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Can Price Controls Be Reconciled With Value-Based Care?

By Ken Terry
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As the healthcare affordability crisis escalates, efforts to fix the U.S. health system seem to have hit a wall. Some policy experts are calling for government price controls, while other experts and healthcare leaders still support value-based care (VBC), despite its limited impact on national health spending.

Can these two schools of thought be reconciled as complementary strategies to curb the relentless growth in U.S. health costs?

'NO OTHER CHOICE'

The basic theme of the calls for price controls is that we have no other choice.

"If the prices are too high and competition has not been able to do anything about it, we really have no choice but to go to [price] regulation," said Paul Ginsburg, former chair of the Medicare Payment Advisory Commission and a professor at the University of Southern California's Schaeffer Institute and Price School of Public Policy in Los Angeles, in MedPage Today.

At the same time, health economists Len Nichols and Paul Hughes-Cromwick propose to establish a system of national all-payer rate setting. In an opinion piece for MedPage Today, they outline a plan that is along the lines of what Maryland did decades ago on hospital prices. While they admit that it would be very difficult to get such a measure through Congress, the economists view it as a necessary first step toward effective healthcare reform. Drastic changes are needed, they emphasize, to ensure that most people will continue to have access to the healthcare system.

THE FAILURE OF VALUE-BASED CARE

To reduce health spending, we need to grapple with high prices, administrative costs and technology diffusion, Andrew M. Ryan, Hayden Rooke-Ley and Robert A. Berenson contend in a recent Health Affairs Forefront piece. In an accompanying podcast, Ryan argues that the government should take a more aggressive approach to "managing prices directly."

The authors focus on why the value-based care (VBC) movement has failed to lower costs after nearly two decades of steady growth. Value-based payment now comprises "half of traditional Medicare" and is also a major component of Medicare Advantage, state Ryan et al. But much of what CMS classifies as value-based payment is pay for performance or upside-only risk. According to the Health Care Payment Learning & Action Network, in 2023 only 34% of traditional Medicare revenues came through two-sided financial risk contracts, which create care budgets that incentivize cost reduction. Forty-three percent of Medicare Advantage payments to providers were risk-based. With Medicaid and commercial insurance payments included, however, only 28.5% of all provider revenues flowed through financial risk arrangements.

This means that the majority of providers are still not taking risk and that many of those who do under some contracts are still being paid largely fee for service. Considering that two-thirds of physicians' revenues must be risk-based before they change how they practice, this is one reason why VBC has not achieved its stated aims: Most doctors and hospitals are still operating in a predominantly fee for service environment.

FINDING THE RIGHT INCENTIVES

Another key point of the Health Affairs piece is that the Medicare Shared Savings Program (MSSP) for ACOs, a focal point of VBC, has saved very little as a percentage of total Medicare spending. In fact, the authors assert the MSSP has probably lost money after accounting for favorable selection and upcoding. Nevertheless, the savings measured by CMS have increased year over year. More importantly, the results show that physician-led ACOs save more than hospital-led ACOs and that ACOs led by primary care physicians save the most. Moreover, as the percentage of MSSP ACOs taking downside risk has risen, so have total savings.

All of this indicates that when the right physicians with the right incentives are leading the charge, the mousetrap actually works. The MSSP model has serious flaws, particularly in its benchmarking methodology, which penalizes more efficient ACOs. But there's clearly something going on here that could help lower spending if it became more widespread.

NATIONAL COMPARISONS ARE INADEQUATE

Risk-taking groups and ACOs use population health management to deliver high quality care within a budget. But the policy experts cast doubt on whether better preventive care and care coordination can make a dent in cost growth. Groups that assume risk for care also strive to decrease the wasteful and inappropriate utilization of resources. The authors question, however, whether it is worthwhile to restrain utilization of hospital, physician and post-acute-care services.

Their central argument against utilization management is that other wealthy countries that spend much less on healthcare than the U.S. does have substantially more physician visits, hospital discharges and high-ticket procedures than we do. While correct, this overlooks some major differences between the U.S. health system and those of other nations.

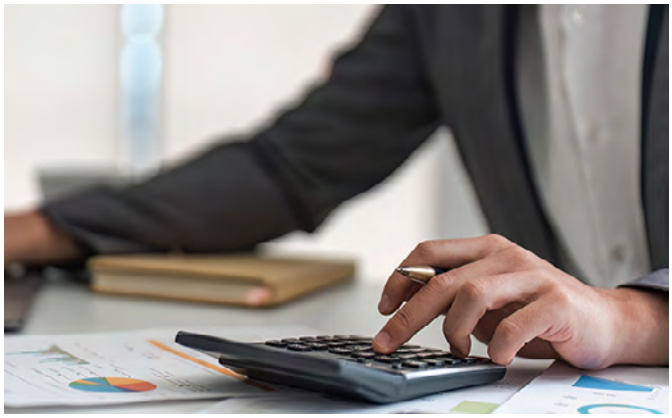
For example, while the U.S. had just over half as many in-person doctor visits as the average of eight other high-income countries in a recent analysis, the cost per physician visit was much higher in the U.S. than in the comparison nations. That price differential explains much of the difference in utilization. Also, a higher percentage of peer nations' citizens can afford healthcare because of universal coverage and low cost sharing, which means there are fewer financial barriers to seeing a doctor. With more primary care physicians and more primary care visits per capita in those countries, their residents are likely to get more preventive care and earlier treatment than Americans do. In general, research has shown that increasing the availability of primary care leads to better outcomes and lower costs for the system.

A similar picture emerges when we compare hospital stays and procedures in the U.S. to those in peer countries. Because of national health insurance and because other nations' governments or their proxies negotiate prices with providers, their consumers get more hospital care and more procedures than we do on a per capita basis. The intensity and cost per episode of those hospital stays, however, is lower than ours. That is partly because patients in those countries tend to be treated at an earlier stage in their illness.

What we can conclude from these comparisons is that, while utilization of health services is relatively low in the U.S., so is access. Therefore, some Americans who need physician care or surgery may not get it, worsening their health and potentially leading to the need for more expensive care. At the same time, as much as a third of U.S. healthcare spending is wasted; while some of that involves administrative work, hundreds of billions of dollars' worth of the clinical care delivered each year is unnecessary, performed in error and/or harmful. In fact, Robert Berenson, one of the VBC paper's authors, told me recently that roughly 20% of the surgical procedures done in the U.S. are inappropriate.

The aim of risk-taking physician groups and ACOs is not to prevent necessary utilization of hospitals and specialists. They can stay within their budgets by reducing waste, such as useless procedures, and by managing population health well. Population health management might not produce short-term savings, because of the expense of additional staff and other infrastructure. But in the long run, more widespread value-based payments would reduce costs by creating incentives for physicians to help people become healthier.

For example, nearly 80% of U.S. adults with hypertension have uncontrolled blood pressure. Of those, 61% are not taking antihypertensive medications. If a much higher percentage of hypertensive patients were identified and took the appropriate drugs, health costs would rise in the short term but would drop over time because of averted coronary artery disease, heart failure and strokes.



So there's nothing wrong with reducing wasteful utilization while increasing other kinds of utilization that improve population health. In the long run, if our healthcare system emphasized primary care more and specialty care less, spending would drop as expensive specialty services became a smaller part of healthcare.

Until then, properly implemented price controls could help risk-taking groups gain a footing or improve their position. For a primary care group or ACO taking full professional risk, limits on what specialists and imaging centers can charge would be beneficial. But these prices should not be reduced too quickly or without forethought.

PROBLEMS WITH PRICE CONTROLS

Government price controls are not a new idea. For example, Medicare sets physician fees, and its diagnosis-related-group (DRG) system specifies how much the government will reimburse hospitals for each kind of case. The never-adopted Clinton Health Plan included standby price controls, and Medicare for All (which may never be adopted) would pay all providers at Medicare rates or some level not far above them. The aforementioned Maryland all-payer rate setting system and the global budgeting of hospitals in that state are also forms of price controls.

That said, having the federal government specify what all healthcare providers in the U.S. would get paid for specific services or cases poses some extraordinary problems. To start with, American healthcare providers are used to operating at higher cost levels than their counterparts abroad. If prices were suddenly cut by government fiat, many hospitals would close and some physicians would leave medicine.

The pain would be less severe if all-payer rate setting resulted in higher Medicare and Medicaid payments and lower private insurance payments. But such an approach would work far better if it were undertaken by individual states. The states have a better handle on local costs than the federal government does, and they could negotiate prices with their hospitals, as Maryland does.

There's another issue that would affect tens of millions of consumers: The U.S. does not have national health insurance, and government-regulated prices would not be low enough for the uninsured. Many other people are under-insured; even with price controls, they'd be confronting big, unaffordable bills if they had to be hospitalized.

Price controls are also insufficient to address the explosion of new drugs and other medical technologies that generate a large part of cost growth. We must find a fair, impartial way to decide which technologies are worth their cost. For that to occur, Congress would have to allow CMS to consider cost-effectiveness in its coverage decisions, and we'd need some kind of technology assessment body. Also, the federal government should negotiate the prices of all approved brand-name drugs, not just selected medications.

MOVING TOWARD A NEW SYNTHESIS

We could introduce price controls that would neither cause a massive shock to the healthcare delivery system nor eliminate incentives to find new cures and other treatment methods, but price controls alone will not make healthcare affordable. To build better healthcare, we need a combination of lower prices, improved population health, and universal coverage.

Making people healthier should reduce costs over time, and it has in some groups and health systems that take financial risk. Based on that premise, it would be a mistake to toss out value-based care because it has not yet made a dent in overall spending growth. In the short run, it may be necessary to control prices directly to preserve access to care while the healthcare system is being restructured. But in the long term, providers must take responsibility for the cost and quality of care so that their incentive will be to keep people healthy. That is the only way to transform our sick care system into a system dedicated to health maintenance and disease prevention, and it's the only way to limit health spending.

AUTHOR

Ken Terry is a healthcare journalist and author who has written or cowritten several books on healthcare reform and value-based care. His latest book, due out later this month from the American Association for Physician Leadership, is "Beyond Medicare For All: Cracking The Code of The Healthcare Affordability Crisis."