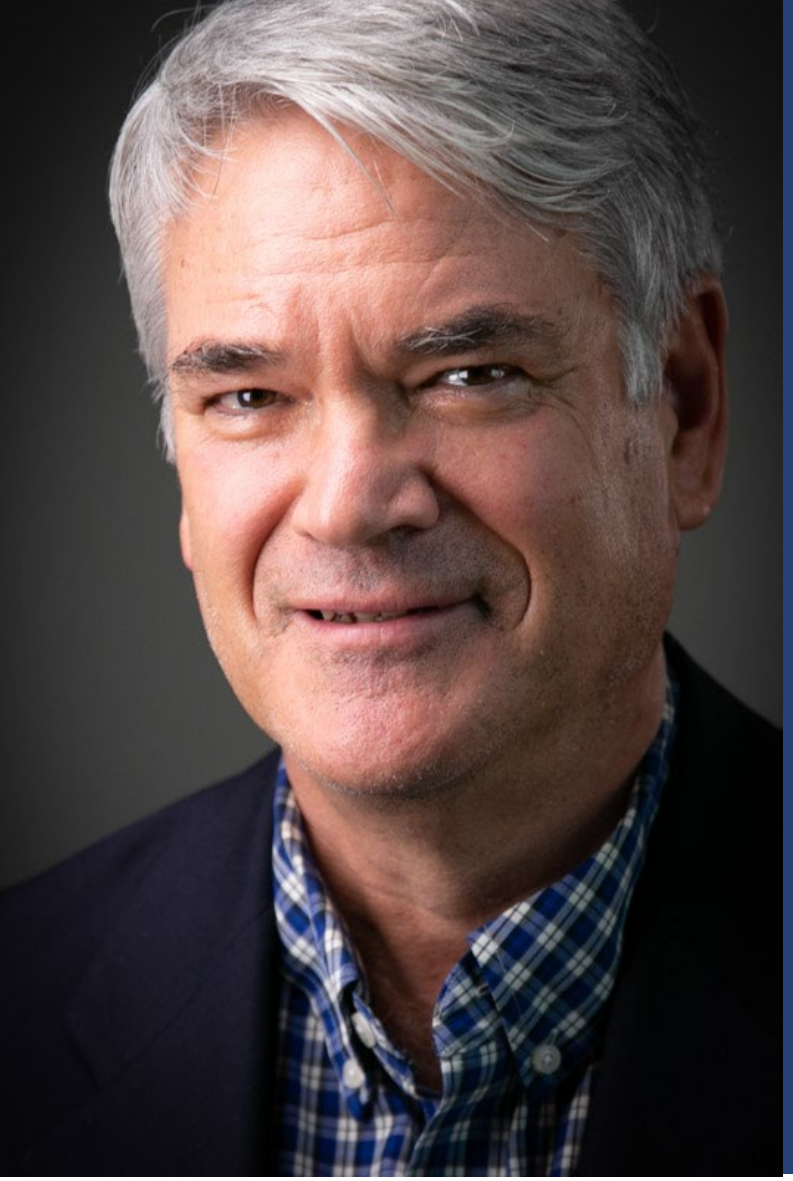


Expert Reaction:
The Employer Perspective

Peter Hayes
Healthcare Purchaser Alliance of Maine

LVBCH℠
Employers for Healthcare Value Since 1980

LEHIGH UNIVERSITY | HEALTHCARE SYSTEMS ENGINEERING

HEALTHCARE PURCHASER ALLIANCE OF MAINE

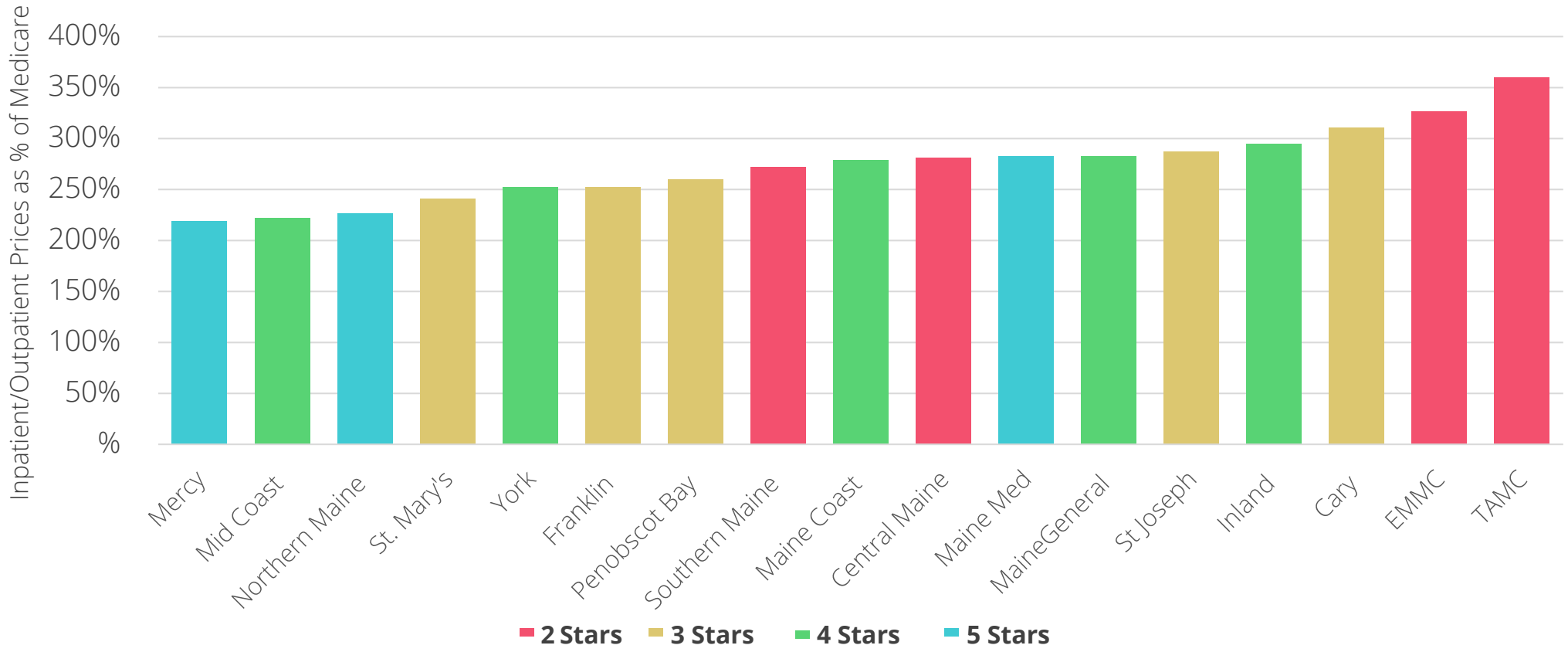
Indexed Pricing

March 22, 2022

RAND 3.0 PRICES AND QUALITY: MAINE HOSPITALS 2016–2018

Among Maine's non-critical access* hospitals, prices ranged from 219 percent to 360 percent of Medicare.

Quality among Maine hospitals is not correlated with price.



Note: Prices are a percent of Medicare (2016-2018). 10/18 CMS Star Ratings

*Critical access hospitals (CAHs) are rural hospitals with 25 or fewer inpatient beds located more than 35 miles from another hospital. Maine has 16 CAHs. Because CAHs are already reimbursed by Medicare on a "reasonable cost" basis, they presumably have less to make up from commercial purchasers to cover costs.

NASHP BREAKEVEN LEVELS & RAND 3.0: SELECT MAINE HOSPITALS

Breakeven Level Definition: Commercial Payments = Commercial Patient hospital Costs, plus balance of Government Programs, Charity Care, Uninsured, and Bad Debt, plus "true up" for any variances resulting from allocations to all payers, plus Medicare disallowed costs, such as research, advertising, home office costs, etc. Physician direct patient service costs are not included, as they are reimbursed separately through RBRVS, fee schedules, etc.

Note: Breakeven percentages calculated using NASHP hospital cost tool, populated with hospital-reported data to CMS (10/1/18-9/30/19 for hospitals A and D; 7/1/18-6/30/19 for hospitals B and C. RAND percentages (from RAND 3.0) cover 2016-2018 and are facility only; professional costs are excluded as the NASHP cost tool is based on facility charges only.

RAND 3.0 PROFESSIONAL AND FACILITY PRICES: MAINE HOSPITALS

	Hospital A	Hospital B	Hospital C	Hospital D	Total HPA BoB
Total Facility Allowed	$53,758,697	$54,007,289	$31,311,761	$120,542,777	**$259,620,524**
Savings at Different Medicare Levels					
200% of Medicare	-$24,057,759	-$20,146,920	-$11,175,580	-$43,023,306	**-$98,403,566**
225% of Medicare	-$20,345,142	-$15,914,374	-$8,658,558	-$33,333,372	**-$78,251,446**
250% of Medicare	-$16,632,525	-$11,681,827	-$6,141,535	-$23,643,439	**-$58,099,326**
275% of Medicare	-$12,919,908	-$7,449,281	-$3,624,513	-$13,953,505	**-$37,947,206**
300% of Medicare	-$9,207,291	-$3,216,735	-$1,107,490	-$4,263,571	**-$17,795,087**
Facility Price as % of Medicare (RAND)	362%	319%	311%	311%	
Breakeven (NASHP)	175%	172%	153%	192%	

DRAFT: FOR INTERNAL HPA USE ONLY

Notes: Total facility costs are total allowed amounts based on 2019 incurred claims for purchaser members in HPA's book of business.
Facility price as a percent of Medicare are RAND 3.0 facility-only data from 2016-2018.
Breakeven percentages are from NASHP's hospital cost tool, based on Medicare cost reports from 10/1/18-9/30/19 (EMMC & Maine Med) and 7/1/18-6/30/19 for CMMC & MaineGeneral.

PATIENT EXAMPLE

Patient advised by their doctor to get a CT scan. Patient has an annual family deductible of $4,000 and an annual salary of $45,000.

TRADITIONAL PPO PLAN	RBP PLAN
• Patient has CT scan at a Maine Hospital	• Patient has CT scan at same Maine hospital
• Because patient hasn't met their deductible, they owe the full $1,528 for the procedure	• Because patient hasn't met their deductible, they owe the full amount, which under RBP is just $150
• $1,528 is 41 percent of the patient's monthly salary, substantially reducing their ability to pay other monthly bills	• The $150 bill is 4 percent of patient's monthly salary
• If patient doesn't pay, the hospital may send them to collections, leading to credit impairment or legal action	• If this is one of the 1 percent of cases where the hospital doesn't accept RBP payment, the RBP vendor's support team works to bring the bill to resolution, keeping patient informed along the way
• If this happens, patient will have no support, and may not know—or want—to contact their HR team	• Patient is guaranteed to never have to pay more than the amount on their original EOB: $150

DEBUNKING ARGUMENTS AGAINST RBP

DEBUNKING ARGUMENTS AGAINST RBP

1) Hospital are barely breaking even; reference-based pricing will force more hospitals into the red

- The American Hospital Association has stated that efficient hospitals can break even at 115 percent of Medicare[5]
- Many hospitals in the country operate in the black with average prices well below the 252 percent of Medicare average price in Maine[6]
- RBP programs can exempt at-risk rural hospitals and continue reimbursement at current (or higher) rates to ensure financial viability and patient access
- In 2019, Maine hospitals' net operating surplus was $256 million, with MaineHealth comprising 61 percent of that[7]

2) Hospitals need to charge commercial payers more to cover losses from Medicare, Medicaid, charity, and uncompensated care

- RAND 3.0 showed that there is no correlation between prices and the percentage of Medicare and Medicaid patients that a hospital serves[8]
- The NASHP tool, which is based on hospitals' own cost reports, calculates break-even points for hospitals; even the most generous break-even points are well below the prices that RAND estimates hospitals are currently charging

DEBUNKING ARGUMENTS AGAINST RBP

3) With unemployment rates at all-time lows, employers should be increasing benefits, not cutting them

- RBP doesn't cut benefits to employees—it ensures that plan sponsors fulfill their fiduciary role by rationalizing payments to hospitals using Medicare reimbursement as a benchmark
- Employers can use the saved dollars to improve employee healthcare benefits—including lower premium and out-of-pocket contributions—as well as other benefits, such as wage increases and tuition assistance

4) Reference-based pricing hurts employees and dependents, whom hospitals can balance bill for costs not covered by the RBP payment

- There is no balance billing when employers execute direct RBP contracts with hospitals
- With traditional RBP vendors, only a small fraction of claims (~1-2 percent of total claims and ~10 percent of facility claims) are balance billed, and RBP vendors offer services to protect patients and resolve their balance bills
- The current system already subjects patients to substantial bills under traditional health plans, with medical issues the #1 cause of personal bankruptcy in the US[9]
- Patients in RBP plans see their costs go down, as plan paid amounts are substantially lower than typical PPO rates, which results in lower costs before patients hit their deductibles and lower coinsurance amounts

DEBUNKING ARGUMENTS AGAINST RBP*

5) Mergers improve quality and efficiency

- Hospital consolidation has not resulted in either improved quality or reduced costs
- When hospitals merge, they face less competition and charge prices that are more than 10 percent higher than hospitals in more competitive markets[10]
- Consolidation is also associated with worse patient experiences and no improvement in overall quality, including readmission and mortality rates[11]

6) Sicker populations drive higher hospital prices

- There is no correlation between hospital prices per state and state public health rating[12]

*** Source:** From National Alliance of Healthcare Purchaser Coalitions, *Myths and Facts: Revealing Hospital Transparency Truths,* 2021. Full document available in Appendix.