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Medicare for All and Beyond

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PAYMENT AND PRICING DECISIONS IN HEALTH CARE REFORM

Rate setting, cost control, and public option proposals

EDITOR'S NOTE

The financial strain on health systems and providers during the COVID-19 pandemic highlights the fragility of our current payment and pricing models. In February 2020, Penn's Leonard Davis Institute of Health Economics (LDI) held a conference, *Medicare for All and Beyond: Expanding Coverage, Containing Costs*, which included a panel discussion on payment and pricing.[1] Public and private insurers pay strikingly different prices for the same services; one study estimated that commercial health insurers pay nearly 4-5 times as much as Medicare and Medicaid for the kinds of care COVID-19 patients require.[2] The broader issue of payment and pricing will figure heavily in upcoming health care reform debates, and is central to the affordability and sustainability of any proposal.

INTRODUCTION

Any effort to reform health insurance in the United States must tackle the prices we pay for health care. High prices for drugs, hospital beds, and physician services in the private insurance market have resulted in family premiums that average $20,576 a year and out-of-pocket costs that can pose a financial barrier to getting needed care.[3] There are many complex challenges to addressing prices. Some proposals build on the existing Medicare fee schedule, while others suggest promoting alternative payment mechanisms—or even starting from scratch. The stakes are substantial, as many reform proposals rely on reining in prices to achieve the savings necessary to expand health insurance to the uninsured.

At Penn's LDI *Medicare for All and Beyond* conference, a panel of researchers, hospital administrators, and policy experts considered issues related to health care payment and pricing that any health care reform proposal must address, including the implications of rate setting for providers and patients.[1] At what level should these rates be set to assure access and quality of care, while incentivizing innovation and rewarding excellence?

BACKGROUND:
The Current Payment Landscape

The U.S. insurance market has three main payers: *Medicare* (financed by the federal government), *Medicaid* (financed by states and the federal government), and *private health insurance* (funded by premiums charged to businesses and households). Overall, Medicare and Medicaid account for 49.4% of all health insurance payments, a share that has slowly risen over time.[4]

Because public payers generally cover higher-cost populations (elderly, disabled, and low-income individuals with complicated social needs), per-person annual spending is much higher in Medicare ($12,784) and Medicaid ($8,201, excluding CHIP) than in private health insurance ($6,199).[4] But Medicare and Medicaid have been more successful than private insurers in limiting the growth of spending for their enrollees. Since 2008, spending per enrollee has increased the most in employer-sponsored insurance (46.4%), followed by Medicare (21.5%), and Medicaid (12.5%).[5] In 2018, for example, per-enrollee spending grew by 6.7% for private insurers, compared to 3.7% and 2.0% for Medicare and Medicaid, respectively.[6] So, if the privately insured population tends to be younger and healthier, what is driving the surge in spending? In short, it is payment and pricing.

DIVERGING PUBLIC AND PRIVATE RATES

Across nearly all services, public programs like Medicare pay, on average, substantially less than private insurers. A recent literature review found that private insurers pay roughly double Medicare rates for hospital services and 40% above Medicare rates for physician services.[7] Private prices vary tremendously by hospital, with one study finding that negotiated prices are from 150% to 400% higher than Medicare rates across different health systems.[8]

Why are private payment rates so much higher than public ones? Many policymakers cite the increasing consolidation of hospitals, which decreases market competition.[9] There is strong evidence that hospital mergers raise prices, and much of the recent price increases appear concentrated in hospitals.[10] Additionally, as hospitals buy and integrate physician practices, the bargaining (i.e., price control) power of private insurers continues to shrink relative to Medicare and Medicaid, who continue to set prices themselves.

LIMITING THE GROWTH OF COSTS

Any sustainable health care reform plan must consider how to control cost growth and set initial rates. In fee-for-service Medicare, the Centers for Medicare and Medicaid Services (CMS) sets base payment rates and annual fee increases. Payments to hospitals are made based on diagnosis-related groups (DRGs), a prospective, capped payment for inpatient services based on a patient's diagnosis and complexity. In the managed care Medicare Advantage program, Medicare pays private plans a capitated, risk-adjusted per-member-per-month fee. The private plans establish networks, pay providers, and are ultimately responsible for most beneficiary costs. Medicare Advantage can control cost growth through annual payment policy updates, though some observers argue that Medicare Advantage overpays relative to fee-for-service beneficiaries.[11] Medicare also controls spending through a variety of alternative payment models to control utilization and per-episode costs, such as population-based Accountable Care Organizations and episode-based bundled payments.[5]

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State Medicaid programs set base payment rates and annual increases to providers and hospitals. Providers in Medicaid are paid through either fee-for-service or managed care arrangements, in which the state sets a per-enrollee capitated payment to a Medicaid managed care organization (MCO) to organize and deliver care.[12] Fee-for-service rates are set by Medicaid administrators, who typically use a percentage of Medicare's fees or a state-developed fee schedule. Capitated rates to MCOs are based on those fees and expected utilization.[13] Annual fee increases are controlled by state Medicaid programs, at the direction of state governments. States may also experiment with alternative payment models through the federal waiver process.

Medicaid base payment rates alone do not represent the full payment to providers.[14] A 2017 MACPAC analysis found that in 2011, Medicaid fee-for-service base payment rates averaged 78% of Medicare rates.[15] Medicaid base payment rates are supplemented through other programs, such as the Medicaid Disproportionate Share Hospital (DSH) payment, which goes to hospitals serving high proportions of Medicaid or low-income patients. Whether these supplemental payments are sufficient is a contentious issue, but a 2016 MACPAC analysis of disproportionate share hospitals found that total Medicaid payments (including supplemental payments) covered an average of 107% of patient costs, with a range of 81% to 130% across states.[16]

Private insurers, in contrast, try to control costs by negotiating directly with providers, and by forming networks of providers that agree to accept their rates. Private payers and providers may rely on the published Medicare rate as a benchmark during these negotiations, but ultimately the levels are determined by market conditions and relative bargaining power.[17, 18]

RATE SETTING AND COST CONTROL:
State-based Public Options

In response to rising costs and an unclear outlook for federal health care reform, states have taken the lead in enacting reforms to provide consumers with an affordable coverage option. While these initiatives are new, they provide a window into how rate setting could work under a federal Medicare for All system. In particular, panelists discussed public option plans for the individual market that passed in Washington and were proposed in Colorado. In the debate over these reforms, states had to wrestle with, and decide on, how to set rates and control costs in a new program.

In May 2019, Colorado Governor Jared Polis signed legislation that directed state officials to design a plan for a public health insurance option.[19] State lawmakers introduced legislation (HB 1349) to create a Colorado Health Care Option in March 2020.[20, 21] However, in May 2020, the bill's sponsors announced they would withdraw the legislation due to the COVID-19 pandemic, with the intention of re-introducing it in 2021.[22]

Under the proposed option, regulators design the insurance plan, including coverage requirements, premiums, and the medical loss ratio. Private insurers administer it through the state's insurance marketplace. Hospitals in Colorado would be required to accept public option plans with state-mandated rates. As a result, rate setting was a contentious, political exercise; state officials held over a dozen stakeholder meetings and received hundreds of letters. The final rates were a political compromise to ensure that physicians, critical access hospitals, and providers with high shares of Medicaid and Medicare patients would stay financially healthy.

Colorado's proposed plan sets a base payment rate for all services at 155% of Medicare rates, with upward adjustments, including rate increases for critical access hospitals and providers with large shares of Medicaid patients, as well as incentives for efficiently managing costs.[23] After taking these adjustments into account, the actual payment rate ranges from 155%-238% of Medicare, down from an average of 269% of Medicare rates that private insurers paid in 2017.[23, 24] As a result, the plan is expected to save consumers between 7% and 20% on premiums, largely due to rate setting.[25]

Washington took a slightly different approach to rate setting. In May 2019, Governor Jay Inslee signed legislation to create Cascade Care, a privately-administered public option for the individual marketplace in 2021. Similar to Colorado's proposal, the state will procure subsidized plans from private health insurers. As in Colorado, residents can use Affordable Care Act subsidies to purchase the plan. However, as hospitals and physician practices face financial strains due to COVID-19, there has been renewed pushback against the proposal and requests to delay its implementation.[26]

To control costs, Washington set an aggregate spending cap of 160% of what Medicare would pay for the same set of services, excluding prescription drugs. However, for critical access and sole community hospitals, there is a "floor" of at least 101% of private allowable costs (i.e., private negotiated rates). For primary care providers, payments must be at least 135% of Medicare rates.[27] In effect, many primary care providers and critical access hospitals will have minimal changes in payment rates. Unlike Colorado, which sets rates for each service, Washington does not specify a cap for each service. Rather, the aggregate cap averages total costs across all services provided and allows insurers the flexibility to negotiate individual rates to meet the benchmark.[28]

Additionally, hospitals are not compelled to participate in Washington's public option, as they would be in Colorado. This may have decreased hospital opposition to rate setting, but the tradeoff is greater risk that insurers will not be able to build out adequate provider networks. It is too early to tell how these different approaches will affect the affordability and accessibility of care in public option plans.

Legislators in Washington and Colorado have attempted to blend both private and public approaches to rate setting and cost control. Minimum and maximum per-service and aggregate payments are set as a multiple of Medicare rates (like many Medicaid programs), but the actual negotiation of those rates and establishment of networks is left to insurers, akin to Medicare Advantage.

State legislators also explored how to build on alternative payment models when designing rates and ensuring adequate network size. Colorado's proposal mandated participation by hospitals, which is similar to how hospitals and doctors generally have no choice but to accept fee-for-service Medicare. Washington, in contrast, is relying on private insurers to establish adequate networks. In both cases, rates had to be set well above the existing Medicare fee schedule. Both states require state agencies or insurers to promote value-based insurance design, but the specific mechanisms to do so are vague.

CONSIDERATIONS FOR RATE SETTING

What can we learn from these state experiences in setting payment rates for a public option? Because these plans have yet to launch, we do not yet know the extent to which they produce adequate networks, are attractive to consumers, and control costs for consumers and state budgets. Nevertheless, the process of rate setting did generate some insights.

First, state governments created public options without overhauling the existing system. Both Washington and Colorado's plans leveraged the existing state-based marketplaces and relied on private insurers to administer plans. While both states faced considerable pressure from hospitals and physicians' groups to not set rates too low (i.e., at the current Medicare level), political leadership was able to see the process through to final passage in Washington State and gain strong support in Colorado.

However, to move public options towards the finish line, policymakers had to set baseline rates higher than the current Medicare fee schedule, though they are not necessarily as generous as private insurers. This is likely a product of both political realities, and for some providers, economic necessity.

Additionally, state public option plans had to make adjustments for different types of providers. In the context of national Medicare for All, this may require higher rates based on hospital teaching status, research focus, and pre-existing market share to avoid severe fiscal shocks—to name a few. For example, many safety-net hospitals would be unable to operate without supplemental DSH payments to cover shortfalls from Medicaid and uninsured patients. A relatively tight range of payment rates may reduce the incentives for health care systems to invest in biomedical, clinical, and operations research. No state has contended with how to incentivize scientific research as part of rate setting. How those—and other—supplemental payments would interact with public option rates remains an open question.

Developing a national health care reform plan would involve a similar back and forth with stakeholders in the health system. On the one hand, reform efforts will likely fail without stakeholder input, for both political and administrative reasons. On the other hand, it is important that government rate setting does not entrench the problems it is seeking to reform. The U.S. Government Accountability Office (GAO) finds that some medical societies (such as surgeons) may have outsized influence in setting Medicare rates.[29] One panelist put the issue succinctly: "[e]ntrenched interests really dictate how policy is written...we can't seem to bring the health care sector under control in the way that we would like."

Finally, layered on top of the discussion of rates is the reality that the health care system is shifting towards alternative payment models, such as bundles, ACOs, and other pay-for-performance mechanisms. These models range from modest quality bonuses built on a fee-for-service chassis to population-based, capitated programs. Many of these models do not approach cost control through rate setting. Rather, they set targets for cost and quality and put financial risk on providers for hitting those benchmarks. Some of these payment reforms have begun to yield reduced costs with either neutral or positive impacts on quality, while others have had little impact thus far.[30-32]

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A few states have also implemented payment alternatives that a Medicare for All plan would need to consider. Maryland, for example, has a longstanding all-payer rate setting system.[33] More recently, the state implemented a global budget for hospitals that caps annual cost growth.[34] In the future, to reap the benefits of these payment experiments, a Medicare for All program would have to carefully incorporate elements of the current alternative payment landscape. Policymakers must consider how a national public option or single-payer program would preserve or enhance innovative experiments that go beyond adjusting payment rates for specific services.

HOW FEDERAL REFORMS STACK UP

How have policymakers approached rate setting and cost control in recent legislative and campaign proposals for national health care reforms? In Congress, national single-payer proposals from Senator Sanders and Representative Jayapal require Medicare to set a fee schedule similar to current Medicare rates. These plans also rely on global hospital budgets set by the government to control overall spending. Both plans update how fees are set and introduce mechanisms for some negotiations between the government and providers, but in general, they would shift nearly all provider payment much closer to current Medicare rates.[35]

Proposals focused on creating a public option, such as the Center for American Progress' (CAP) "Medicare Extra" plan and Bennet-Kaine-Delgado's "Medicare-X" plan, have similar approaches to rate setting, in that they assume that a new public option would have to pay above current Medicare rates. In the case of Medicare Extra, rates would be set at the average of Medicare, Medicaid, and commercial insurance rates, with adjustments in favor of primary care. The Center for American Progress estimates this would result in payment rates of 108% and 132% of Medicare rates for physicians and hospitals, respectively.[36] The Medicare-X proposal allows the Secretary of Health and Human Services to establish reimbursement rates up to 125% of Medicare rates for services in underserved areas, but otherwise relies on the existing fee schedule.[35]

While most plans put forward during the 2020 Democratic primary did not propose specific fee schedules, they all relied on Medicare's ability to set rates. As in his Congressional proposal, Senators Sanders argued for a national health care budget to control costs, with payments based on current Medicare rates. Senator Warren's plan proposed paying providers higher than Medicare (though the specific rates were not given), and suggested those rates would be much closer to Medicare's fee schedule than private insurance rates.[37] Former Vice President Biden's public option offers little detail on rate setting, but it indicates that it "[w]ill reduce costs for patients by negotiating lower prices from hospitals and other health care providers."[38]

These proposals differ from recent state experiences, in which private insurers set up networks and negotiate rates for publicly sponsored plans. While state regulators set guidelines for rates, the implementation was left to insurers. Additionally, states found rate setting to be politically contentious, and it is not clear that current national proposals would easily pass if payment rates were near current Medicare levels.

CONCLUSION

Controlling health care spending and careful approaches to rate setting are key to the success of any national health care reform effort. Many Medicare for All proposals at the federal level leave these crucial questions unanswered.

Recent state experiences with a public option show that base rates had to be set higher than current Medicare rates, with a highly diverse set of adjustments based on provider types. Some federal proposals assume rates can be far closer to current Medicare fees. Current proposals differ in the extent to which they acknowledge the need for higher rates and specific adjustments, such as rate enhancements for primary care and rural hospitals. For reasons of both economic and political feasibility, far more work remains to be done.

Additionally, policymakers will need to incorporate successful value-based payment strategies into rate setting decisions in public plans. While many value-based programs are relatively new, it will be important to build in the flexibility to include value-based payments as evidence of their effectiveness mounts.

Finally, policymakers will have to consider the current state of hospital finances, especially during and following the significant financial challenges hospitals have faced in the ongoing response to COVID-19. As panelists noted, some hospitals might not survive if the payer mix rapidly shifted to Medicare at existing rates. Moving from current proposals to realistic policy will entail accounting for varying levels of provider consolidation, existing hospital margins, and incentives for innovation.

Policymakers will have to consider the current state of hospital finances, especially during and following the significant challenges hospitals have faced in the ongoing response to COVID-19.

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AUTHOR

Aaron Glickman, MPA
Policy Analyst
Leonard Davis Institute of Health Economics
University of Pennsylvania

THANK YOU

We thank our conference speakers for their valuable insights and contributions to the panel: **Julian Harris**, MD, MBA (moderator); **Gerard Anderson**, PhD; **Miriam Laugesen**, PhD; **Kevin Mahoney**, MBA, DBA; and **Kavita Patel**, MD.