How Much Can We Rely on Market Forces to Lower Healthcare Spending?

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Healthcare Cost Control: What Is The Path Forward?

Outline

- Define the problem
- Describe potential solutions
- Assess the solutions

Is cost control the objective?

- Almost every health economist would say “No.”

- The problem is not that we spend too much, per se, but that we don’t get a dollar’s worth of value for every dollar we spend.
  - Cutler, David M. “What Is The US Health Spending Problem?” *Health Affairs* 37:3 (2018): 493–497

- They’re almost right.

The real problem

The real problem is pervasive and systemic inefficiency (high fees, overuse, underuse, and misuse) caused by perverse incentives, and resulting in problems of affordability, patient safety, and fairness.

Anderson, Gerard F., Reinhardt, Uwe E., Hussey, Peter S. and Varduhi Petrosyan. **"It's The Prices, Stupid: Why the United States Is So Different from Other Countries,"** *Health Affairs* 22:3 (May/June 2003) 89-103.

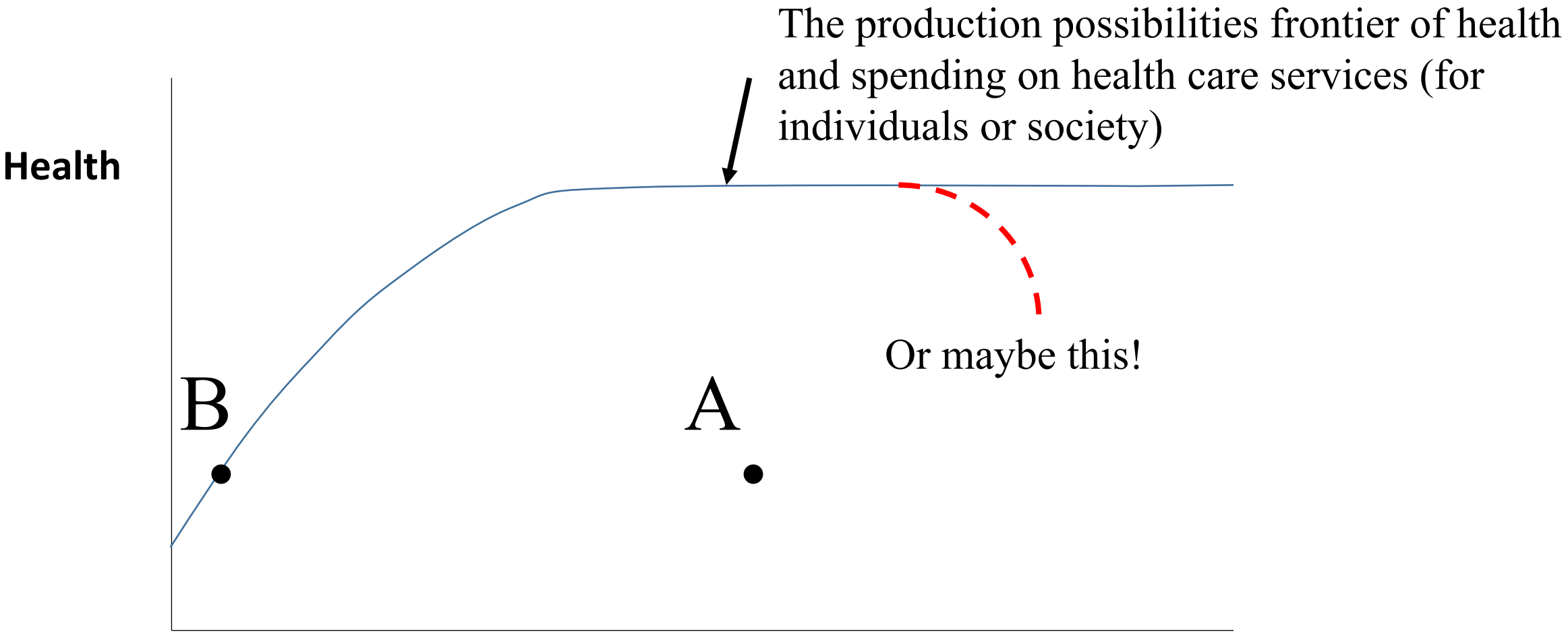
Berwick, Donald M. and Andrew D. Hackbarth. **"Eliminating Waste in US Health Care,"** *Journal of the American Medical Association.* 307:14 (April 11, 2012) 1513-1516.

Young, Richard A. and Jennifer E. DeVo. **"Who Will Have Health Insurance in the Future? An Updated Projection,"** *Annals of Family Medicine* 10:2 (March/April 2012) 156-162.

Makary, Martin A. and Michael Daniel. "**Medical error—the third leading cause of death in the US**," *British Medical Journal* (May 2016) 353.

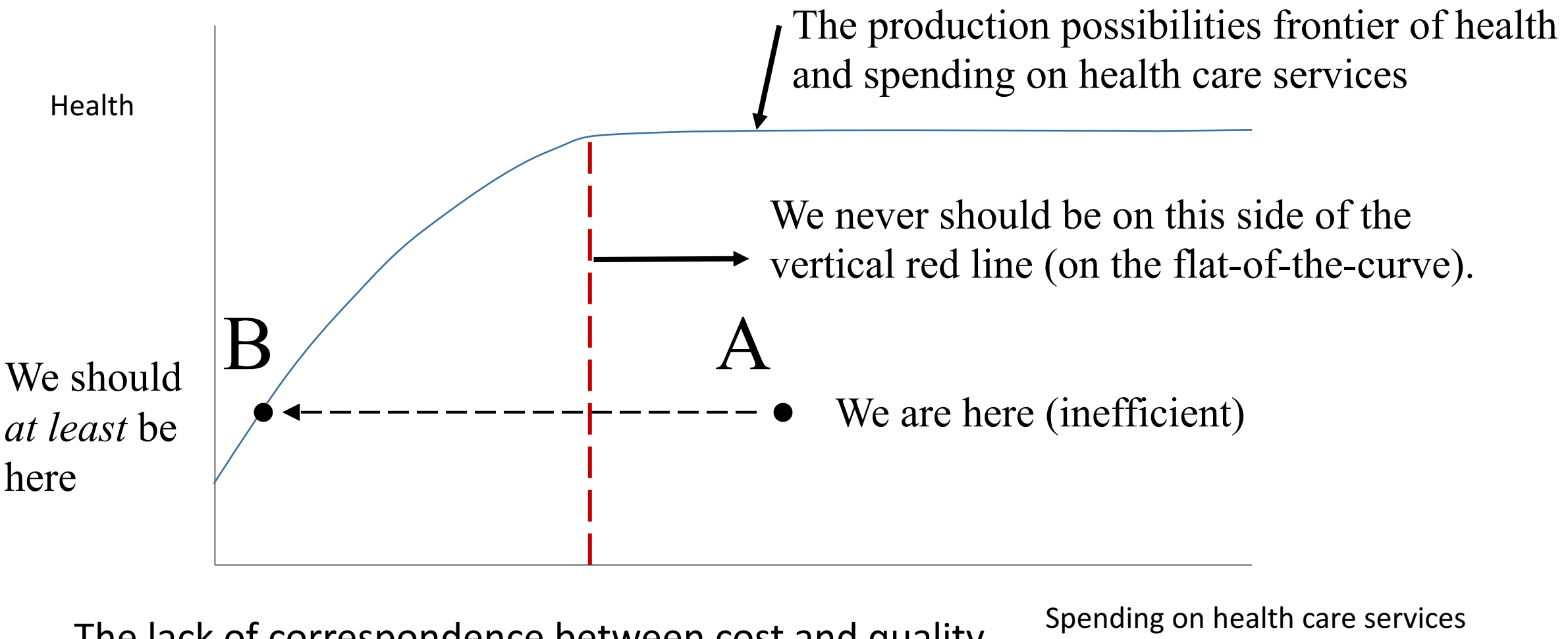
https://www.propublica.org/series/wasted-medicine

Health Care Reform in Several Easy Diagrams



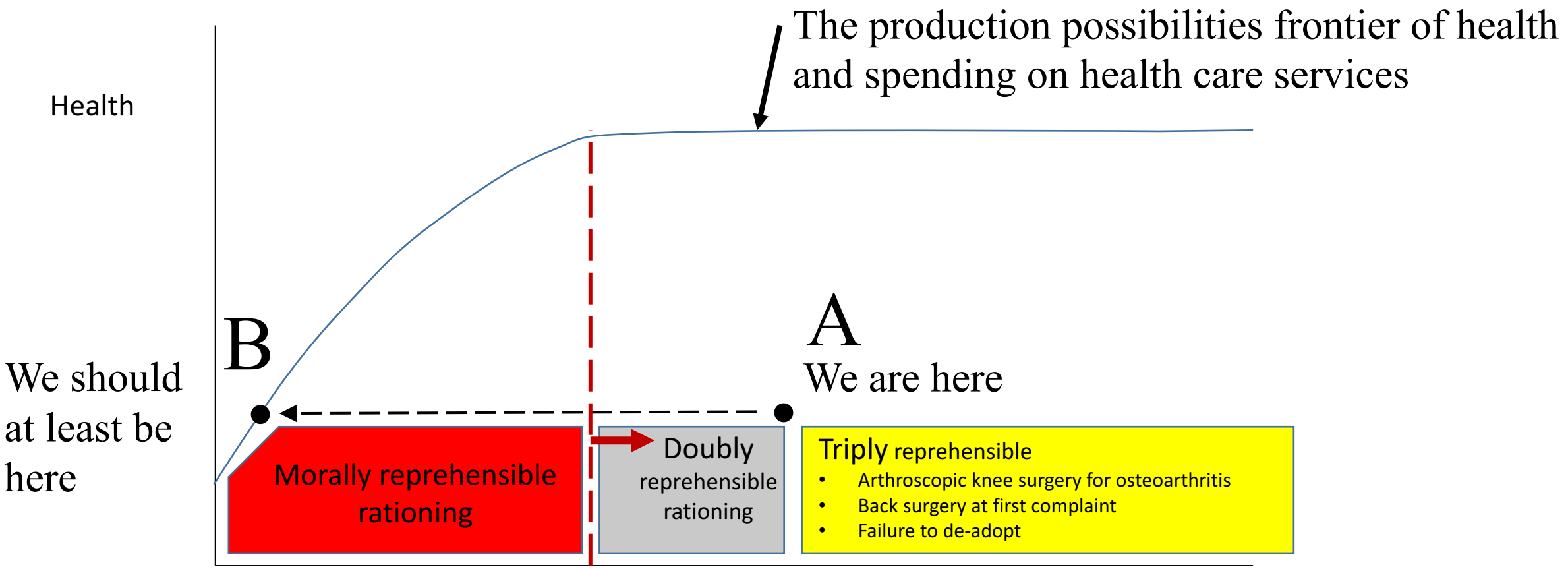
Combines unit prices and quantities of services.

Our present condition



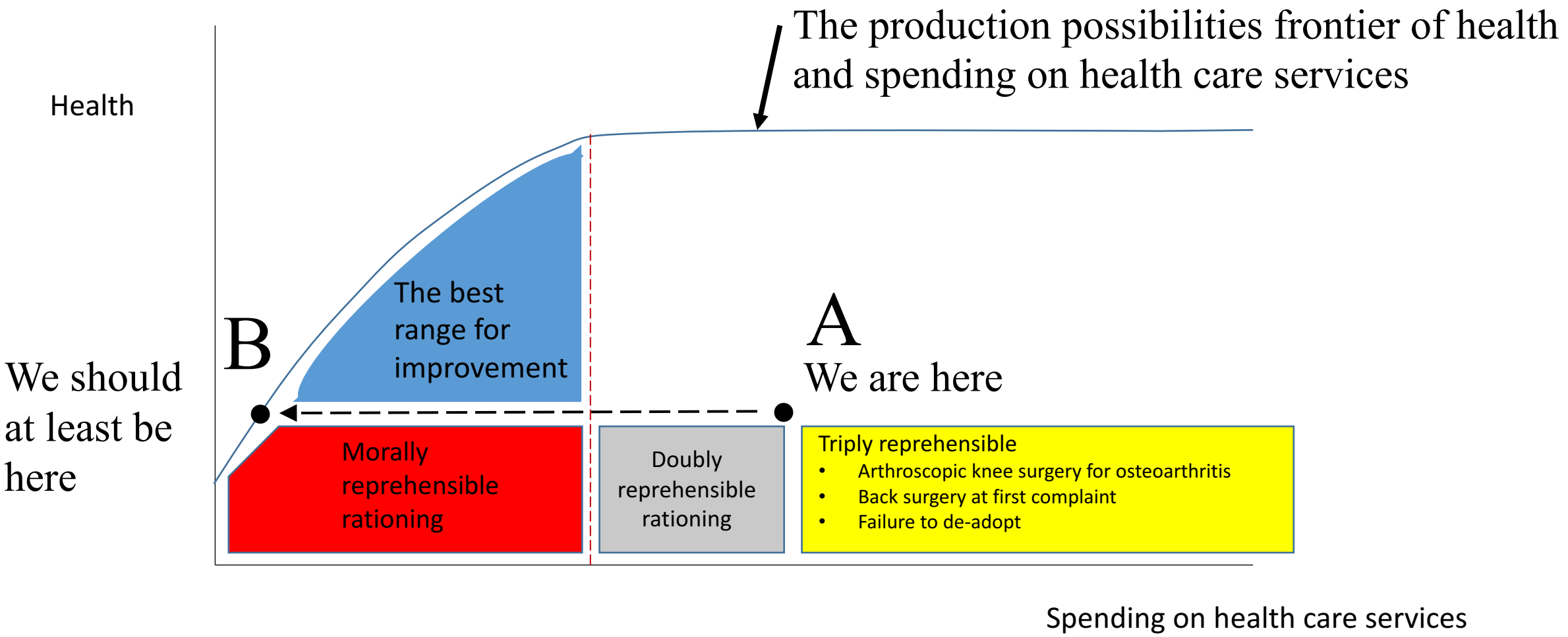
The lack of correspondence between cost and quality suggests that we are not on the frontier.

Questions we shouldn't be asking

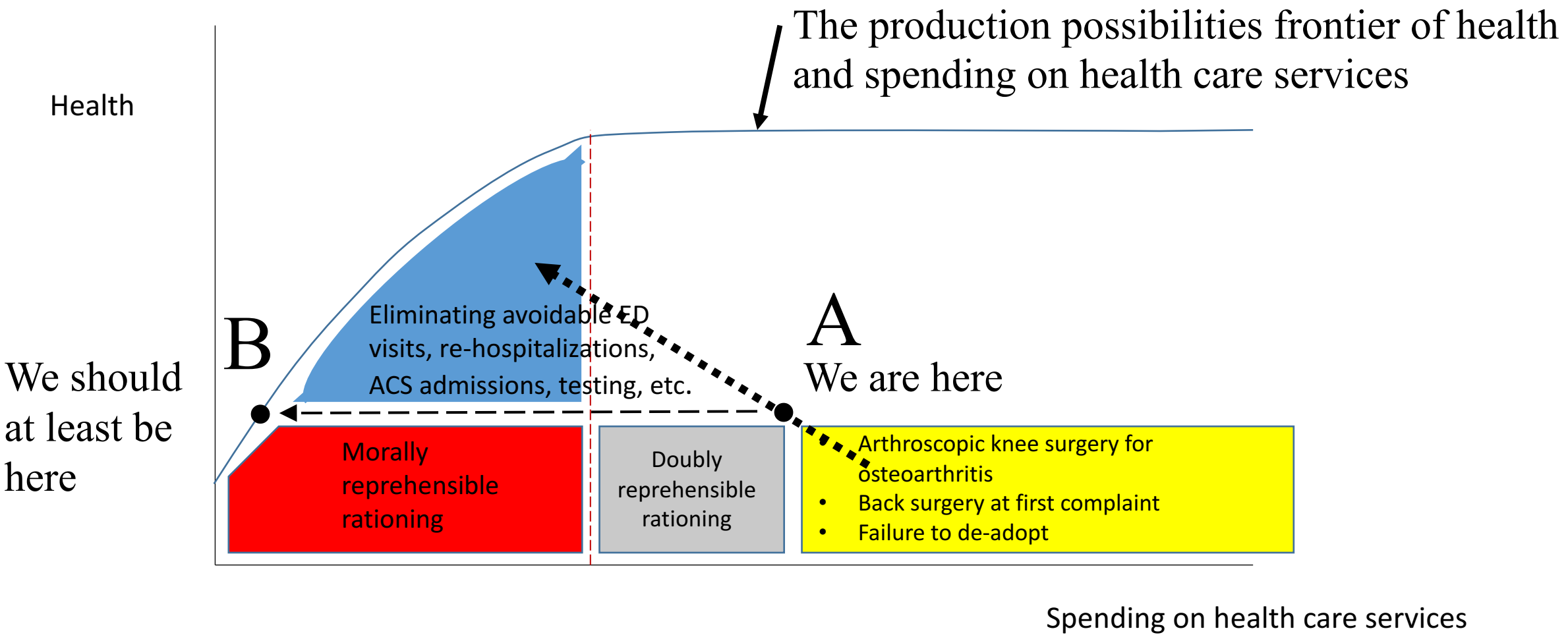


So if you're so smart …

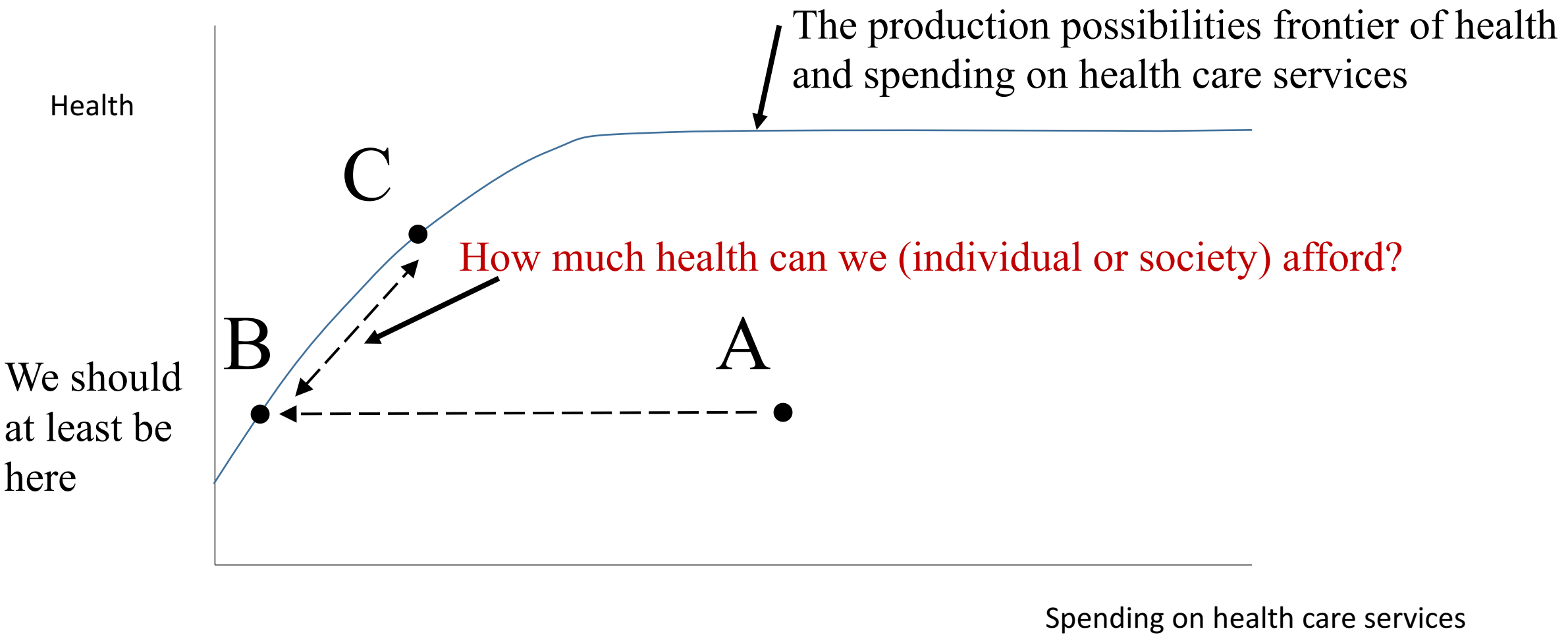
The best range for improvement



The low-hanging fruit



The difficult and unavoidable question



What accounts for persistent inefficiency? Two types of market failure

- Intrinsic market failure: Inherent in the nature of the commodity. Not applicable to health insurance or health care services.
  - Pure public goods → Public provision or financing
    - Non-exclusion
    - Non-rival consumption
  - Decreasing marginal cost → Monopolies regulated as public utilities.
- Remediable: Can be corrected if expected benefits are greater than the expected cost.
  - Externalities
  - Restricted entry
  - **Poor information**
  - **Distorted prices**

Poor information

- The terms of insurance coverage;
- The value of specific medical tests and treatments
- The unit prices (fees) of services
- The return on investment in practice improvements.
- **The physician's style of practice:**
  - **Does the physician adhere to "step therapy?"**
  - **Are they available on nights and weekends or are you referred to the ED?**
  - **What is the primary care physician's rate of avoidable ED visits; ACS admissions; potentially preventable re-hospitalizations; unnecessary tests?**

Distorted prices

- Price-reduction insurance itself.
- Massive premium subsidies for the non-poor in both private and public health insurance.
- Inadequate consumer incentives to adopt healthy behaviors.
- **Identical consumer out-of-pocket exposure regardless of the provider's efficiency.** We refer to this as "non-discriminatory" coverage, where "discriminatory" is a good thing.

Two types of reform initiatives

- Provider-oriented initiatives (primarily payment reform). Inefficient providers typically lose a portion of their revenue per patient. Results have not been overwhelming.

Burns, Lawton R. and Mark V. Pauly, Transformation of the Health Care Industry: Curb Your Enthusiasm?, *Milbank Quarterly* 96:1, (2018) 57-109.

- Consumer-oriented initiatives that give consumers both the *information* and an *incentive* to choose more efficient providers. Inefficient providers lose **all** the revenue associated with the patient.

Examples of provider and consumer initiatives
(None of these are bad ideas)

1. Provider-oriented initiatives
   - Salaried or capitated providers
   - Shared savings program
   - Accountable Care Organizations
   - Pay for performance
   - Bundled payments
   - Comparative performance data for providers
   - Denied payment, e.g., avoidable re-hospitalizations and “never” events
2. Consumer-oriented initiatives
   - Premium competition
   - CDHPs and HDHPs
   - Coinsurance rather than copayments
   - PPOs and narrow networks
   - Pay to shop (New Hampshire, Vermont, Kentucky)
   - **Reference pricing** (for a single procedure, e.g., knee surgery)
   - **Tiered cost-sharing** (drugs, hospitals, physicians, etc.)

The Big “If”

We think that consumer-oriented incentives are more likely to elicit a serious efficiency-seeking response from providers, but...

Poor information and distorted prices must be addressed simultaneously

- Initiatives to provide consumers with better information on price and quality but no incentive to act on it have produced disappointing results.
- High deductible (CDHP) plans and coinsurance (rather than copayments), give the consumer an incentive to seek more efficient providers, but no helpful information.
- There is accumulating and encouraging evidence on initiatives that combine better information with incentives to choose more efficient providers: **Reference pricing and tiered cost-sharing.**

Whaley, Christopher, Brown, Timothy, and James Robinson. "Consumer Responses to Price Transparency Alone Versus Price Transparency Combined with Reference Pricing," (January 2018) forthcoming in the *American Journal of Health Economics*.

Reference pricing

- As implemented by CalPERS for orthopedic surgery. Providers are ranked by their prices for a bundle of services and the health plan's payment is set at one of the lower prices. Financial incentives can be draconian.

Whaley, James C., Guo, Chaoran, and Timothy T. Brown. "The moral hazard effects of consumer responses to targeted cost-sharing," *Journal of Health Economics* (available online October 2017).

Robinson, James C., Whaley, Christopher M., and Timothy T. Brown. "Reference Pricing, Consumer Cost-Sharing, and Insurer Spending for Advanced Imaging Tests," *Medical Care* 54:12 (December, 2016) 1050-1055.

Robinson, James C., Whaley, Christopher M., and Timothy T. Brown. "Association of Reference Pricing with Drug Selection and Spending," *New England Journal of Medicine* 377 (August 17, 2017) 658-665.

Tiered cost-sharing

Consumer cost-sharing varies as a function of provider efficiency. Some recent studies are promising. But what should be tiered? A drug? The provider of a specific procedure? The hospital? The primary care clinic?

Prager, Elena. "Tiered Hospital Networks, Health Care Demand, and Prices," mimeo, University of Pennsylvania (December 15, 2015).

Anna D. "How Do Quality Information and Cost Affect Patient Choice of Provider in a Tiered Network Setting? Results from a Survey," *Health Services Research* 46:2 (April, 2011) 427-455.

Sinaiko, Anna D. and Meredith B. Rosenthal. "The Impact of Tiered Physician Networks on Patient Choices," *Health Services Research* 49:4 (2014) 1348-1363.

The right level and time for shopping

- Obviously not when your unconscious in the back of the ambulance. (Let's try to have an adult conversation.)
- Procedures with a reasonable lead time (reference pricing).
- Therapeutically substitutable drugs (a longstanding system).
- But the best level for *comprehensive* tiering might be a clinic or care system, and the best time might be during an annual open enrollment period, although under tiered cost-sharing, mid-year changes are feasible with adequate risk adjustment.

Who will take the lead?

- It's unrealistic to ask providers to work against their best economic interests. And elimination of waste is not in their best economic interest under the current set of incentives.
- Private health plans, like all manufacturers, have to balance the demands of their customers (enrollees), who want low prices and high quality against the demands of their suppliers (providers) who want high input prices and minimal oversight. Without consumer demand to back them up, health plans' leverage may be limited.
- Public health plans are constrained politically. (See IPAB.)

Who will take the lead?

- That leaves employers and employees in the commercial insurance sector.

- But in 2017, among firms with 50 or more employees, only 12 percent featured a high-performance or tiered provider network in their most popular health plan (about the same percentage as in 2016).

Kaiser Family Foundation and the Health Research and Educational Trust. Employer Health Benefits: 2017 Annual Survey. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017

What are the steps?

1. Educate employers and employees about the natural variation in provider prices and quality and the general lack of correspondence between the two.

Star and Tribune – January 3, 2018

That surgery will cost you $6,200. Or maybe $47,000

First study of its kind shows wide range in prices for Minnesotans.
By Glenn Howatt

Minnesota insurers paid as much as $47,000 for a patient's total knee replacement and as little as $6,200 — a nearly eight-fold price difference, according to a study released Wednesday by the Minnesota Department of Health. The wide range was also seen for hip replacements, vaginal baby deliveries and C-section deliveries.

What are the steps?

2. Decide how to incorporate quality information. Should you just give the information to employees or incorporate quality data into the incentives?

3. Then ask, “Why should an employee who is willing to patronize a low cost provider subsidize an employee who prefers a high cost provider?” That opens the door for a discussion of reference pricing and tiered cost-sharing.

But you have to make it easy

- Employers typically have neither the expertise nor the dedicated resources to reform the US health care system.
- That suggests the need for an organization that will create an option to which employers and employees can transition with minimum disruption.
- History suggests that the organization should incorporate existing health plans, rather than compete against them.
  - Christianson, Jon and Roger Feldman. "Exporting the Buyers Health Care Action Group Purchasing Model: Lessons from Other Communities," *Milbank Quarterly* 83:1 (2005) 149-176.
- But the health plan's job might become easier under reference pricing or tiered cost-sharing. (No need to negotiate prices?)

The organization must…

1. Collect data on provider price and quality. Some communities are ahead of the curve.
2. Risk-adjust the data. Providers should be held responsible only for the components of cost and quality over which they have control. This is trickier than it sounds.

Einav, Liran, Finkelstein, Amy, Kluender, Raymond, and Paul Schrimpf. "Beyond Statistics : The Economic Content of Risk Scores," *NBER Working Paper* (2015).

3. Categorize providers by price and quality.
4. Establish the types and levels of incentives. This step requires some theoretical work. "What precisely is the goal of health insurance benefit designs?" (Next slide)
5. Arrange negotiation of provider contracts and claims payment.

What is the goal of benefit design?

- The traditional goal has been to balance moral hazard against risk protection.
- An additional goal might be to remove the price distortion associated with non-discriminatory insurance, i.e., consumers facing the same marginal out-of-pocket cost regardless of provider efficiency.
- Who should bear the marginal cost of less efficient providers? If providers are differentiated solely by point-of-purchase out-of-pocket cost sharing, then the marginal cost of less efficient providers will be borne entirely by members who use services.
- Should there also be a premium differential so that part of the cost differential is borne by individuals who choose less efficient primary care providers, for example, but don't happen to use any services?

So How Much Can We Rely on Market Forces to Lower Healthcare Spending?

- Answer: "As much as we want."
- … which currently seems to be "Not very much."
- At every point where cost might matter to consumers, we have taken steps to ensure it doesn't.
- But at some point the bill comes due:
  - For the uninsured and commercially insured it takes the form of increasing premiums and decreasing coverage with no information to avoid higher cost.
  - For Medicare, our bills will be presented to our children and grandchildren.
  - For Medicaid, the (primarily long-term care) bill will come due for states (who are subject to a balanced budget constraint).

The Bottom Line

If market forces don't produce efficient health care spending it won't be because they <u>can't</u>, but because <u>we don't want them to</u>.

"What distinguishes CCHP from the others is that it seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choices."

Entoven, Alain. "Consumer Choice Health Plan: Second of Two Parts) *NEJM* (1978)

"Waste always makes me angry."
Rhett Butler to Scarlett O'Hara in "Gone With The Wind."

"Our point is that systems of people ultimately tend to perform the way they are structured and rewarded to perform. This tendency is likely whether the people involved are well- or ill-intentioned. Poor structure tends to beget poor incentives, and poor incentives tend to beget poor performance. Incentives are quite as important in the public sector as in the private sector. If we desire improved performance of any major societal system, we must improve its structure and incentives."

McClure, Walter. "Structure and Incentive Problems in Economic Regulation of Medical Care," *Milbank Quarterly* (1981)

It’s not the prices, stupid

- It’s remediable (but not addressed) market failure leading to perverse incentives that foster inefficiency and result in problems with access, safety and fairness.

Market Failure → Perverse incentives → Inefficiency → Poor access
Patient Harm
Unfairness