

Drivers of Health Care Costs

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Where Does Your Health Care Dollar Go?

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. **Here is where your health care dollar really goes.**

This data represents how your commercial health plan premiums pay for medical care, as well as related services and essential operations. This data includes employer-provided coverage as well as coverage you purchase on your own in the individual market. Data reflects averages for the 2018-20 benefit years. Percentages do not add up to 100% due to rounding.

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Prescription Drug Cost Drivers

Government-
Granted
Monopolies



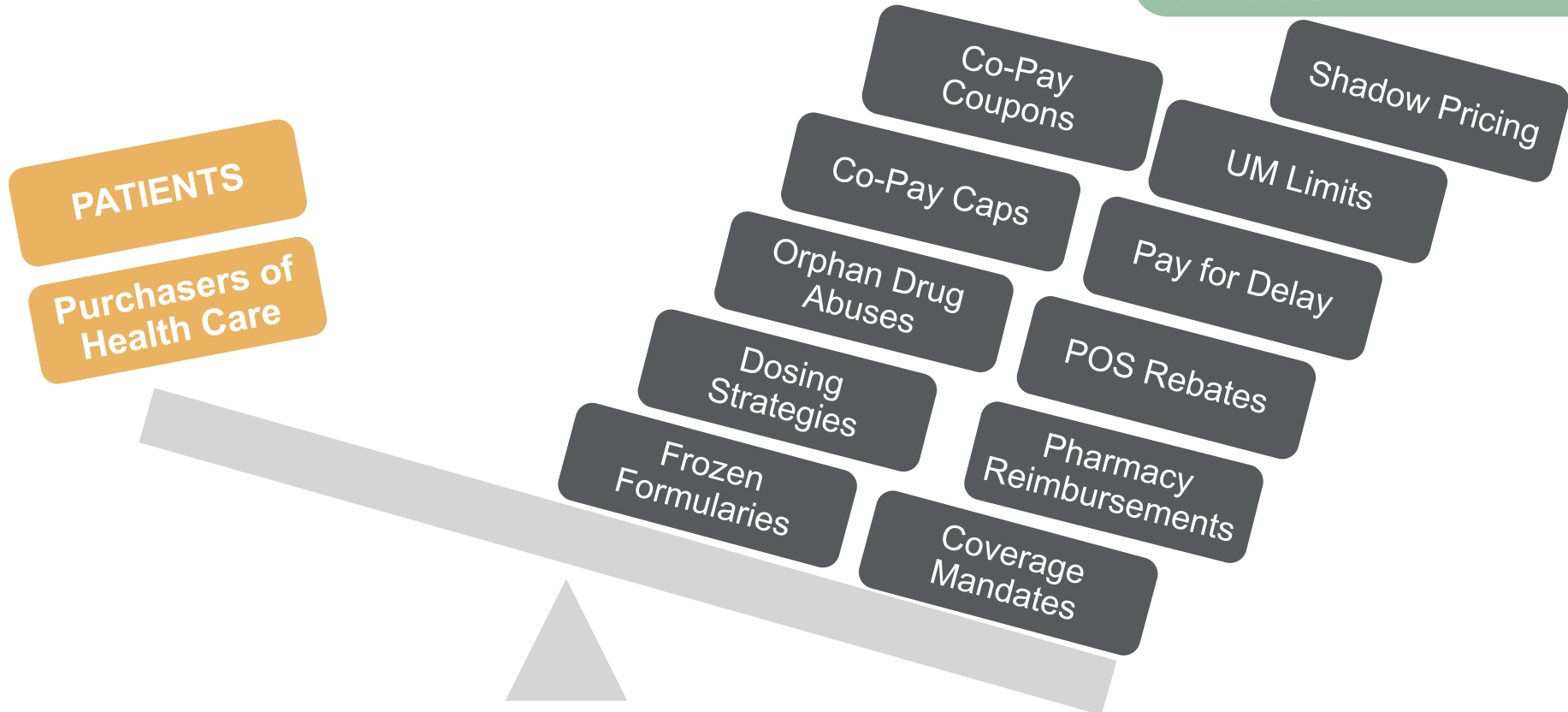
Market
Dysfunction



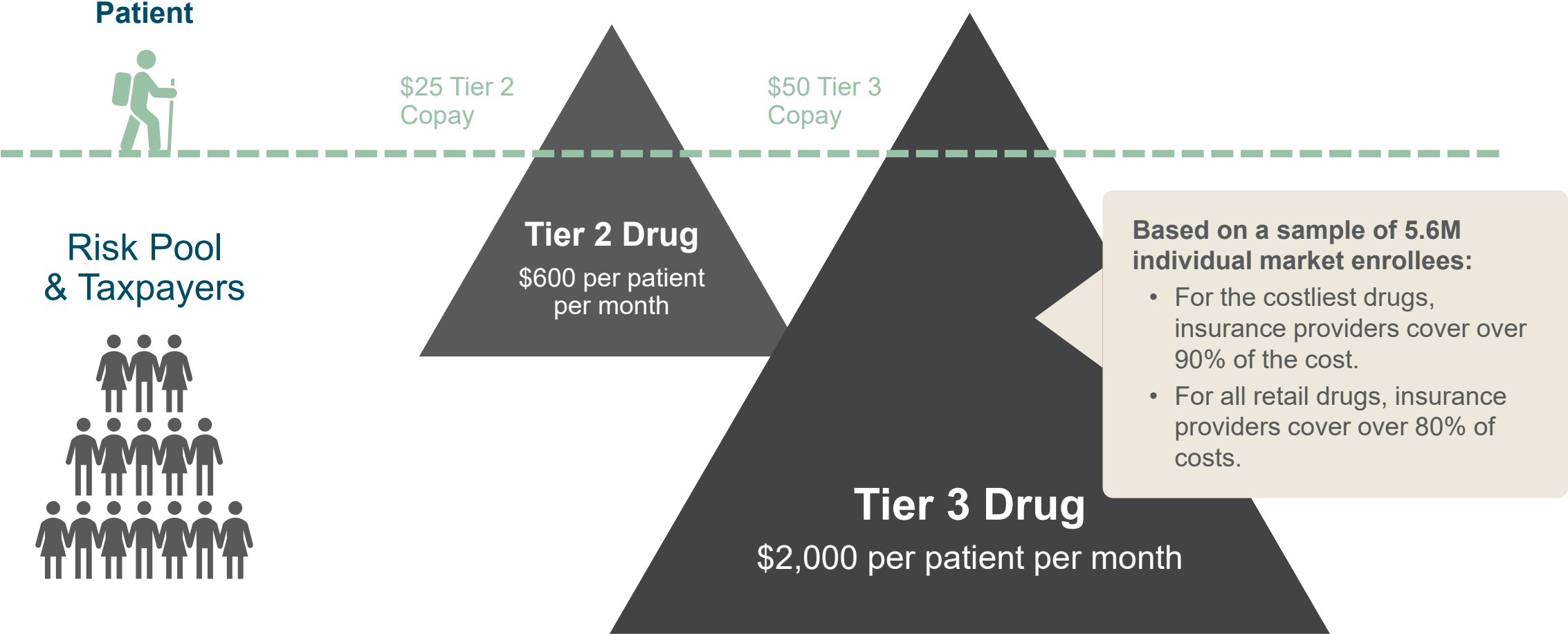
Limits on
Purchasers' Cost-
Saving Measures



HIGH LAUNCH PRICES
LARGE INCREASES
UNSUSTAINABLE SPEND



Big Pharma’s “Pharmacy Counter Strategy” – Coupons



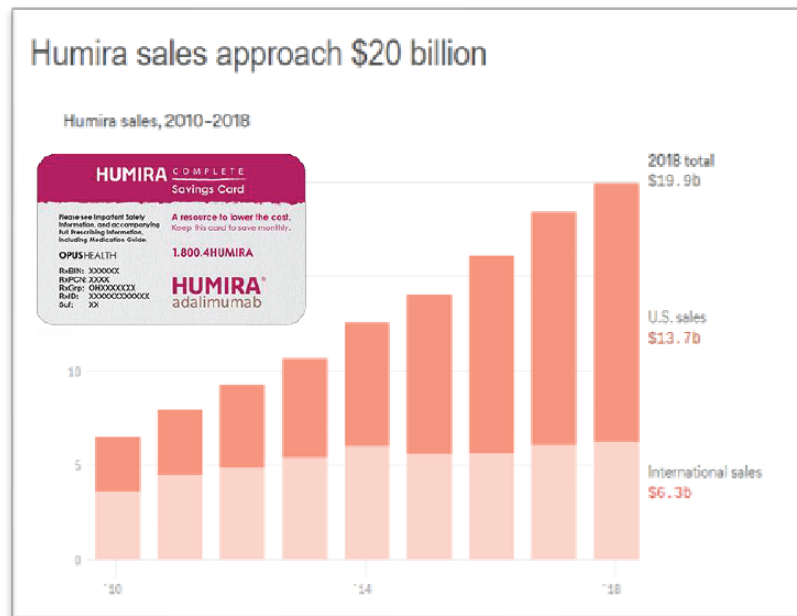
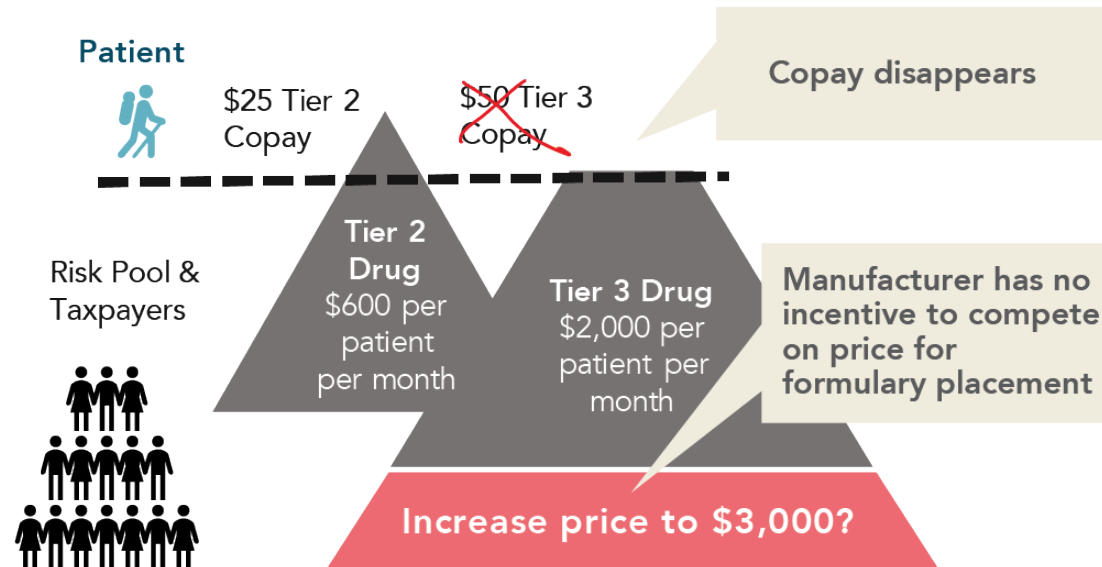
Co-pay Coupons Are A Kickback Keeping Drug Prices High

Coupons remove incentives for:

- (1) patients to consider lower cost drugs and
- (2) drug manufacturers to compete on cost.



Pharma profits increase at the expense of people, employers and taxpayers who pay premiums.



Hospital Cost Drivers

- **Consolidation**

- In concentrated health systems, prices do not flow from competitive negotiations.
- Hospital concentration has been linked to average annual marketplace insurance premiums that are 5% higher than those in less concentrated areas.
- Some consolidated systems leverage their significant market shares by requiring contracts with all affiliated facilities and preventing directing patients to lower-cost, higher-quality care.

- **Physician-Administered Drug Markups**

- For drugs administered in hospitals, [research](#) shows that hospitals, on average, charge double the prices for the same drugs than specialty pharmacies.
- Costs per single treatment can average \$7,000 more than those purchased through a specialty pharmacy, while drugs administered in physician offices can average \$1,400 higher.

- **Lack of Site-Neutral Payment Policies**

- Patients can go to a variety of care settings to receive comparable care, but their financial obligations may differ dramatically depending on their care setting. And patients may not know about the cost difference until they receive a bill.
- Hospital outpatient offices may charge the same amount as if care was delivered in the hospital itself. And hospital systems may add on facility fees, which raise costs for patients even more.
- Free-standing emergency departments have sprung up in many states that are more akin to urgent care centers but charge out-of-control prices. For [example](#), some of these sites have charged more than \$1,000 for a single COVID-19 test that could be obtained elsewhere for closer to \$100.

Provider/Outpatient Care Cost Drivers

- **Private Equity**

- Private equity firms' acquisition of providers is undermining affordability, access, and choice for patients and consumers.
- These growing monopolies often refuse to participate in networks in order to demand higher prices from health insurance providers, which results in higher premiums for everyone.
- By 2018, private equity represented 45% of all health care mergers & acquisitions.
- Raising prices has been a common strategy after a private equity acquisition. One [study](#) found that hospitals have increased their prices after being acquired by private equity firms.
- The private equity model is also leading to poorer patient outcomes, in addition to raising costs. [Research](#) has shown that private equity firms may try to lower labor costs after an acquisition by reducing overall staffing.

- **Telehealth**

- Once seen as a cost-saving measure, providers demanded parity in reimbursement – sometimes add on facility fees – which eliminates the cost savings.

- **Dialysis**

- Today, the dialysis industry is essentially a [duopoly](#): Two for-profit companies control nearly 75% of the market for dialysis services.
- These two companies have an outsized impact on the private market for dialysis care. In the commercial market, private health insurance providers in 2017 paid one of the two large dialysis providers an [average of 4 times more per treatment](#) than CMS did.
- In addition to these price impacts, these duopolies inhibit consumer-centric innovation..

Recently Passed Laws in CT – Improve or Challenge Affordability?

- Prohibitions on Copay Accumulator Programs (Public Act No. 21-14)
- Frozen Formularies (Public Act No. 21-4)
- Insulin Copay Caps (Public Act No. 20-4)
- Telemedicine Payment Parity Requirements (Public Act No. 20-2 & Public Act No. 21-9)
- Mandated Benefits
 - Hearing Aids (Public Act No. 19-13)
 - Mammograms/Breast Ultrasounds (Public Act No.)19-117)
 - Immunization Consultation (Public Act No. 21-6)
 - Breast and Ovarian Cancer Screening (Public Act No 22-90)
 - Children's Mental Health Wellness Exams (Public Act No. 22-47)

On the Horizon – Medicaid Redeterminations

- **Pre PHE:** Before the public health emergency (PHE), states were required to annually verify Medicaid eligibility for most members.
- **What Changed:** As a condition of receiving the enhanced Federal Medical Assistance Percentage (FMAP) under the Families First Coronavirus Response Act, states are required to maintain enrollment for their Medicaid enrollees through the end of the PHE.
 - Very narrow exceptions, including if an individual moves out of state
 - No change to Medicaid coverage throughout the duration of the PHE
- **Post-PHE:** When the PHE ends, states must resume the Medicaid redetermination processes.
- **Why is this significant?**
 - The volume within the condensed time period is unprecedented. Total Medicaid/CHIP enrollment grew to 89.4 million, an increase of 18.2 million from enrollment in February 2020. [KFF Analysis of Recent National Trends in Medicaid and CHIP Enrollment](#)
 - States will have 12 months to initiate and 14 months to complete a full renewal of all individuals enrolled in Medicaid, CHIP, and the Basic Health Program.
 - States, counties, and beneficiaries have not done this in more than 2 years.

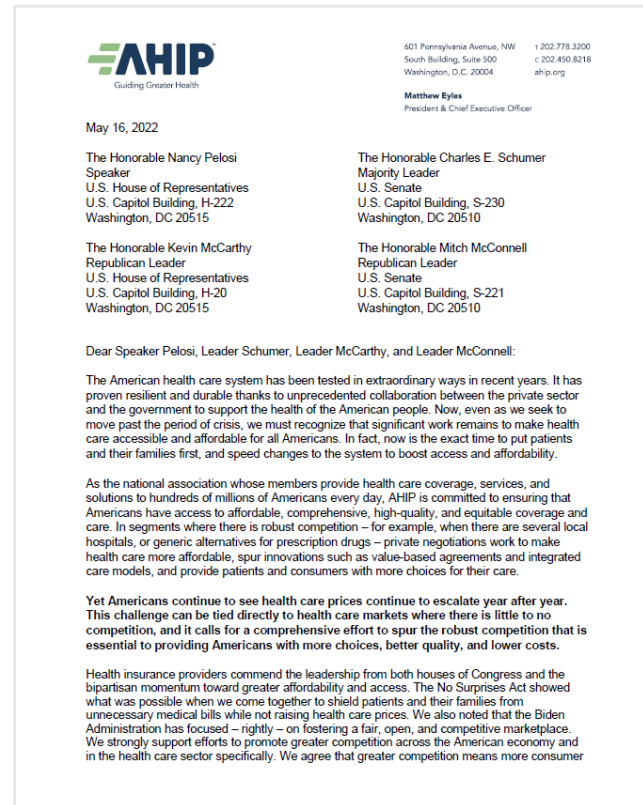
Restoring Competition: Healthier People Through Healthier Markets

Solutions to Improve Health Care Affordability and Access for Every American

Promoting solutions that will lower the underlying price of care so we can lower costs for consumers.

- Increase Competition
- Improve Transparency
- Expand Choice
- End Provider/Rx Schemes

American consumers strongly support these solutions.



Healthier People Through Healthier Markets

Solutions to Improve Health Care Affordability and Access for Every American

Every American deserves access to affordable, comprehensive, high-quality coverage and care. But health care prices continue to escalate year after year, making coverage and care less accessible for everyone. As we seek to move past the COVID-19 pandemic, now is the time to take action. We must work together to spur the more robust competition that is essential to providing all Americans with more health care choices and better quality at lower costs. Let's work together - for real solutions that work.

By improving competition in 10 key areas of our health care system, we can improve affordability and access for everyone. Health insurance providers are committed to working with federal and state officials and other stakeholders to take decisive action, and to advocate for the laws, regulations, and needed enforcement. Consumers deserve no less.

1. **Support consumer-centric expansion of home-based advanced care** through value-based care and payment models – an alternative that can offer patients better, more convenient, and more affordable care outside of the hospital.
2. **Bring much-needed transparency to private equity firms' monopoly power** in air ambulance, emergency, and certain specialty services that often provide services on a fee-for-service basis.
3. **Advance site-neutral payments** to defend consumers against having to pay more for the same services depending on the site of care.
4. **Support patients' choice of telehealth**, when clinically appropriate, as a less costly and more convenient method of care, by removing government impediments, modernizing network adequacy regulations, and guarding against regulatory structures that reduce telehealth's competitive benefits.
5. **Address the harms caused by the dialysis duopoly** by preventing its further expansion, removing barriers to care alternatives that are better for patients, and curbing the use of charitable structures that redirect resources to fortify the duopoly.
6. **Stop consolidated health systems from using their monopoly position to stifle negotiation and innovation** through the use of all-or-nothing, anti-tiering, and other take-it-or-leave-it contract terms.
7. **Accelerate the availability of prescription drug biosimilars** to ensure that the pace of access matches the pace of innovation.
8. **Stop drug manufacturers from engaging in patent games** that distort the system to maintain monopoly profits.
9. **Reform the system for provider-acquired drugs**, which has resulted in ever-escalating prices for such drugs.
10. **Address the ways in which drug manufacturers have abused charitable structures** to protect their monopolies, rather than help patients.

Questions?

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