

DRAFT – FOR DISCUSSION ONLY
**Questions and Answers About the
Recommendations for the Transformation of
Health Care in Minnesota**

Single Prices for Services

Why is it important for providers to charge the same price for services to all payers?

One goal is to make it feasible for consumers to know the cost of services that they receive or are planning to obtain, and to compare those costs across providers (often referred to as “transparency”). Another goal is to avoid having providers charge more to one payer in order to allow them to charge less to another (otherwise known as “cost-shifting”). And a third goal is to reduce the significant administrative costs for providers of managing multiple fee schedules and the costs for both providers and payers of negotiating different fees for every contract.

Won't the requirement that providers set a single price for a service result in many payers paying more for health care services?

No, it won't, except potentially in cases where the payer is actually paying below the actual costs of delivering a service (in which case, the payer is really getting an unfairly large discount).

Here's why. 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 when applied across a large volume of patients would have a large cost impact on the payer), and the provider will not want to see #2 happen (since the provider 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 currently a monopoly provider, it already 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), but there is no reason why it would charge significantly more under the single-pricing system than today.

Why shouldn't large employers or health insurance plans have the ability to negotiate discounts for health care services, just as they do today?

Although it is true that large payers (employers or health plans) currently negotiate and receive discounts below a health care provider's stated "charges" for services, few if any payers actually pay the full charges, and no payer knows for certain what another payer is paying since payment rates are confidential. So a larger payer could potentially be paying a provider more than a smaller payer does, depending on when and how their contracts were negotiated.

Moreover, under the current system, if one payer successfully negotiates a large discount with a provider, even if it involves a large volume of patients, the provider has an incentive to shift costs to other payers by charging them higher prices, rather than reducing the actual costs of delivering services.

The Transformation Recommendations propose that providers would charge the same price to all payers, which would enable all payers, large or small, to know that they are getting the lowest price that any payer is paying, and to prevent providers from cost-shifting.

Would providers have to charge the same price for a service, regardless of the complexity of the patient?

No, the goal is to have the provider charge the same price for the same group of services provided to similar patients. A provider would likely want to charge more for a particular service for patients who had more complex needs or higher risks of complications, but if so, the provider would charge the same price to all payers for providing the service to that type of patient.

Bidding on Total Cost of Care**Isn't a system of bidding on total cost of care for patients the same as capitation?**

No, under traditional capitation programs, a health care provider is paid a fixed amount per patient, regardless of how sick or well those patients are. This gives an incentive to the provider to avoid sick patients and to undertreat patients.

The total-cost bidding system avoids these problems by adjusting the payment to a provider up or down based on the health status and complexity of the provider's patients. The bid would define what the provider would be paid for a "typical" patient population. If the provider had patients who were sicker, or more complex in other ways (e.g., non-English speaking), the provider would be paid more. (The exception would be if the patients were sicker in ways that reasonably could have been prevented by the provider.) This would remove any disincentive to treating sicker patients. The system would give the provider an incentive to eliminate unnecessary care (since it would increase costs without providing any benefit in terms of health improvement), but would also give the provider an incentive to provide necessary care (since it would avoid more expensive care later on).

Aren't the recommendations for bidding on the total cost of care and for consumer choice on individual services inconsistent and incompatible?

Not at all. Although the exact details on how bidding and competition would work still need to be developed, here's how the system could work:

Suppose that a clinic plans to bid to cover the total cost of care for a patient, but there is some particular service that the clinic doesn't directly provide, say, MRIs. The clinic might contract with one or more MRI providers for that service (to ensure that the clinic's patients would have access to the service), or simply have a list of those providers available for patients to use. The clinic will presumably select quality MRI providers that will deliver the service at a low price. If there is a contract between the clinic and an MRI provider, it will be at the provider's stated price that is charged to all payers and patients, so there would be no negotiation over price in the contract.

If a clinic physician then determines that a particular patient needs an MRI, the patient could use one of the MRI providers the clinic recommends, but if the patient finds a higher quality, lower-cost MRI provider, it will be in both the patient's and the clinic's interest for the patient to use that alternative provider. If the patient decides they want to use a higher-cost MRI provider, they would be free to do so, but they would pay the difference in cost between that provider and the lower-cost provider recommended by the clinic, so there would be no cost penalty to the clinic of providing the patient with that choice.

Even if the clinic does provide MRIs itself, the patient could be given the option of using an outside provider. The clinic could define an allowance it would give the patient to use an outside MRI provider, and then if the patient wanted to use such a provider, the patient would pay the difference, if any, between the allowance and the outside provider's price. This is similar to what happens today under many health insurance plans, where a patient is not prohibited from using an out-of-network provider, but has to pay more to do so.

Why does there need to be bidding on the total cost of care? Wouldn't competition among providers on individual services be sufficient to reduce costs?

Although competition on price and quality should help to reduce the costs of individual services, it would not reduce unnecessary utilization of services. In fact, without either the bidding system under Level 3 or the pay-for-performance incentives under Level 1, a provider might decide to charge less for a particular service, but encourage more patients to use that service, in effect, making up in volume what it loses on each service, or the provider might set a competitive price for services that are visible and more likely to involve consumer shopping, but make up for that by charging much higher prices for highly specialized or emergency services. In addition to the competitive incentive to reduce unit costs on each service, providers also have to have an incentive to reduce the overuse of services. That is provided by having them accountable for the total cost of care, since the total cost of care equals the rate of service utilization times the unit price of services. (However, they would not be responsible for differences in the total cost of care that are due to non-preventable differences in the health of their patients.)

Won't the bidding system encourage or even force greater consolidation of health care providers?

In contrast to a capitation system, where providers need to have a large number of patients in order to minimize the risk that a high proportion of their patients would be sick and require many expensive services, the proposed bidding system would adjust the payments to a provider based on how sick or well their patients are, regardless of the total number of patients they have. That will enable a small provider to enter a bid on a level playing field with a large provider. Moreover, specialists, hospitals, and other providers to which the small provider refers patients will charge the same price for their services to all patients, regardless of whether they are referred by small providers or large providers, so small providers would not be at a disadvantage.

Although a multi-specialty provider might have a head start on defining and making arrangements for the provision of care under a bid compared to a small primary care provider, the proposed Health Care Transformation Organization would establish procedures that would ensure that smaller providers have the ability to bid without consolidating with other providers, and it might facilitate providers receiving technical assistance in bidding, if that would be helpful.

The primary pressure for consolidation today comes from the desire by providers to increase their strength in negotiations with payers and to resist discounting of prices. The Transformation Recommendations' proposal for having providers charge the same price for services to all payers would eliminate this current incentive to consolidate.

How the System Will Work in Rural Areas**How can this system work in rural areas that have relatively few providers?**

In a rural area, all of the existing providers are critically important to providing health care for the residents. The best rural care happens with good teamwork and collaboration.

Under the proposed payment reforms, the providers in a rural area would have their prices/costs and quality reported publicly, and they would be compared to similar providers in other areas on a risk-adjusted basis. This would enable the residents of the community to better understand the value of the health care they are receiving, and to encourage improvements by providers if needed. Patients might decide that traveling to another community for some kinds of care would be worthwhile in order to get better quality or lower cost, and new providers would be able to see the opportunity to provide better, more efficient services.

Under Level 3, any group of providers in a rural area (perhaps all of the providers in a county, or all of the physicians who use a particular hospital) could place a bid in the new system to manage the total cost of care for the population in that area. Once the bid is placed, the care system would have the same incentives to improve health and improve efficiency as a care system in any other location. If the costs of the bid are higher than other areas, or if the quality of care is lower, the employers and citizens of that community would be able to see that (which they cannot today) and could encourage their providers to become more efficient and/or improve their quality.