All-Payer Rate Setting:

A Framework for a More Efficient Health Care System

by Eric Flanagan

The United States is unique among countries with health care systems that rely primarily on private insurance companies because there are generally no regulations that mandate a standard fee schedule for health care services. The prevalence of multiple private and public insurers is known as a multi-payer system. Other countries that have multiple payers set prices unilaterally, as is the case in Japan, or through negotiations between payers and providers, as is the case in Germany. The outcome is a uniform set of prices that applies to all payers within a single hospital. This framework is known as all-payer rate setting.

This paper explains how all-payer rate setting regulation can mitigate several problems plaguing the US health care system. Examples include cost shifting, price discrimination, and provider market leverage. The paper then analyzes how these problems negatively affect the US health care system. Finally, the benefits of all-payer rate setting are explained, followed by the downsides (or tradeoffs) of such a system.

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The research in this paper finds that the price variations in the US health care system are simply a function of market power and do not reflect a difference in quality or input costs. All-payer rate setting, whether through unilateral rate setting by a government or a market-based approach, can eliminate price discrimination and improve both transparency and administrative efficiency.

INTRODUCTION

The United States maintains the most expensive and inefficient health care system in the world. A 2014 Commonwealth Fund report found that the United States ranked last among 11 countries in multiple measures of performance and cost (Davis et al. 2014, 1). The United States health care system is characterized by high prices, administrative waste, and price variations that are not explained by quality or input costs. As will be shown in this paper, these inefficiencies are primarily caused by the lack of a coherent and integrated price setting framework.

The United States is unique among countries that rely on multiple payers to cover the cost of health care services on behalf of its citizens. The prevalence of multiple private and payers is known as a multi-payer system (Ridic, Gleason, and Ridic 2012, 116). A payer generally refers to a third-party entity that pays the cost of health care services, such as a private insurance plan or public payer such as Medicare. A unique type of multi-payer system includes standard fee schedules whereby all payers pay a particular provider the same price for identical health care services (Cheng 2014, 6). This framework is known as all-payer rate setting.

This paper will explain how all-payer rate setting regulation can mitigate several of the problems that contribute to the high cost and inefficiency of the US health care system. These problems include wide variations in health care prices within hospitals and physician practices, market power imbalances between providers and payers, and price discrimination. It will provide an overview of these issues along with an analysis of the how the aforementioned problems negatively affect the US health care system. Additionally, it will explain the benefits of all-payer rate setting and the disadvantages (or tradeoffs) of such a system.

PRICE VARIATIONS AND ADMINISTRATIVE SPENDING

The lack of all-payer rate setting or a comparable payment model results in wide variations in payment rates and methods among private and public payers. In the United States, prices for health care services are listed on a hospital's chargemaster. A chargemaster is an itemized listing of every procedure that a hospital provides to its patients. Chargemasters may contain tens of thousands of line items that are assigned to a procedure code, such as the American Medical Association's Current Procedure Terminology (CPT) source codes (Tompkins, Altman, and Eilat 2006, 48). Hospitals generally do not implement a common method for adjusting their chargemasters. For example, one hospital may increase every listed price by the same percentage each year, while another hospital may increase individual items separately by different percentage points (Reinhardt 2006, 58-59).

The list prices on the chargemaster

reflect the "sticker" price of services offered and are many times higher than the reimbursement amount that a provider will negotiate with a payer, although patients paying out of pocket may face such prices. Consequently, public and private payers do not actually pay the prices listed on a hospital chargemaster. Instead, each payer negotiates lower prices with each provider for each plan they manage. The prices that insured patients actually pay are called negotiated charges, and they vary by payer even within a single hospital, and even within a single insurance company depending on which plan a patient has (Mack 2014, 4). These negotiated rates are treated like trade secrets since insurers and hospitals do not want their competitors to know what they are actually paying (Mack 2014, 5).

During a briefing sponsored by the Alliance for Health Reform and Robert Wood Foundation, health economist Dr. Uwe Reinhardt recalled his discussion with an insurer while serving as the chairman of New Jersey governor Jon Corzine's Health Reform Commission:

> …in New Jersey… I asked an insurer a very silly question – what do you pay for a colonoscopy. And he said what do you mean? You cannot answer that. It turns out the prices they pay to different hospitals vary by a factor of three. In California I asked the same thing. Give me some prices for an appendectomy. It ranged anywhere from $800 to $13,000. So I'm not sure what this market actually needs. There are no prices in this. It is whatever you can grab and negotiate (Reinhardt 2008, 18).

Variations in payments among payers cause many problems. Patients insured by payers that can demand relatively low prices may have access to a limited number of participating hospitals and physicians, while patients insured by payers that pay higher prices may have difficulty paying for health insurance due to higher premiums (Anderson & Herring 2015, 1). Furthermore, resources that should be devoted to providing health care are allocated to keeping up with multiple payment arrangements. Health care journalist Sarah Kliff from Vox notes the following:

> A system with so many prices can be inefficient: each time a patient comes in for an appointment, a billing clerk has to look up what rate his or her insurance company out to be charged. All those billing clerks' salaries become part of the country's $2.7 trillion health care system (Kliff 2015, 3).

A 2014 study titled, *A Comparison of Hospital Administrative Costs in Eight Nations: US Cost Exceeds All Others by Far* found that administrative costs accounted for 25 percent of total US hospital spending, which was the highest among eight countries included (Himmelstein et al. 2014, 4). According to the study, countries with multiple payers have higher administrative costs as a percentage of their overall health care spending than countries with single-payer systems. However, as noted earlier, the United States does not require hospitals to maintain a standard fee schedule and has even higher administrative costs than other countries with multiple payers, such as France and Germany, which use tightly regulated all-payer diagnosis-related group payment systems. In 2004, the American Medical News Network interviewed Dr. Allan Korn, the medical director of the Chicago-

based Blue Cross Blue Shield Association to discuss the state of relations between physicians and the Blue Cross system. Dr. Korn explained that a physician office in Chicago might deal with 17,000 different plan designs, each with a presumably unique payment schedule (AMN 2004).

PROVIDER MARKET LEVERAGE

Market power plays a major role in prices paid for health care services. In some geographic areas and local markets, health care providers with substantial market power can demand relatively high prices, while in other areas, one or two dominant health plans are able to bargain for relatively low prices (Anderson and Herring 2015, 1). Some hospital networks, referred to as "must-haves," are able to use their clout to demand higher prices since a health insurance plan must include them in their network in order to attract employers and consumers (Berenson et al. 2012, 974).

Insurance companies can resist price increases by limiting their provider network (Giovannelli et al. 2016). Additionally, insurers may increase market concentration by consolidating, which in turn reduces competition and limits choice for consumers. Even a large hospital cannot afford exclusion from the network of a dominant health plan that reserves the right to contract with a competing hospital (Frakt 2011a, 15-18). However, a study by Berenson, Ginsberg, Christianson, and Yee (2012, 974), found that even in markets with dominant health plans, insurers must be sensitive to customer preferences for stable provider networks. Moreover, they find that insurers are generally not aggressive in constraining rate increases, possibly since they can simply pass the costs to employers and plan holders.

Berenson, et al. (2012, 974) found an overall market leverage trend favoring hospitals across twelve markets, although there was a degree of variation concerning which hospitals or health plans were perceived as having the upper hand in negotiations. Their study included interviews of 539 local health care leaders in twelve communities across the country. Intra-market variations in negotiating leverage were substantial across all twelve markets. The respondents described the varying degrees of hospital negotiating leverage in terms of tiers. The top tier, or must-have hospitals, had substantial leverage over prices and related contract terms and conditions. The second tier consisted of hospitals that were notable for particular specialties, such as organ transplantation. The third tier hospitals included standalone, community hospitals that generally lacked the leverage of the higher tiers and accepted rates near Medicare levels.

The findings of the Berenson, Ginsburg, and Kemper (2010) study mirror those from the 2010 Massachusetts Health Care Cost Trends Final Report initiated by the state of Massachusetts Attorney General's Office (AGO) to examine cost drivers in the state's health care market. The primary focus of the examination was to determine whether the differences in prices paid to providers could explain a difference in measurable value. The report found that the price variations within the state were correlated to market leverage—defined in the report as the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic

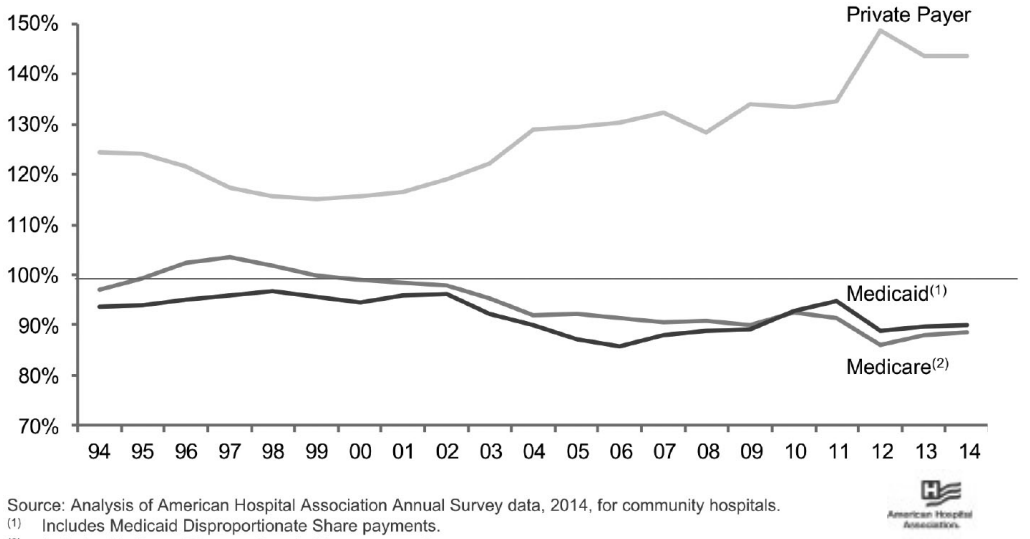
region. The examiners explained that this leverage places hospitals with lower payment rates at a disadvantage—and that if left unchecked, there is a risk that such systemic disparities will over time create a provider marketplace dominated by very expensive "haves" as the more moderately priced "have nots" are forced to close or consolidate with higher-paid systems (AGO 2010, 48). The prices paid to providers were not only found to vary significantly within the same geographic area and amongst providers offering the same levels of services, they were also found to not be correlated with: 1) Quality of care; 2) Sickness of the population served or complexity of services provided; 3) The extent to which a provider cares for a large portion of patients on Medicare or Medicaid; 4) Differences in hospital costs of delivering similar services at similar facilities (AGO 2010, 6).

In a market that works well, characteristics such as better quality or complexity of services provided should explain higher prices. However, providers usually do not know how their prices compare to other providers, and insurers do not know how the prices they pay compare to other insurers since prices are determined in private. The 2010 Massachusetts AGO report found that under the current market power dynamic, neither insurers nor providers can be relied on as agents of cost control (AGO 2010, 4-5).

COST SHIFTING

In 2010, America's Health Insurance Plans published a report titled, Recent Trends in Hospital Prices in Oregon and California. The report showed the growth in average transaction prices actually paid by the ten largest private health insurers to hospitals in Oregon between 2005 and 2009, and the growth in net revenue per

Figure 1.1. Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare and Medicaid, 1994-2014.



Source: AHA 2016b.

patient day paid to California hospitals by Medicaid (Reinhardt 2011, 2125). The report noted that, "the combination of slow growth in reimbursements from Medi-Cal and moderately growing Medicare payments has likely played a major role in the rapid growth of prices charged to private insurers" (Reinhardt 2011, 2126). In other words, relatively low reimbursement rates from Medicare and other public payers caused higher payments to private payers—a situation referred to as "cost-shifting." Cost shifting occurs when providers make up for losses incurred by underpayments, usually a large government payer, or the uninsured, by shifting costs to private insurers (Coughlin et al 2014, 1). According to the American Hospital Association (AHA), Medicare and Medicaid underpay hospitals and physicians for health services relative due to the government's ability to set payments by law rather than a negotiation process, as with private payers (AHA 2016a). The dichotomy between public payers and private payers is illustrated in Figure 1.

A 2008 report by actuarial consulting firm Milliman shows that in 2007, Medicare and Medicaid paid $48.9 and $39.9 billion, respectively, less than they would have if all payers paid equivalent rates (Fox and Pickering 2008, 2). The Milliman study states that the estimated cost shift of $88.8 billion is 15% of the amount paid by private payers on hospital and physician services. In other words, if there were no cost shift, private medical payments would be 15% lower.

PRICE DISCRIMINATION

The prevalence of differential pricing strategies is not universally accepted evidence of cost shifting (Culyer 2014, 126). Skeptics assert that a strategy known as price discrimination is taking place. Price discrimination is the practice of charging different prices to different consumers for similar goods (Pindyck and Rubinfield 2013, 401). Dr. Uwe Reinhardt explains that economists tend to have trouble with the cost shift theory because it implies that providers "leave money on the table" when they bargain with private insurers over prices and that providers tap this "reservoir" whenever government lowers the prices it pays them (Reinhardt 2011, 2127). He phrases this contention in the form of a question: "Why would a provider wait for a shortfall in public revenue to negotiate higher rates from its private payers if those payers are willing to pay higher prices?" (Reinhardt 2011, 2127-2128). The reservoir that Reinhardt references is analogous to the economic concept of consumer surplus, which is the amount that a buyer is willing to pay for a good beyond the market price. Price discriminating providers seek to extract as much consumer surplus as possible. Reinhardt explains that the ability of providers to cost shift illustrates the inability of private payers to resist price increases. In the same study, Reinhardt quips, "if the argument is that the private market sets prices for health care appropriately, and that government should adapt the prices it pays to those private-sector norms, then the question is how exactly one would determine these price norms, given the huge variation of prices for identical services within the private market, even within small areas such as cities." (Reinhardt 2011, 2128).

THE ALL-PAYER FRAMEWORK

All-payer rate setting is a price setting mechanism whereby all third parties pay the same price for services delivered by a provider. In the current system of unregulated prices, Medicaid pays the lowest rates followed by Medicare, large insurance plans pay lower rates than smaller plans, and the uninsured pay the highest rates of all. An all-payer system does not necessarily require every provider to charge identical prices—it simply requires a uniform fee schedule within a single hospital or physician practice.

While there is no one approach to health care reform that will solve every problem, all-payer rate regulation would lead to a more efficient health care system for the United States due the existence of multiple private and public payers. All-payer rate setting can 1) eliminate price variations; 2) equalize market power between providers and payers; 3) eliminating price discrimination and cost shifting (to the extent that it exists).

All-payer rate setting eliminates price variations since it requires a provider to charge all payers the same price for identical services. Eliminating price variations also simplifies billing, thereby reducing administrative costs. Price transparency is promoted since the fee schedule would apply to all health plans contracted to a particular provider and the listed prices would reflect the actual prices paid. Providers would not be able use their market leverage to price discriminate since prices would be established by a government or through negotiation with an association of payers. Price discrimination and cost-shifting would be eliminated since a provider would no longer be able to charge different payers different prices for the same services.

There are multiple ways to implement an all-payer model. For example, Japan and the Netherlands have taken a unilateral, administrative approach to rate setting. That is, the government sets prices for all health services by implementing a uniform fee schedule. In the state of Maryland, the Health Services Cost Review Commission (HSCRC) sets the price based on negotiations with hospitals within the state. The administrative approach has the benefit of simplicity.

An alternative form of rate setting consists of a more market-oriented approach, such as the model employed in Germany and Switzerland. Dr. Reinhardt proposes that the U.S. adopt a "quasi-market" approach to all-payer whereby prices for health care services and products are subject to uniform price schedules that are either set by government or negotiated on a regional basis between associations of health insurers and associations of providers of health care (Reinhardt 2011, 2126). This quasi-market approach would essentially allow insurers to combine their individual degrees of market power for the purposes of price negotiation. Health economist Austin Frakt describes this as "bulk purchasing on steroids." This means they would have monopsony power, allowing them to collectively drive prices lower (Frakt 2011b, 2).

While insurers would have monopsony powers as payers, "they would not necessarily have monopoly power as sellers of insurance" (Frakt 2011b, 2). A degree of price competition could be retained by allowing some variation in prices between hospitals. Each provider would be paid using a common relative value scale based

on a standard fee schedule negotiated with the association of payers (Reinhardt 2009, 1-2). For example, for inpatient services, Medicare pays hospitals a flat fee per hospital case based on roughly 500 diagnosis-related groups (DRGs). Each DRG has a payment weight assigned to it based on the average resources used to treat patients in that DRG. The relative payment weight of a DRG is then multiplied by a monetary conversion factor, which is a base payment amount (in dollars) that is set annually by Congress.

In a hypothetical all-payer framework, each individual provider would "set their own monetary conversion factor for their relative value scale and compete on that simple one-dimensional price indicator" (Reinhardt 2009, 1). Reinhardt explains that employers, insurers, and patients all would be able to understand this price indicator, which would replace the thousands of itemized charges in a typical hospital's chargemaster or physician's fee schedule. The effect would be a system where prices may vary between hospitals, but a single hospital cannot charge different prices to different payers for similar services. These conversion factors could be "negotiated between associations of providers and associations of insurers with a region (e.g. a state) and make them binding on all providers and insurers in the region" (Reinhardt 2009, 2).

In a jointly authored paper titled, *The Changing Role of Government in Financing Health Care: An International Perspective, Stabile and Thomson* (2013, 26) note that there has been some convergence among Organisation for Economic Co-operation and Development (OECD) health systems towards the increased use of market-like mechanisms such as DRGs to pay hospitals, and that some countries have attempted to encourage hospital competition. They state "where prices are set administratively, competition has improved productivity and quality. DRG payment also appears to have improved productivity and quality, although its effect on overall system costs is mixed" (Stabile and Thompson 2013, 26).

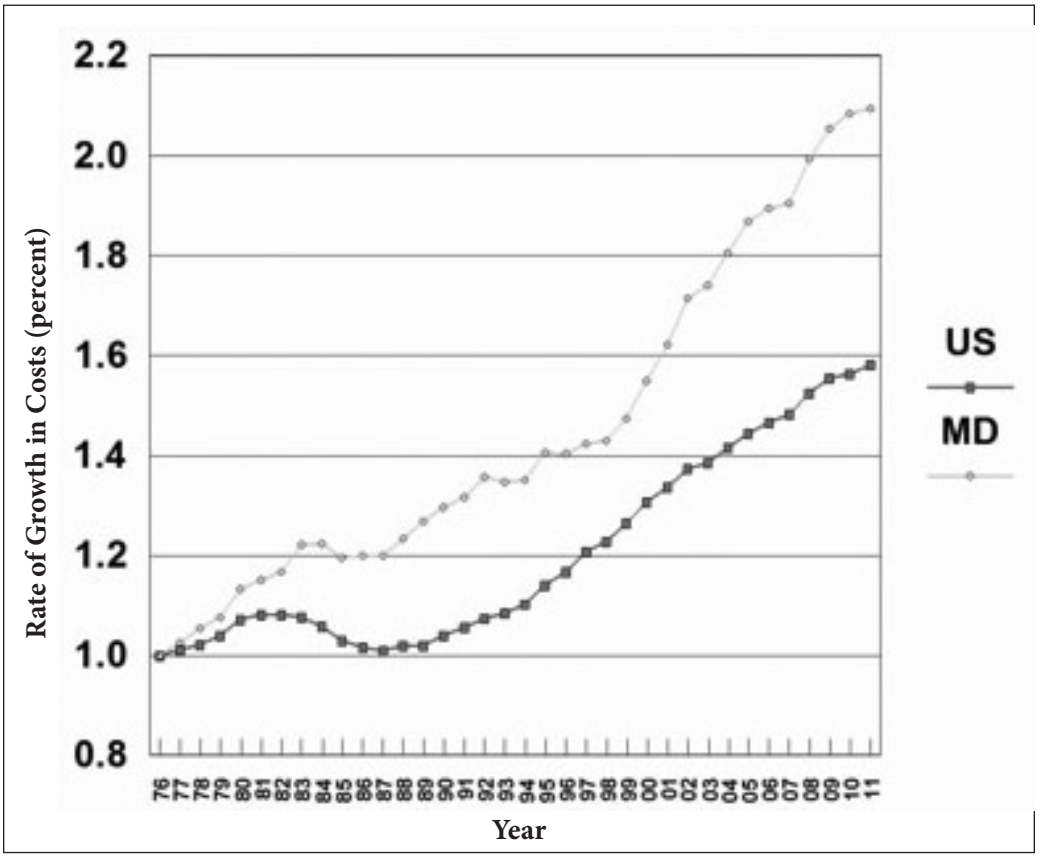
All-payer rate setting is not without tradeoffs. The health systems in Germany and Switzerland for example, do not feature dominant public payers such as Medicare and Medicaid. All-payer rate setting would necessitate an equalization of fee rates among payers, meaning Medicare and Medicaid would pay higher prices than they do under the current system. Reinhardt notes that public policy research is needed to determine what kind of entity would organize the negotiating and rate setting, whether the decisions of the organization would be subject to government approval, whether there would be an appeal mechanism, and to whom appeals would be made (Reinhardt 2011, 2129-3130). Furthermore, it may be politically impossible to secure Medicare, Medicaid, and Children's Health Insurance Program involvement without guarantees that their costs will not increase more rapidly under all-payer rates than they would if they did not participate.

Perhaps the best place to look for both the challenges and potential benefits of an all-payer payment model would be the state of Maryland, considering it implemented the framework over 40 years ago with the establishment of its HSCRC. Although Maryland has performed well in controlling hospital length-of-stay, cost per admission, and the rate of growth of hospitals' year-to-year payment levels, the growth in

overall hospital volume in recent years has undermined the system's overall cost performance (Murray 2009, 1399-1400). Maryland's all-payer system significantly reduced its costs per admission due to the power to set prices, but hospitals responded to price constraints by increasing the volume of services. The growth in volume of admissions undermined its ability to control total costs, and per-capita costs were among the highest in the nation (Rajkumar et al. 2014, 493). This is due the fact that fee-for-service (FFS) is the predominant payment model in the United States, including the state of Maryland at the time. Under an FFS arrangement, hospitals are paid each time they deliver a service, and are not paid unless they do so. Therefore, FFS encourages hospitals to increase the volume of services provided and discourages them from reducing unnecessary services. Figure 2 illustrates Maryland's inability to control volume of admissions relative to the United States as a whole.

In January 2014, the Center for Medicare and Medicaid Services' Center for Medicare & Medicaid Innovation approved the implementation of a new all-payer model for Maryland as part of an initiative that replaced its 36-year old Medicare waiver (Adamopoulos 2014, 1). In contrast to the previous Medicare waiver, which focused on controlling

Figure 2. Indexed Rates of Growth in Hospital Volume (Maryland vs. the U.S. 1976-2011)



Source: Murray 2014

increases in Medicare inpatient payments per case, the new model focuses on controlling increases in total hospital revenue per capita (HSCRC 2015, 1). The terms of the new model requires Maryland to cut its Medicare expenditures by $330 million within a five-year period and limit outpatient costs to 3.58 percent, which is the 10-year compound annual growth rate in per capita gross state product (CMS, n.d.). Maryland must transition to the national Medicare payment systems if it fails to meet the cost targets after the five-year performance period.

Maryland's new all-payer system will center on the Global Budget Revenue (GBR) methodology, which replaces FFS for hospitals within the state. GBR is a population-based payment system that establishes an annual revenue cap for each hospital. The hospitals' annual revenues are known at the beginning of the year, and annual revenue is determined from a historical base period that is adjusted annually for utilization changes related to market shifts, population, and service mix, among other factors (HSCRC 2016, 2). Former HSCRC executive director Robert Murray explained to *USA Today*, "When a hospital is on a budget, it naturally has an incentive to provide fewer services and avoid waste…That's a 180-degree turn from the current model" (Vestal 2014, 1). While Maryland's administrative approach differs from the one promoted by vocal advocates like Reinhardt and Frakt, it offers by far the most tangible example of what a successful US all-payer implementation could look like—as well as some valuable lessons learned.

CONCLUDING THOUGHTS

All-payer, though rarely mentioned outside of health policy circles, would eliminate cost shifting and price discrimination, simplify health system administration, enable price transparency, and potentially slow the increase in health care prices by countering the market power effects of provider consolidation. Most importantly, if integrated with emerging global payment models, all-payer rate setting can accomplish all of these things while preserving the existing system of private insurers—therefore making it a more *politically* feasible alternative to single-payer in many states or even nationally.

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