

Cost Control of Physician Fees under Balanced Choice

(SO/IO Split = 80%/20%)

The Balanced Choice proposal, via its balancing mechanism and use of market forces at the doctor-patient level, incorporates checks on both under-funding by the plan and on excessive fees by doctors. If Standard Option (SO) fees are set too low for doctors to cover their practice costs and earn a reasonable income commensurate with their training, they will try to push as many of their patients as possible to accept care under the Independent Option (IO). If doctors are simply greedy, they may also push more of their patients to accept the IO, but unreasonably. In either case, the SO/IO split will fall below 80/20. When this happens, it is up to the Balanced Choice Board to assess whether the problem is under-funding by the plan or over-charging by the doctors, and take the appropriate action to correct the problem and restore the 80/20 split. To accomplish this, they could either to increase SO fees or cut the IO base payment as a percentage of SO fees.

On the other side, if SO fees are higher than they need to be, then more doctors will be happy with accepting patients under the SO and the SO/IO split will rise above 80/20. In this case, the remedy would be to cut SO fees or hold them steady and let inflation catch up, or else increase the IO base payment to be closer to the SO, until the SO/IO split has been restored to 80/20.

Consider the following hypothetical scenario:

Balanced Choice for physician fees has been implemented. Each State has a governing board that is required to keep a 80/20 funding split between the Standard Option (SO) and the Independent Option (IO). They have two “levers” to control this: setting SO fees, and setting IO base payments as a percentage of SO fees. These are set separately by health care region in the state. Hospitals are paid on global budgets, so patients receive no bills for anything but co-pays for physician services and drugs (and perhaps lab tests?).

A State Governing Board starts out by setting SO fees at Medicare rates, with a 5% co-pay for those who can afford it – chosen as a compromise between Medicaid, Medicare, and Commercial rates, since all these groups are now covered in a universal plan. IO base payments are set at 90% of SO fees, and doctors can charge whatever they want above that for IO patients. They have to offer something for the extra cost, so they give IO patients things like prime appointment times after working hours and on Saturdays, and expanded access via e-mail. Benefits are the same as with Medicare (all medically necessary services) for both SO and IO patients. Medical malpractice and worker’s comp premiums have dropped to 1/3 of what they were before because health care costs have been taken out of these insurance systems and put into the universal plan, and patients no longer need to sue to get their injury related health care needs covered. Formulary and prior authorization policies are now set on a state-wide basis and are vastly simplified and transparent. A typical 5-doctor small group practice now needs only one ¼ FTE person for billing.

One year later, in “City A”, most patients have negotiated with their doctors to be seen under the SO, with co-payments waived for those with very limited means, and those with at least moderately complex problems and who are well to do are choosing the IO. On average, cardiologists in “City A” charge IO patients 120% of SO rates, with the plan covering 90% of SO rates and the patient paying 30%. After a year, about 80% of patients are being seen under the SO, with co-payment waived for about a third of them. The doctors are happy. They are netting about 108% of Medicare rates (and the plan is paying an average of 98% of Medicare rates), but their administrative costs and hassles are much less, so they don’t mind. (This is how it is supposed to work.)

Two hundred miles away, in “City B,” the cardiologists have resisted the SO and are pushing their patients to be seen under the IO. Many patients just can’t afford the IO, so their doctors relent and accept them as SO patients. After a year “City B” ends up with 70% in the SO and 30% in the IO. The “City B” cardiologists are doing fewer catheterizations, since all those IO patients are concerned about the high co-pay for expensive procedures and price discussions have become a part of treatment planning with patients. However, the Governing Board has to do something about the SO/IO split having veered from 80/20.

The State Governing Board sees what is going on in “City A” compared to “City B” and thinks the SO fees in “City B” are not in fact too low, but they have to correct the split. Therefore, instead of raising SO fees, they pull the second “lever” and cut the IO base payment to 80% of SO fees for “City B”. Now the “City B” plan is paying only 94% of SO fees on average (including both SO and IO), and the IO patients are paying 40% of the SO rate as a co-pay. Many IO patients are now demanding that their doctors convert them to SO, since they are quite willing to take time off from work for daytime appointments and forgo e-mail access to save the high co-pay under the IO. The IO requires agreement between doctor and patient, so the cardiologists must either convert those who want it to SO, or tell them to find another doctor.

I cannot imagine that the “City B” cardiologists would be able to keep 30% of their practices as IO under these circumstances, and many would be compelled to accept more of their patients as SO, correcting the SO/IO split without raising SO fees. Furthermore, the immediate pressure on doctors to shift more patients to the SO would be brought to bear by their own wealthier and more demanding IO patients, not by the central plan. This would be a powerful and effective means to keep physician fees reasonable under Balanced Choice, using market forces at the doctor-patient level under the IO.

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