

OPTIONS FOR LOWERING COSTS FOR THE PRIVATELY INSURED



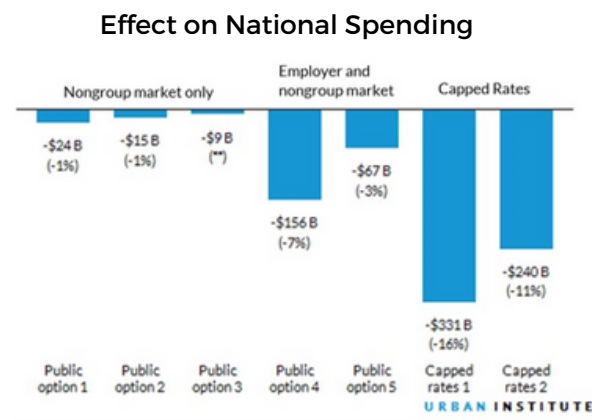
Overview

There is no shortage of proposed solutions to reduce health care costs and expand coverage in the U.S. However, central to many policy options is the concept of increased market competition and/or increased regulation of health care insurance markets. In other U.S. markets, competition is a tool used to achieve standard levels of quality and efficiency, spur innovation, and drive down costs, thereby improving affordability. However, in health care, market competition can take many forms but does not guarantee quality of care.

To explore this further, the Alliance for Health Policy, in collaboration with Arnold Ventures, hosted a public briefing on April 21, 2021. This session delved into how cost-saving proposals to spur market competition or enhance regulation impact: (1) Federal fiscal priorities; (2) Individual coverage; (3) Patient accessibility (including out-of-pocket costs and equity); and (4) Provider reimbursement. Panelists also discussed how the COVID-19 pandemic increases urgency or complicates discussions around these policies. All of the materials, including slides, that accompanied this event can be found here.

Key Lessons

- Affordability for consumers, specifically those impacted by high premiums, has necessitated policy solution discussions at many levels of government. This event focused on two potential solutions: Implementing a public option and capping rates in various markets.
 - A **public option** is a government run program that provides insurance. This option can externally contract administrative services and can be implemented in the Affordable Care Act's individual marketplace, or in the nongroup and employer market. A public option would generally set provider payment rates below commercial rates and often serves as a benchmark premium, which affects coverage and government subsidy costs.
 - Rate caps** are limit rates paid by all insurers, and resemble how Medicare Advantage works in the Medicare program. Rate caps could be implemented in nongroup and employer markets or can be combined with a public option. Individuals would potentially benefit from lower premiums while keeping their private insurance—something that some consumers would like to do.



Source: "Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets." Holahan, J., Simpson, M. Urban Institute. March 2021. Available at <http://allh.us/Exde>

- The Transparency in Coverage final rule released on October 28th, 2020, is shedding a light on unwarranted variation in prices and few hospitals are complying with the transparency requirements. The underlying market concentration issue and market power dynamics are not likely to be changed by transparency.
- Existing, but non-comprehensive, mechanisms that have helped in the fight to lower costs for consumers include:
 - **Coverage expansion** and the availability of marketplace plans for the private insurance market and Medicaid expansion have cut the uninsured rate in half.
 - One of the most successful and long-lasting aspects of the Affordable Care Act (ACA) was the **financial assistance**. About 80% of people on the marketplace gained access to tax credits under the ACA, and 50% of people are receiving cost-share reduction support.
 - **Limits on out-of-pocket spending** under the ACA, is one of the provisions that translated the most in terms of reducing costs and demonstrated that people have better access to care.
 - **Wraparound support** programs, like the navigator program under the ACA, helped consumers better understand what their benefits and protections are.

Questions & Answers

It could be argued that health care payers and providers should resist the emergence of a competitive health care marketplace and make competing on values central to their strategy. What are the challenges and opportunities of payer and provider buy-in to the concept of increased market competition?

"The value conversation in general is one that while there are meritorious ideas and a lot of good people working on value-based insurance design. Value based outcomes and provider settings, etc. One thing that's really important to understand about the value conversation is that value is not the same thing as price. So, if the point of value-based care is to say we're going to pay you more for good outcomes or we're going to pay less for bad outcomes. Those are relative descriptions of the price you're paying, and what matters is the absolute price that you're paying. So, unless we get the absolute price and absolute spending of health care under control, the impact of value-based care on affordability is uncertain." – Avik Roy, President, The Foundation for Research on Equal Opportunity

"A lot of providers are not participating in value-based arrangements and this has been a huge problem. A big part of why is if you're a hospital, what incentive do you have to get paid less? Because the way payers are trying to do value-based care is we're going to pay more, relative to the standard rate for a good outcome, and less relative to the standard rate for a bad outcome. That less part is not particularly attractive to providers." – Avik Roy, President, The Foundation for Research on Equal Opportunity

"I do want to address this point that if we had some sort of external ceiling to prices that it would basically blow up the private insurance industry. People who participate in Medicare Advantage would be very surprised to learn that ceilings on reimbursement rates blow up the private health industry. In fact, in Medicare Advantage we do have ceilings in the forms of Medicare Fee-for service reimbursement rates, which effectively are a kind of cap on what Medicare Advantage plans pay. They can pay more if they want to, but they're not forced to. Basically, the hospitals have to accept that Medicare standard fee-for-service rate as an alternative to the negotiated rate if the payer and the provider don't come to an agreement. That has turned out to be a really successful model, and in the MA case, dozens of plans are competing with each other all the time." – Avik Roy, President, The Foundation for Research on Equal Opportunity

A public option in the employer market could destabilize the employer group. Some groups might not then meet participation requirements if their employees are opting out into the public option, and the plan would unwind. Isn't this a slippery slope to single payer?

"I don't think all employers would choose the public option, even if it were less expensive. There are certain advantages to them tailoring benefit cost sharing, networks, etc. That might have real value to their employees. I think it would likely be attractive to smaller, lower wage businesses, and providing them with a better option than they have today. It is not completely clear to me that it's a better option for larger employers. The other point I'd like to make is that public options are in the non-group market, a public option is not going to wipe out other insurance plans in the more competitive market. In the work that we've done, we don't see the public option having a major effect in competitive markets. It does have a big effect in places where the market gets more concentrated, and that's what you want." – John Holahan, Ph.D., Institute Fellow, Urban Institute

In light of new transparency laws for hospitals and insurers, do you think employers may be interested in using this information to pressure their insured shares and negotiate better rates for their plans?

"Yes, and in fact you are right on target. We are doing working right now with employer groups in a few different markets, and we are digging around trying to find this hospital pricing. We're using that data as it becomes available, with claims data so we can look at utilization and cost, and then taking that data to really try and give us a broader view of value. Value is a very subjective topic, but I think that is the intent or one of the beneficial offshoots of the price transparency efforts is not only arming consumers, and we can argue about whether consumers can make sense of that data or not, but certainly self-employed employers are going to use it. I think one of the challenges is, and this is no slight at employers, but even the largest employer has 3 or 4 HR folks, and they are focused on managing their network. I think they have limited literacy and understanding around this data, and how to make decisions. So, I don't want to pretend that all this additional data is really going to transform it, but it adds very valuable insight and rounds out the picture on which hospitals are actually delivering value for the prices that they're getting paid." – Fred Bentley, MPP, MPH, Managing Director, Avalere

Is it fair to assume that all stakeholders in the health care industry, patients, regulators, providers, insurers, and employers, have roles in creating competition?

"I would point out that the purchase of health insurance is so complicated, the system is so complex, that people, generally speaking, really aren't interested at this point in shopping because it feels like they can't figure anything out. So, I think first and foremost, it does reinforce the important role of consumer assistance and making sure there are resources available to help people make decisions about what the right health care plan is for them, and what is inline with what they can afford. It also speaks to the value and importance of figuring out a systems approach that does work better for people. Even people who work in health care and who are privileged with time and money find it very difficult to navigate when they get surprise bills or figure out what actually is covered versus what isn't covered in their plan. So that to me is one of the biggest barriers to giving people space to promote competition." – Emily Stewart, Executive Director, Community Catalyst

Experts

Fred Bentley*

Avalere Health, Managing Director
fbentley@avalere.com

James Capretta, MPP

American Enterprise Institute (AEI)
Resident Fellow and Milton Friedman Chair
jcapretta@aei.org

Lanhee J. Chen, Ph.D, J.D.

Hoover Institution
David and Diane Steffy Research Fellow
lanhee.chen@stanford.edu

Allison Hamblin, MSPH

Center for Health Care Strategies
President and CEO
ahamblin@chcs.org

John Holahan, Ph.D.*

Urban Institute, Institute Fellow
jholahan@urban.org

Avik Roy*

Foundation for Research on Equal Opportunity
President
aroy@freopp.org

Claudia A. Salzburg, Ph.D.

American Hospital Federation
Vice President, Quality
csalzburg@fah.org

Emily Stewart*

Community Catalyst, Executive Director
estewart@communitycatalyst.org

Cori Uccello, MAAA, FSA, MPP

American Academy of Actuaries, Senior Health Fellow
uccello@actuary.org

Joel White

Council for Affordable Health Coverage, President
joel.white@cahc.net

**Served as panelist for April 21, 2021 event “Options for Lowering Costs for the Privately Insured.”*

Resources

“Introducing a Public Option or Capped Provider Payment Rates Into Private Insurance Markets.” Holahan, J, Simpson, M. Urban Institute. March 17, 2021. Available at <http://allh.us/uH3A>.

“Economic Shocks and Probable Expansions to a Public Option.” Chen, L., Church, T., Heil, D. Partnership for America’s Health Care Future. February 2021. Available at <http://allh.us/aqpU>.

“Affordable Hospital Care Through Competition and Price Transparency.” Roy, A. The Foundation for Research on Equal Opportunity. January 31, 2020. Available at <http://allh.us/aB6Q>.

“Health Care Cost Control: Where Do We Go From Here?” Altman, S., Mechanic, R. Health Affairs. July 13, 2018. Available at <http://allh.us/m7vD>.

This event was hosted by the Alliance for Health Policy on April 21, 2021. The Alliance gratefully acknowledges the support of Arnold Ventures for this event. For additional resources, please visit allh.us/BTFP.

