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Improving Competition and Transparency in Health Care Markets

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Nearly every health policy challenge is magnified by the high underlying cost of health care in the United States. High expenditures in programs like Medicare or Medicaid create budgetary pressures for state and federal governments. This stresses tax bases and crowds out valuable spending in other programs. Meanwhile, the high cost of employer-sponsored insurance reduces wage growth of workers. Across all settings, this phenomenon makes it more costly to expand coverage to new services or people.

High health care costs are not necessarily problematic if they reflect preferences of individuals. However, there is ample evidence that some health spending reflects market imperfections, like a lack of information or choice. In some cases, these reflect natural features of health care markets (e.g., some care is purchased in urgent circumstances) while in others they reflect explicit policy decisions (e.g., policies that encourage consolidation or mute cost sensitivity). Regardless, these features can generate high expenditures that do not reflect value to consumers.

Increasing transparency and competition within health care will improve market functioning and can help target spending that does not reflect consumers' preferences. Congress has a number of policy options to do that across many settings within health care. In the rest of my testimony, I will outline specific areas where policy changes can improve transparency and competition within health care markets.[1]

Policy Options to Improve Competition and Transparency

Increasing Transparency and Oversight of Consolidation

Rising consolidation represents a major challenge to the functioning of health care markets. Economic theory predicts that less competition will reduce pressure for firms to lower costs and improve quality. As Adler and Ippolito (2023) note, empirical research has confirmed these predictions within health care markets.

[1] Throughout this testimony I rely heavily on material from Loren Adler and Benedic Ippolito "Procompetitive Health Care Reform Options for a Divided Congress," *American Enterprise Institute and The Brookings Institution* (March 16, 2023).

A large body of evidence finds that the merger of potential competitors within health care markets increases costs[2] to consumers and is suggestive that it also reduces the quality of care.[3] That is, when hospitals or physician groups in the same geographic market merge together (or one acquires the other) they are able to extract higher prices from private insurers and employers. Newer research suggests that similar effects also may arise from mergers that occur across different markets within the same state.[4] Higher costs are at least partially passed on to individuals in the form of higher premiums and cost-sharing[5] or to employees in the form or lower wages.[6] A growing body of evidence now also suggests that vertical consolidation between hospitals and physician groups leads to increased costs[7] (above and beyond the effects of any resulting horizontal consolidation in the physician specialties being acquired by hospitals) with unclear effects on quality.[8]

While the potential harm of anticompetitive mergers and acquisitions is relatively clear, many such transactions can still occur (of course, not all consolidation raises competitive concerns). In this section, I

[2] E.g., Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107, https://doi.org/10.1093/qje/qjy020; Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *The RAND Journal of Economics* 50, no. 2 (2019): 286–325, https://doi.org/10.1111/1756-2171.12270.

[3] E.g., Nancy D. Beaulieu et al., "Changes in Quality of Care after Hospital Mergers and Acquisitions," *New England Journal of Medicine* 382, no. 1 (January 2, 2020): 51–59, https://doi.org/10.1056/NEJMsa1901383; Thomas Koch, Brett Wendling, and Nathan E. Wilson, "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries," *Health Services Research* 53, no. 5 (October 2018): 3549–68, https://doi.org/10.1111/1475-6773.12825.

[4] Dafny, Ho, and Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of Economics* (April 10, 2019), https://doi.org/10.1111/1756-2171.12270.

[5] Daniel Arnold and Christopher M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages* (Santa Monica, CA: RAND Corporation, 2020), https://doi.org/10.7249/WRA621-2.

[6] See Conor Lennon, "Employer-Sponsored Health Insurance and Labor Market Outcomes for Men in Same-Sex Couples: Evidence from the Advent of Pre-Exposure Prophylaxis," *Economics & Human Biology* 47 (December 2022): 101156, https://doi.org/10.1016/j.ehb.2022.101156; Gruber, Jonathan. "The incidence of mandated maternity benefits." The American economic review (1994): 622-641.

[7] E.g., Soroush Saghafian et al., "The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices" (Cambridge, MA: National Bureau of Economic Research, February 2023), https://doi.org/10.3386/w30928; James Godwin et al., "The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 58 (January 2021), https://doi.org/10.1177/0046958021991276; Brady Post, Tom Buchmueller, and Andrew M. Ryan, "Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality," *Medical Care Research and Review* 75, no. 4 (August 2018): 399–433, https://doi.org/10.1177/1077558717727834.

[8] See Thomas G. Koch, Brett W. Wendling, and Nathan E. Wilson, "The Effects of Physician and Hospital Integration on Medicare Beneficiaries' Health Outcomes," *The Review of Economics and Statistics* (August 16, 2021), 1–15, https://doi.org/10.1162/rest_a_00924.

highlight reasons for this and discuss policies to improve oversight of consolidation. Later in this testimony I discuss related policy reforms that would decrease the incentives for health care firms to consolidate.

Firms are required to notify federal antitrust authorities if the value of their merger or acquisition exceeds a threshold—$111.4 million in 2023 (adjusted annually for inflation).[9] Many transactions within health care fall below this threshold, including most involving physician practices, which greatly decreases the odds of a transaction being challenged.[10] These smaller mergers can still have important implications for competition, particularly if a single owner assembles a large market share through a series of smaller transactions. Private equity investors often follow this strategy.[11]

Congress can improve transparency and oversight of these transactions in a number of ways. First, it can lower the threshold for pre-merger notification. Second, it can require notification if the cumulative value of acquisitions in a given market by a single owner exceed the reporting threshold (even if a single transaction does not rise to that level). Third, it can task the antitrust agencies with tracking market concentration levels in health care markets. Together, these would give the agencies greater knowledge of transactions and help them better assess when smaller mergers, or a series of such mergers, present competitive concerns.

Relatedly, Congress can consider legislation that makes ownership structures more transparent making it easier to identify when one owner amasses a significant market share via smaller, less-salient acquisitions (proposals like HR 6885 or HR 5825 embody this idea).[12] In addition, they can expand the Transparency in Coverage rule to include information about the total volume of each service that was used by each plan's enrollees. Doing so would make it easier to calculate information about market shares and average prices.

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[9] Federal Trade Commission, "FTC Announces 2023 Update of Size of Transaction Thresholds for Premerger Notification Filings and Interlocking Directorates," January 23, 2023.
[10] E.g., Thomas Wollmann, "How to Get Away with Merger: Stealth Consolidation and Its Effects on US Healthcare" (Cambridge, MA: National Bureau of Economic Research, May 2020), https://doi.org/10.3386/w27274.
[11] See Erin C. Fuse Brown et al., "Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions," *USC-Brookings Schaeffer Initiative for Health Policy* (October 5, 2021).
[12] For the complete text of HR 6885, see https://www.congress.gov/bill/117th-congress/house-bill/6885. For the complete text of HR 5825, see https://www.congress.gov/bill/116th-congress/house-bill/5825.

Finally, some have suggested that Congress amend the Clayton Act to make it easier to challenge potentially anticompetitive mergers.[13] They could, for example, require regulators to demonstrate only that a merger "meaningfully" lessens competition rather than "substantially" so. It could also be modified to allow regulators to challenge a series of transactions that collectively have the same effect. These changes could be directed specifically at transactions within health care to reduce potential unintended consequences.

Discouraging Consolidation Through Site Neutral Payments

Congress can work to dissuade further consolidation by revisiting Medicare payment policies. Specifically, Medicare typically pays a higher price if a given service is performed at a hospital outpatient department (HOPD) than if it is delivered at a physician's office. This differential payment rate across sites of service provides an incentive[14] for hospitals to acquire physician's offices. A growing body of evidence[15] finds that this type of consolidation increases costs for both Medicare and commercial payers. In addition, it can directly increase costs to beneficiaries.[16]

In a market without these distortions, we would expect non-hospital-based providers to compete for patients as services become routine enough to be delivered outside of hospitals. Current payment models impede this. As Adler and Ippolito (2023) summarize, there have been recent efforts to address these incentives:

[13] E.g., Leemore S. Dafny, "How Health Care Consolidation Is Contributing to Higher Prices and Spending, and Reforms That Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets," *Testimony Before the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law*, April 29, 2021.
[14] See Brady Post et al., "Hospital physician Integration and Medicare's Site based Outpatient Payments," *Health Services Research* 56, no. 1 (February 2021): 7–15, https://doi.org/10.1111/1475-6773.13613.
[15] E.g., Marah Noel Short and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review* 77, no. 6 (December 2020): 538–48, https://doi.org/10.1177/1077558719828938; Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001; Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs* 33, no. 5 (May 2014): 756–63, https://doi.org/10.1377/hlthaff.2013.1279.
[16] Patient liability is typically 20% coinsurance if patients do not have supplemental coverage. Even if beneficiaries do have supplemental coverage, this phenomenon can increase Medigap premiums or costs to Medicaid and former employers.

> In recent years, both Congress and the Trump Administration have taken steps to require site-neutral payments in limited circumstances.[17] As a result, clinic visits at off-campus HOPDs and any service delivered at an off-campus HOPD that was established after November 2, 2015 are reimbursed based on the physician fee schedule (PFS) rather than the more generous outpatient prospective payment system (OPPS). However, these provisions did not address services other than clinic visits at grandfathered off-campus HOPDs, services at on-campus HOPDs, or services performed at other types of facilities such as [Ambulatory Surgery Centers], freestanding emergency departments, and cancer hospitals.

Congress can further reduce consolidation incentives stemming from Medicare's payment policy. For example, a recent proposal from Representative Victoria Spartz would reimburse all off-campus HOPD services based on the PFS.[18] Congress could also reduce payments to all HOPDs for certain services that can be safely delivered outside of the hospital setting (MedPAC has identified a number of such procedures[19]). Both the Obama and Trump administrations included similar proposals in their budget submissions.[20] Basing payments on the physician fee schedule for all off-campus HOPDs and certain services at on-campus HOPDs would lower deficits by about $140 billion over 10 years.[21]

Increasing Transparency into Pharmacy Benefit Managers

Policymakers have expressed concerns about the role of Pharmacy Benefit Managers (PBMs) and whether they contribute to high drug costs or other market distortions. PBMs, which manage drug benefits for insurers by negotiating with drug makers, designing formularies, and contracting with pharmacies, have attracted attention for a number of reasons. As Adler and Ippolito (2023) note:

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[17] See Loren Adler et al., "CMS' positive step on site-neutral payments and the case for going further," *USC-Brookings Schaeffer Initiative for Health Policy,* (August 10, 2018).
[18] For the complete text, see https://www.congress.gov/bill/117th-congress/house-bill/8133/.
[19] MedPAC, "Medicare and the Health Care Delivery System," *Report to the Congress*, June 15, 2022.
[20] See Department of Health & Human Services, "Budget in Brief: Fiscal Year 2016"; Department of Health & Human Services, "Budget in Brief: Fiscal Year 2021."
[21] Congressional Budget Office, "Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget," March 25, 2020.

> Concerns about PBMs are largely based on a few key facts. First, the PBM market has become relatively consolidated over time, with three firms—Caremark, Express Scripts, and OptumRx—controlling 80 percent of the market.[22] (The major PBMs are also now vertically integrated with insurance companies.) In addition, PBMs are also alleged to facilitate pricing structures that increase costs for some consumers. Notably, they may encourage drug makers to set very high list prices while selling to insurers or PBMs at much lower "net" prices. Because consumer out-of-pocket liability can be a percent of the list price, this increases costs to sicker enrollees taking expensive medications. They may also affect competition within the pharmacy market by steering patients to use pharmacies that they own. Using selective contracting can lower costs to consumers but also may drive independent pharmacies out of business. Finally, PBM contracts are relatively opaque, which makes it harder to assess the harms or benefits of their behavior.

The opacity of these contracting arrangements makes it difficult for policymakers to assess their role in drug markets and for plan sponsors to make informed decisions when choosing a PBM. There are a number of ongoing efforts to improve policymakers' understanding of PBMs. The Federal Trade Commission recently announced an investigation[23] into PBMs while requests from the House Oversight Committee[24] will also elicit information on contracting practices.

In addition, legislative proposals like the Lower Health Care Costs Act of 2019 would require PBMs to disclose a host of information, including rebates, costs, and fees.[25] CBO estimated that this would lower

[22] For coverage, see Adam J. Fein, "The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger," April 5, 2022.
[23] For coverage, see Ed Silverman, "FTC will investigate pharmacy benefit managers and their role in prescription drug costs," June 8, 2022.
[24] Committee on Oversight, "Comer Launches Investigation into Pharmacy Benefit Managers' Role in Rising Health Care Costs, March 1, 2023.
[25] For the complete text, see https://www.congress.gov/bill/116th-congress/senate-bill/1895.

deficits by $1.7 billion by helping plan sponsors to better evaluate contracts and triggering more competition between PBMs.[26]

Increasing Competition Through Contracting Reforms

Dominant firms in health care markets can reduce choice and impede entry of potential competitors by demanding certain provisions in their contracts. Congress is well-justified in considering restrictions on these clauses in an effort to encourage more cost competition, particularly in markets that are already relatively consolidated.[27]

For example, dominant health care providers can require that insurers agree to clauses which disallow them from incentivizing patients to seek care at potentially lower-cost providers (through "anti-tiering" or "anti-steering" clauses). A dominant hospital might also require an insurer to include all affiliated providers in their network or none ("all-or-nothing" clause). This can effectively extend a provider's dominant position in one part of the market to others (these clauses can interact with network adequacy laws in ways to make them particularly powerful). These types of contract provisions directly undercut insurers' main tools for encouraging price competition.

Similarly, dominant insurers can stifle competition by demanding "most favored nations" clauses. These require that providers not give any other insurer a lower price than the dominant insurer. This makes it very challenging for other insurers to compete on price, even if they use tools like narrower networks.

These types of contracting provisions have less bite in competitive markets. In a market with many providers, for example, an insurer could simply avoid contracting with a hospital that demands an anti-tiering, anti-

[26] Congressional Budget Office, "S. 1895, Lower Health Care Costs Act,' July 26, 2019.
[27] See Brent D. Fulton, "Health Care Market Concentration Trends In The United States: Evidence And Policy Responses," *Health Affairs* 36, no. 9 (September 2017): 1530–38, https://doi.org/10.1377/hlthaff.2017.0556.

steering, or all-or-nothing clause (or negotiate price concessions in exchange). Thus, efforts to restrict the use of these contract provisions are likely to target markets with meaningful consolidation.

The Lower Health Care Cost Act[28] would have banned the use of these contracting terms, which CBO estimated would modestly reduce premiums in the private insurance market and increase federal revenues by $1.1 billion over the budget window.[29] The CBO recently indicated that cost savings would be larger in updated estimates.[30]

Addressing Consolidation Incentives in the 340B Program

The 340B drug discount program may have the unintended consequence of encouraging greater consolidation within provider markets. Policymakers should consider whether redesigning the program can reduce this incentive while achieving the program's stated goals.

The 340B program requires drug makers to give large discounts to qualified health care providers, which include disproportionate share hospitals, federally qualified health centers, hemophilia centers, and others. The discounts are large (estimated at 25-50 percent in 2011) and are largely designed to subsidize providers that treat large volumes of low-income patients.[31] The program has grown very rapidly over time.[32]

This design has the potential to increase consolidation incentives and overall costs, however. Adler and Ippolito (2023) summarize the key concerns:

[28] See footnote 26.
[29] See footnote 27.
[30] Congressional Budget Office, "Policy Approached to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," p. 24, September 29, 2022.
[31] Government Accountability Office, "Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement," September 23, 2011.
[32] See Karen Mulligan, "The 340B Drug Pricing Program: Background, Ongoing Challenges, and Recent Developments," *Schaeffer Center White Paper Series*, (October 14, 2021).

First, a 340B hospital has an incentive to acquire private physician practices since it can purchase drugs cheaper than the practice can, increasing consolidation in those fields. Second, these discounts could mean hospitals earn high margins on products that are more expensive for insurers, encouraging them to prescribe costlier medicines.

One paper found that hospitals have responded to these incentives by dispensing more drugs, acquiring more physicians in some drug-intensive specialties, and treating fewer patients on Medicaid.[33] However, it did not find evidence that hospitals provided more or better care to low-income patients. On average, 340B hospitals also have higher Part B spending per beneficiary, which is consistent with (but not proof of) them altering their prescribing behavior due to the program.[34]

As CBO notes,[35] "a policy change that applied drug discounts under the 340b program on a patient-level basis—that is, to patients with certain characteristics rather than to all patients at certain sites of care—might reduce hospitals' and physicians' incentives to consolidate." While we are not aware of a formal score for this kind of proposal, we expect cost savings to be small in the budget window, partly because of uncertainty and because it would take some time for this policy to play out. Still, this reform improves incentives, more effectively subsidizes providers treating many low-income individuals, and would potentially fit well within legislation that reformed other aspects of the program.

Beyond this type of program redesign, Congress could also reduce payments to 340B hospitals to reflect lower acquisition costs, which should lower consolidation incentives to some degree. This

[33] Sunita Desai and J. Michael McWilliams, "Consequences of the 340B Drug Pricing Program," *New England Journal of Medicine* 378, no. 6 (February 8, 2018): 539–48, https://doi.org/10.1056/NEJMsa1706475.
[34] Government Accountability Office, "Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals," June 5, 2015.
[35] See footnote 31.

would also save Medicare money directly. For example, the Centers for Medicare and Medicaid Services estimates that Medicare would save $1.6 billion per year by lowering payments from the current 106% of ASP to 77.5% of ASP. HHS' recent attempt to implement a policy along these lines was overturned[36] in court because the agency did not complete the required survey of hospital acquisition costs. While the administration could revisit this, Congress could pass legislation along these lines instead.

Improving Upon Recent Transparency Rules

The federal government has recently made an effort to increase transparency in the commercial health care markets through two federal rules—the Hospital Price Transparency Rule and the Transparency in Coverage Rule. These efforts have the potential to fill in gaps in existing data and improve market functioning.[37] Congress has the opportunity to build on these policies by increasing compliance and, in some cases, the breadth of information provided.

The Hospital Price Transparency Rule, which took effect January 1, 2021, requires hospitals to disclose a variety of pricing information.[38] These data include information about gross charges, negotiated rates, and cash prices for all services, along with a consumer-friendly display for a set of shoppable services. The Transparency in Coverage Rule, which began to take effect in 2022, requires insurers to post in-network rates for covered services, allowed amounts and billed charges for out-of-network care, and price comparison tools to aid consumers.[39]

[36] For coverage, see James Romoser, "In an opinion that shuns Chevron, the court rejects a Medicare cut for hospital drugs," June 15, 2022.
[37] For a discussion, see Yang Wang et al., "Insurer Price Transparency Rule: What Has Been Disclosed?," *Health Affairs Forefront* (February 2, 2023), https://doi.org/10.1377/forefront.20230127.553761.
[38] See https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180#180.40.
[39] For the complete text, see https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147/section-147.210.

However, early evidence suggests that full compliance with transparency requirements among hospitals has been relatively low.[40] This may, in part, reflect the relatively modest penalties associated with noncompliance. Following an increase in 2022, penalties ranged from $300 to $5,500 per day based on hospital size. By comparison, the insurer rule comes with a penalty of $100 per day per impacted individual, which can increase substantially for large insurers.[41] Congress could consider increasing the penalties for hospitals that are out of compliance with the rule. For example, a bill introduced by Senator John Kennedy proposes doubling these fines.[42]

In addition, there are opportunities to improve the drug pricing information collected via the Transparency in Coverage Rule. Critically, researchers have noted that these data do not include information about the dosage for a physician-administered drug (essentially how much of the drug the price corresponds to).[43] This makes it very challenging to understand the price for a standard dose and to compare across insurers. In addition, the rule was meant to include information about pharmacy-dispensed medications, but that was delayed by CMS. Should Congress want to codify this rule, including these elements would make the data more useful to researchers and policymakers.[44]

Improving Competition in Medicare Advantage

By generating competition among insurers, Medicare Advantage (MA) has the potential to lower costs, improve plan design and, in turn, patient health. However, there is reason to believe that competition could both be more robust and better directed towards cost and quality.

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[40] E.g., Maanasa Kona and Sabrina Corlette, "Hospital And Insurer Price Transparency Rules Now In Effect But Compliance Is Still Far Away," September 12, 2022, https://doi.org/10.1377/forefront.20220909.326193.; Turquoise Health, "Price Transparency Impact Report," October 18, 2022; Patient Rights Advocate.org, "Fourth Semi-Annual Hospital Price Transparency Report," February 2023.
[41] See footnote 38.
[42] For more information, see https://www.kennedy.senate.gov/public/press-releases?ID=8BEB2EF5-5C5F-45B4-BFE0-0E27AE780E50.
[43] See footnote 38.
[44] See Centers for Medicare & Medicaid Services, "FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49," August 20, 2021.

MA plans are currently paid a capitated amount per enrollee that is based on beneficiary spending in Traditional Medicare (TM) in that area. These payments are risk adjusted to reflect the higher costs associated with enrolling sicker beneficiaries. Each MA plan submits a bid which reflects their estimated cost of providing Parts A and B coverage to a typical beneficiary. If they submit a bid below the local benchmark, they can keep part of the difference, allowing them to lower premiums or offer more services.

One of the primary concerns with MA is that the current structure encourages insurers to effectively compete on coding intensity—that is, making enrollees appear sicker—instead of other features that are more valuable to enrollees.[45] By doing this, insurers can generate higher risk-adjusted payments from the federal government, which allow them to offer more generous plans than their competitors. While MA plans do appear to generate cost savings,[46] they are paid more[47] than it costs to cover similar beneficiaries if they enroll in TM. Excess payments to MA plans are only partially passed through to enrollees.[48]

As Adler and Ippolito (2023) note, there are a number of options to improve competition within MA:[49]

> First, rather than the government collecting about 35% of the difference between plan bids and benchmarks, more of that difference could be paid to plans to fund extra benefits or reduce premiums. Limiting what is effectively a tax on lower bids would encourage greater price competition. On its own, this proposal would likely increase federal Medicare spending and the generosity of MA benefits, but it could be combined with a reduction to MA

[45] See Michael Geruso and Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," *Journal of Political Economy* 128, no. 3 (March 2020): 984–1026, https://doi.org/10.1086/704756.
[46] See Vilsa Curto et al., "Health Care Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics* 11, no. 2 (April 1, 2019): 302–32, https://doi.org/10.1257/app.20170295.
[47] MedPAC, "Improving the Accuracy of Medicare Advantage Payments by Limiting the Influence of Outliers in CMS's Risk-adjustment Model," June 15, 2022.
[48] See Marika Cabral, Michael Geruso, and Neale Mahoney, "Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage," *American Economic Review* 108, no. 8 (August 1, 2018): 2048–87, https://doi.org/10.1257/aer.20151362; Mark Duggan, Amanda Starc, and Boris Vabson, "Who Benefits When the Government Pays More? Pass-Through in the Medicare Advantage Program" (Cambridge, MA: National Bureau of Economic Research, March 2014), https://doi.org/10.3386/w19989.
[49] In addition to those listed here, many policy experts argue in favor or a more fundamental shift towards a competitive bidding model for MA.

benchmarks. Empirical evidence suggests that the reduction to benchmarks would also enhance MA plan competition, causing plans to price more aggressively.[50] Federal savings or costs from this proposal will depend on the magnitude of reduction to benchmarks.

Others have argued[51] that a clearer choice infrastructure could improve MA plan competition, for instance by more clearly communicating[52] premium reductions below the standard Part B premium to potential enrollees.

Other policy reform proposals, including some from MedPAC, aim to limit the ability of MA plans to game the risk adjustment system in an effort to increase payments from the government.[53] Lessening this incentive would discourage insurers from focusing as many resources on coding intensity and, instead, encourage more competition over prices and quality. CBO estimates that increasing the adjustments for coding intensity such that MA plan payments better reflect the actual expected costs of enrollees would reduce deficits by about $50 billion over the 10-year budget window (budgetary savings estimates would likely be substantially higher today).[54]

The current administration also recently expanded risk adjustment data validation (RADV) audits to reduce excess or inappropriate payments made to plans. However, there are arguments to allocate more funding through legislation to expand this further by auditing more

[50] See Mark Duggan, Amanda Starc, and Boris Vabson, "Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program," *Journal of Public Economics* 141 (September 2016): 50–67, https://doi.org/10.1016/j.jpubeco.2016.07.003.; Daria Pelech and Zirui Song, "Pricing and Pass-Through in Response to Subsidies and Competition: Evidence from Medicare Advantage Before and After the Affordable Care Act," *Harvard Medical School Working Paper* (October 19, 2018), https://www.hcp.med.harvard.edu/sites/default/files/Pricing_Pass-through_MA_10-19-2018_HCP.pdf.
[51] E.g., John Bertko, et al., "Medicare Advantage: Better information tools, better beneficiary choices, better competition," *USC-Brookings Schaeffer Initiative for Health Policy* (November 27, 2017), https://www.brookings.edu/wp-content/uploads/2017/11/ma-consumer-reforms.pdf.
[52] For evidence, see Karen Stockley et al., "Premium Transparency in the Medicare Advantage Market: Implications for Premiums, Benefits, and Efficiency" (Cambridge, MA: National Bureau of Economic Research, June 2014), https://doi.org/10.3386/w20208.
[53] See footnote 48.
[54] Congressional Budget Office, "Modify Payments to Medicare Advantage Plans for Health Risk," *Options for Reducing the Deficit: 2019 to 2028*, December 13, 2018.

> contracts and potentially increasing penalties, which is likely to have a large return-on-investment for the federal government.[55]

Spurning More Competition Among Physician-Administered Drugs

By reforming the way Medicare pays for physician-administered drugs, Congress can increase competition between branded products and lower spending levels.

When providers administer certain drugs, Medicare reimburses them 106% of the drug's Average Sales Price (ASP), which is a measure of the average purchase price for the product.[56] (In addition, they are paid a fee to administer the product). Because the six percent "add on" payment scales with a drug's price, it gives providers an incentive to administer more expensive medications when there are multiple treatment options. Moreover, competitive pressures across drugs are further reduced because tools like formularies, step therapy, or prior authorization are not typically used in Part B. Evidence is consistent with these features affecting outcomes. Enrollees in Medicare Advantage plans, which are better able to influence choices, are more likely to receive lower-cost products in these situations.[57]

There are a number of proposed reforms aimed at improving these incentives to create more robust competition among these drugs, as Adler and Ippolito (2023) highlight:

> One method to improve price competition among drugs would involve shifting the direct drug purchasing decisions from providers to payers or third-party vendors. In Medicare, legislation could set up a vendor model similar to those proposed (but ultimately retracted) by the Obama

[55] E.g., Travis C. Williams et al., "Medicare Advantage Audit Changes Let Plans Keep Billions In Overpayments," (February 27, 2023), https://doi.org/10.1377/forefront.20230224.7772.
[56] Following the Budget Control Act of 2011, the effective payment rate became 104.3% of the ASP. See Cole Werble, "Medicare Part B, "Health Affairs Health Policy Brief, August 10, 2017.
[57] Anderson, Kelly E., Daniel Polsky, Sydney Dy, and Aditi P. Sen. "Prescribing of low-versus high-cost Part B drugs in Medicare Advantage and traditional Medicare." *Health services research* 57, no. 3 (2022): 537-547.

and Trump Administrations.[58] Under such a model, large vendors with significant purchasing power would buy drugs and compete to provide them to physicians. Alternatively, Congress could shift the coverage of some drugs from the Part B benefit into Part D.[59] One study suggested that doing so could reduce spending on affected drugs by 7 to 18%.[60] Such savings should be weighed against the difficulties imposed on patients by the tools such as formularies, step therapy, and prior authorization that are largely generating the savings.

Congress could also reduce providers' financial incentive to administer more costly drugs when there are therapeutic substitutes available. Both the Obama and Trump Administrations proposed doing so by shifting at least part of the 6% of ASP add-on into a flat dollar amount, which could also be done through legislation.[61] Alternatively, Medicare could generate price competition in these cases by paying the same amount for drugs that are substitutes for each other. This gives providers a strong incentive to choose the cheaper option. MedPAC has suggested doing so when biologic drugs have nearly-identical biosimilar competitors.[62]

Congress embraced a similar goal in the IRA by temporarily increasing the add-on payment for biosimilars to 8% of the reference biologic's price (instead of 6%) as long as the biosimilar had a lower ASP than the reference product.[63] This gives both products an incentive to compete on price while giving a leg up to the new competitor. Given that providers are generally averse to switching patients who are well managed by the originator biologic drug, it

[58] Rachel Sachs, "Administration Outlines Plan to Lower Pharmaceutical Prices in Medicare Part B," *Health Affairs Forefront* (October 26, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20181026.360332.
[59] Department of Health and Human Services, "American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs," May 16, 2018.
[60] Thomas J. Hwang et al., "Analysis of Proposed Medicare Part B to Part D Shift with Associated Changes in Total Spending and Patient Cost-Sharing for Prescription Drugs," *JAMA Internal Medicine* 179, no. 3 (March 1, 2019): 374, https://doi.org/10.1001/jamainternmed.2018.6417.
[61] See footnote 59.
[62] See footnote 19.
[63] See Centers for Medicare & Medicaid Services, "Frequently Asked Questions: Inflation Reduction Act Biosimilars Temporary Payment Increase," October 1, 2022.

is not unreasonable to preference biosimilars in such a way. Congress could extend this policy beyond its 2027 expiration date.

Medicare could generate greater savings by extending this type of policy to classes with multiple clinically comparable branded products.[64] This type of policy would come with additional considerations, like accommodations for cases where products may not be interchangeable for some patients.

[64] Committee for a Responsible Federal Budget, "Injecting Price Competition into Medicare Part B Drugs," *The Health Savers Initiative*, July 26, 2021.