SAVINGS ESTIMATES FOR OPTIONS TO REDUCE SPENDING ON HEALTH CARE AND PRIVATE INSURANCE PREMIUMS

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INTRODUCTION AND SUMMARY

Costs for health care goods and services in the United States are high and rising. As a result, so are premiums for the health insurance policies that cover those costs. Those trends raise interest in developing options to reduce costs both for federal health programs and for privately insured individuals and families. But a crucial question, of course, for any option is: What effects would it have on health care spending? Quantifying those effects plays a key role in determining which options are worth pursing and which are not.

In that light, the Blue Cross Blue Shield Association (BCBSA) sought estimates for the budgetary and spending effects of a wide range of policy options that they have proposed to make health care more affordable. The results presented here seek to reflect the rigorous methods that the Congressional Budget Office (CBO) employs when conducting its analyses of policy options. However, not all of the options that BCBSA has proposed could be estimated in this report because the sorts of publicly available data needed to construct such estimates were lacking or because the evidence base was not sufficient to develop an estimate.

The table below summarizes the estimated impact of six specific options on the federal budget and on private insurance premiums – with the latter effects shown both in billions of dollars and as a percentage of total insurance premiums. The figures span the 10-year budget window covering 2024 through 2033 that will be used for analysis of federal legislation this year. As the table shows, **those six options combined would generate federal savings of $337 billion, would reduce private insurance premiums by $298 billion, and would save enrollees in Medicare and private plans a total of $206 billion in out-of-pocket (OOP) costs. The combined savings would be $767 billion over 10 years.**[1]

All six options would require changes in federal laws and policies to achieve savings. The most impactful option would adopt site-neutral payment policies under Medicare – a change which would carry over to the private sector as well and generate substantial savings on premiums and cost sharing under private plans. Currently, Medicare pays significantly more for a service provided in a hospital setting than for the same service provided in a physician's office – even when the service involved is commonly and safely performed outside the hospital. **Option 1** would generally equalize payments for such services at the lower, office-based rate, an approach that has been recommended by many experts. Combined, the resulting savings for the federal budget, private insurance premiums, and enrollee's OOP costs would sum to $471 billion over 10 years.

[1] To avoid double-counting of savings when combining the three figures, it is necessary to subtract the effects of reductions in private insurance premiums on the federal budget – that is, to subtract 25 percent of the savings on private premiums from the sum of the three components. Note also that the figures for OOP savings include reductions in premiums for Medicare enrollees.

Summary of Estimates
10-Year Effects for 2024-33 ($Billions)

Option	Proposal	Federal Savings	Private Premium Savings *$ Billions*	Private Premium Savings *Percent*	Enrollee OOP Savings	Combined Savings *
Options that Generate Savings by Changing Current Law						
1	Adopt Site-Neutral Payment Policies	231	117	0.75%	152	471
2	Expand Antitrust Funding & Enforcement	17	69	0.44%	10	79
3	Prohibit Anti-Tiering Provisions	8	33	0.21%	5	38
4	Facilitate Generic Drug and Biosimilar Entry **	7	5	0.03%	4	15
5	Limit the Exclusivity Period for Biologicals	41	49	0.31%	23	101
6	Tax Spending on Direct-to-Consumer Drug Ads	33	25	0.16%	12	63
	TOTAL	**337**	**298**	**1.90%**	**206**	**767**
Options that Protect Against Cost Increases						
7	Preserve Drug Benefit Management Tools	21	84	0.54%	13	97
8	Preserve Prior Authorization	67	268	1.71%	41	308
	TOTAL	**88**	**352**	**2.25%**	**53**	**405**

* To avoid double-counting, combined savings exclude the effects of private premium savings on federal revenues.
** These savings estimates are based on Congressional Budget Office scores that may be particularly conservative.

Two other options would try to offset the effects of the highly concentrated markets for hospitals and some specialists that exist around the country. **Option 2** would sharply increase funding for antitrust enforcement, which would limit the future growth in concentration of those markets, thus reducing growth in prices for hospital and specialist services. Total savings would be $79 billion over the 2024-2033 period. **Option 3** would prohibit hospitals from imposing " anti-tiering" provisions on insurers – provisions which prevent insurers from establishing tiered hospital networks and incentivizing enrollees to use lower-cost hospitals and also prohibit insurers from excluding high-cost hospitals from their networks. The combined savings over a decade from that option would be $38 billion.

Three other options would address spending on prescription drugs including biologicals in various ways.

- **Option 4** would combine several recent legislative proposals that would ban "pay-for-delay" arrangements between drug manufacturers and would bar or limit other practices that impede entry of less costly generic drugs and biosimilars. Based on recent CBO estimates of savings for those bills, their aggregate effects would be relatively small – $15 billion over 10 years. But some studies suggest that pay-for-delay arrangements by themselves raise drug spending by several billion dollars per year, so the effects of the proposals may be larger than CBO has estimated.
- **Option 5** would reduce the effective period of market exclusivity for biologicals from the current 12 years to seven years. Bringing more biosimilars to market would take time but would yield aggregate savings of $101 billion over the next decade.
- **Option 6** would effectively tax spending on direct-to-consumer (DTC) advertising for prescription drugs – ads which have been shown to increase total drug spending, not just shift spending from one product to another. That option would generate $33 billion in net savings for the federal government, reduce private insurance premiums by about $25 billion, and reduce enrollees' OOP costs by $12 billion over 10 years.

Finally, the table also shows separately the effects of two additional options that would preserve existing utilization management methods that health plans employ to control costs – the tools that health plans use to manage drug costs and the prior authorization (PA) requirements that health plans use to manage medical costs. Together, preserving those methods would prevent potential cost increases amounting to $405 billion over the 10-year budget window – combining the estimated effects on the federal budget, private insurance premiums, and enrollees' OOP costs.

The remainder of this paper explains in more detail the estimates for each approach and how they were developed – and provides year-by-year figures. (An appendix adds more information about the methodology used and sources of data across the options.) Admittedly, this analysis is not an exhaustive list of options; many other possible approaches could be developed and assessed – particularly as more evidence emerges to inform estimates of their effects. For example, research on the comparative effectiveness of medical treatments might help reduce spending by highlighting cases where more expensive treatment methods are not more effective clinically. Currently, however, the evidence base seems too limited to draw firm conclusions about the net effects that more federal funding for such research would have on practice patterns and medical spending. Those limitations notwithstanding, this paper should contribute to a useful and robust discussion about the best ways to address the chronic and gradually worsening problem of high and rising costs for health care in this country.

OPTION 1: Adopt Site-Neutral Payment Policies

One recent analysis of this issue described it well: "The Medicare program pays different rates for equivalent or identical services depending on where the service is performed. Generally, procedures performed in hospital outpatient departments are paid at a higher rate than the same procedures performed in a physician's office or an ambulatory surgical center."[2] For those services, there is little or no evidence that the quality of care is higher when they are provided in a hospital setting – and in many cases, physician offices were simply purchased by hospitals and relabeled as part of the hospital's outpatient department (HOPD) in order to generate the resulting higher payments.

In that light, the Medicare Payment Advisory Commission (MedPAC) and others have recommended establishing site-neutral payment policies for Medicare – at the lower total payment rate that would apply for care provided in a stand-alone physician office. In 2020, the CBO scored a proposal for site-neutral payments as saving $141 billion over the 2021-2030 budget window that applied at that time.[3] That analysis implies that the proposals would reduce Medicare's total spending on all hospital services by about 4 percent. Updating that analysis to cover the current 10-year budget window of 2024-2033, the proposal would save Medicare an estimated $202 billion.

CBO did not estimate effects on private sector spending related to those proposals – because if they had, they would have shown effects on federal revenues stemming from them. However, a fairly strong case can be made that such effects would arise, at least to some extent. A primary argument for spillover effects on private sector prices is that private insurers generally use Medicare's payment system and simply vary their average level of payments compared with Medicare's rates – such as paying 150 percent of Medicare's fee schedule – while using the same ratios of payments across different services as are set by Medicare. From that perspective, a reduction in Medicare's fees to hospitals for services commonly performed in other settings would have the same proportionate effect on private sector prices for those services. A counter-argument is that, unlike Medicare, insurers have to negotiate their payment rates with hospitals – and hospitals may have enough bargaining leverage to force insurers to continue paying higher rates for HOPD services (rates which reflect the higher costs of care overall in the hospital setting).

A recent study by Clemens and Gottlieb sheds important light on the question of how changes in Medicare's rates affect commercial pricing – and its findings tend to support the argument that commercial prices move largely in parallel with Medicare's fee schedule.[4]

[2] Committee for a Responsible Federal Budget, "Equalizing Medicare Payments Regardless of Site-of-Care" (February 23, 2021), https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.
[3] CBO, "An Analysis of the President's 2021 Budget" (March 30, 2020), https://www.cbo.gov/publication/56278. For the total Medicare savings from site-neutral payment policies, combine estimate numbers 38 and 39, which are here: https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf.
[4] Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *Journal of Political Economy*, vol. 125, no. 1 (February 2017), https://www.journals.uchicago.edu/doi/10.1086/689772.

The study examined changes in relative payments under that schedule and found that an increase in Medicare's fees of $1.00 led to an increase in private payment rates of $1.16, on average. The study used several years of data, and thus was able to capture any adjustments that might have been made in subsequent contract renegotiations. The authors found that private payment rates were about 45 percent higher than Medicare's rates, on average, in the period they examined. A full pass-through of Medicare's price changes to private rates would thus have raised private rates by $1.45 for each $1.00 increase in Medicare's rates. Their finding that the average effect was $1.16 suggests that about 80 percent of Medicare's price changes ($1.16/$1.45) were ultimately passed through to private prices, with the remainder offset via subsequent renegotiations.

A second and equally important question for this estimate is how much spending occurs under private insurance plans for HOPD services that are commonly provided outside of the hospital. Data from several years ago suggests that the share of such services provided in HOPDs was similar between private insurance and Medicare.[5] But in the last few years, insurers have taken additional steps to limit coverage for those serves when provided in HOPDs. One such step is requiring higher cost sharing when using an HOPD, which also limits the costs to insurers of those HOPD services.

On that basis, a reasonable assumption is that the proportional effects of site-neutral payments on private insurance spending would be half as large as those estimated for Medicare. Adding in the additional effect of contract renegotiations between insurers and hospitals would reduce that effect on private insurance to about 40 percent of the effect for Medicare. Consequently, if site-neutral payments would reduce overall Medicare spending on hospital services by about 4 percent, then the estimated effect on private-sector hospital spending would be a reduction of about 1.6 percent.

Using those assumptions, site-neutral payments would yield an estimated reduction in costs and premiums for private insurance plans of $117 billion over 10 years – which amounts to a cut in costs and premiums of about three-quarters of one percent, relative to this paper's projections under current law.[6] About 25 percent of those savings would accrue to the federal government as the composition of compensation shifted from non-taxable health benefits to taxable wages (to hold total pre-tax compensation about the same). As a result, federal revenues would increase by about $29 billion over 10 years, and total federal savings under this option would come to $231 billion. Along with those savings, enrollees in private health plans would see reductions in their out-of-pocket payments for care, and Medicare enrollees

[5] For private insurance, see John Hargraves and Julie Reiff, "Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices," Health Care Cost Institute (April 2, 2019), https://healthcostinstitute.org/in-the-news/shifting-care-office-to-outpatient; for Medicare, see Table 3-8 on page 76 of MedPAC's 2014 Report to Congress (March 2014), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_ch03.pdf

[6] BCBSA has also proposed requirements for appropriate billing designed to ensure that providers list the proper site of care on the correct claim form, but publicly available data were not sufficient to estimate the effects of such changes over and above the impact of adopting site-neutral payment policies.

would save on both their cost sharing and their Part B premiums – with those savings adding up to $152 billion over 10 years.

OPTION 1: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	13.4	15.1	16.5	18.4	20.1	22.2	25.3	28.9	33.1	37.9	**230.9**
Private Premium Savings	8.0	8.8	9.5	10.2	11.1	12.0	12.9	13.9	14.9	16.0	**117.4**
Enrollee OOP Savings	8.8	9.9	10.9	12.1	13.3	14.7	16.7	19.0	21.8	25.0	**152.2**
Combined Savings	28.3	31.5	34.5	38.2	41.7	45.9	51.7	58.3	66.1	74.9	**471.2**

OPTION 2: Expand Antitrust Funding and Enforcement

One key factor driving high prices in the U.S. health care system is the concentration of providers – particularly hospitals but also specialist physicians – which reduces competitive pressures to control their costs and limit the prices they charge. According to one recent summary of the evidence, 65 percent of metropolitan areas had “highly concentrated” hospital markets in 1990, and that figure grew to 77 percent by 2006.[7]

Several observers have proposed to address that problem, at least in part, by sharply increasing funding for the antitrust enforcement. It stands to reason that increased funding would allow the federal government to challenge more hospital and physician mergers, which, in turn, would limit the continued growth of market concentration – thus limiting future growth in prices. One recent analysis by Martin Gaynor of Carnegie Mellon University and Zach Cooper of Yale University found that a 10 percent decrease in hospital market concentration would reduce hospital prices, on average, by one half of one percent.[8] And a recent review of the relevant literature by CBO found even larger effects – with a 10 percent decrease in hospital concentration reducing prices by 1.3 percent, and a 10 percent decrease in physician concentration reducing prices by 0.8 percent.[9] For this analysis, the effects on physician prices

[7] Brent D. Fulton, “Health Care Market Concentration Trends in The United States,” *Health Affairs*, vol. 36, no. 9 (September 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556.
[8] Zack Cooper and Martin Gaynor, “Addressing Hospital Concentration and Rising Consolidation in the United States,” (February 8, 2021), https://onepercentsteps.com/wp-content/uploads/brief-hc-210208-1700.pdf.
[9] Congressional Budget Office, “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services” (September 29, 2022), https://www.cbo.gov/publication/58222.

were applied to spending on specialty care, which accounts for about three-fourths of all spending on physician services.[10]

The estimate presented here was based largely on those findings as well as a related paper by Gaynor that assessed recent changes in hospital market concentration and in antitrust funding.[11] That study found that from 2010 to 2016, hospital market concentration increased by about 5 percent – while at the same time, antitrust funding was held roughly flat in nominal terms and thus fell by 15 percent relative to general price inflation. It seems reasonable to assume that about half of that increase in concentration would have been prevented if funding had not been effectively cut. Using those assumptions, this analysis examines the effects of a 30 percent increase in antitrust funding, which would be maintained over a decade.

With the funding increase, hospital market concentration in 2033 would be about 9 percent lower than under current law, and concentration among physician specialists would be about 8 percent lower. As a result, prices for hospital services covered by private insurance would be about 1.2 percent lower than current projections a decade from now, and prices for physician specialists would be about 0.7 percent lower. Over that period, the cumulative reduction in hospital payments, and thus in private premiums, would be about $54 billion over the next 10 years, and the cumulative reduction in spending on the services of physician specialists would be about $15 billion lower – bringing the total effect on private premiums to $69 billion. The federal government would capture about a quarter of those combined savings, or roughly $17 billion.

The costs of the added federal funding would themselves be modest. Gaynor estimated that total antitrust funding across the federal government was about $500 million per year, and that covers all forms of antitrust activities – not just those for health care. A reasonable assumption is that antitrust activities for health care account for about 20 percent of that total, since that is the rough share of the economy devoted to health care. A 30 percent increase devoted solely to that sector would thus amount to about $300 million in new spending over 10 years. Although larger increases could, in theory, yield bigger results, absorbing and spending new resources in an effective way would become more difficult the larger the increase.

Potentially, the increase in funding could also be used to address other forms of concentration in the health care sector, including hospital system acquisitions that are not in the same geographic area, vertical integration between hospitals and physician groups, and acquisitions of competitors by health insurance plans. Effects of such actions were not included in this estimate, however, in part owing to limited data about their effects on spending and premiums. Notably, a recent analysis of trends in health care markets found that concentration

[10] Specialty care accounts for about 65 percent of physician office visits, but makes up a larger share of spending because the prices for those visits are higher than for primary care visits. See Steven R. Machlin and Emily M. Mitchell, "Expenses for Office-Based Physician Visits by Specialty and Insurance Type, 2016," MEPS Statistical Brief #517 (October 2018), https://meps.ahrq.gov/data_files/publications/st517/stat517.shtml.

[11] Martin Gaynor, "What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work" (March 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf.

among insurers did not change appreciably over the 2010-2016 period, even though antitrust funding declined in real terms over that period.[12]

OPTION 2: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	0.0	0.3	0.6	0.9	1.3	1.7	2.2	2.7	3.2	3.9	**16.9**
Private Premium Savings	0.0	1.2	2.5	3.9	5.4	7.1	9.0	10.9	13.1	15.7	**68.8**
Enrollee OOP Savings	0.0	0.2	0.4	0.6	0.8	1.1	1.4	1.7	2.0	2.4	**10.5**
Combined Savings	0.0	1.3	2.8	4.4	6.2	8.2	10.3	12.6	15.1	18.0	**78.9**

OPTION 3: Prohibit Anti-Tiering Provisions

One way that dominant hospital systems can exert their market power is by preventing insurers from encouraging enrollees to use other hospitals that charge less. Insurers often seek to do so by establishing tiers among the hospitals within their coverage network and reducing the cost sharing for enrollees when they use hospitals in the most-preferred tiers. Insurers may also seek to exclude some of the most expensive hospitals from their coverage networks altogether, at least for some of the plans that they offer. But a dominant hospital system may be able to demand contract provisions that prevent such tiering – and could require insurers to include all of the system's hospitals, even the more expensive ones, in their coverage networks (sometimes referred to as an "all-or-nothing" provision).

Under this option, such provisions would be prohibited. Estimating the effects of this option is difficult, however, partly because information is not readily available about how widespread these anti-tiering practices are. CBO recently estimated that the conditions needed for anti-tiering provisions to arise are present in areas that comprise about one-fourth of the population.[13] Those areas lack a monopolistic hospital system, which makes tiering a viable option, but also have dominant hospitals that might be able to demand anti-tiering provisions. And in CBO's estimation, those areas must also lack a monopolistic insurer (the logic being that such insurers could probably reject anti-tiering provisions, even if they are allowed).[14]

[12] Brent D. Fulton, "Health Care Market Concentration Trends in The United States," *Health Affairs*, vol. 36, no. 9 (September 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556.
[13] See CBO's cost estimate for S. 1895, which is here: https://www.cbo.gov/publication/55457.
[14] CBO seemed to assume that anti-tiering provisions were prevalent in all such areas, which could be an overestimate. At the same time, even areas with monopolistic hospital systems may be affected by all-or-nothing contracting provisions – if there are multiple hospitals in the area but some are more expensive flagship hospitals. Assuming that those two considerations essentially offset each other, the CBO estimate that one-fourth of the population is subject to anti-tiering provisions was applied for this estimate.

The next considerations for this estimate involve how much the use of tiering might reduce spending and premiums, and how much enrollment might shift to tiered-network plans. One recent study found that such plans could reduce medical spending by about 5 percent, but another found premium reductions of 16 percent.[15] In that light, assuming a midpoint of about 10 percent savings for this estimate seemed reasonable. It also seemed reasonable to adopt CBO's assumption that enrollment in tiered-network plans would ultimately increase by about 10 percent in the affected areas – thus bringing the reduction in premiums to about one percent in those areas. Averaged across the entire country, therefore, the reduction in premiums would grow to about 0.25 percent over the next decade.

Translating those effects into dollars, premiums for private health insurance would be reduced by $33 billion over the next 10 years if anti-tiering provisions were prohibited. The resulting savings for the federal government (via increased tax revenues) would be $8 billion over that period. The effects on premiums and the federal budget could be larger if the ban on anti-tiering provisions was combined with a requirement for insurers to offer tiered-network plans, or with a requirement for employers offering multiple plans to include a tiered-network option. But those requirements would also be more difficult to implement, and their effects are harder to estimate.

OPTION 3: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	0.5	0.5	0.6	0.7	0.8	0.8	0.9	1.0	1.1	1.3	**8.3**
Private Premium Savings	1.9	2.2	2.4	2.7	3.0	3.4	3.7	4.1	4.6	5.0	**33.1**
Enrollee OOP Savings	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.6	0.7	0.8	**5.0**
Combined Savings	2.2	2.5	2.8	3.1	3.5	3.9	4.3	4.8	5.2	5.8	**38.1**

[15] See Anna D. Sinaiko, Mary Beth Landrum, and Michael E. Chernew, "Enrollment in a Health Plan with a Tiered Provider Network Decreased Medical Spending by 5 Percent," *Health Affairs*, vol. 36, no.5 (May 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1087; and Leemore Dafny and others, "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth," *Health Affairs*, vol. 36, no. 9 (September 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1669.

OPTION 4: Facilitate Entry of Generic and Biosimilar Drugs

Generic and biosimilar drugs are generally much less expensive than their brand-name and biological versions, but various obstacles may impede the entry of those cheaper drugs. For example, drug manufacturers may enter into "pay-for-delay" arrangements with the first generic competitor that is planning to come to market – which allows the manufacturer to avoid generic competition for a longer period and effectively shares a portion of the higher revenues that result with that generic manufacturer.

In recent years, a range of legislative proposals has been introduced to block pay-for-delay arrangements and other tactics that may be used to impede generic and biosimilar entry – and importantly, CBO has estimated federal savings for each of the following options:

- **H.R. 153, the Protecting Consumer Access to Generic Drugs Act of 2021**. This bill would ban pay-for-delay arrangements.[16]
- **H.R. 2883 and S. 1425, the Stop STALLING Act**. These bills would deny citizen petitions that are designed to delay entry of low-cost drugs.[17]
- **H.R. 2853, the BLOCKING Act**. This bill allows the FDA to approve generic drug applications that are ready for full approval if no first generic applicant has received final approval and certain other conditions are satisfied.[18]
- **S. 1435, the Affordable Prescriptions for Patients Act**. This bill would prohibit "product hopping" for brand-name drugs and would also limit the number of patents that may be included in infringement claims against applicants for a biosimilar product license.[19]

Updating CBO's scores for that package of proposals to reflect the current budget window of 2024-2033 yields estimated savings for the federal government of about $7 billion over that period. Over the next decade, private insurance premiums would be about $5 billion lower in the aggregate, and enrollees in Medicare and private insurance would save $4 billion on their out-of-pocket costs for health care. Combined savings would be $15 billion.

Those figures for savings reflect CBO's recent estimates, but some studies indicate that the aggregate effects of pay-for-delay arrangements on drug spending may be much larger – several billion dollars per year, at a minimum. A study by the Federal Trade Commission (FTC) published in 2010 indicated that those arrangements could have increased drug spending by

[16] CBO's cost estimate for the 2019 version of this legislative proposal, H.R. 1499, is available here: https://www.cbo.gov/system/files/2019-04/hr1499.pdf.
[17] CBO's cost estimate for the 2019 version of this legislative proposal, H.R. 2374, is available here: https://www.cbo.gov/system/files/2019-05/hr2374.pdf.
[18] CBO's cost estimate for the 2019 version of this legislative proposal, H.R. 938, is available here: https://www.cbo.gov/system/files/2019-04/hr938.pdf.
[19] CBO's 2022 cost estimate is here: https://www.cbo.gov/system/files/2022-06/s1435.pdf. As CBO put it, the term product hopping "refers to an attempt by a brand product manufacturer to impede the availability of generic competition or to renew market exclusivity periods by reformulating a product."

about $3.5 billion per year.[20] Updating that estimate to reflect current levels of drug spending – and then projecting the figures forward for a decade – yields a cumulative effect of about $70 billion over the 2024-2033 period. And a more recent study found even larger effects, reporting that "at a minimum, the annual cost of pay-for-delay settlements on the U.S. population between 2006 and 2017 was $6.2 billion – nearly twice the amount estimated in the FTC study."[21] Further, that study's "methodology with the largest result suggests that the cost could be as high as $37.1 billion per year – ten times higher than the FTC estimate." If nothing else, those figures suggest that the savings from pay-for-delay legislation may be larger than CBO has estimated, that there is scope to draft legislation that would be scored as yielding more savings – or a combination of those two possibilities.

OPTION 4: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	0.1	0.3	0.5	0.6	0.7	0.7	0.8	0.9	0.9	1.0	**6.6**
Private Premium Savings	0.1	0.3	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	**5.1**
Enrollee OOP Savings	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.6	0.6	0.6	**4.1**
Combined Savings	0.3	0.8	1.2	1.3	1.5	1.5	1.8	1.9	2.0	2.1	**14.6**

OPTION 5: Limit the Exclusivity Period for Biological Drugs

When a practical pathway was created for biosimilar drugs to enter the marketplace, as part of the Affordable Care Act, the original biologicals were essentially allowed to retain up to 12 years of market exclusivity before a biosimilar drug could enter. Under this proposal, that period of exclusivity would be reduced to seven years. Clearly, shortening the exclusivity period would accelerate entry of biosimilars, which have tended to have prices about 30 percent lower than their biological counterparts and have captured about 30 percent of the markets that they have entered (although biosimilar market shares vary substantially by drug).[22] The more difficult

[20] FTC, "Pay-for-Delay: How Drug Company Pay-Offs Cost Consumers Billions" (January 2010), https://www.ftc.gov/sites/default/files/documents/reports/pay-delay-how-drug-company-pay-offs-cost-consumers-billions-federal-trade-commission-staff-study/100112payfordelayrpt.pdf.
[21] Robin Feldman, "The Price Tag of 'Pay-for-Delay,'" *The Columbia Science & Technology Law Review*, vol. 23, no. 1 (Fall 2021), https://journals.library.columbia.edu/index.php/stlr/article/view/9389/4798.
[22] IQVIA Institute, "Biosimilars in the United States 2020–2024" (October 2020), https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/iqvia-institute-biosimilars-in-the-united-states.pdf.

part of developing an estimate of the resulting savings may be projecting what the path of biosimilar entry will be under current law.[23]

Biologicals and biosimilar drugs are generally administered by doctors, and thus are counted as medical benefits rather than drug benefits under insurance plans. According to a recent study by IQVIA, total spending on biologicals in 2019 was about $170 billion.[24] For this analysis, spending was projected forward using a growth rate of 7 percent per year (which is lower than the growth rate for spending on biologicals observed over the last few years). However, some of that spending is for drugs that would not be subject to competition from biosimilars for many years. According to the same IQVIA report, about half of current spending on biologicals is for drugs that would not face biosimilar competition over the next decade. Under the proposal, however, an estimated 40 percent of spending on biologicals could, in theory, face biosimilar entry in 2024, and that share would grow substantially by 2033.

Even if earlier entry by a biosimilar was made legal, biopharmaceutical companies would have to take significant steps to actually introduce biosimilars into the market – a process that takes many years. Reflecting that fact, a key assumption in this analysis is that the share of biologicals that would actually face new competition would rise from an estimated 10 percent of those subject to biosimilar entry in 2028 to 60 percent in 2033. Some of that entry would reflect more rapid development of biosimilars that are already in the pipeline to take advantage of the new opportunities under this option. On average, biosimilar entry is estimated here to reduce spending by about 12 percent for the drugs involved. That is, combined spending for the originator biological and its biosimilar would be about 12 percent less than what spending would have been on the originator biological alone in the absence of biosimilar entry.

Using those assumptions, the estimated total savings on biological products would be about $101 billion across the U.S. health care system over the 2024-2033 period. About 40 percent of those savings would accrue within the Medicare program, and some of those savings will be captured by enrollees through lower premiums and cost sharing. About 10 percent would accrue to Medicaid, of which about 60 percent would be captured by the federal government. And about half of the health care system's savings would be captured through privately insured plans – with downstream savings for the federal government coming through the tax exclusion and other subsidies for such insurance. Overall, there would be savings of $41 billion to the federal government and reductions in private insurance premiums of $49 billion over the 2024-2033 period.

[23] Additionally, some reduction in the number of biologicals developed in the first place would likely occur – given the reduced financial incentives to undertake those efforts, for which the payoff will be substantially smaller than it is under current law. On average, that reduction in supply would tend to reduce spending on health care over the next decade. Given the uncertainties involved, however, that effect was not incorporated into this estimate.

[24] IQVIA Institute, "Biosimilars in the United States 2020–2024" (October 2020), https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/iqvia-institute-biosimilars-in-the-united-states.pdf.

OPTION 5: Estimated Effects ($ Billions by Calendar Year)											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	0.0	0.0	0.0	0.0	1.1	2.7	4.7	7.3	10.5	15.2	**41.4**
Private Premium Savings	0.0	0.0	0.0	0.0	1.3	3.1	5.5	8.5	12.4	17.9	**48.7**
Enrollee OOP Savings	0.0	0.0	0.0	0.0	0.6	1.5	2.6	4.0	5.8	8.4	**23.0**
Combined Savings	0.0	0.0	0.0	0.0	2.7	6.5	11.4	17.7	25.6	37.0	**100.9**

OPTION 6: Tax Spending on Advertising for Prescription Drugs

Recent studies have found that direct-to-consumer ads for prescription drugs tend to increase total sales of drugs within a therapeutic class, particularly in the case of ads that are broadcast on television or via other media.[25] In other words, those ads do not simply move market share from one producer to another, but rather increase the total volume of drug sales. It follows, therefore, that limiting such advertisements or reducing their frequency would reduce spending on prescription drugs. Recent legislative proposals would seek to discourage such advertising by excluding manufacturers' expenditures on DTC from tax-deductible business expenses – which would effectively tax those expenses.[26]

According to the Government Accountability Office (GAO), drug manufacturers spent about $6 billion on DTC ads in 2018.[27] One older study found that "every additional $1 the industry spent on DTC advertising … yielded an additional $4.20 in sales" for the relevant therapeutic class of drugs.[28] Disallowing the tax deduction for those expenses would discourage DTC advertising to some extent – and for this analysis, it was assumed that the reduction in DTC spending would be equal in magnitude to the increase in tax liability. That is, total costs for manufacturers related to DTC advertising (including the costs of the tax) would be held constant.

However, drug manufacturers have other means of promoting their products, and while those are evidently less effective than DTC ads, drug makers would presumably shift some resources to those other methods of promotion if spending on DTC ads was taxed. That

[25] Dhaval Dave and Henry Saffer, "The Impact of Direct-to-Consumer Advertising on Pharmaceutical Prices and Demand," NBER Working Paper No. 15969 (May 2010), https://www.nber.org/papers/w15969.
[26] See S. 141 ("End Taxpayer Subsidies for Drug Ads Act") and H.R. 6392 ("No Tax Breaks for Drug Ads Act"), which were introduced in 2021 and 2022, respectively.
[27] GAO, *Medicare Spending on Drugs with Direct-to-Consumer Advertising* (May 2021), https://www.gao.gov/assets/gao-21-380.pdf.
[28] Kaiser Family Foundation, "Impact of Direct-to-Consumer Advertising on Prescription Drug Spending" (June 2003), https://www.kff.org/wp-content/uploads/2003/06/6084-impact-of-direct-to-consumer-advertising-on-prescription-drug-spending-summary-of-findings.pdf.

spending on other forms of drug promotion would limit the decline in drug sales. Overall, it seemed reasonable to conclude that spending on other forms of drug promotion would offset about half of the decline in spending on DTC ads and that, at the margin, those forms would be half as effective at generating sales as DTC ads have been.

A final consideration involves effects on other types of spending on health care. The available evidence indicates that greater use of prescription drugs yields partly offsetting savings on hospitalizations and doctors' visits.[29] Following that logic, a reduction in the quantity of prescriptions that are filled that results from a tax on DTC ads would increase spending on those other medical services somewhat. That calculation takes into account evidence that DTC ads result in more visits to physician offices in order to obtain prescriptions and discuss the underlying medical conditions that are involved.

Taking all of those considerations into account, disallowing tax deductions for DTC drug ads would yield savings to the federal government of $33 billion over the 2024-2033 period. Most of the federal savings would accrue to Medicare. On balance, spending under private insurance plans would decline by about $25 billion – which would probably translate into total reductions in premiums of that magnitude, holding all other factors equal. In addition, people with private health insurance coverage would see net reductions in their out-of-pocket costs, and Medicare enrollees would save on their premiums and cost sharing – with aggregate OOP savings amounting to $12 billion over 10 years.

OPTION 6: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	3.0	3.0	3.1	3.2	3.3	3.3	3.4	3.5	3.6	3.7	**33.1**
Private Premium Savings	2.2	2.2	2.3	2.4	2.4	2.5	2.5	2.6	2.7	2.7	**24.6**
Enrollee OOP Savings	1.0	1.1	1.1	1.1	1.1	1.2	1.2	1.2	1.3	1.3	**11.6**
Combined Savings	5.6	5.8	5.9	6.1	6.2	6.4	6.5	6.7	6.9	7.0	**63.1**

[29] CBO, "Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services" (November 29, 2012), https://www.cbo.gov/publication/43741.

OPTION 7: Preserve Drug Benefit Management Tools

Health plans use a range of tools and techniques to help manage costs for prescription drugs, which are typically implemented by Pharmacy Benefit Managers (PBMs). These include prior authorization – particularly for specialty drugs and other high-cost medications – as well as step therapy programs and preferred pharmacy networks. With step therapy, a patient typically must try less expensive drugs first and will get coverage for more expensive drugs only if the cheaper alternatives do not work. If a health plan has a preferred pharmacy network, patients pay less when they use those pharmacies – and pay more when they use in-network (but non-preferred) pharmacies or out-of-network pharmacies. Some patients and providers have concerns about these methods, which, at a minimum, can be inconvenient. These concerns have prompted legislative proposals to restrict their use.[30] The option examined here would block restrictions on health plans' use of those tools.

Evidence about the effects of these tools on health care spending is limited. One recent review of the available studies found that step therapy programs for certain substantial classes of pharmaceuticals have generated savings of 9 percent to 15 percent on drug costs.[31] But the overall effect on drug spending of restricting the use of step therapy would be much smaller than that for several reasons. For one, step therapy is not applicable to all types and categories of drugs; another recent review found that 10 classes of pharmaceuticals were most commonly subject to step therapy.[32] Moreover, that same review indicated that about 60 percent of private insurance plans were not applying step therapy protocols.

Similarly, evidence about the effects of prior authorization requirements on drug spending is hard to come by. One recent review of the evidence found some mixed results across a range of drug and non-drug categories, but did indicate that prior authorization requirements had been successful in reducing spending on specialty drugs – which make up a small share of prescriptions, but now account for as much as half of all drug spending.[33] That review also found that step therapy programs for specialty drugs reduced spending on those drugs by about 10 percent.

An additional consideration is that an important source of savings from step therapy programs for prescription drugs may not have been captured by many existing studies – namely, the effects of those programs on the rebates that health plans negotiate with drug

[30] An even more crucial method that health plans and PBMs use to control costs is to establish formularies or lists of preferred and covered drugs – and negotiate price rebates from drug manufacturers in return for favorable formulary placement, which, in turn, increases sales of those preferred drugs. Those rebates now account for a large percentage of gross drug spending, averaging 15 to 20 percent in commercial health plans and 30 percent or higher in Medicare drug plans. The analysis here does not account for restrictions on drug formularies.

[31] Sara Heath, "How Does Step Therapy Impact Patient Care, Access, Costs?" *Patient Engagement HIT* (August 9, 2018), https://patientengagementhit.com/news/how-does-step-therapy-impact-patient-care-access-costs.

[32] Kelly L. Lenahan and others, "Variation in Use and Content of Prescription Drug Step Therapy Protocols, Within and Across Health Plans," *Health Affairs*, vol. 40, no. 11, (November 2021) https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00822.

[33] Ani Turner, George Miller, and Samantha Clark, "Impacts of Prior Authorization on Health Care Costs and Quality," National Institute for Health Care Reform (November 2019), https://www.nihcr.org/analysis/impacts-of-prior-authorization-on-health-care-costs-and-quality/.

manufacturers. In general, those rebates are larger the more that health plans can "move market share" – that is, the more they can increase use of a specific drug at the expense of competing drugs. Step therapy, along with favorable formulary placement and lower cost sharing for preferred drugs, are mechanisms that help encourage such shifts and, thus, tend to make rebates larger. Because rebate data is generally proprietary, existing studies related to step therapy have probably missed those effects.

One way to quantify those effects is to look at the supplemental rebates that states are able to negotiate for drugs under Medicaid in return for inclusion on the state's preferred drug list – which generally means that a drug will be exempt from prior authorization requirements. According to a recent report, those supplemental rebates amounted to about $1.7 billion over the years 2011 and 2012.[34] Over those two years, Medicaid's drug spending totaled about $42 billion, which implies that supplemental rebates accounted for about 4 percent of that spending. Since then, supplemental rebates have grown as a percentage of drug spending. And the similarities between prior authorization and step therapy suggest that limits on step therapy would have similar (albeit smaller) effects on such drug rebates.

A final component of the tools examined here is the use of preferred pharmacy networks. Because of the confidential nature of such arrangements, finding data about their effects is particularly hard. Even so, studies indicate that gross margins for pharmacies can account for between 15 and 20 percent of drug spending, and that their net margins are about three percent of total spending on prescription drugs.[35] In that light, it seemed reasonable to estimate that preferred pharmacy arrangements could affect roughly one percent of total drug spending. It is also worth noting that health plans must balance the savings they can obtain from having a more restrictive network of pharmacies with the value that consumers place on having convenient access to pharmacies. And in Medicare's drug benefit, there are specified requirements for pharmacy access.

All told, the estimates shown here reflect an assessment that major restrictions on the use of these three cost management tools would increase drug spending on net by about 6 percent. One percentage point of that effect would stem from provisions regarding preferred pharmacy networks, and the remaining 5 percent would come from prior authorization and step therapy measures – in roughly equal proportion. Conversely, blocking those restrictions would reduce drug spending by about 6 percent.

The final consideration was which markets the options would affect. Health plans that are fully insured – that is, where the insurer bears the financial risk for covering health care costs – account for about 40 percent of the private insurance market. Those plans are generally subject to state-level regulations. Thus, a narrow estimate would simply capture the effects on those plans to account for possible restrictions imposed at the state level and would yield an

[34] Office of the HHS Inspector General, "States' Collection of Offset and Supplemental Medicaid Rebates," (December 2014), https://oig.hhs.gov/oei/reports/oei-03-12-00520.pdf.

[35] See Neeraj Sood and others, "Flow of Money Through the Pharmaceutical Distribution System," (June 6, 2017), https://healthpolicy.usc.edu/research/flow-of-money-through-the-pharmaceutical-distribution-system/; and Pew Charitable Trusts, "The Prescription Drug Landscape, Explored" (March 8, 2019), https://www.pewtrusts.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored.

estimate at the lower end of the potential range. At the other end of the spectrum, one could consider the effects of preserving these cost management tools on the full spectrum of private insurance plans, including self-insured plans that are exempt from state-level regulations – which would yield
a higher estimate of the effects because more drug spending would be affected.

In all likelihood, however, changes that directly affected only those plans that are fully insured would likely have spillover effects on costs for self-insured plans because: 1) the same insurers are generally involved in managing costs for both types of plans; and 2) doctors tend to follow the same prescribing patterns for all of their patients. Therefore, even if this option was technically limited to fully insured plans, its impact on spending is likely to fall in between the results for that market alone and for the whole private insurance market due to spillover effects. The table below shows the year-by-year effects on spending under that middle scenario – and the estimate for that scenario is shown in the summary table at the beginning of this report.

OPTION 7: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	1.8	1.8	1.9	2.0	2.0	2.1	2.2	2.3	2.4	2.5	**21.1**
Private Premium Savings	7.0	7.3	7.5	7.8	8.2	8.5	8.9	9.3	9.7	10.1	**84.3**
Enrollee OOP Savings	1.1	1.1	1.1	1.2	1.2	1.3	1.3	1.4	1.5	1.5	**12.8**
Combined Savings	8.1	8.4	8.7	9.0	9.4	9.8	10.2	10.7	11.2	11.7	**97.1**

OPTION 8: Preserve Prior Authorization for Medical Services

To help ensure that certain services are medically necessary and are the most appropriate treatment for a given patient, insurance plans may require prior authorization for those services in order for them to be covered. Meeting those requirements typically involves having the patient's doctor submit additional information about their condition and the treatment plan for review by the insurer. Providers and patients sometimes object to these requirements, however, which gives rise to legislative proposals at the state and federal levels to restrict the use of prior authorization as it applies to medical services and benefits.

The available evidence indicates that prior authorization requirements are effective in reducing overall health care expenditures – even after counting the additional administrative costs that insurers bear for implementing them. It follows that placing restrictions on prior authorization would tend to increase health care spending and insurance premiums – and,

conversely, that blocking such restrictions would generate savings. Although the precise form of the proposals involved may vary, this paper seeks to estimate the effects of blocking such restrictions on spending for medical services under private insurance plans. For this option, the analysis was limited to spending on hospital and physician services and did not include effects of prior authorization on spending for prescription drugs (which are addressed by Option 7).

A recent analysis summarizing evidence about the effects of prior authorization found mixed results, but nonetheless highlighted several examples of savings.[36] The most notable findings were as follows:

- A recent report by GAO found that prior authorization requirements had been effective at reducing spending within the Medicare program across a variety of medical services and supplies, including home health care and powered wheelchairs.[37]
- GAO also reported that "there is evidence that [prior authorization] for medical imaging can be effective in reducing utilization and associated health care costs. Multiple studies have found PA policies were associated with reduced use of magnetic resonance imaging, computer-aided tomography scanning, and cardiac imaging."

Large insurers have undertaken many initiatives in this area. In one case, a prior authorization program for chemotherapy regimens reduced spending in Florida by about 20 percent, relative to trends in other areas.[38] In another, a "centers of excellence" program was established for organ transplants to encourage and assist patients in using a select set of high-quality transplant centers – even if the centers were not nearby. As a result of the screening processes used by those centers, an organ transplant was actually found to be inappropriate on medical grounds in about 16 percent of cases.[39]

Overall, it seems reasonable to conclude that prior authorization programs can reduce spending by about 10 to 20 percent for services that account for about 10 to 20 percent of spending on covered services. The midpoint of that range is roughly a 2.5 percent reduction in overall covered spending.

That estimate does not account for the effects of prior authorization requirements on costs to providers – such as costs for having to provide the additional information that is requested. Estimates of those costs vary quite widely, however, and many appear implausibly high. Even if those costs could be reduced, limited competition in many markets for specialty physician care means that reductions in their costs might not translate into reductions in their

[36] Ani Turner, George Miller, and Samantha Clark, "Impacts of Prior Authorization on Health Care Costs and Quality," National Institute for Health Care Reform (November 2019), https://www.nihcr.org/analysis/impacts-of-prior-authorization-on-health-care-costs-and-quality/.
[37] GAO, "CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending" (April 2018), https://www.gao.gov/assets/700/692138.pdf.
[38] Lee N. Newcomer, "Paradox of Prior Authorization: How Do We Get Value?," *Journal of Oncology Practice*, vol. 14, no. 8 (August 2018), https://ascopubs.org/doi/full/10.1200/JOP.18.00279.
[39] See the discussion on page 35 of "Farewell to Fee for Service?," UnitedHealth Group (December 2012), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2012/UNH-Working-Paper-8.pdf. In full disclosure, I was the primary author of that report.

payment rates.

As with the estimates presented above regarding cost management tools for prescription drugs, estimates for this option could be developed for three different scenarios. In the first scenario, the effects would be limited only to fully insured health plans with no spillovers affecting self-insured plans. In the second scenario, all fully insured and self-insured plans would be covered by the proposal, which would imply larger savings because the scope of affected spending would be much larger – roughly twice as large. In a third or middle scenario, the option would
be limited in its application and would formally address only plans that are fully insured – but spillover effects for care of enrollees in self-insured plans would yield a result about halfway between the first and second scenarios. The year-by-year effects of that third scenario are shown in the table below, with federal savings of $67 billion and reductions in private insurance premiums of $268 billion over 10 years.

OPTION 8: Estimated Effects
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings	5.3	5.6	5.9	6.2	6.5	6.8	7.1	7.4	7.8	8.2	**66.9**
Private Premium Savings	21.4	22.6	23.7	24.8	25.9	27.2	28.5	29.8	31.2	32.6	**267.5**
Enrollee OOP Savings	3.2	3.4	3.6	3.8	3.9	4.1	4.3	4.5	4.7	5.0	**40.7**
Combined Savings	24.6	26.0	27.3	28.5	29.9	31.3	32.8	34.3	35.9	37.6	**308.2**

APPENDIX: NOTES ON METHODOLOGY

Because the options examined in this paper constitute an eclectic mix of approaches towards reducing health care costs, a wide variety of sources was used to help estimate their quantitative effects. One key source that proved useful across a range of options is the National Health Expenditure (NHE) projections that the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary develops and releases each year.[40] The baseline projections of spending on federal health programs that the CBO produces, as well as selected CBO cost estimates for legislative proposals, were also useful. Additional sources are noted in the discussion of each option.

In some cases, the impact of an option on federal spending stems from its effects on the Medicare program. More commonly, however, the budgetary effects derive from the impact the option would have on spending and premiums for private insurance plans. The reason those changes have ripple effects on the budget is that employer-sponsored insurance (ESI) and many individually purchased plans receive some form of tax subsidy, so changes in their costs affect federal revenue collections. In the case of plans purchased through the exchanges or marketplaces set up under the Affordable Care Act, those subsidies are explicit.

In the case of ESI, however, the subsidy stems from the fact that wages and salaries are treated as taxable compensation, but health benefits are not. Additionally, economists generally believe that an employer's total compensation for their workers is roughly fixed, so reductions in costs for ESI plans will translate into higher wages and salaries for workers and, thus, higher tax revenue for the government. In effect, those decreases in health care costs reduce the "tax expenditure" that the government makes to subsidize the purchase of ESI. The appropriate tax rate to apply is the combined income and payroll tax rate faced at the margin for a typical worker, which is roughly 25 percent.[41]

Because those federal savings stem from a reduction in private insurance premiums, it would be double-counting to add together the federal savings and the savings on private premiums that are shown in this report. Instead, 25 percent of the effect on private insurance premiums should be subtracted if those figures are combined. A third element of the analysis is the effects of the options on OOP costs for consumers. For enrollees in private health plans, the savings reflect reductions in their cost sharing only. The estimate of those effects was based on a recent study examining spending under private insurance plans, which found that average OOP costs represented about 13 percent of allowed costs.[42] Put another way, the average plan covered about 87 percent of enrollees' medical costs. For Medicare enrollees, the OOP savings

[40] The NHE projections are available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected. Those projections currently extend to 2030. For this project, the relevant figures were projected out to 2033 using the growth rates projected for the end of this decade.

[41] Some observers doubt that savings on health insurance costs for employers will translate into higher wages for workers – but the alternative is that those reductions in costs would increase the firms' profits, which would also be taxable at roughly the same marginal tax rate.

[42] Matthew Rae, Rebecca Copeland, and Cynthia Cox, "Tracking the Rise in Premium Contributions and Cost Sharing for Families with Large Employer Coverage," Peterson-KFF Health System Tracker (August 14, 2019), https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/.

also include reductions in premiums for Part B and Part D (which would not otherwise be reflected in the analysis). For Medicare enrollees with supplemental insurance such as a Medigap plan that covers some or all of their cost sharing, their savings may come in the form of lower premiums rather than lower copayments.

Two additional points are worth mentioning here. First, the analysis reflects an assumption that these options would be enacted relatively quickly and thus would generally be implemented in calendar year 2024. For a few options, however, the effects would phase in more gradually or take some time to materialize (as indicated in the body of the text and the tables that accompany each option). To the extent that those timelines for implementation seem unduly optimistic, the figures presented should be useful as indicators of the opportunities for savings that exist under these options.[43] A second key point of context is that the denominator being used to calculate the effects of each option as a percentage of premiums over 10 years is very large – $15.7 trillion or about $15,700 billion. That large figure reflects the fact that private insurance covers about half of the U.S. population.

Importantly, that figure is the sum of the NHE projections for private insurance payments for hospitals, physician and clinical services, and outpatient prescription drugs, with an additional 10 percent added for the net costs of private insurance plans (to include administrative costs and profits). The figure thus does not include every category of spending that private insurance plans typically cover. If the options would also affect costs for those categories of spending in a proportional way, then the estimates shown here are correct for the impact as a percentage of premiums but may understate the dollar amounts of the savings that would be generated.

[43] Although this report was commissioned by BCBSA, and BCBSA provided guidance on which options to examine, I retained full editorial control over the paper and the underlying analysis.