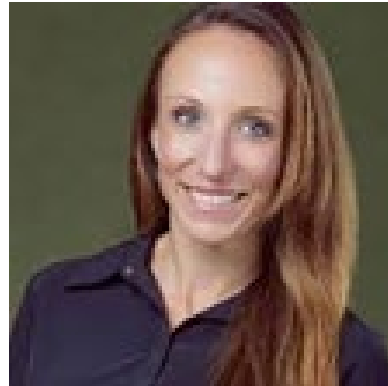


# Transparency, Accountability, and Action All Star Panel



**Marilyn Bartlett,  
CPA, CMA, CFM**  
*Senior Policy Fellow*  
National Academy for  
State Health Policy



**Christin Deacon**  
Principal Owner  
VerSan Consulting

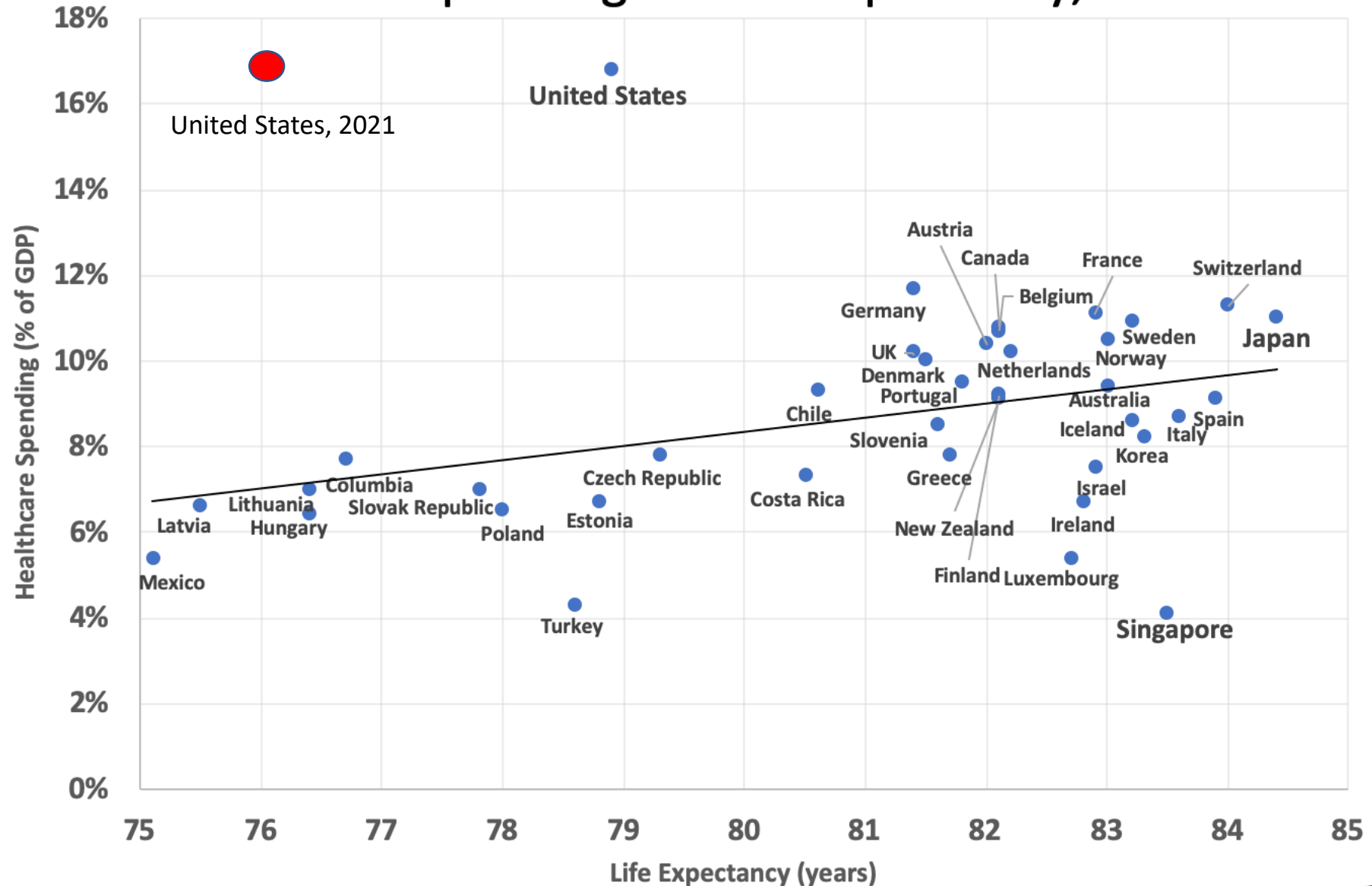


**Cynthia Fisher, MBA**  
*Founder and Chair*  
PatientRightsAdvocate.org



**Alex Jung**  
*Principal*  
Alex Jung Consulting

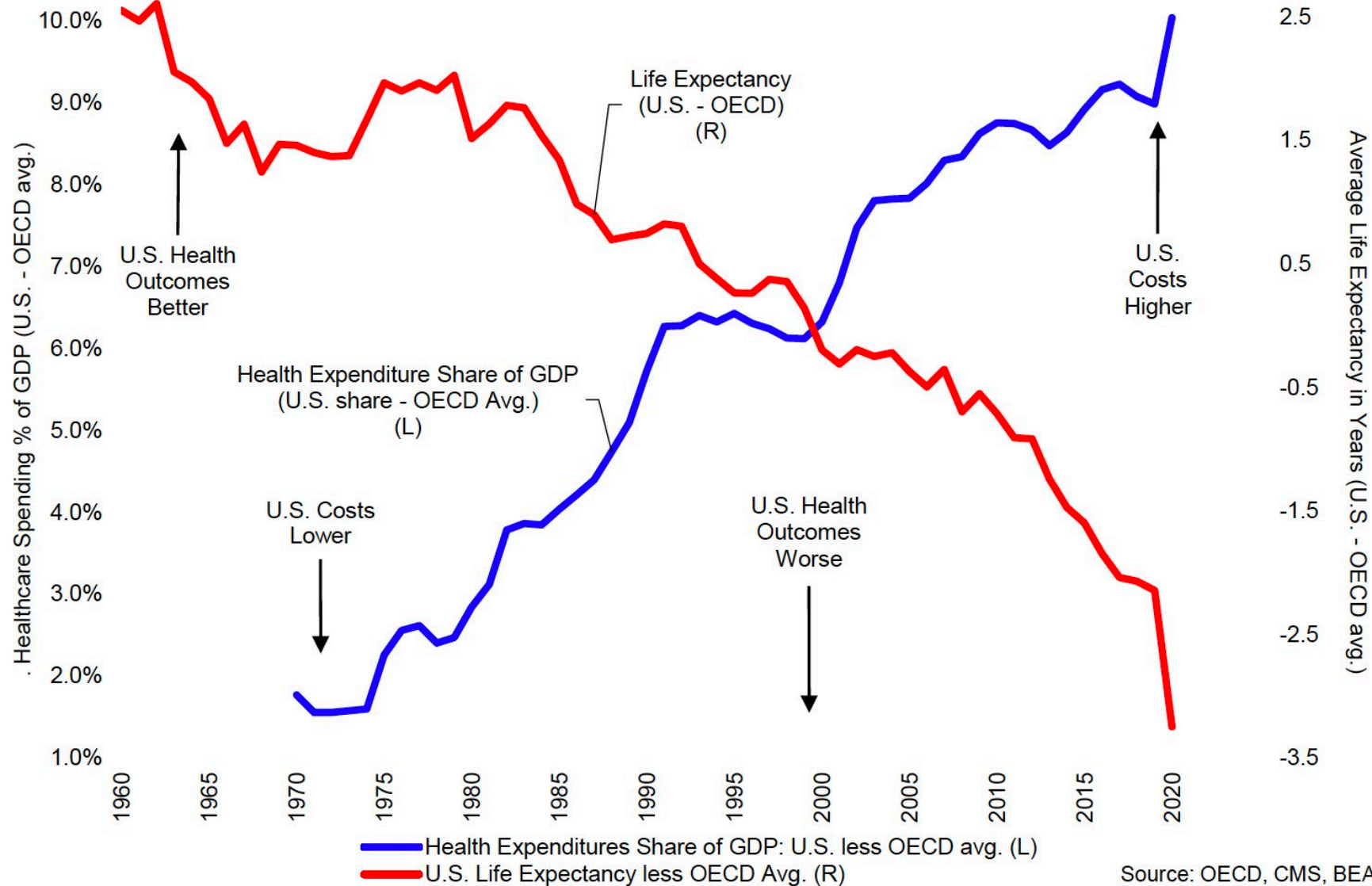
# Healthcare Spending vs. Life Expectancy, 2019



Sources: OECD.Stat Health Expenditure and Financing, OECD.Stat Health Status: Life Expectancy, and (for Singapore) World Bank

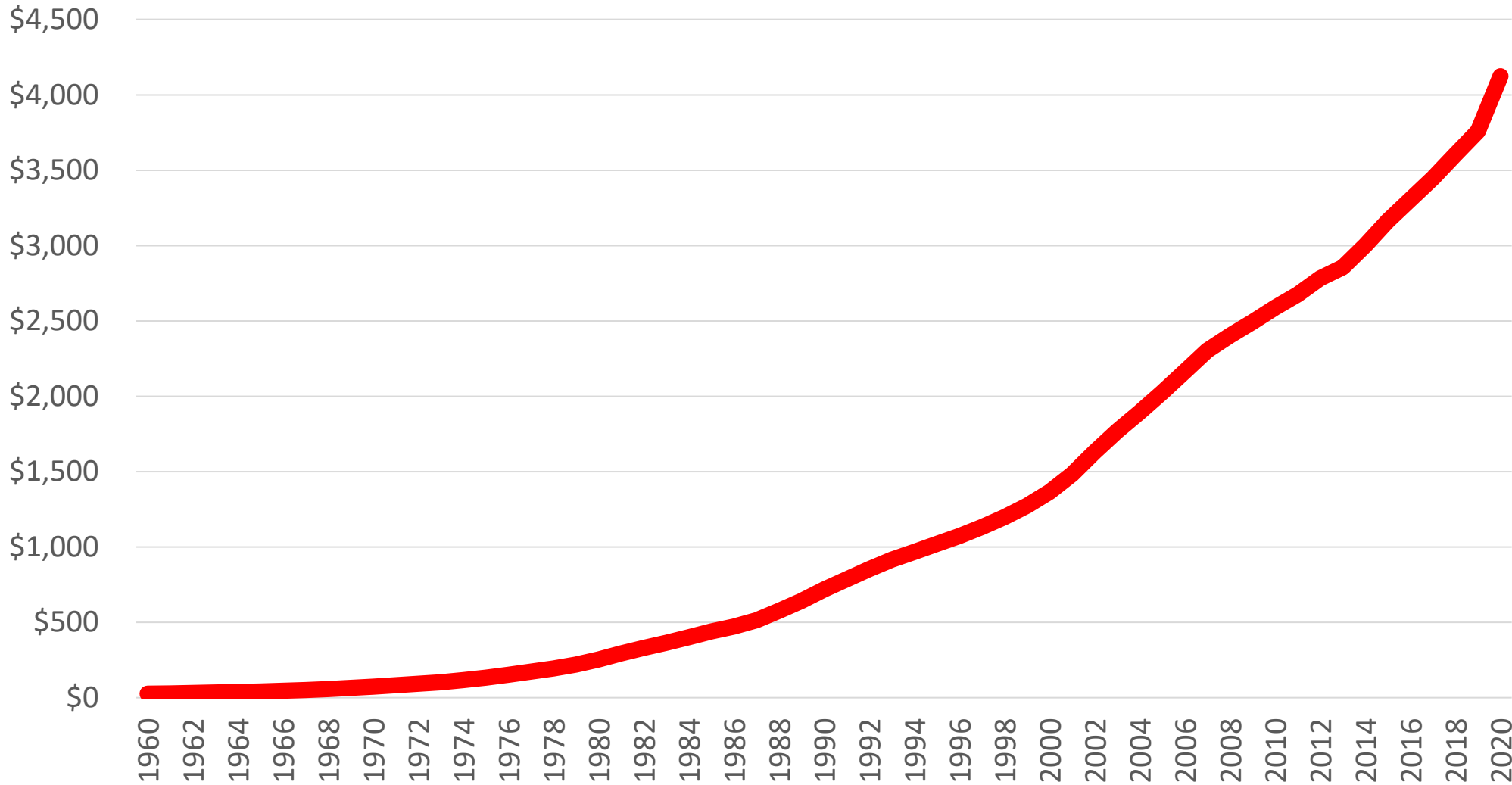
## U.S. Average Life Expectancy less OECD Average (ex. U.S.) vs. U.S. Health Expenditures as a Share of GDP less OECD (ex. U.S.) Average

(annual, Life Expectancy: 1960 through 2020, Health Expenditures: 1970 through 2020)



Source: OECD, CMS, BEA

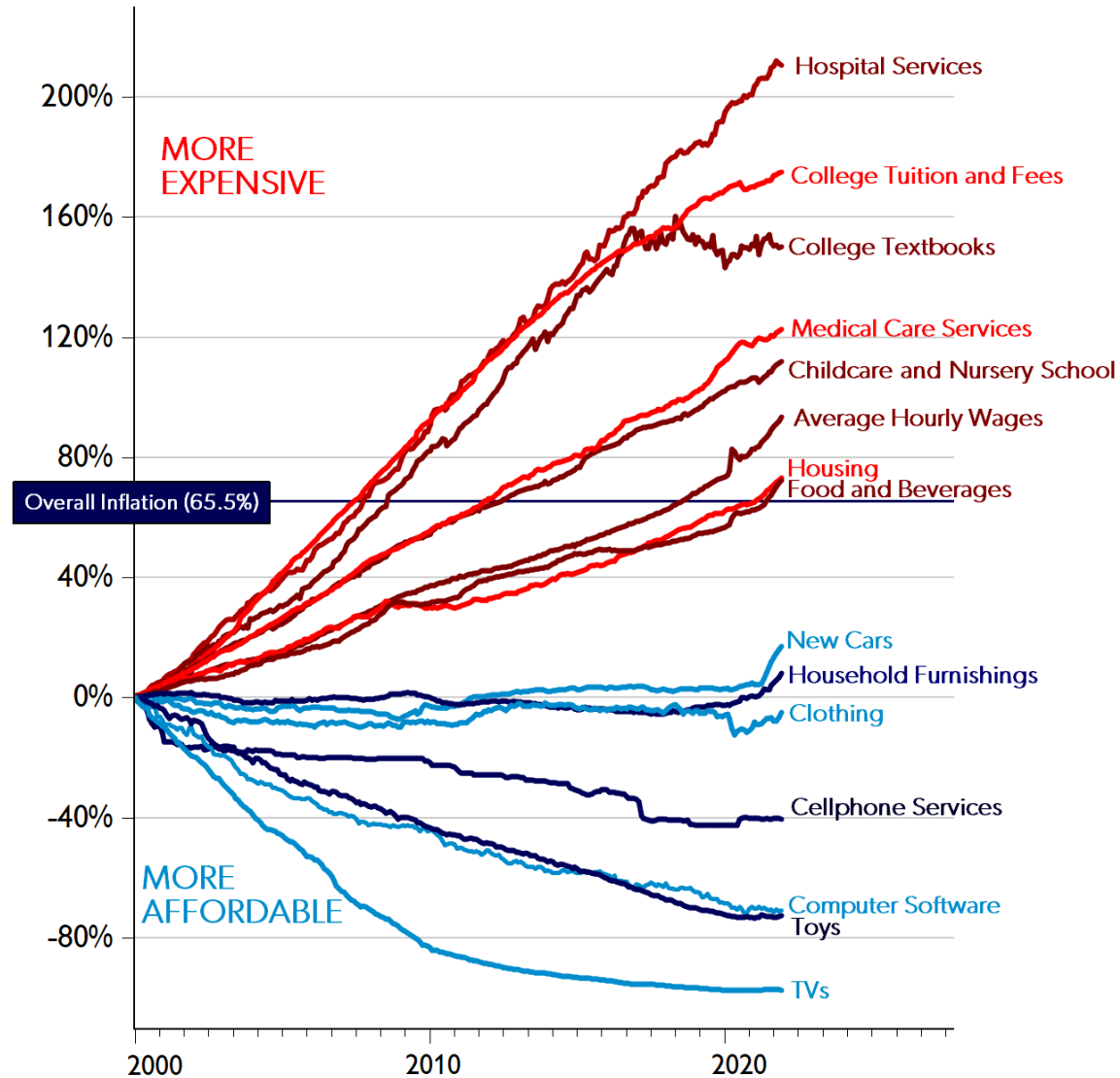
# Health Expenditures, 1960-2020, U.S. \$ Billions



Source: National Health Spending Explorer, Kaiser Family Foundation

# Price Changes: January 2000 to December 2021

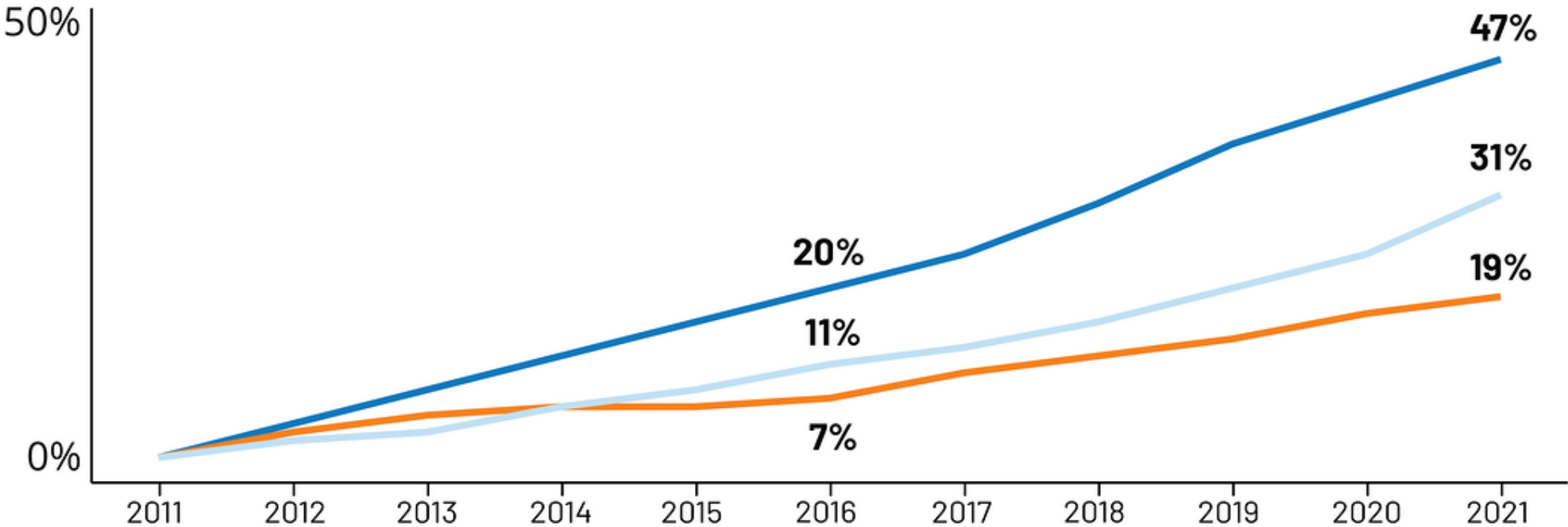
Selected US Consumer Goods and Services, Wages



Source: Bureau of Labor Statistics

# Over Time, Family Premiums Have Risen Faster than Wages and Inflation

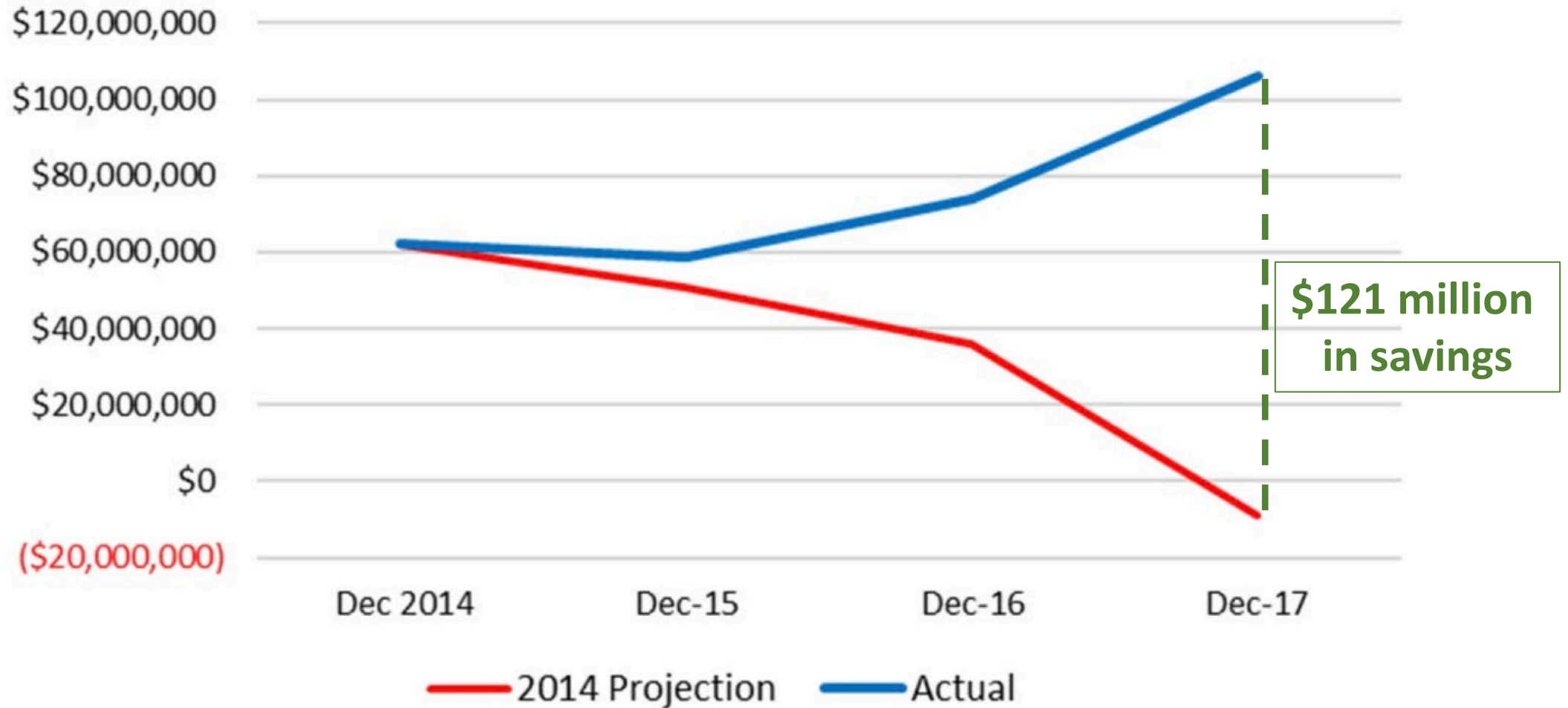
● Family Premiums    ● Workers' Earnings    ● Overall Inflation



SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2011-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2011-2021.



# Montana State Employee Health Plan Reserves



Source: National Academy for State Health Policy

# Decisions and Policy driven by Data

Marilyn Bartlett, CPA, CMA, CFM, CGM

Senior Policy Fellow, NASHP

*April 2023*



NATIONAL ACADEMY  
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[nashp.org](https://nashp.org)



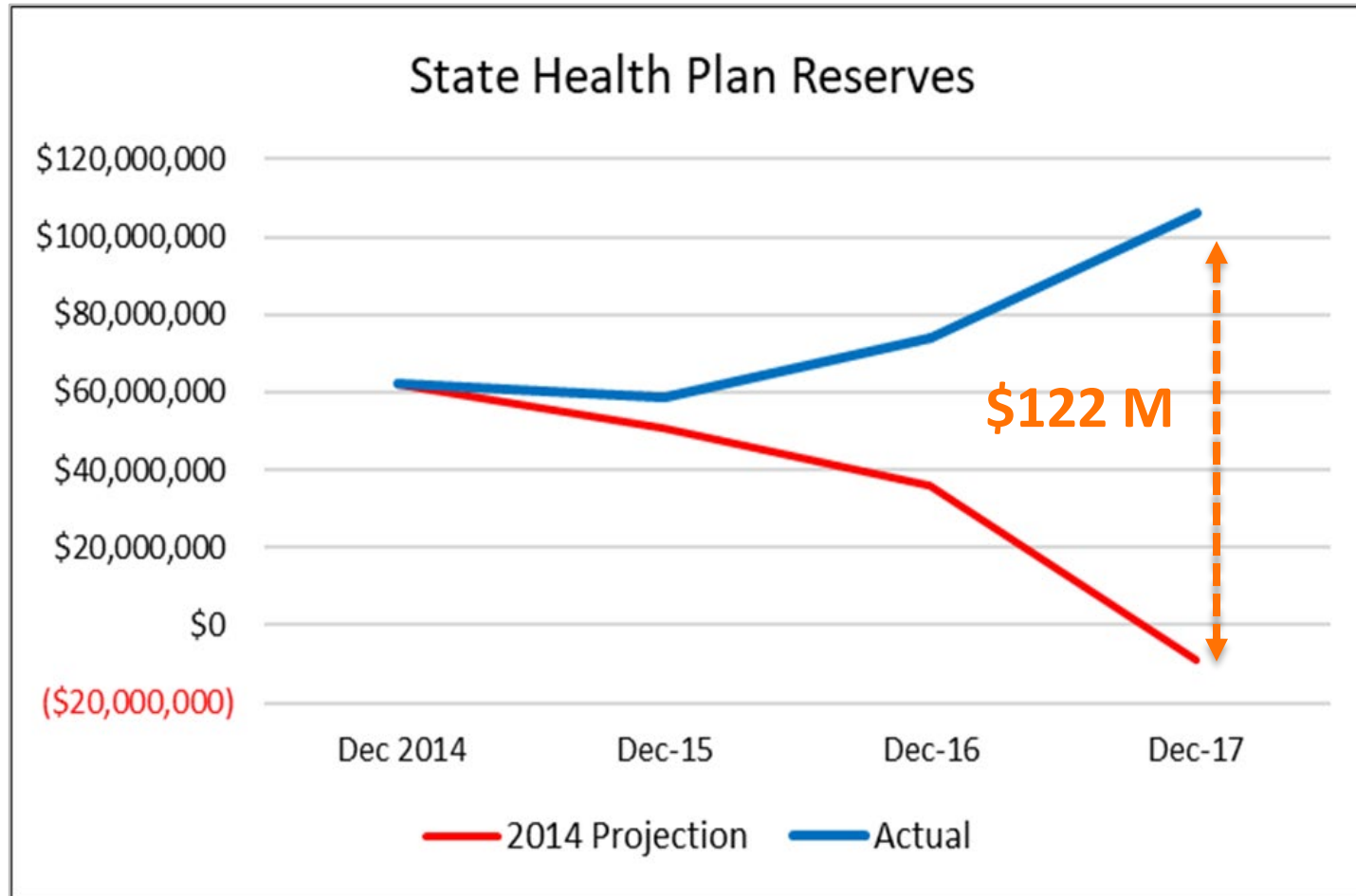
# Patient Service Revenue is not the only revenue source

- Grants, Donations
- Investments
- Municipal Bonds (low interest rate)
- Tax Exemptions
- Non-Patient Services
- Government Payments
- Group Purchasing Organizations
- 340B Drug Program
- Drug Manufacturers
- Hospital Owned Physician Practices
- Hospital Owned Businesses and Joint Ventures

## Hospital Revenue Streams



# It all started in 2015 – MT State Employee Health Plan



- Reference Based Pricing Contracts with all MT Hospitals
- Transparent, Pass Through RX Benefit. Eliminated High-Cost Pharmacy Chain
- On-site Primary Care Clinics
- New TPA, PBM, Consultant, Data Warehouse, Administration System
- No rate increases for 7 years (2017 - 2023)
- Lowered Health Plan Reserves to increase State Budget - \$25 million (2017); \$27 million (2021)
- Enhanced Plan Benefits

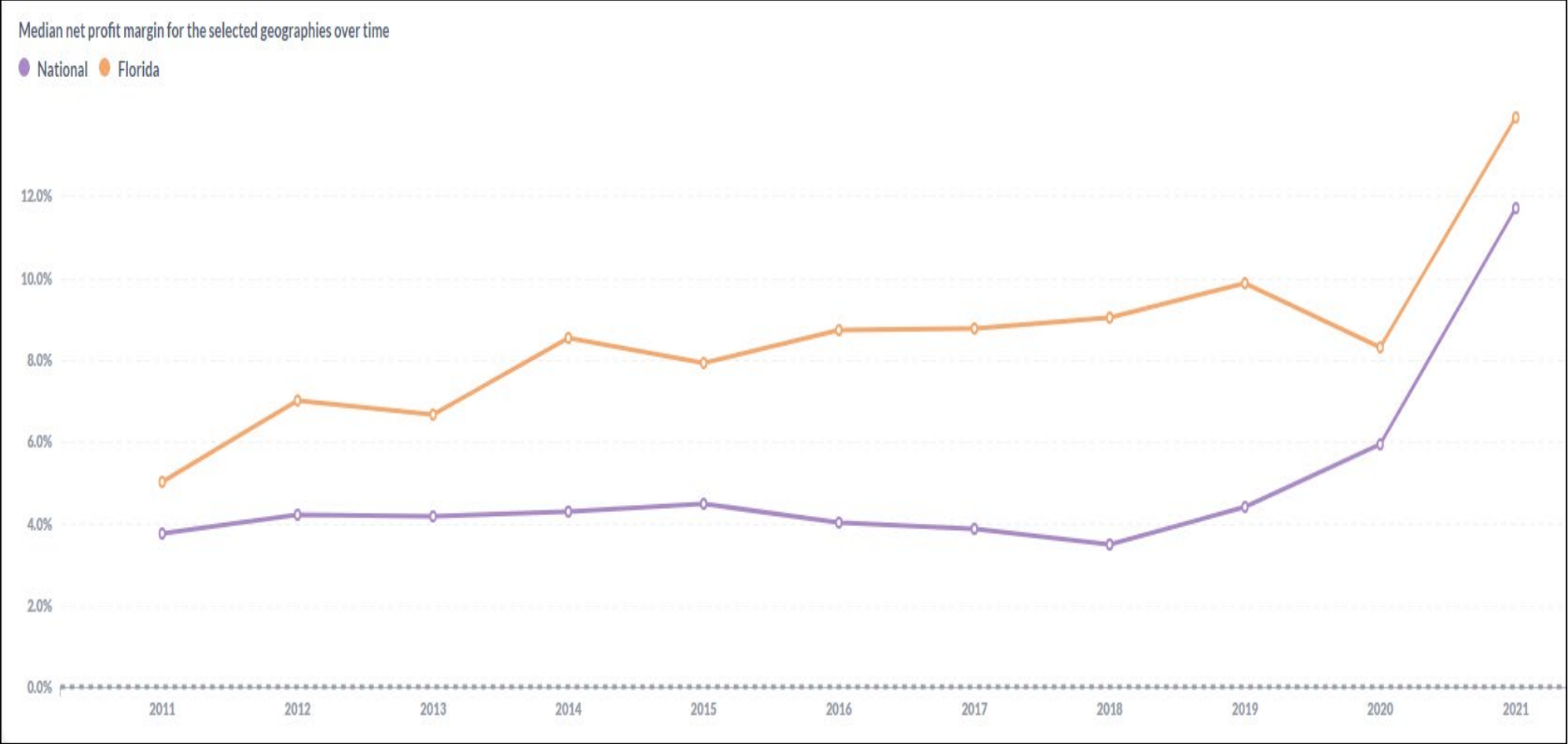
# NASHP Hospital Cost Tool

- **Online tool health purchasers, including state officials, can use to better understand and address hospital costs and prices**
- **Identifies financial data and benchmarks using Medicare Cost Reports**
  - Hospital specific
  - 11 years of data – 4,600 hospitals (Acute Care and Critical Access). 2011-2021 reporting years.
  - MCRs provide hospital level data and are the only national, public source of hospital costs
  - HCRIS Data Base
- **Developed by the National Academy for State Health Policy (NASHP) alongside Rice University, with support from Arnold Ventures. Dashboard by Mathematica.**

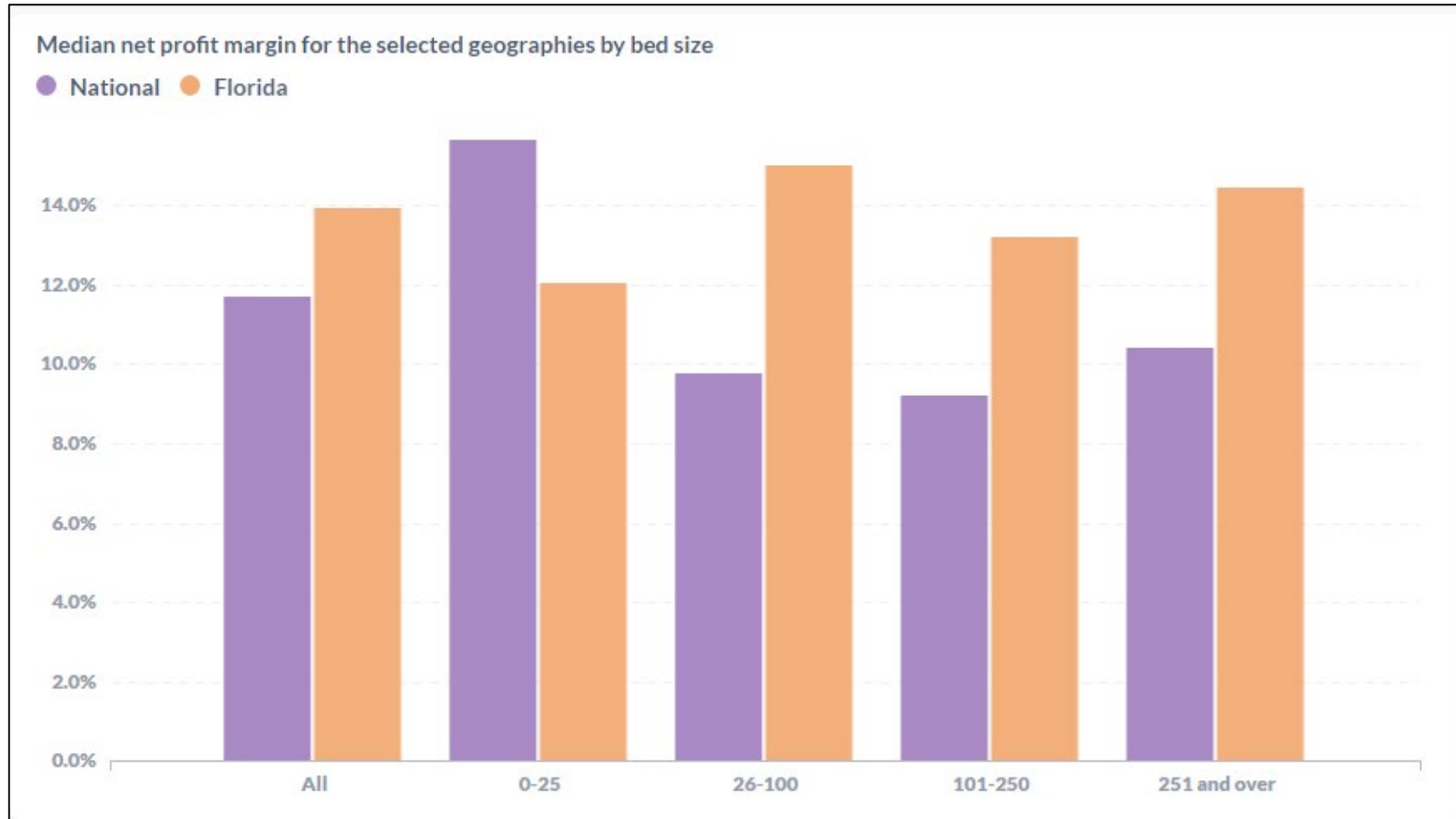
# Florida Hospitals – Median Operating Profit Margin



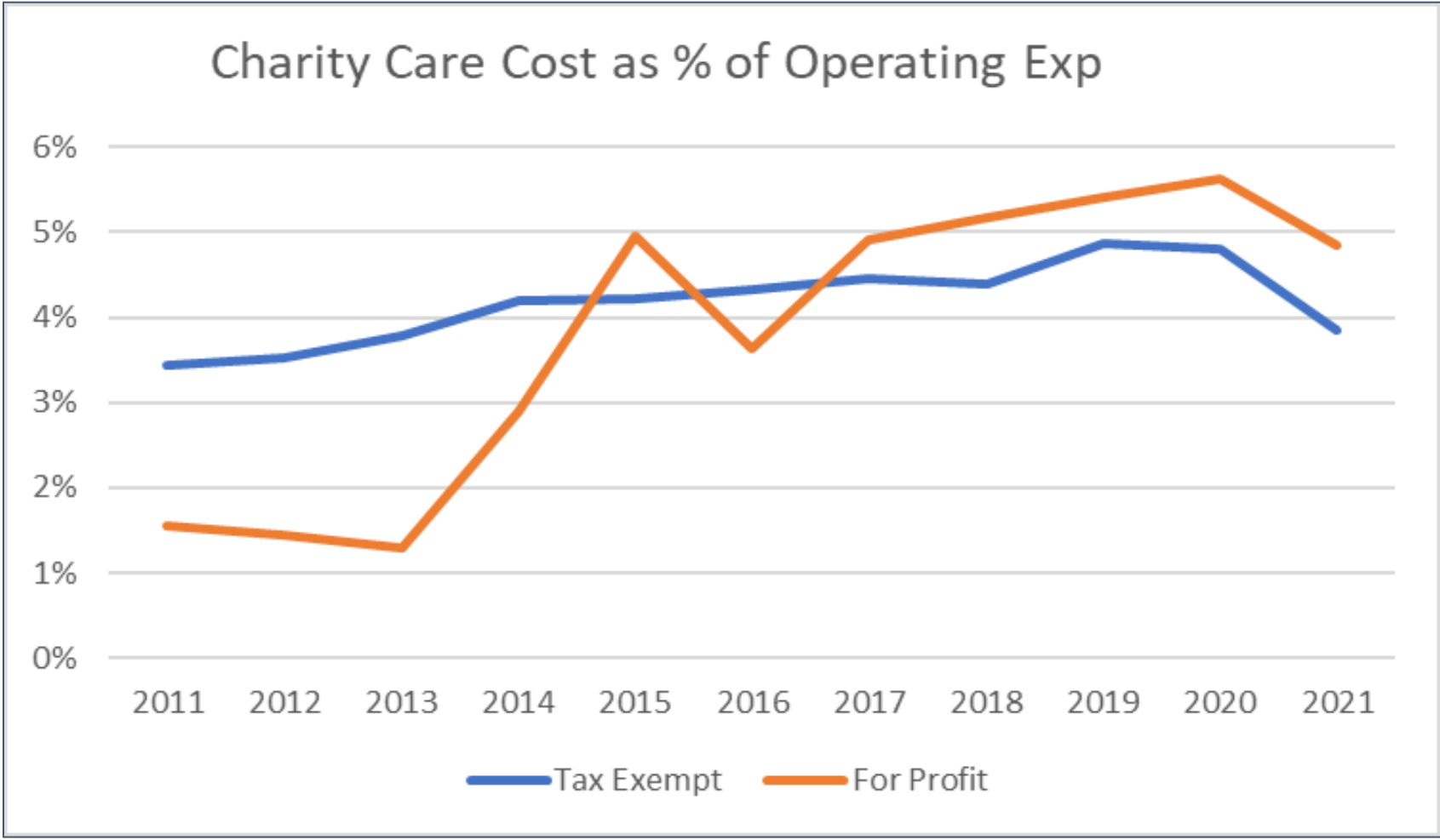
# Florida Hospitals – Median Net Profit Margin



# Net Profit Margin by Bed Size (2021)



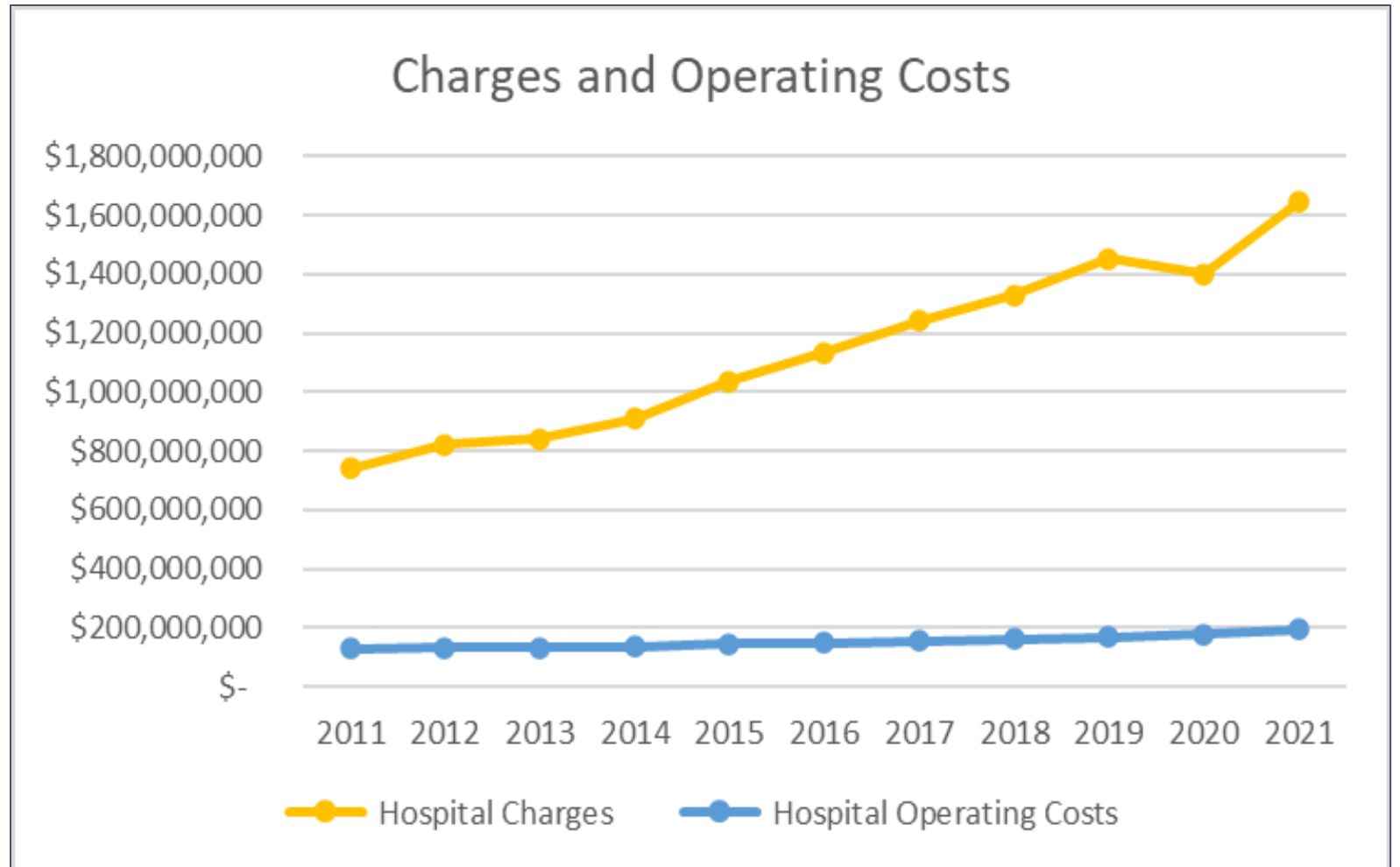
# Florida Hospitals



# Florida Hospitals

Acute Care Hospitals –  
Median

Discount off Charges vs  
Cost Plus?





# Labor Metrics

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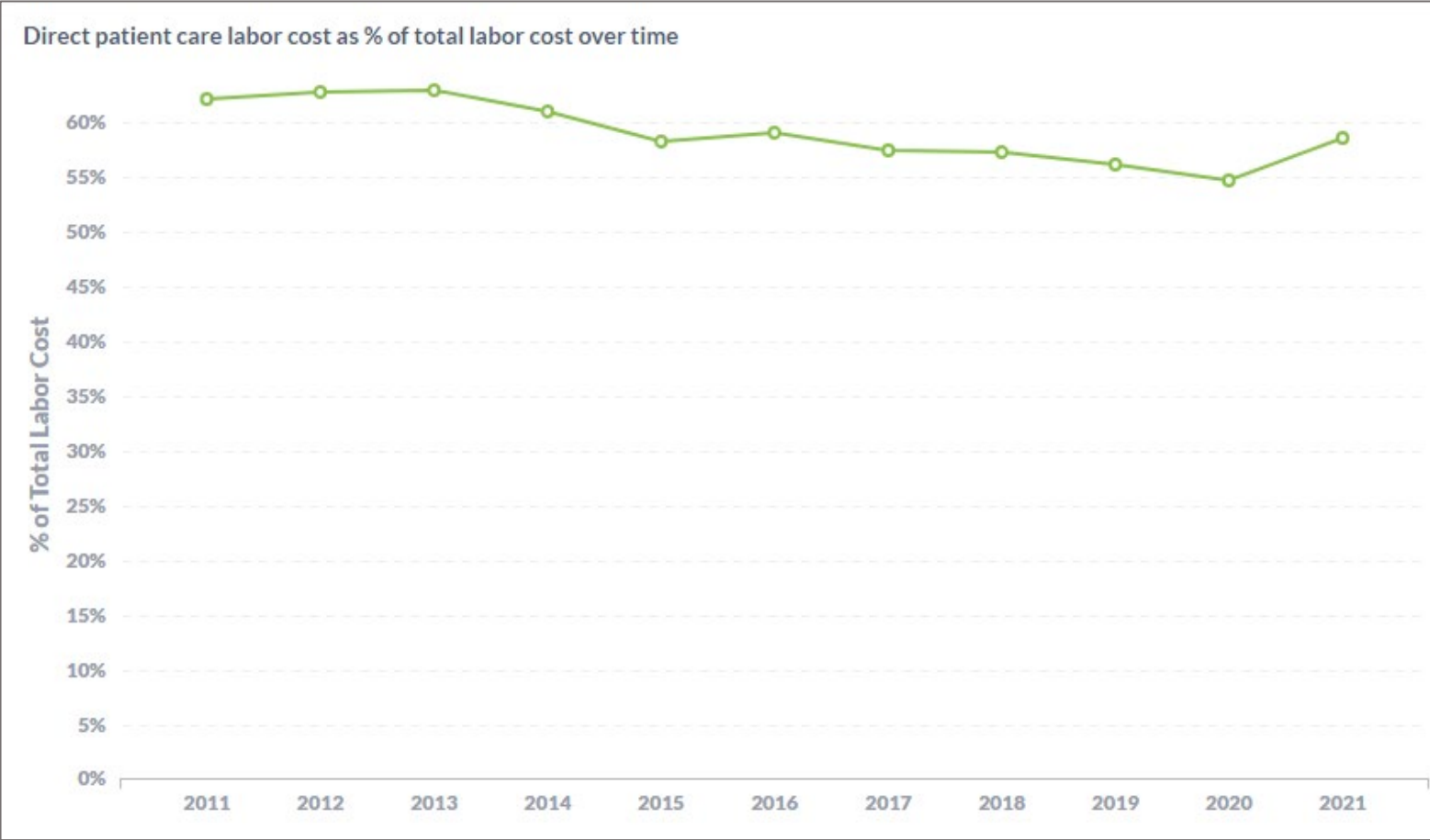
- **Direct Patient Care.** *Nursing and other patient care staff. Excludes physician.*
- **Overhead.** *Housekeeping, Dietary, Maintenance*
- **Administration.** *Executive, Administrative, Management*
- **Home Office.** *Allocated Staffing, Shared Admin Services*

FTE, Hourly Rates, % Staffing Costs, Contracted vs Staff, Costs and FTEs per  
Adjusted Discharge and more

# Direct Patient Care Labor as % of Total Labor

Average Annual Rate Increases  
Hospital Staffing (2011-2021)

- 4% Direct Patient Care Labor
- 4% Overhead Labor
- 7% Executive/Management Labor



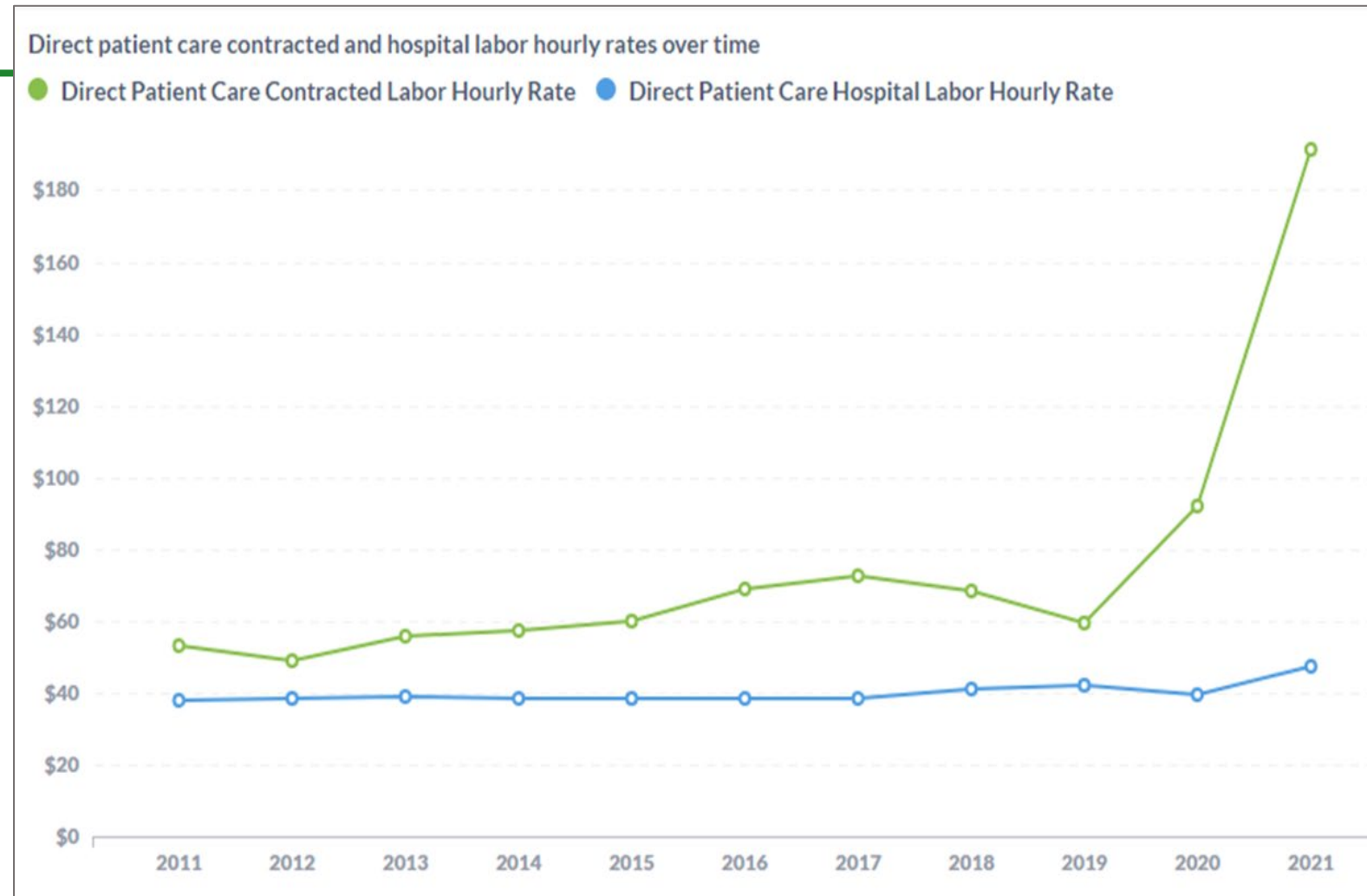
# Direct Patient Care Labor Hourly Rates

## 2021 Contracted Staff

- 3.3% of FTEs
- 12% of Direct Patient Labor Cost

## Managing forward?

- Hospital Staff vs Contracted Staff?
- Hospital Staff Hourly Rates?
- Staffing Levels?
- Increased Outpatient vs Inpatient Utilization?

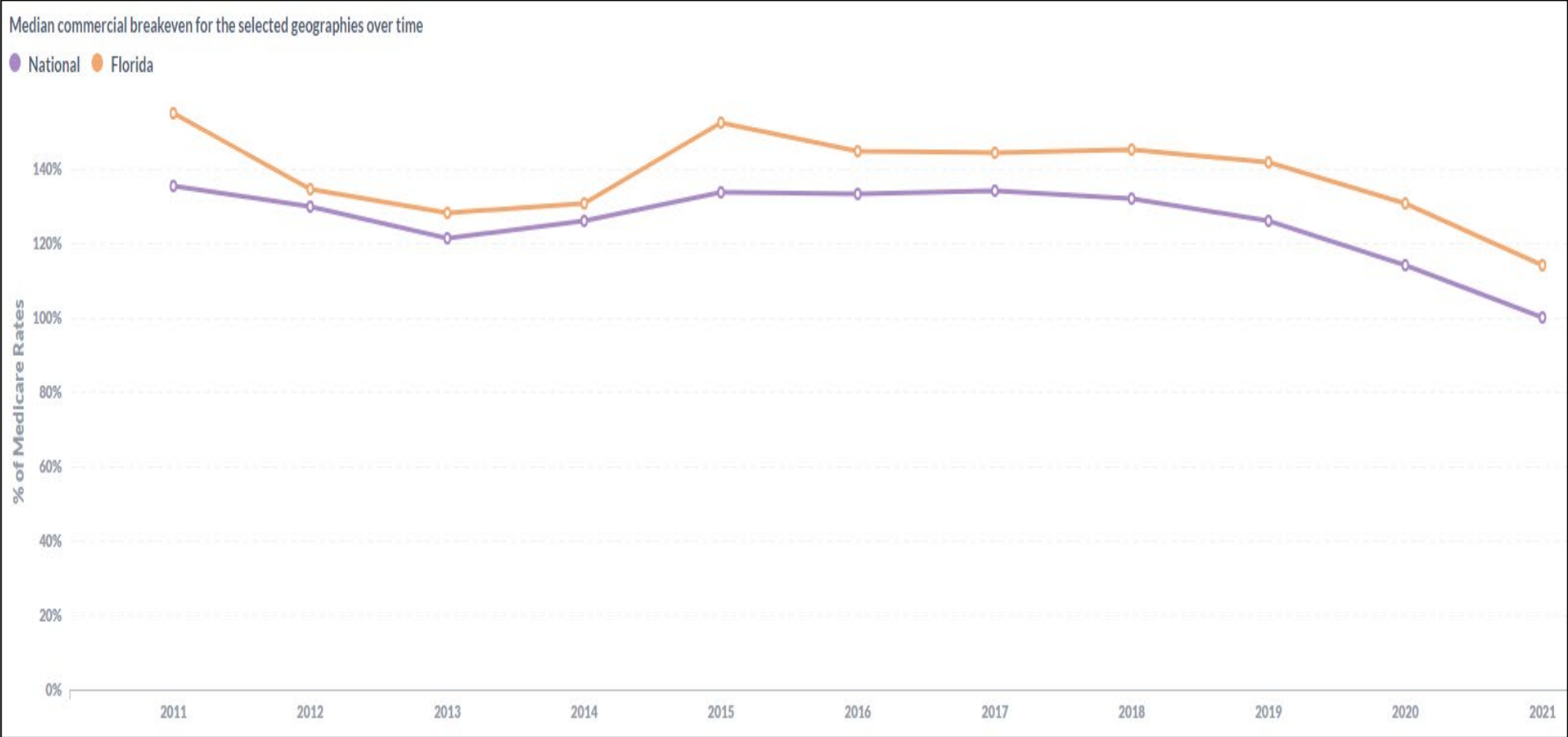


# Breakeven Analysis

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- NASHP's Hospital Cost Tool calculates a hospital's breakeven point: **Revenue = Expenses**
- **NASHP Commercial Breakeven** – how much a hospital needs to be reimbursed by commercial payers in order to cover commercial patient hospital costs, losses from other payers, charity care, uninsured, all Medicare disallowed costs, and other income/other expense.
- **Physician Direct Patient Services** not included, Billed and Reimbursed through other methods.
- **Breakeven and Price expressed as multiples of the individual hospital's Medicare rates for comparability purchases**

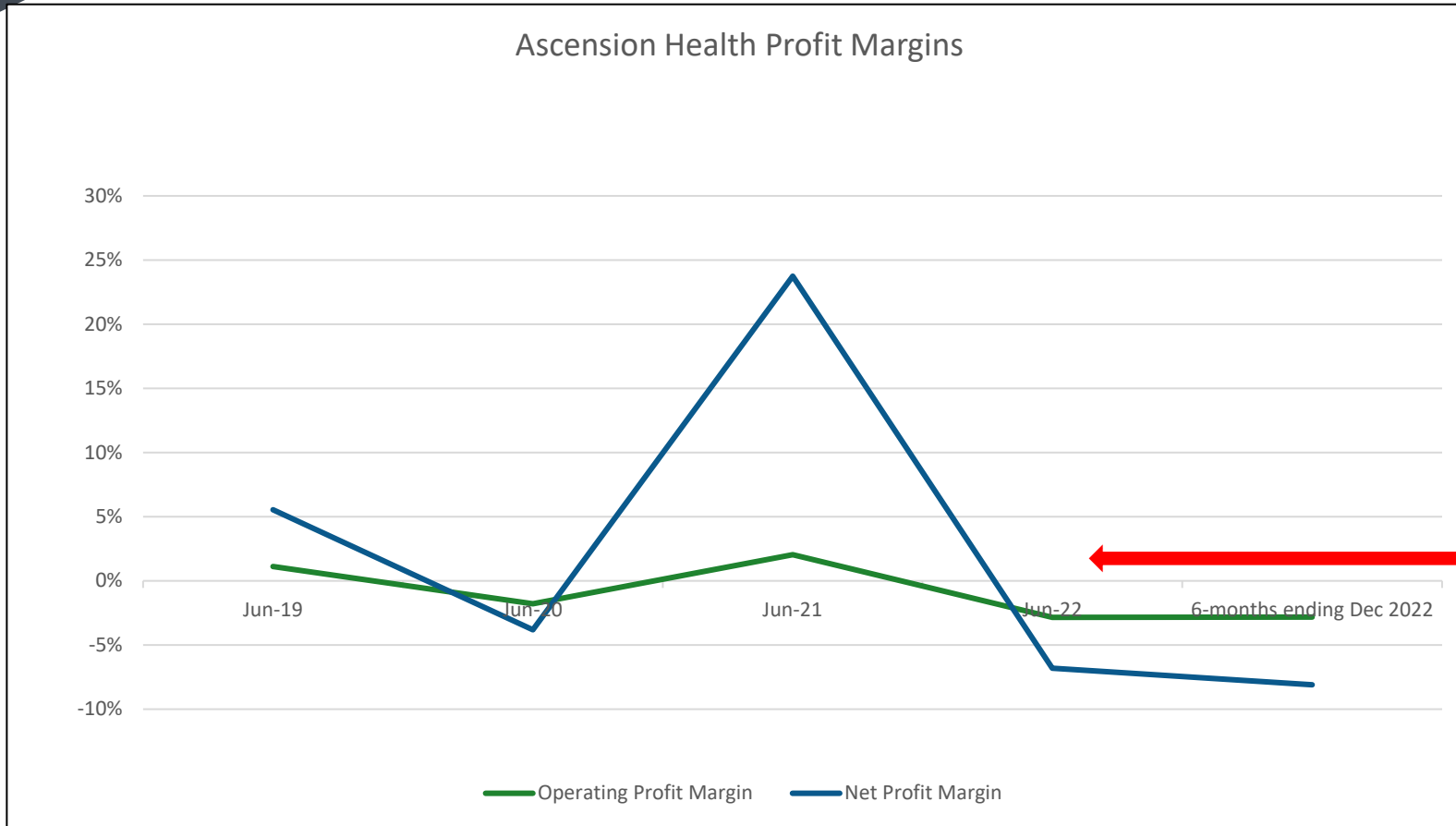
# Florida Hospitals - Median



September 19, 2022

Modern  
Healthcare

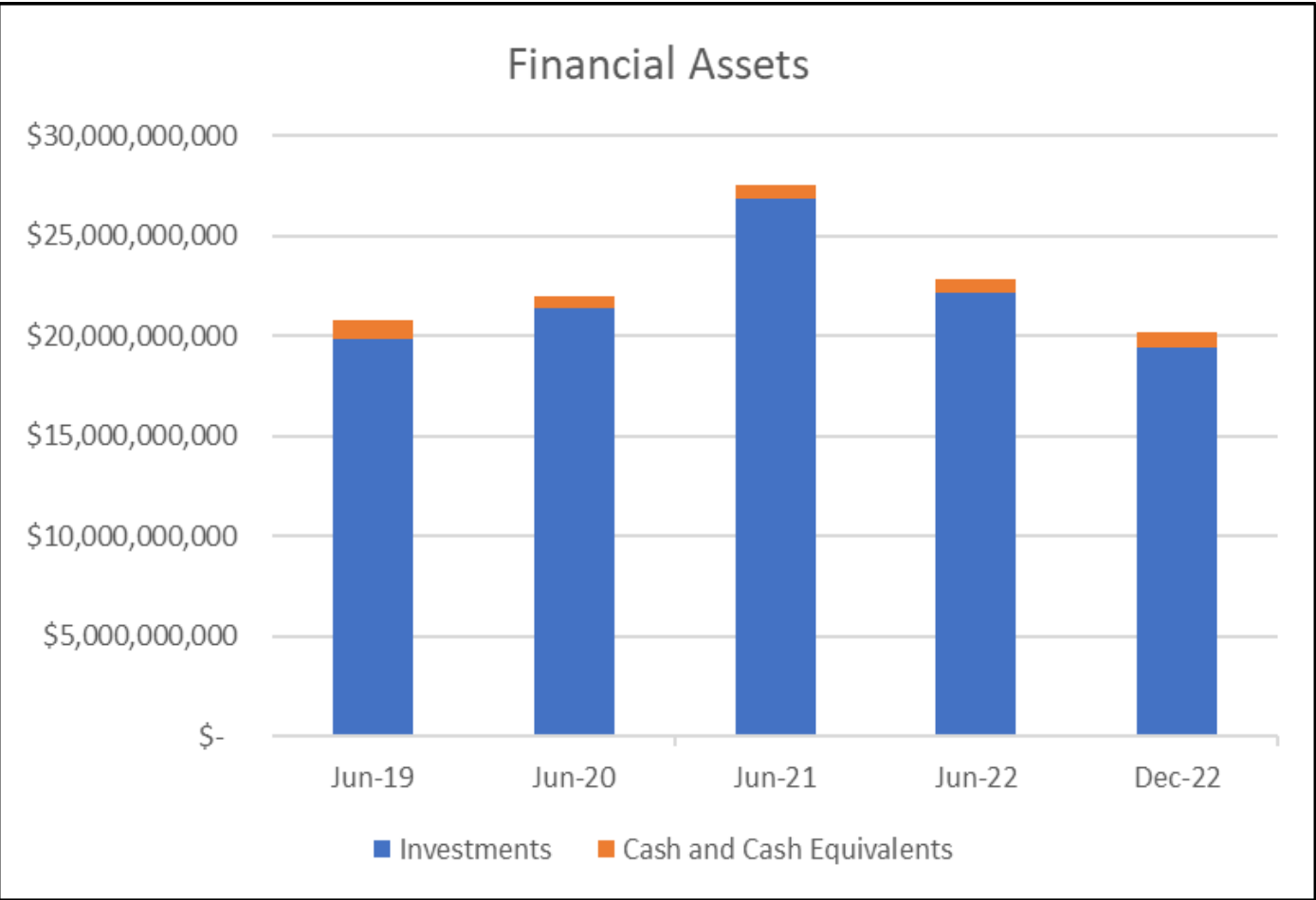
# Ascension's annual losses near \$2B as expenses increase



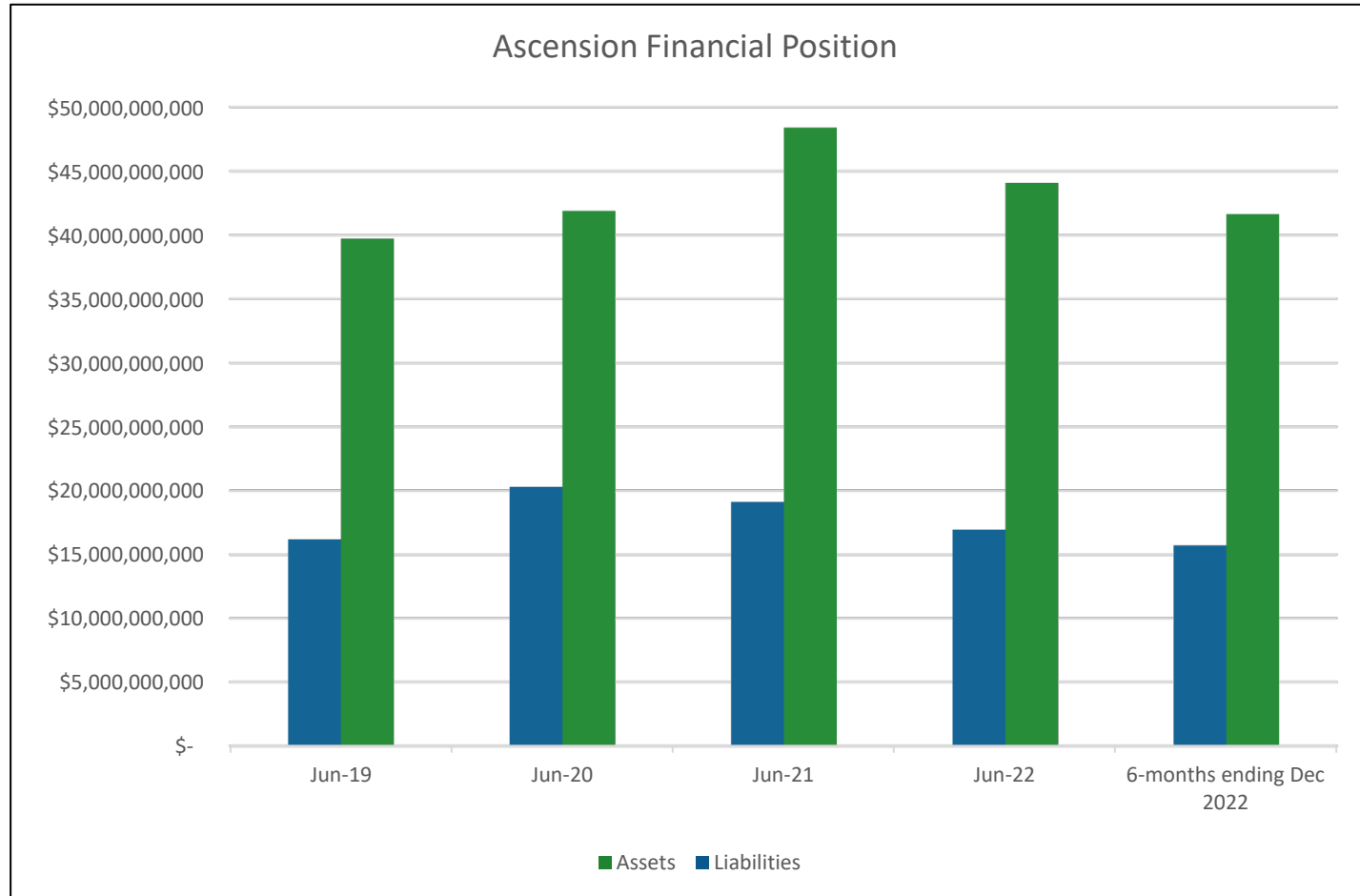
\$2.3 Billion  
UNREALIZED  
Investment Losses

# Ascension Health

- *June 2022 reduced by \$2.3 Billion UNREALIZED Market Losses*
- *Dec 2022 reduced by \$654 million for UNREALIZED Market Losses*



# Ascension Health Net Assets

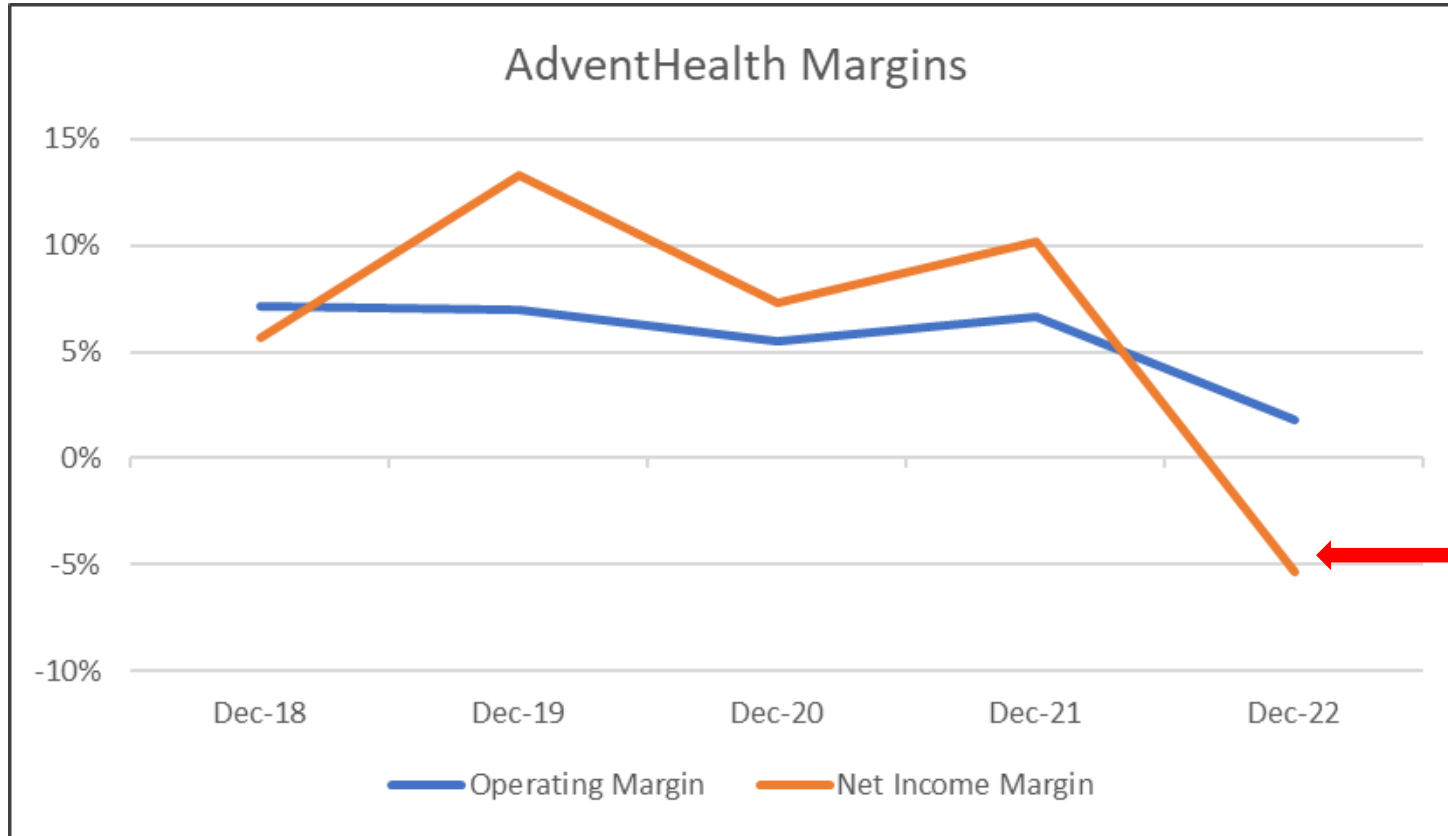


- Total Assets minus Total Liabilities
- “Net Worth”
- 2022 Net Assets = \$26 Billion
- Includes UNREALIZED Losses



March 1, 2023

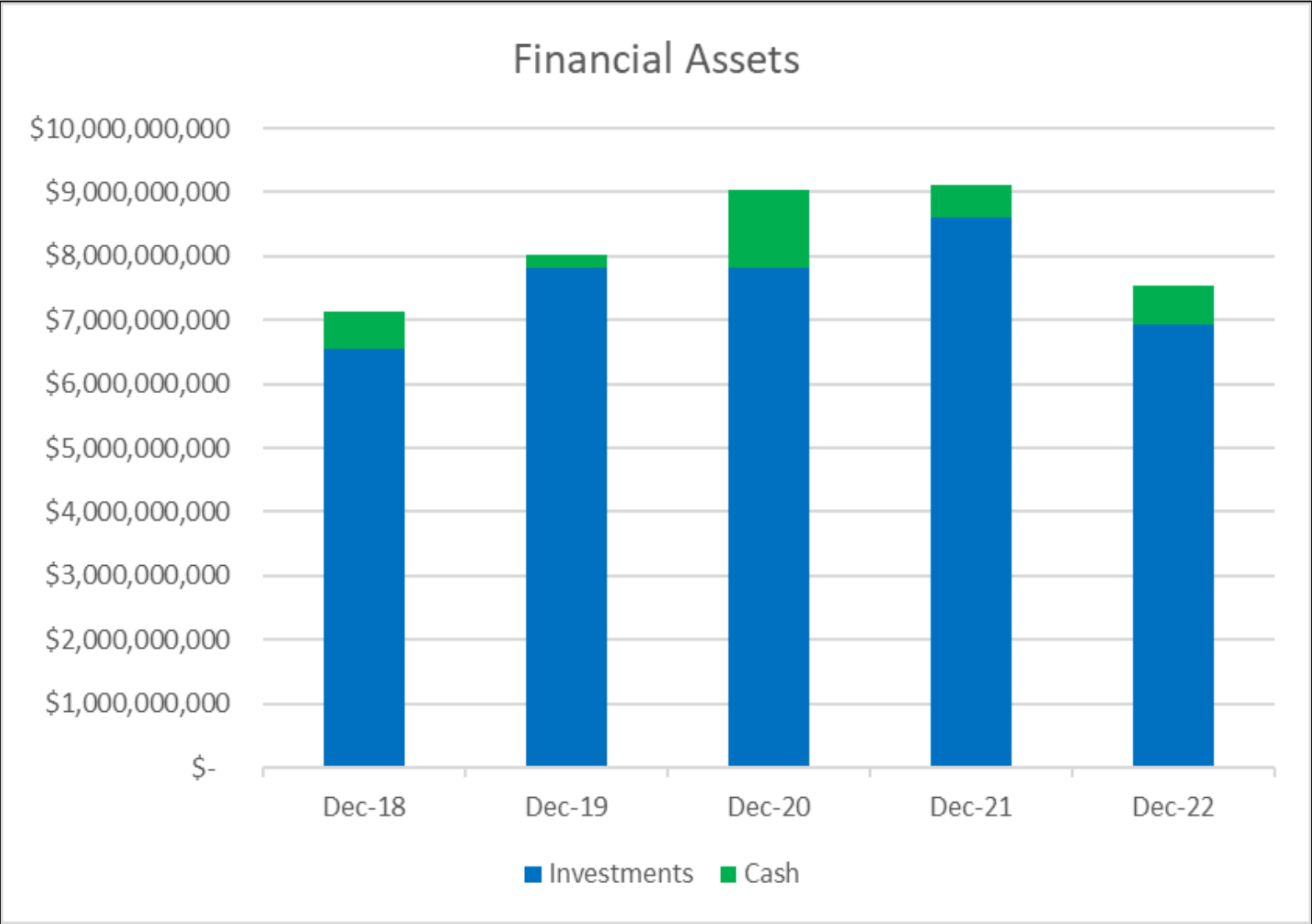
**AdventHealth lost \$839M in 2022 after gains in 2021**



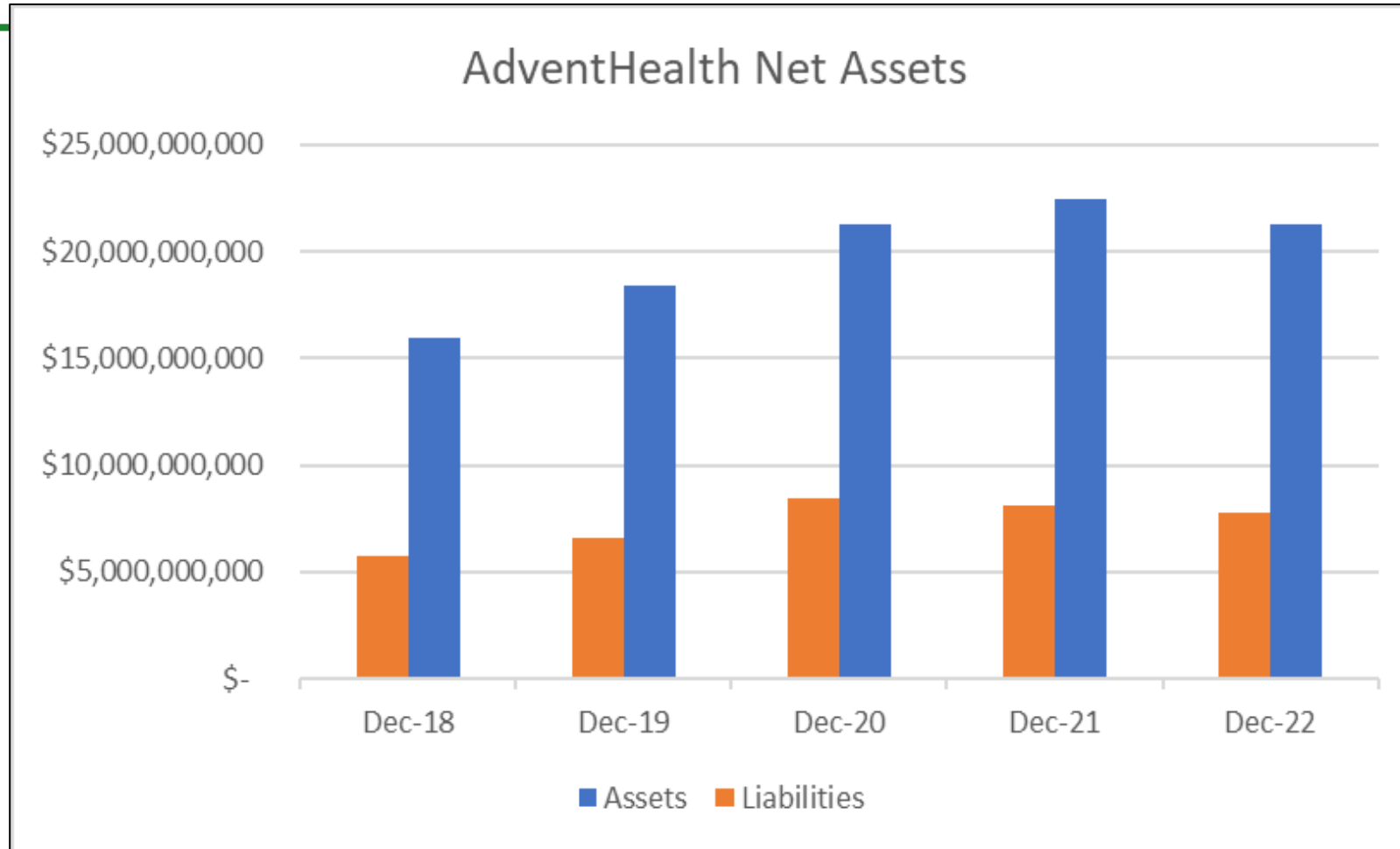
**\$1.3 Billion  
UNREALIZED  
Investment Losses**

# AdventHealth

*December 2022  
Investment balance  
reduced by \$1.3  
Billion UNREALIZED  
Market Losses*

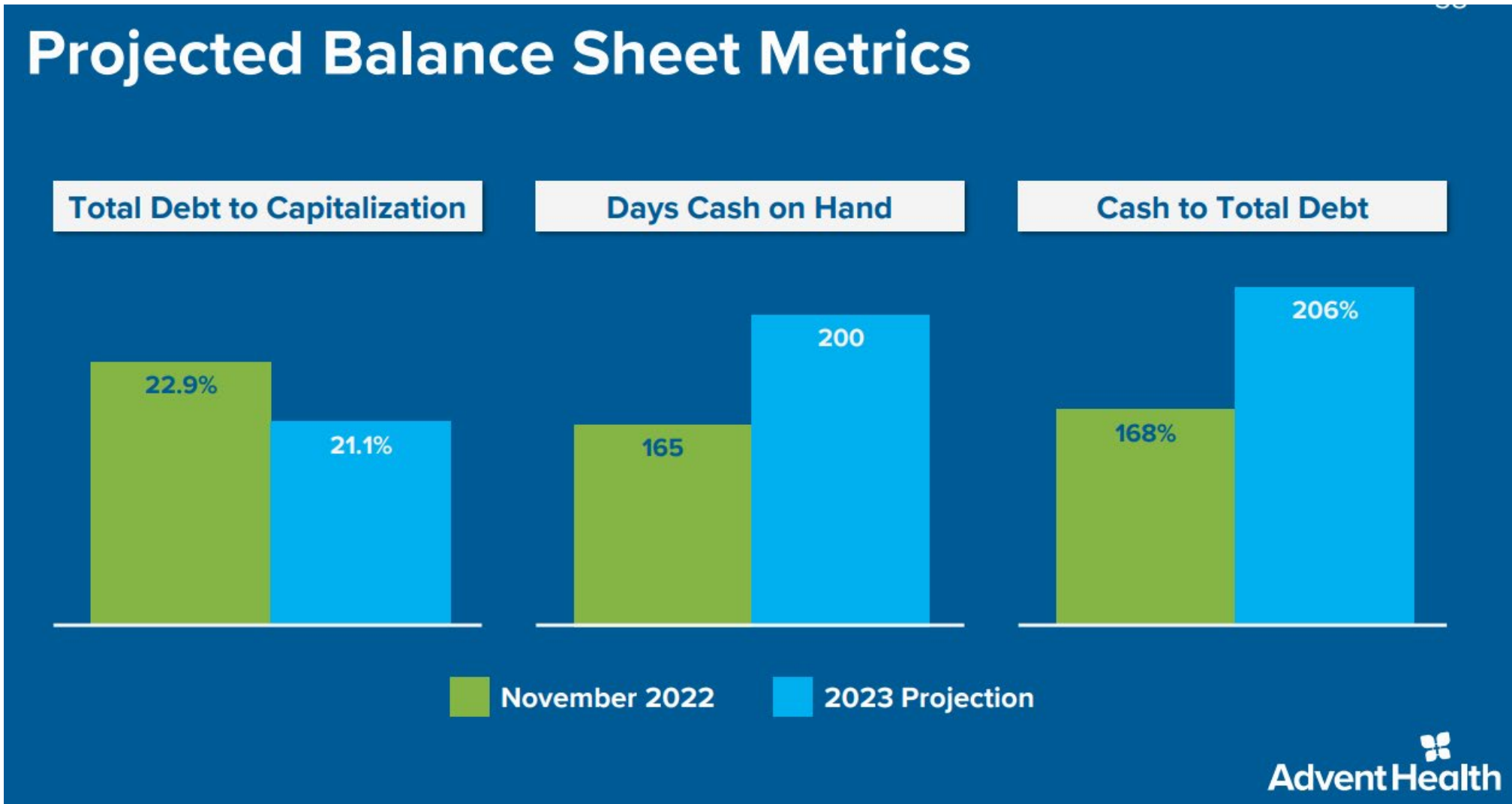


# AdventHealth Net Assets



- Total Assets minus Total Liabilities
- “Net Worth”
- 2022 Net Assets = \$13.5 Billion
- *Dec 2022 Assets reduced by \$1.3 Billion UNREALIZED losses*

# AdventHealth, JP Morgan Presentation January 2023



# Thank you!

Hospital Cost Tool and Calculator

<https://www.nashp.org/policy/health-system-costs>

<https://www.nashp.org/hospital-cost-tool/>

Electronic Municipal Market Access – MSRB

<https://emma.msrb.org>



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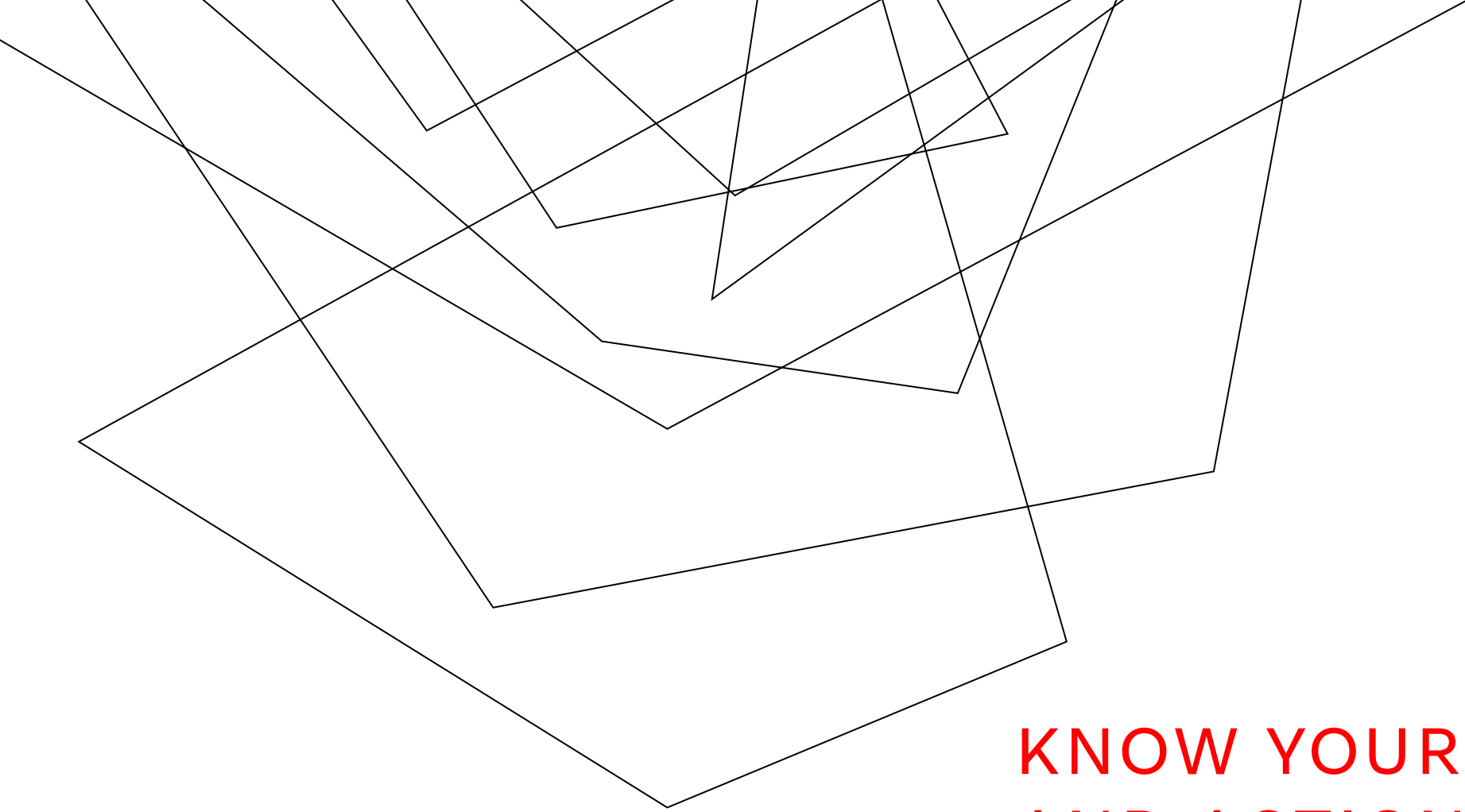
nashp.org



@NASHPhealth



@NASHP



# KNOW YOUR NUMBERS AND ACTIONABLE RECOMMENDATIONS

Presented by Alex Jung

# KNOW YOUR NUMBERS!

- Know what your prices are for the top 100 procedures and the top 50 drugs in your plan. There is no such thing as a separate medical and drug plan. You have a single trust for a single plan. Your benefits schedule is an internally created framework with zero legal foundation.
- Employers/plan sponsors spend way too much time on customer service issue resolution and not enough time on plan governance and controls.
- You may be compliant with the “big stuff” but ignoring the little things is what will drive cost increases, lawsuits, and fines.

# KNOW YOUR NUMBERS (CONT'D)

- Your priority should be managing high-cost claimants. Period. You cannot outsource that. Pay attention to their hospital and drug claims. Ask for the price data underlying the expenses. Actively manage their care by insisting that the health plan assign case managers to every patient with claims above \$25K YTD (or up to your stop loss or reinsurance limit).
- If you can't do the analysis yourself, pay for a reputable data analysis firm to audit for fraud, waste, and abuse. It's your fiduciary duty and has always been.
- If you encounter data request delays, engage your general counsel immediately. It won't look good in your defense to claim your health plan or PBM is working on it or you outsourced the responsibility. It's not their responsibility.





# ACTIONABLE RECOMMENDATIONS

- Get your claims data. Ideally 18-24 months. Look at it yourself. Ask your data vendor to walk you through the details. Make the time. Don't rely on reports that aggregate information or apply grouping methodology to hide unit costs. Acuity and severity adjustments hide the details.
- Conduct a price benchmarking study on the top 10 facilities, providers, and hospitals. Do this by procedure and by diagnosis. Don't rely on bundling or episode of care logic. Look at the unit prices paid.
- Conduct a fraud, waste, and abuse study. Hire someone who is independent of the health plan or your broker, advisor, and/or consulting company. Don't be penny-wise and pound-foolish. Fraud is rampant, your plan has a 100% chance of it.
- Stop buying drugs based on discounts and stop asking for rebates. Insist on paying the lowest cost net price or market cash price. Make your PBM do the hard work. They know what those numbers are, so make them deliver real savings, not imaginary ones.

## ACTIONABLE RECOMMENDATIONS

- Seek independent legal advice on your obligations and level of compliance with the CAA. You aren't just required to report, you must also attest. Attestations are legal disclosures of honesty, transparency, and truth. You are personally and legally liable for non-compliance whether you realize it or not.
- Insist that your health plan carrier require hospitals in their network to be fully compliant with the hospital price transparency regulations. That includes public access to the data and valid machine-readable files. Make the carrier provide you with a performance guarantee or a refund if their network providers are not in compliance.
- It's their job to check that all the providers in their network are compliant with all regulations, licensing requirements, and patient safety regulations. Don't let them off the hook.