Current policy efforts to lower the cost and improve the value of health care

Hospital Association Meeting

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Arnold Ventures Health Care

Arnold Ventures is a philanthropy dedicated to addressing some of the most pressing problems in the United States.

Health Care Objective > Reduce health care spending for patients, employers, and taxpayers while maintaining access to needed, high-quality care and supporting health care delivery system reform.

Approaches > Research, policy development, technical assistance and education, visibility and communications, advocacy.

US Health Care Affordability Problem

- Federal debt held by the public is projected to rise from 98% of gross domestic product (GDP) in 2023 to 118% in 2033.[1]

- Medicare's Hospital Insurance Trust fund is projected to be insolvent by 2031.[2]

    - Payroll tax would need to be increased immediately from 2.9% to about 3.6% or spending would need to be reduced by 15.6%.[3]

- Medicare Part A is financed largely by payroll tax revenue, whereas general revenue finance large shares of Parts B and D.[4]

Affordability and Access

> The average premium for family coverage has increased 20% over the last five years and 43% over the last ten years; in 2022 average premiums exceeded $22,000.[5]

> 100M+ Americans carry medical debt – the most prominent form of debt in the U.S. – which is estimated to total $195B.[6]

> 4 in 10 adults with employer-sponsored insurance report having trouble affording their medical bills.[7]

> Nearly 1/3 of adults reported not taking their medication as prescribed in 2018 because of cost.[8]

Improving Care for Dual-Eligible Beneficiaries

> The Problem

- > We spend nearly 2x more on care for the 12.8M people simultaneously enrolled in Medicare and Medicaid than other Medicare and Medicaid-eligible individuals.[9]
- > Despite significantly more spending, dual-eligible individuals report poorer health and suffer from more chronic conditions than their Medicare-only counterparts.[9]
- > Poorer health often leads to last-resort, more expensive settings of care for people who are dual-eligible compared to Medicare-only counterparts.[10]

> Policy Solutions

- > Increase access to meaningfully integrated Medicare and Medicaid coverage
- > Support informed decision-making and seamless enrollment into integrated coverage
- > Ensure the delivery of services under integrated coverage creates accountability and meets peoples' needs

Payment and Delivery Reform

- The Problem
  - Fee-for-service (FFS) reimburses based on the number and type of individual services
    - Incentivizes volume over value
    - Results in unnecessary and potentially harmful care - up to $345 billion in wasteful spending that arises from overtreatment or failures of care coordination or delivery[11]
    - Drives inefficiencies across the health care system[12]
  - The Medicare fee schedule fails to accurately reimburse providers for all services
    - Overvaluation for specialty care and undervaluation for cognitive/primary care services[13]
    - Not structured to support comprehensive primary care and fails to give primary care providers sufficient flexibility to manage population health[14]
- Policy Solutions
  - Shift to population-based payment models that hold providers accountable for the cost and quality of care
  - Reform the Medicare fee schedule
  - Implement hybrid capitated payment for primary care (i.e., prospective, per-beneficiary per-month payment)

Unnecessary Spending – Medicare Advantage Plans

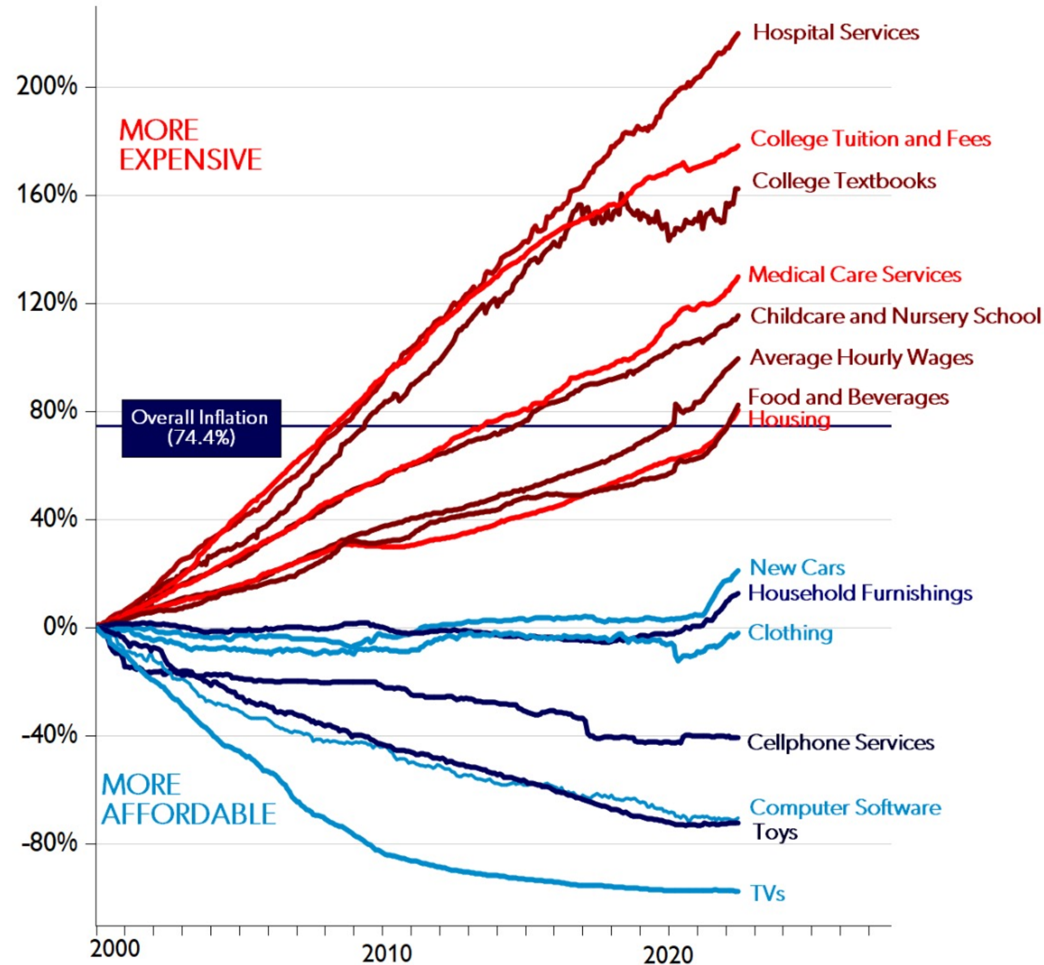
- The Problem
  - In 2010, about 25% of eligible Medicare beneficiaries were enrolled in Medicare Advantage (MA) plans; in 2023, that figure is over 50%.[15]
  - Quality bonus program accounts for at least $15B in payments annually.[15]
  - Coding and selection drove roughly $80B in overpayments to MA in 2023.[15]
  - 2023 MA risk scores were about 19% higher than scores for similar FFS beneficiaries.[15]
  - Selection effects increase payments by 9%.[15]

- MA Solutions
  - Reduce upcoding
  - Correct for selection
  - Budget neutral quality payments
  - Marketing practices
  - Payment denial/ prior authorization

Unnecessary Spending - Drugs

- The Problem
  - List prices for 25 brand-name drugs with the highest total Medicare Part D spending in 2021 increased by an average of 226% - or more than tripled – since they first entered the market.[16]
  - Average net prices of brand-name prescription drugs paid by Medicare Part D plans, which account for rebates, more than doubled over the last decade.[17, 18]
  - Brand-name manufacturers often obtain additional patents on features of drugs that do not change clinical effectiveness as a tactic to delay more affordable generic drugs from entering the market. [19, 20]
    - Example: Humira
  - Anticompetitive behaviors by brand-name drug manufacturers extend monopoly pricing power. 75% of new patents between 2005 and 2015 were for existing drugs already on the market. [21]
  - Single source brand-name drugs are ~3 to 4 times higher in the US than in the UK, Japan, and Canada. [22]
  - NIH funding helped develop all new FDA-approved molecular entities between 2010 and 2016. Funding supported over 200,000 years of grant funding and totaled over $100 billion. [23]
- Policy Solutions
  - Patent reform
  - FDA evidence reform
  - Middle market reform (PBMs; pharmacies)
  - Coverage and prices

Notable Price Changes



Unnecessary Spending – Commercial Sector Prices

- The Problem
  - Hospital consolidation raises hospital prices without resulting in gains in quality. 90% of hospital markets are considered highly concentrated.[24, 25, 26]
    - Commercial inpatient hospital rates range from about 150% - 220% of Medicare.[27]
    - Commercial outpatient hospital rates from about 160% - 350% of Medicare.[27]
    - RAND found that private insurers paid more than 200% of Medicare.[28]
  - Consolidation among physicians also increases prices; certain physician specialties are also able to charge excessive prices. For example, anesthesiologists charge privately insured patients 3.5 times what Medicare would pay on average.[29]
  - MedPAC analyses find that hospital costs rise with prices. When hospitals receive high commercial payments, they have higher costs per patient because they have less incentive to operate efficiently. Some of the wealthiest hospitals have the lowest Medicare margins.[30, 31]

- Policy Solutions
  - Transparency
  - Anticompetitive contracting
  - M&A oversight (federal and state)
  - Curbing prices (premium growth limits; site neutral; price limits; and public option)
  - Support for rural and safety net hospitals

Hospital Pressures

- Industry outlooks (e.g., Fitch, Moody's, Kaufman Hall)[32, 33, 34]
  - Mixed hospital performance
  - 2024 outlook more positive than 2022 – 2023
- Inflation/wages
- Workforce shortages
- COVID utilization rebound
- Capital/bond market pressures
- Payer pressures
- Medicare Advantage

Current Policy Landscape

- Inflation Reduction Act (IRA) and No Surprises Act (NSA) Implementation
- Patents
- Medicare
    - Medicare Advantage
    - Sustainability/ entitlement reform
- Transparency, NPI, and site neutral
- Medicare-Medicaid Integration

Discussion

- Do you see affordability challenges in our system?
  - If so, are they comprised of the situations discussed today?
- If you disagree with the policy options discussed here, what are alternatives that you would support that would meaningfully address the challenges discussed?
- What do you see that policymakers, employers, and patients do not?
- How can we better support safety net and rural hospitals?

Appendix: The Cost-Shifting Argument - Providers

> Prices charged to privately insured patients are not systematically higher when they treat more Medicare/Medicaid patients. Instead, a larger portion of variation is explained by hospital market power, which allows hospitals to extract higher prices from insurers in their price negotiations.[35]

> Economic evidence shows that cost shifting does not occur. Some studies even show that hospitals have lowered private insurance payments in response to cuts in government payment rates, contradicting what the cost shifting theory predicts.[36, 37]

> The Congressional Budget Office (CBO) recently conducted an updated literature review and continues to conclude that cost-shifting does not occur. They find that the share of Medicaid and Medicaid patients a hospital treats is unrelated to the prices paid by commercial insurers and conclude that providers do not raise the prices charged to commercial insurers to compensate for the lower prices paid by government programs.[38]

> Both for-profit and non-profit hospitals raise prices to what the market will bear and maximize profits across all payers at any given time. Their commercial prices are determined by their market power and their ability to name their price, not their underlying costs or what public programs pay.[31]

> MedPAC analyses find that hospital costs rise with prices. When hospitals receive high commercial payments, they have higher costs per patient because they have less incentive to operate efficiently. Some of the wealthiest hospitals have the lowest Medicare margins.[30, 31]

Appendix: The Cost-Shifting Argument – IRA Drug Rebates

- Based on a large body of economic research, CBO expects the following about the inflation penalty's effect on the commercial market:[32]
  - CBO expects that net prices will decrease on average in both Part D and commercial markets.
  - CBO projects that commercial drug prices, and therefore health insurance premiums, will be lower than they would have been absent the policy.
  - Rebate payments, lower drug prices, and lower health insurance premiums in the commercial market will lower federal spending and increase federal revenues, according to CBO's estimates.

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