

Debate Positions

Position A: If the U.S. is serious about reducing costs for the health system at large, hospitals are going to need to cut costs and operate using Medicare dollars.

Position B: Hospitals already operate on thin margins, and regulation drives much of their cost. Few hospitals can achieve profitability at Medicare rates, so forcing them to accept Medicare rates would cause many to go broke, especially those in rural areas.

Discussion Questions

1. Why are hospitals the largest driver of healthcare costs in the US? There is significant variation between the costs of different hospitals with little evidence that this variation is tied to different outcomes. What's the takeaway from the data?
2. When discussing high hospital costs critics draw comparisons internationally to countries like Switzerland that have lower hospital costs but better outcomes. Are international comparisons of this sort fair? Why or why not?
3. What do hospitals need from a public policy perspective to lower costs?

At a Glance

Who?

■ Who are the stakeholders most affected by this?



Providers: Hospitals



Payers: Government & Private



Patients



Employers

What?	<ul style="list-style-type: none"> ■ What issues are novel to the U.S. vs other countries with more regulated systems of universal coverage? <ul style="list-style-type: none"> – Benchmarked across several OECD quality measures, the U.S. lags behind similarly wealthy countries (based on GDP and GDP per capita). (1) <ul style="list-style-type: none"> » The U.S. is not improving as quickly as other countries, for the following rates, which means the gap is growing: <ul style="list-style-type: none"> ▶ All-cause mortality ▶ Premature death ▶ Death amenable to healthcare ▶ Disease burden – Potential issues specific to the U.S. versus 11 OECD countries include: (2) <ul style="list-style-type: none"> » A large heterogeneous population- 323 million » High poverty and other social determinants- U.S. poverty rate is 12.7% of the population » High administrative costs <ul style="list-style-type: none"> ▶ Administrative costs account for 30% of health care expenditures in the US, double that of Canada » High pharmaceutical spending at \$1,443 per capita, with a mean of \$749 per capita » More high-margin, high volume procedures- 2x knee replacements/capita vs. the Netherlands » Low life expectancy (78.6 years for a baby born in 2017 in the US) influenced by increased rates of <ul style="list-style-type: none"> ▶ Obesity- 36.5 % of the U.S. population ▶ Diabetes- 13% of Americans ▶ Car crash deaths ▶ Gun homicides
Where?	<ul style="list-style-type: none"> ■ Where are revenues distributed? <ul style="list-style-type: none"> – 96.9% of hospital revenues are distributed across 4 main payer categories (3). The remaining came from other government payers and non-patient costs. <ol style="list-style-type: none"> 1. Medicare: 40.8% 2. Private payers: 33.4% 3. Medicaid: 18.5% 4. Uncompensated care: 4.2% – There is a wide and growing gap between public and private rates. (4) <ul style="list-style-type: none"> » Patients with private insurance account for one-third of hospital costs but are the source of most hospitals' profit » Private insurance rates for hospital services are well above hospitals' cost of providing care – A recent Health Affairs study revealed that hospital facilities themselves, rather than the physicians who staff them, are the primary driver of rising hospital costs. (5) <ul style="list-style-type: none"> » From 2007 to 2014, inpatient hospital prices grew 2x as fast (42% increase over the period) as physician prices (18% increase over the period) » For outpatient services, hospital prices rose more than 4x faster than physician prices—25% and 6% increases, respectively
Why?	<ul style="list-style-type: none"> ■ Why are hospital costs such an important issue? <ul style="list-style-type: none"> – In 2017 hospital care represented 33% of total healthcare spending, amounting to \$1.1 trillion in hospital spending (23)

- » Hospital spending is projected to have grown 4.4% in 2018, which is slightly slower than the rate observed in 2017 of 4.6% (24)
- » Currently, national health spending is projected to grow at an average rate of 5.5% annually for 2018-2027 likely reaching \$6 trillion by 2027 (24)
 - For reference, Canada spends \$1,589 per capital less on physicians and hospitals than the US (25)
 - This difference can be accounted for by administration (39%), incomes (31%) and higher utilization of medical services (14%) (26)

- Increasing Hospital Profits (6,7)

- » Total margin: Common hospital profitability measure. The difference between revenues and expenses relative to revenues, considering all hospital business activity
 - 2016 Total margin: 7.8%
- » Operating margin: which measures the expenses and revenues that are directly associated with patient care
 - 2016 Operating margin: 6.7%
- » Payment-to-cost ratio: Another metric for hospital profitability. Average payment relative to average cost by payer, this includes patient-specific clinical costs + fixed costs ex. equipment, buildings, administrator salaries (4, 9)
 - Private insurance payments: 144.8 % of cost
 - Medicare payments: 86.8 % of cost
 - Medicaid payments: 88.1% of cost

- Variable Hospital Costs based on

- » Where You Live
 - Per capita health care expenditures in high-spending regions of the United States are ~40% higher than those in lower-spending regions (8)
- » Who is Paying
 - There is a wide and growing gap between public and private rates (4)
 - Variation in costs are driven by (4)
 - Utilization for the Medicare population as reimbursement rates are set by the federal government, with some adjustment for regional costs
 - Prices for the privately insured as reimbursement rates are negotiated between insurers and providers
 - Patients with private insurance are one-third of hospital costs but are the source of most hospitals' profit. Private insurance rates for hospital services are well above hospitals' cost of providing care

- Cost Shifting & Price Transparency

- » Federal laws and regulations require hospitals to maintain uniform charge structures. Payments, however, do not correspond to those charges (2)
- » Hospitals may engage in cost-shifting, raising prices on private payers to compensate for insufficient payment from public programs. Potential causes include hospitals' (10,11)
 - Market power
 - Need for a financial cushion to decrease pressure to contain costs, which makes Medicare and Medicaid payments look low by comparison

How?

■ How are policies seeking to reduce hospital costs?

- Surprise Billing

- » Surprise bills: Come from out-of-network physicians working in an in-network facility or

from emergency situations in which patients cannot be expected to locate an in-network provider ([12](#))

- ▶ More than a dozen states have passed legislation to protect patients from surprise bills
- ▶ Bipartisan bills proposed in the U.S. House of Representatives and U.S. Senate within the past few months provide promising options for relief ([13](#))

– Reference Pricing ([14](#))

- » Reference pricing: Individual payers can set the maximum it will pay for a service or bundle of services, which could be tied to a percentile in commercial claims or to Medicare rates
 - ▶ Providers that decline to accept the reference price are either excluded from the payer's network, or patients who choose that provider take responsibility for paying the difference out of pocket. Reference pricing incentivizes patients to visit lower-cost providers and puts pressure on providers to lower costs in order to keep their business.
 - ▶ Several states have implemented forms of reference pricing for public plans- California, Montana, Oregon, Washington

– Hospital Price Transparency ([12](#))

- » Starting January 2019, CMS began requiring hospitals to publish their list of retail charges for healthcare services. The goal was to make it easier for patients to understand the cost of a hospital service before accessing care, but patients rarely pay those rates
- » Under the latest Medicare Outpatient Prospective Payment System proposed rule, CMS would go a step further by requiring hospitals to publish the negotiated price by specific payer and plan for "shoppable services"

– Antitrust Enforcement of Hospital Industry

- » Mergers between hospitals in close proximity have the greatest effect on prices ([15](#))
Cross-market mergers can also result in higher hospital prices by weakening insurers' bargaining power ([16](#))
- » The Federal Trade Commission and the U.S. Department of Justice need greater resources in order to monitor the large volume of mergers in healthcare ([17](#))

– Site-Neutral Payments

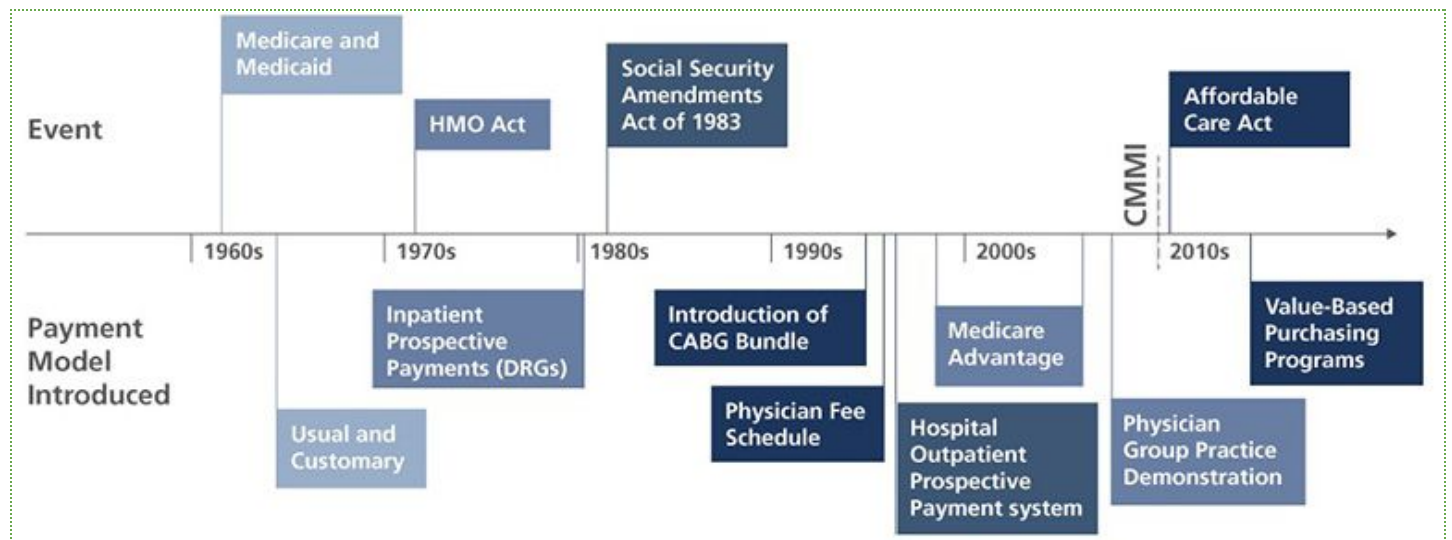
- » Medicare payment rules have generally paid higher rates for a service when delivered by a hospital than in another setting. CMS has already altered its payment rules to impose site neutrality for payments to ambulatory care centers and hospital outpatient services, which is expected to save \$760 million in 2019 ([18](#))
- » Expanding site neutrality policies to level payments across additional settings such as between physician offices and hospital outpatient departments, where clinically appropriate, may benefit taxpayers and Medicare beneficiaries alike ([19](#))

– Rate Regulation



- » Rate regulation: State or federal regulators set or cap all payers' rates closer to costs to bring down hospital prices while slowing price inflation
 - ▶ Former Obama administration officials Robert Kocher and Donald M. Berwick recommend capping hospital prices at 120% of current Medicare rates ([20](#))
- » Lower payment levels present a trade-off between cost-savings and patient access ([14](#))
Rate-setting proposals need to consider:
 - ▶ Financial sustainability of providers, crucial to patient access in rural areas where



	<p>providers have already-low margins</p> <ul style="list-style-type: none"> ▸ Pace at which hospitals would be expected to adapt to major payment reforms
When?	<ul style="list-style-type: none"> ■ When can we anticipate hospital reimbursement changes if ‘Medicare for All’ took hold? <ul style="list-style-type: none"> - It depends on whom you ask. Some Democrats would (3) <ul style="list-style-type: none"> » Encourage incremental plans » Expand Medicare to cover people over the age of 50 » Keep private health insurers, including those that now offer Medicare plans

Historical Background How did hospital reimbursement get this way? (21)



Stakeholders & Impacts

	Patients	<ul style="list-style-type: none"> ■ Many Americans are paying more than needed for hospital care evidenced by the variation in hospital prices across markets and over time. (2)
	Providers	<ul style="list-style-type: none"> ■ “The profit margins on Medicare are ‘razor-thin’” - <i>Laura Kaiser, Chief Executive of SSM Health</i>. In some markets, her Catholic health system hospitals lose money providing care under the program. (2) ■ “Everyone being on Medicare would have a large impact on their bottom line. You would have to have a very different cost structure to survive.” - <i>Melinda Buntin, Chairwoman for Health policy at Vanderbilt University School of Medicine</i>. (2) ■ Policy experts believe rural hospitals would be hit hard as patient numbers dwindle because of ‘Medicare for All’; because they lack the financial cushion of larger systems. Others, they say, would try to offset the steep cuts by laying off hundreds of thousands of workers

			and abandoning lower-paying services like mental health. (2)
	Payers	Government	<ul style="list-style-type: none"> ■ “If you’re in a consolidated market, you are a monopolist setting the price. The prices paid by private insurers are ‘completely unjustified and out of control’” - <i>Mark Miller, Former Medicare Payment Advisor to Congress</i> (2)
		Private	<ul style="list-style-type: none"> ■ “‘Medicare for All’ proposals would destabilize the nation’s health system and limit the ability of clinicians to practice medicine at their best.” - <i>David Wichmann, Chief Executive UnitedHealth Group</i> (2)
	Employers		<ul style="list-style-type: none"> ■ RAND Corporation study found that employer-sponsored plans pay hospitals 241% of Medicare levels on average for inpatient and outpatient care, with some hospital systems receiving as little as 150% and as much as 400% of Medicare rates. (22) ■ A report on California hospitals found similar results, with private insurers paying 209% of Medicare rates. (11)

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