



A New Vision for HEALTH REFORM



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Abstract

Health spending is the largest component of the federal budget. Left unchecked, federal health spending is expected to double over the next decade. A similar sharp increase in health spending is projected for consumers, employers, and state governments. A viable agenda for growing the economy must include policies to control the growth of health care spending while promoting access to affordable, quality health care and better health outcomes. Otherwise, there is a big risk that much of the federal budget and the economy's future growth will be absorbed by an excessively costly health system without appreciable gains in health. Controlling costs will require a comprehensive approach that addresses the root causes of high spending. It must increase competitive pressures on health care prices, both from the demand- and supply-sides, allowing pressure from patients to help control costs. This paper details how to arm purchasers – consumers, physicians, insurers, employers, and the government – to make cost-effective decisions in a competitive market environment. Key elements include: promoting competition among health care providers and insurers to lower health care prices; improving information on prices and outcomes to help patients and their physicians make more cost-effective decisions; shifting to new ways of paying for health care that promote efficiency, innovation, and better outcomes; and recognizing the appropriate and necessary role of regulation where markets are not workable.

Introduction

America's health care bill hit \$3.5 trillion in 2017, or \$10,739 per person.¹ For many years, health spending grew rapidly as a share of the economy, nearly doubling from 8.9 percent of gross domestic product (GDP) in 1980 to 17.3 percent of GDP in 2010. Spending growth has slowed in recent years and health spending was 17.9 percent of GDP in 2017. But the slower growth may not last. Actuaries at the Centers for Medicare and Medicaid Services (CMS) project that national health spending will reach nearly \$6.0 trillion by 2027.²

The federal government finances much of that spending through Medicare, Medicaid, subsidies for health insurance available through the Affordable Care Act (ACA), and the Children's Health Insurance Program. According to the Congressional Budget Office (CBO), federal spending for major health care programs totaled nearly \$1.2 trillion in 2018, which represents 28.8 percent of federal outlays.³ By 2029, that spending is projected to double, rising to \$2.4 trillion or 33.8 percent of federal outlays. The Medicare trustees report that Medicare's Hospital Trust Fund will be unable to cover all its expenses as soon as 2026.⁴

A viable agenda for growing the American economy must include policies to control the growth of health care spending. Otherwise, there is a big risk that much of the economy's future growth will be absorbed by an excessively costly health system without appreciable gains in health. This

paper lays out a set of policies that we believe could restrain the growth of health care spending—at a minimum keep it from rising faster than the country’s gross domestic product (GDP)—while ensuring that affordable health care is available to all and improving the effectiveness of care.

Our proposals build on the existing health care system with its mix of private and public financing, markets, and regulation. While the current system is complex and requires constant monitoring and adjustment, we do not believe that pulling it up by the roots and starting over – say, with a single payer system such as Medicare for all – would be worth the cost and disruption. Most Americans are reasonably satisfied with their health care, although they would like to pay less, and fear giving up what they have in favor of a new, untried system imposed by the government.

Anyone seeking to reduce health care costs in the United States must realize that success will take strong political will and sustained effort. The health care industry is large, profitable, and politically powerful. Inefficiencies and waste abound, but one person’s inefficiency is another’s income. The health care industry also has long history of obfuscation about costs and outcomes. Change will take painstaking effort to produce more accurate information and keep improving it.

Controlling health care costs in this country will require a comprehensive approach that addresses the root causes of high spending. A key component of such an approach must increase competitive pressures on health care prices, both from the demand- and supply-sides, allowing pressure from patients to help control costs.

We propose giving patients access to transparent prices that reflect what they will actually owe, alongside meaningful measures of hospital and physician quality. The growing prevalence of high-deductible insurance plans already appears to have somewhat slowed health care cost growth by reducing utilization, although for both high- and low-value services alike. Arming patients with transparent information on prices and quality, then, offers the possibility of improving consumer shopping within the deductible phase of their insurance benefit, hopefully placing downward pressure on prices and incentivizing more targeted reductions in utilization.

For more “shoppable” services such as elective surgeries and imaging, reference pricing has proven effective in reducing costs and driving down provider prices. (The health plan determines how much it will pay for a service based on a reference price determined through bidding or negotiations with providers, with the patient free to choose any provider but required to pay any amount above the plan’s payment. The reference price is typically based on the cost of an average or relatively low-cost provider.) Effective reference pricing requires a health plan to engage its enrollees and offer transparent price and quality information among competing options.

Reference pricing has been used to reduce health plan costs while maintaining high quality standards. In 2010, the California Public Employees’ Retirement System (CalPERS) established a reference price limit for knee and hip replacement surgery. Initially, 41 hospitals charged less than the limit while scoring well on quality measures.⁵ CalPERS also launched an outreach

program informing employees of their new options: having their surgery performed at a hospital charging no more than the reference price or paying extra to have the surgery performed at a higher-priced hospital.

CalPERS patients selecting low-priced hospitals increased significantly once the program was in place. Moreover, half of the high-price hospitals cut their rates to fit within the reference price. As a result, CalPERS saved \$6 million in the first two years of the program.

While approaches that rely directly on consumers to seek out the best price for medical services are part of the solution, there is a limit to their effectiveness. Consumers typically (and appropriately) rely on the advice of their physicians for referrals to specialists and more sophisticated services. In emergency situations, the patient is clearly in the hands of medical professionals. Even for routine services, such as imaging and testing services, patients are likely to go to the provider suggested by the primary physician rather than actively shopping for a better price. Shopping takes time and energy that many patients may be unwilling to invest.

Consequently, financial incentives also should be aimed at the patient's agents – their insurance company and physician(s) managing their care. As long as there is competition among health plans in a market, a patient's health plan has strong incentives to negotiate lower prices on his or her behalf. And unlike the patient, the health plan has far more information at their disposal about the preferred course of treatment, the quality of competing providers, and alternative options. Physicians also need a clear financial incentive and adequate information to direct patients to lower-cost, high-quality providers. Their current incentives are often to direct patients to additional and more costly services that contribute to the physician's income under fee-for-service health care.

In addition to these demand-side approaches, supply-side barriers often instituted by states should be lowered to promote robust price competition among providers. Certificate of need or certificate of public advantage regulations, any willing provider laws, so-called "freedom of choice" laws and other restrictions on the ability of health plans to manage care, scope of practice limits, and barriers to licensing more physicians all serve to hinder price competition among providers and often entrench monopolies.

Broadly, our approach relies on four main tools:

- First, greatly improving information about prices and outcomes to spur cost-reducing pressure from patients and help consumers, providers, and insurers make more cost-effective choices.
- Second, shifting away from fee-for-service payment where possible, holding organized provider groups responsible for the cost and quality of the treatment provided to patients. For example, patients should choose whether to enroll in an Accountable Care Organization (ACO) and have an incentive to cooperate with care coordination and other efforts to lower costs.

- Third, removing barriers to competition among insurers and health care providers, using the power of competitive markets to drive toward cost-effective health care delivery.
- Fourth, appropriate regulation and direct intervention where markets are demonstrably not workable (for example, in sparsely populated rural areas).

Such pro-competition approaches can promote greater efficiency in our health system and slow the growth of health spending, freeing up resources that can lead to stronger economic growth over the long term.

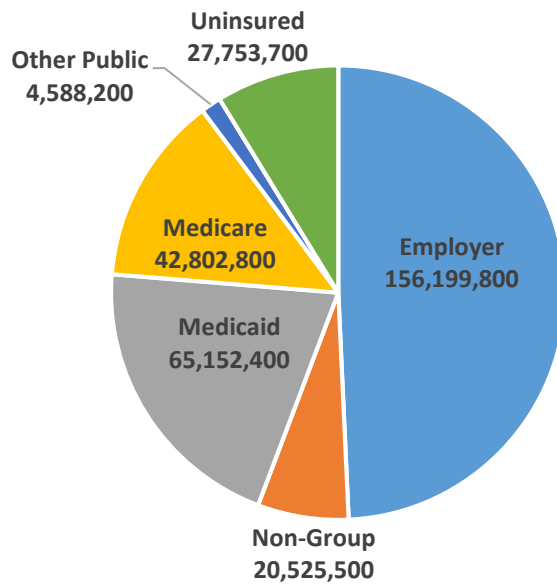
American Health Care in 2019 and How We Got Here

Unlike many other countries, the U.S. never made a national decision about how to deliver and pay for health care. Growth of employer-based health insurance, heavily favored by tax treatment, ensured that most workers and their families would rely on their employer for health care. The challenge, with which policy makers have wrestled for decades, has been how to provide access to adequate, affordable health insurance for those not covered by the employer-based system. In 1965, the federal government enacted Medicare to expand coverage to the elderly and some of the severely disabled and Medicaid, a joint federal-state program, to cover the very low-income population, especially mothers and children. Later the Children's Health Insurance Program (CHIP) expanded coverage to all low-income children and their families.

However, many were still uninsured, and the number began to grow rapidly. As health care costs rose, small firms and those paying low wages were unable to offer their employees coverage and many workers, including the self-employed, found themselves unable to purchase affordable coverage in the individual insurance market. Insurers competed in the individual market to attract the healthiest clients whose health spending was likely to be low. The less healthy (those with preexisting conditions) were charged more or denied coverage entirely. Households with low earnings found coverage unaffordable or were forced to buy insurance with only limited benefits that did not help them when they became ill.

The Affordable Care Act (ACA) enacted in 2010, attempted to make coverage more affordable by providing income-related subsidies to purchasers in the individual market, set minimum essential benefits that all insurance must cover, prohibited insurers from discriminating against people with preexisting conditions, mandated insurance purchase and imposed penalties for not obtaining coverage, and offered states strong financial incentives to expand their Medicaid programs. As a result, the uninsured rate in America dropped by almost half after the ACA took effect, but many beneficiaries faced high deductibles, and those ineligible for subsidies often found premiums unaffordable.

Figure 1. Health Insurance Coverage of the U.S. Population



Source: Kaiser Family Foundation

There are many obstacles to controlling health care spending in the United States:

Advances in biomedical research have led to breakthrough interventions and increasingly effective treatment of disease, but most of these advances are more expensive than the treatments they replace. Patients and providers, not surprisingly, want the latest treatments.

The predominance of fee-for-service payment incentivizes more care, rather than better care.

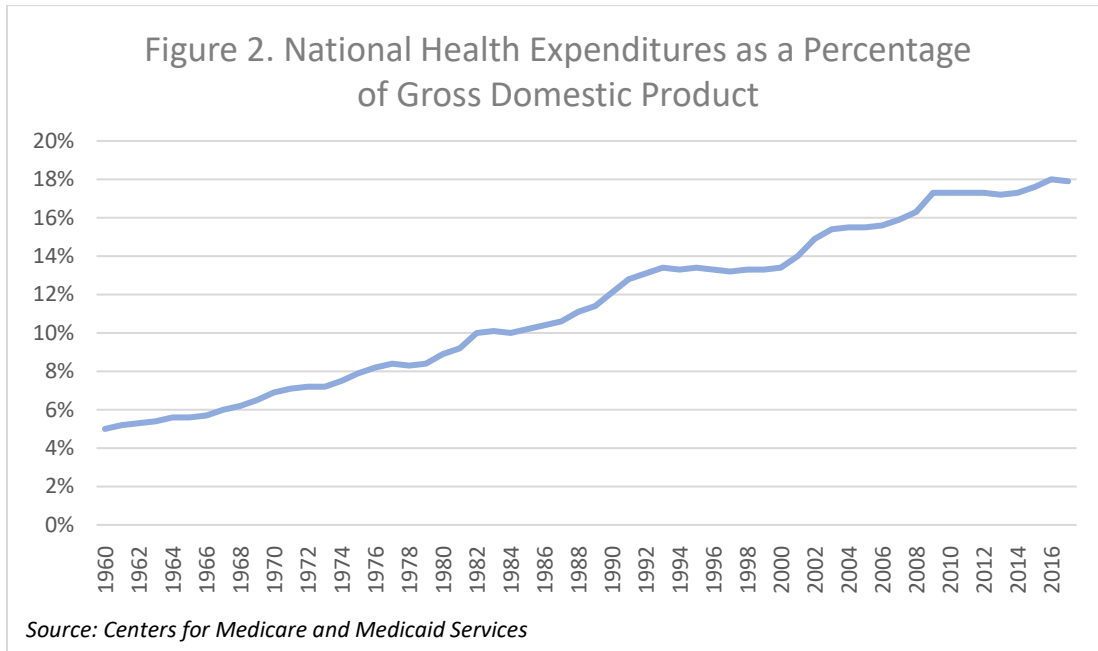
The prevalence of third-party payment means that patients do not consider the full costs of their decisions at the point of care. However, Americans do not like to be surprised by health care bills, do not feel confident shopping in the health care market, and often prefer to follow their doctor's advice when selecting other providers, especially for the costliest advanced care.

The high concentration of spending among very sick patients makes it difficult for insurance companies to set prices for their products and inhibits competition from driving toward cost-efficient care decisions.

The consolidation of providers, especially large hospital systems, gives them more market power to demand very high prices for health care services

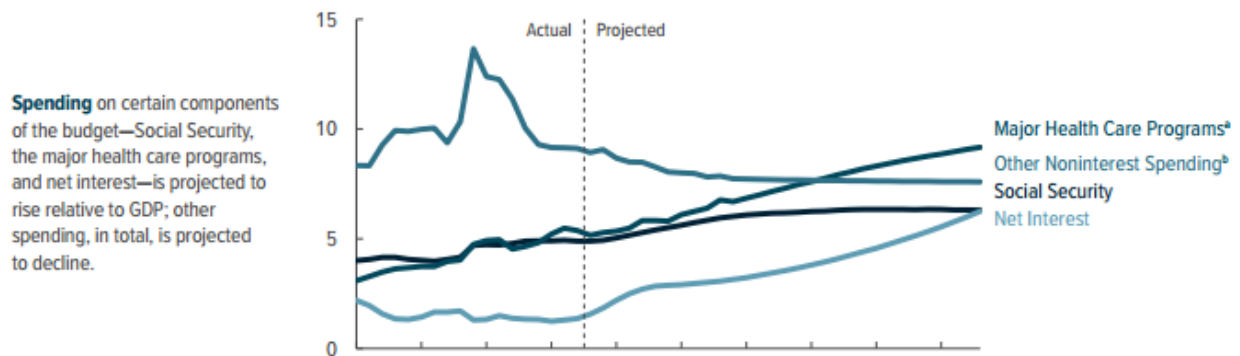
For many decades, health spending in the United States rose substantially faster than GDP and Americans seemed doomed to spending an ever-increasing share of the income on healthcare, especially as the Baby Boomers got older. However, the last decade has witnessed a pronounced slowdown in health care spending, with both system-wide and federal health spending barely

growing faster than GDP despite a sizable coverage expansion resulting from the Affordable Care Act (ACA).



Whether this slowdown will continue, though, is the trillion-dollar question, with most prognosticators, including the Congressional Budget Office (CBO) and the actuaries at the Centers for Medicare and Medicaid Studies, betting against it. Reinforcing the slowdown and making sure it continues, taking heed of lessons learned, is critical.

Figure 3. Percentage of Gross Domestic Product



Source: Congressional Budget Office

The high cost of American health has multiple causes and no one remedy will ensure slower growth. This paper details how to arm purchasers – consumers, physicians, insurers, employers, and the government – to make cost-effective decisions in a competitive market environment.

Consumers as Purchasers

While health care presents more challenges to competition than other markets, pressure from the bottom – consumers – must be a key component in containing health costs.⁶ Americans make many important decisions in directing their health care – choice of provider, choice of insurance plan (whether government- or private-run), and choice of lifestyle – yet incentives to choose effectively are often weak (and sometimes perverse) and consumers typically lack the tools necessary to make the right decision for their circumstance.

American health care is one of the few markets where finding out the cost of a prospective service can prove immensely burdensome, if not impossible. Part of the reason for this difficulty is the dispersion of different “prices” in our system. Providers often have a list price that can be found, but almost no one pays this price.

Most consumers perceive the price as the amount they will owe in cost-sharing, which depends on whether their insurance plan uses copayments (a fixed amount regardless of the price of the service) or coinsurance (a percentage of the service’s cost to the insurer) and whether they have fulfilled their deductible or already reached their annual out-of-pocket limit, among other factors.

Price Transparency

For price shopping to be possible, purchasers need to know what price they would actually pay. Informing someone with insurance of different surgeons’ comparative list prices, for instance, is meaningless because these rates bear little relation to rates negotiated by insurers and to what the patient would actually owe out-of-pocket.⁷ Moreover, without understandable quality metrics alongside information on prices, there is a risk that patients automatically associate higher prices with higher quality, which often is not the case.⁸ When choosing your primary care physician, which hospital to go to for a pre-scheduled surgery, where to go for an MRI, or where to send a lab test, patients need to know the prices relevant for them as well as the quality of competing options in order to compare and make a cost-effective choice.

As expected, studies routinely find that consumers utilizing price transparency tools receive lower-priced services, particularly for more commodity-like services such as imaging, lab tests, and medical equipment.⁹ Some research further suggests that this price transparency can trigger increased provider competition.¹⁰ However, studies also find that transparency tools are only used by a small percentage of consumers, primarily for a subset of more “shoppable” services (services whose use is predictable in advance and are offered by multiple providers with sufficient information about prices and quality). Consequently, such tools have had little impact on overall spending.¹¹ One analysis estimates that requiring all private plans to provide enrollees with

personalized out-of-pocket cost data could reduce total spending by \$18 billion over the next decade – not meaningless, but that amount represents less than one-tenth of a percent of total system-wide health spending over that same period.¹²

Several key hurdles limit the effectiveness of price transparency in isolation. The prevalence of third-party payment (insurance) shields patients from the full cost of care. Given the existence of expensive, hard-to-predict risks inherent in health care, some level of health insurance is certainly desirable and efficient, but the coverage of more routine, predictable expenses weakens incentives to price shop or control utilization. Much of employer-provided private health insurance remains quite generous, with copayments (which do not vary with service cost) rather than coinsurance due from patients at the point of service, and 15 percent of covered workers are enrolled in a plan without any deductible (in 2018).¹³

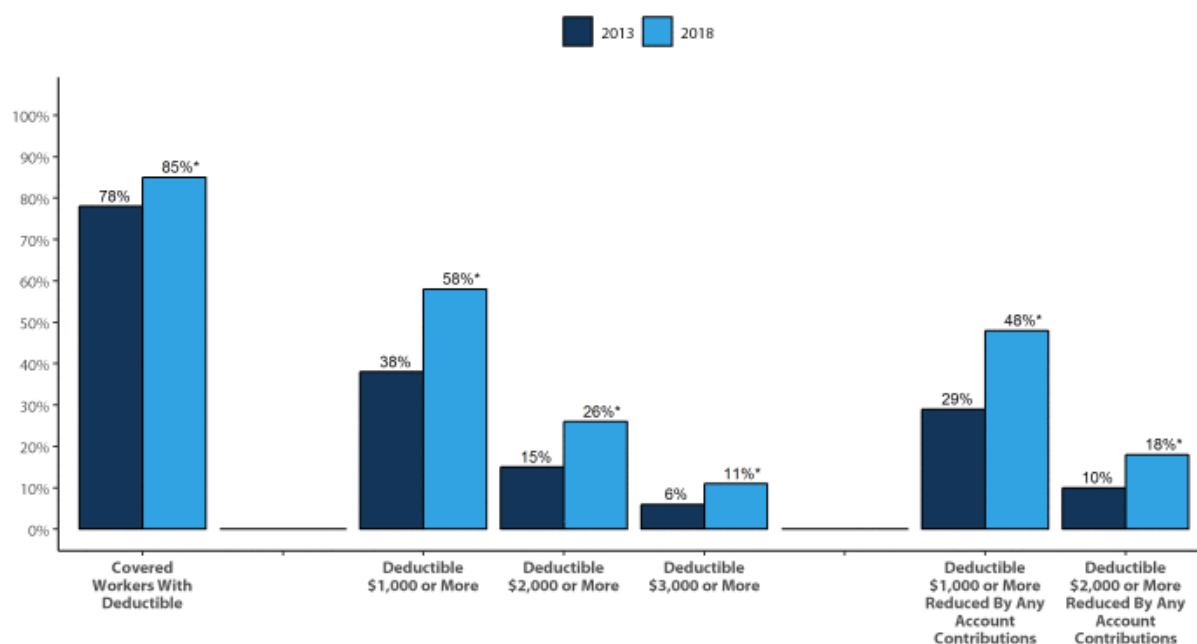
In short, we believe that greatly improved information on prices and outcomes, made easily accessible to patients and providers, can help put downward pressure on costs and rein in high-cost outliers. However, given the concentration of spending among the seriously ill and the preference of patients for coverage that avoids unpleasant surprises, the ability of patient choice to control costs is limited.

High-Deductible Insurance and Health Savings Accounts

In part aimed at addressing these concerns, there has been a marked shift toward higher deductible health plans in recent years. Fifty-eight percent of covered workers now have a health plan with a deductible of at least \$1,000 and individual market enrollment is largely in high-deductible plans – the average “Silver” plan offering, the most popular individual market coverage level under the Affordable Care Act, includes a deductible of roughly \$4,000 for single coverage and \$8,000 for family coverage.^{14,15} The theory of high-deductible health plans is that they would make consumers more sensitive to costs, and that individuals could be incentivized to better save for health care costs by offering a tax break to contribute to a health savings account (HSA).

This shift placed downward pressure on health care costs and played some role in the last decade’s spending slowdown.¹⁶ Evidence is clear that deductibles reduce overall spending, but they appear to do so almost entirely by reducing the amount of care enrollees receive rather than inducing patients to shop, and the reductions in care appear to come equivalently from high- and low-value services.¹⁷ The one area where deductibles have been shown to increase price shopping is for the choice between the generic and brand of the same drug.¹⁸ That may be the exception that proves the rule, though, as there is no more commoditized choice in health care than choosing between two chemically-equivalent medicines.

Figure 4. Percentage of Covered Workers with Various Single Coverage Annual Deductible General Levels, 2013 and 2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Account contributions include an employer's contribution to an HSA or HRA. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013

Source: The Kaiser Family Foundation, 2018 Employer Health Benefits Survey.

Deductibles typically fail to incent significant price shopping. Consumers typically (and appropriately) rely on their physicians for referrals to specialists and more sophisticated services, which inhibits consumer shopping.¹⁹ In emergency situations, the patient is clearly in the hands of medical professionals. Even for routine services, such as imaging and testing services, patients are likely to go to the provider suggested by the primary physician rather than actively shopping for a better price.²⁰ Moreover, those patients with the highest costs will inevitably reach even the highest deductibles or annual out-of-pocket limits, and typically know at the beginning of the year they will do so, blunting the incentive to shop for lower prices. The highest-cost 5 percent of the population makes up 50 percent of all health spending.²¹

Although there are still some untapped savings achievable through higher deductibles, particularly for those currently in low-deductible plans, increasing the level further for high-deductible plans offers diminishing returns. The benefits of higher deductibles must be weighed against the financial strain they place on plan enrollees.

One option to balance access to care with the move toward higher deductibles is to eliminate certain restrictions on who can contribute to an HSA, which allow consumers in high-deductible

plans to put aside tax-free dollars to use or save for health care expenses. Eligibility for HSAs is tied to a minimum deductible size (\$2,700 in 2018 for a family plan). However, if a plan offers first-dollar coverage for a high-value service but otherwise has a high deductible, enrollees are not allowed to have HSAs associated with that plan.²² A better policy would base HSA eligibility on the level of overall cost-sharing required by the insurance plan rather than a deductible level, thus allowing for more innovation in plan design.²³

While deductibles have increased for people under 65 in private coverage, the traditional fee-for-service Medicare program still includes a relatively low deductible for the physician services component (Part B), at \$183 in 2018, and zero patient cost-sharing responsibility for certain services such as home health and shorter skilled nursing facility stays. Moreover, most Medicare enrollees have some form of supplemental coverage (including Medigap) that buys down patient cost-sharing, making patients less sensitive to the price of care. CBO estimates that modernizing Medicare's benefit design to include a combined Part A and B deductible of \$750 and an out-of-pocket limit of \$7,500 with uniform 20 percent coinsurance for most services, combined with restricting Medigap plans from filling in the deductible and more than half of coinsurance amounts, would reduce federal deficits by \$116 billion over ten years.²⁴ A variation on that policy, such as a proposal by the Committee for a Responsible Federal Budget, would reduce utilization of services, resulting in savings for the average beneficiary and the Medicare program.²⁵

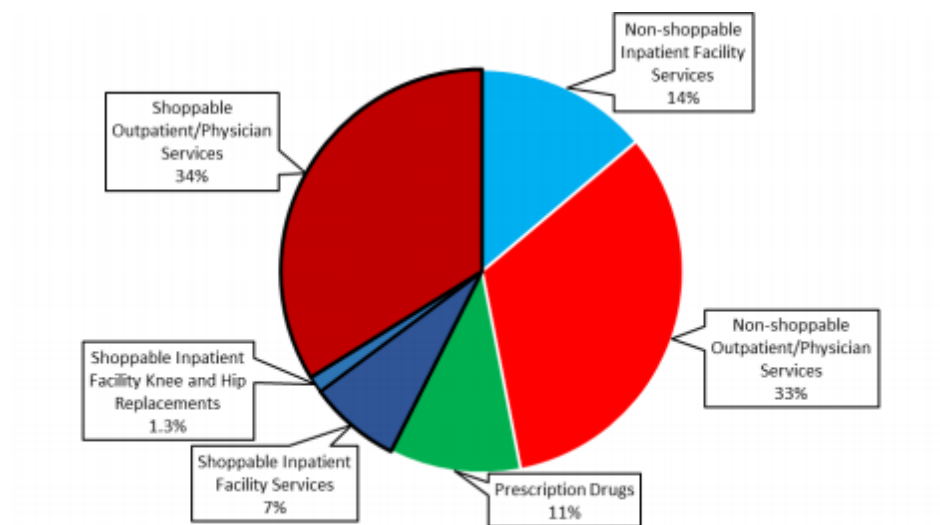
Reference Pricing

Some insurers use reference pricing to set the payment for a covered service. The reference price may be based on an average price for similar services in the market area or might be set through a bidding or negotiating process. The patient may be free to choose any provider but would be responsible for any additional payment for providers who charge more than the reference price. In other cases, the employer or plan may limit coverage to those providers who accept the reference price.

Evaluations of reference pricing efforts by employers (including state agencies such as CalPERS) have found significant spending savings for orthopedic surgery, colonoscopies, prescription drugs, and laboratory tests, on the order of 10, 20, or even 30 percent in one instance.²⁶ Effective reference pricing requires a health plan to engage its enrollees and offer transparent price and quality information among competing options, which the government can facilitate by continuing its efforts to improve public reporting of relevant provider quality metrics.

Reference pricing is a promising approach to pursue further, but its effectiveness is generally limited to services that patients can reasonably shop for. One study estimates that at most 43 percent of health spending is shoppable and another 11 percent is spent on prescription drugs, some of which is shoppable.²⁷ It may be hard to shop for some people even for these types of services.

Figure 5. Distribution of Total ESI Spending by Shoppable/Non-Shoppable Services, 2011



Source: HCCI, 2016. Claims data from employer-sponsored insurance (ESI) population younger than age 65 for the year 2011, data weighted to be nationally representative.

Source: Health Care Cost Institute, 2016.

Choice of Health Plan

Roughly 65 percent of the insured population under age 65 receives health coverage through their employer, yet most employers offer limited (if any) choice of health plans to their employees. While there are many reasons for this phenomenon, one hindrance to competition in this market is that employer-provided health insurance benefits are exempt from taxation, which blunts pressure for employees to choose a less costly plan option. As a result of the exclusion, employers are incentivized to offer more compensation in the form of health benefits (because they are untaxed) rather than in employee wages (which are taxed). In turn, this increases demand for health care and therefore prices throughout the system, and given how fast health care costs grow, leads to smaller raises for workers each year.

Capping the tax exclusion would increase the incentive for employers to offer and for employees to choose health plans that are more appropriate for their needs. Allowing the so-called Cadillac tax on high-cost plans to take effect (originally scheduled to take effect in 2018, now delayed until 2022 through bipartisan legislation) would have a similar salutary effect.²⁸ Either approach would also raise significant tax revenue – CBO estimates that replacing the Cadillac tax with a cap on the income and payroll tax exclusion at a level equal to the 50th percentile of premiums would reduce deficits by \$638 billion over 7 years.²⁹

There is also room to improve consumer choice of health plans in the individual market. Some of this improvement will occur naturally as the market continues to stabilize, especially if policy uncertainty surrounding the fate of the Affordable Care Act (ACA) ever fully dissipates. New plan entry can be further facilitated by limiting barriers to entry, such as medical loss ratios that pose difficulties on new plans and limit the upside when taking on new risk.³⁰

The Medicare program could also benefit from greater competition between the traditional Medicare option and the array for private Medicare Advantage (MA) plans, which now serve 34 percent of Medicare beneficiaries.³¹ Converting Medicare to a competitive bidding structure, where the government contribution would be based on health plan bids to deliver the Medicare benefit package, offers the potential to facilitate better consumer plan choices.³² The current bidding structure reduces incentives for plans to become more efficient. Because the government pockets 30-50 cents of every dollar of lower premiums, consumers face weaker incentives to choose lower-cost plans.³³ This competitive bidding structure could be used to set premiums for both traditional Medicare and Medicare Advantage plans (commonly referred to as “premium support”), or it could be confined to MA plans.

In addition, reforms would simplify the complex choice environment that hampers Medicare’s efficiency and makes shopping for plans more difficult. Standardizing MA plan offerings and improving the tools available for comparing options can improve the consumer shopping experience.³⁴

Insurers and Employers as Purchasers

Health plans have strong incentives to negotiate lower prices with providers, allowing them to offer lower premiums and better benefits to their enrollees. Negotiating on behalf of many customers allows them to get better prices from providers. Plans also have more information at their disposal about the quality of competing providers. However, many obstacles currently hinder the ability of insurers to obtain lower prices and efficiently manage patient care.

Selective Contracting

Selective contracting is the main tool by which insurers seek to control health costs for hospitals, clinicians, and prescription drugs. In exchange for steering their enrollees to certain providers, those providers (or drug manufacturers) offer price concessions. The threat of excluding a provider altogether from a plan’s provider network (or a drug from their formulary) amplifies this leverage. A more limited provider network can also help an insurer manage and coordinate patient care (although this is not always the case in narrow network plans).

Policymakers should not unnecessarily impede the ability of health plans to restrict provider choice, as long as enrollees still have the opportunity to receive adequate care within the plan’s network. In particular, Medicare Advantage and states should avoid overly prescriptive network adequacy requirements and create a formal appeals process when appropriate in-network care is unavailable.³⁵

Similarly, states should avoid any-willing provider and freedom of choice laws, both of which hinder the ability of insurers to selectively contract with preferred providers. Any-willing provider laws require health plans to include in their network any licensed provider who is willing to accept the contract terms offered to other providers, making it more difficult to steer enrollees to more efficient providers. As expected, studies find that these laws increase health care expenditures in a state and reduce a plan's ability to control costs.³⁶ Freedom of choice laws require managed care plans to reimburse providers outside of the plan's network when seen by an enrollee and have been found to reduce HMO penetration in a state.³⁷

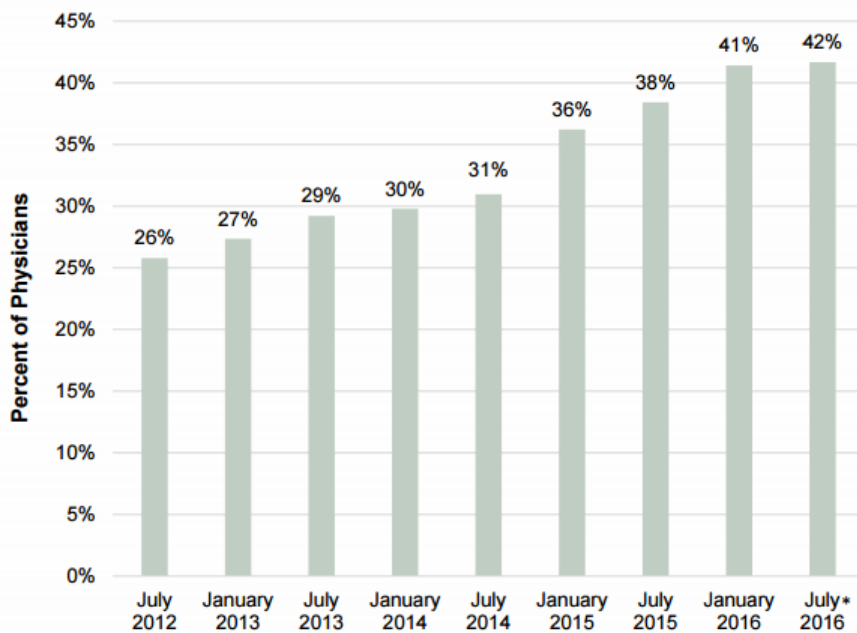
Provider Competition

The biggest obstacle insurers face as purchasers is the lack of vibrant provider competition in many markets across the country. Selective contracting is ineffective when there's little or no ability to choose between different providers. A recent analysis estimates that 77 percent of Americans live in metropolitan areas with highly or super concentrated hospital markets.³⁸ At the same time, hospitals have continued buying physician practices. In 2016, 42 percent of physicians were employed by hospitals, compared to 26 percent in 2012.³⁹

While mergers and vertical integration could create efficiencies or economies of scale, the evidence shows that consolidation among competing hospitals leads to increased prices and spending.⁴⁰ More broadly, the level of hospital competition in an area is highly correlated with prices and contract structure. Utilizing nationwide data from private insurers, one study finds that prices at monopoly hospitals are 12 percent higher than in areas where four or more competing hospitals operate.⁴¹ And when prices for hospital care are fixed, such as in Medicare or many other countries, quality of care appears to suffer when hospital markets consolidate.⁴² Similarly, hospital ownership of physician practices is associated with higher prices and spending.⁴³ One study found that prices for services supplied by physicians rose 14 percent after being acquired by a hospital.⁴⁴

Policymakers should move aggressively to roll back barriers to competition and improve enforcement against anticompetitive consolidation. First, Medicare should adopt site-neutral payments for services that can safely be performed in hospital outpatient departments (HOPDs) and freestanding physician's offices. Currently, Medicare pays more when a service is performed at a HOPD than at a physician's office. This payment differential creates an incentive for hospitals to acquire physician practices, which increases their revenues and raises taxpayer costs.⁴⁵ Congress took a first step in the Bipartisan Budget Act of 2015 and the Trump administration is moving further in this direction through rulemaking. One report finds that additional reforms could yield additional substantial savings for Medicare.⁴⁶

Figure 6. Employment of Physicians; Percent of Hospital-Employed Physicians



Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files

*In July 2016, the total number of physicians decreased. As a result, the number of employed physicians decreased slightly but the percentage employed physicians increased.

Source: Physicians Advocacy Institute. 2018.

Second, a plethora of anti-competitive policies to restrict the supply of health care professionals and hospitals exist at the state level. State certificate of need laws (originally pushed by the federal government in a different era of provider payment) make it more difficult to build new health care facilities or expand existing ones and certificate of public advantage regulations allow merging health providers to avoid antitrust scrutiny. Many hospitals exert their market power to require anti-competitive provisions in their contracts with insurers, such as clauses that prevent insurers from steering patients to higher quality or less costly providers or requiring higher patient cost-sharing to get treatment at that hospital versus other less costly ones.⁴⁷ By restricting competition, these types of policies and provisions drive up health care costs.⁴⁸ Some states have begun addressing these issues, but more needs to be done. States should consider repealing regulations that restrict competition or protect consolidation from scrutiny and move to prohibit anti-competitive provisions in hospital contracts. State attorneys general or the Federal Trade Commission (FTC) should also consider challenging these anti-competitive contract provisions, as some state attorneys general have begun to do.

Third, increasing the supply of physicians can both increase access to care and create more robust competition and consumer choice, potentially driving down prices and improving quality. More federal subsidies for graduate medical education is not the answer. Instead, one promising option

is to expand opportunities for medical education and training for highly-qualified foreign-trained doctors, and to create a new pathway to simplify accreditation. There are many more qualified undergraduate students who wish to become doctors than there are spaces available in U.S. medical schools or residency slots for training, and we rank near the bottom of the developed world in medical graduates per capita.⁴⁹ In a well-functioning market, this mismatch would not persist, but the supply of medical schools and residency slots is largely decided by currently licensed physicians and their trade groups.⁵⁰ Supply can further be boosted by making it easier for foreign-trained doctors to immigrate and practice here, especially in less desirable locations or specialties where they already comprise a sizeable portion of U.S. physicians.⁵¹ Studies find no drop-off in quality when care is provided by foreign-trained physicians, and they may have lower mortality rates than U.S.-trained physicians.⁵² Policymakers should identify a list of foreign residency programs comparable in rigor to American ones that qualify people to directly seek state licensure and create an expedited pathway for foreign-trained physicians to obtain legal status in America and license to practice medicine.

State-based provider licensure plays an important role in ensuring safe care delivery, but certain practices also inhibit competition. Specifically, scope of practice restrictions often unnecessarily prevent health care professionals from practicing to the top of their license. State restrictions often result from politics rather than risks of patient harm.⁵³ States should amend their criteria such that the only justification for restricting scope of practice is the safety of the public. States should also promote practices such as telehealth that offer potential to generate greater competition and access to care, even if that access comes with associated costs. In addition, licensure reciprocity between states would help bring physicians to areas facing shortages of medical personnel.

Vigorous antitrust enforcement is critical to keeping markets competitive. Federal antitrust agencies should continue scrutinizing horizontal mergers and apply increased scrutiny to vertical mergers, particularly when hospitals are buying physician practices, which also has implications for horizontal competition. While an individual purchase of a physician practice might not normally trigger federal review, agencies should consider the full state of competition in a given market in assessing whether an acquisition violates antitrust concerns. The Federal Trade Commission (FTC) should be given authority to enforce antitrust violations from non-profit firms. This restriction poses a significant hurdle in health care markets where many hospitals are organized as non-profits, for which antitrust enforcement could also produce value.⁵⁴ While more radical in nature, the FTC should study the impacts of breaking up certain hospital systems in highly-consolidated markets or revisiting old mergers.

Limited Contracting and Price Regulation

Competition and markets should be relied upon wherever possible to improve our health care system, but there are certain areas where that will prove insufficient. In highly consolidated provider markets, without competition and with government subsidies covering much of the cost of health care, a sole hospital is typically able to charge high rates. In such instances, rate

regulation may be the preferable course of action in order to protect consumers and taxpayers from excess market power.

Emergency care, by definition, is unmoored by normal market forces and does not allow for shopping. Patients typically do not know an emergency is coming and must seek care immediately, often at whatever facility is closest or wherever an ambulance takes them. And by law (The Emergency Medical Treatment and Labor Act, or EMTALA), hospitals must treat patients presenting with an emergency until they are stabilized. Exacerbating the problem, emergency physicians typically contract with health plans independently from the hospital(s) at which they practice. Thus, even when patients go to an in-network hospital for emergency care, they are frequently treated by an out-of-network physician, who can then balance bill the patient the difference between their list price, which tends to be extremely high, and the amount actually paid by the health plan.⁵⁵ As a result, it is not surprising that payment rates from insurance companies to emergency department physicians average roughly 300 percent of Medicare rates (significantly higher than for other physician specialties).⁵⁶ To fix this problem, the federal government should require hospitals to set a single bundled price for emergency department services, including physician services, forcing the hospital rather than the patient to negotiate with their physicians.⁵⁷

Prescription Drug Purchasing

Spending on prescription drugs constitutes roughly 10 percent of overall health care spending, and this share has remained relatively consistent over the last 20 years.⁵⁸ Patents and other forms of intellectual property protection promote investment in the costly research and development of innovative drugs and other treatments. Limiting the duration of patent protection allows the introduction of generic competitors, which gives consumers a lower cost option. The policy challenge is determining the proper balance between promoting innovation and promoting competition. There are also many policy options that can increase efficiency in prescription drug markets and better incentivize the most valuable types of innovation.

Dedicating more resources to the U.S. Food and Drug Administration (FDA) or streamlining procedures can help speed approvals of new brand and generic drugs to create competition and for generic drugs in the wake of a price spike. A particular focus should be placed on faster approval of biosimilars.

Policymakers and the FTC should move to tamp down on certain anticompetitive actions of drug manufacturers. Specifically, they should enforce antitrust laws against pay-for-delay deals that keep generic competitors off the market and anticompetitive uses of the Risk Evaluation and Mitigation Strategies (REMS) loophole by brand drug manufacturers to avoid having to share samples to follow-on manufacturers at market prices. In addition, policymakers should restrict abuse of the Orphan Drug designation.⁵⁹

Insurers attempt to hold down costs and extract price concessions from drug manufacturers through the use of formularies or tiers, similar to how they negotiate with providers. However,

the use of copay coupons allows brand drug manufacturers to undermine this aspect of competition, and this practice has grown in recent years.⁶⁰ By offering to pay a patient's copay (whether directly or through a third-party charity), a manufacturer can make their drug less costly to a consumer even if the insurer is paying much more for it than its competitor. The higher cost is passed on to consumers in the form of higher premiums. This practice is barred in Medicare, but is quite prevalent in private insurance, making it more difficult for insurers to steer patients toward less costly brand or generic drug alternatives and increasing system costs. Federal policymakers should move to ban copay coupons aimed at individual drugs, at least when there are competitors on the market.

Government as Purchaser

Both federal and state governments would benefit from the lower costs expected from the policies outlined above to enhance consumer choice and boost provider and prescription drug competition. Indeed, state governments should aggressively pursue price transparency and reference pricing tools for their state employee health plans. But more can be done to make the government a better purchaser of health care goods and services.

Delivery System Reform

Provider payment in this country has long taken place primarily on a fee-for-service (FFS) basis, reimbursing providers more for the more services they provide. This structure predictably leads to high utilization of health care services, which largely drives the wide spending variation across the country in Medicare.⁶¹ Medicare Advantage plans, which are paid on a capitation basis, have stronger incentives for efficiency and are an alternative to fee-for-service Medicare. As part of the ACA, Medicare has begun shifting away from FFS, experimenting with accountable care organizations (ACOs) and bundled payments.

An ACO is a group of health care providers who together are judged on total per member spending and quality, often either led by a primary care group or a hospital. By judging their members' spending against a benchmark and sharing any savings created if quality targets are met, the goal is to reward managing costs and quality rather than simply how many services you can perform. Roughly 20 percent of Medicare beneficiaries and nearly a third of traditional Medicare (that is, excluding Medicare Advantage enrollees) beneficiaries now are part of an ACO.⁶² To date, ACOs have produced modest savings while roughly maintaining quality, and evidence suggests that savings percentages grow over time.^{63,64} However, building on this progress will involve strengthening financial incentives and allowing greater engagement of ACO members. To achieve the program's goals, the incentives must apply to hospitals as well, and not only to physicians.⁶⁵

Bundled payments also offer potential to curtail some of the impacts of volume-based reimbursement. Often targeted at a specific procedure (e.g., hip or joint replacement surgery) or course of treatment (e.g., oncology care), bundled payments seek to make a single payment for a course of treatment surrounding a procedure, rather than individual payments for each aspect

of treatment. For example, a hospital might receive a fixed lump sum payment to manage a patient's hip replacement surgery, putting that entity at financial risk for controlling the costs of post-surgery rehabilitation, any hospital readmissions, or the medical devices used during surgery. The program appears to be generating moderate savings.⁶⁶

The continuing growth in Medicare Advantage penetration can also bolster the move away from unfettered FFS payment. Indeed, ACOs and MA plans combined now account for more than half of Medicare enrollment. Originally, the MA program was enacted with the goal of reducing Medicare expenditures and producing savings for taxpayers, but as a result of a series of legislative decisions, MA enrollees have consistently cost taxpayers more than those in traditional Medicare. This discrepancy shrunk in recent years as a result of payment cuts in the ACA, but a small gap still remains. However, evidence strongly suggests that costs are lower in MA than in traditional Medicare for similar beneficiaries, a result of lower utilization and similar provider payment rates.⁶⁷ As mentioned earlier, utilizing a competitive bidding system to set MA plan payments would take advantage of this relative efficiency to generate savings for taxpayers and reduce overall costs, with estimated federal savings of roughly \$10 billion per year.⁶⁸

Medicare Prescription Drug Coverage

Medicare and Medicaid pay for a large percentage of prescription drug spending in America, and while both programs would benefit from the pro-competitive reforms detailed in the previous section, certain policies specific to these programs merit attention. In Medicare, a requirement on Part D prescription drug plans to include at least two drugs in any class on its formulary and stricter requirements to include all drugs in certain "protected" classes weaken their ability to negotiate pricing discounts. The administration has proposed a rule to provide more plan flexibility for drugs in these protected classes, and they should continue moving forward with relaxing these restrictions.⁶⁹

While most prescription drugs in Medicare are contracted for through private insurance plans, physician-administered drugs in Medicare Part B are paid for through an administered reimbursement system based on commercial market prices. Physicians purchase the drugs and then are reimbursed by Medicare for the average sales price to commercial plans plus a 6-percentage point add-on fee intended to cover the costs of administration and risk of storing the drug before use, which has the perverse impact of incentivizing physicians to use more costly alternatives that are therapeutically appropriate. This add-on payment should be converted to an equivalent flat fee.⁷⁰ Congress and CMS should also consider a competitive acquisition program for Part B drugs that would relieve the physicians administering the drug of having to both buy and bill for the drug (and the financial risk that entails), as recommended by MedPAC.⁷¹

Conclusion

Health spending is the largest component of the federal budget, accounting for more than one-quarter of all federal spending. Left unchecked, federal health spending is expected to double over the next decade. A similar sharp increase in health spending is projected for consumers,

employers, and state governments. An agenda to promote economic growth in the U.S. must include policies that slow the rise of health care spending while promoting access to affordable, quality health care and better health for all Americans.

Our vision for reform builds on the existing health care system, which is a mix of private and public financing, markets, and regulation. Key elements of that reform include:

- Promoting competition among health care providers and insurers to lower health care prices,
- Improving information on prices and outcomes to help patients and their physicians make more cost-effective decisions,
- Shifting to new ways of paying for health care that promote efficiency, innovation, and better outcomes, and
- Recognizing the appropriate and necessary role of regulation where markets are not workable.

Such pro-competition approaches can promote greater efficiency in our health system and slow the growth of health spending, freeing up resources that can lead to stronger economic growth over the long term.

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