
Payment Policy and the Value of Care

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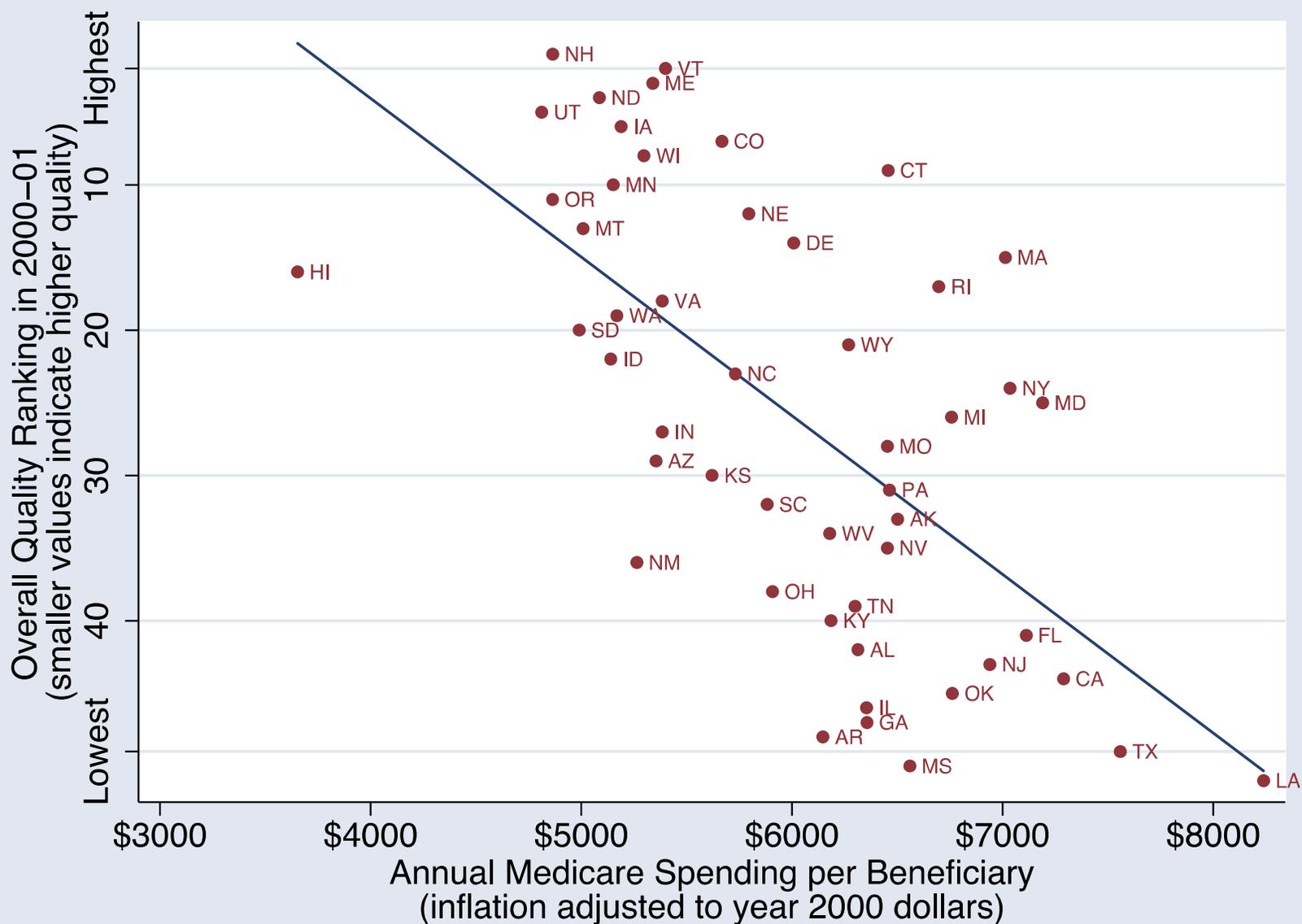
Two Goals of Health Reform

- Covering the uninsured (the easy part!)
 - Covering the uninsured improves outcomes, but at a cost
- Slowing spending growth (much harder)
 - Recent slowdown gives hope, but causes unclear
 - Private side: employees bear costs of rising premiums
 - Not about competitiveness or jobs
 - Public side: rising spending comes with DWL
 - Medicare, Medicaid, tax subsidy of employer insurance, and exchange subsidies
 - Half of health spending financed with public dollars – drives federal and state fiscal outlooks
 - Policy levers aimed at improving efficiency of Medicare

High Spending – High Value?

- Stemming spending growth focus of reform debate, but right metric?
 - Reasons we might want to spend more: rising incomes, worthwhile programs
 - Reasons for concern: cost of public financing, inefficiency
- Underlying problem: disconnect between costs and benefits
 - Goal: preserve access, drive value
 - Ample evidence that we could be getting higher value

Higher Spending Does Not Necessarily Lead to Higher Quality



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Source: Baicker and Chandra, *Health Affairs*

Medicare Variation

- Variation gives insights into spending patterns
 - Symptom – not root cause
 - Much within-area variation
 - Higher spending driven by higher intensity within episodes
 - Evidence of coordination failure (especially with increasing specialization)
- Financing a big contributor to inefficiency – but solution not simple

Implications for Reform

- Finance reform key – but not simple across-the-board cuts
 - Bundling, shared savings, integrated delivery
- Several approaches to improving value built into ACA
 - Many controversial
 - Great uncertainty about probability of success
- Start with fundamentals about how public insurance payments connect to total spending and value delivered
 - Payments based on “costs” of each service delivered may not promote high value

Medicare Payment Structure

- Many services paid based on weights * conversion factors
 - Weights based on intensity/costliness of inputs
 - RBRVS: based on RVUs and adjustments
 - Conversion factor a \$ amount updated annually
- MedPAC recommends updates based on:
 - Beneficiary access to high-quality care
 - Provider access to capital and margins
 - Margins are not dispositive – payments can drive costs
 - Focus on “efficient providers” – putting pressure on inefficient use
 - Not overall budget targets, but financial consequences gauged

Challenges of FFS

- Prices are always going to be “wrong”
- If mispricing → misutilization, why not just “fix” mispricing?
 - Very hard to know what “right” price is
 - Limited market signals of competitive price
 - Focusing on resources used requires minute detail
 - Focusing on spending per service combines quality and quantity
 - Perpetuates current “cost” structures, even if inefficient
- Across-the-board cuts thus unlikely to succeed
 - Requires different payment structures – bundling, ACOs, etc.
- MedPAC considers policies in context of promoting more efficient delivery

Current Efforts in Medicare

- Part A hospital coverage
 - Initially a retrospective, cost-plus reimbursement system
 - DRG system introduced in 1980s
 - Based on charges and cost-to-charge ratios
 - Area cost indices
 - Adjustments – DSH, rural, IME/DME, etc.
 - Designed to be prospective, but eroded
 - Based on patient characteristics, diagnoses
 - Also defined based on some procedures; outliers
 - Small steps toward quality-based payments
 - Bigger bundles?

Current Efforts in Medicare

- Part B physician services
 - RBRVS – fee schedule (replacing charge calcs)
 - Known problems – mispricing, plus rising volume
 - SGR intended to address, but . . .
 - ACA reforms
 - Incentive payments; review of misvalued services; limits on adjustments; quality reporting; feedback
 - ACOs
 - Physician decisions affect many components of care
 - Intermediate between FFS and MA – in risk and integration
 - Many complications; questions about incentives

Current Efforts in Medicare

- Part C/Medicare Advantage – 25%+ of enrollees
 - Managed care option – like private plans
 - Competitive bidding, risk adjustment
 - Quality adjustments
 - Limited success to date – but potential spillovers
- Part D drug coverage
 - 21% of beneficiaries lacked drug coverage in 2002; 10% in 2006
 - Enrollee choice among plans – some evidence that choose lower cost plans
 - Premiums set by competitive bids
 - Subsidies for low-income; penalty for late enrollment
 - Management tools – e.g. formularies
 - “Donut hole” – partially filled in ACA

Additional Policy Levers Could Amplify

■ Patient-side

- Medicare: Significant gaps in coverage
 - Covers only half of health spending on elderly; elderly spend >20% income on health
 - Results in widespread supplemental coverage
 - Much of this first-dollar coverage → moral hazard, undermines availability of cost-sharing as tools – otherwise a powerful incentive
- Align cost-sharing with value
 - For insurance: limit tax preference, rationalize Medicare benefit
 - For care: Base cost-sharing on value
- Limited success to date
 - Integrated plans/ACOs could facilitate choice and competition
 - Role for higher-powered promotion of (and payment for) wellness

Additional Policy Levers Could Amplify

- Changing the playing field
 - Invest in (and use!) more sophisticated info on comparative effectiveness
 - Increase competition in insurance and provider markets
 - Balance competition and coordination
 - Medical malpractice a red herring
 - Regulatory reform grounded in insurance market principles

Fiscal Future: Public Spending Comes with Cost

- Current reforms don't pay for themselves
 - Expansions offset by revenue raisers (could have been used elsewhere)
 - Current law projections \neq current policy projections
- Rising health care spending generates DWL, increases debt
- Reality: tough trade-offs – can't cover all things for all people