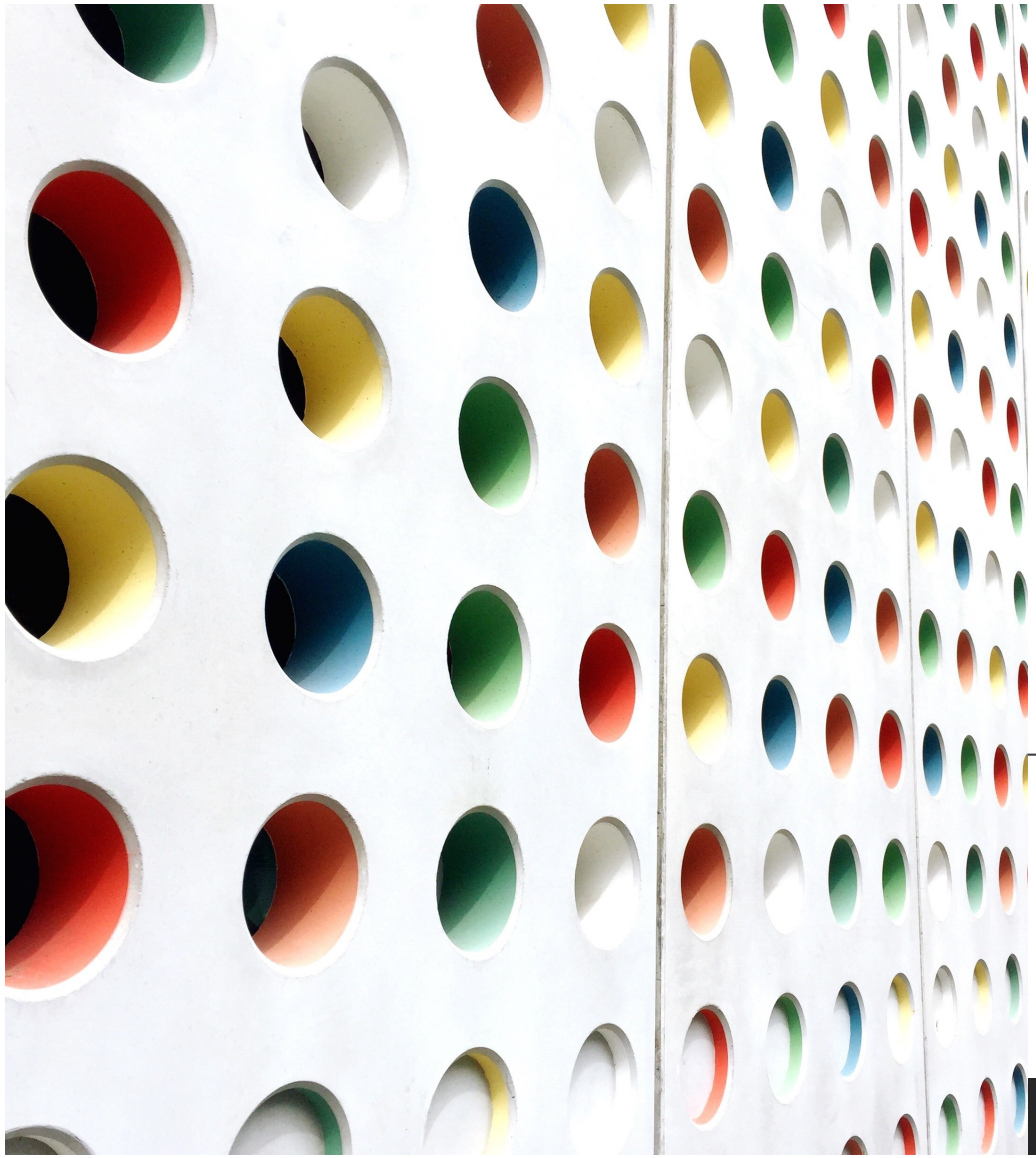

Economics of Health Care

FEBRUARY 2025

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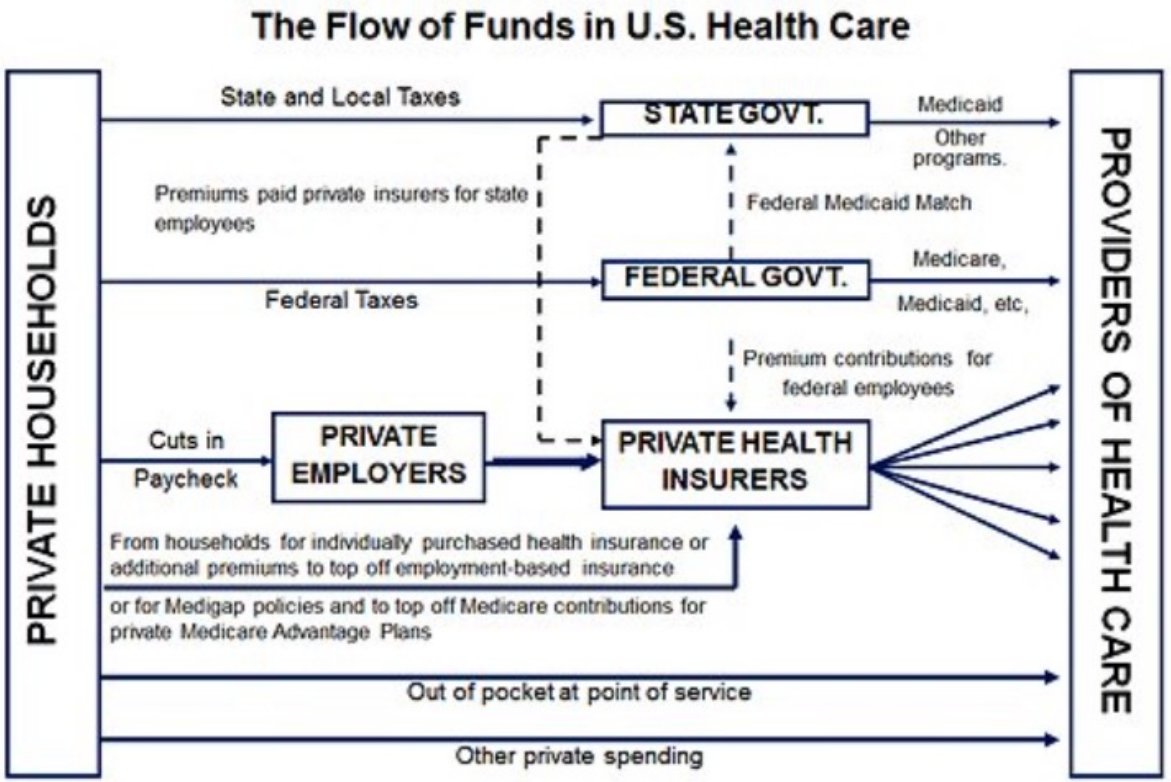
Purpose

1. Health care spending and the "Market" for health care
2. Payment models & behavior - Incentives matter
3. State tools to make health care markets "work"

Who foots the bill on health care spending in US?

WE ALL DO, IN MULTIPLE WAYS…



Why do we spend so much on health care in the US (and in Vermont)?

The US health care system is rife with market failure, thus leading to…

1. **Inefficient Resource Allocation**: Market failure results in an inefficient distribution of goods and services, where the quantity supplied does not match the quantity demanded.
2. **Misalignment of Incentives**: Individual rational behavior leads to irrational outcomes for the group, with the market failing to achieve efficiency.

Spending Waste

(e.g. administrative, excess prices/use etc.)

Why doesn't the health care market work?

Market Failure	
Poor Information	Patients have less medical knowledge than providers, nor is the value of a service or prices for services well understood in advance, leading to inefficient decision making (and possible overconsumption or overpayment for services).
Conflicts of interest	Patients and providers (and the organizations they work for) may not share the same interests (e.g. maximize revenue vs. minimize health care spending).
Emotional decisions	People are not rational actors, and health care decisions are emotional; this can lead to individual decisions to overspend on health care that yields only marginal returns, or to go into debt to get the care (they think) they need.
Lack of competition	High start-up costs (facilities, equipment, medical degree etc.); in rural areas, insufficient volume to support competition; in more dense areas more consolidated markets strangle competition amongst providers.
…and more	

Attempts to "Fix" market failures in health care: some examples…

Problem	Intervention (example)
Eligibility based on preexisting conditions led many unable to afford health care, and instability of health insurance markets	Coverage requirements; eliminate eligibility restrictions and price discrimination based on health (Affordable Care Act)
Low/High relative purchasing power of some geographies (population density/payer mix) leads to gaps in access to care or excess infrastructure	Direct government provision (U.S. Veterans Health Administration)
	Provider subsidies (HRSA's grants for FQHCs)
	Planning Oversight (CON, health resource planning)
Monopoly pricing power, health care spending growth, and related behaviors (investing in high margin services as opposed to those most needed by the community)	Market Oversight of Healthcare Providers (CT, CA, MA, OR…)
	Price controls and spending caps (RI affordability standards, MD FFS rate setting and Hospital global budgets)
	Transparency and information sharing (Hospital Price Transparency Rule)
Misallocation of health care dollars to sick care, at the expense of preventative care	Financial incentives (Medicare Shared Savings, Quality Incentive Payments)

Payment models in Health care: three concepts

CAPACITY BASED

PAYMENT FOR FUTURE CAPACITY FOR A RANGE OF SERVICES; USEFUL TO ENSURE AVAILABILITY OF SERVICES (E.G. FLOOR FOR FACILITY-BASED PAYMENT); OR LIMIT EXCESS GROWTH (E.G. GLOBAL CAP ON SPENDING).

ACTIVITY BASED

MODELS PROVIDE REIMBURSEMENT CONDITIONAL ON THE DELIVERY OF UNIT OF SERVICE, SUCH AS DISCHARGE, ADMIT, BUNDLE OF TREATMENTS (E.G. FEE-FOR-SERVICE); ENCOURAGES GREATER USE OF UNIT SERVICES.

POPULATION BASED

MODELS THAT PAY AN ORGANIZATION (E.G. ACO) TO MANAGE CARE FOR A POPULATION; ENCOURAGES GREATER USE OF MORE PREVENTATIVE (VS ACUTE) CARE AND LOWER COST SETTINGS.

How does payment matter?

First, a quick reminder in finance...

Fee-For-Service

Medicare sets fees based on the "cost of production"

Medicaid determined by the state; generally aligns with Medicare but pays less

Commercial payers negotiate contracts to set prices per service

Revenue = Price x Volume

Fee-For-Service: volume responses to price change

Table 1 - Analysis of an orthopedic surgery practice

Type of Service	Allowed Charges		Allowed Services		Price change	Volume change
	1994	1996	1994	1996		
Procedures	$38,430	$27,890	29	34	-27%	17%
Visits	$4,555	$9,773	45	83	14%	84%
Tests	$465	$228	5	5	-55%	0%
TOTAL	$43,451	$37,891	79	122	-23%	54%

From CMS actuarial report

Capitated Payments (Two Flavors)

Fixed payment per person per a specified period of time to an organization. Two examples…

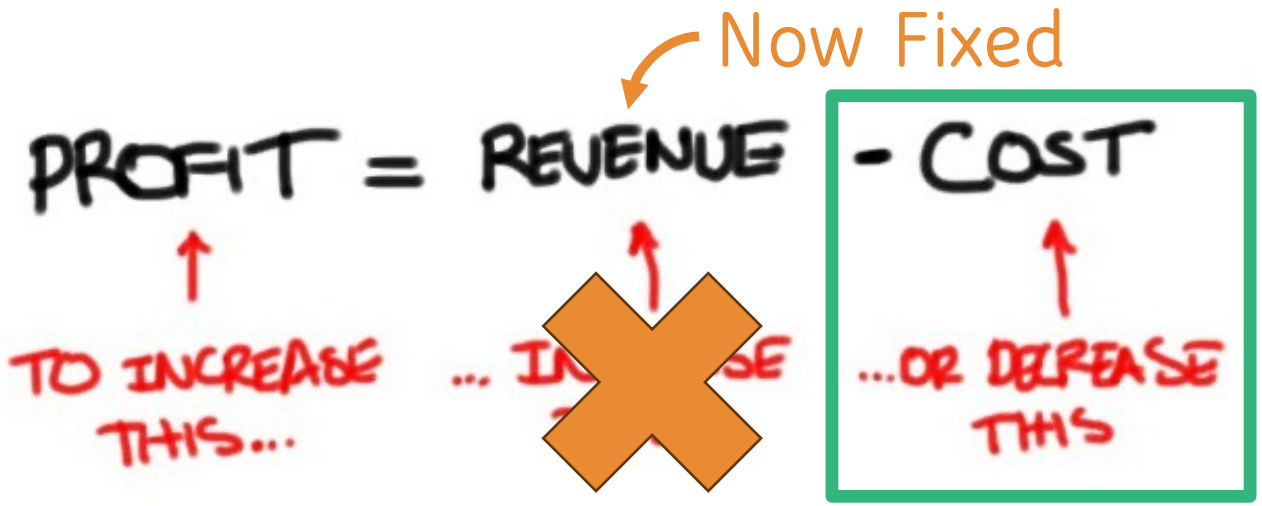
Kaiser Permanente Medical Group

- Vertically integrated insurance + delivery organizations (hospitals, primary care etc.)
- Budgets for all their health care expenses for a group of beneficiaries & providers work together to manage the overall budget (including costs)

Medicare Advantage (MA)

- Commercial health insurer (plan administrator) that gets paid by Medicare to manage care for enrolled beneficiaries, may or may not own delivery organizations
- MA administrator receives a (risk-adjusted) fixed payment for all beneficiaries and manages this budget through plan design (selection of providers within a network and payments to those providers)

Back to our equation (under capitation)…



Managing Costs: Rationing vs. Redesign

NEWS

'Deny, deny, deny': By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients

SHARE & SAVE

NEWS

'Deny, deny, deny': By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, say CEOs

Medicare Advantage plans "are taking over Medicare and they are taking advantage of elderly patients," said the CEO of one Mississippi facility.

"They don't want to reimburse for anything," Dr. Kenneth Williams, the CEO of Alliance HealthCare, said of Medicare Advantage plans.
Andrea Morales for NBC News

Facts at a Glance

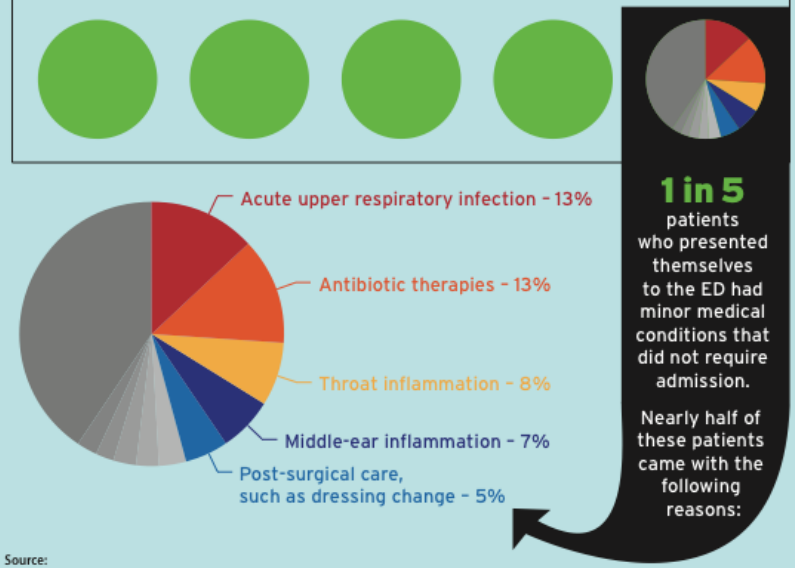
Sources of Potentially Avoidable Emergency Department Visits

Emergency departments (EDs) give priority to those patients with critical or emergency needs who require timely and highly skilled care. Despite this, many Canadians visit the ED for conditions that might be better dealt with in a different care setting.

This study looks at **two groups** of patients whose visits to the ED could potentially be avoided or addressed in other settings:

1. Those who visited the ED for minor medical complaints and were not admitted to hospital
2. Seniors in long-term care residences who visited the ED for conditions that were identified as potentially preventable or for less urgent reasons where they were not admitted to a hospital bed.

More than **1.4 million** visits to Canadian EDs were potentially avoidable.



1 in 5 patients who presented themselves to the ED had minor medical conditions that did not require admission.

Nearly half of these patients came with the following reasons:

Source:
Sources of Potentially Avoidable Emergency Department Visits,
Canadian Institute for Health Information (CIHI)

So, when might FFS vs. capitated payments make sense?

ACTIVITY BASED (FFS OR EPISODES)

Supply < Demand for services

Prices for services can be controlled

Optimal prices can be known

Monitoring for over-utilization is possible

CAPACITY BASED (CAPITATION)

Demand < Supply of services, but ongoing capacity is expected

Supply > Demand of services, but…

- Costs of delivery are too high
- Service volume (and spending) are too high

Monitoring for (unwanted) rationing is possible

*And hybrid forms are possible!

“Every system is perfectly designed to get the results it gets”

Not just about selecting an approach (FFS vs. Capitation), but understanding ***how the whole system works together*** (this is why the legislature established the Green Mountain Care Board)…

1. Which services should be paid in which way and how much?

2. How to make sure payment (encourages/discourages) utilization that we (want/don’t want)?

3. How do we know if access is improving or not (where and for which services)?

4. Are people getting primary and preventative care when they need it to avoid more costly care down the line?

Conclusion

There is no Silver bullet.

To take advantage of the opportunities and address the risks associated with any of these payment models, states may best serve the public interest by establishing a strong state agency tasked with:

1. **Health System Evaluation**: measure health care spending, access, and quality; how are funds flowing and what are we getting for what we are paying; and what are the drivers of underperformance?
2. **Planning**: Assess what patients need, leveraging broad community engagement to develop a plan that efficiently and effectively delivers what is needed.
3. **Payment Reform**: using incentives to improve affordability and access using targeted payment designs.