Health Care Prices in Colorado:

What They're Doing to Us. What We Can Do.

A Discussion with the Employers Forum of Indiana

"A problem well stated is a problem half solved."

Charles Kettering

Colorado Business Group on Health
Working Together to Improve Health Care Value

Robert Smith, MBA
Executive Director
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About CBGH

An employer-led, multi-purchaser 501c3 committed to ***value-based health care*** through collaboration on:

- Quality and price transparency.
- Reference-based contracting/pricing.
- Alternative payment methods (e.g., *pay for value vs pay for volume*).
- Common provider performance measures.
- Value-based benefit designs that incentivize consumer engagement.

CBGH works with national and regional health leaders and employer coalitions.

Education vs. Health Care

A Tale of Two Industries in Colorado

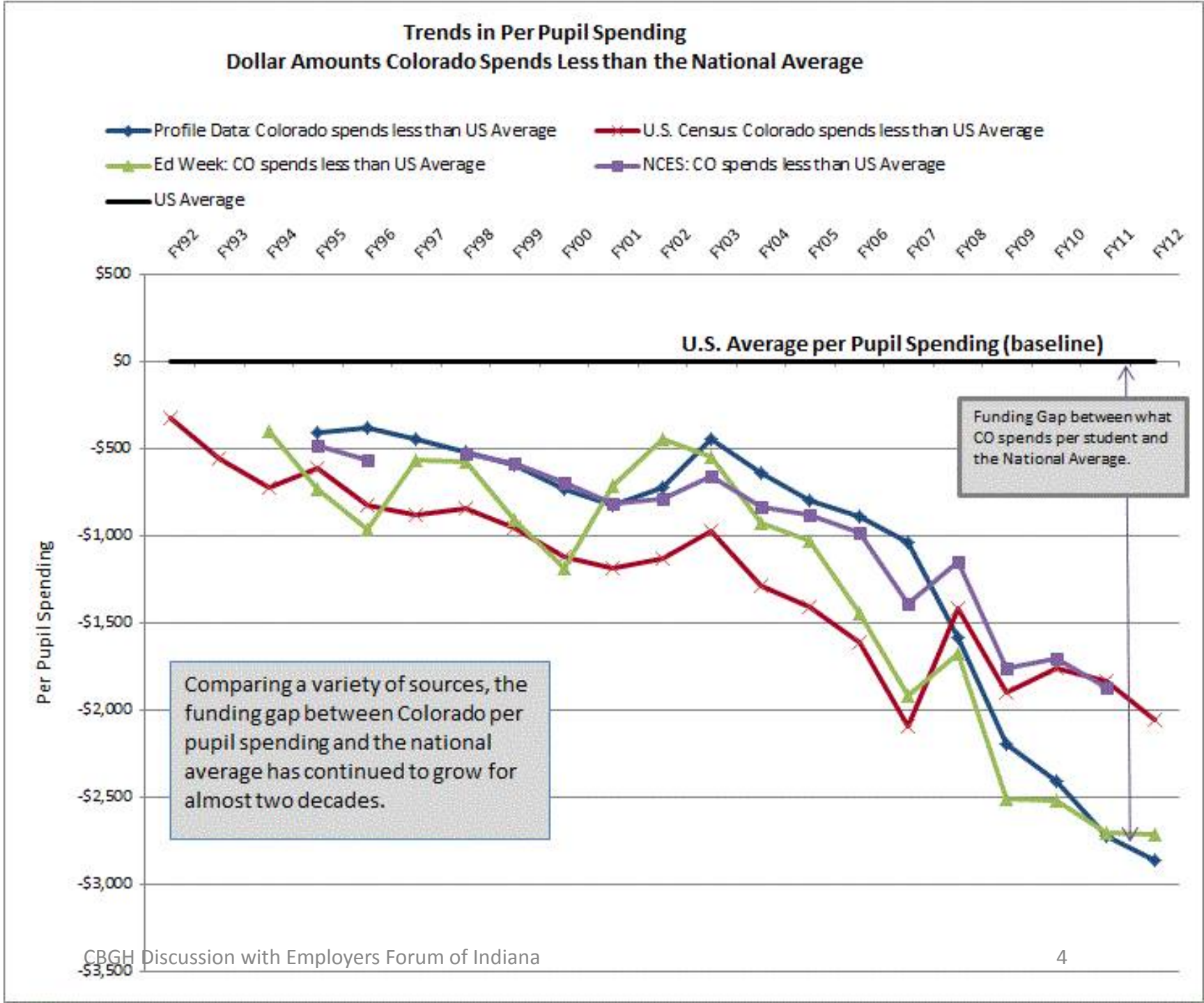
PK-12 Education	Health Care
Due to the negative factor, St. Vrain has seen cuts in per pupil revenue totaling nearly **$200,000,000**.	Health care costs for SVVS went from $13m to almost $23m in 10 years – **77%**.
Colorado is **50th** in country in average teacher salaries. (Colorado School Finance Project)	From 2010-2015 Aetna's earnings rose **628%**; United's went up **814%**; Cigna's up **1112%** (Insurance Week)
CO recently slipped to **41st** in early childhood spending	Q1 profits '17 at UC Health have doubled since 2014 alone; Some hospital margins as high as **40+%**
>50% of Colorado schools operate on a four-day week.	Despite occupancy rates below 65%, CO has built **10 large new hospitals** (Baumgarten report)
Colorado is **40th** in overall per pupil spending (less than every contiguous state (49th adjusted for income)	Hospitals realizing 10th yr of **record high net incomes** on record low occupancy rates.

CCAHC* Report to the Colorado General Assembly

Colorado health spending…

- Up more than four times the level of two decades ago.
- Just since 2000, that spending is up 122.7 percent — 3.7 times the rate of inflation in the state.

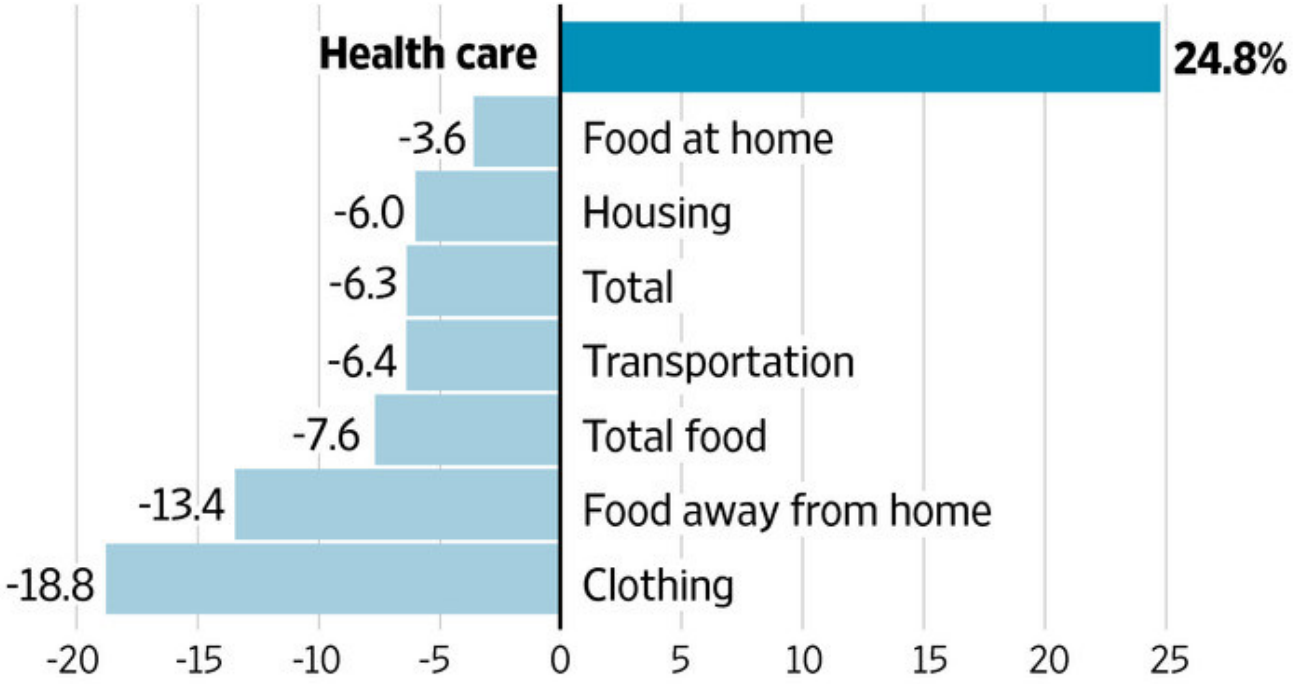
*Colorado Commission on Affordable Health Care, 2018



A Bigger Bite

Middle-class families' spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

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



Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department

THE WALL STREET JOURNAL.

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

Edging Out Salary Growth & Economic Development

Opinions

Where did our raises go? To health care.

Personal finances, budgeting, living paycheck to paycheck. (Mark Jensen/Istock)

By **Robert J. Samuelson**
Columnist
September 2

It's wages vs. health benefits. On this Labor Day, just about everything seems to be going right for typical American workers, with the glaring and puzzling exception of wage stagnation. The unemployment rate is 3.9 percent, near its lowest since 2000. The number of new jobs exceeds the peak in 2008 by about 11 million. Then there's wage stagnation.

Corrected for inflation, wages are up a scant 2 percent since January 2015, according to the Bureau of Labor Statistics. The gain is roughly one-half of 1 percent annually. Little wonder that many workers feel they're not getting ahead. They aren't.

HEALTHCARE PRICE VARIANCE REPORT

MARKET | DENVER

Procedure	Low Price	High Price	Variance
Abdominal Ultrasound	$115	$1,029	895%
Carpal Tunnel Surgery	$1,634	$5,806	355%
Chest CT (no contrast)	$248	$2,492	1005%
Cholecystectomy (laparoscopic)	$6,368	$19,530	307%
Colonoscopy (screening)	$1,296	$4,052	313%
Ear Tube Placement (Tympanostomy)	$1,737	$12,765	735%
Hysteroscopy (with biopsy)	$3,705	$9,316	251%
Knee Arthroscopy	$2,796	$23,462	839%
Shoulder MRI (no contrast)	$450	$4,999	1111%
Sleep Study	$899	$4,341	483%
		Average Variance	**837%**

EQUIVALENT VARIANCE IN A GALLON OF GAS	$2.20	$18.41	837%

What gas would cost per gallon with the same price variance

Shop for Health Care Services

Select Service: 70551 - MRI scan of brain

Select Your ZIP Code: 81504

Sort List By: Closest Distance

Facility Name	Distance (Miles)	Price Estimate		Quality
		Average Price	Price Range	Patient Experience
SCL Health St Marys Medical Center	4.1	$2,150	$1,950–$2,390	★★★★☆
Community Hospital Medical Imaging	7.1	$1,970	$1,360–$2,230	★★★☆☆
Montrose Memorial Hospital	53.3	$1,560	$1,320–$1,560	★★★★☆
Valley View Hospital	68.6	$3,350	$2,850–$3,390	★★★★☆
Aspen Valley Hospital	89.3	$2,880	$2,880–$2,950	★★★★★
Gunnison Valley Health	110.0	$1,240	$1,210–$1,270	★★★★★
UCHealth Yampa Valley Medical Center	130.1	$470	$170–$850	★★★★★
Middle Park Medical Center	130.2	$1,910	$460–$2,090	*
Heart of the Rockies Regional Medical Center	137.1	$1,870	$1,470–$1,940	★★★★☆
Centura Health St Thomas More Hospital	180.7	$1,840	$200–$2,060	★★★☆☆
Boulder Community Hospital	182.6	$620	$600–$620	*
Centura Health St Anthony	182.8	$530	$480–$560	★★★☆☆

Lowest to Highest Prices

Statewide Variances….

CAT Scans

Abd. & Pelvis	2,855%
Head & Brain	1,528%

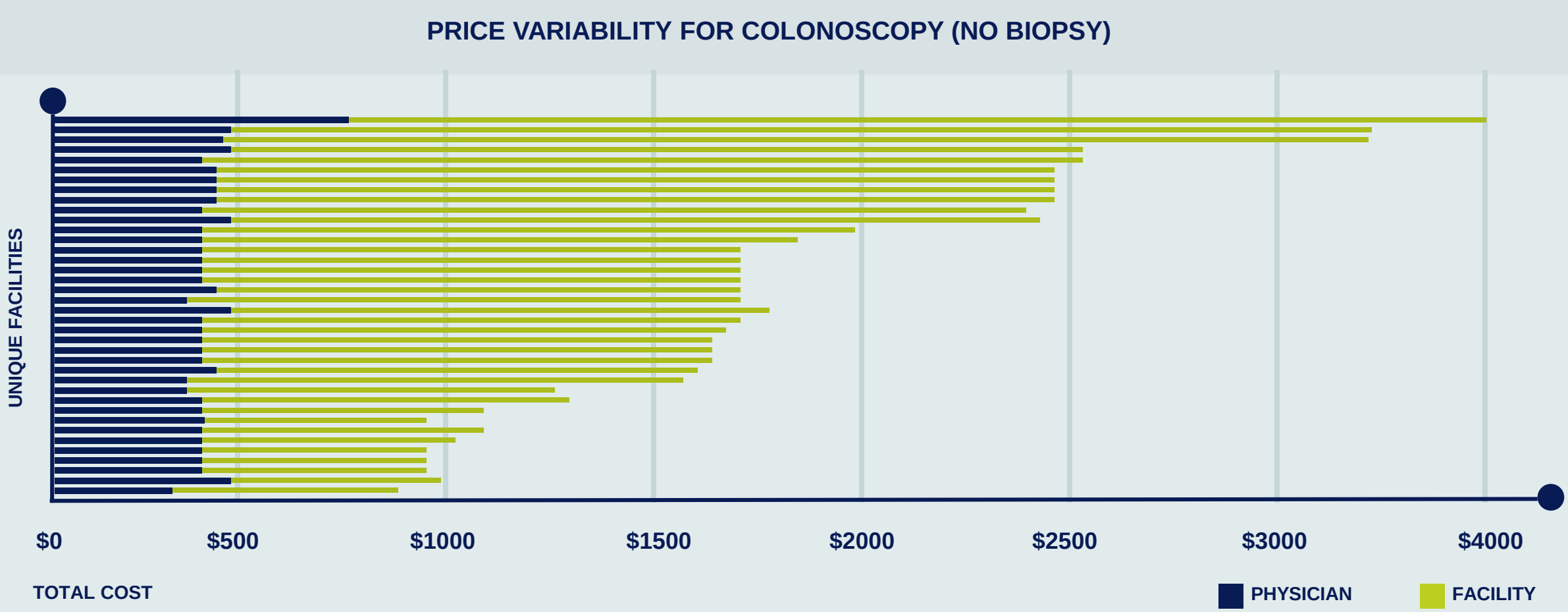
MRI

Brain	712%
Joint	14,200%

Ultrasound

Breast (single)	980%
Abdomen	1,180%

It’s not the ***physician***, it’s the ***facility***…



Healthcare Bluebook™

Baumgarten's 2017 Market Review - Colorado

- **For the 10th straight year, Denver-area health systems improved net incomes.**
  - Overall hospital income: **15.2%** of patient revenues.
  - Swedish Medical Center, Englewood led with a notable profit margin of ***44.1%***
  - Sky Ridge Medical Center, Lone Tree, had the second highest profit margin at ***40.8%***
  - Rose Medical Center of Denver realized **34.6**%net income
  - Presbyterian/St. Luke's Medical Center of Denver - **33.8%**
  - University of Colorado came in at **15.2%**
- **Despite inpatient occupancy rates falling below 65% in 2016…**
  - Five new hospitals.
  - Five large replacement hospitals.
  - Free-standing EDs (where 3 of 4 visits are non-emergent).

Over the last two-decades, the market has created a…

Negative Feedback Loop for Hospitals

Increases in FFS hospital payments above costs and the CPI

Increases in spending:

- Practice Acquisitions
- Additional services
- Mergers & new facilities
- Administrative salaries & other overhead

Demand for increased payment to cover new costs

WEB FIRST

By Jeffrey Stensland, Zachary R. Gaumer, and Mark E. Miller

Private-Payer Profits Can Induce Negative Medicare Margins

ABSTRACT A common assumption is that hospitals have little control over their costs and must charge high rates to private health insurers when Medicare rates are lower than hospital costs. We present evidence that contradicts that common assumption. Hospitals with strong market power and higher private-payer and other revenues appear to have less pressure to constrain their costs. Thus, these hospitals have higher costs per unit of service, which can lead to losses on Medicare patients. Hospitals under more financial pressure—with less market share and less ability to charge higher private rates—often constrain costs and can generate profits on Medicare patients.

Jeffrey Stensland (jstensland@medpac.gov) is a principal health policy analyst at the Medicare Payment Advisory Commission (MedPAC) in Washington, D.C.

Zachary R. Gaumer is a senior analyst at MedPAC.

Mark E. Miller is the executive director of MedPAC.

Laws of Improvement

Don Berwick, MD

Founder IHI, circa 2005

"Every system is perfectly designed to realize exactly the results that it is getting."

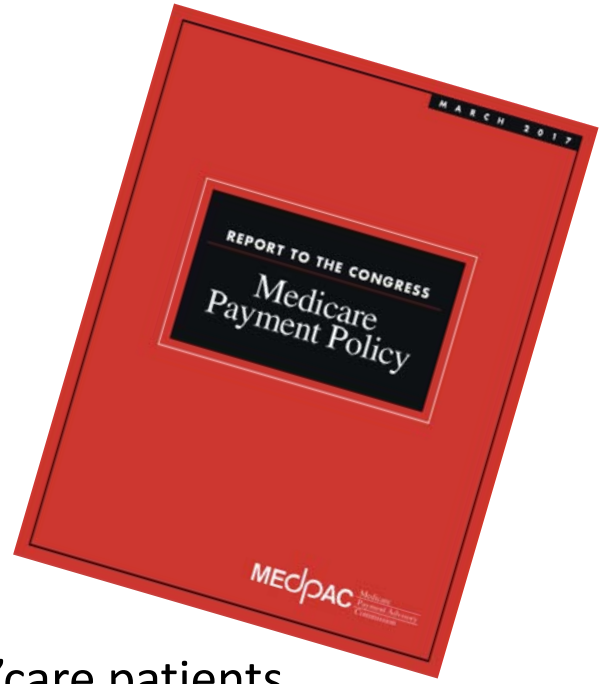
Niccolo Machiavelli

Author, The Prince, 1534

"It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than a new system. For the initiator has the enmity of all who would profit by the preservation of the old institution and merely lukewarm defenders in those who gain by the new ones. "

Why Medicare Payment Provides

A Reasonable Pricing Benchmark



- **MedPAC** (Medicare Payment Advisory Committee) advises Congress on ***payment adequacy*** using multiple measures and considering multiple variables.
- **March 2018 report** concludes that for 2016:
  - Payment rates were 8% higher than variable costs associated with M'care patients.
  - ***Overall margins were zero for "efficient" hospitals.***
  - Hospitals' all-payer operating margins ***near record high*** of 2015, primarily ***because of increased charges to private payers.***
- **Implication**: Medicare payment provides a transparent, tangible, empirically-based ***point of reference*** at which an "efficient" hospital with adequate volumes can break-even.

Statewide Results: Commercial Market

Percent of Medicare Fee Schedule Comparison/Trend

Service Type	2012 Avg % Medicare*	2016 Avg % Medicare*	% Point Increase 2012-2016
Inpatient Services (Top 12 By Volume/Price)	**250%** (Range 210%-300%**)	**290%** (Range 260%-330%**)	↑ 40
Outpatient Services (Top 10 By Volume/Price)	**440%** (Range 210%-1,160%**)	**520%** (Range 250%-1,150%**)	↑ 80

* Average % Medicare reflects an average of the individual service category averages analyzed for IP and OP.
** Range reflects lowest average % Medicare rate and highest average % Medicare rate across the individual services analyzed.

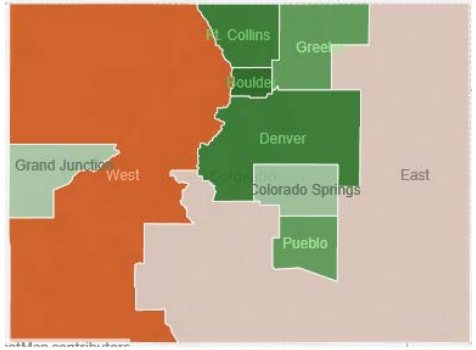
In 2016, Commercial Payers paid 290% - 520% Medicare rates (IP/OP), and OP rates have increased nearly 80% points

Regional Inpatient Results:

Price Comparison, High to Low as % Medicare, 2016

Division of Insurance Region	Median Inpatient Price as % of Medicare	Inpatient Current Spend (Top 12 by Volume/Price)
West	386%	$26.7 Million
East	374%	$4.9 Million
Ft. Collins	354%	$17.8 Million
Grand Junction	347%	$11.6 Million
Greeley	326%	$5.6 Million
Denver	280%	$156.2 Million
Pueblo	278%	$5.8 Million
CO Springs	251%	$21.0 Million
Boulder	242%	$34.7 Million

1.6x Difference



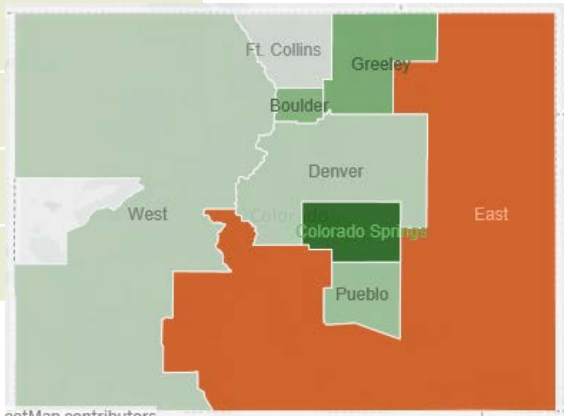
Note: Map included for demonstration of CO Division of Insurance (DOI) Regions only and do not reflect color ranking order per table above.

Regional Outpatient Results:

Price Comparison, High to Low as % Medicare, 2016

Division of Insurance Region	Median Outpatient Price as % of Medicare	Inpatient Current Spend (Top 12 by Volume/Price)
East	694%	$2.4 Million
West	648%	$6.4 Million
Pueblo	564%	$2.0 Million
Denver	563%	$28.6 Million
Greeley	534%	$1.8 Million
Boulder	495%	$6.8 Million
Ft. Collins	453%	$5.3 Million
Grand Junction	410%	$1.6 Million
Colorado Springs	324%	$4.0 Million

2.1x Difference



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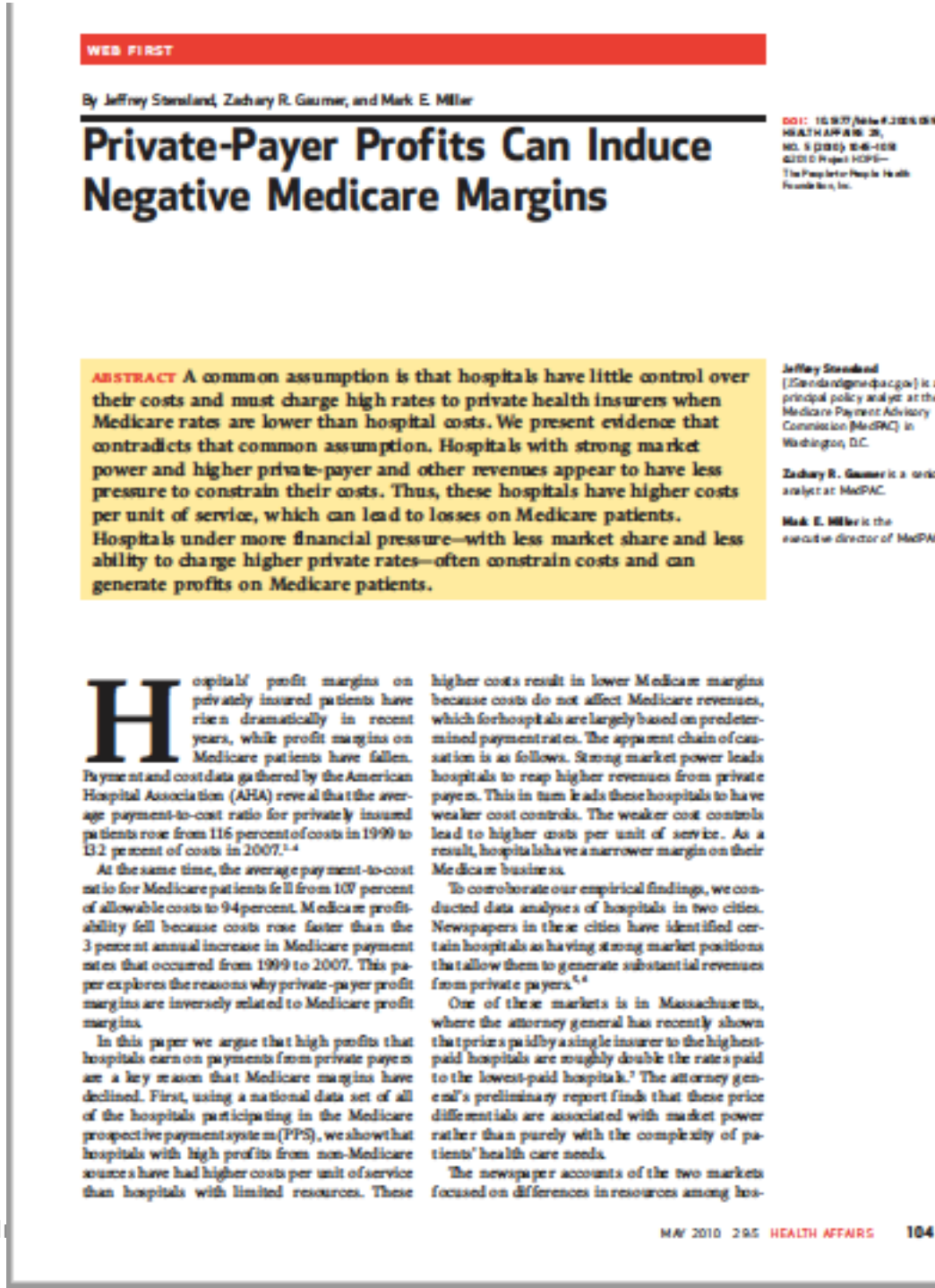
Why are most hospitals…
Losing Money on Medicare?”

“Strong market power leads hospitals to reap higher revenues from private payers. This in turn leads these hospitals to have weaker cost controls. The ***weaker cost controls lead to higher costs per unit of service***. As a result, hospitals have a narrower margin on their Medicare business.”

Jeffrey Stensland, PhD
Sr. Principal Policy Analyst
Medicare Payment Advisory Committee



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Hospitals' profit margins on privately insured patients have risen dramatically in recent years, while profit margins on Medicare patients have fallen. Payment and cost data gathered by the American Hospital Association (AHA) reveal that the average payment-to-cost ratio for privately insured patients rose from 116 percent of costs in 1999 to 132 percent of costs in 2007.[1-4]

At the same time, the average payment-to-cost ratio for Medicare patients fell from 107 percent of allowable costs to 94 percent. Medicare profitability fell because costs rose faster than the 3 percent annual increase in Medicare payment rates that occurred from 1999 to 2007. This paper explores the reasons why private-payer profit margins are inversely related to Medicare profit margins.

In this paper we argue that high profits that hospitals earn on payments from private payers are a key reason that Medicare margins have declined. First, using a national data set of all of the hospitals participating in the Medicare prospective payment system (PPS), we show that hospitals with high profits from non-Medicare sources have had higher costs per unit of service than hospitals with limited resources. These higher costs result in lower Medicare margins because costs do not affect Medicare revenues, which for hospitals are largely based on predetermined payment rates. The apparent chain of causation is as follows. Strong market power leads hospitals to reap higher revenues from private payers. This in turn leads these hospitals to have weaker cost controls. The weaker cost controls lead to higher costs per unit of service. As a result, hospitals have a narrower margin on their Medicare business.

To corroborate our empirical findings, we conducted data analyses of hospitals in two cities. Newspapers in these cities have identified certain hospitals as having strong market positions that allow them to generate substantial revenues from private payers.[5,6]

One of these markets is in Massachusetts, where the attorney general has recently shown that prices paid by a single insurer to the highest-paid hospitals are roughly double the rates paid to the lowest-paid hospitals.[7] The attorney general's preliminary report finds that these price differentials are associated with market power rather than purely with the complexity of patients' health care needs.

The newspaper accounts of the two markets focused on differences in resources among hos-

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Three Observations/Suggestions

1. **Let's *fix problems*, not blame**.
   - Problem not: "*Health care's broken*."
   - Is: *The market's* ***dysfunctional*****.** (We all contribute to the dysfunction.)
2. **"Supply and demand" dynamics drive markets**. Employer must address :
   - "Demand" **individually.**
   - "Supply" **collectively** (with each other) **and collaboratively** (with providers).
3. To reform provider behavior**, *employers must reform purchasing and benefits.***
   - Colorado employers pay >1/2 of healthcare costs, yet that purchasing power hasn't meant greater influence - **largely because purchasing is fragmented**. (Think "RFP.")
   - **Direct contracting** and **multi-year goal setting** (five areas) between buyers and sellers is more likely to result in a more effective and efficient market.
   - **Value-based insurance designs (V-BID)** recognize variant value of health care services.

Since Unit Use x Unit Price = Total Cost…

Challenges & Five Corresponding Goals

Unit Utilization: Improve under-, over-, and mis-use.

1. Reduce the risk, incidence, and burden of chronic disease (through increased prevention and use/payment for primary care).
2. Identify and reduce use of most over-utilized procedures.
3. Measure and encourage use of highest quality hospital by ***service line***.

Unit Price/Payment Mechanism: Reduce price and shift risk for effectiveness and efficiency to providers (and align incentives).

4. Negotiate hospital prices as a percent of Medicare and move to bundled payments so *net income reflects high performance* (not high price).
5. Group purchase pharmacy through a transparent PBM.

Because as markets evolve and change, so must our purchasing…

What CBGH is Pursuing

- **Media Coverage**: Healthcare as a family, corporate, and community Issue
- **Group Purchasing**
  - School Districts
  - Summit County
  - Pharmacy
- **User Groups** - Two Health Plans
- **Regional Employer-Physician Collaboratives**
- **Denver Metro Chamber Collaborative** – Feasibility Plan
- **Analysis of State Savings** Using RBP and a **Multi-State Workgroup**
- **Multi-state Price Benchmarking** of Hospital Pricing - Rand Corporation
- **Hospital Value Report** (January)
- **Consumer-Purchaser Collaborative**

Comments and Discussion