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Options for Lowering Costs for the Privately Insured

April 21, 2021

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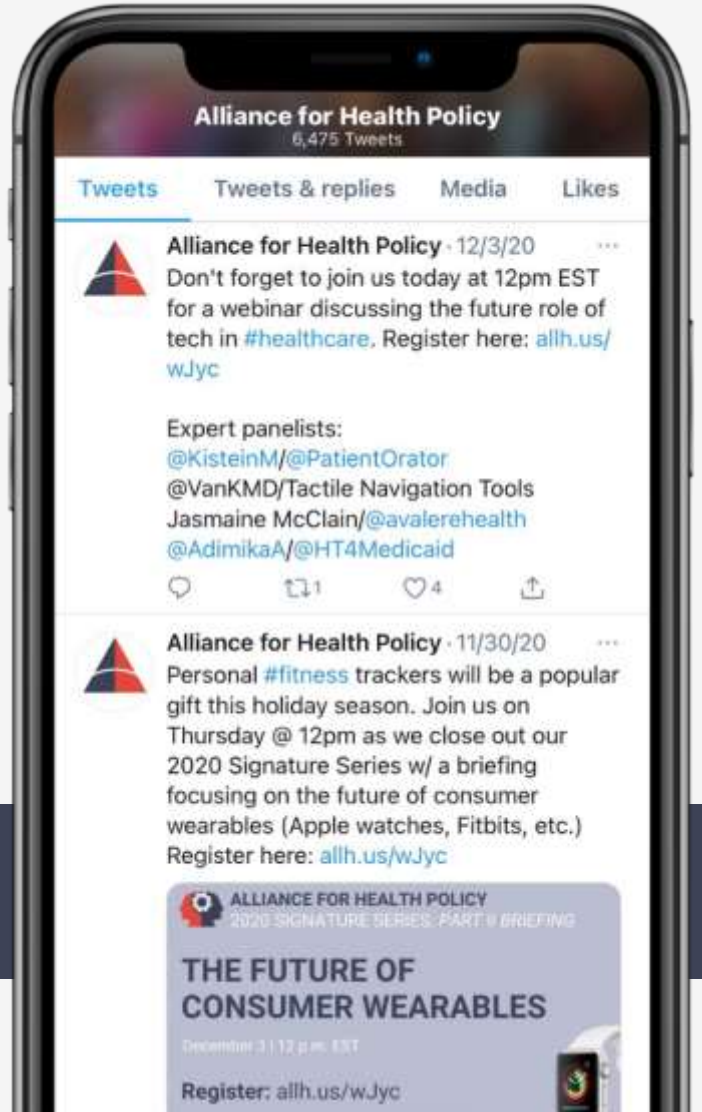

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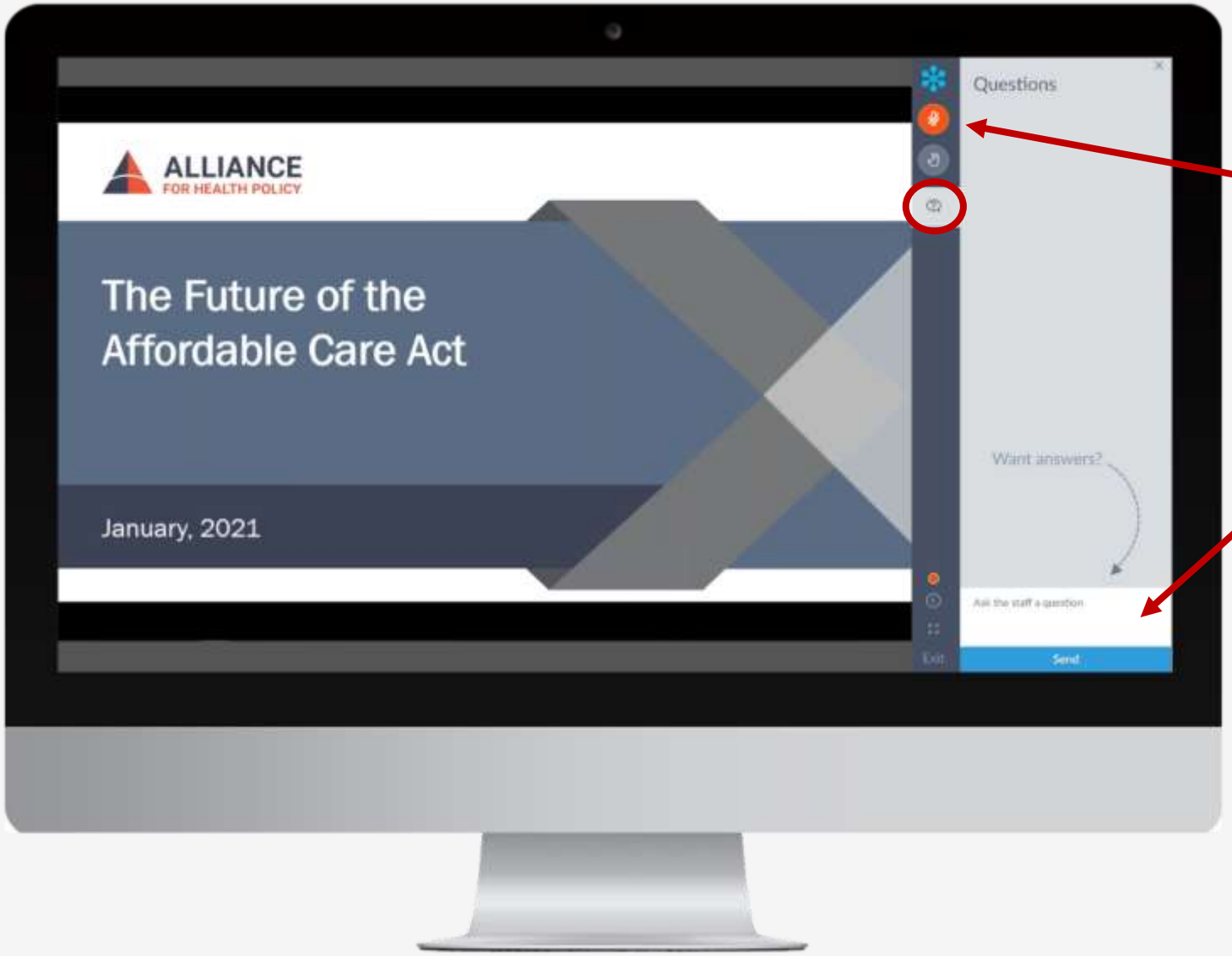

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To ask a question, click the ? icon and enter your question in the chat box below.

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A Public Option and/or Capped Rates as a Response to Market Concentration

John Holahan and Michael Simpson

Research Supported By Arnold Ventures

Interest in public option policies stems from high provider payment rates in many markets, leading to high premiums

Estimates of Private Insurance Prices Relative to Medicare Prices from Various Sources

		Ratio of Private Insurance to Medicare Prices			
	Data source	Hospital	Inpatient	Outpatient	Physician/ professional
Urban Institute	FAIR Health (2017–18)	2.4	1.9	3.4	1.2
Congressional Budget Office	HCCI (2013–14)	NA	1.9	NA	1.1–2.4 (service-specific)
Cooper and colleagues	HCCI (2007–11)	NA	2.2	NA	NA
White and Whaley	Multiple (2015–17)	2.4	2.0	2.9	NA
Medicare Payment Advisory Commission	2017	NA	NA	NA	1.3

Sources: CBO estimates come from Maeda and Nelson (2017) and Pelech (2018). See Cooper and colleagues (2018), MedPAC (2019a), and White and Whaley (2019).
Notes: HCCI = Health Care Cost Institute. NA = not available.

Public Option

- Government-run program provide insurance
  - Could be implemented in the nongroup markets or both the nongroup and employer markets
- Would generally set provider payment rates below commercial rates
- Depending on payment rates, public option would be the benchmark premium, affecting coverage and government subsidy costs
- Could reduce participation of private insurers who would find it harder to compete

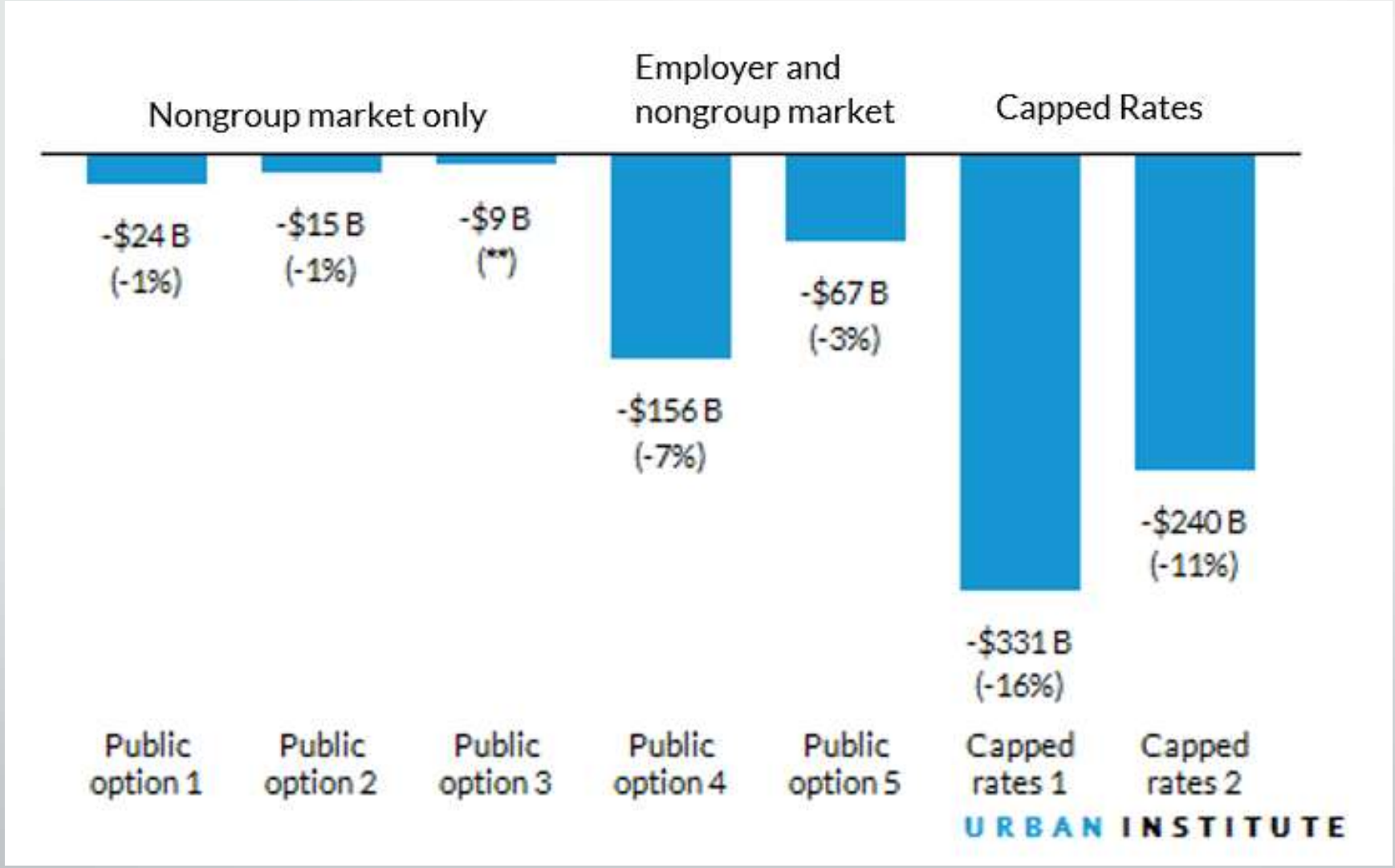
Capped Rates

- Would limit rates paid by all insurers
- Could be implemented in nongroup and employer markets
- Could be combined with public option, same as Medicare Advantage
- Individuals would benefit while keeping their private insurance
- More insurers could enter and exit in markets than with the public option alone

Key Findings from Urban Institute Studies

- Potentially significant impact on premiums in the nongroup market but small national effects because nongroup market is small; much larger if extended to employer market
- The lower provider payment rates are, the lower premiums will be, and the more savings to households, employers, and government, but the greater the reduction in provider revenues and the more political resistance
- Capped rates result in more savings than with the public option alone because payment reductions apply more broadly
- Policies could exempt rural areas without much effect on national results
- Policies could be limited to highly concentrated insurance and hospital markets and achieve substantial effects on federal spending and national health spending

Effect on National Health Spending



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. B = billion.

@FREOPP

Avik Roy

President

Foundation for Research and Equal Opportunity

Monopoly Power Threatens Affordable Health Care

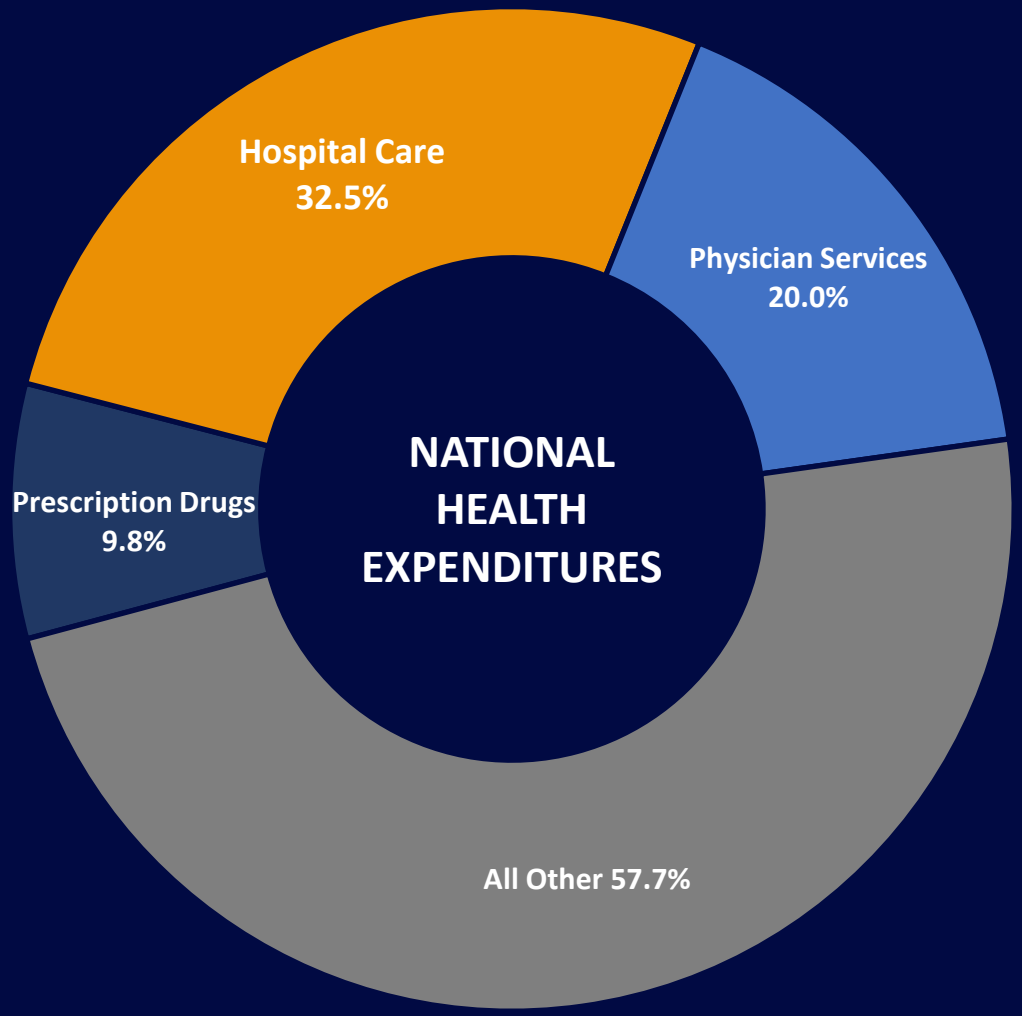
AVIK ROY / @AVIK
PRESIDENT, THE FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY
AROY@FREOPP.ORG

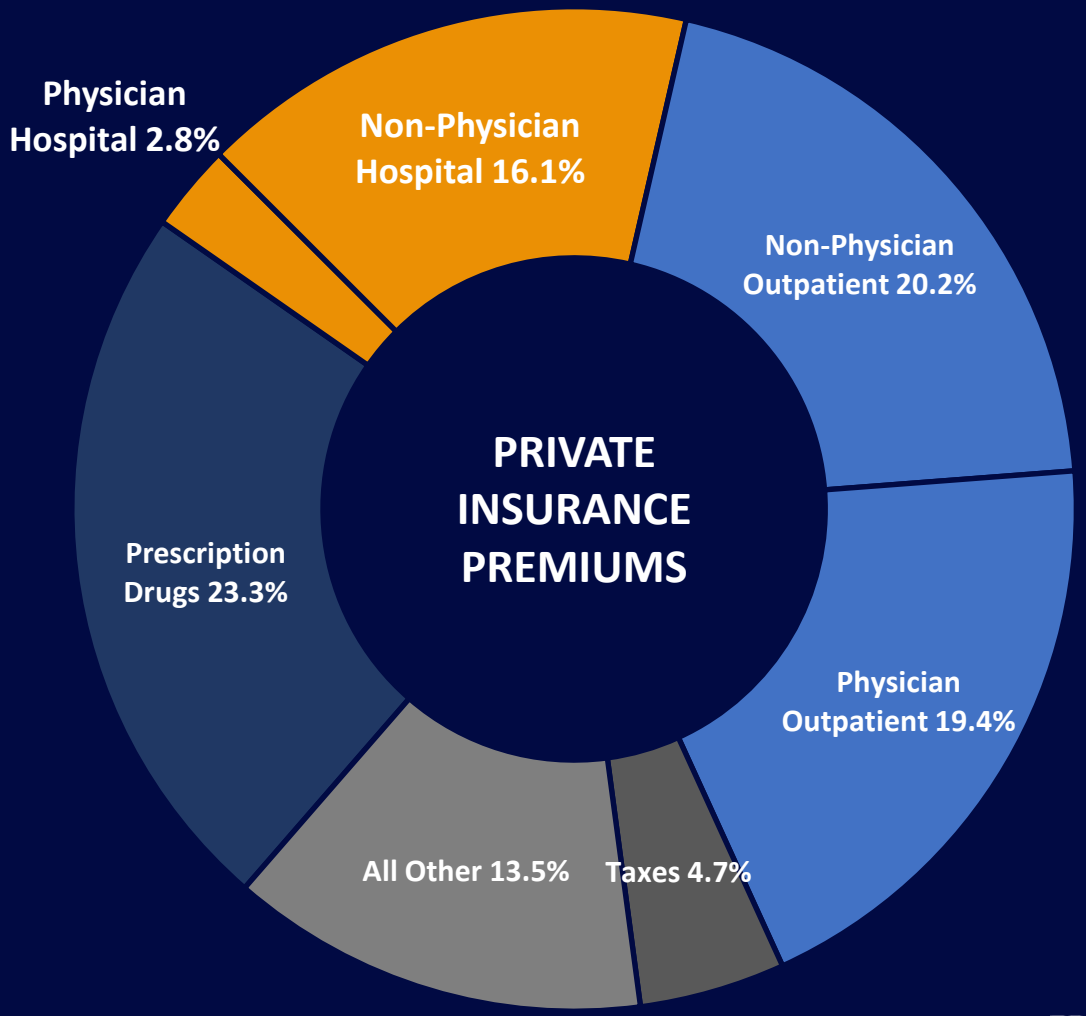
FREOPP: A NEW MODEL FOR BIPARTISAN REFORM

- **Our mission:** We conduct original public policy research that expands economic opportunity to those who least have it
- **Our values:** We advance ideas that advance both conservative and progressive values, at the same time
- **Our focus:** Market-based reforms that improve the lives of Americans whose income or wealth is below the U.S. median
- **Our structure:** Non-profit, non-partisan, 501(c)(3) funded exclusively by charitable donations

HOSPITALS: THE LARGEST NATIONAL HEALTH EXPENDITURE

Prescription drugs as a share of national health expenditures vs. private insurance claims





Sources: CMS, Milliman, AHIP

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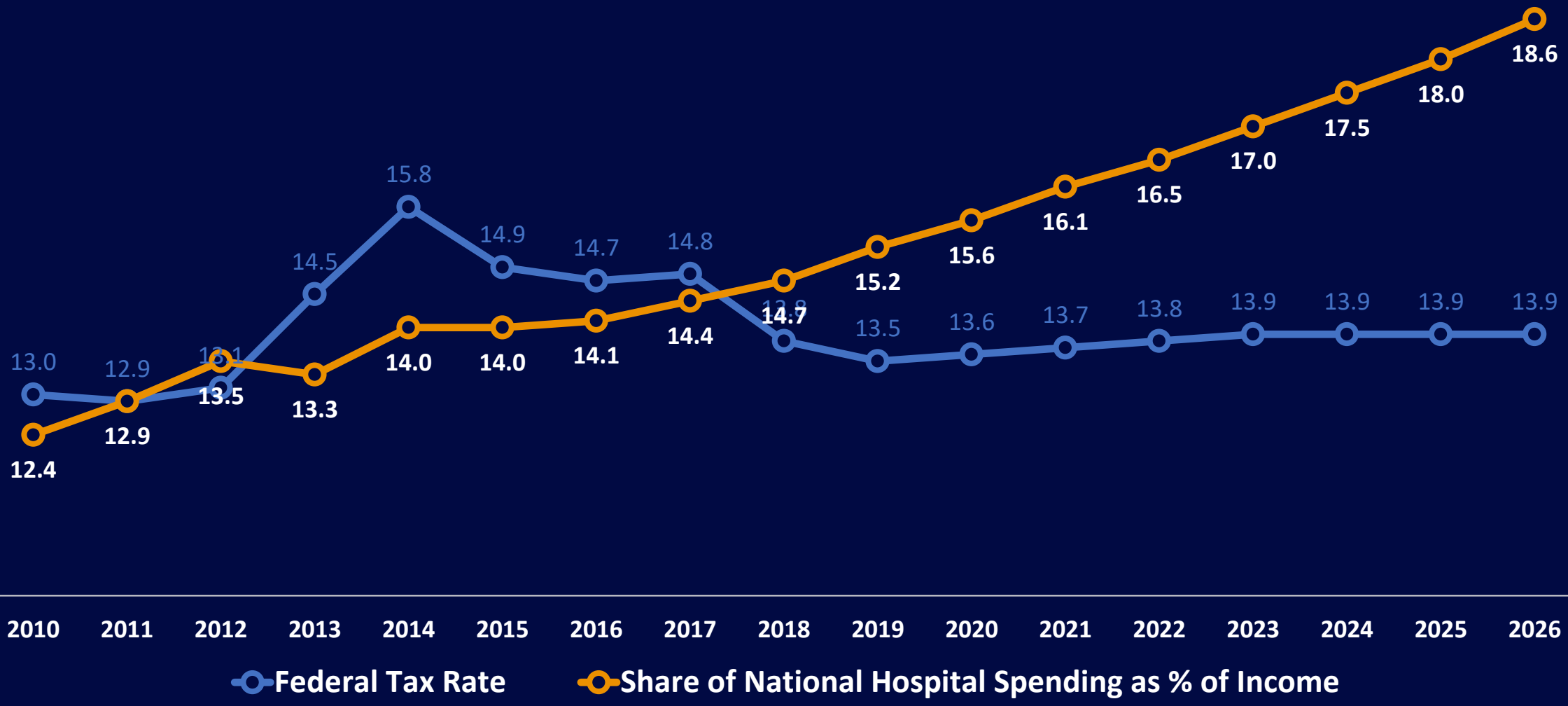
AVERAGE FAMILIES PAY MORE TO HOSPITALS THAN TO THE IRS

Median household federal tax rate vs. median household's share of U.S. medical spending (%)



Sources: FREOPP, JCT, CBO, CMS

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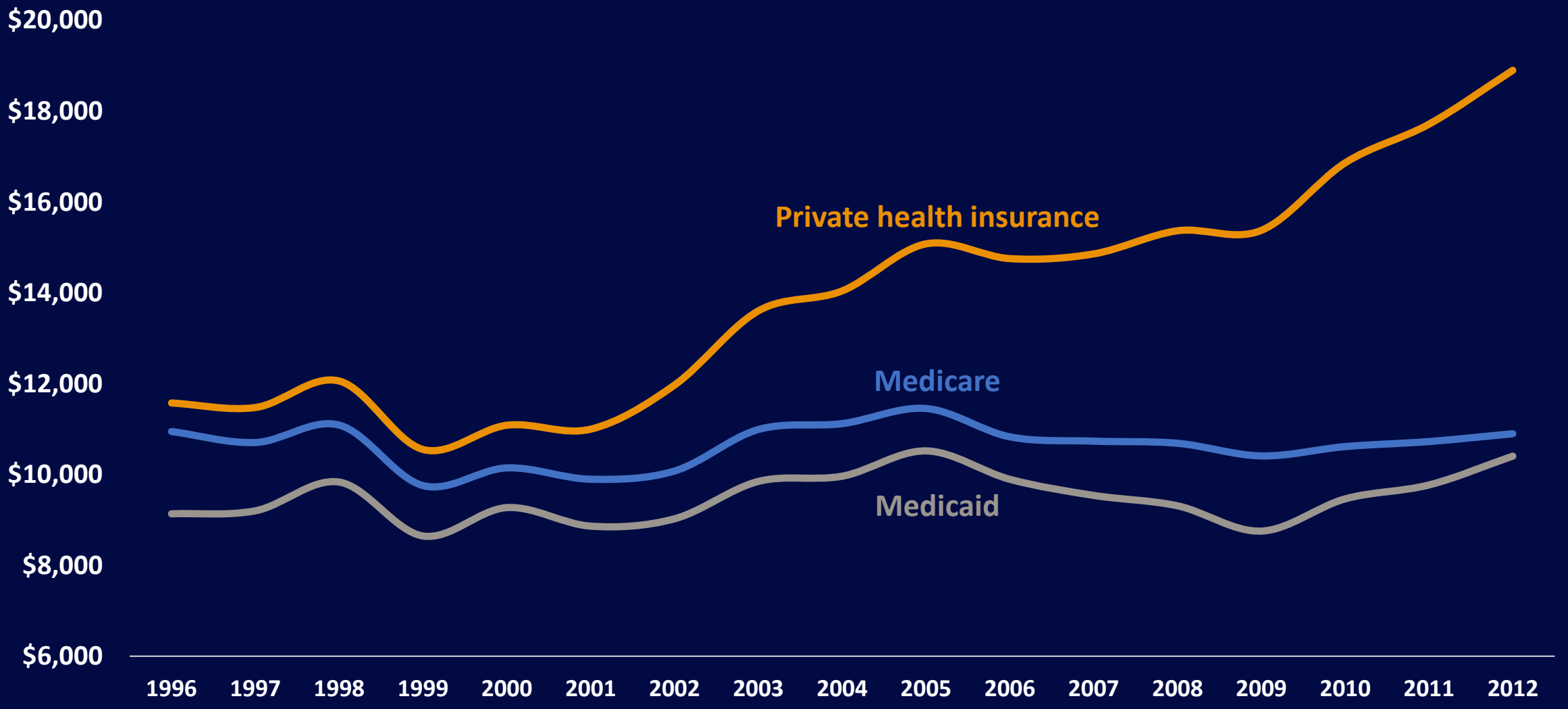
THE MYTH OF HOSPITAL ‘COST-SHIFTING’

Avg. standardized payment rates per inpatient stay, by primary payer, 1996–2012 (2012 dollars)



Sources: FREOPP, JCT, CBO, CMS

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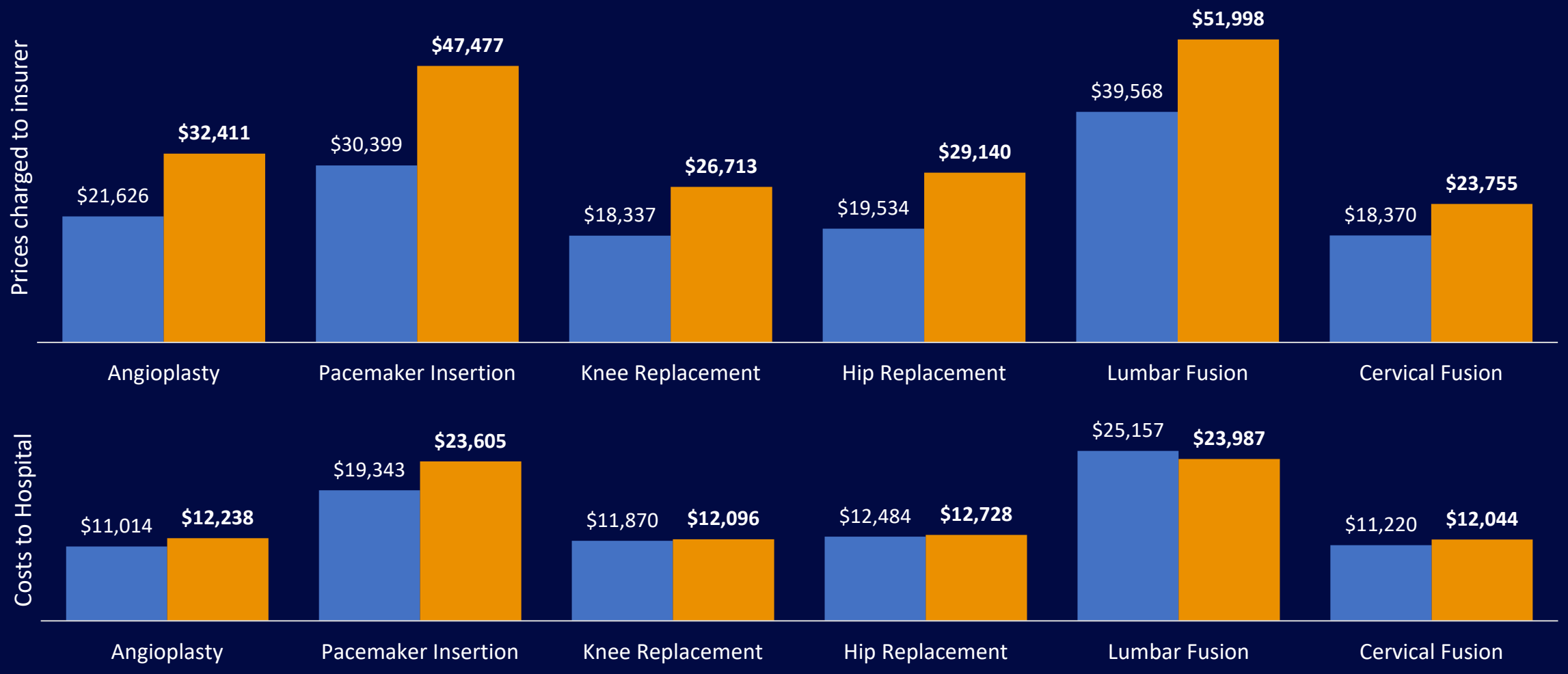
HOSPITAL CONCENTRATION = 44% HIGHER PRICES



Source: Robinson, AJMC 2011

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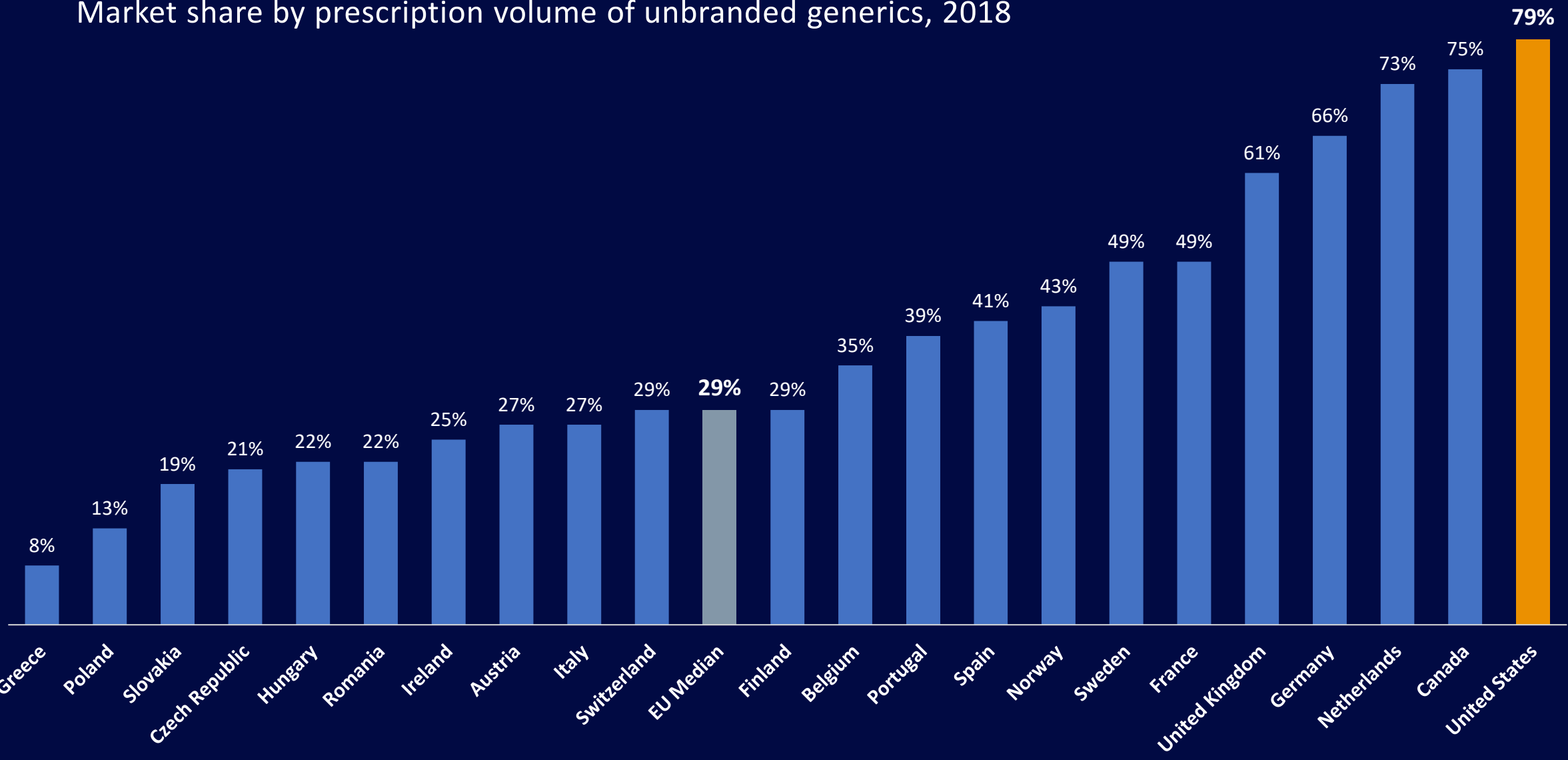
U.S. LEADS THE WORLD IN GENERIC UTILIZATION

Market share by prescription volume of unbranded generics, 2018

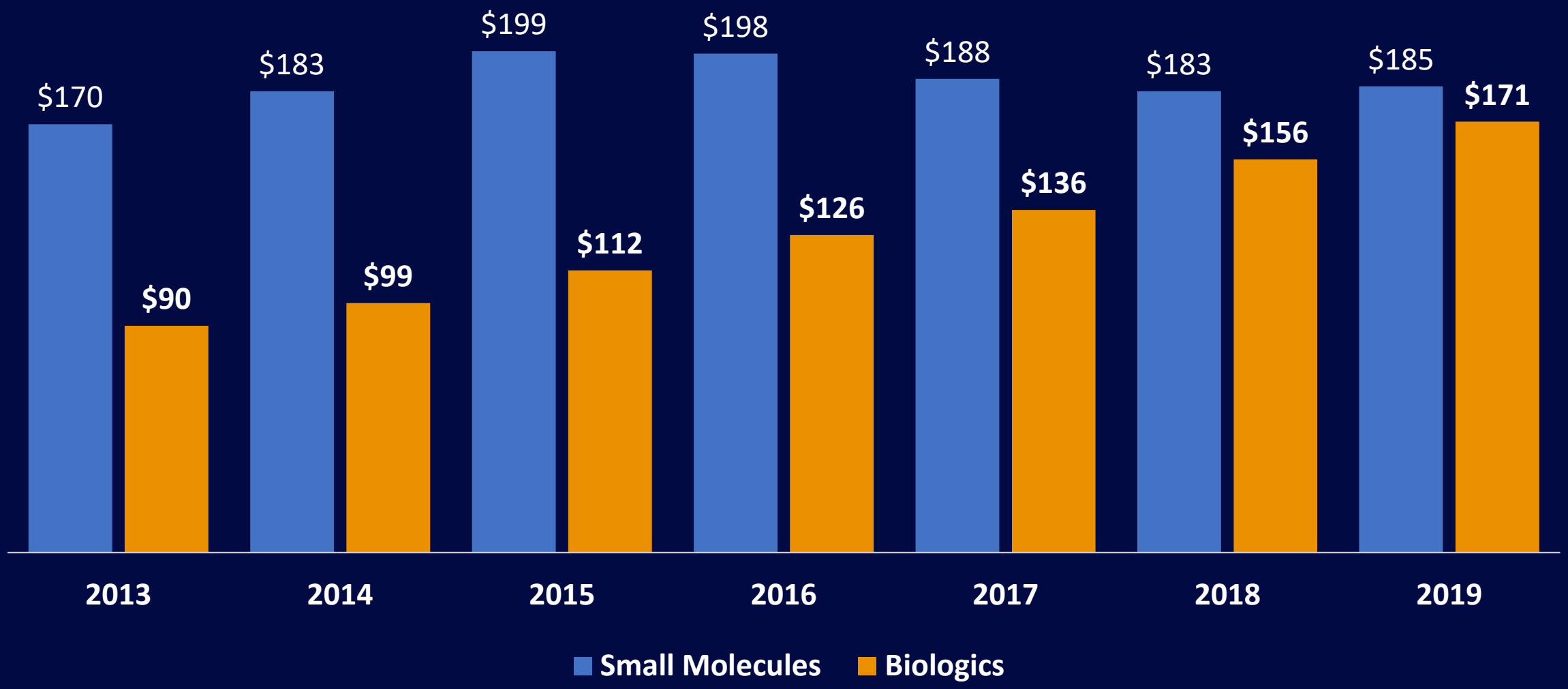


Sources: IQVIA Institute, FREOPP Analysis

FREOPP.org

BIOLOGIC DRUGS EXPLOIT MONOPOLY PRICING

U.S. net drug spending, biologics vs. small molecules, 2013–2018 (billions)



Source: IQVIA Institute

@avalerehealth

Fred Brentley, MPP, MPH
Managing Director
Avalere Health

Provider Perspective on Competition & Regulation to Improve Affordability

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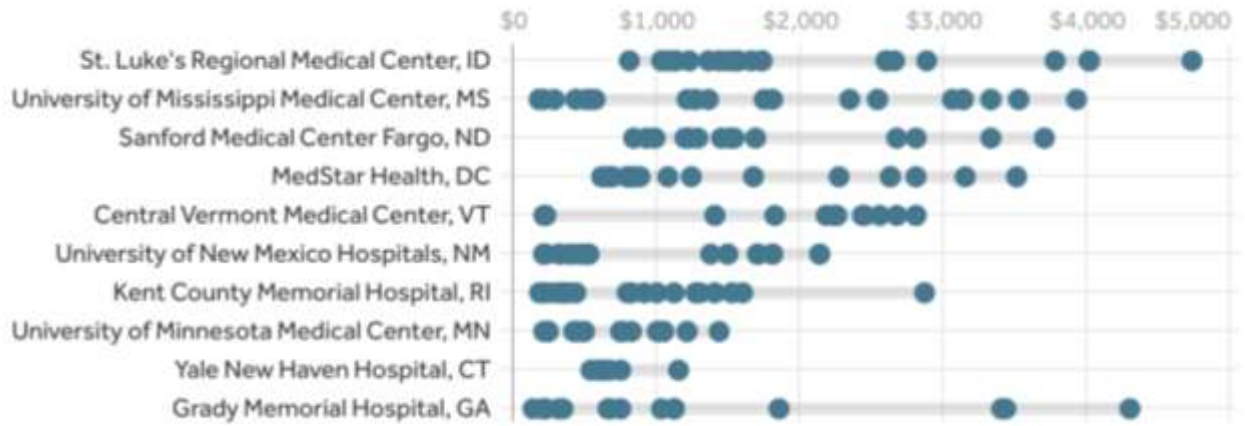
Reality #1: Transparency Mandate's Impact Mediated by Relative Market Power of Payers and Providers

Transparency Mandate Putting a Spotlight on Unwarranted Variation in Prices…

Negotiated Rates for MRI of Lower Spine



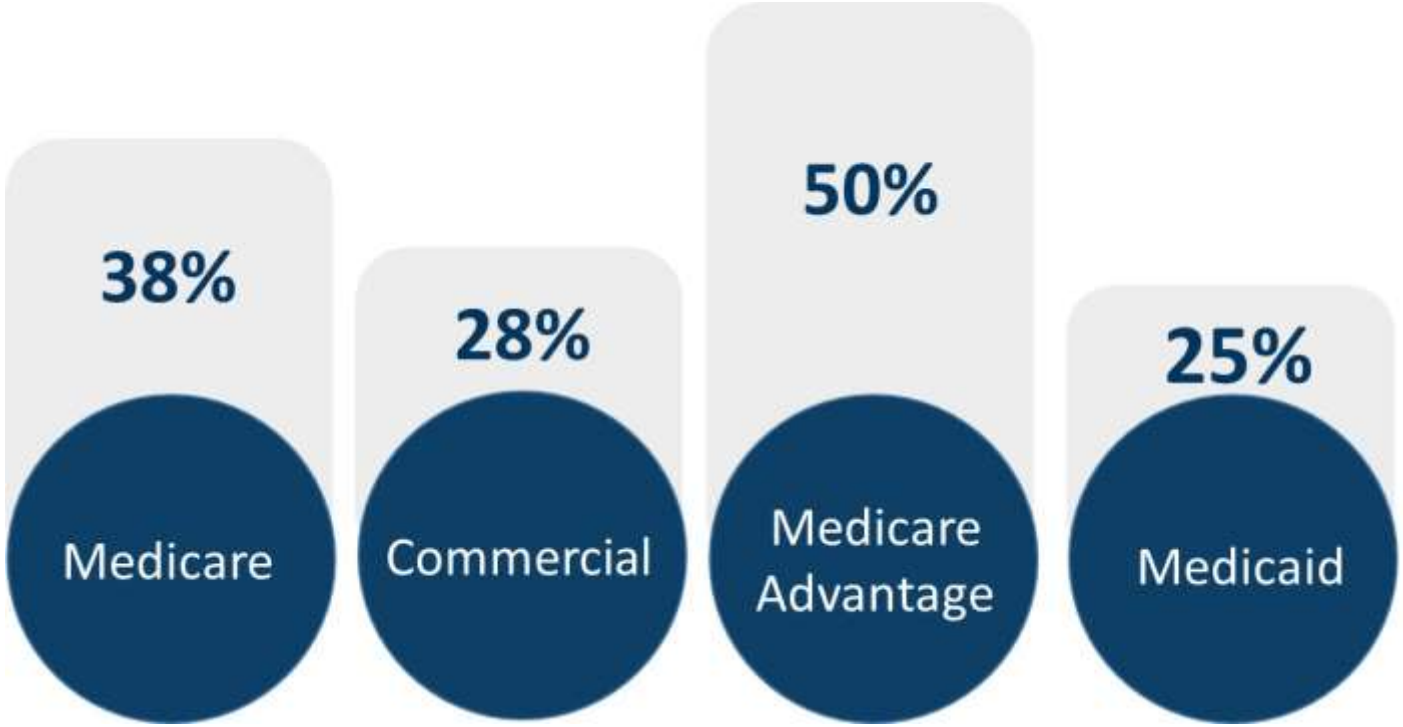
… But Few Hospitals Fully Complying with Requirements

Availability of Payment Rate Data (n = 102 Hospitals)

	Consumer tool	Machine-readable file
Gross charge	80 hospitals (78%)	83 hospitals (81%)
Discounted rate (uninsured/self-pay rate)	57 hospitals (56%)	43 hospitals (42%)
Payer-specific negotiated rates (2 or more payers)	3 hospitals (3%)	35 hospitals (34%)

Reality #2: “Volume-to-Value” Transition Producing Some Results, But Moving at a Snail’s Pace

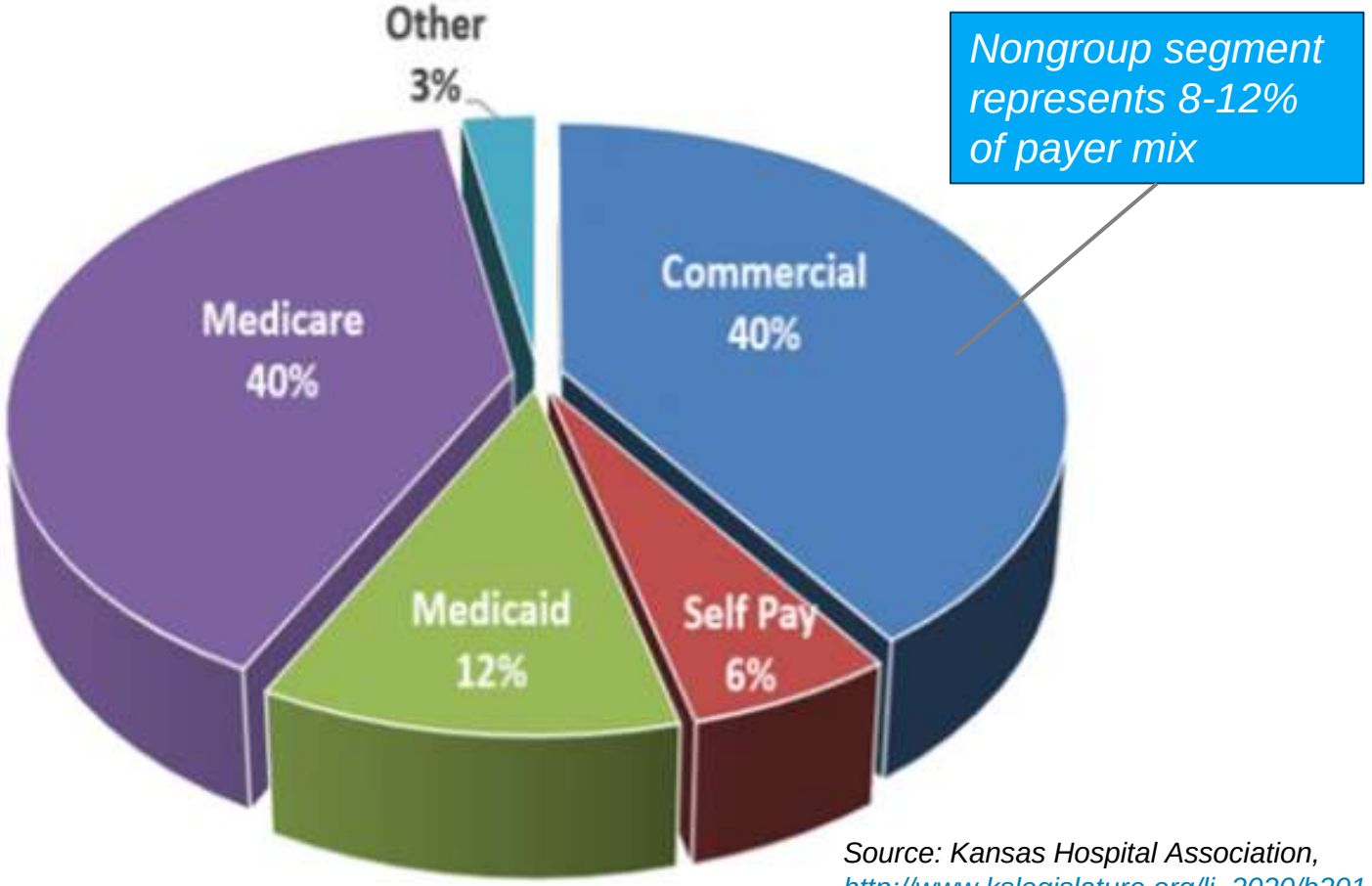
Proportion of Provider Reimbursements Flowing Through Value-Based Model, by Payer Type



Source: Duke Margolis Center for Health Policy, 2018

Reality #3: Reforms in Nongroup Market Unlikely to Significantly Alter Provider Behavior

Breakdown of Hospital Revenue Sources (2019)



Source: Kansas Hospital Association, http://www.kslegislature.org/li_2020/b2019_20/committees/ctte_spc_2019_financial_institutions_insurance_1/documents/testimony/20191029_13.pdf

Several States Moving Forward with Expansive Public Option Models

California

- CA has created a new council to conduct a feasibility study of a public option in the state
- Legislation has been proposed that would expand access, through a buy-in, to state or municipal employee plans

Colorado

- In May of 2020, sponsors of HB 1349, which would have created the CO Health Care Option (i.e., the public option to be offered on the state's exchange), announced the bill would be withdrawn to allow focus on COVID-19
- Under the proposed option, employers could have been required to offer plans through the exchanges and the recommended reimbursement for hospitals was a base rate of 155% of Medicare

Oregon

- In July 2019, SB 770 established a Universal Health Care Commission to study a publicly funded, comprehensive healthcare option for all OR residents
- The bill, along with HB 2021, also requires OR to develop a plan for a Medicaid buy-in program or public option with the goal of providing affordable health care to OR residents

Washington

- In May of 2020, WA Gov. Jay Inslee (D) stated the implementation of WA's public option, Cascade Care, will take a "preliminary approach" in its 2021 implementation
- Despite scaling back initial implementation due to COVID-19, WA released rate filings for the 2021 plan year, which include standardized options under Cascade Care
- Provider reimbursement under standard plans is capped at 160% of Medicare

PHE: Public Health Emergency

Reality #4: Cost-Shifting and Access Challenges Inevitable with Any Large-Scale Payment Reforms

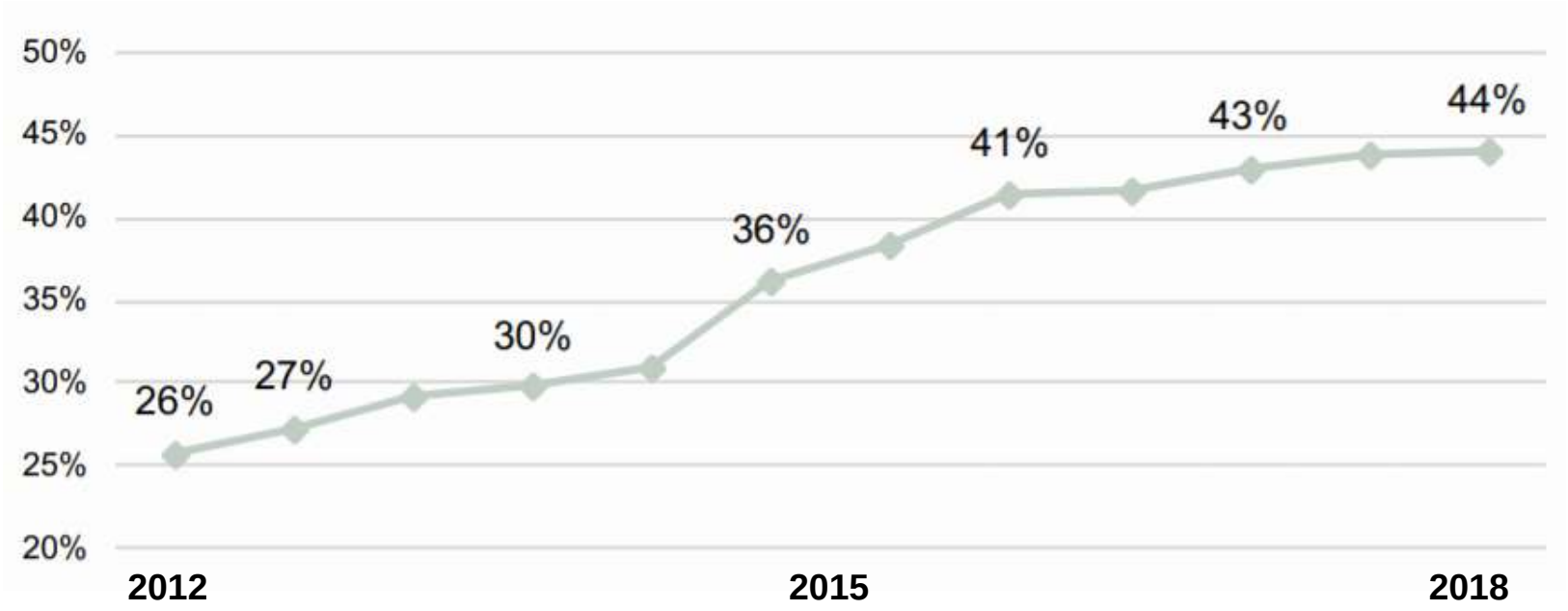
Aggregate Hospital Payment-to-Cost Ratios

	Medicare	*Medicaid*	*Commercial*
2008	91.3%	88.9%	128.0%
2009	90.4%	89.1%	133.8%
2010	92.7%	93.0%	133.4%
2011	91.7%	94.9%	134.4%
2012	86.3%	89.1%	148.9%
2013	88.2%	89.9%	143.6%
2014	88.9%	90.4%	143.7%
2015	88.2%	89.6%	144.1%
2016	87.2%	88.9%	144.1%
2017	86.6%	87.6%	144.8%
2018	86.6%	89.3%	144.8%

Source: American Hospital Association, Trendwatch Chartbook 2020.

Reality #5: Downward Pressure on Provider Rates Likely to Spur Further Consolidation

Hospital-Owned Physician Practices as Percentage of All U.S Practices, 2012 - 2018



Avalere analysis, http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117

@CommCatHealth

Emily Stewart

Executive Director

Community Catalyst

Building a Health System Accountable to People

Emily Stewart, Executive Director

Centering health experience of people.

Is health care affordable for people? No.

Nearly 1 in 4 Americans are skipping medical care because of the cost

Published Thu, Mar 12 2020•6:01 AM EDT • Updated Thu, Mar 12 2020•10:12 AM EDT

Megan Leonhardt
@MEGAN_LEONHARDT

Finance

Survey: More Americans fear medical bills than becoming seriously ill

by Alicia Caramenico | Apr 3, 2018 7:57am

Workers With Health Insurance Face Rising Out-of-Pocket Costs

A new survey from the Kaiser Family Foundation shows annual premiums for a family now top $21,000, and deductibles have more than doubled since 2010.

Study: Patient out-of-pocket costs up 4x in 12 years

Aug 20, 2019 | Federal Issues, News, Out of Pocket Costs | Out of Pocket Costs

What has helped.

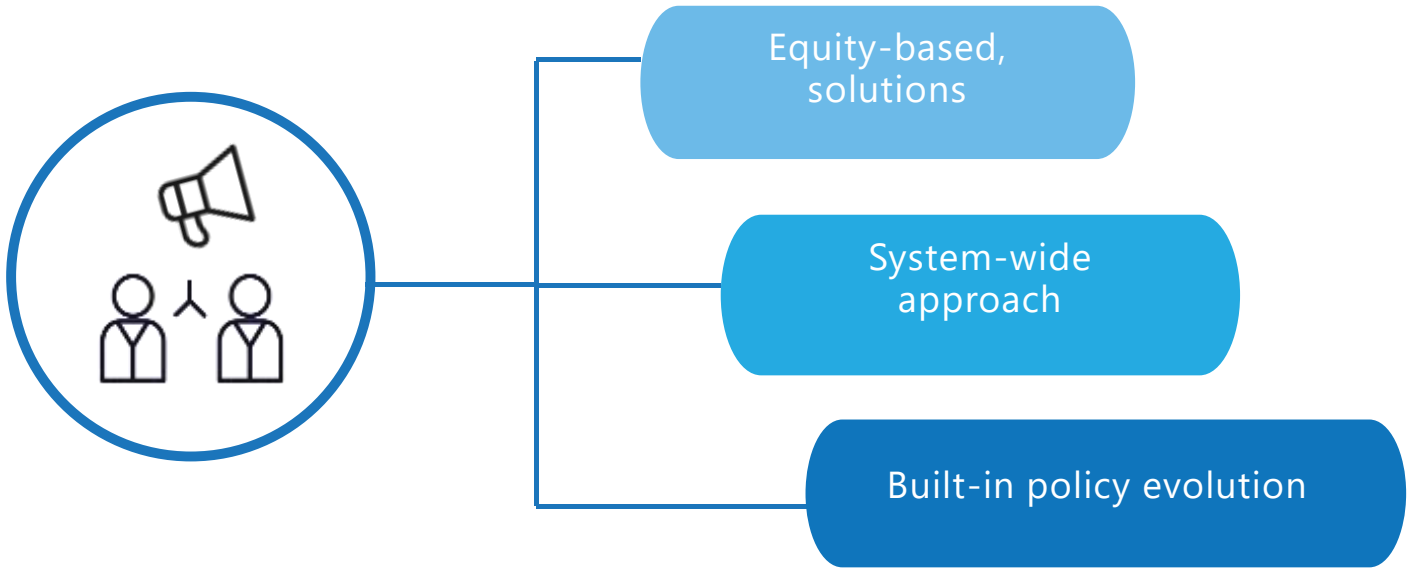
Coverage expansions.

Financial Assistance.

Limits on out-of-pocket spending.

Wrap around support.

What is missing



Thank You

We value your input!

Please fill out the evaluation survey you will receive immediately after this presentation, or via email this afternoon!

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Thank you for attending.