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Getting Better Value in Health Care

On July 16, the House Budget Committee held a hearing entitled "Getting Better Value in Health Care" that produced useful testimony on opportunities for making health care more effective and affordable. Below are some highlights from the hearing.

Rising health care costs are a major factor in the government's projected long-term fiscal imbalance. Total health care spending in the United States has been growing faster than GDP for some time and is expected to continue to do so. The Congressional Budget Office (CBO) projects that total spending (private and public) on health care may rise from 16 percent of GDP today to nearly half of GDP in 75 years. This overall trend would have direct and significant effects on the federal budget. CBO projects net federal spending on Medicare and Medicaid will rise from 4 percent of GDP to almost 20 percent over the next 75 years.

Evidence of inefficiency in health care reveals opportunity. Per capita Medicare spending varies widely across the United States – even after controlling for things like demographics and local cost of living – with no corresponding variation in care quality or health outcomes. In short, some regions spend more on Medicare because they provide a higher volume and intensity of services to comparable patients. CBO Director Peter Orszag noted that extrapolating the Medicare data to the entire U.S. health care sector suggests that as much as 30 percent of health care spending, or $700 billion, cannot be shown to improve health outcomes – in other words, it has no value to the patient. The challenge – and the opportunity – is to identify and reduce spending on inappropriate and unnecessary care without harming access to necessary care.

Health care is not a normal consumer good. Health policy expert Jeanne Lambrew, an associate professor at the University of Texas at Austin, noted that purchasing health care is not like buying a car: arming consumers with price information and telling them to shop for health care is more like telling them to buy the parts for a car and put it together themselves. Consumers want choices, she said, but they want help in structuring those choices. She noted that most workers want their employers to continue to play the important role of figuring out what a high-value insurance plan looks like for their workers and to offer a choice of a few health insurance plans.

Access to reliable, affordable health insurance matters. Dr. Lambrew argued that high-value care cannot be consistently applied when so many Americans have health insurance that is either unstable or inadequate. She noted that in a two-year period, one in three individuals can expect to lose health coverage for at least a month.

Consumer actions are driven by non-financial factors. Dr. Orszag noted that a growing body of research shows that individuals' behavior is heavily influenced by social norms, by the way things are presented, and by what the default option is – in other words, what happens automatically. Financial incentives can matter, but they often play a relatively small role

compared with the power of inertia. For example, increasing the flu vaccination rate for Medicare beneficiaries to close to 100 percent would improve beneficiary health and save Medicare money. But simply sending a letter to people telling them they should get vaccinated will have only a small effect on vaccination rates, while automatically making flu vaccination appointments for patients (with a choice of opting out) greatly increases take-up rates. The role of non-financial influences on behavior has significant implications for policy design.

Price transparency does not always reduce costs. Dr. Orszag said promoting price transparency in health care might actually increase costs in some situations. Many health care markets are local and are highly concentrated with a limited number of competitors. In such settings, publishing prices can facilitate collusion. Dr. Orszag also noted that price awareness would have limited effect because health insurance coverage dilutes a patient's incentive to shop around, and patients rely heavily on their health care providers to advise them on what services they should buy and from whom. Finally, awareness of prices makes little difference in an emergency situation or in high-cost cases.

Better value in health care requires better information. Dr. Lambrew suggested that federal policy focus on building the capacity to communicate information and best practices to health care providers, and to bring expertise and data from all parts of the health care system into the process for developing standards for what constitutes high-value care. Regardless of how health insurance is provided, the health system can benefit from the development and communication of standards for high-value health care and from incentives for providers to adhere to these standards. The standards would not replace the authority of patients to make decisions about their own care in consultation with their doctors. Rather, they would serve to advance a common understanding of what constitutes good health care practices – the basic building block for improving performance. Dr. Lambrew laid out five specific policies Congress could enact in the short term to lay the groundwork for value-oriented health care:

- *Increase investment in comparative effectiveness research.* "Comparative effectiveness research" is the rigorous assessment of the relative safety and effectiveness of various treatments for the same medical condition. The Agency for Healthcare Research and Quality at the Department of Health and Human Services received $30 million for this research for 2008, a relatively small amount given that health spending in the United States will reach a projected $2.4 trillion in 2008. A wide range of businesses, consumer groups, and experts support proposals to increase funding significantly for comparative effectiveness research, through a combination of public and private sources.
- *Create a Federal Reserve-like board to develop standards.* This board would be an authoritative source of information on the value and tradeoffs associated with health care services and delivery mechanisms. Currently, different and sometimes conflicting standards are used across the nation, developed by various specialty societies, some government programs, insurers, and other actors. This has resulted in low rates of use of recommended care, high use of questionable care, and unnecessary confusion and complexity for health care providers and patients. Dr. Lambrew envisions that the new board would focus only on analyzing the evidence to determine what works and what doesn't, and at what cost. Other public and private actors in the health sector would determine how to use this information.
- *Accelerate the adoption and use of health information technology.* Drs. Orszag and Lambrew said widespread adoption of electronic health records could bring some

efficiency improvements by reducing the likelihood of repetitive tests, for example. But they said the more significant potential to reduce health costs and improve quality would come from integrating electronic health records into a system that uses the information to evaluate what works and what doesn't, supports informed decision-making by doctors and their patients, and provides appropriate financial incentives to reward effective care rather than just quantity of services provided.

- *Align financial incentives with value.* Dr. Lambrew suggested that financial incentives for providers and patients be steered toward value, not just costs. She recommended that Congress give the Medicare program the authority to adopt payment policies based on value-oriented standards. She noted that public subsidies of private insurers could also leverage value-based coverage.
- *Prioritize prevention.* Dr. Lambrew recommended reforms with an eye toward designing payments for preventive services to promote their widespread use and to encourage behavioral change.