2019 Martin Feldstein Lecture
Economic Analysis for Evidence-Based Health Policy: Progress and Pitfalls

Katherine Baicker
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Economic analysis for health service efficiency: Econometric studies of the British National Health Service (Contributions to economic analysis)

Feldstein, Martin S
Economics and Evidence-Based Health Policy

• Characterize “EBHP”
• Strengths and weaknesses
• Current reform debates
  – Key features and goals of very different proposals
  – Contributions (many by those in the room!)
    • Drawing out first-order issues; analytical insights; tradeoffs
• Achieving impact
  – Economists and evidence-based health policy

THE UNIVERSITY OF CHICAGO
Harris Public Policy
Economics and Evidence-Based Health Policy

- Characterize “EBHP”
- Strengths and weaknesses Opportunities and challenges
- Current reform debates
  - Key features and goals of very different proposals
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- Achieving impact
  - Economists and evidence-based health policy
Evidence-Based Health Policy

• Everyone is in favor of EBHP, right? Right?
  – “You can’t put a price on your health”

• What do we mean by “evidence-based health policy”?
  – Each word should have commonly-understood meaning
Evidence-Based Health Policy

• Slogans ≠ policies
  – “Population health” or “single payer”

• Policies ≠ goals
  – Same policy may have multiple goals
    • Pay for care coordination
  – Multiple policies may target same goal
    • Reduce adverse health consequences of “bad hand-offs”
Evidence-Based Health Policy

- Theory $\neq$ evidence
  - Inherently empirical – magnitude if not signs
    - Introspection
    - Often competing effects
- Evidence often requires interpretation
  - Nuance in interpretation and synthesis
  - Filter based on quality, not goals
  - Realism about level of certainty
Evidence-Based Health Policy

• How does evidence actually translate?
• Reckoning with difficult trade-offs
• Multiple factors play into decisions
  – Reality of political constraints
Evidence-Based Health Policy

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NBER WORKING PAPER SERIES

BALANCING THE GOALS OF HEALTH CARE PROVISION
Martin Feldstein
Working Paper 12279
http://www.nber.org/papers/w12279

NATIONAL BUREAU OF ECONOMIC RESEARCH
1050 Massachusetts Avenue
Cambridge, MA 02138
May 2006
Our Strengths

• High causal bar
  – Skepticism; testing things that sound like good ideas

• Deep understanding of incentives; markets; incidence
  – Point to intended and unintended consequences
  – Static and dynamic effects of policies

• Analytical framework for interpreting evidence

• Separation of evidence from advocacy
Our Weaknesses

• Hesitance to be decisive*
  
  * Depending on circumstances; limitations apply; further study is needed

• Timeliness

• Willingness to put aside 2nd order concerns and to focus on choice set available under constraints

• Translational efforts
  
  – Tension between translation and rigor
  
  – Effort to engage broader audiences
Current Reform Debate

• Multiple goals – allocative and productive
  – Access to care/coverage – social insurance
    • Why – externalities or altruism?
    • Fundamental differences in preferences
      – Appetite for redistribution – Is “health care a right?”
        » Implicit priorities
      – Preferences over government provision and production
Insurance Coverage

Source: Tabulation from NHE/CMS
Insurance Coverage

Source: Baicker & Sommers tabulation of Census data
Current Reform Debate

- Multiple goals – allocative and productive
  - Access to care/coverage – social insurance
    - Expanding coverage to the uninsured
  - Efficiency of production and delivery
    - Little disagreement that we spend a lot – but attention can be focused in wrong place
    - Could we get more for every dollar we spend?
Health Care Value

- Denominator: we know we spend a lot . . .
  - Where does all that money come from?
  - Where does all that money go?
Health Spending

Source: Tabulation from NHE/CMS
Health Spending

Source: Tabulation from NHE/CMS
High Spending

$ per capita, 2018

Source: OECD Health Statistics
Health Care Value

• Denominator: we know we spend a lot . . .
  – Where does all that money come from?
  – Where does all that money go?
  – Why more than other countries?
    • P? Q?
      • Insights into measurement and mechanisms
Health Care Value

• **Denominator:** we know we spend a lot . . .
  . . . But too much?

• **Numerator:** health
  – Hard to measure
  – Multiple inputs
High Value?

Map: Price-Adjusted Total Medicare Reimbursements per Enrollee (Parts A and B), by HRR
(Price, Age, Sex, and Race adjusted)

Map: Discharges for Ambulatory Care-Sensitive Conditions per 1,000 Medicare Enrollees, by HRR

Source: Dartmouth Atlas of Health Care
Health Care Value

• Geographic variation is symptom, not root problem
• Wide variation in private spending as well
  – Emerging data on variation in prices as well as utilization
• Multiple potential policy levers
  – Particular market imperfections
  – Financing key driver
  – Dynamic effects on efficiency and innovation
Key Policy Levers

• Patient side
  – Coverage subsidies and mechanisms
  – Cost-sharing within plans

• Provider side
  – Payment models

• System level
  – Competitive landscape
  – Mechanisms for addressing asymmetric information
Key Policy Levers

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Chapter in 1976 NBER Volume:
Mechanisms for Expansion

- ACA/Obamacare
  - Medicaid; Exchanges + subsidies; Dependent coverage; Mandate/penalty
- Differential selection, risk pooling, crowding out
  - Community rating/underwriting
  - Generosity and form of subsidies
- Different types of coverage
  - Effects on utilization, health, and other outcomes
Effects of Coverage Expansion

• Theoretically ambiguous
  – Costs
    • Health care utilization
  – Benefits
    • Protection against financial risk
    • Health
• Wide literature
  – Range of empirical strategies
Evidence from Oregon HIE

Source: Baicker, Finkelstein et al.
Effects of Patient Cost-Sharing

• Optimal copays
  – Balancing moral hazard and risk protection
  – Evidence dating back to RAND

• Current system leaves substantial room for improvement
  – Medicare benefits surprisingly lousy → Medigap
  – Well-known distortions on employer side
Effects of Patient Cost-Sharing

- Optimal copays
- Current system leaves substantial room for improvement
- Policy options
  - HDHP/HSAs
  - Shared savings/reference pricing
  - Medigap reform
Effects of Patient Cost-Sharing

- Prices matter a lot . . .
  - . . . but not exactly as standard theory suggests
  - More nuanced behavioral response

- Evidence of both underuse and overuse
  - Underuse: adherence, even for life-saving drugs with minimal side effects; pre-natal care; preventive care
  - Overuse: MRIs for low back; prostate surgery; antibiotics for ear aches
Effects of Patient Cost-Sharing

• Behavioral responses to prices
  – Prices change inspire changes in high- and low-value care
  – Small price changes matter a lot – even for care with major health implications

• Policy alternatives
  – VBID/safe harbors
  – Narrow networks
Effects of Payment Reform

• Providers are price-sensitive too
  – Particularly important with info asymmetries
  – Also human, subject to behavioral factors

• Medicare has disproportionate effect
  – Known problems with FFS
Effects of Payment Reform

• Lots of experimentation with alternatives
  – Cautionary tale of SGR
  – Bundled payments, ACOs – evidence emerging

• Important questions about dynamic effects
  – Particularly difficult to estimate
Insurance Markets

• Private insurance vs. social insurance

• Market functioning
  – Challenge of imperfect information
  – Availability of intertemporal insurance

• Effect of medical innovation
  – Changing value of private insurance
  – Sectoral insurance against innovation
  – Missing availability of limited benefits
Effects of Competition

• Competition
  – Many proposals hinge on choice driving efficiency
  – Need sophisticated risk adjustment, quality metrics

• Consolidation – provider and insurer markets
  – Ample evidence that consolidation leads to higher prices/premiums; scant evidence of higher quality

• Competition vs. consolidation tension
  – Policies sometimes working at cross-purposes
Improving Delivery

• Increasingly investigating delivery innovation
  – New data, new tools, RCT opportunities
  – Important contributions
    • Opioid crisis, decision aids, disease management, . . .

• Opens doors to new outlets and audiences
  – But requires different modes of dissemination and translation
So, Does Evidence Change the Debate?
5 Things the Oregon Medicaid Study Tells Us About American Health Care

A landmark new study of Oregon’s Medicaid program reveals what’s wrong with American health care.

Does the Oregon Health Study Show That People Are Better Off With Only Catastrophic Coverage?

Here’s what the Oregon Medicaid study really said

How to Use the Oregon Medicaid Study to Your Ideological Advantage

Medicaid Access Increases Use of Care, Study Finds

Spending on Medicaid doesn’t actually help the poor

Is health insurance an antidepressant?
New findings show that wider coverage has one clear effect on the population, and it’s not one that anyone is talking about.

Oregon’s Lesson to the Nation: Medicaid Works

Four Reasons Why The Oregon Medicaid Results Are Even Worse Than They Look

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Harris Public Policy
Medicaid Is Worse Than No Coverage at All

New research shows that patients on this government plan fare poorly. So why does the president want to shove one in four Americans into it?

By SCOTT GOTTLIB

The Washington Post

How the Medicaid expansion could actually save states money
THE WALL STREET JOURNAL

OPINION

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The Washington Post

How the Medicaid expansion could actually save states money
Successes – in Challenging Times

• Meaningful Congressional testimony
• Citations in laws, regulations, and rulings
• But oxygen scarce, expertise devalued
WHAT DO WE WANT?
EVIDENCE-BASED CHANGE
WHEN DO WE WANT IT?
AFTER PEER REVIEW