Wronged by Wrong Prices: Protecting Consumers in Healthcare Markets

Leemore S. Dafny, PhD, Bruce V. Rauner Professor of Business Administration

Massachusetts Health Policy Commission Cost Trends Hearing
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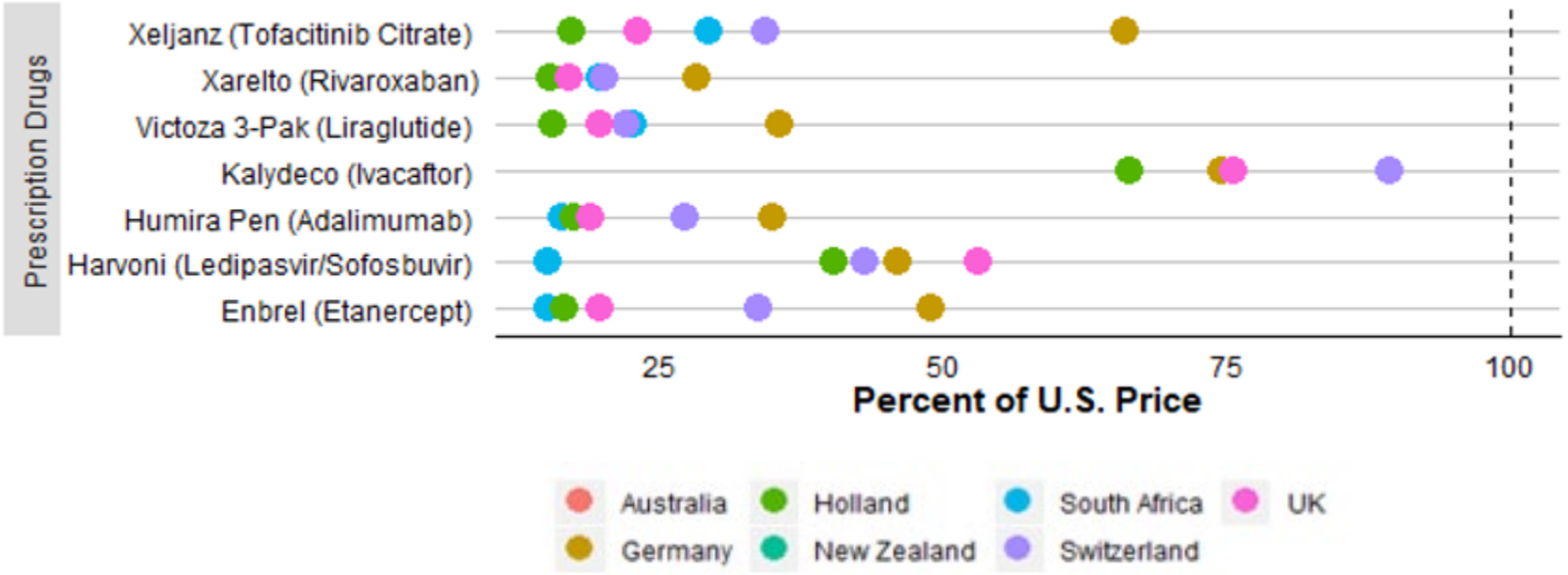
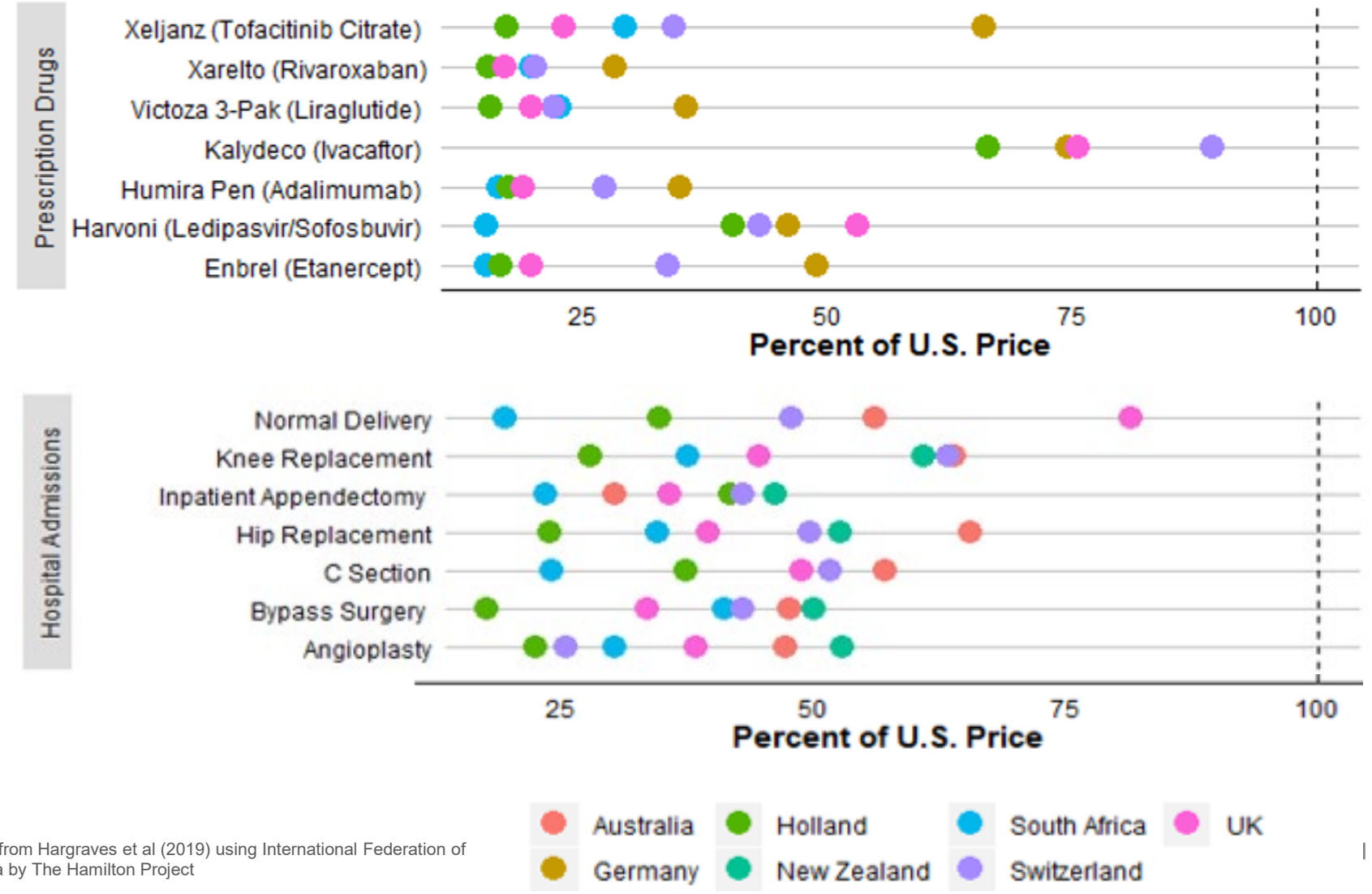
Agenda

- Prices are wrong
- Why prices matter
- What the state (and regulators) can do about it

It's well-known that the US pays much higher prices for branded drugs

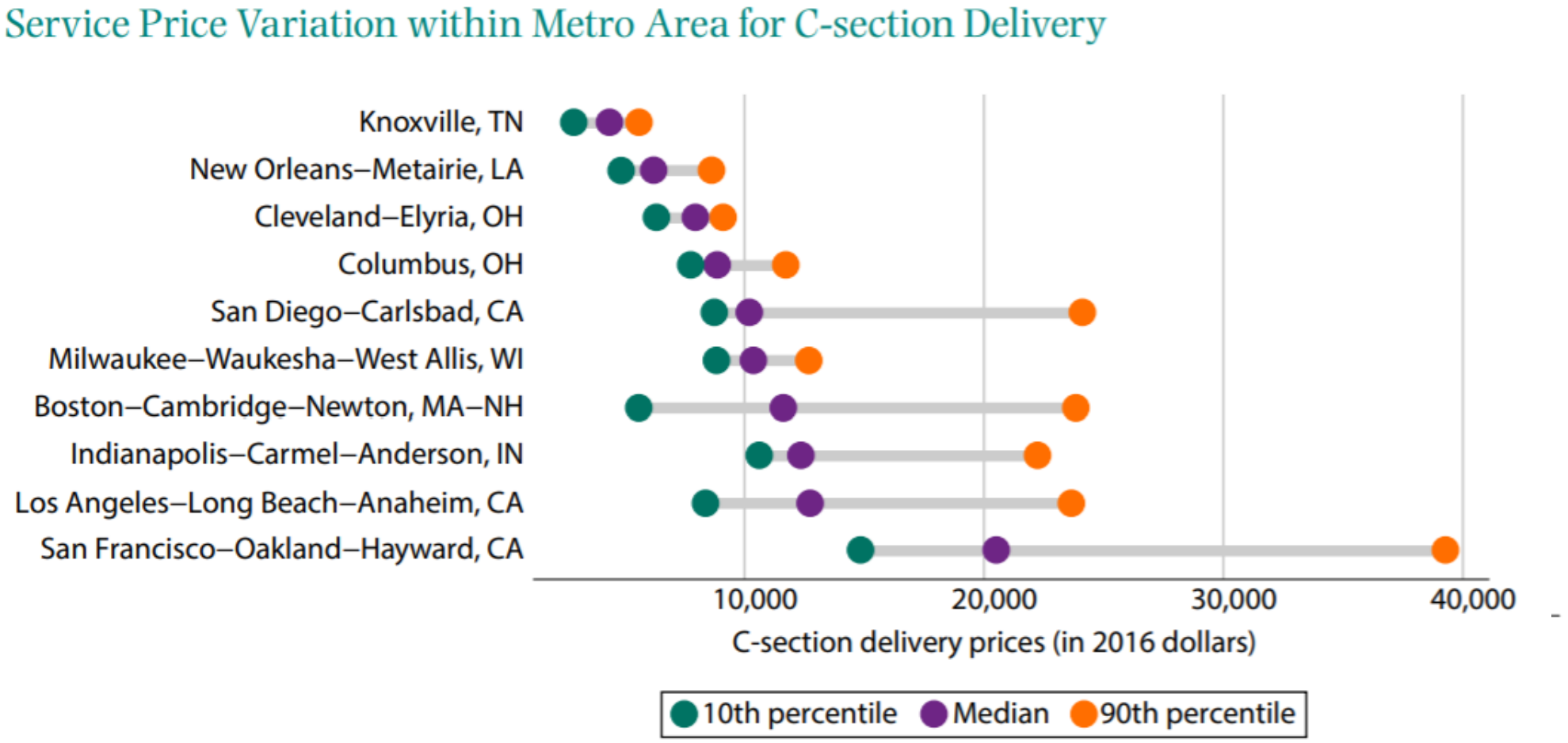


It's less well-known that the US pays much higher prices for hospital services, too



Source: Adapted from Hargraves et al (2019) using International Federation of Health Plans Data by The Hamilton Project

We also pay *different* prices for the same inpatient services in the same markets…



Source: Adapted from Kennedy et al. (2019) using Health Care Cost Institute data.

Notes: Percentiles (10th, median, 90th) show within-metro variation in price for the indicated service. Metro areas are defined as the 112 core-based statistical areas in the United States. A select group of metro areas is shown.

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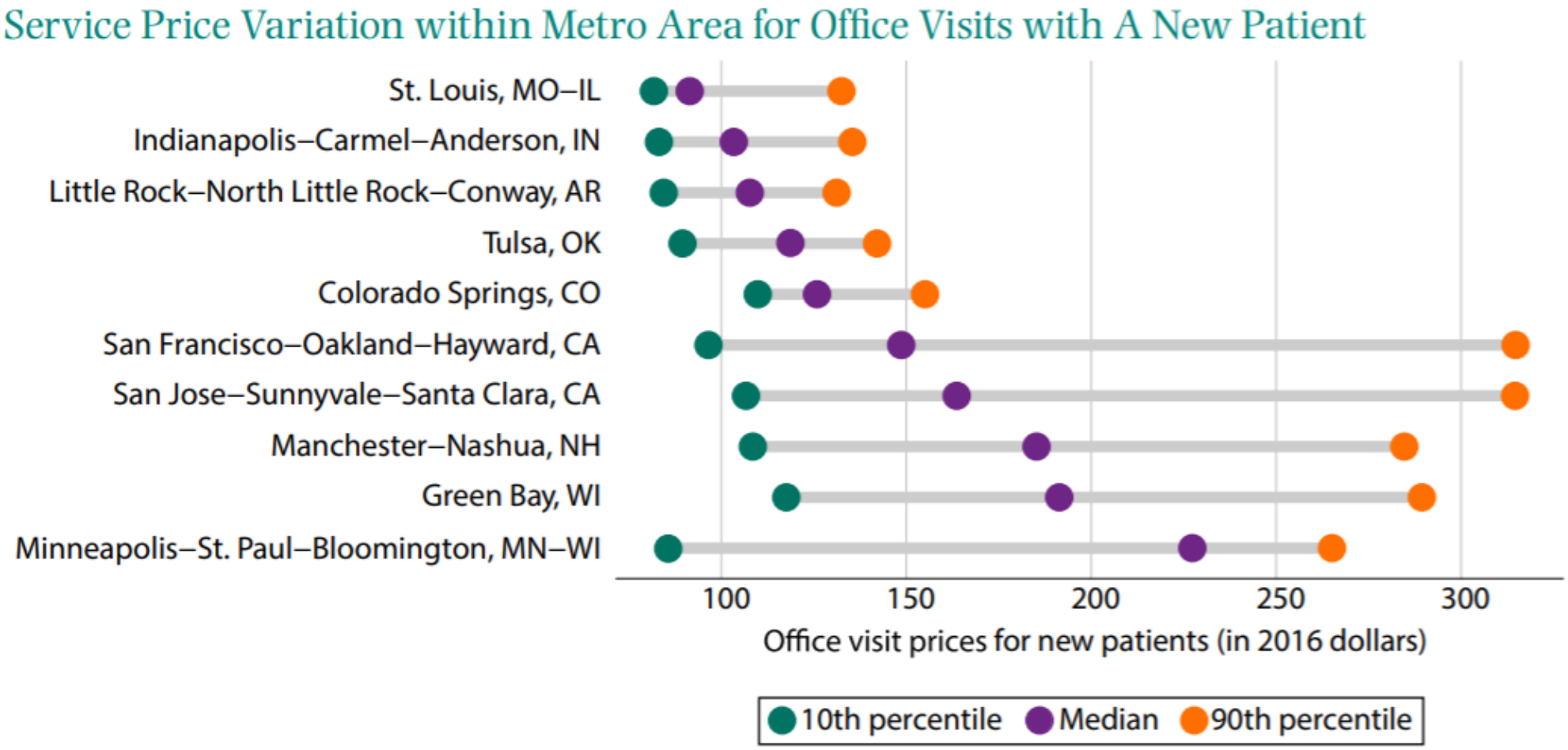
…and for the same outpatient services



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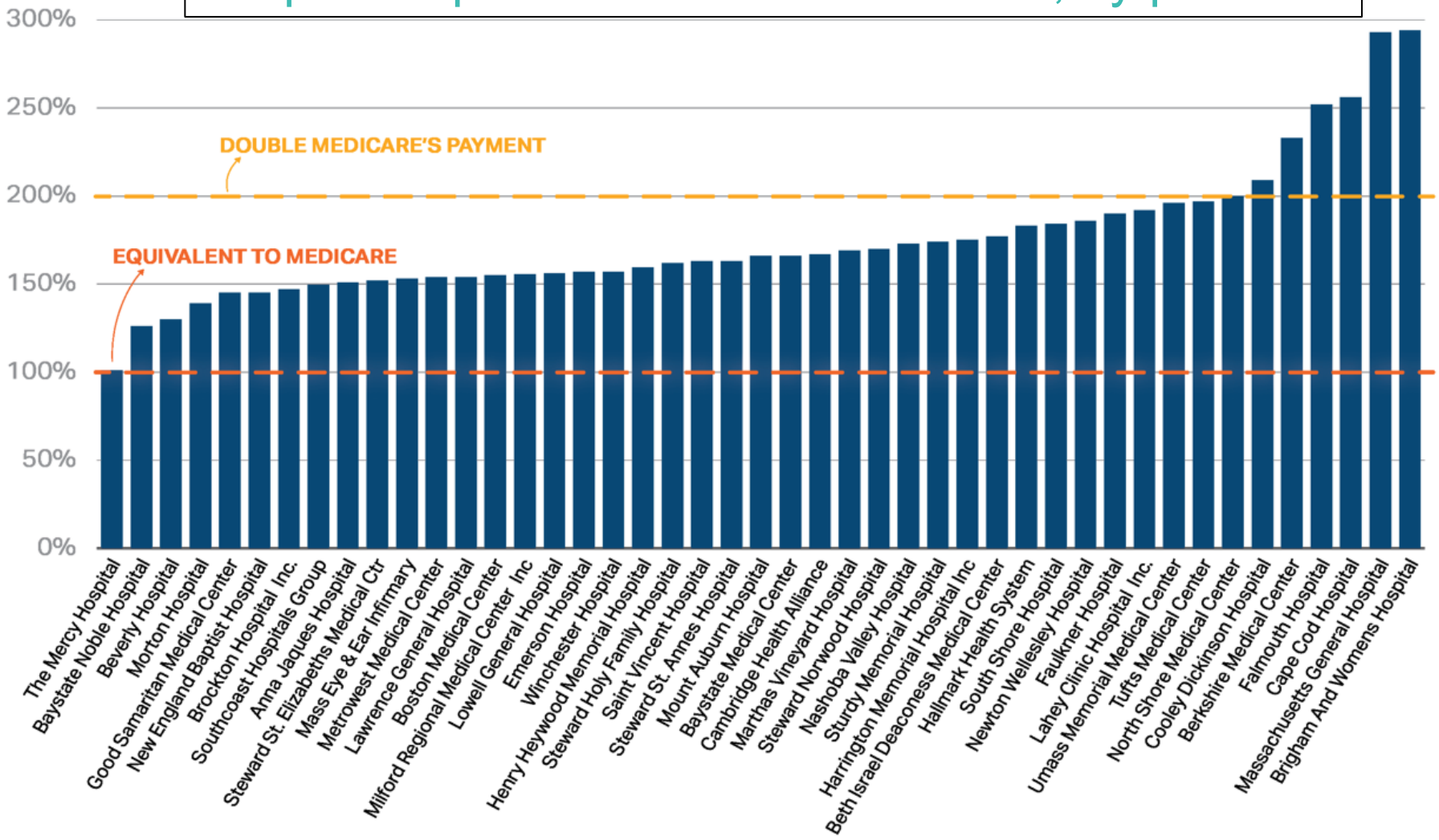
Plenty of price variation in Massachusetts too (1/2)

Outpatient prices relative to Medicare, by provider



Source: Massachusetts Health Policy Commission's analysis of data from Whaley et al, "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative," *RAND* 2021, https://www.rand.org/pubs/research_reports/RR4394.html; *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021*

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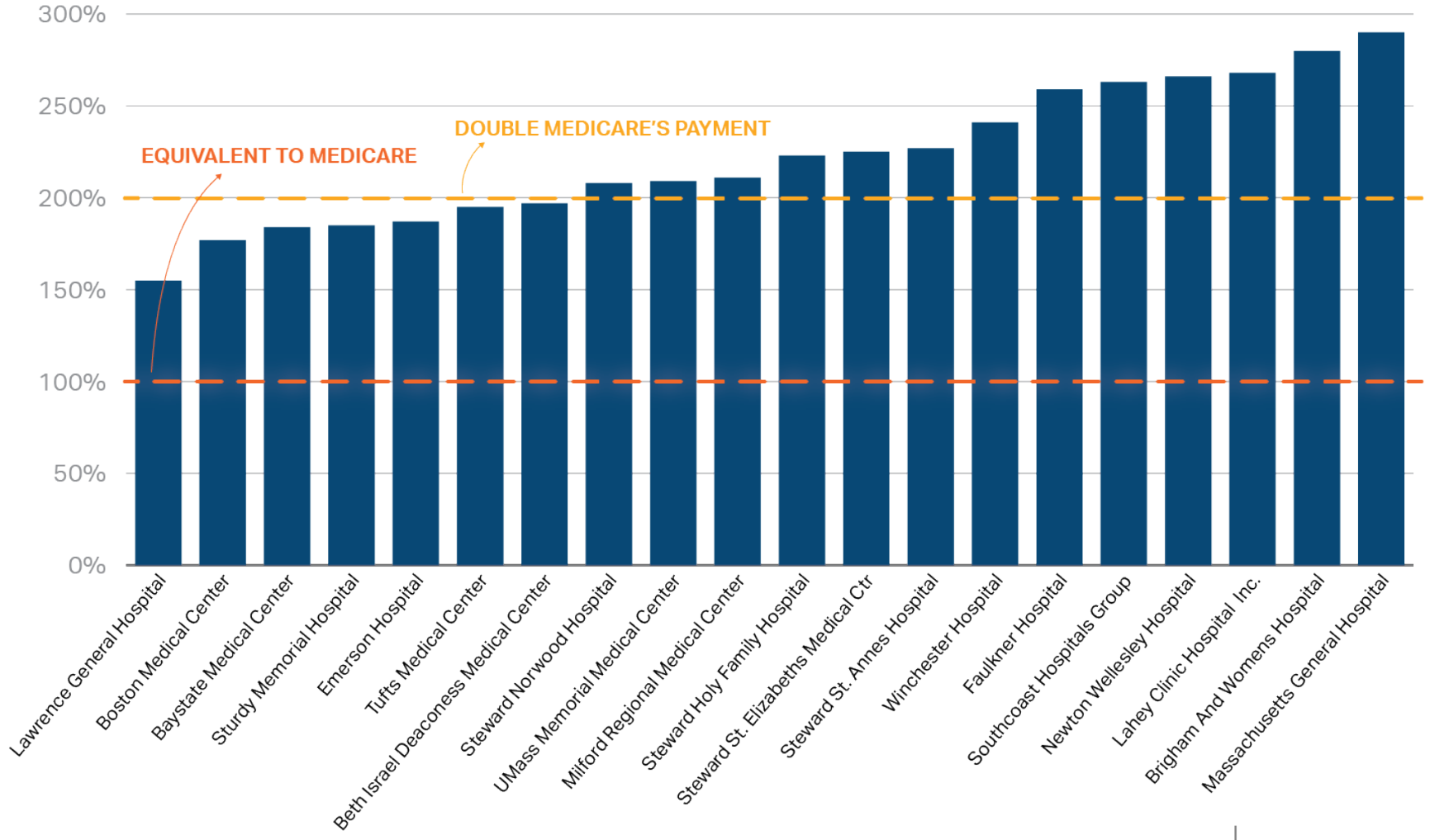

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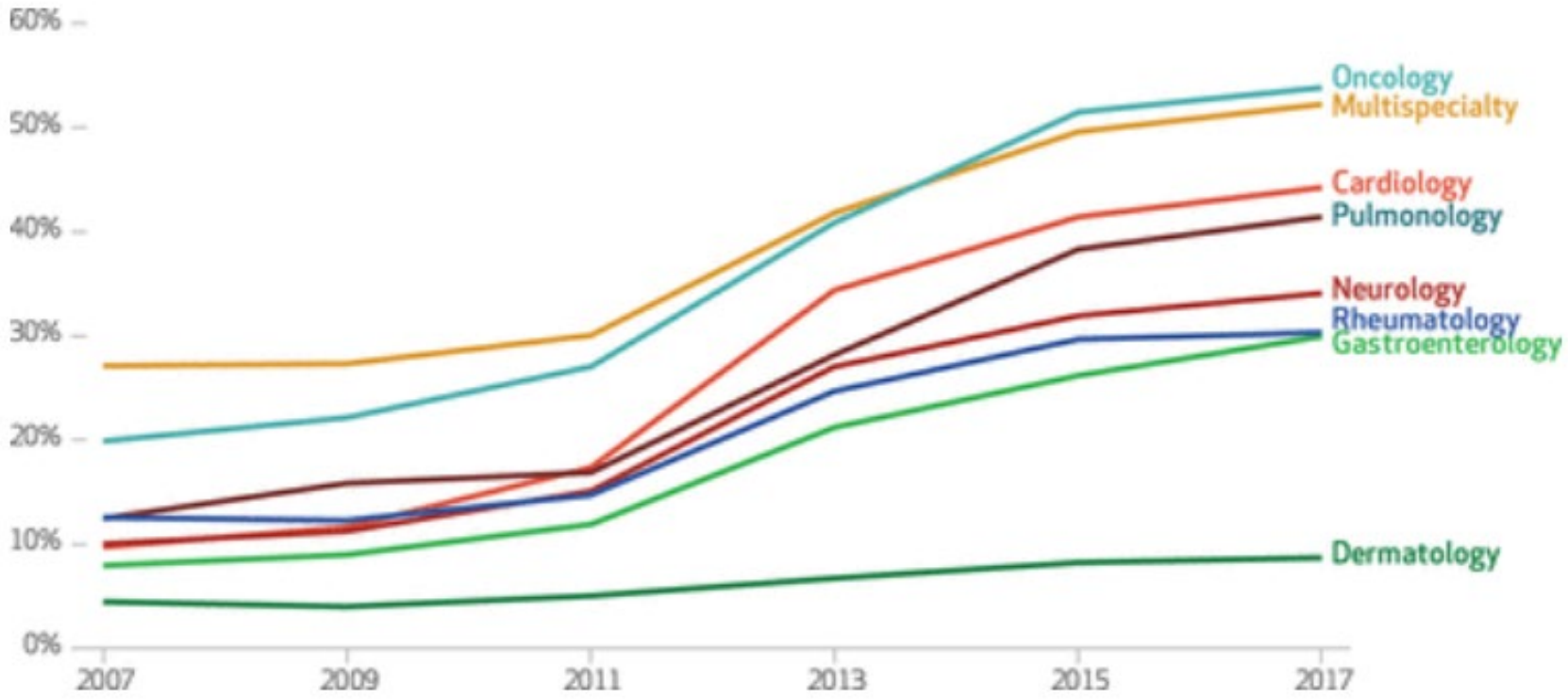
Why wrong prices matter (1/3)

- We use prices to allocate resources
  - High prices in health care attract resources (human and financial, public and private) to the sector…and away from other sectors
  - Variable prices affect organizational structure

Higher payments for hospital-based services may be one driver of physician practice acquisition

Percent of physician practices reporting hospital/system ownership



Source: Nikpay et al, "Hospital-Physician Consolidation Accelerated In The Past Decade In Cardiology, Oncology," *Health Affairs* 2018.

Why prices matter (2/3)

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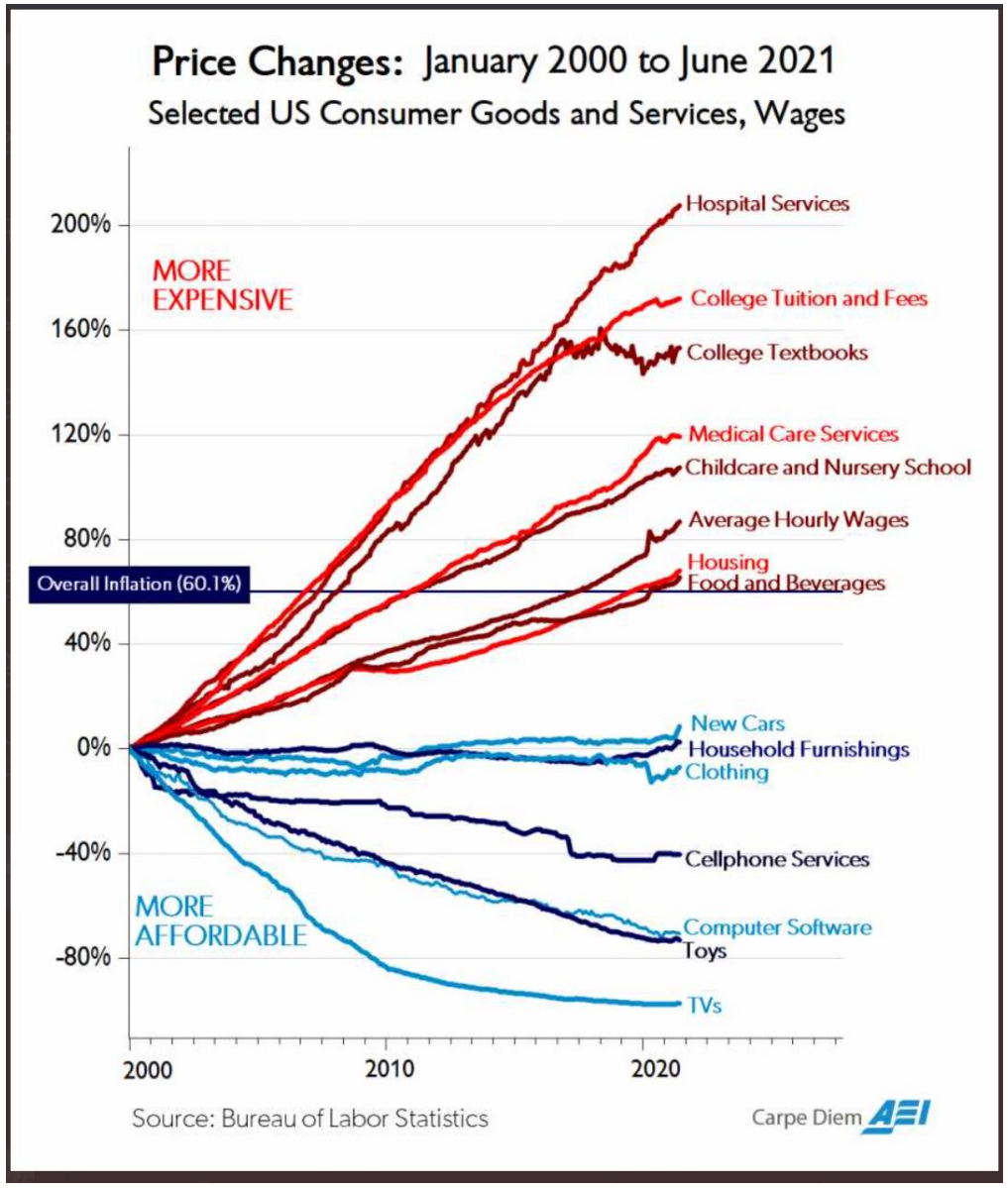
- Wrong prices create domino effects

Prices for hospital services in particular have soared



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  - Workarounds
    - to keep patients out of the hospital/ancillary services (and countervailing efforts by hospitals)
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Why prices matter (3/3)

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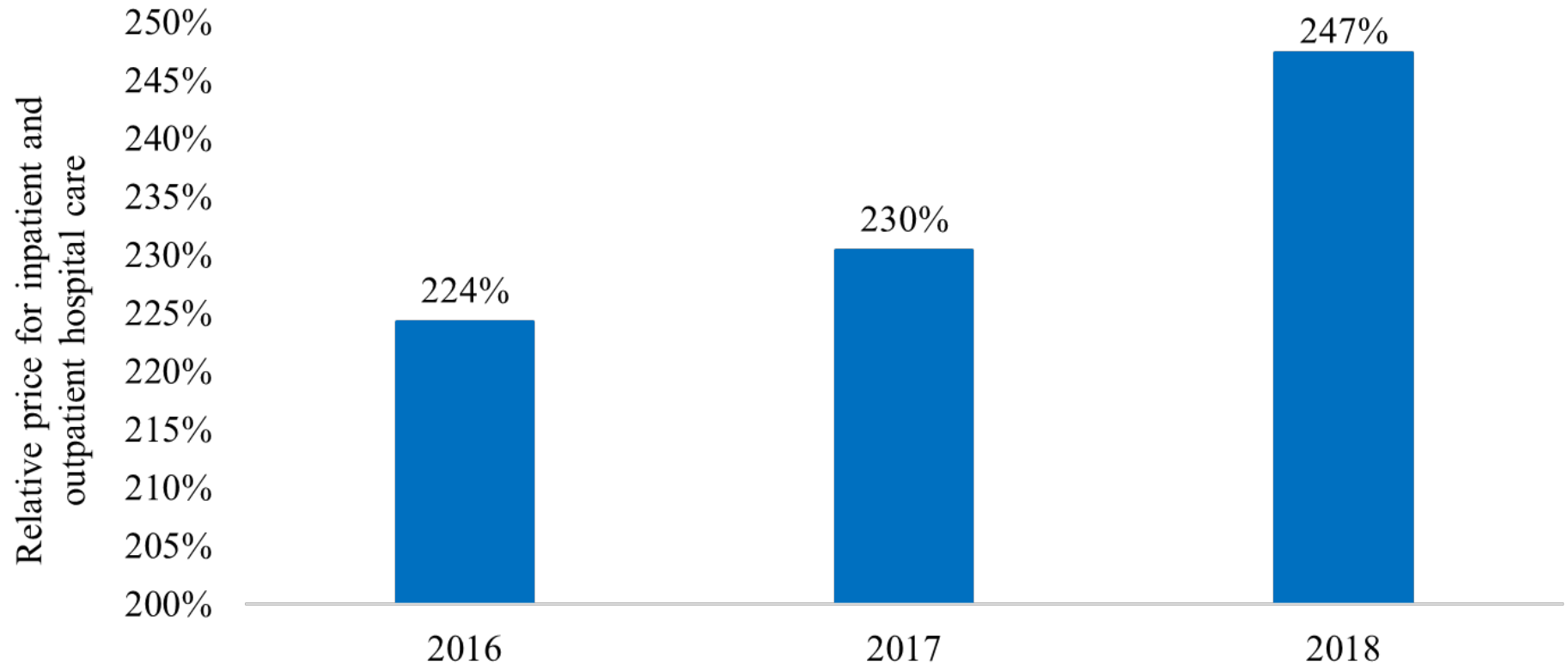
    - to manage specialty drug spending (and coupon/copay assistance by biopharma)
- Prices are driving higher premiums → higher deductibles and cost-sharing → poor health choices and outcomes & inequity

Nationally, hospital prices are growing rapidly

Average actual spending per commercial enrollee compared to spending priced at Medicare rates



Source: Whaley et al. (2020) "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative"

Prices – particularly hospital prices – are also a major driver of commercial spending growth in Massachusetts.

Massachusetts price growth overall

- Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, and Harvard Pilgrim Health Care all reported annual prices grew from 2015 to 2018 more than twice the rate of utilization.
- The Health Care Cost Institute found that Massachusetts commercial health care prices grew 15.6% from 2014 to 2018 while utilization grew 7.0%.

Massachusetts price growth by category, 2016 to 2018 (2021 Cost Trends Report)

- Hospital inpatient services: 9.1%
- Hospital outpatient services: 6.6%
- Office-based services: 4.4%

Sources: HCCI 2018 Health Care Cost and Utilization Report. Available at: https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report; Massachusetts Health Policy Commission. 2021 Cost Trends Report. Sept. 2021. Available at: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download

What to do? (1/2)

- Insist on paying lower prices
  - Drug-pricing reform proposals include: Medicare “negotiating” price, relying on other countries to cap/set price, capping price growth

National because drug markets are national

  - Service pricing reform proposals: Medicare *already* sets its prices, but private sector is on its own

Can be state-level because provider markets are local and insurers are regulated by states

What to do (2/2)?

(1) All payers pay uniform rate set by state regulator

(2) “Public option” insurance plans with access to regulated price rates

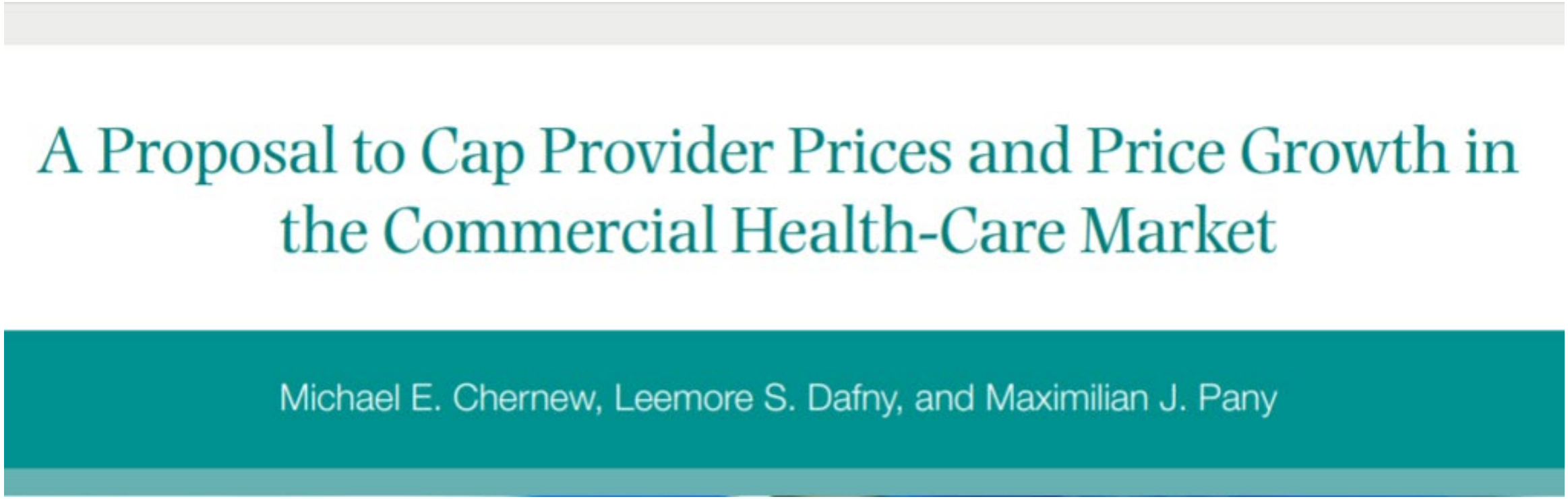
(3) Cap commercial price levels and/or growth rates

(4) Set global caps (e.g., caps on total medical expenditure levels or growth)

Price caps (1/3)

- Benefits of price caps (over price-setting)
  - Doesn't require an administrative authority to set prices
  - Market forces can operate beneath the cap, (potentially) rewarding providers who offer "better" services (broadly defined)
  - Less disruptive (unless caps set low)
  - Blunts incentive to consolidate/expand & negotiate higher rates
- Many details to decide
  - How to set cap and how it will evolve over time
  - Unit of service, e.g. DRG, RVU, episode of care
  - Apply to all prices or just out-of-network
  - How to enforce and how to ensure benefits passed through to consumers

We simulated the effect of price caps on national spending



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We proposed service-level caps based on local market prices

- For every inpatient and outpatient service (e.g., DRG and CPT)
  - ➢ Use distribution of MSA commercial prices to set cap, e.g 5 times the 20th percentile, 2 times the 50th percentile or the 90th percentile

Alternative caps:

5 x 20th = $875
2 x 50th = $850
1 x 90th = $875

Note: Illustrative example; does not use actual data

Estimated National Savings from Alternative Price Caps on Inpatient Admissions

Percentile of price distribution	Multiple	% of admissions affected	% savings
20th	5	5	9
50th	2	9	13
90th	1	12	8

Notes: (1) Caps vary by DRG and MSA (2) The 20th and 50th percentile caps are themselves capped at the 75th percentile nationwide

Estimated National Savings from Alternative Price Caps on *Out-of-Network* Inpatient Admissions

Percentile of price distribution	Multiple	% of admissions affected	% savings
20th	5	0.4	1.1
50th	2	0.5	1.2
90th	1	0.3	1.0

Notes: (1) Caps vary by DRG and MSA (2) The 20th and 50th percentile caps are themselves capped at the 75th percentile nationwide (3) Assumes no effect on in-network prices

We proposed supplementing with price growth caps and flexible oversight

- Price *growth* caps impact *all* providers (not just those beneath the cap)
  - Version 1: all subject to same caps
  - Version 2: higher-priced providers subjected to more stringent caps
- Can establish growth caps without level caps
- Additional oversight
  - Monitoring/regulatory body to monitor evasion, to ensure that "side payments" (e.g., via alternative payment mechanisms) and/or gaming don't undo the effect of price regulation, e.g. by monitoring TME

Several states have introduced service price caps that apply to certain insurance plans

Montana (2016)	▪ **Cap on state employee health plan payments** for inpatient and outpatient hospital services ▪ Cap is **234%** of Medicare rates (for average price of all services) ▪ All major hospitals are in network, due to public pressure
Oregon (2019)	▪ **Cap on state employee health plan payments** for inpatient and outpatient hospital services ▪ Cap is **200**% of Medicare rates (for in-network services) ▪ Cap is **185%** of Medicare rates (for out-of-network services)
Washington (2019) Colorado (2021) Nevada (2021)	▪ **Created public options** offered through private insurers ▪ Cap is **160**% of Medicare rates in Washington ▪ Floor is **155**% of Medicare rates in Colorado, but lower rates can be mandated by insurance commission if premium targets not met ▪ All three states set provider participation requirements

Source: *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021 (*see https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

Two states cap price growth for plans regulated by state insurance commissioners

Rhode Island (2010)	▪ **Cap on price growth in insurer-hospital contracts** subject to rate review and approval by Office of Health Insurance Commissioner. ▪ Cap is **Medicare iPPS growth + 1 percent** ▪ Growth is defined using average of inpatient and outpatient services
Delaware (2021)	▪ **Cap on price growth for non-professional services in insurer-hospital contracts** subject to rate review and approval by Department of Insurance ▪ Cap is **CPI + 1 percent** (begins at 3 percent in 2022, hits 1 percent by 2024) ▪ Non-professional services are inpatient hospital, outpatient hospital, and other medical services like home health

Source: Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. Health Affairs, 38(2), 237-245; *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021* (see https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

Rhode Island's reforms have slowed fee for service spending

- Rhode Island's spending initially above control states
- Spending growth declined in Rhode Island starting in 2012; spending was **15%** below control states by 2016
- Most of the savings came via a reduction in **spending per hospital inpatient visit.**
- Cost-sharing also dropped markedly
- Quality of care was unchanged

"Rhode Island's experience thus suggests that mandated price control measures may effectively leverage state regulatory power to reduce healthcare costs, particularly in areas where the market power of providers is greater than insurers."
– Baum et al. Health Affairs, 2019

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Challenges (2/2)

- Caps could impact ability and incentive to improve quality of services
  - No compelling evidence that increases in price lead to increases in quality
  - Oversight could enable price changes that don't increase TME
- Caps set in advance may not be optimal in light of current market developments, e.g. wage growth/workforce retention challenges
  - Need mechanism for short-term departures from target that reflect unexpected increases *or* decreases in costs
- Caps in Massachusetts could affect ability to recruit/retain top medical talent

Discussion

- Healthcare prices are wrong, and they're wrong in Massachusetts too
  - Market power is a key driver of price; curbing monopoly prices – with requirements the price cuts be passed through (perhaps by supplementing price level/growth caps with premium growth caps) – should help protect consumers
- In Massachusetts, key issue is place of service, so consider variants like tougher caps for outpatient hospital services (i.e., closer to site-neutral payments)
- Identifying and facilitating ways to take *out* costs is essential