“Most Favored Nation” Clauses in Health Care:

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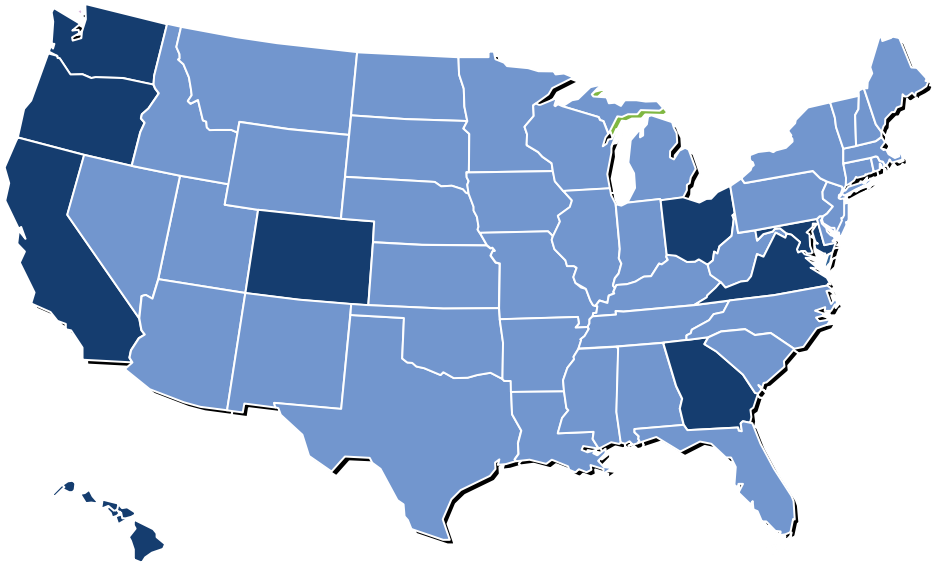
Overview

- My goal is more to stimulate questions than to provide answers
- Kaiser Permanente: who we are
- Market for health care services is fundamentally different
  - Minimal price sensitivity on the part of consumers/patients
  - Duality of markets: care delivery and insurance—with varying competitiveness
  - Non-standardized product whose production cost depends on the consumer
- Medicaid Rebate Program: a case study in MFN
  - Desire to get “best price” for taxpayers imposes costs on privately insured
- As payment models evolve, is focus on unit price the right one?
  - Blurring of provider insurance company roles

Kaiser Permanente: who we are



- 9 million members
- 16,000+ physicians
- 170,00 employees
- 36 hospitals
- 500+ other facilities
- $48 billion revenue (2011)

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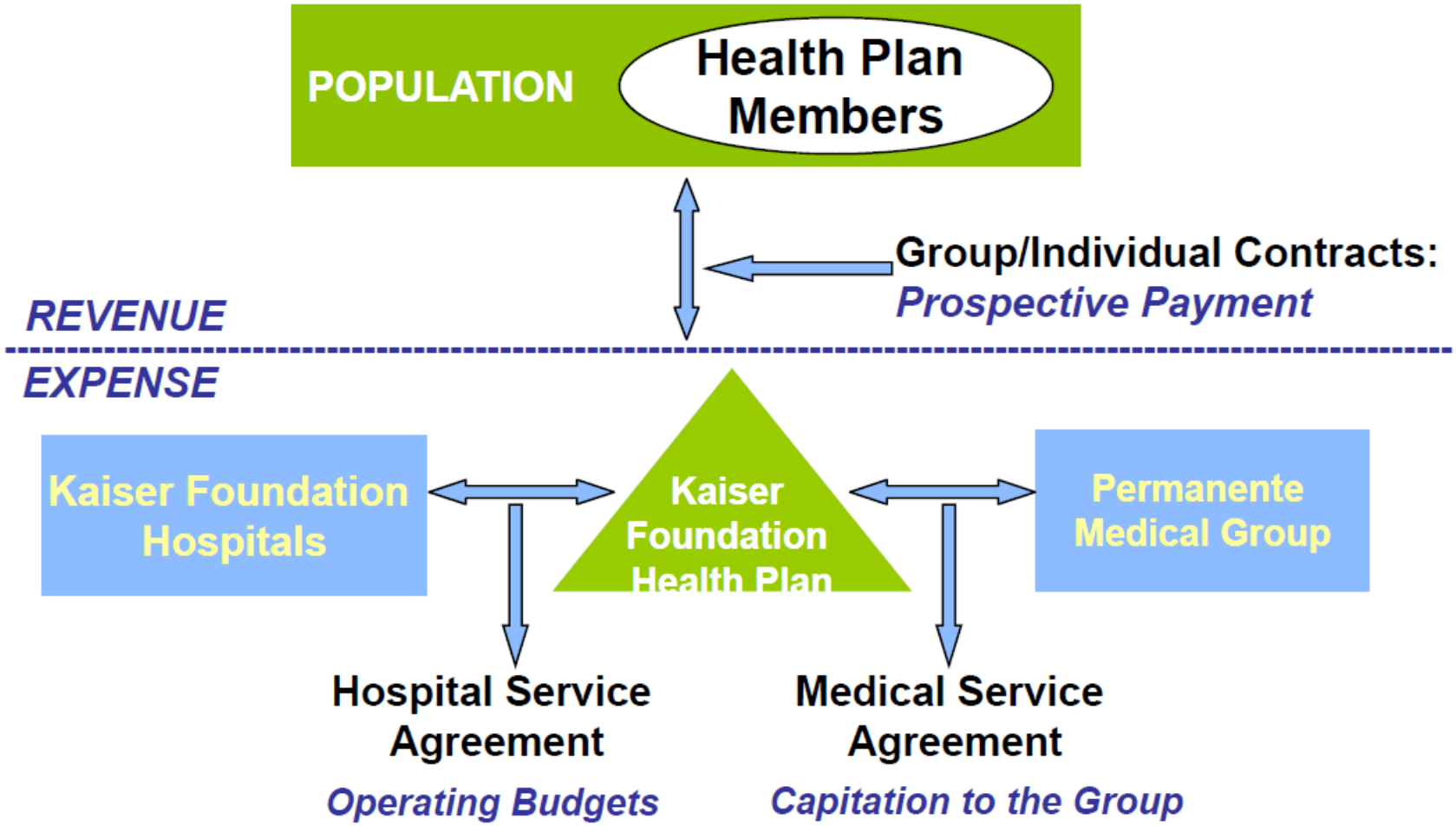
Kaiser Permanente Medical Care Program



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Market for health care is different

- Few consumers face the marginal cost of care or insurance
  - Beyond the deductible, insured people make co-payments or pay coinsurance (on a negotiated price—perhaps an MFN); only the uninsured pay retail
  - Few consumers see marginal cost of insurance; fixed dollar contributions rare
- Varying degrees of competitiveness in care/insurance markets
  - Geographic and reputational monopolies in hospital markets
  - Concentration in insurance markets varies widely across states
  - Highly inelastic demand for some services
  - Regulatory barriers to entry
- Difficult to define the product
  - An office visit is not an office visit; insurance not standardized
- Does the theory of the second best apply here?

The Medicaid rebate program

- Enacted originally to protect taxpayers

- Requires manufacturers to rebate to Medicaid the greater of 23.1% of reported AMP or the difference between AMP and the "best price" offered in the private market
  - Given Medicaid share of market, manufacturers reluctant to offer larger discounts to private insurers
  - This effectively sets a floor under prescription drug prices, limits ability of formularies to drive competition among manufacturers

- One solution: flat rebates to Medicaid, sever link to privately negotiated prices

Is unit price the right focus?

- Health care payment models are slowly evolving
  - Cost-based (whatever providers wrote on the bill)
  - Cost-based with limits (“usual, customary, and reasonable”)
  - Fee schedules (statutory or negotiated)
  - Capitation
  - Mixed models (bundled payments, shared savings)
- The reason for this evolution is that focusing on unit prices has not worked to constrain cost growth
  - Increasingly, public & private payers recognize that absent price sensitivity on the part of patients, efficiency requires putting providers at financial risk
  - This in turn means a blurring of the insurer provider roles
- In a world of payment reform, is a focus on price the right one?

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