

DRAFT – FOR DISCUSSION ONLY
**How Health Care Competition and Cost Control
 Will Work Under Minnesota’s Transformed System**

The success of Minnesota’s Transformed Health Care System in reducing health care costs and controlling their growth will depend on a combination of two factors:

- Whether the mechanisms for cost control in the transformed system will be at least as good, and hopefully much better, than the cost control mechanisms which exist today; and
- Whether the incentives for cost increases that exist today have been reduced or eliminated, and ideally replaced by incentives for improved quality and value.

MECHANISMS FOR COST CONTROL IN TODAY’S SYSTEM	MECHANISMS FOR COST CONTROL IN THE TRANSFORMED SYSTEM
<p>Price Negotiation by Health Plans with Providers:</p> <p>Health insurance plans negotiate with health care providers to keep prices (i.e., fee levels) for individual services low. If a provider demands prices that are too high, a health plan may exclude them from the health plan’s network, meaning that patients with that health plan’s insurance would have to pay a higher price, or full price, for using that provider.</p>	<p>Under Levels 1, 2, and 3 of Payment Reform:</p> <p>Health insurance plans could still negotiate with health care providers regarding whether they would be included in the health plan’s network. If the provider sets prices that are too high, the health plan could (a) exclude them from the health plan’s network completely, or (b) assign them to a lower value tier and require the patient to pay more to use them.</p> <p>NET RESULT: At a minimum, there would no less ability to control costs than today. The greater use of provider tiering would likely result in more patient movement to lower-cost, higher-value providers than current network-inclusion decisions do, since changing the cost to the patient is easier than telling the patient they cannot use the provider at all. Use of single pricing would mean that small payers and self-pay patients (including the uninsured) would experience significantly lower costs, since they would benefit from the price negotiations that occur with the largest payers. The only situation in which costs would increase for a particular payer would be where that payer is currently paying below the</p>

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	<p>minimum achievable costs for a provider's service, in which case that payer's costs for that service today are, in actuality, being subsidized by other payers or by other services.</p>
<p>Control by Health Plans of Utilization of Services by High-Cost Patients:</p> <p>Health insurance plans establish disease management programs, utilization review, and other mechanisms to try and reduce utilization of expensive services by individuals with chronic disease. Disease management vendors and health plan staff are paid for providing care management services above and beyond what providers are paid to do, and also receive bonus/penalty payments based on their success in reducing utilization of expensive services by the patients they deal with.</p>	<p>Under Level 1 of Payment Reform:</p> <p>Providers would be measured based on the outcomes they achieve for their chronic disease patients, including the extent to which those patients use expensive services at a high rate, and would receive bonus/penalty payments based on those measures of quality and efficiency.</p> <p>Under Level 2 of Payment Reform:</p> <p>Patients with chronic disease would be encouraged to choose and use a medical home, which would be paid a care management fee for managing the patient's care in order to improve their health and reduce utilization of expensive services. Medical home providers would also receive a bonus/penalty payment based on the quality of their outcomes and on the extent to which their patients utilize expensive services.</p> <p>Under Level 3 of Payment Reform:</p> <p>Health care systems would bid for providing the total costs of care to a population, including patients with chronic disease. The health care system would need to provide coordinated, effective care and find ways to reduce utilization of expensive health care services by individuals with chronic disease in order to (a) set a bid price that would be accepted by the health plan and which would translate into a premium cost that would attract patients, (b) keep their costs within the bid price, and (c) maintain or improve health outcomes.</p> <p>NET RESULT: Under Level 1, there would be an explicit incentive for physicians to improve care of chronic disease patients, since it would affect their quality ratings and also their incentive payments.</p> <p>Under Level 2, to the extent that care</p>

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	<p>management fees and incentive payments to medical homes are similar in amount and provided to the same patients as are currently covered by disease management vendors, there would be no increase in costs. Moreover, research suggests that care management which is part of the primary care physician's practice may be more effective in reducing utilization than a separate disease management program. Under Level 3, the health care system would receive only the amount of its bid (after adjustment for the severity/risk of the actual population it is caring for), which means that it would receive no increases in total payment if health outcomes deteriorated or if utilization increased for the same patient population, which would be a more effective way of controlling costs than an add-on incentive payment.</p>
<p>Preventive Care by Health Plans: Health insurance plans encourage preventive care by their members through information programs, lower copays, etc.</p>	<p>In General: Goals for improvement in the health of Minnesotans would be established and pursued, and Minnesotans would be encouraged to take steps needed to maintain and improve their health, with support and encouragement from employers, communities, schools, and health care providers.</p> <p>Under Level 1 of Payment Reform: Providers would be measured based on the extent to which they reduce the incidence of preventable illness for their patients, and the providers would receive bonus/penalty payments based on those measures of quality.</p> <p>Under Level 2 of Payment Reform: Patients would be encouraged to choose and use a medical home, which would be paid a care management fee for managing the patient's care in order to prevent illnesses. Medical home providers would also receive a bonus/penalty payment based on the extent to which their patients' health status improves or is maintained.</p>

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	<p>Under Level 3 of Payment Reform:</p> <p>Health care systems would bid for providing the total costs of care to a population. The health care system would need to provide effective care management, including preventive care, in order to (a) set a bid price that would be accepted by the health plan and which would translate into a premium cost that would attract patients, (b) keep their costs within the bid price, and (c) maintain or improve health outcomes.</p> <p>NET RESULT: In general, the health of Minnesotans would increase, which would reduce their need for health services, particularly expensive services, thereby reducing costs.</p> <p>Under Level 1, there would be an explicit incentive for physicians to practice preventive care effectively, since it would affect their quality ratings and also their incentive payments.</p> <p>Under Level 2, to the extent that care management fees and incentive payments to medical homes are similar to the average amount currently spent by health plans on prevention programs, there would be no increase in costs, and there would be a reduction if prevention efforts improve.</p> <p>Under Level 3, the health care system would receive only the amount of its bid (after adjustment for the severity/risk of the actual population it is caring for), which means that it would receive no increases in total payment if health outcomes deteriorated and/or utilization increased for the same patient population, which would be a more effective way of controlling costs than an add-on incentive payment.</p>

INCENTIVES FOR COST ESCALATION IN TODAY'S SYSTEM	CORRECTIONS TO MISALIGNED INCENTIVES IN THE TRANSFORMED SYSTEM
<p>Health Plan Competition For Market Share of Patients:</p> <p>Patients may decide to switch insurance plans</p>	<p>Under Levels 1, 2, and 3 of Payment Reform:</p> <p>Patients would be able to use most or all</p>

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<p>if the providers they believe are higher quality are not included in the health insurance plan's network. This discourages health plans from excluding a provider, which in turn limits the health plan's ability to negotiate prices</p>	<p>providers, but would pay a difference in copay and/or insurance premium if they use providers with higher prices.</p> <p>Moreover, quality ratings of each provider would be available to provide an objective assessment of whether a provider with higher prices is actually delivering higher quality or not.</p> <p>NET RESULT: At a minimum, there would no less ability to control costs than today. The greater use of provider tiering would likely result in more patient movement to lower-cost, higher-value providers than current network-inclusion decisions do. Use of single pricing would mean that small payers and self-pay patients would experience significantly lower costs. The only situation in which costs would increase for a particular payer would be where that payer is currently paying below the minimum achievable costs for a provider's service, in which case that payer's costs for the service today is, in actuality, being subsidized by other payers or by other services.</p>
<p>Provider Consolidation for Greater Negotiating Power with Health Plans</p> <p>Providers which consolidate or otherwise achieve the scale necessary to dominate a particular market can resist efforts by health plans to control fees in negotiations, since the health plan will be unable to exclude the dominant provider from its network (since other providers would not have the capacity to handle the patients).</p>	<p>Under Levels 1, 2, and 3 of Payment Reform:</p> <p>Providers of all sizes would have their prices and quality for services published for consumers to use in choosing services, and higher prices for services would mean consumers would have to pay more.</p> <p>New providers would be able to enter the marketplace by providing a specific subset of services.</p> <p>NET RESULT: If large providers charge more for services without providing comparable improvements in quality, consumers would have an incentive to select alternative providers, thereby decreasing the volume of patients and services that the large provider is able to provide. Moreover, small providers would be able to enter the marketplace to provide only certain services, thereby encouraging the large providers to lower prices on those services. If the large provider tries to make up the lost revenue by raising prices on</p>

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	<p>other services where there is no competition, it will increase the incentive for new providers to enter the marketplace for these services as well. Even if there are no providers offering lower prices directly in the specific geographic market, comparisons to prices in other markets will lead to significant public pressure on providers (particularly through non-profit provider boards of directors) to lower prices to the levels achieved in other markets.</p>
<p>Ability of Providers to Charge Higher Prices to Smaller Payers:</p> <p>Providers can charge higher fees to smaller payers and uninsured patients, which enables them to offset price cuts by other payers and to make up for inefficiencies in care delivery.</p>	<p>Under Levels 1, 2, and 3 of Payment Reform:</p> <p>Health care providers would have to charge the same price to all payers.</p> <p>NET RESULT: Small payers and self-pay patients would experience significantly lower costs.</p> <p>In addition, large payers would not experience any increases in prices. If the provider sets a price that is higher than the lowest price they charge some payers today (e.g., by setting its price at its average reimbursement level), then the payers that are paying less today would face three choices -- (1) pay the higher amount, (2) drop the provider from its network, or (3) charge the patient the difference between the current price and the new price. Presumably, the payers that get the highest discounts today are those that give the provider its highest volume, so the payer is unlikely to be willing to do #1 (since even a small increase in price x large volume would be a big cost impact on the payer), and the provider will not want to see #2 happen (since they would lose a lot of revenue). The payer's willingness to do #3 presumably depends on the extent to which there is choice available in the market that would enable it to tell the patient that there is a cheaper, higher quality option available. But if there is choice and the payer does charge the patients the difference, then the provider loses volume, although not as much as under #2. This means that the provider will have a strong incentive to set its price at the lowest level it charges (or is reimbursed at) today. If the provider is a monopoly provider, it already</p>

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	<p>presumably has resisted deep discounting of its prices even with its major payers, although it may well be charging non-major payers and the uninsured a substantial premium.</p>
<p>Inability of Providers to Reduce Fees on Selected Services:</p> <p>Under most health plans, health care providers are paid from a fixed schedule of relative fees, which is changed up or down in groups by adjusting a base payment rate. Even if a provider is willing to reduce its price for a particular service, it generally cannot do so without reducing its prices across a broad array of services, so the opportunity to reduce fees/prices for some services is lost.</p>	<p>Under Levels 1, 2, and 3 of Payment Reform:</p> <p>Health care providers would be able to set prices for individual services and to market those services in comparison to services from other providers in a competitive marketplace.</p> <p>NET RESULT: If a provider has the ability to reduce its costs or otherwise lower its price on a particular service and thereby attract more patients, it can and will do so.</p>
<p>Lack of "Bundling" of Services:</p> <p>Fee schedules for providers pay separate fees for multiple services involved in a particular procedure that a patient receives, rather than a single "bundled" fee for all of the services the patient receives for that service. As a result, providers have a financial incentive to provide unnecessary services to a patient as part of the procedure, thereby generating more revenue.</p>	<p>Under Levels 1, 2, and 3 of Payment Reform:</p> <p>Providers would be encouraged to set bundled prices for baskets of services that are typically provided together for a particular procedure, and also for the care management and services provided for a chronic illness over a particular period of time. Patients would choose providers based on the quality and price they charge for the overall basket of services.</p> <p>NET RESULT: A provider would have an incentive to limit services provided as part of the basket to those which are absolutely necessary and appropriate, in order to maintain a competitive price and a reasonable profit margin while maintaining or improving health outcomes.</p>
<p>Ability of Health Care Providers to Increase Utilization in Order to Offset Price Controls:</p> <p>Health care providers can authorize and/or encourage patients to utilize more services and/or unnecessary services in order to increase revenues, regardless of the levels of prices/fees that are negotiated by health plans.</p>	<p>In General:</p> <p>Benefit sets in health insurance plans would be adjusted so that they allow payment or full coverage only on services which provide value to the particular patient in question.</p> <p>Under Levels 1 and 2 of Payment Reform:</p> <p>Health care providers would receive incentive payments based on the quality, outcomes, and efficiency of the care they provide.</p>

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	<p>Under Level 3 of Payment Reform:</p> <p>Providers would bid based on the overall cost of care they provide to patients, so that overutilization would result in reductions in fees for services in order to keep total billings within the bid price.</p> <p>NET RESULT: A provider would have an incentive to reduce overutilization and utilization of ineffective services, since it would not be able to increase revenues as easily. A provider would have no incentive to reduce necessary and effective services, since this would adversely affect health and quality outcomes.</p>