# NAIC National Meeting Fall 2022 Health Innovations (B) Working Group

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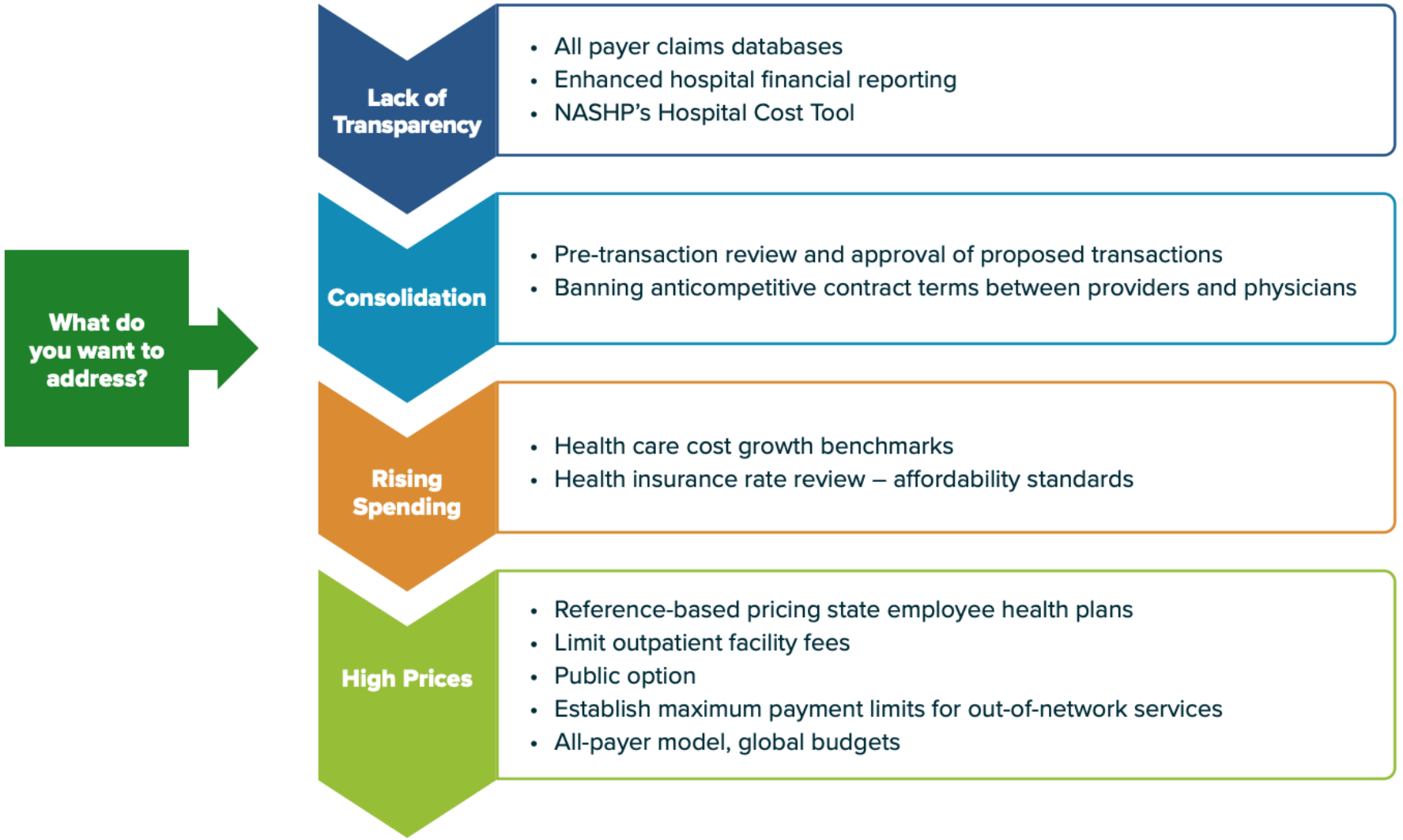
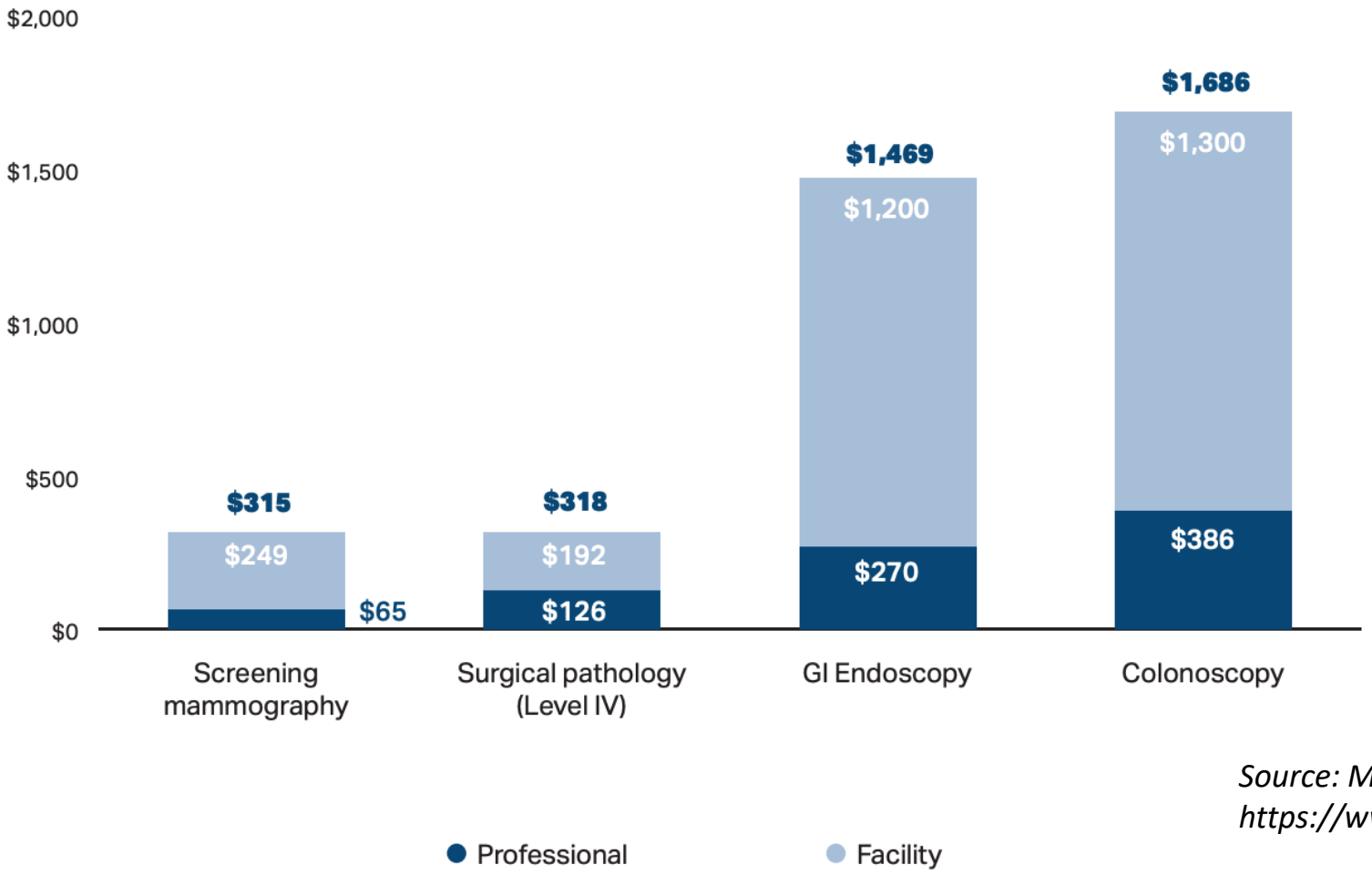
# Policy Tools to Lower Costs



# Average Price for Common HOPD Services by Professional and Facility Component, 2018 in MA




**Services displayed had the highest aggregate HOPD spending in 2018.**

For each of these services, the office price is higher than the HOPD professional component alone, but far lower than the total. For example, the office-based price for a colonoscopy was $748 in 2018; a difference of $938.

*Source: MA Health Policy Commission, 2021 Cost Trends Report Chart Pack, https://www.mass.gov/doc/2021-cost-trends-report-chartpack/download*

# Option 1: NASHP Facility Fee Model Legislation

- Prohibits certain facility fees:
  - **Site-specific facility fees:** services rendered at physician practices and clinics located more than 250 yards from a hospital campus.
  - **Service-specific facility fees:** typical outpatient services that are billed using evaluation and management codes, even if those services are provided on a hospital campus.
- Responsible agency can annually identify services to be subject to service-specific limitations that may reliably be provided safely and effectively in settings other than hospitals
- Requires annual reporting of facility fees charged or billed by health care providers

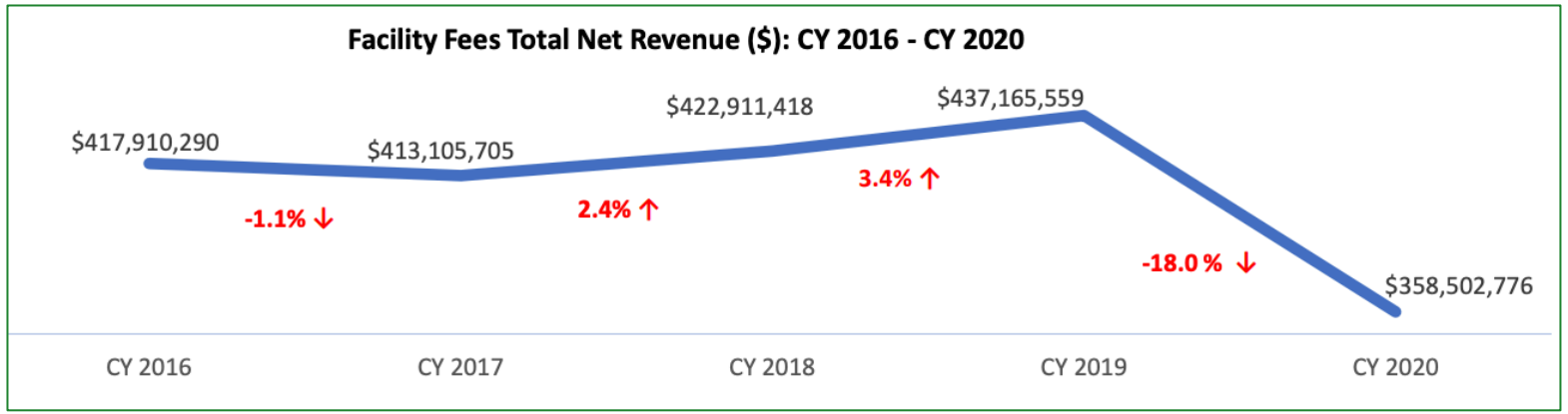
# Facility Fees Restrictions in CT

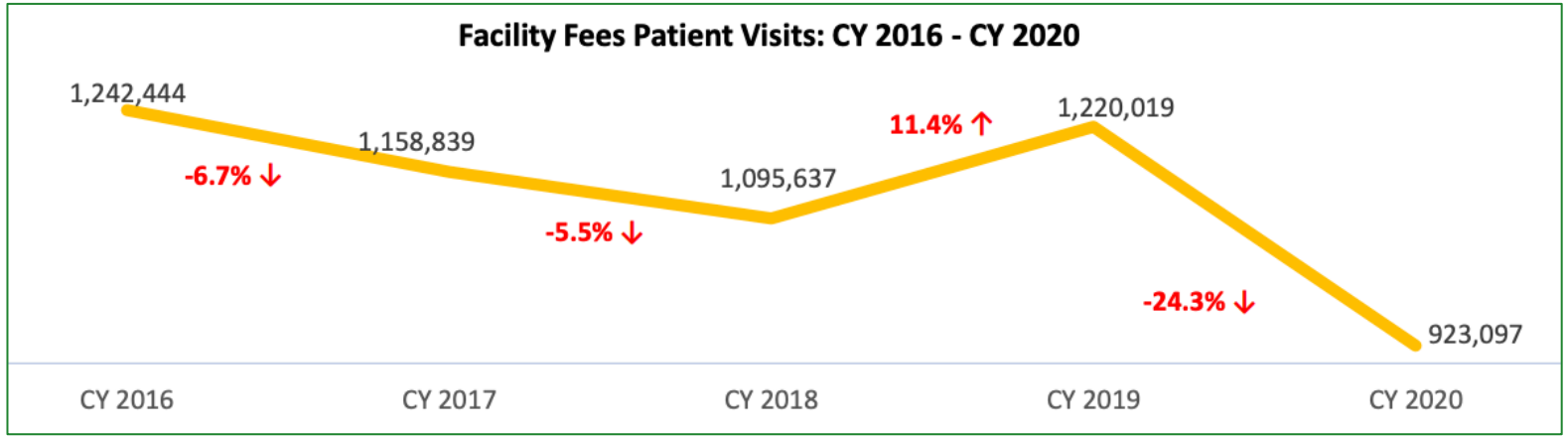
- **Consumer Notice:** Required facilities to provide notice to consumers of facility fees for evaluation and management services in 2014 (HB 5337)
- **Facility Fee Prohibition:** No hospital, health system or hospital-based facility shall collect a facility fee for:
    1. Outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT A/M) code and are provided at a hospital-based facility located off-site from a hospital campus, or
    2. Outpatient health care services provided at a hospital-based facility located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate.

**First enacted in 2015, effective in 2017 (SB 811)*

# Facility Fee Restrictions in CT

- Connecticut has updated its facility fee regulations several times since 2014
  - Added a prohibition on services that use assessment and management (CPT A/M) codes in response to hospital gaming (2021)
  - Added a prohibition on facility fees for telehealth no matter the location of services (2022)
- Connecticut also requires hospitals to provide notice to consumers about facility fees and to submit data on facility fee revenue to the Office of Health Strategy (OHS)
  - OHS publishes data annually




# Facility Fee Revenue Trends, 2016 – 2020

- Facility Fee Total Revenue was increasing before the pandemic
- Total patient visits with facility fees have fluctuated over time but were most recently increasing

Source: https://portal.ct.gov/-/media/OHS/ohca/Facility-Fees/CY-2016-2020-Facility-Fee-Filing-Trend-Report.pdf

# Key Findings from CT's 2020 Facility Fee report

- Outpatient facility fees were down 18% to $358.5 million from 2019 to 2020
- Patient visits generating facility fees decreased 24.3%
- In CY2020, cardiovascular procedures generated the most facility fee revenue, nearly $19 million
- 62% of the facility fee revenue was paid by employer and commercial health plans on behalf of policyholders
    - These health plans also paid the highest average facility fees at $620 per visit.



Source: https://portal.ct.gov/OHS/Press-Room/Press-Releases/2021-Press-Releases/Office-of-Health-Strategy-Releases

# Option 2: Promote More Equitable Contracting

- Bar use of anticompetitive contracting terms in contracts between health systems and plans (all-or-nothing contracts, anti-tiering or anti-steering, most-favored nations, or gag clauses)
- NASHP resources:
  - Model law and policy brief to prohibit anticompetitive contracting between providers and health plans
- Health plans could negotiate reduction or elimination of facility fees on certain services

## All-or-nothing contracting

Health systems leverage the status of their "must-have" providers and require plans to contract with all providers in the system or none of them. This forces insurers to face a difficult choice - include all of the systems' providers (even if they are low-value or high-cost) or lose them all.

## Anti-tiering or Anti-steering Clauses

Dominant systems may require a health plan to place all physicians, hospitals, and other facilities associated with a hospital system in the most favorable tier of providers (i.e. anti-tiering) or at the lowest cost-sharing rate to avoid steering patients away from that network (i.e. anti-steering). These clauses undercut a plan's ability to direct patients to high-value providers.

## Most-Favored Nation (MFN) clauses

Typically used by a dominant insurer in combination with a dominant health system, MFN clauses are contractual agreements in which a health system agrees not to offer lower prices to any other insurer. For a dominant insurer, this ensures they are getting the best price and that no rival insurer can negotiate to offer a novel product at lower rates. MFNs may also allow insurers and providers to collude to raise prices.

## Gag Clauses

Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. The lack of transparency from gag clauses and the mistaken notion that prices are trade secrets undermines price transparency tools for consumers and decreases plan sponsors' ability to push back on rising prices.

# Thank you!

**NASHP's Health System Costs Resources:**

- Written research and analysis & state legislative tracking
- Model legislation & regulation to address consolidation and more
- Hospital Cost Calculator & hospital financial transparency reporting template
- Available Now! Interactive Hospital Cost Tool
- https://www.nashp.org/policy/health-system-costs/

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