TEENAGE SEX AND U.S. HEALTH CARE

Uwe Reinhardt
Princeton University

National Summit on

Health Care Price, Costs and Quality Transparency

December 3, 2013

II. WHY THE ALLUSION TO TEENAGE SEX?

Paraphrasing Dan Ariely, Professor of Duke University's *Center for Advanced Hindsight*, the following might be said of price transparency in health care:

"Price transparency in health care -- like so many other innovations in health care -- has been like teenage sex:

- **Everybody has been talking about it;**
- **Only a few really know how to do it;**
- **But everyone things everyone else is doing it;**
- **So everyone claims to be doing it."**

It really has been so for a long time in U.S. health care.

Over the decades, there have been thousands of new, new things tried out at various locations:

- Managed competition in the 1970s
- The “Pro-Competitive Strategy” in the 1980-90s,
- Managed care in the 1990s, along with
  - virtual HMOs and
  - PHOs
- Integrated health care
- P4P and P4P
- “Value” this and that
- you name it

I am now working on a new, new management concept for health care called

VALUE VALUING® or V²®

It is bound to be tried somewhere.

Each new, new thing in U.S. health care always has triggered hundreds of exciting conferences with bold visions all over the country (and beyond).

And sometime, somewhere in America the new, new thing really did work.

But nothing ever really scaled up.

For example, paper still rules in U.S. health care.

American physician proudly showing off his new, 21st century, state-of-the-art filing cabinet

In IT, most other nations are still ahead of the U.S.

KIOSK for personal medical record and drug information in Taiwan

So the question before us is this:

WILL THIS TIME BE DIFFERENT?

Will reliable, informative, user friendly price- and quality information really be available at long last to Americans prospective American patients?

REASONS TO THINK WHY IT MIGHT BE:

1. **Health IT has far advanced -- except in some quarters! -- and is relatively cheap and every cell phone is a powerful computer.**

2. **There is a huge body of literature suggesting that higher prices in health care are poorly correlated with quality.**

3. **The dominant decision makers in the U.S. seem to believe that price and quality competition is superior to more regulatory approaches to cost control.**

4. **Like *PacMan*, the health-care sector has been chewing up the budgets of governments and households.**

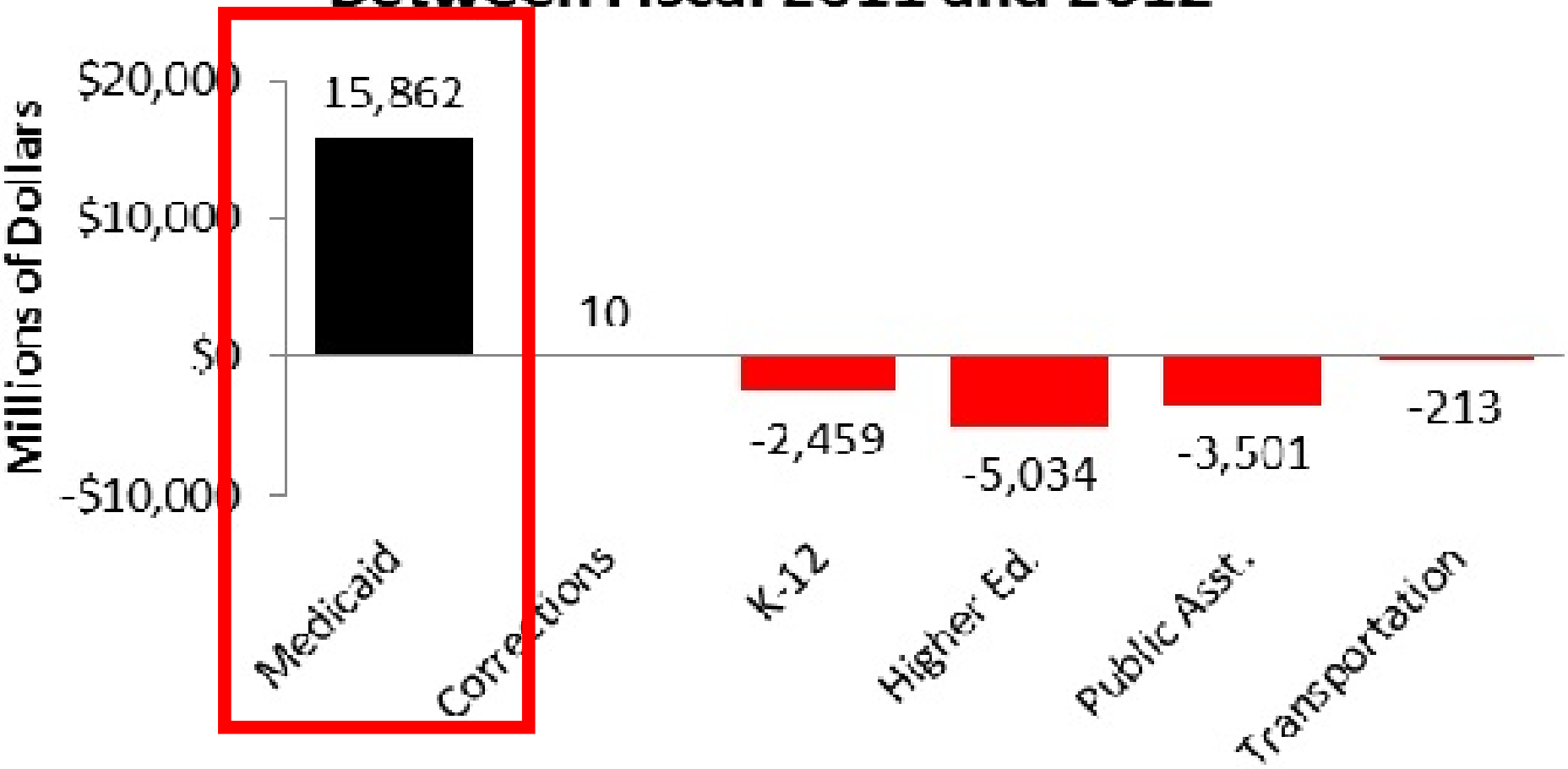
So we are becoming ever more aware of the opportunity costs of the otherwise fine product "health care.":

Net Social Value Added by the Health System = **Gross Value Added by Health Care to Patients** − **The Opportunity Costs of that Care for Society**

Among these opportunity costs are:

- Neglecting the education of our young
- Neglecting basic science and R&D
- Neglecting the nation's public infrastructure
- Neglecting national security and the safety of our warriors
- Giving up other enjoyable things that households enjoy

Changes in State General Fund Spending Between Fiscal 2011 and 2012

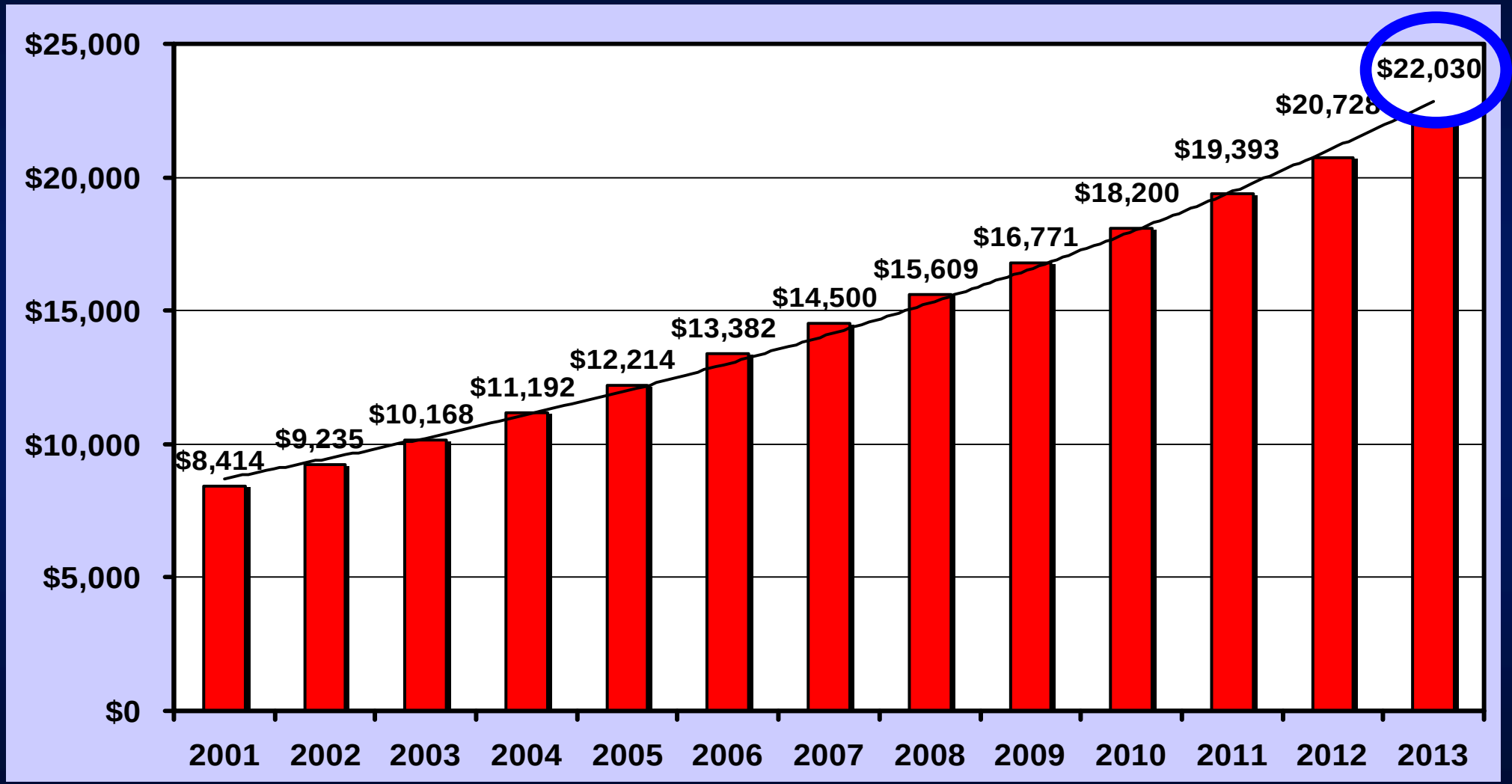


SOURCE:Fiscal 2011 data based on enacted budgets; fiscal 2012 data based on governor's proposed budgets Source: National Association of State Budget Officers, as presented by Dan Crippen, National Governors Association. Cited by Eugene Steuerle, Education *Presidents And Governors: Ain't Gonna Happen*, February 20, 2013.

The benefit consulting firm Milliman annually publishes its Milliman Medical Index which traces the total cost of health care (employer contribution to the premium, employee contribution to the premium and employees' out of pocket spending) for a typical family of 4 under age 65 covered by an employment-based Preferred Provider (PPO) policy.

MILLIMAN MEDICAL INDEX (MMI)

Average Annual Medical Cost for a Typical Family of Four



http://insight.milliman.com/article.php?cntid=8359&utm_source=milliman&utm_medium=web&utm_content=MMI-mktg&utm_campaign=Healthcare&utm_terms=Milliman+Medical+Index

By David I. Auerbach and Arthur L. Kellermann

DOI: 10.1377/hlthaff.2011.0585
HEALTH AFFAIRS 30,
NO. 9 (2011): 1630–1636

A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family

David I. Auerbach (auerbach@rand.org) is a health economist at RAND in Boston, Massachusetts.

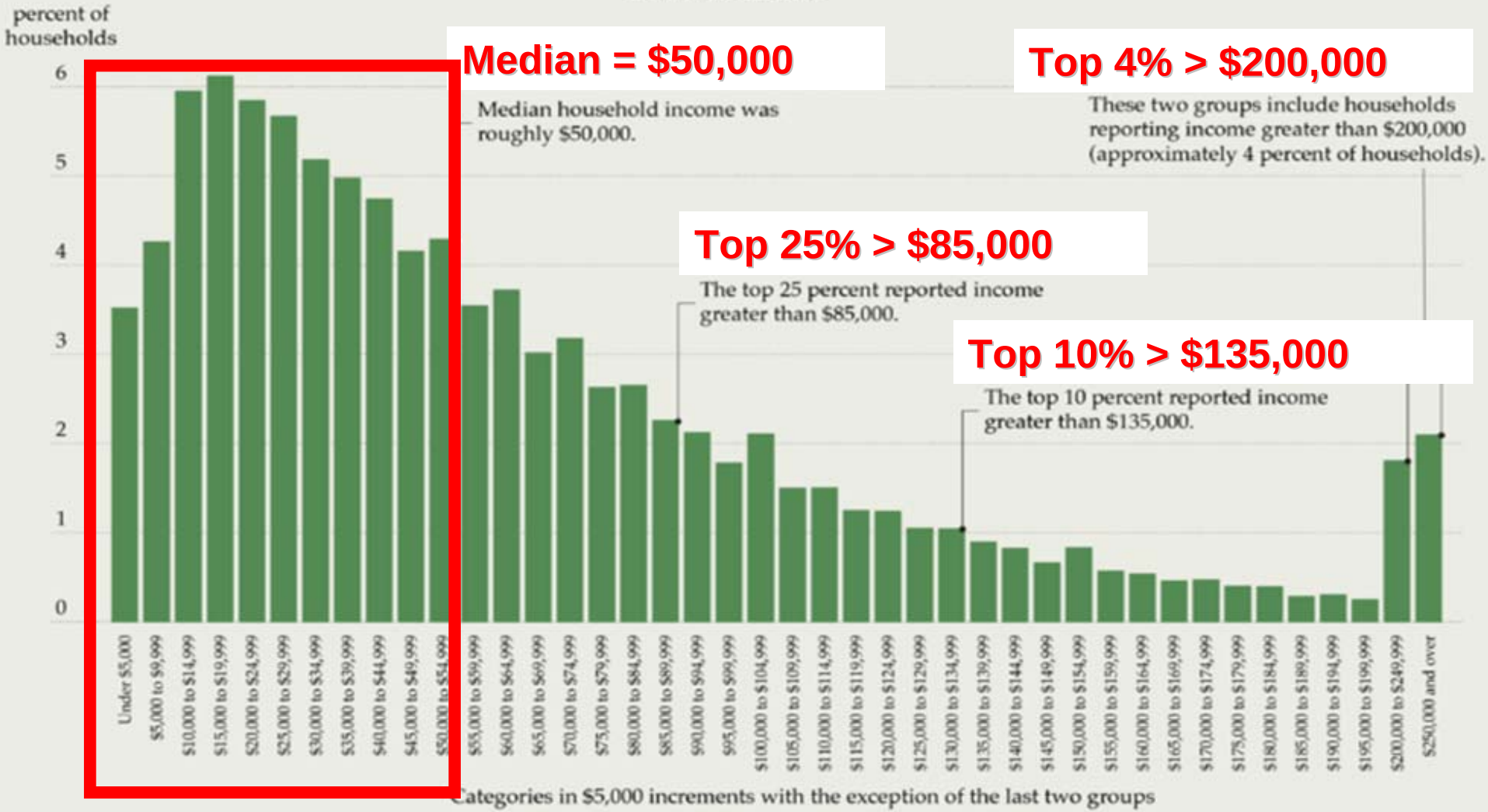
Arthur L. Kellermann is vice president and director of RAND Health, in Santa Monica, California.

ABSTRACT Although a median-income US family of four with employer-based health insurance saw its gross annual income increase from $76,000 in 1999 to $99,000 in 2009 (in current dollars), this gain was largely offset by increased spending to pay for health care. Monthly spending increases occurred in the family's health insurance premiums (from $490 to $1,115), out-of-pocket health spending (from $135 to $235), and taxes devoted to health care (from $345 to $440). After accounting for price increases in other goods and services, the family had $95 more in monthly income to devote to nonhealth spending in 2009 than in 1999. By contrast, had the rate of health care cost growth not exceeded general inflation, the family would have had $545 more per month instead of $95—a difference of nearly $5,400 per year. Even the $95 gain was artificial, because tax collections in 2009 were insufficient to cover actual increases in federal health spending. As a result, we argue, the burdens imposed on all payers by steadily rising health care spending can no longer be ignored.

Now contrast the figure of $22,000 with the distribution of money income (after taxes and transfers) among U.S. families.

Distribution of annual household income in the United States

2010 estimate



Source: U.S. Census Bureau, Current Population Survey, 2011 Annual Social and Economic Supplement

If people should be responsible for the cost of their own health care, how does it work with this kind of income distribution, when health care is that expensive?

II. MUDDLING THROUGH IN U.S. HEALTH CARE

Over the last half century, we have conducted in this country an endless debate on the theme

Government vs. Market

The clever, bi-partisan solution has been to settle on what Stu Altman has called

Half-hearted market vs. half-hearted regulation

So when President Reagan ascended to the White House, he promptly promoted his so-called “pro-competitive” strategy and just as promptly introduced Soviet style pricing in the U.S.

Talk about cognitive dissonance in health policy!

THE AMERICAN

AEI The Online Magazine of the American Enterprise Institute

Confessions of a Price Controller

By Joseph Antos
Saturday, October 30, 2010
Filed under: Economic Policy, Health & Medicine, Lifestyle

The government price controls in America's healthcare system always push prices up. Here's why.

The Wall Street Journal reports that Medicare pays too much for specialist services and too little for primary care—even though doctors themselves decide how the money should be divvied up. That drives up the cost of the program and intensifies the shortage of primary-care doctors needed to care for the 32 million people who will get health coverage over the next few years.

This is neither surprising nor new, at least to me. I oversaw the study that created Medicare's physician payment mechanism during the 1980s; I oversaw the implementation of that mechanism during the early 1990s; I am currently an appointed member of a state commission that sets prices for hospitals—and for those 25 years, I

“Medicare ignores the market, setting prices for physician services based on an academic theory with its roots in the Soviet Union and implemented by the American Medical Association.

Joe Antos goes on to say:

“Those prices do not reflect the value patients receive from their care, and they do not reflect shifts in the demand for particular kinds of services (such as primary care) as the population ages or as more people have health insurance.”

True. The DRGs and RBRVS are cost based schedules, not value based schedules.

So let's have a look at how private markets price on "value."

The Wall Street Journal

Cash Before Chemo: Hospitals Get Tough

Bad Debts Prompt Change in Billing; $45,000 to Come In

By Barbara Martinez Updated April 28, 2008

LAKE JACKSON, Texas -- When Lisa Kelly learned she had leukemia in late 2006, her doctor advised her to seek urgent care at M.D. Anderson Cancer Center in Houston. But the nonprofit hospital refused to accept Mrs. Kelly's limited insurance. It asked for $105,000 in cash before it would admit her.

Is this what we have in mind when we talk about pricing according to “value”?

When people are desperate, they are willing to pay anything for some more hope.

Do Americans want a health-care pricing system that exploits this price-insensitivity?

Now look at the price differentials on the next two slides.

Do these prices reflect a more sensible, value-based pricing policy in the private market, relative to the "dumb price fixing" of Medicare?

Is this efficient, market-driven value pricing?

Table 6.5:

Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)

[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

And how about this one?

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

AHIP
Center for Policy and Research

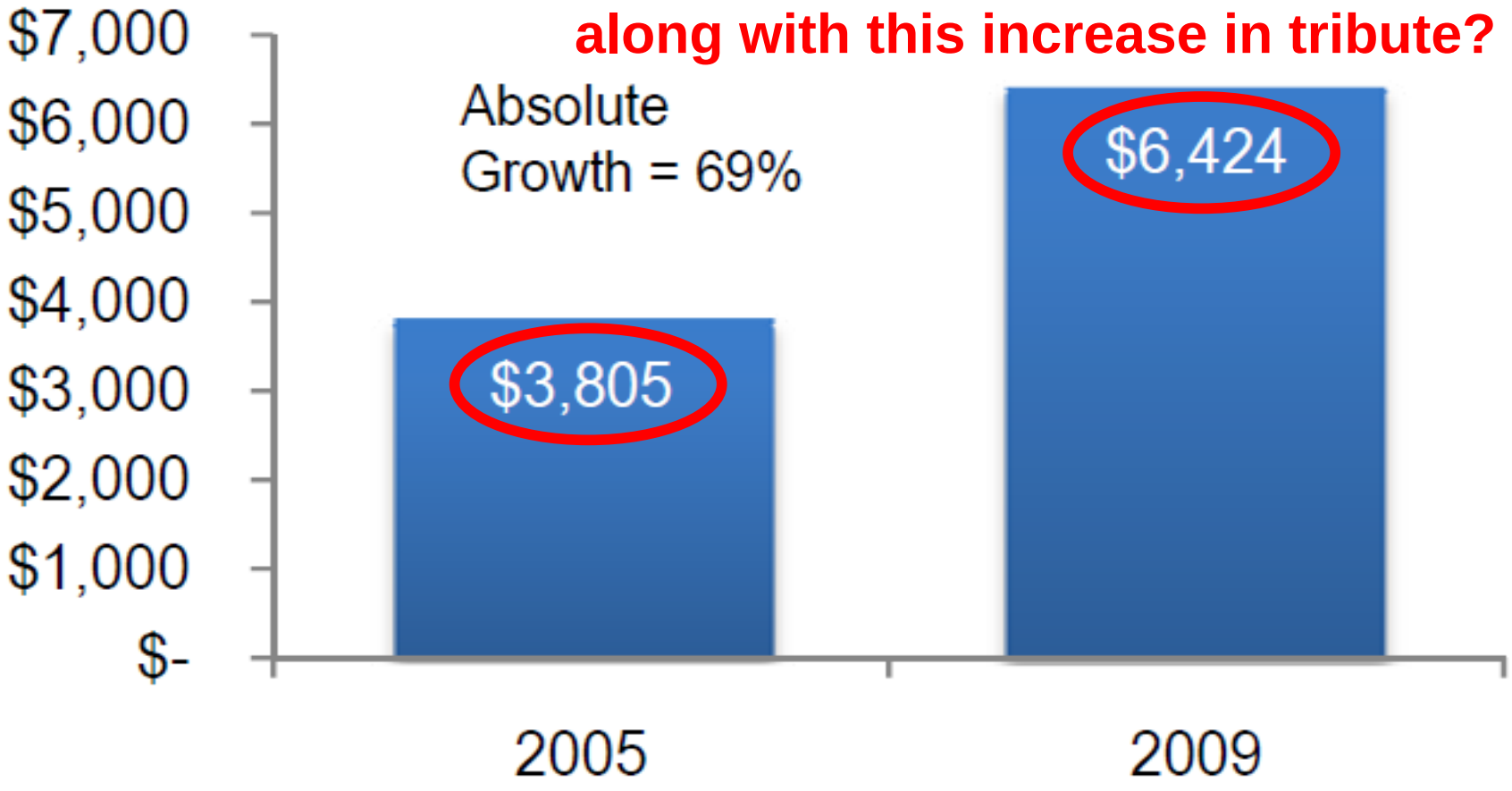
How the value of having a baby on Oregon almost doubled in 4 years.

December 2010

Recent Trends in Hospital Prices in California and Oregon

Figure 2a. Oregon Statewide Average Reimbursement for Normal Vaginal Delivery, 2005-2009

QUESTION: Why did private employers and their agents, health insurers, go along with this increase in tribute?



Frankly, I would much rather be asked to make the case for the Virgin Birth than for the argument that private markets in the U.S. price health care efficiently and on the basis of value to the patient – not even to mention "humanely."

III. PRICE OPACITY IN OUR HEALF-HEARTED MARKET

The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy

An economist's insights into what causes the variation in pricing, and what to do about it.

by Uwe E. Reinhardt

ABSTRACT: Although Americans and foreigners alike tend to think of the U.S. health care system as being a "market-driven" system, the prices actually paid for health care goods and services in that system have remained remarkably opaque. This paper describes how U.S. hospitals now price their services to the various third-party payers and self-paying patients, and how that system would have to be changed to accommodate the increasingly popular concept of "consumer-directed health care." [*Health Affairs* 25, no. 1 (2006): 57–69]

DOI 10.1377/hlthaff.25.1.57

One can understand why the providers of health care have been fond of the price- and quallity opacity that has made life cozy for them and allowed them to lay a huge and ever growing claim on the nation’s GDP.

I blame them not for that attitude; for it is only human.

It is more difficult to understand why employers and their agents – private insurers – have gone along with the gig for so long.

Even more remarkably, for decades now the federal and state governments have gone along with this opacity as well, with the exception of a few state governments.

Clearly, government has represented providers more so than patients.

CATALYST FOR PAYMENT REFORM

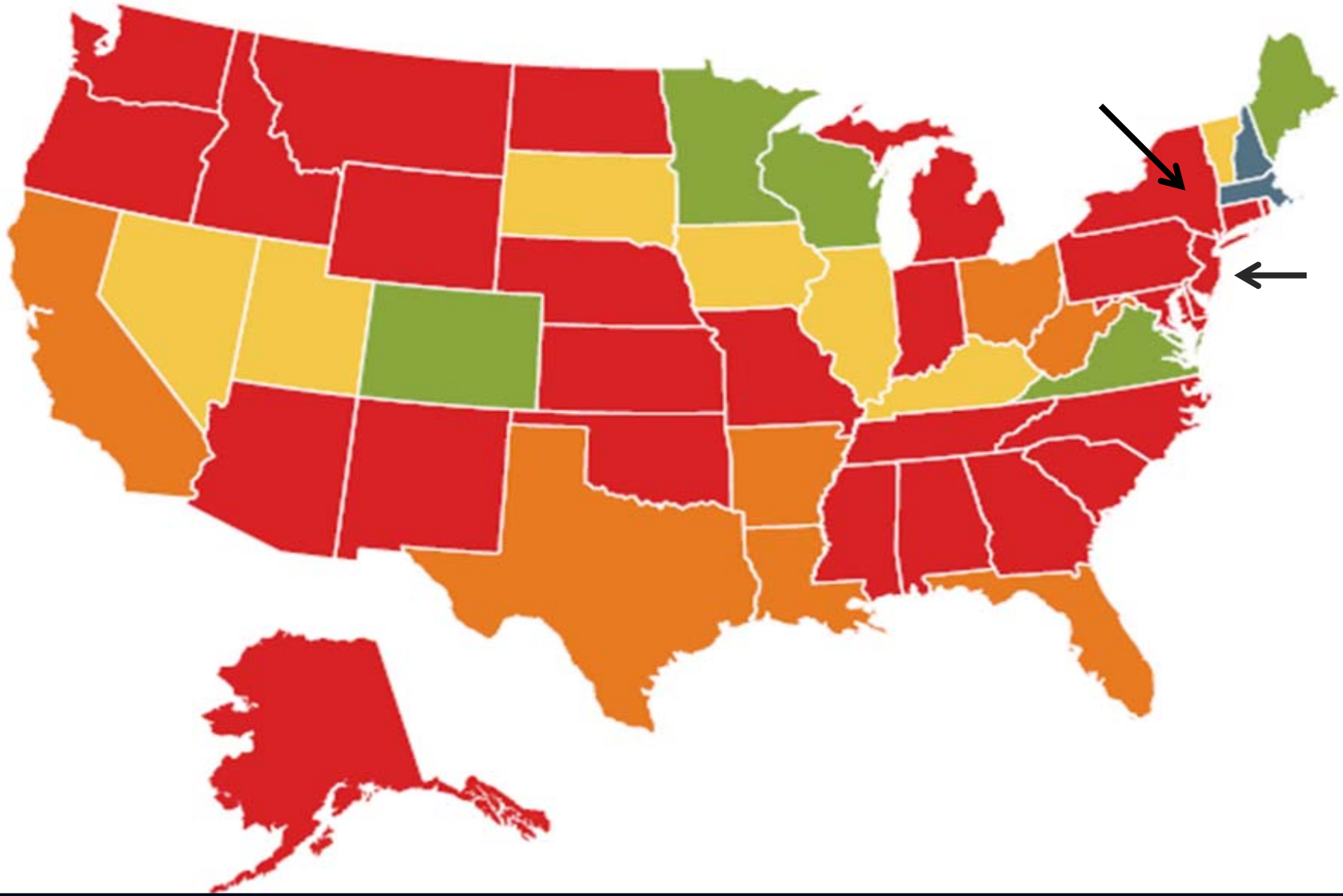
HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE Inc

Report Card on State Price Transparency Laws

March 18, 2013

GRADE	FROM	TO
A	60%	100%
B	50%	59%
C	40%	49%
D	30%	39%
F	0%	29%

Figure 1: Map Overlay



STATE	GRADE
Alabama	F
Alaska	F
Arizona	F
Arkansas	D
California	D
Colorado	B
Connecticut	F
Delaware	F
Florida	D
Georgia	F
Hawaii	F
Idaho	F
Illinois	C
Indiana	F
Iowa	C
Kansas	F
Kentucky	C

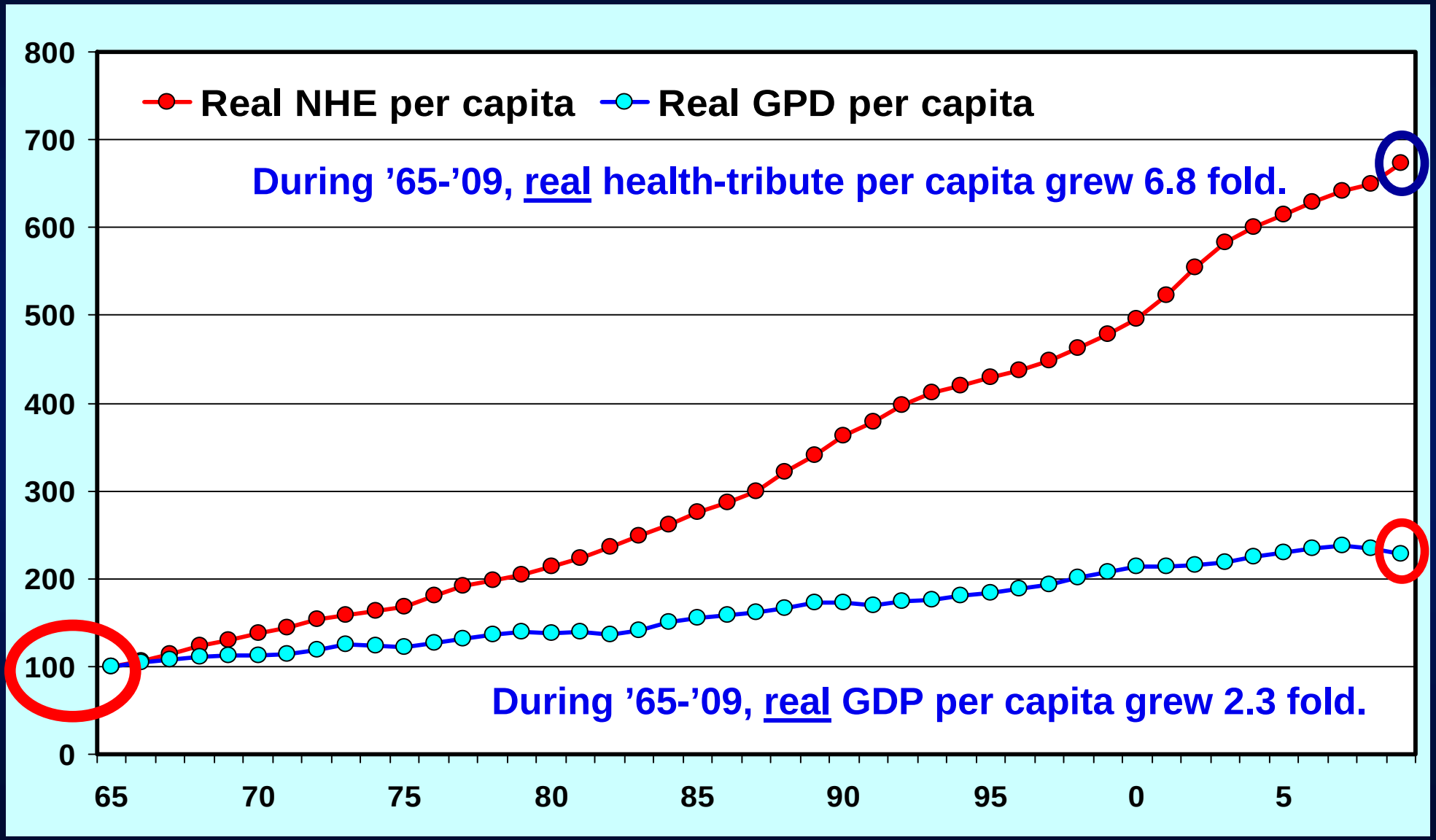
STATE	GRADE
Louisiana	D
Maine	B
Maryland	F
Massachusetts	A
Michigan	F
Minnesota	B
Mississippi	F
Missouri	F
Montana	F
Nebraska	F
Nevada	C
New Hampshire	A
New Jersey	F
New Mexico	F
New York	F
North Carolina	F
North Dakota	F

STATE	GRADE
Ohio	D
Oklahoma	F
Oregon	F
Pennsylvania	F
Rhode Island	F
South Carolina	F
South Dakota	C
Tennessee	F
Texas	D
Utah	C
Vermont	C
Virginia	B
Washington	F
West Virginia	D
Wisconsin	B
Wyoming	F

Instead of getting anything even remotely resembling a properly working market, from an economic perspective the U.S. health care “market” (so-called) has been a living joke.

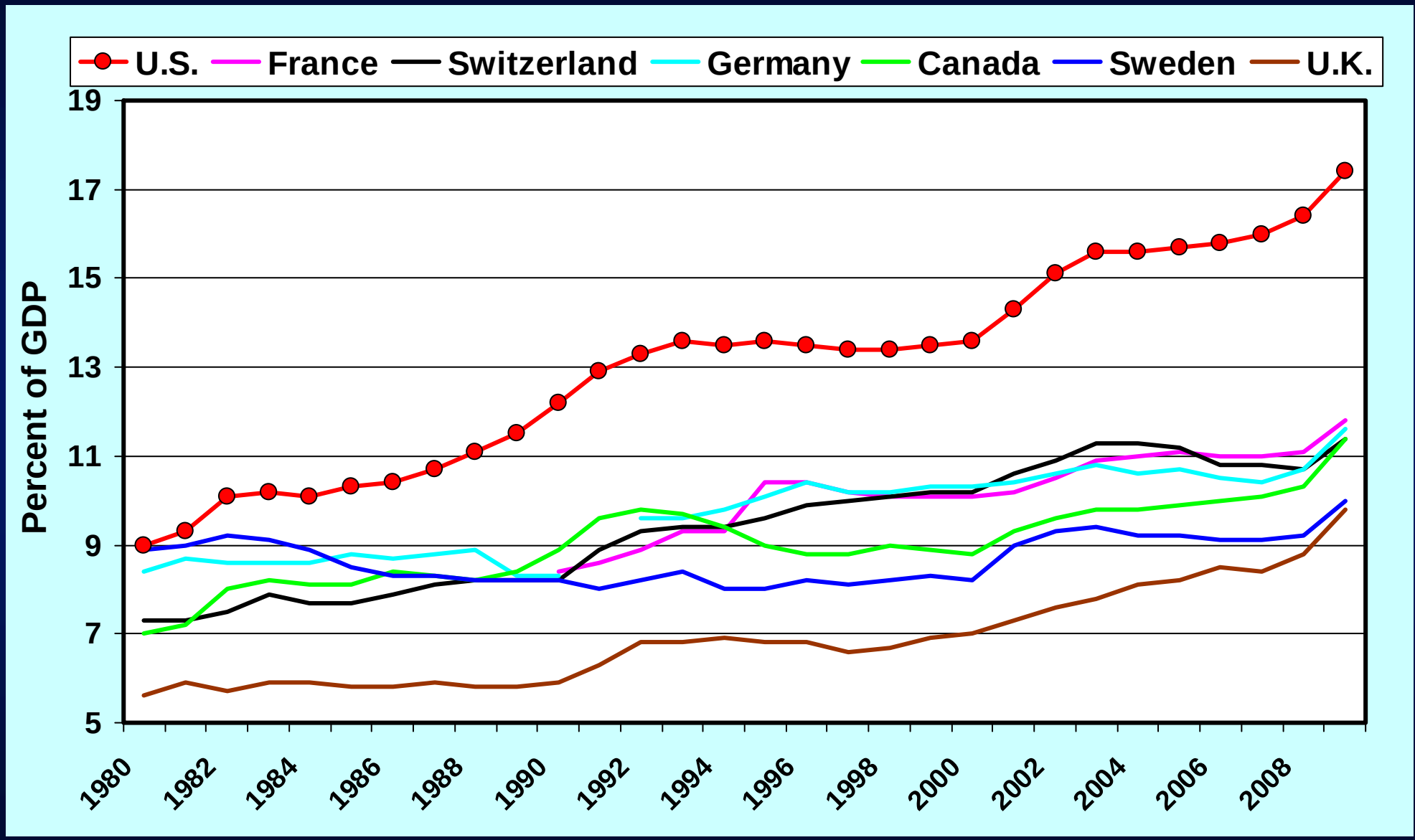
The economic footprints of this joke are clear for anyone to see.

GROWTH OF REAL NATIONAL HEALTH INCOMES (NHE) AND REAL GDP, BOTH PER CAPITA, IN CONSTANT 2009 $s,1965 = 100 (GDP Deflator)



SOURCE: CMS Data & Statistics and Economic Report of the President 2010.

PERCENT OF GDP CLAIMED BY HEALTH CARE, 1980-2009



Source: OECD Data Base, 2011.

IV. PUSHING BACK ON COSTS THROUGH UTILIZATION

For decades, we have focused on controlling spending by reducing utilization of health care

The favorite instrument here is *"Consumer Directed Health Care"* – policies with very high cost sharing.

But absent user-friendly information on the prices of health care, "Consumer Directed Health Care" is roughly on par with pushing blindfolded shoppers into a department store, there to shop around smartly for what someone told them they need and should have.

You wanted this.

You ended up with this

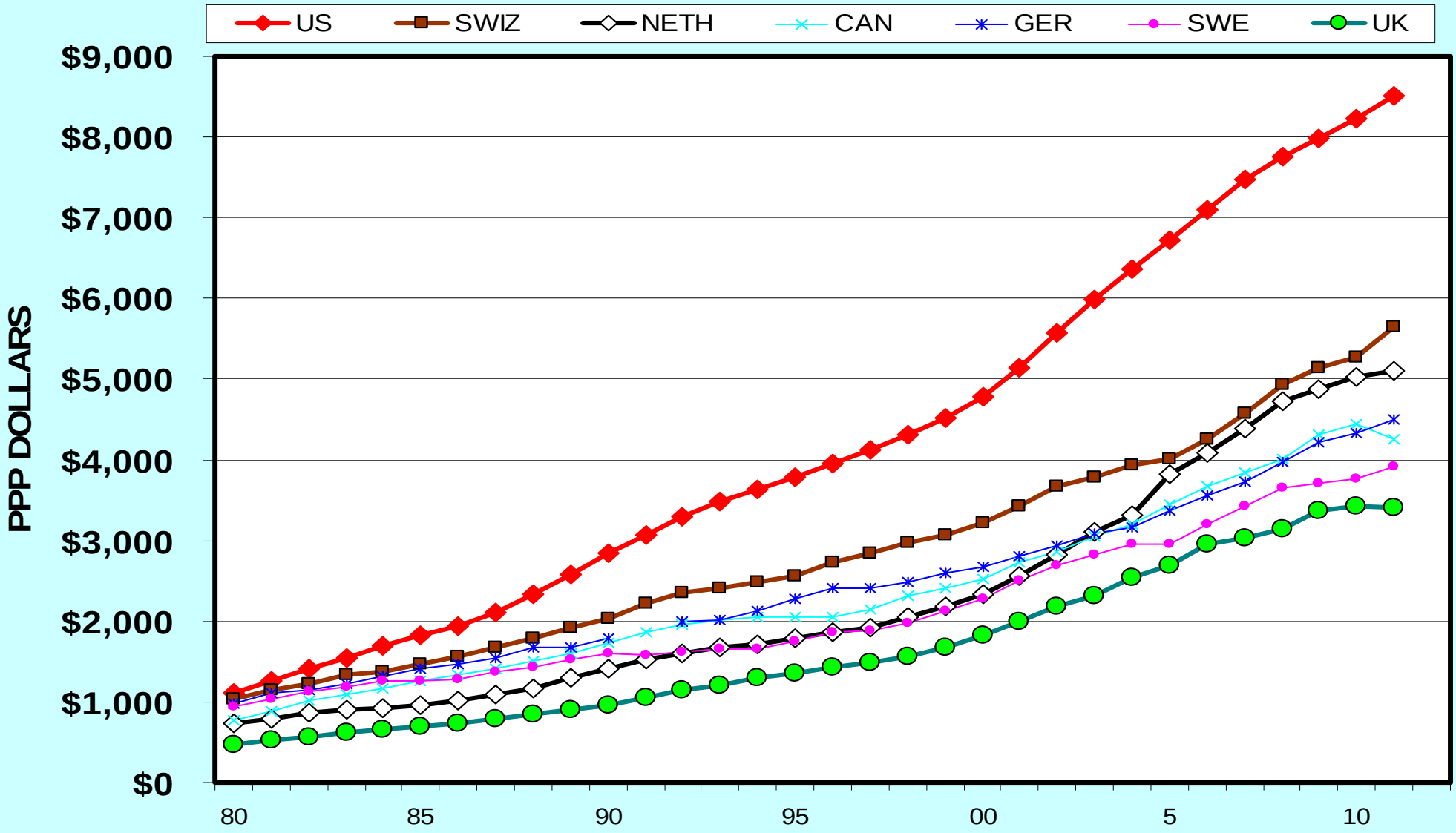
And a month later you find out what it costs you.

U.S. health care still largely functions like that.

V. FOCUSING NOW ON PRICES

It took a remarkably long time, but it finally dawned on us that high prices are the real culprit.

PER-CAPITA HEALTH SPENDING IN PPP DOLLARS -- SELECTED OECD COUNTRIES, 1980-2011



HEALTH AFFAIRS - *Volume 22, Number 3*

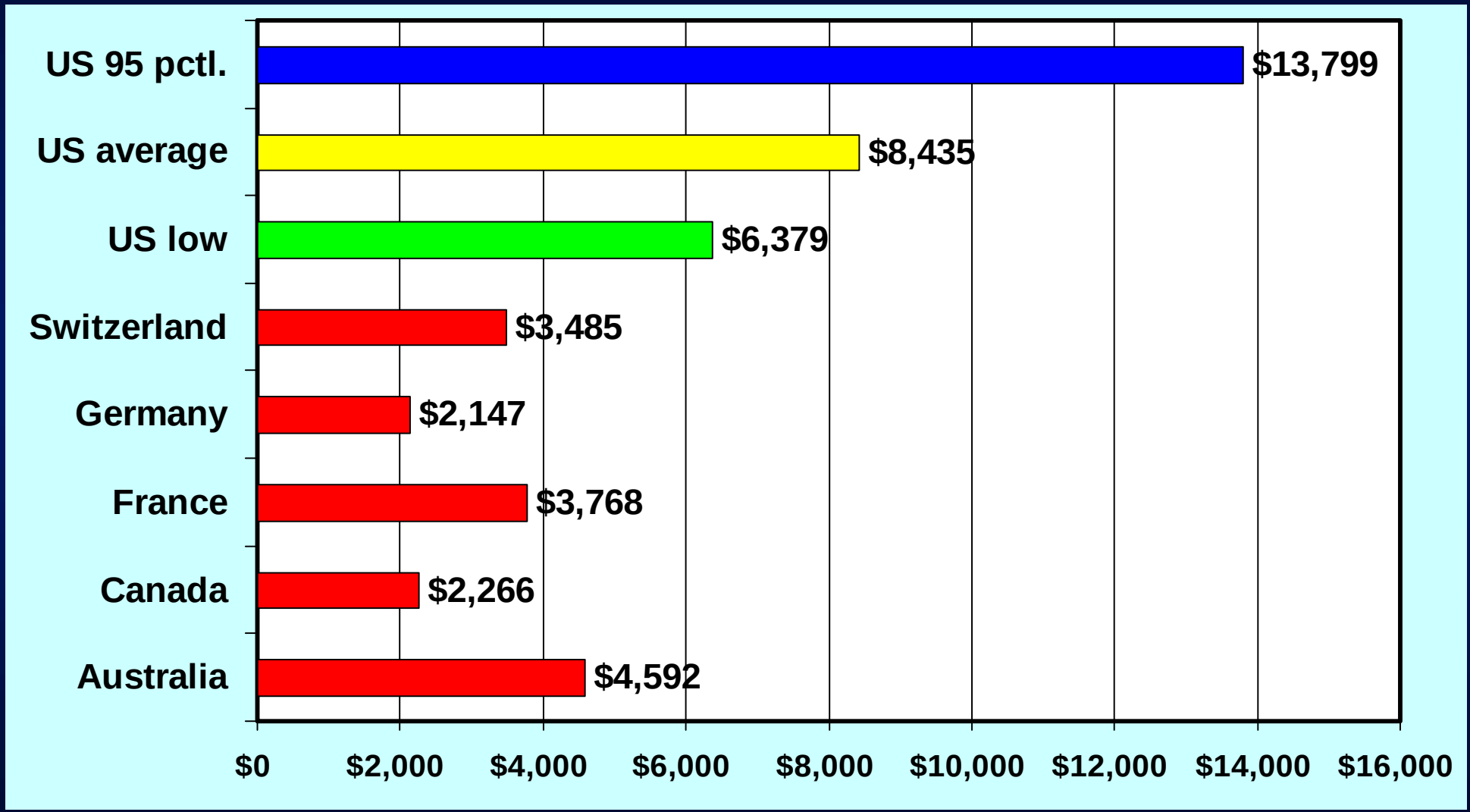
It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

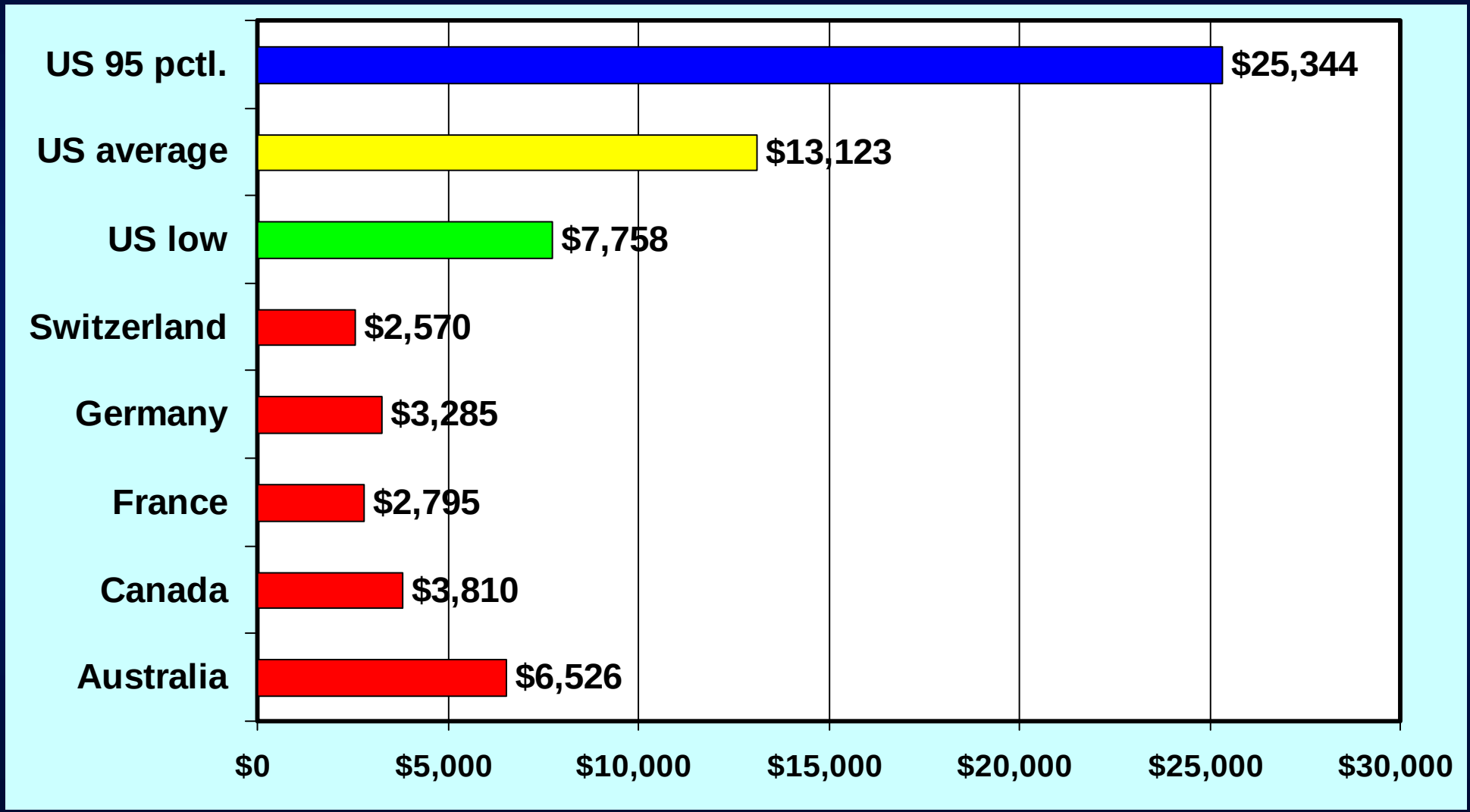
PROLOGUE: In Fall 1986 *Health Affairs* published the first of nearly two decades' worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and

COMPARATIVE PRICES FOR A NORMAL DELIVERY:
Total hospital and physician cost



SOURCE: International Federation of Health Plans, *2010 Comparative Price Report*.

COMPARATIVE PRICES FOR AN APPENDECTOM:
Total hospital and physician cost



SOURCE: International Federation of Health Plans, *2010 Comparative Price Report*.

Healthcare Business News

Tweet

Commentary: Catalyst for Payment Reform calls for price transparency by 2014

By Suzanne Delbanco
Posted: November 1, 2012 - 12:01 am ET
Tags: Costs, Guest Commentary, Payers, Purchasing, Suzanne Delbanco

Delbanco

Related Content

Groups urge pricing transparency in healthcare

"We all know we need to be careful stewards of our healthcare dollars. But if we can't get at the price information, it's just not doable."

It is a complaint and concern we hear frequently working with large employers and other healthcare purchasers, such as state public employee and retiree systems. Along with everyone else in our healthcare system, purchasers know costs are going up, but they have no idea if their employees and their families are getting the right care at the right price as a result. Given that prices for the same procedure can vary

This Week's Issue

Table of Contents
Digital Edition
Subscribe

- Q3 Healthcare Reform Update: ACA takes center stage in government budget battle
- Doctor shortage warnings don't match reality, some policy experts say
- Work needed to close gaps in coverage for mental health, substance abuse treatment
- Largest post-acute-

At this time, the tranquil life afforded by price opacity is increasingly under siege by insurgents equipped with two powerful weapons:

1. **modern electronic information technology,**
2. **reference pricing.**

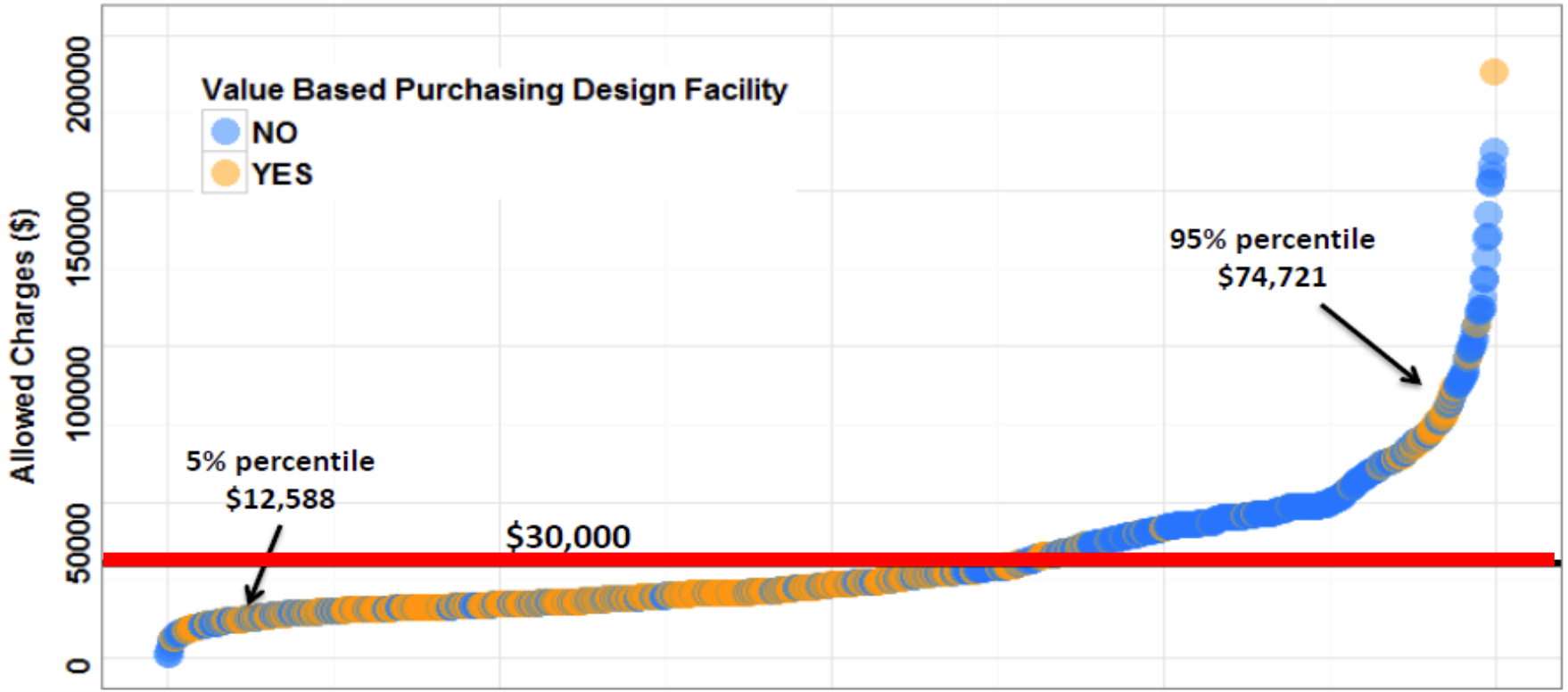
CalPERS Reference Pricing Program for Hip or Knee Replacement

David Cowling, PhD
Chief, Center for Innovation
CalPERS

CalPERS

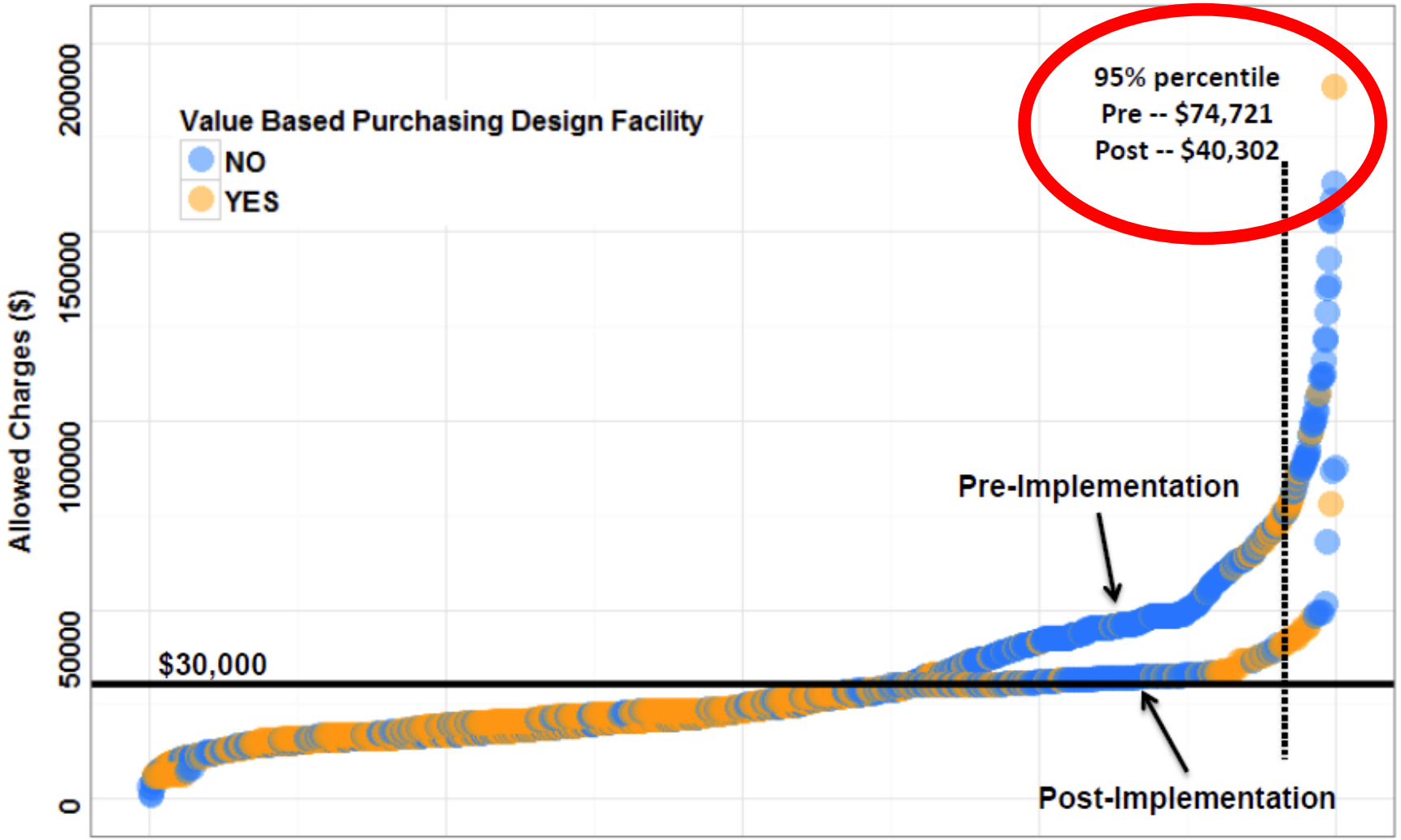
Why choose $30,000 for allowed charges?

- High volume, high quality facilities with geographic dispersion were charging less than $30,000



CalPERS Source: University of California, Berkeley analysis, June 2013. Data for 2008 to 2010.

Allowed charges for the hip or knee replacement pre- and post-implementation of value based purchasing design program



Source: University of California, Berkeley analysis, June 2013. Pre-implementation data for 2008 to 2010 and post-implementation data for 2011-2012.

CalPERS

VI. A MODEST PROPOSAL FOR PRICE TRANSPARENCY

A major problem in price transparency is how to convey to prospective patients binding prices of health care in a user friendly way.

The Medicare physician fee schedule has over 9,000 items in it.

A hospital charge master can have 20,000 items in it. The next slide shows an excerpt. How useful is that information to a prospective patient?

EXCERPT FROM CALIFORNIA'S SAMPLE CHARGEMASTER

3043442	CATH MAHURKAR	510.00
3043445	CATH MRI SINGLE	1,642.00
3043446	CATH MRI DUAL	2,181.00
3043448	CATH PERITONEAL TENCHOFF	396.00
3043449	CATH PORTA CATH ARTERIAL	2,842.00
3043450	CATH PORTA CATH INTRO 9FR	198.00
3043451	CATH PORTA CATH PERIT	1,878.00
3043452	CATH PORTA CATH TITANIUM	2,875.00
3043453	CATH PORTA CATH VENOUS A	2,842.00
3043454	CATH PORTA CATH VENOUS B	1,416.00
3043455	CATH ROUND 6FR	76.00
3043456	CATH TPN	99.00
3043459	CLIP APPLIER	420.00
3043462	CLIP WECK	180.00

EXCERPT FROM CALIFORNIA'S SAMPLE CHARGEMASTER

2982446	SWS-CPSP-GROUP	39.00
3038402	SCISSOR TIP ENDOCUT	351.00
3038407	PUMP PAIN MEDTRONIC SYNII	56,710.00
3038409	CATH MEDTRONICS SYNMED	3,570.00
3038419	PATCH KUGEL LG 19X24	34,058.00
3038420	PATCH KUGEL 13X17	11,533.00
3038421	STENT SET BILARY FARELLI	13,091.00
3038422	SET EXPLORE COMMON BILE	13,642.00
3039395	SURGERY LEVEL 1 GEN	3,089.00
3039396	SURGERY LEVEL 2 GEN	3,718.00
3039397	SURGERY LEVEL 3 GEN	4,463.00
3039398	SURGERY LEVEL 4 GEN	5,368.00
3039399	SURGERY LEVEL 5 GEN	6,435.00
3039400	SURGERY LEVEL 6 GEN	7,736.00

To provide user-friendly price information on physician- and hospital services requires more standardization and aggregation in the units of health care being priced.

Fortunately, the Medicare DRGs for inpatient care already represent aggregated units of care.

We could start with them.

If hospitals were required to use the relative value scale implicit in the DRG system for all private patients and charge all payers the same prices, they could signal the level of their prices simply by setting and announcing their own monetary conversion factor.

Prices for inpatient care could then be posted easily.

It is not the ultimate solution, but it might be a good, practical start.

Once could do the same with the RBRVS for physician services, as long a FFS remains the main method of payment.

In thinking about al this, however, we must acknowledge that such a system would be unfair as long as providers are saddled to provide charity care to low-income uninsured and as long as Medicaid does not cover the full cost of caring for Medicaid patients.

There certainly is something to that argument.

It is why I personally favor an all-payer system, such as Maryland's.

By Uwe E. Reinhardt

DOI: 10.1377/hlthaff.2011.0813
HEALTH AFFAIRS 30,
NO. 11 (2011): 2125–2133

ANALYSIS & COMMENTARY

The Many Different Prices Paid To Providers And The Flawed Theory Of Cost Shifting: Is It Time For A More Rational All-Payer System?

ABSTRACT In developed nations that rely on multiple, competing health insurers—for example, Switzerland and Germany—the prices for health care services and products are subject to uniform price schedules that are either set by government or negotiated on a regional basis between associations of health insurers and associations of providers of health care. In the United States, some states—notably Maryland—have used such all-payer systems for hospitals only. Elsewhere in the United States, prices are negotiated between individual payers and providers. This situation has resulted in an opaque system in which payers with market power force weaker payers to cover disproportionate shares of providers' fixed costs—a phenomenon sometimes termed *cost shifting*—or providers simply succeed in charging higher prices when they can. In this article I propose that this price-discriminatory system be replaced over time by an all-payer system as a means to better control costs and ensure equitable payment.

Uwe E. Reinhardt (reinhardt@princeton.edu) is the James Madison Professor of Political Economy and a professor of economics and public affairs at Princeton University, in Princeton, New Jersey.

Thank you for you attention!