

Setting Payment Levels

Most discussions about healthcare payment reform focus on different *methods* of paying providers – fee-for-service payments, episode payments, capitation payments, etc. Different payment methods have advantages and disadvantages, but the goal is to ensure that the payment system rewards healthcare providers for delivering high-value services, rather than rewarding them for high volumes of services, and that it does not penalize providers for improving quality and reducing costs. (For more information on payment methods, see *Better Ways to Pay for Health Care: A Primer on Healthcare Payment Reform*.)

But choosing the payment *method* is only half of the challenge in reforming payment systems. The other half is choosing the right *amount* of payment. Even if the payment method provides the right incentives, if the payment level is too low (i.e., below the minimum cost of providing care), providers will be unable to provide quality care, and if the payment level is too high, there is no incentive for efficiency.

So how should payment levels (i.e., prices) be set? There are three basic methods that are used in healthcare today:

1. Government Regulation or Rate-Setting

This is the method that Medicare uses to pay hospitals, doctors, and other providers for 745 hospital DRGs, over 8,000 HCPCS/CPT codes, and many other categories of services. Despite complex methodologies intended to reflect the costs of procedures and the differences in costs in different geographic areas, for different types of providers, and different types of patients, there are many concerns about overpayment for some types of services and underpayment for others.

Moreover, although Medicare controls what *it* pays, it does not control what providers charge for non-Medicare patients, and so this type of single-payer rate-setting can lead to cost-shifting, i.e., providers may charge more to commercial insurers and uninsured patients to make up for the regulated rates that are viewed as “too low.” A recent study by Milman claims that Medicare and Medicaid payment levels are shifting \$38 billion in physician costs and \$51 billion in hospital costs to commercial insurers nationally through higher rates.

One solution to cost-shifting is all-payer rate setting. Although at one time, many states had all-payer rate-setting for hospitals, the only state which does so today is Maryland, through its Health Services Cost Review Commission. Maryland has a special Congressional waiver which allows it to set hospital payment rates for Medicare as well as all other payers.

2. Negotiation Between Payers and Providers

Negotiation is the approach typically used by commercial insurers to determine how much they will pay providers. In many cases, insurers use Medicare’s payment methodology and even the same relative values among services; what is negotiated is the “conversion factor,” i.e., the ratio of the insurer’s payments relative to Medicare payment levels.

As in any negotiation, the outcome depends on the relative size and power of the negotiators. In a region that has a single dominant health insurance provider and relatively small providers, the outcome may be little different than if the rates were set by government. In a

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region that has a dominant health system and multiple, small payers, payment rates may be much higher. Negotiated payments also tend to come with contractual requirements for secrecy about the payment levels, which serves as a barrier to efforts to help consumers and employers identify the highest-value providers.

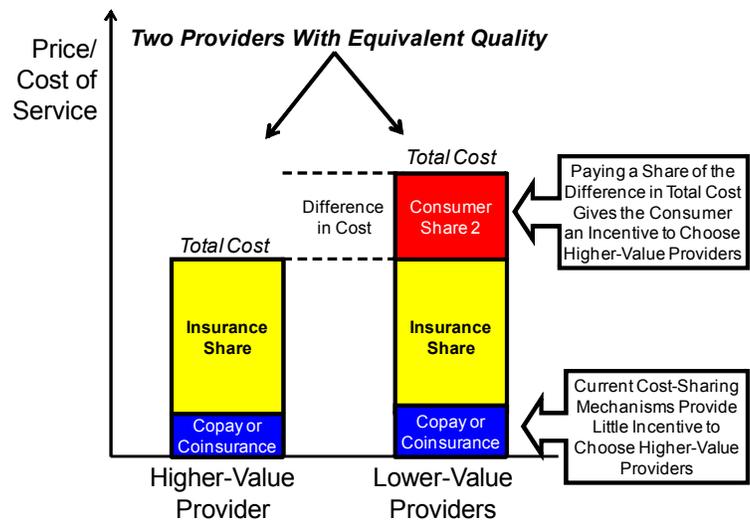
Payer-by-payer negotiations can result in a provider receiving very different prices for the same service for different patients, which means the provider’s profit or loss will depend on their mix of patients as well as their own efficiency. This can also encourage cost-shifting. In 2008, the State of Minnesota enacted legislation requiring all payers to pay the same price for a selected set of “baskets of care” to those providers who offer those services. This is, in effect, a middle ground between negotiation and all-payer rate-setting.

3. Competition Among Providers for Patients Based on Price and Quality

Although price-based competition is fairly common for healthcare services that are not typically covered by insurance (e.g., Lasix and cosmetic surgery), competition is relatively rare for services that are covered by insurance, since insurance shields consumers from most or all of the cost/price differences among providers. Fixed copays make the consumer completely indifferent to cost differences among providers. Requiring consumers to pay co-insurance services (i.e., a percentage of the total price) provides some sensitivity, but also can create barriers to using services where there is no competition. High deductible plans make the consumer highly sensitive to price differences on low-cost services, but insensitive to price differences in services that cost more than the deductible.

An alternative approach is to charge consumers for the “last dollar” of cost, i.e., all or part of the difference in total prices between higher-cost and lower-cost providers. This would create a significant incentive for consumers to seek out lower-cost providers, and thereby also create an incentive for providers to lower their costs. For example, the Patient Choice payment system in Minnesota uses this approach. Creating this kind of price sensitivity requires a change in the patient’s benefit structure, in addition to a change in the method by which providers are paid.

This approach will only have an impact where there are two or more providers of equivalent quality that the consumer can choose from. Moreover, in order for price competition to be successful, consumers need to be able to compare prices in advance. The ability to do this would be greater under episode-of-care payment systems and condition-specific capitation payment structures than fee-for-service, since a bundled price facilitates comparison of different providers’ relative value.



Which is Better?

None of the methods is perfect, and their relative feasibility and desirability will vary from region to region depending on the structure of the healthcare system in that region.

However, it is important to recognize that even in the same region, the different methods for setting payment levels are not mutually exclusive. For example, rather than setting an *exact* price for a service, as Medicare does today, a payer could establish a *maximum* price, and create incentives for its members or beneficiaries to use providers which can offer that service in a high-quality fashion at a lower price.

Moreover, the same payment method does not need to be used for *all* services; regulatory models could be used for services that have limited competition, whereas price competition could be encouraged for services where there are multiple providers.



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