Containing Health Care Costs: Market Forces and Regulation

Paul B. Ginsburg, Ph.D.
Center for Studying Health System Change and National Institute for Health Care Reform
Presentation to 2011 Health Care Cost Trends Hearings, Massachusetts Division of Health Care Finance and Policy, June 30, 2011
Some Historical Context

• Decades of debate on markets versus regulation
• Reality of neither having been pursued effectively
  – Employer response to backlash against managed care
  – Experience with Certificate of Need programs
What is Different Now?

- Health spending much larger in relation to income
- Fewer people can afford health insurance without government help
- State and federal health care spending ballooning in relation to revenues
Market Forces and Regulation Heavily Intertwined

- Regulatory frameworks underpin market forces
- Trend in regulation towards greater use of incentives
- Behavioral economics points way for regulation to support markets
  - GIC incentive to reenroll in health plans
Cost Containment Tools with Market/Regulatory Components (1)

- Insurance benefit design
  - Degree of patient cost sharing
  - Incentives to choose lower-cost providers
- Price transparency
Cost Containment Tools with Market/Regulatory Components (2)

- Provider payment reform
  - Deemphasize use of fee for service
- Level of provider prices
- Insurance premiums or MLRs
Needed to engage consumers in cost containment
  – Cost sharing leads to lower spending
  – Trend toward increased cost sharing in private coverage
    • But not in Medicare
Insurance Benefit Design: Patient Cost Sharing (2)

- Regulation has limited the degree of cost sharing
  - Tax treatment of employer-based health insurance
  - Premiums subsidized but not patient cost sharing
  - State mandates on services to cover
Health reform requires increased government role in benefit design

- Define insurance products to subsidize and/or mandate
- Federal government grapples with “essential benefits”
- Budget constraints will lead to more conservative decisions on benefits
Insurance Benefit Design: Provider Choice (1)

• Limited potential of high-deductible plans to influence provider choice
  – But choice incentives can be added
Insurance Benefit Design: Provider Choice (2)

• Key designs: tiered networks and narrow networks
  – Prediction that tiered designs will be more important
    • Experience with drug benefit designs
  – Recent increase in take up of these tools
    • Leadership of GIC
    • Increased interest of small employers
Insurance Benefit Design: Provider Choice (3)

• Designs will become more powerful
  – Better assessments on relative costliness of different providers
  – Better data on quality
    • Increased consumer willingness to choose lower-cost providers
  – Value of developing Medicare tools for private payers
Insurance Benefit Design: Provider Choice (4)

• Designs and market forces
  – Savings from shifts in providers
  – Savings from response by higher-priced providers
    • Potentially much larger

• Barriers to tiered networks
  – Some hospitals have refused to contract
  – Little choice in some areas
Insurance Benefit Design: Provider Choice (5)

- Government action to support tiered designs
  - Prohibition of some contracting practices
  - But regulation of network adequacy can undermine plan leverage
    - California example
  - Advise against regulating analytic techniques
Price Transparency Initiatives (1)

• Need to focus on what consumers/patients pay
  – Irrelevant price information has downsides
  – Can spur higher prices in concentrated markets
  – Can lead to frustration
Price Transparency Initiatives (2)

• For insured services: it’s the benefit structure that matters
  – Example of three tiers of deductibles
  – Actionable price information the role of insurers
  – Exception is coinsurance
    • But tiered approaches more powerful
• Transparency of prices--even when not paid by patients--valuable for policymaking
Provider Payment Reform (1)

- Broad consensus on potential for gains in quality and efficiency
  - But little “on the shelf” to replace fee for service
  - Beginning of period of development and experimentation
Provider Payment Reform (2)

• Innovative private insurer contracting
  – Blending capitation and fee for service
    • Alternative quality contract
    • ACOs
  – Bundled payments around hospital episode
Provider Payment Reform (3)

- ACA authorizes and funds many Medicare initiatives
- Medicaid programs lead in medical home initiatives
- Many of these innovations compatible with each other
  - Medical homes and episode bundles can underlie an ACO
Coordination among Payers (1)

• Challenge to providers when payers not coordinated

• Improved efficiency per episode or per capita can lead to losses under FFS

• Potential for coordination to speed transition
  – Higher motivation for providers
  – More protection for providers
Coordination among Payers (2)

• Question of timing
  – When is it time to come together on payment methods?
  – Can there be room for further innovation?
• Massachusetts’ pioneering thinking on this
Provider Rate Setting

• Experience of 1970s: Varying degrees of accomplishment on cost containment

• Reasons for abandonment in late 1980s and 1990s
  – Medicare prospective payment
  – Managed care and selective contracting
  – Poor relationships with hospitals
  – Political culture became more hostile to regulation

• Staying power of Maryland system
Rate Setting
Design Issues (1)

• Limited to private payers only?
  – Challenge of including Medicaid and Medicare
    • Transfer of authority
    • Need for grandfathering differential

• Dealing with wide variation in private payer rates
  – Need for careful lengthy transition
Rate Setting Design Issues (2)

- Opportunity to lead payment reform
  - Might require expansion of scope beyond hospitals
  - Maryland ahead of Medicare
- Remaining open to innovative contracting between private payers and providers
  - Maryland and West Virginia appear to have achieved this