

Q&A

A Conversation with James C. Robinson, PhD, MPH

Waiting for Economic Pressure To Force Our Hand

The UC–Berkeley health care economist says the cost-control and performance-improvement methods we’ve been developing for years can work, but implementing them on a wide scale may come as a last resort

James C. Robinson, PhD, MPH, teaches classes and does a wide range of research in health economics, health care technology policy, and public health. What’s most important today, however, is not to perform research but to implement what we’ve been learning, he says.

“We have the ideas and the tools to have a sustainable health care system — coordinated care, technology assessment, purchasing methods, payment

methods, performance metrics — but we need to be serious about using them.” That may not happen until the government is forced to make major cuts in the Medicare budget, he says. Yet while Robinson is the Leonard D. Schaeffer Professor of Health Economics and director of the Berkeley Center for Health Technology at the School of Public Health at the University of California–Berkeley, he is also the senior director for medical technology at the Integrated

Healthcare Association, where he leads an effort to promote value-based purchasing for medical devices in orthopedics and cardiology. The information he supplies is used by health plans, physician group practices, and hospital systems in California as they try to make more cost-effective decisions about care

“We have been very active in helping our members get better information and use better methods of purchasing medical devices,” he says. That will make an impact on cost and actually help ensure that innovation in medical technology continues, he says. Robinson has published two books and more than 100 articles in peer-reviewed journals. He is a contributing editor at *Health Affairs* and has served as a peer reviewer for a dozen scientific journals and foundations. He earned a bachelor’s degree in eco-



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nomics and philosophy at the University of California–Santa Cruz and a master of public health and a PhD in economics from the University of California–Berkeley. He completed a fellowship in health policy at the University of California–San Francisco. Robinson spoke recently with Managed Care Editor John Marcille.

MANAGED CARE: What have you learned in evaluating medical technologies that would surprise health plans?

JAMES C. ROBINSON, PhD, MPH: That drug and device industries are feeling a lot of stress about their ability to get reimbursed for their products at a rate that will permit them to continue financing innovation. It would surprise them because health plans correctly think that they are paying ever higher rates for new implantable devices, imaging, and other technologies.

MC: It sounds like you are saying opposite things.

ROBINSON: Yes. Everybody who is paying for health care, which includes employers, individuals, and health plans, honestly feels that they can't keep on paying at these rates. And everyone who is providing services, such as physicians, hospitals, and medical device and pharmaceutical companies, honestly and legitimately feels that the rates they are paid are not sufficient to allow them to continue providing care and products at the rate that they have been doing in the past. Both have legitimacy. A huge collision is coming.

MC: Are you concerned that innovation will falter?

ROBINSON: New clinical technologies such as cancer drugs and implantable devices are the most important improvements in health care today, but they also account for a large part of the increase in expenditures. That increase includes the devices, the procedures, the staffing, and the facilities that surround them. The biggest challenge facing the nation as it seeks to moderate the rate of growth in health care costs is how to balance affordability and continued innovation.

MC: How do we reconcile this?

ROBINSON: A good way to do it is to develop a smarter system that assesses technologies more carefully, uses them more judiciously, and does not use them when there's no evidence of strong benefits and cost-effectiveness. That's the way we all hope to moderate costs.

MC: Right. That would help the payers.

ROBINSON: And it gives a signal to the medical device and pharmaceutical firms that if they want to have successful products, their products have to be innovative and better than previous products. That's a good signal to them that we will reward true innovation rather than more of the same.

MC: Are drug and device manufacturers spending too much money producing me-too products?

ROBINSON: They are shifting. Pharmaceutical companies are really moving away from me-too drugs in the cardiac space, in particular where a number of antihypertensives and statins are already off patent and therefore cheap. They are focusing their research activities in areas such as cancer and autoimmune conditions, where they can charge much higher prices for their products because there's a greater unmet need.

MC: As a matter of policy, is that a useful, desirable situation?

ROBINSON: Yes. We want the drug and device industry to be putting their research into areas where there are fewer therapies.

MC: Will payment reforms and value-based insurance design affect technology companies?

ROBINSON: Moving more toward episode payments, bundled payments, shared savings, and partial capitation will change the overall structure of how the drug and device industry gets paid. And as provider organizations get paid less, they will need to reduce their supply chain costs. This is more and more evident with Medicare as a dominant payer. Medicare has been underpaying hospitals for years, and they have had to increase prices to commercial insurance companies to cover shortfalls. But now they are realizing that Medicare is a dominant payer and they need to produce a health care product that covers their costs at a decent margin at Medicare rates. That is going to lead to them saying to drug and medical device companies, "Listen, we have got a limited revenue stream here. We cannot give so much of our revenue out to you as the supplier of the drugs and devices, so your prices need to be sustainable within the context of the world that we live in, which is the world of Medicare payment." There's a domino effect of cost pressures, starting with government and employers, moving through the insurance enti-

ties, then hitting the hospitals, and then hitting the drug and device firms.

MC: You've written quite a bit about providers' tendency to shift costs from Medicare to private plans. Is that something we still have to worry about?

ROBINSON: It's clear that hospitals charge higher prices to private insurance companies than they do to Medicare and Medicaid, but economists would call that price discrimination rather than cost shifting. It just means that you are charging two different entities two different prices for the same service. That happens in large parts of the economy. Hotels charge different rates to different buyers, depending on whether it is a large buyer or a single-room buyer. The question going forward is whether this is a sustainable path.

MC: It goes back to what you said about hospitals needing to operate within their Medicare payments.

ROBINSON: Ultimately, what Medicare pays is what people in the United States feel that they can afford for health care. It's imperative that hospitals bring their cost structure down to what Medicare will pay. Charging private health plans so much more than they charge Medicare could lead to rapid increases in consumer cost sharing and continued erosion of the market share of private health plans, leading more people to enroll in Medicare and Medicaid. That could mean a gradual, rolling nationalization of the insurance sector.

MC: So you don't see any radical change in the structure of health care in America, given the political situation?

ROBINSON: No. There's no appetite for a major change. Everybody dislikes the system, but no one can agree on what they want. Everyone's second-best option is to keep things the way they are. The tipping point will come when interest rates rise again. The interest rates that finance the federal debt are at virtually zero, and that cannot continue. When the Chinese become less willing to buy U.S. Treasury bills and the Treasury has to raise interest rates to attract purchasers, that will dramatically increase the cost of servicing the federal debt, which in turn will force the federal government to cut other aspects of its budget. That would mainly mean cuts in entitlement programs such as Medicare. When interest rates

rise, radical change will have to happen.

MC: What are things that Medicare could be doing to cut costs without radically cutting care?

ROBINSON: Medicare is a purchaser, not a provider, so it cannot directly produce a more efficient health care system. It could move more expeditiously in bundling physician and hospital payments for inpatient procedures, combining Part A and Part B for payment. That would allow hospitals and physicians to do gainsharing, which gives them an incentive to reduce their costs. Medicare could also move more expeditiously in paying on a partial-capitation basis to provider organizations that are able to accept that form of payment.

MC: What about organizations that can't take that form of payment?

ROBINSON: Providers who are not participating in those innovative payment mechanisms cannot just keep on doing what they have been doing and receiving the same rates because that would not be fair to those who are cutting costs. That is a dilemma. Medicare is going to have to cut its payment rates at the same time it is changing its structure. The ideal would be for Medicare to do this continuously at a modest rate to allow the delivery system to predict and plan and adjust. It would be like putting the delivery system on a planned diet, not a crash diet.

MC: What would be the role of the Medicare Advantage program?

ROBINSON: I am a fan of Medicare Advantage. Accountable care organizations are supposed to do what Medicare Advantage was designed to do, without the Medicare Advantage platform. It's ultimately the same goal, which is to pay a provider organization for a whole package of services rather than for individual services and to allow the provider organization to figure out more cost-effective ways to deliver that package. The fate of Medicare Advantage will be a political matter to some extent. The Democrats seem to like ACOs to do what Republicans want to do through Medicare Advantage.

MC: With the Affordable Care Act, the government is pushing for the establishment of ACOs. Plus, we are seeing a lot of consolidation on the provider side right now. You've done research on the value of competitive environments in reducing costs. How is this going to work out?

ROBINSON: Physicians and hospitals are consolidating with or without the Affordable Care Act. It was happening before it was passed. The consolidation of hospitals, the movement of physicians from individual and small group practices to larger group practices, and the consolidation of physician practices into hospital systems in various forms of employment or alliances is vertical integration, and it's a long-term trend. That will continue. One reason is the pursuit of efficiencies and better coordination between physicians and hospitals. Another is to increase marketing power vis-à-vis those who sell to them and those they sell to. Organizations that sell to physicians and hospitals are drug and device companies, and the people who buy from physicians and hospitals are insurance companies. Provider organizations are gaining leverage on both sides.

MC: Is that good?

ROBINSON: Most of us believe that competition is a good thing and reductions in competition are bad for short-term price effect and for the dampening effect they have on innovation. Then again, I do empathize with hospitals. They have to provide care for the uninsured; they have to accept Medicaid rates; and they have a variety of other mandates that are placed on them. At the Integrated Healthcare Association, our primary stakeholder organizations are health plans, hospital systems, and physician groups. We work on projects that have a common interest among those three entities, such as payment reform, performance measurement, and the establishment of ACOs. We are certainly interested in physician-hospital integration for the reasons we discussed earlier: bargaining power, purchasing power, pricing power. From the worldview of the IHA, the benefits outweigh the concerns.

MC: Your research shows that a more competitive environment leads to more cost cutting by providers.

ROBINSON: We don't know where the current wave of consolidation is going to produce efficiencies large enough to overcome the socially undesirable effects on increased pricing power. In the short term, providers may use their consolidated structures to raise their prices against the private insurance companies. In the long term, they are

going to be stuck with Medicare and Medicaid and various forms of regulation. It varies from state to state, from market to market. Some markets are consolidated yet very competitive. I generally believe that physician-hospital integration is pro-competitive most of the time, whereas hospital-to-hospital mergers tend to be anti-competitive and tend to be ones in which the efficiency gains are modest and pricing power is more significant. So I like vertical integration between physicians and hospitals, and I am skeptical of integration between hospitals unless there is excess capacity or other reasons.

MC: What about insurance companies as part of integrations?

ROBINSON: Health plans are acquiring different types of physician practices, and it's too early to tell whether that is a major strategy change to more closely resemble a staff-model HMO or whether it is a more transitory initiative that really reflects the dynamics of particular local markets. The goal may not be to employ physicians, for example, but to acquire the capabilities of running local networks and relating to local physicians in a way that they couldn't do nationally.

MC: Do national plans struggle to relate to local markets?

ROBINSON: The insurance industry has consolidated over the past 20 years, and we see fewer and fewer local plans. National plans have lost touch with the dynamics of many local markets because their attention is distracted in all directions, and they have to seek uniformity in their network strategy. This uniformity has ironically limited their ability to be creative and innovative in some markets. So when a large health plan acquires a physician entity, an IPA or medical group, it may be an attempt for that national health plan to get close to the dynamic of the hospitals and physicians and the consumers in a particular market in a way that's different than they do it in other markets. Health care is delivered locally, but the health plans are now mostly national plans.

MC: You mentioned earlier that the need to reduce costs could lead to greater cost sharing for consumers, which is a large part of consumer-directed health care. What are your favorite features of this movement?

ROBINSON: Consumer-directed health care is often

used as a term for a high-deductible health insurance plan. If that's what consumer-directed health care is, it has had a limited impact and will continue to have a small effect. But if we use consumer-directed health care in the broad respect, by which we mean having the consumer, the patient, take on a greater overall responsibility for paying for care, which doesn't have to be through a high-deductible plan, then I think we are moving into a different, stronger role for the consumer. Someone has to take responsibility for managing the cost of care. It is politically and culturally unpopular in the United States for the government to do it, as they have done in many other nations. It is also unpopular for employers or insurance companies to do it, which is what led us into the backlash against managed care. The third option would be the physicians and the hospitals, the providers of care, and they are very unenthusiastic about controlling costs. They like to provide more and better care; they don't want to be cost-control bad guys. That really leaves the consumer spending his or her own money as the American protagonist for health care cost control. That is going to have big effects, some desirable and some very undesirable.

MC: What are you learning in the areas of orthopedic and cardiac surgery that will help reduce costs?

ROBINSON: These are acute services, often for underlying chronic conditions, and they are the areas of greatest potential for efficiency improvement. These areas tend to be the ones where it is easier to apply protocols and clinical pathways, and to use principles of lean manufacturing to standardize the service lines. Chronic illness is driven by patient behavior and has many small but cumulatively high expenses. The acute domain, which is really the hospital and ambulatory surgery, is an area of great potential. We see huge differences in how care is provided and paid for, and we see dramatic differences in areas such as the rate of complications and readmissions. There are a lot of potential improvements that can be made just by getting the worst performers to imitate the better performers.

MC: You've talked about the need to apply these kinds of strategies. Can we make that happen?

ROBINSON: In the past decade, we've learned that providing innovative care and controlling costs

are harder than we all believed. It would be realistic to have continued modest expectations so that we don't continue on this cycle of illusion and disillusion that we've been on so many times. We cannot deliver on lower cost care because we have been on this trajectory of high cost care for so long. We will only get serious about this when the macroeconomic pressures force us to get serious. Then I hope we will be able to make up for lost time and implement the strategies we have developed, which are basically good strategies. We have not been diligent about implementing them because the health care system has been allowed to expand at the rate it has.

MC: What are the biggest challenges that CMOs at health plans are going to face in doing their jobs over the next few years?

ROBINSON: They are going to be under great pressure to bring down the costs of the services that they pay for, yet America is not willing to give much direct authority to private insurance companies. We still have only modest social acceptability of that. The reality is that controlling health care costs is a matter of saying no to certain technologies, saying no to particular providers, and saying no to patients who want services when there is no need. The question is, Who is going to say no? The government doesn't want to do it, the health plans don't want to do it, and so far the providers don't want to do it. There's a pressure to control costs, and yet no one wants to be demonized as the institute that restricts care.

MC: Thank you. **MC**

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