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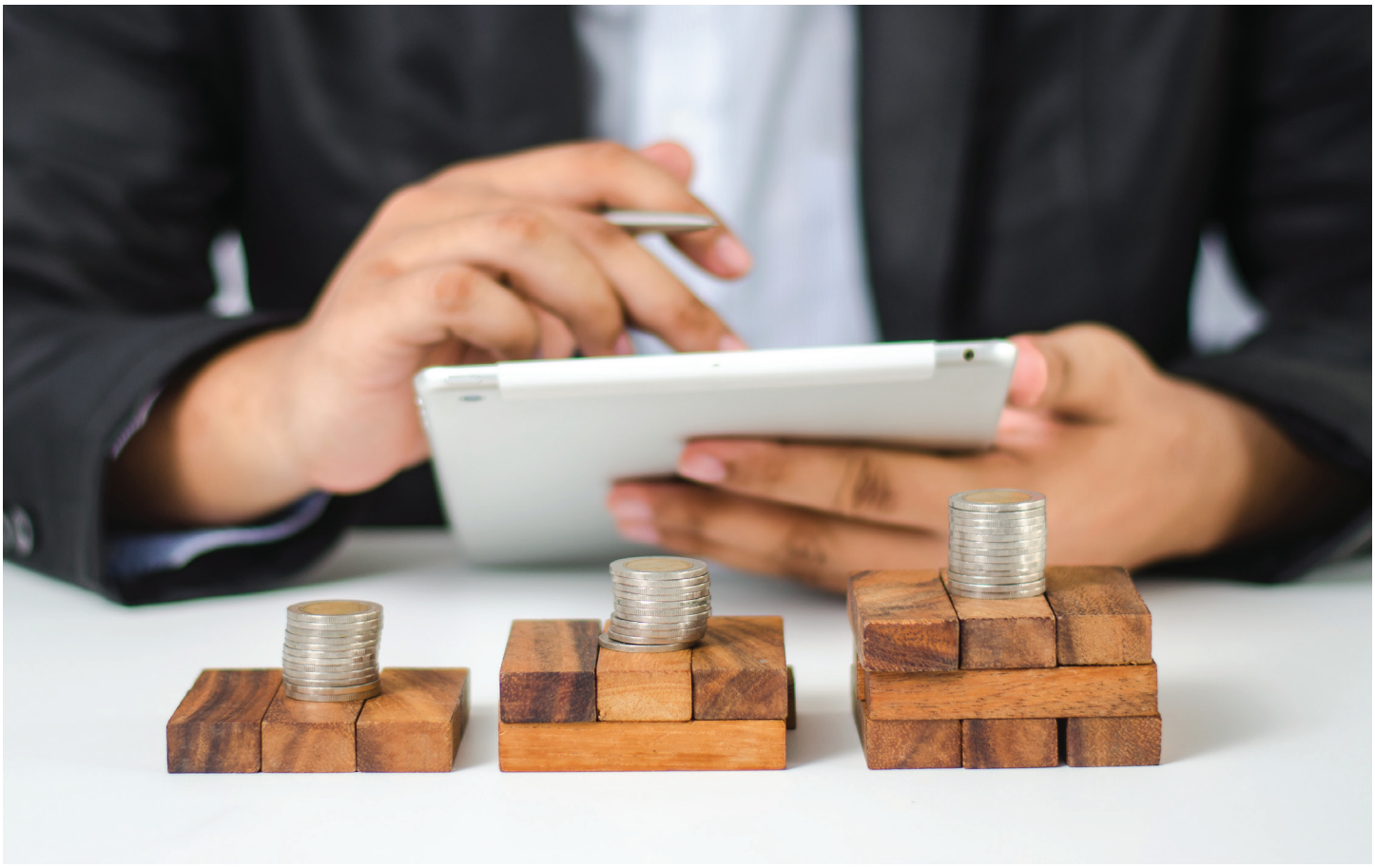

Could an All-Payer System Improve the Affordability of US Health Care?

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Overview

Do you ever get annoyed knowing that someone on your flight paid less than you did for the same trip? How much time do you spend trying to get "the deal" only to find out someone paid less? This same situation exists in health care although it doesn't get as much attention as you might expect. Most of the covered lives who have jobs and are covered through their employer's plan are consistently charged the highest rate for health care services.

Those covered through Medicaid plans are charged the least for identical services. The aged covered through Medicare are usually charged somewhere between these two levels. This charge disparity leads to what is known as the "cost shift". As the private sector pays the highest prices they subsidize the highly discounted public program prices. This "hidden tax" drives up the cost of health care when deeper discounts for government sponsored programs are legislated. This article addresses the impact of a system that charges all patients the same rate, and its various advantages or disadvantages.

How Did We Get Here?

Prior to the introduction of Medicare and Medicaid in the mid-1960s health care was much like other industries. The charge was the charge and you were expected to pay it. As the government formally entered the health care marketplace, the concept of the government "getting a better deal" emerged. Around this time it was uncommon for carriers and health plans to negotiate discounts with providers. Although billed charges varied by provider, it was expected that health plans and insurance companies would pay billed charges. There was a considerable amount of emphasis on usual, reasonable and customary charges to be sure price gouging was minimized. The government and most payers started to develop maximum fee levels for payment based upon fee and charge surveys.

Providers responded with higher charges to be sure they covered their operating costs now forced to accept the government discounts. Providers with substantially higher fees were partially reimbursed with responsibility for the unreimbursed excess fees often transferred to the patient unless the provider was a "participating provider". Participating providers agreed to hold the patient harmless for any excess unreimbursed charges.

As the health care market matured, health plans and insurance companies started to develop the concept of provider networks and preferred provider networks (i.e., HMOs and PPOs). Carriers started to negotiate discounts with providers. After all if the provider was willing to offer a discount to the government why not the carrier or health plan.

Teams of provider negotiators emerged and health plans started to aggressively try to get significant discounts with providers and lower the cost of care. The deeper the discounts offered government payers, the more providers wanted to raise their fees to offset the discounts and lost revenues. This emerged into a market where providers have developed complex provider fee setting mechanisms reflecting lost governmental revenues and widely varying private sector payment structures. Revenue cycle management consultants have flooded the market helping providers manage this process. Each payer is different, has different objectives and approaches, with each provider responding as needed trying to manage their required revenue streams.

To simplify the process providers can express their charge levels in terms of Medicare payment levels. Commercial carrier and health plan reimbursement levels, when expressed in terms of Medicare payment levels, are in the 105% - 175% of Medicare range. Medicaid payment levels are usually less than Medicare in most states, many times in the 50% - 75% range.

What Charge Level is Reasonable or Appropriate?

If the question is "what is the right or correct level" there is no single answer. If the question is "what level is the most reasonable" a good answer is possible. Each provider has their own unique situation, has a different risk profile, has different financial requirements, has different capital needs and commitments, etc.

Medicare payment levels provides a good starting point. CMS expends considerable effort to determine fair and reasonable payment levels. For institutions CMS requires institutional providers to complete Medicare Cost Reports which are used to determine reasonable costs and reasonable payment rates. This analysis can be very useful to similarly determine reasonable cost and reasonable payment rates for the commercial marketplace. Medicare also relies on input from MedPAC to help establish reasonable payment levels.

Under the assumption that a single all-payer payment level could be used to replicate revenues in the market, the question becomes, what might that single payment level be? A secondary question is whether or not that charge is greater or less than Medicare payment levels for that market. Table 1 shows an illustrative calculation.

Table 1: Development of Common Rate

Line of Business	Distribution	% of Medicare	Common Rate
Medicaid	20%	50.00%	103.75%
Meidcare	25%	100.00%	103.75%
Commercial	55%	125.00%	103.75%
Total	100%	103.75%	103.75%

Table 1 shows that the illustrative average payment rate based upon a specific distribution of fees and a specific payment rate in terms of Medicare is 103.75% of Medicare. Assuming no change in distribution or underlying payment rates, the use of a common rate of 103.75% would replicate the revenues for this illustrative situation. In other words, if everyone paid 103.75% in this example, providers would receive the same revenue.

The all-payer model is built around this type of scenario. The all-payer model tries to determine what single payment level would match the current payment levels for all providers. Under this approach all payers would pay the same price for the identical service with the same provider. In the above hypothetical example, the composite fee was greater than Medicare payment levels. In most situations, the composite fee at Medicare payment levels was more than adequate to cover the revenue requirements. It is the author's opinion that an all-payer payment level of Medicare would more than adequately cover the revenues of the current system.

Advantages and Disadvantages of the All-Payer Model

The most obvious disadvantage of the all-payer model is the impact to Medicaid payment rates. In the example shown in Table 1, resulting Medicaid payment rates are more than doubled. Currently Medicaid costs are jointly funded by both the State and Federal governments. The current administration has expressed a desire to move that to the State government. The adoption of an all-payer system would have a significant financial impact at the State level since health care costs are a major budget item. The private sector would experience a significant savings, lowering the cost of health care and ending the significant cost shift and the hidden tax.

A major advantage of this approach is the simplification of the provider fee determination process. Although this would limit the need for much of the provider fee contracting and negotiation staffing in both health plans and providers, it would significantly reduce administrative expenses related to the process. Revenue planning processes would be simplified for providers. Provider payment analysis would be simplified as provider payments are moved to a more consistent process with provider payment levels expressed in terms of Medicare payment levels. Payment methodologies could be standardized with significant efficiencies introduced into the process.

Some competitors believe their ability to offer a more competitive product requires them to provide “lower costs” or “deeper discounts” than other plans. The author suggests as an alternative that the best performing plan will achieve the lowest costs. The use of an all-payer model emphasizes performance.

To the extent that society determines that a Medicaid payment rate should be lower than for other payers, the subsidy can more readily be quantified and accepted as appropriate under the all-payer model than under the current payment model. Some sort of transition from the current approach to the all-payer model would likely be required since Medicaid payment rates would increase substantially.

Conclusion

The current approach results in a significant cost shift to the private sector including a hidden tax to fund the health care system. The all-payer approach simplifies the payment process and opens up the market to broader and more complete transparency opportunities. The all-payer approach helps minimize confusion about the cost of health care.

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