American Bar Association Tax Section 2019 May Meeting

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**Group Health Plans vs. Health Care Providers: Managing Provider Operations and Relationships to Construct a Group Health Plan That Can Deliver Better Care at a Fair Price**

William M. Freedman, Esq.
Dinsmore & Shohl LLP
255 East Fifth Street, #1900
Cincinnati, Ohio 45202
Direct Phone: (513) 977-8232
Firm Phone: (513) 977-8200
Fax: (513) 977-8141
bill.freedman@dinsmore.com
www.dinsmore.com
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B. Acosta v. MagnaCare Admin. Servs., LLC (SDNY 7-13-2017)-TPA Supplying Self-Insured Group Health Plans Access to In-Network Providers and Claims Adjudication Services Admits to Fiduciary Status and Violations of Fiduciary Duty by Failing to Disclose Mark-Up of In-Network Provider Claims That the TPA Retained and Failing to Follow ACA-Required Standard for Emergency Services Claims

This outline was first presented at the American Bar Association Joint Committee on Employee Benefits 29th Annual National Institute on Health and Welfare Benefit Plans, on October 30, 2018, with the title, “Group Health Plans vs. Health Care Providers: Understanding Provider Operations and Relationships to Construct a Group Health Plan That Can Deliver Better Care at a Fair Cost.” This version contains updates through April 5, 2019.
I. The World of Health Care Has Become Complicated

Physician Practice Corporation

100%

Physician Practice Corporation

Hedge Fund Investment Vehicle

b%

PhysCorp Practice Management, LLC

100%

Other Shareholders

C%

Population Health, LLC

65,000 shares

PhysCorp Practice Management, LLC

Air Care Holdings, Inc.

State A Holding, LLC

State B Holding, LLC

100%

100%

Population Health, LLC

51%

Agility Health Corporation

51%

100%

Third Party Administrator, Inc.

20 year management services agreement

Fee for service business

100%
II. Health Care Costs Continue to Increase--and The Increase in Cost is Not Linked to Better Health Outcomes


1. Annual family premiums for employer-sponsored health insurance rose 5% percent to average $19,616 this year, extending a seven-year run of moderate increases. On average, workers this year are contributing $5,547 toward the cost of family coverage, with employers paying the rest.

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2018

2. This year’s premium increases are comparable to the rise in workers’ wages (2.6%) and inflation (2.5%) during the same period. Over time, the increases continue to outpace wages and inflation. Since 2008, average family premiums have increased 55 percent, twice as fast as workers’ earnings (26%) and three times as fast as inflation (17%).

This year’s survey also finds the burden of deductibles on workers continuing to climb over time in two ways: a growing share of covered workers face a general annual deductible, and the average deductible is rising for those who face one.
4. 26% of all covered workers are now in plans with a deductible of at least $2,000, up from 22 percent last year and 15 percent five years ago. Among covered workers at small firms (fewer than 200 workers), 42 percent face a deductible of at least $2,000.

B. The Health Care Cost Institute’s “2017 Health Care Cost and Utilization Report,” published February 2019--Health Care Costs Reach All Time Highs

1. “The Health Care Cost Institute was launched in 2011 to promote independent, nonpartisan research and analysis on the causes of the rise in U.S. health spending. HCCI holds one of the largest databases for the commercially insured population, and in 2014 became the first national Qualified Entity (QE) entitled to hold Medicare data. For more information, visit healthcostinstitute.org.”

2. The 2017 Health Care Cost and Utilization Report examines medical and prescription drug spending, utilization, and average prices, and is based on health care claims data from 2013 through 2017 for Americans under the age of 65 who were covered by employer-sponsored insurance.
a. “The report relies on claims data from four of the country’s largest insurers – Aetna, Humana, Kaiser Permanente, and UnitedHealthcare. As we recently announced, we are sunsetting our data collaboration relationship agreement with United, however we plan to continue publishing annual reports of health care spending trends and have already begun preparations for the 2018 report, which will include data from all 4 current insurers.

b. “Note that because we rely on claims data, spending on prescription drugs reflects average point-of-sale prices, and do not account for manufacturer rebates provided through separate transactions, so readers should read and interpret the sections dealing with prescription drugs with this in mind.”

3. “In 2017, per-person spending reached $5,641, a new all-time high for this population. This total includes amounts paid for medical and pharmacy claims. While it reflects discounts negotiated from wholesale or list prices for prescription drugs, it does not account for manufacturer rebates provided in separate transactions, because these data are not available.”

4. “Spending per-person grew at a rate above 4% for the second year in a row, rising 4.2% from 2016 to 2017. This year’s spending growth was slower than the 4.9% growth from 2015 to 2016 (2016 spending estimate revised up from previous report).”

5. “The overall use of health care services changed very little over the 2013 to 2017 period, declining 0.2%. In 2017, utilization grew 0.5% compared to 2016.”

6. “Average prices increased 3.6% in 2017. Year-over-year price growth decelerated throughout the five year period, rising 4.8% between 2013 and 2014 and slowing to 3.6% in 2016 and 2017. That trend reflects a slowing in the year-over-year changes in average point-of-sale prescription drug prices.”

7. “Out-of-pocket spending per-person increased 2.6% in 2017. The growth was slower than the rise in total spending, resulting in out-of-pocket costs comprising a smaller share of spending by 2017.”

C. What Areas of Health Care Are Driving Cost Increases?

1. Let’s take a look at what the trade association representing large health plan insurers reports as costs: America’s Health Insurance Plans May 28, 2018 Study of Inflation-Adjusted Average Annual Amounts Paid By
Commercial Health Insurance Plans In 2014-2016 For Types of Medical Care and Administrative Expenses for Plan Members

"Here is where your health care dollar really goes.

- 23.2 cents goes to pay for prescription drugs;
- 22.2 cents goes to pay for doctors;
- 20.2 cents goes to pay other costs at doctors’ offices and clinics;
- 16.1 cents goes to pay for hospital stays;
- 4.7 cents goes to pay federal, state, and local taxes;
- 1.8 cents pays for customer engagement and customer service;
- 1.6 cents pays for care management;
- 1.6 cents goes to pay for activities related to claims; and
- 2.3 cents of every health care dollar goes to health insurance provider profits.

2. Now, for a look at data from a less-compromised source: “Why Americans Spend So Much on Health Care—In 12 Charts—Prices Are Hidden Behind Insurance Deals, Hospital Consolidation Pushes Up Costs And The Health Sector Is A Growing Power In The Economy” (Wall Street Journal, 7-31-18)

a. “The U.S. spends more per capita on health care than any other developed nation. It will soon spend close to 20% of its GDP on health—significantly more than the percentage spent by major Organization for Economic Cooperation and Development nations.”

b. “What is driving costs so high?” “Americans aren’t buying more health care overall than other countries. But what they are buying is increasingly expensive.”

c. “Despite the higher spending, the U.S. fares worse than the OECD on most major measures of health. The pace of improvement by other advanced nations has been faster on most measures since 1970.”

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2 https://www.ahip.org/health-care-dollar/
3. Drug prices have risen the most of the three largest components of health spending since 2000, followed by hospital care and physician services.
III. Let’s Understand How Health Care Providers Document Their Decisionmaking Process and the Services They Provide

A. To Understand Provider Behavior--and the Efficacy of Provider Services--Let’s Review How Providers Code and Record Their Thought Process and Services

1. International Classification of Diseases (ICD Codes)
   a. Diagnostic codes that describe causes of injury, illness and death. Established by the World Health Organization in the late 1940s. The number following “ICD” represents the revision of the code.
   b. Current version: ICD-10-CM (“CM” = Clinical Modification, the set of revisions instituted by the National Center for Health Statistics (NCHS), a division of the Center for Medicare & Medicaid Services (CMS). The transition -- forced by CMS for Medicare, Medicaid and other governmental plans, and mimicked by third party administrators and insurers in the employer-sponsored plan world, occurred in October, 2015. Lots of consternation: the AMA advocated for its repeal (the call went unheeded).
      i. At the time of its supercession, ICD-9 was 34 years old. ICD-10 added codes to reflect current state of the art and added specificity as to precisely what was being analyzed.
         (a) ICD-9: 13,000 codes
         (b) ICD-10: 68,000 codes
      c. ICD-10-CM codes are used to describe diagnosis and patient’s condition. In the billing process, these codes are used to determine medical necessity.
      d. ICD-10-PCS (Procedures) Codes: the code set providers use to report procedures performed only in U.S. hospital inpatient health care settings.

2. CPT Codes
   a. Used to document majority of the medical procedures performed in a physician’s office.
   b. Published and maintained by the American Medical Association and are updated annually.
   c. CPT codes are five-digit numeric codes that are divided into three categories. The first category is used most often-- divided into six
ranges. These ranges correspond to six major medical fields: evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, and medicine.

3. HCPCS
   a. Healthcare Common Procedure Coding System (HCPCS) (“hick picks”): a set of codes based on CPT codes. Developed by CMS, and maintained by the AMA, HCPCS codes correspond to services, procedures, and equipment not covered by CPT codes.
   b. durable medical equipment, prosthetics, ambulance transport, and certain drugs and medicines.
   c. HCPCS is also the official code set for outpatient hospital care, chemotherapy drugs, Medicaid, and Medicare, among other services.

4. wRVUs
   a. The Medicare Physician Fee Schedule (Medicare Part B) is used by CMS -- and by employer-sponsored plans to determine the amount of payment for physician services.
   b. Although “value-based” payment is a popular mantra, most physician compensation is still volume-driven: physicians are paid based on the volume of services they provide.
   c. “Under the fee schedule, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide clinician services: clinician work, practice expenses, and PLI. The RVUs for clinician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based on the expenses clinicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums clinicians pay for professional liability insurance.”

   i. CMS reviews the RVUs of new, revised, and some potentially misvalued services annually. HCPCS codes and the conversion factor are also updated annually. The update of RVUs includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group

5 MedPAC October 2017 Payment Basics Overview--“Physician and Other Health Professional Payment System”
of physicians and other health professionals sponsored by the American Medical Association and specialty societies.”


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<th>CODE SET</th>
<th>DEFINITION</th>
<th>PAYMENT INFORMATION</th>
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| ICD-10-CM (Diagnoses) | - All providers, including physicians, use it in U.S. health care settings  
- Providers select codes based on documentation in the patient’s medical record  
- Centers for Disease Control and Prevention (CDC) developed and maintains the code set | - When physicians report diagnosis codes on claims, in general, the Medicare Administrative Contractor (MAC) will use the codes to determine coverage, not to determine the amount CMS will pay for furnished services  
- Inpatient providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims, which the MAC will use to assign discharges to the appropriate Medicare Severity-Diagnosis Related Group (MS-DRG) |
| ICD-10-PCS (Procedures) | - The code set providers use to report procedures performed only in U.S. hospital inpatient health care settings  
- Physicians do not use the code set to report their services, including ambulatory services and inpatient visits  
- Providers select codes based on documentation in the patient’s medical record  
- CMS developed and maintains the code set | - Physicians, suppliers, outpatient facilities, and hospital outpatient departments:  
  - Report and receive payments for furnished services, including physician visits to inpatients, based on CPT and HCPCS codes  
  - Use only ICD-10-CM (diagnosis) codes, not ICD-10-PCS (procedure) codes, on claims  
  - Inpatient providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims, which the MAC will use to assign discharges to the appropriate MS-DRG |
| HCPCS | Level I codes and modifiers are the CPT codes  
Level II codes and modifiers primarily identify products, supplies, and services not included in the CPT codes (such as ambulance services; drugs; devices; and durable medical equipment, prosthetics, orthotics, and supplies) | When providers report HCPCS codes on claims, the MAC uses the codes to either determine coverage or the amount CMS will pay for furnished services (less beneficiary coinsurance and copayments) |
| Level I HCPCS: CPT | The code set providers use to report medical procedures and professional services furnished in ambulatory/outpatient settings, including physician visits to inpatients  
The American Medical Association (AMA) developed, copyrighted, and maintains the code set | When providers report Level I HCPCS CPT codes on claims, the MAC uses the codes to determine the service performed. Claims are paid when the decision is made that Medicare can reimburse for the services (less beneficiary coinsurance and copayments).  
- Physicians, suppliers, outpatient facilities, and hospital outpatient departments:  
  - Report and receive payments for furnished services, including physician visits to inpatients, based on CPT codes  
  - Use only ICD-10-CM (diagnosis) codes, not ICD-10-PCS (procedure) codes, on claims.  
  - Follow CMS guidance when reporting CPT codes, including CPT modifiers for laterality. |

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6 Id.  
B. The Fly in the Ointment: wRVU Codes Overvalue Invasive Procedures, and Undervalue Cognitive Thought and Diagnosis

1. “Work RVUs are based on an assessment of how much time and intensity (e.g., mental effort and technical skill) services require relative to one another. If estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, the work RVUs become inaccurate. Because of advances in technology, technique, and clinical practice, efficiency improves more easily for procedures, imaging, and tests than for ambulatory E&M services, which are composed largely of activities that require the clinician’s time and so do not lend themselves to efficiency gains. When efficiency gains reduce the amount of work needed for a service, the work RVUs for the affected services should decline accordingly.”

2. But that has not occurred: CMS relies on input from the American Medical Association/Specialty Society Relative Value Scale Update Committee, whose members representing the invasive specialties are loath to reduce the number of wRVUs assigned to procedures which have become routine. That is compounded by the lack of current, accurate, and objective data on clinician work time and practice expenses. Result: “We have concerns about these data; for example, the surveys have low response rates and low total number of responses, which raises questions about the representativeness of the results” -- ambulatory E&M services become passively devalued over time.”

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8 “Report to Congress-Medicare and the Health Care Delivery System” (Medicare Payment Advisory Commission, June 2018)
9 Id.
C. Electronic Health Records: The Slick Time-Saving Device That Easily Captures Key Data that Enables Physicians and Plan Benefits Analysts to Facilitate Better Treatment--Or A Wildly Overblown, Time-Consuming Wastrel?

1. Congress dangles bait to entice practitioners and hospitals to use electronic health records.
   a. American Reinvestment & Recovery Act, enacted on February 17, 2009, included the "Health Information Technology for Economic and Clinical Health (HITECH) Act". HITECH provided incentives to practitioners to engage in the “meaningful use” of interoperable electronic health records “Meaningful Use”: defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services information on quality of care and other measures.
   b. CMS grants an incentive payment to “Eligible Professionals” (EPs) and to “Eligible Hospitals” (EHs) who or which demonstrate that they have engaged in efforts to adopt, implement or upgrade certified EHR technology.
   c. Phased approach:
      i. 2011: data capture and sharing
      ii. 2013: advanced clinical processes
      iii. 2015: improved outcomes
      iv. Incentive payments range from $44,000 over 5 years for Medicare providers and $63,750 over 6 years for Medicaid providers (starting in 2011). Participation in the CMS EHR incentive program was totally voluntary; however if EPs or EHs failed to join in by 2015, they would have incurred negative adjustments to their Medicare/Medicaid fees starting at 1% reduction and escalating to 3% reduction by 2017 and beyond.

2. With the enactment of MACRA, the HITECH Medicare EHR Incentive Program was transitioned to become one of the four components of the MACRA Merit-Based Incentive Payment System.

3. As of 2017, nearly 9 in 10 (86%) of office-based physicians had adopted any EHR, and nearly 4 in 5 (80%) had adopted a certified EHR. U.S.

a. HITECH incentive payments: $36 billion.

4. The bad news: electronic health records have not lived up to their expectations and billing.

5. Section 4004 of the 21st Century Cures Act, enacted on December 13, 2016, added section 3022 of the PHSA (the “PHSA information blocking provision”), defines conduct by health care providers, health IT developers, and health information exchanges and networks, that constitutes information blocking
   a. The information blocking provision added to PHSA defines and creates possible penalties and disincentives for information blocking, and applies to health care providers, health IT developers, exchanges, and networks.
   b. The information blocking provision also provides that the “Secretary, through rulemaking, shall identify reasonable and necessary activities that do not constitute information blocking for purposes of the definition at section 3022(a)(1) of the PHSA.

6. Where are we today?
   a. The Cures Act’s information blocking provision deals only with one aspect of the failure of electronic health records: the unwillingness of plans and practitioners (read, large hospital systems) to actually share their electronic health data with anyone else.
c. “5 Key takeaways:

i. “Patient harm: Electronic health records have created a host of risks to patient safety. Alarming reports of deaths, serious injuries and near misses — thousands of them — tied to software glitches, user errors or other system flaws have piled up for years in government and private repositories. Yet no central database exists to compile and study these incidents to improve safety.

ii. “Signs of fraud: Federal officials say the software can be misused to overcharge, a practice known as “upcoding.” Some doctors and health systems are alleged to have overstated their use of the new technology, a potentially enormous fraud against Medicare and Medicaid likely to take years to unravel. Two software makers have paid a total of more than $200 million to settle fraud allegations.

iii. “Gaps in interoperability: Proponents of electronic health records expected a seamless system so patients could share computerized medical histories in a flash with doctors and hospitals anywhere in the country. That has yet to materialize, largely because officials allowed hundreds of competing firms to sell medical records software unable to exchange information.

iv. “Doctor burnout: Many doctors say they spend half their day or more clicking pulldown menus and typing rather than interacting with patients. An emergency room doctor can be saddled with making up to 4,000 mouse clicks per shift. This has fueled concerns about doctor burnout, which in January the Harvard T.H. Chan School of Public Health and Massachusetts Medical Society called a “public health crisis.”

v. “Web of secrets: Entrenched policies continue to keep software failures out of public view. Vendors of electronic health records have imposed contractual “gag clauses” that discourage buyers from speaking out about safety issues and disastrous software installations — and some hospitals fight to withhold records from injured patients or their families.

d. Two proposed regulations, issued on March 4, 2019 seek to address interoperability and information blocking:

i. The Office of the National Coordinator for Health Information Technology (ONC), published a proposed
regulation with the title, “21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program,” 84 Federal Register 7424-7610. This “Information Blocking Proposed Regulation” lists seven exceptions which, if all of the elements for a particular exception applies, a health plan or health care provider’s refusal to divulge ePHI (electronic personal health information) will not constitute impermissible information blocking.

ii. The Centers for Medicare and Medicaid Services published a proposed regulation with the title, “Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally- Facilitated Exchanges and Health Care Providers,” 84 FR 7610-7680. This “Interoperability Proposed Regulation”

(a) The Interoperability Proposed Regulation does **not** apply to self-insured employer-sponsored group health plans, nor to any non-governmental employer-sponsored group health plan other than those sponsored by small group employers that utilize Marketplace plans. The Interoperability Proposed Regulation 3. MA organizations, Medicaid state agencies, state CHIP agencies, Medicaid managed care plans, CHIP managed care entities, and qualified health plans issuers in federal facilitated exchanges.

(b) “A variety of information must be made accessible to...enrollees [in these plans] via “openly published” (or simply “open”) APIs [application programming interfaces] – that is, APIs for which the technical and other information required for a third-party application to connect to them is publicly available. This will provide these patients with convenient access to their health care information in accordance with the HIPAA Privacy Rule access standard at 45 CFR 164.524, and an increase in their choice of applications with which to access and use their own electronic health information, and other information relevant to managing their health, enabling open APIs to improve competition and choice as they
have in other industries...MA organizations, Medicaid state agencies, state CHIP agencies, Medicaid managed care plans, CHIP managed care entities, and QHP issuers in FFEs (by requiring them to comply with the proposed ONC standard) must implement open APIs [that satisfy the standards detailed in the Interoperability Proposed Regulation]” and must “support enrollees in coordinating their own care via plan to plan coordination.” “In addition to existing care coordination efforts between plans, we propose that a plan must, if asked by the beneficiary, forward his or her information to a new plan or other entity designated by the beneficiary for up to 5 years after the beneficiary has disenrolled with the plan.

7. When will these requirements migrate to employer-sponsored plans? When Congress amends ERISA....

IV. How are Practitioners Paid? And How Does Money Influence Provider Behavior?

A. Most Physicians Continue to be Paid Based on the Number of wRVUs They Perform

1. Here are samples from employment agreements between hospital systems and physicians (over the last ten years, hospital systems have engaged in massive acquisitions of physician practices; in many metropolitan statistical areas, hospital systems employ 50% or more of all physicians).

2. A primary care physician (adult internal medicine):

(a) Base Salary: As compensation for the Services provided under this Agreement, the Physician shall be paid a base annual salary (the “Base Salary”) equal to approximately $329,640 (prior to deductions for taxes, etc.). The Base Salary will be paid in biweekly payments of approximately $12,678 made on the standard Hospital pay days. The Base Salary is predicated on the Physician achieving a total adjusted Work RVU (“wRVU”), as defined below, approximating 7,830 or more per Calendar Year or 1,958 or more per Calendar Year quarter. In the event the Physician fails to achieve the related wRVUs for two consecutive Calendar Year quarters, the Base Salary for the immediately succeeding Calendar Year quarter will be reduced for the deficiencies in earnings as calculated in accordance with the wRVUs tier schedule then-in effect during such Calendar Year. The total annual wRVU compensation earned in a given year pursuant to Section 1(a) and 1(b) of this Exhibit C shall be determined by an end of year reconciliation, which shall not include or be based upon allowable time off, but shall consider only actual CMS wRVUs with no payment for allowable time off.
(c) Quality and Clinical Measures Annual Incentive: Subject to the limitations noted in Total Compensation Cap section below, Physician shall be eligible to receive additional incentive compensation of up to $15,000 (prior to deductions for taxes, etc.) per Contract Year for assisting in achieving and maintaining certain quality and clinical performance improvements (i.e., patient satisfaction, third party payor quality designations, core clinical measurements in Physician’s specific patient base, adoption of evidence based medicine protocols and procedures, adoption of EMR and other innovations, etc.) in the Medical Practice (the “Quality and Clinical Measures Incentive”).

The “Total Compensation Cap” works to make the highly productive physician (i.e., lots of RVUs) unable to collect the relatively small quality incentive.

3. A surgeon:

(a) Base Salary. As compensation for Services rendered, Hospital shall pay Physician an annual base salary of Six Hundred Eighty-Five Thousand and 00/100 Dollars ($685,000.00) per calendar year, prorated for partial calendar years, less applicable taxes and withholdings and paid in accordance with Enterprise’s payroll practices. Notwithstanding the foregoing, for each calendar year, if Physician fails to achieve a total adjusted wRVU target of 8200 wRVUs in a calendar year, then, Physician’s annual base salary shall be reduced by the shortfall in wRVUs times the then current 75th percentile compensation per wRVU ratio for Physician's Specialty. The total annual wRVU compensation earned in a given year pursuant to Section 1(a) of this Exhibit B shall be determined by an end of year reconciliation, which shall not include or be based upon allowable time off, but shall consider only actual CMS adjusted wRVUs with no payment for allowable time off.

B. Do Manufacturers of Medical Devices and Drugs Pay Physicians? Does That Influence Practitioner Behavior?

1. The federal fraud and abuse antikickback statute (which applies to federal health care programs) and the federal Stark II physician self-referral statute (which applies to Medicare -- and, in two states, to Medicaid -- patients) (i) prohibit the payment or receipt of remuneration in exchange for the referral of a federal health care program patient for services covered by that federal health care program (antikickback) and (ii) prohibit physicians from referring Medicare patients to entities with which the physician has a financial relationship for the performance of specified “designated health services.”

a. Both statutes contain a variety of exceptions. Medical device and drug manufacturers seek to structure their payments to physicians so as to satisfy the exceptions. So do hospitals in their relationships with physicians who are not employed by the hospital but from which the hospital would love to receive referrals.
b. These federal statutes do not apply to employer-sponsored group health plans. Few states have adopted statutes to mimic the federal statutes in order to apply the federal statutes’ limits to fully insured health benefit plans.

2. Do payments from medical device and drug manufacturers influence practitioner behavior? Yes.

a. “Physician Payments from Industry Are Associated with Greater Medicare Part D Prescribing Costs” (Perlis and Perlis, PLoS One, 2016)\(^{10}\): “While distribution and amount of payments differed widely across medical specialties, for each of the 12 specialties examined the receipt of payments was associated with greater prescribing costs per patient, and greater proportion of branded medication prescribing. We cannot infer a causal relationship, but interventions aimed at those physicians receiving the most payments may present an opportunity to address prescribing costs in the US.”

b. “Industry Payments to Physician Specialists Who Prescribe Repository Corticotropin” (Hartung et. al., JAMA Network Open, June 29, 2018)\(^{11}\):

i. “Question What is the association of industry payments to physicians and prescriptions for repository corticotropin (H. P. Acthar Gel; Mallinckrodt Pharmaceuticals)?

ii. “Findings In this cross-sectional study of 235 specialist physicians who frequently prescribe corticotropin to Medicare beneficiaries, 207 (88%) received a monetary payment from the drug’s maker, with more than 20% of frequent prescribers receiving more than $10,000. There was a significant association between higher dollar amounts paid to these prescribers and greater Medicare spending on their corticotropin prescriptions.”

iii. “Meaning Financial conflicts of interest among physicians may be driving corticotropin expenditures for the Medicare program.”

c. “Financial Relationships between Urologists and Industry: An Analysis of Open Payments Data” (Maruf et. al., Urology Practice, May 2018)\(^{12}\): “There were 232,207 payments totaling $32,418,618 made to 8,618 urologists (73.6% of practicing urologists in the

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\(^{10}\) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4868346/
\(^{11}\) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2686039
\(^{12}\) https://www.urologypracticejournal.com/article/S2352-0779(17)30086-9/fulltext
United States) during calendar year 2014. Median payment was $15 (IQR $11 to $24). While the majority of individual payments (68%) were $20 or less, 82% of the urologists in the database received more than $100 from industry during 2014. The frequency of industry payments was positively correlated with Medicare Part D prescribing frequency as well as the sum of claims…”

d. Physician-Owned Medical Device Distribution Companies.
Surgeons create a distributorship company (the “POD”), which then enters into a distributor relationship with a medical device manufacturer or distributor. POD then contracts with Hospital at which surgeons have admitting privileges. Hospital purchases implantable devices from POD.


ii. Hospitals spent $24 billion on devices and supplies for Medicare-covered services in 2014
   (a) $14 billion on implantable medical devices
   (b) $10 billion on medical supplies
   (c) 15% of total hospital costs

iii. 2013: CMS Office of Inspector General found some evidence of induced demand and equal or higher device costs associated with PODs
   (a) Rate of spinal surgery grew faster for hospitals that began buying devices from PODs compared with all hospitals (16% vs. 5%)
   (b) None of the devices was less costly when supplied by a POD; spinal plates averaged $845 more when supplied by a POD ($2,475 vs. $1,630)

iv. Senate Finance Committee Report: PODs operating in at least 43 states as of November 2015

e. PODs can be structured so as to qualify for an exception to the Stark statute -- and most states have nothing comparable to the Stark statute.

f. Result: surgeon choice can be driven by surgeon ownership of the medical device distributorship.

3. Result: Sponsors of employer-sponsored self-insured plans in particular should be aware of what institutions or manufacturers may be making payments to practitioners that may influence their treatment recommendations/prescribing behavior.

C. One Resource: The Open Payments Website Maintained By CMS

a. The “Sunshine Act”-Affordable Care Act §6002

i. Applicable manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid or the Children’s Health Insurance Program must report annually to HHS certain payments or transfers of value provided to physicians or teaching hospitals

ii. Applicable manufacturers and applicable group purchasing organizations must report annually certain physician ownership or investment interests.

iii. HHS must publish applicable manufacturers' and applicable GPOs' submitted payment and ownership information on a public website

b. The CMS Website: Open Payments, https://www.cms.gov/openpayments/
Open Payments

Open Payments is a national disclosure program that promotes a more transparent and accountable health care system by making the financial relationships between applicable manufacturers and group purchasing organizations (GPOs) and health care providers (physicians and teaching hospitals) available to the public.

Learn more about Open Payments.

We Want to Hear from You!
Do you have input on the Open Payments program you would like to share?
The Open Payments team welcomes feedback and wants to hear from you. Send your feedback to openfeedback@cms.hhs.gov.
Learn more about providing feedback here.

View the Data
View Summary Data
Search the Data
Create Charts and Graphs with the Data Explorer
Download Open Payments Datasets
States custom reports

STRYKER CORPORATION

- Michigan
- United States

Summary

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<td>Total Research Transactions</td>
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Applicable Manufacturers and Group Purchasing Organizations
- Learn how to register
- Already registered? Login here
- Attend helpful events to learn more about Open Payments
D. Why Do We Care?

1. Physicians who are compensated based on the number of wRVUs -- and interventional physicians who perform newer procedures receive disproportionately high numbers of wRVUs--have every incentive to perform those procedures, regardless of their relative value to other therapies.

2. Physicians who receive payments from medical device manufacturers and pharmaceutical companies appear to be influenced in their treatment decisions by those payments.

E. How Does This Play Out In Real Life Robotic Prostate Surgery Versus. Traditional Surgical Procedure (Versus Other Treatment Modalities)


   a. Since 2001 the number of centers in the United States that offer proton beam therapy has grown from three to 12.

   b. Eight more are being developed or built now, each costing more than $100 million.
c. No reliable study or evidence that proton beam radiation is better than standard X-ray radiation treatment.

d. January 2, 2013 Journal of the National Cancer Institute: team led by James Yu, a radiation oncologist at the Yale School of Medicine in New Haven, Conn., reviewed Medicare records of nearly 55,000 prostate cancer survivors and found evidence that proton therapy may be associated with small reductions in urinary side effects—but only within the first six months of treatment. After that, Yu says, “We found no difference [in these side effects] between proton radiation and IMRT.”


a. “The number of proton therapy centers operating in the United States has more than doubled in the past three years, from 12 in 2015 to 28 in 2018.

b. “Cost has been a primary concern with proton therapy since the expansion of clinically focused centers in the mid-2000s. A single-room proton therapy machine costs anywhere from $30 million to $50 million, which is about five to ten times the price of an advanced linear accelerator. These high costs can make achieving ROI a challenge: Hampton University's multi-vault proton therapy institute lost $2.99 million in 2017, and IU Health's proton therapy center closed in 2014 after sustaining a $3.5 million operating loss in 2013.”

c. “PBT's higher costs demand higher prices: By analyzing Medicare fee-for-service (FFS) data, we found that proton therapy Medicare payments in the hospital outpatient department (HOPD) setting averaged about $27,000 per patient, compared with $10,000 for intensity-modulated radiation therapy (IMRT) and about $8,500 for stereotactic radiosurgery. While private insurers have long pushed back on the price of proton therapy versus alternatives, we may increasingly see referring providers balk at the cost as more participate in total cost-of-care contracts, such as ACOs and Medicare Advantage networks.

d. “Moreover, despite the significant cost, the clinical case for protons is unclear. Looking at Medicare FFS data, we found that only a few of the roughly 800 patients who received proton therapy in 2013 had future claims involving common radiation therapy side effects in the three years after their therapy—but side effects among
patients treated with IMRT and stereotactic radiosurgery were also rare.

e. “And when Washington State Health Care Authority, which is often seen as a harbinger for future coverage decisions, completed an exhaustive report studying PBT's efficacy, it recommended limiting coverage to relatively low-incidence pediatric, ocular, and central nervous system tumors. In addition, a recent randomized controlled trial comparing PBT to IMRT in lung cancer found no difference in efficacy or toxicity between the two arms, signaling caution to those banking that future trials will show clear benefit.


a. In a Wall Street Journal June 24, 2018 article, Ashutosh Tewari, system chairman of the department of urology at Mount Sinai Health System in New York City, argued that robotic surgery is better. William Catalona, professor of urology at Northwestern University’s Feinberg School of Medicine, disagreed -- open surgery is and continues to be at least equal to, if not superior to, robotic surgical procedures when measured by outcome and cost.

b. How do the two hospitals’ websites describe the treatment options to patients?
From the Mt. Sinai Hospital Website:

**Prostate Cancer**

The prostate is the walnut-sized gland that produces semen. After skin cancer, prostate cancer is the most common form of cancer among men in the United States. More than 161,000 men will be diagnosed with the disease in 2017, according to the Prostate Cancer Foundation. Fortunately, when we find the cancer early, treatment can be highly effective.

At Mount Sinai Urology, we provide the most up-to-date services available for the diagnosis, treatment, and management of prostate cancer. Our doctors are fellowship-educated clinicians and researchers known for their expertise and innovation in current and emerging treatment for prostate cancer. Our surgeons are among the few trained in open, laparoscopic, and robotic prostate surgery.

In addition, Mount Sinai is considered one of the premiere centers for brachytherapy and intensity-modulated radiation therapy (IMRT). Brachytherapy, which Mount Sinai helped to pioneer, and IMRT are advanced types of high-precision radiation treatment that deliver radiation doses more precisely while minimizing damage to nearby normal tissues.
Robotic Prostate Surgery
Robotic radical prostatectomy is a minimally invasive, or laparoscopic surgery to remove the cancerous prostate gland and some of the tissue surrounding it. Mount Sinai doctors performed the first robotic radical prostatectomy in New York using minimally invasive robotic surgery. We use a state-of-the-art robotics surgical system to remove the prostate through a few small incisions instead of one large incision.

Benefits

Robotic prostate surgery is extremely precise, which offers a variety of benefits over traditional (open) prostate surgery, including:

- Smaller incisions
- Shorter hospital stay
- Less pain
- Less risk of infection
- Less blood loss and transfusions
- Less scarring
- Faster recovery
- Superior cancer control
- Superior nerve sparing

In addition, with robotic prostate surgery, a temporary catheter remains in place for considerably less time (five to seven days instead of two weeks), and there is less risk of urinary incontinence and impotence following the robotic prostate surgery procedure.

This approach results in complete removal of cancer for nearly 95 percent of all patients whose cancer is confined to the prostate. In published long-term follow-up studies performed by Mount Sinai Urology Center, Ashutosh (Ash) K. Tewari, MD, this also means that these patients have an extremely good chance (95 percent) of reaching the 10-year survival mark.

Robotic prostate cancer surgery is extremely safe in experienced hands, but some complications are possible in any abdominal procedure. Possible complications may include bleeding, infection, blood clotting, heart attack, hernias, permanent urinary incontinence, impotence, and strictures. While intraoperative mortality is almost unheard of, it is possible with any anesthesia and surgery. Equipment malfunction is rare, happening in less than 0.4 percent of cases. Mount Sinai has three backup robots to address this remote possibility.

Surgical Outcomes

We usually evaluate the outcome of primary prostate cancer treatment by looking at cancer control, preservation of urinary continence, and preservation of sexual function. The Advanced Robotic technique, developed by Dr. Tewari, is highly successful on all three measures, producing minimal disruption to your daily life.

- **Cancer control** is the ability of the surgeon to remove all cancerous tissue from the body. We measure this by looking at the surgical margins (the rim or border of the tissue removed in surgery). Once we complete the procedure, we send the prostate to the Pathology department to test margins and cancer grade (any remaining malignancy) if the margins are "clean" or cancer-free, we assume that we have removed all of the malignancy.

- **Urinary Incontinence** is determined by whether the bladder and surrounding anatomy are unaffected by removal of the prostate.

- **Sexual potency** is about sexual functioning, a chief concern of men undergoing prostate cancer treatment.

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Meet the Director

Ashutosh Tewari, MD

Chairman and Director of the Milton and Carroll Petrie Department of Urology

Phone: 212-941-9999

© View Full Bio
Genomic Revolution and its Impact on Prostate Cancer Care: Ash Tewari, MD, Chairman of Urology

Patient Story: Richard LoRubbio

All in the Family. As the lights began to dim and the music started, Richard LoRubbio, his wife Laura, and their son Christopher took their seats and began to clap. Their daughters’ dance recital was about to begin.
From the Northwestern University website:

Northwestern Medicine Urology Program

The Northwestern Medicine Urology Program ranks amongst the nation's most experienced and well respected, providing comprehensive inpatient and outpatient care, including state-of-the-art diagnostic and treatment capabilities for men, women and adolescents.

Services

The Northwestern Medicine Urology Program at Northwestern Memorial Hospital prides itself on its service to patients. The urologists at Northwestern offer comprehensive urologic care for sensitive conditions, working with patients to find the best individualized treatment for their urologic conditions.

The Department of Urology has a longstanding tradition of providing state-of-the-art, multidisciplinary approaches to the evaluation and management of the urologic cancers with recognized specialists in each branch of cancer care.


Edward Schaeffer, MD, PhD
Chair, Department of Urology
Northwestern Memorial Hospital

Edward Schaeffer, MD, PhD, discusses how our physician scientists are always on the lookout for new discoveries in the lab.
Coordinated care
Patients with urologic conditions are evaluated and managed with emphasis on an integrated, multidisciplinary approach. All of the team members are recognized leaders in their field of expertise, and all potential therapeutic options are considered and discussed with each patient, including:

- Observation (no active treatment)
- Medical management
- Surgery

Areas of Care

Benign Prostate Diseases and Male Voiding Dysfunction
Our urologists offer comprehensive urologic care focusing on the diagnosis and treatment of benign prostatic hyperplasia, incontinence and other male bladder conditions:

- Benign prostatic hyperplasia (BPH)
- Incomplete bladder emptying
- Incontinence
- Urinary frequency
- Urinary urgency

Bladder Cancer
Our urologic oncologists offer advanced laparoscopic and robotic surgical techniques in addition to multidisciplinary treatment in collaboration with Northwestern Medicine's medical and radiation oncologists.

Congenital Urologic Conditions
Our urologists provide long-term expert care for men and women with congenital genitourinary conditions:

- Disorders of sex development
- Spina bifida
- Neurogenic bladder and bowel

Male Fertility
Our urologists offer full medical evaluations and treatment options for male infertility in addition to fertility preservation for men with cancer:

- Hypogonadism
- Klinefelter’s syndrome
- Testicular failure

Male Sexual Dysfunction
Our men’s health specialists provide a complete evaluation to restore sexual function and intimacy for men struggling with sexual dysfunction:

- Ejaculatory disorders
- Erectile dysfunction
- Low testosterone
- Peyronie’s disease

Prostate Cancer
Our Comprehensive Prostate Cancer Program offers multidisciplinary diagnostic, therapeutic and preventive services for prostate cancer, working with patients to provide individualized treatment tailored to their condition.
Prostate cancer develops in the prostate, the muscular, walnut-sized gland that's located below the bladder and in front of the rectum. The prostate makes the thin fluid that's part of semen and plays an important role in both sexual function and urinary function.

As a man ages, the cells of his prostate may change and form tumors or other growths. Cancer cells, in particular, grow out of control and spread beyond the prostate. Cancer that spreads is harder to treat. Prostate cells can create four types of growths, including:

- **Noncancerous growths**: As a man ages, the prostate may grow larger. This is called benign prostatic hyperplasia (BPH). With BPH, extra prostate tissue often squeezes the urethra, causing symptoms such as trouble urinating. BPH is not cancer and does not lead to cancer.

- **Atypical cells**: Some cells, called prostatic intraepithelial neoplasia (PIN), don't look like normal prostate cells. Although they are not cancer cells, PIN may be a sign that cancer is likely to form.

- **Cancer**: When abnormal prostate cells grow out of control and start to invade other tissues, they are called cancer cells. These cells may or may not cause symptoms. Some tumors can be felt during a physical exam, and some can't.

- **Metastatic cancer**: Prostate cancer may grow into nearby organs or spread to nearby lymph nodes, the small organs around the body that are part of the immune system. In some cases, the cancer spreads to bone or organs in distant parts of the body. This is called metastasis.
Prostate Cancer Treatments

Your physician will closely monitor your cancer through a series of prostate-specific antigen (PSA) blood tests and exams, known as "watchful waiting". In this active surveillance, treatment is not initiated. Because prostate cancer often grows slowly, some men may never need treatment for their prostate cancer. Your physician will discuss this option if you are a candidate.

Surgery

Surgical treatment options for prostate cancer include:

- **Prostatectomy**: Removal of the entire prostate
- **Transurethral removal**: Removal of part of the prostate
- **Cryosurgery**: Freezing of the cancerous cells

Specially trained surgeons may use the da Vinci® Surgical System for robotics-assisted removal of the prostate with greater precision, faster healing and less pain.
Radiation therapy

Your oncologist will discuss radiation therapy treatment options with you. Options include:

- **Intensity Modulated Radiation Therapy (IMRT):** IMRT is a high precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor.
- **Gamma Knife® radiosurgery (stereotactic radiotherapy):** Gamma Knife® radiosurgery is the delivery of a single high-dose radiation treatment.
- **Proton therapy:** Proton therapy targets tumors, not healthy tissues, so the dose to the bladder and rectum, which are near the prostate, is greatly reduced.
- **Internal radiation or brachytherapy:** Brachytherapy uses tiny radioactive seeds or tubes put into your body to send radiation to your prostate.
- **Hormone therapy:** For cancer that has spread or recurred, hormone therapy can be used to reduce the amount of testosterone, which can stimulate the growth of prostate cancer.

Chemotherapy

Chemotherapy drugs may be administered, either intravenously or orally, to treat cancerous cells that have spread outside the prostate or have not responded to hormone therapy.

Novel therapies

We offer state-of-the-art therapy, such as vaccine therapy, also called immunotherapy (sipuleucel-T) and targeted radiation (Radium-223).
Palliative medicine

Side effects from cancer treatment can impact your quality of life and your body’s ability to respond to treatment. Northwestern Medicine is home to a diverse team of palliative medicine specialists who work with your oncologist to help relieve your pain and manage your symptoms. The palliative medicine specialists:

- Treat pain and other physical symptoms of cancer, such as fatigue, nausea, trouble sleeping, poor appetite, breathing difficulties and weight loss
- Treat emotional symptoms, such as depression and anxiety
- Improve your body’s ability to tolerate cancer treatments
- Help you better understand tests, procedures and options
- Guide you and those who care for you to helpful outside resources

From your initial diagnosis through your care, the palliative medicine team can help you remain stronger in your fight against cancer and feel better, every step of the way.

ALREADY TREATED FOR PROSTATE CANCER: WHAT’S NEXT?
c. Which procedure do the two physicians regularly use to treat patients who present with prostate cancer?

i. Dr. Tewari admitted in the article that he regularly uses the robotic procedure. Note how his institution has allowed the cult of personality to dominate its presentation of prostate cancer treatments.

ii. Northwestern University takes a less personality-driven approach. But:

   (a) In the article, Dr. Catalona says that he regularly uses the open surgical technique.

   (b) The Northwestern website lists a variety of treatment options -- but no mention is made of robotic surgery as one of the surgical treatment options.

d. What have reasonably sized, well-designed, scientifically valid studies shown? In the Journal article, Dr. Tewari does not cite any
clinical studies to support the claim that robotic surgery is superior to the traditional, open, surgical technique. Dr. Catalona:

i. “In outcomes most men care about—death, complications and mortality—the 2017 Ontario Health Technology Assessment concluded: “We did not find high-quality evidence that the robot-assisted approach improves cancer-related outcomes” or major functional ones, such as urinary and sexual function.”

ii. Consider 20-year cancer-specific survival rates reported from the patients with clinically significant tumors operated upon, using open surgery, by Patrick Walsh of Johns Hopkins. Among men whose tumor was confined to the prostate with cancer-free surgical margins, the cancer-specific survival rate was nearly 100%. The highest level of evidence for open prostatectomy comes from randomized clinical trials showing that open surgery significantly reduces metastases and prostate-cancer deaths. They show tumor progression, metastases and cancer deaths are significantly lower in men treated with open surgery. No such evidence exists for any other type of prostatectomy.”

F. OK-Surgeons Love to Perform the Procedure With Which They Trained or Feel Comfortable, Regardless of Evidence That Might Indicate Other Treatment Modalities are Better. How Widespread is This Phenomenon?

1. Very widespread. And, as we shall see, money from treatment sponsors — and not necessarily a lot of money — can influence physicians’ choice of treatment options.

2. “It’s hard for doctors to unlearn things. that’s costly for all of us—procedures live on even after they’ve been proved ineffective—it can lead to harms and wasted resources.” Aaron E. Carroll, Professor of Pediatrics, Indiana University School of Medicine, New York Times, September 10, 2018.14

   a. Case study: management of glucose levels of children in intensive care units.

   b. 2001 study: tight control appears to work better than traditional, and less strict, control.

   i. Problem: the 2001 study was not a double-blinded study; mortality in the control group was higher; the control group

consisted of a tiny sub-set of pediatric intensive care patients (post-cardiac surgery patients).

c. Notwithstanding the weaknesses in the study, treatment guidelines changed, and tight glycemic control was widely adopted.

d. 2009: a much larger, and vastly superior (from a quality-of-study standpoint) is published:

i. A significantly higher rate of death in the tight control group (27.5 percent vs. 24.9 percent), as well as a much higher rate of severe hypoglycemia (6.8 percent vs. 0.5 percent).

ii. These findings applied to patients overall and to subgroups (like surgical versus medical patients).

e. Result: Guidelines changed again; physicians were advised to stop the widespread tight control.

f. 2015: A study is published, in which researchers assessed whether physicians in fact changed their behavior in response to the 2009 study and the resulting change in guidelines.

i. The study showed that, between 2001 and 2009, the use of tight glycemic control increased from 17% of admissions to 23%.

ii. Did the percentage decline after the 2009 guidelines reversed course? No. “From 2009 through 2012, there was no decrease in tight glycemic control. The authors argued that ‘there is an urgent need to understand and promote the de-adoption of ineffective clinical practices.’”

V. Provider Consolidation is One Culprit in the Rise of the Cost of Health Care

A. Hospital Mergers: Hospital Prices Go Up

1. “Market Concentration Variation of Health Care Providers and Health Insurers in the United States” (Fulton et. al., Commonwealth Fund, 7-30-18)\textsuperscript{15}

a. “Over the past several decades in the United States, more and more health care providers and health insurers have consolidated, increasing their market power. Highly concentrated markets have contributed to the growth in U.S. health care spending because they

\textsuperscript{15} https://www.commonwealthfund.org/blog/2018/variation-healthcare-provider-and-health-insurer-market-concentration
are associated with higher health care prices and insurance premiums, yet are not typically associated with higher quality of care.” [Citations omitted.]

b. “Our previous research has shown that in markets with both high provider and insurer concentration, insurers have bargaining power to reduce prices, yet consumers and employers don’t usually benefit.”

c. “When looking at market concentration levels across the United States, we found that, for both providers and insurers, the concentration levels varied, typically between two concentration categories. For providers, the vast majority of the MSAs were at the concentrated end of the spectrum, either being highly concentrated (47.1%) or super concentrated (43.0%). By comparison, for insurers, almost all the MSAs fell into the middle categories, either being highly concentrated MSAs (54.5%) or moderately concentrated (36.9%).

d. “When examining the relative concentration between providers and insurers, providers generally had the upper hand. Provider concentration was in a higher category relative to insurers in 58.4 percent of the MSAs, while the opposite was true in only 5.8 percent of the MSAs.”

2. Mergers don’t reduce costs--but they do increase prices.

a. There have been 1,519 hospital mergers in the past 20 years, with 680 mergers since 2010, resulting in many markets being dominated by one large, powerful health system. Physician services markets are also more concentrated, with 33% of all physicians and 44% of all primary care physicians being employed by hospitals

b. February 14, 2018 U.S. House Committee on Energy and Commerce Subcommittee on Oversight and Investigations hearing on “Consolidation Trends In The Health Care Sector, Reasons Behind The Trends, And Their Effects On The Cost And Quality Of Care”

c. Leemore Dafny, Ph.D., a Professor of Business Administration at Harvard Business School:

i. Substantial academic literature demonstrates that horizontal mergers of competing health care providers tend to raise prices.

ii. Only very limited evidence to suggest that there are offsetting benefits in the form of improved quality.
iii. Systematic price and spending increases occur in mergers of providers in different geographic areas, in particular after hospital systems acquire additional hospitals in the same state and after hospitals acquire physician practices.

iv. Studies of physician markets also find that concentration is associated with higher commercial prices.

v. Studies have found that premiums increase more in more concentrated markets and there are typically lower insurance premiums in areas with more insurers.

d. Martin Gaynor, Ph.D., a Professor of Economics and Health Policy at Carnegie Mellon University:

i. Consolidation between competitors leads to substantial price increase for hospitals, insurers, and physicians, without offsetting gains in improved quality or enhanced efficiency.

ii. Upon an examination of all hospital mergers in the United States over a five year period, the average merger between two nearby hospitals leads to a 6.2% price increase, and that prices continue to rise for at least two years after the merger.

iii. Recent evidence shows that mergers between hospitals in different markets may lead to price increases, as well as evidence that patient health outcomes are worse in concentrated hospital markets and that the quality of care delivered by physicians suffers when they face less competition.

e. “Mergers and Marginal Costs: New Evidence on Hospital Buyer Power” (Stuart Craig, Matthew Grennan, Ashley Swanson, National Bureau of Economic Research, NBER Working Paper No. 24926 Issued in August 2018)\(^{16}\)

i. We estimate the effects of horizontal mergers on marginal cost efficiencies – an ubiquitous merger justification – using data containing supply purchase orders from a large sample of US hospitals 2009-2015. The data provide a level of detail that has been difficult to observe previously, and a variety of product categories that allows us to examine economic mechanisms underlying “buyer power.” We find that merger target hospitals save on average $176 thousand (or 1.5 percent) annually, driven by geographically local efficiencies in price negotiations for high-tech “physician

\(^{16}\) http://www.nber.org/papers/w24926.pdf
preference items.” We find only mixed evidence on savings by acquirers.

ii. Result: no evidence of any cost savings, much less savings passed to plans/enrollees.

f. “Medical Cost Trend: Behind the Numbers 2019 (PwC, June 2018)\textsuperscript{17}

i. PwC’s Health Research Institute “estimates that by 2019, 93 percent of most metropolitan hospital markets will be considered highly concentrated. In the short term, this trend likely will lead to higher prices…”

ii. In 2017, the number of announced hospital and health system deals increased nearly 13 percent from 2016, the highest number of transactions since 2000. Of 115 health system and hospital mergers announced in 2017, 10 were mega-deals involving sellers with net annual revenues of at least $1 billion. ‘There has been little to no action taken to stop providers from concentrating or taking price increases,’ said Sherry Glied, dean of New York University Wagner Graduate School of Public Service, in a recent interview with HRI. ‘If inflation ramps up and consolidation continues, expect to see strong upward pressure on prices.’”

3. The trend of mergers of hospital systems in the same or overlapping geographic markets continues:

a. On October 1, 2018, Dallas-based Baylor Scott & White Health and Memorial Hermann Health System of Houston announced their merger, which will create a 68-hospital system with 73,000 employees and annual revenues of more than $14 billion.

b. September 21, 2018: Jefferson Health and Einstein Healthcare Network announced that the two systems “signed a definitive merger agreement to combine two prominent academic medical centers and create the largest residency program in the greater Philadelphia region. Einstein Medical Center Philadelphia, the largest independent academic medical center in the region, is responsible for the training of greater than 3,500 health professional students and 400 residents in excess of 30 programs each year. The merger would also bring together MossRehab and Magee Rehabilitation, two of U.S. News & World Report’s top-ranked rehabilitation hospitals. With the agreement in place, Einstein and

\textsuperscript{17} \url{www.pwc.com/us/medicalcosttrends}
Jefferson will seek all necessary state and federal regulatory clearances.”

VI. Value Based Care vs. Volume Based Care: Theory and Challenges

A. Value Based Care: A Quick Overview

1. Purpose: encourage providers (and enrollees) to choose health care options based on their value.

2. Value means:
   a. For a particular procedure: which provider offers the procedure at the lowest cost, without compromising outcome?
   b. For choosing among competing procedures: which procedure provides the best combination of cost and outcome?

B. The First Challenge: Getting Providers to Avoid Deploying Treatment Regimens That Offer Little or No Value (or Which are Harmful) and to Adopt Guidelines That Do Work

1. See above: even when studies show that a treatment regimen’s harm can outweigh its benefit, practitioners do not quickly change their habits.

2. Treatment Guidelines
   a. Choosing Wisely,19 sponsored by the American Board of Internal Medicine Foundation, identifies care that physicians routinely recommend but should not. Almost 600 different tests, procedures or treatments, collected over the last six years, are currently listed on the Choosing Wisely website.20 Almost all the recommendations basically say “don’t do” them.

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19 http://www.choosingwisely.org/our-mission/
20 http://www.choosingwisely.org/clinician-lists/

i. “Clinical practice guidelines are a key component of medicine, as they provide evidence-based recommendations for physicians and other health care professionals about the management of care for patients with diseases or other clinical conditions. A number of important developments involving clinical practice guidelines have emerged in the past few years.”

ii. 2011 Institute of Medicine (IOM, now the National Academy of Medicine) report, “Clinical Practice Guidelines We Can Trust”\footnote{Greenfield S, Steinberg EP, Auerbach A, Avorn J, Galvin R, Gibbons R. Clinical Practice Guidelines We Can Trust. Washington, DC: Institute of Medicine; 2011.}: the seminal report that provided authoritative rules that should be used to create a clinical practice guideline.

iii. Problem: too many guidelines. “In 2003, 1402 guidelines were indexed on the NGC [the National Guideline Clearinghouse, an initiative of the HHS Agency for...}
Healthcare Research and Quality, was created in 1997 by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America’s Health Insurance Plans [AHIP])...By 2013, that number had increased to 2619. Many of these guidelines are about the same or similar topics but were produced by different organizations. Guidelines from different groups can either agree or mostly agree with each other (making them redundant and a potential waste of scarce guideline development resources) or they can disagree, leaving clinicians and patients uncertain about which recommendation to follow.”

iv. Problem: free access to the NGC, the repository that houses all of the guidelines -- the handy place for employers designing effective health benefit plans to look to vet participating providers (or to query the insurer/TPA from which the plan will rent the network of participating providers) -- has been defunded by the current Administration as of July 16, 2018. “This means the 2.6 million annual visitors to the site will no longer have free access to summaries of 1385 guidelines, many of which have also been assessed using the NGC Extent Adherence to Trustworthy Standards assessment tool. This shuttering of free access to the NGC undermines one of the key recommendations of the IOM Trustworthy Guidelines report, namely that the NGC provide users with information to help in distinguishing trustworthy guidelines from the rest...The loss of free access to the NGC is a major step backward for users of clinical practice guidelines.

c. Failure to follow treatment guidelines generates wasteful spending on health care.

i. “The High Costs of Unnecessary Care” (Aaron E. Campbell, The JAMA Forum, November 14, 2017)\(^23\): “In a recent study published in PLOS One, researchers surveyed physicians across the United States to ask about their perspectives on unnecessary medical care. These physicians reported that more than 20% of overall medical care was not needed. This included about a quarter of tests, more than a fifth of prescriptions, and more than a 10th of procedures.”

\(^23\) https://jamanetwork.com/journals/jama/fullarticle/2662877
The analyses we have seen so far swatted at the easiest to quantify wasteful provider behaviors: deploying treatments that have no value.

The more difficult task: weighing the relative merits of competing treatments that have some incremental value—but at widely varying costs.

“Adding Cost-Effectiveness to Define Low-Value Care” (Ankur Pandya, JAMA, 4-23-2018)

a. “By not using a cost-effectiveness analysis, physicians and researchers aiming to identify and reduce low-value health care are not putting a widely cited and intuitive conceptual value equation created by Porter5 [Porter ME. What is value in health care? N Engl J Med. 2010;363(26):2477-2481] into practice (i.e., health care outcomes gained per dollar spent). Incremental cost-effectiveness ratios, which are the main results used in cost-

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24 https://jamanetwork.com/journals/jama/fullarticle/2679461
effectiveness analyses, can be used to identify low-value health care services that improve the health of patients but are not worth the additional costs required to achieve these health care gains. Incremental cost-effectiveness ratios greater than $100 000 to $150 000 per quality-adjusted life-year (QALY) suggest low-value health care in the United States.6 [Neumann PJ, Cohen JT, Weinstein MC. Updating cost-effectiveness—the curious resilience of the $50,000-per-QALY threshold. N Engl J Med. 2014;371(9):796-797].

4. The Institute of Clinical and Economic Research uses this benchmark to evaluate the value of new prescription drug therapies.

5. Pandya (paragraph #3, above) identifies these resources for clinical therapies:

a. “Including cost-effectiveness in the definition of low-value health care is not a simple task, but not because of lack of data. The number of published cost-effectiveness analyses has increased every year since 1990 with more than 735 published in 2016, and more than 5000 total cost-effectiveness studies published since 1975, all of which are cataloged in the Tufts Cost-Effectiveness Analysis Registry.7 [Tufts Medical Center. Cost-Effectiveness Analysis Registry. http://healtheconomics.tuftsmedicalcenter.org/cear4/home.aspx. Accessed April 10, 2018.] Per this registry, 331 cost-effectiveness studies for the United States have been published since 2005 and have identified health care services with incremental cost-effectiveness ratios greater than $150 000 per QALY.

b. “Among these services, the top 50 (i.e., the lowest-value health care services among all that improve the health of patients) had incremental cost-effectiveness ratios well above the $150 000 per QALY threshold (range, $2 500 000-$60 000 000 per QALY). For example, among treated patients with advanced-stage Hodgkin disease, annual follow-up with computed tomography for 5 years was found to result in 0.0005 incremental QALYs (equivalent to an additional 4.4 hours of perfect health per patient) with incremental per-patient lifetime costs of $4800 vs follow-up without computed tomography, resulting in an incremental cost-effectiveness ratio of $9 000 000 per QALY.8 [Guadagnolo BA, Punglia RS, Kuntz KM, Mauch PM, Ng AK. Cost-effectiveness analysis of computerized tomography in the routine follow-up of patients after primary treatment for Hodgkin’s disease. J Clin Oncol. 2006;24(25):4116-4122.]
6. “The most important challenge of including cost-effectiveness to define low-value health care is finding the political will to do so. It is relatively easier to create barriers to low-value health care based on clinical effectiveness alone. Who would (convincingly) argue against reducing the use of harmful health care services? It is more difficult to discourage the use of health care services that incrementally improve the health of patients but are not worth the cost it takes to do so, but this is an important step that should be taken to control health care costs. To ignore health care costs implies society would pay any amount of money for services that improve the health of patients even if those services result in patients achieving only marginal improvement in health outcomes. Cost-effectiveness analysis provides a systematic and quantitative basis to distinguish high- from low-value health care for services that improve the health of patients and it could be a useful tool in the current efforts to identify and reduce low-value health care in the United States. [Pandya, supra. Emphasis added.]

D. The Third Challenge: Designing a Reimbursement System That Deemphasizes Volume Unlinked to Value

1. Episode-Based And Population-Based Attempts To Place Providers At Financial Risk For The Care They Provide
   a. CMS has been the leader and innovator.
   b. CMS Models have the advantage of (relative) transparency: the data that will be used to benchmark performance are open, detailed in advance, and accessible to providers.
   c. Commercial insurers are now beginning to unroll versions of CMS models that, to varying degrees, mimic CMS models.

2. Example of a population-based design: accountable care organizations, in which a group of providers contracts with a payer to link a portion of the otherwise volume-based reimbursement to the degree to which the actual consumption of health care services (not all of which may have been provided by the group) of a discrete population of enrollees assigned to the group bears to an agreed upon budget for the population.

3. Example of an episode-based design: specific disease episodes are identified and an agreed, all-inclusive reimbursement for the treatment of a patient who presents with that disease diagnosis is agreed upon between the payer and the principal health care provider--the inpatient hospital. It’s up to the inpatient hospital to contract with any other providers the hospital does not otherwise employ or own; the payer pays a single bundled payment per admission.
4. The issues:

   a. Population-based: does the hospital possess a sufficient patient base to adequately manage the risk? How much financial risk must the hospital be forced to accept before it possess sufficient incentive to focus on value and insist on deploying only high-value treatments?

   b. Episode-based: Do payers have the will and market power to induce hospitals and other institutional providers to agree to participate (or force them to participate) in these models.

VII. The World of Self-Insured Plans

A. Whether Fully Insured Or Self-Insured, Employer-Sponsored Health Benefit Plans Typically Turn To One Of The Major Health Insurers To Provide Three Functions

   1. Supply a network of health care providers with whom the insurer has entered into participating provider agreements that fix the reimbursement to which the provider will be entitled, obligate the provider to treat the employer’s participants, and forbid the provider from billing plan participants for any amounts other than the participant’s out of pocket obligation under the terms of the plan;

   2. Process claims, re-price services, and perform other plan administrative tasks, which may include providing subrogation and coordination of benefits services and claims adjudication, and

   3. Serve as the plan’s pharmacy benefits manager.

B. The Plan’s Contractual Undergirding Focuses on Volume-Based Cost and Reimbursement

   1. Typically, the agreements between the insurer and the employer, on the one hand, and the insurer and the health care providers, on the other, pay the providers for the services they provide regardless of their comparative efficacy or the quality or measurable outcome of the services.

   2. Typically, the services agreement between the insurer and the employer obligates the employer to pay the contracted price, again without regard to efficacy, quality or outcome.

25 Wherever there is a general rule, there is sure to be an exception. One frequently appears here: the typical participating provider agreement permits a provider to close its practice to new enrollees, as long as the provider has taken that action with respect to all patients -- not merely those enrolled in plans administered or sponsored by the health insurer.

26 The health insurer may -- or may not -- serve as a plan fiduciary with respect to the determination as to whether a claim is a covered claim under the terms of the plan and, if it is covered, whether it is eligible for reimbursement under the terms of the plan (for example, whether the claim is for medically necessary services)
As we will see, changing that model is occurring -- but it’s not easy, particularly in major metropolitan markets where a single hospital system is the dominant provider of inpatient and outpatient hospital services.

VIII. CMS Has Taken The Leading Role in Migrating From Volume-Based Payment to Models That Attempt to Induce Attention to Value--But May Be Retreating

A. CMS’s Initiatives to Move Medicare to Value-Based Care

1. Medicare has taken the initial steps to migrate reimbursement from a system based solely on the volume of services provided to one influenced by the value of the services provided.

2. These initiatives are well documented, easy (relatively) to understand, have provider participation at their center to assure provider cooperation -- and in theory could be adopted by an employer as the methodology to compensate those same providers (although in all likelihood in amounts larger than those Medicare pays).

B. CMS Innovation Center

1. The CMS Innovation Center was established by §1115A of the Social Security Act, added by Affordable Care Act §3021, for the purpose of testing “innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.). Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.

2. The Innovation Center’s initiatives include population-based payment episode-based payment models and initiatives to speed the adoption of best practices:

C. Population-Based Payment Model: Accountable Care Organizations

1. The Medicare Shared Savings Program contains two basic models for accountable care organizations: those in which the ACO bears no (or very little) downside financial risk and modest upside financial reward; and those -- the “Next Generation ACO” model -- in which the ACO bears substantial downside financial risk and substantial upside financial reward.

a. CMS develops a benchmark for savings to be achieved by each ACO as a condition to receiving shared savings/be held liable for losses.
b. Each ACO must meet or exceed CMS-mandated quality performance standards to be eligible to receive any shared savings. The better the quality rating, the larger the share of any savings to which the ACO will be entitled (and the smaller the share of any losses).

2. Studies to date on the original ACO models that did not obligate ACOs to take material financial risk: there is little difference in provider behavior, health care outcome, or cost of care between hospitals that do not participate in any ACO, and hospitals that participate in Medicare Shared Savings Program ACO models with no or little downside financial risk.

3. Next Generation ACO model:

a. The Next Generation ACO [NGACO] Model began in January 2016. NGACOs have nearly complete financial risk sharing (either 80 percent or 100 percent risk) and must take on downside risk (risk for losses), unlike predecessor ACO models. There are no minimum savings or loss requirements. 18 NGACOs launched in 2016.


i. “In PY1 [2016] NGACO providers reduced spending for their beneficiaries by $100.08 million (1.7 percent). The estimated decrease in Medicare spending of -$18.20 per beneficiary per month (PBPM) in PY1 is similar to the decrease noted in the first two years of the Pioneer ACO model and larger than the decrease noted for Medicare SSP ACOs in the early years [i.e., not much better than the non-risk-bearing ACOs performed.]. However, there was wide variation in spending across ACOs. Seven NGACOs showed Medicare spending point estimates exceeding -$30 PBPM, while two showed point estimates exceeding +$30 PBPM.”

ii. “Most of the decline in spending could be attributed to reduced Medicare spending on post-acute care, most notably on spending in skilled nursing facilities (SNFs) that reached statistical significance for three ACOs (-$16.61 million, $3.00 PBPM, or -3.1 percent).”

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4. Bottom line: it takes a great deal of financial risk on the part of providers to produce even modest savings for a population-based model -- and those savings may not easily replicate themselves in the employer-sponsored health care marketplace, because the covered age cohort tends to have fewer needs for post-inpatient discharge rehabilitative stays.

D. Episode-based payment models. Examples include:

1. Acute Myocardial Infarction (AMI) Model. “Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to AMI treatment and recovery, beginning with a hospitalization for AMI treatment and extending for 90 days following hospital discharge. Under the AMI Model, the hospital is financially accountable for the quality and cost of an AMI episode of care, which incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.”

28 “For each performance year of this model, CMS will set Medicare episode prices for each participant hospital that include payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who are treated and discharged for AMI eligible DRGs at that hospital. Prices will also be set based on census region and the target prices used will be a blend of provider specific and regional pricing… The AMI Model has the potential to improve quality in four ways. First, the Model adopts a quality-first principle where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price. Second, higher episode quality, considering both performance and improvement, may lead a hospital to receive quality incentive payments based on the hospital’s composite quality score… Third, in addition to quality performance requirements, the Model incentivizes hospitals to avoid expensive and harmful events, which increase episode spending and reduce the opportunity for reconciliation payments. Fourth, CMS provides additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. These tools include: 1) providing hospitals with relevant spending and utilization data; 2) waiving certain Medicare requirements to encourage flexibility in the delivery of care; and 3) facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.”

29

28 https://innovation.cms.gov/initiatives/ami-model/

29 Id.
2. Bundled Payments for Care Improvement Initiative, Models 2-4.
   a. Model 2: “Model 2 involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under this payment model, Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 2 episodes. The total expenditures for a beneficiary’s episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate performance compared to the target price. In Model 2, the episode of care includes a Medicare beneficiary’s inpatient stay in the acute care hospital, post-acute care and all related services during the episode of care, which ends either 30, 60, or 90 days after hospital discharge. Awardees select up to 48 different clinical episodes to test in the model.”

3. Initiatives to speed the adoption of best practices. Examples include the Cardiac Rehabilitation (CR) Incentive Payment Model.
   a. “[A]cute care hospitals in certain selected geographic areas participate in retrospective incentive payments for Beneficiary utilization of cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR) services for the first 90 days following an acute myocardial infarction (AMI) episode of care or a coronary artery bypass graft (CABG) episode of care. Increasing the use of cardiac rehabilitation services has the potential to improve patient outcomes and help keep patients healthy and out of the hospital.”

E. Clinicians

1. The Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) repealed the Medicare Sustainable Growth Rate (“SGR”) methodology for updates to the Physician Fee Schedule (“PFS”) and replaced it with the Quality Payment Program, a program that offers clinicians two alternative systems to demonstrate their delivery of high-quality patient care and qualify (or suffer) adjustments to their Medicare Part B reimbursement rates, beginning in 2019 (payment adjustments for 2019 will be based on performance during 2017).
   a. The two options -- Advanced Alternative Payment Models (“Advanced APMs”), and the Merit-based Incentive Payment System (“MIPS”) -- adjust the traditional, Medicare fee for service...

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31 https://innovation.cms.gov/initiatives/cardiac-rehabilitation/
payment methodology to reflect the provider’s performance in quality and outcome measures.

b. Four performance domains--

i. Quality

ii. Resource use (called “cost” in the Final Regulation)

iii. Clinical practice improvement activities (called “improvement activities” in the Final Regulation)

iv. Meaningful use of certified EHR technology (“CEHRT”) (called “advancing care information” in the Final Regulation)

F. CMS Announces a Retreat:

1. CMS Final Regulation, 82 FR 57066 (December 1, 2017).

2. CMS cancelled the Episode Payment Models and the Cardiac Rehabilitation incentive payment model and rescinded the regulations governing those models.

3. The Comprehensive Care For Joint Replacement Model, which when promulgated under the Obama administration, was to be a mandatory program for all hospitals in 67 Metropolitan Statistical Areas, has been changed to a voluntary model for 33 of the MSAs.

IX. Tools Offered to Plan Sponsors and Enrollees to Assess Cost and Quality: Availability is Limited; They are Less Than Transparent

A. Powerful Hospital Systems Negotiate Agreements with Insurers That Prohibit Posting of Systems’ Charges

1. “Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition--Contracts With Insurers Allow Hospitals To Hide Prices From Consumers, Add Fees And Discourage Use Of Less-Expensive Rivals” (Wall Street Journal, September 18, 2018)

2. “Dominant hospital systems use an array of secret contract terms to protect their turf and block efforts to curb health-care costs. As part of these deals, hospitals can demand insurers…mask prices from consumers…”

3. “The Wall Street Journal has identified dozens of contracts with terms that limit how insurers design plans, involving operators such as Johns Hopkins Medicine in Maryland, the 10-hospital OhioHealth system and Aurora Health Care, a major system in the Milwaukee market. National hospital
operator HCA Healthcare Inc. also has restrictions in insurer contracts in certain markets.”

4. “In some cases, contract clauses prevent patients from seeing a hospital’s prices by allowing a hospital operator to block the information from online shopping tools that insurers offer. Because of such restrictions, some health-insurance enrollees can’t find prices for hospital systems, including BJC HealthCare in St. Louis and New York-Presbyterian.

a. “The gaps frustrate consumers such as Bob McKitrick, a teacher who lives near St. Louis and has insurance with a $5,400 family deductible. Mr. McKitrick checks prices carefully before getting care, he said, and he finds them for most providers. The website for his insurer, UnitedHealthcare, a unit of UnitedHealth Group Inc., doesn’t include information about hospitals owned by BJC, the parent of the well-known Barnes-Jewish Hospital and 14 others.

5. “‘How can we keep costs down if we can’t even get an estimate for care?’ he said. ‘If you’re buying a car, they don’t say, ‘with this one, you won’t know how much it costs until you check out.’”

B. Tools That Do Tell Enrollees The Costs Providers Will Charge And The Quality Ratings For Providers Are Hard To Access, Incomplete; Can’t Be Used For Emergency Or Inpatient Care -- And Enrollees Seem Uninterested.

1. “[I]mproved transparency isn’t working as well as hoped. Health care pricing apps and websites don’t always help patients spend less. That’s the conclusion from a study published this year in The Journal of the American Medical Association. It investigated the effect of the Truven Treatment Cost Calculator, a website available to more than 21 million workers and their family members. It provides users with the costs — both the total price and the portion the user would be responsible for — from over 300 services, including various sorts of imaging, outpatient operations and physician visits. The researchers compared outpatient health care spending of about 150,000 employees who had access to the website with that of about 300,000 comparable employees who didn’t. (They did not examine inpatient spending because it is dominated by nonelective procedures that are not amenable to shopping. ). Despite its features, the cost calculator wasn’t popular. Though 60 percent of employees with access to it faced a deductible over $500, only 10 percent used it in the first year of availability and 20 percent after two years. The study found that price transparency did not reduce outpatient spending, even among patients with higher deductibles or who faced higher health care costs because of illness. Study after study has showed the same thing. Health plans report that use of their price transparency tools is limited, with many enrollees unaware they exist. The vast majority of plans now provide pricing information to enrollees, but only 2 percent of them look at it. Aetna
offers a price transparency tool to 94 percent of its commercial market enrollees, but only 3.5 percent use it.32


a. Public Agenda, with support from the Robert Wood Johnson Foundation and the New York State Health Foundation, set out to explore how Americans are trying to find and use health care price information and how residents of four states—New York, New Hampshire, Florida and Texas—are doing so.

b. Finding 1: Half of Americans have tried to find price information before getting care. People who have to pay more out of pocket are more likely to have tried to find price information.

i. 50 percent of Americans have tried to find out before getting care how much they would have to pay out of pocket, not including copays, and/or how much their insurers would pay.

ii. Higher percentages of Texas, Florida and New Hampshire residents have tried to find price information and have tried to compare prices than New York State residents and Americans overall.

c. Finding 2: Only some Americans have tried to compare prices. Of those who have tried to compare prices, more than half say they saved money.

i. 20 percent of Americans have tried to compare prices across multiple providers before getting care.

ii. About one in three Americans—28 percent—have tried to find out a single provider’s price rather than comparing. Larger percentages of Texas, Florida and New Hampshire residents have tried to compare prices.

d. Finding 3: Most Americans do not think prices are a sign of quality in health care. Of those who have tried to compare prices, most have chosen less expensive care.

32 “Health Price Transparency is Failing to Rein in Costs--Price Transparency is Nice; Just Don't Expect it to Cut Health Costs” (Austin Frakt, New York Times, 12-19-2016)
i. Using four different questions, we found most Americans understand that health care price and quality are not associated. Seventy percent of Americans say, for example, that higher prices are not typically a sign of better medical care. This is similar to what we found in New York State, Texas, Florida and New Hampshire.

ii. 59 percent of Americans who have tried to compare prices say they chose a less expensive doctor, hospital, medical test or treatment.

iii. Among people who have not ever tried to find price information before getting care, 40 percent indicate they would be inclined to choose less expensive doctors if they knew prices in advance. However, 43 percent of them would not be inclined to do so, and 17 percent don’t know.

e. Finding 4: Americans turn to friends, relatives and colleagues; insurance companies; doctors; and receptionists when they try to find price information.

i. In our national survey, 17 percent of residents of states with state-administered price information websites indicate they have heard of the names of their states’ websites. Seven percent of people in those states who have tried to find price information say they have used their states’ websites.

3. CMS obligates participating hospitals to post their chargemaster prices. Does this provide meaningful information to assist patients make informed pre-treatment decisions about which provider to use?

a. The CMS Fiscal Year 2019 Inpatient Prospective Payment System Final Rule (83 FR 41144, August 17, 2018, supplemented on October 3, 2018 by a rulemaking that corrected technical and typographical errors in the August 17, 2018 document, 83 FR 49836) contains this obligation.

b. Section 2718(e) of the Public Health Service Act, enacted as part of the Affordable Care Act, requires that each hospital operating within the United States, for each year, establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act. Beginning in 2015, CMS reminded hospitals of this statutory obligation and encouraged hospitals to “undertake consumer friendly communication of their charges to help patients understand
what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals.” 83 FR at 41686. In that preamble, CMS noted (i) what hospitals had done with CMS gentle coaxing had accomplished little, for few hospitals had posted any data.

c. Although CMS expressed concern that chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay, CMS finalized the update to its guidelines to require hospitals to make available a list of their current standard charges via the internet in a machine readable format and to update this information at least annually, or more often as appropriate, effective January 1, 2019. This could be in the form of the chargemaster itself or another form of the hospital’s choice, as long as the information is in machine readable format. CMS published “Additional Frequently Asked Questions Regarding Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet,”

d. The two obvious problems:

i. Even if a patient can identify the DRG that probably applies to the procedure for which the patient is being admitted, there may be a variety or combination of other codes that will also apply.

ii. The Chargemaster price is the list price—not the price CMS pays, and not the in-network negotiated price between a participating hospital and the insurer/network with which the hospital negotiated and with which the employer sponsored plan has engaged to supply the network.

e. Another resource to identify actual negotiated, rather than chargemaster list, prices: some hospital systems have begun offering online tools that allow patients to retrieve an all-inclusive price for common outpatient services, and determine the actual out of pocket obligation the patient may incur if the patient also supplies the patient’s health plan enrollment information.

i. “St. Luke’s University Health Network, a 10-hospital system with 300 outpatient clinics in Pennsylvania and New Jersey, several years ago launched an online tool with two
features, “PriceLock” and “PriceChecker.” Francine Botek, the hospital’s senior vice president for finance, said PriceLock allows patients to get an all-inclusive price for most — 80 percent — of the hospital’s outpatient services even if a patient doesn’t enter insurance information. PriceChecker permits people to enter insurance information and other data to help calculate their out-of-pocket costs. The tools are only slowly gaining traction among consumers, said Botek. In 2018, 35,200 people used PriceChecker, averaging about 2,500 a month. Over the past three years, about 3,600 have used PriceLock.”

ii. “The University of Utah, which owns four hospitals, has a similar online out-of-pocket cost estimator for about 600 common (mostly outpatient) services and procedures — giving a single price that rolls up itemized charges for each. People with or without insurance can use the tool. Those without insurance get an across-the-board 30 percent discount off the list price, and deeper discounts are sometimes available. Kathy Delis, who oversees billing at University of Utah Health, said the hospital system plans this year to market the tool to the public more aggressively.”

C. Legislative Attempts At Price Transparency Have Been Uneven—And Hospitals Oppose Attempts to Force Them to Disclose: The Ohio Example


2. Text of the statute:

5162.80 Good faith estimates for charges and payments.

(A) A provider of medical services licensed, accredited, or certified under Chapter 3721. [skilled nursing facilities], 3727. [hospitals], 4715. [dentists], 4725. [optometrists], 4731.[physicians], 4732. [psychologists], 4734. [chiropractors], 4747. [hearing aid dealers], 4753. [speech-language pathologists and audiologists], 4755. [occupational and physical therapists and athletic trainers], 4757. [counselors, social workers, marriage and family therapists], or 4779. [orthotists, prosthetists, pedorthists] of the Revised Code shall provide in writing, before products, services, or procedures are provided, a reasonable,

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33 “As Hospitals Post Price Lists, Consumers Are Asked To Check Up On Them” (Kaiser Health News, 3-8-19)
34 Id.
good-faith estimate of all of the following for the provider's non-emergency products, services, or procedures:

(1) The amount the provider will charge the patient or the consumer's health plan issuer for the product, service, or procedure;

(2) The amount the health plan issuer intends to pay for the product, service, or procedure;

(3) The difference, if any, that the consumer or other party responsible for the consumer's care would be required to pay to the provider for the product, service, or procedure.

(B) Any health plan issuer contacted by a provider described in division (A) of this section in order for the provider to obtain information so that the provider can comply with division (A) of this section shall provide such information to the provider within a reasonable time of the provider's request.

(C) As used in this section, "health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company and a health insuring corporation. "Health plan issuer" also includes a managed care organization under contract with the department of medicaid and, if the services are to be provided on a fee-for-service basis, the Medicaid program.

(D) The medicaid director shall adopt rules, in accordance with Chapter 119. of the Revised Code, to carry out this section.

3. "Price Transparency In Medicine Faces Stiff Opposition - From Hospitals And Doctors" (Kaiser Health News, 7-25-17):

“[The] Ohio Hospital Association… has filed a court injunction that is currently delaying enactment, peppered local news media with editorials, and lobbied Republican Gov. John Kasich, who has eliminated funding that would allow implementation from the latest state budget.

“Joining the hospital association in its legal action are a wide range of provider groups including the Ohio State Medical Association, the Ohio Psychological Association, the Ohio Physical Therapy Association, and the Ohio chapters of the American Academy of Pediatrics, the American College of Surgeons, and the American Osteopathic Association.

“These groups say that the law, which applies only to elective procedures, is too broad and that forcing providers to create estimates before procedures would slow down patient care. “The only way to even try to comply with the law is to delay care to patients in order to track down information from insurance companies, who
may or may not provide the requested information,” wrote Mike Abrams, the president and CEO of the Ohio Hospital Association, in an op-ed in The Columbus Dispatch in January.

“But Jerry Friedman, a retired health policy adviser for the Ohio State University Wexner Medical Center, said the opposition doesn’t stem from genuine concern about patients but from a desire to keep the secret rates that providers have negotiated with insurers under wraps. Transparency would mean explaining to consumers why the hospital charged them $1,000 for a test, he said, adding that providers “don’t want to expose this house of cards they’ve built between hospital physician industry and the insurance industry.”


D. Resources to Determine Hospital Prices


   a. “The Source on Healthcare Price & Competition’s mission is to provide up-to-date and easily accessible information about healthcare price and competition in the United States by posting news articles, policy papers, academic articles, litigation documents, and legislative/regulatory materials, as well as legal and policy-based analysis of those materials. Further, we aim to offer a diverse array of stakeholder perspectives on the problems associated with healthcare prices and markets, as well as potential solutions, to apprise our readers of the full scope of the existing debate. The Source aims not only to bridge the gaps between health policy, health services research, and legal experts working on these issues, but also to serve as a resource for journalists, state attorneys general, potential litigants, and others seeking to understand and/or promote cost control and competition in healthcare. Specifically, the Source focuses on market issues, such as provider leverage and reform efforts, including the promotion of price transparency in healthcare.

   b. “Although the Source is academically based and not aligned with any advocacy-based organizations or parties to litigation, it aims to serve as a catalyst for change within the U.S. healthcare system. It
will operate as a core repository and central resource of materials that will empower individuals and groups seeking to bring rationality to healthcare markets. We at the Source believe that effective solutions to healthcare price and competition problems must be drawn from diverse disciplines including economics, health services research, medicine, and the law. We are pleased to provide a forum for this important discussion.”

2. Publicly available (with a membership) Priority Health Cost Estimator Tool (http://thinkhealth.priorityhealth.com/how-to-pay-less-for-the-most-commonly-used-medical-procedures/).

3. CMS Hospital Inpatient Utilization and Payment Public Use File
   c. The file includes discharges, average Medicare payments, and average hospital charges. The Inpatient PUF has information for 3,000 hospital providers and over $109 billion in Medicare payments.
   d. Remember: hospital “charges” are the hospital’s Chargemaster “list” price—not the discounted price the hospital likely has agreed to receive in its negotiations with insurers and other network assemblers. But, employer-sponsored health plans can use individual claims data to secure the contracted price data for particular claims and compare them to the Medicare PUF data to get a sense of average discounts and, therefore, what should be competitive pricing for similar services. See “X,” below.

X. The Interesting and Not-So Secret World of Hospital Service Pricing
   A. A Hospital’s Methodology for Establish the Price of Its Services May Not Bear Any Connection to Cost
      1. “What Does Knee Surgery Cost? Few Know, and That’s a Problem-- The Price We Pay For Health Care Often Has Little Connection To What It Actually Costs-One Hospital Decided To Investigate” (Wall Street Journal, August 21, 2018)
      2. “For nearly a decade, Gundersen Health System’s hospital in La Crosse, Wis., boosted the price of knee-replacement surgery an average of 3% a year. By 2016, the average list price was more than $50,000, including the surgeon and anesthesiologist.
“Prompted by rumblings from Medicare and private insurers over potential changes to payments, Gundersen decided to nail down the numbers. During an 18-month review, an efficiency expert trailed doctors and nurses to record every minute of activity and note instruments, resources and medicines used. The hospital tallied the time nurses spent wheeling around VCR carts, a mismatch of available postsurgery beds, unnecessarily costly bone cement and delays dispatching physical therapists to get patients moving.

“The actual cost? $10,550 at most, including the physicians. The list price was five times that amount. Yet even as administrators raised the price, they had no real idea what it cost to perform the surgery—the most common for hospitals in the U.S. outside of those related to childbirth. They set a price using a combination of educated guesswork and a canny assessment of market opportunity.”

B. Hospital Markups from Cost to List Can Be Staggering

1. Note the Gunderson cost-to-list ratio --500%.


   a. Hospital reimbursement data was obtained from the Magellan Rx Management Medical Pharmacy Trend Report™: 2016 Seventh Edition (the “Magellan report”)36 and charges were calculated from Medicare claims data (that PUF file).

   b. “Hospitals are generally not paid 100% of billed charges; however, hospital outpatient departments are routinely reimbursed as a percent of billed charges by commercial payers. In the hospital outpatient setting, payers surveyed for the Magellan report indicate that 54% of covered lives had their services reimbursed under a percent of charges model.37 More than half of payers surveyed (51%) for the 2018 EMD Serono Specialty Digest indicate that percent of billed charges remains the most common reimbursement

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mechanism in the hospital outpatient setting for single source, brand specialty medicines.

c. “We found that, on average, hospitals charge 479% of their cost for drugs nationwide. [The authors derived this figure by comparing reported cost data to the hospital’s Chargemaster list price.] This matches closely with the findings from our prior analysis. Most hospitals (83%) charge patients and insurers more than double their acquisition cost for medicine, marking-up the medicines 200% or more. The majority of hospitals (53%) markup medicines between 200-400%, on average. A small share of hospitals - one in six (17%) - charge seven times the price of the medicine. On a medicine with an ASP of $150, a 700% mark-up would result in a charge of $1050. One out of every twelve hospitals (8%) has average charge markups greater than 1000% - meaning they are charging at least 10 times their acquisition cost for medicines, on average.”

C. Costs for Common Procedures Vary Wildly Among Providers

1. Remember that CMS Hospital Inpatient Utilization and Payment Public Use File? One analyst dissected the data.

2. “Hospital Prices Are All Over the Board”-- 2016 Medicare Data Show More than 9 Out Of 10 Hospitals Charge At Least $30,000 For Joint Replacement Surgery And 1 Out Of 6 Hospitals Charges $90,000 Or More; Many Hospitals Also Heavily Increased Prices From 2015 To 2016” (Bob Herman, Axios Vitals, August 30, 2018)38

a. More than nine out of 10 hospitals charge (i.e., post a list price of) at least $30,000 for joint replacement surgery — one of the most common inpatient procedures — and one out of six hospitals charges $90,000 or more.

i. For reference purposes: Medicare’s allowed charge for the most common joint replacement procedure is approximately $13,000.

b. For-profit companies own (or used to own in 2016) nine out of the 10 hospitals with the highest list prices for joint replacement surgeries.

c. Memorial Hospital of Salem County, a small hospital in New Jersey owned by the publicly traded Community Health Systems, had the highest joint replacement price in the country in 2016 at $267,726.

38 https://www.axios.com/hospital-joint-replacement-prices-all-over-the-board-52a741fb-e430-42c0-a0b2-719c0c4cf688.html
d. HCA Healthcare, another for-profit hospital chain, owns two facilities that each charged more than $200,000 for joint replacements in 2016.

e. Many well-known not-for-profit hospital systems, like Cedars-Sinai in Los Angeles, also rank among the highest-charging hospitals for joint replacements.

3. That Axios analysis also revealed that, in addition to the wide distribution in what hospitals charge for joint replacements, many hospitals also heavily increased prices from 2015 to 2016.

a. St. Francis Medical Center in New Jersey raised prices for joint replacement surgeries the most of any hospital in the country in 2016 — a 77% hike to more than $135,000.

b. More than 400 hospitals raised joint replacement prices by at least 10% in 2016.

4. 2012 study from the University of California, San Francisco, published in the Archives of Internal Medicine, “Health Care as a ‘Market Good’? Appendicitis as a Case Study”

a. Analyzed 2009 data from 19,368 adult patients treated for appendicitis in California hospitals. In order to ensure valid comparisons, the researchers examined “only uncomplicated episodes of acute appendicitis” that involved “visits for patients 18 to 59 years old with hospitalization that lasted fewer than four days with routine discharges to home.”

b. The study’s findings include:

i. The lowest charge for removal of an appendix was $1,529, while the highest charge was $182,955. The median charge was $33,611.

ii. Even within the county with the lowest range of charges — Fresno — the highest and lowest costs varied by $46,204, suggesting that geography does not fully explain the dramatic variations.
5. “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured”

a. Analyzes employer sponsored insurance claims from Aetna, UnitedHealth, and Humana that includes negotiated transaction prices

b. Studies the variation in private health care spending, analyze the contribution of prices to spending variation, and examine providers’ price variation

c. Key Findings – Price Plays Crucial Role in Spending by Privately Insured

i. Low correlation (0.140) between Medicare and private spending per person

ii. Price explains large portion of national variation in inpatient private spending (variation in inpatient Medicare spending is attributable to volume of services consumed)

iii. Substantial variation in prices, both within and across markets

iv. Higher hospital market concentration is associated with higher hospital prices

d. The price of a knee replacement is higher in South Dakota than it is in Manhattan

30 http://www.nber.org/papers/w21815
e. National Variation in Prices and Medicare Fees: Knee MRI
Knee Replacement Facility Prices Within Markets

**Denver, CO**
- Min/Max Ratio: 3.09
- Geo: 0.120
- CoV: 0.382

**Atlanta, GA**
- Min/Max Ratio: 6.10
- Geo: 0.170
- CoV: 0.316

**Manhattan, NY**
- Min/Max Ratio: 2.10
- Geo: 0.125
- CoV: 0.260

**Columbus, OH**
- Min/Max Ratio: 2.77
- Geo: 0.121
- CoV: 0.282

**Philadelphia, PA**
- Min/Max Ratio: 2.94
- Geo: 0.162
- CoV: 0.292

**Houston, TX**
- Min/Max Ratio: 5.42
- Geo: 0.167
- CoV: 0.304

**Note:** Each column is a hospital. Prices are regression-adjusted, measured from 2008 – 2011, and presented in 2011 dollars.

© Cooper, Craig, Seynier, and Van Reenen
Colonoscopy Facility Prices Within Markets

Denver, CO
Min/Max Ratio: 3.33
Gini: 0.169
CoV: 0.370

Atlanta, GA
Min/Max Ratio: 5.76
Gini: 0.232
CoV: 0.449

Manhattan, NY
Min/Max Ratio: 3.50
Gini: 0.186
CoV: 0.406

Columbus, OH
Min/Max Ratio: 4.50
Gini: 0.230
CoV: 0.441

Philadelphia, PA
Min/Max Ratio: 5.03
Gini: 0.180
CoV: 0.339

Houston, TX
Min/Max Ratio: 4.41
Gini: 0.159
CoV: 0.320

Note: Each column is a hospital. Prices are regression-adjusted, measured from 2008 – 2011, and presented in 2011 dollars.
f. Conclusions

i. Private health spending per beneficiary per HRR [there are 306 “Hospital Referral Regions” in the U.S.] varies by a factor of three across the nation.

ii. The correlation between HRR-level spending per Medicare beneficiary and spending per privately insured beneficiary is low (14.0%).

iii. There is extensive private spending variation within and across markets – up to 400% within markets and far higher than Medicare within/across markets.

iv. Price is the primary driver of spending variation for the privately insured.

v. Monopoly hospitals have a 15.3% price premium.
XI. Initiatives that Employer-Sponsored Self-Insured Plans May Wish to Implement -- And The Hurdles That Must Be Surmounted

A. Narrow the Size and Scope of In-Network Providers to Maximize Provider Discounts and Quality of Care

1. Relatively easy to achieve: insurers have developed narrow-network plans for both the Affordable Care Act Marketplaces and for the Medicare Advantage market.

2. Issue: do narrow networks compromise quality?
   a. For employers, network adequacy is regulated by the states -- at least, that’s the case for employers that contract with insurers who lease their fully-insured network providers to self-insured employers. That regulatory framework varies widely. In 2014, the consumer representatives to the NAIC commissioned a survey of state departments of insurance (DOIs); 38 states responded to the survey. The results showed that (1) many states used different standards and systems to regulate HMOs and PPOs, (2) most state DOIs relied on complaint data to monitor network adequacy, and (3) state DOIs rarely took enforcement actions for violations of network adequacy requirements. The survey showed that states were conducting network adequacy reviews for HMOs and regulating HMOs more extensively than PPOs. Such differentiation made sense when only HMOs were offering limited provider networks, but it has less justification today. The NAIC moved toward eliminating the differential treatment of HMOs and PPOs by revising the Model Act to apply to a variety of health plans, not just managed care plans. However, some states still have separate standards for HMOs and other types of plans.”

B. Problem: States That Do Regulate Network Capacity Focus on Size, Not Quality

1. Result: State regulation focuses primarily on number of providers, grants deference to the insurer’s assessment of quantitative needs, and, as to quality, rarely looks beyond timely access. That leaves quality to analyze.


   a. The authors convened a panel to review and evaluate plans offered through one of the largest marketplaces developed for the Affordable Care Act: Covered California.

   i. Results:

      (a) Cost vs. Performance as Perceived by Enrollees:
      While the lowest-performing plan-products had only one to three hospitals, other plans with very narrow networks had composite scores that were comparable to most other scores. There was no significant relationship between raw network size and performance.

      (b) Cost vs. Quality: “We found network performance explained about 25 percent of the variation in premiums. While higher premiums may suggest higher hospital quality, it is a modest relationship and may not be the driving force behind premium differences; other factors, such as physician performance or regional differences, may also influence the relationship.”
ii. Conclusion: “Except for a handful of outlier networks, consumers can have confidence that the hospital care in their region is comparable to other plans’ product networks, and that network size does not seem to typically influence performance. The major caveat is that some extremely narrow networks with overall lower-performing hospitals probably would benefit from a more inclusive network structure or a marked improvement in performance of the participating hospitals.”

3. The news is not uniformly good. See “Relation Between Narrow Networks and Providers of Cancer Care” (Yasaitis et. al., Journal of Clinical Oncology, July 2017): Oncologists at the 69 National Cancer Institute-Designated Cancer Centers are Twice As Likely To Be excluded by lower-cost narrow network individual health plans offered on Marketplace Exchanges.

a. “Narrower provider networks are more likely to exclude oncologists affiliated with NCI-Designated or NCCN Cancer Centers. Health insurers, state regulators, and federal lawmakers should offer ways for consumers to learn whether providers of cancer care with particular affiliations are in or out of narrow provider networks.”

C. Tools to Identify High Performing Providers


4. California Healthcare Compare: created by UC-San Francisco researchers and Consumer Reports for the state insurance agency with a federal grant from the Centers for Medicare & Medicaid Services. The site provides information on quality for five common conditions or procedures: childbirth, hip and knee replacement, colon cancer screening, diabetes, and

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back pain. And it gives cost information — by county for 100 procedures, ranging from treating a broken ankle to cancer chemotherapy.

5. Approximately 60% of the more than 1,000 U.S. hospitals at which heart surgery is performed voluntarily share complication and mortality rates, using metrics developed by the Society of Thoracic Surgeons, to Consumer Reports or the STS. Consumer Reports. Consumer Reports uses that data to publish heart hospital ratings: http://www.consumerreports.org/hospitals/HowToChooseAHospital/. The raw data is at http://www.sts.org/adult-public-reporting-module.

D. A Warning About Hospital Comparison Websites

1. “Hospital Ratings Sometimes Conflict and Confuse, But Far Better Than Nothing”
   a. “Various publicly-available reports shed light on things such as how often patients at a given hospital die unexpectedly, come down with infections, end up with a surgical tool left inside them, or get sent home without clear discharge instructions. The bad part is that it’s common for a hospital to get a good grade from one rating organization and a poor grade from another.”
   b. “To cite an example, Lehigh Valley Hospital near Allentown, Pa. gets lackluster marks from several rating organizations, including Leapfrog, which rates hospitals according to safety. Yet U.S. News and World Report ranks it the fourth best hospital in Pennsylvania, and among the nation's better hospitals in more than a dozen specialties. "Regrettably, there isn't a single grade or score or letter that adequately describes the quality and safety of care [at a hospital], despite nearly 25 years of work in this field," says Dr. David Nash, a nationally-known health care quality at Thomas Jefferson University in Philadelphia.

   a. “This study takes a systematic approach to review the main features of 9 existing hospital rating systems, each of which is described using 9 areas of evaluation. The hospital rating systems included in this study vary widely in scope, methodology, transparency, and presentation of their results. Their results often present conflicting conclusions regarding the performance of the same hospital. This review of hospital rating systems demonstrates how public

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43 http://journals.sagepub.com/doi/abs/10.1177/1062860614558085
reporting may add confusion to patients’ health care decision making.”

b. "The information on the quality of hospital care is chaotic and inconsistent at best," and noted information used in the rating systems "has rarely gone through peer review."


a. “Healthgrades, U.S. News, and Leapfrog charge hefty licensing fees to hospitals that want to advertise their awards. The fees can range from $12,500 to the mid-six figures. Healthgrades, for example, told NYU Langone Medical Center in Manhattan it would cost $145,000 to use its citations, according to Dr. Andrew Brotman, NYU’s chief clinical officer.

b. “MedStar Health, which runs three hospitals in the District and seven in Maryland, pays $80,000 to US News to use its name and awards when promoting its hospitals, says Jean Hitchcock, MedStar’s vice president for public relations and marketing. With such an economic structure, it’s no surprise that the raters keep finding more ways to rank hospitals.

c. “A number of the raters, including Healthgrades and Truven, offer consulting services to hospitals seeking better performance. "Some of the rating agencies have conflicts of interest and the consumer probably doesn't know about that," says John Sackett, the president of Shady Grove Adventist Hospital in Rockville. He adds that when he ran a hospital in Colorado, Healthgrades tried to charge $30,000 to use its ratings in advertising and offered consulting services that would have cost more than $100,000.

E. Set Volume-Based Prices on a Standard Other Than a Discount from List-Chargemaster

1. We have seen that hospitals’ list (chargemaster) prices --

a. can exceed their reported costs by a huge amount; and

b. Medicare’s rates are easily accessed and far more widely accepted.

2. Confirm that pricing is based on a the Medicare rate, rather than a discount from list-chargemaster.

a. Example: “A Tough Negotiator Proves Employers Can Bargain Down Health Care Prices”--Montana State Health Care Plan
successfully used Medicare reimbursement as the benchmark to contract with hospitals.44

i. “In the illusory world of hospital billing, the hospitals typically charge a high price for a procedure, then give insurers in-network discounts. These charges and discounts might be different for each procedure at each hospital, depending on who has more leverage during negotiations.

ii. “The discounts, however, are meaningless if the underlying charges aren't capped. When [Marilyn] Bartlett [the newly hired director for the plan’s negotiations with providers] looked at a common knee replacement, with no complications and a one-night hospital stay, she saw that one hospital had charged the plan $25,000, then applied a 7 percent discount. So, the plan paid $23,250.

iii. A different hospital gave a better discount, 10 percent, but on a sticker price of $115,000. So, the plan got billed $103,500 — more than four times the amount it paid the other hospital for the same operation. Bartlett recalled wondering why anyone would think this was OK.

iv. Under Bartlett's proposed new strategy, the plan would use the prices set by Medicare as a reference point. Medicare, the federal government's insurance for the disabled and patients over 65, is a good benchmark because it makes its prices public and adjusts them for hospitals based on geography and other factors. Montana’s plan would pay hospitals a set percentage above the Medicare amount.”

v. The plan had to switch insurer-TPAs to secure one that did not have provider agreements with Montana hospitals in order to pursue this strategy.

3. Is Montana’s experience typical -- i.e., do hospitals generally contract with health insurers-TPAs in the employer-sponsored marketplace based on a discount from list? Or on the basis of a multiple of the Medicare rate?

a. Sample from a 2012-era agreement:

44 https://www.npr.org/sections/health-shots/2018/10/02/652312831/a-tough-negotiator-proves-employers-can-bargain-down-health-care-prices
### HMO/POS/PPO

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<tr>
<td>Default IP % HMO Only</td>
<td>55.9%</td>
</tr>
<tr>
<td>IP DRG rate (R x W)</td>
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<tr>
<td>IP DRG Outlier rate %</td>
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<tr>
<td>Outlier threshold</td>
<td>$65,000</td>
</tr>
<tr>
<td>IP Burns DRGs 504-507</td>
<td>70.9%</td>
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<tr>
<td>IP Trauma DRGs 484-487</td>
<td>70.9%</td>
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#### DRG Case Rates

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<tr>
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<tbody>
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<td>DRG 558</td>
<td>$14,588</td>
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#### DRG Carvouts

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<td>Neuro (DRG 497,498,519,520,531,546) (R x W)</td>
<td>$10,929</td>
</tr>
<tr>
<td>Ortho (DRG 209,471,491,496,544,545) (R x W)</td>
<td>$10,189</td>
</tr>
</tbody>
</table>

b. Sample #2:
I. **REIMBURSEMENT METHODOLOGY**

The applicable Insurer Rates are set forth on the attached Rate Sheet.

1) **Inpatient and Outpatient Services**

   a) **Insurer Rate**: The Insurer Rate, including Cost Share amounts, for Facility Covered Services provided to Covered Individuals shall be as follows:

   i) For Claims paid according to Per Diem Rates or Per Visit Rates, unless a different or additional payment is set forth in this PCS, Facility shall be paid the lesser of (i) the Insurer Rate(s) as set forth on the Rate Sheet, multiplied by the number of Patient Days or (ii) Facility’s total eligible billed Charges for Covered Services for the entire admission or visit.

   ii) For Claims paid according to Case Rates, Global Case Rates, and/or DRG methodology unless a different or additional payment is set forth in this PCS, Facility shall be paid the lesser of (i) the Insurer Rate(s) as set forth on the Rate Sheet or (ii) Facility’s total eligible billed Charges for Covered Services for the entire admission or visit.

   iii) For Claims paid according to a Fee Schedule Rate or Per Unit Rate, Facility shall be paid the lesser of (i) the Insurer Rate as set forth on the Rate Sheet or (ii) Facility’s total eligible billed Charges for the Covered Services as set forth on the Fee Schedule Rate, which shall be calculated on a line by line basis. [see example below]

   **Fee Schedule Rate Example**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Facility's billed Charge</th>
<th>Insurer Fee Schedule</th>
<th>Insurer Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>$25</td>
<td>$50</td>
<td>$25</td>
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<tr>
<td>#2</td>
<td>$30</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td></td>
<td>TOTAL ALLOWED</td>
<td></td>
<td>$45</td>
</tr>
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</table>

   c. Lesson to be learned: Montana’s example is not as troublesome at it may seem.

F. **Consider Contracting with Providers on a Global Capitation Basis**

1. Global capitation: provider receives a fixed (adjusted by patient acuity) per enrollee per month amount to provide care in the provider’s specialty to patients assigned to the provider.

2. Where is this model showing traction? Not surprisingly, Texas, California and southern Florida.

   a. The mechanism: group health plan contracts with a management company that owns (or has contracted with) a network of physician providers. Enrollees must select a practitioner; once assigned, the management company receives and then disburses compensation to the providers, who may be compensated based on the same global capitation model.

   b. Most popular application: Medicare Advantage plans are the most active users of this model, and include Humana and UnitedHealth.
c. Specialties and physician practice management companies that are active in this market:

i. WellMed (Florida and Texas): primary care, 35,000 enrollees

ii. ChenMed (Atlanta, Chicago, Columbus, OH, Louisville, New Orleans, Richmond, Tidewater VA): primary care, 50 primary care practices

iii. Iora Health (Atlanta, Hartford, CT, Hanover, NH, Queens, NY, Boston area, Denver area, Seattle, Tucson, Phoenix), number of patients and practitioners not disclosed

3. Risks and Barriers to Success

a. This model, used with primary care practitioners, failed miserably in the period between 1995-2006--the practice management companies and independent physicians associations could not manage the financial risk (cap payment in, physicians paid based on fee for service model). Speculation: this model would work far better with specialists, who could be paid a fixed monthly amount per patient regardless of whether surgery/specialty services were performed, eliminating the incentive to overtreat or undertreat.

b. The model is touted as ideal for older, Medicare enrollees: the primary care physician is assigned far fewer patients than is customary in an office-based practice, and spends a great deal more time with each patient (and supervises a physician extender care team). The savings in reduced hospitalizations and emergency room visits can be shared between the plan and the practice management company, either directly, or through a budgeted retrospective financial risk sharing arrangement. The savings may not be nearly so great for a patient population that skews much younger -- the cohort enrolled in most employer-sponsored group health plans.

c. Plan design: enrollees must choose a primary care physician. This is a classic HMO model, but it has not proved popular for many employer-sponsored group health plans.

5. Some Blue Cross Blue Shield programs are turning to hospital systems that have participated in the Medicare accountable care organization program and have enlisted them to use the same model in the commercial marketplace.

a. Example: On January 15, 2019, Blue Cross Blue Shield North Carolina announced that it has entered into ACO agreements with five major health systems to use the ACO risk-based model.

b. “Five major health systems have demonstrated their commitment to transforming health care in North Carolina by agreeing to participate in Blue Premier. Beginning in January 2019, the five health systems joining Blue Cross NC in the Blue Premier effort include:

- Cone Health
- Duke University Health System
- UNC Health Care
- Wake Forest Baptist Health
- WakeMed Health & Hospitals

“Blue Premier ties payments to doctors and hospitals over time to the value of services that improve patient health. This means that total payments to the health systems under Blue Premier will be based on the health systems’ ability to manage the total cost of care and their overall performance, measured by industry quality standards. Through a ‘shared risk’ financial model, the health systems will share in cost savings if they meet industry-standard goals to improve the health of patients – and share in the losses if they fall short. The unprecedented commitment from these five large health systems makes Blue Premier one of the most advanced and comprehensive value-based care programs in North Carolina and the nation.”

G. Identify Low-Value Procedures and Procedures With High Future Costs; Require Pre-Authorization and/or Identify High Value Providers Who Avoid Those Procedures

1. See above on Choosing Wisely: identify health care systems and physician practices that follow those recommendations, and place them in the plan’s preferred tier (lowest out of pocket cost) of providers.

2. Another method: use claims data to identify providers that demonstrate a fatal attraction for these low value/high cost procedures or services; flag them and require pre-authorization.

3. Simple example: knee replacement surgery for patients under the age of 60.
   
a. Warning: as surgeons begin to exhaust the supply of Medicare patients eligible for knee replacement, surgeons have begun recommending that procedure for increasingly younger cohorts.

b. “About 12 percent of adults in the United States have painful arthritic knees that limit mobility, and each year more than 640,000 have them replaced with artificial joints at a cost well in excess of $10 billion a year. The annual rate of total knee replacements doubled between 2000 and 2015, especially among people aged 45 to 64, many with significantly less severe symptoms” than surgeons have traditionally required as a condition precedent to eligibility for the procedure.46

i. One recent study conducted by Daniel L. Riddle, a physical therapist at Virginia Commonwealth University, and two medical colleagues, for example, examined information from 205 patients who underwent total knee replacements. Fewer than half — 44 percent — fulfilled the criteria for “appropriate,” and 34.3 percent were considered “inappropriate,” with the rest classified as “inconclusive.”47

c. Why worry?
   
i. The cost.
   
ii. The benefits of the replacement, in terms of reduced pain and increased mobility, are significantly reduced.

iii. Replacements have a limited useful life. Have the surgery too young, and the enrollee will be back at the surgeon’s doorstep too soon. “A recent study examined how long knee or hip replacements last, and how their durability is affected by the person’s age at the time of surgery. As published in the April 2017 edition of the medical journal The Lancet, researchers found that:

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• Among more than 60,000 people who had a hip replacement, only 4.4% required revision surgery in the first 10 years after surgery, but by the 20-year mark, 15% required revision.

• Among nearly 55,000 people who had a knee replacement, only 3.9% required revision surgery within 10 years of surgery; by 20 years, 10.3% required revision.

• Age did matter. Of those over 70 having hip or knee replacement, the lifetime risk of having a second operation on the replaced joint was about 5%. But this risk was much greater in younger individuals, especially for men. Up to 35% of men in their early 50s required a second operation.48


a. As early as 2000, the FDA authorized the sale of one of the first robotic surgery systems, the da Vinci Surgical System, for some urological and gynecological procedures. A similar robotic surgical system, the Senhance Surgical System, was approved for gynecological and colorectal surgical procedures, among others.

b. Both were approved via the 510(k) premarket notification procedures, which exempt the manufacturer from having to submit safety and efficacy studies on the ground that the product is substantially the same as existing, fully verified methods/equipment (in this case, traditional, open surgical procedures).

c. What has happened? Proliferation of off-label uses for robotic surgery, and promotion of these expensive systems to patients and physicians in a position to refer patients.

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48 https://www.health.harvard.edu/blog/how-long-will-my-hip-or-knee-replacement-last-2018071914272
Robotic surgery is a type of minimally invasive surgery. "Minimally invasive" means that instead of operating on patients through large incisions, we use miniature surgical instruments that fit through a series of quarter-inch incisions. When performing surgery with the da Vinci Si—the world's most advanced surgical robot—these miniaturized instruments are mounted on three separate robotic arms, allowing the surgeon maximum range of motion and precision. The da Vinci's fourth arm contains a magnified high-definition 3-D camera that guides the surgeon during the procedure.

The surgeon controls these instruments and the camera from a console located in the operating room. Placing his fingers into the master controls, he is able to operate all four arms of the da Vinci simultaneously while looking through a panoramic high-definition monitor that literally places him inside the patient, giving him a better, more detailed 3-D view of the operating site than the human eye can provide. Every movement he makes with the master controls is replicated precisely by the robot. When necessary, the surgeon can even change the scale of the robot's movements: if a patient's thorax is too restricting, the tip of the robot's arm all moves just one inch for every three inches the surgeon's hand moves. And because of the console's design, the surgeon's eyes and hands are always perfectly aligned with his view of the surgical site, minimizing surgeon fatigue.

The ultimate benefit is to give the surgeon unprecedented control in a minimally invasive environment. As one of our surgeons notes, "It's as if I've miniaturized my body and gone inside the patient." Utilizing this advanced technology, our surgeons are able to perform a growing number of complex, minimally invasive, gynecological, cardiothoracic, and general surgical procedures. Since these procedures can now be performed through very small incisions, our patients experience a number of benefits compared to open surgery, including:

- Less trauma on the body
- Minimal scarring, and
- Faster recovery time

We invite you to explore our website to learn more about our robotic surgery team and the procedures we offer. If you're facing surgery, you couldn't be in better hands.

- About the Robot
- How the da Vinci Si Works
- How does the da Vinci Si Help Surgeons?
d. The problem: much higher cost; mixed evidence of better outcome.

e. Off label uses have now spread to cancer surgery and mastectomies. Not only is there no evidence of lower post-surgical complication, but also there is growing evidence of elevated risk of diminished long-term survival.

i. “The FDA takes women's health issues very seriously. The FDA is issuing this safety communication because it is important for health care providers and patients to understand that the safety and effectiveness of using robotically-assisted surgical devices in mastectomy procedures or in the prevention or treatment of cancer has not been established. There is limited, preliminary evidence that the use of robotically-assisted surgical devices for treatment or prevention of cancers that primarily (breast) or exclusively (cervical) affect women may be associated with diminished long-term survival. Health care providers and patients should consider the benefits, risks, and alternatives to robotically-assisted surgical procedures and consider this information to make informed treatment decisions.

g.

XII. The Health Plan Has Identified High Value Providers. Steps -- and Potential Roadblocks -- to Promoting the Use of Those Providers

A. Example That Illustrates The Possibilities: Wal-Mart

1. 2013: Wal-Mart begins cardiac and spinal surgery center of excellence option for individuals enrolled in the Wal-Mart group health benefit plans.

2. Enrollees may access consultations and care for certain cardiac and spine procedures at no out of pocket cost. Wal-Mart will also cover the cost of travel, lodging, and food for the patient and one caregiver.

3. Six "Centers of Excellence":

   a. Cleveland Clinic;

   b. Geisinger Medical Center in Danville, Pa.;

   c. Mayo Clinic sites in Arizona, Florida, and Minnesota;

   d. Mercy Hospital Springfield in Springfield, Mo.;

   e. Scott & White Memorial Hospital in Temple, Texas; and
f. Virginia Mason Medical Center in Seattle.

4. Methodology:
   a. Payment to Provider: a bundled payment, that includes payments when the provider concludes that the initial recommendation for surgery is not appropriate.
   b. Incentive to participants: dramatically lower out of pocket obligation if a participant elects to use the center of excellence facility.

5. Results:
   a. “Two years into the program, an unexpected pattern is emerging: the biggest savings and improvements in care are coming from avoiding procedures that shouldn’t be done in the first place. Before the participating hospitals operate, their doctors conduct their own evaluation. And, according to Sally Welborn, the senior vice-president for benefits at Wal-Mart, those doctors are finding that around thirty per cent of the spinal procedures that employees were told they needed are inappropriate. Dr. Charles Nussbaum, until recently the head of neurosurgery at Virginia Mason Medical Center, confirmed that large numbers of the patients sent to his hospital for spine surgery do not meet its criteria.”

Source: “Walmart, Other Employers Get Choosier About Workers’ Doctors-Companies Find Benefits In Health-Care Costs And Results With Employees Going To Their Selected Doctors” (Melanie Evans, Wall Street Journal, April 4, 2019, https://www.wsj.com/articles/walmart-other-employers-get-choosier-about-workers-doctors-11554382801

6. 2019: Wal-Mart contracts with Pacific Business Group on Health and Health Design Plus, and with Embold Health, to analyze patient encounter data generated by physicians to (i) identify top-performing physicians in local communities for patients with chronic diseases; and (ii) incentivize patients to use those physicians for management and treatment of their conditions.50

a. NB: instead of choosing a “center of excellence” that effectively includes the hospital system and all of its physician-employees in the specialty in question, this effort focuses on choosing individual physicians.

b. “Many big companies are mining data from their own health plans and public records and working with consultants to compare physicians, searching for those with the best results and competitive costs. Top doctors earn favored spots in health insurance offered to workers; poor performers are more costly for patients or excluded entirely.”51

c. “One employer coalition, the Health Transformation Alliance, has pooled health-plan data for roughly three million workers across 50 large employers, including International Business Machines Corp., JPMorgan Chase & Co. and Berkshire Hathaway Inc.’s BNSF Railway Co., and is analyzing physician performance with IBM Watson Health, according to HTA’s chief executive, Robert Andrews. The coalition’s first target is diabetes care by endocrinologists, comparing costs of medical care and outcomes such as hospitalization rates for complications, said George

50 “Walmart, Other Employers Get Choosier About Workers’ Doctors-Companies Find Benefits In Health-Care Costs And Results With Employees Going To Their Selected Doctors” (Melanie Evans, Wall Street Journal, April 4, 2019, https://www.wsj.com/articles/walmart-other-employers-get-choosier-about-workers-doctors-11554382801

51 Id.
Murphy, who oversees health benefits for Lincoln Financial Group and is leading the alliance’s analysis. The effort seeks to compare similar patients across doctors, so physicians who care for sicker patients aren’t penalized.”

B. Hurdles

1. If the target provider is not an in-network provider, the employer must negotiate an amendment to the insurer’s template master services agreement to include the provider and grant it special status.

2. If the target provider is an in-network provider, then the provider’s participating provider agreement with the insurer and the insurer’s master services agreement with the employer must be modified to reflect both the special status and the reimbursement methodology.

3. Language in the master services agreement that should be reviewed include:

   a. “Insurer shall process claims for Plan benefits incurred on or after the Effective Date using Insurer’s normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the Plan(s), any applicable provider contract, and the Agreement.”

   b. “Insurer shall provide Plan Participants with access to Insurer’s network hospitals, physicians and other health care providers (“Network Providers”) who have agreed to provide services at agreed upon rates and who are participating in the applicable Insurer network covering the Plan Participants.

   c. “Contracted rates with Network Providers may be based on fee-for-service rates, case rates, per diems and in some circumstances, include performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems and other provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance.”

4. These provisions give the insurer complete control over the roster of participating providers and the manner in which they are displayed to

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52 Id.
participants (preferred, tiering) and the compensation arrangement -- which may not be disclosed to the employer. Result: must negotiate.

5. Even if the insurer is willing to negotiate, the dominant hospital in its marketplace may have an agreement with the insurer that requires that the hospital and its physician-employees must be included in all plans offered by the insurer and may prohibit the insurer from designing plans that steer enrollees to lower-cost facilities with lower out of pocket obligations.

a. “Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition--Contracts With Insurers Allow Hospitals To Hide Prices From Consumers, Add Fees And Discourage Use Of Less-Expensive Rivals” (Wall Street Journal, September 18, 2018):

b. Provider agreements between hospital systems and insurers may include “anti-steering clauses” “that prevent insurers from steering patients to less-expensive or higher-quality health-care providers. In some cases, they block the insurer from creating plans that cut out the system, or ones that include only some of the system’s hospitals or doctors. They also hinder plans that offer incentives such as lower copays for patients to use less-expensive or higher-quality health-care providers. The restrictive contracts sometimes require that every facility and doctor in the contracting hospital system be placed in the most favorable category, with the lowest out-of-pocket charges for patients—regardless of whether they meet the qualifications.”

c. “Insurer Anthem Inc.’s agreement with New York-Presbyterian restricts its ability to exclude the hospital system, which includes the prestigious Columbia University Irving Medical Center and Weill Cornell Medical Center, from its health plans. To help win the New York area business of the Health Transformation Alliance, an employer group, Anthem partnered with a small company called Brighton Health Plan Solutions, which had its own plans that don’t include New York-Presbyterian. Simeon Schindelman, chief executive of Brighton, said the company is ‘very open to strategic alliances that help us bring lower cost, better quality health care to even more families.’ Anthem declined to comment on its contracts.”

d. “Companies have been thwarted from developing new plans for workers. A few years ago, officials at Home Depot asked Anthem, which administered its coverage, to create a plan for employees around the country with a more-limited network of health-care providers. The retailer wanted to include only hospitals and doctors with the lowest costs and highest-quality care. The insurer turned down its client’s request, and a major reason was restrictive contracts with hospital systems. A spokeswoman for Home Depot
confirmed the account of the situation and declined to comment further.’’

6. Gathering valid data to make valid comparisons of physician performance is not easy. ‘‘Comparing doctors’ quality is challenging; to judge performance, an analysis needs to look at doctors who care for at least 35 to 45 similar patients, research suggests. A doctor may have patients from multiple employers and insurers, and data on the doctor’s performance is spread across each. Patients may also see multiple doctors, making it difficult to decide which is most responsible for their care, and results can be affected by hospitals and other medical staff. ‘‘We’re still struggling with how to profile individual physicians,’’ despite two decades of research, said physician and Harvard Medical School researcher Ateev Mehrotra. ‘‘There is an enormous disconnect between what patients want and what we can give them,’’ he said.  

XIII. The Narrower the Network, the More Likely Enrollees Will Receive Services From Out of Network Providers: Strategies to Reduce Costs Associated with (High-Priced) Out of Network Providers

A. The Issue

1. Out of network providers frequently (i) offer inducements to enrollees by offering to waive the plan’s out of network copayment and deductible obligations (which were deliberately set higher than those that apply to in-network providers) and (ii) seek payment from the group health plan at levels far higher than the in-network provider’s “usual and customary” (i.e., list) price and much, much higher than the in-network provider’s charge after contractual allowance.

2. Out of network providers must seek a litigating approach that can invoke ERISA (since ERISA exempts group health plans from all state law based claims and since the out of network provider can’t point to a contract). Result: Out of network providers adopt either or both of these ERISA strategies:

a. The out of network provider obtains an assignment of benefits and payments from the enrollee. The out of network provider then files an ERISA Section 502(a)(1)(B) claim against the plan. ERISA Section 502(a)(1)(B): “A civil action may be brought (1) by a participant or beneficiary—(B) to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” The out of network provider is, therefore, stepping into the shoes of the enrollee.

53 Id.
b. The out of network provider either argues that it has the right to enforce the enrollee’s claims without an assignment (most courts have rejected this argument).

c. The out of network provider obtains an assignment of benefits and payments from the enrollee. The out of network provider then files an ERISA Section 502(a)(2) or (a)(3) claim against the plan’s fiduciaries (which the out of network provider will construe loosely) -- a claim for appropriate relief for breach of fiduciary duty (502(a)(2)) and obtain other equitable relief (i.e., to force the plan to pay the claim as submitted) (502(a)(3)).

B. Recent cases


b. The complaint notes that the surgery center “took assignments of these claims from its patients.”

c. “As the claims administrator for the Plan Defendants, and as a plan fiduciary because it retains discretion in interpreting the terms of the plan and determines appeals, Aetna must cover and pay benefits to members of the Plan Defendants and fully insured members in accordance to the terms of the plan, and in accordance with ERISA. Aetna violated its legal obligations under the ERISA-governed plans when it denied and under-reimbursed the surgical and other

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procedures and services PSSC billed to it as described in this Complaint, in violation of ERISA § 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B).”

d. The complaint then asserts this claim against each employer-sponsored plan (with one claim as an example):

As the plan administrator and sponsor for the Bank of America plan, Bank of America must cover and pay benefits to Bank of America plan members in accordance to the terms of the plan, and in accordance with ERISA. Bank of America violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B). Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date its claim was originally submitted. It also seeks attorneys’ fees, costs, prejudgment interest and other appropriate relief against Bank of America.”

2. Aetna Life Ins. v. Huntington Valley Surgery Ctr. (3rd Cir. July 19, 2017): Out of Network Facility’s Routine Waiver of Copayments and Patient Payment Obligations Raises Question of Fact as to Possible Fraud When Facility Lists Chargemaster Rates as Total Charges

a. Aetna’s complaint accused the surgery center of routinely waiving or reducing Aetna members' co-payment, co-insurance, or deductible obligations. The surgery center’s third-party billing services routinely sent bills to Aetna listing the full Chargemaster price for care provided to Aetna members, without informing Aetna that the patients’ payment obligations have been waived. Aetna asserted that this practice violated the fraud provisions of Pennsylvania’s insurance fraud statute.

b. Interesting aspect of this case:

i. Aetna contracted with two provider networks each of which contracted with providers who were not members of Aetna’s in-network panel. Aetna entered into contracts with each rental network, agreeing to pay bills to out-of-network providers, discounted at the rates negotiated by the rental networks.

ii. “Almost all of the bills at issue in this case were processed through two “rental networks” named Beech Street Corporation and MultiPlan, Inc. App. 6. HVSC’s contract
with Beech Street states that, for bills processed through Beech Street’s network, HVSC will be “reimbursed at 80% of usual billed charges, less applicable Copayments, Deductibles, and Coinsurance.” App. 2253 ¶ 1. The term “usual billed charges” is undefined. For bills processed through MultiPlan, HVSC will be reimbursed for 75% of “billed charges, less any Co-payment, Deductible, and/or Co-insurance, if any, specified in the Participant’s Benefit Program.” App. 823 ¶ 3.1. The term “billed charges” is defined as “the fees for a specified health care service or treatment routinely charged by [HVSC] regardless of payment source.” App. 809 ¶ 1.2. The term “routinely charged” is not defined.

c. The surgery center sought a dismissal of this element complaint, arguing that the terms in its agreements with the rental networks did not require disclosure and the forms it used to submit claims did not obligate it to disclose any enrollee payment obligations.

d. Court: “Since both the billing form and contracts are ambiguous as to HVSC’s disclosure obligations, there is an issue of fact as to whether it submits fraudulent bills when it lists its Chargemaster rates as its “total charges” without deducting the waived patient fees from that figure or informing Aetna that it routinely provided such waivers. Thus, the District Court erred in concluding that HVSC’s billing practices are not fraudulent as a matter of law.”

C. Potential Solutions

1. The most draconian solution: eliminate all coverage for out of network services (except for emergency services), prohibit all assignments to out of network providers, and provide that out of network expenses do not apply to the plan’s deductible obligation.

a. This is an increasingly common plan design feature.


c. “With the growing use of managed care plan designs and narrow networks, OON coverage is becoming increasingly rare. This tendency is more pronounced in the fully insured market. In the individual market in particular, there has been a steep decline in the percent of plans that offer OON coverage, from 58 percent in 2015 to 29 percent in 2018. The decline in the small group market has

been far less sharp, and probably tracks more closely to what is happening in larger employer plans.”

2. The slightly less draconian solution: same as most draconian solution, but allow enrollees to apply their documented out of network expenses toward their deductible obligation.

3. The substantially less draconian solution: instead of constructing the plan to pay a percentage of the “usual and customary” charge -- which provides out of network providers a club to use to contest how the plan determined that amount -- specify the dollar amount, or percentage of the lowest in-network charge (after contractual allowance). Specify that any waived deductible or copayment obligation either (i) eliminates the plan’s obligation to pay anything; or (ii) reduces the amount the plan will pay on a dollar for dollar basis. Require documentation of payment by the enrollee. Oh yes: the plan and the SPD should specifically forbid any assignment of the right to benefits or payment to out of network providers (and should only permit assignment of the right to payment, but not to benefits, to in network providers).

D. Emergency Room Professional Charges Remain a Challenge

1. Affordable Care Act Section 1001 amended the Public Health Service Act by, among other additions, adding Section 2719A(b), “Coverage of Emergency Services”:

(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive
than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

2. Result: if the enrollee encounters an out of network provider at an emergency room, the enrollee’s financial obligation is capped at the in-network deductible-copayment-coinsurance level. The employer pays the difference. And that difference can be large when compared to the charges accepted by in-network providers.


a. “Early last year, executives at a small hospital an hour north of Spokane, Wash., started using a company called EmCare to staff and run their emergency room. The hospital had been struggling to find doctors to work in its E.R., and turning to EmCare was something hundreds of other hospitals across the country had done. “That’s when the trouble began. Before EmCare, about 6 percent of patient visits in the hospital’s emergency room were billed for the most complex, expensive level of care. After EmCare arrived, nearly 28 percent got the highest-level billing code. On top of that, the hospital, Newport Hospital and Health Services, was getting calls from confused patients who had received surprisingly large bills from the emergency room doctors. Although the hospital had negotiated rates for its fees with many major health insurers, the EmCare physicians were not part of those networks and were sending high bills directly to the patients. For a patient needing care with the highest-level billing code, the hospital’s previous physicians had been charging $467; EmCare’s charged $1,649.

b. “Newport’s experience with EmCare, now one of the nation’s largest physician-staffing companies for emergency rooms, is part of a pattern. A study released Monday [July 24, 2017,
http://www.nber.org/papers/w23623] by researchers at Yale found that the rate of out-of-network doctor’s bills for customers of one large insurer jumped when EmCare entered a hospital. The rates of tests ordered and patients admitted from the E.R. into a hospital also rose, though not as much. The use of the highest billing code increased.”

c. “The researchers focused on 16 hospitals that EmCare entered between 2011 and 2015. In eight of those hospitals, out-of-network billing rose quickly and precipitously. (In the others, the out-of-network rate was already above 97 percent, and it did not go down.) They also looked at a larger sample of 194 hospitals where EmCare worked and found an average out-of-network billing rate of 62 percent, far higher than the national average.”

4. “UnitedHealth Warns Hospitals About Envision ER Contracts” (Reuters, September 24, 2018)55

a. “UnitedHealth Group Inc. will treat emergency room and other hospital services performed by Envision Healthcare as out-of-network claims beginning next year after failing to reach a new contract agreement with the staffing company, UnitedHealth said on Monday. The health insurer sent a letter seen by Reuters to 300 hospitals informing them of the decision on Friday.”

b. “UnitedHealth first said it was considering terminating its contract with Envision in April. Envision also sued UnitedHealth earlier this year, saying it was not paying its bills. That ended up in court-ordered arbitration, which is ongoing.”

c. “Envision has agreed to be bought by KKR & Co for more than $5.5 billion in a deal expected to close in the fourth quarter.”

d. “UnitedHealth said in the letter that Envision is asking for payment rates that are nearly 600 percent of the rates in the Medicare program for seniors and the disabled and twice the average amount paid for ER physicians according to the National Bureau of Economic Research. Envision said its goal is to have in-network relationships with partner insurers ‘so that patients don’t have to worry about surprise bills caused by surprise gaps in coverage.’”

5. Word to the wise: query in-network hospital providers to determine whether professional emergency care services have been outsourced and, if so, to whom.


XIV. Does the Employer’s Third Party Administrator Rent the In-Network Providers to the Self-Insured Plan? If So, Does the Amount the Plan Pays for an In-Network Provider Encounter Equal the Amount the TPA Pays the In-Network Provider

A. Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan, 2014 WL 1910554 (6th Cir. 2014)--6th Circuit Sustains $5 Million Award to Self-Insured Health Benefit Plan for Fiduciary Violation Triggered by Third Party Administrator’s Undisclosed Fees

1. The plan sponsor sued the TPA, which among other services supplied the provider network, after discovering that the TPA paid claims that included “network access” and other fees imposed by the TPA but which did not appear in the administrative services agreement or Form 5500 information prepared by the TPA. Trial court found the TPA liable for self-dealing under ERISA’s prohibited transaction rules and for breach of fiduciary duty; the 6th Circuit agreed.

2. In the past week, 30 claims have been filed by other clients of Blue Cross Blue Shield of Michigan, alleging the same conduct. BNA’s Health Care Daily Report™, August 15, 2017.

B. Acosta v. MagnaCare Admin. Servs., LLC (SDNY 7-13-2017)-TPA Supplying Self-Insured Group Health Plans Access to In-Network Providers and Claims Adjudication Services Admits to Fiduciary Status and Violations of Fiduciary Duty by Failing to Disclose Mark-Up of In-Network Provider Claims That the TPA Retained and Failing to Follow ACA-Required Standard for Emergency Services Claims

1. Complaint was filed by the U.S. Department of Labor after an investigation by the Employee Benefits Security Administration.

2. Settlement: MagnaCare has agreed to pay at least $14.5 million in repayment of fees to its self-insured health plan clients and $1.5 million in civil penalties to the DOL.