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**PRESENTATION:
Employer Driven
Hospital Price
Transparency**





RAND 3.0 National Hospital Price Transparency Study

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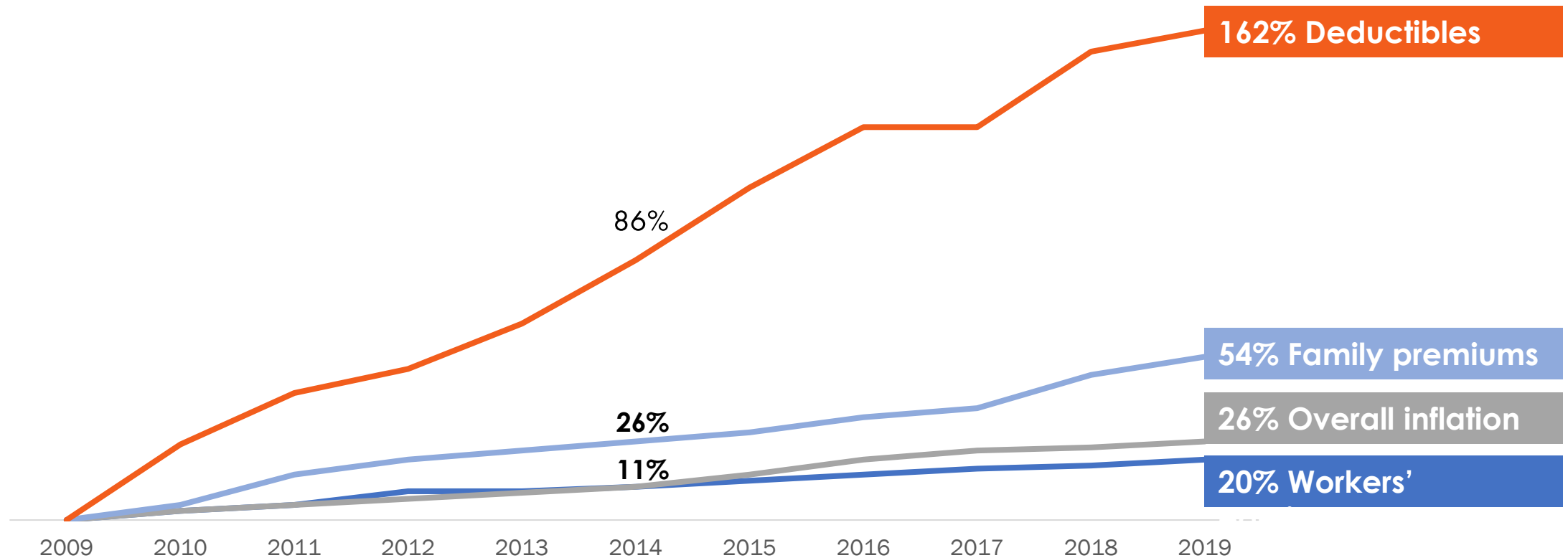
Employer-sponsored plans cover half of Americans

\$1.2 trillion
health care costs in 2018

\$480 billion
hospital costs in 2018

160 million
people

Over the past decade, premiums and deductibles have outpaced wages



What do we *not yet* know?

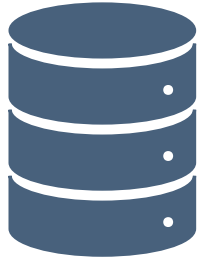
- How do prices compare across the country?
- Are hospital prices continuing to rise?
- Which hospitals/systems are getting the highest prices?
- ***What are the prices that individual self-funded employers are paying, and are these prices in line with the value that employers are getting?***

Hospital prices in the time of COVID-19

- COVID-19 is placing enormous financial pressure on both hospitals and employers
- Hospitals and health professionals are critical members of their communities
- Health benefits are one of the largest expenses for employers
- Now more than ever, employers need transparent information about hospital prices

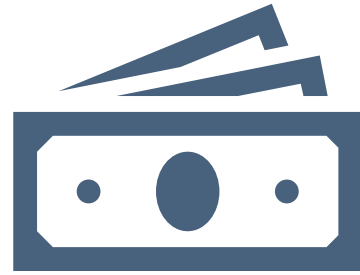
Why did RAND undertake this study?

- We do not know what the “right” price is for hospital care
- Self-funded employers cannot act as responsible fiduciaries for their employees without price information
- Employers can use the information in this report— together with knowledge of their own employee populations—to decide if the prices they and their employees are paying align with value



Obtain claims data from:

- self-funded employers
- APCDs
- health plans



Measure prices in two ways:

- relative to a Medicare benchmark
- price per case-mix weight



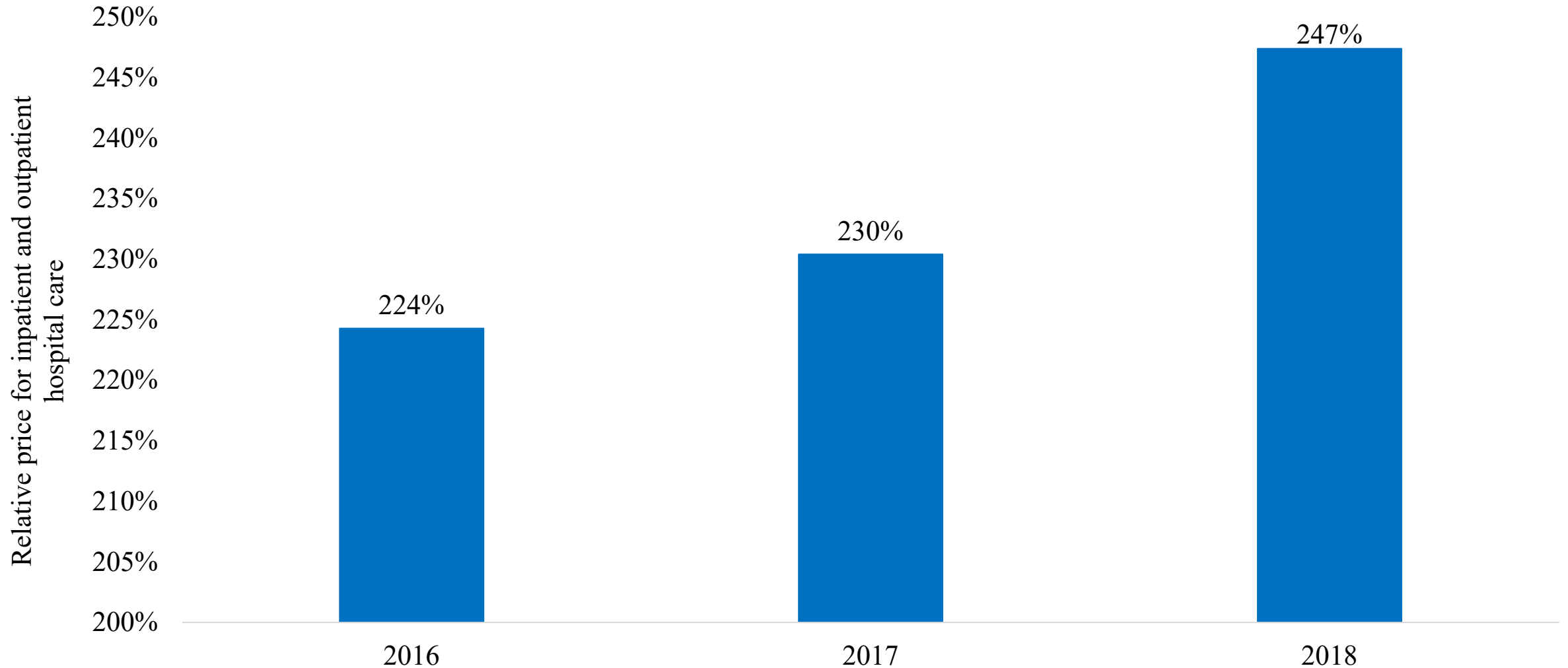
Create a *public* hospital price report:

- posted online, downloadable
- named facilities & systems
- inpatient prices & outpatient prices

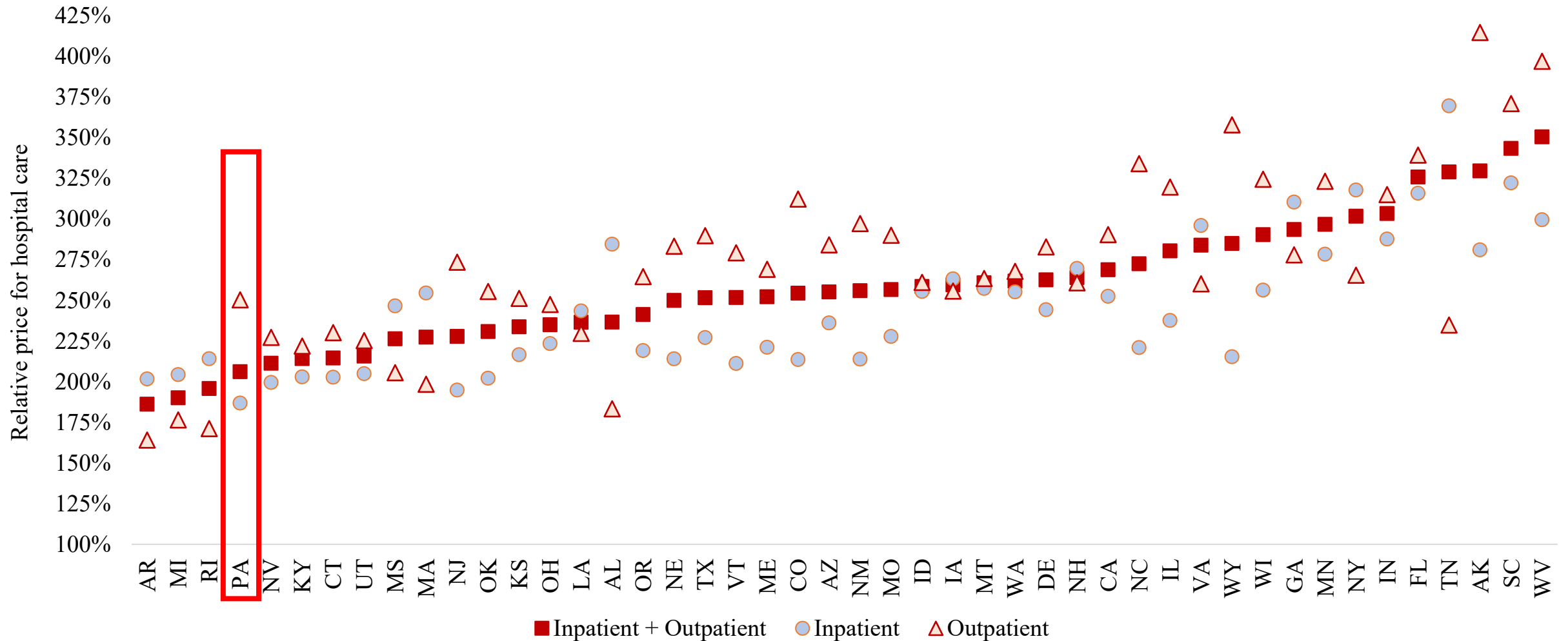


Create *private* hospital price reports for self-funded employers

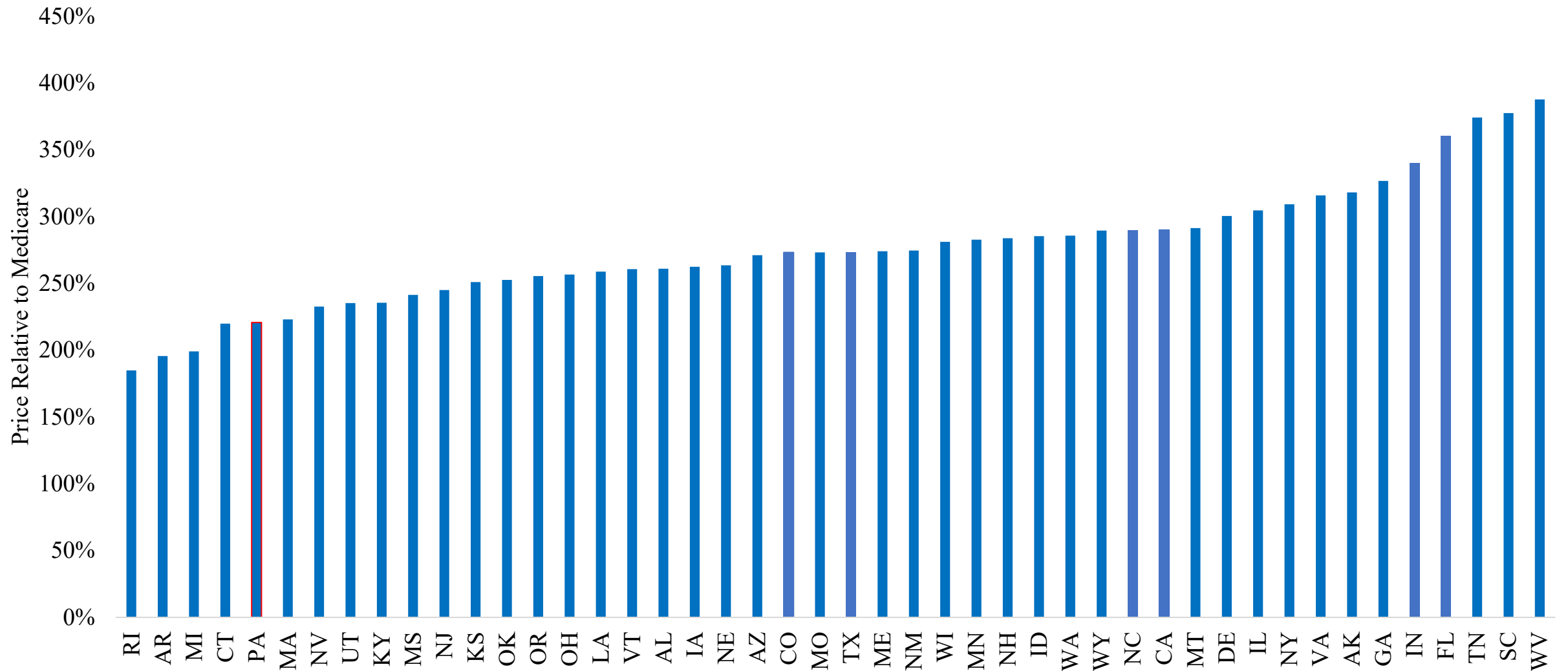
Commercial prices relative to Medicare have increased steadily



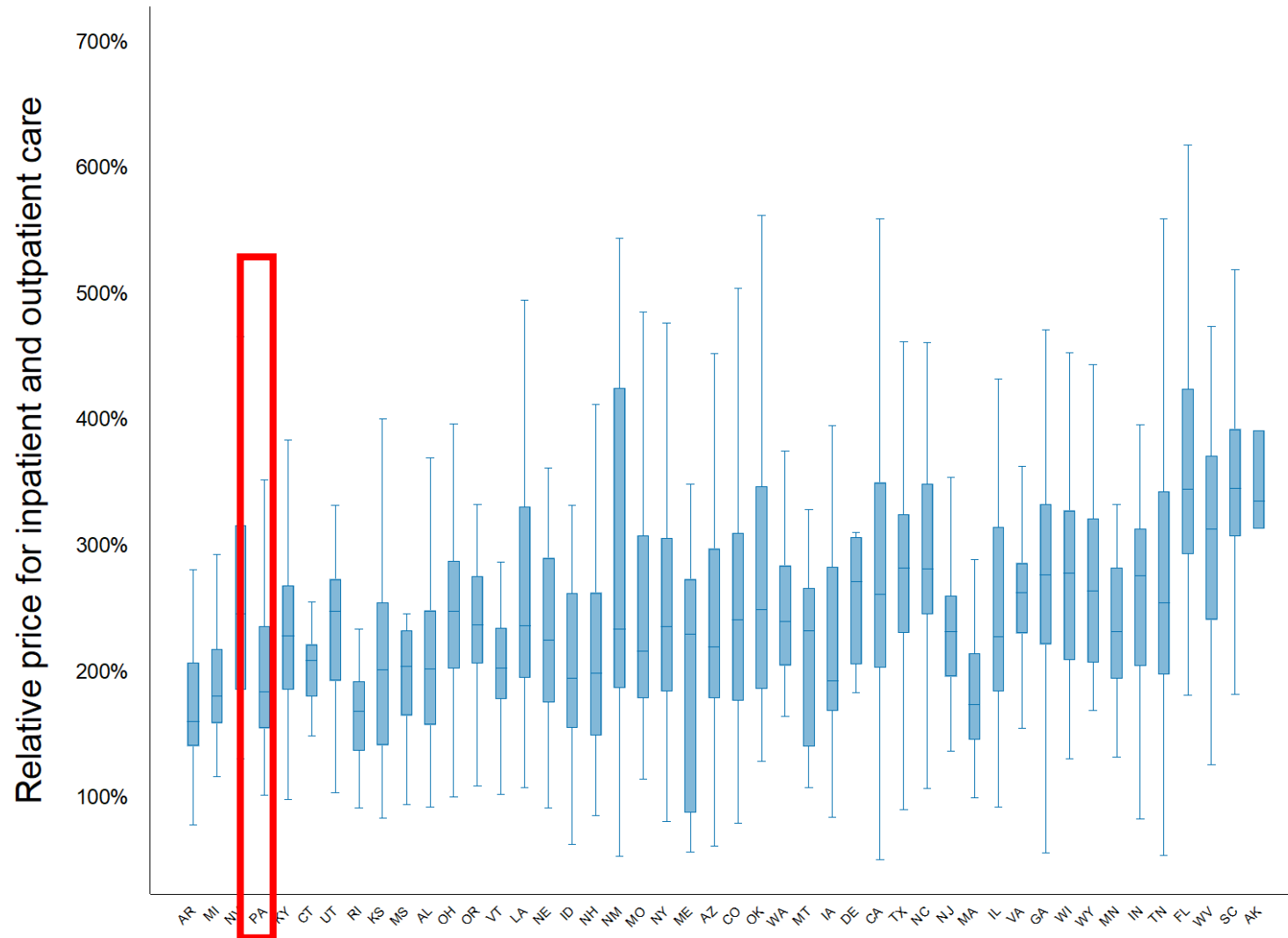
Commercial prices relative to Medicare vary widely across states



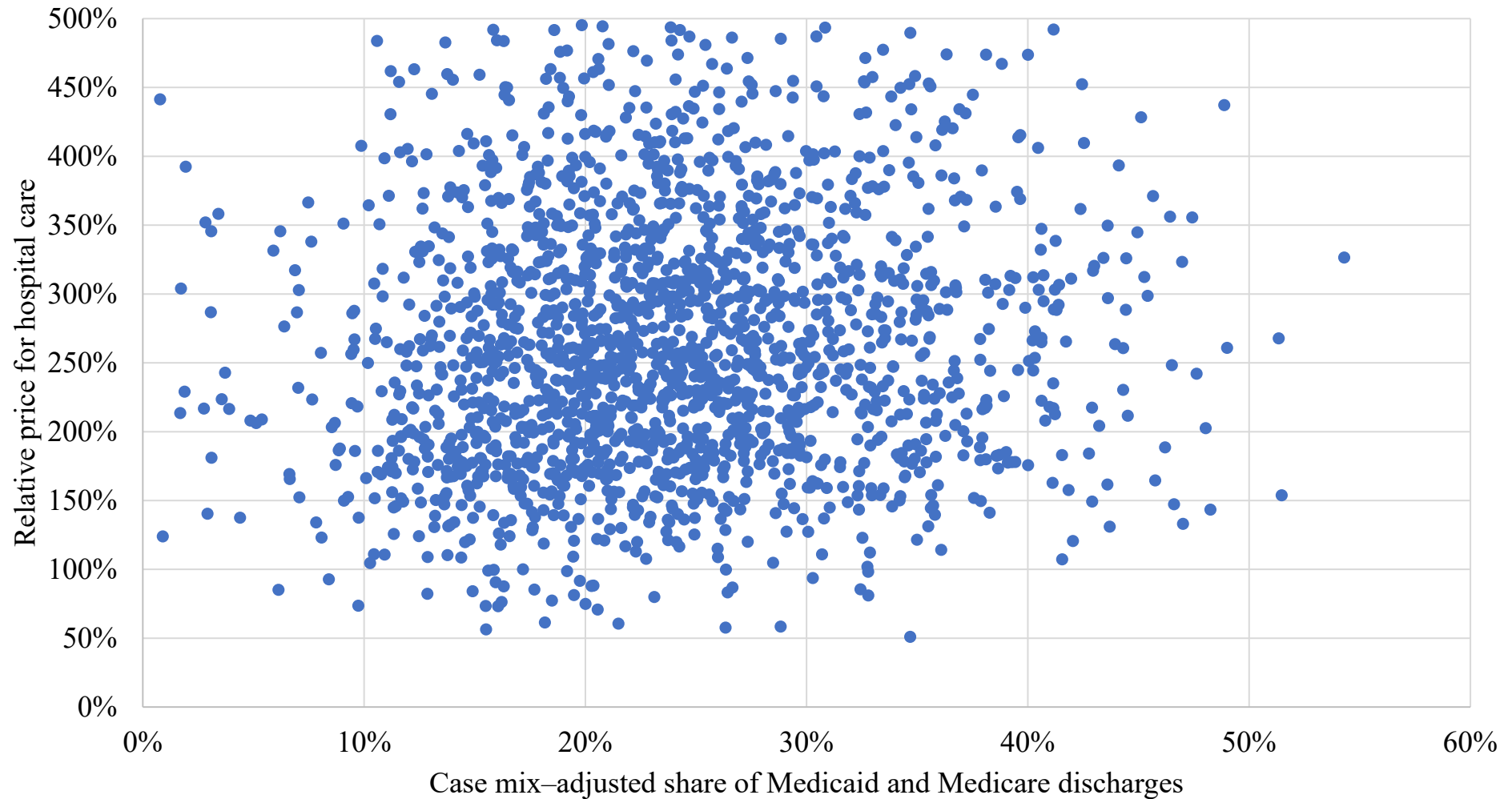
Facility prices relative to Medicare, by state:



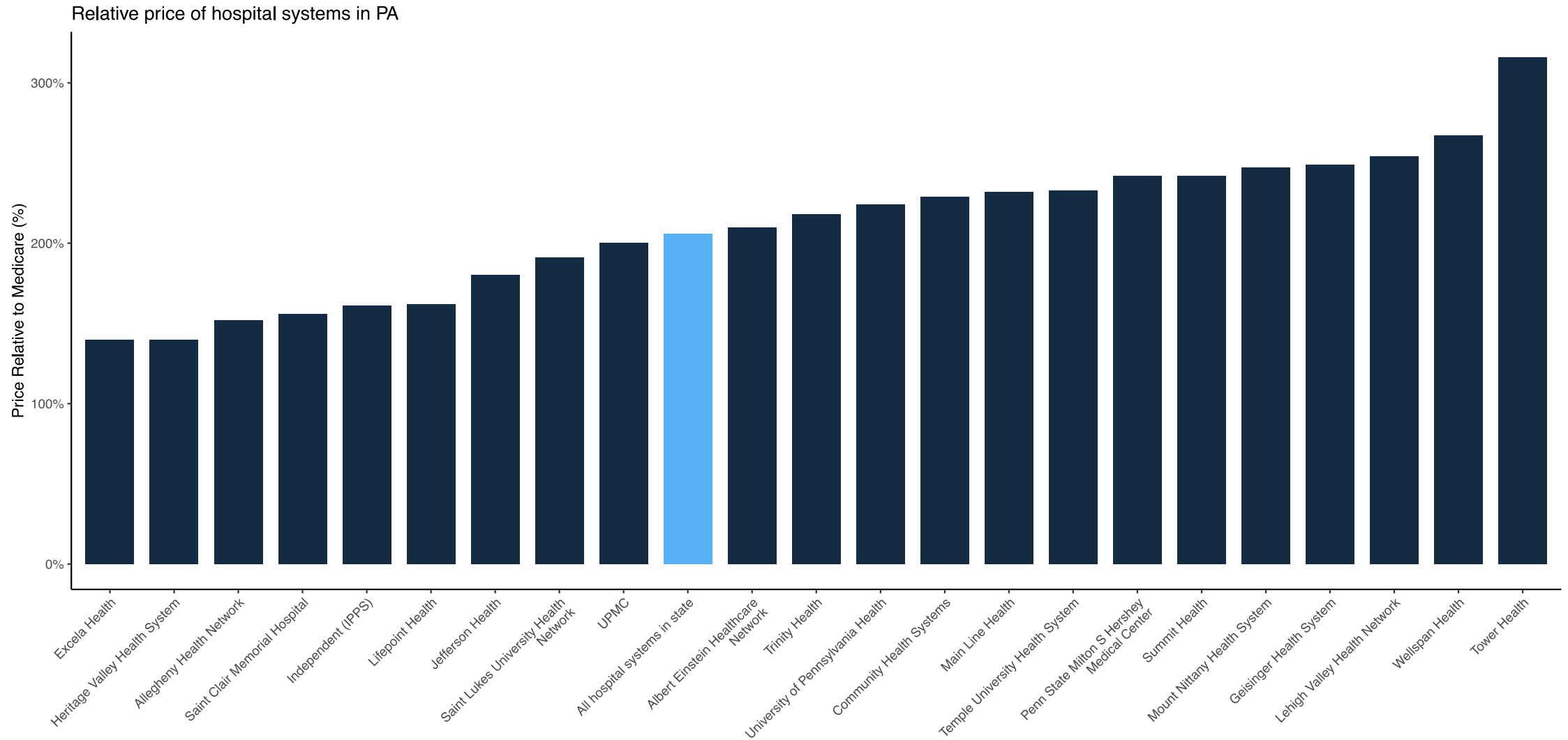
Prices vary widely within states



Patient mix doesn't explain price variation



Pennsylvania hospital system prices: inpatient + outpatient



How can employers and policy makers use price transparency?

Finally have
information
about prices



Benchmark
prices



Change
hospital
networks



Employers are collecting information about prices

- The Colorado Business Group on Health used RAND 2.0 data to produce a report on value of Colorado hospitals
- The report proposed options for Colorado employers to address prices in their specific markets

The image shows the cover of a report titled "Colorado Hospital Value Report". The title is in a large, bold, dark blue font. Below the title is a thin red horizontal line. Underneath the line, the subtitle "Benchmarking Pricing & Quality Reliability for Inpatient Care Across Acute Care Hospitals" is written in a smaller, dark grey font. At the bottom of the cover, the text "SUMMER 2019" is displayed in a bold, dark blue font. The background of the cover is light grey with a faint, abstract orange and white geometric pattern.

Colorado Hospital Value Report

Benchmarking Pricing & Quality Reliability for
Inpatient Care Across Acute Care Hospitals

SUMMER 2019

What are Employers Doing with Price Transparency Information?

Gloria Sachdev

Change is Possible!

In order to have a functional market,
healthcare purchasers must demand
Price and Quality Transparency

Reliable, actionable
data to make
informed decisions
& hold the entire
supply chain
accountable

Benefit design
with incentives
for covered lives
to go to high
value

Payment models
which are
aligned with
high value

Enact legislative
policy to allow
for fair practices


Stimulate Provider Competition around High Quality at Best Price

Employers Must: **OWN** Their Data

Employers must review their carrier and data warehouse contracts carefully to assert ownership of all financial and clinical data

- Data analysis must be conducted by unbiased, knowledgeable, and reputable partners so that the results can be trusted.
- Financial resources currently provided to vendors for analysis should be reallocated to a neutral partner of the employers' choice as vendor analyses of themselves are inherently biased and can not be trusted.
- Auditing privileges are not an effective substitution for due diligence. Not restrictions on auditing should be permitted.

Employers Must: **UNDERSTAND** Their Data



● Adequately Resource
Your Own Health
benefits department
with staff that have
strong clinical,
financial, and data
analytic credentials.

● Ideally, bring management
of ALL aspects of health
services analyses under
one's own roof as this will
assure healthcare dollars
spent align with the value of
services provided.

Employers Must: **ALIGN** Partner Incentives with data

Ensure that ALL third-parties whom you partner with have performance guarantees so that financial incentives align with improvement with employee quality & reduction in employer costs. NO more PEPM, PMPM, PMPY without performance guarantees!

- Performance Guarantees based on achieving improvement in actual clinical measures & economic measures, NOT process measures.
- Insist on 100% transparency: all partners must disclose financial relationships with any service or vendor they recommend. Bribes are the norm and termed “sales fees”, “service fees”, etc.

Employers Must: Pay Based on Data

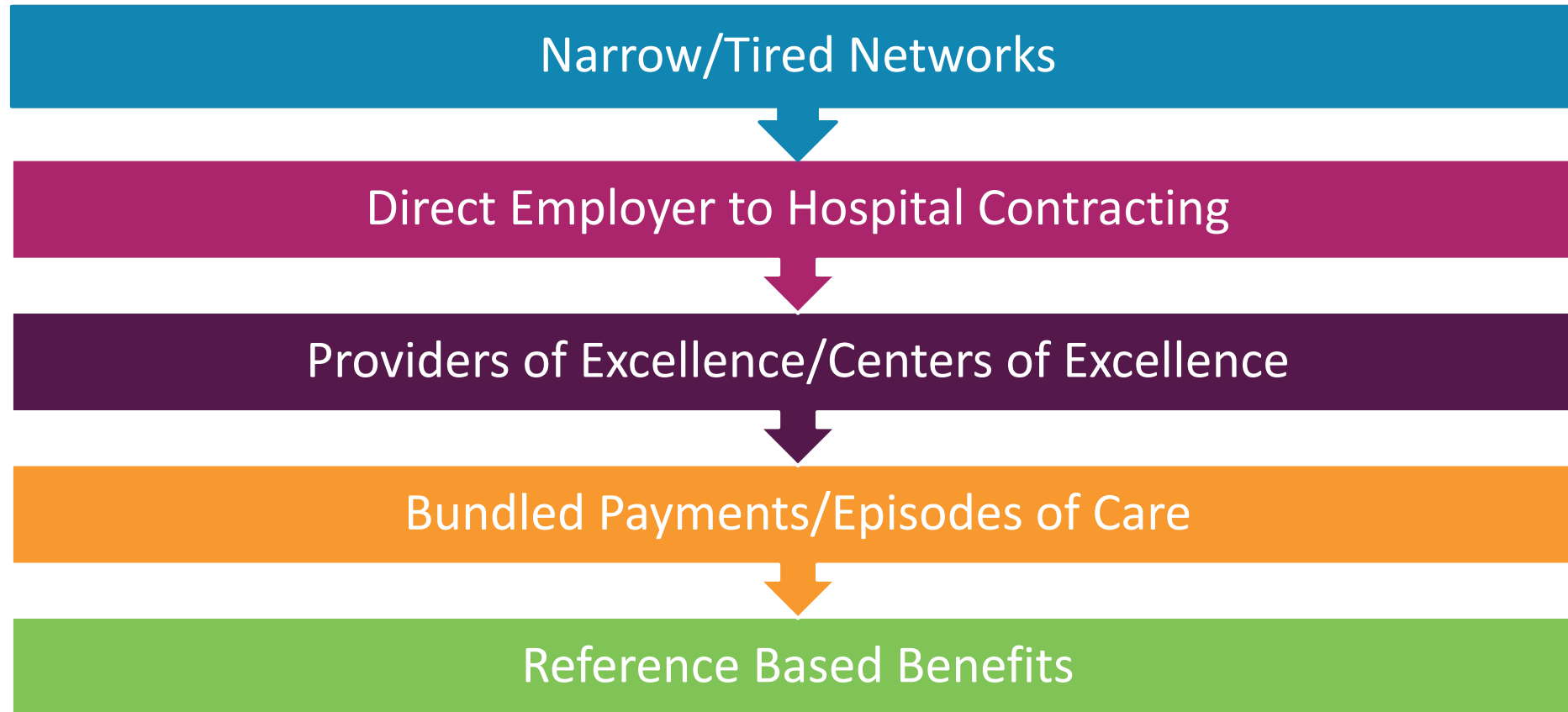


Employers have fiduciary responsibility to assure funds are being spent responsibly.

- To help interpret results, employers can benchmark the prices paid and the quality obtained to Medicare price and quality (which is freely and publicly available).
- Payment as a Percent of Medicare should be considered as it is evidence-based and simple to execute versus other highly complex payment models.
- Many insurers avoid providing price and quality information, but instead report “value” or “total cost of care”. This is fine but employers must know the actual negotiated prices and specific quality metrics used to ensure that the prices paid do in fact represent high value.

Look at Benefits Design Levers based on Value

...consider contracting all the below as a multiple of Medicare



Payment Reform, Indiana

Payment Model: Anthem Indiana was negotiating outpatient services based on discount of charges, which is terrible!

Beginning January 2020, they began contracting using percent of Medicare corporate wide for outpatient services, which is much better.

Contracts: Employer Pressure and Support for Anthem led to them renegotiating a Parkview Health contract in Fort Wayne. Agreement on 7-30-20: reduced in-network payment rates. Doing better with numerous other hospital contracts renegotiated since.

Empowering Employers, Indiana

Direct Contracting: Purdue University with Franciscan Mooresville and Cummins with Ortho Indy, both for orthopedics

Narrow Network: State of Indiana issued in RFP in 2021 to negotiate directly as a percent of Medicare and have robust performance guarantees. Resulted in optional narrow network. Purdue and Red Gold have this too.

Performance Guarantees: on a variety of price and quality measures for TPAs, vendors such as onsite clinics, and benefit consultants = accountability

Data Informed Decisions: using independent vendors

Legislative Policy, Indiana 2020

House Enrolled Act 1004

- **Good Faith Estimate** - providers must provide GFE within 5 days of patient request 7-1-20, & provide without patient request beginning 2021 **LAW**
- **Surprise Billing** - Prohibits in-network providers or practitioners from charging patients more than in network rate cost of care according to the patient's network plan unless at least 5 days before the health care services are scheduled to be provided, the covered individual is provided a statement that of GFE and patient signs consent to be charged for out of network rate. **LAW**
- **Site of Service** - Specifies health care billing forms to be used in certain health care settings. **DIED**

Read the latest version [here](#)

Legislative Policy, Indiana 2020

Senate Enrolled Act 5

- **Prohibit Gag Clauses** - Prohibits non-disclosure clauses in health provider contracts so purchasers can request the negotiated rate from insurers and providers. **LAW**
- **Price Transparency** - Requires hospitals, ambulatory surgical centers, and urgent care facilities to post certain health care services pricing information on their Internet web sites. **LAW**
- **Benefit Consultant Disclosure** - Requires an insurance producer to disclose commission information to client. **LAW**
- **All-Payer-Claims-Database (APCD)** - Requires the department of insurance to submit a RFI, RFP, and contract with an org to set up an APCD. **LAW**

Read the latest version [here](#)

Legislative Policy, Indiana 2021

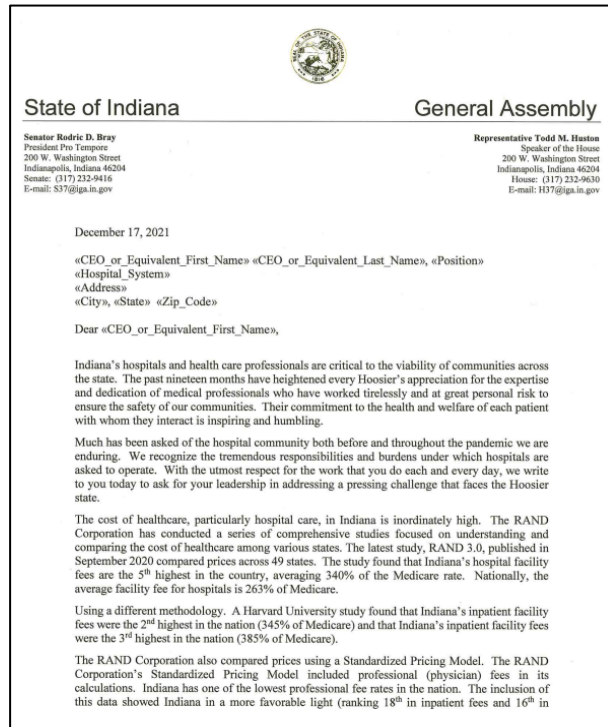
HB 1405 and SEA 325

- **Annual Public Forum meeting** for select non-profit hospitals to which their BOD must attend, discuss their finances, how help community, and receive community feedback. **LAW**
 - Indiana University Health announced December 2021 that they will FREEZE prices until they reach the national average! National news coverage.
- **Shore up APCD** by adding advisory board. **LAW**
- **White Bagging**....**successfully blocked legislation**
- **Certificate of Public Advantage (COPA)****passed but blocked worst part**
- **Prohibit Anticompetitive Contract Language**, i.e. prohibit all-or-none, anti-steering, and anti-tiering language in provider contracts. **DIED**

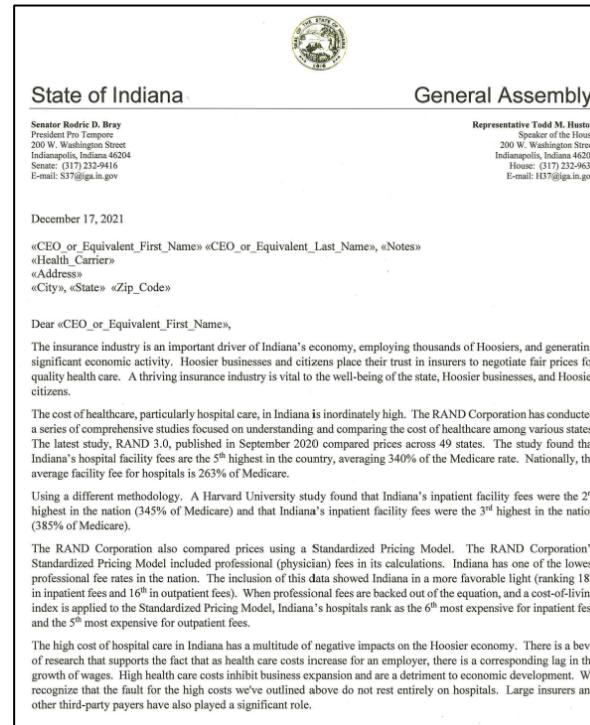
Read review [here](#)

Indiana Legislature Sent Letters to Hospitals & Insurers, 2022

By 4/1/2022 hospitals and insurers executives must submit to legislators a plan regarding how they are going to get hospital prices to the national average by 1/1/2025



Letter to Hospitals: [Link](#)



Letter to Insurers: [Link](#)



EMPLOYERS'
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Legislative Policy, Indiana 2022

➤ HB 1153: Workers Compensation

- Extend current cap of 200% of Medicare for hospitals to Ambulatory Care Surgical Centers. **LAW**

■ HB 1001: COVID-19 Immunizations

- Addresses employer vaccine mandates requiring employers to have individual exemptions for religious, medical, COVID-19 testing max of 2 times a week, or employee natural immunity within past 3 months. **LAW but blocked worst aspects**

■ HB 1158: Healthcare

- Increases PA and NP scope of practice, Established an advisory council board for the division of disability and rehabilitation services.....**LAW but blocked white bagging language altogether**

■ HB 1270: Nonprofit Hospital Transparency and Hospital/Insurer Public Forums

- Shoring up nonprofit hospital and insurer public meetings and non-profit hospitals required to submit their Schedule H of their IRS Form 990. **DIED**

Data Made Easy...INTRODUCING... Hospital Value Dashboard

Freely and Publicly available 5/5/22!

Comprised of 5 Data Sources:

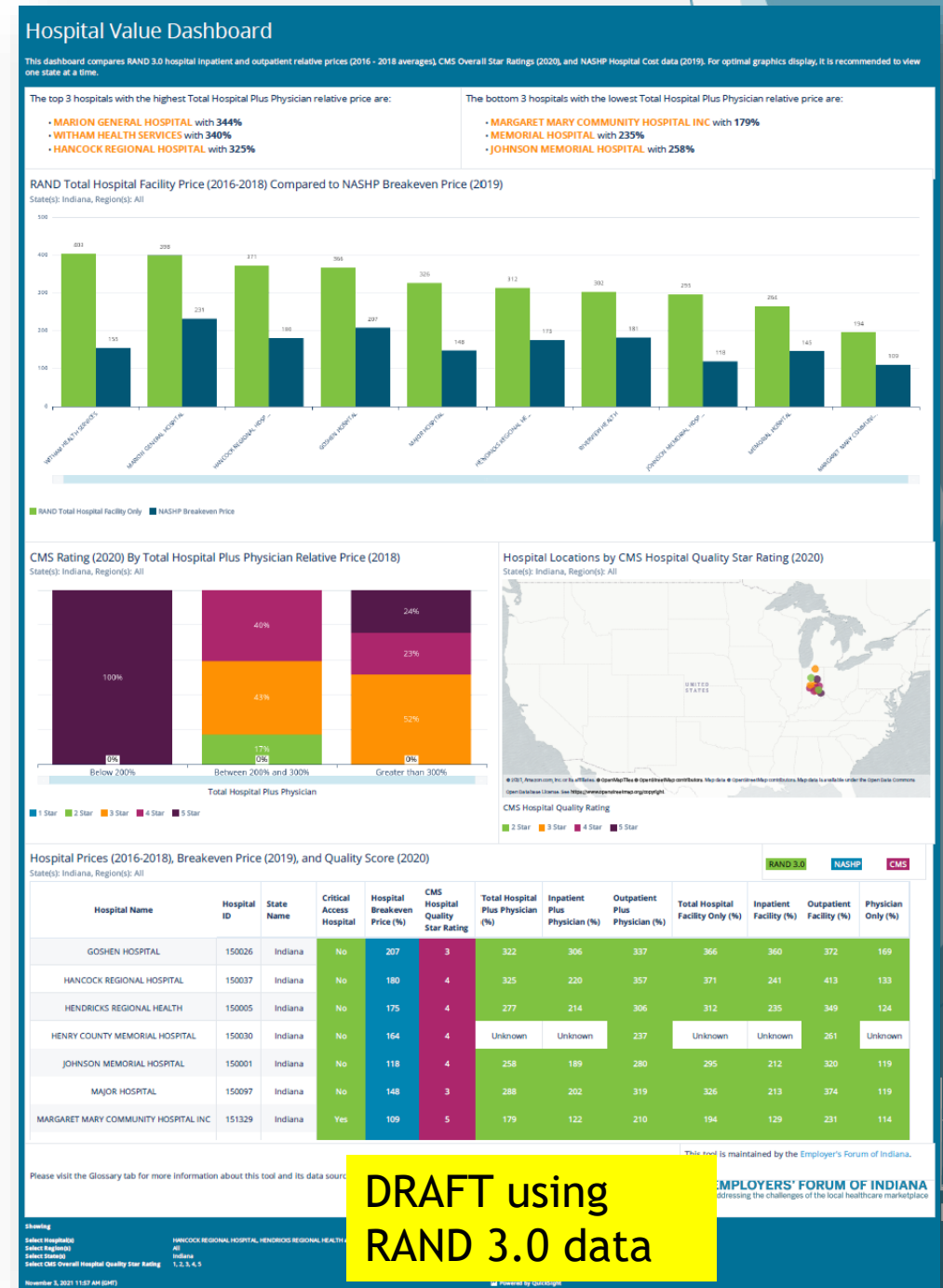
- ▶ RAND 4.0
- ▶ NASHP (National Academy of State Health Policy) Hospital Cost Tool - hospital commercial breakeven as a Percent of Medicare
- ▶ CMS Hospital Quality Star Ratings
- ▶ Turquoise Health over 4000 hospital prices organized by clinical category per hospital, noted as Percent of Medicare and Standardized Prices
- ▶ Healthcare Bluebook Hospital Quality for clinical categories

Launch of Hospital Value Dashboard & RAND 4.0 will be at the National Hospital Price Transparency Conference

Complimentary Registration Now Open!

<https://employersforumindiana.org/conference/>

Young Professionals: This is your opportunity to help your elders be evidence based. 😊



Price & Quality Transparency Allows for Honest Conversations:

Hospital Value Dashboard Example

Hospital Prices (2016-2018), Breakeven Price (2019), and Quality Score (2020)

State(s): Indiana, Region(s): All

RAND 3.0 NASHP CMS

Hospital Name	Hospital ID	State Name	Critical Access Hospital	Hospital Breakeven Price (%)	CMS Hospital Quality Star Rating	Total Hospital Plus Physician (%)	Inpatient Plus Physician (%)	Outpatient Plus Physician (%)	Total Hospital Facility Only (%)	Inpatient Facility (%)	Outpatient Facility (%)	Physician Only (%)
TERRE HAUTE REGIONAL HOSPITAL	150046	Indiana	No	150	3	361	253	406	412	275	477	131
UNION HOSPITAL INC	150023	Indiana	No	166	4	279	220	311	314	242	354	121
UNION HOSPITAL CLINTON	151326	Indiana	Yes	111	2	Unknown	Unknown	212	Unknown	Unknown	222	Unknown

INDIANA AND NATIONAL BENCHMARKS
 (from RAND 3.0 original supplement data), 2018

Indiana	304%	288%	315%	340%	317%	359%	131%
National	247%	231%	267%	263%			171%

DRAFT using RAND 3.0 data

3 Key Employer Take-Aways

Insist on \$
transparency &
ACCOUNTABILITY
through the
ENTIRE supply
chain



Be **EVIDENCE**
BASED in your
decision
making



Get comfortable
with **QUALITY**
because it is
NOT all the
same



Thank You
Questions Welcome

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