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THE CHALLENGE OF ‘REAL’ COMPETITION IN MEDICARE

by Michael J. Kalison and Richard F. Averill

Prologue: Three years after the implementation of Medicare’s prospective payment system (PPS), this program of paying hospitals on a per case basis has met with a significant degree of success in reducing the rate of increase in inpatient costs. Yet, argue the authors of this article, while PPS has planted some seeds of competition, the system has not yet achieved “real” competition on the basis of price. Michael Kulison and Richard Averill, among the architects of the New Jersey payment system of diagnosis-related groups (DRGs) on which the Medicare PPS is based, now put forth a proposal which would create an opportunity for providers to participate in what Kulison calls “unvarnished competition” for Medicare patients. “We’re at a bend in the road” with PPS, said Kalison. The system can either move towards a national rate as is currently the case, or, as proposed by the authors, it can be restructured to provide an environment in which providers can truly compete for Medicare patients by stating their price up front. Kalison, who graduated from the Wharton School of Business and received a law degree from the University of Pennsylvania, was instrumental in developing the DRG system while employed by the State of New Jersey Department of Health from 1976 to 1979. He is now a founding partner in the law firm of Manger, Kulison, Murphy & McBride which specializes in corporate and financial aspects of hospital representation. Averill, who received a master of science in business from Yale University, worked on both the development and implementation of the New Jersey payment system while director of health-related research at the Yale School of Management, from 1972 to 1982. He is currently vice-chairman of Health Systems International.
The Medicare prospective payment system (PPS), with its diagnosis-related group (DRG) pricing system, now provides the necessary framework for competition in inpatient services. Prior to PPS, pricing information was valueless to the consumer. Different units of payment were used, for example, per diems and a la carte charges. The composition of these units varied from hospital to hospital and, since final liability varied with the number of units consumed, a price could not be “fixed in advance.” With the patient case, or DRG, as a common denominator, PPS allows the consumer to compare prices among providers. Rather than individual charges for thousands of separate items (an impossible situation for purchasers), the costs of various inputs involved in responding to a given kind of inpatient episode have been reduced to 469 prices per case—a price list, a baseline. The switch in basis of payment three years ago, from retrospective to prospective, has also produced a second key precondition for competition, excess capacity. With the steady decline in utilization, the practice of marginal pricing has entered hospital economics.

Medicare, the largest purchaser of health care services, will obviously have a significant impact on the direction which the development of the marketplace takes. Given the establishment of a pricing framework and the decline in utilization, it is somewhat ironic that the program, which only a few years ago reimbursed the “reasonable costs” of individual providers, is now progressing rapidly in the opposition direction: toward a “national” set of rates. (For purposes of this article, “national” set of rates refers to the common PPS price list within a given local market.) The national rate is certainly a seductive concept. Nevertheless, at least three kinds of issues suggest that this course should be reconsidered: (1) Technical issues, such as legitimate variations in medical practice among regions, could compromise the equity of the payment system. (2) Technical issues notwithstanding, centrally determined pricing inevitably creates artificial production incentives. Thus, a common rate, which makes PPS both a ceiling and a floor, has the practical effect of prolonging certain hospital programs for a time period longer than the market would have allowed and, at the same time (under a “budget neutral” system), denying other programs adequate resources to expand in response to real demand. (3) Moreover, with respect to consumers, there is the issue of a lost opportunity. Since all providers within the same local market will have the same rate, except for adjustments such as teaching and “disproportionate share,” price is removed as an element in the consumer decision-making process. Thus, the practical effect of this policy is to eliminate potential opportunities for price competition.

The rush toward a national rate is perhaps a vestige of the reaction toward the initial break with cost-based reimbursement. Nevertheless, given our society’s basic economic preferences, administrative judgment
should be substituted for the market only where the latter fails to function, as a general rule. On a technical level, the issues of equity and artificial production incentives which affect providers gain strength proportionately as PPS moves toward a national rate. As we also noted, prior to PPS, meaningful price competition was simply not possible because pricing information was incomprehensible to the consumer. Under PPS, however, linking prospective payment to a manageable system of patient classification has provided purchasers with the requisite basis for comparison. Since real changes to the health care system usually result from shifts in patient volume, it is time to test whether or not the competition resulting from price differentiation can actually induce such shifts.

The Basic Proposal

Approximately one year ago, we began circulating to our colleagues in the industry a proposal based on two simple rules: establish a standard price, and permit relative pricing. Based initially on discussions within the provider community, we have since received various comments from regulators, consumers, and students of the industry. Thus, in addition to a discussion of the two basic rules, this article will review these comments, which were generally concerned with consumer protection: that is, the current structure of the deductible and copayment, the role of the physician, and the role of the purchaser. The article will also address a recent Department of Health and Human Services (HHS) proposal to allow hospitals to waive or discount the Medicare deductible and will conclude with a discussion of the likely industry response.

Establish a standard price. The magic of PPS is that it provides a standard: a list of 469 case prices which can be utilized as a basis to make comparisons. Our proposal could make use of PPS in its current form, as a national rate, or many variations in between—all of these formulations will provide the requisite price list. However, the kind and extent of the compensating adjustments discussed herein will necessarily vary with the “quality” of the standard; the better the standard, the fewer the adjustments. Accordingly, it is suggested that attention be devoted to improving the integrity of PPS as a standard in the following ways.

First, include inpatient physician costs and capital costs on a DRG-specific basis; such “fine-tuning” adjustments will promote equilibrium in the health care delivery system over time by allocating all of the resources required to treat an inpatient episode (that is, labor, supplies, and capital) in a manner consistent with differing case-mix needs. It will also result in an all-inclusive rate which significantly reduces complexity, and purchaser confusion.

Second, refine the DRGs to account for severity of illness differences.
Implementing a principal diagnosis-specific complication and comorbidity factor in the DRGs and improving the specificity of the International Classification of Diseases Ninth Revision Clinical Modification will substantially improve the DRGs.\(^3\)

The steps outlined above will improve the homogeneity of the DRGs and thus the value of PPS in support of the market function. Nevertheless, DRGs are not perfect. For example, there exist substantial medical practice pattern differences among regions which are unexplained by the DRGs. Accordingly, it is submitted that unresolved issues, such as regional differences, should be adjusted for by utilizing the coefficient of variation to blend regional and national rates on a DRG-specific basis.\(^4\)

Such an adjustment would operate automatically: the more homogeneous the DRG (as measured by the coefficient of variation), the larger the proportion of the national rate which would be incorporated into the standard price. In addition to improving the equity of the system, such an adjustment would also immediately advance the cause of the components of the national rate by totally eliminating the hospital-specific component of some DRGs now. Finally, refinements, such as the severity-of-illness adjustment, which improve the homogenity of the DRGs, will reduce the coefficients of variation, thereby naturally increasing the proportion of the national rate in the standard price. In summary, although this proposal could operate utilizing even the current PPS price list, improving the integrity of the standard price will reduce the need for compensating adjustments.

**Permit relative pricing within defined boundaries.** Much like other kinds of businesses, different hospitals project different images. For example, one institution might wish to emphasize the quality of its tertiary care, while another might desire to underscore the reasonableness of its price for more general geriatric services. In addition to price and quality, convenience and scope of service also provide avenues for competition. The reality test for these images is, of course, the market. Purchasers may or may not agree to pay a premium for quality, or decide to retain in their own pockets the savings which a volume service generates. An intelligent consumer decision, however, requires an effective interaction between seller and purchaser. Facilitating such an interaction requires a meaningful exchange of information. Thus, in addition to accurately projecting image (a marketing function), economic demands must be reduced to relative price information so that the consumer can accurately weigh the value of quality or convenience in light of associated premiums or discounts. This information must be furnished in a format which is both intelligible and digestible, and responsive contractual options offered so that a decision can be acted upon.

The *sine qua non* of this process is the standard price. Once the standard price is established, Medicare should permit individual providers to
place either a premium or a discount on their services, that is, a premium or a discount could be placed on individual DRGs, group of DRGs, or across the board, consistent with the following two rules: (1) prices are established in terms of DRGs (to preserve the incentives of the payment system), and (2) prices are expressed in relation to the standard price (to preserve the value of the information to the consumers).

An Example

For purposes of this example, let us assume that the current structure of deductibles and copayments does not exist, and that Medicare will pay the standard price. Also, let us assume that within the geographic area under consideration, there are three providers. Provider A, a community hospital relatively strong within tertiary services, has agreed to accept the standard price as payment in full. Provider B, a community hospital which is seeking additional volume, notifies Medicare that it will offer a 12 percent discount on all services to Medicare beneficiaries. Provider C, a major teaching and referral center with a world-class reputation (which is located in a city near the community), decides to place a 7 percent premium on tertiary care.

Utilizing the standard price as a basic point of reference, Medicare would furnish relative pricing information to its beneficiaries in a simple format indicating that, unless otherwise noted (by exception), a hospital will accept the standard price as payment in full. Thus, Provider B would be identified with a discount of 12 percent across the board; whereas the listing next to Provider C might indicate “Trt: Std + 7%” (tertiary care: standard price + 7 percent). The same information would be provided to physicians with instructions to inform beneficiaries of such pricing implications prior to admission to a given institution. Beneficiaries admitted to Provider A would be fully covered. Beneficiaries seeking care at Provider C would be responsible for the premium, whereas those which utilized Provider B would receive a discount in the form of a cash payment.

Deductibles And Copayments

Under current law, Medicare beneficiaries pay a deductible of approximately $500 upon admission. Elsewhere we noted: “Under the Department of Justice interpretation of Section 1877 of the Social Security Act, 42 U.S.C. Section 1395 NN, the waiver of the Part A deductible or coinsurance constitutes a federal crime. The Health Care Financing Administration (HCFA) is currently considering a proposal which would enable hospitals to waive all or part of the deductible. This is an important first step toward introducing competition into PPS. The availability
of direct financial benefits to the beneficiary is a critical element of an effective competitive framework.”

The article goes on to point out, however, that the HCFA proposal has several shortcomings: the financial benefits are limited to the beneficiary. Since Medicare will not share in the savings, this proposal does not represent an alternative to the arbitrary cuts in the rate of increase in the PPS payment amount which Medicare will require to reach its budgetary goals. Furthermore, the proposal fails to furnish providers with the flexibility to implement a “premium” pricing strategy—a survival strategy for certain kinds of institutions. Also, because the proposal is limited to the current deductible structure, it lacks real price sensitivity.

In addition to the $500 deductible, current law requires the payment of daily coinsurance of $123 on the sixty-first day through the ninetieth day, and $246 per day thereafter. This structure was developed during an era when the basis of payment was cost, and the unit of payment was the per diem. The deductible was designed to discourage marginal admissions, whereas the copayment was intended to insure that the patient, once admitted, consumed no more days than necessary. Prospective payment by the case has obviously neutralized the problem of excess days. Managed care, peer review organizations, and the technological advance which has enabled alternative providers to compete with hospitals for certain kinds of admissions, are the probable cause for the decline in admissions which has been observed since the inception of PPS. Given these dramatic changes, it is probably time to reconsider the structure of the deductible and copayment. As we noted elsewhere, “Although a hospital-specific deductible based on a case-mix adjusted per diem could add extra price sensitivity, limiting the discount to the extent of the deductible only begins to explore the potential for competition under PPS. Although the HCFA proposal would allow beneficiaries to avoid certain out-of-pocket costs and would allow certain hospitals to achieve the economic benefits associated with increased volume, the DRG pricing framework does provide a natural basis for expanding price flexibility beyond simple deductible discounting.”

**Reasonable Boundaries**

Reactions to the proposal set forth in this article seemed to coalesce around opposing poles. The providers who first examined it expressed the fear that unrestrained discounting freedom would result in destructive short-term price wars. Prices set significantly below cost could affect quality of care. In contrast, individuals more sensitized to the national political climate feared that all providers might gravitate to the top of the scale by adding a premium. This would naturally invite a backlash from organizations such as the American Association of Retired Persons. The
suggested compromise involved the setting of a corridor around the standard price to provide some measure of control over the change and to balance the needs of consumers and providers. For example, hospitals could charge the standard price + or − 15 percent, under the two rules set forth in this proposal. It is submitted that the actual width of the corridor should be influenced by at least three factors: the extent of the current variations in PPS hospital-specific prices, implementation of the DRG refinements set forth in this article, and the current level of out-of-pocket costs incurred by the beneficiaries as a result of deductibles and copayments. However, given the dominance of the political climate, set forth below are two ways to initiate the proposal which build on the current HCFA proposal; a proposal which essentially benefits the beneficiaries.

### Relying On Process

Consistent with the rules set forth in this article, hospitals should be permitted to discount. In discussing the HCFA proposal, we noted: “Such discounts would not be limited to the deductible. At the beginning of each fiscal year hospitals would submit their DRG specific discount schedules to Medicare. The discount schedule would remain in effect for the entire fiscal year. In subsequent fiscal years a hospital would be able to increase, decrease, or eliminate entirely its discounts. The provision of discounts would be at the hospital’s discretion and no hospital would be required to provide a discount. The savings resulting from the discount would first be used to reduce or pay entirely the beneficiary’s deductible. If the amount of the discount exceeded the deductible, then the additional savings would be shared between Medicare and the beneficiary. When a hospital offered a discount greater than the deductible, 50 percent of the difference between the standard DRG payment amount and the discounted amount, less the deductible, would be retained by Medicare as a means of reducing Medicare expenditures. The remaining 50 percent would be paid as a cash rebate to the beneficiary. Such cash rebates would be similar in concept to the cash rebates that were proposed in the Medicare Voucher Act of 1986 (S. 1985).”

Following the close of the first year under the system, Medicare would determine the results of the experiment. To the degree that Medicare enjoyed savings as a result of discounting in excess of the deductible, half of these savings would be utilized to offset the need to reduce the otherwise objectively determined level of increase in PPS rates, and half would be applied to establish an upside corridor for the industry. Each year the process would be repeated until the upside and downside boundary reached the limits suggested by the three factors set forth above. The following simple illustration assumes a standard price of $3,000,
and a maximum discount of $1,000. Further, assume that every DRG has the same standard price of $3,000, and that every hospital provides every patient the $1,000 discount. During the first year the benefit to the beneficiary would be payment of a $500 deductible and a $250 cash payment. The benefit to Medicare would be $125 to reduce Medicare expenditures. And the benefit to industry would be $125 to the year 2 premium pool. Assuming no projected increase in the number of Medicare hospitalizations, $125 could be added to the standard price to determine the maximum permissible premium which a hospital could charge in Year 2. Assuming no inflation adjustment, the maximum premium price would be $3,125. Furthermore, the $125 saving would provide Medicare with resources to adjust for inflation. Finally, it should be noted that the “pooling” approach is essentially a response to concerns which we believe are addressed by other elements of our proposal, for example the corridors. Thus, one alternative which might obviate the need for a lengthy process solution is the determination of an asymmetrical set of corridors: for example, a maximum discount of $1,000 coupled with a maximum premium of $500-(2/3, 1/3). Also, other sharing formulas are possible, for example, the three parties could share equally beginning with the first dollar of savings.

**Provider Strategies**

Political fears aside, it is unlikely that many hospitals would be willing to risk being permanently labeled “high cost” unless they could make a clear “added value” demonstration to the beneficiary population. With the exception of a few major teaching hospitals of national reputation which could develop a marketing strategy around quality of care, cutting-edge experimentation, and the like, the probable outcome will be more practical forms of market differentiation. Of course, some hospitals may seek to develop and emphasize specialization. For example, either a discount or a premium strategy could be built around a program such as cardiac surgery. With the standard price framework, such a strategy could be projected regionally, or nationally. Such specialization has the desirable byproduct of generally improving quality of care. The specialization concept could easily expand on a regional basis to departments or group of services, such as tertiary or primary, with premium or discount strategies, as appropriate. However, the likelier path of competition will focus on amenities. In this regard, the airline industry may provide a useful example:

“There are no frills airlines which attempt to provide basic transportation at the lowest cost with no extra services. Often associated with low fares are inconveniences such as off-peak departure times or restriction on cancellation. Alternatively, there are full service airlines with a com-
plete range of services, many frequent flights, and no restrictions on cancellation. For the full service airlines there is also the option, at a significant premium, for first class service. Customers choose the airline and service level which best suits their personal preferences. Under a competitive framework hospitals may position themselves similarly. For example, some hospitals may market themselves as providing basic hospital services. Early morning admissions, multiple patients per room and family assistance with routine nursing services during the recuperative period might all be required to obtain the lower price. A hospital providing a traditional level of hospital services might require none of these restrictions and would not discount the PPS price. There could also be the equivalent of first class service in which private rooms, many hotel type amenities, and options for extended recuperative times would be available at a premium price.”

Physician/Patient Interaction

Consumers of health care services tend to fall into two broad categories: those who will accept some up-front restriction on freedom of choice in order to retain income, and those who will not. In reality, however, the value of freedom of choice to any individual is likely to vary with relative significance of the health episode. For example, such freedom may be more important in the case of cancer and less so in the case of the flu. Since a beneficiary must choose between contractual options, such uncertainties form a natural barrier for many to selecting a restricted option, such as a health maintenance organization (HMO), particularly at a time in life when at least the opportunity of preserving choice may be perceived as uniquely important. However, with relative pricing, the beneficiary can secure many of the financial benefits of HMOs, with limited financial risk, and without relinquishing freedom of choice in advance. Perhaps most important, relative pricing is responsive to varying patient needs and desires at the point in time at which these considerations become better formed. The key to effectiveness is the patient/physician interaction. Much like obtaining informed consent, the physician should review the financial implications involved in electing one hospital over another, in light of the nature of the immediate medical problem. Rather than physician finances, convenience, or politics in general, such choices should be made by giving due weight to patient convenience, scope of service, and price.

Continuum Of Options

By simply agreeing to pay the standard price, relative pricing allows Medicare to create a voucherless voucher system. However, because the
needs and desires of Medicare’s beneficiaries do vary, it is useful to consider the relative pricing proposal as one option along a continuum, from least restrictive to most: from relative pricing, to preferred provider arrangements, to HMOs. Of course, beneficiaries who wish to preserve freedom of choice, but are risk averse, would purchase supplementary insurance as they do now. (Even in this case, however, a beneficiary could be provided a financial benefit for choosing a low-cost provider; the benefit could come in the form of either a cash rebate or a reduction in premium.) On the other hand, the concept of a standard price could be quite useful to the capitation portion of the continuum. Prospective payment, refined DRG definitions, relative pricing, and complementary DRG-type units of care, will materially improve the capitation computation for such care.

In a nutshell, relative pricing is a framework which will enable Medicare to better control and enhance the link-up between HMOs and DRGs, thereby harnessing the best features of both concepts.

Conclusion

A recent edition of Hospitals suggests that adding some logic and structure to the health care marketplace may be as important to the providers as it is to the consumers. Referring to the California practice of selective contracting, John Edelston, vice-president of operations and management, Hospital Council of Southern California, observed: “Now, I know of at least two hospitals with 90 different contracts.” The article goes on to point out that, “[c]ontracting has also severely taxed hospital’s management information systems and undermined strategic planning . . . ,” noting among other things, that, “[r]eimbursement may be determined prospectively or retrospectively and paid on a capitated, per diem, or discounted fee for service basis.” If this sounds familiar, it is submitted that the starting point for sorting out the marketplace is the determination of the standard price by Medicare, coupled with simple rules which clarify deviations from the standard price. With this structure, both providers and purchasers will clearly understand both product and price. Although there will be sufficient flexibility to encourage change, there will also be sufficient structure to assure that decisions are not made based on confusion or misinformation. Thus, the framework proposed in this article will provide the basis for real competition.
NOTES


2. M. Kalison and R. Avetill, “Building Capital into Prospective Payment,” Business and Health (June 1985): 34-37. See also M. Kalison and R. Avetill, “Regulation vs. Contract: The Future of Capital Under PPS,” Healthcare Financial Management Association Monograph Series Edition (1984). Also, were a policy decision made to subsidize medical education, this could easily be accommodated through either a direct subsidy or through the development of a dual standard, for example, DRG 238 and DRG 238T.


6. Ibid.

7. Ibid.

8. Several other issues arose during the course of discussion: “sole community provider” and other less drastic situations may present limited opportunities for competition across all DRGs. Although regional opportunities to fill in the gaps should not be ignored, it is submitted that “market indexing,” such as the kind currently used in antitrust situations, could be used to screen out areas which may be unable to provide the critical mass necessary to implement this proposal. Where the problem of lack of competition is limited only to certain DRGs, or where the existence of unique services creates a “medical necessity,” the standard price could be imposed as a limit. In the case of higher cost DRGs or extended stays, Medicare should give consideration to a “catastrophic override” to protect individual families against undue financial hardship. Also, several “demonstrations” could be conducted to refine the exchange of information, identify any ancillary rules which may be needed, and to provide several case studies of provider behavior.

9. Indeed, one could easily visualize two matrices, both with well-defined, discrete units of care down one axis which correspond to the various mandated services set forth in the May 25, 1984 edition of The Federal Register. The opposite axis in matrix number 1 would stratify the Medicare population in order to reveal incidence of units by appropriate sub-group (such as age). The opposite axis in matrix number 2 would set forth the relative price for each offered unit of care, by provider. Capitation rates will be developed by summing the kind and number of units required by a given population, at the price offered by the selected providers. Sellers will be able to communicate precisely what is being sold, and for how much. Purchasers, armed with incidence information for their respective Medicare populations, can be expected to contract with different providers (or groups of providers) for different groups of units. Relative price will obviously be a consideration, and CMPs can be expected to use their market positions to bargain for further discounts “off list” based on volume. Nevertheless, CMPs must also give consideration to factors such as convenience, continuum of service and, in particular, quality (or image) in order to stay competitive with other CMPs for beneficiary loyalty.

10. Avetill and Kalison, “The Voucherless, Voucher System.”