

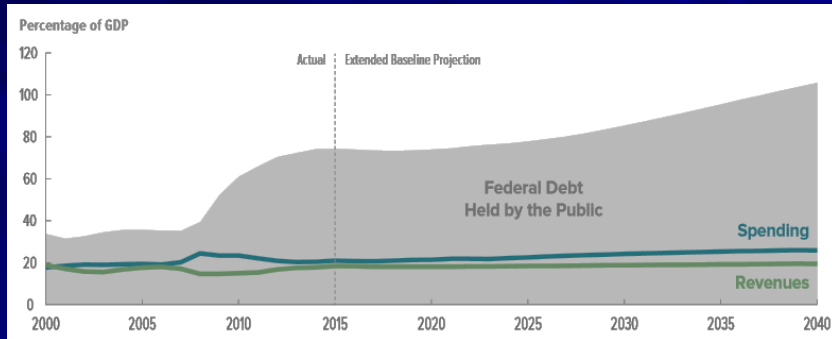
Addressing Health Care Spending

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Our Debt is Unsustainable:



Source: Congressional Budget Office, The 2015 Long-Term Budget Outlook.
<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250-LongTermBudgetOutlook-3.pdf>

Consequences of Higher Taxes

- If finance higher health care spending by taxes:
 - Marginal tax rates of high income earners could rise to 70% by 2060
 - GDP declines (relative to trend) by 11%.
- Magnitudes depend on the exact assumptions about tax policy

Source: Baicker and Skinner: 2011: Assumes health care spending growth consistent with 2010 CBO long run forecast

What Will Slow Spending Growth

- New Benefit Designs
- Payment Reform
- Competition/Managed Care

Benefit Design

Benefit Design Options

- Higher copays, co-insurance or deductibles
- HDHPs/HSAs
- Value-Based Insurance Design (V-BID)
 - Align copays with value.
- Reference pricing
- Tiered networks

What We Know

- HDHPs:
 - Reduce health care spending by 5 to 14%
 - Do not affect price shopping
- Reference pricing:
 - Shifts volume (>30% shift from high price providers)
 - Aggregate spending effects likely modest
- Tiered Network
 - Shifts volume (~7%)
 - Lowers spending ~ 5%
- VBID
 - Increases value
 - Savings depends on design

Sources: **Brot-Goldberg et al.** 2015. "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics." NBER Working Paper No. 21632.;
Bundorf M.K. "Consumer-directed health plans: Do they deliver?" The Synthesis Project, 2012. Robert Wood Johnson Foundation.

Concerns

- Risk
- Disparities
- Consumer information
- Reductions in appropriate use same as for inappropriate use (Sui et al. 1986)

Price Transparency Not an Easy Solution

- No effect on spending
- Very low use
- Not harmonized with benefit design

Payment Reform

Payment Reform Options

- Pay less
- Move away from FFS
 - Episode based payment
 - Population based payment

What We Know

- Paying less saves money
- Episodes save \$ (~4% per episode)
 - Much better results in some settings
 - Aggregate effects will be smaller
- Population based payments save \$ (1-2% to start; can grow to 10+%)
 - Commercial programs more effective than public program
 - Savings grow over time
 - Independent practices likely do better (there will be heterogeneity)
 - Savings come from post acute and shifting site of care
 - Quality similar or better; patient experience better

Sources: **Brot-Goldberg et al.** 2015. "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics." NBER Working Paper No. 21632.;
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Population-Based Payment vs Episode-Based Payment

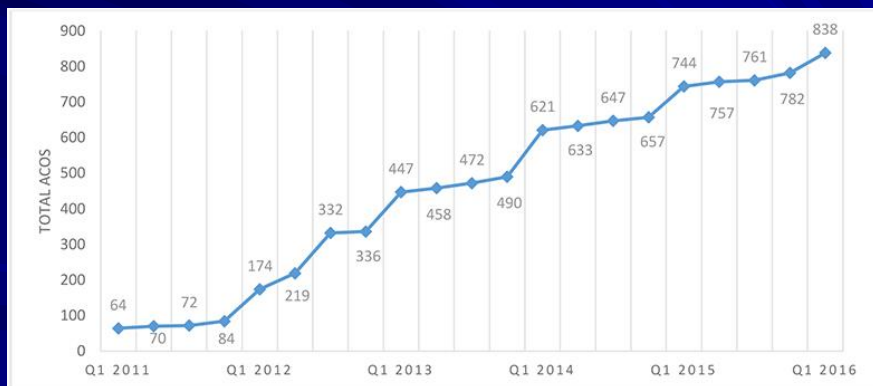
- Both save \$.
- Episodes must save more to have same PMPM effect.
- Episodes must avoid volume expansion.
- How do you get delivery system involved?

Caveats

- Details Matter
- Execution Matters

ACOs

- The number of ACOs grew from 64 in 2011 to 838 at the start of 2016.



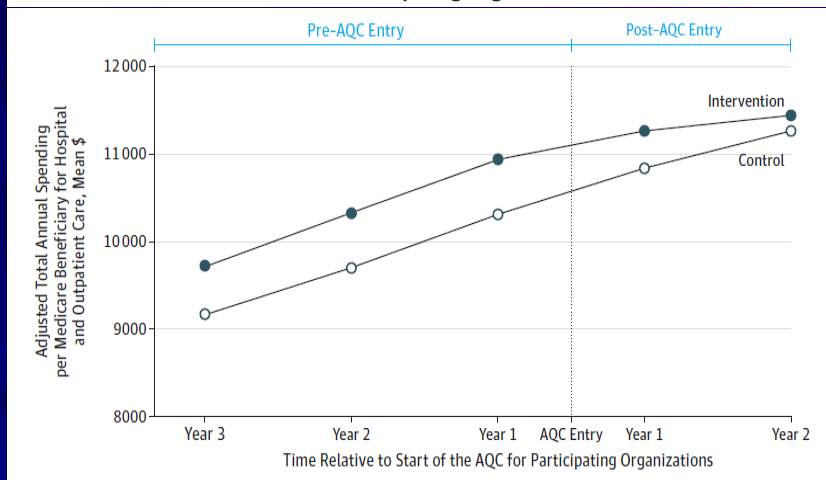
Source: <http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/>

Why Progress is Slow

- Operational difficulties
 - Attributing people to systems; IT
 - Risk adjustment
 - Multiple concurrent episodes
- Culture
- Weak/ mixed provider incentives (provider ROI?)
- Mixed/ overwhelming messages from CMS (too many programs)
- Purchasers/ payer ROI
 - Savings get shared
- Spillover

Spillover

Mean Annual Spending in Medicare Between AQC Participants and Nonparticipating Providers Before and After Participating Organizations Entered the AQC



Source: McWilliams et al. "Performance Differences in Year 1 of Pioneer Accountable Care Organizations." *New England Journal of Medicine* (2015).



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