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The Facts

In 2018, US health care spending reached $3.6 trillion or 17.7% of GDP.

The US spends dramatically more than other wealthy countries but has worse outcomes.

Estimates show waste accounts for approximately 25% of US health care spending. (JAMA 2019)

Costs of COVID-19 are expected to be high, but there is extreme variation in cost estimates due to uncertainty about the pandemic.

Elective procedures and outpatient care are likely to be avoided as individuals postpone care.

Medicaid spending is expected to increase due to both COVID-19 and rising enrollment as unemployment grows.

Overall, net health spending could be higher next year than expected, but it is not clear how upward and downward cost pressures will balance out.

What’s Driving Spending?

Price increases, rather than changes in utilization, have been the primary driver of rising health care spending.
While drug spending has grown rapidly, most health care dollars are spent on hospitals and physicians.

In 2018, they accounted for over half of health care expenditures.

Source: KFF analysis of National Health Expenditure (NHE) data (2018 data)
High costs of care represent a trade-off...

What if we could invest some of those resources in other priorities, such as social determinants of health or working to achieve health equity, etc.?

Source: KFF analysis of National Health Expenditure (NHE) data (2018 data)
Health Care Consolidation Trends

Since 2003, the share of “super-concentrated” hospital markets has increased.

Source: MedPAC analysis of Medicare cost reports from CMS and the American Hospital Association Annual Survey of Hospitals. Note: “Super concentrated” indicates a Herfindahl-Hirschman Index exceeding 5,000. Hospital markets are defined as metropolitan core-based statistical areas.
Health Care Consolidation Trends

% of highly concentrated markets:
- 90% of hospital markets
- 65% of specialty physician markets
- 57% of insurer markets
- 39% for primary care physicians

Health Care Consolidation Trends

Hospital ownership of physician practices has more than doubled over 5.5 years

Source: Avalere slides at Physicians Advocacy Institute, February 2019.
Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files

The steady stream of hospital acquisitions resulted in a **129% increase**, more than doubling the ownership percentage over 5 ½ years.
Consolidation → Higher Prices, But Not Increased Quality

- Vertical consolidation leads to higher health care costs — including higher hospital prices, 14% higher physician prices, and 10-20% higher total expenditures per patient.

- Consolidation can also lead to the addition of facility fees – fees hospitals can charge for outpatient services provided by their acquired physicians.
  - According to Massachusetts claims data, average facility fees for outpatient evaluation and management services, such as colonoscopies and MRIs, can exceed $1,000.

- Meanwhile, consolidation has been shown to have little to no impact on improving quality of care, reducing utilization, or improving efficiency.

Consolidation due to COVID-19

Declining provider revenue due to delayed or foregone care, changing payer mixes, and higher costs due to purchasing personal protective equipment could spur more consolidations depending on the severity and duration of revenue losses.

*Changes in personal expenditures on health care services, 1960 - 2020*

NOTE: Note: Monthly spending data are annualized
SOURCE: KFF analysis of BEA Data
The Cost-Shifting Challenge

Theory: Underpayment by Medicare directly results in higher rates for other payers. Would equalizing public and private payment rates reduce cost shift?

- One study* revealed that when confronted with reduced Medicare rates, hospitals also reduced their commercial rates in order to attract a larger volume of higher-paying patients. (Producing the opposite of the expected cost shift.)
- Another study** found hospitals that received an unexpected 10% increase in Medicare payment rates did not reduce their other rates, but instead:
  - Added new technology;
  - Increased nursing staff; and
  - Increased payroll by one-third.

Results from the RAND 3.0 study show that patient mix does not explain hospital price variation.

The typical nonelderly family in the US spends 11% of its income on health care – excluding employer contributions – but this can vary substantially by income, type of insurance, and health status.

As income inequality is often linked to race/ethnicity, communities of color are impacted more by high health care costs. For example, that rate of spending approaches 20% among Black households.
Impact on Consumers: Out-of-Pocket Costs Continue to Climb

Per capita out-of-pocket expenditures, 1970-2018

Source: KFF analysis of National Health Expenditure (NHE) data

Total OOP National Health Expenditure per capita 2018 - $1,150
Impact on Consumers: Total Health Care Spending Has Far Outpaced Wages

Cumulative growth in out-of-pocket and total health spending for people with large employer coverage, 2007-2017

Source: Peterson-KFF HealthSystem Tracker; KFF analysis of IBM MarketScan Commercial Claims and Encounters, 2003 – 2017
Both Employer and Employee Spending Has Increased Faster than Wages

Cumulative growth in premiums and out-of-pocket spending for families with large employer coverage, 2008-2018

- Worker share (OOP and premium)
- Employer share (premium)
- Workers' wages

Note: Out-of-pocket (OOP) costs are inflated from 2017 to 2018 because data are not yet available. Large employers are those with one thousand or more employees.

Rising Costs = Lower Wages, GDP, and Employment

- Consumers bear the brunt of rising health care costs in the form of higher out-of-pocket spending, but also in reduced wages.
- Research shows hospital mergers lead to a $521 increase in mean hospital prices, a $579 increase in per-enrollee hospital spending among the privately insured population, and a similar $638 reduction in wages per worker.*
- Other studies show that incremental increases in health care costs can impede wage growth.**
- Some economists also report that rapidly rising health care spending lowers GDP and overall employment, while raising inflation.***

Sources:
**Baicker and Chandra 2006, and Clemens and Cutler 2014
Impact on Consumers: Costs of COVID-19

• Recent analyses suggest that people with employer coverage who are admitted for COVID-19 treatment could face out-of-pocket costs exceeding $1,300.
• There is also an increased chance that individuals treated for COVID-19 will be “surprise billed” despite federal prohibitions.
• These costs will likely impact Black, Latinx, and Native American populations disproportionately as these communities are experiencing exponentially higher rates of COVID-19.

Source: Peterson-KFF Health System Tracker, “Potential costs of COVID-19 treatment for people with employer coverage” (March 2020)
Impact on Consumers: Costs of COVID-19

- Between March and May 2020, more than 31 million people filed for unemployment, indicating they may also lose their employer-sponsored insurance.

- Many are eligible for ACA coverage, but a small number will fall into a “coverage gap” – they are ineligible for Medicaid but have incomes too high to qualify for tax credits to help pay marketplace premiums.

- As people of color and women experience higher rates of unemployment, these individuals are expected to be at greater risk of losing coverage and facing higher health care costs.

Sources: KFF, “Eligibility for ACA Health Coverage Following Job Loss” (May 2020); Health Affairs, “COVID-19 Job Losses Threaten Insurance Coverage And Access To Reproductive Health Care For Millions” (August 2020)
The burden of high health care costs falls on individuals as taxpayers, employees, employers, and consumers.
While patient care is often the most discussed part of hospital finances, it only represents one revenue stream for most systems...
When addressing hospital costs, policymakers must be aware of the many sources of funding for a hospital.

- Federal Government
- Income Tax Exemption (Federal and State)
- Property Tax Exemptions (State)
- State Government and Municipal Bonding
- Investments
- Grants, Donations, Foundation Funding
- Patient Care Revenues
- Nonpatient services
- Group Purchasing Organizations
- 340B Drug Program
- Drug Manufacturers
- Hospital-Owned Medical Practices
- Hospital-Owned Businesses and Joint Ventures
- Hospital-Owned Businesses and Joint Ventures
- Patient Care Revenues
What Can States Do?

- Increase hospital financial transparency:
  - Model Act to Ensure Financial Transparency
  - Model Reporting Template: Hospital Financial Transparency Report Template
- Follow federal CARES money:
  - Blog: Why States Need to Follow the Federal Money to Hospitals
  - Model Reporting Template: Follow the Money – A Template for States to Track Federal Relief Funds by Hospital
- Control costs through restrictions on facility fees, out-of-network charges, and balance billing:
  - Model State Legislation to Prohibit Unwarranted Facility Fees Reporting Requirements
- Negotiate hospitals prices with an understanding of how hospitals are recovering costs:
  - NASHP Cost Recovery Tool
What Can States Do?

- Limit cost increases over time through a total cost-of-care, cost-growth benchmark:
  - Chart: Overview of States’ Health Care Cost-Growth Benchmark Programs
- Control hospital cost increases through more stringent insurance rate review.
- Contain costs and reduce cost shifting through an all-payer or global hospital budget model.
- Address health care consolidation through attorney general action, determination/certificate-of-need programs, transaction approval, etc.
  - White Paper: State Policies to Address Vertical Consolidation in Health Care
  - Blog: Should We Re-Invent State Health Planning and Certificate-of-Need Programs
  - Chart: 50-State Scan of State Certificate-of-Need Programs