How Are States Lowering Health Care Prices in the Private Sector: Policy Recommendations to HELP Committee

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I. Background

The main reason why the United States spends considerably more on health care compared to other industrialized countries is that the US pays higher prices for most medical services.[1,2] The US has lower inputs of real resources (hospital beds, physicians and nurses) per capita than most other industrialized nations.[2] Of growing concern is the growth in private sector prices compared to prices paid by public programs. Ten years ago, the prices that private insurers paid for hospital, physician, drug and other services were similar to what the public sector paid. Today, the differential between private and public prices is substantial and growing.[3]

In most areas, large self-insured corporations and private insurers pay more than double the Medicare rate for hospital and physician services.[3] This differential has grown substantially over the last 10 years and may be reaching a tipping point where it may be necessary for federal policy makers to take action. Many states are already taking initiative and their experiences could provide guidance for federal action.

The problem is not necessarily that public insurers pay too little, as some might suggest. The familiar cost shifting argument, that hospitals and physicians must offset lower public prices with higher private prices in order to break even, has been shown to lack evidence.[4] There is considerable evidence that hospitals adjust their costs according to their revenues.[5,6] The more revenue that providers generate from private payers, the less pressure on the provider to control the costs, and the more likely that costs will increase.

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[1] Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's the prices, stupid: Why the United States is so different from other countries. Health Aff. 2003;22(3):89-105. https://doi.org/10.1377/hlthaff.22.3.89. doi: 10.1377/hlthaff.22.3.89

[2] Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: Why the US spends so much on health care, and A tribute to Uwe Reinhardt. Health Aff. 2019;38(1):87-95. https://doi.org/10.1377/hlthaff.2018.05144. doi: 10.1377/hlthaff.2018.05144

[3] Cooper Z, Craig S, Gray C, Gaynor M, John VR. Variation in health spending growth for the privately insured from 2007 to 2014. Health Aff. 2019;38(2):230-236. https://doi.org/10.1377/hlthaff.2018.05245. doi: 10.1377/hlthaff.2018.05245

[4] Frakt AB. How much do hospitals cost shift? A review of the evidence. Milbank Q. 2011;89(1):90-130. https://www.ncbi.nlm.nih.gov/pubmed/21418314 https://www.ncbi.nlm.nih.gov/pmc/PMC3160596/. doi: 10.1111/j.1468-0009.2011.00621.x

[5] White, C. Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private payment rates. Health Aff. 2013;32(5):935-943. https://doi.org/10.1377/hlthaff.2012.0332. doi: 10.1377/hlthaff.2012.0332

[6] MedPAC. March 2018 Report to Congress. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf

Higher prices and rapid growth of prices paid by large self-insured companies and private insurers undermines the affordability of health care for employers and employees. Recent benefit design features, such as high deductibles and narrow networks accompanied by high out-of-network prices, are making it difficult for many patients to afford health care services.[7, 8] Further, the growing price differential could affect accessibility to health care for public patients because hospitals and physicians may be less likely to see these patients.

If the US aims to lower or at least stabilize health care prices, the process must start with the prices paid by the private sector. By focusing on the high prices paid in the private sector the US should be able to lower the rate of increase in health spending to a rate commensurate with overall economic growth. Medicare actuaries predict that private sector health care prices will increase faster than overall inflation through 2027.[9] Lowering the rate of increase in the private sector will also allow for slower price increases in the public sector since public insurers must keep up to some extent with private prices to ensure access for Medicare and Medicaid beneficiaries.

Currently, the private sector seems unable to substantially affect prices paid to hospitals and physicians in many markets. Private, self-insured companies may not have sufficient market power to negotiate rates that are similar to public insurers. In many localities there are only one or two dominant health systems and these systems must be included in insurer networks. Policymakers, therefore, may need to take action to achieve price containment in the private sector. States have taken a number of different steps to address this issue, including regulating prices, broadening provider markets to increase competition, and investing in alternative payment models such as all-payer accountable care organizations (ACOs) and global budgets. States are often the laboratories for federal actions. In this paper, we discuss these state policy and regulatory efforts. Congress should consider supporting these efforts through federal legislation and hearings.

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[7] Haviland AM, Eisenberg MD, Mehrotra A, Huckfeldt PJ, Sood N. Do "consumer-directed" health plans bend the cost curve over time? J Health Econ. 2016;46:33-51. doi: 10.1016/j.jhealeco.2016.01.001 [doi]

[8] Abdus S, Selden TM, Keenan P. The financial burdens of high-deductible plans. Health Aff (Millwood). 2016;35(12):2297-2301. doi: 35/12/2297 [pii]

[9] Sisko AM, Keehan SP, Poisal JA, et al. National health expenditure projections, 2018–27: Economic and demographic trends drive spending and enrollment growth. Health Aff. :10.1377/hlthaff.2018.05499. https://doi.org/10.1377/hlthaff.2018.05499. doi: 10.1377/hlthaff.2018.05499

II. Private-Public Price Difference in the United States

There is substantial variation in private health care prices for hospital services across states, within states, and among different private insurers.[3] Studies have found no link between medical prices and quality of medical care, suggesting that these price differences are primarily a function of market and provider characteristics (e.g., provider market power), as well as population characteristics.[10] Using Medicare payment rates as a benchmark, we begin by comparing Medicare rates to private sector rates. Medicare prices are set administratively while private prices are a product of negotiation between payers and providers. In making this comparison, we are not suggesting that the Medicare rate is necessarily the "gold standard" for comparison but we believe that it does provide a useful benchmark to compare rates in different states and markets, based on one standard formula.

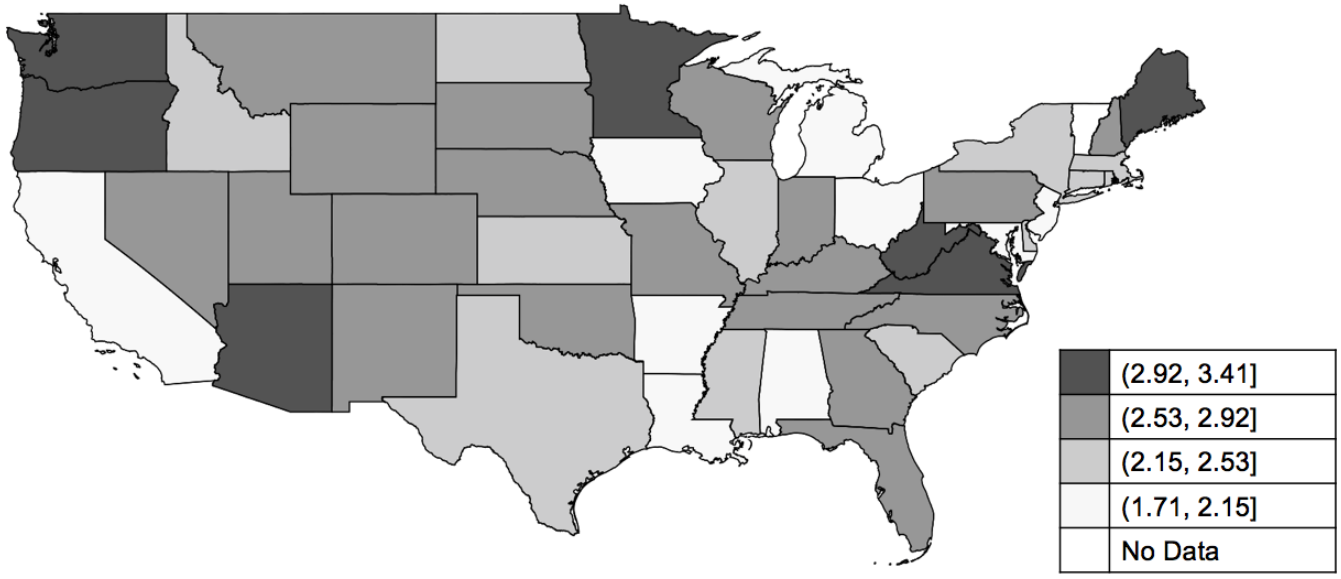
In Figure 1, we show the state-level ratio of the average private insurer payment to the Medicare rate for a market basket of inpatient services. The market basket includes the 15 most frequent hospital services (ranked by diagnosis related group or DRG). These 15 DRGs represent a significant amount of health care – 46% of total admissions and 37% of total spending.[11] The average state has a ratio of 2.55, that is, the average private insurer paid 2.55 times what Medicare paid for the market basket of services. The state with the highest ratio is Alaska (3.41) and the state with the lowest ratio is Michigan (1.71).[12] Other states with high ratios are: Minnesota (3.38), Washington (3.35), Maine (3.19), West Virginia (3.15), and Oregon (3.06).

[10] Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. JAMA. 2018;319(10):1024-1039. doi: 10.1001/jama.2018.1150 [doi]

[11] The 15 DRGs include: Vaginal delivery w/o complicating condition (CC), Major joint replacement or reattachment of lower extremity w/o major complicating condition (MCC), Cesarean section w/o CC/MCC, Cesarean section w CC/MCC, Psychoses, Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC, Vaginal delivery w complicating diagnoses, Esophagitis, gastroent & misc digest disorders w/o MCC, Septicemia or severe sepsis w/o MV >96 hours w MCC, OR procedures for obesity w/o CC/MCC, Uterine & adnexa proc for non-malignancy w/o CC/MCC, Spinal fusion except cervical w/o MCC, Septicemia or severe sepsis w/o MV >96 hours w/o MCC, Cellulitis w/o MCC, PTCA.

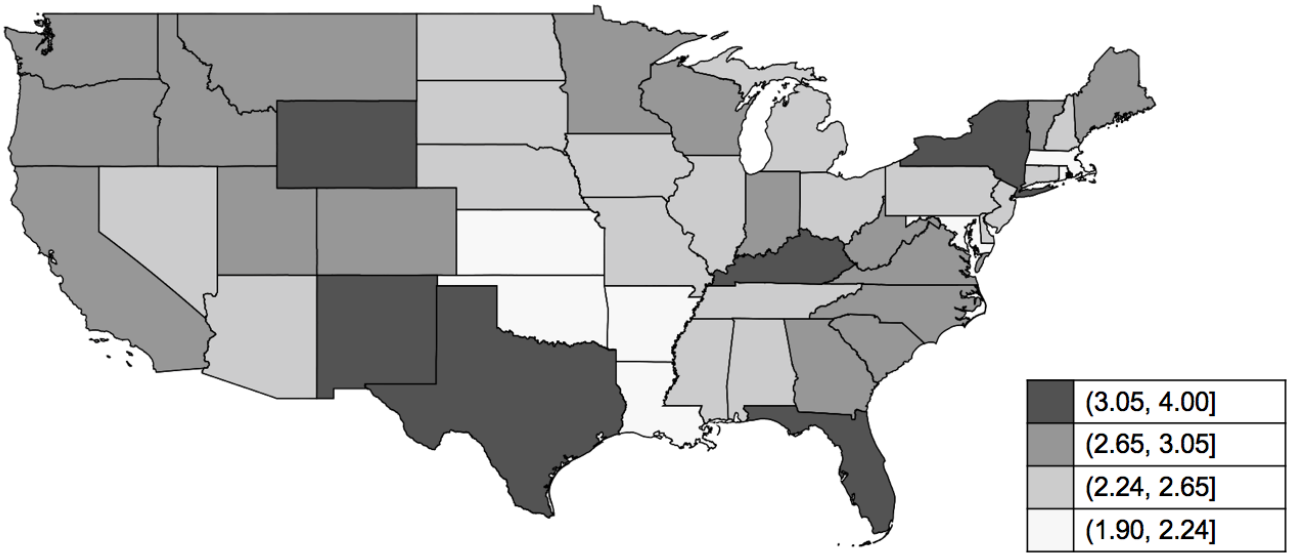
[12] Maryland has an All-Payer model in which rates are consistent across private and public payers. Thus, we would expect Maryland to have a ratio of 1. The method we use to calculate Medicare rates is based on the standard formula used to generate payment rates across states and thus does not incorporate Maryland's unique model.

Figure 1. Ratio of Private and Medicare Prices for Basket of Inpatient Services, 2016



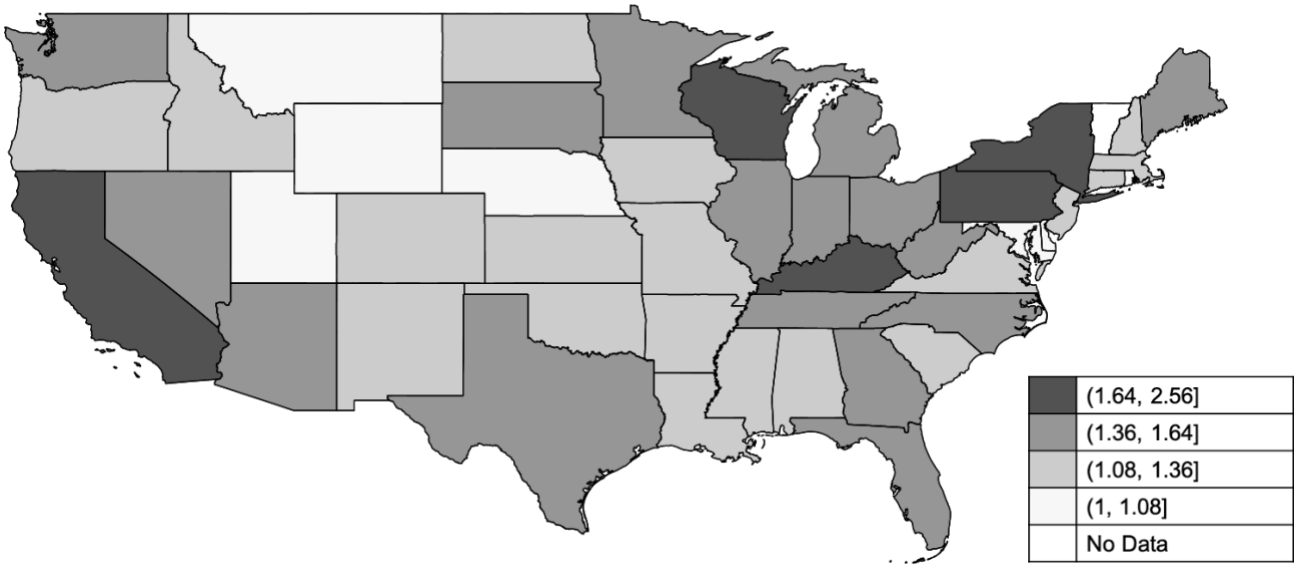
In Figure 2 we show the variation for a hip and knee replacement (DRG 470), a very common surgical procedure in the US. This type of joint replacement surgery is generally fairly standardized, and thus we would not expect there to be significant variation in prices if the price was a pure reflection of the costs of performing the procedure. In contrast, we see that the private price is, on average across states, 2.67 times the Medicare price for hip and knee replacement, and that there is substantial variation in this ratio across states.

Figure 2. Ratio of Private and Medicare Prices for Hip and Knee Replacement, 2016



Examining variation in this payment ratio at the state level masks some of the variation that occurs within the state. Thus, we examine the variation across Metropolitan Statistical Areas (MSAs) within states (Figure 3). Specifically, we show the ratio between the MSAs with the highest and lowest private prices within each state for the same basket of inpatient services as in Figure 1. Across states, the average ratio is 1.36, i.e., the most expensive MSA in the average state has a price 1.36 times as high as the least expensive MSA. Some states have substantially greater variation; for example, California has the greatest variation with a ratio of over 2.5. New York also has a high within-state ratio of 2.0. States with the least within-state variation are Maryland and Wyoming (1.02). Variations in prices within and across states are due in part to market and population characteristics (e.g., consolidation in hospital markets) as well as policy efforts to control private sector prices.

Figure 3. Within-State Ratio of Highest-to-Lowest-MSA Price for a Basket of Inpatient Services, 2016

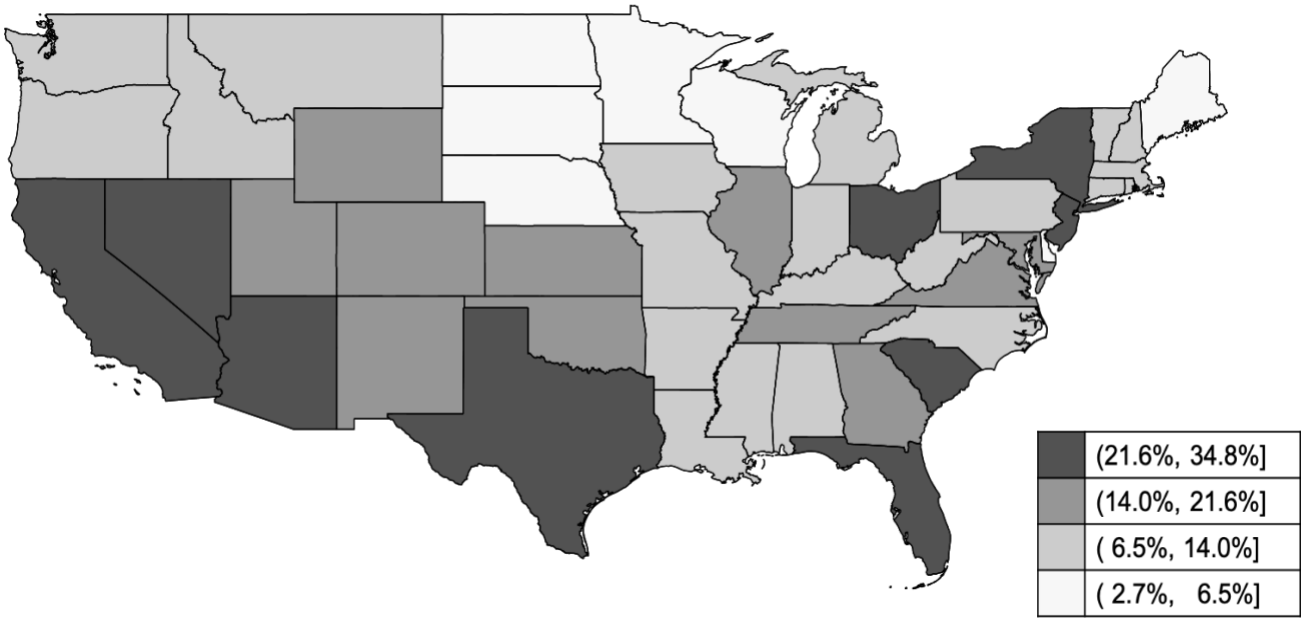


One way in which high private prices can cause a particular burden on patients are "out-of-network" bills, which refer to high charges for hospitals and physicians who are not in the patient's network. Private insurers create networks of hospitals and physicians with whom they negotiate prices for their enrollees as a way of controlling spending.[13] Out-of-network hospitals and physicians do not have a contract or negotiated rate, leaving patients susceptible to balance

[13] Lucia K, Hoadley J, Williams A. Balance billing by health care providers: Assessing consumer protections across states. The Commonwealth Fund. 2017:1-10

billing (also known as surprise billing) if they receive care from these out-of-network hospitals and physicians.[14] These bills arise after the health plan pays the provider what they deem fair for a service and the provider bills any remaining difference to the enrollee.[13]

Figure 4. Percent of Admissions with At Least One Service Billed Out-of-Network, 2016



While consumers can generally choose facilities or providers that are in-network, there are three occasions where this is challenging. First, in the case of emergency care when there is no time or choice in selecting an in-network provider. Second, when a facility providing the care is in-network but one of the health care providers (e.g. the anesthesiologist) is out-of-network. Third, when the majority of providers operate solely out-of-network (e.g. dentists, psychologists etc.). These out-of-network bills can be substantial and have real impact on consumer's financial well-being.[15] In Figure 4, we show the percent of inpatient admissions with an out-of-network bill by state. Nationwide, 15% of all inpatient admissions have at least one service within the admission billed out-of-network, however some states have rates of over 30%. In Alaska, close to 50% of admissions have an out-of-network bill. In New York, approximately 35% of

[14] Hoadley J, Lucia K, Schwartz S. Unexpected charges: What states are doing about balance billing. California HealthCare Foundation. 2009

[15] Cooper Z, Scott Morton F. Out-of-network emergency-physician bills — an unwelcome surprise. The New England Journal of Medicine. 2016;375(20):1915-1918. https://www.nejm.org/doi/full/10.1056/NEJMp1608571. doi: 10.1056/NEJMp1608571

admissions have an out-of-network bill. Rates of admissions with of an out-of-network bill are lowest in Minnesota (2.8%) and South Dakota (2.7%).

III. What Policy Actions Have States Taken?

States are often laboratories for federal policy. Many states have taken action to control private sector prices. Below we outline several approaches states are pursuing to lower private health care prices.

State Actions Protecting Patients from High Prices

1. Regulation of out-of-network prices

Since there are no federal protections against out-of-network bills, states have begun to address this issue. A 2019 Commonwealth Fund report found that 25 states have some law related to restrictions on out-of-network bills, however only nine of those states have comprehensive laws.[16] California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New York, and Oregon make up those nine states and are classified as having comprehensive protections since their laws cover emergency room and non-emergency room situations, cover HMO and PPO insurance plans, require insurers hold enrollees harmless and prohibit providers from balance billing, and have a mix of payment methods to resolve balance billing disputes.[16] One challenge is that state laws are constrained by ERISA, which stipulates that self-insured firms (which cover 61% of privately insured employees) are exempt from state health insurance regulations. Thus, federal legislation to address the issues of balance billing is necessary to ensure broad protection for most privately insured people (discussed further in Section V).

2. Rate Regulation for Specific Populations

[16] Hoadley J, Lucia K, Kona M. State efforts to protect consumers from balance billing. The Commonwealth Fund: To the Point. 2019

States have recognized that price and quality are not necessarily correlated and have begun to take action to lower private sector prices. These efforts often start with state employee health plans. State employee health care expenses are a large and growing portion of state budgets and states have begun to wonder if state employees should be paying much higher prices for hospitals and physicians services than people insured by Medicare and Medicaid.

Montana and California have instituted rate regulation, or reference-based pricing, for their state employees. This process involves the state health plan setting a maximum amount it will pay providers for specified services.[17] In Montana, the state set a rate of 234% of Medicare payments for hospital services for state employees.[18] All large hospitals agreed to this pricing model and to not balance bill patients.[19] State employees are allowed to go to hospitals not accepting the price if they are willing to pay the difference.[20] Savings to Montana in 2018 were estimated at $15.6 million.[18, 21]

California's state-based CalPERS insurance program uses a different reference-based pricing model. The state started in 2011 by capping payments for hip and knee replacements, and expanding in 2012 to include colonoscopies, cataract surgery, and arthroscopy procedures.[17] Prices are set to include two-thirds of hospitals in its preferred-provider organization network, and patients going to hospitals charging more have to cover the difference.[22] With the implementation of this model, the average prices charged to CalPERS declined by 26.3%[23] and $6 million was saved over two years for just knee and hip replacements.[17]

[17] Connor K, Cusano D. Reference pricing: An overview and suggested policy considerations. State Health Reform Assistance Network of the Robert Wood Johnson Foundation. 2015
[18] Appleby J. 'Holy cow' moment changes how Montana's state health plan does business. Kaiser Health News. June 20, 2018. Available from: https://khn.org/news/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/. Accessed Oct 6, 2018
[19] Allen M. A tough negotiator proves employers can bargain down health care prices. Shots: Health News from NPR. Oct 2, 2018. Available from: https://www.npr.org/sections/health-shots/2018/10/02/652312831/a-tough-negotiator-proves-employers-can-bargain-down-health-care-prices. Accessed Oct 10, 2018
[20] Health Care & Benefits Division. Transparent pricing. Montana Official State Website Web site. http://benefits.mt.gov/transparentpricing#Intro. Accessed Oct 6, 2018
[21] Health Care & Benefits Division. State of MT - RBP initiative. Center for Improving Value in Health Care. 2018
[22] Delbanco SF, Murray R, Berenson RA, Upadhyay DK. Reference pricing. Urban Institute & Catalyst for Payment Reform. 2016
[23] BCHT. Reference pricing for surgical procedures. UC Berkeley Web site. https://bcht.berkeley.edu/reference-pricing-surgical-procedures. Accessed Oct 13, 2018

3. Increasing Price Transparency

The market for health care in the United States is unlike the market for most goods in that patients rarely have access to the prices of medical services before they need the service. Hospitals and physicians keep prices private, which prevents consumers from "shopping around" for their health care.[24] While there are steps being taken to change this (e.g., federal mandate requiring all hospitals to publish a list of their standard charges by January 1st, 2019), it remains nearly impossible for patients to compare the prices they will actually face across providers.[25] The potential for price transparency to allow consumers to shop is limited for several reasons. First, knowing the prices for all the services that the hospital provides is not helpful unless the patient also knows exactly what services they will need, which patients may not know. Further, it is the physician who orders the test and makes decisions, and patients may have limited ability to counter physician orders or discuss alternatives, even if they have access to price information.

Beyond informing consumer choice, improving price transparency has the potential to put downward pressure on prices.[24] The challenge is how to provide the prices in a meaningful way. Many states are actively pursuing some form of price transparency and requiring providers to submit their cost data to a central agency.[26] A handful of states provide price information that varies in comprehensiveness, but is otherwise publicly available, consumer-oriented, and includes public and private plans.[27] New Hampshire and Maine have done more than any other state to promote price transparency by mandating an all-payer claims database and launching an easy-to-use website which combines cost estimates with quality scores for each provider based on the consumer's insurance, medical service, and zip code. However, these websites focus on inpatient services and require significant state resources to maintain.

[24] Mehrotra A, Schleifer D, Shefrin A, Ducas AM. Defining the goals of health care price transparency: Not just shopping around. NEJM Catalyst. June 26, 2018. Available from: https://catalyst.nejm.org/health-care-price-transparency-goals/. Accessed Oct 18, 2018

[25] American Hospital Association. REMINDER: New CMS price transparency requirements go into effect Jan. 1. American Hospital Association. 2018

[26] NCLS. Transparency and disclosure of health costs and provider payments: State actions. National Conference of State Legislatures Web site. http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx#Examples. Updated 2017. Accessed Oct 20, 2018

[27] de Brantes F, Delbanco S, Butto E, Patino-Mazmanian K. Price transparency and physician quality report card 2017. Altarum and Catalyst for Payment Reform. 2017

Websites in Oregon, Colorado, and Maryland provide similar information as New Hampshire's and Maine's, but for fewer medical services and use average costs across all types of third-party payers, rather than allowing a consumer to select their own insurance provider.[27] Vermont's website is not as consumer-friendly as it requires finding and synthesizing written reports or the data itself and Virginia's website provides regional cost data rather than linking cost information to specific hospitals.[27] California publishes all hospital charge lists in one place along with a statewide average charge for the 25 most common Medicare DRG services, which can be used to compare to a specific hospital charge list.[28] This option is less administratively demanding, however, it is also less useful to consumers since it requires them to understand the difference between hospital charges and negotiated prices as well as all the cost components that go into an episode of care.

There are concerns about patients using and understanding these transparency tools; for example, many consumers incorrectly correlate price with quality.[29] Furthermore, having meaningful price information requires that information is presented in a user-friendly way and reflects not just provider charges, but the actual negotiated prices that would be paid for an entire health care event.[27] Due to the limitations of transparency, it must be accompanied by other efforts to lower prices directly.[30, 31, 32]

Actions to Lower Prices in Both the Public and Private Sectors

4. Increasing Competition

Hospital and physician markets in the US are becoming increasingly characterized by a lack of competition. Concentration is commonplace among hospital markets (90% of MSAs are highly concentrated), physician markets (65%), and even primary care physician markets

[28] OSHPD. 2018 chargemasters. OSHPD Web site. https://oshpd.ca.gov/data-and-reports/cost-transparency/hospital-chargemasters/2018-chargemasters/. Updated 2018. Accessed Feb 21, 2019
[29] PBGH. PBGH policy brief: Price transparency. Pacific Business Group on Health. 2013
[30] Lieber EM. Does it pay to know prices in health care? American Economic Journal: Economic Policy. 2017;9(1):154-179. https://pubs.aeaweb.org/doi/pdf/10.1257/pol.20150124. doi: 10.1257/pol.20150124
[31] Sinaiko AD, Joynt KE, Rosenthal MB. Association between viewing health care price information and choice of health care facility. 2016;176(12):1868-1870. https://dx.doi.org/10.1001/jamainternmed.2016.6622. Accessed 2/28/2019. doi: 10.1001/jamainternmed.2016.6622
[32] Sinaiko AD, Rosenthal MB. Examining a health care price transparency tool: Who uses it, and how they shop for care. Health Aff (Millwood). 2016;35(4):662-670. doi: 10.1377/hlthaff.2015.0746 [doi]

(39%).[33] A surge of hospital mergers and hospital acquisition of physician practices is driving this consolidation.[34] While integration may facilitate coordination of care, it also contributes to a lack of competition and it is well-established that a lack of competition increases prices. Indeed, evidence suggests that prices can go up over 50 percent following a hospital merger or physician practice mergers and acquisitions.[34, 35, 36]

States have utilized a number of policies to intervene in highly concentrated health care provider markets. One antitrust approach is to give the state increased scrutiny over hospital mergers with the goal of managing consolidation in provider markets. In California, the state gave its Attorney General greater power to block non-profit health care provider mergers.[37] Florida created an "antitrust no-action letter" to provide merging parties early clarity on the legality of their actions.[38] Certificates of Public Advantage (COPAs), which are granted by a state to allow providers to merge under the state's oversight, also have the potential to be a complement to federal antitrust actions.[39] They are designed to allow the state to monitor cost trends and quality improvements as the result of the mergers. While legislation allowing COPAs has been passed in 19 states, only a fraction have actively disseminated COPA arrangements.[39]

Another approach is to limit hospital and physician incentives to consolidate. Receiving outpatient facility fees are one of the primary motives hospitals have for acquiring physician practices. Following acquisition of a physician practice, a facility fee may be attached to services that patients receive in that practice, raising costs for patients. In addition to limiting the incentives hospitals have to acquire physician practices, regulation of these fees increases price transparency and can reduce expenses for insurers and patients. This policy effort could reduce market consolidation and keep hospitals from securing even greater market and bargaining

[33] Fulton BD. Health care market concentration trends in the United States: Evidence and policy responses. Health Aff. 2017;36(9):1530-1538. https://doi.org/10.1377/hlthaff.2017.0556. doi: 10.1377/hlthaff.2017.0556
[34] Gaynor M. Examining the impact of health care consolidation. Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee U.S. House of Representatives. Feb 14, 2018
[35] Koch TG, Ulrick SW. Price effects of a merger: Evidence from a physicians' market Bureau of Economics, Federal Trade Commission. 2017
[36] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. Journal of Health Economics. 2018;59:139-152. https://www.sciencedirect.com/science/article/pii/S016762961730485X. doi: 10.1016/j.jhealeco.2018.04.001
[37] Delbanco S, Bazzaz S. State policies on provider market power. Catalyst for Payment Reform. 2014
[38] Health Information & the Law. Florida statutes § 408.18. Health Information & the Law Web site. http://www.healthinfolaw.org/state-law/florida-statutes-%C2%A7-40818. Updated 2015. Accessed Nov 4, 2018
[39] Bovbjerg RR, Berenson RA. Certificates of public advantage: Can they address provider market power? Urban Institute. 2015

power. This type of regulation can be particularly effective in smaller mergers and acquisitions since federal antitrust laws require business activity of $75.9 million or greater to be reported.

As far as we are aware, Connecticut is currently the only state to regulate hospital facility fees.[40] Senate Bill 811, passed by the Connecticut House and Senate and signed by the Governor, requires the disclosure of any facility fee for services rendered by a physician that is charged for outpatient hospital services provided in a hospital-based site of care. The bill also requires that the patients be notified of the fee and told if it is higher than the fee they would have received for the same service provided in a non-hospital-based facility. Furthermore, providers that issue a facility fee are required to report the charge to the Commissioner of Public Health. The Commissioner will then publish the name of the facility and the amount of revenue they derived from the fee. From January 1, 2017 the bill prohibits outpatient physician services provided at a hospital-based facility from issuing a facility fee.[40]

Another set of policies can be used to encourage entry to provider markets, including repealing Certificate of Need (CON) laws, broadening scope-of-practice laws, and adjusting state licensure laws. CON laws require health care facilities seeking to expand, build, or acquire a new service to demonstrate to a state board the need for their project. CON laws, which have been fully repealed in 13 states, often have safeguards in place to ensure continued access to rural health care.[41, 42] The main reason for the repeals is that CON laws have been used by established hospitals in the region to keep out new entrants.

States have also begun to expand the licensure laws to allow additional clinicians to perform certain services. Nurse practitioners (NPs) working in 13 states are allowed to evaluate, diagnose, order diagnostic tests, test, manage, and prescribe; effectively increasing the supply of providers delivering care.[43] Finally, most states limit the licensure requirements for alternative

[40] HCMA. New legislation will dramatically impact healthcare in Connecticut. Hartford County Medical Association. 2015
[41] NCSL. Con-certificate of need state laws. National Conference of State Legislature Web site. http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx. Updated 2018. Accessed Nov 3, 2018
[42] NHA. Hospital certificate of need: Rural necessity, urban expense. Nevada Hospital Association. 2011
[43] Scope of Practice Policy. Nurse practitioners overview. Scope of Practice Policy Web site. http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/. Updated 2018. Accessed Dec 2, 2018

low-cost retail clinics and urgent care facilities to avoid burdensome requirements which increase their costs.[44]

5. All-Payer Accountable Care Organizations

Fee-for-service payment models pay for each medical service that is billed individually. This payment system has been shown to be associated with costly duplicative services and provides little incentive to promote health.[45] Accountable Care Organizations (ACOs) are becoming a popular alternative in which a network of health care providers agrees to work together to be responsible for the costs and quality of care for a defined group of patients. ACOs are typically characterized by a value-based capitation payment model in which the provider group receives a monthly payment per patient to cover all health care services.[45] If the ACO meets certain quality criteria and receives more payment than they need to cover costs, they can keep a portion of their savings.[46] The theory behind this model is that it increases care coordination and eliminates unnecessary spending, leading to less repetitive testing and fewer prescriptions of conflicting drugs.[46] Furthermore, capitated payments help to control health care costs through the use of growth targets and reduce the complexity of health care billing leading to lower administrative costs.[45] Of course, if ACOs incentivize integration across providers in order to facilitate coordination of care, there are concerns that consolidation may exacerbate price increases. Monitoring this balance between integration for improved quality of care and potential price raises due to consolidation is an important role for policymakers.

The all-payer ACO model suggests that all three major payers, Medicare, Medicaid, and commercial insurance, use the same ACO capitated payment system. Vermont is the only state to pursue this payment system and began allowing these three payers to voluntarily join ACOs in 2017.[47] While ACOs are generally responsible for developing and implementing their own delivery system, Vermont's Medicaid ACO program was given additional support by Vermont's

[44] NASI. Addressing pricing power in health care markets: Principles and policy options to strengthen and shape markets: The final report of the academy's panel on pricing power in health care markets. National Academy of Social Insurance (NASI). 2015
[45] House Committee on Health Care. Overview of Vermont's all-payer accountable care organization model. Vermont Green Mountain Care Board. 2016
[46] Kaiser Health News. The ABCs of ACOs. [YouTube]; 2015
[47] CMS. Vermont all-payer ACO model. Centers for Medicare & Medicaid Services Web site. https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/. Updated 2016. Accessed Oct 13, 2018

Agency of Human Services (AHS).[45] All ACOs are monitored by Vermont's Green Mountain Care Board (GMCB), who sets the all-payer and Medicare growth targets (3.5% for all-payers and 0.1-0.2% below the national projections for Medicare).[45] By 2022, Vermont hopes to have 70% of their residents attributed to an all-payer ACO and 90% to a Medicare ACO.[47]

6. Global Budgets

Under a global budget, the fee-for-service payment model is replaced with a prospective payment system that is made to hospitals annually and involves both price and quantity.[48] The intention of this type of system is to give hospitals a predictable budget and allow them greater flexibility in how they spend their resources while also incentivizing hospitals to reduce spending through improved care management and efficiency. Taking actions to keep patients out of the hospital is likely to be the best option for hospitals aiming to save money and say within the global budget.

Greater predictability is also useful for payers and policymakers and the nature of fixed, prospective payment facilitates predictability of cost growth (e.g., by requiring that hospitals stay below a pre-determined target growth).[48] Global budgets may be introduced by a single payer or include all payers.[48] In either case, protections through performance measurement are needed to ensure continued access and quality; accurate data is also needed to establish a fair global payment.[48]

Although used in many other countries, Maryland is the only state to have implemented an all-payer global budget model. Maryland has a federal waiver that allows the Medicare and Medicaid programs to participate. In the Maryland system, a fixed payment is determined at the beginning of the year using historical data and adjusted for inflation, infrastructure requirements, population and payer changes, and quality and efficiency performance.[49] After this budget is created, the contributions made by payers are assessed and adjusted retroactively to determine if the hospital was compliant with their global budget.[48] To encourage hospitals to continue to meet the health care needs of the community, Maryland's model rewards hospitals that increase their

[48] Berenson RA, Upadhyay DK, Delbanco SF, Murray R. Global budgets for hospitals. Urban Institute and Catalyst for Payment Reform. 2016
[49] The Maryland Health Services Cost Review Commission. Global budgets. Maryland.gov Web site. https://hscrc.state.md.us/pages/budgets.aspx. Updated 2018. Accessed Feb 2, 2019

market share.[48] Evaluations of the Maryland model show reductions in hospital admissions (including ambulatory care sensitive admissions) and total hospital expenditures.[50] Pennsylvania is now implementing all-payer global budgets for rural hospitals, and other states are considering following suit as well.

IV. Johns Hopkins Effort to Support State Efforts to Reduce Private Health Care Prices

The Laura and John Arnold Foundation has provided grant funding to a team of health policy researchers at Johns Hopkins and the National Coalition on Health Care to examine the growing divergence between rates paid by public programs and those paid by commercial payers for the same services and support the efforts of state governments to reduce private sector health care prices. To assist states, we analyze data from databases of individual medical claims from both commercial and Medicare-covered patients, hospital financial reports, and Medicare cost reports to shed light on the causes and extent of price growth in the commercial market. We examine available data to quantify price differentials between public and commercial payers to inform state policymakers on potential strategies to slow the trend in private sector price growth.

We recognize there is no predetermined, one-size-fits-all set of policy recommendations; rather, the data on state market conditions and state leadership preferences help determine the policy interventions the state is willing to consider. Using evidence from other states, as well as rigorous analyses of local market conditions, the team is assisting local decision makers in assessing which interventions are likely to be most effective and politically feasible.

Specifically, we compare prices paid by the private sector to Medicare rates for a range of medical as well as a standard "basket" of inpatient services. We use this data to identify the states and the communities where the private sector pays considerably more than the public sector and present the results to states to demonstrate the magnitude of the price problem in their cities and rural communities. We show them where within the state the price differential is greatest.

[50] Haber S, Beil H, Adamache W, et al. Evaluation of the Maryland all-payer model: Second annual report RTI International. 2017

We also inform policy makers on available policy options to address the high prices in their states, which could involve 1) reducing the prices on out of network and emergency services, 2) helping state employees get lower prices, 3) global budgets, particularly for rural hospitals, and 4) other approaches. We tailor the policy options to reflect the state's specific concerns and characteristics.

In Delaware, for example, we presented data on the differential between commercial and Medicare prices to the State Employees Benefits Committee. The Committee is responsible for the design of and contracting for the health plan for state employees and is considering rate regulation for their employees (e.g., a set percent of Medicare payment). In Washington, we are working with the Health Care Authority on strategies to manage prices in rural hospitals (e.g., global budgets) and how efforts to reduce prices may build on alternative payment models such as bundled payments.

V. Policy Recommendations for the HELP Committee

States are trying to address health care prices through a myriad of legislative and regulatory means. Many of these methods can be translated to opportunities for action at the federal level to: regulate out-of-network prices, regulate rates for specific populations, increase price transparency, increase competition, and facilitate the transition to alternative and value-based payment models.

1. Regulate out-of-network prices

a. Introduce legislation to limit out-of-network prices

Given that ERISA exempts self-insured plans from state regulations, federal action on out-of-network billing is important. States are showing that there are different ways for Congress to address out-of-network pricing. Options range from protecting consumers from certain especially egregious bills, such as surprise bills from emergency department services, to approaches that addresses all out-of-network activity. Options for determining the out-of-network rate include reference pricing to other benchmarks and allowing for a binding arbitration

process.[51] The draft "Protecting Patients from Surprise Medical Bills Act" is an approach to protecting Americans in both self-insured employer health plans and private insurance from high out-of-network costs.

2. Regulate rates for specific populations

a. Rate regulation for FEHBP

The federal government is the nation's largest employer, employing approximately 2 million individuals. The federal government could reduce health costs associated with the Federal Employees Health Benefit Plan (FEHBP) by regulating prices to be a percentage of the prices Medicare pays for the same services. For example, similar to Montana, the rate paid by FEHBP can be set at a certain percentage above the Medicare rate.

3. Increase price transparency

a. Support state development of all-payer claims databases

There is limited data on public and private sector health care utilization and prices available for state policymakers to use to understand pricing trends in their state. Improving availability of these data is critical for policymaking – for example, to set reference prices the state must be able to examine current payment rates. All-payer claims databases, which aggregate health care service claims from all payers in a state, are a promising tool as they allow state policymakers to examine prices across payers, regions, and providers

b. Develop national price transparency tool

As discussed above, many states are undertaking price transparency efforts, however the federal government is the only entity that could create a national resource that could be used to compare health care prices across providers and regions. The national tool could display prices for a set of frequent hospital services (e.g., top 25 DRGs as in the California model) or be broader and display prices for a range of inpatient and outpatient services. A national transparency tool could serve a variety of audiences. Consumers could potentially use it to

[51] Adler L, Fiedler M, Ginsburg PB, et al. State approaches to mitigating surprise out-of-network billing. USC-Brookings Schaeffer Initiative for Health Policy. 2019

"shop" for health care services, though evidence suggests that the extent to which consumers use such tools is limited.[30, 31, 32] Such a tool could be very useful, however, for employers and insurers developing networks based on value and for policymakers to see where unreasonable prices are taxing the system.

The current effort by CMS is a good start but is unlikely to be of much value to consumers. The main problem is that knowing the prices for all the services the hospital provides does not give the patient the information that he or she needs about the services they will receive. Patients want to know how much their specific service is likely to cost them. The Medicare program pays on the basis of diagnosis related groups which are the exact services that the person is receiving. Examples include: DRG 5 is lung transplant; DRG 313 is chest pain; and 508 is arthroscopy. These are services that the patient could understand and if the information was presented in DRG form then the patient would be able to compare prices. This kind of information would also be informative for payers, employers, and policymakers as discussed above. Hospitals routinely calculate DRG payments for all patients so this would not be an additional burden for hospitals.

4. Increase competition

a. Increase action on vertical integration

The primary federal policy tool to manage consolidation of health care providers is antitrust law, implemented through case-by-case decisions by the Federal Trade Commission (FTC). The large number of cases, however, makes it unrealistic for federal policymakers to oversee every merger and acquisition. Some states have turned to state-level monitoring of provider mergers through additional oversight by their Attorney General or through a Certificate of Public Advantage. There is little evidence on whether these tools are having the intended effect of preventing the potential downsides of consolidation, e.g., higher prices. A GAO report on the use of these state tools to monitor consolidation and their effects on patients and payers would be helpful. In addition, increased resources for the FTC to investigate vertical as well as horizontal integration, both of which have been shown to raise prices, is necessary. One problem

is that many of the mergers have already occurred and breaking up the existing relationships will be difficult.

b. Incentivize states to expand scope of practice for NPs

The FTC has identified restrictions of Advanced Practice Registered Nurses and Nurse Practitioners as leading to higher prices. The federal government should give states incentives to set scope of practice laws based on public health considerations by providing grants (e.g., public health service grants) and encourage revision of state licensure laws to lower market entry barriers for these non-physician clinicians to provide primary care and other appropriate services.

c. Support site neutral payments and regulate use of facility fees for non-hospital care

Patients may receive non-inpatient care in several settings, including hospital outpatient departments (on the hospital campus), hospital-owned outpatient clinics (off the hospital campus), and standalone physician offices. The same service may have different prices across settings, resulting in employees and employers paying substantially more in some settings. In particular, prices in hospital-owned outpatient settings (either on- or off-campus) are likely to be higher than prices for the same service in an independent physician office due to the "facility fee" that is charged in addition to the "professional fee" that is charged for the care.

The Centers for Medicare and Medicaid Services announced that they would be moving towards site-neutral payments for clinic visits and estimated that this change would save patients about $150 million in lower copayments.[52] CMS is also looking to eliminate differential payments between Ambulatory Surgical Centers and hospital outpatient departments starting in 2019.[53] These revisions should be encouraged.

[52] CMS. CMS empowers patients and ensures site-neutral payment in proposed rule. CMS Newsroom. Jul 25, 2018. Available from: https://www.cms.gov/newsroom/press-releases/cms-empowers-patients-and-ensures-site-neutral-payment-proposed-rule. Accessed Feb 28, 2019

[53] CMS. CMS finalizes rule that encourages more choices and lower costs for seniors. Centers for Medicare & Medicaid Services Web site. https://www.cms.gov/newsroom/press-releases/cms-finalizes-rule-encourages-more-choices-and-lower-costs-seniors. Updated 2018. Accessed Feb 17, 2019

5. Facilitate transition to alternative and value-based payment models

States as well as payers, both private and public, are increasingly interested in moving towards value-based payment and delivery models. Given this interest, the Center for Medicare and Medicaid Innovation (CMMI) should continue to (1) test and evaluate these models and (2) provide technical and financial support to states and other entities who want to pursue these models. Where possible, CMMI should create templates and national models that make it easier for states to implement them. The key is having all of the different insurers using the same incentives. Congress should examine ways to integrate all of the different systems into one common approach.