STRATEGIC HEALTH CARE

DR. ROBERT BERENSON DISCUSSES HEALTH CARE PRICING

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P R O C E E D I N G S

MR. OOSTRA: Hello, my name is Randy Oostra, President and CEO ProMedica. I'm pleased to welcome you to this eight part series of health care reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy, including health care pricing, long term care and the social determinants of health.

This series is part of an ongoing two year effort by more than a dozen hospital CEOs from around the US to urge Congress to take up significant health care policy reform legislation, largely by calling for the creation of a national commission on health care reform.

It is our intent that these policy reforms discussed during these interviews demonstrate our desire for substantive national reform. Moreover, that these interviews help to further inform congressional members and committee staff as they work to craft legislation to improve health care delivery, and financing during the next Congress.

Our motivation is straightforward. Well

before the onset of the COVID-19 Pandemic, we were adamant that race, age and/or economic circumstances should not be defined as preexisting conditions. Nor do we accept the premise that Americans should be resigned to live shorter lives in poorer health. We invite you to listen to, or to read the transcripts of all eight interviews. If you'd like to provide comment, you can do so via the contact information noted at the conclusion of these interviews.

MR. INTROCASO: Welcome to the second interview in this series of eight concerning federal health care policy reform. Again, I'm David Introcaso. Any discussion of health care reform must include examining health care pricing, what drives health care spending? Health care prices. Here to discuss the topic is Urban Institute Fellow and former three term MedPac Commissioner Dr. Robert Berenson. Dr. Berenson, welcome.

DR. BERENSON: Pleasure to be here, David.

MR. INTROCASO: Dr. Berenson's complete bio is posted with this interview's audio file and transcript. Briefly on background, as has been well documented, US

health care prices, moreover in commercial markets, have for decades been significantly higher than in comparative countries. In addition, US health care markets suffer wide price heterogeneity, or significant price discrepancy.

Total-US healthcare spending, per capita spending and spending growth are in multiples of other rich countries, despite the fact, among others, Americans do not consume more health care services. For example, in 2019, the US spent approximately two and a half times the per capita OECD average.

While there's been and will remain debate regarding how to best calculate prices or interpret price signals, there is consensus US health care suffers a significant pricing problem. As Uwe Reinhardt and his colleagues concluded in a widely referenced 2003 article it is “the price is stupid.”

Among numerous other problems, high priced health care, as Dr. Wolf discussed in the preceding interview, explains our significant health disadvantage. Again, Americans suffer or bear a high disease burden, resulting in our living shorter lives.

So, with that, Bob, as intro or background, as I just noted, the US health care has a price problem. I didn't explain what accounts for this, so that's my first question. What accounts for our pricing problem?

DR. BEENSON: Well, first I want to just say that, while researchers and policy wonks, understand that we have a pricing problem, and particularly for hospitals, to a lesser extent for other for health professionals. Public policy hasn't in any significant way addressed the problem. There's a lot of discussion about pharmaceutical prices and legislation to address it. Pharmaceuticals represent about 10 percent of the total health bill. Hospitals represent 45 percent of the total health bill and with health professionals together over 60 percent of the health bill. And so the first thing to just understand is that it deserves policy action, not just documentation of what the problem is.

And why do we have such a problem, is because we have at this point broken markets. At one time, insurers and hospitals negotiated fairly equally to arrive at a price for paying for the hospital services.

But over the last two decades hospitals have figured out that they could gain market leverage in those negotiations by basically merging, by becoming larger, by becoming what some people call must haves. An insurer can't go to market for an insured product without having that hospital system in its network.

It gives an inordinate leverage to the hospitals in negotiating their prices. And so what we've seen is that in 1996, the estimate was that hospitals were getting paid at about 106 percent of the Medicare level. And we'll get back to that. But Medicare pays close to the costs of hospitals.

Now, a very recent report from RAND shows that on average hospitals are getting 247 percent of Medicare. It's just been a straight line upwards. And why? Because hospitals can do what pharmaceutical companies can do, is they can basically name their price and so that's what the problem is.

MR. INTROCASO: Okay, thank you. And just to put a finer point on that market concentration, 90 percent of Metropolitan Statistical Areas, MSAs, where highly concentrated for hospitals. This is the noted

Herfindahl-Hirschman Index score. And concentration amongst 58 percent, excuse me, of MSAs provider concentration was higher than insurer concentration. And the opposite where insurer concentration is higher than hospitals is true in only six percent of MSAs. To add a bit more detail here. So, thank you.

And of course, per your point, the latest statistic I saw reinforced the fact that market share and prices go positively together is that monopoly hospitals tend to have rates 12 percent higher than those that are not.

One of the solutions, of course, and this --

DR. BERENSON: Wait, wait, I just need to make one other point about this.

MR. INTROCASO: Please.

DR. BERENSON: I mean, it's one thing to be getting 247 percent of hospital, I'm sorry, of Medicare rates. And the -- keep in mind that Medicare and Medicaid actually, both pay about 90 percent of cost, it's drifted down recently. Hospitals argue that, well they have to charge more because they've got these huge shortfalls in Medicare and Medicaid.

Well, if you do the math, and this is really junior high school algebra, you can figure out that to be made whole, if they're getting 90 percent of their costs from Medicare and Medicaid, they will, should be getting 140 to 150 percent of Medicare, to make up for those shortfalls based on the payer mix percentages. They are getting dramatically more than that.

And what does that result in? Incredible profits being made by not for profit, supposedly not for profit hospital systems. The large majority of hospitals are not for profit.

So, during COVID, during the second quarter, many hospitals had markedly reduced revenues in the tens of millions of dollars. But many of these systems have literally billions of dollars. There's one system which I won't name today has $20 billion sitting in marketable securities. And yet, they were getting a Federal bailout for the shortfall they had in one quarter.

So, these high prices are not providing medical care for anybody. They are not primarily going to capital expansion and developing new treatment protocols or new facilities. They are paying generous

salaries, high staffing, and most of it, or much of it, is sitting just in the stock market. And so that's what I think we need to understand.

MR. INTROCASO: Okay, so thank you again. So, the more possibly traditional discussion relative to addressing market failure is to stimulate competition. So, let's spend a moment on that. And in fact, that was largely this current Administration's approach that they outlined in some detail in their late 2018 report, "Reforming America's Health Care System through Choice and Competition." Most of that, of course, was their effort to try to improve price transparency.

What's your sense of our ability to stimulate competition in a market, as I noted and you noted as well as is already highly concentrated?

DR. BERENSON: Well, yeah there are some marginal policies that can help. There are still some hospital mergers that the antitrust authorities could try to prevent some of the major problems right now we're seeing in what's called cross market mergers, where hospitals in different geographic areas often nearby, but in different market areas, merge and develop

sort of large system power. Even though they may not violate antitrust rules in the local market, they have market power because of their consolidated impact on any insurer or any employers -- employees.

So, there's some things that can be done to try to make sort of traditional markets work better. But the basic question I'd ask is, who wants to come into markets with new hospitals. It's one thing to come in with a new insurance company, there's not a lot of bricks and mortar to actually try to come in with a new hospital system means you need to create a provider network, and the incumbent hospitals have a huge advantage. It is very hard for a new insurer could come in and develop a network without that must have hospital that has market power. So, I don't think we're going to be creating real markets the way most US economists think about the price competition.

And one other thing I'd say here is that the OECD countries, including most of the European countries, actually have significant market competition and broad choice of providers for individuals. And they do it by administered pricing. If the prices are

limited and paid by government, essentially, or if not paid by government, but the prices are determined by government, there actually is good competition over quality and service and innovation. And in the context of the US, it would increase the likelihood of having insurer competition as well.

So, I think, while there might be a role for the traditional antitrust and transparency and those kinds of things to promote more market competition, I think we are at a point when we have to take very seriously the opportunity to have government influence or even directives on the prices that hospitals and to a lesser extent physicians get to charge. And that I'm arguing actually promotes competition over the kinds of things that patients and consumers really care about is the quality of care.

MR. INTROCASO: Yeah, so to say a word or two further about competition, your comment was, the textbook argument. And that's barrier to entry in highly consolidated markets, it's a high barrier to entry. There are other, of course, price transparency as we're well aware under the current Administration,

again, although the research on that is not that promising. Most people shop based on convenience versus price. There's, of course, opportunities for benefit design, risk based contracts. But these are all seen as limited and relative to antitrust. The phrase is, it's very difficult under antitrust laws to, as they would say, put the toothpaste back into the tube. And then you did note, limiting anticompetitive contracting, all or nothing and other types of contracting practices.

Let's go to administrative pricing. And that gets to rate setting and regulatory oversight of pricing there. Any number of ways this is done. Capitation, reference pricing, price caps, limiting price growth, global payer, all payer, et cetera. What one or two of these do you think would be most appropriate for our market or are the best approach?

DR. BERENSON: Well, the first thing to say is you combine two different kinds of approaches. One is new payment incentives, new payment models, and then new ways of putting limits on the price.

I don't believe new payment models necessarily have much to do about the prices. You could say pay by

capitation. But a provider with market power is going to get a very high capitation rate. And that actually does happen. California has capitated medical groups for many years and they, if they have a monopoly in an area, get high capitation rates. So, having new payment models, which is important to discuss, and you'll be doing that I believe with Mike McWilliams --

MR. INTROCASO: Yes.

DR. BERENSON: -- to me doesn't really address the pricing issue. So, what we are left with is essentially do we want to sort of focus on the outliers, the hospitals that are, that almost everybody would agree are extracting monopoly profits? If the average is 247 percent, there are hospital systems that are getting 300, 350, 400 percent of Medicare.

North Carolina actually published data that showed that a medical group in North Carolina was getting 996 percent of Medicare. Do you want to just do that? And there's a growing consensus amongst even very pro-market economists that at some point, you have to put some limits on those kinds of extremes.

And that I think we could do, and it's

relatively easy to do that. And that is what some would recommend. But you can go all the way to what a Maryland system has had for 35 plus years, which is actually setting the actual rates that all hospitals are getting. Not just putting limits on the outliers, but setting the rates. And they've actually moved to a system of hospital budgets. There are both conceptual and theoretical concern -- I'm sorry, conceptual and practical concerns about trying to do this on a national basis.

Maryland's been doing it and most people are leery of the kind of infrastructure that would be required for every state to move to that kind of system. So, there are some intermediate approaches that could be taken in addition to putting an upper limit on what negotiated prices could be.

There was a proposal from the Governor of Massachusetts to basically tier the hospitals based on their baseline per capita, I mean, their baseline prices for comparable procedures. And the ones that are at the high level of pricing this would get limited or no increases in their rates. It's a regulatory model, but

it doesn't require having to actually interfere with all the established rates that exist in the system, it just limits the updates.

And over many years, you would start now, you would be narrowing the differentials between what are called the haves and the have nots. And that is a point I'd want to emphasize.

We do have a cost problem generated by the must have monopoly hospitals. But we have a lot of hospitals, usually not big systems maybe safety net hospitals, that do not have lots of money sitting in reserves and they are exposed and in some cases having to actually shut down because they have no leverage in their negotiations. So, one could develop a system in which there's a floor, some protection for those hospitals, and then limited updates for those who have had inordinate market power over many years.

MR. INTROCASO: Thank you, sir. So, per your comment about Maryland all payer, the state likes to argue that, per your earlier point about how regulation can actually drive or stimulate competition, or that rate setting is not anti-competitive, they like to point

out that Blue Cross's market share dropped over the years because what they found is providers and insurers compete on other dimensions, including, of course, quality.

You did mention Massachusetts, and there are any number of states. So, let's go there. You know, Rhode Island -- we know North Carolina, Washington now has started with a public option. Between and amongst the states that have moved on rate regulation, amongst these, what do you find are the most promising?

DR. BERENSON: Well, Oregon is another state that's been pretty assertive. I mean, some states, including Montana which you wouldn't think of in this area, are simply starting by putting limits, attempting to put limits anyway, on what the public employees plan would pay. There the states have direct responsibility for paying for government employees, which usually includes teachers and retiree -- former public employees who are now have retirement plans.

They would put limits, and Oregon has a specific plan to then expand that to nonpublic employees, to put limits that over time would be sort of

ratcheted down. So, I think that that does have some practical appeal. I think you could combine that with the Massachusetts proposal, which did not go anywhere. One of the points I would make there is that sometimes systems that have market power also have political power. And so it is possible that if the market isn't restraining their prices, they have the ability to prevent the legislature from restraining their prices.

But assuming that there was the will, the political will to do it, the idea of putting an upper limit on prices, and then having -- tiering the hospital so they get different update factors, which doesn't destroy a system. I mean, there have been some proposals, for example, very aggressive proposals to simply say, next year we're going to pay 120 percent of Medicare.

When the -- if you've got a system that's getting 250 or 300 percent of Medicare, and say next year you're going to get 120 percent of Medicare and all of your commercial products or your commercially insured patients that you're seeing, it would cause tremendous disruption, unemployment, they would take many service

lines out and you can't really practically do that.

That would be one of the problems of moving right away to a Medicare for all approach. You have to give the system some time to adjust to the new reality that we're asking them to significantly cut back the excesses in their systems.

So, by giving differential updates, including zero percent updates for systems that have had market power for years and have put away a lot of money, and that they could be using for the shortfalls, if they're not getting anything beyond -- they're not even getting inflation, over time they would come more into line. So, I think that would be the kind of an approach that could be adopted.

One other thing to say, I think it's important to say is, there were, you know, two or three decades ago, there were a number of states that actually had all payer rate setting systems, and Maryland is the only one that still survives. There are practical realities to trying to do this.

Let's say at the state level, there's the potential problem of regulatory capture where the

regulated entities actually have an inordinate influence over the government rate setting process. And you can have what's called regulatory failure where -- which was seen in New York and elsewhere. Which it became so complex that nobody could understand what the -- with lots of exceptions for this kind of hospital or that kind of hospital.

That is the downside of rate regulation is if it's too complicated, and if it's subject to capture by the regulated entities, it could fail. So, that does suggest starting with more limited objectives. And then over time, as you learn how to do it well, you start bringing those prices down and start more aggressively narrowing the differentials that have been created over the years between the haves and the have nots.

MR. INTROCASO: Yes, thank you again. As you noted, Montana, they -- it's reference pricing, so they peg their health plan hospital rates to Medicare reimbursement. North Carolina's discussed this. Rhode Island has an interesting approach. An insurer cannot accept a hospital contract if the price increases in excess of CPI plus one percent. And then there are

other states, including several that are actually going a somewhat different way. But they're creating, trying to create established Medicaid buy-in programs.

There is one state, of course, Washington that has now instituted a public option. And their formula is rates cannot exceed 168 percent of Medicare. And they also have a floor for primary care reimbursement.

DR. BERENSON: That's all correct. But I just point out that in Washington, as well as in North Carolina, the hospitals really push back in a fairly significant way. And the ability to actually come up with a reasonable rate is challenging. The hospitals still do have some clout and will say that there will be tremendous disruption. So, there really needs to be the political will at the state level to actually go ahead.

North Carolina actually could not implement rates that hospitals would accept with their public employee plans. And my understanding is that Washington State, the rate is much higher than the original proposers had in mind. But again, I think it's better to start somewhere. And then over time, as it becomes documented that quality does not suffer, because

hospitals have tremendous excess reserves, then you can ratchet down.

MR. INTROCASO: Thank you, since I did mention the public option, and regardless of who's in the majority in the Senate, obviously this was part of Vice President Biden's campaign platform. This, of course, was discussed in '09, relative to the Affordable Care Act, it was excluded.

He has some variations on the idea, including although not explained, auto enrollment, et cetera. It is interesting we already have a public option, in a sense and however quasi-public. And that's Medicare Advantage where Medicare Advantage plans, their rates are extremely -- are very close to comparable to Medicare, traditional Medicare. What's your overall general assessment, leaving politics aside, of a public option?

DR. BERENSON: Well, Medicare Advantage, I use as the example, the primary example of where rate regulation and competition are not only compatible, but complimentary on its own. I mean, as I said earlier, the insurers are paying well over 200 percent to

hospitals for care. And yet in Medicare Advantage, they pay pretty much the Medicare rate. And the reason they pay the Medicare rate is that there's a simple provision in the Medicare statute that says that the hospitals or any other providers are not allowed to balance bill patients beyond the Medicare allowed charges, essentially the Medicare payment level.

So, that completely changes the negotiating leverage between the providers and the insurers. You can either be in network at Medicare levels, or you can be out of network at Medicare levels, you can't be out of network at 247 percent of Medicare. And so that is a game changer.

And we actually have reasonably good competition within Medicare Advantage, not as much as we should have, but in most markets there are dozens of plans. There are many fewer different insurance companies, but there is reasonable competition. And so whether -- it's an example.

But in the interviewing that I've done, as to try to understand why this difference, why do private insurers accept or why do hospitals accept Medicare

levels for Medicare Advantage, but not for commercial? It is because there's still a large percentage of their revenues are coming from commercial. So, they are able to make up those Medicare Advantage rates at Medicare levels with the ever-increasing rates being charged through the commercial insurers.

The whole system, if there was not a safety valve, I guess is what I'm saying. And everybody was getting paid Medicare rates, then you would have that situation where somehow, unless it was phased in, over many years, you would have significant disruption in the system.

So, it is one thing to say that for marginal revenues you're going to use the Medicare rates it's completely different to say that all payments should be at Medicare levels.

MR. INTROCASO: Yes, this entire conversation is really about as an economist would term, economic rents. And that, as in other industries in mature economies, health care in the US is no different, has a massive economic rent problem. The upside relative to your comments, Bob, is that MA plans avoid for their

beneficiaries, the problem we haven't been able to solve for the last two years and that is surprise billing.

And surprise billing, of course, is probably considered to be one of the most egregious examples of the economic rent issue.

Let me ask you about MA, there's been some, not much but some discussion of expanding Medicare Advantage markets. So, for example the most commonly or frequently discussed is allowing Medicare Advantage plans to participate in state marketplaces. What's your sense of that?

DR. BERENSON: Well, I think that hospitals would strongly object, if that means they get to pay Medicare rates. In other words, the crucial policy decision on that one would be whether the current prohibition on balance billing, which I suggest it occurs. And Medicare and Medicare Advantage would be extended to Medicare Advantage in the marketplaces.

Without that provision, they're essentially the same as a commercial insurer. And the hospitals would have market power and the prices would immediately go up to the commercial, towards the commercial rates.

They wouldn't function the way a Medicare Advantage plan functions with that protection that they have against the hospitals wanting to be out of network.

So, I don't think that's, I mean I -- that that one doesn't make any sense. I don't think there will be a real prospect that I mean, basically all commercial insurance will become Medicare Advantage if that happened, and the hospitals have enough clout to prevent that from happening.

MR. INTROCASO: Okay, my last question is, the theory is with more affordable coverage, you can expand coverage which means you have crudely phrased more paying customers. And, for example, if Federal regulation produced scorable savings, then those savings could be used to shore up some markets, particularly mentioned in the context here, rural hospitals, whom are financially suffering if for no other reason than their occupancy rates are half or less on average bed days than metro hospitals. So, to what extent does expanded coverage make these options more palatable?

DR. BERENSON: You make it up with volume. Well, there's no question that a patient who has

insurance paying 90 percent of cost is better than a patient who has no insurer. There's clearly a lot of bad debt from people, because people simply can't pay when they're charged directly.

But, so I mean, I think for lots of reasons we need to move towards 100 percent coverage, mostly reasons of health and well-being. Everybody deserves to have health insurance. It would help somewhat the hospital situation. The hospitals really do not want to have a system where most patients are getting paid Medicaid or Medicare rates, because they've gotten accustomed to the generosity of commercial insurance payments.

Again, I think we need to move away from that generosity. But it can't be done like in a year, it has to be phased in over many years so that hospitals understand and can make adjustments.

We also need to do a much better job of correcting the distortions in payment. It's well known and well documented that mental health services are underpaid to hospitals. And so hospitals frequently eliminate that service or have limited behavioral health

coverage. Whereas, surgical services are overly well paid. And that's what hospitals invest in. We need to correct those distortions.

One of the areas that I'm working in right now is envisioning a world in which Medicare is used as the reference point. And hospitals are paid some percentage above Medicare. We got to correct the distortions in the payment in Medicare, not only for hospitals, but for physicians and to some extent, even for other providers, like home health agencies and skilled nursing facilities, et cetera.

We have distortions that reward certain kinds of care and penalize other kinds of care. And that results in shortages. And I'm aware actually, somebody who I know has spent days in an emergency room, because he now has dementia he needs to be placed in a special facility that can treat his behavioral problems with dementia. And there were none available in the state of North Carolina. So, he spent six days in a little room, in a hospital emergency room.

So, we've got to correct, and that was not primarily a COVID problem. That was because the

hospital was filled with COVID patients. They simply do not, that hospital did not invest in sufficient beds for geriatric psychiatry, which is going to be a growing problem. And there were very few facilities in the state.

So, we have lots to do to get the prices and better relationship to the underlying costs, to try to correct for those kinds of distortions in price, which create distortions in care delivery. And so Medicare needs to actually get that improved when it wants to be or, when it is being held out to be the reference point for paying all health care.

MR. INTROCASO: Okay, thank you, Bob. We're at our time. So, I do appreciate this overview of our pricing problem. Bottom line, again, is a better grip on rate setting relative to the commercial market. So, with that, Bob, thank you very much.

DR. BERENSON: Yeah, let me just finish and just repeat --

MR. INTROCASO: Please.

DR. BERENSON: -- what I said earlier, is that the assumption that competition and rate setting are --

have nothing to do with each other or incompatible is wrong. And the sooner we understand that markets actually can work better in the context of administered pricing, rate setting, breaking down the myth that these, this use of government pricing interferes with markets, needs to be broken down. They actually would promote more competition in better markets.

MR. INTROCASO: And if we had time we could discuss how that works in numerous states or countries in Europe. So, thank you.

DR. BERENSON: That's right.

MR. INTROCASO: Thank you again, Bob.

DR. BERENSON: All right, bye, bye.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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