

SIEPR

policy brief

Stanford Institute for Economic Policy Research

on the web: <http://siepr.stanford.edu>

Can Financing Reforms Reduce Costs While Improving Health Care Quality?

By Jeffrey Clemens

With expenditures totaling \$2.5 trillion, or \$7,500 per person, the United States consumes more health care than any other country in the world. The magnitude of U.S. health spending makes the health sector's productivity an issue of great importance. Are our health dollars delivering reasonable value, or are there ways to obtain better outcomes at lower cost?

Comparisons with other countries raise concerns about the cost-effectiveness of U.S. health care. While other countries spend far less, outcomes in the United States are not obviously better. Detailed analyses find U.S. care delivery to be excellent in some areas, such as care for individuals with cancer, and lagging in others, such as the management of care for diabetics. While it is difficult to rank national health outcomes in a compelling, comprehensive manner, few would read the evidence as

placing the United States unambiguously above its peers.

While international quality comparisons are debatable, spending comparisons are clear. The United States spends substantially on health care and does so across a broad range of settings and services (see Figure 1). As a share of gross domestic product (GDP) total spending more than tripled from 5 percent in 1960 to 18 percent in 2009, with significant long-run growth in spending at hospitals, in physicians' offices, on prescription drugs, and in other settings. In per capita terms, the United States spends twice as much as France and Germany (\$3,700) 83 percent more than Canada (\$4,100), and 50 percent more than relatively high-spending Norway (\$5,000).

High health expenditures place substantial pressure on household, employer, and

continued on inside...

About the Author

Jeffrey (Jeff) Clemens is a postdoctoral fellow at SIEPR. He received his PhD from Harvard University in 2011 and will start as an assistant professor at the University of California at San Diego after his year at SIEPR. Jeff's research areas include social insurance, health care finance, and issues related to the finances of state and local governments.



SIEPR *policy brief*

government budgets. A desire to reduce these pressures while improving the quality of care has generated significant interest in health-financing reforms.

Payment Systems Matter

The financing of U.S. health care creates incentives that spur high spending. In public and private insurance arrangements, as applied to both hospitals and physicians' offices, volume-based compensation dominates the landscape. The quality and efficiency of care delivery have little impact on physicians' incomes.

Fee-for-service reimbursements illustrate volume-based compensation at

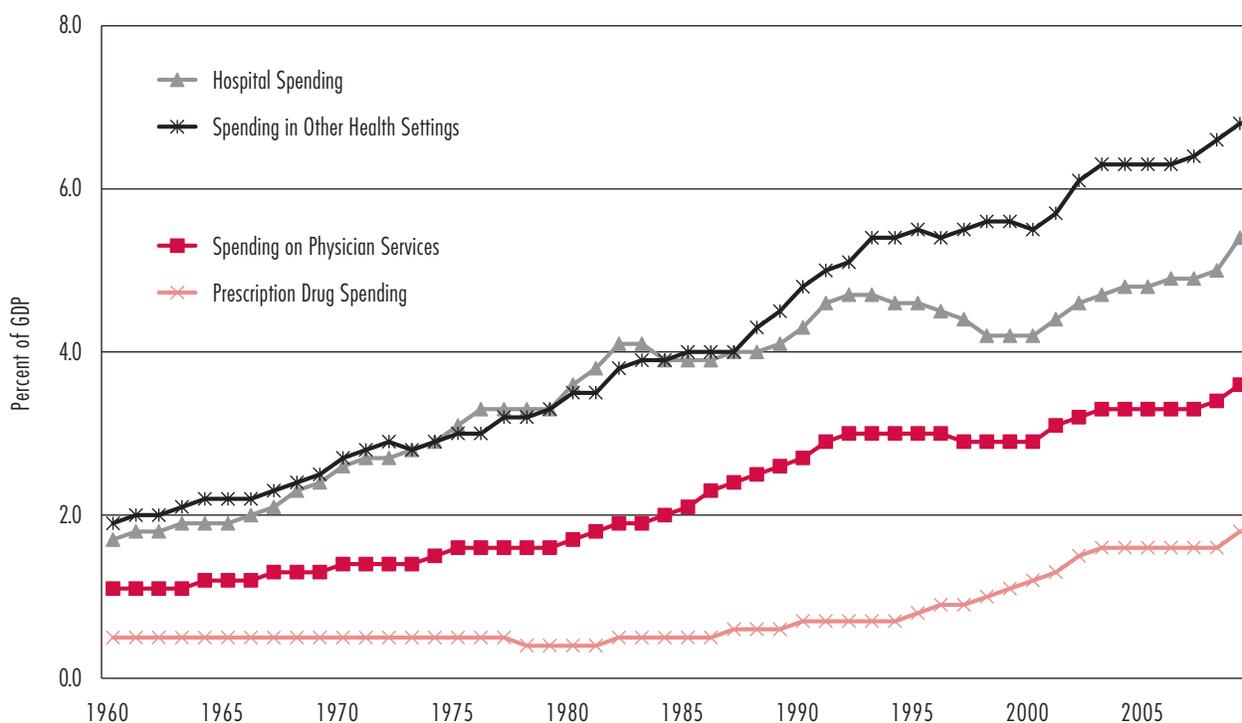
its most basic level. Medicare reimburses physicians separately for each uniquely billable service (of which there are more than 10,000) provided to an elderly American. Medicare reimburses a tenth diagnostic test the same as a fourth or a first, even in cases of overlap or outright redundancy.

Medicare reimburses hospitals on a per-admission basis, with adjustments made for the costs expected given a patient's primary diagnosis. This creates an incentive to control costs, but only within individual episodes of care. Perversely, if a rushed discharge results in a need for re-admission, the re-admission generates additional revenue for

the hospital; further monitoring prior to the initial discharge does not. Follow-up care highlights a related gap in the existing system. Post-discharge communication with patients can be helpful in improving their adherence to prescription drug regimens. While efforts to improve adherence go unreimbursed, re-admission due to a failure of adherence would, once again, generate revenue.

A growing body of research shows that, in a variety of settings, health care providers respond strongly to financial incentives. When insurance coverage expands or becomes more comprehensive, hospitals build capacity. When payments

Figure 1: Health Spending by Category





encourage expensive treatment courses, hospitals and outpatient clinics invest in new equipment and technologies. And when payment changes make care provision (either for particular treatments or in aggregate) more lucrative, patients receive more services.

This research implies that the United States is not locked into its state of high costs and questionable cost-effectiveness. If incentives influence how providers practice medicine, then well-crafted financing reforms can reduce costs while improving quality. The next sections of this policy brief discuss how existing reform proposals, some of which are scheduled for trial implementation through the Patient Protection and Affordable Care Act (the PPACA), seek to solve problems with existing payment systems.

The Fee Adjustment Approach

In the annual ritual known as the “doc fix,” Congress staves off across-the-board reductions to Medicare’s payments for outpatient services. The scheduled cuts, which stem from the Balanced Budget Act of 1997, would currently be on the order of 30 percent. Across-the-board payment cuts are a blunt instrument for reducing health care spending. While the potential cost savings are clear, the ramifications for care quality are less so. Discretionary services respond more dramatically than other

services when payments change, suggesting that the overall cost-effectiveness of care would improve as payment rates fall. Nonetheless, fee adjustments can be better designed for the purpose of improving care quality.

Pay-for-performance models of fee adjustment could significantly improve on across-the-board payment reductions. Performance-based fee adjustments involve linking payment changes to a health service’s capacity to improve patient outcomes or its clinical appropriateness. Targeted payment changes of this form are called for by the PPACA, which enlists the politically controversial Independent Payment Advisory Board (IPAB) for this purpose. In 2018, for example, if the PPACA phases in as scheduled, the IPAB will recommend payment changes if growth in Medicare spending exceeds the growth of GDP plus 1 percent.

The potential advantages of value-added payments are straightforward. By definition, a system of value-based reimbursements increases incentives for providing high value care and reduces incentives for providing low value care. Difficulties in implementing such payments lie in cases of uncertainty. Physicians may disagree over what constitutes best-practice care, and the benefits of procedures can vary substantially across patients.

Two examples may clarify how value-based reimbursements might work. First, one can look to advances in the treatments

available for patients following heart attacks. Innovations over the last several decades have enabled relatively precise diagnosis of arterial blockages (using cardiac catheterization), removal of these blockages (using angioplasty), and provision of subsequent support for the artery (by inserting cardiac stents) with moderately invasive procedures. While these procedures are expensive, they have significantly increased post-heart-attack life expectancies. A system of value-based reimbursements would prioritize such services by reimbursing physicians sufficiently to ensure widespread access.

Next, consider expansions in the options available for treating individuals with lower back pain. In addition to non-invasive treatment via physical therapy, back pain treatments include epidural steroid injections and a variety of surgical procedures. The medical literature reports limited benefits and substantial risks for the latter set of procedures. Until the expected benefit of these treatments (net of costs associated with complications) could, at minimum, be shown to exceed the benefits of less costly and less risky treatment courses, a value-based payment system would discourage their usage through relatively low reimbursement rates. These payments would not be permanently entrenched but would rise if future evidence supported the effectiveness of lower back surgeries.

The uncertainty built into much medical knowledge may make comprehensive use of

value-added reimbursements implausible. Nonetheless, it is difficult to argue against reducing reimbursements for costly and ineffective treatments, in particular when alternative courses exist.

The Premium Support Approach

An alternative to altering provider payments involves reforms focused on consumers. Consumer-oriented proposals are often described as following the “premium support” model. Premium support can take a variety of forms and has been associated with public figures including Congressman Paul Ryan, Senator Pete Domenici, and former Director of the Office of Management and Budget Alice Rivlin. Operationally, such reforms give beneficiaries vouchers for the purpose of purchasing insurance plans. These plans could be modeled after the benefits provided under Medicare or could take a different course.

In thinking about premium support, it is helpful to be clear about how it relates to the current system. As it stands, Medicare implicitly acts as a source of premium support for the package of benefits to which beneficiaries have access. The same benefits could be administered through a premium support system by sending beneficiaries a check, requiring them to purchase a pre-specified insurance plan from the Centers for Medicare and Medicaid Services (CMS) and requiring

CMS to charge the same premium to each beneficiary. The result of this cosmetic change would be a system equivalent to that currently in place (plus some added cost of postage). Reductions in the premium support checks would require CMS to scale back the services it covers.

Premium support plans rein in spending growth by requiring their vouchers to grow more slowly than health spending might otherwise grow. In the Domenici-Rivlin plan, for example, allowing premium support to grow at the rate of the GDP plus 1 percent would restrain health spending by \$90 billion in 2020 and by more in subsequent years. Paul Ryan and Oregon Senator Ron Wyden recently proposed a similar plan that would cap the growth of vouchers at that same rate.

Relative to centrally administered fee adjustments, premium support offers the benefit of greater choice at a cost of greater administrative complexity. Greater flexibility emerges along two dimensions. First, beneficiaries would have more choice over the set of services for which they reduce provider reimbursements. Some people may forgo coverage for back operations, while others may perceive small benefits from a different set of services. Second, premium support allows benefit packages to be altered through cost sharing as well as fee adjustments. Some people may prefer to keep all services on the table but to pay a deductible before coverage

kicks in. Such plans would more closely follow the major-risk approach to insurance coverage than does Medicare in its current form.

Of course, individuals will not literally make decisions about co-payments and physician fees on a service-by-service basis. Plan choice would require advice from physicians and other experts, and many beneficiaries may simply select (or decline to opt out of) a default plan recommended by CMS. For beneficiaries who do not actively select an alternative plan, the premium support model may more closely parallel the fee adjustment model than one might expect.

Solving the Care Coordination Problem

The fee adjustment and premium support approaches operate within the confines of the existing payment system. While they would tilt incentives against care that has low value and high cost, they would not fundamentally alter the volume-based orientation of U.S. health care finance. Incentives for delivering high-quality care and coordinating effectively across providers would not improve.

Improvements in care quality and coordination are the more ambitious goals of arrangements like Accountable Care Organizations (ACOs). The concept behind ACOs is to shift away from volume-based compensation by changing the unit at which we reimburse

continued on flap...



physicians. Rather than paying physicians for providing individual treatments or for isolated treatment episodes, an ACO would contract to provide all of the care that a beneficiary requires. Payments at this level have two important features. First, they eliminate the revenue gains associated with redundant services, which improves incentives for coordination across providers. Second, since costs associated with hospital re-admissions would be borne by the ACO, ACO arrangements extend the horizon over which providers must consider a patient's health. When follow-up care genuinely saves costs, ACOs will find it profitable.

ACOs hold the promise of giving providers incentives to control costs and improve their patients' long-term health. There is much uncertainty, however, regarding the difficulty of implementing these arrangements in practice. ACOs will need to be of substantial scale, for example, to ensure their capacity to provide beneficiaries with a comprehensive range of health care services.

Uncertainty highlights the importance of enabling our health-financing institutions to adapt as we learn more about their strengths and weaknesses.

However, the current system's weaknesses are sufficiently clear, and the stakes sufficiently high, to make the search for alternatives a top priority. The PPACA takes several steps in this direction by opening channels through which ACOs and other ideas can be tried and tested. The judgments of taxpayers and beneficiaries will determine the future of these efforts.

References:

Acemoglu, Daron, and Amy Finkelstein. 2008. "Input and Technology Choices in Regulated Industries: Evidence from the Health Care Sector." *Journal of Political Economy*, 116(5): 837-880.

Beaulieu, Nancy Dean, David M. Cutler, and Katherine E. Ho. "The Business Case for Diabetes Disease Management at Two Managed Care Organizations." Working Paper.

Clemens, Jeffrey, and Joshua Gottlieb. 2011. "Do Physicians' Financial Incentives Affect Treatment Patterns and Patient Health?" Working Paper.

Cutler, David M., and Mark McClellan. 2001. "Is Technological Change in Medicine Worth It?" *Health Affairs*, 20(5): 11-29.

Docteur, Elizabeth, and Robert A. Berenson. 2009. "How

Does the Quality of U.S. Health Care Compare Internationally?" Urban Institute.

Domenici, Pete, and Alice Rivlin. 2010. "Restoring America's Future." Report of the Debt Reduction Task Force of the Bipartisan Policy Center. <http://bipartisanpolicy.org/projects/debt-initiative/about>.

Feder, Judy, and David Cutler. 2010. "Achieving Accountable and Affordable Care: Key Health Policy Choices to Move the Health Care System Forward." Center for American Progress.

Finkelstein, Amy. 2007. "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare." *Quarterly Journal of Economics*, 122(1): 1-37.

Kaiser Family Foundation. 2011. "Health Care Spending in the United States and Selected OECD Countries." <http://www.kff.org/insurance/snapshot/OECD042111.cfm>.

Standard, Christopher J., et al. 2011. "Comparative Effectiveness of Exercise, Acupuncture, and Spinal Manipulation for Low Back Pain." *Spine*, 36: 120-130.

Weinstein, James N., et al. 2006. "Surgical vs. Nonoperative Treatment for Lumbar Disk Herniation." *Journal of the American Medical Association*, 296(20): 2441-2450.

SIEPR *policy brief*

Stanford University
366 Galvez Street
Stanford, CA 94305
MC 6015

A publication of the
Stanford Institute for
Economic Policy Research

Non-Profit Org.
U.S. Postage
PAID
Palo Alto, CA
Permit No. 28

SIEPR

About SIEPR

The Stanford Institute for Economic Policy Research (SIEPR) conducts research on important economic policy issues facing the United States and other countries. SIEPR's goal is to inform policymakers and to influence their decisions with long-term policy solutions.

Policy Briefs

SIEPR policy briefs are meant to inform and summarize important research by SIEPR faculty. Selecting a different economic topic each month, SIEPR will bring you up-to-date information and analysis on the issues involved.

SIEPR policy briefs reflect the views of the author. SIEPR is a non-partisan institute and does not take a stand on any issue.

For Additional Copies

Please see SIEPR website at
<http://SIEPR.stanford.edu>.