Beyond Hospital Transparency

GETTING TO FAIR PRICE

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

NCBCH
NC BUSINESS COALITION ON HEALTH

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

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; health systems increasingly operate with little or no competition and few market constraints. This has allowed indefensible hospital pricing and minimal constraints 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 for decades, not until recently did employers and other purchasers gain access to the data they needed to truly understand just how nonresponsive 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 that hospital profit margins are indefensible, even after accounting for high underlying cost structures and subsidies of other markets.

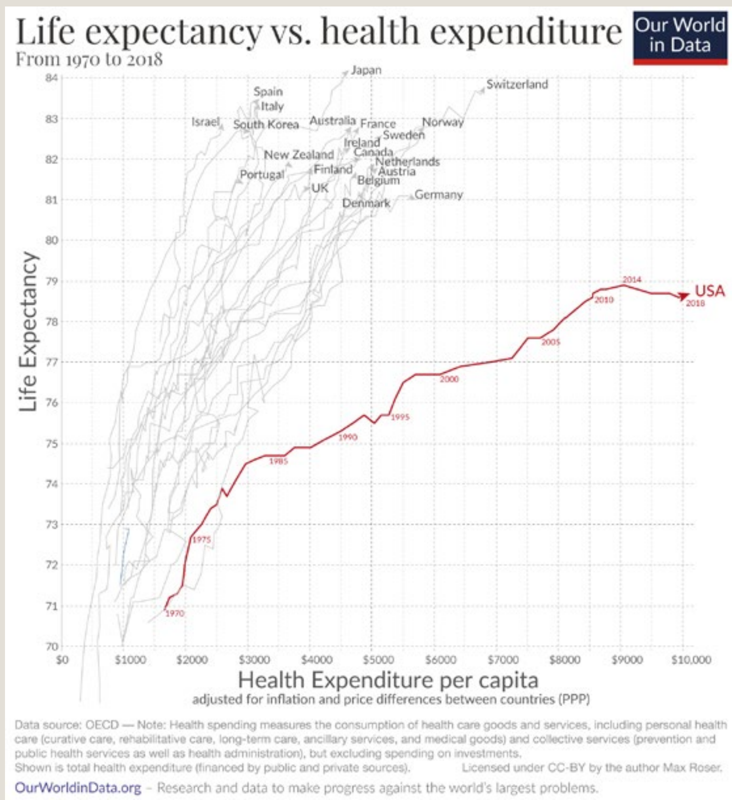
Clearly, prices cannot be evaluated independently of quality and the complexity of patients and the services provided to them, but the data shows that better quality and higher prices do not go hand-in-hand. This has been an eye-opener in many markets, debunking the claim that current hospital prices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

Sage Transparency (employerptp.org/sage-transparency) is helping synthesize multiple sources of data to bring greater focus to the current state of hospital prices in the commercial market (i.e., plan sponsors—not Medicare, Medicaid or other government programs). This playbook will help purchasers navigate the data, understand their rights and responsibilities as a plan sponsor fiduciary, determine a fair price for hospital services in specific marketplaces, and offer guidance about options available individually and collectively to achieve fair pricing for hospital services.

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

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 ourworldindata.org/us-life-expectancy-low.



Act (CAA) not only enabled greater transparency in healthcare but also reinforced the employer's fiduciary responsibility to ensure the reasonability of the price they pay for each 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, although transparency can be illuminating, there can also be unintended consequences if employers and purchasers don't act promptly and decisively. As some 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!

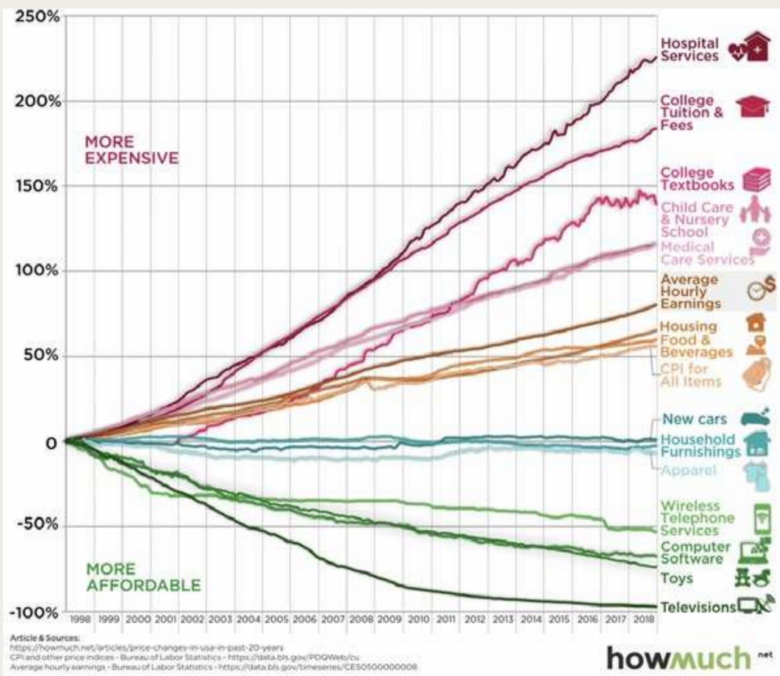
"Regional purchaser coalitions, with the active support and engagement of their members, can play a major role in driving and leveraging transparency data to improve quality and value. In fact, much of the transparency on quality and price achieved to date is directly attributable to the work of regional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

The data makes clear that the market has not controlled hospital costs, 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: 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 the way 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 so they can contract for hospital provider services that offer the greatest value—the best quality care at a fair price.
- Until recently, employers had no way 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 shows

- Now in its fourth round, the RAND National Hospital Price Transparency Report (employerptp.org/rand) 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 (nashp.org/hospital-cost-tool) that indicated a hospital's commercial breakeven averaged 127% of Medicare rates nationally and varied widely by both state and health system. This amount would not only cover the costs of employer-related admissions, but also 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 been unconstrained by commercial payers. They also conclude 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. Many parties have contributed research that supports these conclusions, including RAND, Rice University, Mathematica, NASHP, and MEDPAC.

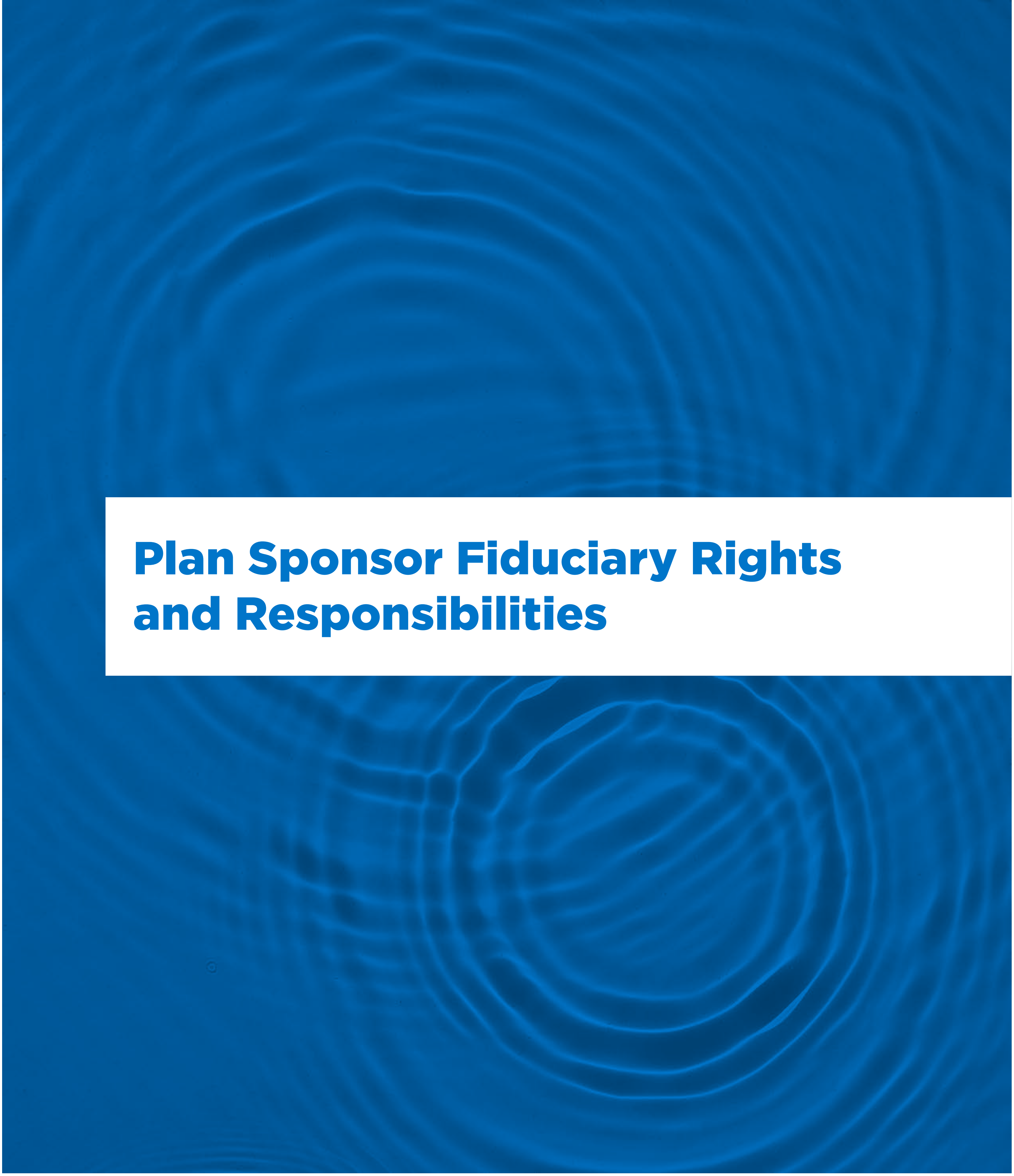
Where do we go from here?

- 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 in independent research findings, the growing number of credible studies and tools only reinforces 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 a responsibility to understand and demand fair prices for services provided to plan beneficiaries. As such, they must act quickly and decisively, using this new information to exert pressure on health plans and hospitals to negotiate reasonable prices, and on 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 prices in line, then policy-based corrections (regulations) should be considered. This is especially true where monopolies or providers with market power have raised prices above a reasonable level. Stronger oversight of proposed mergers and acquisitions is needed to ensure they will not result in higher prices, and prohibitions on anti-competitive practices such as gag clauses should be put in place.

Fair Health Costs Initiative

The Fair Health Costs Initiative is another way to mobilize employer purchasers, educate policymakers, and advocate for public policies to reduce health care prices.
It is an Arnold Ventures-backed effort by the Purchaser Business Group on Health and National Alliance of Healthcare Purchaser Coalitions (National Alliance).
Visit pbgh.org/program/fair-health-costs-initiative/ for information.

Fair Health Costs
A partnership between PBGH and National Alliance



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 are required 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 who do not know whether they're paying reasonable prices could face a heightened risk of lawsuits and considerable fines. According to a RAND Corporation report, in 2020, employers and health insurers paid hospitals more than double what Medicare would have paid, on average, and sometimes much more. The data suggests 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?

A plan sponsor who 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, just as it did for sponsors of retirement plans years ago. Personal liability to restore any losses to the plan resulting from their actions or inaction may include:

- 20% penalty assessed by the US Department of Labor.
- Removal from fiduciary status.
- Possible criminal penalties.

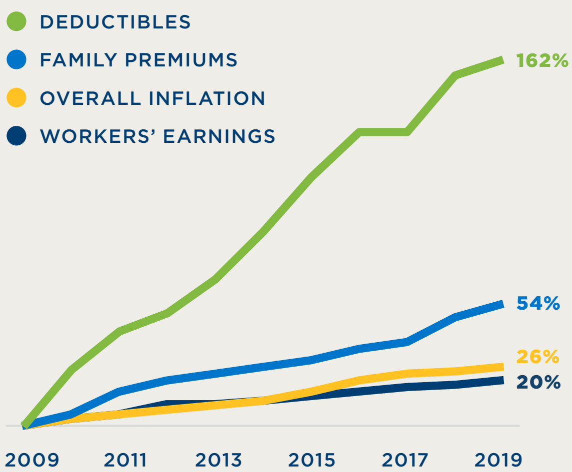
Plan Sponsor Requirements

- Act *solely* and *exclusively* in the best interest of 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.

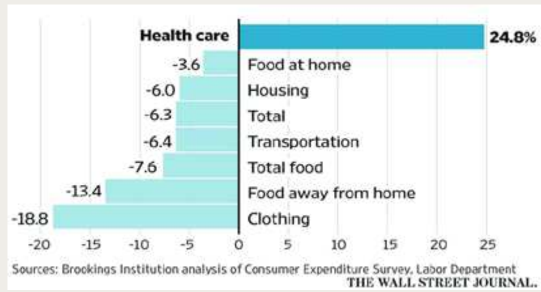
Premiums and Deductibles Have Outpaced Wages



Spending on Healthcare Crowds Out Other Priorities

"Twenty years of wage stagnation on the middle class has been 95% caused by exploding healthcare costs."

Percent change in middle-income households' spending on basic needs (2007 to 2014)



Source: Anna Louie Sussman, "Burden of Health-Care Costs Moves to the Middle Class," *Wall Street Journal*, August 25, 2016. Available at: https://www.wsj.com/articles/burden-of-health-care-costs-moves-to-the-middle-class-1472166246 and Dave Chase, "Economic Development 3.0: Playing the Health Car," January 2017. Available at: https://www.linkedin.com/pulse/economic-development-30-playing-health-card-dave-chase/.

> *"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

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 a hospital's performance to that of other hospitals in their peer group. Ratings are calculated from an average of approximately 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 contribute 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 score is extremely helpful in evaluating quality at the procedure level.

LEAPFROG HOSPITAL SAFETY GRADES

The Safety Grade is composed of 22 measures from CMS, the Leapfrog Hospital Survey, and other sources that 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 the results publicly reported at hospitalsafetygrade.org.

NATIONAL ACADEMY FOR STATE HEALTH POLICY (NASHP)

The NASHP Hospital Cost Tool (HCT) dashboard provides 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 the 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 from data mainly from the national Healthcare Cost Report Information System (HCRIS). 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 (employerptp.org/rand/) reports 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.

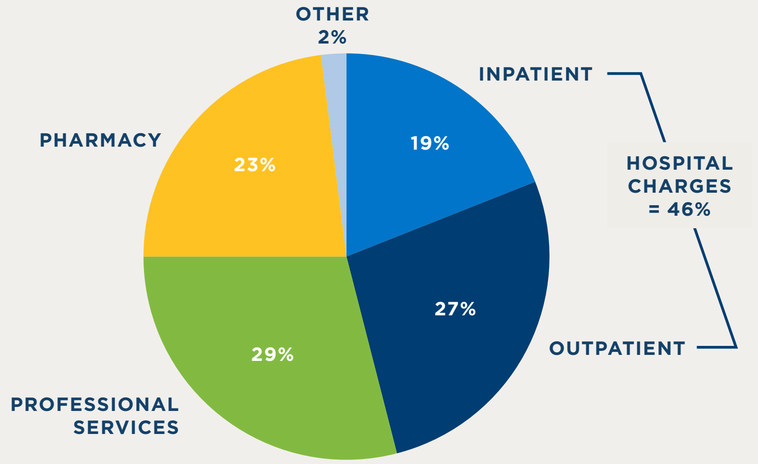
TURQUOISE HEALTH

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 key to achieving the highest quality care for the lowest cost is to identify which hospitals in your market are performing better and at lower costs than other hospitals. One way to determine 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 rates (even if they have higher overhead spending).
- Some of the "other considerations" are included 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 46% of Plan Sponsor Healthcare Spending 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 (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	**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	

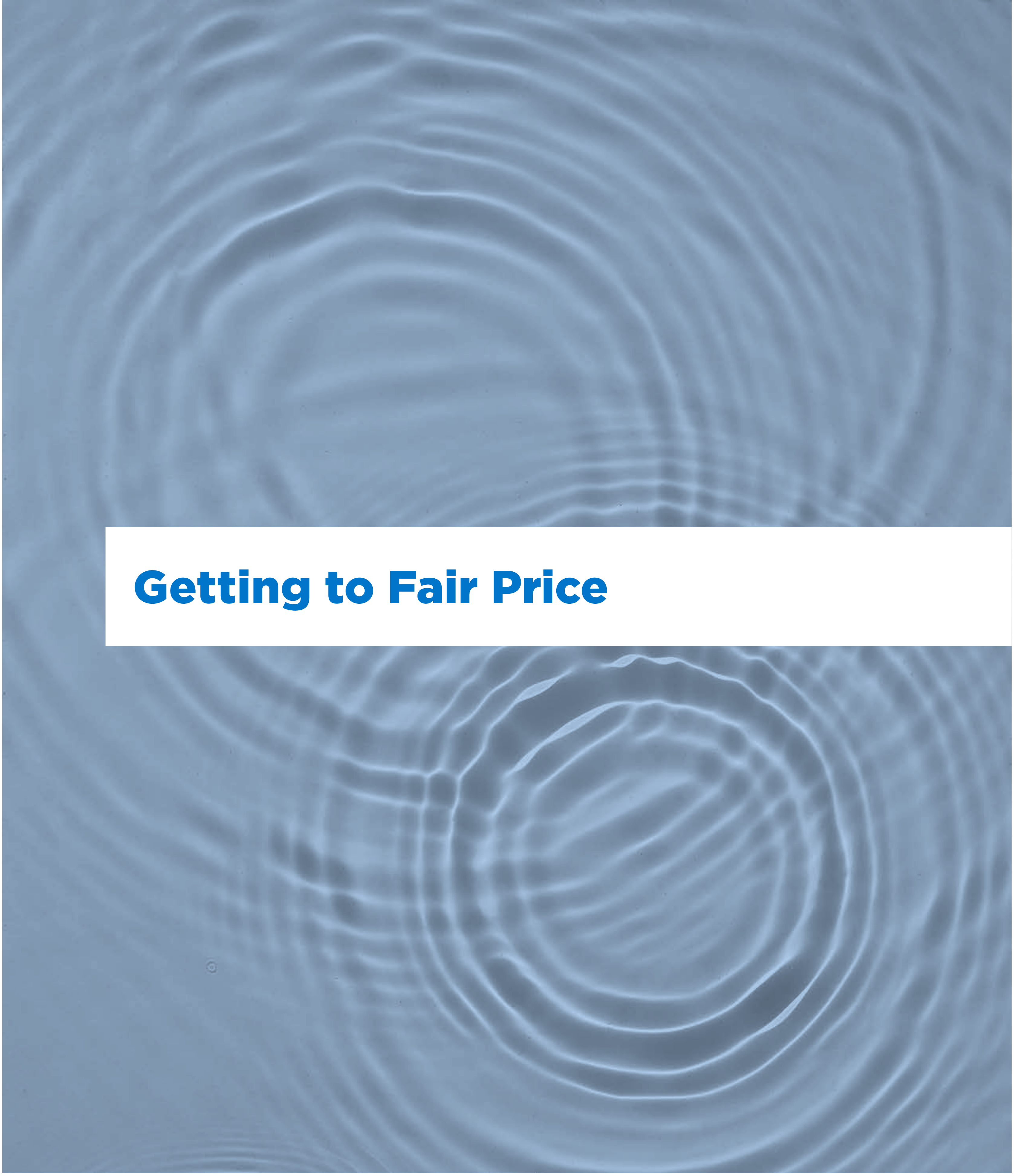
NASHP Commercial Breakeven Covers More than You Think

Sage Transparency provides 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 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**—expenses beyond those described above, which may include 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



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 by 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, actionable strategies for determining a fair price. Because there is no 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.

Although 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 prices hospitals charge the commercial sector. In fact, the national average NASHP commercial breakeven 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 Breakeven over 130% of Medicare prices) should anticipate lower margins over current cost levels, recognizing that some of the margin should be achieved through cost reduction or containment. Hospitals with cost structures 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

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

B > 130% of Medicare

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

C > 130% of Medicare + 10% margin

< 130% of Medicare + 20% margin

If the commercial breakeven is over 130% of Medicare, add 10% margin and assume that's reasonable; if it's under 130%, add 20% and assume that's reasonable.

2 Comparison to peers

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

B > 2x Medicare

If peer group hospitals in your market charge 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.

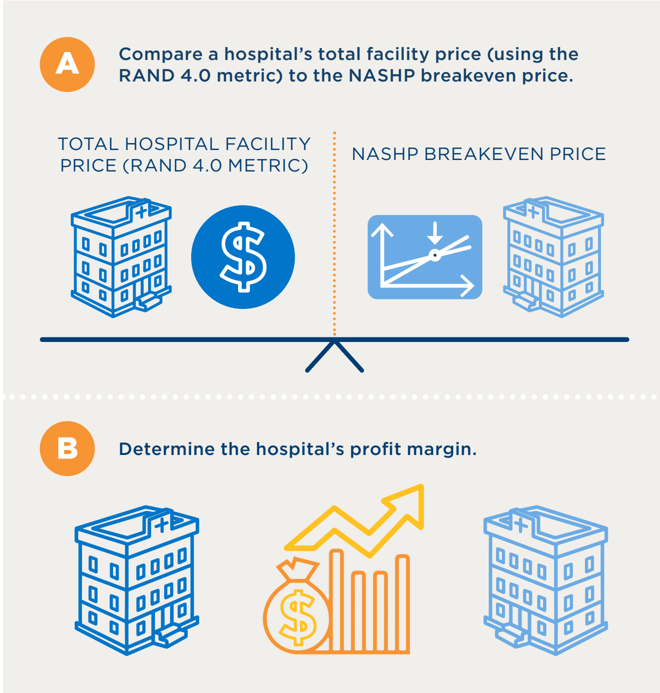
Determine what the hospital needs to charge.

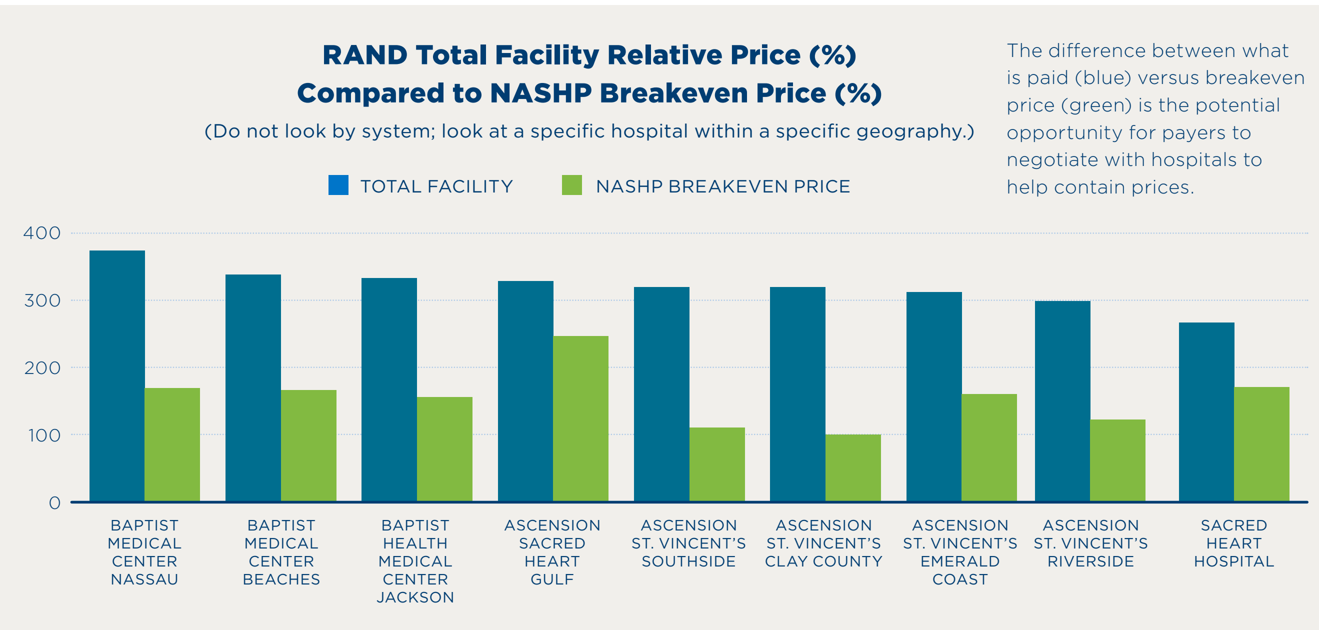
Determining a fair price relative to Medicare is a helpful benchmark because Medicare uses an objective approach by adjusting for factors that include cost of living, whether the facility's a teaching hospital, and uncompensated care. Accordingly, NASHP developed a commercial breakeven calculation that 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, expressing what hospitals need to charge commercial payers in order to break even as a percentage of their Medicare reimbursement rate. 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 median US breakeven point is 127% of Medicare.

To use a specific example, the picture at right 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.





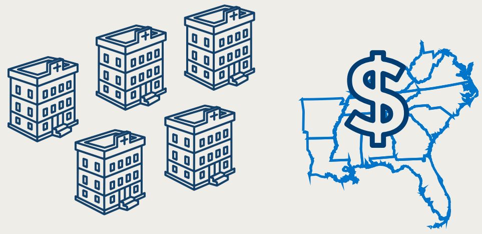
Determine if a hospital's prices are in line with those of competitors

ACTION STEPS

1

Consider regional peer group.

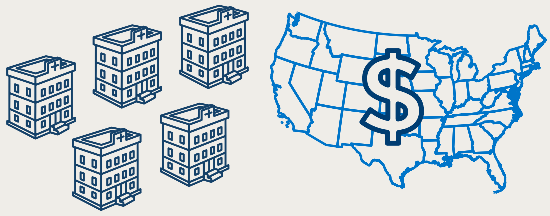
Consider a regional peer-grouping of similar hospitals to develop a regional pricing benchmark. Peer groups should be hospitals with similar characteristics, such as quality scores and regional/geographic region.



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—e.g., grouping with other clinics within the system that are in different geographic areas.

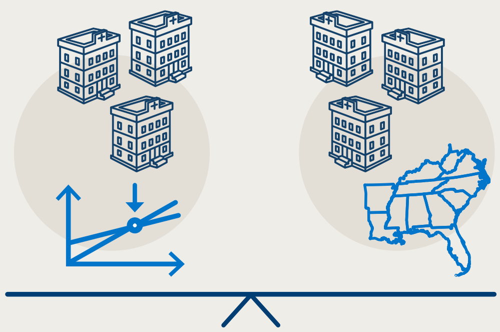


3

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

If peer hospitals charge more than two times Medicare rates, consider comparisons 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 whether there is a justifiable reason for significantly higher prices compared to peer groups or Medicare.

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

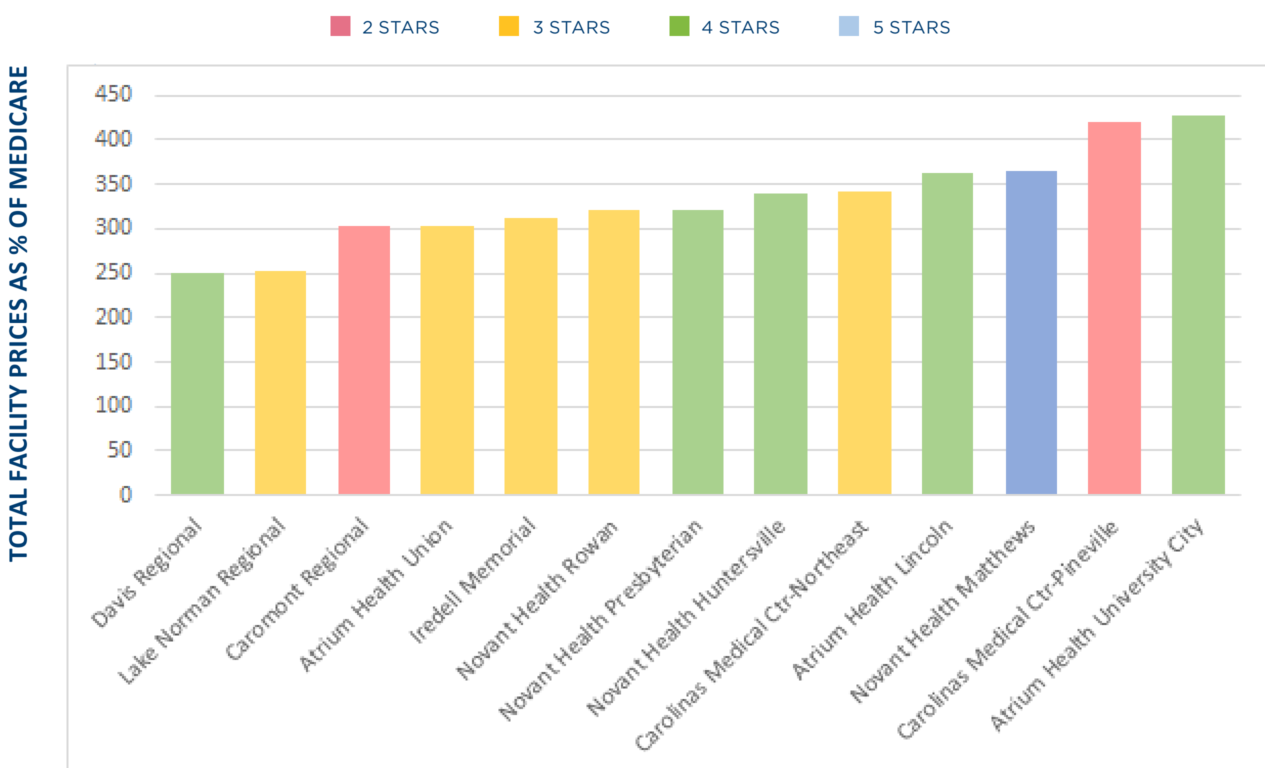
The chart below combines what commercial payers are paying as a percentage of Medicare rates with the hospitals' quality scores. This demonstrates there isn't a relationship between better quality and higher costs.

Employers typically look to one of three major sources when evaluating quality: CMS Stars, Quantros, and the Leapfrog Group. (See page 5 to learn more about various rating systems.) Below are two examples of how to use CMS stars and the Quantros quality data to evaluate whether a hospital's higher costs are justified by better quality.

In the example on page 17, which compares cost and quality, it's clear that some of the worst-performing hospitals charge the most, as represented by the dots on to the lower right of the chart. The dots in the upper left represent the highest-quality hospitals with the lowest relative price. When comparing market-based peer groups, the goal is to be on the lower end for price and as close to Medicare costs as possible.

Quality among North Carolina hospitals is not correlated with price.

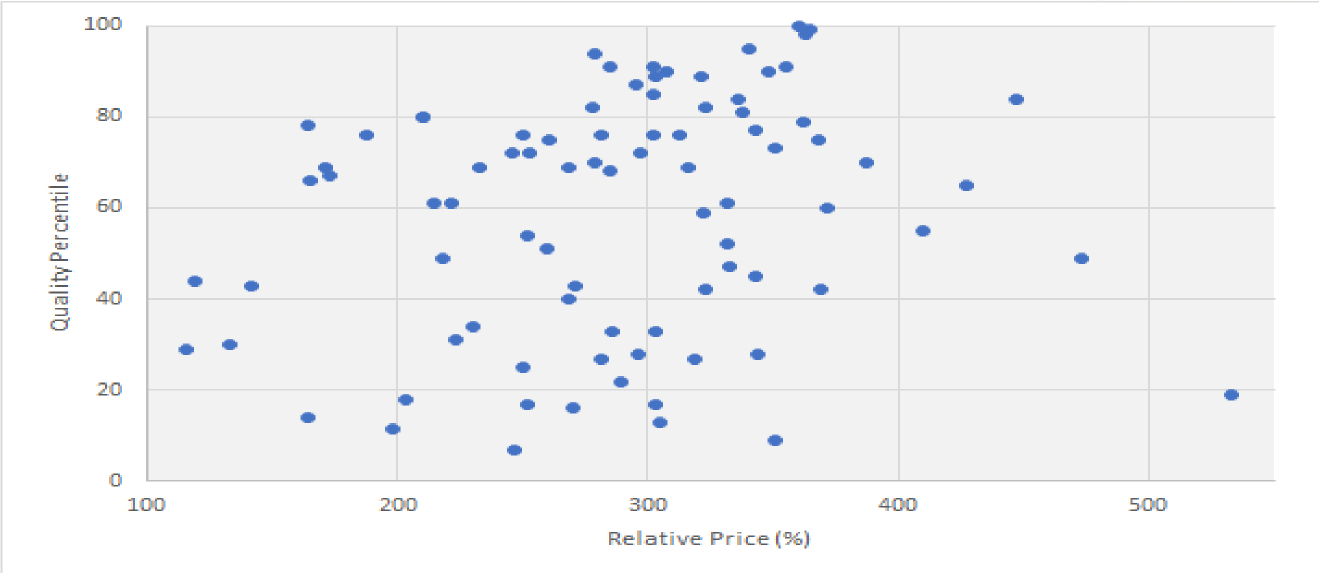
Below, prices employers paid at hospitals in the Charlotte region varied from 250% to 427% of Medicare.



Variations in Value Across North Carolina Hospitals

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

Healthcare Bluebook



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 TO 2019.

A fair price generally should fall between a reasonable markup from costs and a competitive market price for peer hospitals. If there are normal market competition conditions or effective regulatory oversight, it is reasonable to expect a price close to a reasonable markup on costs.

Evaluating Current Options/Strategies

Examining Market-Based and Policy-Based Strategies for Considering Fair Pricing of 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. Fiduciary actions can take many forms, both market-based and policy-based, and may come with limitations on their impact. Plan sponsors may choose different approaches, ***but a common voice on fair hospital pricing is of utmost importance.***

Market-Based Strategies

At their 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 a fair price. This could be a percentage of Medicare or reflect 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 would 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 one 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 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 rates 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 hospitals need 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 with close to the Medicare fee schedule overall.
- NASHP Commercial Breakeven provides a percentage of Medicare rates at which any given hospital can run, considering its current cost structure and other economic factors (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 rates 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, 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 by encouraging providers 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 from both fairer pricing and the achievement of more appropriate and high-quality care.

LIMITATIONS: Not all services lend themselves to the center-of-excellence model. Where it is feasible, this approach can help negotiate a fair price, but purchasers will not buy into any tiering toward providers who 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 the use of other sites of care (e.g., ambulatory surgical centers) or contracting with unaffiliated providers who are not compromised by health-system ownership and can help mitigate the use of services that are either not high value or not fairly priced.

LIMITATIONS: Not all services lend themselves to mitigation outside the hospital setting. This may have no impact on hospital pricing practices, particularly since the economic incentive 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 in 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 promote 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 of employees and their families. It will also likely be difficult for purchasers to meet with every health system their 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 data, analyzing the reasonability of prices and margins, and examining the relationship 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 empathize with hospitals, which are often one of the largest local employers, most influential political entities, and significant local patrons. 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 hospital competition in a region, the hospital "market" may function more like a "utility" than a market. Hospital consolidation has resulted in more regions being noncompetitive and, as a result, it may be necessary to create a formal regulatory environment for oversight of hospital pricing. Regulatory approaches could apply across all institutions or be triggered based on certain circumstances (e.g., prices above X% of Medicare rates). 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, hospitals 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 reorient hospitals toward operating within budget constraints and in 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 account for both the current state of expenses and the 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 operate service by service or on a more aggregated basis. This approach is intended to reorient hospitals toward operating within budget constraints and in 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 reflect fair prices, not the current state of pricing.

Public Option

One policy approach that has been floated at the federal and state levels is the offering of a "public option." Although design details could vary, a likely part of the public option would be standardized rate-setting by the public sector. These rates might 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—the individual market, public exchanges, employers, and other plan sponsors? Also, would those covered retain the ability to supplement the public option with other coverage (as they can with 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 effective if employers and other plan sponsors have the opportunity to offer such a plan. If they do not, 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, legislation is being targeted to specific language commonly used by large healthcare providers in their contracts with insurance companies. One example addresses 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 effective banning anti-competitive practices and enforcing anti-trust laws will be in many markets.

Surprise Billing Oversight

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

Medicare payments and costs: Relatively efficient hospitals broke even in 2020

	Relatively efficient (15%)	Other (85%)
Performance in 2020		
Share rating hospital a 9 or 10 (out of 10)	72%	69%
Risk-adjusted percent of national median		
Mortality rate (30-day)	92	101
Readmission rate	96	102
Medicare costs per stay (standardized)	91	104
Median margin in 2020		
Overall Medicare margin	1	–6
All-payer total margin	7	5

Note: Relative values are the median for the group as a share of the median of all hospitals. Per stay costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the 3M methodology to compute risk-adjusted mortality for all conditions. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) due to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and risk-adjusted quality metrics.
Source: MedPAC analysis of cost report and claims-based quality data from CMS.

MEDPAC

Results are preliminary and subject to change

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ADDENDUM:

Additional Resources for Action

24 Understanding Sage Transparency Dashboard Tabs

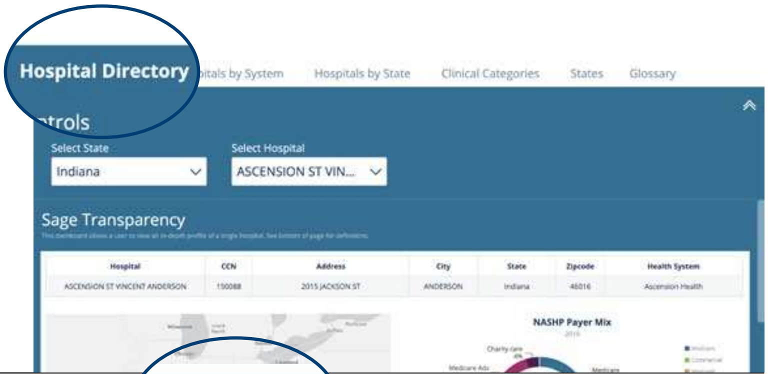
27 Hospital Myths and Facts

Additional resource information and links can be found in the online version of this booklet, available in the Resources section of NCBGH.org.

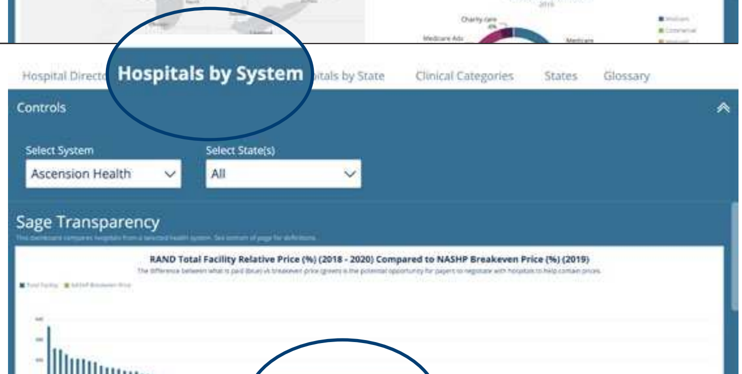
Understanding Sage Transparency Dashboard Tabs

(employerptp.org/sage-transparency)

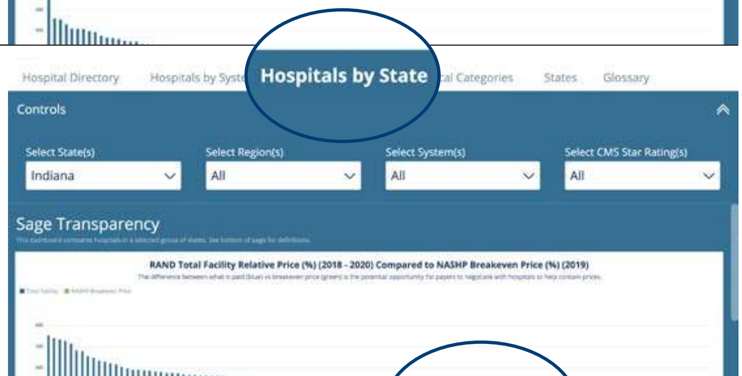
HOSPITAL DIRECTORY: View an in-depth profile of a single hospital, bringing together hospital quality scores from CMS and Quantros, RAND relative prices, and outpatient and inpatient clinical category relative prices from Turquoise Health.



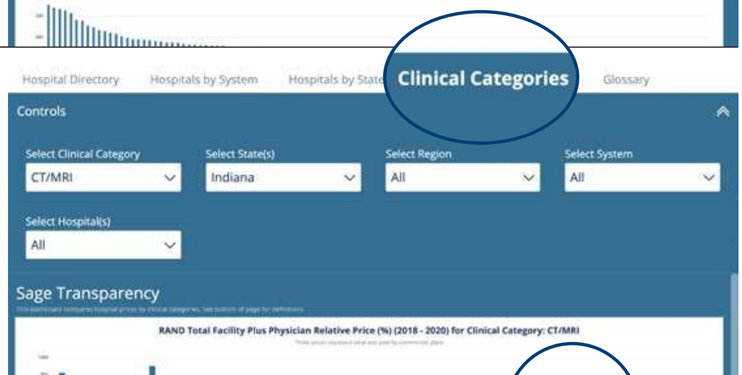
HOSPITALS BY SYSTEM: Compare a group of hospitals' quality scores and relative prices within a selected health system.



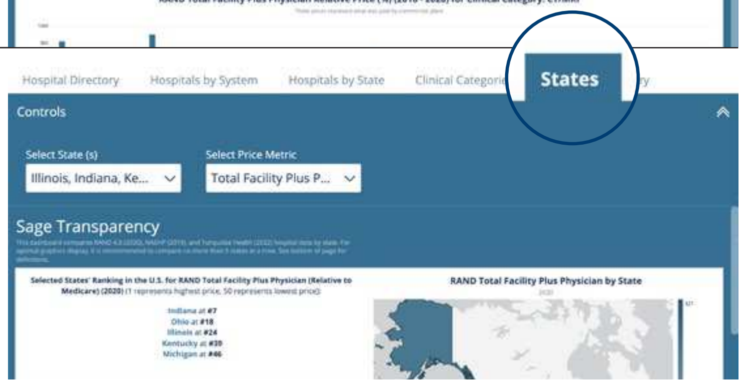
HOSPITALS BY STATE: Compare a group of hospitals' quality scores and relative prices within selected states.



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

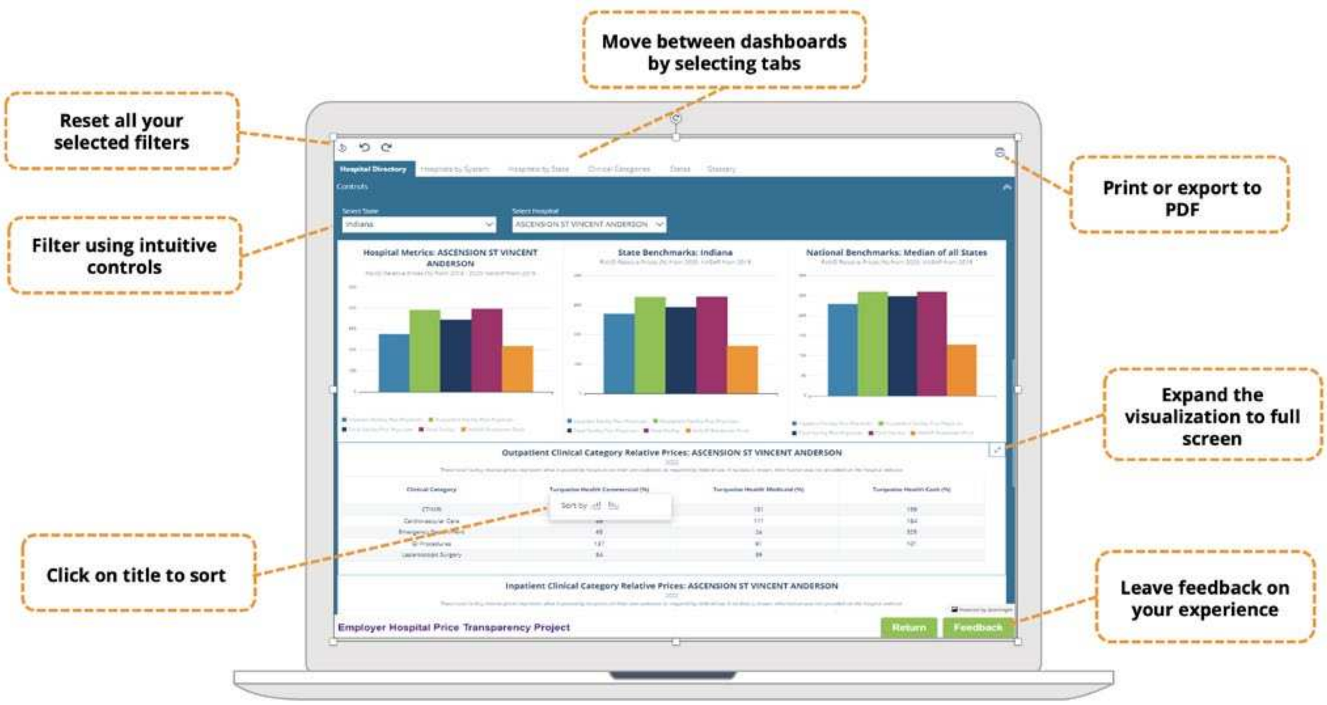


STATES: This dashboard provides hospital price, cost and quality data at the state level. You can explore price differences among selected states and how these states compare based on any of nine price metric options.



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.

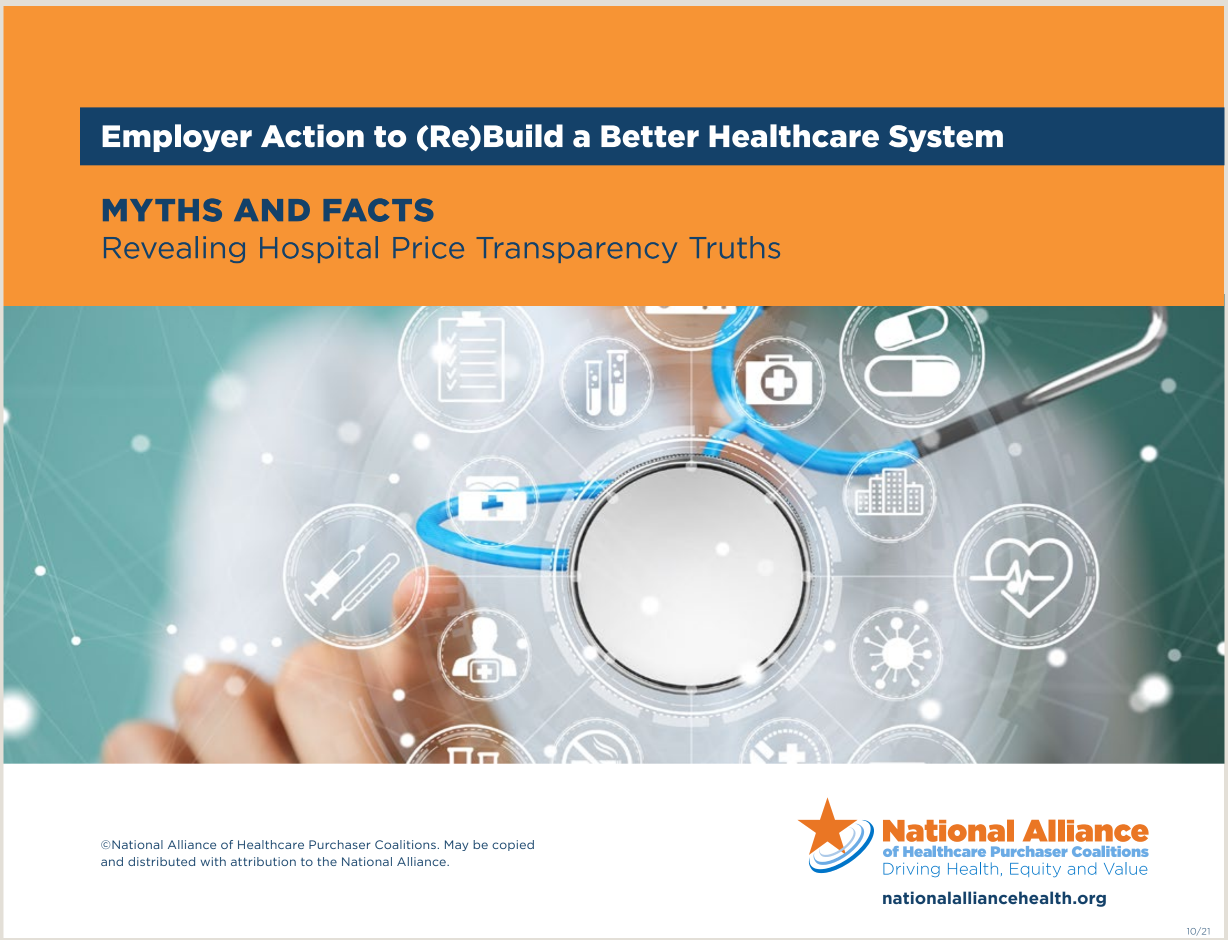
- 8+ year trend
- Hospital breakeven by market
- % Medicare breakeven
- Commercial breakeven



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:

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



Visit NCBCH.net resources section to download a digital copy.

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NCBGH is a non-profit coalition of employers and other key healthcare stakeholders across the state using their collective voice to influence decisions and impact the quality and cost of healthcare delivery systems across North Carolina. For more information, visit https://ncbgh.org

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

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Its members represent private and public sector, nonprofit, and Taft-Hartley organizations, and more than 45 million Americans spending over $300 billion annually on healthcare. Visit nationalalliancehealth.org, and connect with us on Twitter and LinkedIn. ©National Alliance of Healthcare Purchaser Coalitions. May be copied and distributed with attribution to the National Alliance.

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