Benchmarking Hospital Pricing

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Montana Office of Commissioner of Securities and Insurance
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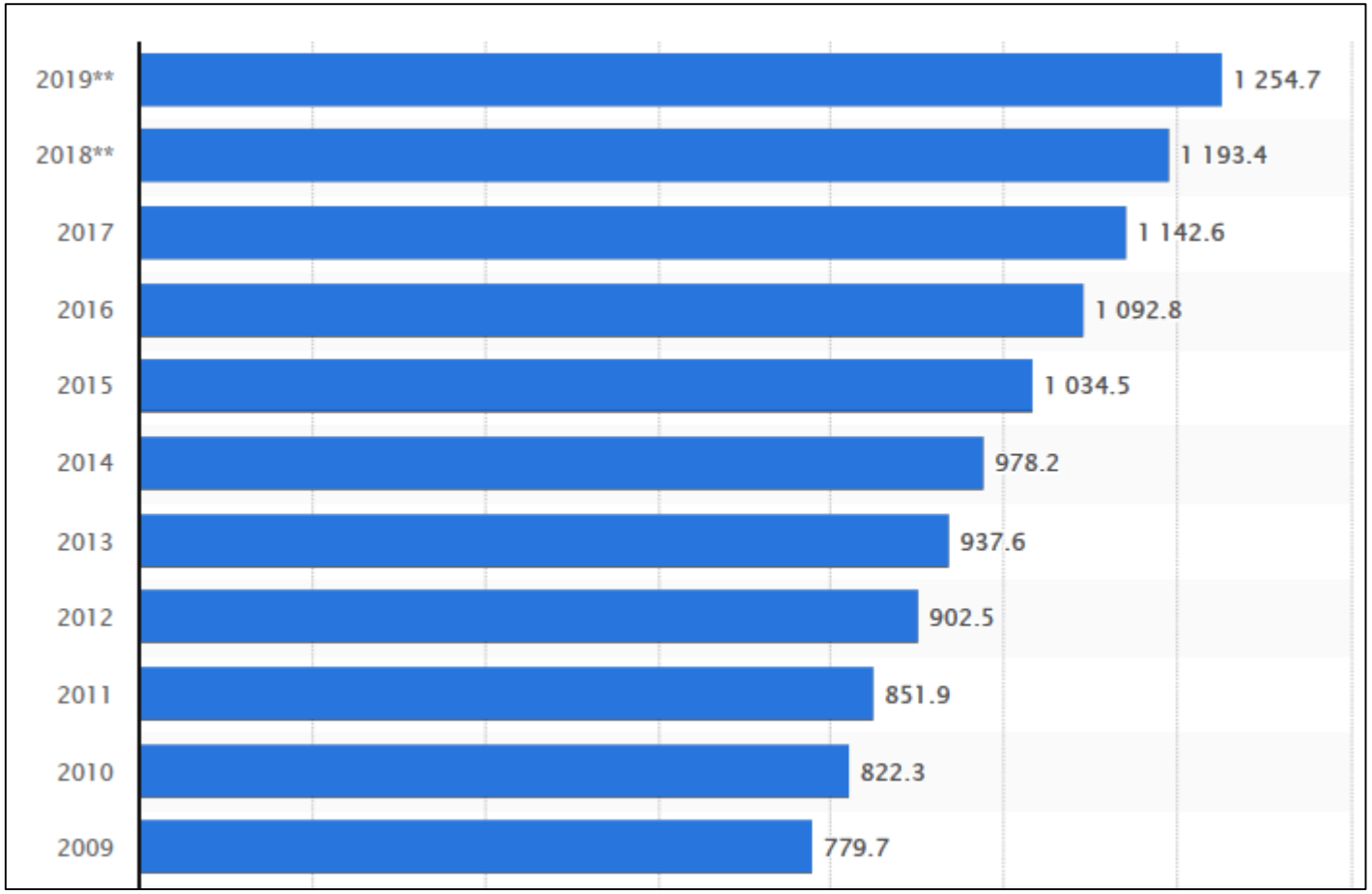
Commissioner of Securities & Insurance

US Hospital Reimbursements (in billion dollars)

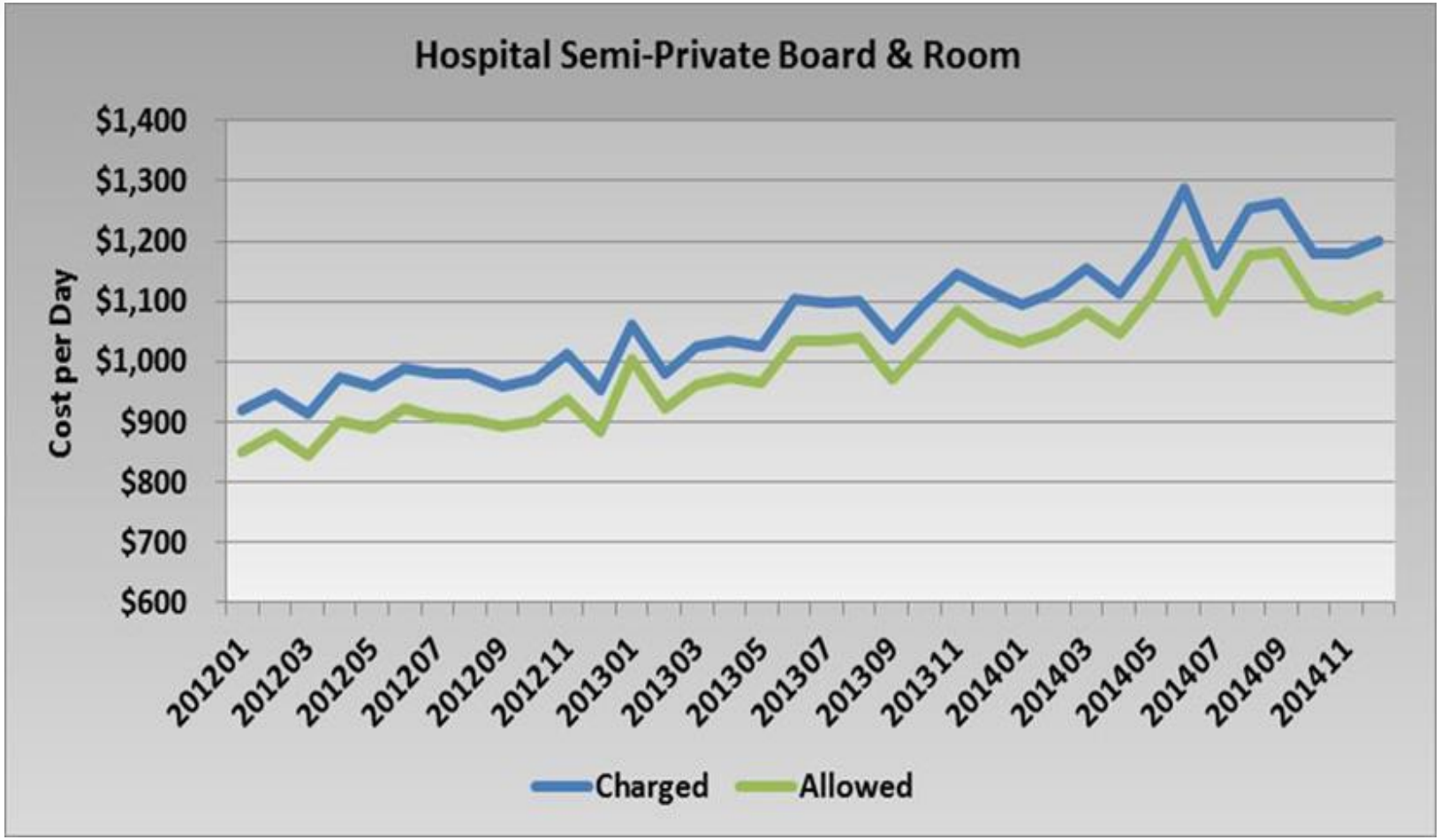


Source: Statistica

Hospital costs

- 30% of US healthcare spending
- More than $1.2 trillion annually
- Hospital System mergers/acquisitions result in higher prices
- US has highest hospital costs per day of any country
- Inpatient utilization has been steadily declining for 4 decades - fewer hospitals and hospital beds in US than there were in 1980s
- Outpatient utilization steadily increased for more than 3 decades (routine tests, x-rays, ER visits, outpatient procedures)
- Outpatient Revenue about half of total hospital revenue

How are hospitals paid?

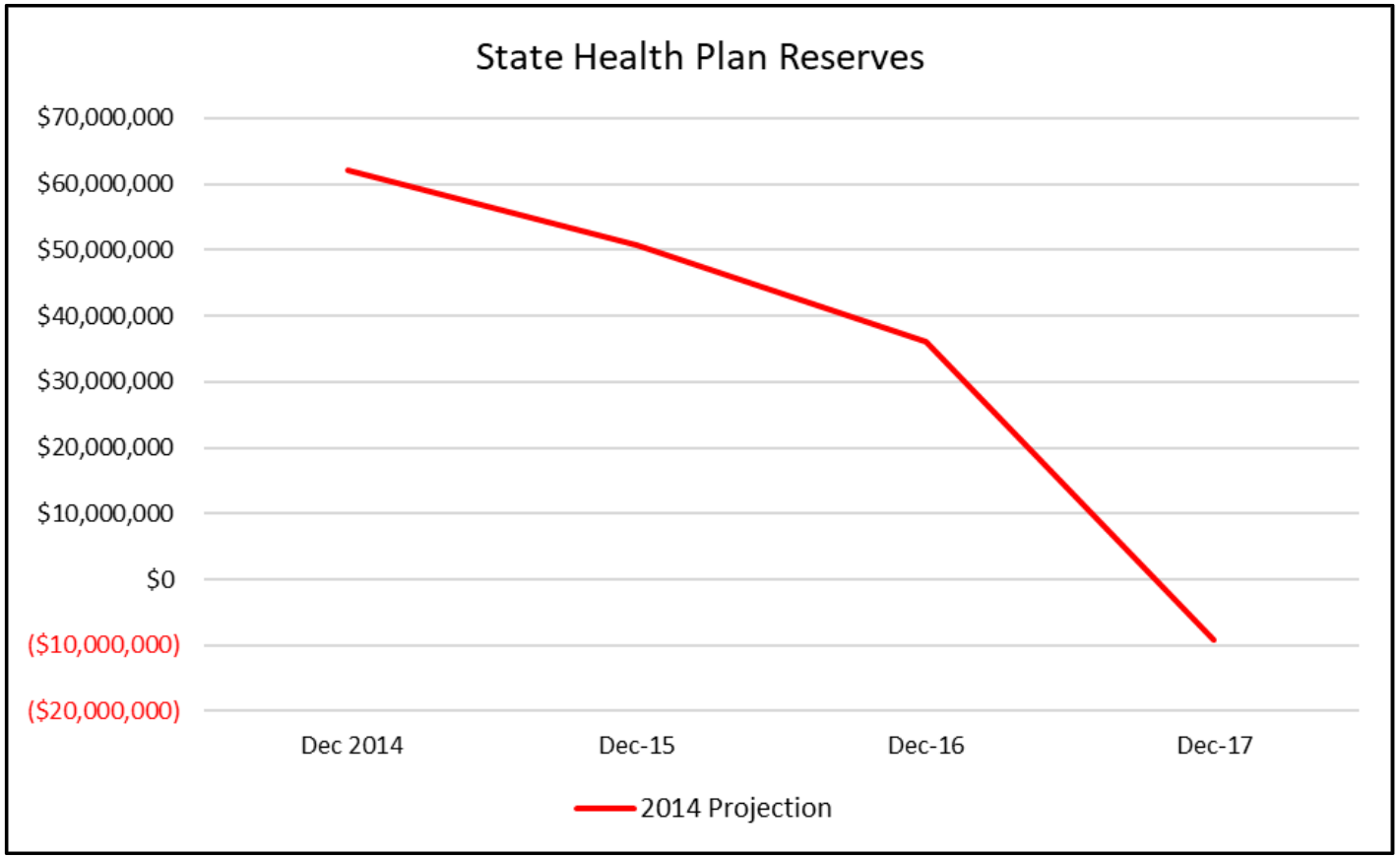


"Charge Master"

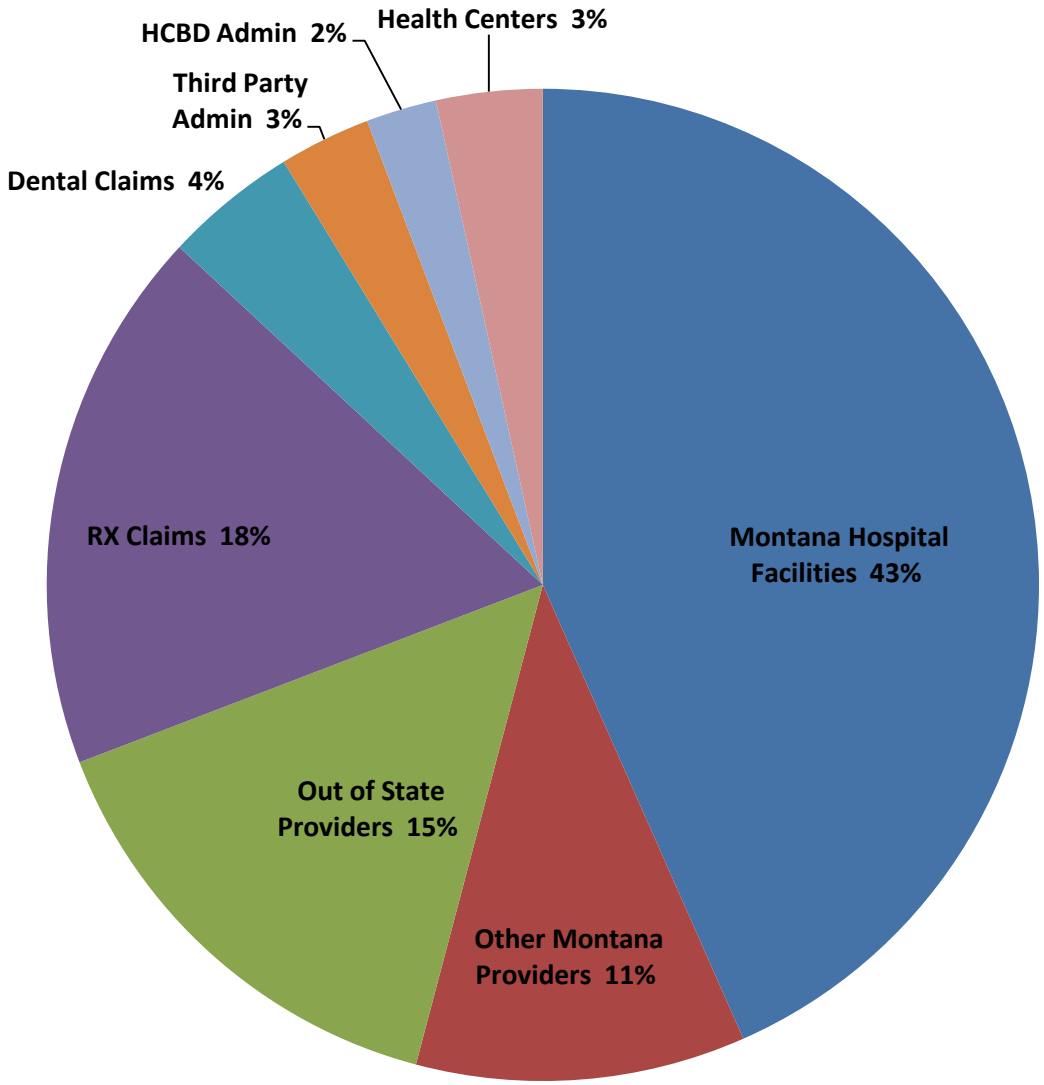
- Began in early 1950s with advent of indemnity insurance products
- Hospitals set Charge Master Rates; Insurance Companies negotiate discount
- Hospital Specific
- Hospitals control Charge Master as trade secret" – state laws and courts often accept this view
- Discounted payment (Allowed Amount) will follow the Charge Master trend
- Discounts aren't lowering the trend

Beginning of Montana's journey

- Montana State Employee Health Plan
- 12,700 Employee Lives; 2,000 Retirees
- 31,000 Total Lives
- Largest Self-Funded Plan in Montana
- Senate Bill 418 (2015)



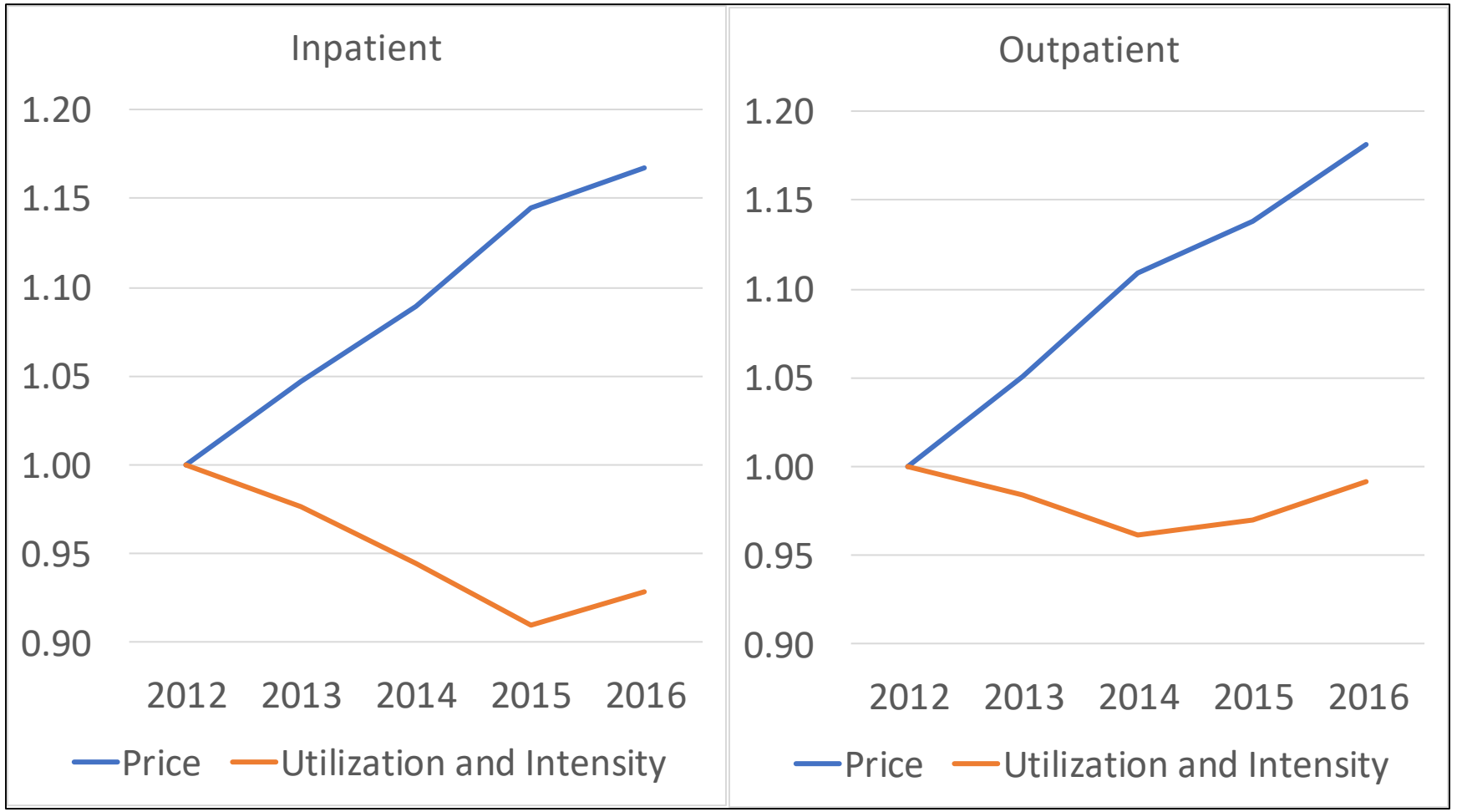
$200 Million Plan – Where are the costs?



How can we manage costs and provide a good benefit program?

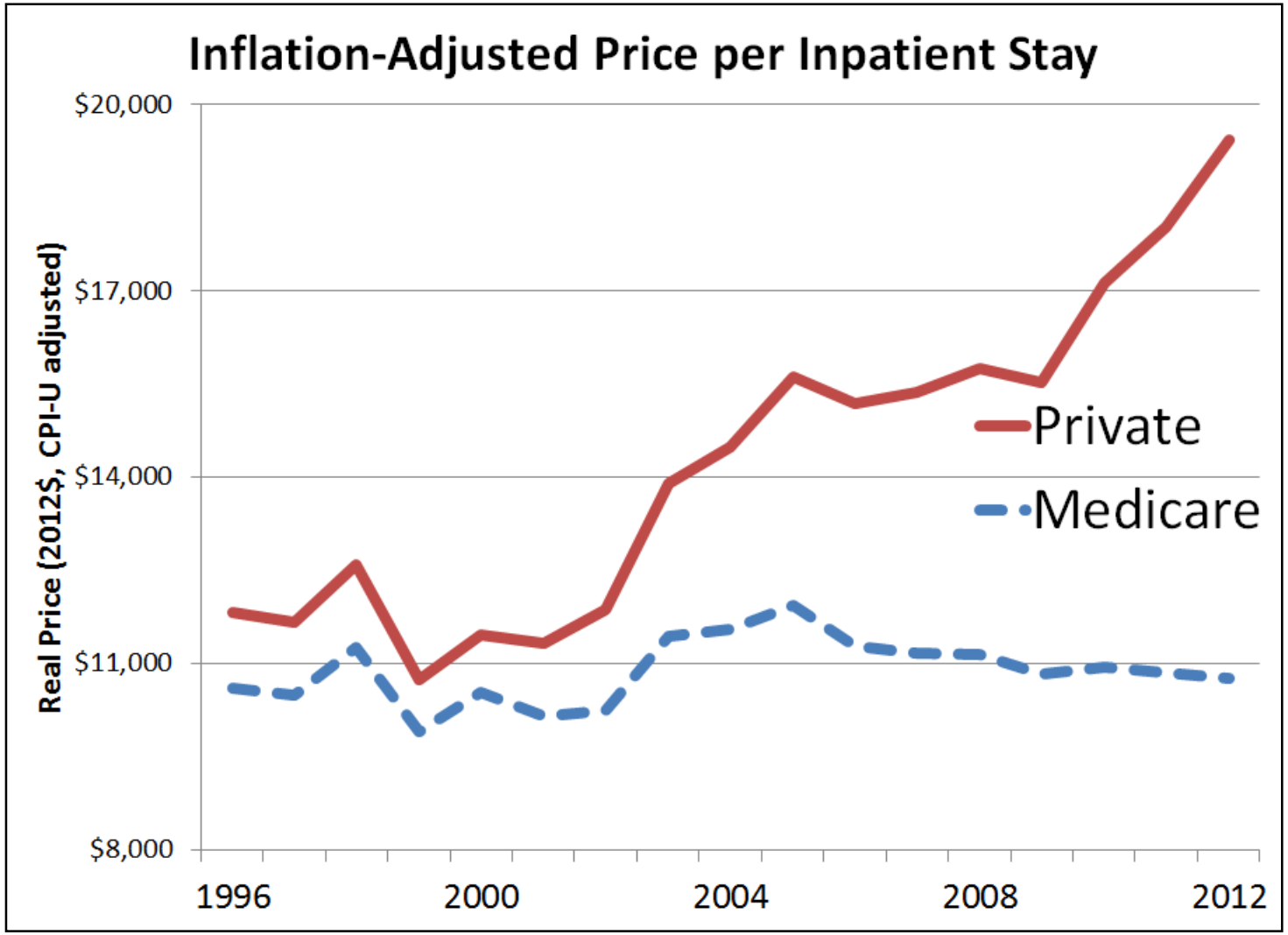
How can we “pull” money out of the system, rather than increase rates or decrease benefits?

Price is the Issue



Health Care Cost Institute. *2016 Health Care Cost and Utilization Report*.

Discounted Charges vs. Medicare



Source: Sel Source: Selden, T. M., Karaca, Z., Keenan, P., White, C., & Kronick, R. (2015). The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care. Health Affairs, 34(12), 2147-2150.

Develop Fair, Transparent Reimbursement

Benchmark Montana Hospital and Provider Reimbursements at Multiple of Medicare

- Selected Medicare as reference point:
  - Common reference to overcome variation in charge masters and differences in billing practices
  - Largest healthcare payer in the world
  - Prices and methods are empirically based and transparent
  - Medicare prices intended to be fair
  - Uses quality measures/value-based payment

- State of Montana Plan requirements:
  - Prefer No Balance Billing = Contracting
  - Prefer no steerage or narrow network
  - Needed quick financial results
  - Control over future reimbursement increases
  - State Procurement Regulations

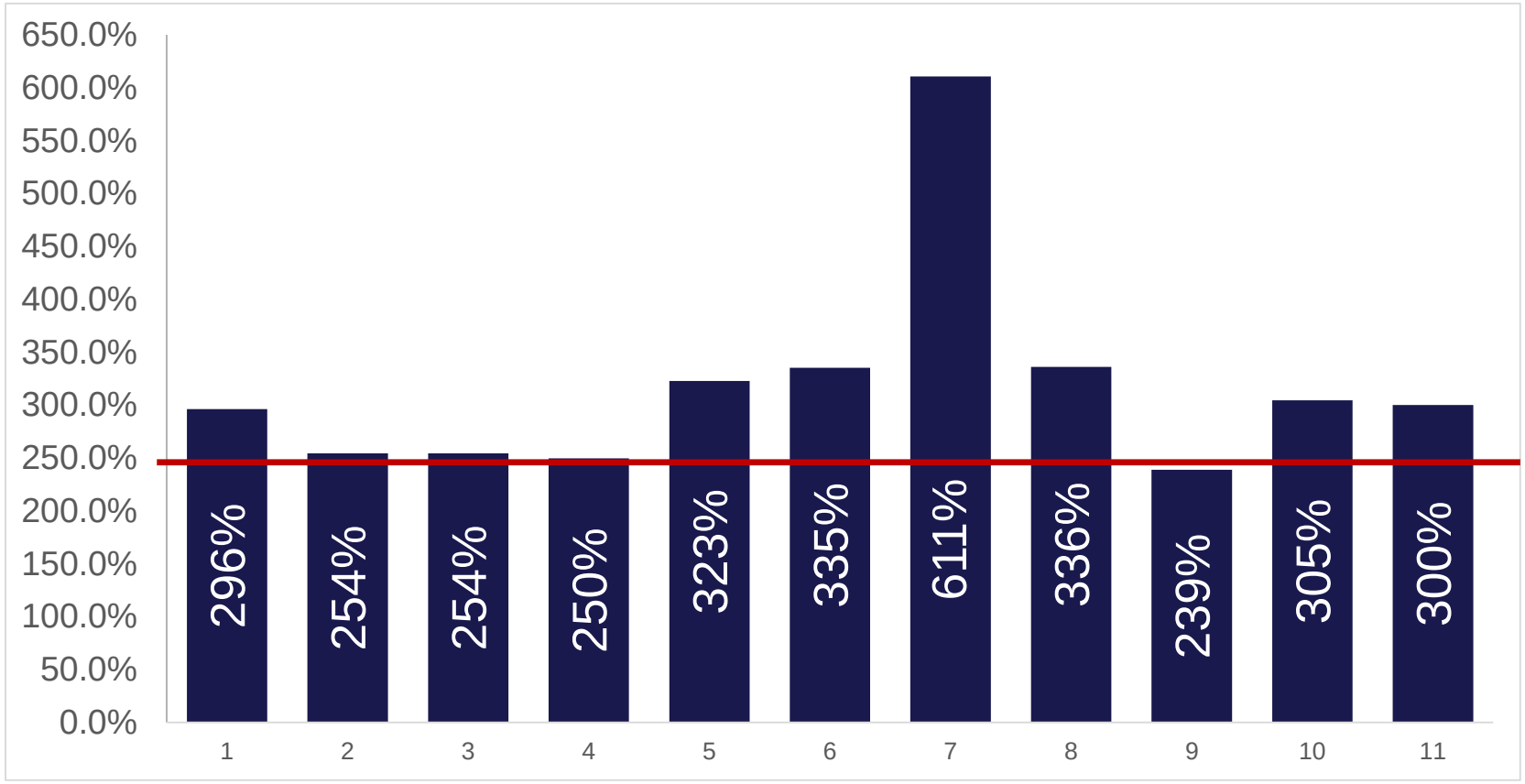
Implementing our Strategy

Partnered with Allegiance Benefit Plan Management

- *Ability to accomplish the change*
- *Data analysis and staff*
- *Provider Contracting*
- *Shared focus*

- Data Driven Initiative
- Medicare Repricer – Claims sample
- Direct Negotiations began in Summer 2015; RBP went live July 2016
- Was there opposition? **YES!**

Outpatient Cost Comparison



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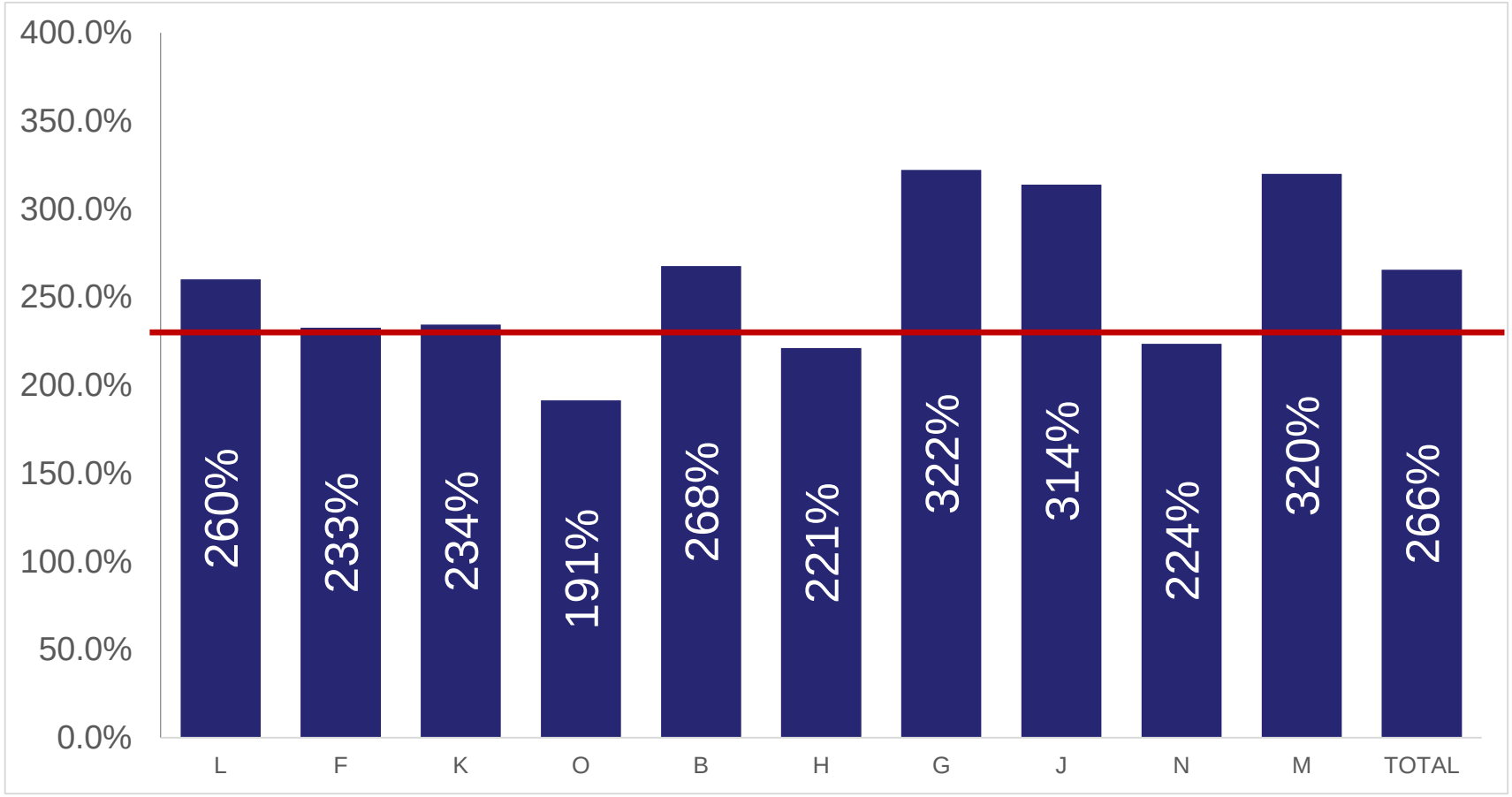
Inpatient Cost Comparison



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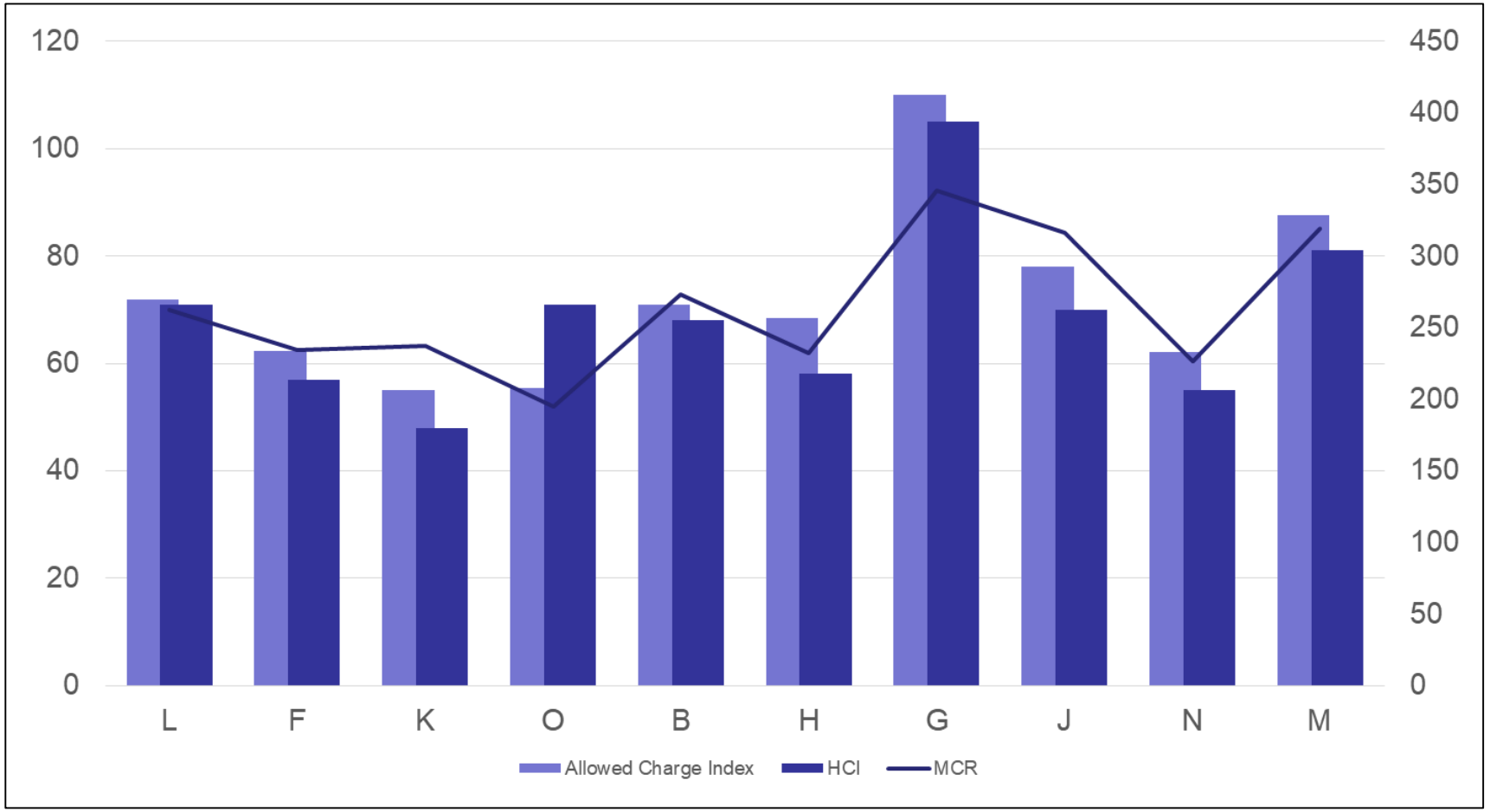
Data Verification



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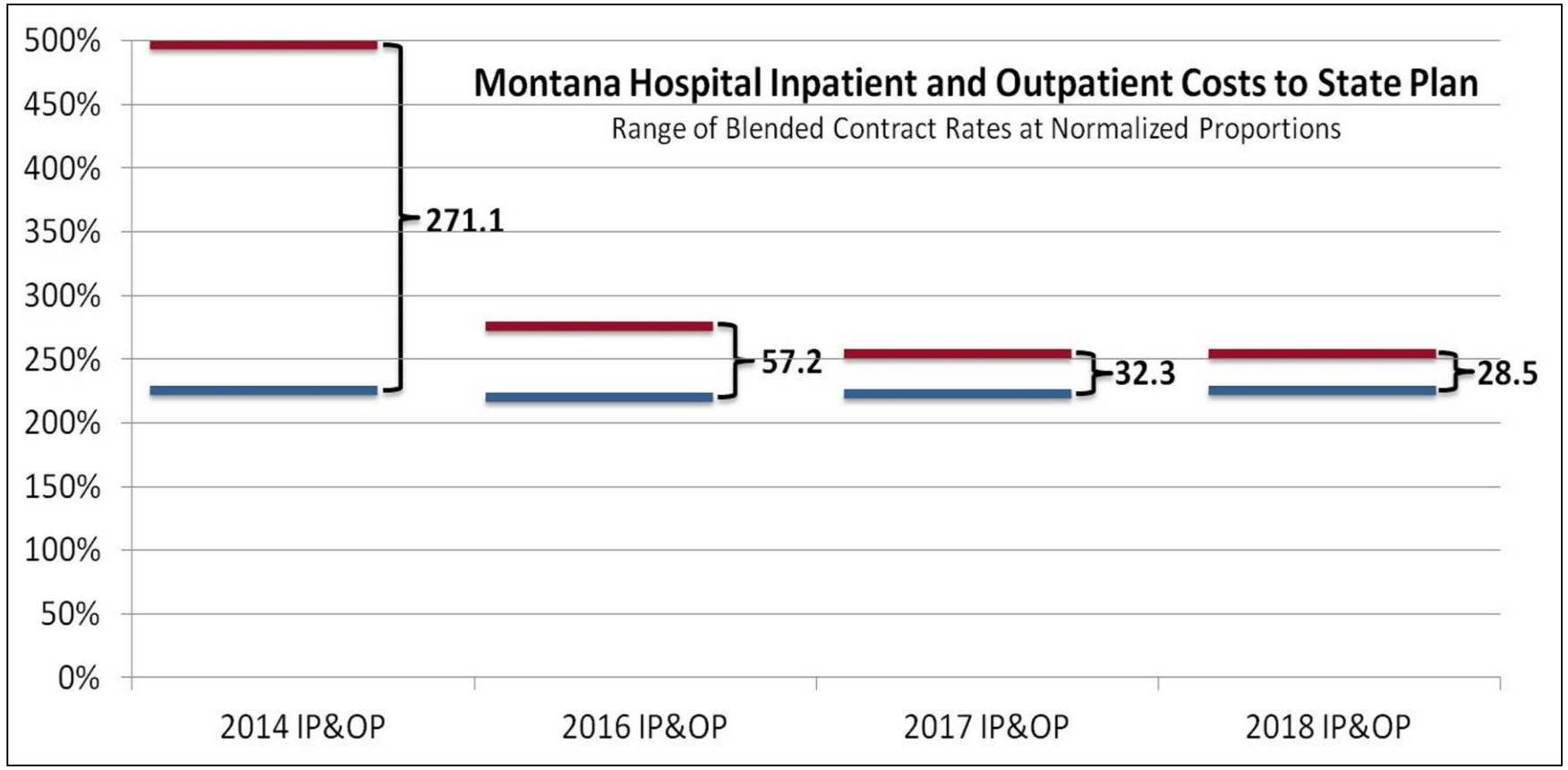
Our Strategy



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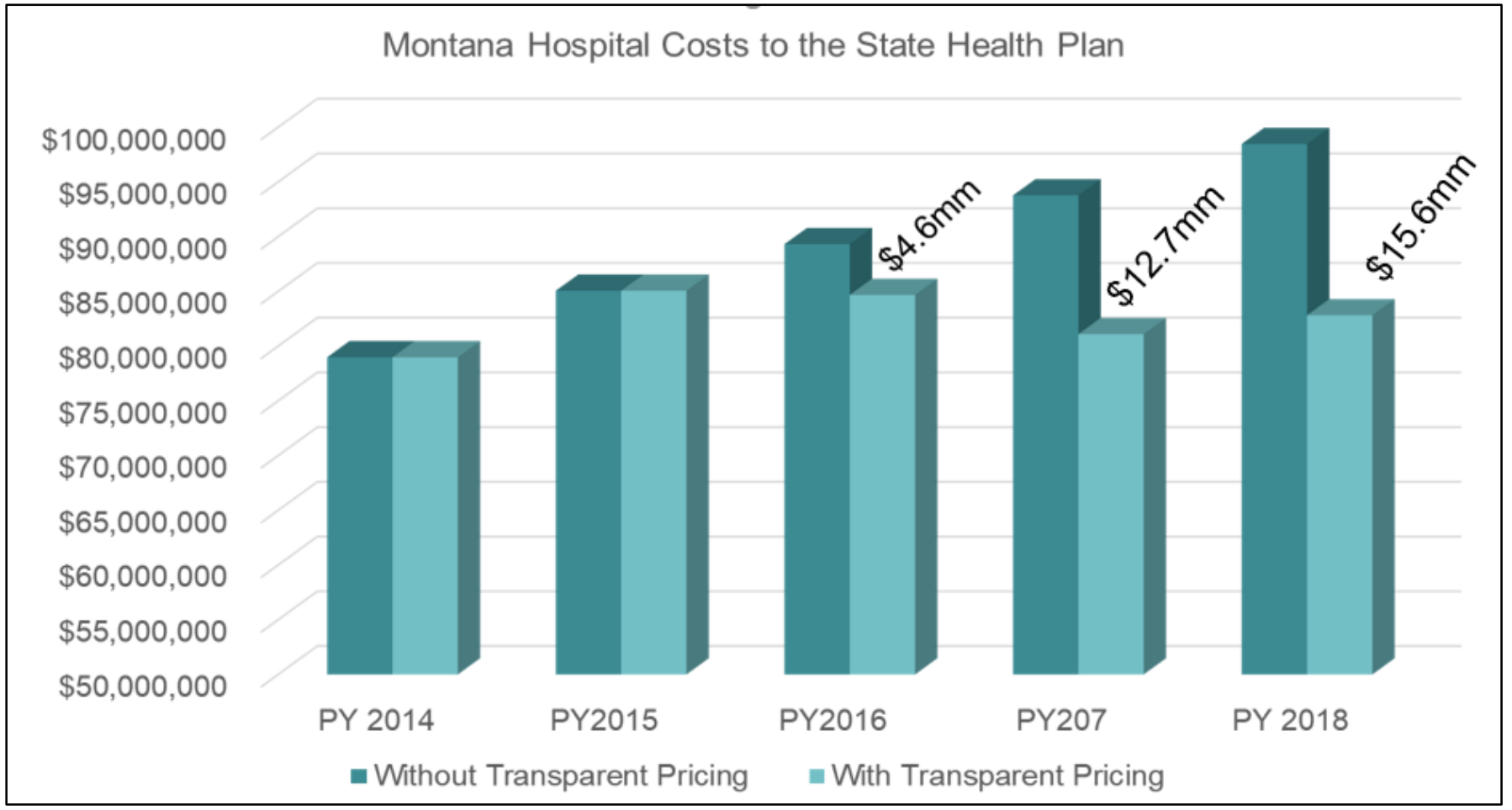
Control over future price trend



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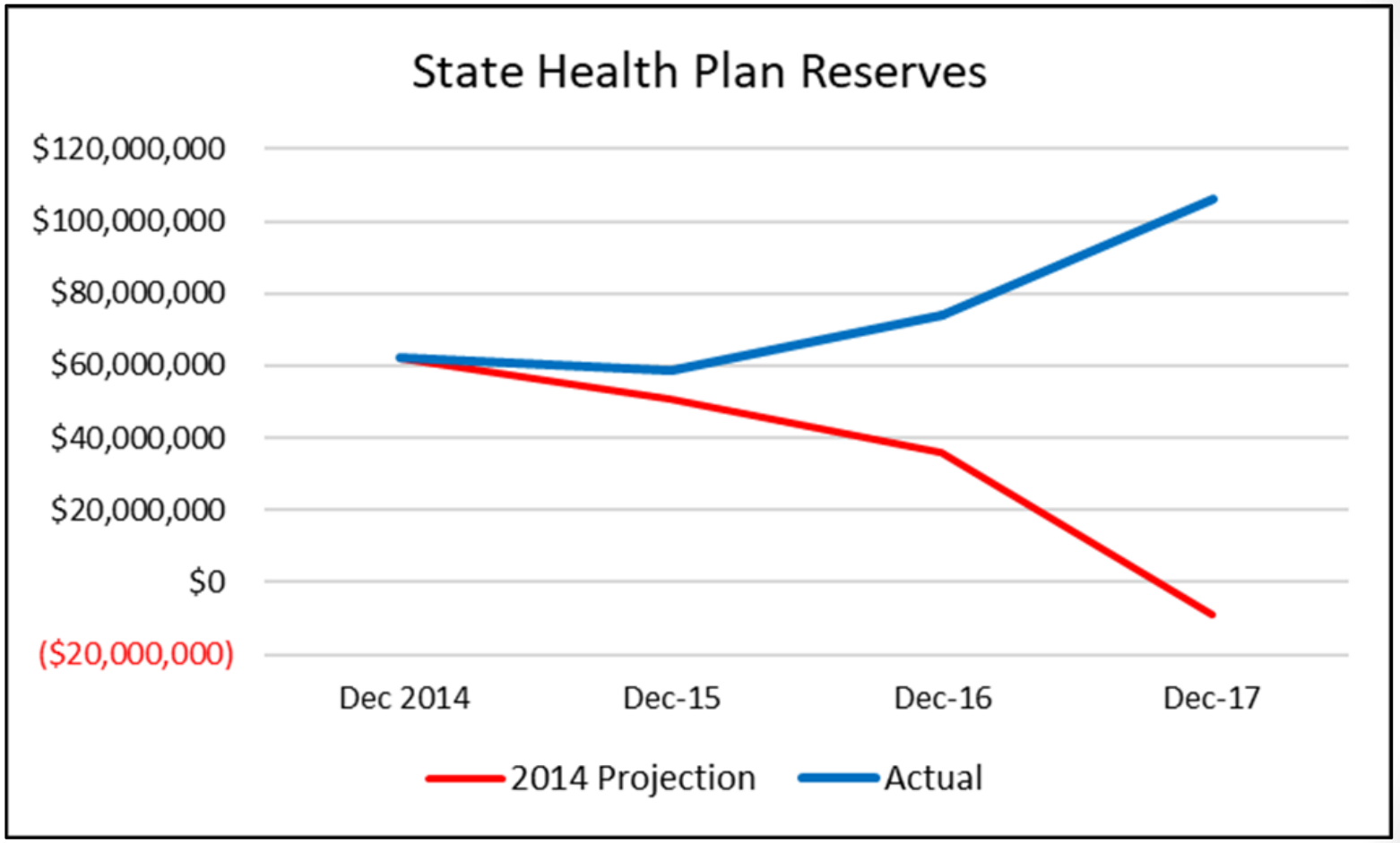
We found other efficiencies and savings

- Transparent, Pass-through PBM; Eliminated 1 Large Retail Chain
- EGWP Retiree RX Program
- MTM Program – A Montana Solution
- Eliminated Duplicate Programs/Renegotiated contracts
- Primary Care focus through On-Site Health Centers (Lowered capitated payment, added incentive bonus)
- Updated Benefit Plan
- Rolled out Health Care Blue Book
- Moved to cloud-based Enrollment/Administration System
- Implemented cloud-based Data Warehouse/Analytics

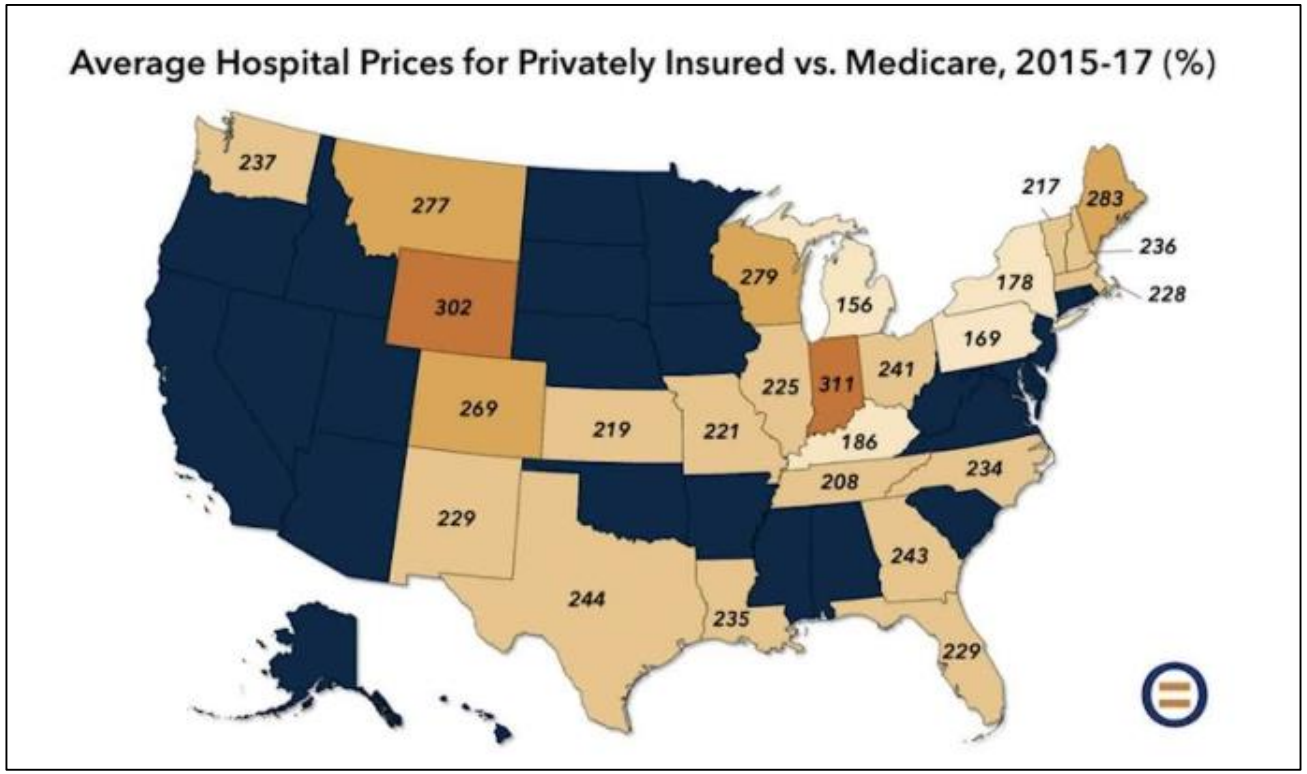
So what happened in 2017?

- Reserves reached $112 million
- What we didn't expect - Health Plan Reserves larger than MT General fund in 2017
- Legislative Special Session – SB 3 for ***$25 million*** employer premium holiday to benefit State budget



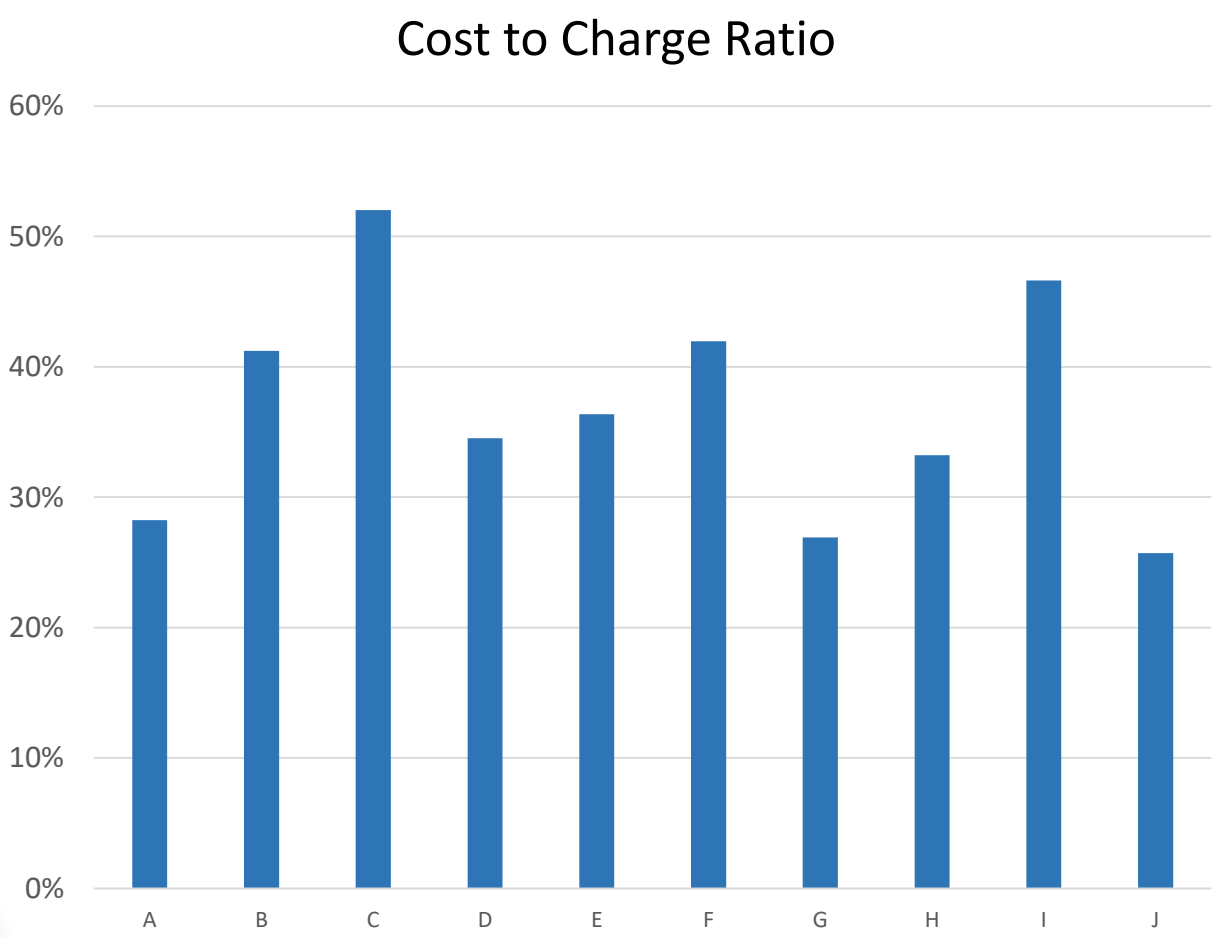
Our Research

- MT Hospital Financials
- Medicare Reimbursements
- Medicaid Reimbursement
- Federal and State Supplemental Payments
- Grants to Subsidize Charity Care
- Uncompensated Care
- Tax-Exempt Status
- Insurance Company “Value Based Payment” Incentive Programs
- Insurance Company MLR reporting (Quality Expenses; PBM Spread Pricing; PBM Retained Rebates)



Rand Corporation, 2019

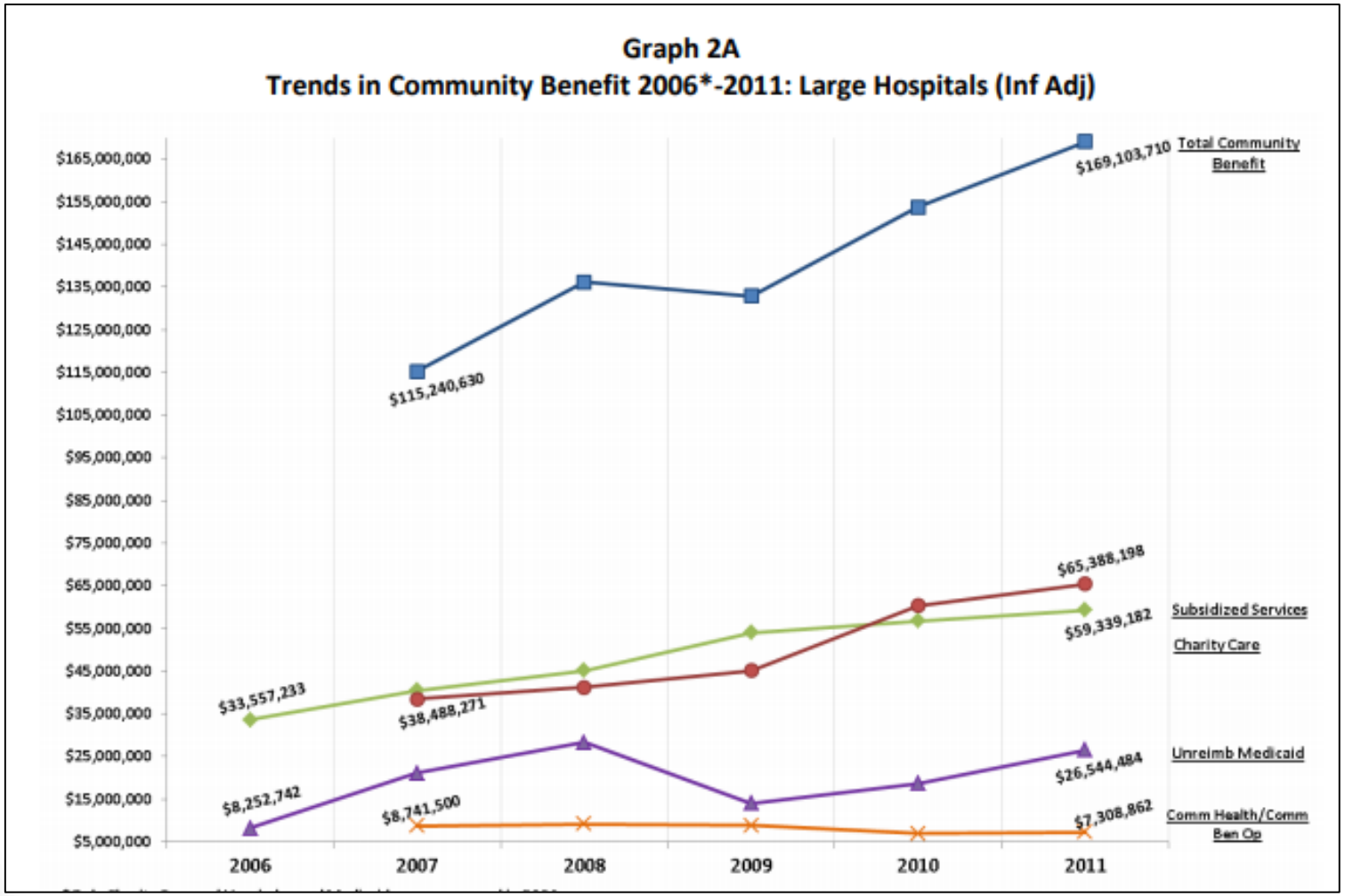
Hospital Charge Master



- Charges have little, if any, relationship to costs; Medicaid or Medicare reimbursements; or competitor charges.
- Ratio of cost to charges is most commonly used by a hospital to “estimate” the cost of a procedure.

- Cost to charge ratios ranged from 26% to 52% for the 10 large acute care facilities in Montana
- How is Cost to Charge Ratio used in reporting:
  - Public Messaging?
  - Financial Statements?
  - Medicare/Medicaid Reporting?
  - Community Benefit Reporting?
  - Bad Debt Expense Calculation?

Community Benefit Reporting – Tax Exempt Hospitals



2014 Report – Prepared for Montana Attorney General by School of Public and Community Health Sciences (University of Montana)

- 41% Subsidized Services
- 37% Charity Care
- 17% Unreimbursed Medicaid
- 5% Community Benefit

Total Community Benefit = $169 Million
Charity Care = $59 million
Calculated tax benefit = $56 million

Reporting Standards – FASB Topic 606

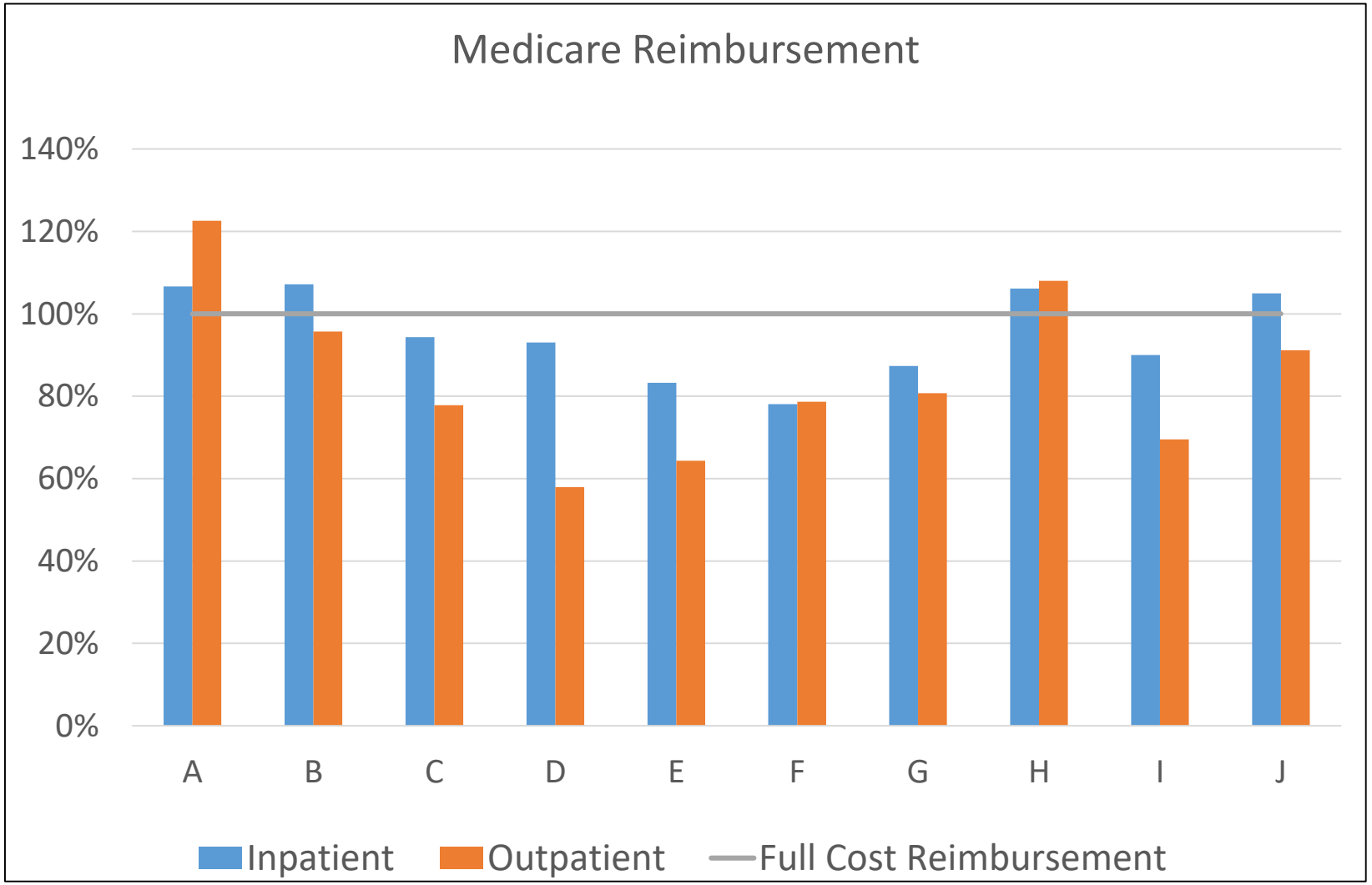
2014 Report	Description	FASB Topic 606 (Effective for Fiscal Years beginning after Dec 15, 2018)
Subsidized Services	*Explicit Discounts.* Discount from charge master rates negotiated by insurance companies, Medicaid, Medicare	Only report the contracted amount as revenue. No longer gross up revenue and show expense for discounts.
Subsidized Services	*Implicit Discounts.* Difference between charge master and amount collected on uninsured.	Only record revenue based on historical or expected collection, not charge master rates. If actual collections vary significantly, reduce revenue.
Charity Care	*Bad Debt Expense*	Report only uncollected insurance contracted amounts.
Charity Care	*Charity Care*	Report COST of charity care provided under hospital documented charity care program.

What to expect – FASB Topic 606

- Applies to Financial Statement Reporting; Audited Statements
- Not yet adopted by CMS (Medicare Cost Reports) and IRS (Form 990, Schedule H)

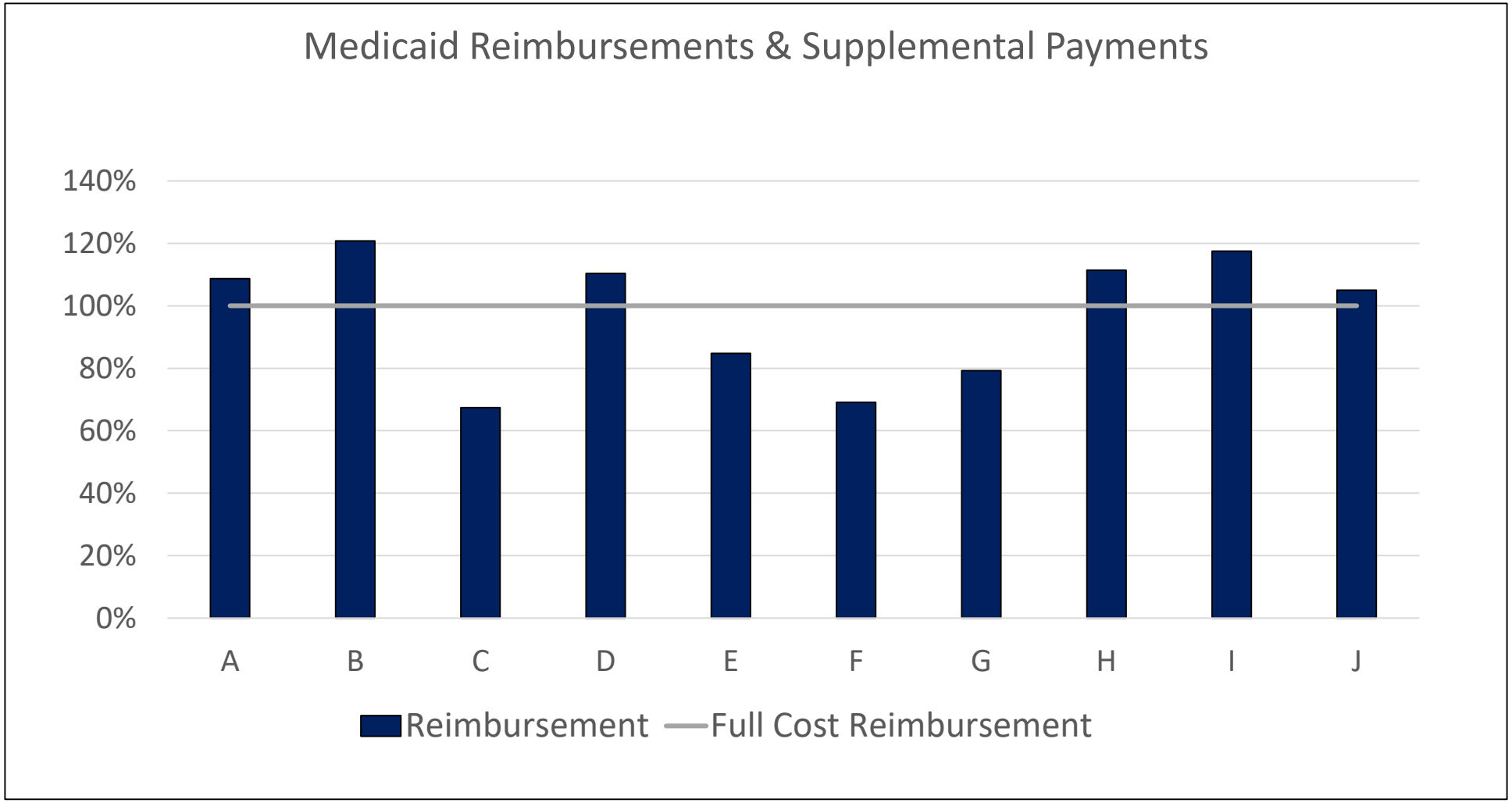
- Impacts:
  - Froedtert Hospital (Wisconsin). Bad Debt $61.4 million for 2018 fiscal year; $0 for 2019 fiscal year
  - 2017 bad debt reporting by hospitals was $53.3 billion; Would have been $5.1 billion under new rules *(Modern Healthcare Metrics)*
  - Hospitals will comply with FASB rule for **audited** statements, and not change reporting for CMS Medicare Cost Reports, IRS Form 990, or lobbying/public messaging.
  - States considering increased hospital financial transparency:
    - Revise Community Benefit Reporting requirements
    - Require hospitals submit Audited Financial Statements
    - Revisit tax exemption status - Property Tax and State Income Tax

Medicare & Supplemental Payments



MT 10 Largest Hospitals

Medicaid & Supplemental Payments



MT 10 Largest Hospitals

340B Program

Covered Entity

Covered Entity pays 340B Price to Manufacturer

Manufacturer distributes Outpatient Drug to Covered Entity

Drug Manufacturer

Plan (or PBM) pays their contracted rate

If insured, Patient pays Cost Sharing

Covered Entity Dispenses Outpatient Drug

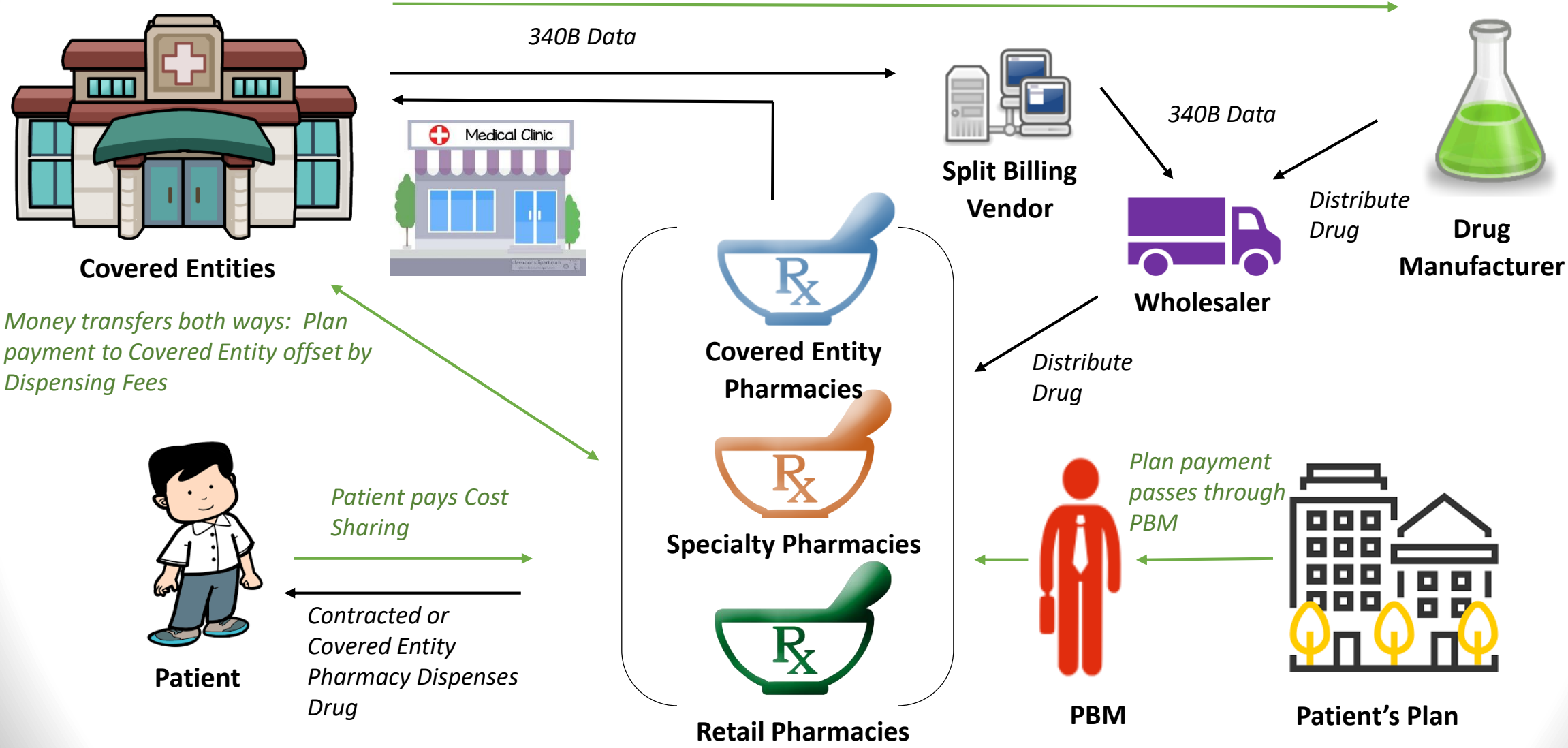
Patient

Patient's Plan (if insured)

Congressional Intent:

- Uninsured Patient receives deep discount
- Insured Patient – Plan benefit paid. Covered Entity uses spread benefit low income, indigent patients

340B More Players Enter the Game



Fact Checking

10 Montana Large Acute Care Hospitals:

- Medicare Reimbursements covered average of 91% of the hospital's Medicare Costs
- Medicaid Reimbursements with CMS Supplemental Payments covered average of 97% of the hospital's Medicaid Costs
- Additional Medicare HVBP payments totaled $1.2 million
- Hospitals receiving huge profits from 340B Program

Additional Considerations:

- Uncompensated Care is NOT Uncompensated Care: Tax-Exempt Hospital Community Benefits, Bad Debt Expense, and Revenue/Expense overstated. Profit Margin understated
- The Middlemen (Insurance Companies, Brokers, GPO's, etc.) – driving up costs?
- Incentive Programs – Driving up Costs?
- COPA and CON state laws promoting anti-competitive behaviors

Taking Action - Lower hospital prices

HAPPI Bill (Hospital and Provider Payment Initiative) – HB 747

- ✓ 250% Medicare, Approval required by Commissioner for price to exceed allowed price
- ✓ Appeals Process, Monitoring and Reporting
- ✓ Penalty = $5,000 per violation

And what happened?

March 27: Passed House Business and Labor Committee 13-6

March 28: MHA activates Voter Voice portal; Insurance Carriers, Hospitals, MHA lobbyists work overtime

March 29: House Floor – Amended bill failed 38-62

March 30: House Floor – Reconsideration – failed 34-66

Wrap up

- You are the **PAYER**! (Taxpayer, Employer & Employee, Consumer)
- Our Goal = Fair, Transparent Reimbursement
- Reference Based Payment (Contracted) for **Montana** Providers and Hospitals
- Out of State claims paid under a **national carrier network** (Discounted Charges)
- Price has to be included in value:

$$Value = \frac{Price}{Quality}$$

- Expect Opposition
  - Hospitals and Hospital Associations
  - Middlemen (Insurance Companies, brokers, etc.)
  - Lobbyists
- How we dealt with the Opposition
  - Champions
  - Education
  - Research
    - Know the Numbers; Know the Data
    - Know what is driving the opposition

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