BENDING THE COST CURVE:

What would we have the government do?

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Princeton University

The National Congress on Health Reform

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BENDING THE COST CURVE:

What would we have the government do?

I. AUDIENCE COMPETENCE TEST

This lecture contains serious adult material whose comprehension presupposes a high level of mathematical competence.

Let me therefore subject you to a little mathematical test, to gage the level of technical difficulty I can adopt for this lecture.

Consider this equation:

$$\underset{8}{Y} = \underset{3}{X} + \underset{5}{Z}$$

Is that ok with you?

Now consider the following:

$$\underset{\downarrow \atop 7}{Y} = \underset{\downarrow \atop 3}{X} + \underset{\downarrow \atop 5}{Z}$$

Is that ok with you?

If you had a problem with the second slide, in which I made 3+5 =7, you passed the math test and will be able to follow the rest of my exposition.

As I will explain anon, most Americans would have been perfectly comfortable with the second equation, because they sincerely seem to believe that, in America, we are free to lower the left-hand side of an equation without touching any of the variables on the right-hand side and that the Affordable Care Act should have done so..

I discovered that cultural proclivity during the wondrous health-reform debate we just had.

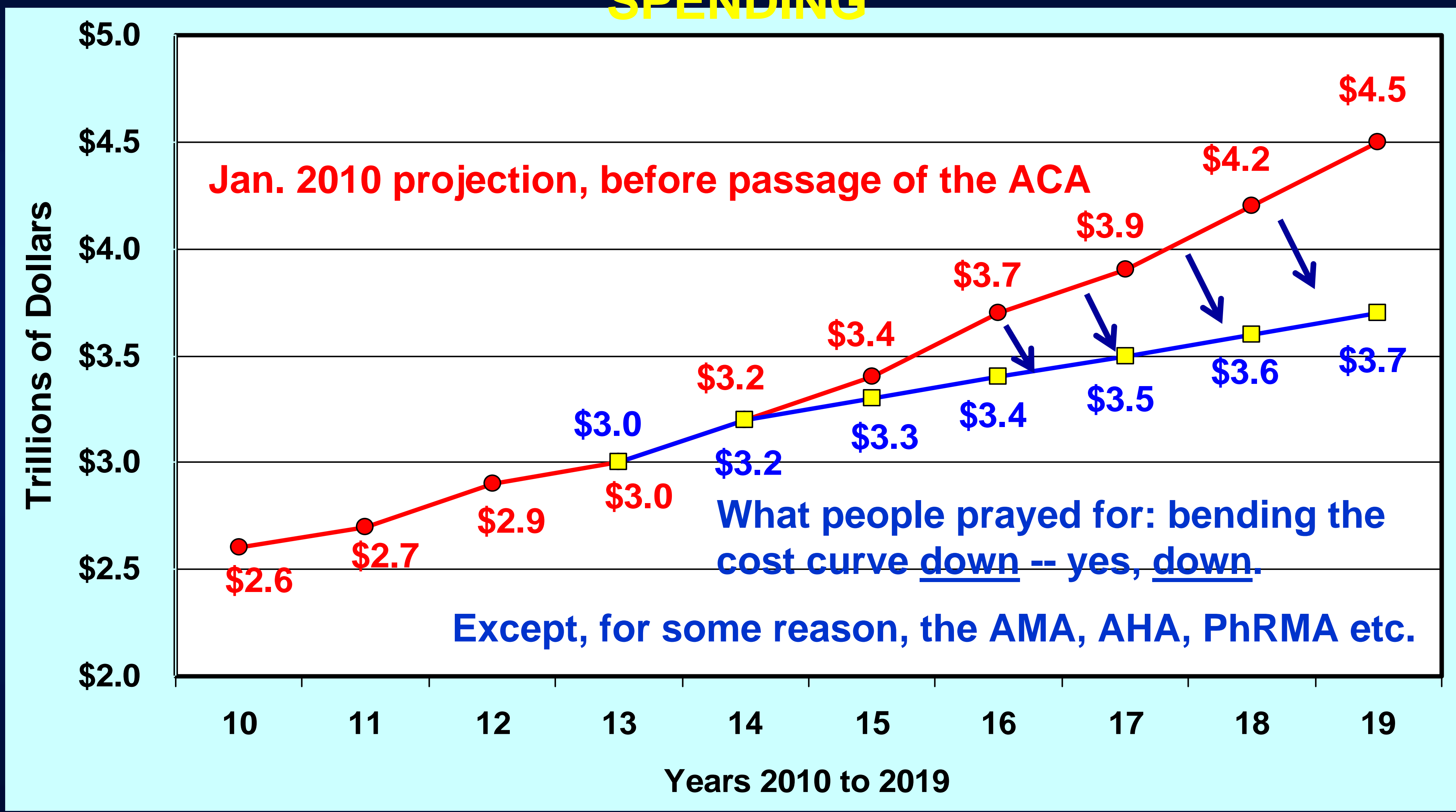
BENDING THE COST CURVE:

What would we have the government do?

I. AUDIENCE COMPETENCE TEST

II. WHAT AMERICANS WANTED GOVERNMENT TO DO

BENDING DOWN THE CURVE OF FUTURE HEALTH SPENDING



SOURCE: CMS DATA & STATISTICS

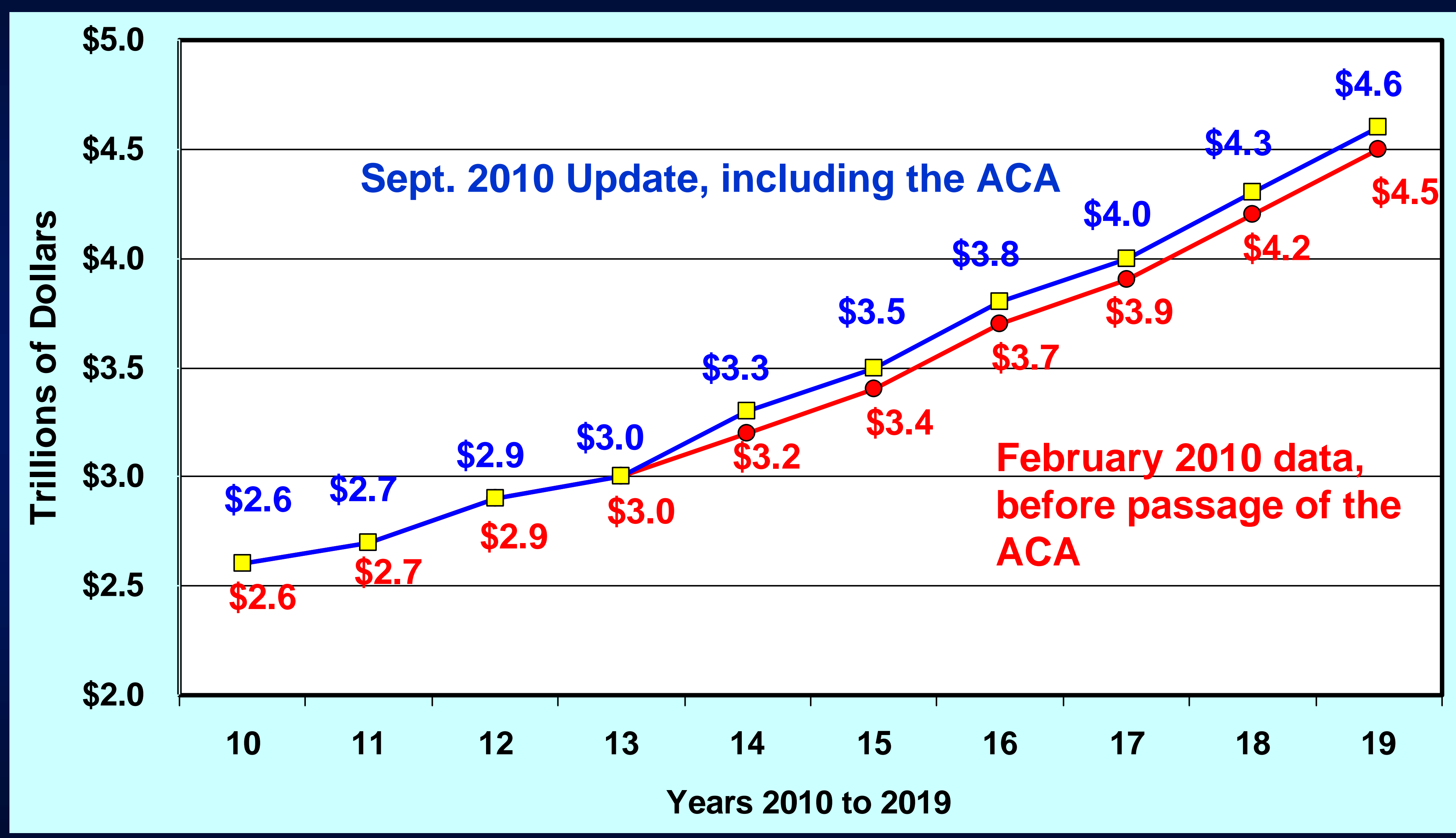
So, what actually happened to projected health spending?

The cost curve was bent alright.

Alas, <u>upward</u>!

(According to the CMS actuaries.)

CURRENTLY PROJECTED U.S. HEALTH SPENDING



SOURCE: CMS DATA & STATISTICS

And so the plebs was disappointed, and none more so than the business sector, which is groaning under the growing financial burden of employment-based health insurance.

Here’s the lament of the business community:

“Employers’ greatest disappointment with the health reform law is how little it will help contain cost growth in the short term, despite the fact that the president set this as a top goal.”

Helen Darling,
President of the National Business Group on Health,
In “Health Reform: Perspectives from Large Employers,” Health Affairs, June 2010, p. 1221.

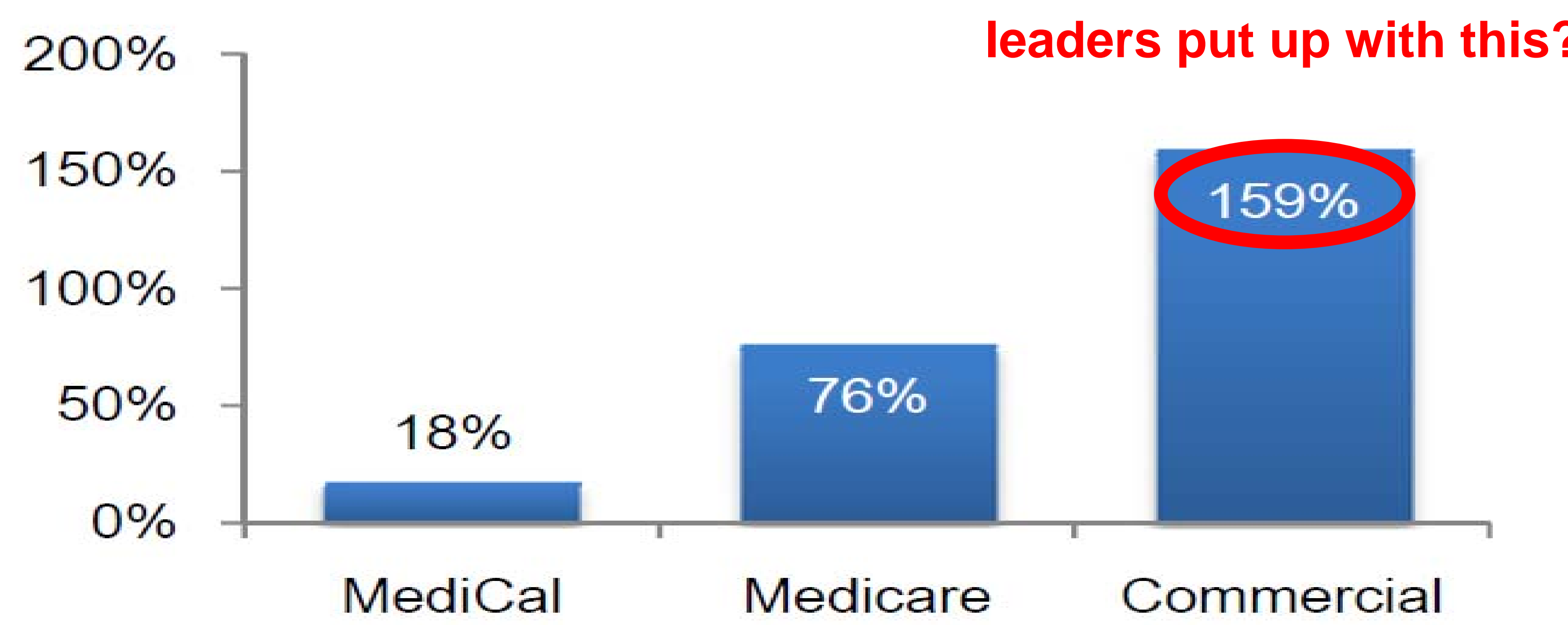
But who are business leaders to cry, when they do so little themselves to constrain the growth of health spending and usually naysay or sabotage everything government does in health reform?

After all, they are the ones who permit the cost of health care to rise as fast as it does.

December 2010

Recent Trends in Hospital Prices in California and Oregon

Figure 1. Statewide Absolute Growth in Net Inpatient Revenue per Day, California Hospitals, 2000-2009



Source: State of California, Office of Health Planning and Development (OSHPD). Calculations by AHIP Center for Policy and Research.

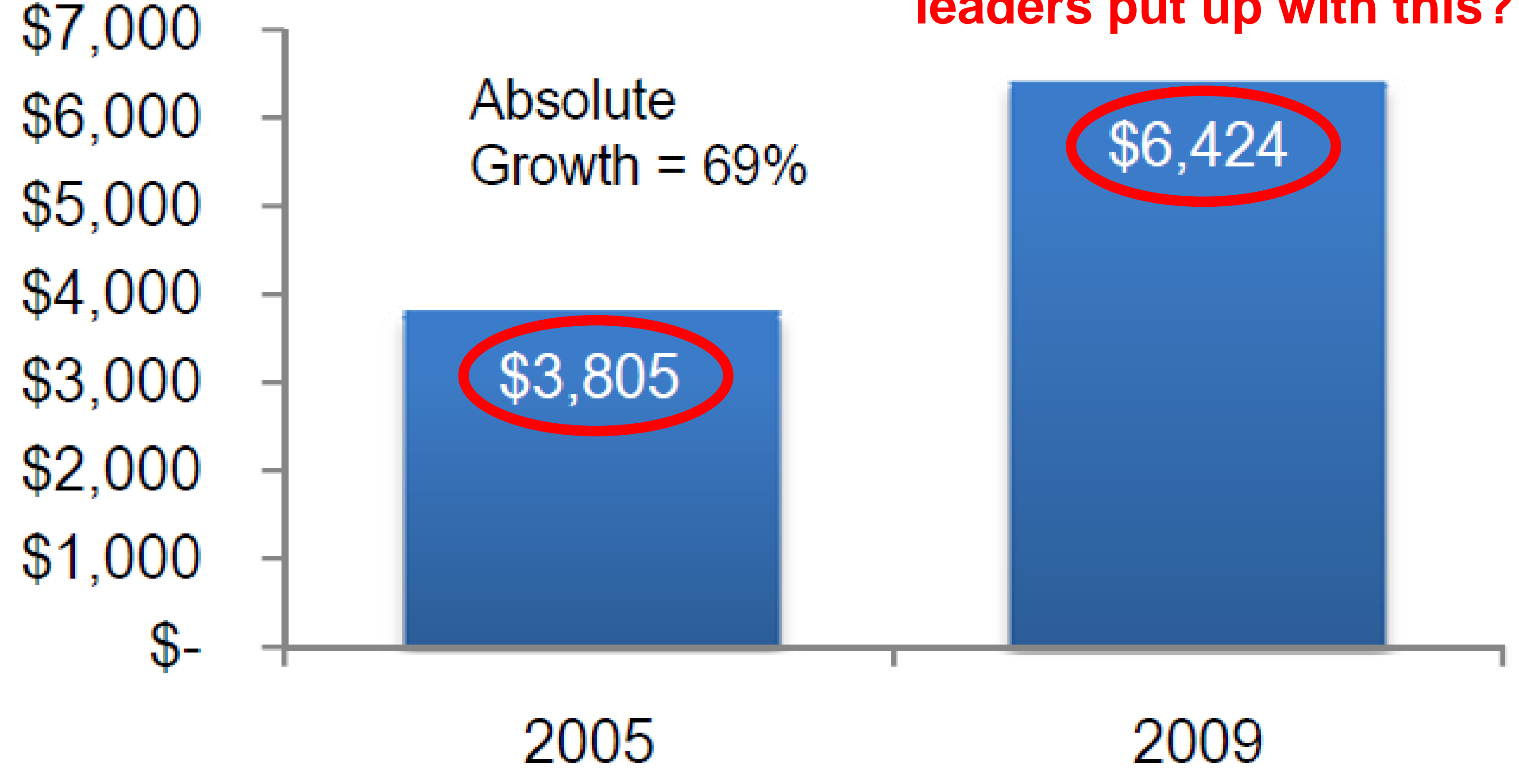


Figure 2a. Oregon Statewide Average Reimbursement for Normal Vaginal Delivery, 2005-2009
How is it that business leaders put up with this?
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$-
Absolute Growth = 69%
$3,805
$6,424
2005
2009

Figure 2b. Oregon Statewide Average Reimbursement for Knee Joint Replacement, 2005-2009
How is it that business leaders put up with this?
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$-
Absolute Growth = 44%
$19,866
$28,682
2005
2009
Source: Office for Oregon Health Policy and Research (OHPR).
Note: Data from nine private health insurance plans.

In Oregon, hospital prices faced by commercial insurers for common discharge categories also grew very rapidly between 2005 and 2009:

How is it that business leaders put up with this?

	2005-2009 Average Annual Rate of Price Inflation
Appendix removal:	11.3%
Balloon angioplasty without heart attack:	8.4%
Cesarean delivery:	11.5%
Hip joint replacement:	10.9%
Normal newborn:	10.4%
Pneumonia:	9.6%
Upper spine and neck procedures:	11.9%
Vaginal delivery:	14.0%
Vaginal hysterectomy (excluding cancer or non-malignant tumor):	12.9%

BENDING THE COST CURVE:

What would we have the government do?

I. AUDIENCE COMPETENCE TEST

II. WHAT AMERICANS WANTED THE GOVERNMENT TO DO

III. THE POLITICAL ECONOMY OF BENDING THE COST CURVE

THE POLITICAL ECONOMY OF "BENDING THE COST CURVE"

At a very high and rough level of aggregation, one can think of total national health spending (NHE) as:

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

Here P stands for prices, Q for volume of services per capita, and N for the number of persons served.

Subscript "G" stands for government programs, "P" for private health insurance and "U" for the uninsured.

Now, this is what I discovered during the recent health-reform debate is this:

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

The American people wanted the President and the Congress to lower the left-hand side of this equation without touching any of the variables on the right hand side.

To a people that does not recognize the international interpretation of the symbol "=" this seems to make perfect sense.

It must be part of what we call "American exceptionalism."

BARRIERS TO "BENDING THE COST CURVE"

Now look the variables on the right-hand side. What is it that the American people want their government to do?

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

If the government lowers P_G -- as in the ACA for Medicare -- it is accused of "shifting costs" to private payers. Spokesmen for the U.S. Chamber of Commerce, which represents U.S. business, have gone so far as to call such a fee cut a "tax increase." So now the extraordinarily high prices American business pays for health care get blamed on – you guessed it! – government, when it seeks to lower prices.

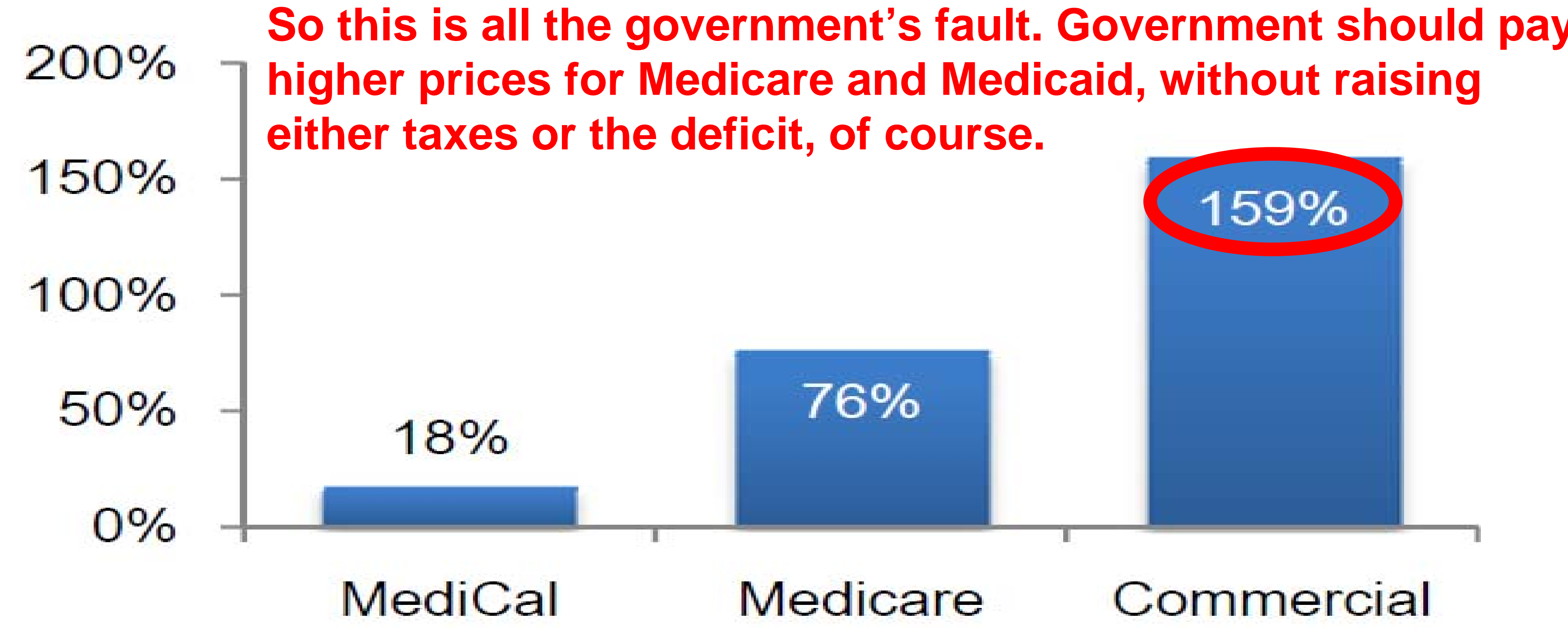


Figure 1. Statewide Absolute Growth in Net Inpatient Revenue per Day, California Hospitals, 2000-2009
So this is all the government's fault. Government should pay higher prices for Medicare and Medicaid, without raising either taxes or the deficit, of course.
200%
150%
100%
50%
0%
18%
76%
159%
MediCal
Medicare
Commercial
Source: State of California, Office of Health Planning and Development (OSHPD). Calculations by AHIP Center for Policy and Research.

BARRIERS TO “BENDING THE COST CURVE”

Continue to look at P_G on the right-hand side.

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

If the government cuts P_G, the nation’s elderly rise in protest as well, fearing that at the lower prices paid by Medicare no one will care for them any more. That anxiety can easily be fueled and exploited for partisan purposes, as it was during the health-reform debate.

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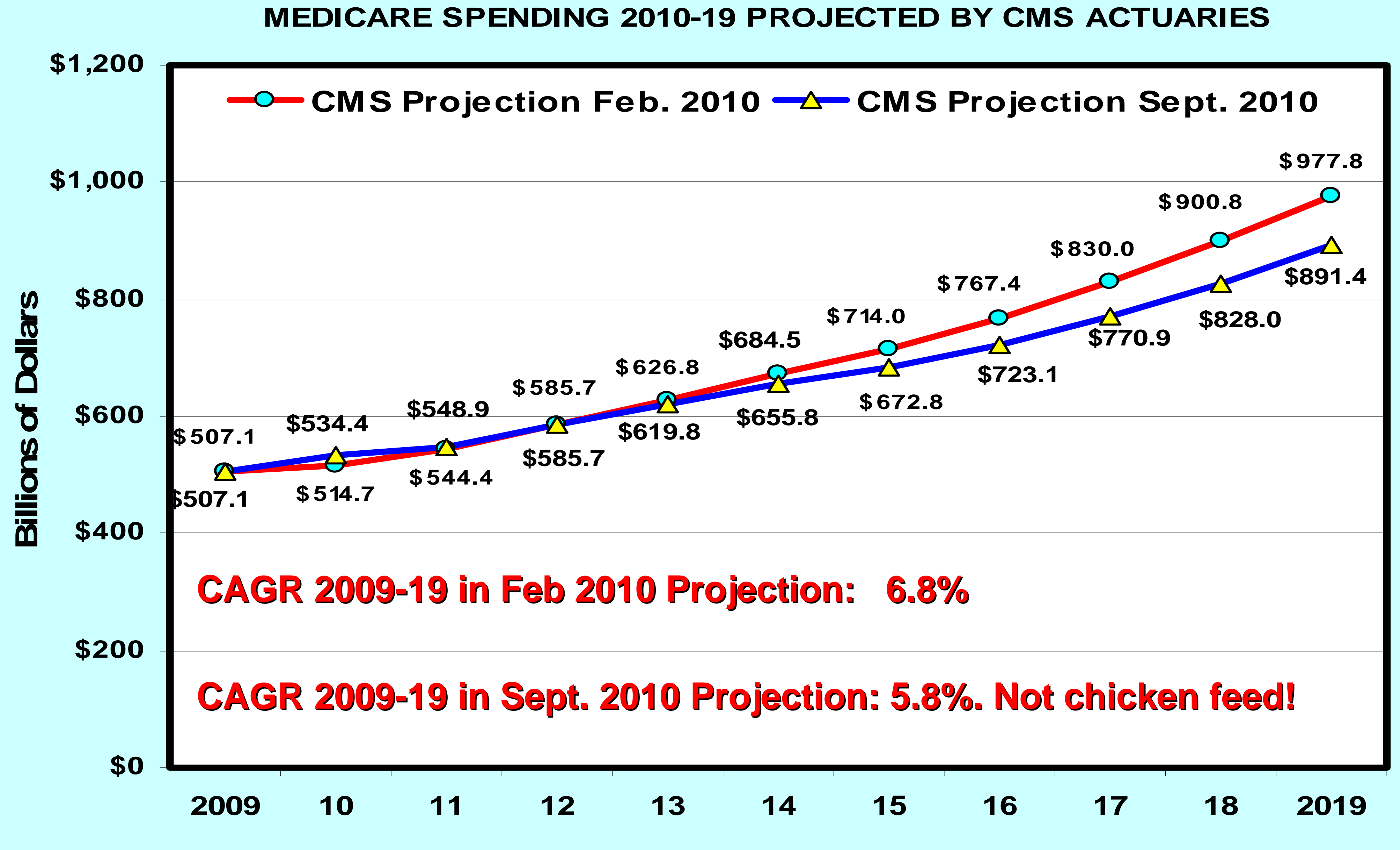
VOLUNTEER

My view is that if America’s health care leaders cannot make it through the decade with the relatively mild cuts to Medicare spending being proposed, one must wonder about their managerial acumen.

Does any other industry out there face as secure and nice upward sloping revenue line as the one shown on the next slide?

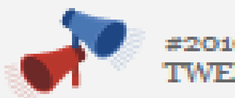


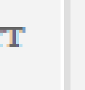
SOURCE: CMS Data & Statistics, projections of Feb. 2010 and Sept. 2010.

The New York Times **Politics**

WORLD | U.S. | N.Y. / REGION | BUSINESS | TECHNOLOGY | SCIENCE | HEALTH | SPORTS | OPINION | A

POLITICS HOME


#2010: NYT TWEETS


HOUSE

SENATE

GOVERNORS

Ads Use Medicare Cuts as Rallying Point

By JENNIFER STEINHAUER

Published: October 30, 2010

WASHINGTON — The backdrops differ — a cactus for Arizona, some lovely fall leaves for Pennsylvania — but the message, delivered by a series of nervous-looking older Americans, is uniform: Democratic Congressional candidates voted for billions of dollars in cuts to Medicare (or, if they were not in office, would have) and let their constituents down.

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“Kilroy voted to gut Medicare by $500 billion,” says the announcer in one advertisement, paid for by the U.S. Chamber of Commerce, against Representative Mary Jo Kilroy of Ohio; in Florida, the 60 Plus Association, a conservative group, ran an ad featuring some older residents saying that Representative Allen Boyd, a Democrat, ‘betrayed Florida’s seniors’ with votes to cut the program. “

BARRIERS TO "BENDING THE COST CURVE"

Now suppose the government wanted to control volume Q_G – the volume of services per capita in the public sector.

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

It might be done with the aid of cost-effectiveness analysis or other forms of utilization control. It would swiftly be condemned as rationing health care, forming death panels, killing Granny, and so on.

In an op-ed piece in the Washington Post, former House Speaker Newt Gingrich suggested that we could save $33 billion a year on Medicare spending if all elderly had living wills.

The Washington Post

TODAY'S NEWSPAPER
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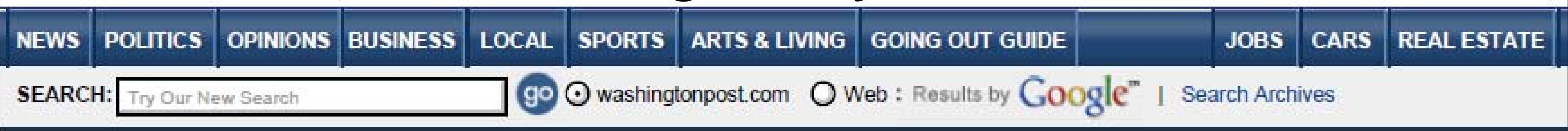
Former Republican Speaker of the House Newt Gingrich, in an op-ed piece in the Washington Post, advocating living wills for the sake of saving money on Medicare.



Health Care Rx

Main Page | About Health Care Rx | The Panel | R

Experts debate their policy prescriptions for America's health-care

FORMER SPEAKER OF THE HOUSE

Newt Gingrich

Newt Gingrich is the founder of the Center for Health Transformation and former speaker of the U.S. House of Representatives.

THE DAILY DOSE

Interactive Graphic: How the E

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RECENT POSTS

- A Simple Answer: Yes
- Who Pays for Whose

Across the Country, Some Systems Are Getting It Right

As Newt Gingrich wrote in that op-ed piece:

"More than 20 percent of all Medicare spending occurs in the last two months of life. Gundersen Lutheran Health System in La Crosse, Wisconsin has developed a successful end-of-life, best practice that combines:

1. community-wide advance care planning, where 90 percent of patients have advance directives;
2. hospice and palliative care;
3. and coordination of services through an electronic medical record.

And he goes on:

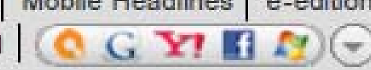
“The Gundersen approach empowers patients and families to control and direct their care.

The Dartmouth Health Atlas has documented that Gundersen delivers care at a 30 percent lower rate than the national average ($18,359 versus $25,860).

If Gundersen's approach was used to care for the approximately 4.5 million Medicare beneficiaries who die every year, Medicare could save more than $33 billion a year.”

Alas, when the idea to have Medicare PAY physicians for end-of-life counseling of patients was written into an early House bill, the opponents of the reform quickly morphed that idea into "Death Panels"

Similarly, cost-effectiveness analysis was swiftly decried as a Nazi tool.



EDITORIAL: Health 'efficiency' can be deadly

By | Wednesday, February 11, 2009

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Article | Comments (27)

Secreted in the House version of the stimulus bill the President is trying to rush through Congress is the germ of a major overhaul of the American health care system. One provision causing increasing concern is the future role of the National Coordinator of Health Information Technology, who will be in charge of collecting

Click the photo to enlarge.

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Business Owners: Do you...

BARRIERS TO "BENDING THE COST CURVE"

I conclude that, rhetoric to the contrary notwithstanding, the American people really don't want government to cut public-sector spending on health care.

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

Now suppose the government came to the rescue of business and tried to help control prices or volume in the private insurance sector.

All hell would break loose!

There would be cries of a "government takeover" of health care.

BARRIERS TO "BENDING THE COST CURVE"

So what is left, then?

$$NHE = P_G \times Q_G \times N_G + P_P \times Q_P \times N_P + P_U \times Q_U \times N_U$$

Is the thought that government should let the number of uninsured go up, because they use less than half the health care that similarly situated insured Americans get?

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IV. WHAT MIGHT WORK TO CURB THE GROWTH IN SPENDING?

A. Bundled payments

ALTERNATIVE SYSTEMS FOR PAYING HEALTH-CARE PROVIDERS

Method of setting fee level	- Base for Payment -			
	Piece Rate (Fee-for-Service)	Bundled Payments for treatments	Capitation per patient	Budgets or Salary per year
Unilateral administrative fee setting				
Negotiation between associations				
Individual, free-market fee setting				

Although the concept is not new, “evidence-based bundled payments per episodic case” has captured the imagination of health policy wonks and the policy makers they advise.

The concept is intuitively appealing; but it will not sweep the nation soon:

1. It is not easy to reach agreement on the evidence-based bundle of services that should go into the treatment of a medical episode, and then to develop the bundled price.

1. The approach works well only if the payment is received by an entity that can manage the episodic care properly and distribute the bundled payments among the contributors of the treatment. This is where Accountable Health Organizations (ACOs) come in.

Besides, if bundled payments actually reduced health spending significantly – that is, the income of some providers of health care -- the losers undoubtedly would pay some front – perhaps a think tank or two – to demagogue the whole idea of bundled payments, which could easily be done..

The same people why decried living wills as devices to make elderly patients cut their lives short could be made to argue that bundled payments “allow you doctor to profit from withholding care from you!”

If we have the temerity to proceed with bundled payments, one pragmatic approach might be the following:

1. Every hospital would be mandated to use the DRG relative value scale for all patients, but initially could set its own monetary conversion factor and even price discriminate (for a while yet) among payers.

2. Over time, more and more services would be bundled into the DRGs, across settings – e.g., including ambulatory care and prescription drugs.

3. Over time the system would move towards an all-payer system in which all payers in a region pay a given providers (ACO) the same bundled payments, although different ACOs could compete on the size of the bundled payments.

Health Affairs Blog

A Modest Proposal On Payment Reform

July 24th, 2009

I have fleshed this idea out a bit in this post.

by **Uwe E. Reinhardt**

Editor's Note: *In the post below, Uwe Reinhardt proposes to move from the present, price-discriminatory system of private-sector pricing of health services toward an all-payer system that could serve as a transition to an eventual system based on bundled payments per episode of illness for acute care, or capitation for chronic care.*

In a response to Reinhardt's post, Paul Ginsburg suggests that an all-payer system could apply pressure on providers to contain costs in a "far less radical" manner than the public plan proposed by many advocates of health reform. Ginsburg discusses the success of Maryland's all-payer system. For a thorough discussion of the Maryland's regulatory scheme and its results, look for the article by Robert Murray, chair of the Maryland Health Services Cost Review Commission, in the Sept/Oct issue of Health Affairs*, to be released Sept. 9.*

While this is technically possible, can we see this move easily through Congress, which has become more and more beholden to special interest groups?

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A. Bundled payments

B. Accountable Health Organizations

Mark Smith, President of the California Health Foundation, has likened the ACO to "a unicorn, an animal with fantastic powers, although no one has ever seen one."

Actually I have seen one: it is called "Kaiser Permanente."

So I define an ACO as "an organization that comes as close as possible to Kaiser Permanente without anyone noticing it."

And why should no one notice it?

Because "Kaiser" sounds like a German name, and Germans are Socialists. That's why.

By being able to receive and manage bundled payments (or capitation for chronic care) ACOs <u>might</u> contribute to bending the cost curve downward, as many people hope they would.

But ACOs are also a nifty way for providers in a region to band together and to develop more monopoly power on the supply side than has already been developed through mergers or the formation of large group medical practices.

Thus, bundled payments with ACOs may turn out not to be cheaper after all and actually become a cost driver! Think about it!

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A. Bundled payments

B. Accountable Health Organizations

C. Increasing the number of insurers?

PROPOSITION

Other things being equal, the larger the number of insurers competing in a market area, the weaker each will be in bargaining with providers over prices.

The widely popular idea that increasing the number of insurers in a region will increase competition and, therefore, naturally decrease premiums does not make sense to this economist.

HealthAffairs Blog

Will More Insurers Control Health Care Costs Better?

July 9th, 2010

I have blogged on that as well.

by **Uwe E. Reinhardt**

A common theme among health reformers has been that the small-group and individual markets for health insurance are too concentrated and thus inadequately competitive. The proposed remedy is to have more independent insurers compete within local markets.

Reformers left of center on the ideological spectrum – President Obama prominent among them – advanced this thesis frequently in their advocacy of a new, public health plan, or of insurance cooperatives, for Americans under age 65.

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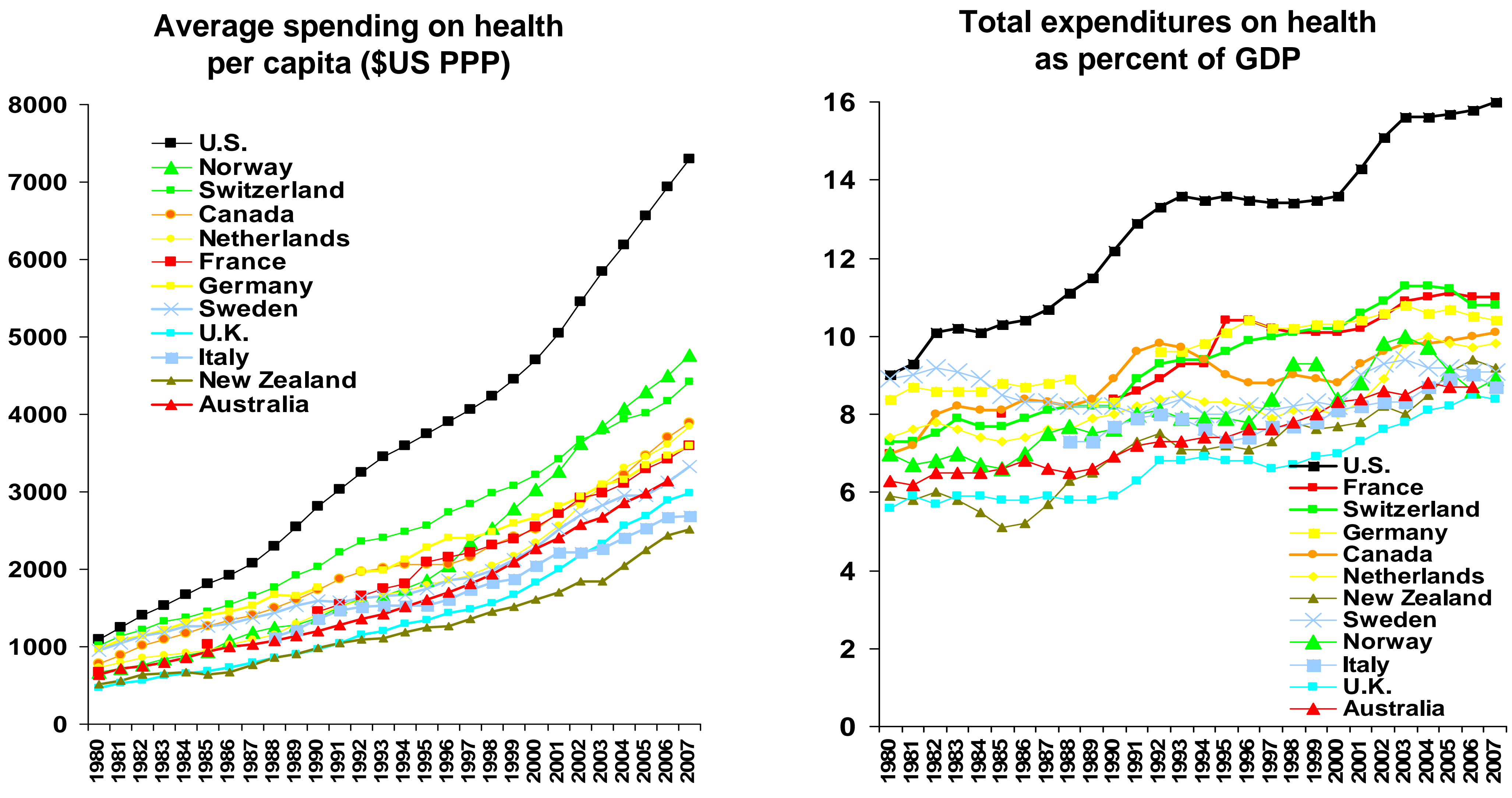
V. RATIONING BY INCOME CLASS

By now surely every American must know that the U.S. spends more per-capita or as a percent of GDP on health care than any other nation in the OECD, even though we are and shall remain one of the youngest nations in terms of the age structure of pour population.

International Comparison of Spending on Health, 1980–2007



SOURCE: Gerard Andersen and Patricia Markovich, "Multinational Comparisons of Health Systems Data, 2009," PowerPoint presentation prepared for the Commonwealth Fund, based on OECD Data 2009.

Other nations pay lower prices for health care and control health care spending by strengthening the payment side of the health sector – typically with direct or indirect intervention by government that keep prices lower than those we pay in the U.S..

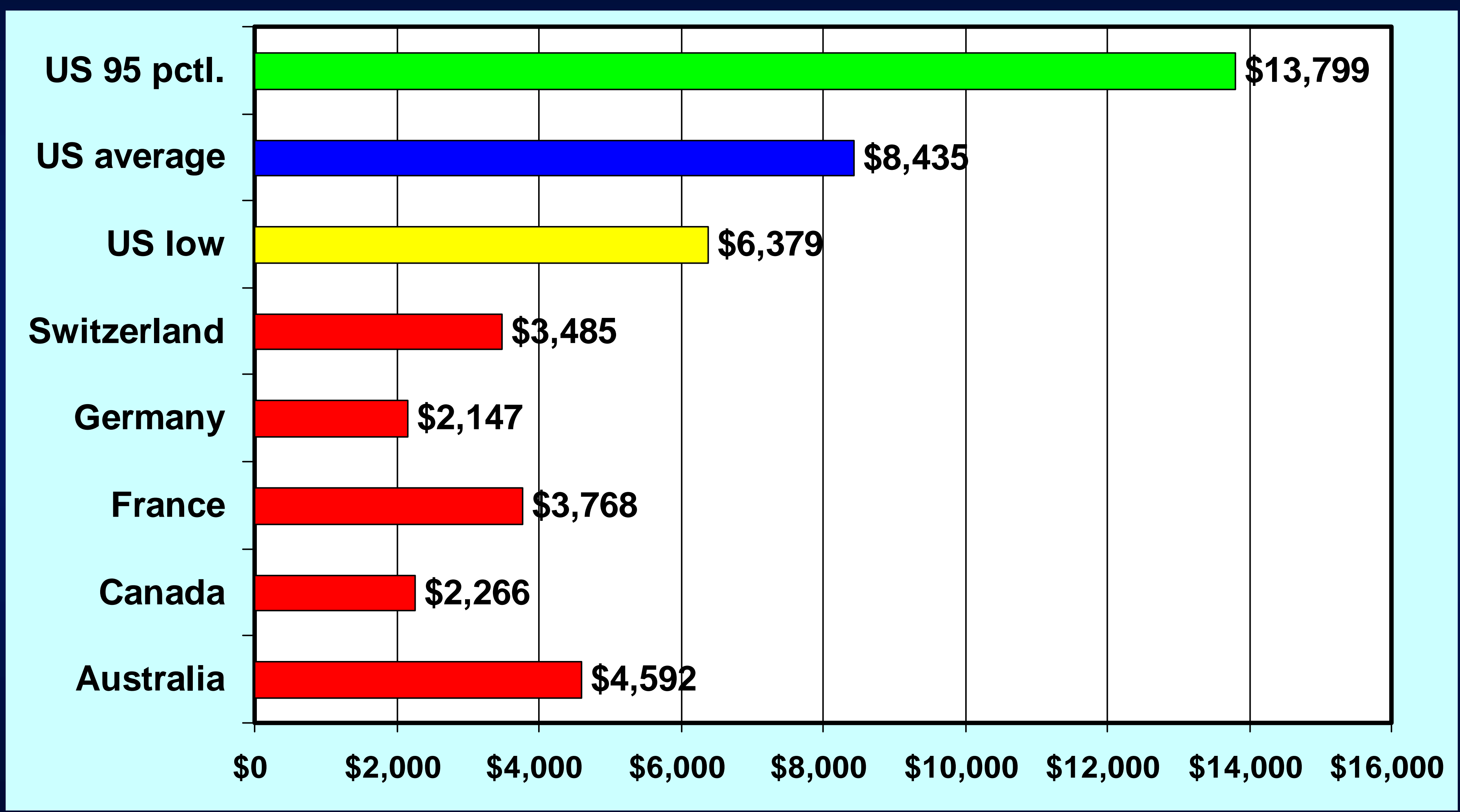
By contrast, we in the U.S. have splintered the payment side so much that each payer is weak relative to the more concentrated supply side – especially in the hospital sector.

The result is that we pay higher prices – often double – for identical health care goods and services than do citizens in other nations.

The *International Federation of Health Plans* annually surveys its members on the prices they pay in the various countries for standard health services or goods.

Here are the latest numbers – just out.

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



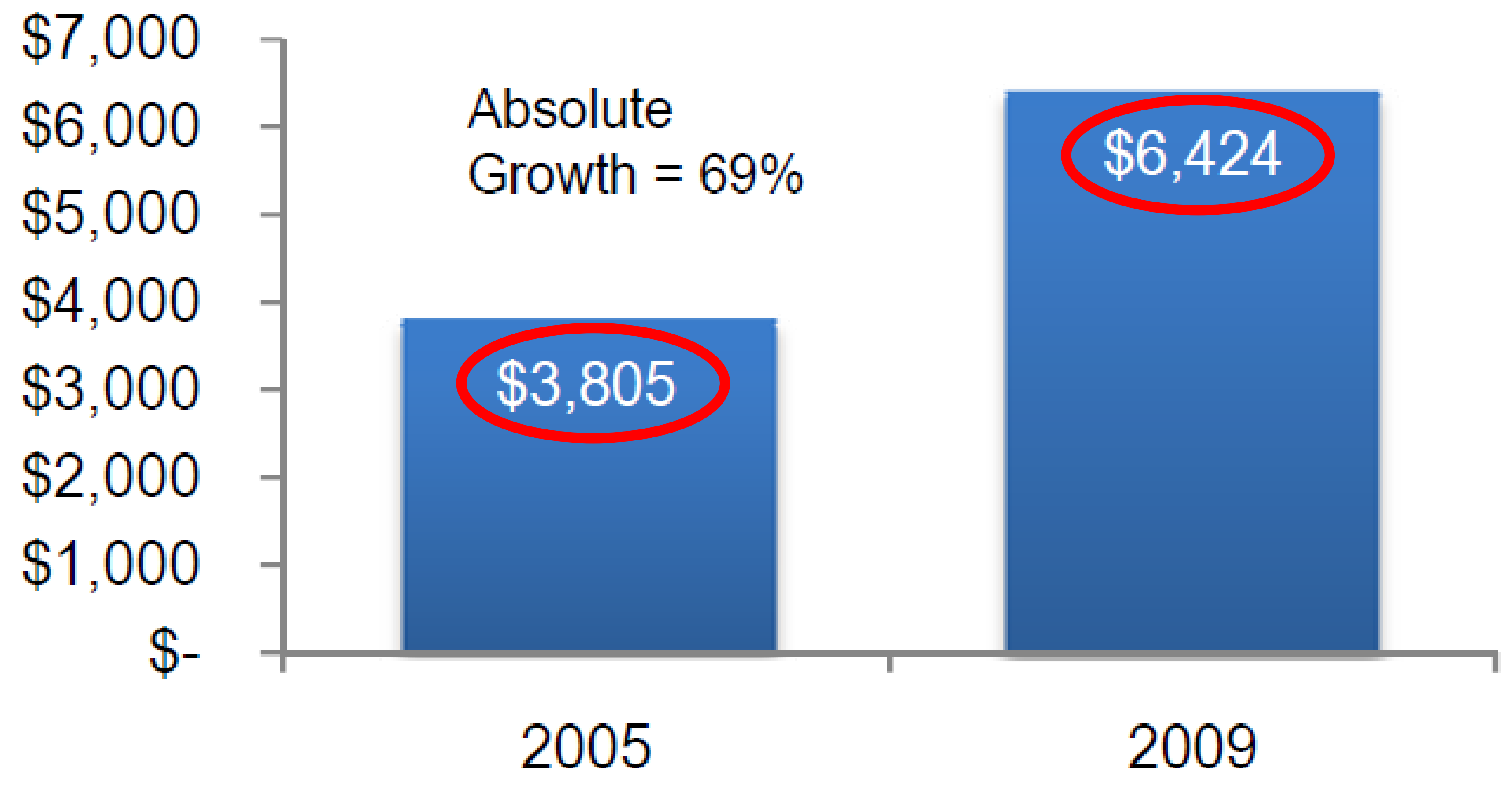
SOURCE: International Federation of Health Plans, *2010 Comparative Price Report*.

You may argue that America produces superior babies that simply cost more to produce, which is intuitively appealing.

But why, then, does the quality of babies vary so much even within the United States (see the three bars at the top of the graphs).

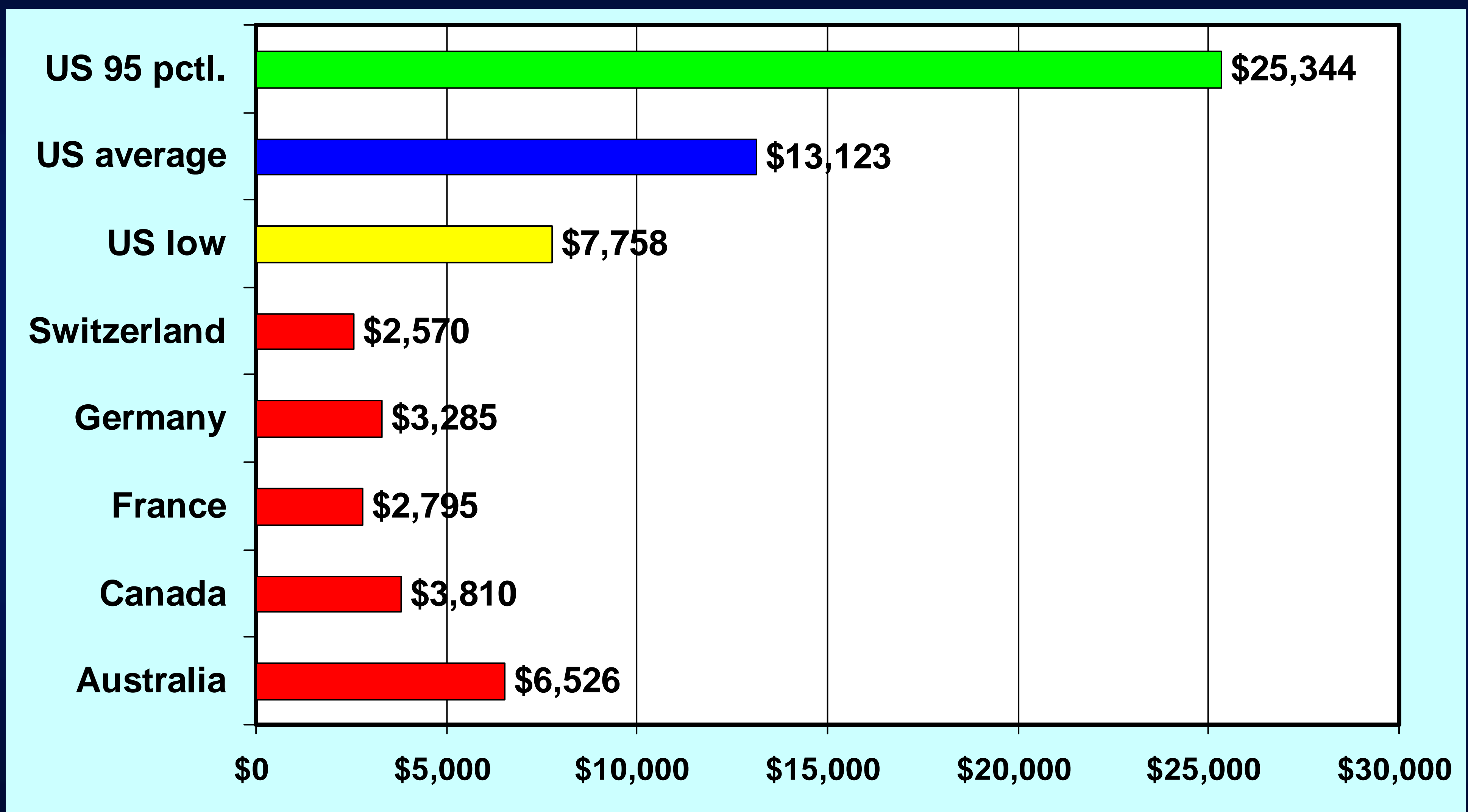
And has the quality of Oregon babies really improved that much over only four years, from 2005 to 2009?

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



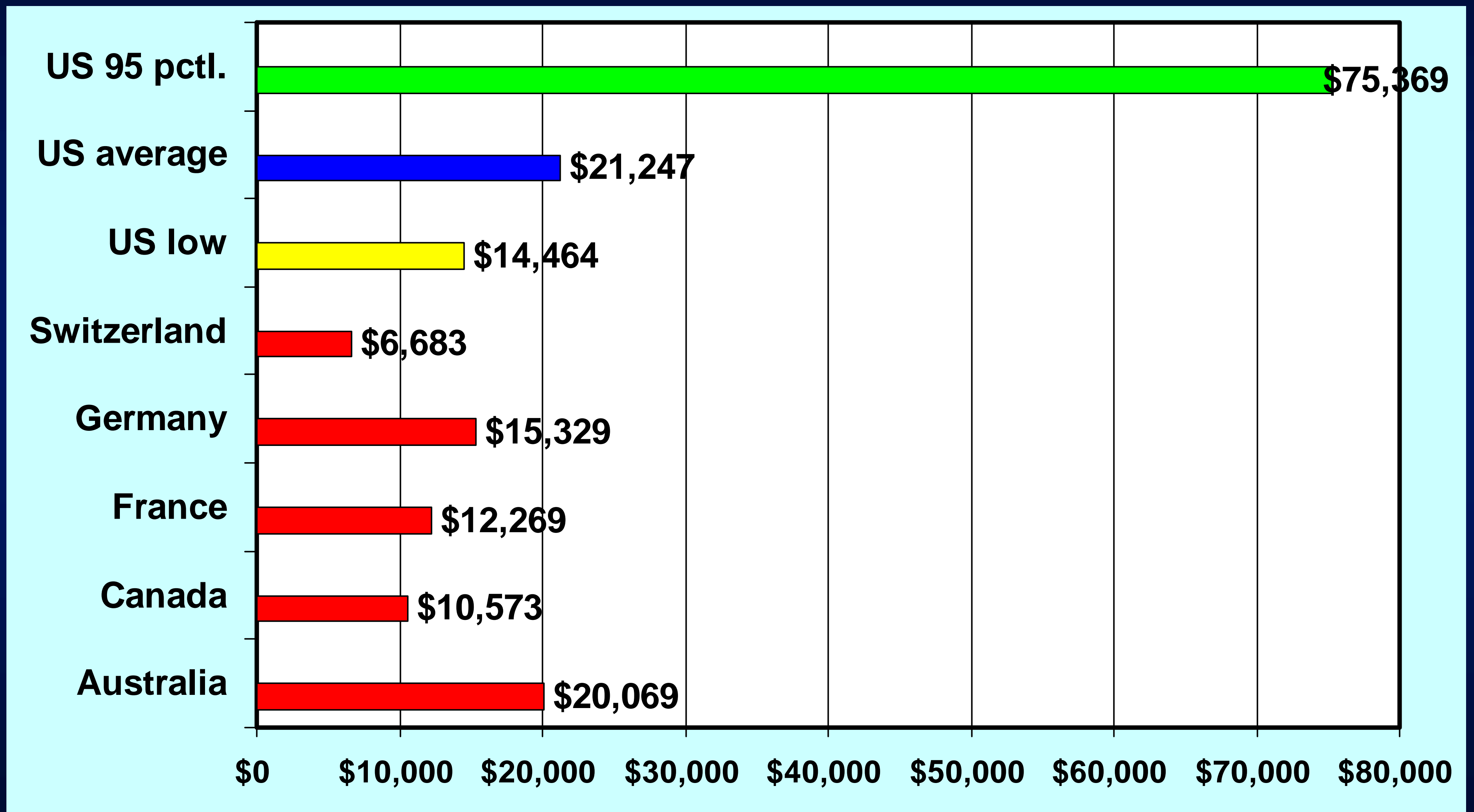
More international price data.

COMPARATIVE PRICES FOR AN APPENDECTOM:
Total hospital and physician cost



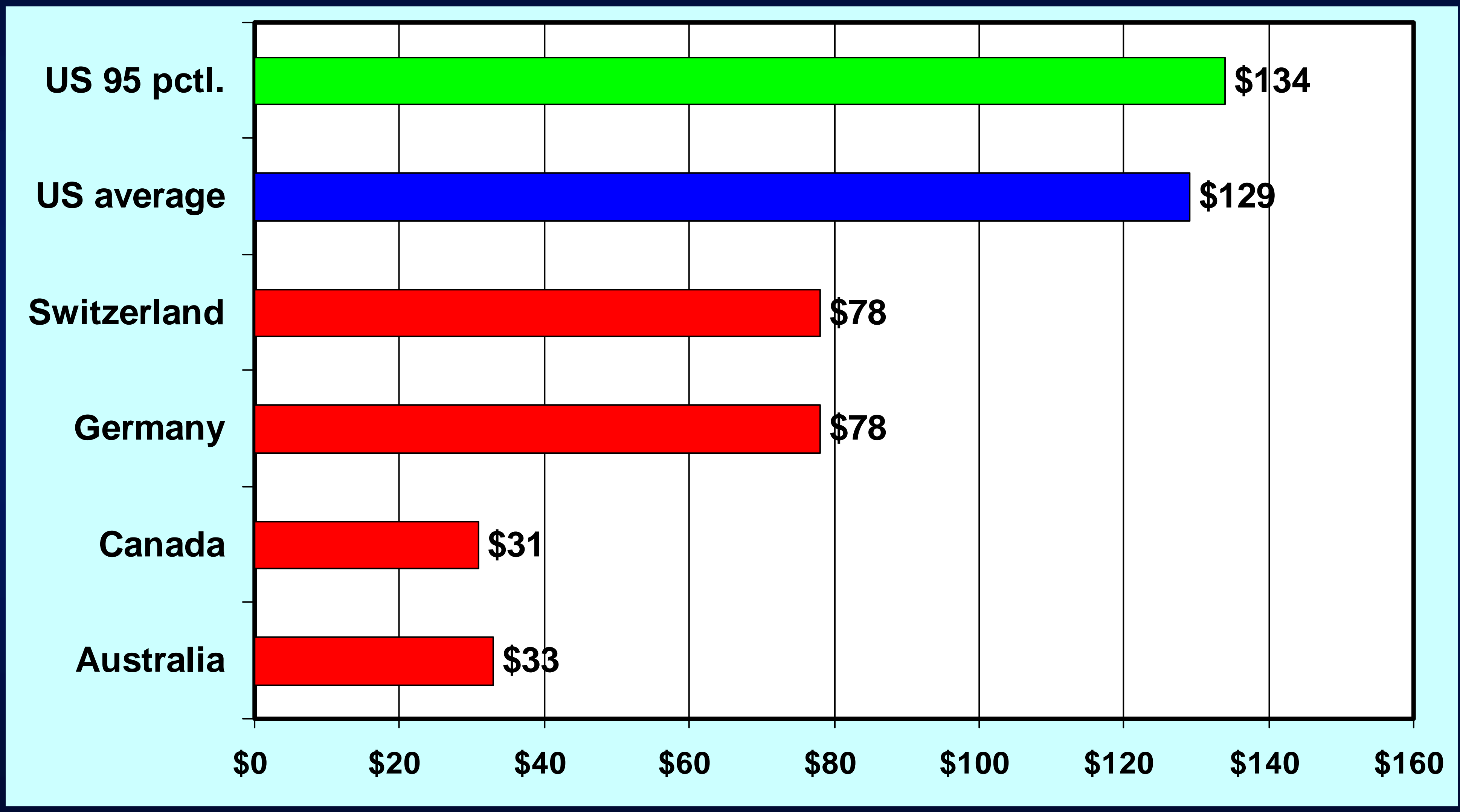
SOURCE: International Federation of Health Plans, *2010 Comparative Price Report*.

COMPARATIVE PRICES FOR HIP REPLACEMENT:
Total hospital and physician cost



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

COMPARATIVE PRICES FOR LIPITOR:



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

HEALTH AFFAIRS - Volume 22, Number 3

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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

We are unlikely ever to follow the European or Canadian approach to controlling health spending.

Therefore, we are likely to look for a market mechanism to ration health care by income class which, for some reason, we do not consider "rationing."

Culturally we are already conditioned to ration that way in our justice- and educational system.

Health care may be next.

If we do want to move to rationing by income class, we will likely use one or both of the following instruments to that end:

1. **High cost sharing by patients at point of service;**
2. **Reference pricing.**

HIGH COST SHARING BY PATIENTS

Rationing by income class through high cost sharing can be achieved in two ways:

1. **So-called "Consumer Directed Health Plans", i.e., policies with very high deductibles and coinsurance, coupled with tax-preferred Health Savings Accounts (HSAs), which actually makes health care cheaper for high-income people than for low-income people..**

2. **Defined-contribution health insurance, e.g., the plan for Medicare put forth by Dr. Alice Rivlin of the Brookings Institute and Congressman Paul Ryan (R-WIS). They would let Medicare's defined contributions grow at only GDP growth + 1%, much below the historical experience.**

REFERENCE PRICING

Under reference pricing, insurers would pay for a relatively low cost version of a service or product, requiring the patient to pay for the entire difference between that low-cost "reference price" and whatever the price is of the version chosen by the patient (e.g., a brand name drug rather than the low-cost generic, or a high-cost hospital for a procedure rather than a lower-cost hospital).

Pervasive reference pricing could tier health-care delivery in quite subtle ways by income class.

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VI. CONCLUSION

In thinking about "bending the cost curve" down, we must always keep in mind Alfred E. Neuman's *Cosmic Law of Health Care*, to wit:

Alfred E. Neuman's
Cosmic Health Care Equation

HEALTH SPENDING = HEALTH CARE INCOME

Including fraud, waste and abuse.

K-Street in DC is full of money-laden warriors bent upon protecting the upward slope of the cost curve, whatever campaign financing it may take.

Bending the cost curve down against the will of this armada will be a long and arduous struggle.

Think Afghanistan for a good analogy.

In the meantime American voters, world-renowned for their legendary savvy, are vexed by the ineptitude of the politicians whom they send to Washington – politicians who promised that they could lower the left-hand side of an equation without changing the right-hand side and, once in DC, can’t do it.

These savvy voters are mad as hell and won’t take it anymore.

I HATE
EVERYONE

Listening to the cacophony we called the "health-reform debate" I was reminded of a marvelous ditty I once heard at *Le Lapin Agile* in Paris (not Paris, Texas, but a city by that name in France).

Le Lapin Agile
22 Rue Saules, 75018 Paris, France

THE REFRAIN OF THE DITTY

"Messieur le President! Faites quelque chose. Je ne sais pas quoi. Mais faites quelques chose!"

(Mr. President. Do something! I don't know what. But do something.)

And so it goes.