SOCIETY OF ACTUARIES

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Escaping the Addiction

From Preferred Payer to Rational Pricing

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How do you want your doctor to be paid? Answering this question is crucial to get at the heart of any health care financing system and to help identify what features of provider compensation are potentially compatible with that system and which are not. It is just as important, however, and perhaps more so, to state and define the general rules we need to be able to choose amongst alternatives that might be put forth in answer to the question.

So, how should our doctors get paid? Given the human tendency to a self-serving bias, a truly honest answer often boils down to something like: "I am happy for *your* doctor to be paid on some basis that holds cost to society to a minimum, but *my* doctor should be paid whatever it takes so that I can have the best care possible." But even this answer begs a series of questions: what should the mechanism be? Should they be paid a salary within a larger organization? Should we allow private practice, or should all physicians be employees of the state?

Thus far, attempts to answer these questions have failed because there is no true way to measure the cost of health care. All sides of the reform debate to date have talked about the need to bend the cost curve. Part of the problem is figuring out what the cost is, and that is one of the reasons no one seems to have come up with a set of proposals that will bend that curve, at least as consistently reported from the GAO every time they analyze the latest package or bill. By leveling the playing field for the basic economic transactions of health care, we allow for creative and innovative solutions to function in their ability to impact cost levels immediately and with lasting effect. Arguing about benefit levels, preventative care, package pricing, who is covered, and (heaven help us) establishing *commissions* whose purpose is to control costs by controlling the inexorable rise in the Medicare *budget*, etc., all miss the target because they aren't even taking aim.

Considering our historical and current financial dilemmas within the health care system, we need an additional reform that will establish the principle rules necessary for making rational choices. By constructing an appropriate, logical formulation for evaluation of financial parameters, we may choose one or several of the provider reimbursement schemes that will positively impact our health care provision system. If the rules are fair, rational, and consistent, the winner, or winners, will evolve naturally. What is needed is a proper metric and a structure in which it is allowed to function.

At the core of the myriad problems woven through the current health care financing system is the fact that there is no basic, fundamental, usable "metric" for evaluating alternatives for care provision, treatment protocols, or financing options. The ideal economic transaction, whereby money is paid by a patient to a provider for a medical service, which would allow the determination of such a metric, has been shunted aside. And what replaced it? Payment by third party payers, be they a government program, one of the jumbo health plans/carriers, or a small regional insurer or local HMO.

The combination of the historical development of Medicare and the government's regulation of it is the major culprit in creating this displacement. I do not for one minute discount the positive results that Medicare has accomplished in terms of lifting the economic burden from the elderly since its enactment. I aim to remind society about what the program has cost, what it is costing, and how it has resulted in a disruption in the general health care financing sector of the economy.

Currently, Medicare fixes prices, denies variation based on quality differences, causes a huge cost shift to the general economy, and allows the government to feign control of health care costs. The differential by which Medicare underpays providers equates to a massive tax on the economy. Congress avoids responsibility through controlling a *budget* rather than actual costs because they are trapped in a vicious cycle. They dare not increase taxes directly to cover the true cost of benefits, cut the benefits provided, or increase user premiums because none of those choices are politically palatable. Instead, they ratchet down the screws on providers, and then,

to put icing on the cake, claim that they are controlling health care costs, when they are merely playing with figures in a budget.

The government plays the "pusher" in the analogy where Medicare has transformed providers into "revenue addicts." It started when providers discovered the euphoria of having a steady and reliable revenue stream in the early days of Medicare, when reimbursement was essentially at a fee for service level. Compared to the traditional difficulty of collecting bills directly from elderly patients, Medicare was like the pleasure of the first hit. As the population of senior citizens covered by Medicare grew, and Medicaid programs also came into being covering a more demographically diverse population, this stream of government revenue became an important part of providers' income, too important to ever turn down.

The resulting negative impact on the Federal budget provided the impetus for a change in the reimbursement methodology from fee for service to something else, something that would allow for more control on the part of the government. In other words, they needed a way to "cut" the strength of the revenue stream. The result, after the initial implementation phase when the goal was largely one of revenue neutrality in order to "set the hook," was a mechanism that provided exactly what the Congressperson—I mean the doctor—ordered: a way to control the budget impact of Medicare financing, and in a manner that hid the true cost of the program.

Medicare patients simply made up too big a chunk of their business flow for providers to escape the trap. They had become fully addicted to the steady, if now lower strength, flow of funds from the government programs. In order to feed their habit, providers had to make up the revenue loss that those cuts represented by getting money elsewhere to cover the deficit created by the too-low payment rates of the government traffic. (In the analogy, providers are like addicts who go steal stuff from the neighborhood in order to pawn it to get the extra cash they need for their next fix.) For decades now, the providers have cost shifted to non-governmental payers of services in order to make up for the Medicare and Medicaid deficiencies.

This historical cost shifting produced the inexorable upward spiral in *billed* charges by providers; currently, the bill master is a concept that has no realistic relationship to actual cost in most situations. If the government programs were paying a fair rate of reimbursement to providers (leaving aside the issue of value for different quality of services), then why shouldn't the rest of society have been able to pay something similar? If they were not paying a fair rate, then why have we let the government get away with it?

Why weren't the providers yelling and screaming considering they were being so materially shortchanged by such an important source of income? Probably because they had a false sense of security from their now routine addiction—the steady injection of the revenue they received, even though it kept getting increasingly diluted each time Congress ratcheted down the payment schedules. And what about senior citizens? They have most certainly been co-dependent on the addiction. Senior citizens do not want to lose what has become an entitlement, regardless of the price to the rest of society. Can you blame them? It is one heck of a good deal! And their political power completes the circle of addictive contagion, freezing the politicians who control

the Medicare provider reimbursement button into political cowardice; we are stuck in a rut of a dysfunctional system. And you know the difference between a rut and a coffin? The lid.

The inertia on the part of both parties in this distorted transactional structure reflects a "preferred payer" system that causes disruption, disinformation, and destruction to the limited market system that has been allowed to barely survive in the health care sector. What the government does and what the large health plans have done in their own version of cost shifting has created a system with no controls on the increase in the infamous "bill master." Because of the lack of logical rationality and transparency in pricing, there is no economic equilibrium through competitive supply and demand. Current bill masters and fee schedules are useless instruments as guides to actual costs and prices; they have no value as a metric.

How do we accomplish truly effective change through establishing a valid, usable metric? Firstly, require that all providers establish their pricing schedule however they wish. The pricing, however, must be applied consistently to all comers. (An alternate approach for hospitals and other facilities is to use some variation on the Maryland hospital commission system for establishing the rate/bill schedule by facility.) To facilitate comparison and allow for quality and effectiveness analysis, the "format" of the fee schedules will need to be regulated. For example, a template similar to the current DRG system for hospitals and the RBRVS system for physicians could be utilized, but sufficiently robust and dynamic to allow for change, variation, and innovation. The key is that providers will be free to set their own rates/prices by item in the template to reflect quality and market conditions as they see fit. (In any such approach, an "emergency care" feature should establish an all-payer charge basis that must be accepted as the allowed charge by all third party payers as well as the providers. Appropriate legal and contractual definitions of what comprises such care will need to be established, but that should be straightforward in applying to the large majority of relevant situations.) The fundamental principle holding sway is that there can be no discounting allowed for third-party payer affiliation, including any government program.

While providers are given freedom to establish what they charge, the insurer/health plans and the government programs will be free to establish whatever schedule they will allow for non-emergency care. Third-party payers will not, however, be permitted to pressure or negotiate with any provider to accept any amount as total payment unless the provider agrees to the same for every patient they have for the same service. Note that there is nothing here that suggests that third-party payers *must* agree to pay benefits based on whatever a provider's charge schedule happens to be. Third-party payers *may* pay benefits on that basis, however. The price set by providers for services rendered to their patient must, however, be the full charge submitted to any third-party payers involved with that patient.

This scenario redefines the role of the patient in his/her interaction with the provider as regards the economic transaction from the assignment dynamic of recent decades. Any insured patient will be responsible for any benefit cost sharing such as copayments, deductibles, and coinsurance. In addition, the patient will be responsible for any "non-eligible" amount of the charges being made, which can arise either from services not covered by the benefit plan, or provider charges that exceed any defined maximum schedule set contractually (in the benefit plan agreement) by the third-party payer as *allowed* charges. Thus, *balance billing* will be an essential feature in such situations, though providers are allowed to discount or waive net amounts owed by patients *only after* the claim has been processed (and policy cost sharing elements applied) so that the total final amount reimbursed by the third party payer is already a known quantity. This will allow true consumerism in the marketplace, will serve as an arbiter of quality and its value in that marketplace, and allow true competition between third-party payers (private insurers), vendors of health care utilization services, etc.

Such an environment allows for substantial flexibility in the design of different provider reimbursement structures, including traditional HMOs, scheduled benefits, and packaged or global pricing initiatives. True "value for money" networks of providers can be established instead of the current "preferred" provider networks. None of these need run afoul of the required principles of rational pricing espoused herein. Innovation and creativity will have a playing field on which to flourish and not be totally shackled, as has been the case for decades.

Critics will decry the imposition and unfairness of balance billing, and that people reliant on government programs will be reduced to receiving services from low cost (read "low quality") networks of providers. Isn't this what is already happening to Medicaid and even Medicare patients in many communities? Rationing of care is inevitable, at least for the foreseeable future and in any reasonable scenarios of provision and financing. There is rationing of access to care (whether or not it is available at all) and then there is rationing in quality. An egalitarian position will demand that no class subset of society be favored in obtaining access to services or the best levels of quality of those services. Practical people will recognize that human nature demands that there be variability. And while it might be possible to more or less guarantee access to service at a satisfactorily minimal level (and we should most assuredly work to accomplish this through universal coverage initiatives), guaranteeing access to the "best" service is simply a non-starter—as they say in some regions of the country, "That dog won't hunt." The only mechanism that can reasonably sort out how quality and price can be brought into a workable equilibrium is a moderately regulated but essentially free market system. We can address perceived inequities through other means, and where the efforts can be accurately measured (income tax subsidies, vouchers, etc.). It is vital to discontinue the disruption to the economic equilibrium of the health care sector by price-fixing and coerced provider participation as has happened heretofore.

With rational pricing rules implemented, our myriad problems can be addressed anew without the distortion of the old habits. Then, and only then, will alternative concepts and ideas for reforming provider reimbursement become both viable and measureable. Then we can identify what works and where, which is not possible today because the landscape is socked in with the fog of obfuscation created by our lack of a rational pricing mechanism. Then we can require standardization of medical records, technology and administration, etc., and measure the impact. Then we can save billions in administration costs because providers will not have to maintain dozens of price schedules. Then we can escape the addiction to the "preferred" payer. ■

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