Strategies to Get to Fair Hospital Pricing

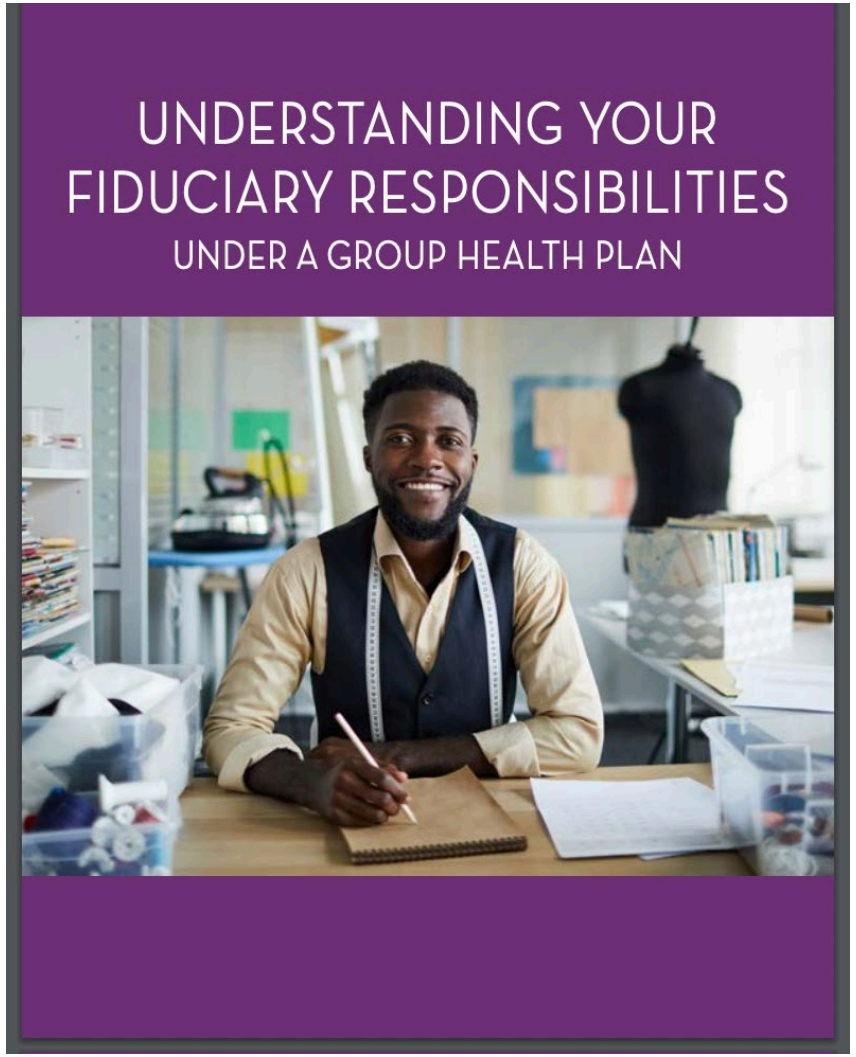
Kentuckiana Health Collaborative

December 2022

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

Understanding the Fiduciary Duty

Obligation of Plan Sponsors



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 one's duties *prudently*, which means with expertise and a thoroughly-documented process
- Holding Plan Assets in Trust

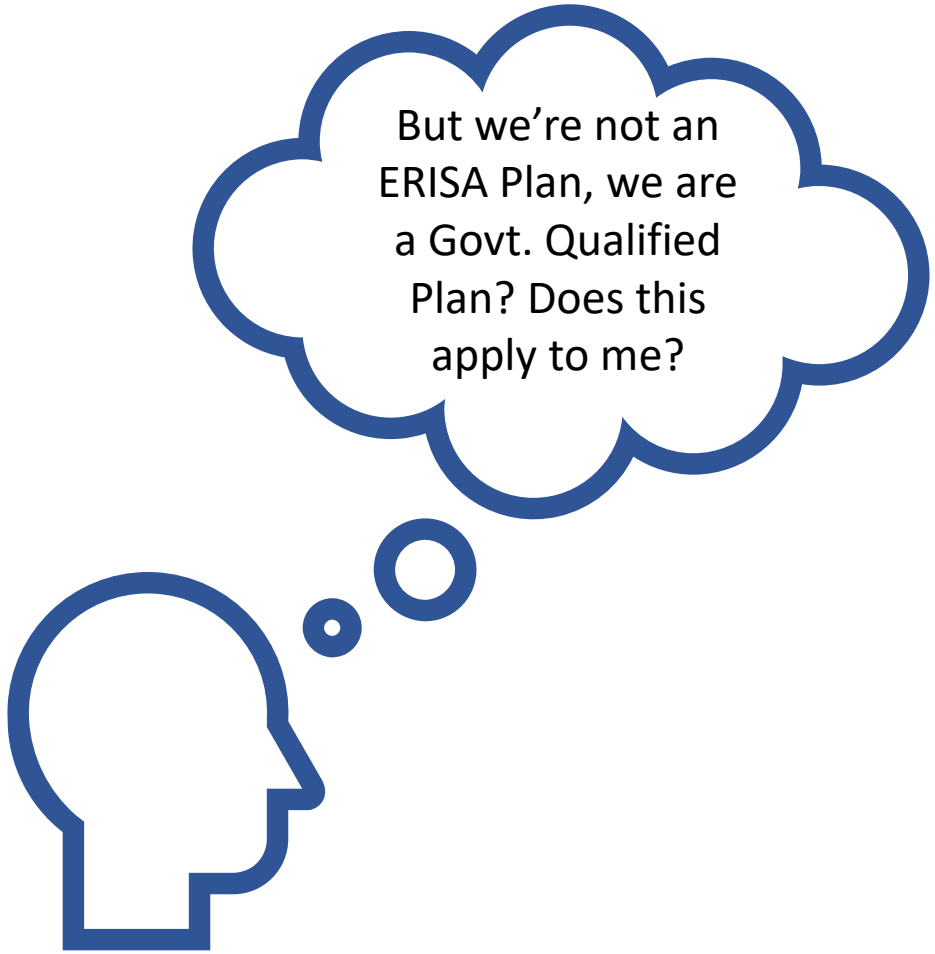
NOTE: Selecting the lowest cost option is decidedly not a fiduciary's duty

* For more information on fiduciary responsibilities from the DOL: Understanding Your Fiduciary Responsibilities Under a Group Health Plan

Who is a Fiduciary?

A person using discretion in administering and managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control.

Thus, fiduciary status is based on the functions performed for the plan, not just a person's title.



“NASHP Commercial Breakeven” – Covers More than You Think

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

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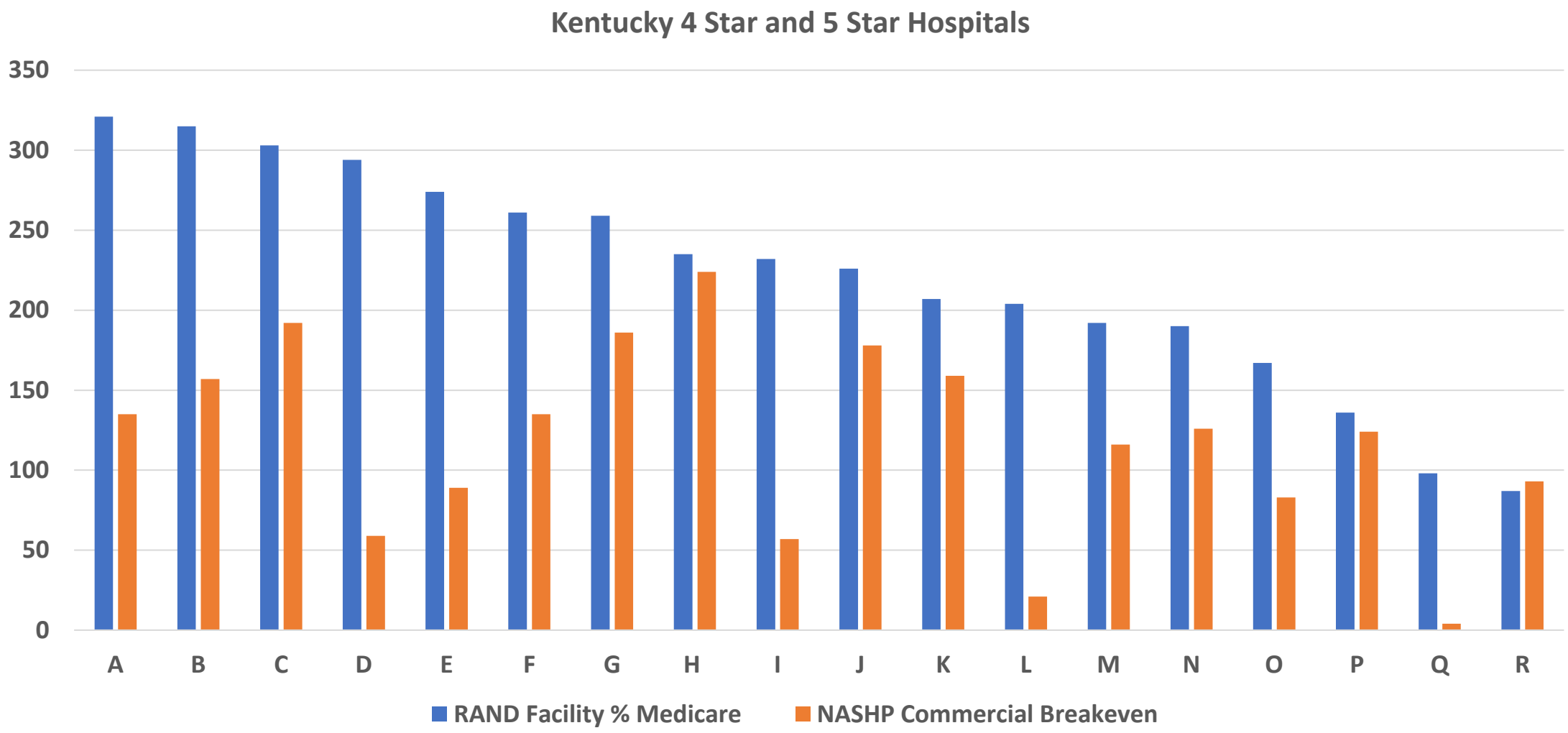
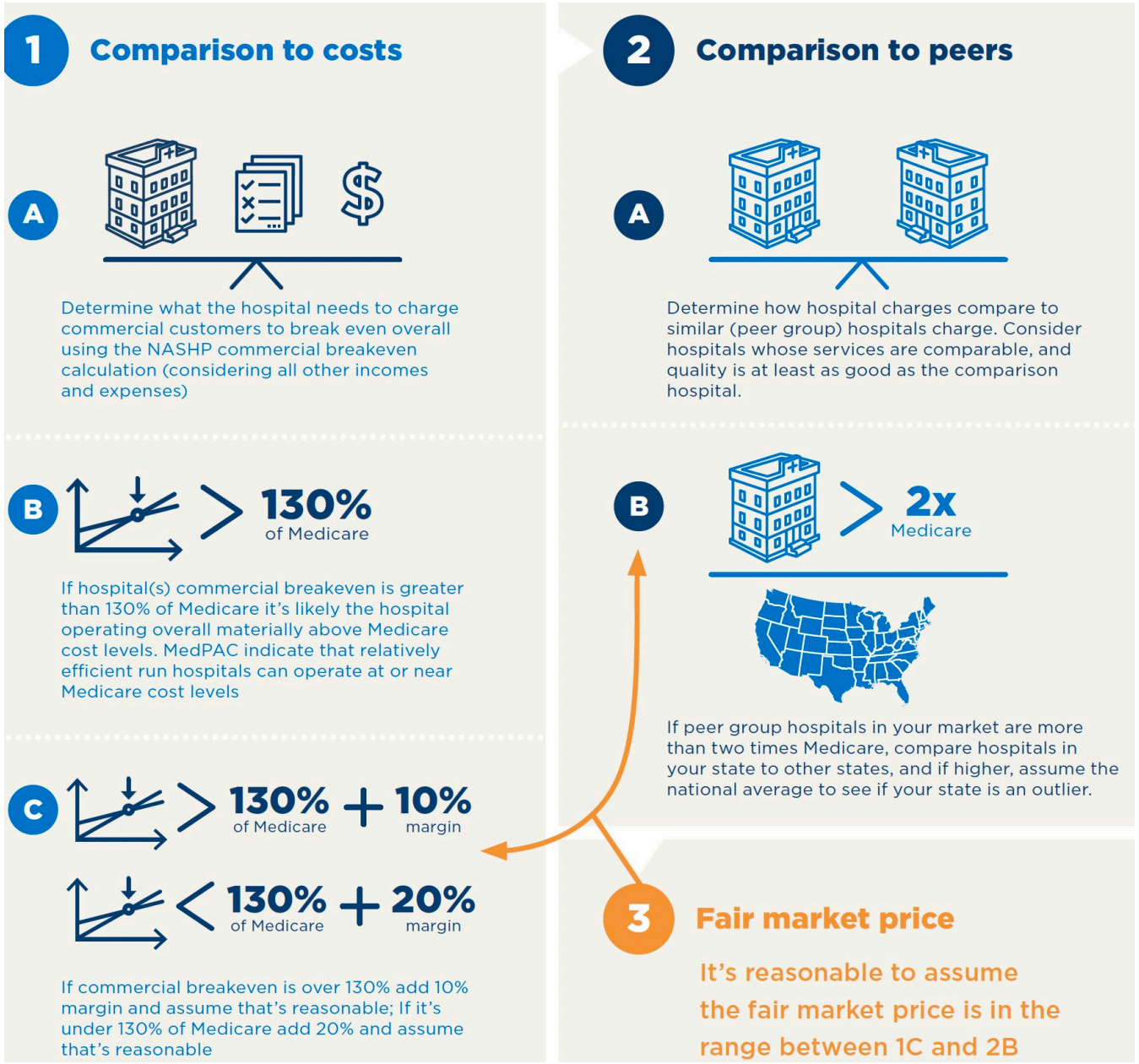
Variation in Price and Costs at High Quality Hospitals in Kentucky



Fair Price Methodology

- Cost plus Margin
- Comparison to Peers
- Other considerations
  - Are Costs Very High?
  - Are Peers Very Costly?



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Step 1: Comparison to Costs

How much does hospital need to break even, using the NASHP commercial breakeven calculation?

- If hospital's breakeven is greater than 130% of Medicare, hospital likely operating materially above Medicare cost.
- If commercial breakeven is over 130% add 10% margin and assume that's reasonable;
- If it's under 130% of Medicare add 20% and assume that's reasonable

Relatively efficient hospitals can operate at or near Medicare cost levels.

-MedPAC

Note that margin added here is on Commercial only so is a smaller percentage of the overall hospital business

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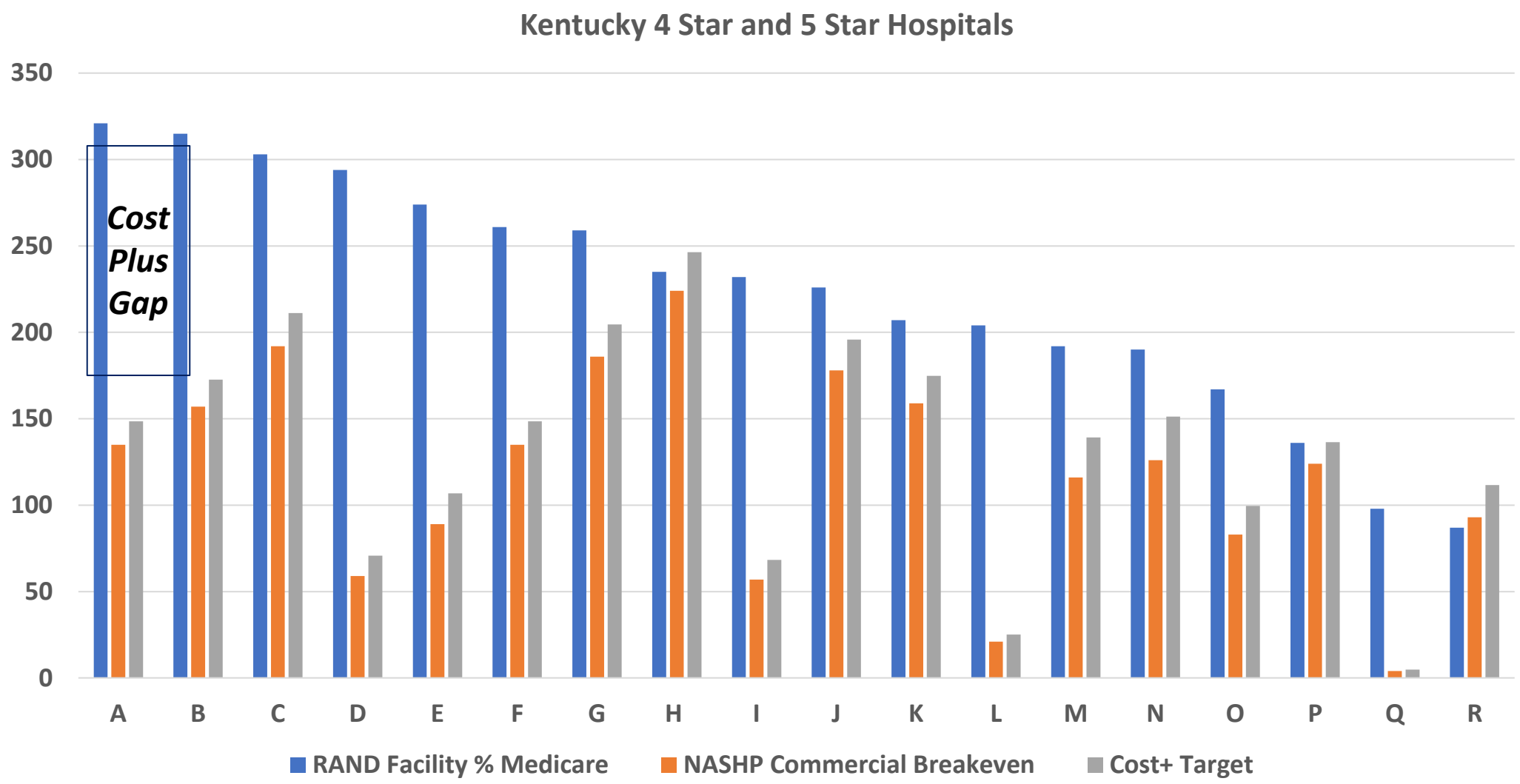
Comparison to Costs



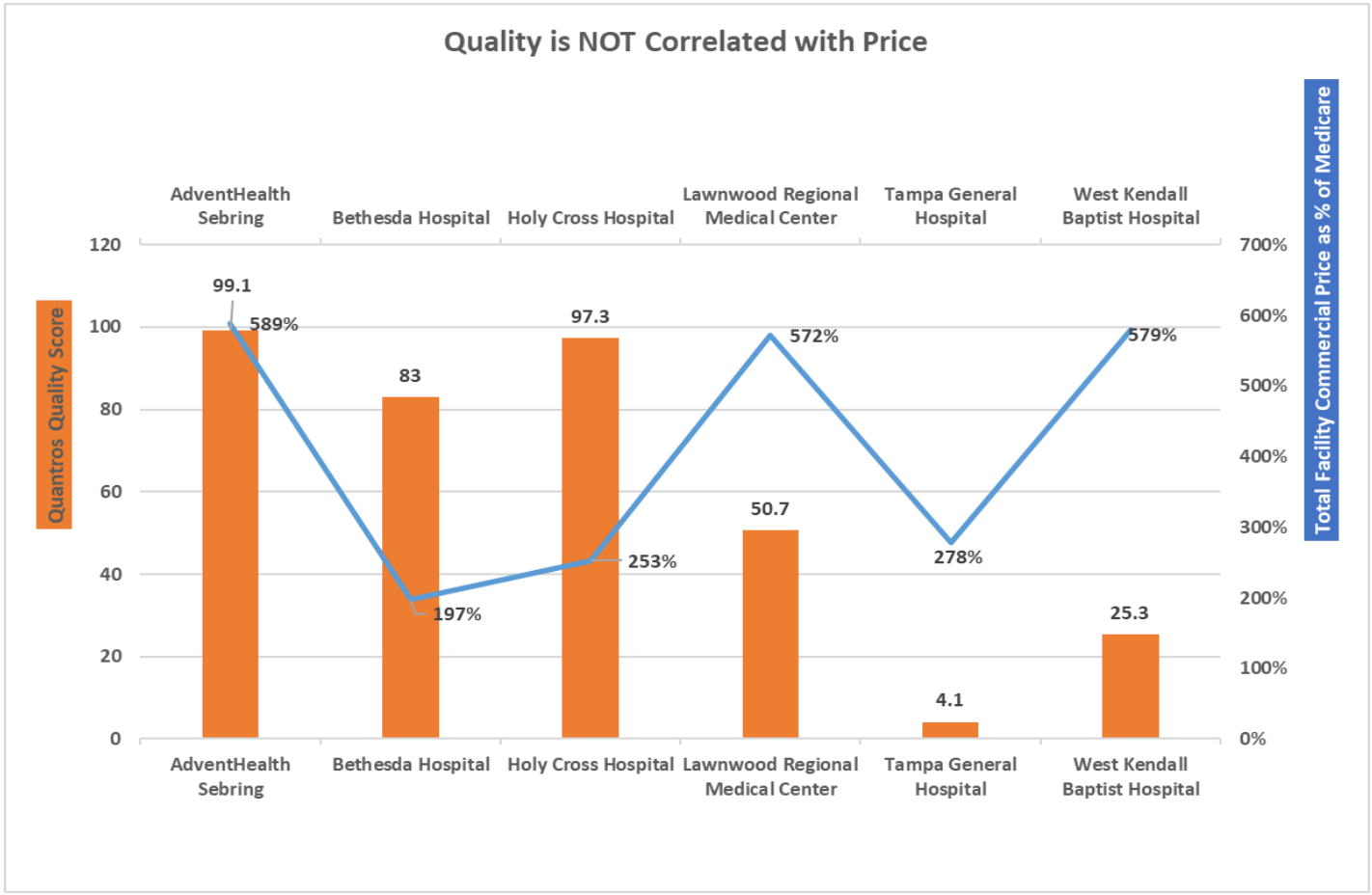
Step 2: Comparison to Peers

How do hospital costs compare to hospitals with similar services and quality?

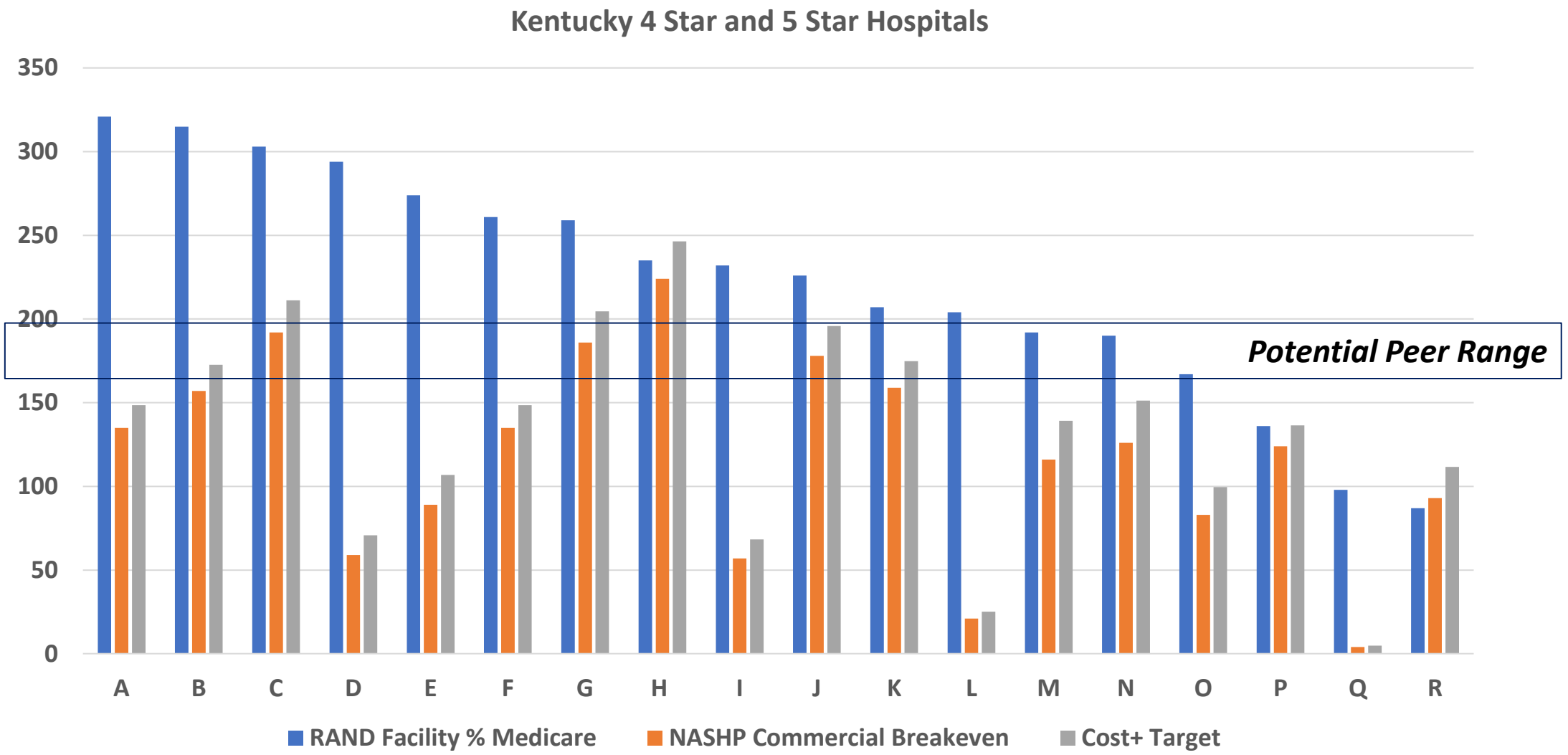
- Compare hospital charges to hospitals with similar services and quality
- Regional judgment call
- Quality metric may help

Other Considerations

- Variation within Health Systems
- Comparisons to cash price
- Variations by payer and within payer
- Quality by procedure or service



Comparison to Peers



Step 3: Arrive at Fair Price

A fair price should generally be between a reasonable markup from costs and a competitive market price for a peer hospital

- If there is market competition it is reasonable to expect a price close to reasonable markup on costs
- At a minimum, need to expect a reasonable price comparable to high performing peers and favorable to regional and national averages

Typically a Fair Price is 140%-200% of Medicare

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Potential Market-Based Strategies to get to Fair Price

- Reference-Based Pricing
- Rebasing Contracts to a Percentage of Medicare, Performance Guarantees
- Tiered Networks, Centers of Excellence, Episodes of Care
- Advanced Primary Care, Site of Care, Unaffiliated Providers
- Health System Engagement
- Transparency

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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 reference-based price that is deemed to be a fair price.
- This could be a percentage of Medicare or consider multiple factors that are deemed appropriate for to ensure reasonable accommodation of diverse circumstances.

Limitations

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

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Rebasing Contracts to a Percentage of Medicare, Performance Guarantees

Rebasing to a % of Medicare can:

- Constrain the growth in charges to be no greater than that in Medicare itself.
- Create a universal framing can help health plans and purchasers better understand, evaluate and negotiate the reasonability of charges relative to what is needed to break even and what services should cost.

Performance guarantees that tie price to a % of Medicare (rather than discount) could align with employer goals.

Limitations

- Restructuring to a percentage of Medicare alone will not ensure a fair price for hospital services (must be reasonable)
- The same market dynamics may cause this to be a frustrating exercise of market power versus 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

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

Limitations

- Not all services lend themselves to being offered on a center of excellence basis.
- Where it is feasible to do so, this can help to negotiate a fair price, but purchasers will not buy in to any tiering toward providers that are not first screened for high quality.

Advanced Primary Care, Site of Care, Unaffiliated Providers

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

Limitations

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

Health System Engagement

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

Limitations

- Local business leaders are often not informed on 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, employees and their families.
- It will also likely be difficult for purchasers to meet with every health system that their employees may utilize.
- This is particularly true for national employers.

Transparency

- Transparency alone can have some impact on value and is foundational to restoring a functioning market
- Brings 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 the facts and the data.
- Press coverage and local chambers of commerce have tended to lean in to being empathetic to the hospital point of view as one of the largest local employers, most influential political entities and significant local patron.
- There is also little evidence that price and quality transparency alone can influence consumer discretionary use of higher value institutions.

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Potential Policy-Based Strategies to get to Fair Price

- Rate Regulation
- Global Budgets
- Healthcare Cost Growth Caps
- Public Option
- Anti-Competitive Practices/Anti-Trust Enforcement
- Surprise Billing

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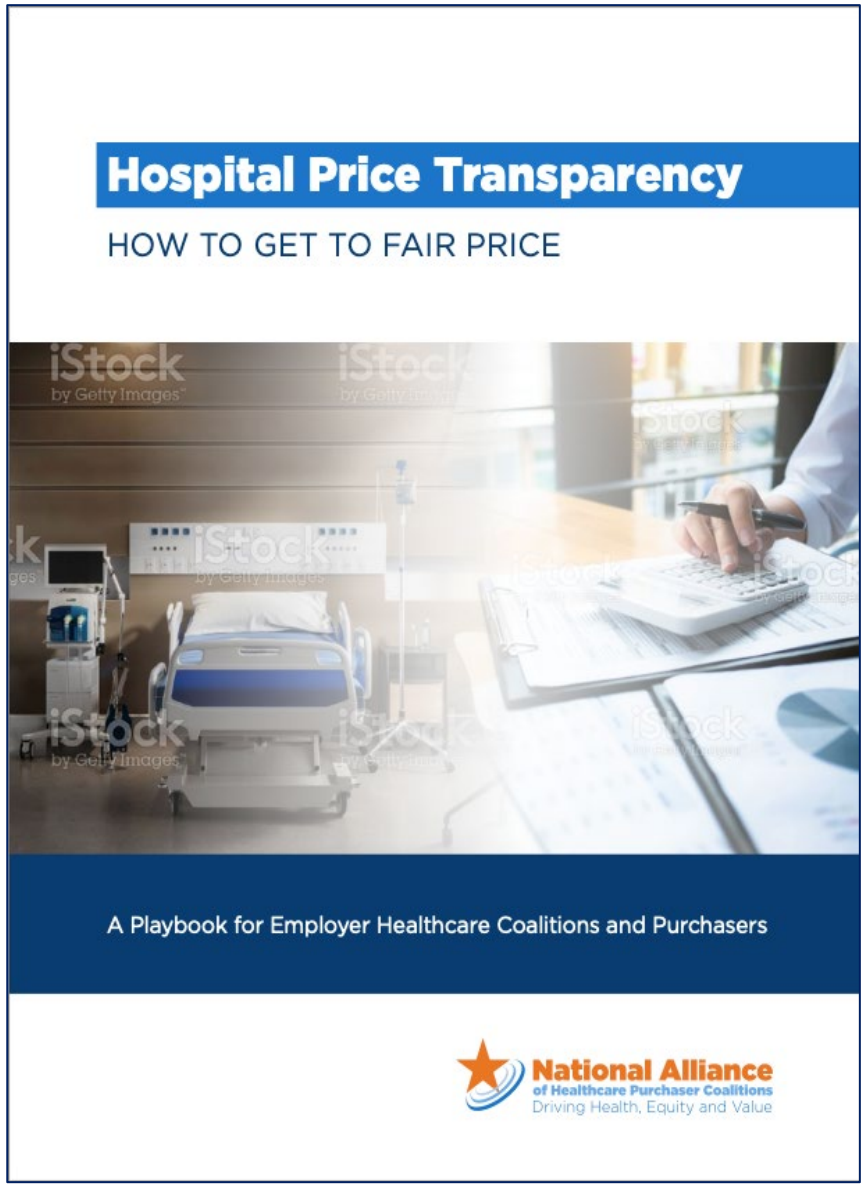
Questions?

Employer Playbook - How to Get to Fair Price

- Fiduciary Rights & Responsibilities
- Introduction to Sage Transparency
- How to get to Fair Price
- Market & Policy Options
- Appendices



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