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Addressing Economic Challenges in an Evolving Health Care Market

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Exploring a Tradeable Credit System for the Nonprofit Hospital Sector

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A Floor-and-Trade Proposal to Improve the Delivery of Charity-Care Services by U.S. Nonprofit Hospitals

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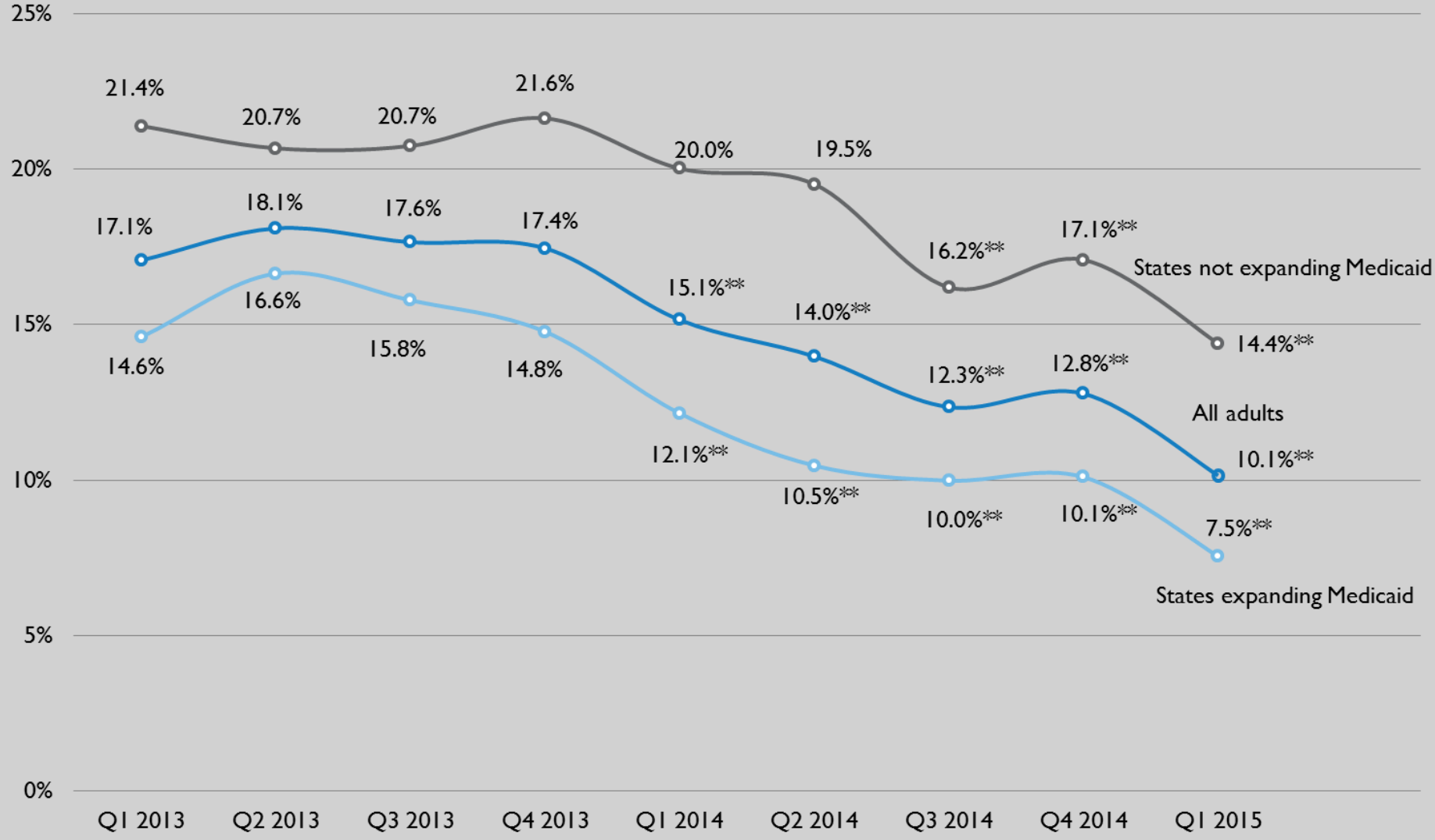
Figure 1. Trends in Uninsurance for Adults Ages 18 to 64 from Quarter 1 2013 to Quarter 1 2015

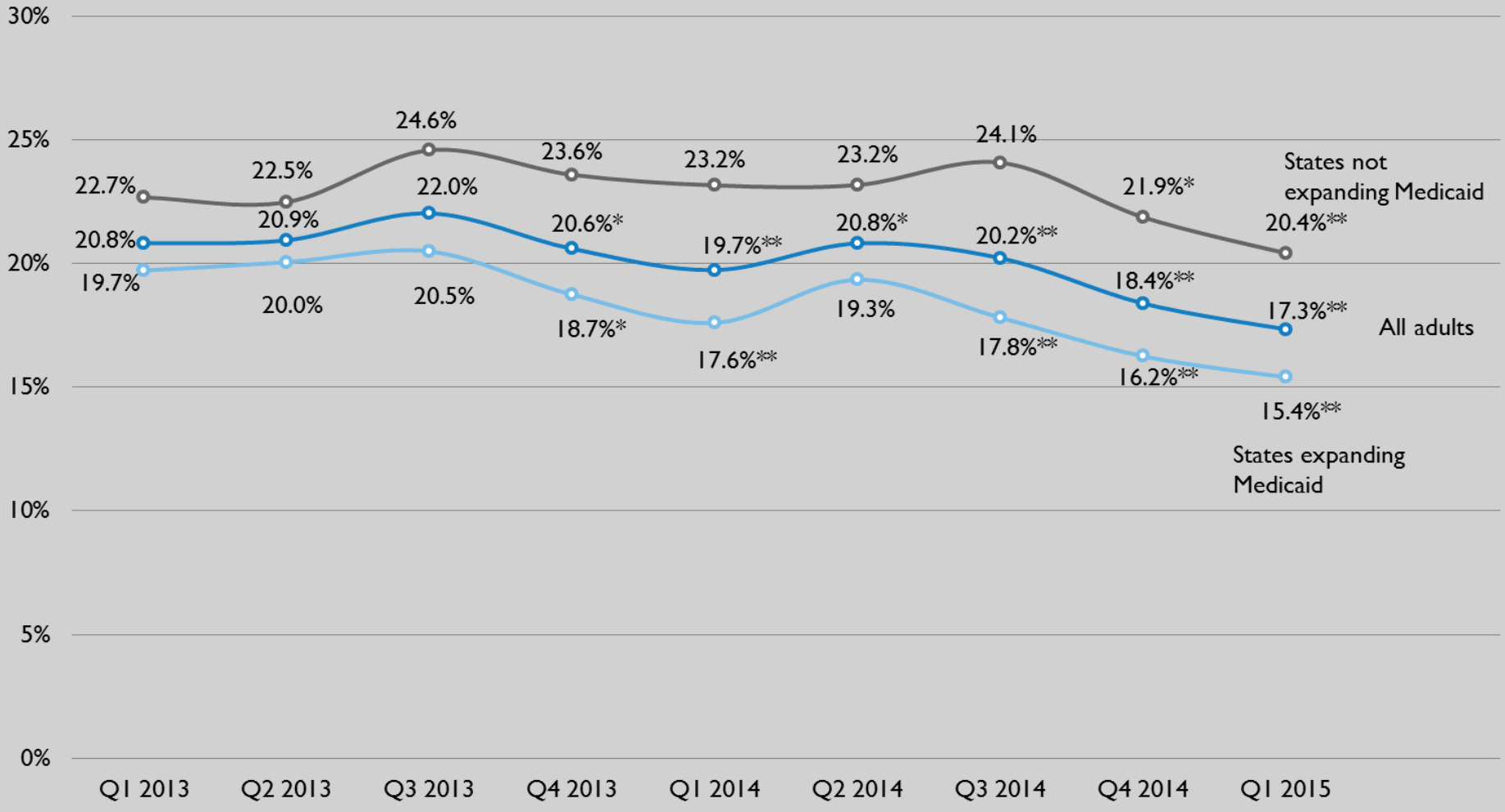


Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 1 2015.
Notes: Estimates are regression adjusted. Medicaid expansion status is as of March 2015.
*/** Estimate differs significantly from quarter 3 2013 at the .05/.01 levels, using two-tailed tests. Statistical significance is only reported for estimates after quarter 3 2013.

The Hospital Safety Net

- The uninsured in the United States don't go without access to any medical care
- For a variety of reasons hospitals provide care to those who cannot pay (Garthwaite, Gross, and Notowidigdo 2015)
- A primary reason is the nonprofit status of the majority of hospitals
- Nonprofit hospitals pay no taxes. In exchange, they are expected to provide a community benefit
  - This exemption cost approximately $25 billion in 2011
- However, this safety net has some glaring holes
  - Low-income individuals often face crushing medical debt that is relieved by expansions of public insurance (Gross and Notodiwidgo 2011; Finkelstein et al. 2012)

Figure 1. Share of Adults Ages 18 to 64 with Problems Paying Family Medical Bills in the Past 12 Months, Overall and by State Decision to Expand Medicaid, Quarter 1 2013 to Quarter 1 2015



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Decentralized Nonprofit Standard

- One reason for the holes in the safety net is that hospitals are not required to provide any specific type of community benefit
- Some hospitals receive idiosyncratic benefits from research and teaching
  - As a result, they may provide more than the socially optimal amount of these services
  - In addition, hospitals in higher-income markets provide more of these services and less uncompensated care
- Complicating matters further, as a practical matter hospitals have difficulty providing charity care services outside of their local markets
  - Uneven distribution of income means that hospitals in higher-income markets that want to provide uncompensated care to low-income patients find it difficult

A Floor-and-Trade System

- We propose a series of tradeable charity-care credits to solve this geographic mismatch. This involves three key steps:
  1. States set a charity-care "floor" for all hospitals
  2. States establish a charity-care "income threshold" for families to qualify for charity care
  3. Hospitals can transfer resources to meet their obligations under (1) and (2)
- For a variety of reasons we believe that this is best implemented at the state level
- Our proposal would still leave hospitals able to provide a meaningful amount of non-charity care community benefits at their discretion
  - Each state could determine the appropriate floor for charity-care services

A Simple Example

	Montgomery Burns Memorial Hospital	Hospital for the Poor (HFP)
Average Market Income	$80,000	$25,000
Charity-Care Floor	$2.5 million	$1.5 million
Charity Care	$1.5 million	$2.5 million
Charity Care to Eligible Patients	$1 million	$2.5 million
Costs of Charity-Care-Eligible Services Billed	$0	$0.5 million
Current Value of Charity-Care-Eligible Bills	$0	$0.1 million

- Burns Memorial needs to provide an additional $1.5 million in charity care for eligible patients
- HFP is $1 million above the floor and has unmet charity-care demand of $0.5 million
- HFP will be willing to sell this charity care for at least $0.1 million
- After our proposal, more charity care is provided to low-income patients

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Signals for Innovation in Health Care

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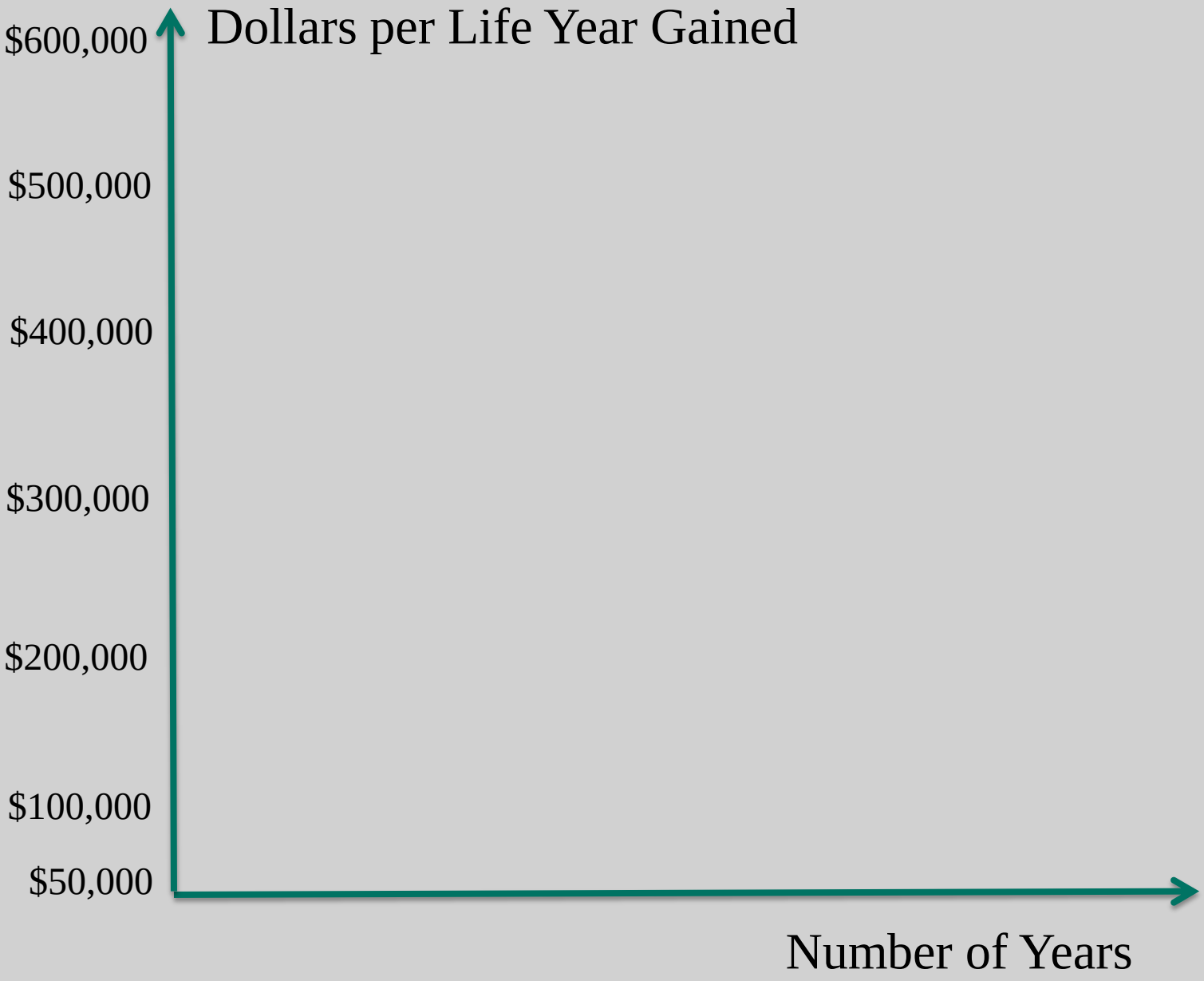
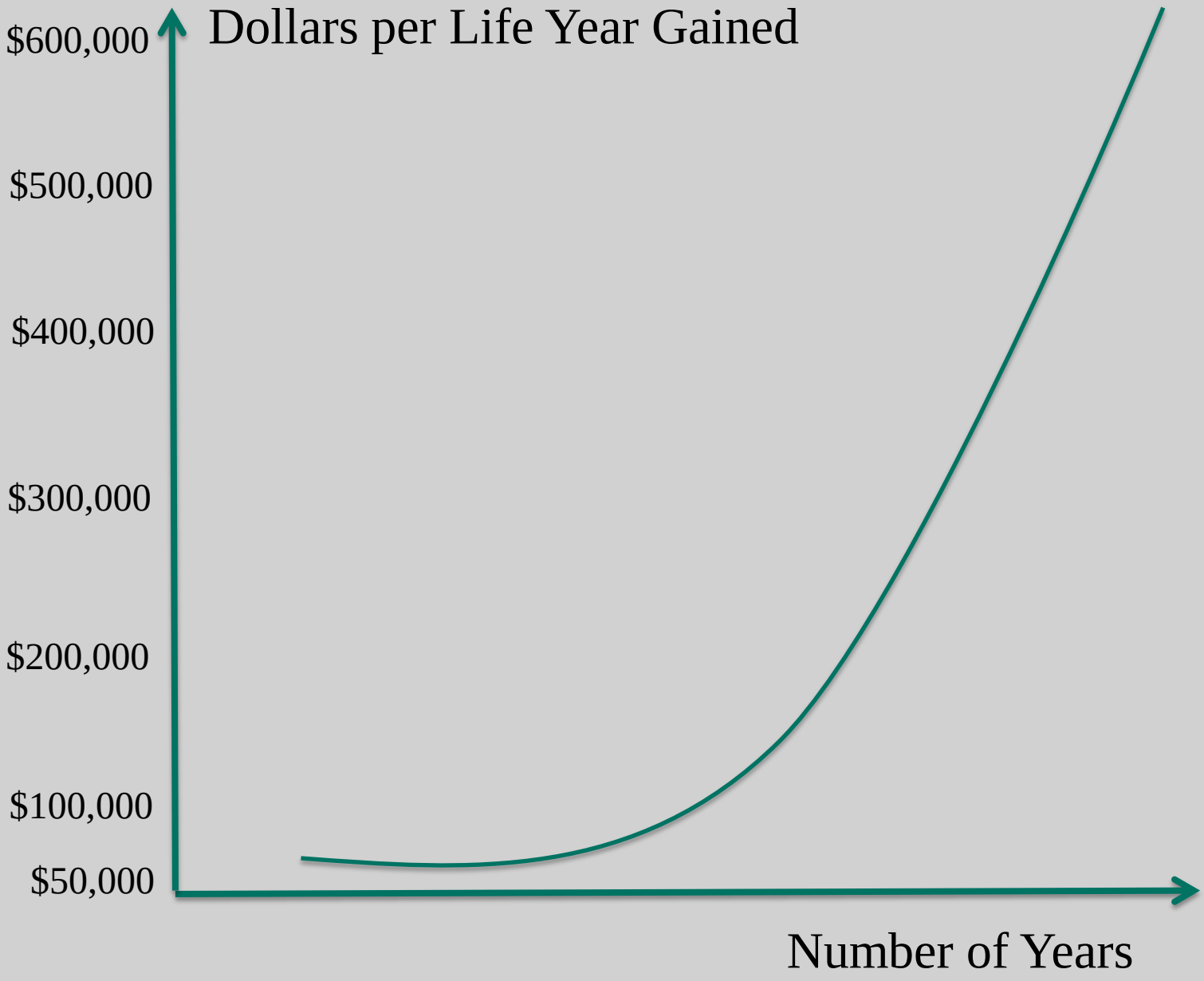
- Innovation responds to market size
- We’re inaccurately signaling market-size — likely upwards because of no cap on willingness to pay, FFS, tax preference for EHI, coverage spillovers
- Manufacturers receive inflated signal of society’s willingness to pay for innovation


Dollars per Life Year Gained
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$50,000
Number of Years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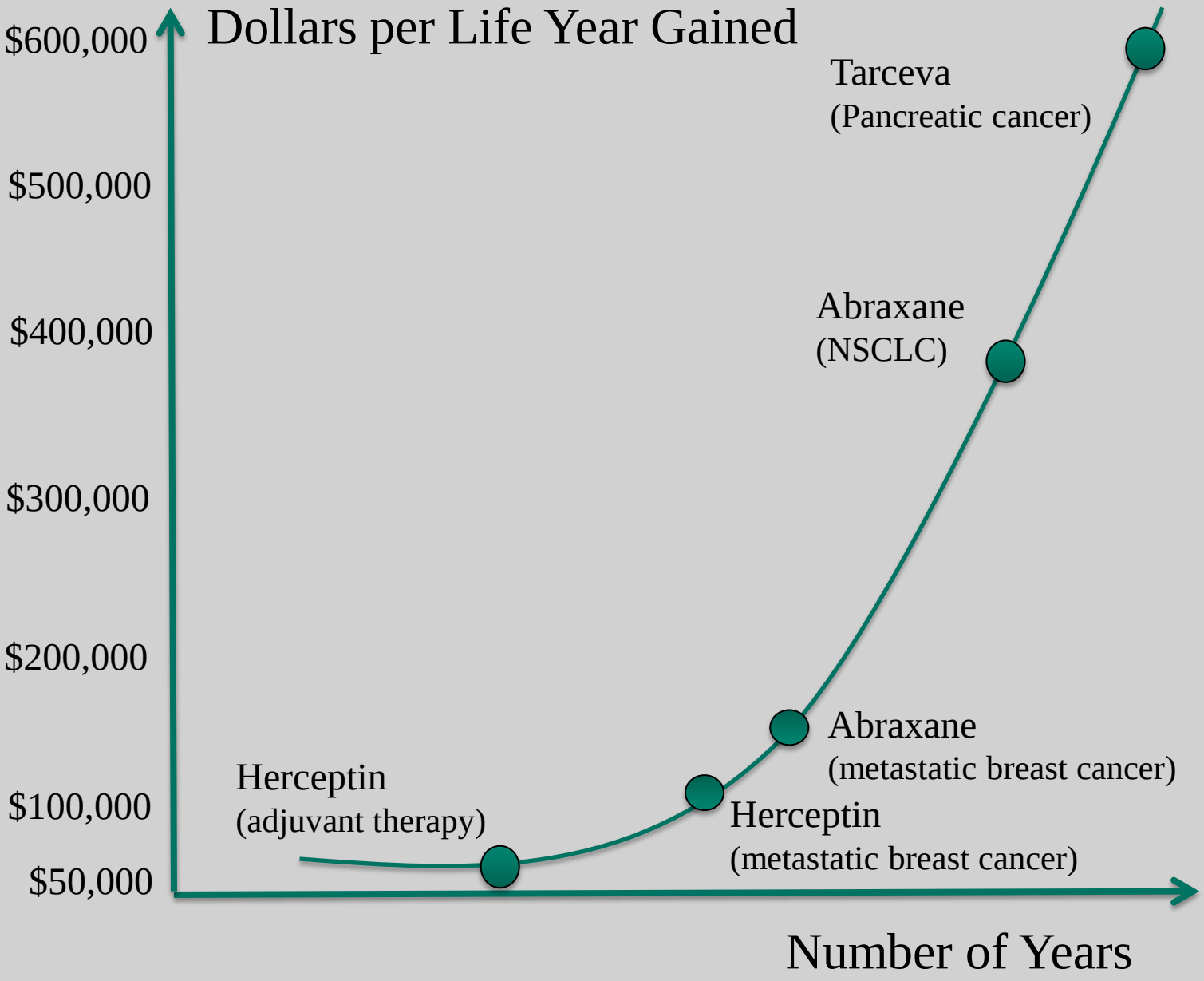
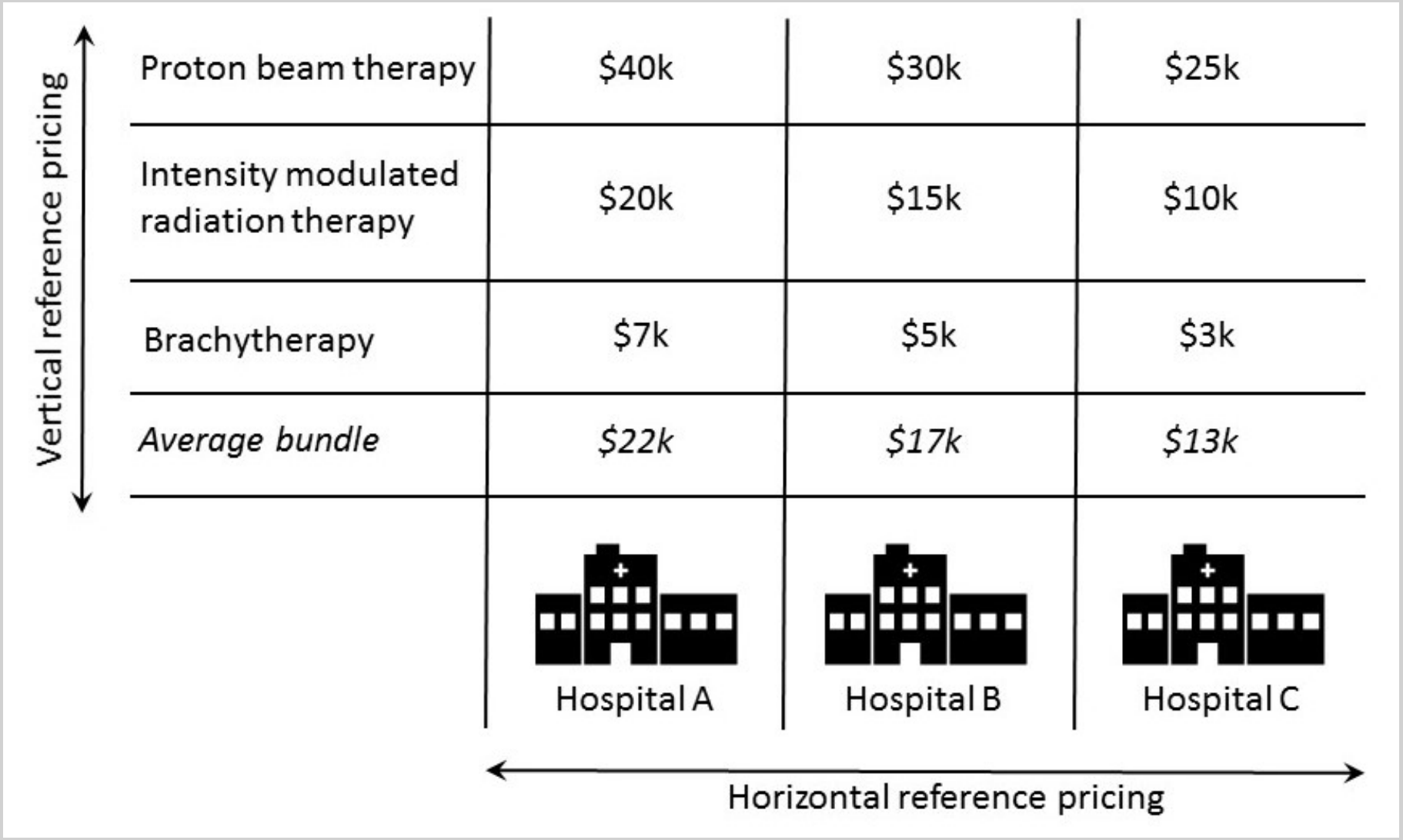
Number of Years


Dollars per Life Year Gained
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$50,000
Tarceva
(Pancreatic cancer)
Abraxane
(NSCLC)
Abraxane
(metastatic breast cancer)
Herceptin
(metastatic breast cancer)
Herceptin
(adjuvant therapy)
Number of Years

- Phase-out tax exclusion for health insurance
  - Replace the exclusion with a tax credit that phases out as income increases
  - Less radically, exclusion could phase out with income
  - Either way, high-income employees would no longer be able to purchase insurance on a tax-preferred basis

- Congress should give Medicare the authority to decline treatments whose costs dwarf their benefits
  - Medicare's coverage-determination process has become more rigorous over the past decade but the program has tiny resources to scrutinize new technologies
  - Better data about the comparative effectiveness of treatments would allow Medicare to superintend new technologies more effectively

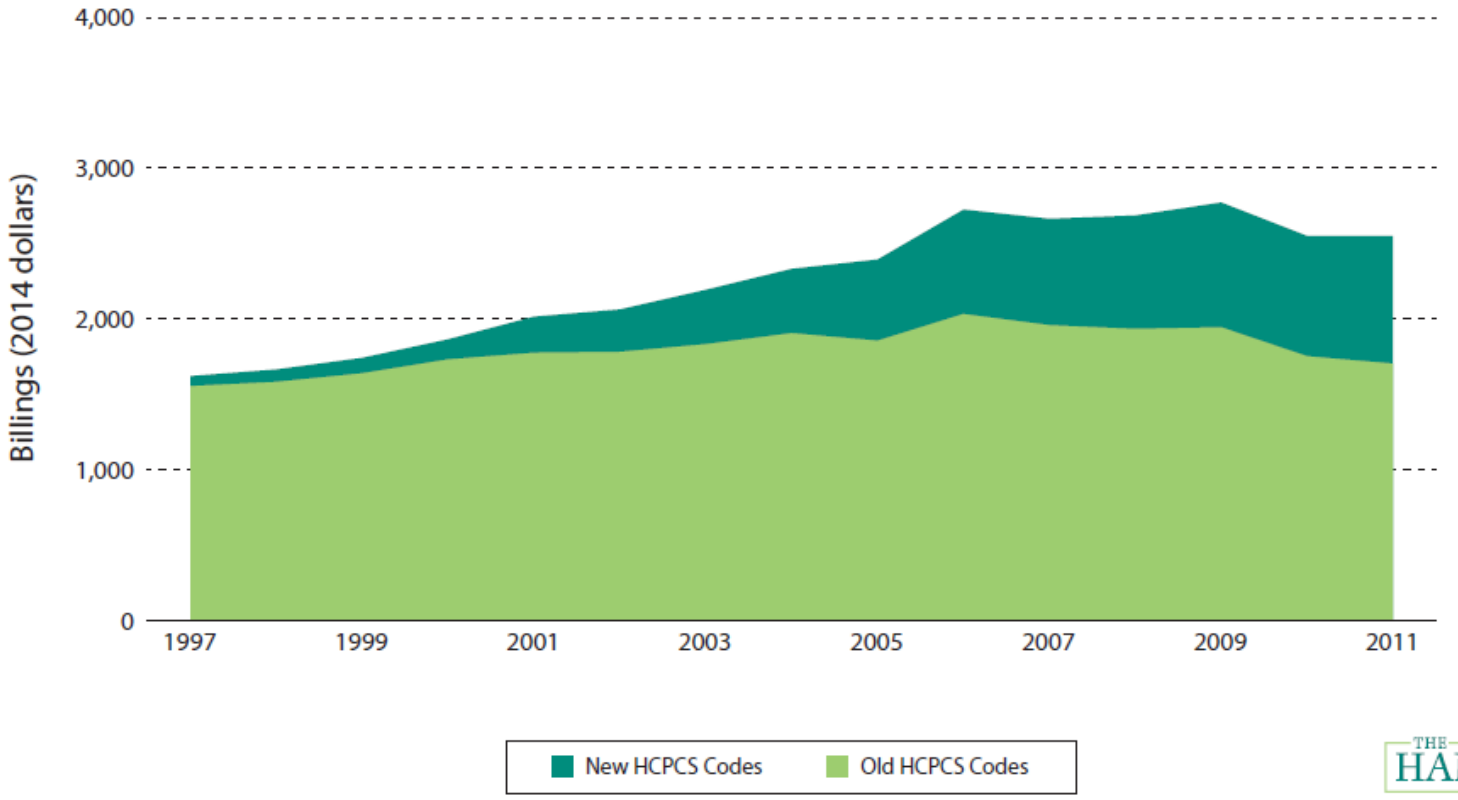
- Medicare should experiment with reference pricing technologies
  - Classify new treatments as superior to existing therapies, equivalent to them, or of uncertain benefit
  - For superior therapies, payment is calculated using current formulas
  - For equivalent therapies, payment would be the same as for the equally effective reference therapy
  - For those of uncertain benefit, Medicare would pay as if the technology were effective and then reevaluate after 3 years
  - Medicare should pay up to a predetermined cost-effectiveness threshold and allow for balance billing


Vertical reference pricing
Proton beam therapy
$40k
$30k
$25k
Intensity modulated radiation therapy
$20k
$15k
$10k
Brachytherapy
$7k
$5k
$3k
Average bundle
$22k
$17k
$13k
Hospital A
Hospital B
Hospital C
Horizontal reference pricing

1 in 3 dollars of Medicare spending is on something that wasn't around a decade ago

FIGURE 1.

Medicare per Capita Payments for New and Old Technologies, 1997–2011



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Source: Authors' tabulations for Medicare carrier and outpatient files since 1997.

Note: HCPCS stands for Healthcare Common Procedure Coding System.

Getting the Most from Marketplaces: Smart Policies on Health Insurance Choice

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Overview

- Major health reforms – ACA and MMA – rely on private provision of insurance with subsidies
- Active, well-informed consumers are crucial for effective market function
  - Immediate consumer benefits
  - Immediate government fiscal benefits
  - Medium to long run benefits from value creation
- Substantial body of research shows systematic choice difficulties
  - Active decision-making, complexity, and limited information
  - Inertia
  - Health insurance, but also other complex financial products

Policies & Goals

We propose two policies:

- Personalized Decision Support
- Smart Defaults

Policy goals:

- Enhance consumer welfare *given existing choice sets*
- Create incentives for innovation to improve quality and lower cost in health insurance markets and health care delivery
- Create productive competition for consumer experience across exchanges
- Reduce the fiscal burden of providing insurance subsidies (e.g., Medicare and ACA)

Part I: Personalized Decision Support

- Builds on general ACA decision-support requirement
- Our proposal:
  - Individualized, forward-looking cost calculator for all plans
  - Plan-specific assessment of downside risk
  - Clear and detailed information on plan provider networks (with personalized info)
- Enabling conditions:
  - Plan-specific data on (i) financial characteristics and (ii) provider networks
  - Individual-specific data on health risk (administrative claims or user input)
  - Model bringing together these components predictively
- Some progress, but (i) comprehensive focus on targeted support and (ii) integration of private sector essential to drive success

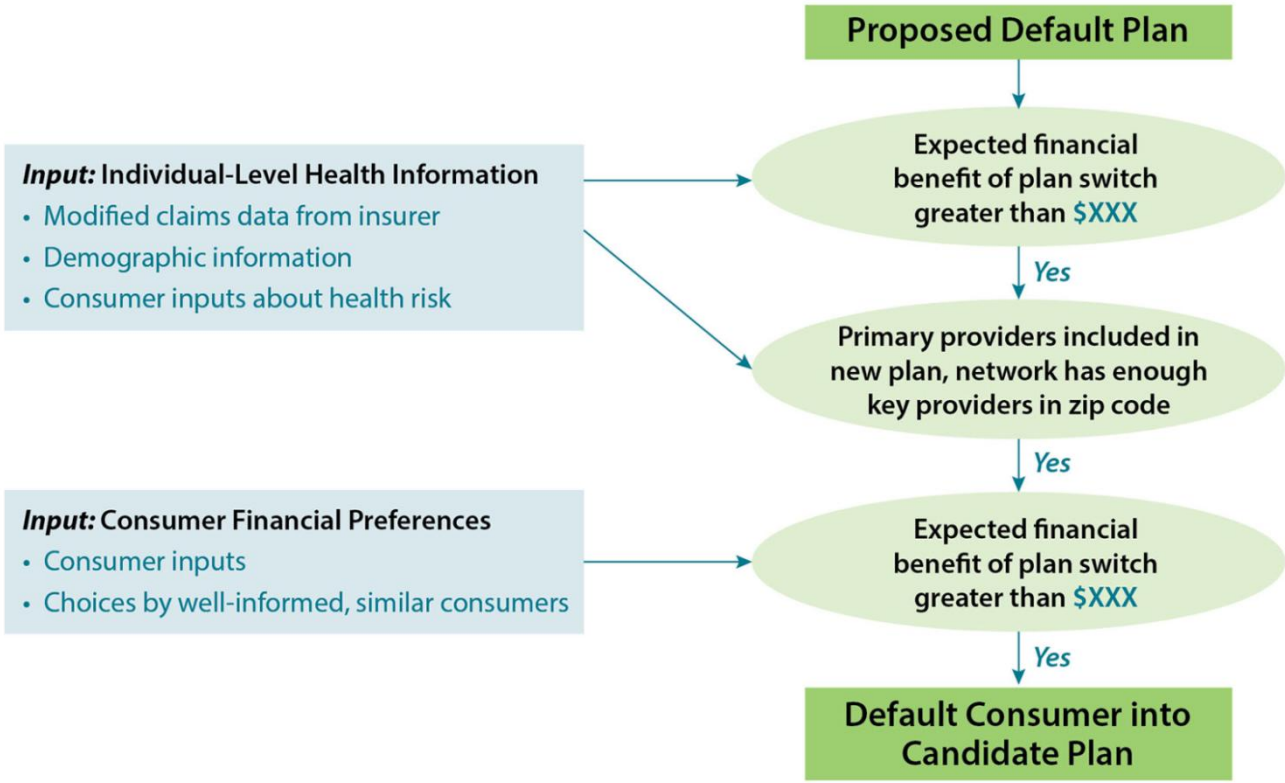
Part II: Smart Defaults

- Personalized decision-support policies have potential for large impacts, but limited by consumer inertia and active engagement
- "Smart" defaults use consumer-specific data to set the insurance option they will be enrolled in each year if they don't actively engage in choice
  - Currently, default option either previously chosen plan, no plan, or random plan
  - Leverages model and data used for personalized decision support
  - Libertarian paternalism
- Examples: default contributions in 401(k), LIS enrollees in Part D
- Policy impacts:
  - Will lead to substantial improvements matching consumers to best plans in market, faster/more-effective path to value creation from private provision
  - Subsidies key motivation for more aggressive policy

Part II: Smart Defaults

FIGURE 1.

Smart Default Example

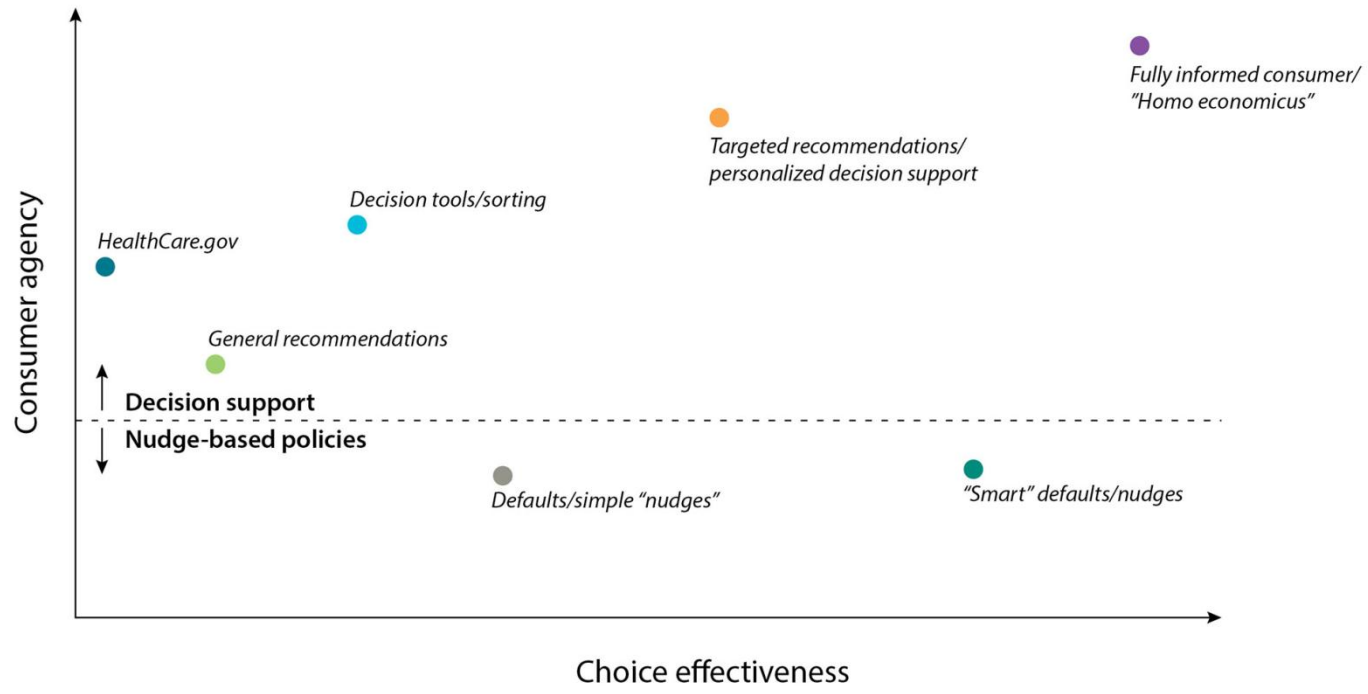


- Policies can be varied based on (i) consumer-specific data available and (ii) regulator preferences on equity

Part II: Smart Defaults

FIGURE 2.

Choice Policies: Consumer Agency and Choice Effectiveness



Downstream implications of smart defaults to consider:

- Adverse selection
- Regulatory capture
- Algorithm favoritism
- Consumer agency as market designers intend?

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