Brainstorming Next Steps to Intervene on Hospital Prices & Quality

National Hospital Price Transparency Conference

May 5, 2022

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

Our Panel

- Michael Thompson (Moderator), National Alliance of Healthcare Purchaser Coalitions
- Charles Cammack, Jr., Fort Wayne Community School Corporation
- Mary Delaney, Vital Incite
- Kate Fischer, Cummins Inc

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Hospital Price Transparency

April 5 – NASHP Hospital Reporting Tool

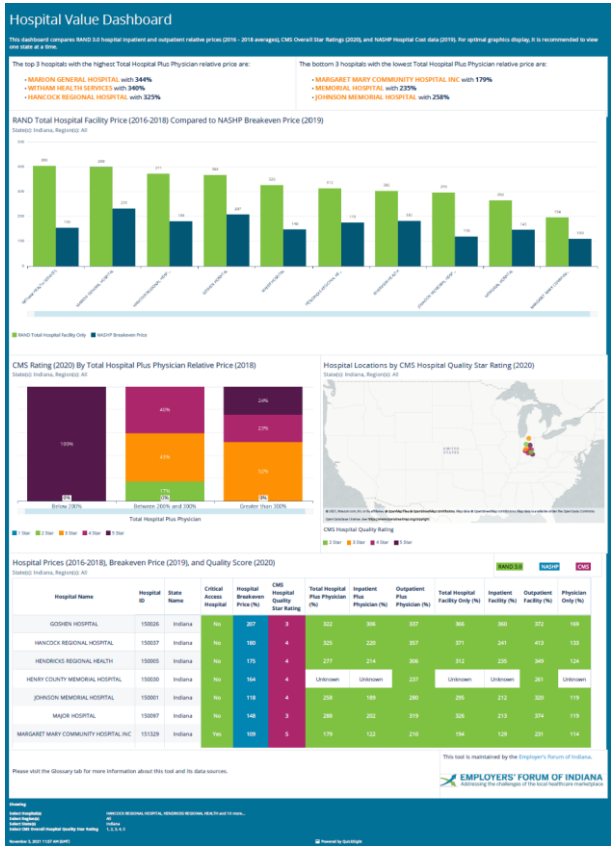
- 8+ Year trend
- Hospital Break Even By “Market”
- % Medicare Break Even
- Commercial Break Even

May 5 – Sage Transparency

- RAND 4.0 published April 2022
- NASHP Highlights
- Sample Turquoise Health Results
- CMS Star Ratings
- Sample Quantros Quality Ratings

July 1 – Plan Sponsor CAA Transparency Compliance

Employers Forum of Indiana
National Dashboard on Hospital Value



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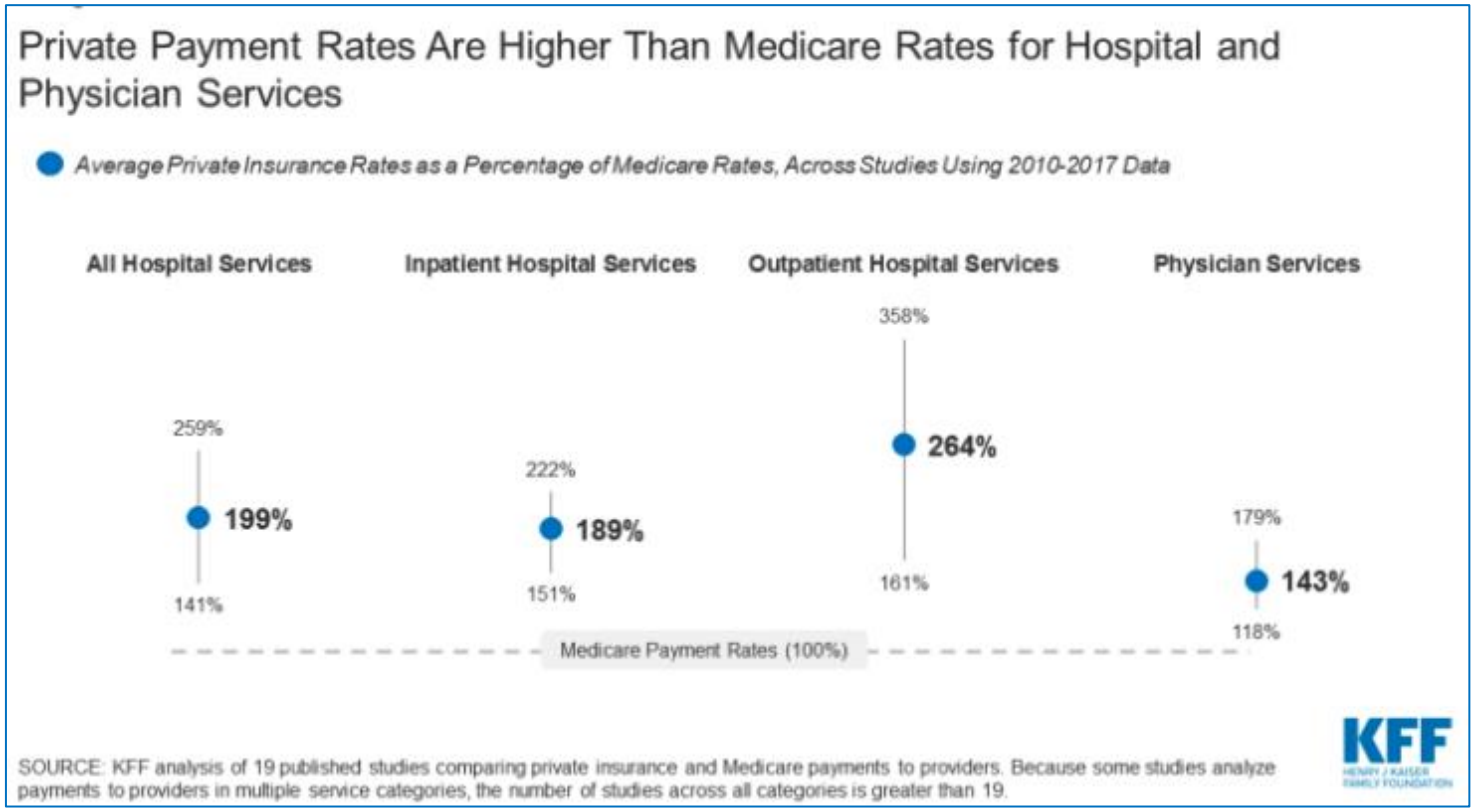
The Fiduciary Dilemma

- 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



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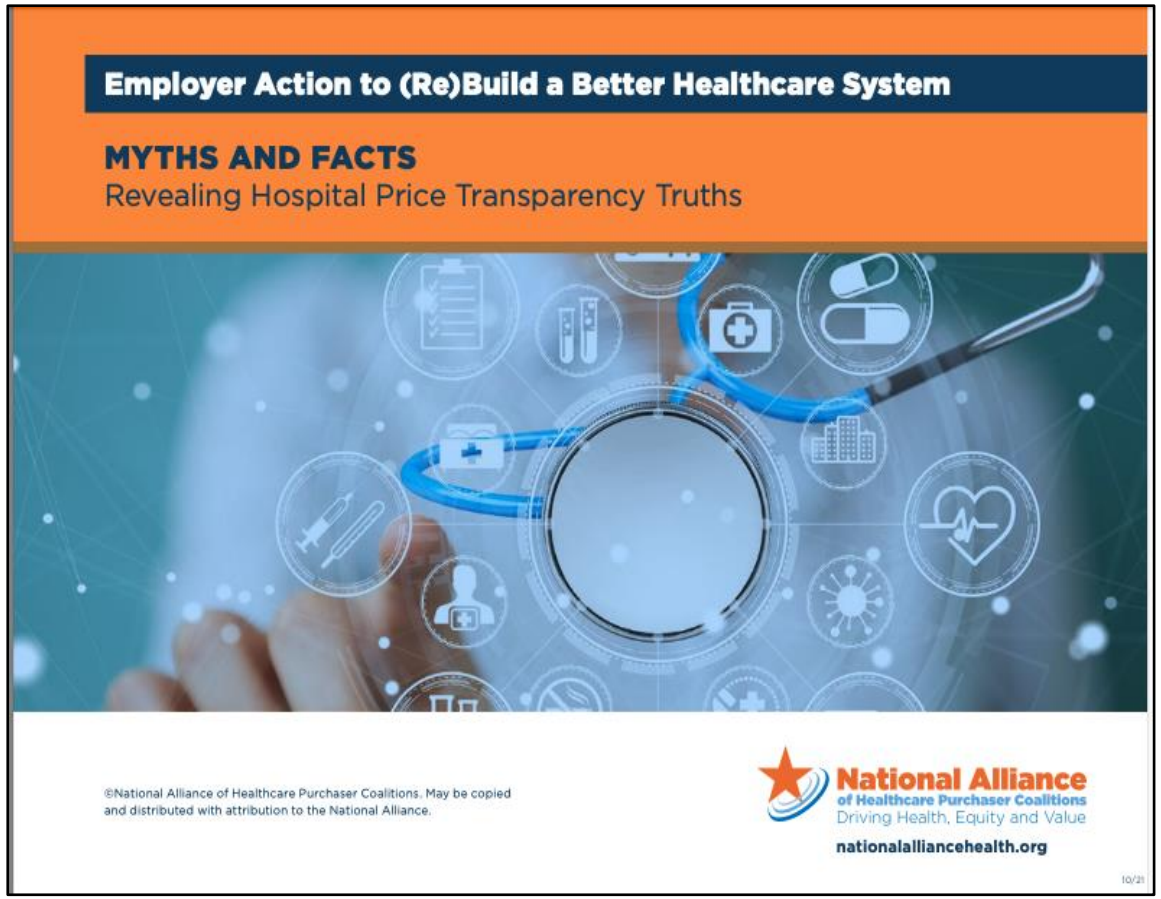
Common Myths about Hospital Pricing

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



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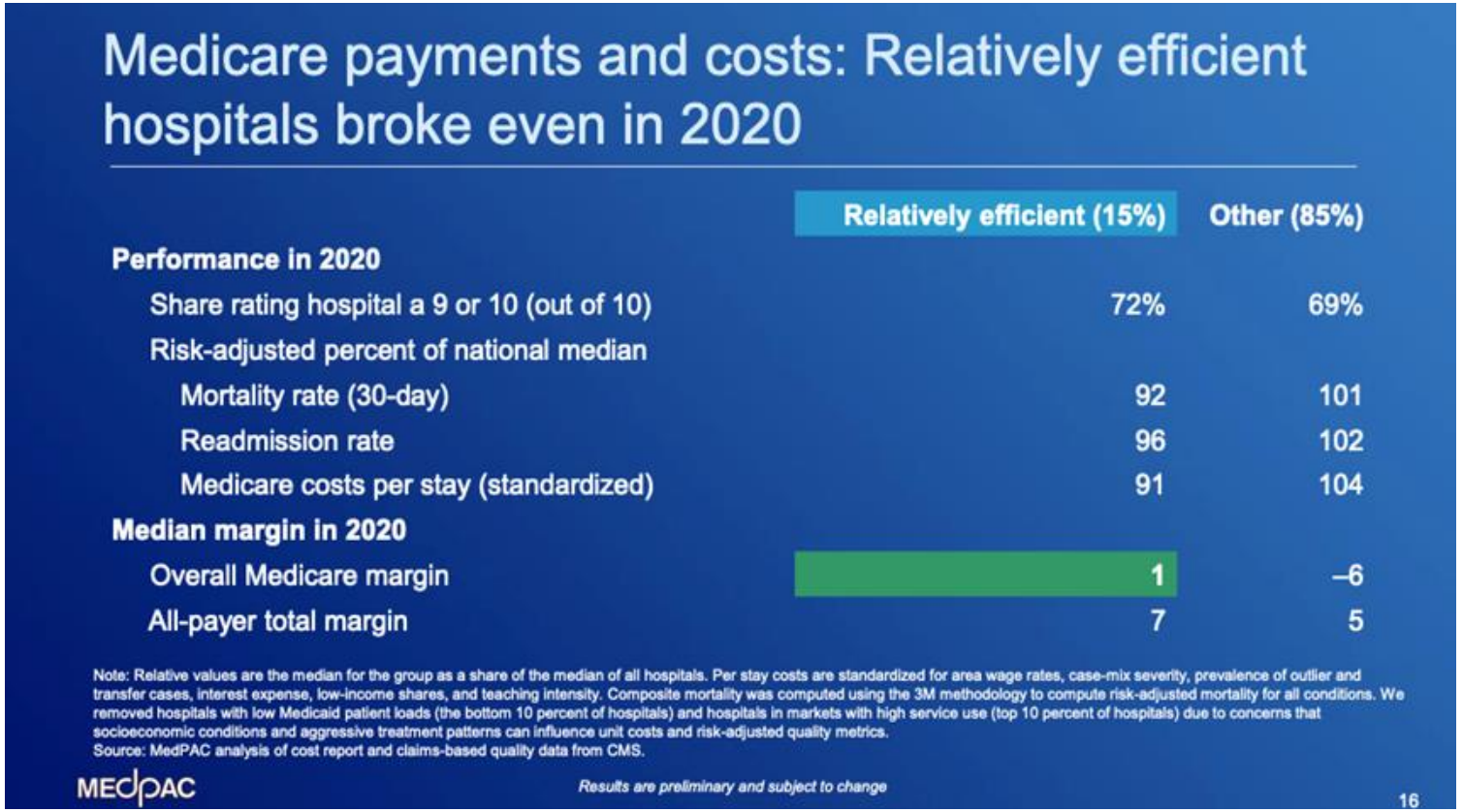
https://connect.nationalalliancehealth.org/viewdocument/myths-and-facts-revealing-hospital

Getting to “Fair Price”

- MedPAC suggests a well-run hospital can manage close to Medicare on average
- NASHP defines current break-even for a hospital as a percentage of Medicare (may reflect higher overhead spending)
- Other considerations:
  - Reasonable margins
  - Existing margins and market share of Medicaid and Medicare
  - Capital investments
  - Market dynamics (e.g., nursing salaries, personnel shortages)
  - Relative quality and safety metrics

Myth: The pandemic wiped out US hospital profitability

Fact: Relatively efficient hospitals broke even in 2020



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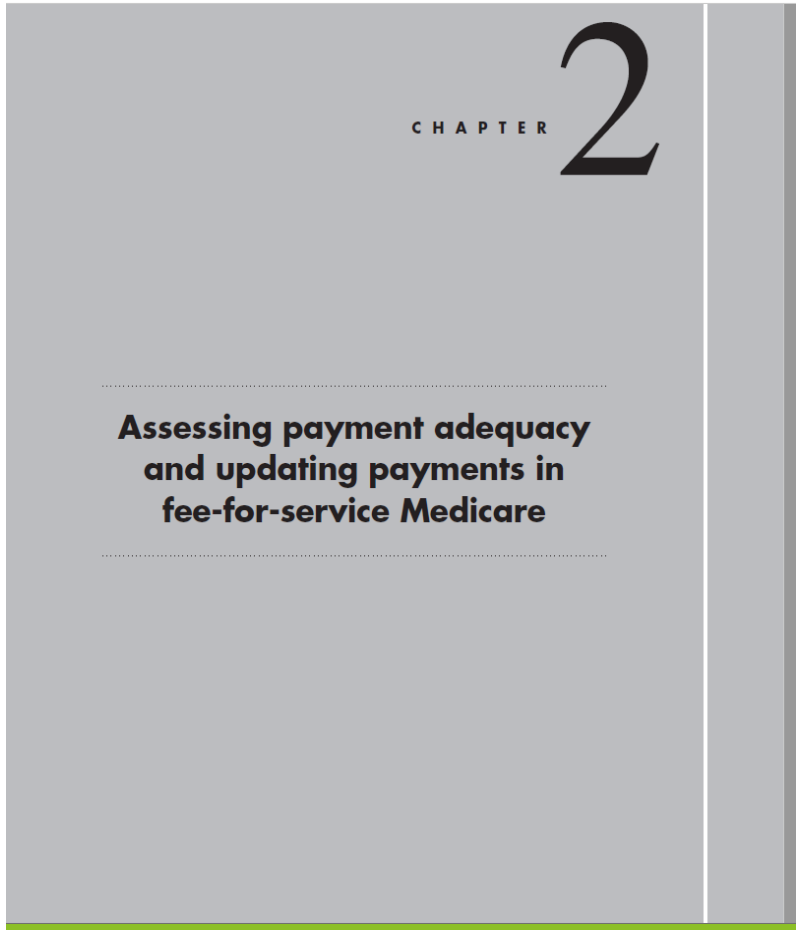
2019 MedPac Report (Excerpts)

Appropriateness of current costs

Costs vary in response to financial pressure

- Low margins on Medicare patients can result from a high-cost structure that has developed in reaction to high private-payer rates.
- Lack of pressure is more common in markets where a few providers dominate and have negotiating leverage over payers.
- If private payers do not exert pressure, providers' costs will increase and, all other things being equal, margins on Medicare patients will decrease.
- Providers under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure.

Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates.



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Coalition/Purchaser Toolkit – Coming Soon!

Employer Actions to Drive Fair Costs for Hospital Care

- From Knowing to Doing
  - CAA and fiduciary rights and responsibilities
  - Understanding Market Dynamics
  - Evaluating Current Prices
  - Choosing your Strategy
  - Organizing for Action
    - Group purchasing
    - Policy advocacy
- RAND 4.0 and NASHP Highlights
- Responding to Myths with Facts
- Additional Resources

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