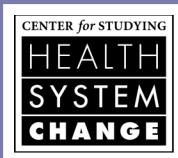


# Pricing Distortions and Capacity

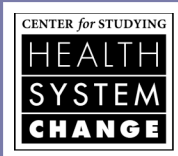
**Paul B. Ginsburg, Ph.D.**

Managing Health System Capacity:  
Market and Policy Approaches,  
December 1, 2008



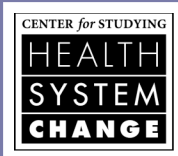
# Introduction

- Payers sending inadvertent signals to providers about types of care that are valued the most
- Providers are responding to these incentives
- For many services response involves increasing capacity
- Ownership of capacity further increases use of those services



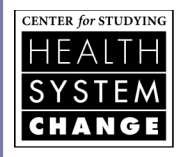
# Payer Objectives in Setting Provider Payment Rates

- Structure of payment rates should not influence decisions on care delivery
- (Public payers) fairness to different providers
- Both achieved when relative payment rates align with relative costs



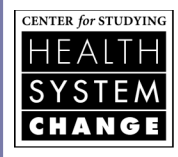
# Pattern of Payment Structure Deviating from Cost Structure

- Surgical DRGs more profitable than medical DRGs
  - Magnitude reduced by CMS revamp of DRG methods
  - Distortions remain for per diem and discounted charges approaches
- Physician procedures involving new technology more profitable than evaluation and management services
  - Physician work component
  - Technical (facility) component
- Patterns not intended by payers



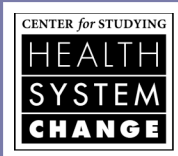
# Vigorous Provider Response to Inadvertent Payment Incentives (1)

- Hospital service line strategies
- Physician investment in freestanding outpatient facilities
- Physician investment in facilities in offices
- Single specialty group mergers to reach scale needed for equipment-intensive services



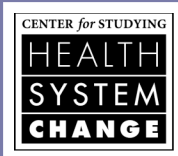
# Vigorous Provider Response to Inadvertent Payment Incentives (2)

- Physicians shifting to more lucrative specialties
  - Primary care shortages seen increasingly
  - Research that specialty mix influences spending
- International spending comparisons (MGI)
  - Higher outpatient service capacity in U.S
  - Used much less efficiently



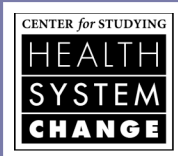
# Capacity Leads to Higher Rates of Service Use

- Greater patient convenience
  - Third party payment changes calculus of patient convenience
- Self-referral incentives apply to more services
  - Not just physician professional time
  - Incentives likely more powerful when services highly profitable
  - Extra incentives when average costs much higher than marginal cost (major equipment)



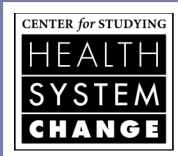
# Policies to Reduce Pricing Distortions

- Medicare best positioned to lead in this area
  - Credibility with providers
    - Engagement of provider leadership in its work
  - Sufficient clout with many providers
    - Introduction of physician fee schedule did not lead to access problems
- Private payers increasingly following Medicare payment structures
  - Extensive use of Medicare RVS
    - But need to deviate to accommodate provider market power



# Medicare Policy Options

- “Easier” part of the payment reform agenda
  - Revision of current methods
- Updating physician work values
  - Identification of services with increasing productivity for reductions
- More accurate estimates of facility costs
  - Frequent updating to reflect declining costs associated with technology
    - Consider projections of unit cost trends
  - Higher assumptions on capacity utilization
    - Absence of entitlement by providers to offer services profitably
- Use of volume trends as indicator of pricing errors
  - Routine use in Japan for imaging



# Concluding Thoughts

- Payment policies a strong driver of capacity
- Revising payment policies more likely to succeed in U.S. political environment than direct regulation of capacity
  - Inherently more powerful tool
- But Medicare's potential to lead needs shoring up
  - Reform of governance
  - Provide insulation from Congressional and White House intervention in payment decisions
  - Provider reliable resources to perform technical functions