How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan

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Center for Advancing Health Policy through Research

Funded by Arnold Ventures

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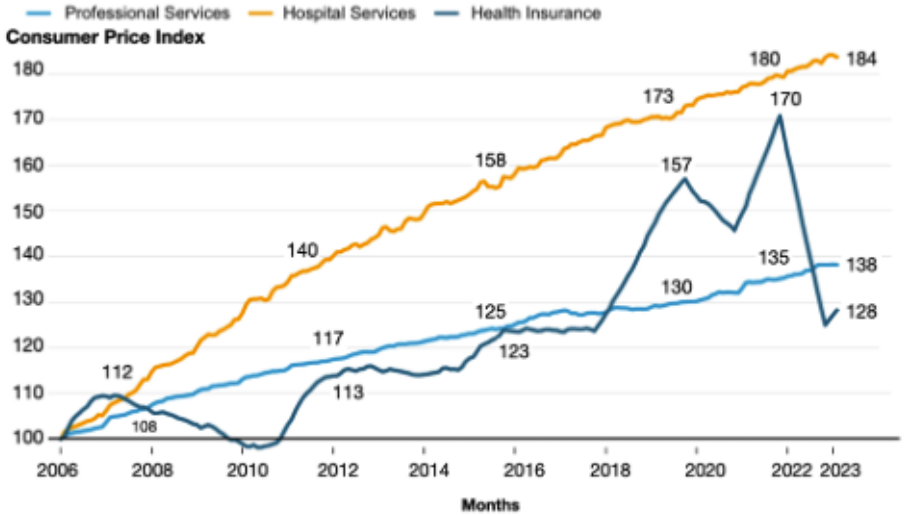
Hospital prices threaten U.S. health care affordability

Figure 2. Consumer price index: medical care, by component 2006-2023. Authors' analysis using data from the BLS, ...



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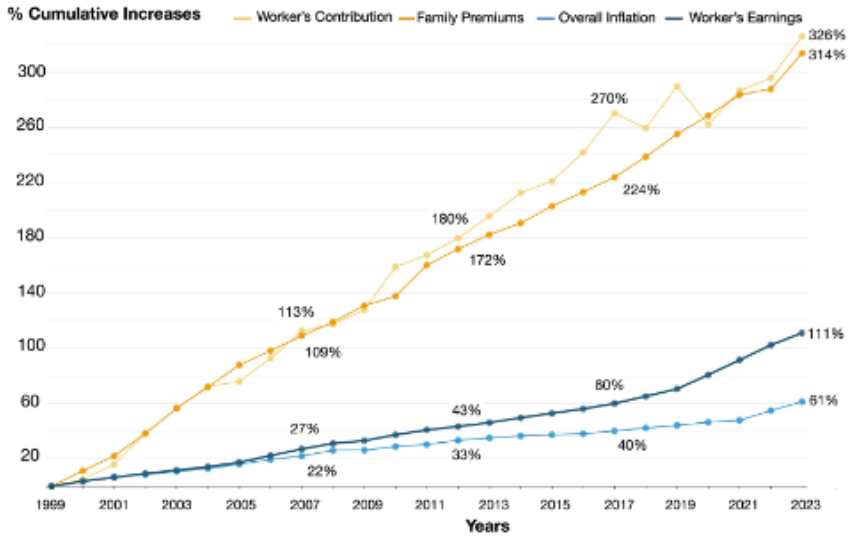
Rising spending primarily affects U.S. individuals/families

Figure 1. Cumulative increases (%) in workers' contribution, family premiums, overall inflation, and workers' earnings, ...



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States are taking a leading role in addressing hospital prices

Price transparency

Promoting competition (e.g., stronger antitrust enforcement/oversight)

Price regulation

Modeling studies predict that **price regulation** will be most effective

Sources: Liu JL et al. 2021; Congressional Budget Office, 2022

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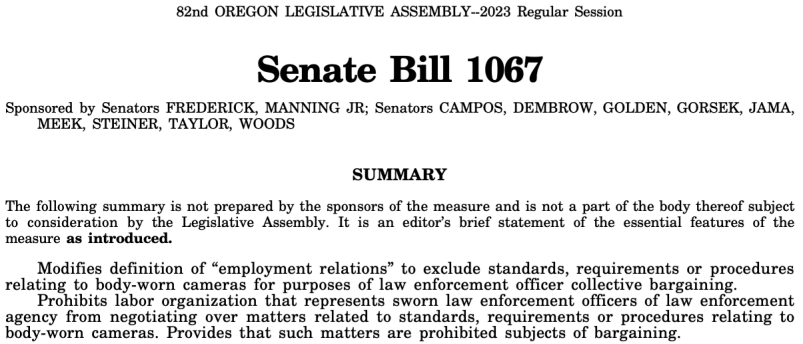
Oregon implemented hospital payment caps in 2019

Caps hospital facility prices at **200% of Medicare for in-network** services *(and 185% for out-of-network services)*

Applies only to…

- **Oregon state employee health plan**
- **24 hospitals**



82nd OREGON LEGISLATIVE ASSEMBLY--2023 Regular Session

Senate Bill 1067

Sponsored by Senators FREDERICK, MANNING JR; Senators CAMPOS, DEMBROW, GOLDEN, GORSEK, JAMA, MEEK, STEINER, TAYLOR, WOODS

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Modifies definition of "employment relations" to exclude standards, requirements or procedures relating to body-worn cameras for purposes of law enforcement officer collective bargaining.

Prohibits labor organization that represents sworn law enforcement officers of law enforcement agency from negotiating over matters related to standards, requirements or procedures relating to body-worn cameras. Provides that such matters are prohibited subjects of bargaining.

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Two research questions

What is the effect of the cap on hospital facility prices?

What is the effect of the cap on out-of-pocket spending?

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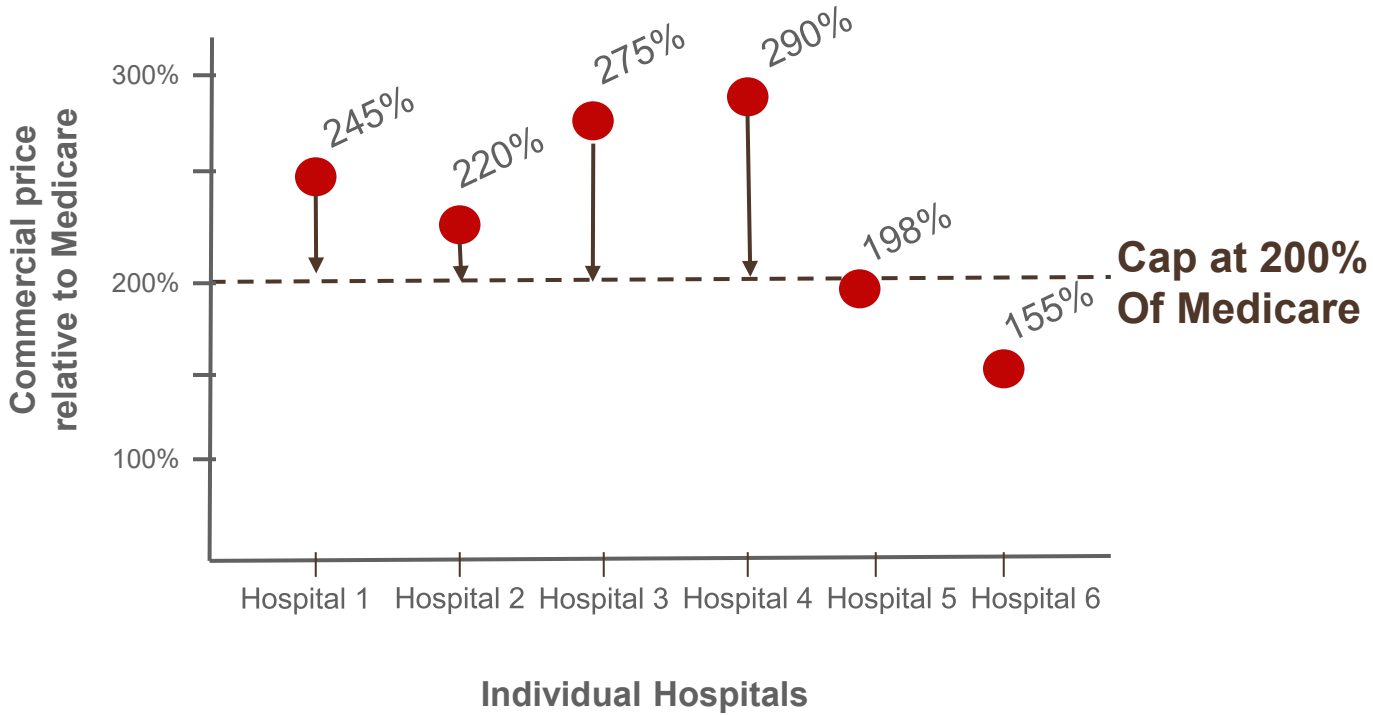
Effect on Hospital Facility Prices

Prices greater than the cap should decline



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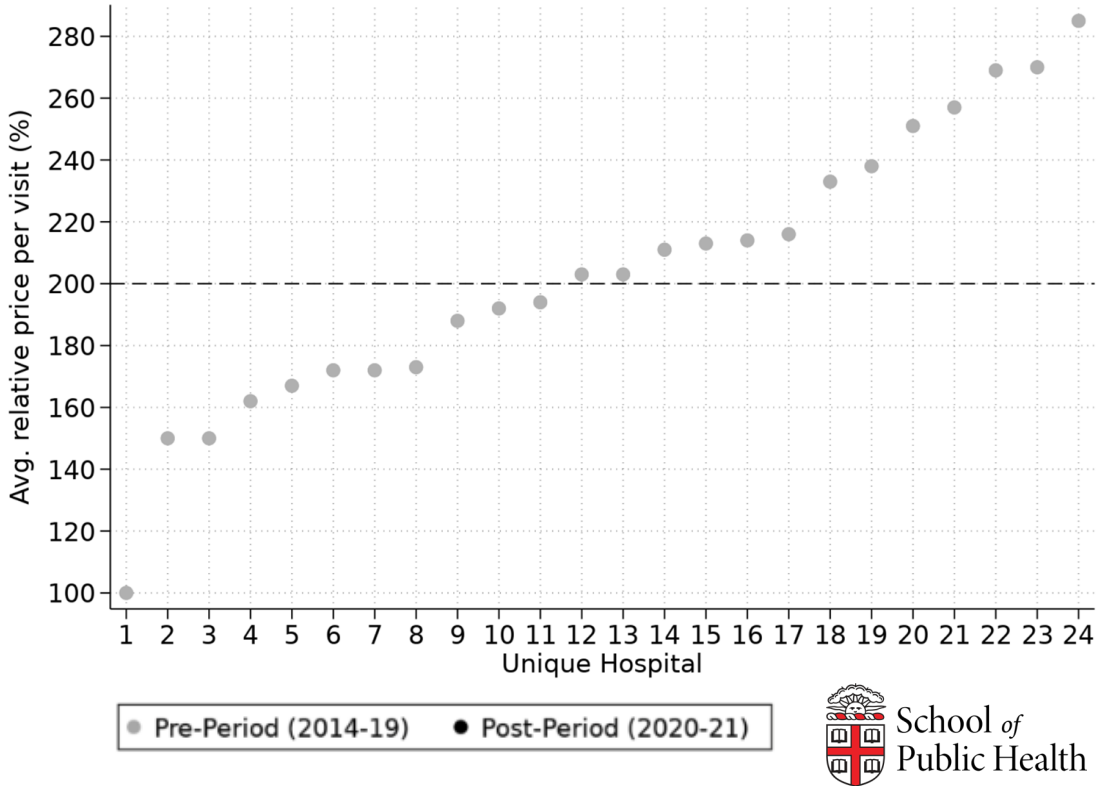
Pre-period average inpatient prices relative to Medicare:

- 13 hospitals greater than cap
- 11 hospitals less than cap

Inpatient Setting:

Commercial prices relative to Medicare before and after implementation of hospital payment cap



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Pre-period average inpatient prices relative to Medicare:

- 13 hospitals greater than cap
- 11 hospitals less than cap

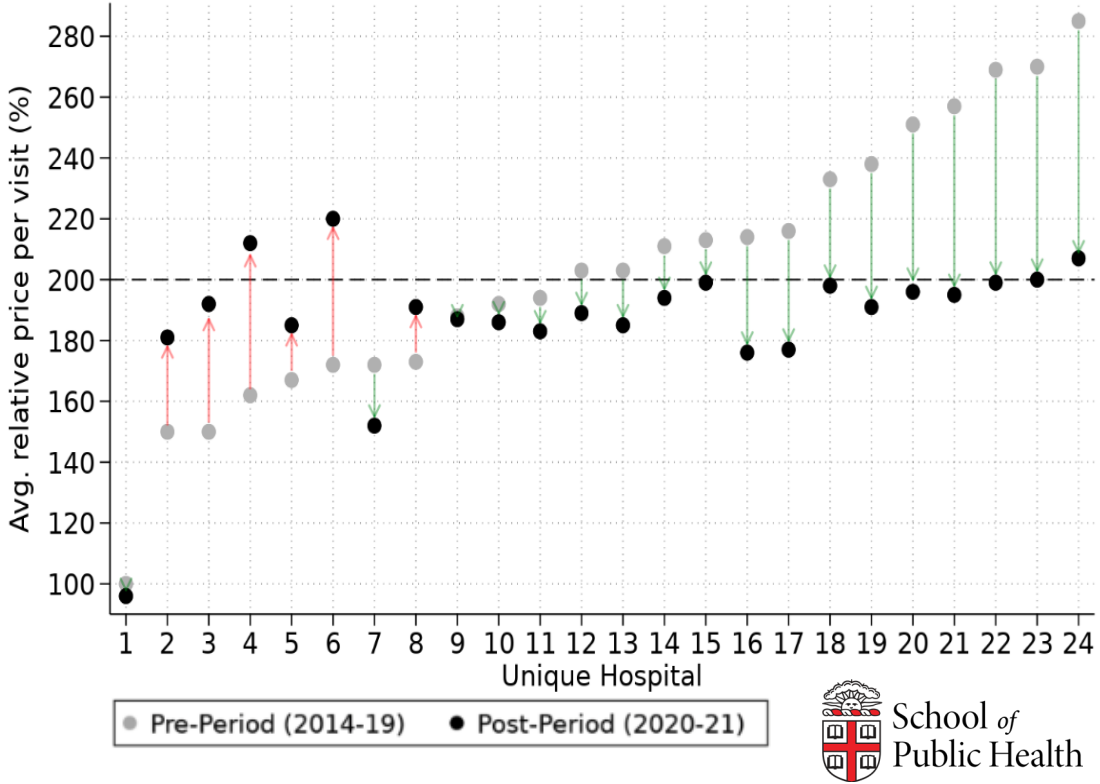
Post-period:

- Declined for all 13 above and 5 of the 11 below
- Increased for 6 of the 11 below

(Stigler 1964; Mollgaard & Overgaard, 1999; Schultz, 2005)

Inpatient Setting:

Commercial prices relative to Medicare before and after implementation of hospital payment cap



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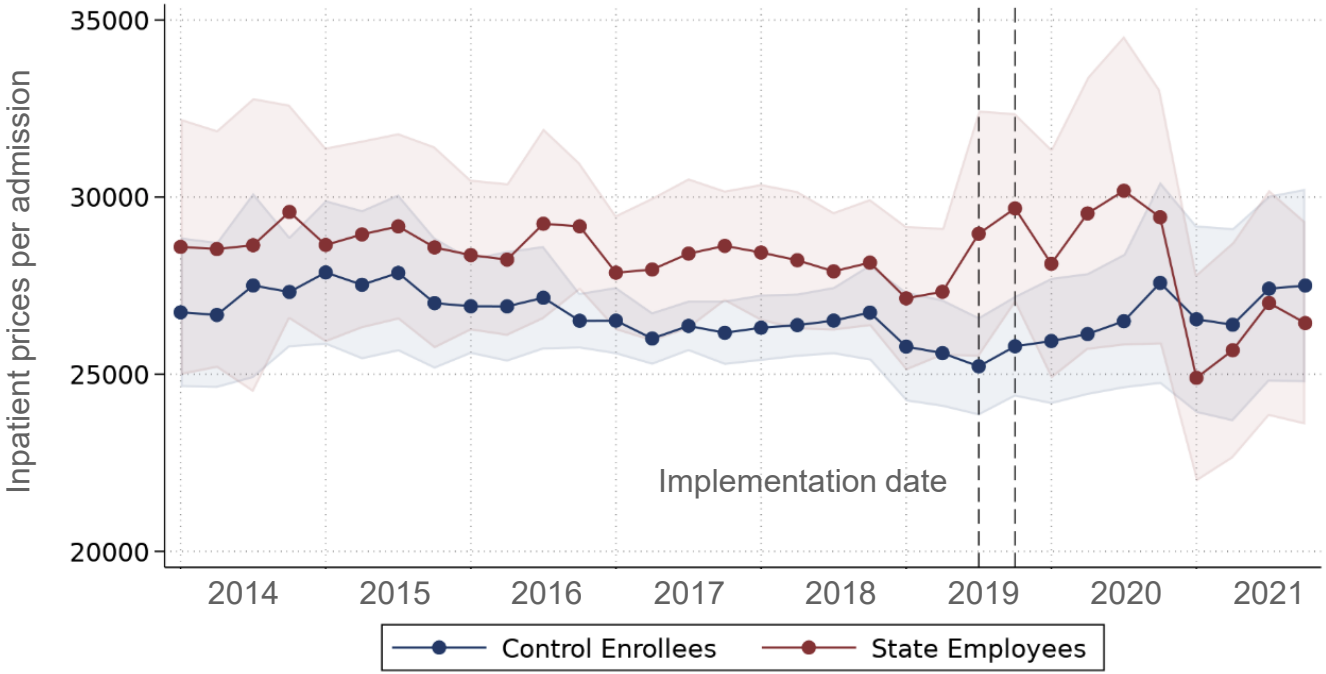
Inpatient Facility Prices per Admission by Quarter for State Employee vs Comparison Enrollees Over the Study Period (2014-21)



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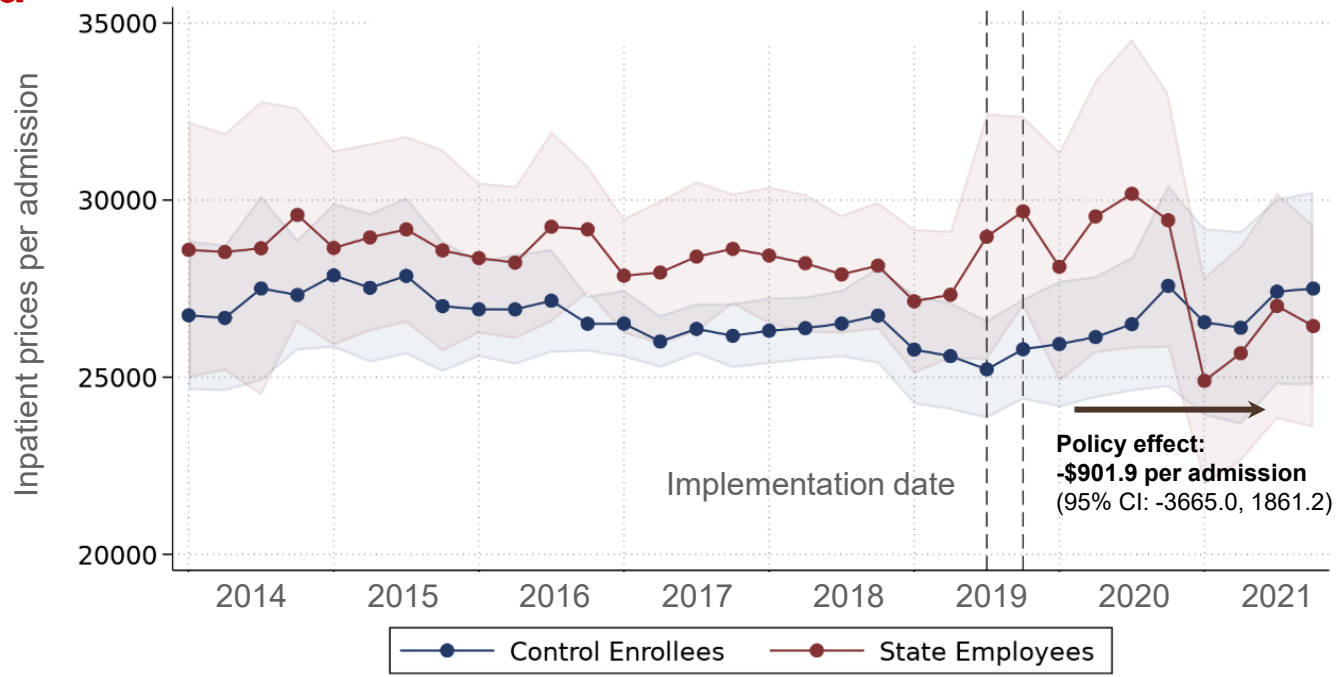
Inpatient prices **did not change** significantly over the post-period

Inpatient Facility Prices per Admission by Quarter for State Employee vs Comparison Enrollees Over the Study Period (2014-21)



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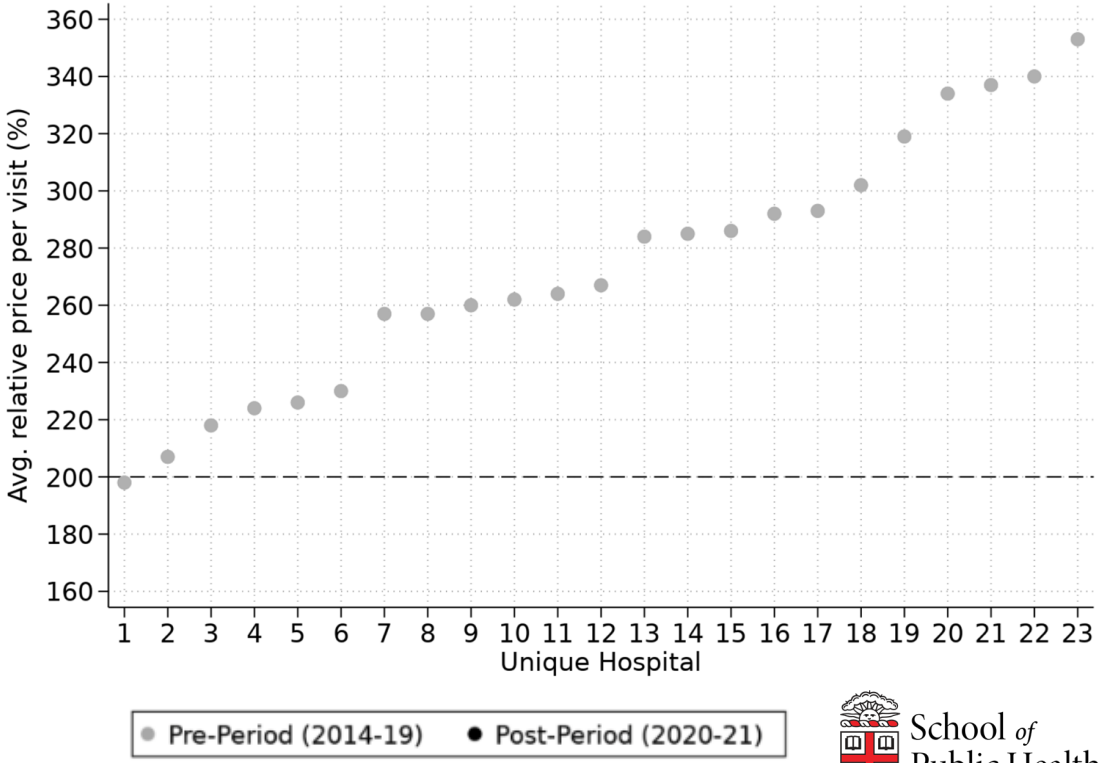
All but one hospital had average outpatient prices relative to Medicare above the cap

Outpatient Setting:

Commercial prices relative to Medicare before and after implementation of hospital payment cap



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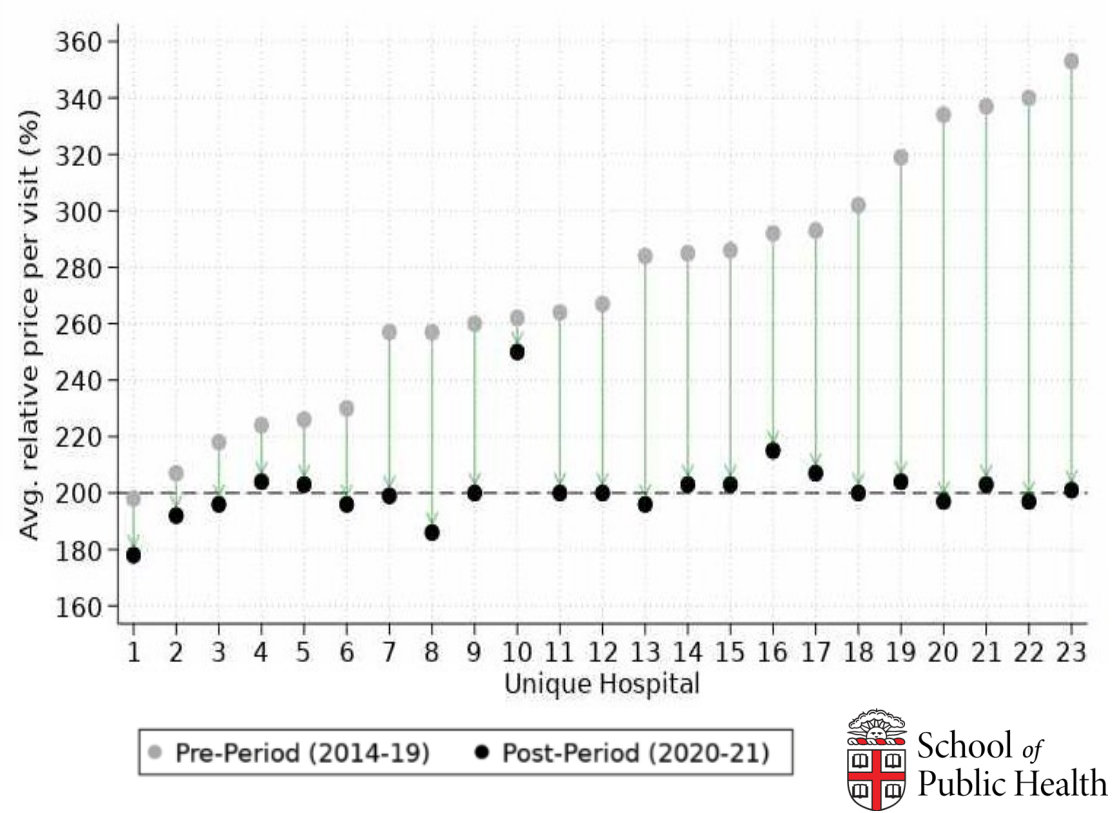
All but one hospital had average outpatient prices relative to Medicare above the cap

Outpatient prices relative to Medicare declined for all hospitals

Outpatient Setting:

Commercial prices relative to Medicare before and after implementation of hospital payment cap



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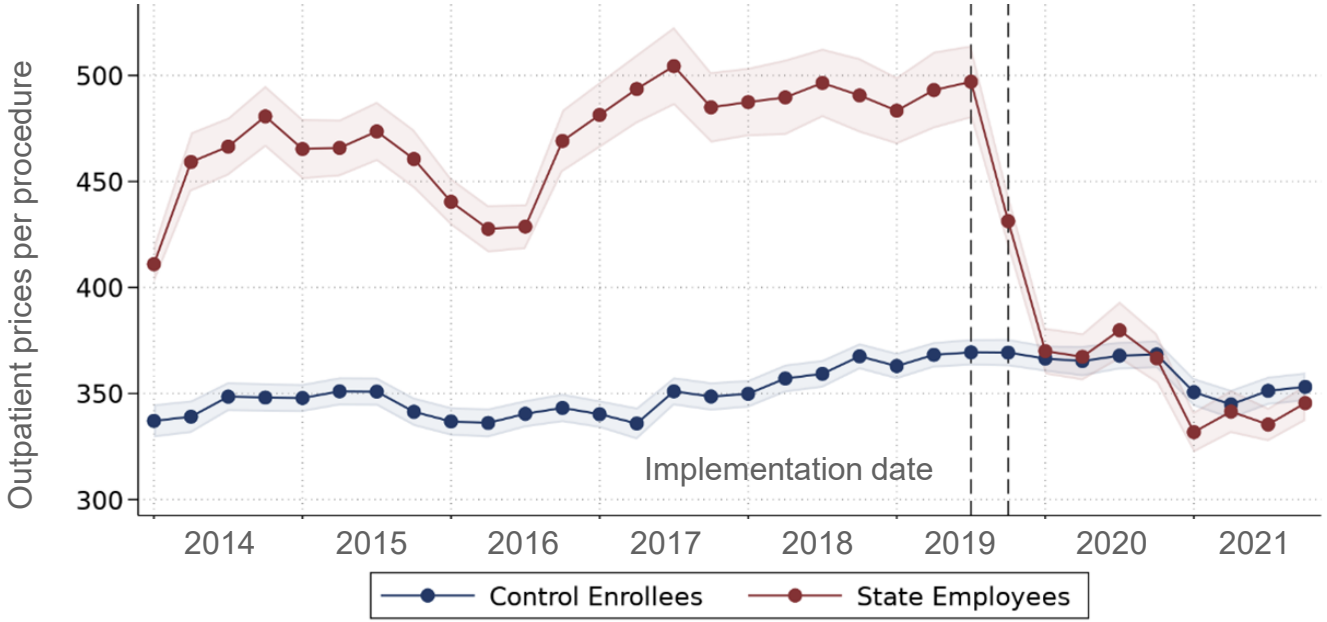
Outpatient Facility Prices per Procedure by Quarter for State Employee vs Comparison Enrollees Over the Study Period (2014-21)



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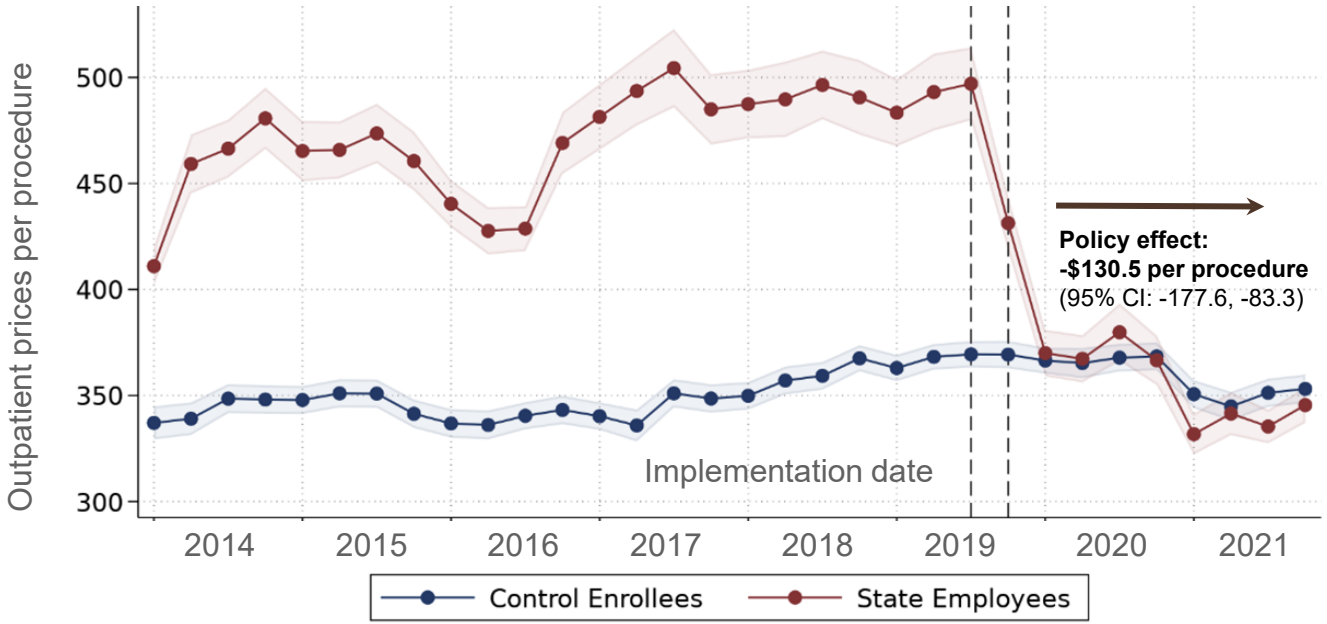
The program was associated with a **25.4% reduction** in outpatient prices per procedure

Outpatient Facility Prices per Procedure by Quarter for State Employee vs Comparison Enrollees Over the Study Period (2014-21)



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The Oregon State Employee Plan saved over $100M

Price reductions resulted in $107.5 million in savings over the first 2 years and four months

- $11.5M from the inpatient setting
- $96.0M from the outpatient setting

Which was about 4% of total plan spending

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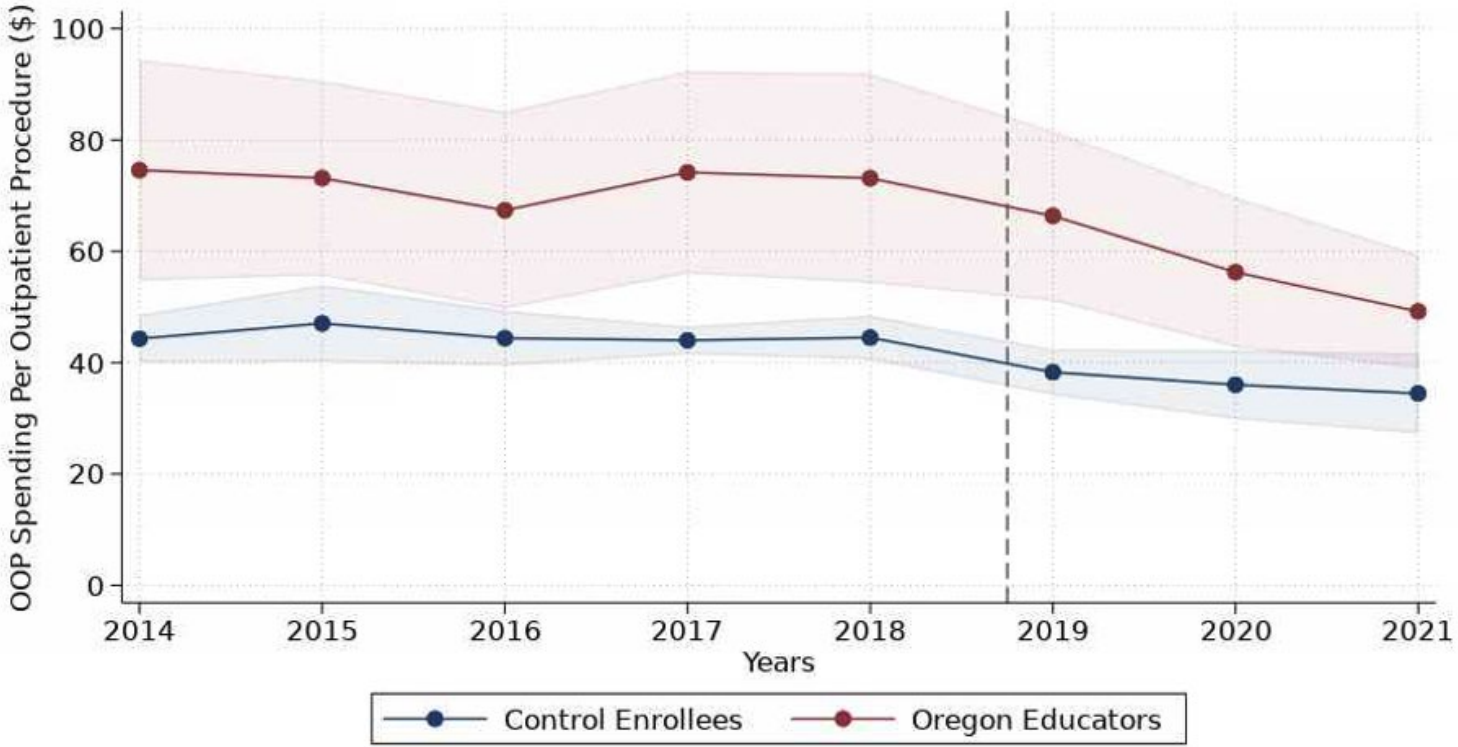
Effect on Out-of-pocket Spending

All Procedures

Outpatient facility out-of-pocket spending per procedure by year (2014-21)



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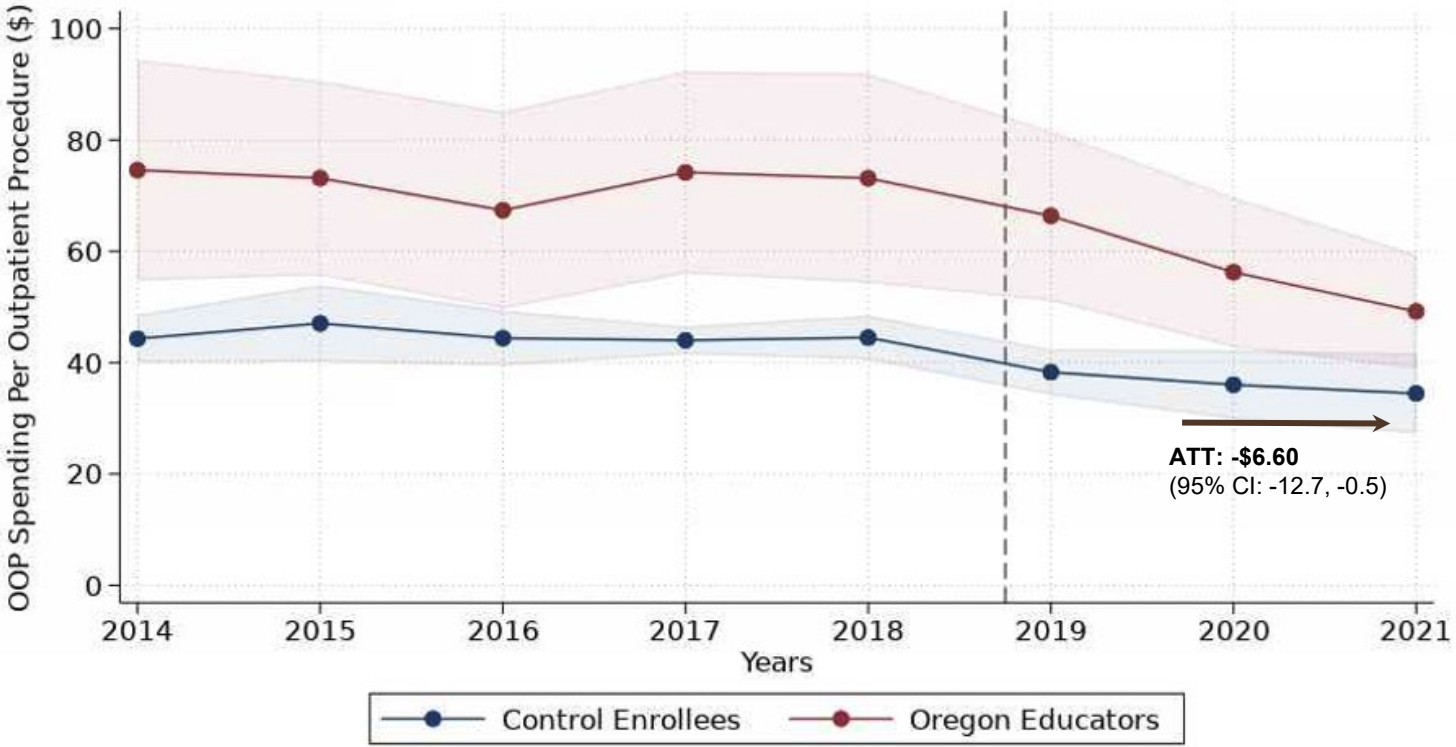
All Procedures

The cap was associated with a **9.5% reduction** in out-of-pocket spending per procedure



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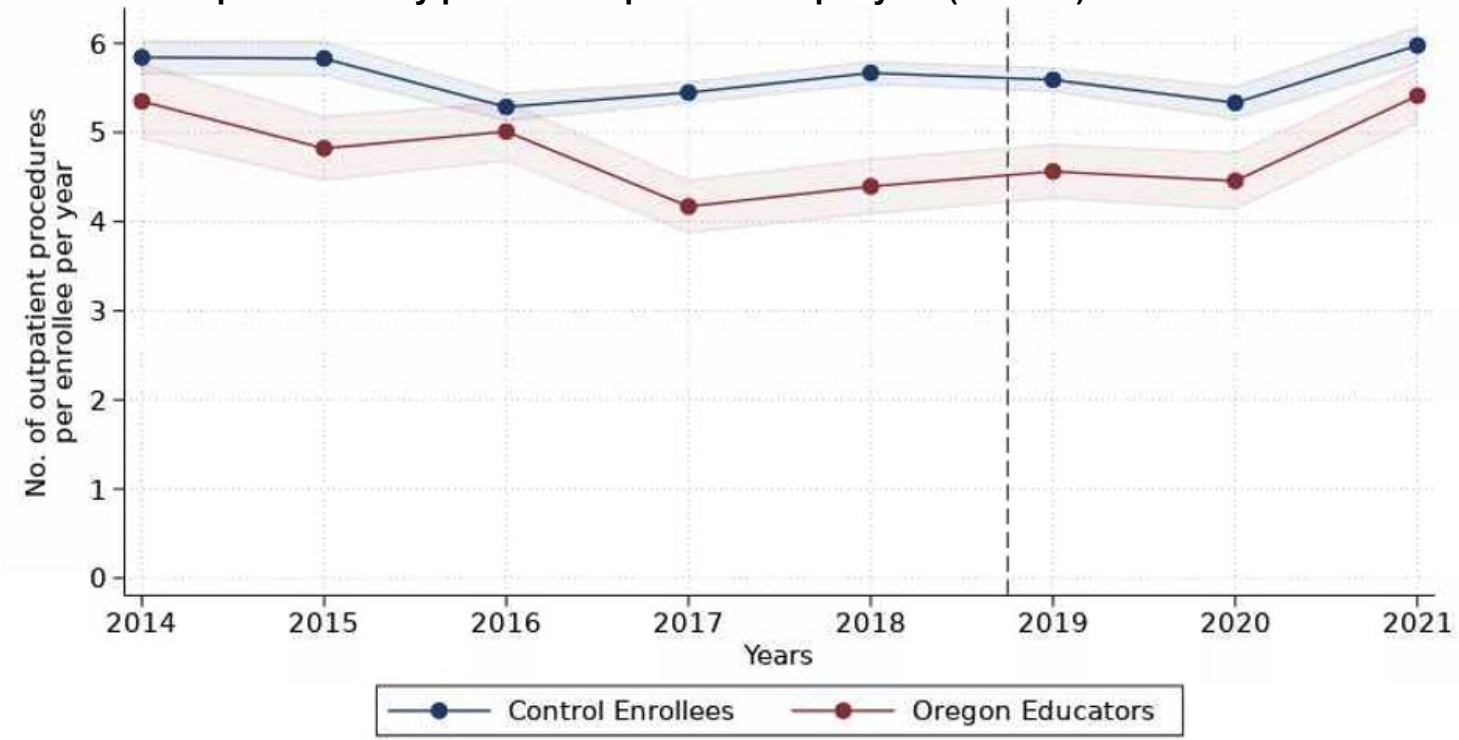
All Procedures

Outpatient facility procedures per enrollee per year (2014-21)



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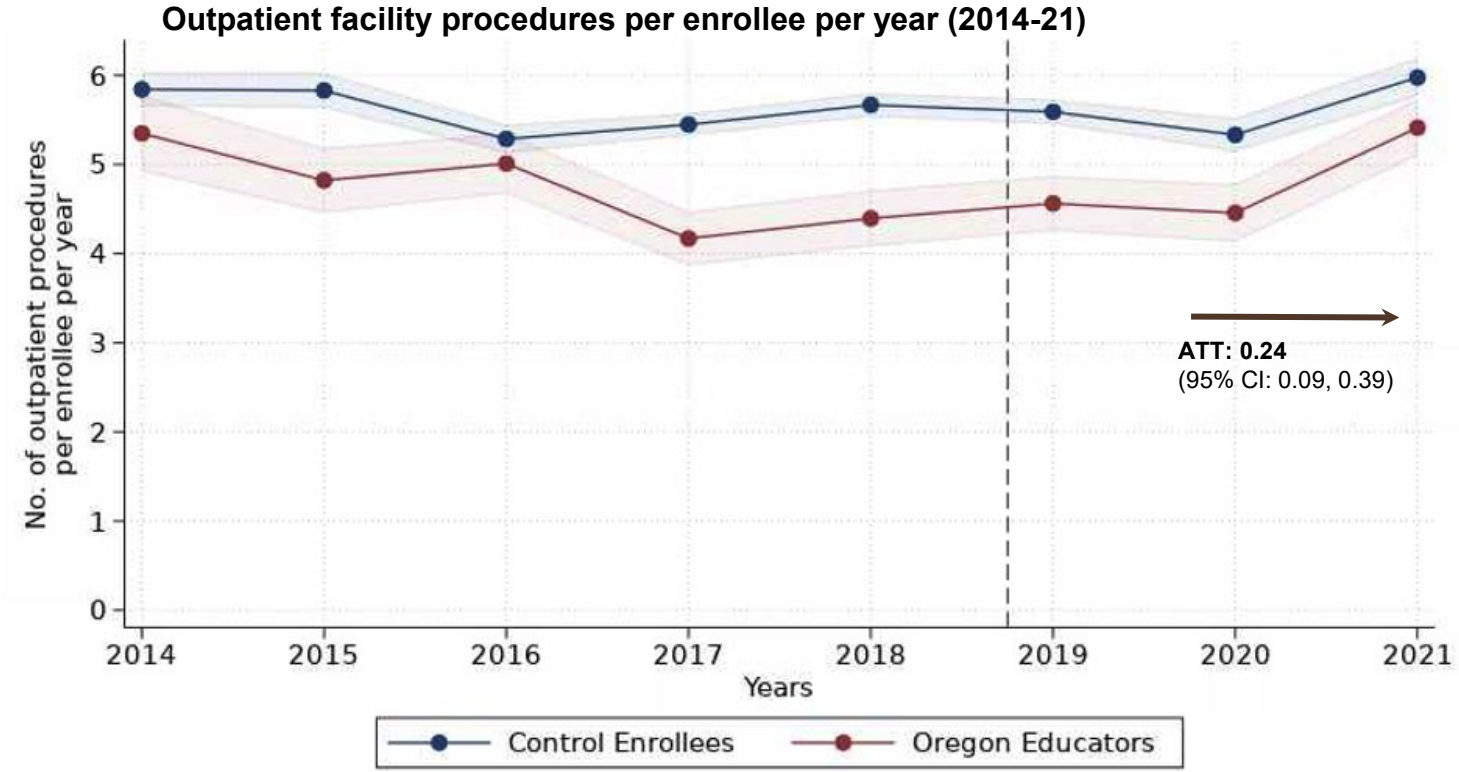
The cap was associated with a **4.8% increase** in service use

All Procedures



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The enrollees saved almost $2M in outpatient out-of-pocket spending

- Reductions in out-of-pocket spending resulted in **$1.8 million** in savings over the first 2 years and four months
- However, increases in service use were associated with **$10.3 million** in lost savings to the plan

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Key Considerations

What to use as the benchmark

Medicare payments	Commercial payments
PROS:	
• Strive to approximate cost of care provision • Formulas have been refined over time • Adjust for geographic, hospital, patient factors • Not influenced by bargaining leverage	• Reflect market dynamics not captured by Medicare payments • Less disruptive • May better reflect costs for commercial patients
CONS:	
• May not accurately reflect costs for certain services (e.g., maternity) • Includes distortions in Medicare fee schedules • Challenging for contracts not paid on the basis of Medicare	• May incorporate negotiating leverage of insurers and providers • Lack of transparency and availability of commercial payments

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Where to set the cap and whether it applies uniformly

Where to set the cap

- **If too high >>** limited savings and low priced hospitals may increase prices
- **If too low >>** could strain hospitals financially
- **Just right? Oregon set 200% cap**
  - Well above Medicare payments (i.e., >100% of Medicare)
  - Marginally below average relative payment, which was 237%

Apply uniformly or by setting or service?

- Could set separate cap for inpatient/outpatient or by service type (e.g., maternity)
- Uniform cap offers administrative and regulatory simplicity

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Other considerations

- **Whether it applies to specific hospitals** (e.g., exempt small, rural hospitals; apply payment floor)
- **Including out-of-network payment cap** (e.g., OON cap can be set at or below the in-network limit to encourage participation)
- **How compliance is examined and enforced** (e.g., in Oregon, compliance is assessed at the hospital-level)
- **How enrollees experience the savings** (e.g., lower premiums, more generous benefits, wage increases, out-of-pocket spending)

Thank you!

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References

2017 Health Care Cost and Utilization Report. [Internet]. Health Care Cost Institute; 2019 Feb 11.

Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's the Prices, Stupid: Why the United States Is So Different from Other Countries. Health Affairs, 2003; 22(3)

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 Affairs, 2019; 38(1)

Arnold DR, Whaley CM. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. Working Paper. 2020 June.

Aron-Dine A, Einav L, Finkelstein A. The RAND Health Insurance Experiment, Three Decades Later. Journal of Economic Perspectives 2013; 27(1):197-222.

Berenson RA, Murray RB. Guiding the Invisible Hand: Practical Policy Steps to Limit Provider Prices in Commercial Health Insurance Markets. The Urban Institute. 2023.

Blavin F, Kane N, Berenson R, Blanchfield B, Zuckerman S. Association of Commercial-to-Medicare Relative Prices With Health System Financial Performance. JAMA Health Forum. 2023 Feb 3;4(2):e225444. doi: 10.1001/jamahealthforum.2022.5444. PMID: 36763368; PMCID: PMC9918880.

Brown ZY. Equilibrium effects of health care price information. Rev Econ Stat. 2019;101(4):699–712.

Centers for Medicare and Medicaid Services. National health expenditures data: historical [Internet]. Baltimore (MD): CMS; 2023 Dec 13

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References

Chernew ME, Dafny LS, Pany MJ. A proposal to cap provider prices and price growth in the commercial health-care market [Internet]. Washington (DC): The Hamilton Project; 2020 Mar.

Congressional Budget Office. Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services. 2022

Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? Hospital prices and health spending on the privately insured. The quarterly journal of economics, 2019:134(1), pp.51-107.

Einav L. Finkelstein A. 2018. Moral Hazard in Health Insurance: What We Know and How We Know It. Journal of the European Economic Association 2018 16(4):957–982

Garmon C, Bhatt K. Certificates of public advantage and hospital mergers. J Law Econ. 2022;65(3):465–86.

Garthwaite C, Ody C, Starc A. Endogenous quality investments in the U.S. hospital market. J Health Econ. 2022 Jul;84:102636. doi: 10.1016/j.jhealeco.2022.102636. Epub 2022 May 14. PMID: 35605497.

Ginsburg PB. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. Center for Studying Health System Change. 2010;(16).

Hartman M, Martin AB, Benson J, Catlin A. National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending. Health Affairs, 2019; 39(1): 8–17

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References

Kronick R, Neyaz SH. Private Insurance Payments to California Hospitals Average More Than Double Medicare Payments.West Health Policy Center. May 2019.

Liu JL Levinson ZM, Shariq Qureshi N, Whaley CM. Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans. RAND 2021;

Manning W.G., Newhouse J.P., Duan N., et al. Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment. American Economic Review. 1987; 77(3):251-277.

Møllgaard HP, Overgaard PB. Market transparency: a mixed blessing? Copenhagen (Denmark): University of Copenhagen, Department of Economics, Centre for Industrial Economics; 1999. (CIE Discussion Paper No. 1999-15).

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

Prager E, Tilipman N. Regulating Out-of-Network Hospital Payments: Disagreement Payoffs, Negotiated Prices, and Access. Working Paper; 2020.

Schultz C. Transparency on the consumer side and tacit collusion. Eur Econ Rev. 2005;49(2):279–97.

Shrank WH, Rogstad TL, Parekh N. Waste in the US health care system: estimated costs and potential for savings. Jama. 2019 Oct 15;322(15):1501-9.

Stensland J, Gaumer ZE, Miller ME. Private-Payer Profits Can Induce Negative Medicare Margins. Health Affairs. 2010; 29(5): 1045-1051. doi: 10.1377/hlthaff.2009.0599

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References

Stigler GJ. A theory of oligopoly. J Polit Econ. 1964;72(1):44–61.

Whaley CM, Briscombe B, Kerber R, O'Neill B, Kofner A. Prices Paid to Hospitals by Private Health Plans. RAND Corporation, 2022.

White C, Bond AM, Reschovsky JD. High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power. Center for Studying Health System Change. 2013;(27):1-10.

White C. Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates. Health Affairs, 2013; 32(5): 935-943.

White C, Wu VY. How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices? Health Serv Res. 2014; 49(1). doi: 10.1111/1475-6773.12101

Yang W, Anderson GF. Hospital resource allocation decisions when market prices exceed Medicare prices. Health Serv Res. 2021;1-11. doi:10.1111/1475-6773.13914

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