As the Biden administration aims to expand health insurance coverage, making insurance plans in the US Affordable Care Act (ACA) Marketplace more affordable is a key priority.

Debate over the ACA Marketplace has focused more on competition among insurers—often measured by the number of insurers offering Marketplace plans in a state—and less on the declining competition between health care delivery organizations. Yet hospital and physician concentration, which raises prices of health care services for Marketplace enrollees and their insurers, directly contributes to higher Marketplace premiums—costing taxpayers through ACA premium subsidies and exacerbating insurer exit from the ACA Marketplace.

There are only 2 ways to lower prices—competition and regulation. Although encouraging hospital and physician competition is often invoked, it is difficult to achieve in practice. Hospital and physician consolidation has not slowed. States often lack resources to evaluate mergers and acquisitions, and the Federal Trade Commission is similarly constrained to challenge most deals. Separating large delivery systems into competitive entities is exceedingly difficult. As a result, policymakers are left with price regulation as the more realistic lever.

### Rationale for Capping Prices in the ACA Marketplace

Although containing prices in the commercial insurance market writ large (which enrolls half of the country) would be challenging, a legislative window of opportunity exists to do so in the ACA Marketplace—a federally subsidized program that enrolls 3% of the population. Doing so would follow precedent for patients across federal health programs, decrease cost sharing for current ACA Marketplace enrollees, and save taxpayer dollars to help finance insurance expansion.

The federal government pays traditional Medicare prices, or less, in nearly all federal health programs. When Medicare Advantage enrollees are seen by an out of network clinician, the clinician must accept traditional Medicare prices as payment in full. Without this provision, enacted by a Republican Congress and administration in 2003, Medicare Advantage plans would face higher prices and likely compete less effectively against traditional Medicare. By foreclosing the opportunity to charge higher prices out of network, it additionally encourages hospitals and physicians to join Medicare Advantage plans’ networks.

Similarly, in the 3 federal health systems—Veterans Health Administration, Military Health System, and Indian Health Service—many services are purchased from community hospitals and physicians, who are also paid roughly Medicare prices. A generation ago, the Department of Defense was concerned that health care spending crowded out resources for force readiness, so it lowered its prices to Medicare levels as well.

In the ACA Marketplace, by contrast, government spending through subsidies reflects commercial prices, which are consistently higher than Medicare prices. Commercial prices nationwide are double Medicare prices for hospitalizations and 43% higher for physicians. Although these gaps may be smaller in the ACA Marketplace due to narrower networks, prices likely remain substantially above Medicare levels.
Options for Capping Prices in the ACA Marketplace

An incremental policy could prevent further escalation of prices. Lawmakers could cap all prices on the ACA Marketplace (both in network and out of network) around current average levels, such as 200% of Medicare for hospitals, to minimize revenue losses.

Alternatively, lawmakers could approach the precedent of other federal programs by capping all ACA Marketplace prices closer to Medicare levels. Based on current commercial-to-Medicare price differences and spending on hospitals and physicians, a cap at Medicare levels would lower insurer expenses by about 30%. If insurers passed these savings onto enrollees and the government (ie, taxpayers) entirely through lower ACA premiums, premiums would decline by the same amount (insurers cannot keep all savings as profit under the ACA requirement that at least 80% to 85% of premiums are spent on care).

Based on 2020 ACA Marketplace enrollment and subsidy rules, if the premiums savings were used entirely to lower government subsidies, the government would save 38% on its subsidies. The government, however, could also share those savings with enrollees, such as by reducing the maximum percentage of income that enrollees could pay in ACA Marketplace premiums. If this “limit on out-of-pocket premiums” were proportionally reduced by 30%—eg, from 10% to 7% of income for a family of 4 at 300% to 400% of the federal poverty level—the family’s maximum premium would fall from roughly $9000 to $6000 per year, and government savings on subsidies would decrease from 38% to 30%. Concretely, 30% of the $577 billion in ACA Marketplace subsidies over the next 10 years still yields over $170 billion in federal savings.

Lower ACA premiums and cost-sharing would also stimulate ACA Marketplace enrollment. Assuming that every 1 percentage-point drop in premiums and cost-sharing increases enrollment by 0.5%, ACA enrollment would increase by 15% (about 1.5 million). The government would spend some of its subsidy savings on new subsidies for these enrollees—estimated to consume roughly one-third of the savings—but its remaining savings, summed across all enrollees, would remain a substantial 20%. This could finance other needs, including helping states pay for new Medicaid enrollees.

The Figure illustrates projected federal savings at levels of the ACA Marketplace price cap. The closer the cap approaches Medicare prices, the larger the federal savings and ACA Marketplace enrollment, but the more hospitals and physicians are affected.

Implications and Extensions

The American Rescue Plan Act of 2021 increased ACA Marketplace subsidies through 2022 by an estimated $35 billion, though it did not directly address the underlying prices of care. Incorporating a price cap would create much-needed revenue to finance these subsidies and other priorities.

Figure. Level of ACA Marketplace Price Cap and Federal Savings*

ACA indicates the Affordable Care Act.

* Federal subsidy savings from capping ACA Marketplace prices at 100% through 200% of Medicare prices are shown as a percent of current law subsidies. The calculations used average commercial and Medicare prices, distribution of spending across inpatient and outpatient care, and current enrollment and subsidy rules. A 1 percentage-point drop in out-of-pocket costs on the ACA Marketplace is assumed to increase enrollment by 0.5%, consistent with assumptions used by the Congressional Budget Office.
Without additional federal spending, lawmakers could extend a price cap to protect the uninsured, whose billed charges usually exceed even commercial prices. Lawmakers could also extend a price cap to the few million people in ACA-compliant plans outside the ACA Marketplace to unify the rules between potentially similar populations.

A price cap would likely trigger opposition and concerns regarding diminished patient access. Although hospital and practice revenue is especially salient during the pandemic, clinicians have long accepted Medicare prices for treating other federal populations—from the children of military families to the elderly enrolled in Medicare Advantage—suggesting they are likely to continue accepting ACA Marketplace enrollees. Hospitals and physicians might respond to a price cap by increasing utilization or raising prices in other settings. The magnitudes of these responses deserve monitoring. Even with increased enrollment, ACA Marketplace enrollees would remain a small share of most hospital and physician and patient panels, for whom a price cap is less consequential to clinical revenue compared with broader price reductions.

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