Recovering the Opportunity Cost of Excess Prices

See also Magnan and Teutsch, p. 1731, and the *AJPH* Wasteful Medical Care Spending section, pp. 1730–1759.

There is widespread agreement that waste in US medical care represents significant annual spending, although research to quantify such waste has produced varying estimates. The synthesis of this research by Speer et al. (p. 1743) in this issue of *AJPH,* their mapping of estimates into six waste categories and the addition of compelling illustrations of the associated opportunity costs, are both valuable and eye-opening. We expand briefly on one of the six categories—the problem of high prices in the US health care system—and what to do about it.

THE PROBLEM OF EXCESSIVE PRICES

At an estimated range of $96 to $241 billion, Speer et al. note that spending as a result of excessive health care prices, if recovered, could instead fund "[u]niversal child care ($42 billion), paid family leave ($28 billion), and double the budget of the Supplemental Nutrition Assistance Program ($68 billion)" (p. 1746). We might quibble with Speer et al.'s ranking of high prices as the smallest contributor to waste, both on pure measurement grounds and because of the way in which high prices seep into each of the other categories; for example, high prices increase the cost of low-value care. Nonetheless, the authors ably illustrate how failing to effectively address high health care prices has significant opportunity costs.

As researchers within a group studying sustainable health spending strategies, we are not surprised to be reminded that "it's still the prices, stupid."[1] Prices, as opposed to use, have been shown to be the major driver of excess per-capita spending in the United States compared with other Organisation for Economic Co-operation and Development countries.[2] Americans see their physicians less often and have shorter hospital stays than do many of our international counterparts, but we pay much more for most procedures and for goods such as prescription drugs. Governments of other nations play a stronger role in constraining prices (e.g., assessing the prices of new drugs based on cost-effectiveness) or setting budgets in ways that better rationalize what is charged for care to each patient, regardless of where care is received or who is paying the bill. US prices also reflect other categories of waste, such as the large administrative burden that is uniquely American.

High US prices are also an equity issue. The tax exclusion for employer-sponsored health insurance (often called the original sin of health care policy) is one of the most regressive features in all of US social policy. The high prices that are embedded in richly covered insurance policies have little effect on high-income and high-wealth individuals. The same cannot be said for those with lower income, especially the "tweeners" who do not have employer-sponsored coverage but earn too much to qualify for Medicaid or Affordable Care Act insurance exchange subsidies. High prices also increase the price tag for universal coverage, making it more difficult to enact from a budgetary and political perspective. These equity issues are exacerbated in the coronavirus disease 2019 (COVID-19) environment, because the recent massive increase in unemployment, and the concomitant loss of health insurance, is having a disproportionate effect on the poor and people of color, who are also more likely to be infected, become ill, and die from COVID-19.

As important as the level of prices is the enormous variability, both between public and private payers and among private payers. Public payer reimbursements have long been below private payer rates,[3] and this differential has grown significantly in recent decades alongside increasing provider consolidation. On pure prices alone (i.e., net of intensity changes), official government price indexes show that hospital prices paid by Medicaid, Medicare, and private insurance since June 2014 have risen by 0.5%, 10.1%, and 15.9%, respectively.[4] Within private insurance, examples abound of extreme price variations for the same service. A recent comparison of hospital prices in two adjacent states found that in Michigan, commercial plans pay about 160% of Medicare rates for hospital outpatient care, whereas in Indiana, plans pay more than 400% of Medicare rates, even though much of this care is provided by the same health system (Table 1).[5] In current headlines, Kliff[6] zeroed in on divergent prices for COVID-19 testing, finding prices ranging from $100 to more than $6000.

In a well-functioning health care market, prices would not vary multifold, with no evidence that higher prices are associated with better quality. In the commercially insured health care market, several degrees of

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This editorial was accepted September 11, 2020.

https://doi.org/10.2105/AJPH.2020.305972

TABLE 1—Prices Paid by Private Health Plans for Hospital Care in Michigan and Indiana

Hospital Setting	Data Source	Year	% of Medicare or Private Price per Service ($), CaseMix-Adjusted: Michigan	% of Medicare or Private Price per Service ($), CaseMix-Adjusted: Indiana	Difference, Michigan vs Indiana, %
Inpatient	RAND 2.0	2017	153%	236%	−35.2
Outpatient	RAND 2.0	2017	161%	403%	−60.0
Inpatient	JHU memo to HELP	2016	171%	255%	−32.9
Inpatient	HCCI	2017	$16 516	$22 139	−25.4
Outpatient	HCCI	2017	$443	$649	−31.7
Inpatient and outpatient	RAND Hospital Data	2016	147%	223%	−34.2

Note. CaseMix = complexity and intensity of treatments provided to individual patients; HCCI = Health Care Cost Institute; HELP = Senate Committee on Health, Education, Labor and Pensions; JHU = Johns Hopkins University; Price = negotiated allowed amount per medical service, including the health plan liability plus any patient cost sharing; RAND 2.0 = RAND Corporation National Hospital Price Transparency Study.
Source. Adapted from White.[5]

separation exist between the consumer and the price being paid. Patients with health insurance are mostly insulated from the price of the services they are receiving. Even the provider may not know the price that will be charged. Those with employer-sponsored insurance have even further separation because the consumer is not directly facing the premium associated with the level of prices.

GOVERNMENT INTERVENTION AS A SOLUTION

Markets that do not function well require government intervention. It is all too easy to argue that the lack of success in countering inefficiencies in the US health care system is driven by a lack of political will or to cite the dictum that every dollar of waste is reflected in someone's income (although, of course, it is). Nevertheless, we see opportunities in the post–COVID-19 era to better rationalize US health care prices.

New, detailed data sources are shining a light on high, variable, and growing prices. Government policy is likewise ushering in a new era of transparency, and thus far, the courts have upheld actions to address issues raised, such as site-neutral payments. Emerging trends also will exert downward pressure on average prices, especially for hospitals, which account for approximately one third of national health expenditures. These trends include a continuing, and possibly accelerating, shift away from hospital to ambulatory care and a short-term (because of higher unemployment) and longer-term (because of the aging population) shift in the payer mix toward lower-paying public programs.

Beyond efforts to increase transparency and competition, we believe that more aggressive government intervention, particularly in the commercial market, is needed to curb excessive prices. We see promise in strategies such as the three-pronged approach developed by Chernew et al.[7]: (1) set rate caps for services at the top of the commercial price distribution, (2) set annual caps on price growth, and (3) provide for oversight by government agencies, triggered when prices or their growth rates exceed established thresholds. In this type of approach, the government is not setting prices under commercial insurance but creating a framework within which payers and providers can negotiate, which constrains excessively high prices when the market cannot. Although more comprehensive reform might eventually be needed to fully address pricing failures in the US health care system, carefully designed market interventions such as this are the best hope for reducing excessive prices while preserving the overall market structure of the commercial segment of the system. The need for such interventions is highlighted by the opportunity costs of unnecessarily high prices that Speer et al. have identified. Health care policy is incredibly complicated, but one policy objective is simple: lower spending by paying less. AJPH

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ACKNOWLEDGMENTS
The authors gratefully acknowledge funding support from the National Institute for Health Care Reform.

CONFLICTS OF INTEREST
The authors have no conflicts of interest to disclose.

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