“Most Favored Nation” Clauses in Health Care:

Murray N. Ross, Ph.D.
Vice President, Kaiser Foundation Health Plan
Director, Kaiser Permanente Institute for Health Policy

US Department of Justice
Workshop
Washington DC
September 10, 2012
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
- 170,000 employees
- 36 hospitals
- 500+ other facilities
- $48 billion revenue (2011)
Kaiser Permanente Medical Care Program

**POPULATION**

Health Plan Members

---

**REVENUE**

Group/Individual Contracts: Prospective Payment

---

**EXPENSE**

Kaiser Foundation Hospitals

Kaiser Foundation Health Plan

Permanente Medical Group

Kaiser Foundation Hospitals

Hospital Service Agreement

Operating Budgets

Kaiser Foundation Health Plan

Medical Service Agreement

Capitation to the Group

© 2012 Kaiser Foundation Health Plan, Inc.
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?
For more information:

Murray N. Ross, Ph.D.
Vice President, Kaiser Foundation Health Plan, Inc.
Director, Kaiser Permanente Institute for Health Policy
One Kaiser Plaza, 22nd Floor
Oakland CA 94612

Email: murray.ross@kp.org

IHP Website: http://www.kpihp.org/