Prices Paid to Hospitals by Private Health Plans

MAINE STATE LEGISLATURE
JOINT STANDING COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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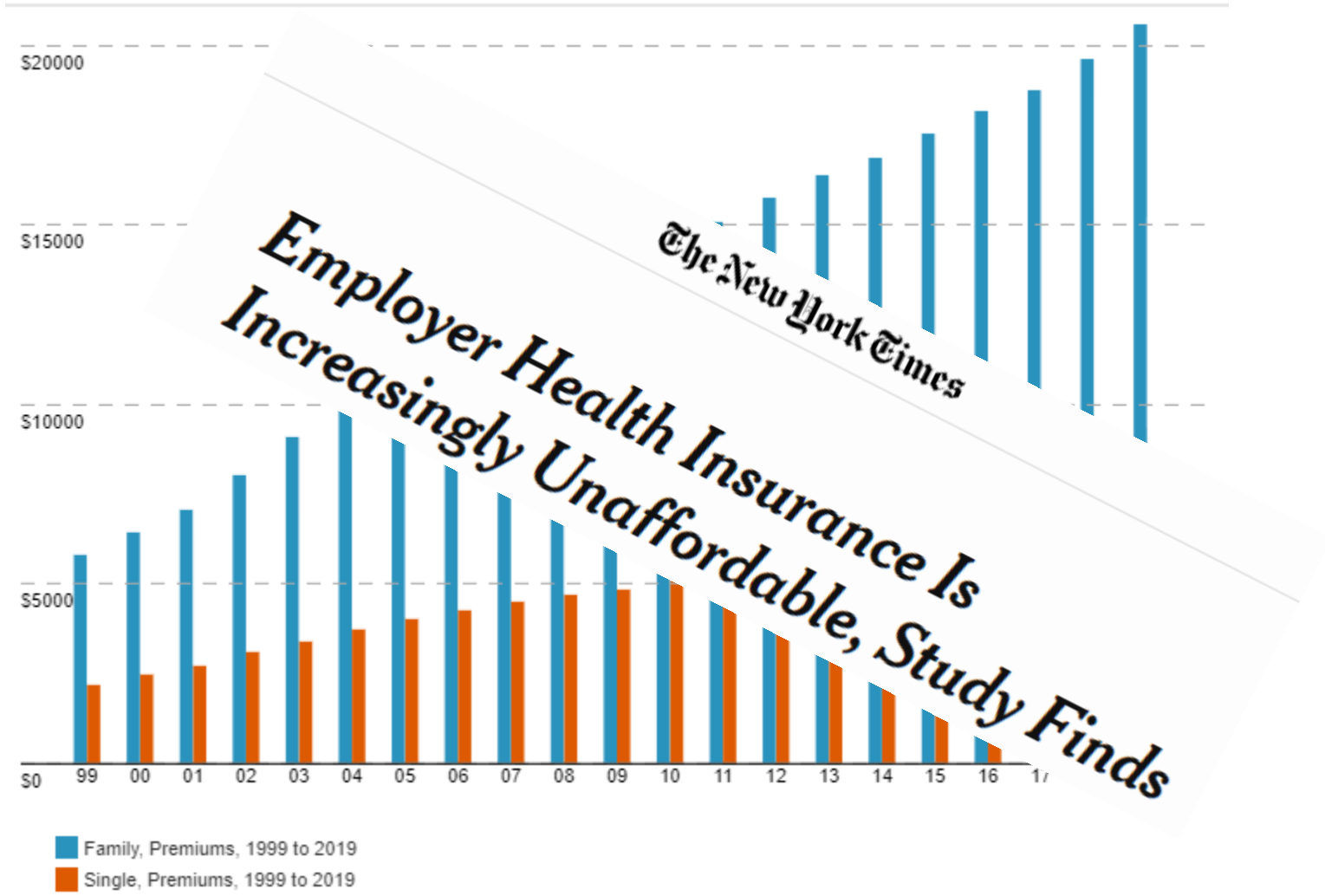
1. Context: Rising Hospital Prices at Heart of Affordability Crisis for Privately Insured

The Context:
Unsustainable Growth in Employer-Sponsored Premiums



The New York Times

Employer Health Insurance Is Increasingly Unaffordable, Study Finds

SOURCE: KFF Employer Health Benefits Survey, 2019 (http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019)

Edging Out Salary Growth & Economic Development

Opinions

Where did our raises go? To health care.

Personal finances, budgeting, living paycheck to paycheck. (Mark Jensen/Istock)

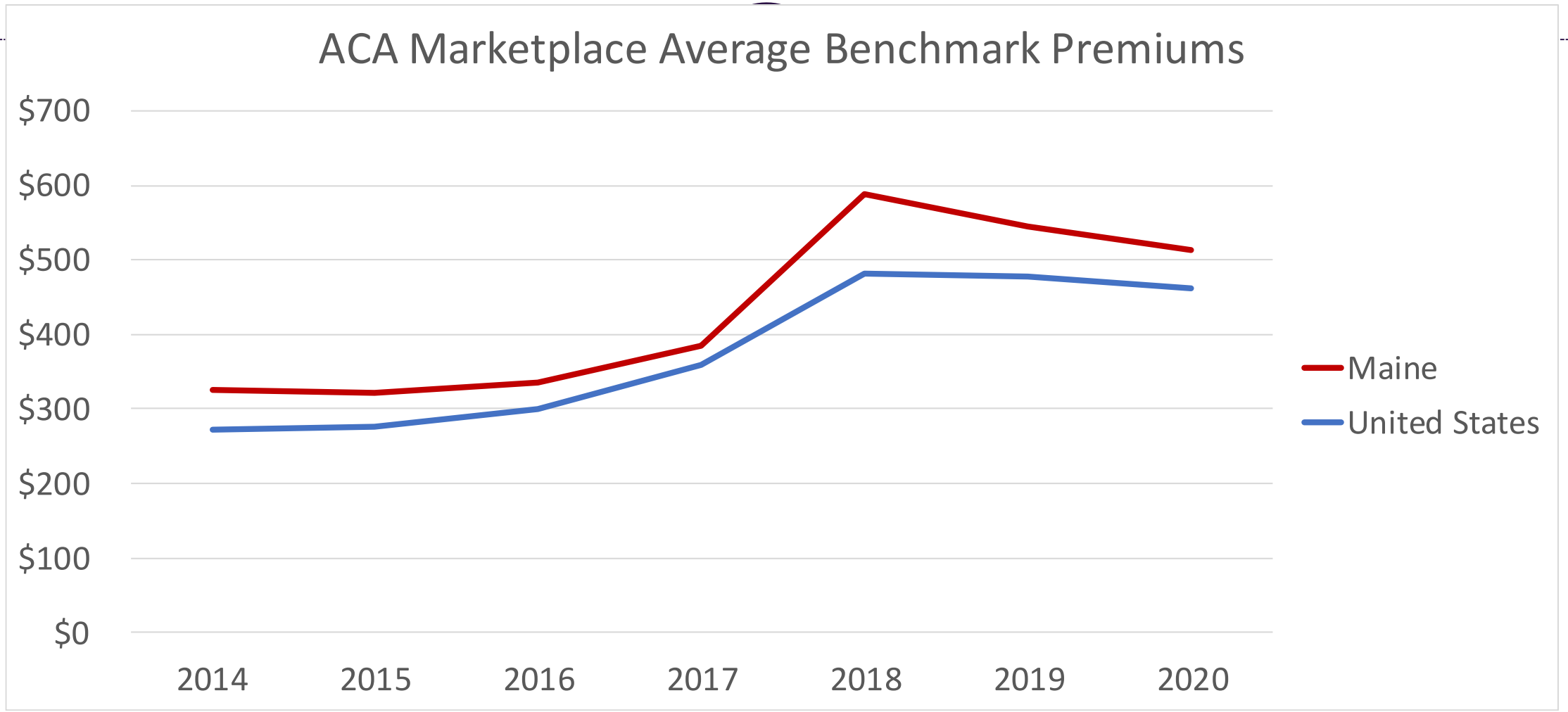
By **Robert J. Samuelson**
Columnist
September 2

It's wages vs. health benefits. On this Labor Day, just about everything seems to be going right for typical American workers, with the glaring and puzzling exception of wage stagnation. The unemployment rate is 3.9 percent, near its lowest since 2000. The number of new jobs exceeds the peak in 2008 by about 11 million. Then there's wage stagnation.

Corrected for inflation, wages are up a scant 2 percent since January 2015, according to the Bureau of Labor Statistics. The gain is roughly one-half of 1 percent annually. Little wonder that many workers feel they're not getting ahead. They aren't.

SOURCES: Samuelson, Robert J., "Where did our raises go? To health care.," Washington Post, September 2, 2018. https://www.washingtonpost.com/opinions/health-care-rules-the-labor-market/2018/09/02/05d13672-ad2f-11e8-b1da-ff7faa680710_story.html. Schieber, Sylvester J., and Steven A. Nyce, Health Care USA: A Cancer on the American Dream, Willis Towers Watson, 2018. https://www.willistowerswatson.com/-/media/WTW/PDF/Insights/2018/08/health-care-usa-a-cancer-on-the-american-dream-full-report.pdf.

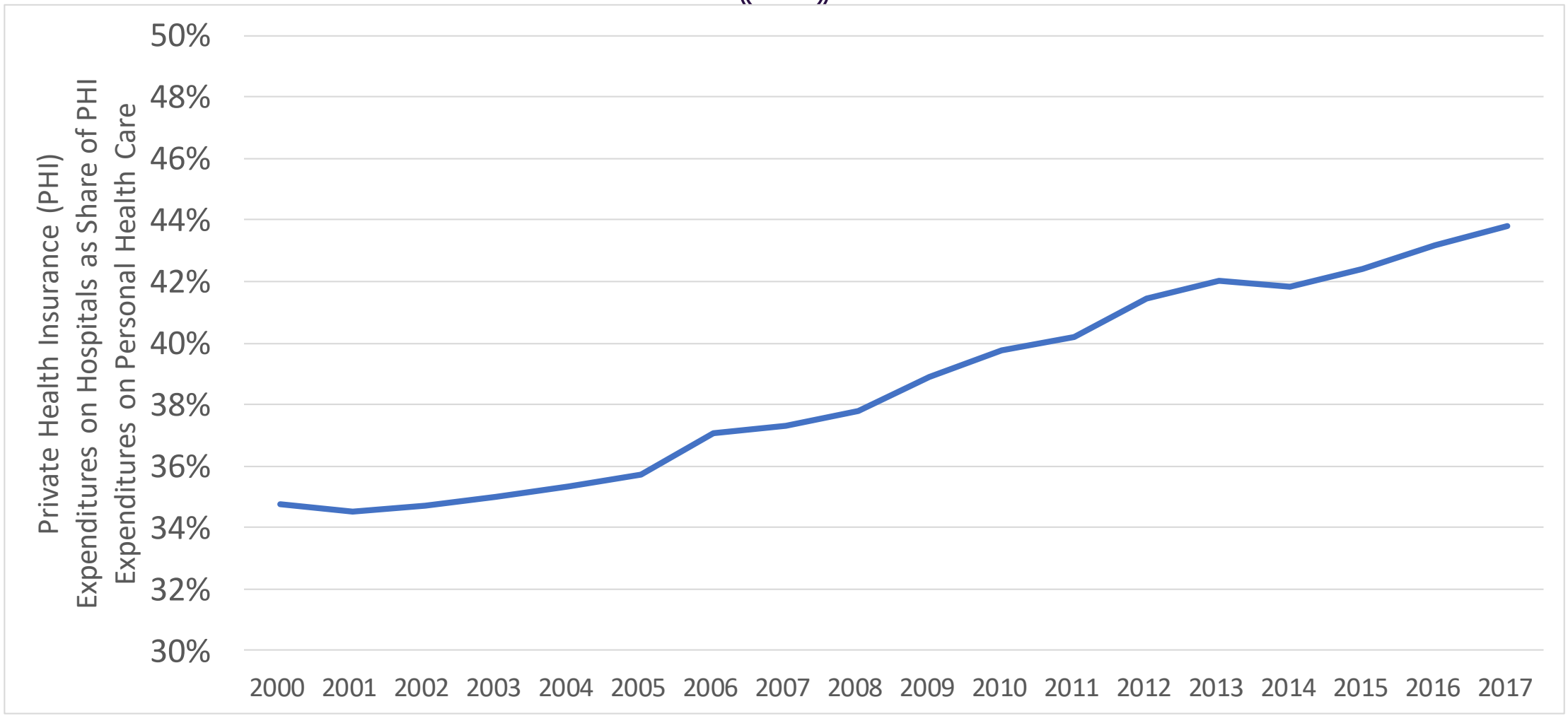
High ACA Exchange Premiums



Note: "Benchmark premium" is the second-lowest silver premium for a 40-year-old nonsmoker.

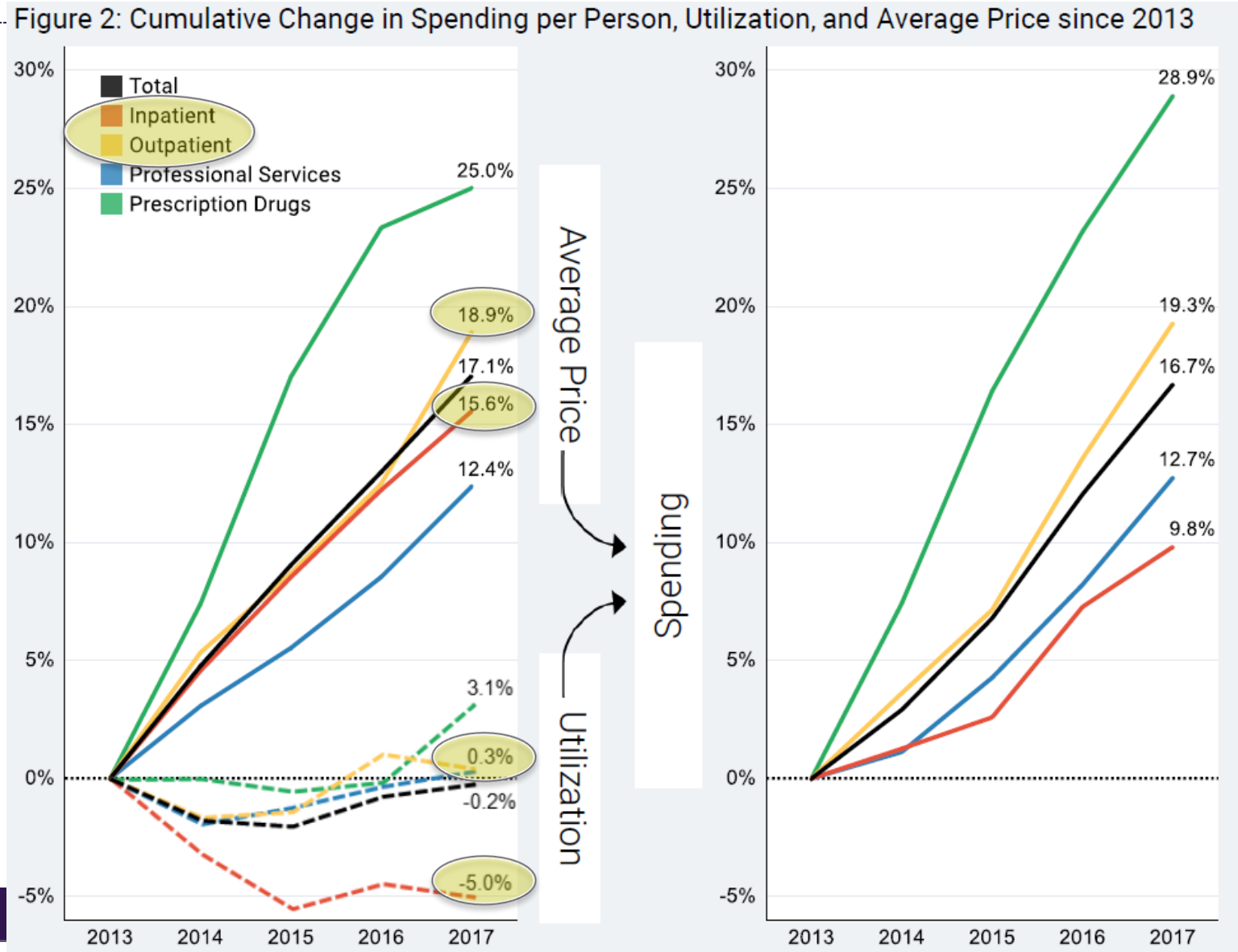
Source: Kaiser Family Foundation, Marketplace Average Benchmark Premiums, 2014-2020, State Health Facts, 2019. https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/

Hospitals Large and Growing Share of Benefits Paid for Privately Insured



Source: Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, Historical NHE Tables, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip, Table 20.

Growth in Spending on Hospital Care for Privately Insured Entirely Due to Price Increases, not Utilization



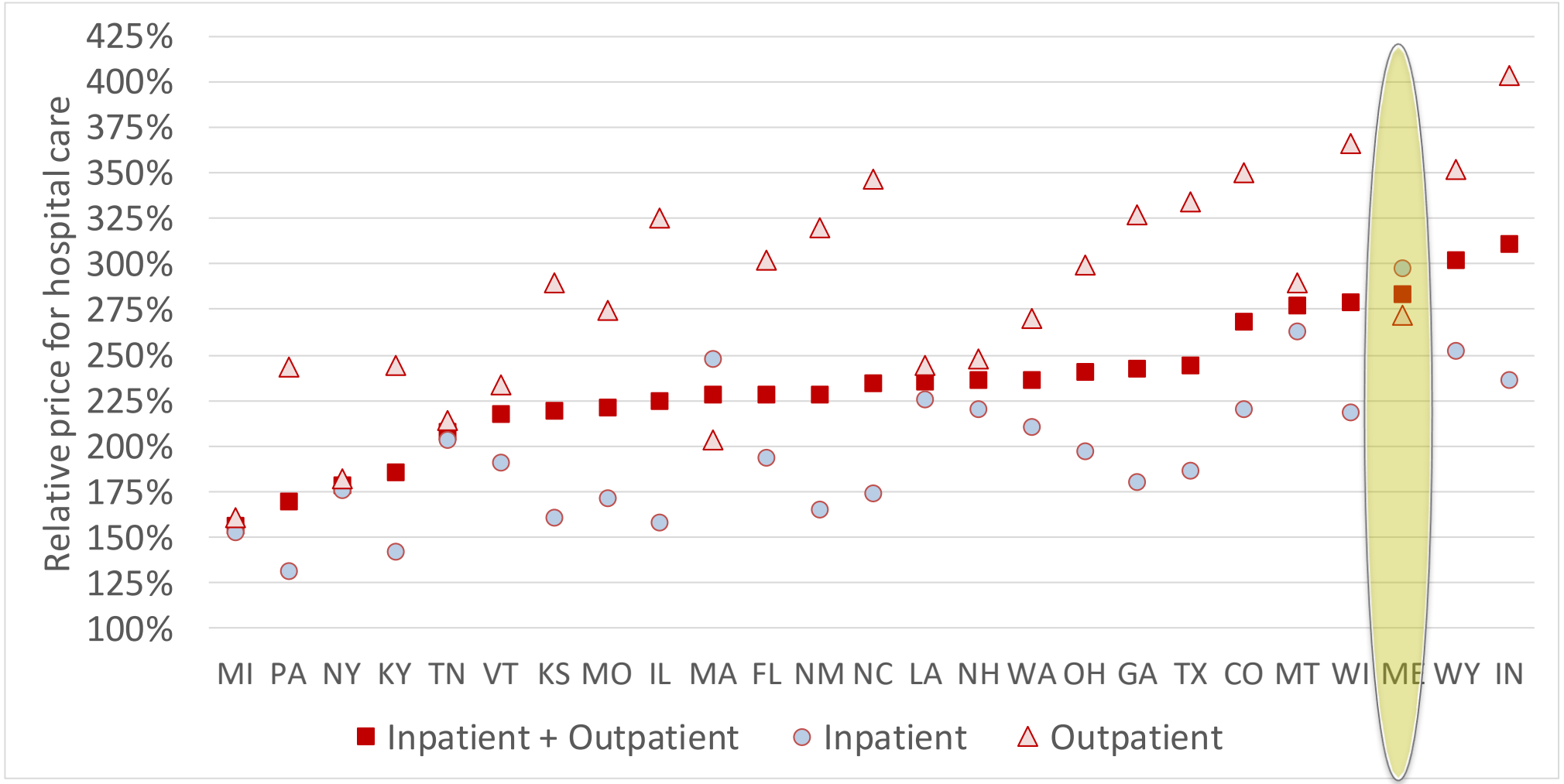
Source: Health Care Cost Institute, 2017 Health Care Cost and Utilization Report, February, 2019. https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report.

Hospital Prices: Key Driver of Growth in Private Premiums

- Premiums = Paid Benefits + Admin/profits
- Paid Benefits = Prices * Quantity – Cost Sharing
- Hospitals: 44% of Paid Benefits for privately insured
- Increasing prices, not quantities, driving growth in hospital spending

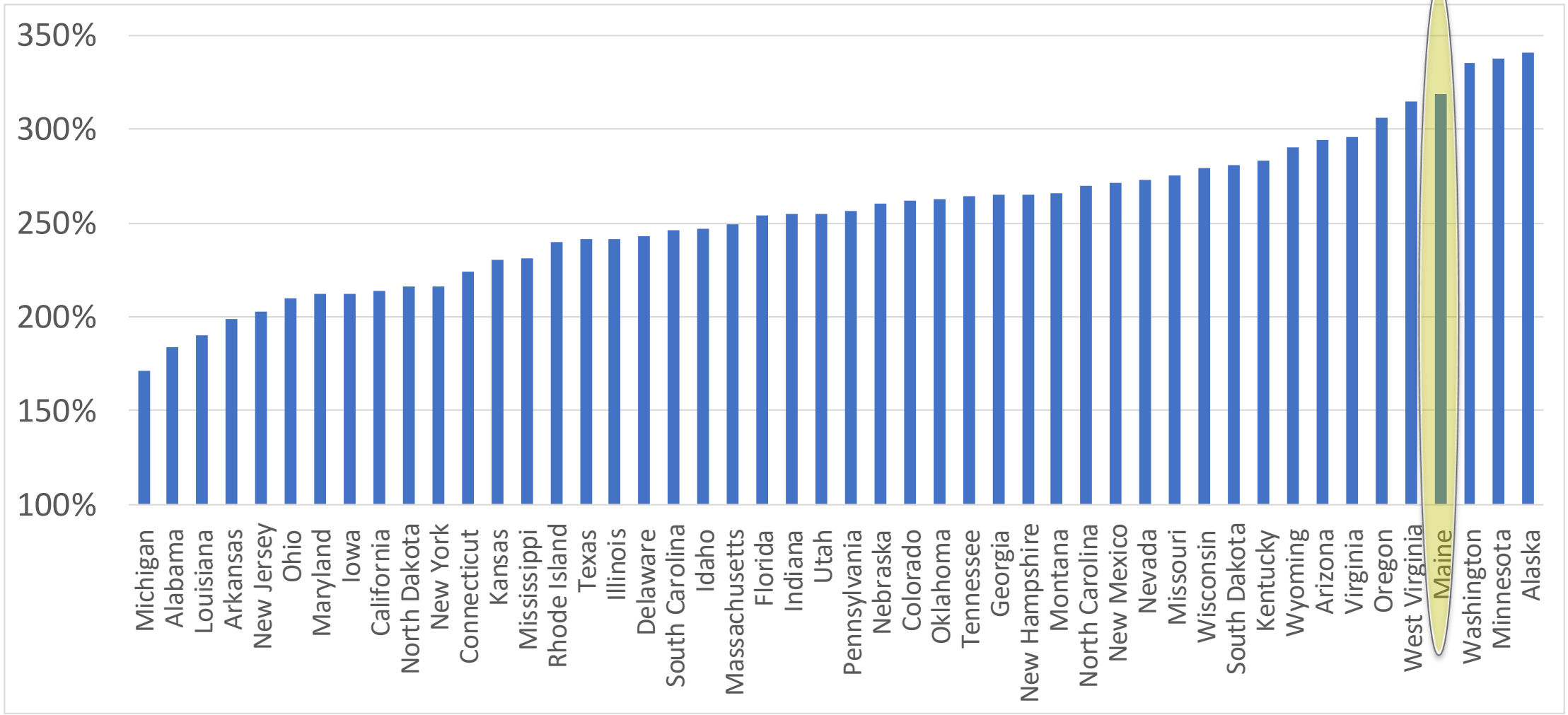
2. Private Prices Relative to Medicare: High and Highly Variable

Hospital Inpatient and Outpatient Prices, RAND "2.0"



Source: White, Chapin, and Christopher Whaley, Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative, 2019. https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.pdf.

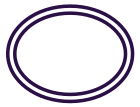
Hospital Inpatient Prices, Johns Hopkins University



Source: Sen, Aditi P., Amber Willink, Allison H. Oakes, Jessica Hale, Matthew D. Eisenberg, Ge Bai, Joshua M. Sharfstein, and Gerard F. Anderson, How Are States Lowering Health Care Prices in the Private Sector: Policy Recommendations to HELP Committee, March 1, 2019.

3. Are High Private Prices Due to "Cost Shifting"?

Definitions

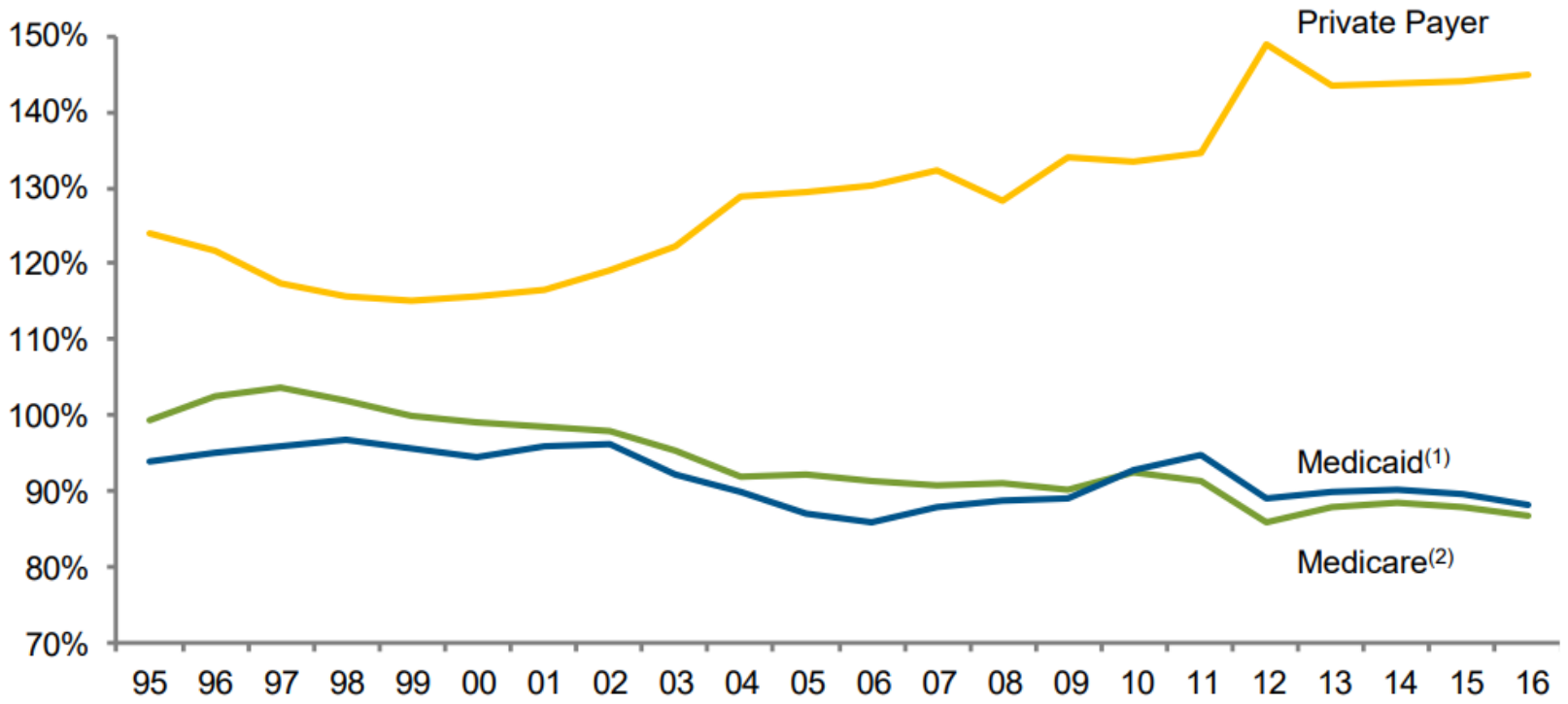


- "Costs": Expenses hospitals incur providing patient care
- "Revenues": Payments to hospitals for providing patient care
- "Payment-to-cost ratio": Ratio of revenues over cost
- "Price": Revenue per service, casemix-adjusted
- "Casemix": Complexity and intensity of services provided

- "Public insurance": Medicare and Medicaid
- "Private insurance": employer-sponsored and ACA exchange

Trends in Payment-to-Cost Ratios

Chart 4.6: Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1995 – 2016

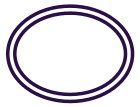


Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.
(1) Includes Medicaid Disproportionate Share Hospital payments.
(2) Includes Medicare Disproportionate Share Hospital payments.

American Hospital Association

Source: American Hospital Association, TrendWatch Chartbook 2018, 2018. https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf.

Interpretations of Divergence in Payment-to-cost Ratios



- "Price discrimination"
  - hospitals are able to negotiate high and growing prices with private insurers because of market leverage
  - high and growing private prices allow hospitals' costs to rise
  - rising costs drive public payment-to-cost ratios lower and lower

- "Cost shifting"
  - hospitals costs' are what they are, and must be reimbursed by insurers
  - because of underpayments by public insurers, hospitals are forced to negotiate high and growing prices with private insurers

Evidence Supports Price Discrimination Interpretation

1. Hospitals' costs are not fixed
   - Hospitals are a not-for-profit industry, hospitals are not cost-minimizers
   - Hospitals facing constrained Medicare prices reduce their costs (White and Wu, 2014)
   - Market power leads to high private prices, high costs, and losses on Medicare (Stensland et al., 2010)

2. Prices paid by private insurers influenced by market leverage on hospital and insurer sides (Cooper et al., 2019)

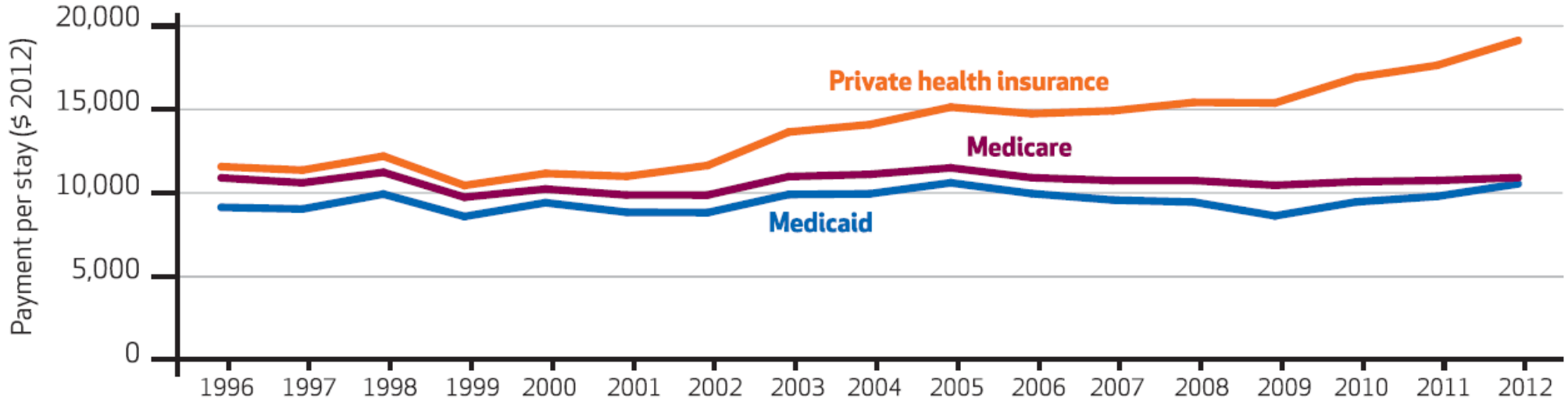
3. Reducing prices paid by public insurers does not increase private prices (White, 2013)

4. Do Public Insurers Underpay, or Do Private Insurers Overpay?

Public Prices for Hospital Inpatient Care Growing In Line With Inflation, Private Prices Rising More Rapidly

EXHIBIT 1

Average Standardized Payment Rates Per Inpatient Hospital Stay, By Primary Payer, 1996–2012



SOURCE Authors' analysis of data for 1996–2012 from the Medical Expenditure Panel Survey. **NOTES** The average payment rates were computed as if each primary payer paid for all nonmaternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays. Estimates and standard errors can be found in online Appendix F and Appendix Table F.1 (see Note 9 in text).

Source: Selden, Thomas M., Zeynal Karaca, Patricia Keenan, Chapin White, and Richard Kronick, "The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care," Health Affairs, Vol. 34, No. 12, 2015, pp. 2147-2150.

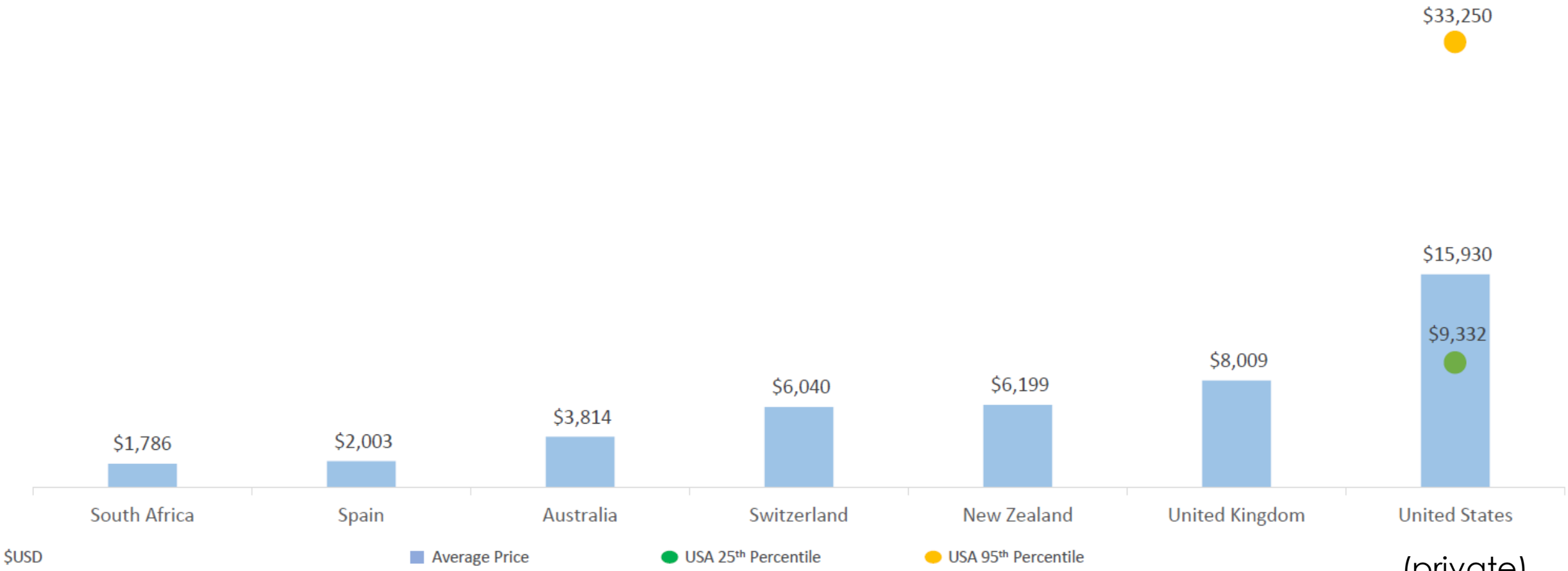
Hip Replacement Prices: Medicare High Relative to International Benchmarks

Hip replacement rate	International range*	Medicare Average	Commercial insurer 25th to 75th percentile
Rate including physician fees	$9,000 to $12,000	$17,000	$25,000 to $88,000
Rate as a share of the average person's wage	20 to 26%	31%	46% to 161%
Rate as a share of the average RN wage (a proxy for input prices)	20 to 26%	24%	36% to 126%

Note: * Range is for the 2nd and 5th highest rates out of six countries: Australia, France, Netherlands, New Zealand, Switzerland, and the United Kingdom. Rates include the amount paid for physician fees.
Source: CMS data on average Medicare hospital payments for joint replacement and data on physician payments. Data on rates in other countries are from the International Federation of Health Plans. All rates are adjusted for purchasing power parity using data from the Organization for Economic Cooperation and Development (OECD). Wage data is from the OECD.

Source: Stensland, Jeff, International Comparison of Rates Paid to Hospitals, Medicare Payment Advisory Commission, October 9, 2014. http://www.medpac.gov/documents/october-2014-meeting-presentation-international-comparison-of-rates-paid-to-hospitals.pdf.

Total Hospital and Physician: Appendectomy



(private)

Source: International Federation of Health Plans, 2015 Comparative Price Report: Variation in Medical and Hospital Prices by Country, 2018. https://fortunedotcom.files.wordpress.com/2018/04/66c7d-2015comparativepricereport09-09-16.pdf.

5. Dysfunctional Hospital Pricing ("The Glitch")

Prices paid to hospitals by private health plans

do not reflect a functioning competitive market

The Three-legged Glitch

Leg 1. bilateral negotiations over prices & networks

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Leg 2. uncapped obligation for out-of-network care

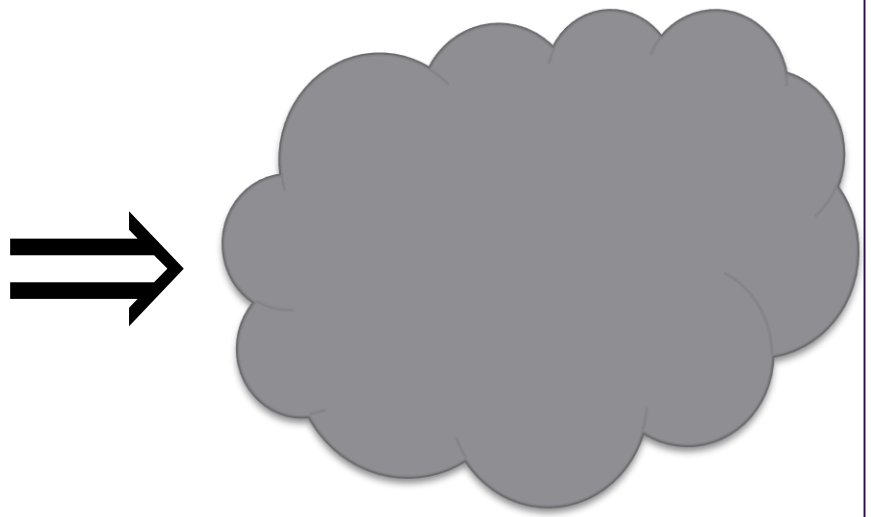
\+

Leg 3. widespread unshoppability

a. natural monopolies

b. humanmade monopolies

c. emergencies



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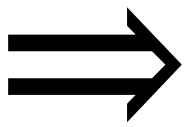


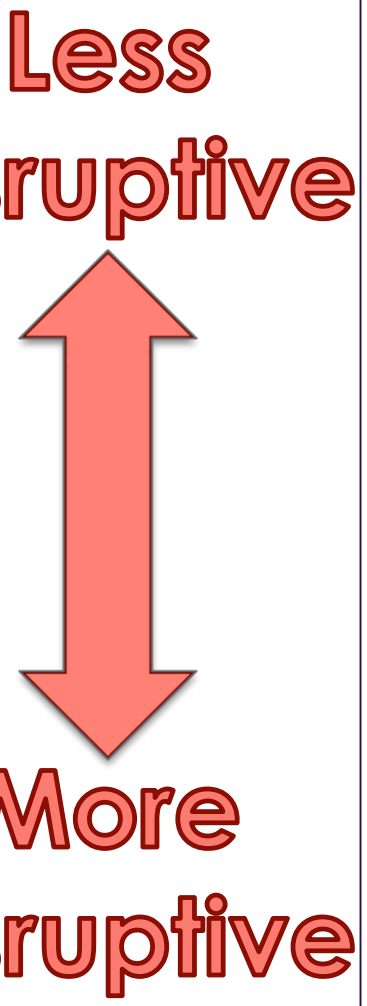
6. What Policy Options Are Available?

Would Boosting Medicaid Payments to Hospitals Reduce Private Premiums?

1. Would reducing private hospital prices reduce premiums?
   - Yes
     - Reduced hospital prices ⇒ reduced paid benefits ⇒ reduced premiums
2. Would private hospital prices fall "naturally"?
   - No
3. Is there an enforcement mechanism to lead to lower prices?
   - No
     - Does Maine regulate private hospital prices or total revenues from private insurers?
     - If so, are regulated limits on private hospital prices/revenues based directly on Medicaid shortfall?

More versus Less Disruptive Approaches

- State employee health plans limit prices they pay (MT, OR)
- State limits on payments for out-of-network care (CA)
- State regulation of health plan contracts with hospitals (RI, MI)
- State-based public option (WA)
- Medicare buy-in
- Direct state rate regulation (MD)
- State-based single payer (proposals in NY, OR)
- Medicare for All

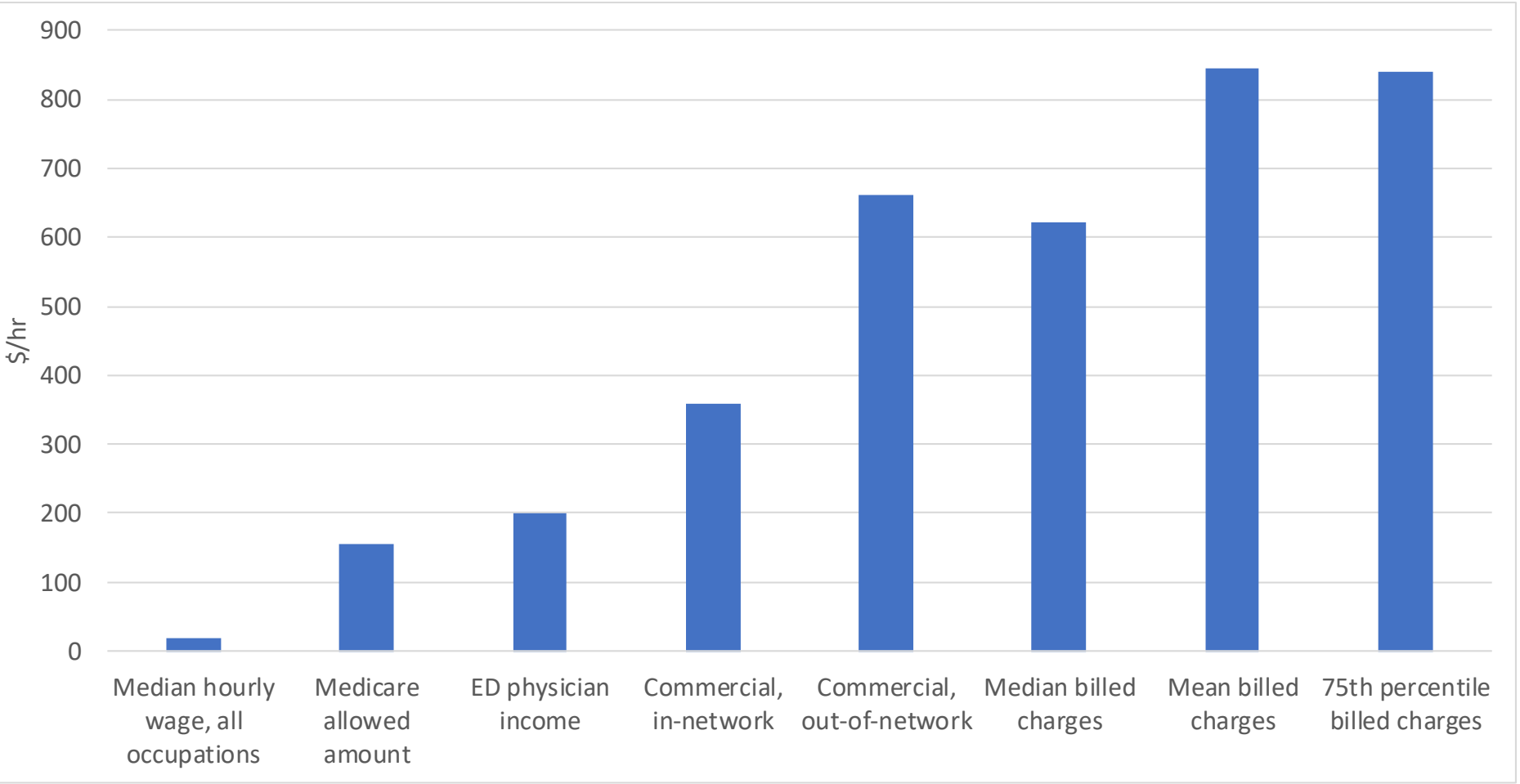


Baum, Aaron, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu, "Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers," *Health Affairs, Vol. 38, No. 2, 2019, pp. 237-245.*

7. Limiting Payments for Out-of-Network Care (Leg 2 of "The Glitch")

Tradeoffs from Provider Perspective

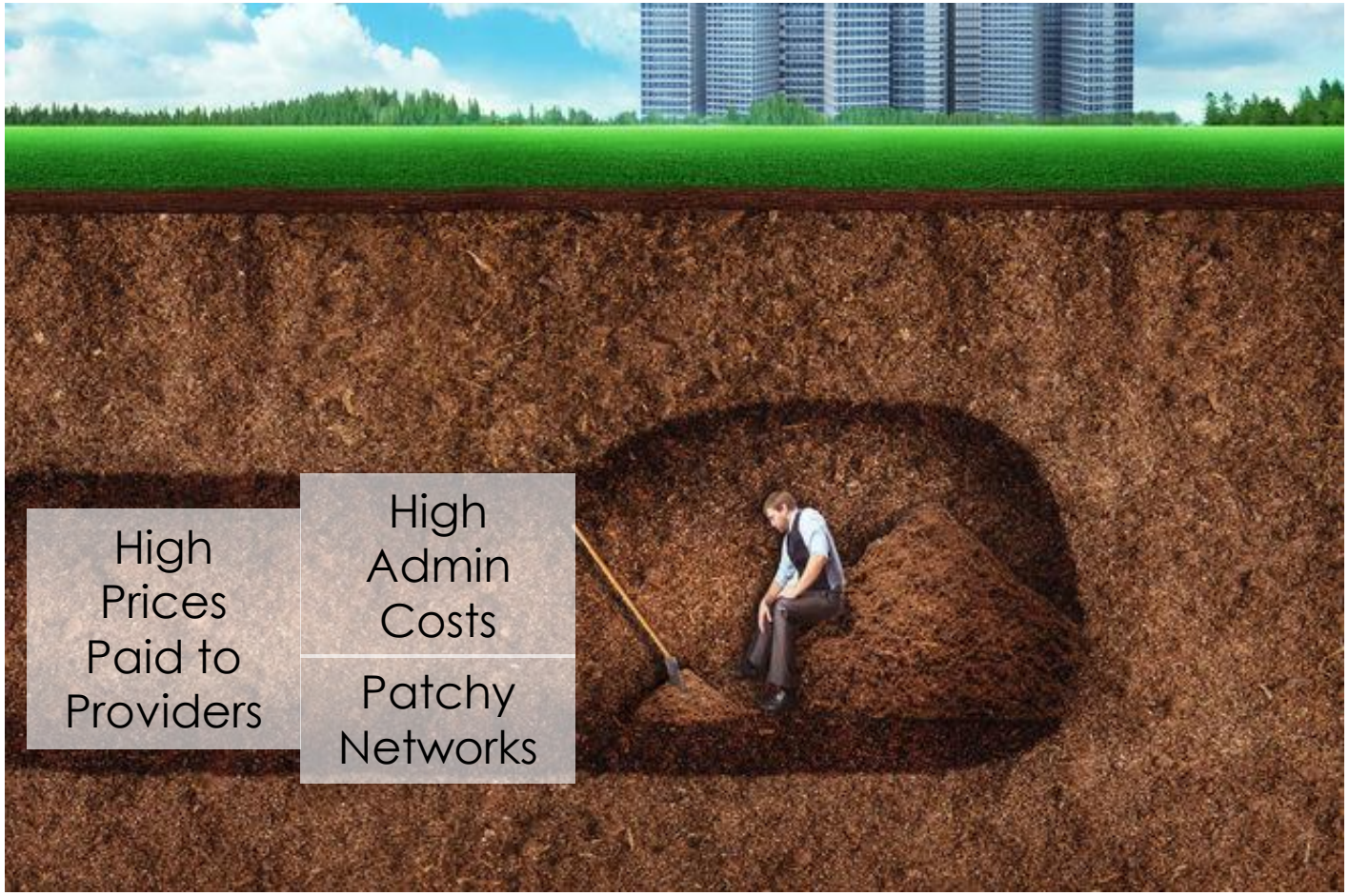
What's A Fair Hourly Rate for an Emerg Dept Physician?



Based on CPT 99284 (ED visit, high severity), assuming 6906 wRVUs per 2000 hours worked (https://www.beckershospitalreview.com/compensation-issues/2015-physician-compensation-work-rvu-by-specialty.html).

Sources:
Median hourly wage: https://www.bls.gov/oes/current/oes_nat.htm
Medicare allowed amount, and mean billed charges: http://www.cms.gov/apps/ama/license.asp?file=https://downloads.cms.gov/files/Medicare-National-HCPCS-Aggregate-CY2016.zip
ED physician income: https://www.acepnow.com/article/emergency-physicians-2016-2017-compensation-report-shows-lack-standardization-specialty/
Commercial in- and out-of-network rates: Pelech, D. (2018). An Analysis of Private-Sector Prices for Physicians' Services (Working Paper 2018-01). Retrieved from https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf
Median and 75th percentile billed charges: Bai, G., & Anderson, G. F. (2017). Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. JAMA, 317(3), 315. doi:10.1001/jama.2016.16230

If You Find Yourself In A Deep Hole, Stop Digging



- Independent dispute resolution benchmarked to "UCR" or charges
  - increases prices and premiums
  - adds administrative costs
  - encourages providers to remain out of network


Surprise Bills
Unshoppable Care
/
Excess Pricing

Broad-Based Out-of-network Guardrail

Because of Out-of-Network Guardrail, Private Medicare Advantage Plans Pay ~ Medicare Rates

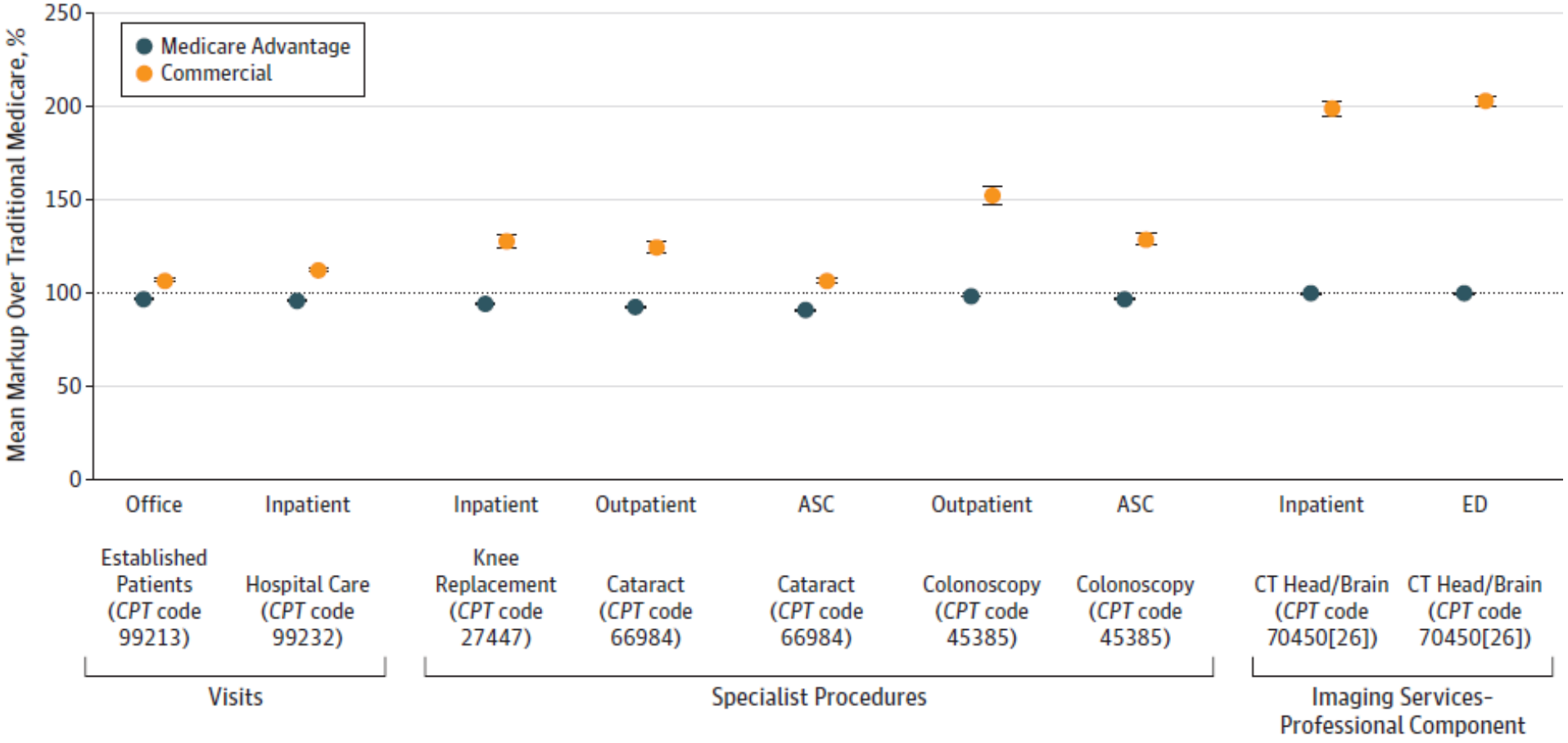
The Reduced Importance of FFS Provider Payment Rates. CBO's assessment of the importance to private plans of FFS payment rates is based on the observation that, on balance, the rates paid for Medicare Advantage enrollees are similar to or slightly above those that Medicare pays for FFS patients' care—even though providers receive substantially higher amounts when they offer the same services to patients in commercial plans focused on the under-65 population.[8] The exact cause of the difference is not known, but it appears to arise in part because private

Through these interviews, we found with rare exception, in our sample of MA plans and hospitals, that MA inpatient and outpatient prices were at or slightly above traditional Medicare payment levels and that the cited explanations for these much-lower-than-commercial payment rates included Medicare statute [section 1866(a)(1)(o) of the Social Security Act], de facto budget constraints, and market equilibrium related to how insurance markets historically work across

Sources: Congressional Budget Office, A Premium Support System for Medicare: Analysis of Illustrative Options, 2013. http://www.cbo.gov/publication/44581. Berenson, Robert A., Jonathan H. Sunshine, David Helms, and Emily Lawton, "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices," Health Affairs, Vol. 34, No. 8, 2015, pp. 1289-1295.

Because of Out-of-Network Guardrail, Private Medicare Advantage Plans Pay ~ Medicare Rates

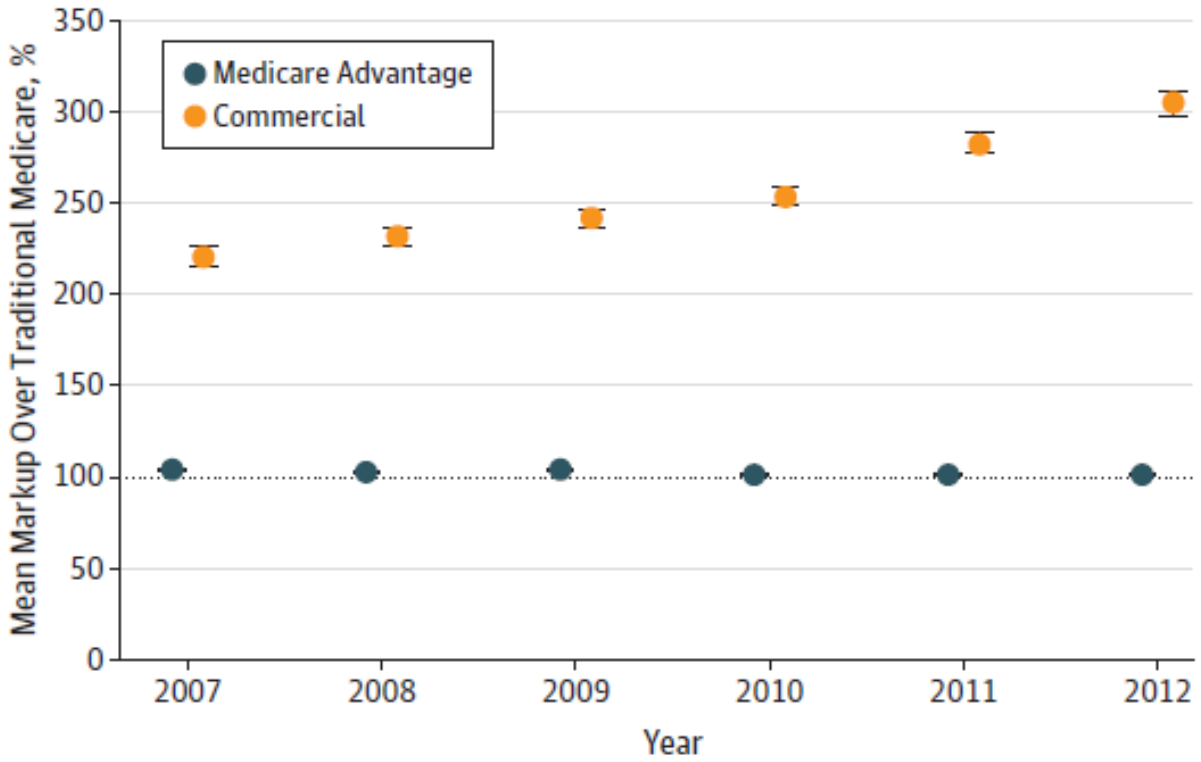
Figure 1. Mean Markup Over Traditional Medicare for Physician Services, for Medicare Advantage and Commercial Patients



Source: Trish, Erin, Paul Ginsburg, Laura Gascue, and Geoffrey Joyce, "Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance," JAMA Intern Med, Jul 10, 2017. https://www.ncbi.nlm.nih.gov/pubmed/28692718

Because of Out-of-Network Guardrail, Private Medicare Advantage Plans Pay ~ Medicare Rates

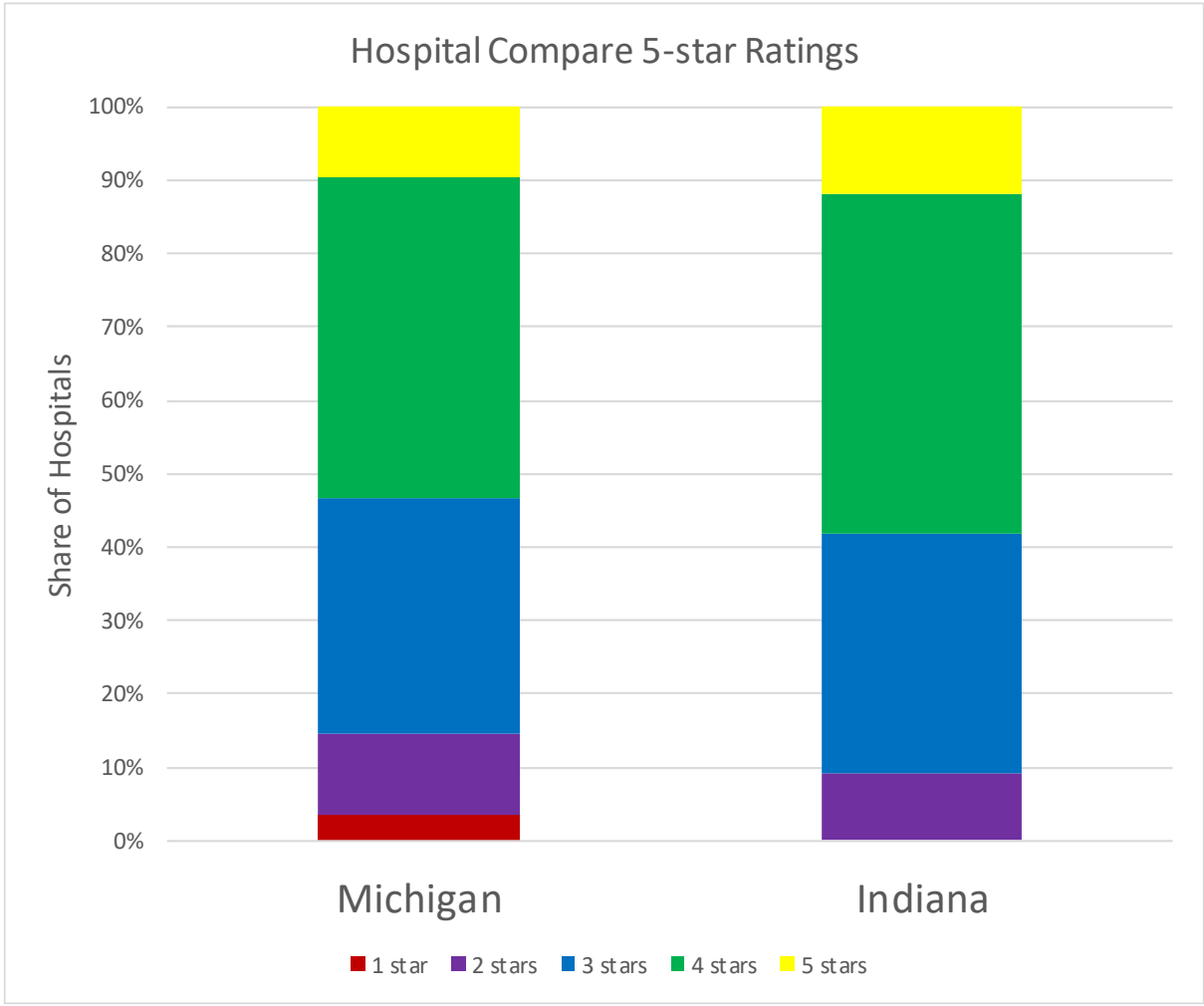
Figure 4. Mean Markup Over Traditional Medicare for Physician Visits in the Emergency Department, for Medicare Advantage and Commercial Patients

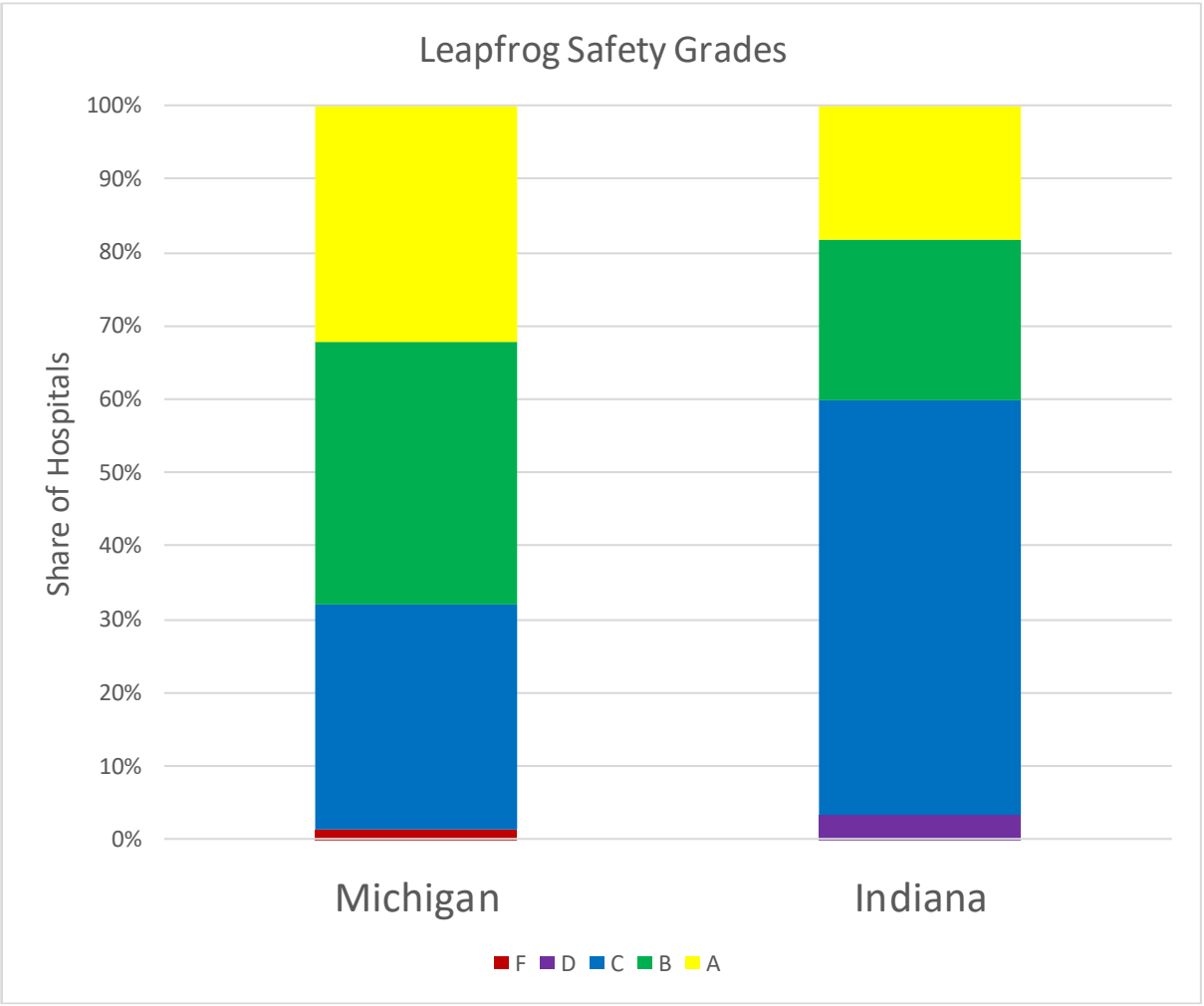


Source: Trish, Erin, Paul Ginsburg, Laura Gascue, and Geoffrey Joyce, "Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance," JAMA Intern Med, Jul 10, 2017. https://www.ncbi.nlm.nih.gov/pubmed/28692718

8. Can Hospitals Survive on Lower Private Prices?

Hospitals in Michigan Paid Much Lower Private Prices than in Indiana, Quality Comparable

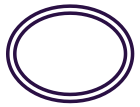




Source: Author's analysis using Leapfrog Group, How Safe is Your Hospital?, 2019. https://www.hospitalsafetygrade.org/search?findBy=state&zip_code=&city=&state_prov=IN&hospital=.; and Centers for Medicare & Medicaid Services, Hospital Compare Datasets, .CSV Flat Files, April 24, 2019. https://data.medicare.gov/views/bg9k-emty/files/8501dcb3-c93d-4e1e-b99a-a594a9e4458f.

Wrapup

Wrapup



1. Rising hospital prices at heart of affordability crisis for privately insured
2. "The Glitch" → pricing dysfunction
3. Policy options are available
4. Reasonable (***not charge-based***) limits on payments for out-of-network care
   - effective
   - less disruptive than other options
5. Hospitals ***on the whole*** can survive on lower private prices
   - rural hospitals face many challenges

Glitch Tests

Health plan	Medicare Advantage	Medicare Advantage	Medicare Advantage	Private employer-sponsored	Private employer-sponsored	Private employer-sponsored
Provider type	Primary care MDs	Hospitals	Emerg. Dept. MDs	Primary care MDs	Hospitals	Emerg. Dept. MDs
Leg 1. negotiated	✓	✓	✓	✓	✓	✓
Leg 2. uncapped OON				✓	✓	✓
Leg 3. unshoppability		✓	✓		✓	✓
Glitch?	No	No	No	No	Yes	Yes

Sources

- Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*," The Quarterly Journal of Economics, Vol. 134, No. 1, 2019, pp. 51-107. https://academic.oup.com/qje/article-abstract/134/1/51/5090426.
- Stensland, Jeffrey, Zachary R. Gaumer, and Mark E. Miller, "Private-Payer Profits Can Induce Negative Medicare Margins," Health Affairs, Vol. 29, No. 5, 2010, pp. 1045-1051. http://content.healthaffairs.org/cgi/content/abstract/29/5/1045.
- White, Chapin, "Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates," Health Affairs, Vol. 32, No. 5, May, 2013, pp. 935-943. http://content.healthaffairs.org/content/32/5/935.abstract.
- White, Chapin, and Vivian Yaling Wu, "How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices?," Health Services Research, Vol. 49, No. 1, February, 2014, pp. 11-31. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12101/abstract.