

# Healthcare Cost Control: Let's Get Real

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The Health Industry Forum  
14 March 2018



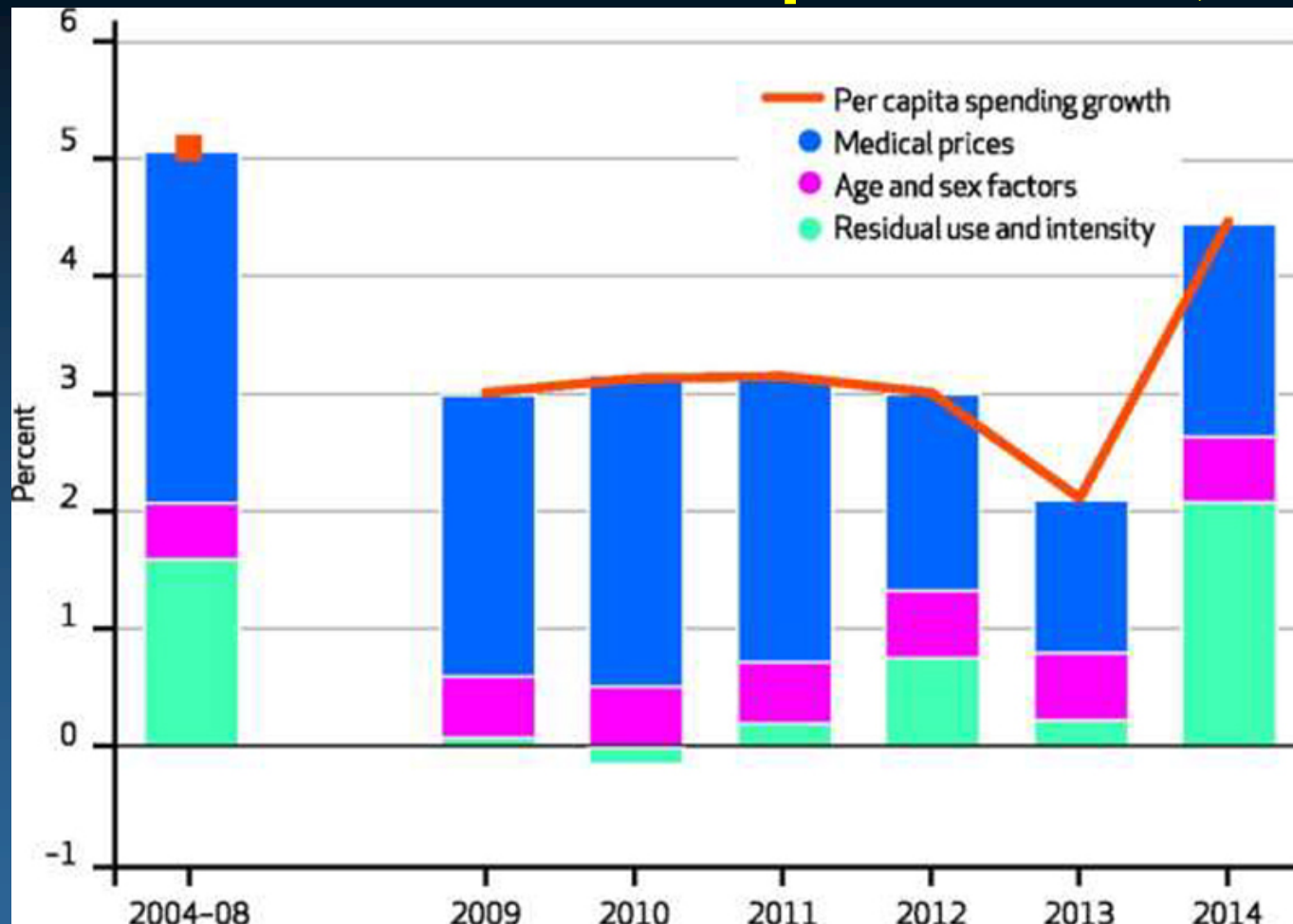
# Prices Are the Major Reason US Spending Exceeds the Rest of the World

- “It's the prices, stupid: why the United States is so different from other countries.” – Anderson et al., *Health Affairs*, 2003
- *Accounting for the Cost of Health Care in the United States* – McKinsey Global Institute, 2008
  - “Input costs – including doctors’ and nurses’ salaries, drugs, and other medical supplies, and the profits of private participants in the system – explain the largest portion of additional spending... [the \$650 billion extra the US spends compared to world norms]”

# Trends in Payment to Cost Ratios

- Aggregate hospital payment-to-cost ratios for private payers increased from about 116% in 2000 to 144% in 2014  
*AHA Annual Survey Data for Chart 4.6, for 2014, AHA Trendwatch Chartbook, 2016*
- Some evidence of a slowdown in price increases in recent years, although some discrepancy in data sources used, i.e., whether Medicare Advantage provider pricing is included
- “Medical Expenditure Panel Survey” data reveal that standardized private insurer payment rates for inpatient hospital services in 2012 were approximately 75 percent greater than Medicare’s – a sharp increase from the differential of approximately 10 percent in the period 1996-2001.” -- Selden et al., *Health Affairs*, Dec. 2015:2147
- CBO (April 2017) found the inpatient rates from 3 major insurers were 189% of Medicare in 2013

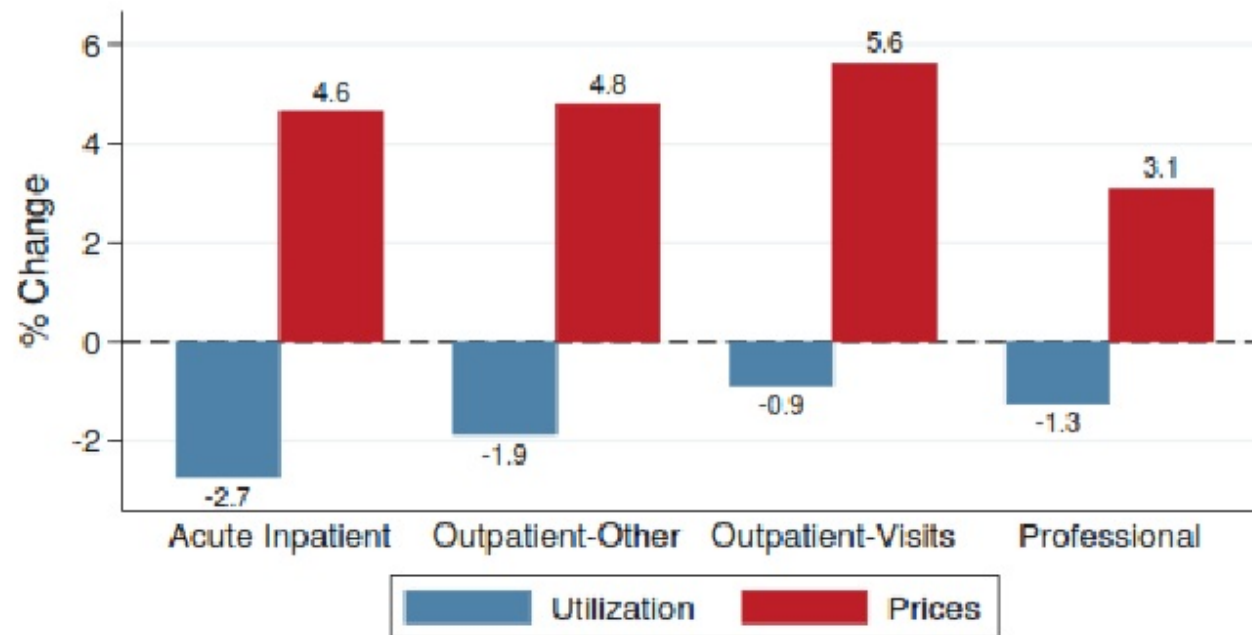
# Factors Accounting for Growth in Per Capita National Health Expenditures, 04-14



Martin AB, Hartman M, Benson J, Catlin A; National Health Expenditure Accounts Team. "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending." *Health Aff (Millwood)*. 2016 Jan; 35(1):150-60

# Changes in Utilization and Prices of Medical Subservice Categories: 2014

**Figure 8**  
**Changes in Utilization and Prices of Medical Subservice Categories: 2014**



Source: HCCL, 2015.  
Notes: All data weighted to reflect the national, younger than 65 ESI population.  
Data from 2013 and 2014 adjusted using actuarial completion.

“2014 Health Care Cost and Utilization Report.” *Health Care Cost Institute, Inc.*, Oct. 2015.  
Available online at: <http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report>

# A Recent Study

- “Factors associated with increases in health care spending, 1996-2013” – Dieleman et al JAMA, 318:1668, Nov 7, 2017
  - after adjustments for price inflation, annual spending on inpt., ambulatory, pharmacy, nursing facility, ED, and dental care increased from \$1.2 trillion to \$2.1 trillion
  - changes in service price and intensity were associated with a 50% spending increase, whereas changes in service use were not associated with any change (N.B. some would put some part of intensity as service use)
  - US population size and aging responsible for 23.1% and 11.6% of the increase, respectively
  - ED -- 6.4% and retail pharmaceutical – 5.6%
  - changes in disease prevalence and incidence – (2.4%)

# The Price Variations Are Huge – Far Exceeding Variations in Service Use

- Across 8 markets, from surveys, average inpatient rates ranged from 147% of Medicare in Miami to 210% in SF but ranged up to 500% for inpatient and 700% for outpatient care
- Within market variations were marked also – hospitals at the 25<sup>th</sup> percentile in LA County received 84% of Medicare payment levels while the 75<sup>th</sup> percentile got 184%

Ginsburg. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." *Center for Studying Health System Change Research Brief No. 16*, 2010.

- From review of paid claims in 13 markets, the average highest priced hospital was paid 60% more than the lowest priced for inpatient services and >100% more for outpatient

White, Bond, and Reschovsky. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." *Center for Studying Health System Change Research Brief no. 27*, 2013.

- In contrast, the 10<sup>th</sup> to 90<sup>th</sup> percentile variation in service use is 30%

# “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured”

Using HCCI data based supplied by Aetna, Humana, and UnitedHealth (27.6% of those with ESI), Cooper et al (Dec 2015) found:

- Per capita spending varies by a factor of 3 across 306 Hospital Referral Areas, with very weak correlation to Medicare per capita spending
- Variation in providers’ transaction prices is the primary driver of spending variation for privately insured
- Large dispersion of inpatient prices and for 7 homogeneous procedures, e.g., hospital prices for lower-limb MRI vary by a factor of 12 across US and on average two-fold within HRRs
- Hospital prices in “monopoly” markets are 15.3% higher than in markets with 4 or more hospitals



# Haves and Have-Nots

- While hospitals receive 175% of Medicare on average, anecdotally, it seems clear that many “haves” obtain >250% of Medicare, and as high as 500-600%
- But other hospitals accept below Medicare rates, because they have few commercially insured patients and are rarely if ever “must haves” in commercial insurance networks
- While commercial insurance physician fees are 125-140% of Medicare overall, anecdotally, in Miami, Las Vegas, and many other places, small practice physicians are “price takers,” accepting as low as 60-70% of Medicare fee schedule rates, while in other places physician groups get as much as 900% of Medicare

# The RWJF Synthesis Project

*The Impact of Hospital Consolidation— Update, June 2012*

## Summary of key findings:

1. Hospital consolidation generally results in higher prices (with new evidence since 2012 confirming these findings)
2. Hospital *competition* improves quality of care
3. Physician-hospital consolidation has not led to either improved quality or reduced costs
4. Consolidation without integration does not improve performance
5. Consolidation between physicians and hospitals is fast increasing (although for various reasons, including to take advantage of FFS payment rules, not only to form ACOs able to receive population-based payments)

# The Competitive Market Solution: Too Little, Too Late

- More active antitrust enforcement
- Transparency
- Repeal CON (where not already)
- Liberalize professional practice acts
- Payment reform
- Above all, promote narrow networks in health plan product design

# The Limits of Antitrust

- Many local markets can't readily support competition among major health care providers
- There are often justifiable, practical reasons for consolidations to take place, and some may improve quality and efficiency in particular situations -- but they can then lead to market power
- The horse is out of the barn, after two eras of hospital merger “mania” and “frenzy” – 1996-2000 and 2011- present, during which antitrust policy has been mostly a passive observer
  - There are not many competitive hospital markets left

“While the antitrust agencies’ efforts to promote and protect competition in health care markets is commendable, it is also the case that the antitrust law has little to say about monopolies legally acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in hospital markets and a growing number of physician specialty markets, it is particularly important to support other measures that promote competition.”

-- Professor Thomas (Tim) Greaney, Testimony to the Committee of the Judiciary, House of Representatives, May 18, 2012

Greaney’s views have evolved – he now includes regulatory approaches in his review of potential approaches – see his *Health Affairs* article, Sept 2017

# Antitrust Can't (or Won't) Address Two Current Pervasive M&A Phenomena

- Cross-market horizontal, hospital mergers
  - Until recently, not even a theory about how it raises prices
  - “We find that hospitals gaining system members in-state (but not in the same geographic market) experience price increases of 7-10 percent relative to control hospitals”  
whereas no price effect from out-of-state consolidations  
*Dafny et al. The Price Effects of Cross-Market Hospital Mergers, NBER, June 2017*
- Vertical integration of hospitals and physicians
  - Antitrust economists find that V.I. in general across the economy can be competition-enhancing
  - Yet, recently a number of studies have demonstrated that V.I. raises both hospital and physician prices, with no demonstrated efficiency gains -- *Casalino HA, Aug 2017*

# Narrow Networks

- A classic example of “making a virtue of necessity”
  - It is often the only tool insurers have to limit provider demands for price increases and works where there is, at least, some provider competition remaining
- The problems with narrow networks –
  - Obtaining price concessions is the reason insurers adopt narrow networks (see recent *Health Affairs* blog by CPR)
  - Limits both consumer choices and clinician referral options artificially – providers, such as health care systems, are not uniformly high or low value
  - Leads to “surprise medical bills” for out-of-network services, which then requires regulation
  - Network adequacy requirements may be counter-productive, but are still necessary

# A Proposition: Regulating Prices Actually Facilitates Competition and Choice

- While directly addressing market power that produce high and varied prices
- Might promote new health plan entrants because it should support ability to develop provider networks
- Would focus competition over quality and service, rather than which insurer gets the decisive advantage of the best rates
  - Exhibit A – Medicare Advantage, which only works because of the prohibition on billing beneficiaries more than Traditional Medicare's allowed charges
  - Exhibit B – 35 years of experience in Maryland



# Administered Pricing Opportunities Short of All-payer Rate or Budget Setting

- Placing price ceilings on out-of-network billing as a percentage above Medicare (not only protects consumers directly, but also changes negotiating dynamics?)
- Price ceilings on rates that result from market negotiations
- Price ceilings on “monopoly” services, where strong volume-outcome relationship (Glied and Altman, *HA* Sept 2017)
- Expand state oversight of provider pricing behavior
  - examples, certificates of public advantage, consent decrees related to M&As
- Restrictions on terms and conditions in plan-provider contracts, e.g., most-favored nations clauses, all-or-nothing contracting, limiting tiered-network products

THANK YOU