AV POLICY FOCUS: COMMERCIAL SECTOR PRICES

Arnold Ventures

Lowering Commercial Prices to Make Health Care More Affordable

Problem: Increased consolidation and a lack of competition among providers have driven up the prices providers charge the privately insured for hospital and physician services, leading to high health care costs in the United States.

Solution: To lower the high prices Americans with private health insurance pay for their health care, solutions should address THREE KEY ISSUES:

1 Transparency and Accountability

One major characteristic of the health care system is its lack of transparency—the prices providers and insurers negotiate are secret, and patients are not typically aware of the cost of their care before they receive the bill. Additionally, some hospitals take advantage of the lack of transparency and accountability in the health care system to engage in practices that can harm patients and their communities.

2 Market Consolidation and Distortions

The American health care system is rife with market failures and misaligned incentives that ultimately increase costs for patients, employers, and taxpayers. Health care markets are becoming increasingly uncompetitive as large hospitals and provider groups consolidate and gain market power, giving them leverage to negotiate higher prices from insurers. Furthermore, the current health care system is designed in a way that incentivizes certain providers to remain out-of-network and provide care in higher cost settings.

3 Excessive Provider Prices

The system for determining the amount we pay for hospital and physician services in the United States leads to irrational and often excessive prices in the commercial insurance market. These prices are often set based on a provider's market power and ability to demand higher prices, rather than the cost or value of the service. This results in high and rising health care prices for privately insured consumers, who must pay higher premiums and out-of-pocket costs.

1. TRANSPARENCY AND ACCOUNTABILITY

Transparency

- **Create a federal all-payer claims database** that provides data on the prices all payers pay each hospital for specific services in each market or allow states to require that self-insured plans report to the state all-payer claims database.
- **Require transparency and reporting of private equity ownership of hospitals and physician groups** to make it easier for researchers and policymakers to determine the role private equity may play in increasing health care prices and in other adverse changes to the health care system.

Predatory Business Practices

- **Stop hospitals from using predatory debt collection practices,** such as garnishing wages and seizing assets of low-income patients who cannot afford to pay the high price of health care.

Hospital Community Benefits

- **Reform hospital community benefit requirements** to ensure hospitals that receive tax breaks are spending money on their communities in such a way that is high value to patients and produces meaningful outcomes for the community.
- **Require hospitals to publish data on community benefit spending** to increase transparency around how hospitals are using their tax benefits to benefit the communities in which they are located.

2. MARKET CONSOLIDATION AND DISTORTIONS

Anti-Competitive Behaviors

- **Prohibit anti-competitive contracting terms** between providers and insurers—such as most-favored-nation, all-or-nothing, or anti-steering contract terms—that limit market competition.
- **Strengthen antitrust enforcement** that will prevent hospital systems or provider groups from gaining a large share of market power that they can use to demand higher prices.

Surprise Billing

- **Add ground ambulance providers to Federal surprise billing protections** to further consumer protections included in the No Surprises Act.

Site-Neutral Payments

- **Pay outpatient hospital departments the same Medicare rate as physician offices** for services that can safely be performed in a lower cost setting, and prohibit providers from charging facility fees for services provided at hospital outpatient departments and standalone emergency rooms when the same service is commonly provided in a physician's office. Eliminating or reducing the payment differential would reduce the incentives for providers to vertically consolidate for financial reasons.

Employer Sponsored Insurance Tax Exclusion

- **Limit the open-ended employer sponsored insurance tax exclusion** to encourage employers and individuals to purchase more cost-effective health care plans.

3. EXCESSIVE PROVIDER PRICES

Direct Limitations on Prices

- **Cap provider prices**, for example, based on a percentage of Medicare rates or in-network rates. There are a variety of ways to implement this, including through a cap on prices at the top of the entire commercial price distribution (e.g., above the 75th percentile nationwide), or a cap on hospital prices in consolidated markets.
- **Enact a public option** that will constrain costs by increasing competition among health plans and limiting provider prices, for example by tying prices to Medicare (or median in-network) rates.
- **Create a public program buy-in** such as a Medicare buy-in program that allows more people to purchase affordable coverage that leverages the payment rates used in public programs.