Hospital Prices:
the Policy and the Practical

A Compendium of State and Federal Policy Interventions to Address Hospital Pricing

All data contained in this paper are derived from 32BJ Health Fund claims data or other cited sources.

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About 32BJ Health Fund

The 32BJ Health Fund is an unusually effective collaboration between a labor union (SEIU 32BJ) and management (represented collectively by the Realty Advisory Board in New York) to provide affordable, comprehensive, and innovative health coverage to working people. The Fund aggregates employer contributions from 5,000 employers, ranging from many small businesses to global real estate firms, and uses contributions to provide benefits to 200,000 people. The 32BJ Health Fund serves members of the SEIU 32BJ union and their families. The union members are cleaners, property maintenance workers, doorpersons, security officers, window cleaners, building engineers, school and food service workers, and airport workers in 11 states and Washington, D.C. The 32BJ Health Fund receives all of our claim data from our vendors, which uniquely allows us to leverage data to make benefit and plan design decisions in the best interest of our participants, so that we can maximize the benefits they receive.

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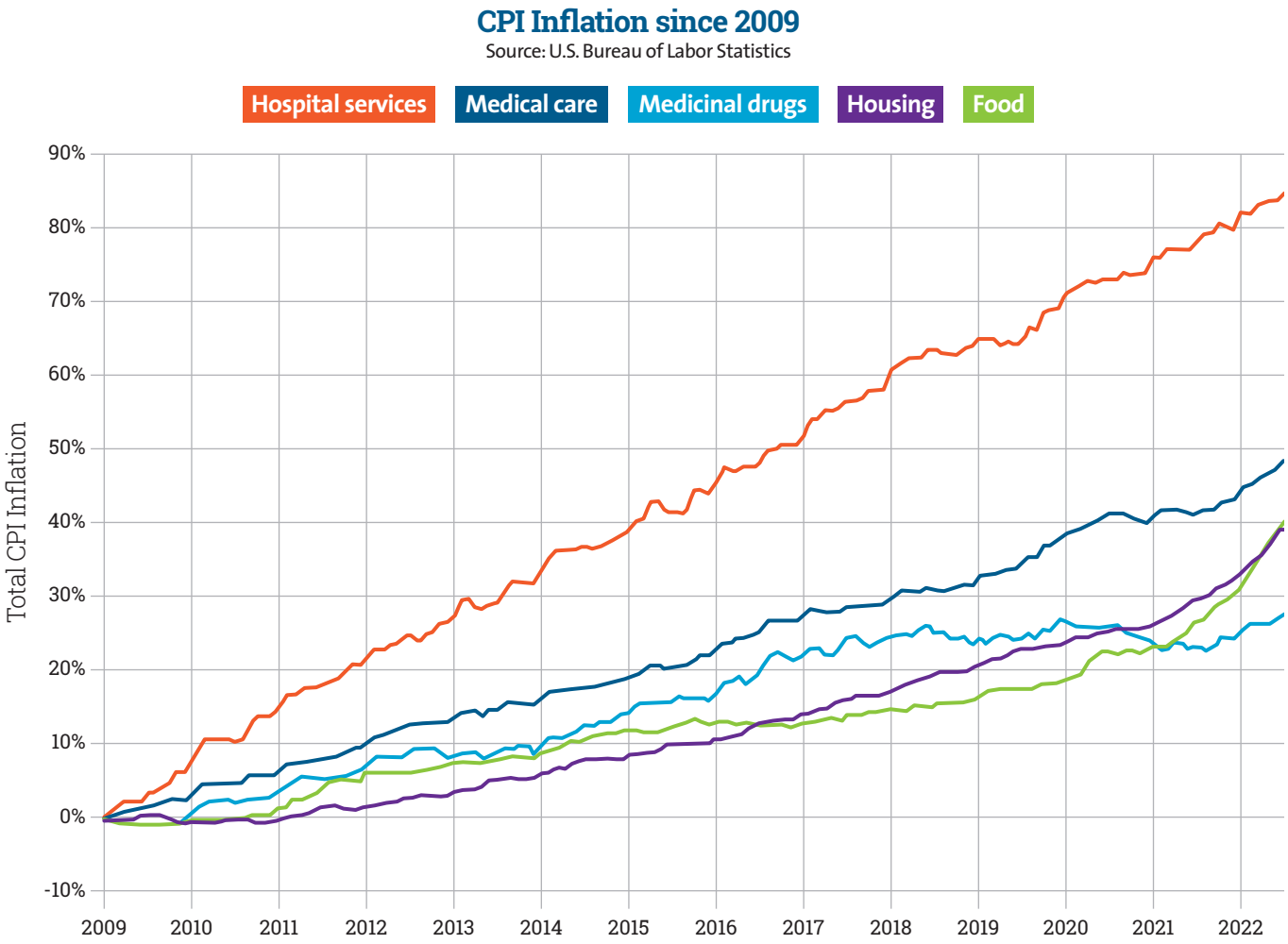


Introduction

The cost of healthcare in the US is high and rising, particularly when compared to other wealthy countries.[1] In 2020, healthcare spending increased 9.7 percent to $4.1 trillion, growing faster than both the economy and consumer prices.[2] Hospital prices are the single largest component of healthcare inflation, outpacing pharmaceutical and provider costs.[3] In New York State, research shows that about 39 percent[4] of healthcare costs are attributable to hospital prices, while the 32BJ Health Fund pays approximately 44 percent of its total health benefit costs on hospital care. The hospital prices charged to commercial insurers are, on average, 247 percent of what Medicare pays for the same service at the same location.[5] Research has shown that higher prices are not generally driven by safety net hospitals, as prices are typically reflective of a hospital's market leverage.[6]

The rising cost of healthcare has a very real impact on workers and employers. The higher costs for providing health benefits applies pressure on all areas of employee compensation, especially wages. As of 2021, 64 percent of covered workers are in a self-funded plan, meaning that the plan pays for some or all health services

directly from its own funds.[7] 32BJ SEIU estimates that the cost of providing health coverage with no employee premium sharing now represents 37 percent of the total increase in compensation for 32BJ workers. If healthcare costs were to simply increase at the rate of inflation, the union estimates that employers would have been able to provide an additional $5,000 in annual wages to 32BJ members without altering their total compensation package. This also affects public budgets, where local and state governments are the largest purchasers of employee healthcare. To the best of our knowledge, there has been limited analysis undertaken in New York about the cost of providing public employees benefit coverage, and the impact of high hospital prices on this cost.

In March 2022, the 32BJ Health Fund published a report, Hospital Prices: Unsustainable and Unjustifiable, identifying where hospital prices are highest and how they impact 32BJ Health Fund participants, while also addressing the most common misconceptions about hospital pricing. This compendium takes a deeper dive into the regulatory and nonregulatory solutions that states are pursuing to contain the healthcare costs driven by hospital pricing and behavior. Without significant reforms to rein in hospital prices, the ability of healthcare purchasers like the 32BJ Health Fund to provide access to high-quality affordable care is in jeopardy. This compendium provides a consolidated resource for stakeholders to learn about the suite of existing efforts occurring all over the country. While not comprehensive, we include available evidence, opportunities, and challenges for each. This is meant to serve as a reference tool rather than to provide an evaluation or a recommendation as to which approaches are best.

This compendium presents regulatory and nonregulatory solutions within three larger frameworks:

1. Large-scale payment reforms such as cost growth benchmarks and pricing strategies;
2. Market reforms that can increase competition and decrease consolidation;
3. Improved hospital accountability through greater transparency and use of the non-profit tax exemption.

In compiling these resources, three takeaways became clear:

1) ***There is no one perfect solution to solve the issue of high hospital prices and healthcare costs.*** Federal, state, and local governments must tackle the problem from multiple angles, and commit to evaluating and iterating on these strategies over time.

2) ***It is possible to lower hospital prices while preserving affordability and access to high-quality providers, and it is happening all over the country.*** Inaction on the issue of high healthcare costs, driven by high hospital prices, is not an option with the scale of lives and economies impacted. These efforts show the tangible savings and results that can accrue to workers, employers, and public budgets.

3) ***New York was notably absent from the states that are actively engaged in tackling the issue of high hospital prices.*** Though several efforts have been attempted, we hope this tool will facilitate the process of finding a set of options for the state to pursue on an ongoing basis.

The 32BJ Health Fund's analysis has shown that long-term reforms on a larger scale are needed to achieve the cost-savings necessary to ensure access to affordable care for its participants. But to pursue large-scale payment reforms and the additional strategies outlined throughout this compendium, a key first step is identifying which entity, newly created or pre-existing, will be accountable for setting key targets or budgets, monitoring progress, and enforcing the standards set. The implementation of large-scale payment reforms, including state healthcare cost growth benchmarks described below, provides examples for how other states have established authority and governance for these entities.

Section 1

Large-Scale Payment Reforms

As the national share of spending on healthcare continues to increase, driven by increases in hospital prices, state and local governments have implemented cost containment efforts using large-scale payment reforms and pricing strategies. Simply put, large-scale payment reform seeks to change the way that purchasers pay for healthcare.

The large-scale payment reforms described below vary in their specificity and level of market regulation, from healthcare cost benchmarks that set a state-level target for cost increases, to global budgets that set an all-payer budget specific to each hospital. Each has its own opportunities and challenges, and can be used as a tool to advance a state's individual policy and population health goals for health system performance, consumer affordability, and health spending priorities.

KEY TERMS

All Payer Claims Database

Large state databases that include medical claims, pharmacy claims, dental claims, eligibility, and provider files collected from private and public employers. Data are reported directly by insurers to states, usually as part of a state mandate.

Cost Growth Benchmark

An annual per capita growth target of total healthcare spending in a state.

Price Cap

Caps set to limit prices for healthcare services at the top of the commercial price distribution.

Reference-Based Pricing

Claim pricing methodology grounded in analysis of an objective value for medical services, and adjudicating medical claims based on some multiple of that value. Simply put, the plan's pricing is based on a reference, typically Medicare pricing.

Global Budget

A payment arrangement that sets a budget to fund the delivery of care to a population over a specified time period, allowing for budget adjustments to reflect factors such as market and population changes, etc., and incorporates financial accountability for the facility or provider.

Global Hospital Budget

A payment arrangement in which the hospital is paid a prospectively set, fixed amount for the total number of services they provide during a given period.

"Shoppable" Services

Services that can be scheduled by a healthcare consumer in advance.

STATE COST GROWTH BENCHMARK PROGRAMS

Healthcare cost benchmark programs provide a vehicle for states to measure healthcare spending against set targets. This allows a state to determine when spending is increasing at an unsustainable rate, propose actionable strategies to contain costs, and provide enforcement as needed. As of July 2022, at least ten different states have adopted state healthcare cost benchmarks, seven using legislation, and three through executive orders.[8] [9]

In 2012, Massachusetts was the first state to pass legislation that established a statewide target for the rate of healthcare spending growth.[10] Massachusetts created an expansive annual reporting and hearing process with diverse statewide stakeholders to set benchmarks and track expenditures against them, using hearings to shape potential policy interventions. Delaware and Rhode Island were next to implement programs in 2018 and 2019, followed by additional action in Oregon, Connecticut, Washington, Nevada, and New Jersey through 2021. California recently passed legislation establishing its Office of Health Care Affordability in June 2022.

As the number of state healthcare cost benchmarking programs has grown, a greater knowledge base has been developed to define best practices and advance the application of benchmarking programs in new states. The learnings reflected below include common features for establishing, implementing, and enforcing a statewide program, as well as for using benchmark programs to advance statewide population health goals and delivery system reforms.

Common Features of Cost Growth Benchmarking Programs

Manatt Health Strategies[11] and the California Health Care Foundation report common features of state cost growth benchmark programs:[12]

Establishing authority, a governing body, and administrative infrastructure for the program

States create authority for cost growth targets using both executive orders and legislation. States also establish authority for these entities to collect comprehensive data in support of these efforts, and some include enforcement authority to ensure that benchmarks are adhered to. States employ different approaches to governing their programs. For example, Massachusetts created a new quasi-independent agency while other states administer their target programs within existing executive branch agencies.

Setting growth targets for healthcare costs

States define a growth target to bring healthcare cost growth in line with other economic indicators, such as gross state product and wage growth. Most current targets range from about 2.4 to 3.8 percent per capita annual growth.[13] States also set targets for specific delivery system reforms, such as adoption of alternative payment models and portion of total spend on primary care. Targets have adapted over time, with Massachusetts recently introducing legislation to propose a consumer affordability benchmark to the statewide target.[14] California's Office of Healthcare Accountability set a statewide target and specific targets for smaller segments of payers, providers, and geographic regions.[15]

Determining how to collect data and to measure and monitor healthcare cost growth

States establish benchmark and data collection processes to aggregate purchaser data to determine per capita healthcare cost growth. Results are generally publicly reported against the growth target. Most states collect all-payer claims data (APCD) as a part of their data systems. Spending data are often supplemented with disaggregated data to identify specific, inflationary cost drivers like low-value services or anticompetitive contracting. Connecticut, for example, annually collects data and reports performance relative to the benchmark at four levels: by state, health insurance market, individual payer by market, and advanced network for providers of a predefined size.[16]

Developing and implementing accountability and enforcement mechanisms

While holding payers and providers accountable to the benchmark is important to states, very few have adopted enforcement mechanisms beyond transparency and public reporting. Recognizing that performance measurement and public reporting are not sufficient to slow cost growth over the long term, several programs are starting to implement new mechanisms for enforcement, such as performance improvement plans and

financial penalties. Massachusetts recently issued a performance improvement plan for a health system that contributed to excessive health spending in the state, and has authority to issue fines for hospital noncompliance with the proposed plan.[17] Oregon recently adopted legislation to impose financial penalties when performance improvement plans do not achieve compliance.

Cost Growth Benchmarks as a Policy Tool

Many states have tailored their benchmarking programs to reflect local priorities for expanding transparency, addressing cost drivers, and investing in various health contributors.[18] Other stated goals of these offices have included investing in health equity and workforce stability; studying provider consolidation; improving healthcare cost transparency; identifying trends in patient cost sharing; targeting behavioral health spending; advancing primary care; and investing in primary care.

In 2019, Massachusetts' Governor Baker called for statewide primary care and behavioral health expenditure targets and set a goal of increasing spending on these services by 30 percent between 2019 and 2022.[19] The Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC) in Massachusetts have since leveraged their data collection authority to begin collecting behavioral health data as part of regular benchmark data collection and reporting processes. Another example includes Connecticut's commitment to investing in primary care. In 2020, Connecticut's Governor Lamont issued Executive Order No. 5, which charged the Office of Healthcare Strategy with developing and recommending a primary care spending target for the state beginning in 2021 to reach a primary care spending target by 2025.[20] The benchmarking program provided the state with a mechanism to measure and monitor primary care spending against total system spend, providing information that can influence the market redistribution of funds to increase primary care investment.

Outcomes

While it has been acknowledged that benchmarking programs are useful to help states identify their key cost drivers, and make more collaborative and data-driven decisions about payment reform, there is mixed existing evidence on benchmark program results and a lack of robust evidence from independent evaluations. Cost benchmarking programs remain a relatively recent endeavor with only one state's program, Massachusetts, predating 2018. Prior to 2019, Massachusetts reported holding statewide spending at or below the benchmark in four out of six years.[21] In 2019, however, three states (including Massachusetts) were reported as exceeding their benchmarks.[22] In addition to performance against the benchmark, policymakers are considering the effect of cost growth benchmark programs on healthcare premiums and out-of-pocket spending for individuals and families.

PRICE CAPS

New policy proposals include the creation of price caps for healthcare services purchased by commercial insurers, a strategy evolved from both state cost growth benchmarks and more definitive rate-setting methods. As opposed to Medicaid or Medicare programs that set prices for a given healthcare service, prices paid by commercial health insurers are rarely regulated in the US. As a result, commercial healthcare prices are both high and widely variable.[23] Current evidence offers at least two reasons for such commercial price variability and market inefficiency: provider consolidation and an idiosyncratic healthcare market, where price and quality are difficult to differentiate.[24]

Price cap proposals claim to combine the strengths of both price setting and market-based pricing approaches: preserving the price variation necessary to a market-based healthcare delivery system while providing a guard-rail against excessive cost inflation. Price caps, or "backstops," would eliminate the top distribution of provider prices, which likely reflect inefficient healthcare markets.

The current price cap proposal formulated by Michael Chernew, Leemore Dafny, and Maximilian Pany of Harvard University includes a three-pronged approach:[25]

Local market and service-specific price caps that regulate maximum prices providers can negotiate
For each geographic region, prices for both in- and out-of-network services are capped by service at 500 percent of the current 20th percentile of commercial in-network prices. Though not benchmarked to Medicare rates, research has shown that this cap tends to fall around five times the Medicare price, largely impacting outlier cases.[26] As such, the 500 percent is not the baseline payment. Providers would be prohibited from being paid rates over this cap, but prices could still vary within and across regions based on existing negotiated rates.

Service, insurer, and provider-specific price growth caps that limit year-on-year growth in provider prices
In addition to capping prices by service, current policies propose including a limit on annual price growth, such as the state healthcare cost growth benchmarks discussed above. Price growth caps would apply to insurer-provider-service combinations (see Rhode Island example below).

Oversight power from state and federal authorities when prices exceed a predetermined threshold
Implementation of a price cap requires technical support and a mechanism to account for provider payments that may circumvent price caps, like per diem payment systems, quality bonuses, or shared savings payments. At present, many states already have the expertise necessary to implement and manage this kind of regulatory program.

Though no states have implemented price caps exactly as described above, Rhode Island has created a system where commercial insurers cannot accept hospital contracts with price increases exceeding the federal Consumer Price Index (CPI-U) plus a certain percentage. This policy is enforced through the insurer-hospital contract review process. A 2019 study attributed an 8.1 percent price reduction in fee-for-service spending to Rhode Island's adoption of price growth caps from 2010 to 2016.[27]

Opportunity and Impact

- No states have implemented price caps as described by Chernew et. al.
- Overall, Chernew, Leemore, and Pany have estimated that price caps on inpatient hospital services alone could reduce commercial inpatient spending by 8.7 percent, further limiting increases in health spending in the long run, and resulting in larger savings over time.
- Chernew, Leemore, and Pany also estimated that capping both inpatient and outpatient commercial hospital prices would reduce commercial healthcare spending by about 3.2 percent. Of the approximately $29.25 billion spent on hospital care by commercial health insurance plans in New York State in 2020, reducing 3.2 percent of spending would create $936 million in annual savings.[28]

REFERENCE-BASED PRICING

Some healthcare purchasers, including several public sector entities and private employers, are moving away from offering traditional coverage with a provider network and instead are using reference-based pricing for some or all of the services they cover. Under reference-based pricing, the healthcare purchaser (supported by a third-party administrator or another vendor) pays a set price for each healthcare service instead of negotiating prices with providers. When a provider bills for the service, the payer remits the set amount. If the provider is dissatisfied with the payment, they can bill the patient for the unpaid portion of the claim, unless the program is specifically structured to prevent this. It is estimated that 2-3 percent of employee benefit plans use a Medicare multiple to pay providers for healthcare services.[29]

Most reference-based pricing initiatives at the state level have focused on public sector employee health plans, where the state is the purchaser of healthcare coverage and an employer. These initiatives have been pursued both with and without legislation and have resulted in both success and defeat.

Reference-based Pricing Initiatives – Successes

California: The California Public Employee Retirement System (CalPERS) was one of the first and largest purchasers to use reference-based pricing, albeit for a limited set of procedures. Beginning in 2008, CalPERS set a reference price at a midpoint measure of prices for a group of procedures. CalPERS was able to generate savings and prompt high-priced facilities to lower their prices. Using CalPERS' experience with a small set of services, a group of researchers estimated that roughly 20 percent of the total spending across services ranging from knee and hip replacements to cataract surgeries to imaging could be saved if reference pricing were expanded across all employers for these services.[30] California achieved its reference-based pricing program through administrative and executive action.

Montana: Montana state employee health plan, which provides benefits to about 31,000 covered lives, transitioned to reference-based pricing and generated significant savings for the state in the years after its implementation.[31] In moving to reference-based pricing, Montana established payment rates for inpatient and outpatient services that were a multiple of Medicare's payment rate for the Montana acute care hospitals. An independent analysis based upon a review of publicly available data released by the state found that the state saved an estimated $47.8 million across SFY 2017 to SFY 2019 by negotiating reference-based prices that "...enabled the plan to become more financially sustainable, achieving Montana's goal without pushing costs onto employees."[32] Montana achieved its reference-based pricing program not via legislation, but rather by administrative and executive action.

Oregon: The State Employee Health Plan (SEHP) in Oregon, which provides benefits for approximately 140,000 eligible state employees, limited its plan to paying no more than 200 percent of the Medicare rate for all in-network hospital services and 185 percent of Medicare for out-of-network hospital services.[33] Oregon adopted its reference-based pricing initiative via legislative action. Thirty-eight hospitals were not included in the program, including out-of-state hospitals, rural hospitals with fewer than 50 beds, critical access hospitals, and sole community hospitals (as defined in the legislation). Oregon's reference-based pricing program had an estimated savings of $81 million, representing roughly 5 percent of total costs.[34]

Reference-based Pricing Initiatives – Setbacks[35]

New Jersey, North Carolina, and Vermont have each unsuccessfully attempted to implement reference-based pricing. Vermont introduced legislation to convene a working group to explore options for designing and implementing a system of reference-based pricing based on a multiple of Medicare reimbursement rates.[36] New Jersey also introduced legislation to implement a limited version of RBP; it died in committee.[37]

The Office of the Treasurer of North Carolina, the office charged with managing the State Health Plan (SHP) covering over 725,000 public employees and retirees, attempted to achieve a reference-based pricing program for the SHP without legislation.[38] North Carolina's attempt to accomplish a broad reference-based pricing was not done through legislation, but rather by administrative action through the Office of the Treasurer. The plan, called the Clear Pricing Project, proposed Medicare reference price contracts with providers for the 2020 plan year.[39] The proposal faced strong resistance from the State's hospital systems, who ultimately did not agree to Medicare-based rates for 2020, thus rendering the project ineffective to address hospital prices in the North Carolina healthcare market.[40] While many physicians and a few independent hospitals did sign contracts with the health plan using rates benchmarked to Medicare, the North Carolina experience illustrates the limitations of non-legislative reforms and the likely opposition from hospital systems in a given market.[41]

Opportunity and Impact

- Reference-based pricing has demonstrated substantial savings for commercial health spending, but the extent often varies by the scale and scope of programming.[42] [43]
- Reference-based pricing has been shown to successfully lower costs for highly "shoppable" services and has been deployed by many large employers, public sector purchasers, and labor groups.[44] [45]

HOSPITAL GLOBAL BUDGETS

Global budgets are an alternative payment model in which providers — typically hospitals — are paid a prospectively-set, fixed amount for the total number of services they provide during a given period. The hospitals and/or providers are generally responsible for expenditures in excess of the set amount in addition to quality outcomes, creating an incentive to reduce unnecessary utilization and invest in prevention.

In addition to the stated goal of overall cost reduction, global budgets can encourage hospital investments in population health initiatives. Although there is limited evidence to show that this works in practice, the theory is that a hospital operating under a global budget will invest in community-based initiatives that emphasize care coordination; expanded access to, and follow-up by, primary care providers; and early intervention for chronically ill patients to realize reduced costs and savings for the hospital. Hospital global budgets could also encourage investments in resources that address social determinants of health and social supports, if the hospital believes such investments will serve its financial interests under the global budget model.

Additional policy features that make global budgets attractive to the hospital/provider community include a guarantee of a predictable revenue flow for the hospital and flexibility to allocate resources efficiently under

the budget constraint, as highlighted during the COVID-19 pandemic. This policy feature is especially beneficial to rural and/or relatively isolated hospitals that serve well-defined patient populations. From a payer perspective, global budgets are attractive because they allow for the control of year over year hospital costs through regulation of allowed budget. Finally, the promise of reduction in administrative burden may be attractive to both the hospital/provider and the payer.

As a policy tool, global budgets are currently uncommon at the state level, with the most notable exception being Maryland, which has implemented global budgets for hospitals as part of its all-payer rate setting program since 2010.

CASE STUDY

The Maryland Model

Currently, Maryland operates the nation's only all-payer rate regulation system for all in-state hospitals, made possible by a waiver from Medicare that allows it to set rates for Medicare services at hospitals. Under the waiver, all payers must pay the same rate, including Medicare, Medicaid, CHIP, and Maryland residents. Because all rates across payers are uniform, commercial rates are lower than national averages.

Initially, hospitals responded to the payment model's unit-price constraints by increasing the volume of services provided.[46] This led to Maryland and CMS entering into a modification agreement in 2014 that allowed hospitals to retain some revenues not spent on treatment as preventable admissions declined. In 2019, Maryland and CMS further refined the structure of the waiver by adopting a total cost of care (TCOC) approach. This payment model is meant to encourage hospitals to use savings under the global budget to offer incentives to non-hospital providers that improve care quality. It also offers monthly, per-beneficiary payments to primary care providers for care coordination services that can reduce hospitalizations and improve outcomes. Savings are anticipated from eliminating unnecessary care, as well as the provision of better preventative and chronic care.

While CMS has primarily focused on the demonstrated savings to Medicare, it is widely accepted that Maryland's model has lowered hospital spending for commercial insurers, including self-funded health plans, as well. The final report evaluating the Maryland all-payer model estimated that, from 2011 to 2017, commercial insurance payments to Maryland hospitals ranged from $392 to $544 million per year lower than they would have been without all-payer rate setting.[47] Commercial insurance rates per inpatient admission in Maryland were 11 to 15 percent lower than what a comparison group paid in other states.[48]

Opportunity and Impact

- Global budgets have the potential for substantial financial impact on both government and commercial payers.
- Limited adoption of this approach has similarly limited the ability to study and improve upon the model at scale.
- The model requires a CMS waiver, as well as substantial administrative investment, stakeholder support, and/or political support.

Section 2

Market Reforms

Healthcare prices have increased dramatically over the last thirty years, due in part to consolidation of U.S. provider and insurer markets.[49] Healthcare has never functioned as a traditional market, but as consolidation continues, policymakers are seeking additional ways to protect the public from escalating prices and substandard care. This section focuses on two primary categories of market reform designed to make the healthcare market function more effectively:

1. Site-neutral Payment and Elimination of Facility Fees
2. Anticompetitive Hospital Behavior Prohibitions

Site-neutral payment refers to policies that eliminate differences in payment for the same service provided in different settings. An example adopted by Medicare and some commercial payers includes setting a base reimbursement level that is the same whether the service is provided in an outpatient facility clinic or an outpatient physician office. For commercial payers, it can also include prohibiting the addition of facility fees when circumstances do not justify additional fees.

Anticompetitive behaviors include the use of anticompetitive contracting terms, which keep payers from understanding the true costs of services and creating networks and payment policies based on cost and performance. These terms include most-favored nation, antitiering, all or nothing, and gag clauses. Another anticompetitive behavior addressed is market consolidation. In 2020, the Medicare Payment Advisory Commission (MedPAC) reviewed the published research on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices."[50]

Some states have also created insurance infrastructure that is supportive of group purchasing efforts. In Colorado, the insurance code was amended to specifically enable group health insurance purchasing cooperatives.[51] This legislation enables Peak Health Alliance, a purchasing cooperative that negotiates with hospitals and insurance carriers which has reduced rates by approximately 40 percent.[52] Other states can explore existing Multiple Employer Trust (MET) and Multiple Employer Welfare Association (MEWA) regulations to do group purchasing.

SITE-NEUTRAL PAYMENT AND ELIMINATION OF FACILITY FEES

KEY TERMS

Site-Neutral Payment

Paying the same amount for a service or procedure regardless of where the care is given.

Facility Fees

Fees charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is (a) intended to compensate the hospital or the health system for the operational expenses of the hospital or the health system, and (b) separate and distinct from a professional fee.

Reimbursement rates can vary significantly based on the site of service and not the healthcare service provided. A 2019 analysis by the Health Care Cost Institute determined that the average price for a given service was always higher when performed in the hospital outpatient setting, and average prices rose faster in the outpatient setting when compared to the physician office setting.[53]

Traditionally, when a service is provided in an independent provider's office, only a provider payment is charged. When the same procedure is provided in a facility, there are two payments — one for the provider and one for the facility. This is a longstanding practice and was intended to compensate hospitals for overhead, such as an emergency department, that an independent provider does not have. However, when a hospital purchases a physician practice, it often assigns the practice an outpatient department designation for billing purposes. This allows it to add a facility fee to the bill — even though no additional overhead has been incurred — because the physician practice is now owned by a hospital. A study found that hospital acquisition of physician practices increased hospital outpatient prices by 14 percent, with a quarter of that increase due to facility fees.[54]

There are two policy interventions to address this. The first is establishing site-neutral payments. The second limits facility fees to specific circumstances.

Site-neutral Payment Policy

Medicare has site-neutral payment policies for a growing number of services where the evidence indicates the same service can be safely provided in different settings. These services are primarily outpatient and do not include an additional facility fee. In this case, the base payment is adjusted so that regardless of where the service is performed, the payment is the same. In 2019, payment for services provided for a doctor's visit in an outpatient clinic and those provided in a doctor's office were made the same. This was a big transition point to site-neutral payment because these visits are the most common service provided to Medicare beneficiaries.[55] Medicare's site-neutral payment policies were recently subject to legal challenge but were ultimately upheld by the Supreme Court. [56]

Massachusetts is one of the only states to legislatively address site-neutral payments with a bill to study the impact of a law that would require any coverage offered to a public employee/retiree of commonwealth through group insurance to offer site-neutral payment for administration of medication.[57] This legislation did not address other services.

A growing number of commercial insurance carriers are also embracing site-neutral payments. Both Anthem and UnitedHealth Group have enacted changes that restrict the services that can be provided on an outpatient basis at hospitals unless medically necessary.[58] Consumers also indicate a preference for receiving care in a location not connected to a hospital.[59]

Facility Fees

Efforts to limit facility fees have occurred primarily at the state level and have largely focused on disclosure and transparency for commercial payers. However, there is also some movement toward more prescriptive limitations on when facility fees can be charged.

Disclosure and Transparency

Almost all state efforts require a hospital or a health system charging a facility fee for outpatient services performed at a hospital-based facility to provide the patient with notice. This includes Connecticut, Washington, Minnesota, Texas, and Maryland. New York passed similar legislation in 2022, but it has not yet been signed into law. There are no limitations in charging these fees, but in theory, consumers can choose to go elsewhere. In practice, going elsewhere can be difficult as more and more physician practices are acquired by hospitals.

Connecticut,[60] Massachusetts,[61] and Washington[62] require hospitals to report on their facility fees to gain a better understanding of their scope.

Payment Restrictions

Connecticut also prohibits hospitals from charging a facility fee for outpatient office visits at an off-campus, hospital-based facility,[63] but this prohibition only applies to Evaluation & Management (E&M) codes used for office visits, not the full range of outpatient services. Connecticut does not limit facility fees for on-campus outpatient visits.[64]

The National Academy for State Health Policy (NASHP) has developed a model act that states can use to prohibit certain facility fees from being charged to consumers accessing primary care and other routine services to which additional facility fees are inappropriately attributed. This legislation is consistent with an existing Medicare provision that prohibits any healthcare facility that is located more than 250 yards from a hospital campus from charging a facility fee for services provided at that location. The model also includes reporting requirements to the state in an effort to help states track the extent of facility fees and their impact on overall healthcare costs.[65]

Opportunity and Potential Impact of Reform

An analysis from the Committee for a Responsible Federal Budget estimated that over the next decade (2021 – 2030), Medicare's site-neutral payment policy for outpatient visits will reduce Medicare spending by $153 billion and reduce premiums and cost-sharing for Medicare beneficiaries by $94 billion. The analysis also indicates that if the same policy were adopted in the private/commercial sector, purchasers could realize savings of between $140 billion to $466 billion over the next decade.[66] There are no comparable estimates for the financial impact of removing facilities fees other than the study cited earlier that hospital acquisition of physician practices increased hospital outpatient prices by 14 percent, with a quarter of that increase due to facility fees.[67]

Potential State Actions to Address Facility Fee Abuse Correspond to NASHP's Model Legislation:

- Prohibit (1) site-specific facility fees for services rendered at physician practices and clinics located more than 250 yards from a hospital campus; and (2) service-specific facility fees for identified outpatient services, such as those billed using E&M codes, even if those services are provided on a hospital campus.
- State enforcement measures, including an annual facility fee audit by the relevant state agency, a private right of action for consumers, and administrative penalties against healthcare providers for violations.
- Improve facility fee transparency by requiring notice to patients with estimates of facility fees, requiring providers to report the facility fees charged by location, and posting the information on a publicly accessible website.

ADDRESSING ANTICOMPETITIVE BEHAVIOR

KEY TERMS

Antitrust

Relating to legislation, regulation, or legal action aimed at preventing or controlling trusts or other monopolies, with the intention of promoting competition in business.

Vertical Provider Market Consolidation

The merger or integration of companies in different lines of work, but who may work with each other, or their services complement the other (e.g., a hospital purchases an outpatient center, or a health plan merges with a hospital system).

Tiering

Payers' means of organizing healthcare providers into benefit levels, or tiers, based on a variety of factors, including negotiated rates, hospital ratings, and quality metrics.

Horizontal Provider Market Consolidation

The merger or combination of two similar companies that formerly dealt with or competed with each other, or that potentially could have, such as two hospitals or two insurers.

Most-favored Nation (MFN)

Contract clause within a health network plan contract in which a dominant health plan obtains a promise that the provider (supplier of healthcare services) will not give an equal or more favorable price to any other plan.

Because of the impact of consolidation, there have been efforts to address anticompetitive contract terms at both the state and federal level.

Of particular note is the recent passage of the Federal Consolidated Appropriations Act, 2021 (CAA), which prohibits a health plan from entering into agreements with carriers and other network providers that impose certain restrictions on the plan's access and ability to share information about the cost and quality of care (i.e., "gag clauses"). Carriers frequently impose contractual restrictions on the disclosure of data they consider to be confidential or proprietary, but these new rules aim to foster an environment of greater transparency and competition by requiring disclosure of price and other information that might otherwise be subject to those restrictions.

The question facing many state policymakers is what can be done at the state level to address the effects of consolidation and bring the price of healthcare to a more sustainable level.

Restoring and sustaining competition in healthcare will require a multifaceted approach. There are tools for policymakers, antitrust enforcers, and state officials to increase scrutiny over and prevent the anticompetitive behaviors in each category.

Addressing Anticompetitive Contract Terms

For each anticompetitive term addressed, we will include (i) a description of the contracting practice and its potential for anticompetitive harm; (ii) a brief analysis of lawsuits and enforcement actions to address the anticompetitive use of these provisions; (iii) a survey of state legislative efforts to regulate the use of these terms; and (iv) best practices for states seeking to regulate the use of the contract clause.

Most-favored Nation Clause (MFN)

In the healthcare context, MFN clauses are imposed by carriers on healthcare providers and systems and require that those providers agree not to give a lower provider payment rate to any other carrier or insurer. These clauses have an anticompetitive impact in several ways. First, these provisions allow a dominant health system or provider to increase prices in exchange for signing contracts with an MFN clause, resulting in higher prices passed on to the consumer by the carrier. Moreover, MFN clauses diminish or even eliminate the incentive for providers to lower price, and likewise give no incentive for a carrier or insurer to lower price.

At least twenty states have restricted MFN clauses in at least some healthcare contracts.[68] The National Academy of State Health Policy (NASHP) has promulgated model legislation prohibiting MFN and other anticompetitive contracting terms.

All-or-nothing Clause

Typically, all-or-nothing contract clauses manifest as a requirement imposed by health systems that all facilities within their system be included in the carrier's network. Health systems and provider organizations can use all-or-nothing provisions to leverage the status of certain "must have" facilities within a certain market. A prime example of this conduct occurred in Northern California, where a large health system leveraged its market dominance and the "must have" status of one of its facilities to demand the inclusion of all its clinics and facilities, even where they were far more expensive than their competitors.[69]

All-or-nothing clauses can exacerbate the dangers resulting from mergers and hospital consolidation, as they expand their ability to demand supracompetitive rates. Often referred to as "tying," these dominant entities utilize their market power over services in one market to exert pressure in another market, thereby limiting or even foreclosing competition.

Massachusetts has successfully prohibited all-or-nothing clauses, but only in the context of limited and tiered network plans.[70] New York, Colorado, and California have attempted to limit all-or-nothing clauses by legislation, but they were unsuccessful. Legislation was proposed at the federal level in 2021 — the Healthy Competition for Better Care Act — but the legislation was not passed out of committee. NASHP's model legislation on anticompetitive contracting terms would also preclude all-or-nothing clauses.

Antitiering and Antisteering Clauses

Employers and health plans have increasingly turned to using "tiered" provider networks in their health benefits design to steer patients to higher quality and lower cost providers. Often they are precluded from engaging in these strategies because of antitiering clauses in provider contracts, which require that a health plan place all physicians, all hospitals, and all other facilities associated with a hospital system in the same tier of a network plan.[71] Similarly, antisteering clauses restrict the ability of the employer or the health plan from encouraging an enrollee to obtain a healthcare service from a competitor of the hospital or health system, including offering incentives to encourage use of a specific provider.[72]

The result of these anticompetitive contract terms is that health plans are precluded from signaling to members and patients that there may be higher value alternatives available to them at different facilities or

systems. Moreover, these clauses hinder a health plan's ability to direct patients to higher value providers by leveraging different copay structures. In 2016, the DOJ and the North Carolina attorney general filed suit alleging that Atrium Health used antisteering and antitiering clauses in healthcare contracts to unreasonably restrain trade in violation of Section 1 of the Sherman Act.[73] A settlement was reached that prohibits Atrium from using anticompetitive steering restrictions in contracts between commercial health insurers and its providers in the Charlotte North Carolina metropolitan area.[74]

Massachusetts successfully passed a law in 2010 prohibiting antitiering/antisteering clauses in contracts between healthcare providers and health insurance carriers.[75] Failed efforts at the state level include New Jersey, New York, and California. NASHP's model legislation on anticompetitive contract terms would substantially limit antitiering and antisteering clauses in contracts. Recognizing that these provisions may have potential for pro-competitive uses, the model legislation includes a waiver process if it can be shown to the proper authorities that the contract term benefits outweigh the harms.[76]

Gag Clauses

Gag clauses are generally used to prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. In the healthcare context, gag clauses have been utilized by carriers to prohibit employers, third parties, and other healthcare stakeholders (including patients) from obtaining necessary information to assess the relative value of healthcare services from providers. While most states require carriers to disclose out-of-pocket costs to health plan members, very few have laws allowing patients, plan sponsors, or even state regulators to obtain price or quality information held by the carrier.[77] Gag clauses have the potential to hide or conceal other anticompetitive terms and behavior, as well as make it more difficult for policymakers to understand how healthcare markets are operating in their respective jurisdiction.

As noted above, the federal CAA has limited gag clauses in some contexts, and several states have also successfully limited their use via legislation. California,[78] Connecticut,[79] Indiana,[80] Massachusetts,[81] and Minnesota[82] have passed laws banning gag clauses, however, California, Massachusetts, and Minnesota limited the scope of those laws to prohibit only contract provisions related to the disclosure of price information to patients. By solely focusing on disclosure to patients, rather than employers and health plan sponsors, the legislation is substantially limited in its potential for impact.

The New York legislature recently passed the Health Equity and Affordability Law (HEAL), which included a prohibition on gag clauses, but it has not yet been signed by the governor at the time of this writing. In addition to gag clauses, HEAL also prohibits the use of MFN provisions, both of which led to anticompetitive practices that have allowed large health insurers and hospitals to set high healthcare prices, according to the bill sponsors.[83] While the bill initially proposed sought to limit all-or-nothing and antisteering/antitiering contract terms, it was subsequently amended to remove those provisions and passed both houses unanimously in amended form.

Addressing Market Consolidation

Not surprisingly, there is a tremendous amount of variation among the fifty states in the laws, regulations, and enforcement practices used to address anticompetitive healthcare provider consolidation. Some states have used legislative and regulatory means to grant additional oversight of merger and consolidation activity, while some states have empowered their states' attorney general office to enforce policies aimed at preventing anticompetitive behavior contrary to the public interest. Due to the nature of antitrust enforcement at the state and federal level, this section will briefly highlight the ways in which federal and state authorities have played a role in attempting to address anticompetitive consolidation in the healthcare marketplace.

In July 2021, President Joe Biden issued an Executive Order that presses the federal government to review and revise guidelines for hospital mergers that can lead to higher prices.[84] The Executive Order was part of a larger effort to boost competition throughout all sectors of the economy. Biden specifically called out hospital mergers that have "left many areas, especially rural communities, without good options for convenient and affordable healthcare service. Thanks to unchecked mergers, the 10 largest systems now control a quarter of the market."[85] The Order encourages the DOJ and FTC to "review and revise merger guidelines to ensure patients are not harmed by such mergers."[86]

State actions intended to limit anticompetitive behavior, whether legislative, regulatory, or legal, can be organized into two categories (1) premerger/consolidation oversight and approval processes and (2) post-merger/consolidation oversight to limit anticompetitive impact of market consolidation. Post-merger/consolidation policies include post-transaction oversight and legal challenges in limited circumstances.

Premerger/Consolidation Policies

- **Notice:** The cornerstone of any effective antitrust enforcement is timely and sufficient notice. Passing legislation or promulgating regulations requiring mandatory and substantial pretransaction notice that is specific to healthcare entities would provide a more meaningful time period for those that should play a role in analyzing the proposed transaction's impact on access, market dynamics, and prices. For example, ninety days of pretransaction notice is likely insufficient in the case of a merger between two multibillion-dollar hospital systems.
- **Review:** States have passed legislation to create a variety of pretransaction notice requirements and waiting periods while the relevant parties review and evaluate the proposed transactions. While the review criteria differ among states, a comprehensive and more standard approach for transactions involving nonprofit hospitals and for-profit hospitals is increasingly cited as a potential means to address the ill-effects of consolidation. For example, a recent policy brief issued by the Milbank Memorial Fund suggests examination of the following criteria in any premerger review process: whether the transaction will (1) harm healthcare markets and competition; (2) increase prices; (3) limit access to healthcare services; and (4) harm the public interest.[87]

  In Pennsylvania, the Office of the Attorney General has issued a Review Protocol to "ensure that the public interest in the charitable assets of the nonprofit organization is fully protected."[88] The materials reviewed as part of the Review Protocol are robust and thorough, and include materials such as detailed financial disclosures, expert fair market assessments, and community and public impact.[89]
- **Approval:** States have passed legislation granting AGs or state agencies the authority to approve, disapprove, or approve with conditions. Approval authority strengthens states' leverage to prohibit or limit transactions to mitigate the anticompetitive effects of healthcare consolidation. Given limitations in resources, staffing, and expertise, some states have adopted a multiagency framework to provide a multilayer review and approval system that can thoroughly vet transactions prior to consummation. Connecticut, Massachusetts, and Rhode Island divide responsibilities among multiple agencies, including Department of Health, state healthcare agencies, and the Attorney General Office.

States that have deployed strong premerger oversight include Connecticut, Massachusetts, Nevada, Oregon, and Washington, each with somewhat different frameworks and elements of notice or review. In the 2021 legislative session, Oregon passed a comprehensive merger review process, and Nevada passed two new notice requirements.[90] Oregon may be a model for other states looking to pass legislation in this area, as it is very comprehensive and was launched in March 2022.[91]

Post-merger/Consolidation Policies

Post-transaction Oversight: Massachusetts, Rhode Island, California, and Connecticut have utilized post-transaction monitoring as a means of enforcing post-merger conditions and have included the following tools:

- Requiring the transacting entity to hire and pay for an independent monitor for a specified period
- Providing compliance reports at regular intervals
- Notifying the AG of any future changes to the agreed-upon transaction or any new acquisitions by the transacting entities
- Reimbursing the AG for the costs of investigation

With effective post-transaction monitoring and enforcement plans, state agencies may be able to identify non-compliance before it is able to severely harm or impact the population.

Potential State Actions to Anticompetitive Market Behavior Correspond to NASHP's Model Legislation:

- Prohibit healthcare providers, insurers, and plan administrators from demanding, soliciting, or agreeing to any healthcare contract that contains anticompetitive contract terms, including:
  - All-or-nothing
  - Antisteering
  - Antitiering
  - Most-favored nation
  - Gag clauses
- Gives a state's insurance commissioner or attorney general the ability to add other clauses through regulation.
- Includes a waiver process where the attorney general or insurance commissioner could approve the use of these contract terms if the benefits outweigh the harms.
- Provides a private right of action to allow parties injured by these contract clauses to recover damages.

Section 3

Hospital Accountability

Hospitals receive approximately one out of every three dollars spent on healthcare in the US[92] and are the single largest component of healthcare inflation.[93] Given the tremendous amount of public and private funds spent at hospitals, which was nearly $1.3 trillion in 2020 alone,[94] there are increasing demands for more accountability and transparency in hospital finances. U.S. nonprofit hospitals are expected to invest in caring for underserved patients and improving the health of their communities, but recent studies suggest that many hospitals are not holding up their end of the bargain.[95] In addition, the opacity of hospital pricing has historically made it difficult for consumers to compare prices for services, and for researchers and policymakers to understand the drivers of hospital spending.

Federal and state policies seek to address these deficiencies by making hospital prices transparent and demanding stronger accountability for nonprofit and tax-exempt status.

INCREASING HOSPITAL ACCOUNTABILITY THROUGH THE TAX EXEMPTION

KEY TERMS

Nonprofit hospitals

A hospital that meets the general requirements for tax exemption under Internal Revenue Code (IRC) Section 501(c)(3) and Revenue Ruling 69-545, as well as the four additional requirements imposed under IRC Section 501(r)(1).[96]

Charity Care

Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria.[98]

Community Benefit

A test the IRS uses to determine whether a hospital is organized and operated for the charitable purpose of promoting health.[97]

Community Health Needs Assessment (CHNA)

According to the Public Health Accreditation Board, a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.[99]

Most hospitals in the US operate as nonprofit organizations and, as such, are exempt from most federal, state, and local taxes. Nonprofit status also allows hospitals to benefit from tax-exempt bond financing and to receive charitable contributions that are tax-deductible to the donors. This favored tax status is intended to be an acknowledgment of the "community benefit" provided by these institutions.

While the initiatives discussed below are not intended to be exhaustive of state action, they are broadly representative of the state action landscape on community benefit policy. Despite many successful efforts to bring more transparency and accountability to community benefit policy and nonprofit status, some states have faced challenges and setbacks.

Federal Action

The Federal Government has recognized the need for additional transparency and accountability addressing the tax-exempt status of hospitals and whether they are meeting their community benefit requirements. In a September 20, 2020 report, the Government Accountability Office (GAO) made recommendations for congressional action and the IRS in addressing whether tax-exempt hospitals are meeting their community-benefit requirements.[100] The GAO report recommends that Congress draft language for the Internal Revenue Code to specify "what services and activities Congress considers sufficient community benefit," because adding clarity to the Code "could improve IRS's ability to oversee tax-exempt hospitals."[101] The GAO report recommendations to the IRS were aimed at helping the IRS, Congress, and the broader public better understand the full scope of the community benefits a hospital provides and whether the benefits sufficiently justify a tax exemption.[102] While no action has been taken to date, there is increasing awareness and a growing body of literature to support such policies.[103]

State Initiatives Addressing Hospital Community Benefit Policy

State Audits of Community Benefit Impact

Montana: The Montana State Attorney General's Office published annual reports on charity care, community benefit, and patient bankruptcies for Montana hospitals from 2008 to 2014, and the Montana Legislative Audit Division resumed reporting audit results in 2020.[104] The Montana audit ultimately determined that "community benefit spending has no clear impact on the health of Montanans" and recommended "the legislature should enact laws defining expectations regarding detailed reporting of community benefit spending and its impact on community health and the state government entity responsible for actively reviewing community benefit spending."[105] To date, however, no legislative action has been taken as a result of the audit or its recommendations.

Financial Reporting and Prescriptive Minimum Thresholds

Illinois:[106] Passed in August 2021, this law aims to more clearly and narrowly define the term "community benefit" and requires more detailed reporting to the Attorney General on charity care spending and financial assistance programs. Notably, the law clarifies that "charity care" does not include the forgiveness or incurrence of bad debt.[107]

Washington:[108] In May 2021, Washington State passed a law intended to make nonprofit hospital operations more transparent by mandating certain reporting requirements above and beyond public filing of their CHNA documentation.[109]

Nevada:[110] Nonprofit hospitals with more than 100 beds in counties with two or more hospitals are required to report "the expenses that the hospital has incurred for providing community benefits and the in-kind services that the hospital has provided to the community in which it is located." They are also required to provide 0.6 percent of the previous fiscal year's revenue in indigent care.[111]

New York: While New York does not require nonprofit hospitals to provide a specified minimum level of charity care or other community benefits, they do require both for-profit and nonprofit hospitals to report on the costs of providing unreimbursed care. [112] At least every three years, a nonprofit hospital must file with the Commis-

sioner of Health a report detailing changes to its mission statement and its operational and financial commitment to meeting community healthcare needs, to its provision of charity care, and to improving underserved individuals' access to care.[113] Despite these reporting requirements, hospitals in New York rank 49th in the country with respect to their spending on charity care and community investment relative to the value of their tax exemptions.[114]

Florida: In April 2020, Florida Statute section 193.019 was signed into law and added certain community benefit reporting requirements for hospitals that apply for property tax exemptions in the state. The legislation also effectively limited a tax-exempt hospital's property tax exemption to the amount of community benefit that the hospital provides to its residing location(s). Although the statute did not affect a hospital's nonprofit status in Florida, it was an example of a taxing authority's effort to tie the state's tax exemption benefits to the value the organization provides to the community. Just one year after the law was passed and prior to its effective date of January 1, 2022, Florida passed HB 7061, which repealed Fla. Stat. 193.1019. The repeal was supported and applauded by the Florida Hospital Association.[115]

Legal Action to Challenge Tax-Exempt Status

New Jersey: The taxing authority in the City of Morristown challenged the nonprofit status of a hospital that ultimately resulted in a 2015 decision denying a property tax exemption to the hospital.[116] Since that decision, numerous municipalities and hospitals entered into litigation in which the municipalities sought to impose property taxes on the hospitals. Other hospitals in New Jersey entered into Payment In Lieu of Taxes programs with their respective taxing jurisdictions to settle or prevent litigation. [117]

In 2021, the New Jersey legislature stepped in and passed a bill that requires tax-exempt hospitals to pay community service contributions, establishes the "Nonprofit Hospital Community Service Contribution Study Commission," and reinstated a property tax exemption for nonprofit hospitals with on-site for-profit medical providers.[118] Thus, local municipalities and taxing authorities were preempted from challenging tax-exempt status of non-profit hospitals. While the bill was ultimately viewed as helpful to nonprofit hospitals and health systems in the New Jersey,[119] it has been considered an example of a taxing authority's effort to tie the state's tax exemption benefits to the benefits that the exempt organization provides to the community.[120]

Pennsylvania: In 2021, a tax court ruled that three nonprofit hospitals of the nonprofit Tower Health system were not tax exempt "charities," and ordered them to begin paying millions in annual local property taxes that fund local school districts.[121].

The National Academy of State Health Policy (NASHP) has proposed numerous ways in which states can leverage their power to improve oversight and accountability of hospitals to ensure a hospital's community investment addresses community and state health plan goals commensurate with the investment that these communities make in these nonprofit hospitals in foregone tax revenue.[122]

PRICE TRANSPARENCY

Federal and state policymakers are leveraging healthcare price transparency as a potential strategy to curb rising healthcare costs. Healthcare transparency is defined by different stakeholders in very different ways, with some focusing on healthcare quality, efficiency, and consumer experience, and others focused primarily on financial transparency. Most federal and state policy, and the initiatives addressed in this compendium, focus on financial transparency.

Federal Transparency Efforts

The healthcare sector has long resisted transparency, keeping the prices charged to payers and consumers largely confidential. However, bipartisan support and recent consumer advocacy momentum have brought about new rules that will push pricing data into the public domain. The three main areas where these rules are taking effect include (1) hospital pricing transparency, (2) plan/carrier pricing transparency, and (3) No Surprises Act transparency. While these transparency initiatives are occurring largely at the federal level, they will be important to further state-level reforms.

Hospital Disclosure Rule[123]

The Hospital Disclosure Rule requires health systems to publicly post the price of their items and services online. More specifically, the rule required all hospitals to post five separate prices for their billing codes: the full chargemaster, which is the "list" price before any discounts; the discounted cash price paid by self-paying individuals; the in-network negotiated prices for each insurance plan with which a hospital has a contract; the lowest in-network price charged (with identification of the insurer hidden); and the highest in-network rate (also with the insurer hidden from view). These prices must be posted online in formats that allow third-party technology companies to build price comparison tools. In addition, hospitals must post their prices for 300 "shoppable" services, including 70 selected by the Centers for Medicare and Medicaid Services (CMS).

While the Hospital Disclosure Rule has been in place for over twenty months, a 2022 report reveals that few hospitals are adhering to the necessary requirements for providing pricing data.[124] The report, which reviewed 1,000 hospitals, shows that along with 86 percent of hospitals being noncompliant, approximately 4.1 percent did not post any standard charges at all.[125] None of the 12 New York City and Long Island hospitals included in this survey were in full compliance.[126]

Transparency in Coverage Rule

At the same time the federal rulemaking authorities were advancing the new transparency rules for hospitals, requirements for health plans and insurers were also being initiated. As of July 1, 2022, health plans, including those sponsored by self-insured employers, were required to post online their in-network prices and their out-of-network allowed charges.[127] Further, health plans will be required to build and maintain a consumer pricing tool for their enrollees that allows for real-time estimates of expected out-of-pocket costs for scores of potential services. It is too soon to assess the quality of compliance, but early indications are that health plans and insurers have posted massive amounts of data.

The No Surprises Act

In December 2020, Congress passed the No Surprises Act to shield patients from unexpected bills from out-of-network physicians and other providers of services. The law also requires insurers to make available to consumers Advanced Explanation of Benefits (AEOBs) starting in January 2023. These disclosures are to inform patients of the expected out-of-pocket cost they will incur from all providers involved in episodes of care. The provision of such estimates will be triggered when a patient is informed about the potential need for a service from a physician or another provider.

State Efforts to Enforce Transparency Compliance

Despite widespread noncompliance with the Hospital Disclosure Rule, to date only two Georgia hospitals have received fines from CMS as a result of their willful noncompliance.[128] As a result of these limitations, states seem eager to explore stepping in to ensure that transparency efforts benefit their consumers.

Colorado: In June 2022, the Colorado legislature passed House Bill 1285,[129] which prohibits a hospital, including critical access hospitals, from initiating or pursuing collection actions against a patient for debt incurred by the patient on dates of service when the hospital was not in compliance with federal hospital price transparency laws.

Texas: S.B. 1127 was passed in Texas in June 2021, codifying the federal price transparency requirements into state law and putting in place its own enforcement mechanisms, including the ability for the state to fine non-compliant hospitals that bring in more than $100 million in annual gross revenue.[130]

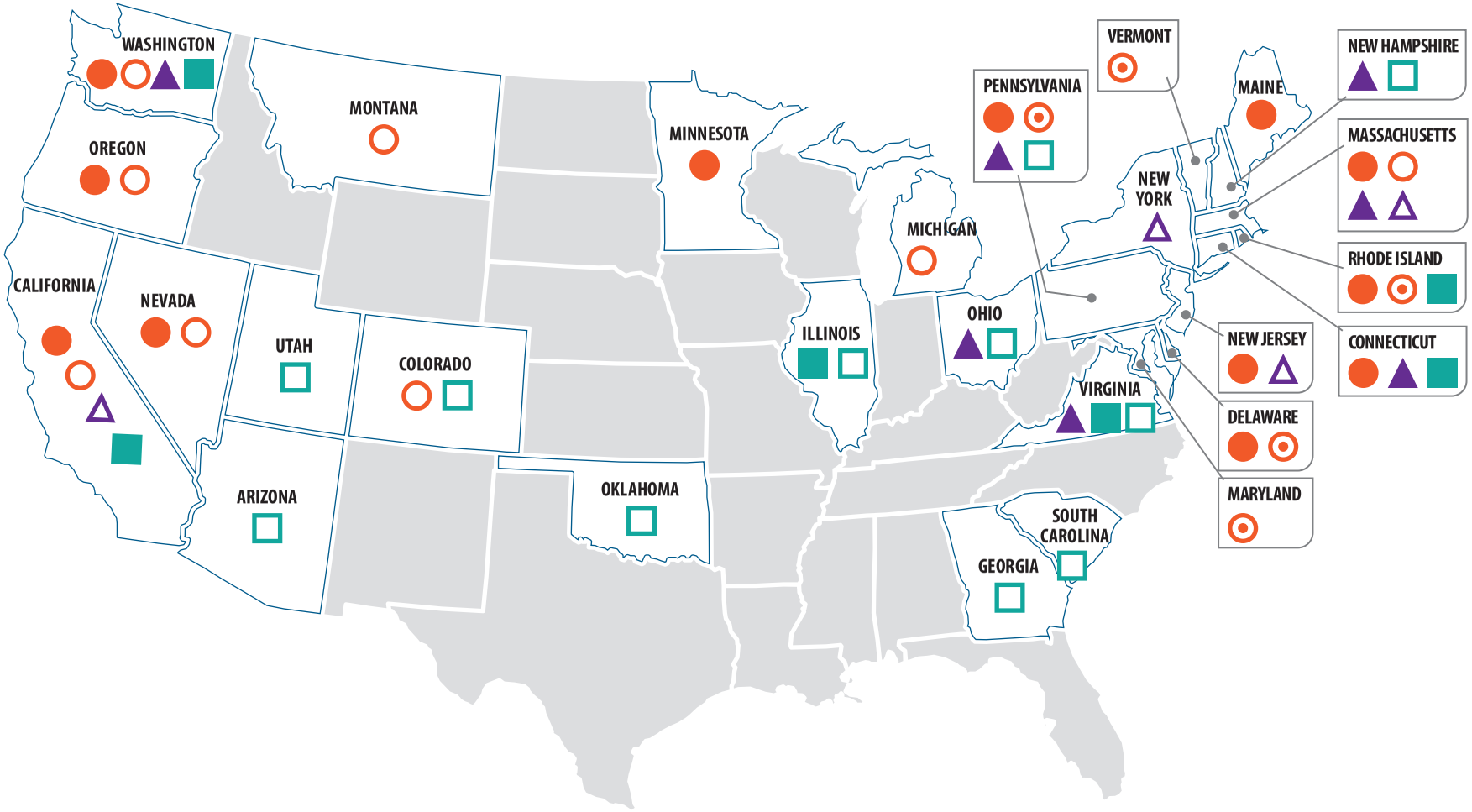
Potential State Action to Enhance Transparency

* Codify federal hospital transparency rule
* Codify federal transparency in coverage rule
* Give state agencies more tools to enforce price transparency by designating state agency (i.e., Dept. of Insurance, Attorney General, etc.) as the enforcer of healthcare price transparency laws

Conclusion

The 32BJ Health Fund mission is to provide affordable, accessible, and quality healthcare for our participants and their families. This is threatened by the high hospital prices driving the increasing cost of healthcare and provision of health benefits. The high prices that hospitals charge create significant costs to our fund (44 percent of all dollars spent on health benefits), and have a direct negative impact on worker wages and the total compensation package. Recognizing that benefit design changes alone cannot solve the issue of rising hospital prices, we have researched and compiled an array of public and government solutions throughout this compendium that may be replicable in New York. Solutions presented within these three frameworks — large-scale payment reform, market reform, and improved hospital accountability — provide examples for how change is possible and happening across the country. As previously stated, there is no perfect solution, but inaction in New York is not an option with the scale of lives and economies impacted. We believe that by partnering with union leadership, employers, our elected officials and appointees, and the greater healthcare provider community, we can find a path forward for equitable and sustainable solutions that tackle the problem of high hospital prices. We hope this compendium will serve as a resource to facilitate discussions that further that process.

State Actions Impacting Commercial Hospital Pricing And Hospital Behavior



Large Scale Payment Reforms

- Cost Growth Benchmark
- Reference Based Pricing
- Other

Health Care Market Reform

- Site Neutral Payment & Facility Fees
- Anticompetitive Contracts

Increasing Hospital Accountability

- Community Benefit
- Price Transparency

State Actions Impacting Commercial Hospital Pricing and Hospital Behavior

	Large-Scale Payment Reforms			Health Care Market Reform		Increasing Hospital Accountability	
State	Cost Growth Benchmark[131 132]	Reference Based Pricing[133 134]	Other[135 136]	Site Neutral Payment & Facility Fees[137]	Anticompetitive Contracts[138]	Community Benefit[139]	Price Transparency[140]
Arizona							✖
California	✖	✖			✖	✖	
Colorado		✖					✖
Connecticut	✖			✖		✖	
Delaware	✖		✖				
Georgia							✖
Illinois						✖	✖
Maine	✖						
Maryland			✖				
Massachusetts	✖	✖		✖	✖		
Michigan		✖					
Minnesota	✖						
Montana		✖					
Nevada	✖	✖					
New Hampshire				✖			✖
New Jersey	✖				✖		
New York					✖ (HEAL)		
Ohio				✖			✖
Oklahoma							✖
Oregon	✖	✖					
Pennsylvania	✖		✖	✖			✖
Rhode Island	✖		✖			✖	
South Carolina							✖
Utah							✖
Vermont			✖				
Virginia				✖		✖	✖
Washington	✖	✖		✖		✖	

Notes:

(1) State actions noted in this grid include both legislative, executive, and administrative approaches.

(2) This grid generally includes states with actions that were either enacted, passed, or in progress as of August 2022.

(3) The Other category includes global budgets and price growth caps via insurance rate review

(4) A much larger compilation of legislation (enacted, in progress, or failed) can be found using the Database of State Laws Impacting Healthcare Cost and Quality (SLIHCQ), created by the Source on Healthcare Price and Competition at the UC Hastings College of the Law catalogues state legislation to contain heatlh care costs and improve quality in a public searchable and sortable format. This tool can be found here: https://sourceonhealthcare.org/legislation/

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