Healthcare Price Transparency: Paths Forward

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Preview

• The Spending/Price Problem
• The Flawed Shopping Process
• Paths Forward
The Spending/Price Problem
How Big is the Spending Problem?

Health Expenditures as Share of GDP

- United States
- France
- Germany
- Canada
- United Kingdom
- Japan

7% of GDP
How Big is the Spending Problem?

\[ 7\% \times \frac{18.0T}{321m} = \]

\$3900 per person

\[ = \]

higher taxes, premiums, out-of-pocket
lower wages
Why is the U.S. So Different?

- Aging
- Obesity/drinking/smoking
- Technology
- Malpractice
- Unit prices
- Administrative costs
Why is the U.S. So Different?

- Aging
- Obesity/drinking/smoking
- Technology
- Malpractice
  - “It’s the Prices, Stupid …” (Anderson et al. 2003)
- Unit prices
- Administrative costs
“Unit Prices”

• Definition: payment per unit of service
  – includes out-of-pocket payments by patient and payments by health plan

• How related to total health care spending?
  – \( S = nQP(1+a) \)
  – total health care spending equals the product of:
    • population (n), quantity of services per person (Q), unit prices (P), administrative loading (1+a)
How Bad is the Price Problem?

Surgeon fee for hip replacement (2008, US$)

Source: Laugesen and Glied (2011)
How Bad is the Price Problem? (2)

Source: Laugesen and Glied (2011)
How Bad is the Price Problem? (3)

Inpatient Hospital Stay
(2011 $USD, casemix-adjusted)

Why Focus on the Privately Insured?

- Prices vary
- Prices are negotiated
- Prices are, in some cases, extremely high
The Health Care Pie

Health Spending by Patient’s Primary Source of Coverage, 2013
Source: Author’s calculations using National Health Expenditures and MEPS-NHEA.
How Bad is the Price Problem in Ohio?
Variation in Hospital Inpatient Prices for Privately Insured Patients Across and Within 13 U.S. Markets

Source: White, Bond, and Reschovsky, 2013, *High and Varying Prices*
Variation in Hospital Outpatient Prices for Privately Insured Patients Across and Within 13 U.S. Markets

Source: White, Bond, and Reschovsky, 2013, *High and Varying Prices*
Variation in Primary Care Physician Prices for Privately Insured Patients Across and Within 13 U.S. Markets

Source: White, Bond, and Reschovsky, 2013, *High and Varying Prices*
Variation in Medical Specialist Physician Prices for Privately Insured Patients Across and Within 13 U.S. Markets

Source: White, Bond, and Reschofsky, 2013, *High and Varying Prices*
The Shopping Process
The Shopping Process: Privately insured

- **Health plans**
  - build provider networks, negotiate unit prices, steer patients

- **Employers/Unions/Marketplaces**
  - choose plan(s) to offer and benefit design

- **Enrollees**
  - choose plans (sometimes), providers (sometimes), and whether to receive a service (sometimes)

- **Physicians**
  - provide services, order services, make referrals
So, What’s Not Working?

- Mega-insurers vs. must-have health systems
So, What’s Not Working? (2)

- Health Plans
  - “go along” (with providers) “to get along”
  - self-funded plans are pass-throughs
    - negotiating with providers is a cost
    - high prices increase base off of which fees are charged
  - “fully insured” plans experience rated in many states
  - don’t need to outrun the bear, just other plans
So, What’s Not Working? (3)

- Employers
  - not qualified to manage health care system
  - want predictable costs, let employees pick up the rest
  - hate dealing with complaints
  - dependent on brokers and consultants
  - “cranky, confused, aimless, and spineless” (Holt, 2013)
So, What’s Not Working? (4)

- **Patients**
  - offended by notion that they should shop on price
  - only pay about 25% of premium out-of-pocket
  - only pay about 14% of total cost out-of-pocket
  - limited ability to discern provider quality
    - grasp at straws (e.g. “nice”)
    - suspicious of low-price providers
  - generally do what physicians tell them to do
So, What’s Not Working? (5)

- Brokers and Consultants
  - their living depends on lack of price transparency
  - price data are a strategic data asset, not to be shared freely
So, What’s Not Working? (6)

- Quality is very difficult to measure
  - price, without quality, means little
  - huge range of treatments and conditions treated
  - right action often unclear
  - patients affect outcomes
    - comorbidities
    - compliance
So, What’s Not Working? (7)

- Government
  - tax code favors profligacy
    - health care benefits over cash compensation
  - tax/regulatory environment favors self-funding
  - protects medical professionals from exposure
    - limits on performance reporting
Paths Forward
Patients, Employers, Physicians

- What’s the scope of potential impact?
- What are the options?
- What is the range of possible impacts?
Path 1: Patient—Scope of Action

- Medicare: 37%
- Medicaid: 11%
- Private (insurer): 44%
- Private (patient): 7%
- Uninsured: 1%
- Medicaid: 11%
Path 1: Patient—Scope of Action

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Non-Discretionary

Medicaid

Medicare

Path 1: Patient

- **Policy Options**
  - mandate availability of prices, price tools
  - reference pricing

- **Impacts**
  - minimal, because
    - shopping tools already available
    - tools are only used rarely

“In theory, price transparency is a powerful tool. In practice, price transparency makes little difference to most insured consumers because the structure of their health benefits does not reward the choice of lower-cost providers.” (Paul Ginsburg, USA Today, March 5, 2013)
Path 2: Employers—Scope of Action

- Private (insurer): 44%
- Medicare: 37%
- Medicaid: 11%
- Private (patient): 7%
- Uninsured: 1%
Path 2: Employers

- **Policy Options**
  - enable self-funded employers to analyze own prices
  - mandate that fully insured plans provide a “receipt”
  - APCD, with price reports that “name names”

- **Impacts**
  - moderate to large, because
    - mid-size and large employers well positioned to shop
    - wide range of responses
Example from Massachusetts
Figure 3: CY 2011 Acute Hospital Relative Price Composite Percentile and Payment Distribution
Path 3: Physicians—Scope of Action

- Medicare: 37%
- Medicaid: 11%
- Private (insurer): 44%
- Private (patient): 7%
- Uninsured: 1%
Path 3: Physicians

- **Policy Options**
  - mandate cost data at point of order entry
  - education

- **Impacts**
  - moderate to very large, because
    - huge scope of impact
  - depends on
    - alignment of physician financial incentives
Questions?
Thank you!

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References


References (cont.)


References (cont.)


References (cont.)

  [http://www.nihcr.org/Reference-Pricing2](http://www.nihcr.org/Reference-Pricing2)

- White, Chapin, James D. Reschovsky, and Amelia M. Bond, *Inpatient Hospital Prices Drive Spending Variation for Episodes of Care for Privately Insured Patients*, National Institute for Health Care Reform, February, 2014.  
  [http://nihcr.org/Episode-Spending-Variation](http://nihcr.org/Episode-Spending-Variation)