How Price Signals Lower Health Costs and Improve Quality

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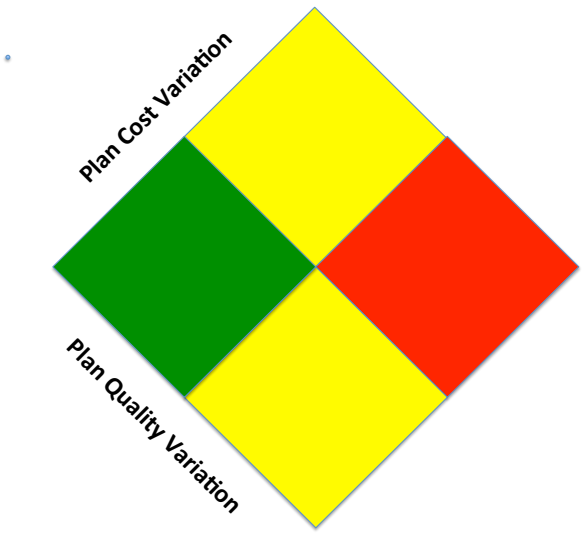
Several assumptions underpin this explanation of how price signals, *if* properly designed, can lower health costs and improve health quality.

First Assumption: Most Americans already gain access to health care through a health insurance plan (Plan), i.e., a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Fee-for-Service (FFS) plan. The Plan insures that, when covered individuals need a defined set of health care services from the Plan's network of doctors, hospitals, and other health care providers, the individuals covered by the plan will pay less far less than full cost of their care. The Plan instead will bear most of the cost. If an individual needs a lot of care, the Plan is likely to pay most of the total cost and nearly all of the "latest" cost (until at least the end of the year).

Second Assumption: Despite these common features, Plans vary a lot. They vary in the location of their facilities. They vary in their networks of providers, i.e., which doctors and hospitals are in their respective networks. HMOs have narrower networks, PPOs broader networks, and FFS plans the widest (often unlimited) networks. Most importantly for this discussion, Plans vary in how much they cost. Even if providing exactly the same benefits for exactly the same persons of the same age, sex, and other risk factors, premiums (or equivalent) will differ. They also vary in their quality of care.

The following four-square shows the two axes along which Plans vary. Along one axis, Plans vary by cost. Along another axis, Plans vary by quality.

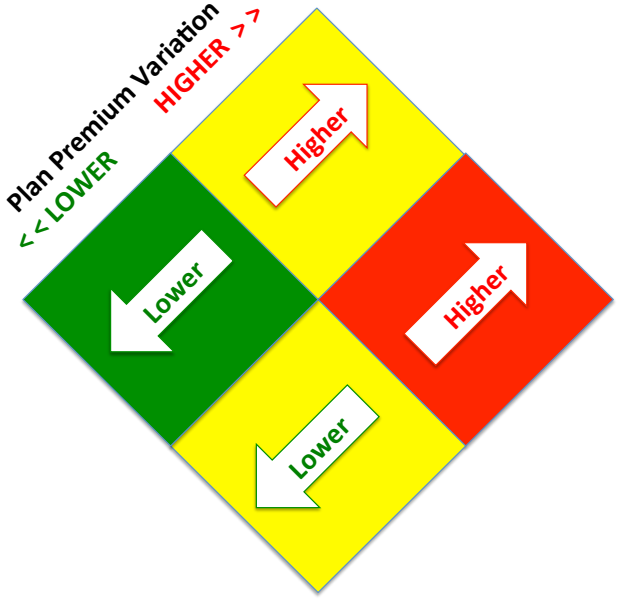


Cost Axis: Let us begin by looking at Plan variation based on cost. Let us further assume that all plans' benefits and enrollment "risk profiles" are identical (or have been

actuarially risk-adjusted to be identical), and that our cost focus is each Plan's benefit-adjusted, risk-adjusted, per-person premium.

Along the cost axis, some Plans have figured out how to operate more efficiently. Thus, they can keep costs down and charge lower premiums. Other Plans have not succeeded in delivering health care as efficiently. Thus, they suffer from higher costs and must charge higher premiums.

In the diagram below, the more efficient, low cost, lower premium Plans occupy the green square and the lower-left yellow square. The les efficient, high cost, higher Premium plans occupy the upper-right yellow square and the red square.



Quality Axis: Now let's look at Plan variation along the quality axis. Again, even if Plans' benefits and risk profiles are identical, Plans quality varies.

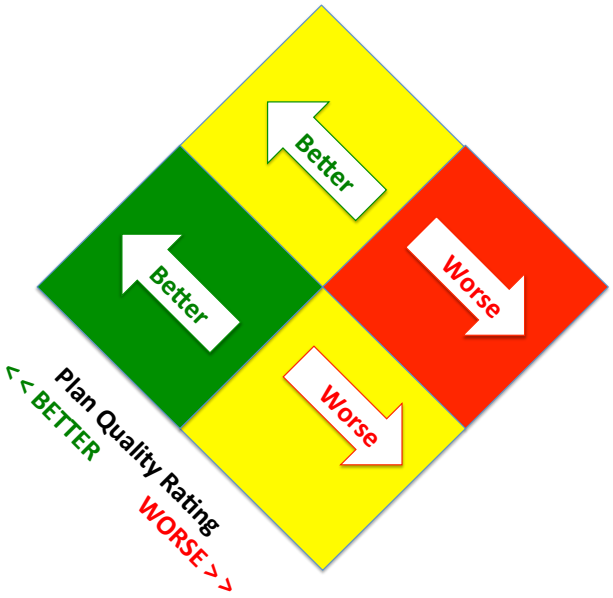
Many Plans provide superb service and excellent care. They give their customers clear and timely information, always treat patients with respect, keep appointments, and provide good follow-up. Their doctors, nurses, and other providers are highly qualified. They make few errors. Care itself is delivered quickly, correctly, and efficiently. These Plans get the highest scores from HEDIS on three measures: customer satisfaction, prevention, and treatment.[1] Their hospitals they get high grades from Leapfrog.[2]

[1] HEDIS is the Healthcare Effectiveness Data and Information Set. It is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care. See: http://www.ncqa.org/hedis-quality-measurement and http://healthinsuranceratings.ncqa.org/2017/Default.aspx

By contrast, other Plans deliver mediocre-to-terrible quality. Some patients may be quite happy with the service and care they get. But applying objective HEDIS and Leapfrog measures as well as subjective assessments, such Plans fare poorly in quality.

It is typically the efficiency of the Plan—more efficient management, more efficient recruitment and use of personnel, more efficient IT systems, more efficient coordination of the Plan's many complex pieces—that drives its rankings for quality. The more efficient Plans are likely to have higher quality, which helps them keep costs down and keep premiums in check. The less efficient Plans are likely to have lower quality, which inhibits their ability to control costs and pressures them to charge higher premiums.

In the diagram below, the more efficient, better quality Plans occupy the green square and the upper-right yellow square. The less efficient, worse quality Plans occupy the lower-left yellow square and the red square.



Combining the Cost Axis and the Quality Axis: Because Plans vary along *both* a cost/premium axis *and* a quality axis, it is possible to group them into four categories:

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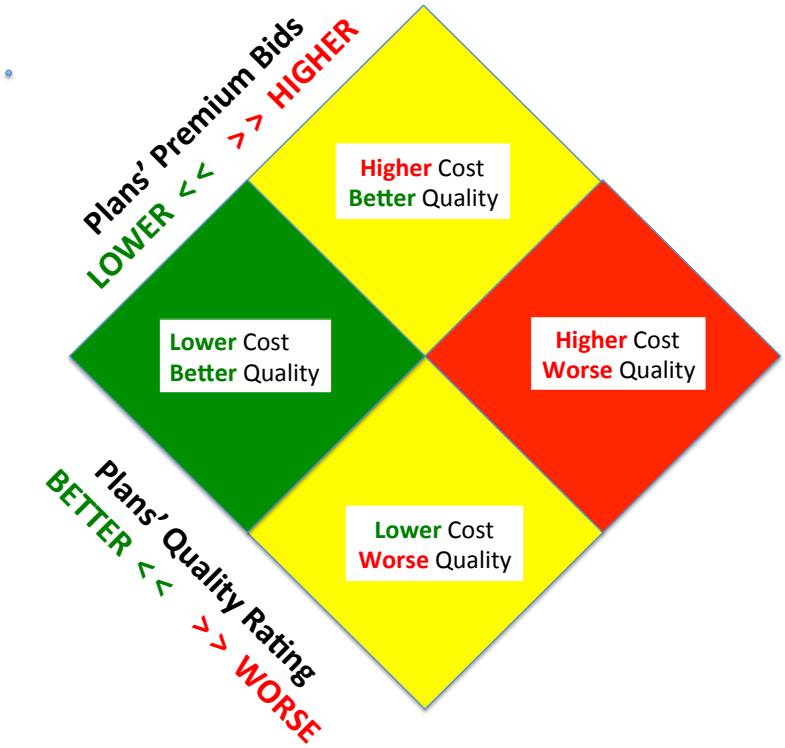
[2] Part of the Leapfrog Group for improving U.S. hospital care, the Leapfrog Hospital Safety Grade assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections. See: http://www.leapfroggroup.org/about

• Green square Plans do the best on both measures. They have a lower cost structure; thus they have the potential to bid lower premiums. They also deliver excellent quality.

•Yellow square Plans score well on one measure, but they fall short on the other measure. Either (as with the lower-left yellow square) their costs and premiums are low, but their quality is mediocre-to-poor. Or (as with the upper-right yellow square) their costs and premiums are high, even though their quality is good-to-excellent.

•Finally, red square Plans do the worst on both measures: They not only suffer from higher costs, compelling them to bid higher premiums. They also have the worst quality.

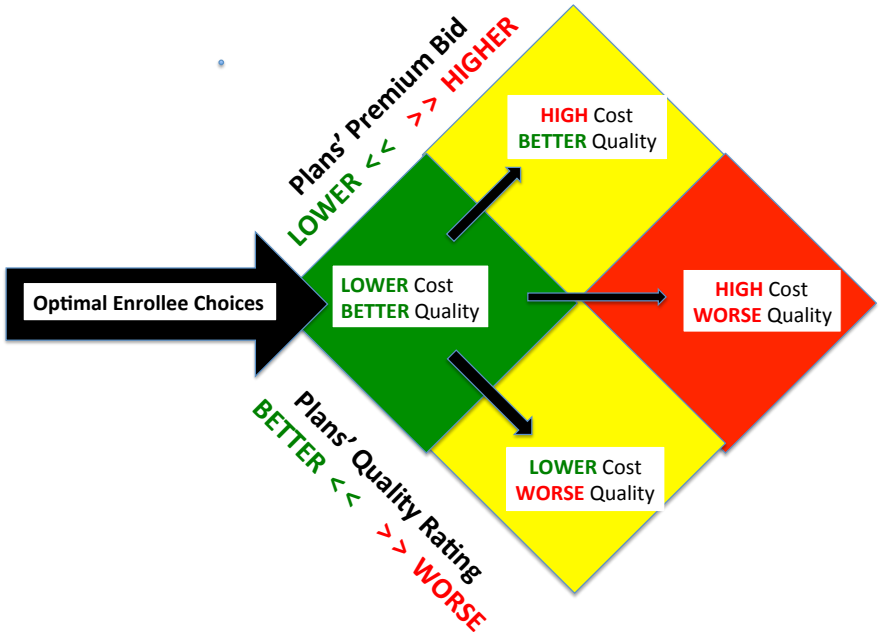


People are funny. But it is likely that Americans, if they have the choice of enrolling in any one of several health care Plans and get accurate information, will at least *say* that they are more likely to enroll in the Green Square Plans whose lower cost justifies lower premium *and* that earn high ratings for better quality.

It is also likely that, given a choice, Americans will *say* that they will shy away from a Yellow Square Plan that only do well on one measure (cost/premium *or* quality), but fare badly on the other measure (cost/premium *or* quality).

And of course it is likely that Americans will *say* that they will never enroll in a Red Square Plan. Who in their right mind, they might indignantly ask, would go out of the way to enroll in a costly plan that charges higher premiums yet delivers terrible health care quality?

The following diagram illustrates what Americans are likely to *say* about their behavior in choosing among competing health care Plans (or any other product or service, for that matter). Who does not want the lowest cost product or service that also happens to be the best product or service? Who would spurn such a choice, in order select the highest cost option that also has the worst record of quality?



But in the absence of a clear and simple price signal that creates a powerful incentive—a strong economic reason—to pick a low-premium/high-quality plan, many Americans will not bother to do so.

They may be suspicious of the lowest-cost option. ("If it's so cheap, how can it possibly be so good?") They may not wish to spend time looking at HEDIS, Leapfrog, or other information about comparative quality. Even if they have no objection to low-cost options *per* se and pay careful attention to quality rankings, they may nonetheless decide—if no cost signal makes them think twice about choosing a more expensive, worse quality Plan—to enroll in it solely based on familiarity.

The lack of price signals to induce Americans to select low-cost, high-quality plans is not just a theoretical concern. It drives up the overall cost of the U.S. health care system,

causing health care to absorb an ever-growing share of GDP without improving health outcomes, and thus choking off resources for other public and private investments that could better improve U.S. health and wealth. The lack of price signals also takes the pressure off the improvement of the quality of care. As a result, more people die and sicken than would otherwise be the case.

It is fairly simple, however, to create clear and simple price signals that encourage Americans to prefer low-cost/high-quality Plans. Such price signals would not deprive anyone of choice. Americans would be free to select any Plan they want, regardless of premium and quality.

What the price signals would do is induce the Plans to become more efficient, hold down their costs, lower their premiums, and improve their quality. No Plan would be required to do anything. They could manage their costs, set their premiums, and try to improve their quality anyway they want. But they would face the stern and constant discipline of the market. They would gain price-sensitive customers, increase revenue, and make higher profits by greatly improving their efficiency, lowering their costs, holding down their premiums, and enhancing the quality of the care they provide. Conversely, they would lose customers, revenue, and profits if they failed to become more efficient, cost more, charged higher premiums, and offers worse quality care.

The next set of four-square diagrams show how a clear and simple system of price signals would operate. It illustrates one basic concept: a coin whose two sides are stated below:

- When enrollees pick a Plan, they *must personally save money* when they select a Plan that is lower in cost, bids a lower premium, and delivers high-quality care.

- Conversely, enrollees *must personally lose money*—out-of-pocket—if they join a plan that is higher in cost, bids a higher premium, and delivers lower-quality care.

For this price-signal mechanism to work, five things are necessary:

1. The Plans must be required to bid on a single, uniform benefit package.

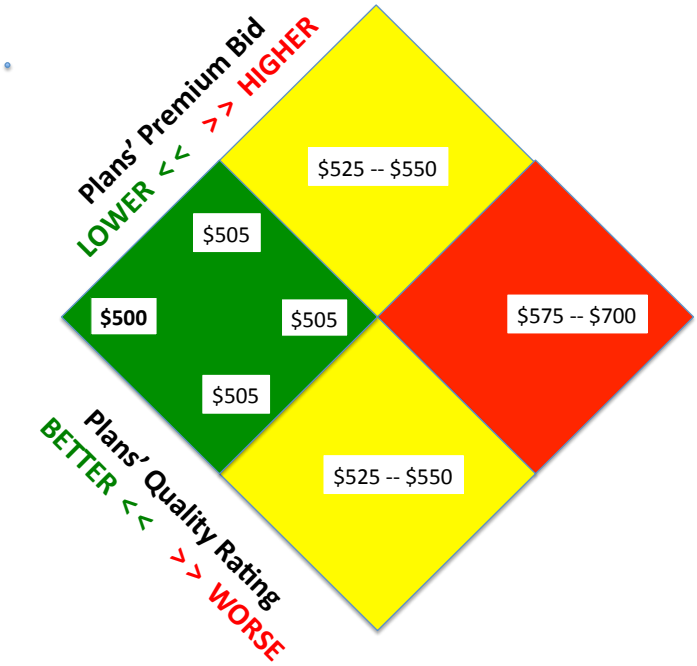
2. The actual monthly dollar amount that enrollees *personally will either save or lose out-of-pocket* cost in joining each Plan must be clearly presented, along with objective information (e.g., HEDIS scores, Leapfrog rankings, etc.) on the competing Plans' quality.

3. Enrollees must *save the most money* (i.e., pay the least) if they join the Plan that bids the lowest premium. Ideally, they should be able to join for free the lowest-bidding Plan with high quality ratings.

4. Enrollees must *lose money* (i.e., pay more) if they enroll if any Plan that bids a premium greater than that of the lowest-bidding Plan.

5. Enrollees must *lose more and more money* in proportion to the difference between the lowest-bidding Plan's premium bid and the premium bid by the Plan they actually join. Ideally, they should pay out-of-pocket the *full entire extra cost* of enrolling in a higher-bidding Plan—that is: 100% of the difference between the lowest-bidding Plan's premium and the premium bid by the Plan they select.

This diagram shows how a hypothetical variety of monthly premiums bid by competing health care Plans. The actual dollar amounts are arbitrary. It is the relationship between them—lowest premiums in the Green Square, higher premiums in the Yellow Squares, and the highest Premium in the Red Square—that matters. Remember: all the Plans are assumed to have the same benefits (or are actuarially adjusted to achieve that outcome, and all the premiums are risk-adjusted.)



The diagram on the next page—keying off the above—shows how much *extra* an enrollee would be obliged to pay, out-of-pocket, to join the various Plans available:

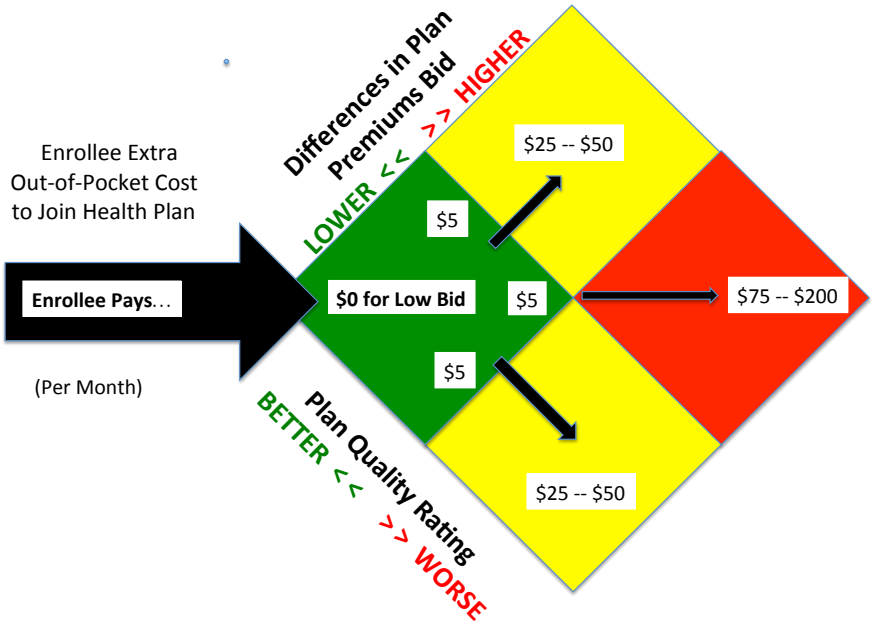
- Ideally, if the enrollee joins the Plan with the very lowest bid (i.e., in the above illustration, the Plan with the $500 monthly premium) and high quality, the

enrollees extra out-of-pocket cost would be zero.[3]

- If the enrollee joins any other Plan, the enrollees extra out-of-pocket cost would be the difference between the lowest premium bid and the higher premium bid by the more expensive Plan selected. (In the diagram, the extra cost ranges from an extra $5 extra per month to an extra $200 per month.)

Any insured individual would be free to join any plan. But with strong price signals like this, enrollees will have a powerful incentive to choose the lowest-bidding Plan, or at least a relatively low-bidding Plan, in order to avoid the substantial additional extra out-of-pocket cost of enrolling in a higher-bidding Plan.

This inducement to enrollees creates exactly the kind of market pressure needed to impel the more expensive Plans and their networks of providers to improve their efficiency, lower their costs, constrain their premiums, and improve the quality of their care.



Isn't this picture that we want? An American health insurance system where:

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[3] If an enrollee is obliged to pay something to enroll in the lowest-bidding Plan (e.g., a monthly percentage of the premium bid by the lowest-bidding Plan, or a monthly flat fee), then the enrollee's monthly out-of-pocket cost to join any higher-bidding plan should be (A) the resulting dollar amount *plus* (B) the entire monthly difference between the premium bid by the lowest-bidding Plan vs. the premium bid by the higher-bidding Plan that the enrollee has chosen.

- Everyone has coverage;
- Benefits are excellent;
- All individuals can select the specific Plans and health care providers they want;
- Individuals can freely change their Plans every year:
- Many of the choices require enrollees either to pay none of the premium or only a modest monthly amount; and
- The price signals that flow through the system create powerful and enduring incentives to health insurers (whether HMOs, PPOs, or FFS plans) and health care providers (hospitals, doctors, and drug companies) to improve their efficiency, lower costs, hold down premiums, improve quality, and perhaps even improve health outcomes.