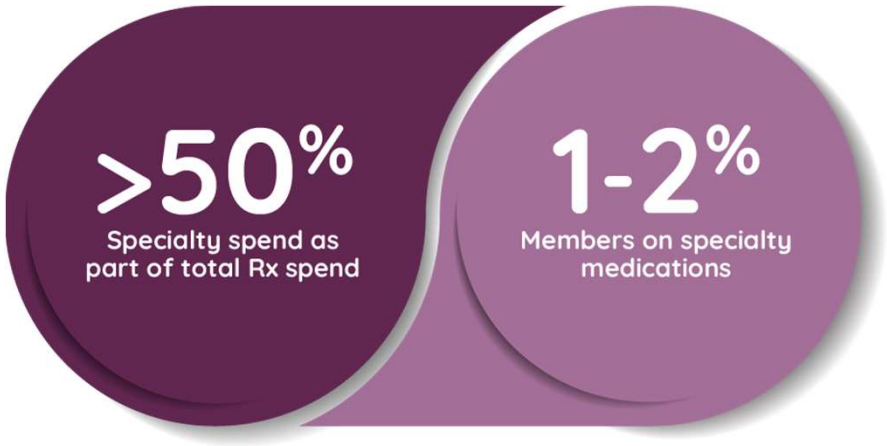
Our colleagues are experts in analytical and process sciences, deeply experienced in clinical development and regulatory affairs, and have proven commercial and marketing capabilities.

Everyone at Coherus is committed to meeting the highest standards, inspiring our teammates, and achieving our goals.

Coherus was founded a decade ago to provide the highest quality biosimilar treatments to patients. We are proud to now be expanding our legacy—to build on our success with biosimilars and to focus our core strengths on immuno-oncology.

Specialty Drugs are Driving Healthcare Costs Significantly Higher

Only 2% of the population use specialty drugs, but it accounts for 51% of total pharmacy spend[2]



It costs 75 times more to cover the drug spend of a specialty patient[2]

- Average annual cost to cover the drug spend of a **specialty patients is $38,000**
- Average annual cost to cover the drug spend of a **non-specialty patient's costs is $492**

1. FDA.gov; Biosimilars: Overview for Healthcare Professionals; https://www.fda.gov/drugs/biosimilars/overview-health-care-professionals; Accessed August 18, 2023.

Biosimilars Can Offer Patients High-quality Treatment While Reducing Costs

A biosimilar is a biologic that is highly similar to another biologic

A biosimilar is a biologic that is highly similar to, and has no clinically meaningful differences from, another biologic that's already FDA-approved (referred to as the reference product or original biologic).

This means biosimilars:

- Are given the same way (same route of administration)
- Have the same strength and dosage form
- Have the same potential side effects

Biosimilars provide the same potential treatment benefits as the original biologic and are generally made with the same types of natural sources as the reference product.[1]

1. FDA.gov; Biosimilars: Overview for Healthcare Professionals; https://www.fda.gov/drugs/biosimilars/overview-health-care-professionals; Accessed August 18, 2023.

Coherus BIOSCIENCES

Innovation: Build More Efficient Paths to Patients with Biosimilars that have Transparent Pricing

Today, intransparency in pharmacy distribution costs, pricing and rebates creates market distortions

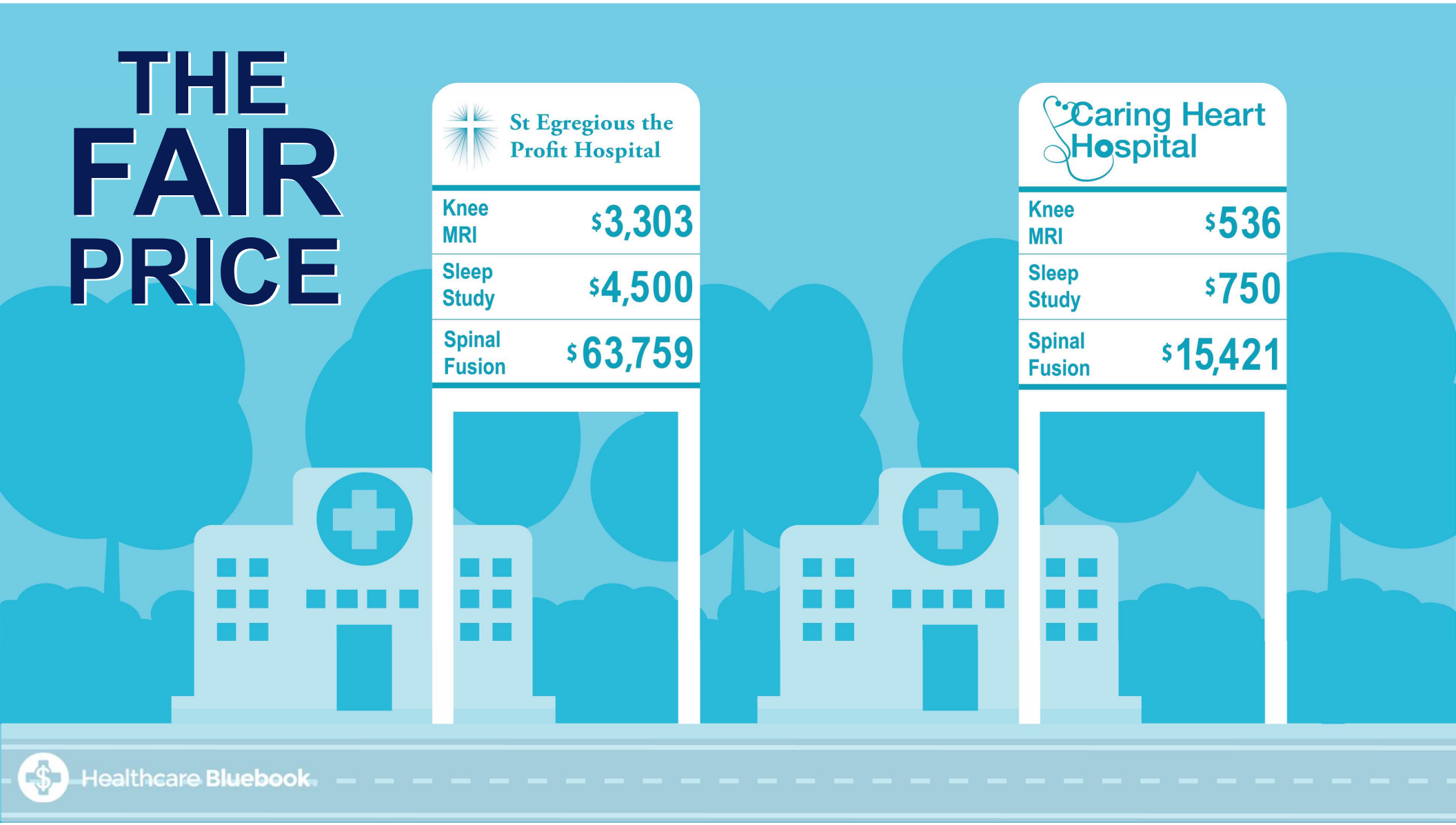
- Biosimilars can create patient savings based on Lower List (WAC) Price
  - Patients typically pay coinsurance based on List Price (Wholesale Acquisition Cost) for specialty pharmaceutical products
- Employers can reduce total drug cost expenditure by utilizing Low Net Price therapies in their pharmacy formulary
- Distribution fees for some products – especially low NET biosimilars – may be equivalent or greater than costs of drug in traditional channels

Simple Math: If your company is paying a Net Acquisition Cost for Branded Originator that is greater than an available Biosimilar List Price (WAC), there are likely savings to be had by your company and employees

Coherus BIOSCIENCES

Innovator #2: Healthcare Bluebook

Healthcare Bluebook™


THE FAIR PRICE
St Egregious the Profit Hospital
Knee MRI $3,303
Sleep Study $4,500
Spinal Fusion $63,759
Caring Heart Hospital
Knee MRI $536
Sleep Study $750
Spinal Fusion $15,421
Healthcare Bluebook

Quality | Cost

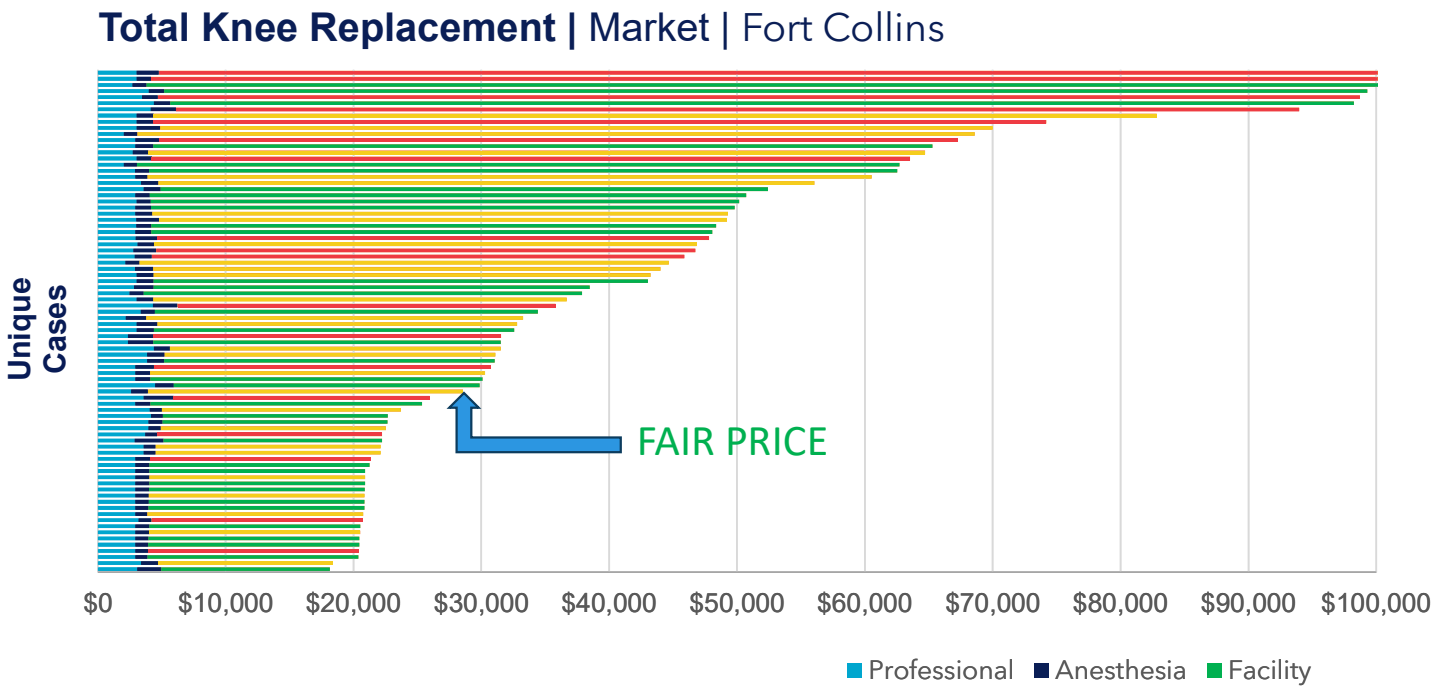
Price Variance Report, Asheville, NC

MARKET BASKET OF COMMON PROCEDURES	LOW PRICE	HIGH PRICE	VARIANCE
1 Colonoscopy (screening)	$831	$6,346	764%
2 Shoulder MRI (no contrast)	$418	$1,472	352%
3 Sleep Study	$733	$4,347	593%
4 Chest CT (no contrast)	$224	$2,250	1004%
5 Knee Arthroscopy	$2,934	$19,564	667%
6 Upper Gastrointestinal Endoscopy (no biopsy)	$881	$6,865	779%
7 Abdominal Ultrasound	$132	$830	629%
8 Cataract Surgery	$1,928	$11,249	583%
9 Heart Perfusion Imaging	$1,045	$7,146	684%
10 Ear Tube Placement (Tympanostomy)	$2,050	$10,393	507%
		Average Market Variance	656%
EQUIVALENT VARIANCE IN A GALLON OF GAS	**$3.50**	**$22.96**	**656%**

Source: Healthcare Bluebook data

Quality | Cost

The facility (not the physician) drives that variability



And often you don't get what you pay for

There is zero (and sometimes negative) correlation between healthcare cost and quality

Source: Healthcare Bluebook data, Healthcare Cost Institute (2016)

Quality | Cost

Hospitals may do everything, but they are not great at everything…

Local Hospital (Charlotte)

Vaginal Hysterectomy
97th percentile

Transplant of Heart
55th percentile

Total Hip Replacement
1st percentile

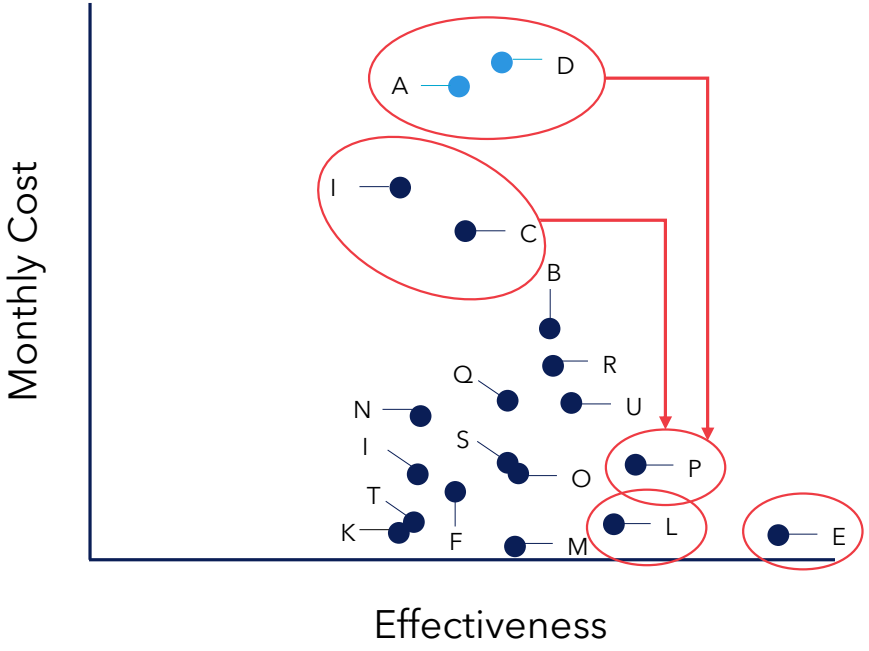
Source: Healthcare Bluebook data

Quality Cost

New drugs are not always better than existing drugs

"New" anti-depressants

Comparative effectiveness research



Source: THE LANCET

Quality Cost

Optimizing quality and cost presents a significant opportunity to reduce wasted dollars in healthcare

18%+ waste in total healthcare spend is typical, as seen in this client example

Healthcare Spend (1,500 EE group)			
	Medical	RX	Total
Annual Spend	$16,000,000	$4,000,000	$20,000,000
Waste	$2,400,000	$1,300,000	$3,700,000
Savings Opportunity	15%	32%	18.5%

Panel: A View Inside the Black Box of Pharmacy

How Transparency Will Change the Way Employers Need To Manage Their Benefits

Moderator

Alex Jung, Business Strategist

Panelists

Michael Thompson, President/CEO, National Alliance

Paula Stop, Director of Total Rewards, The Fresh Market

Josh Golden, Sr Vice President of Strategy, Capital Rx

Pramod John, CEO, VIVIO

Fair Price Initiative
What's next…

Michael Thompson

President/CEO
National Alliance of Healthcare Purchaser Coalitions

Hospital Fair Price Initiative

North Carolina Business Coalition on Health

September, 2023

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Hospital Fair Price Initiative

Developing and executing a fair price national/regional strategy

- Support the national and regional strategy with ***15 regional RESET coalitions***
- Data access training, education, tools and resources
- A core planning group to support the national/regional strategy

Creating a national fair price campaign strategy

- Targeting both media and policymakers
- Deployed nationally and available regionally
- Partnering with "Better Solutions for Healthcare"

RESET Coalitions

- Identify hospital pricing issues in the state
- Engage and educate employer members
- Engage health systems, media and/or policymakers
- Participate in National Fair Price Advisory Council

RESET = Regional Employer Stakeholder Engagement Team

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

RESET Coalitions

- The Alliance (WI)
- Connecticut Business Group on Health
- Economic Alliance for Michigan
- Florida Alliance for Healthcare Value
- Greater Cincinnati Employer Group on Health
- Greater Philadelphia Business Coalition on Health
- Healthcare Purchaser Alliance of Maine
- Lehigh Valley Coalition on Health
- Midwest Business Group on Health
- Minnesota, The PEACH Group
- Nevada Business Group on Health
- New Mexico Coalition for HC Value
- North Carolina Business Group on Health
- Oklahoma Business Group on Health
- St. Louis Area Business Group on Health
- Washington Health Alliance

Partner Coalitions

- Employers Forum of Indiana
- Healthcare Purchaser Alliance of Maine
- Houston Business Coalition on Health
- Purchaser Business Group on Health
- Rhode Island Business Group on Health

Industry Partners

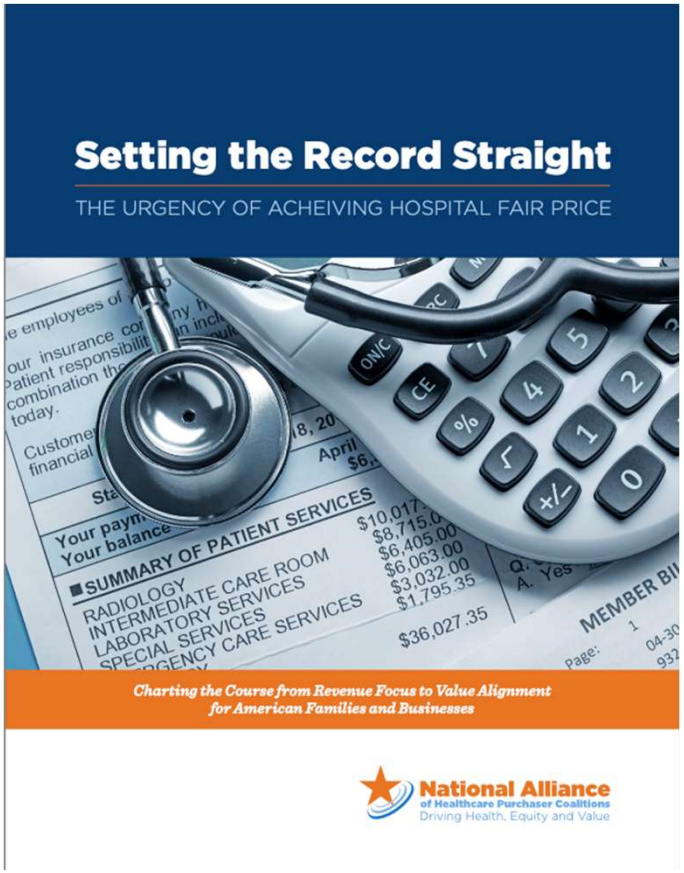
- Arnold Ventures
- RAND
- NASHP
- Rice University

Our Position

- Two scenarios are all too common:
  - Patients are being pushed into catastrophic medical debt due to outrageous and indefensible hospital prices.
  - US employers are facing profitability headwinds as they play a hospital price shell game

- Our position:
  - Hospital prices are high, rapidly rising, and not justified.
  - The era of cost-shifting has run its course.
  - Employers as fiduciaries are demanding a seat at the table to understand how plan assets are being spent.
  - There is a need for more responsible stewardship and accountability by hospitals and health systems.

Hospital prices are the leading driver of higher healthcare costs, crowding out wages and harming employer competitiveness.



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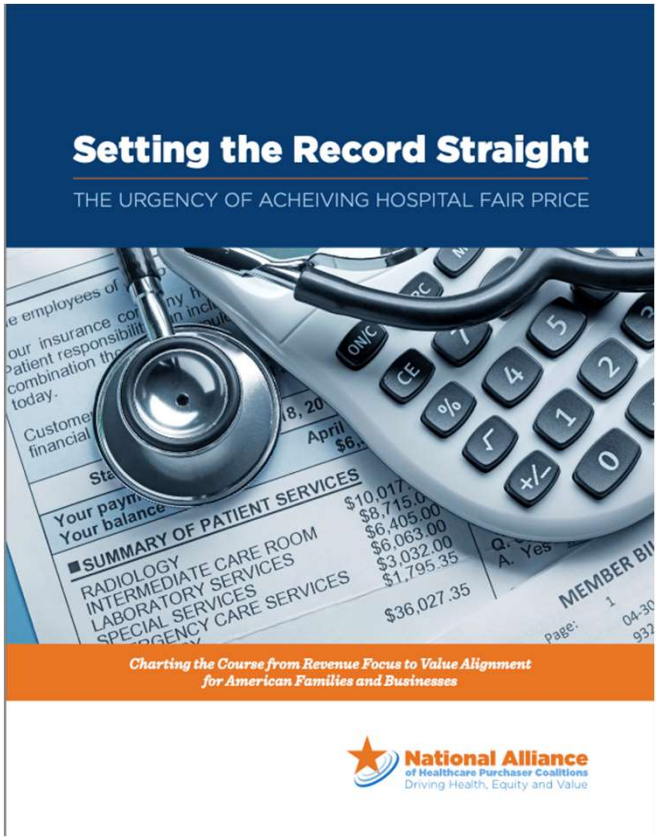
Getting the Facts Straight

MYTH 1:

Hospital prices are based on the cost of providing care to patients and the ability to invest in improvements in quality and infrastructure.

FACT 1:

There is no correlation between hospital prices and the actual cost of providing that care. It is not clear to healthcare purchasers that what is being charged or investing in "improvements" has anything to do with providing care for patients, since there has been no demonstrated improvement in quality or care. Instead, it appears that vertical integration is being used to raise prices to what the market will bear without any cost accounting—and for profit maximization. Hospitals are not transparent about investments, surplus, staffing, overhead costs, acquiring practices, or how they are spending the money or setting prices.



MYTH 2: Medicaid Reimbursement

MYTH 3: Workforce Crisis

MYTH 4: Facility Fees

MYTH 5: Hospital Mergers

MYTH 6: Market Domination

MYTH 7: Uncompensated Care

MYTH 8: Drug Mark-ups

MYTH 9: Rural Hospitals

MYTH 10: Jobs

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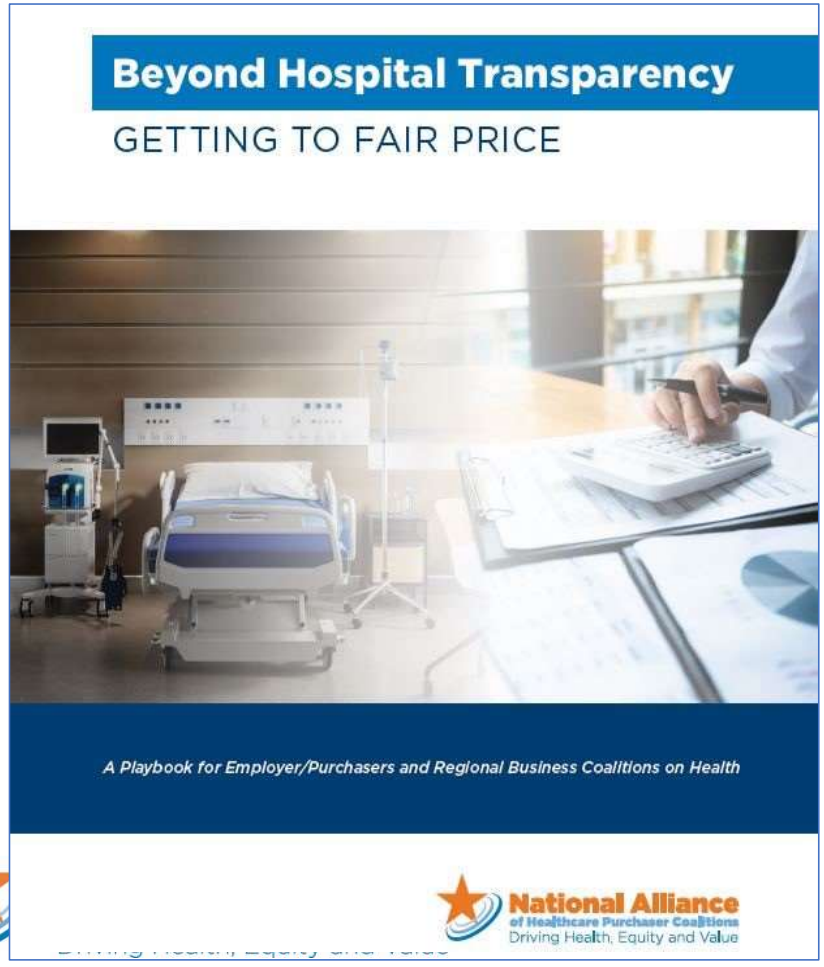
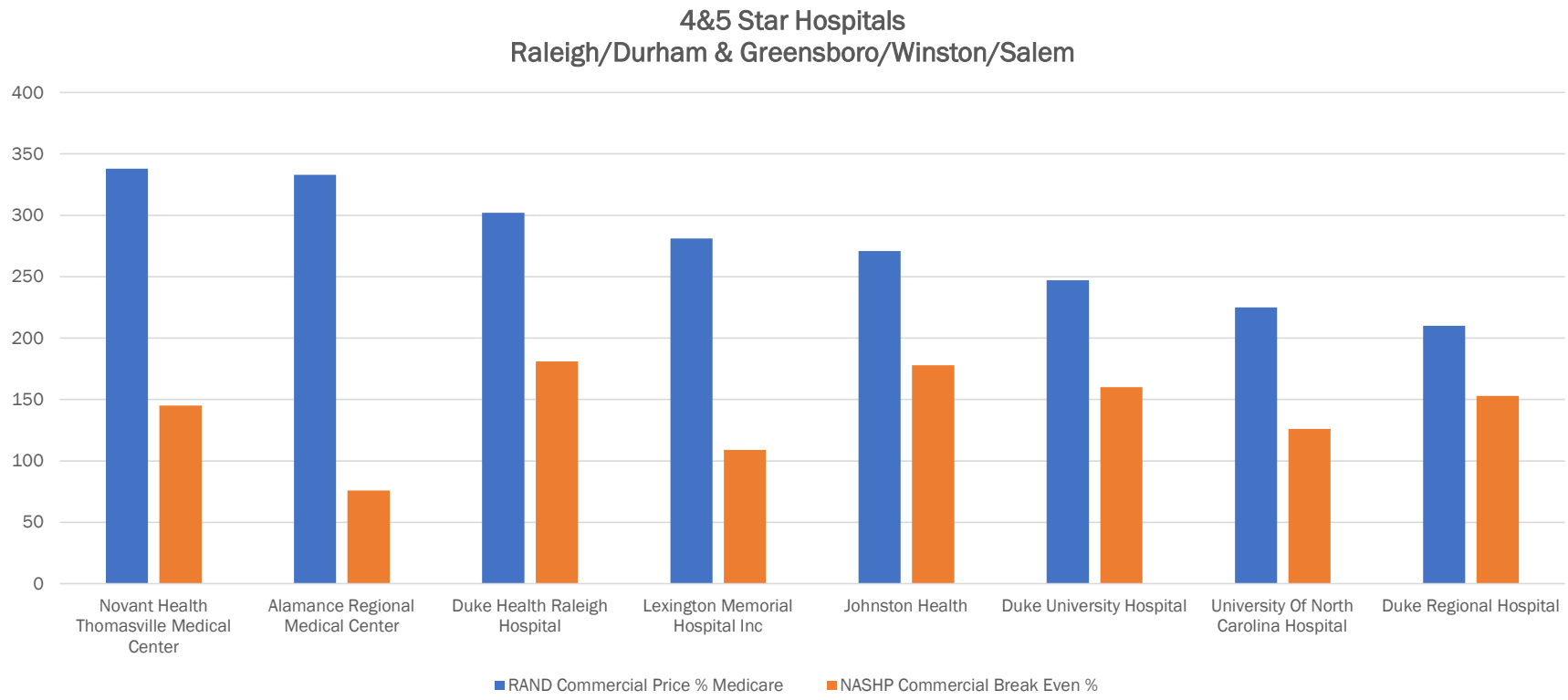
Leveraging Hospital Price Transparency



Hospital Fair Price Playbook Helps Employers/Coalitions:

- *Navigate the data*
- *Understand fiduciary rights and responsibilities*
- *Determine what a fair price is for hospital services in specific markets*
- *Learn about market- and policy-based strategies to leverage transparency and drive change*

Examining the Data



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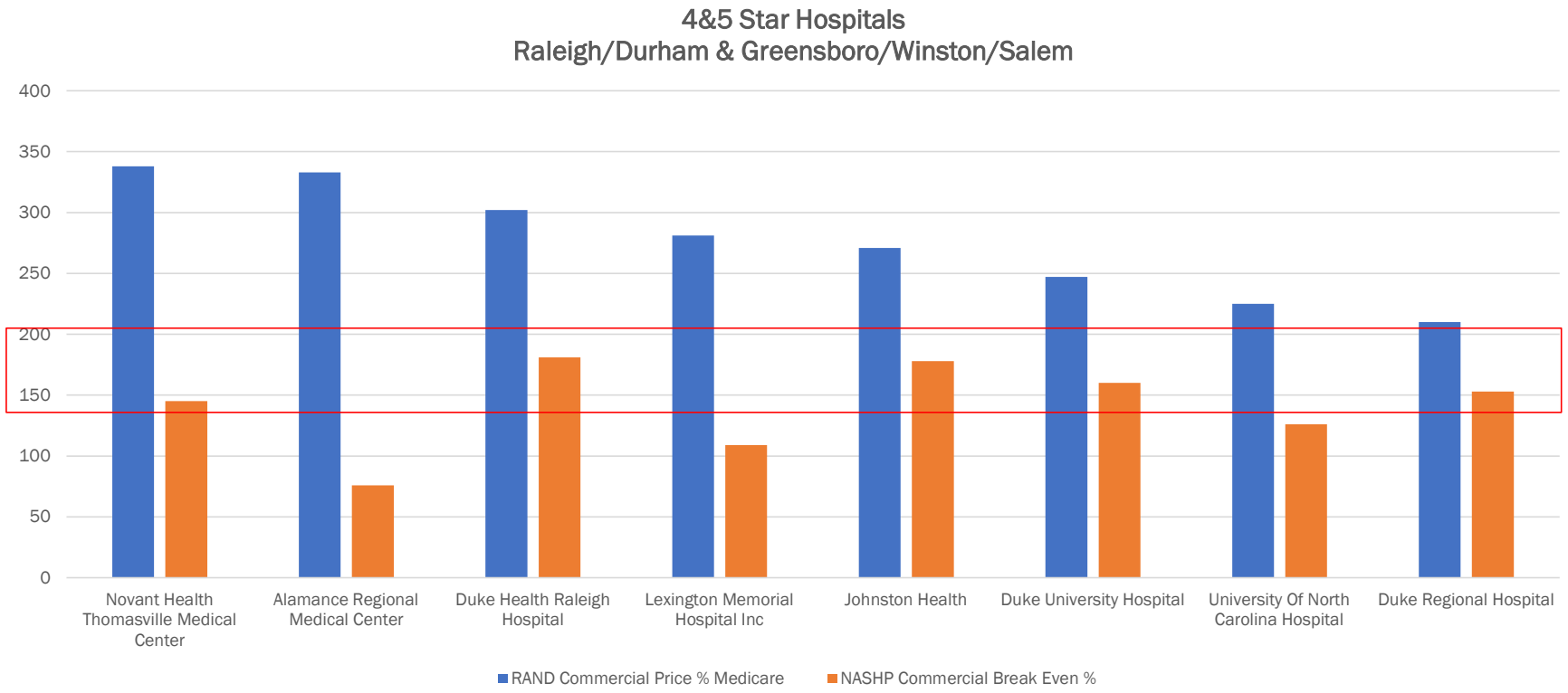
The Hospital Fair Price Range



National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Questions

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973-464-1530

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“Final Items of the Day”

3rd Annual Culture of Wellness Award
Applications open January 2nd

Join us for the Spring Forum: March 14-15

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