The Importance of Relative Prices in Health Care Spending

At least since the publication of the important article “It’s the Prices, Stupid;” it has been known that the substantial gap in health care spending between the United States and other developed countries is largely because of differences in prices, not use of health care services. Moreover, even at higher price (and spending) levels, most health care outcomes in the United States are not superior to those of peer nations. These facts have motivated calls by some to regulate health care prices in the United States.

In doing so, caution is warranted. Putting aside challenges of establishing the correct overall price level, there is reason to be concerned about relative prices of health care goods and services. That is, at any absolute price level, the price of health care service A relative to the price of service B has important implications. For example, variable copayments across drugs (ie, a tiered formulary) drive greater use toward drugs that cost patients less relative to drugs with similar therapeutic effects that cost patients more.

According to Hayek,2 prices convey important signals. Prices guide firms when they make their production decisions and consumers as they allocate their budgets. In efficient markets, prices are the means by which supply and demand equilibrate. But when prices are pushed artificially high or held artificially low relative to one another (eg, through policy), the equilibria to which they lead are inefficient: too much of some goods and too little of others are produced and consumed. This is the case in the health care sector, where both overuse and underuse are widespread. In many cases, this is because of getting the relative prices wrong. For example, cost sharing for maintenance medications is associated with underuse of them by patients with chronic conditions, whereas advanced imaging for low back pain is overused, in large part because it is covered by health insurance.

Some reject the idea that prices play a role in health care. Health is priceless, after all. But many studies show that clinicians and consumers respond to prices. Health care services that are less generously reimbursed are provided in lower volume. For example, when Medicare shifted from hospital cost reimbursement to admission-based pricing, lengths of stay in short-stay hospitals declined.3 When consumers were required to pay higher cost sharing, they reduced care.4 Prices are signals, and even in health care, many individuals follow them in some circumstances.

The problem in health care is not that prices play a role—that is unavoidable. The problem is that prices are distorted in ways that result in inefficient allocation of health care resources. Patients and physicians use too much of health care services that are of low value and not enough of services that are of high value.5

Price distortions are pervasive in health care. Insurance is the obvious example. Insurance alleviates risk by lowering the price for care, but in doing so, also contributes to the well-known problem of overuse. Insurance remains important but trends in benefit design, such as tiered networks and reference pricing, are attempts to address relative price distortions. Under reference pricing, the insurer pays a fixed amount of a service (called the reference price) and the patient pays the difference between that amount and the actual price.

Other important examples arise from well-meaning policy decisions. For example, to help support the high costs associated with the care provided by hospitals, Medicare pays hospitals more for some of the same care that is delivered in office-based settings. This lack of neutrality of payment across sites skews care delivery toward hospitals, and that may not be the most efficient way to provide care. For example, the Medicare Payment Advisory Commission noted in its June 2013 report that Medicare paid 141% more for a level 2 echocardiogram in a hospital outpatient department relative to an echocardiogram performed in a physician’s office.6 Moreover, this arrangement encourages hospitals to buy physician practices, thereby reducing competition and further contributing to the high level of commercial market prices. This problem has received considerable attention, and calls for site-neutral payments are routinely made by the Medicare Payment Advisory Commission and other organizations.7

The mechanism Medicare uses for establishing physician payments also leads to problematic distortions in relative prices. The program largely accepts physician payment recommendations from the Relative Value Scale Update Committee, convened by the American Medical Association. The committee is composed of representatives nominated by major medical societies (not the American Medical Association), and concerns have been raised that the committee has long recommended prices paid to specialists above those paid to primary care physicians. This likely contributes
to the high number of specialists in the United States, at the expense of primary care, and overuse of specialist services. This is not a matter of overall prices for physician services being too high (although they may), but of the relative prices favoring specialists over primary care.8

The government also contributes to distorting outpatient drug prices through its 340B Drug Discount Program. As a condition for Medicaid coverage of their products, this program requires drug manufacturers to sell outpatient drugs to certain health care organizations, typically those that serve vulnerable populations, at discounted prices. In turn, those organizations may dispense the drugs to patients with coverage that pays market prices; the difference may be retained by the dispensing organization. This program encourages overuse of some drugs and the integration of physician groups with 340B-eligible hospitals, apart from the merits of doing so for efficient delivery of care. One rationale for the program is to financially protect some types of hospitals from high drug prices that result from government-granted monopolies (designed to encourage innovation). However, there are other ways to help specific hospitals without introducing price distortions, for example, with direct aid to critically needed hospitals that serve vulnerable populations.

Distortions arise in these areas, and many others, because health care pricing policies give preference to some types of care or some types of health care organizations, such as hospitals, over others. Pricing policies are not neutral with respect to how care is delivered. To address the pervasive and fundamental price-setting problems in health care, some seemingly comprehensive solutions have been proposed, such as setting price based on value or through market forces. Each of these has shortcomings. Value-based pricing requires more knowledge about value than is currently known and pure market-based solutions have well-known market failures.

In the meantime, a potentially helpful approach would be to target price distortions when they are observed and remedy those distortions when clear policy alternatives are available. Sometimes the policy solution might entail changes to administratively set prices (or the processes by which they are determined). In other cases, greater reliance on markets may help.

For example, although it will always be difficult to get prices right—either in an absolute or relative sense—eliminating the 340B program, implementing site-neutral payments, and reforming how the physician fee schedule is updated are examples of potentially simple, although admittedly politically difficult, policy changes. These changes would not reform the entire health system immediately, but incremental change is not necessarily inconsequential change. Nevertheless, changing fee schedules is difficult because politically powerful stakeholders, such as hospitals, that succeed under the current system (many of whom built business models based on the existing prices) vigorously oppose it.9 These groups often maintain they need the revenue resulting from overpriced services to accomplish a valued mission.

Whether those claims are true, subsidization of clinicians and health care organizations by skewing relative prices they are paid (eg, paying more for hospital-based care) is a poor policy choice. Price distortion not only shifts funds toward favored entities, but distorts important decisions. If the goal is to support various classes of clinicians or health care organizations, that should be achieved in the least distorted way possible. Effectively addressing high US health care spending will require considering polices that affect the overall level of prices and paying close attention to how those policies may affect relative prices.

REFERENCES