Unprecedented State Focus on Healthcare

- State legislative summer study committees beginning now

- Joint House and Senate health and insurance committee meetings is very unusual

- Focus on cost is sector-wide (pharma-PBM fight), but will definitely include hospitals

- Multiple committees studying the topic, including impacts on employers but also on Medicaid budget and state government’s healthcare benefits

“I think the next session will be known as the “health care session” due to the intense focus a lot of health care issues will receive.”

State Senator Ed Charbonneau (R-Valparaiso) – Senate Health and Provider Services Committee Chairman
Federal Legislative Activity

General Republican message: “Unless the industry brings solutions, we will get “Medicare for All” and that would be a disaster.”

Medicare for All

- Multiple proposals but a divided Congress makes passage unlikely
- Growing public support for the concept, but confusion about what it really means
- Likely to be a campaign issue in the 2020 election
Comprehensive Bipartisan Senate Legislation

- Sweeping: impacts hospitals, pharmaceutical companies, insurance and public health

- Intervenes in contracts including prevention of “all-or-nothing” clauses and requirement that all bills to be sent to a patient within 30 business days or the patient is not obligated to pay

- Requires providers and health plans to give patients good faith estimates of their expected out-of-pocket costs within 48 hours of a request

- Lays out multiple options to address surprise/balanced billing including reference pricing and arbitration

- Establishes an All-Payer Claims Database (APCD) from self-insured plans, Medicare, and participating states to help stakeholders understand the cost and quality of care, and facilitate state-led initiatives to lower the cost of care, while prohibiting the disclosure of identifying health data or proprietary financial information

“Folks should take this package seriously.”
- U.S. Senator Lamar Alexander (R-TN)
A Breakdown of Health Care Costs
Federal Spending for United States - FY 2018

- Health Care: 29%
- Pensions: 25%
- Defense: 21%
- Education: 3%
- Transportation: 2%
- Protection: 1%
- Welfare: 8%
- Interest: 8%
- General Government: 1%
- Other Spending: 2%

Federal Health Spending by Type of Service or Product

- Hospital Care: 33%
- Physician and Clinical Services: 20%
- Other: 13%
- Other Nondurable Medical Products: 2%
- Other Professional Services: 3%
- Home Health Care: 3%
- Durable Medical Equipment: 2%
- Dental: 4%
- Nursing Care Facilities and Retirement: 5%
- Other Health Services: 5%
- Other Nondurable Medical Products: 2%

*Includes the cost of drugs delivered in health care settings

U.S. Government Publishing Office

Centers for Medicare & Medicaid Services (2017)
A Breakdown of the Hospital Dollar

Nearly 60% goes to wages & benefits

Drug prices increasing faster than medical inflation

Employee wages and benefits constitute the largest percentage of costs for inpatient hospital services.

Source: AHA analysis of 2015 Centers for Medicare and Medicaid Services inpatient market basket update projections, using base year 2010 weights (most recent available).
Where Does Your Health Care Dollar Go?

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive. It also helps to improve health care quality and affordability for all Americans. Here is where your health care dollar really goes.

- **23.3¢** Prescription Drugs
- **22.2¢** Doctor Services
- **20.2¢** Office & Clinic Visits
- **16.1¢** Hospital Stays
- **4.7¢** Taxes
- **3.3¢** Other Fees & Business Expenses
- **1.8¢** Customer Engagement
- **1.6¢** Finance, Claims, & Special Investigations
- **1.6¢** Care Management
- **1.6¢** Technology & Analytics
- **0.7¢** Administration
- **0.5¢** Provider Management
- **2.3¢** Net Profit

Insurance = 13.4¢
**RAND Study 2.0**

- Hospitals and the Employers’ Forum of Indiana agree on the need to reduce health care costs.
- Hospitals are large employers and are committed to reducing the cost of health care.
- Hospital prices alone don’t necessarily translate into total employer spend.
- RAND does not take utilization — the amount of services people are using — into account, which impacts the total cost of care.
  - Choice, quality, and convenience also are important factors.
Indiana Premiums Comparable to Other Midwest States

2018 Average Single Premiums per Enrolled Employee

<table>
<thead>
<tr>
<th>State</th>
<th>Average Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$6,715</td>
</tr>
<tr>
<td>Illinois</td>
<td>$7,123</td>
</tr>
<tr>
<td>Indiana</td>
<td>$6,778</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$6,690</td>
</tr>
<tr>
<td>Michigan</td>
<td>$6,322</td>
</tr>
<tr>
<td>Ohio</td>
<td>$6,804</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$6,816</td>
</tr>
</tbody>
</table>

2018 Average Family Premiums per Enrolled Employee

<table>
<thead>
<tr>
<th>State</th>
<th>Average Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$19,565</td>
</tr>
<tr>
<td>Illinois</td>
<td>$20,407</td>
</tr>
<tr>
<td>Indiana</td>
<td>$19,551</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$19,277</td>
</tr>
<tr>
<td>Michigan</td>
<td>$18,242</td>
</tr>
<tr>
<td>Ohio</td>
<td>$19,640</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$19,555</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
## Indiana’s Employer Premiums - - Not an Outlier

### Total Average Annual Premium per Enrolled Employee for Employer-Based Health Insurance, 2013-2018 by Midwest State

<table>
<thead>
<tr>
<th>Year</th>
<th>Illinois</th>
<th>Indiana</th>
<th>Kentucky</th>
<th>Michigan</th>
<th>Ohio</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$5,824</td>
<td>$6,099</td>
<td>$5,257</td>
<td>$5,319</td>
<td>$5,679</td>
<td>$5,730</td>
</tr>
<tr>
<td>2014</td>
<td>$6,126</td>
<td>$6,041</td>
<td>$5,914</td>
<td>$5,610</td>
<td>$5,930</td>
<td>$5,868</td>
</tr>
<tr>
<td>2015</td>
<td>$6,055</td>
<td>$5,868</td>
<td>$5,984</td>
<td>$5,771</td>
<td>$5,939</td>
<td>$6,011</td>
</tr>
<tr>
<td>2016</td>
<td>$6,268</td>
<td>$6,130</td>
<td>$5,758</td>
<td>$5,906</td>
<td>$6,291</td>
<td>$6,386</td>
</tr>
<tr>
<td>2017</td>
<td>$6,493</td>
<td>$6,162</td>
<td>$6,101</td>
<td>$6,388</td>
<td>$6,247</td>
<td>$6,437</td>
</tr>
<tr>
<td>2018</td>
<td>$7,123</td>
<td>$6,778</td>
<td>$6,690</td>
<td>$6,322</td>
<td>$6,804</td>
<td>$6,816</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
Focus on Total Cost of Care and Value

- As we look to reduce health care costs it’s critical that we understand the total cost of care
  - Hospital prices alone do not determine the total cost of care
  - Important to understand utilization of services – how frequently people are using services
  - Quality is a key component of value
  - Hospitals are committed to working with other key stakeholders including insurers, employers and drug companies

- Hospitals support price transparency
  - IHA embraced transparency in 2015 with launch of MyCareINsight
  - Transparency requires data that is accurate, fair, and complete
  - Several states have adopted All-Payer Claims Data (APCD) bases
Economic Impact and Hospital Challenges
Economic Impact of Indiana’s Hospitals

- Significant contributors to Indiana’s economic health
- Major employers and purchasers of goods and services

### Direct and Indirect Impact on Indiana

**Economic Impact**

<table>
<thead>
<tr>
<th>Component</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>$21.9B</td>
</tr>
<tr>
<td>Supply Purchases</td>
<td>$14.5B</td>
</tr>
<tr>
<td>Capital Spending</td>
<td>$2.7B</td>
</tr>
<tr>
<td><strong>Total Impact</strong></td>
<td><strong>$39.1B</strong></td>
</tr>
</tbody>
</table>

- **243K** Jobs
  - Generated by Indiana hospitals
- **115K** Employees
  - Directly employed by Indiana hospitals

- **143K** Employees
  - Indirectly employed by Indiana hospitals
## Community Benefit for Indiana’s Not-for-Profit Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance/Charity</td>
<td>$387,766,585</td>
</tr>
<tr>
<td>Medicaid Losses</td>
<td>$785,738,188</td>
</tr>
<tr>
<td>Other Means Tested</td>
<td>$19,148,495</td>
</tr>
<tr>
<td>Community Health Improvement</td>
<td>$104,873,561</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>$159,681,574</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>$53,197,601</td>
</tr>
<tr>
<td>Research</td>
<td>$35,030,821</td>
</tr>
<tr>
<td>Cash and In-Kind Contributions</td>
<td>$36,007,692</td>
</tr>
<tr>
<td>Community Building Activities</td>
<td>$11,795,222</td>
</tr>
<tr>
<td>Bad Debt Attributable to Patients Eligible for Financial Assistance</td>
<td>$39,188,127</td>
</tr>
<tr>
<td>Medicare Losses</td>
<td>$777,962,560</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,410,391,426</strong></td>
</tr>
</tbody>
</table>

*Latest Publicly Available Data*
Hospital Challenges: Government Underpayment

*Approximately 50% of all Indiana births are to Medicaid beneficiaries.

Hospitals pay $800 million dollars to increase this low rate.

Medicaid only pays 23¢ on the dollar to hospitals based on the cost of care.

Medicare only pays 87¢ on the dollar to hospitals based on the cost of care.
### Payment Source for Indiana Hospitals

<table>
<thead>
<tr>
<th>Payment Source</th>
<th>Urban</th>
<th>Suburban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Payors including Medicare, Medicaid</td>
<td>86%</td>
<td>43%</td>
<td>76%</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>8%</td>
<td>51%</td>
<td>19%</td>
</tr>
<tr>
<td>Self Pay/Other</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Data source: Analysis of Inpatient/Outpatient Discharge Study, 2018, Indiana Hospital Association
Hospitals Support the Healthy Indiana Plan (HIP)

• HIP is a partnership between hospitals and the State to provide health care to 250,000 Hoosiers.

• Hospitals will pay over $1,000,000,000 in fees in State Fiscal Year (SFY) 2020. The fastest growing portion, $271M, supports Healthy Indiana Plan HIP*

• Hospitals’ share is increasing at a rapid rate - 62% in the past three years (388% increase for the HIP portion)

• Many rural hospitals saw an increase of as much as 45-55% from SFY 2018 to 2019

*$800M is used to make low hospital reimbursement rates sustainable
Lower Marketplace Enrollment

Number of Individuals Selecting Marketplace Applications During Each Open Enrollment Period

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>219,175</td>
</tr>
<tr>
<td>2016</td>
<td>196,241</td>
</tr>
<tr>
<td>2017</td>
<td>174,611</td>
</tr>
<tr>
<td>2018</td>
<td>166,711</td>
</tr>
<tr>
<td>2019</td>
<td>148,404</td>
</tr>
</tbody>
</table>

Sources:
2015 2016 2017 2018 2019
Impact of Scheduled DSH Cuts

Looming cuts in Medicaid DSH will slash the amount of support to Indiana’s safety net hospitals by almost half by 2021.

$4B \rightarrow $84M
Cuts to Medicaid DSH payments on October 1, 2019
Projected loss to Indiana’s safety net hospitals in State Fiscal Year 2020

$8B \rightarrow $1688M
Cuts to DSH next year for FFY 2021 and beyond
Projected loss to Indiana’s safety net hospitals in State Fiscal Year 2021
Hospital Challenges: Regulatory Burden

- Hospitals have to comply with 341 mandatory regulatory requirements.

Source: Data from the American Hospital Association Report: Regulatory Overload - Accessing Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers.
Rural Health Care
Rural Healthcare Challenges

• Rural hospitals are essential to the health of 60 million Americans who live in rural communities

• 113 hospitals across 30 states have closed since 2010

• In Indiana, rural hospitals are fragile
  - 23.1% of Indiana rural hospitals are at high risk of closing unless their financial situations improve.
  - Fayette Regional Health System closed in July after filing for bankruptcy in October of 2018

• Hoosiers losing Access – OB and ER are especially vulnerable
113 Rural Hospital Closures: Jan 2010 - Present
Indiana’s Poor Public Health Metrics
Indiana’s Poor Health Metrics

- Indiana ranks 44th among states, **down 3 places** from 41st in 2017, in the percentage of people who smoke.

- In the past two years, smoking in Indiana **rose 6%** while decreasing in many other states.

<table>
<thead>
<tr>
<th>The Bottom 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>41 Alabama</td>
</tr>
<tr>
<td>42 Alaska</td>
</tr>
<tr>
<td>43 Ohio</td>
</tr>
<tr>
<td>44 Indiana</td>
</tr>
<tr>
<td>45 Mississippi</td>
</tr>
<tr>
<td>46 Arkansas</td>
</tr>
<tr>
<td>47 Tennessee</td>
</tr>
<tr>
<td>48 Louisiana</td>
</tr>
<tr>
<td>49 Kentucky</td>
</tr>
<tr>
<td>50 West Virginia</td>
</tr>
</tbody>
</table>
Indiana Business vs. Health Rankings

**BUSINESS**

- **COST OF DOING BUSINESS**
  - CNBC, America's Top States for Business
- **STATE INFRASTRUCTURE**
  - CNBC, State of State Infrastructure Ranking
- **STATE REGULATORY ENVIRONMENT**
  - Pacific Research Institute
- **PROPERTY TAX INDEX**
  - The Tax Foundation
- **STATE TAX CLIMATE**
  - Tax Foundation 2017 State Business Tax Climate Index

**HEALTH**

- **PUBLIC HEALTH FUNDING**
- **PERCENTAGE OF SMOKERS**
- **INFANT MORTALITY**
- **CANCER DEATHS**
- **OVERALL HEALTH**

*All ratings from America's Health Rankings 2018 Report*

Smoking is a primary factor for the low ranking.
The Cost of Poor Health to Employers

- An employee who smokes costs their employer $6,000 more per year* than an employee who has never smoked.

- Tobacco users spend 175% more per person in inpatient, outpatient, and pharmacy costs and have 66% more medical/Rx claims.

- Tobacco users spend 149% more per person in emergency room visits and are 320% more likely to have an emergency room visit.

*Analysis conducted by: Stanley Jackson, Hayden Skirvin, and Kristen Campbell of Apex Benefits.
Policy and Market Solutions
Policy and Market Solutions

• Support efforts to highlight price and quality transparency
  – Many states are developing/have implemented All Payer Claims Data Bases (APCD)
  – Allows consumers to see benchmarks, by geography, for negotiated prices

• Pass consumer protection legislation to protect Hoosiers from surprise bills

• Invest in public health initiatives
  – Increasing cigarette tax by $2/pack
  – Taxing all e-cigarette products
  – Continue support for efforts to improve infant mortality

• **Change the payment model**
  – Focus on value (quality + price) not on volume of procedures
  – Engage employers to accelerate new models
New Care Models
# Shift From Fee-for-Service to Value

## Value-Based Care

A shift from volume-based care to value-based care incentivizes healthcare providers to offer the best care at the lowest cost.

<table>
<thead>
<tr>
<th>Volume-Based Care</th>
<th>Value-Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basis for Payment</strong></td>
<td>Fee for service</td>
</tr>
<tr>
<td><strong>Also called</strong></td>
<td>Disease-based care</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Quantity of procedures</td>
</tr>
<tr>
<td><strong>Payments</strong></td>
<td>One payment for all services a patient needs, regardless of the outcome</td>
</tr>
<tr>
<td><strong>Incentives</strong></td>
<td>The volume and cost of care provided</td>
</tr>
<tr>
<td><strong>Keys to Success</strong></td>
<td>Efficiency, throughput</td>
</tr>
</tbody>
</table>
ACCOUNTABLE CARE ORGANIZATIONS (ACOs)
Groups of doctors, hospitals, and other healthcare providers, who come together and assume financial risk for managing the health of a population.

DIRECT-TO-EMPLOYER CONTRACTING
Companies bypass insurance companies and negotiate directly with hospitals, healthcare providers to reduce costs and improve health outcomes for employees.

BUNDLED PAYMENTS MODELS
Healthcare providers are paid a single payment for all services performed to treat a patient for a certain condition (e.g., knee replacement) or care for a period of time.

Quality measures are essential to ensure the value-based system works properly.

- Significant investment by hospitals to put the systems in place to identify at-risk patients and manage care
- Establishing an organizational structure in which effective processes, training and incentives are aligned
- Physician adoption of best practice guidelines
- Providers and payers agree to quality metrics up front

A healthier Indiana is a more competitive Indiana
Franciscan Health ACO: Challenges

• Patient-Directed Care

  − ACOs are about managing chronic conditions and ensuring patients receive care in an appropriate setting
  − 20-30% of patients drive 60-80% of the cost; these are frequently people with at least one chronic condition such as diabetes, heart disease, and pulmonary conditions
  − Engaging patients to work with physicians and other clinicians to manage chronic conditions can be challenging
  − When patients can seek care wherever they want, it is difficult to manage chronic conditions, achieve quality metrics, and ensure care is being delivered in the appropriate setting

• Benefit Design

  − For the best outcomes, benefits need to be designed to align financial incentives around prevention and wellness for all parties
  − Employers need to be willing to invest in prevention/wellness, which is a longer-term goal

• Turnover rates in insurance coverage are challenging

  − ACOs are about managing a stable population and high turnover rates make this problematic
Questions?

Thank you for your partnership!

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