NATIONAL INSTITUTE FOR HEALTH CARE REFORM

ADVANCING HEALTH POLICY RESEARCH

Containing Health Care Costs: Market Forces and Regulation

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CENTER *for* STUDYING HEALTH SYSTEM CHANGE

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

Insurance Benefit Design: Patient Cost Sharing (1)

- 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

Insurance Benefit Design: Patient Cost Sharing (3)

- 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