Making Competition in the Healthcare Sector Work: What Would It Take?

Initiative for Regulation and Applied Economic Analysis
Montana State University

Bozeman, MT

April 5, 2018

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The Basic Problem: Neither Fish Nor Fowl

• The provision of medical care in the U.S. lacks cost and quality discipline across-the-board.

• There is no real market discipline, and government regulation is partial and not wholly effective (and oftentimes blunt and unsustainable).
## Counting Up the Waste

<table>
<thead>
<tr>
<th></th>
<th>Mid-Range Estimate (2011, $ Bil.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failures of Care Delivery</td>
<td>128</td>
</tr>
<tr>
<td>Failure of Care Coordination</td>
<td>35</td>
</tr>
<tr>
<td>Overtreatment</td>
<td>192</td>
</tr>
<tr>
<td>Administrative Complexity</td>
<td>248</td>
</tr>
<tr>
<td>Pricing Failures</td>
<td>131</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>177</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>910</td>
</tr>
<tr>
<td><strong>% of Total H.C. Spending</strong></td>
<td><strong>34%</strong></td>
</tr>
</tbody>
</table>

Source: Berwick and Hackbarth, *Journal of the American Medical Association*, 2012
The Key Question

<table>
<thead>
<tr>
<th>Competing Views</th>
<th>A Governmental Process</th>
<th>A Market-Based Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solutions</td>
<td>• Medicare-led “delivery system reforms” (Accountable Care Organizations, Bundling of Payments, Innovation Center) • Governmental Push for Use of Health Information Technology • Comparative Effectiveness Research • Regulated Pricing</td>
<td>• Create incentives for consumers to seek lower-cost care alternatives • Foster competition among suppliers of medical care • Facilitate a model of high-deductible insurance combined with integrated care delivery • More Medicare Advantage and Part D than Medicare Parts A &amp; B</td>
</tr>
<tr>
<td>Criticisms</td>
<td>• A fully governmental process is susceptible to regulatory capture and protection of mediocre incumbents; arbitrary price setting drives out willing suppliers, inhibits innovation, and lowers quality • Cost control by supply control (queues)</td>
<td>• Cost are concentrated in high-cost patients; consumer incentives play little role in choosing service use in these cases • Markets exacerbate risk segmentation • Relying entirely on markets and prices to allocate resources is inequitable to those with less ability to pay</td>
</tr>
</tbody>
</table>
ACOs in 2016

- 432 MSSP ACOs in 2016
  - 410 in Track 1 (95%) -- bonus payment only

- Gross Program Savings = $652 million

- Net Program Cost (after bonus payments) = $39 million

- 31% of ACOs produced savings (measured against a benchmark) beyond corridor (2-3%)

- 25% produced savings within corridor

- 44% increase costs (20%) beyond corridor

- Older ACOs produce more savings

- Physician-led ACOs produce more savings
<table>
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</thead>
<tbody>
<tr>
<td>Aggregate</td>
<td>2.7%</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Per Capita</td>
<td>1.8%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>Medicare:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Aggregate</td>
<td>6.0%</td>
<td>2.9%</td>
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<tr>
<td>Per Capita</td>
<td>3.8%</td>
<td>-0.2%</td>
<td></td>
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<tr>
<td>Medicaid:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate</td>
<td>2.7%</td>
<td>4.8%</td>
<td></td>
</tr>
<tr>
<td>Per Capita</td>
<td>-0.6%</td>
<td>-0.3%</td>
<td></td>
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<tr>
<td>Private Plans:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate</td>
<td>2.0%</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Per Capita</td>
<td>2.8%</td>
<td>1.5%</td>
<td></td>
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</tbody>
</table>

Source: National Health Expenditure Accounts
The Many Obstacles to a Functioning Market

- Assymetric Medical Knowledge (Supplier Advantage)
- Dominance of Third-Party Payments
- Concentration of Spending in High-Cost Cases
- Licensure/Protection of Incumbency/Limitations on Innovation
- Opaqueness
- Excessive Horizontal Consolidation (Non-Competitive, Monopolistic Pricing)
Insurance Deregulation Won’t Fix the Problem

- Insurance Deregulation Agenda:
  - Exemptions from ACA’s Essential Health Benefits
  - More Flexibility for Age-Rating/Lower Premiums for Younger/Healthier Consumers
  - Allowance for Short-Term, Limited-Duration Plans
  - Association Health Plans
- These ideas would shift premium payments among consumers, but would not foster stronger market competition among providers of medical services.
Keep/Replace the Cadillac Tax

- Largest Tax Expenditure: $4.6 Trillion Over Ten Years
- Regressive: Average Per Household of $3,160 for Top 20 Percent, $980 Per Household in Middle Quintile
- Leads to Excessive Insurance Coverage, Suppresses Wage Growth
- Employer Plans Cost 35% More Than They Would Without the Tax Break
Restructured Choices for Medicare Beneficiaries

Beneficiary Options at Enrollment and Annually

- Unmanaged FFS
- FFS Through MPN
- Medicare Advantage

- Restricted Medigap Coverage
- Coordinated Medigap Coverage
- MA Added Benefits
- Stand-Alone Drug Benefit
- MA-PD Plan
HSAs: Standardized Clinical Packages

HSAs are standardized clinical packages that include:
- Primary and Preventive Care Package
- Diabetes Care Services
- Procedure A
- Procedure B
- Procedure C
- Medical Service Provider A
- Medical Service Provider B
- Medical Service Provider C

CMS defines medical services, and competition is based on transparent and fixed prices.
Available at AEI.org