HEALTH CARE
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Health Care Prices: A National Perspective

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Hearing on the Potential Modification of the 2023 Health Care Cost Growth Benchmark

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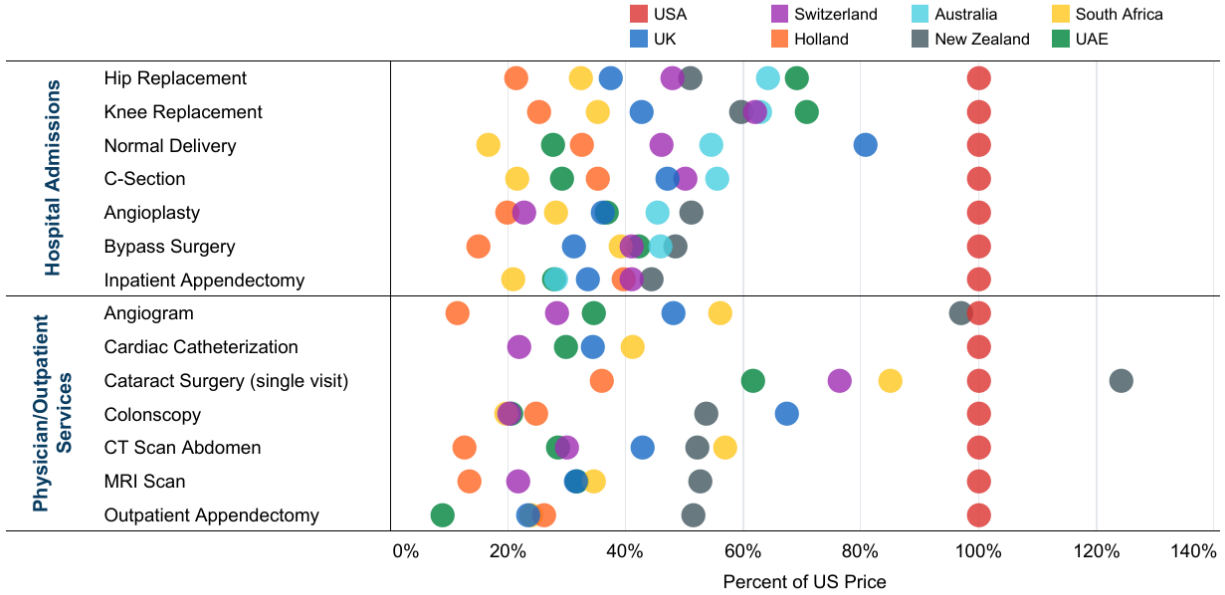
Agenda

- The role of prices in driving spending nationally and why high prices matter
- A closer look at prices:
  - Rising prices for services where use is declining
  - The significant and growing differential between commercial prices and Medicare rates
  - Disparate prices across settings for the same services
  - Substantial variation in price within systems
  - Impact of private equity acquisition on prices
- What is driving prices up and what are the options for state policymakers to reduce prices?
- Wrap-Up: A long view of prices and health care spending

Prices: High and Highly-Variable

- Higher prices than other countries
- Significant variation in prices for the same services:
  - Within markets (across hospitals, payers)
  - Within hospitals (across payers)
  - Within systems (across hospitals)
  - Across settings (physician office vs. outpatient)
  - Across payers (commercial vs. Medicare)
- Link between price and quality is not clearly established and varies across markets and hospitals – many high-quality hospitals with relatively lower prices
- Price variation not explained by patient severity/casemix

Figure 1: Medical Prices in 2017 as a Percent of US Prices



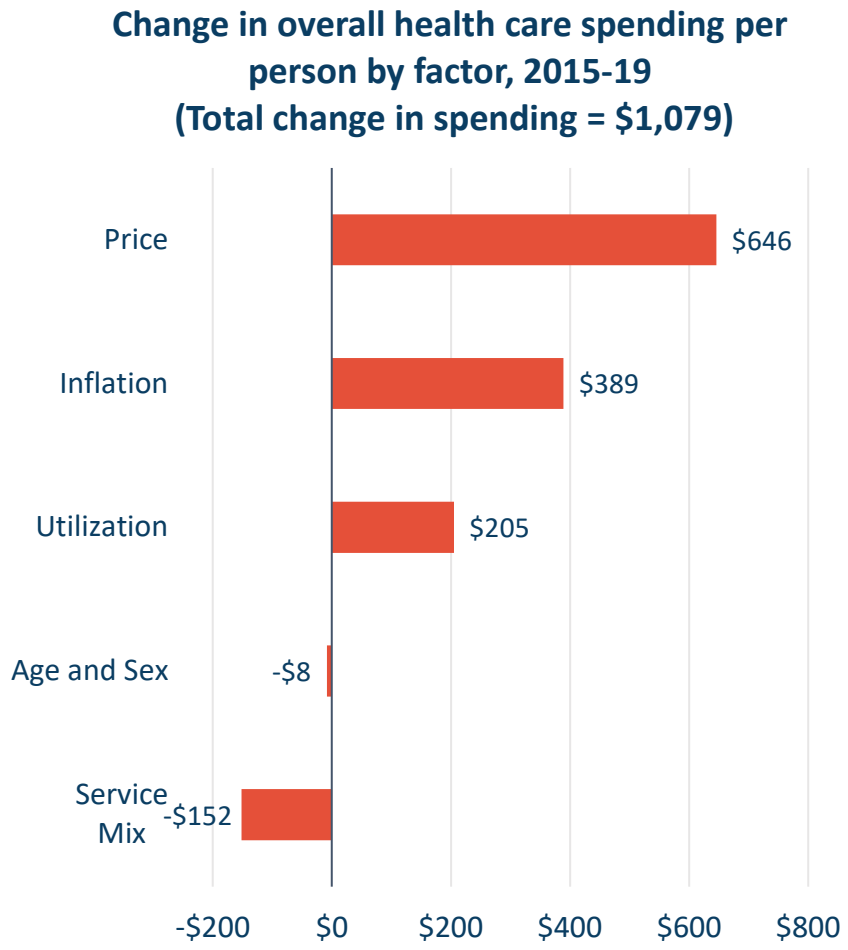
HCCI International comparisons of health care prices from the 2017 iFHP survey (2019)

Why do high prices matter?

- Barrier to accessing needed care
- Translate to higher premiums, less generous insurance, lower wages
- Exacerbate inequities in health care access and outcomes
  - Low-income individuals spend a substantially greater proportion of income on out-of-pocket costs for health care services and health insurance (e.g., premiums, deductibles)
  - About half of households do not have enough liquid assets to pay a typical employer plan deductible and almost two in three households do not have enough resources to cover a higher-end deductible of private health plans (KFF 2022)
- Affect structure of health care markets and firms
- Divert resources away from other sectors
- Incentive to create work-arounds that have broader implications for consumer access as well as health care markets and spending, e.g., drug copay coupons

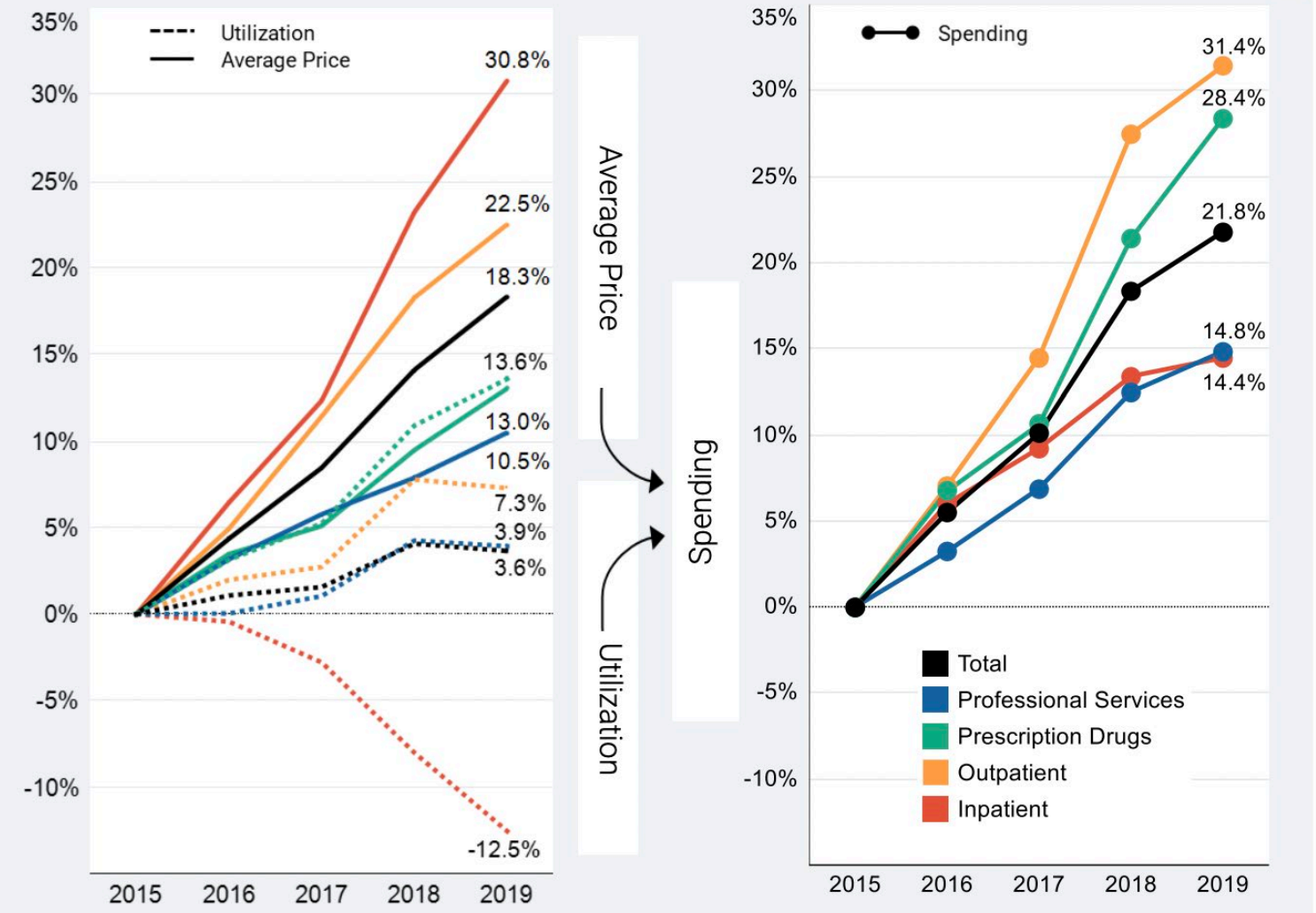
Growing price pressure driving up health care spending

- In 2019, average annual health care spending on inpatient, outpatient, and physician services + prescription drugs for people with employer-sponsored insurance was $6,001
- From 2015 to 2019, spending grew 22%
- ~2/3 of the increase was due to growth in service prices



Prices up across services, driving spending

Figure 4: Cumulative Change in Spending per Person, Utilization, and Average Price by Service Category

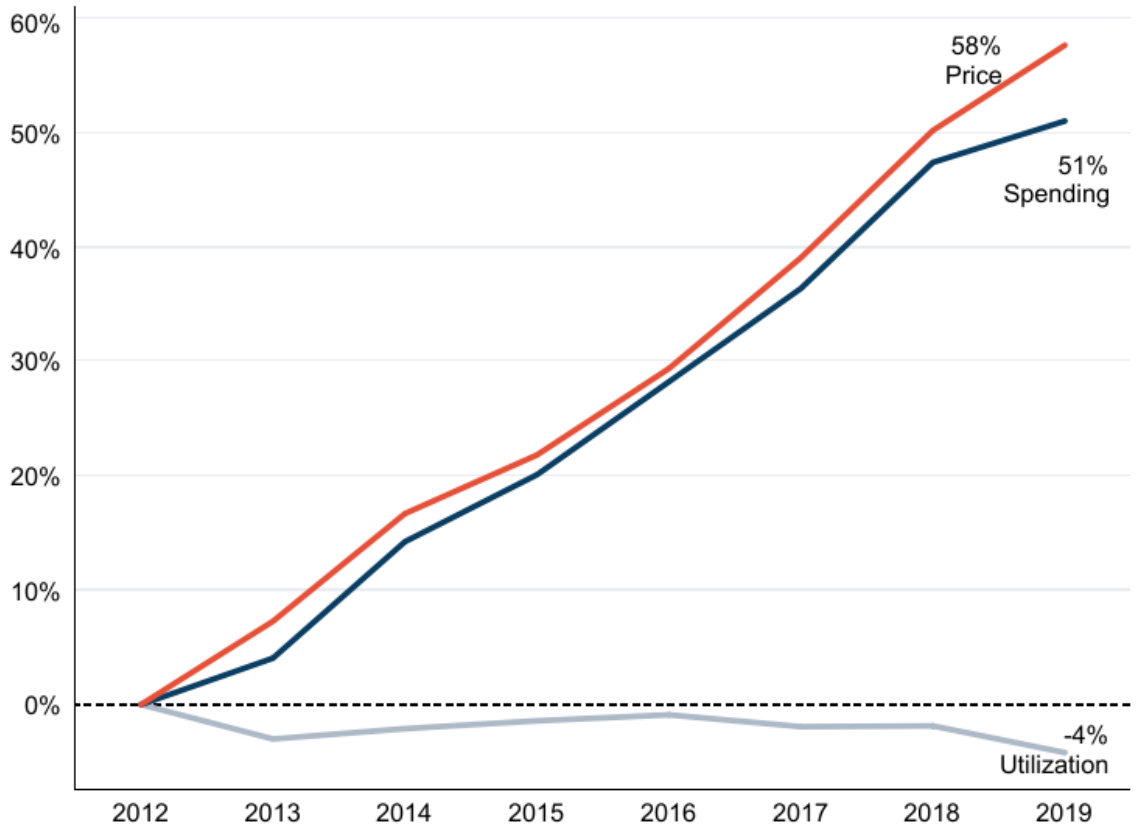


Note: All numbers presented in charts are available as downloadable data tables.

A closer look at prices: Rising prices for services where use is declining

- Inpatient services
  - Utilization down 12.5% (2015-19)
  - Prices up 31% → spending up 14%
- ER services
  - Utilization down 4% (2012-19)
  - Prices up 58% → spending up 51%
  - Coding of ER visits has shifted towards more severe, higher priced codes.
- Physician-administered drugs
  - Average price of administered drug nearly doubled over 2014-18 ($470 to $813).
  - The increase in spending on administered drugs accounted for 39% of the increase in spending on physician services (2014-18)

Figure 1: Cumulative Change in National **Spending**, Utilization, and **Price** of All ER Visits from 2012 to 2019

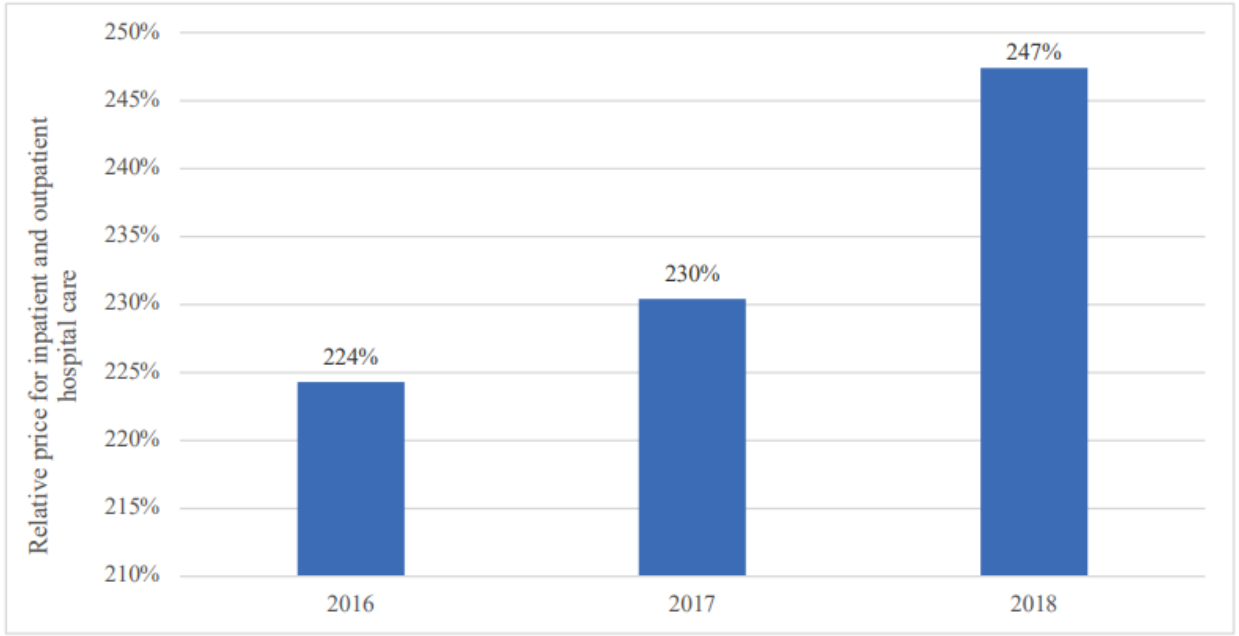


HCCI "Ouch!: New Data reveals ER spending increased by 51% from 2012 – 2019, with patient out of pocket payments increasing by 85%" (2021); HCCI 2019 Health Care Cost and Utilization Report; HCCI 2018 Health Care Cost and Utilization Report

A closer look at prices: Commercial vs. Medicare

- Prices paid by private health plans are higher and growing faster than Medicare
  - Commercial insurers paid 247% of what Medicare would have paid for the same services at the same facilities.
  - Up from 224% in 2016
- Over 50% of inpatient admissions were paid above 150% of Medicare; almost 33% paid above 200%
- Medicare is a useful benchmark – not necessarily an endpoint for prices
  - Medicare rates are comparable across hospitals and take into account regional factors and clinical factors
  - Process for setting Medicare (administered) prices is transparent

Figure 4.1. All-State Trends in Relative Prices

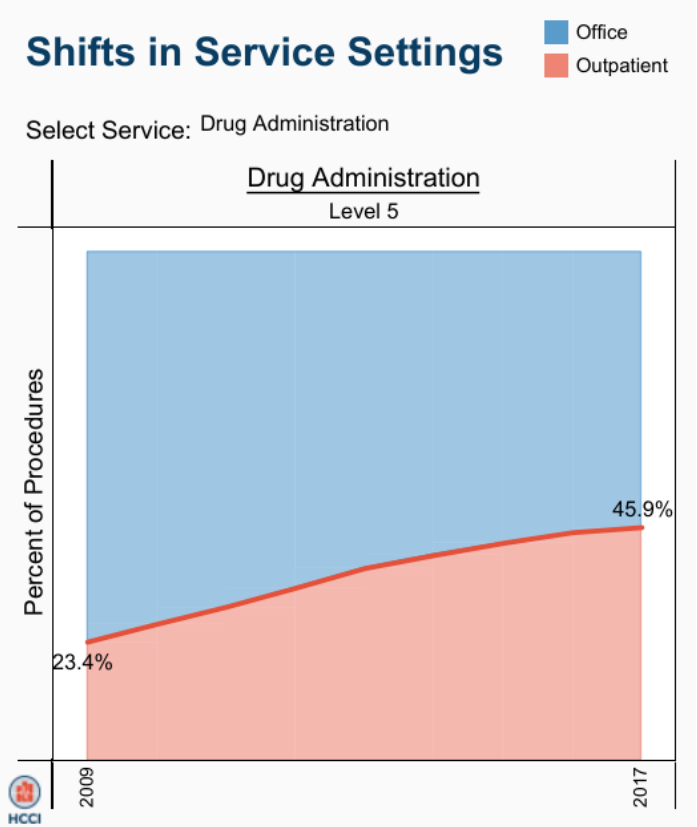


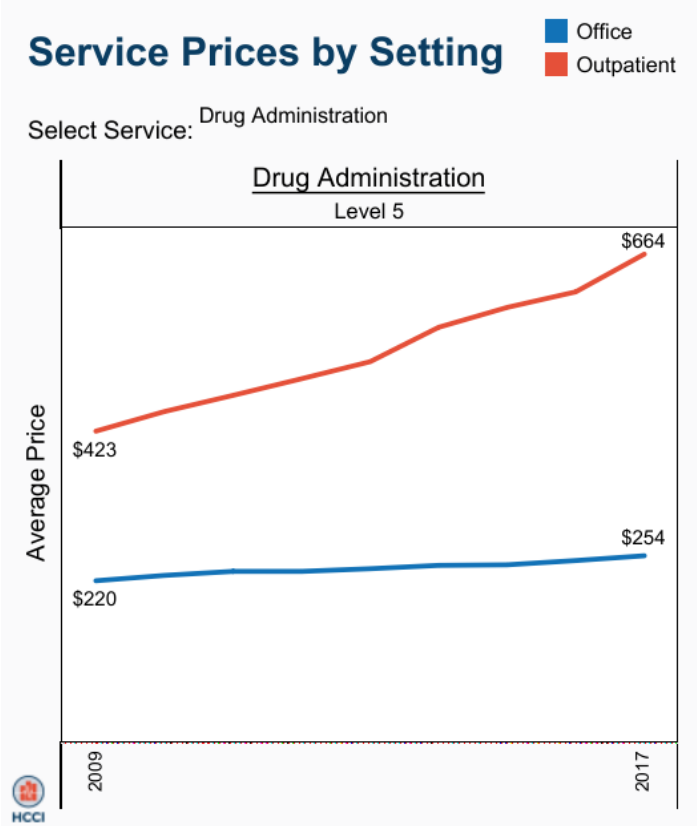
NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. Prices include prices for inpatient and outpatient services and group facility and professional fees.

RAND "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative." 2020.
KFF "Half of Admissions in the Large Group Market Are Paid Above 150% of Medicare Rates, Excluding Maternity Admissions." 2022.

A closer look at prices: Across settings

- We examined 46 services provided in both outpatient and office settings determined by MedPAC to be safe and appropriate when provided in an office.
- Outpatient prices were higher for every service in every year than the price for the same service provided in an office setting.
- Services are increasingly shifting from office to outpatient settings



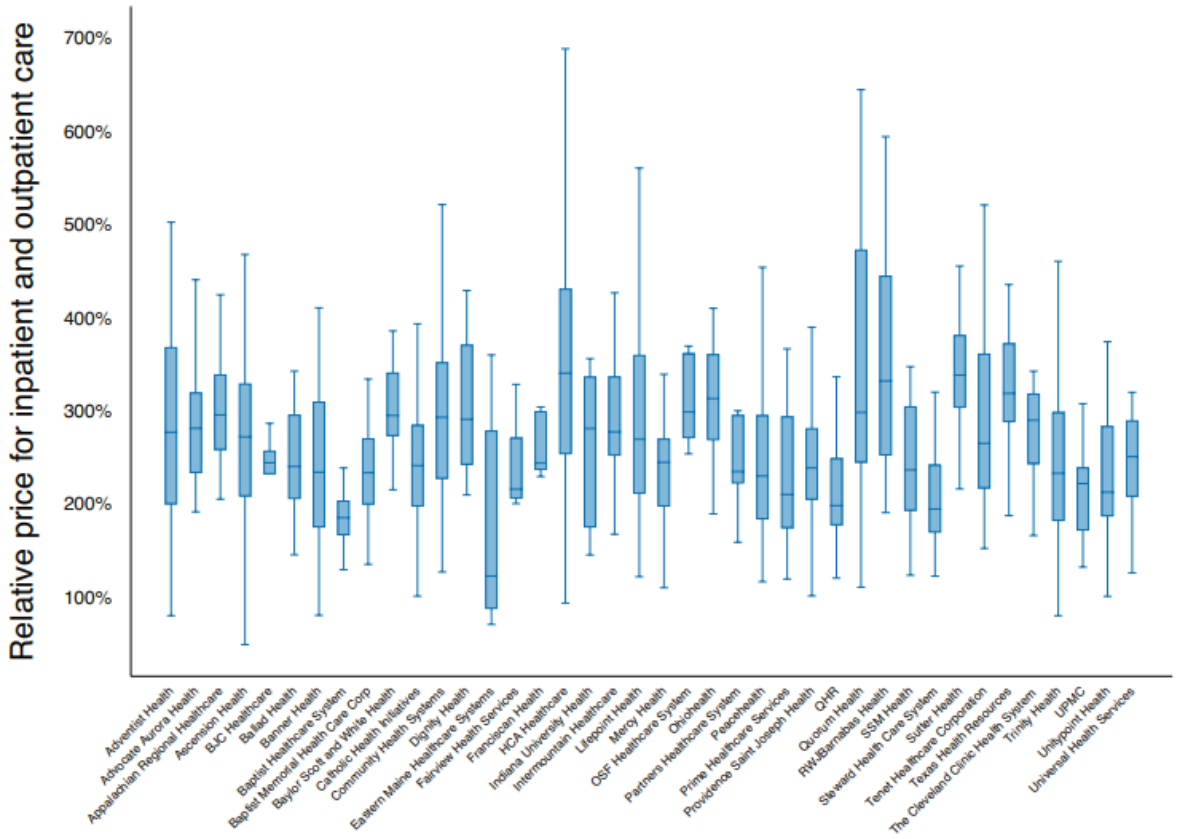


HCCI "Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices" 2019

A closer look at prices: Within systems

- Wide variation in hospital prices across many large systems
- In the average system, the hospital with the 75th percentile price has prices 32% higher than the hospital with the 25th percentile price – suggesting that prices vary more within a system than across systems

Figure 4.4. Distribution of Relative Prices, by Hospital System, 2016–2018



NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. For each hospital system, this figure denotes the 25th-percentile, median (50th-percentile), and 75th-percentile relative prices for hospitals in the system. Only systems with ten or more hospitals included.

RAND "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative." 2020.

A closer look at prices: Impact of private equity acquisition

- Among acute care hospitals acquired by PE firms (Bruch, Gondi, Song, 2020):
  - Increases in hospital charges and charge to cost ratios
  - Increases in case mix index (upcoding?)
  - Reduction in percent of patients discharged covered by Medicare (suggests increase in percent covered by private insurance)

- Among dermatology practices acquired by PE firms (Braun et al., 2021):
  - Prices paid to PE dermatologists for routine medical visits were 3–5% higher than those paid to non-PE dermatologists

- Among anesthesiologists after an outpatient facility contracted with the physician management company (La Forgia et al., 2022):
  - Allowed amounts increased by 16.5%
  - Unit price increased by 18.7%
  - When physician management company was PE-backed, prices rose 26% (vs. 13% when not)

Upward Pressure on Prices

- Increasing consolidation
  - Horizontal and vertical integration associated with higher prices
- Growing role of private equity
- Limited leverage by insurers, employers
  - We found that large self-insured employers had concentrated market power in very few areas (Eisenberg et al., 2021)
  - The mean value of our employer market power measure was **62** for 2016, compared with the mean value of **5410** for hospital market power.
- Though increased prices translate into higher premiums, effects are dampened because
  - Premium contributions by employer vs. employee may not be salient to individuals
  - Premium contributions are generally excluded from taxes
- Links between higher provider rates and labor market outcomes such as wages, health insurance offerings (e.g., narrower benefits) are indirect

What actions are state policymakers taking to lower prices?

Indirect Approaches

- Price transparency
- Cost growth benchmarks
- Insurance regulation/design (e.g., rate review, tiered networks, reference pricing)
- Improving provider market competition

Direct Approaches

- Price caps/regulation for specific:
  - Populations (e.g., state employees, public option enrollees)
  - Services (e.g., out-of-network, facility-based)
  - Providers (e.g., high priced)

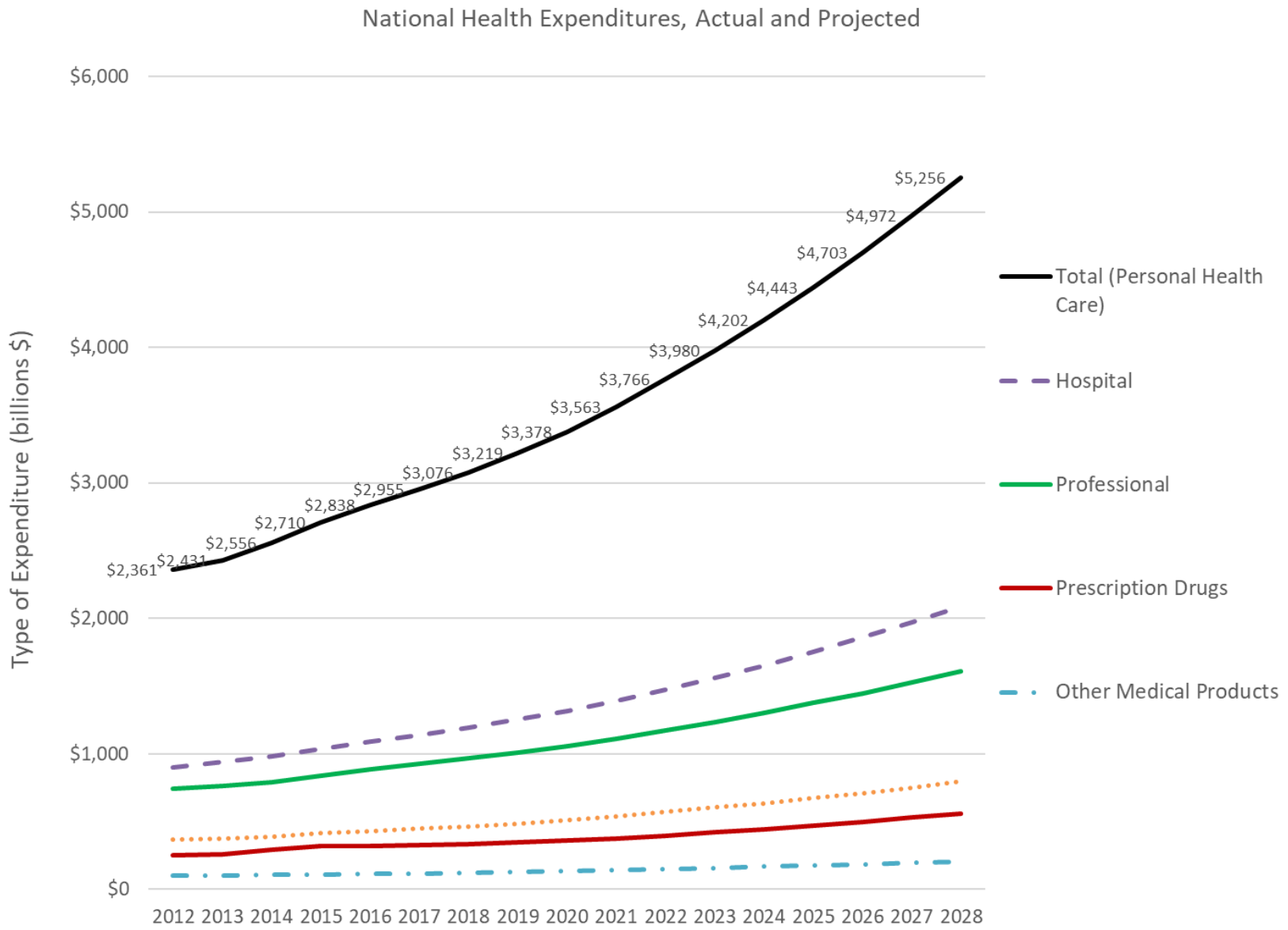
In any context, need to consider options for structure and level of cap

→ Central role of data and analyses in these efforts; MA data and capacity to use data for policy design/implementation is a model for many other states

States actions range from indirect to direct

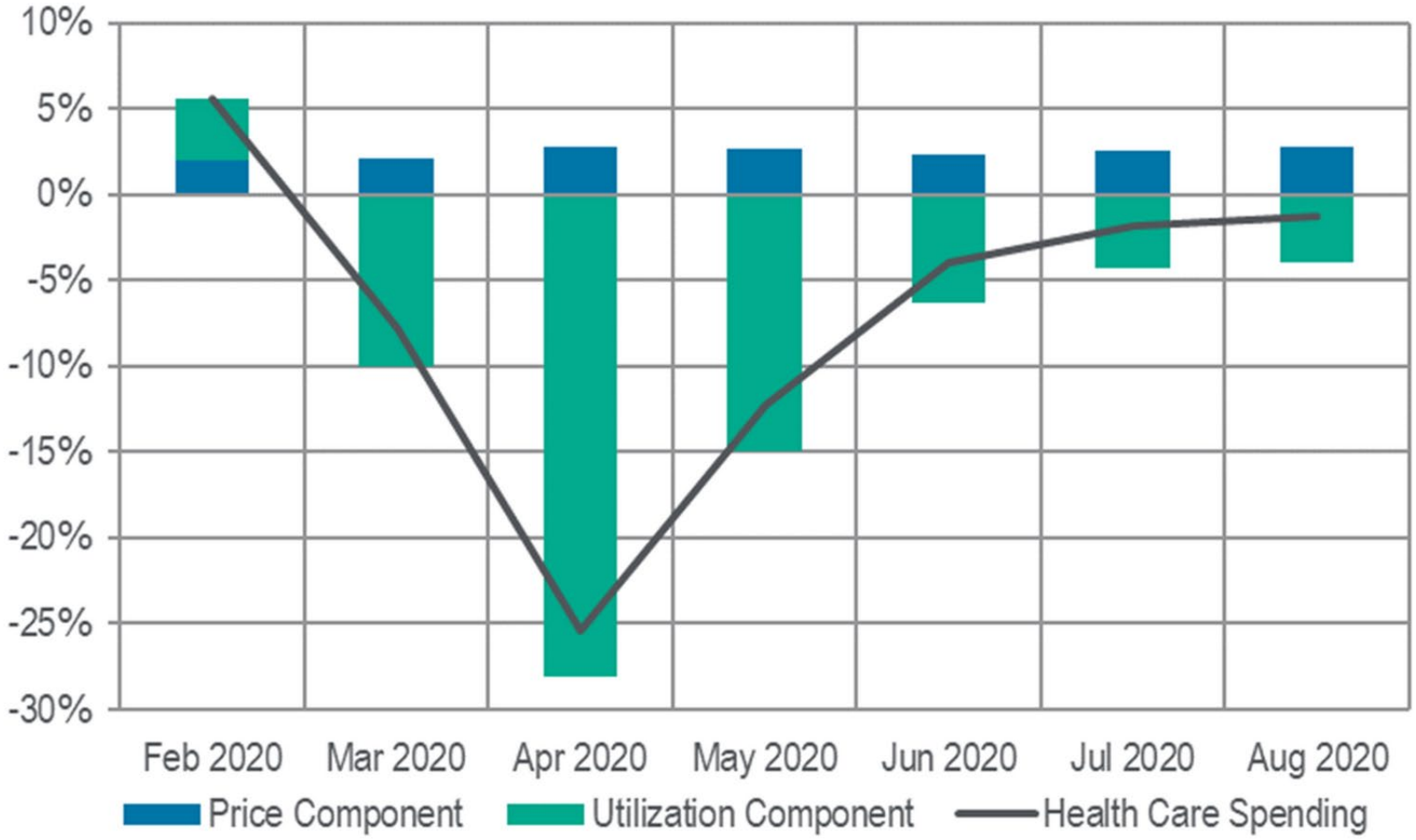
Health care spending benchmarks	MA, DE [3%], RI [3.2%], OR [3.4%], CT [2.9%], WA [TBD]
Health insurance rate review and approval process	Ex: RI imposes inflation caps and diagnoses-based payments on insurer-provider contracts
Premium reduction requirements in a public option	CO: 5% premium reduction for 2023 NV: 5% prem reduction + inflation cap
Regulating rates for out-of-network health care services	Lots of states, mix of payment standards, with implications for overall effects on rates
Benchmarking prices to Medicare in public option	Aggregate reimbursement cap at 160% Medicare in WA public option program
Benchmarking prices in state employee plans	Reference-based pricing to Medicare in MT, OR plans → reported savings

Wrap-up: A long view of health care spending and prices



Office of the Actuary, Centers for Medicare and Medicaid Services

Prices increased even as use fell in 2020

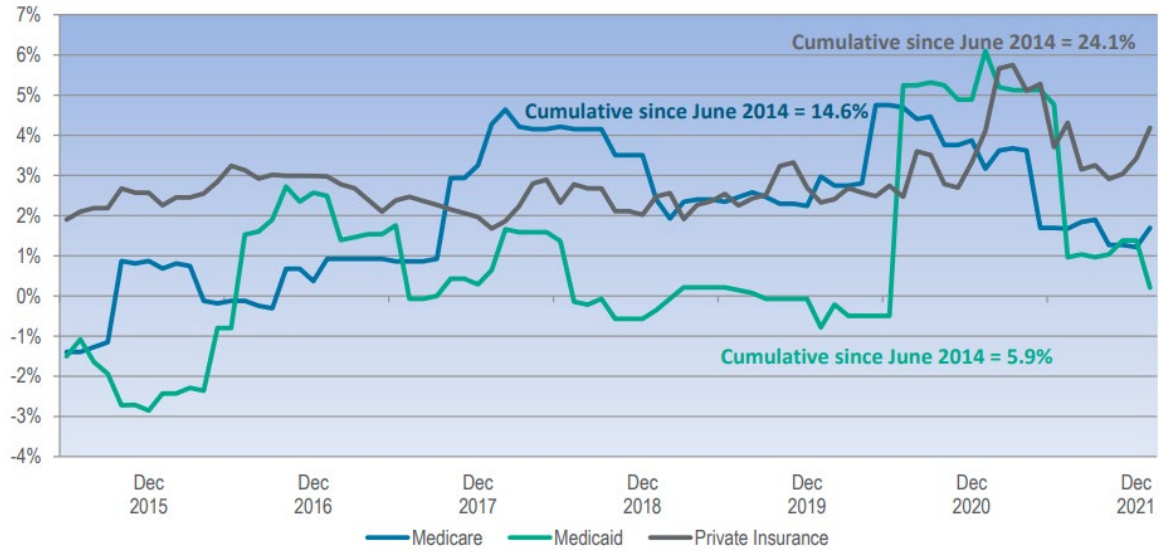


Rhyan, C., Turner, A. & Miller, G. Tracking the U.S. health sector: the impact of the COVID-19 pandemic. Bus Econ 55, 267–278 (2020)

Prices increased even as use fell in 2020

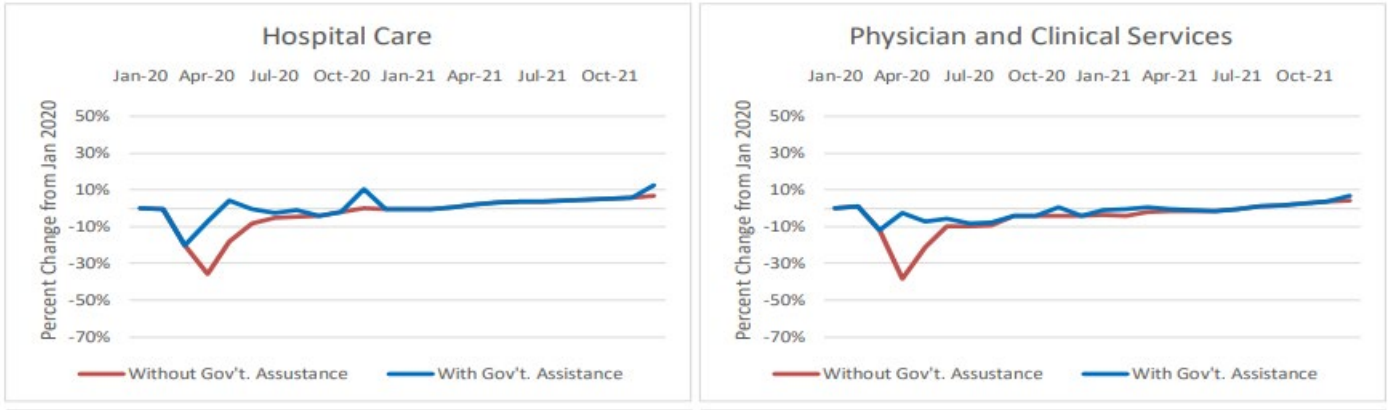
- Hospital prices for care paid for by private insurance increased by 4.2% in January
  - Steady rise from October 2021, when the rate was 2.9% year over year
- With government assistance, spending on hospital care and physician services exceeded the January 2020 level by December 2021
- Among health care components, hospital services were the fastest growing in terms of price growth.
  - Prescription drug price growth also positive in January vs. a year ago, ending streak of negative price growth

Exhibit 6. Year-over-Year Change in Hospital Price Growth by Payer



Source: Altarum analysis of monthly BLS data.

Exhibit 2. Percent Change in Spending Since January 2020, by Major Category



Conclusions

- **Prices for health care services continue to rise**, especially:
  - Hospital inpatient
  - ER
  - Physician-administered drugs
- **Prescription drug spending** is also rising due to price increases and increases in use/intensity
- **Shifting care** to higher priced settings
  - Office → outpatient
  - Lower-priced hospitals to higher-priced hospitals
- "**Upcoding**" practices likely driving up spending

- Evidence suggests that, when faced with lower prices, hospitals reduce costs and become more efficient
- Increasing affordability requires addressing high prices, premiums, cost-sharing structures
- There are a range of options that states are considering and implementing to control health care costs and improve access to and affordability of services