Emergency Departments.

Commonwealth of Virginia
Joint Commission on Health Care

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Conflicts of Interest.

- I have no financial conflicts of interest.
- Opinions expressed are solely my own and do not necessarily express the views or opinions of my current or previous employers.

Arnold Ventures Health Care.

Arnold Ventures is a philanthropy dedicated to addressing some of the most pressing problems in the United States.

Health Care Objective > Reduce health care spending for patients, employers, and taxpayers while maintaining access to needed, high-quality care and supporting health care delivery system reform.

Commercial sector prices	Drug prices/ FDA clinical trials	Provider Payment Incentives/ Medicare Sustainability	Care for complex populations

Approach to Creating Change.

> Research

> Policy development

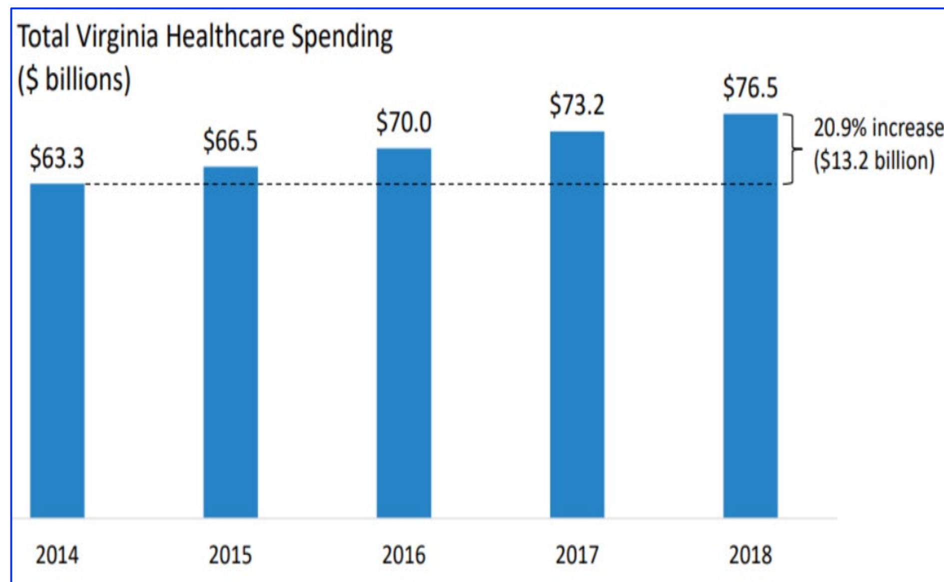
> Technical assistance and education

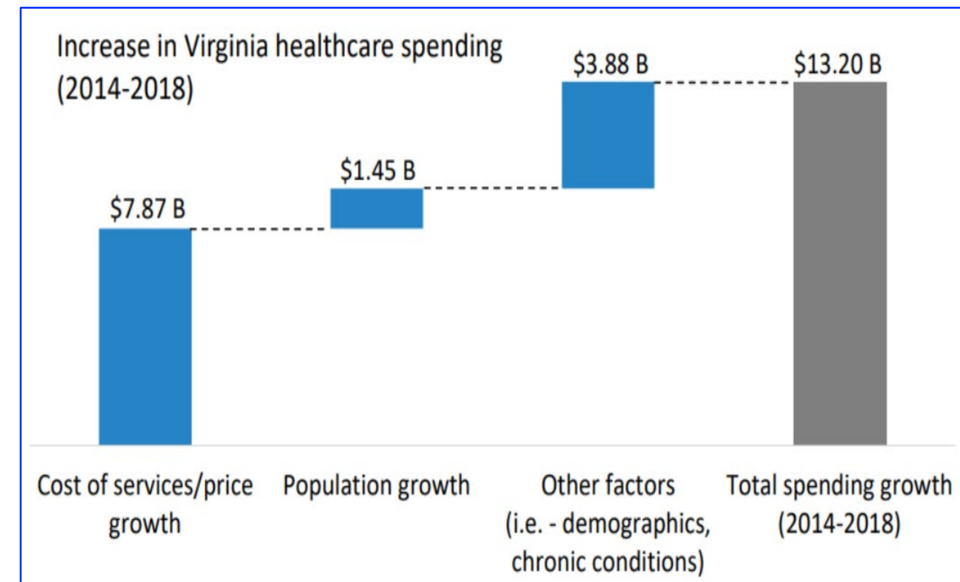
> Visibility and dissemination (communications)

Health Care Spending in Virginia: Growth.

> Health care spending increased 20.9% between 2014 and 2018.

> Growth driven by increased cost of services.





Source: Commonwealth of Virginia Joint Commission on Health Care. Total Healthcare Spending in Virginia. October, 2020.

Health Care Spending in Virginia: Consumer Impact.

- Premiums and deductible increases outpaced total health care spending growth between 2014 and 2018.
  - Premiums in Virginia's individual market increased by 96.7%.
  - Median deductible for QHPs on Virginia's individual market went up 34%.

- Price of Virginia hospital systems relative to Medicare in 2018.
  - Total: 285%.
  - Inpatient: 296%.
  - Outpatient: 263%.

Provider Prices: Arnold Ventures Research/Policy Resources.

> Arnold Ventures Policy Priorities.
- > Surprise Medical Billing
- > Transparency
- > Anticompetitive Contracting
- > Merger Oversight
- > Rate Regulation
- > Public Option
- > Global Budgets

> Other Organizations to Help States.
- > National Academy for State Health Policy
- > Johns Hopkins University
- > UC Hastings

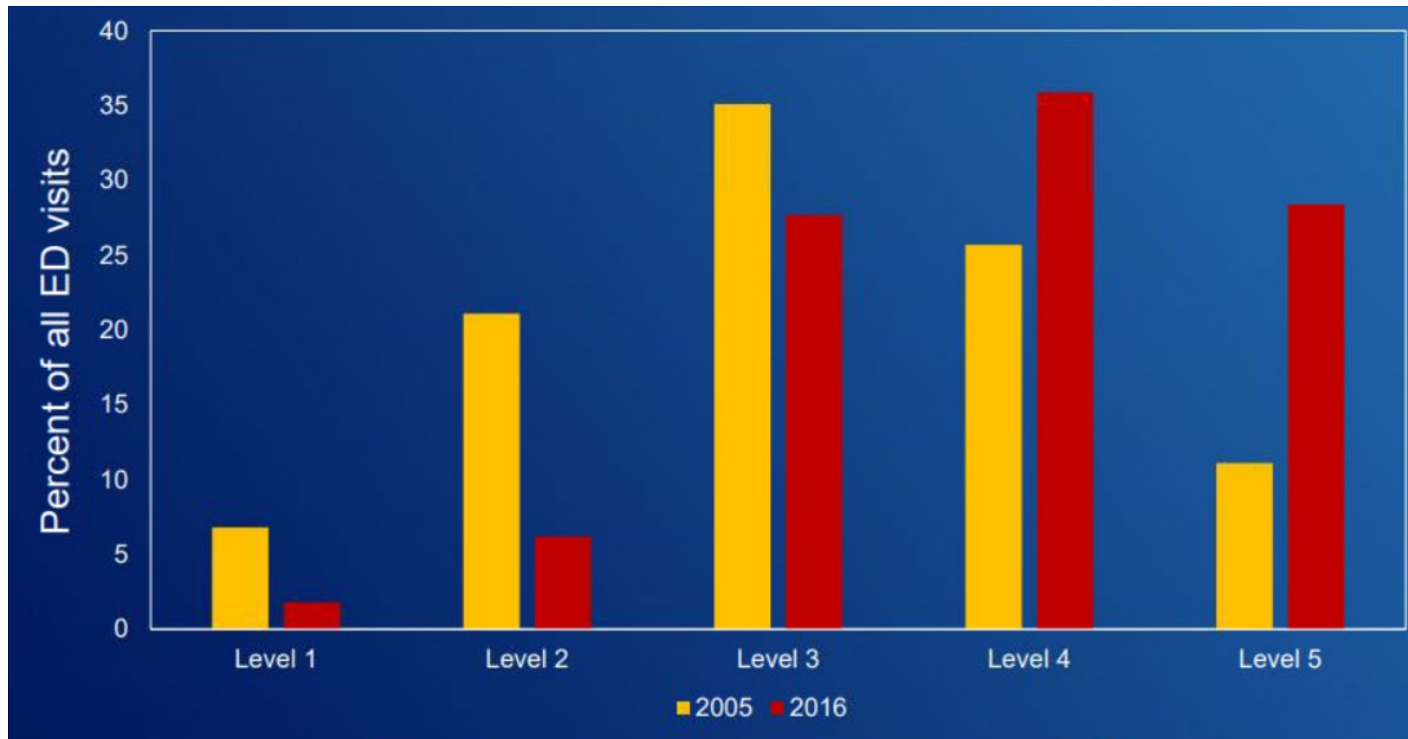
> Hospital Consolidation and Prices.
- > Selected Articles
  - > *It's Still The Prices, Stupid: Why The US Spends So Much on Health Care, And A Tribute to Uwe Reinhardt* - Gerard A. Anderson et al., 2019
  - > *What We Know About Provider Consolidation* – Karyn Schwartz et al., 2020
- > Organizations
  - > RAND Corporation
  - > Urban Institute
  - > Committee for a Responsible Federal Budget

Emergency Departments.

- Factors previously discussed by the Commission.
  - National data indicate that ED visits are more than six times more expensive than primary care visits for the same conditions.
    - 30% of ED visits could have been treated in a primary care or other ambulatory settings, per national claims analyses.
  - Free standing EDs increase access to care but are higher cost than alternate settings.
  - The ‘intensity’ of ED claims billed nationally and in Virginia is increasing.

Coding.

> Each ED visit is coded into one of five levels; payments vary upon level.
> Hospitals use internal guidance; national ED coding guidelines not used.



Source: MedPAC. Medicare policy issues related to non-urgent and emergency care. October, 2018.

Upcoding.

- Fact Set/Issues.
  - Little change in conditions treated in EDs.
  - Change in severity unlikely to explain variation in coding.
    - Migration to Urgent Care Centers (UCCs).
    - Even if all migration was for low acuity patients, does not explain coding shifts in EDs.
  - Spending increased faster than utilization, suggesting upcoding is a driver.
  - Anecdotal evidence of private equity encouraging upcoding and use of EDs.

- Policy Solutions.
  - Establish uniformity of coding to avoid hospitals setting their own rules.
  - Provide incentives to avoid ED use.

Hospital Affiliated Emergency Departments - Medicare.

- On-campus EDs and off-campus EDs within 35 miles of affiliated hospital:
  - Medicare pays full ED rates for hospital-affiliated EDs open 24/7.
  - Medicare pays 70% of ED rates for EDs open less than 24/7.

- Off-campus EDs beyond 35 miles of affiliated hospital:
  - Medicare reimburses as physician office (cannot bill ED facility charge).

- Remember, EDs and UCCs will generally submit both a facility and a physician bill.

Hospital Affiliated Emergency Departments.

- Fact Set/Issues.
  - Use and spending were increasing.
  - Not all EDs see the same level of patient severity; some operate as a true ED, others as a less intense ED, others provide UCC-level care.
    - 1/3 of care in EDs is non-urgent or UCC-level care.
  - Off-campus EDs generally have less complex patients, generally operate less than 24/7.
  - Can be a source of surprise medical billing.

- Policy Solutions.
  - Adjust payment incentives.
    - Reimburse all on-campus, hospital affiliated EDs at 100% of rates.
  - Reimburse all off-campus EDs at 70%, regardless of distance from affiliated hospital or 24/7 status.
  - Measure avoidable ED utilization as performance measure if HMO, system, etc.

Unaffiliated Emergency Departments.

- Fact Set/Issues.
  - Rapid growth primarily in urban, affluent areas. Provide less care for Medicaid and uninsured populations.
  - Patient severity falls between on-campus EDs and UCCs.
  - Lower stand-by costs than on-campus EDs.
  - Medicare pays as a physician office.
  - Commercial sector likely reimburses both facility and physician payments.
  - Can be a source of surprise medical billing.

- Policy Solution.
  - Pay as physician office or UCC.

Urgent Care Centers.

- Fact Set/Issues.
  - Growing number of facilities.
  - 2/3 are independent; 1/3 are hospital affiliated.
  - Patient severity similar to physician office (e.g. cough; UTI; sinus infection).
  - Independent UCCs paid as physician offices.
  - Hospital-affiliated UCCs reimbursed for facility and physician claims.
    - Most likely 70% of rates because open less than 24/7.
- Policy Solution.
  - Pay as physician office regardless of hospital affiliation.

Rural Areas.

- Issue.
  - Special case for isolated communities unable to support a fully operating hospital.
- Policy Solution.
  - EDs integrated with a primary care practice and with ambulances.
  - Pay ED rates at 100% regardless of 24/7 operating status.

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Arnold Ventures

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Arnold Ventures Commercial Pricing Fact Sheet

Health care spending in the U.S. is much higher than other developed countries and growing at an unsustainable rate.

- Health care spending in the U.S. was 17.7% of the GDP in 2018 and projected to increase to 19.7% by 2028.[1,2] This means that roughly one in every five dollars in the US economy will be spent on health care.
- U.S. per capita health spending was $9,892 in 2016 — 25% higher than the next highest, Switzerland, 108% higher than Canada, and 145% higher than the OECD median.[2]
- If the U.S spent at the levels of Switzerland, it would have saved at least $630 billion in health care spending.[2]

Americans pay more money for the same health care services than people in other developed countries.

- The average price of a caesarean section in the U.S. is $16,106, while in Australia it is only $7,901.[3]
- The average price of an MRI in the U.S. is $1,119—double the price in Switzerland.[3]
- The average price of an appendectomy is $15,930, which is double the price in the U.K. ($8,009) and five times the price in Australia (3,814).[3]

These higher prices are the cause of higher health care spending in the U.S. compared to other countries, rather than other factors such as higher utilization or an aging population.

- The U.S. spent approximately twice as much as other high-income countries on medical care, but health care utilization rates were roughly similar to those in other countries.[4]
- The U.S. has fewer physicians and hospital admissions per 1,000 population, fewer physician visits per capita, and fewer acute care days per capita compared to other OECD countries.[4]
- The U.S. does not have a significantly higher number of specialists nor a significantly higher aging population than comparable countries.[4]

High health care prices are a particular concern in the private insurance market, because commercial payers have much less ability to control rising prices than government payers.

- Per enrollee spending for employer-sponsored insurance grew more than twice as much as Medicare spending per enrollee from 2008 to 2018.[5]
- The prices hospitals charge commercial payers far exceed the cost of care. On average, hospital prices in the private insurance market are about 150% of their costs.[6]
- A recent study found that on average hospitals charge the privately insured 241% of what Medicare would have paid, with hospitals at the high end charging prices ranging from 350% to more than 400% of Medicare.[7]
- Between 2014 and 2018, prices accounted for three-quarters of spending growth for people with employer-sponsored insurance after accounting for inflation. Utilization during this five-year period grew 3.1% while prices increased 15.0%.[8]

The prices providers charge the privately insured are not only high but vary widely across provider markets and even across providers in the same market. A significant portion of this variation reflects market power, not quality or underlying costs.

- In El Paso, TX, the price of a blood test can range from less than $144 (10th percentile) to more than $952 (90th percentile) depending on the provider you visit. In Baltimore, MD, the same range is only $22 to $37 for a blood test.[9]
- The median price of a C-section in the greater Boston area was $11,827 but ranged from $5,739 at the 10th percentile to $23,836 at the 90th percentile, a difference of more than $18,000 depending on the hospital.[9]

- In some states (MI, PA, NY, and KY), hospitals charge the privately insured 150-200% of Medicare rates on average. In other states (CO, MT, WI, ME, WY, and IN), prices range from 250-300+% of Medicare.[7]

The employer-sponsored insurance market covers roughly half of all Americans, who ultimately bear the brunt of rising health care prices.

- One way employers have responded to the rising costs of health care is by shifting part of the cost onto their employees through higher deductibles. Between 2014 and 2019, the percentage of covered workers with an annual deductible of $2,000 or more for single coverage increased from 18% to approximately 28%.[10]
- Employers have also increased premiums for their employees in response to higher health care costs. The average amount employees pay for family coverage increased more than 70% from 2009 to 2019.[10]
- Economists have connected rising health care costs to workers' wages—money that would have gone to higher wages has instead gone toward the cost of providing health benefits. Between 2007 and 2017, average out-of-pocket spending for people with large employer plans grew 58%, more than double the increase in wages (27%) during the same period.[11]
- The result of these trends: the median household in the U.S. pays more to hospitals than to the Internal Revenue Service (IRS), 15.2% and 13.5% respectively.[12]

Consolidation in the health care industry is an important driver of high prices.

- Providers are increasingly consolidated, leading to uncompetitive markets where providers have more market power to demand higher prices. Nearly 90% of health care provider markets are categorized as highly or super concentrated, according to U.S. Federal Trade Commission (FTC) standards.[13]
- Many studies have documented an increase in commercial health care prices ranging from 6% to as high as 65% following consolidation.[14,15] However, not only merged hospitals increase prices—their nearby competitors raise their prices as well. In one study, a neighboring hospital increased prices by 17%.[16,17]

Providers have justified consolidation by saying it improves quality, but the data shows otherwise.

- Although provider consolidation results in price increases, it does not result in associated gains in quality. Most studies have shown little to no effect on quality, with some studies even showing that quality decreased.[18,19,20,21]
- Consolidated health care markets have been linked to worse health outcomes. One study conducted by the FTC found that when cardiology markets are concentrated, cardiology patients are more likely to have heart attacks, visit the emergency room, be readmitted to the hospital or die.[22]

Despite the evidence on consolidation, providers argue the real reason commercial prices are high is to compensate for low Medicare/Medicaid reimbursements that do not adequately cover their costs—but this is not true.

- Medicare Payment Advisory Commission (MedPAC) analyses have found that when hospitals receive high commercial payments, they have higher costs per patient.6 This suggests that hospital costs are higher when they have more money to spend and less incentive to cut costs, making Medicare payment rates appear as if they do not adequately cover these costs. These analysis have also found the reverse is true—when hospitals experience greater financial pressure, they have more incentive to constrain costs and thus Medicare payment rates appear appropriate.
- For example, hospitals with low private payer profits between 2009 and 2013 had a cost per case that was 9% less than the national median and generated an overall Medicare profit margin of 6%. In contrast, hospitals with high private payer profits over the same period had a cost per case that was 2% above the national median and generated an overall Medicare profit margin of -8%.[23]

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Resources of Interest to The Commonwealth of Virginia Joint Commission on Health Care

Arnold Ventures Materials:

- **AV Commercial Pricing Fact Sheet.** (see attached)
- **AV Surprise Billing Fact Sheet.** https://craftmediabucket.s3.amazonaws.com/uploads/AV-Surprise-Biling-Fact-Sheet.pdf
- **AV Policy Focus: Commercial Sector Prices.** https://craftmediabucket.s3.amazonaws.com/uploads/AVCommercial-Prices-Policy-Sheet-v2.pdf
  While our "Prices Policy Focus" is generally more federally focused, there are a number of analogous policies that states could pursue to address high hospital and provider process. We also pursue other relevant state-specific policies that are not captured in this document (e.g., cost-growth benchmarks). For more information on these policies, NASHP has a number of resources and model legislation related to cost-growth benchmarks, facility fees, reference pricing (particularly for state employee health plans), and other policies, like prohibiting anticompetitive contracting terms.

Spending in Virginia:

- Total Healthcare Spending in Virginia. Commonwealth of Virginia Joint Commission on Health Care, Oct. 2020, http://jchc.virginia.gov/Health%20Care%20Spending%202020%20SW%20Edits%20-%2010-15-20.pdf.
- Whaley, Christopher M., et al. Nationwide Evaluation of Health Care Prices Paid by Private Health Plans, RAND Corporation, 2020, https://www.rand.org/pubs/research_reports/RR4394.html.

Hospital Consolidation and Prices Resources:

- Schwartz, Karyn, et al. "What We Know About Provider Consolidation." KFF, 2 Sept. 2020, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.
- Anderson, Gerard F., et al. "It's Still the Prices, Stupid: Why the US Spends so Much on Health Care, and a Tribute to Uwe Reinhardt." Health Affairs, 1 Jan. 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

Relevant MedPAC Reports:

- Medicare Payment Advisory Commission, 2019, June 2019 Report to The Congress: Medicare and the Health Care Delivery System, http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.
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Other Resources of Interest:

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