

Clinic Price Reductions in a Tiered Total Cost Benefit Design

Tim McDonald, MPP; Katie M. White, EdD, MBA; Tsan-Yao Huang, PhD; Christopher M. Whaley, PhD; and Bryan Dowd, PhD, MS

There is substantial variation among US health care providers in their prices and use of health care services.¹ There also is a weak relationship between the cost and quality of medical services,^{2,3} suggesting that cost could be reduced without sacrificing quality of care.⁴ One way to encourage improved efficiency—defined as better patient health outcomes and patient satisfaction for less cost—among providers is to give patients (consumers) information and financial incentives to choose providers that offer better quality and lower cost. A simulation by Desai et al suggests that if consumers in commercial plans moved to lower-cost providers for referred services (eg, diagnostic laboratory and imaging tests, durable medical equipment), spending could be reduced by 11%.⁵

There is growing policy interest in consumer cost sharing and price transparency,^{6,7} but many cost-sharing health insurance benefit designs such as high-deductible health plans place the burden of navigating the fragmented health care services system on consumers who lack the information or expertise to integrate services themselves.⁸ Studies have found that consumers have difficulty making sense of complex information in health care,⁸ but indications exist that consumers may choose higher-quality providers.⁹ Some health insurance benefit designs give consumers both the information they need to choose lower-priced providers and a financial incentive to do so. Those options include preferred provider organizations (PPOs) with in-network and out-of-network providers,¹⁰ reference pricing,^{11,12} and tiered cost sharing.¹³⁻¹⁷ Tiered networks and PPOs preserve consumer choices with variable cost sharing, whereas narrow networks restrict choices to only those providers within network. Tiered designs reward consumers who choose better-quality or lower-priced providers with lower out-of-pocket costs and encourage providers to become more efficient.^{13,18}

Although these approaches indicate that consumers will use information if paired with financial incentives, they place the burden of navigating the broader health care system of specialists and hospitals on patients and in some cases are limited to discrete procedures and services. In this study we investigate consumer choice of primary care gatekeeper clinics in a tiered total cost of care system managed by the Minnesota State Employee Group

ABSTRACT

OBJECTIVES: To understand responses of primary care clinics to inclusion in a tiered total cost of care insurance benefit design.

STUDY DESIGN: We used a qualitative design beginning with longitudinal analysis of administrative data on consumer clinic choice, clinic tier placement, and clinic actions, followed by in-depth interviews with key informants from clinics, administering health plans, and program administrators.

METHODS: We collected data via semistructured interviews with purposively sampled key informants selected from clinics that prospectively reduced prices to move to, or remain in, a tier with lower cost sharing. Data from interview transcripts were coded using qualitative coding software and analyzed for thematic responses.

RESULTS: Our findings suggest that clinics respond to the incentives in the tiered cost-sharing benefit design. Two motivations cited by clinics are (1) concern over developing a reputation as a high-cost clinic and (2) concern about the possible loss of patients due to higher cost sharing. Some clinics have agreed to price reductions or risk-sharing arrangements to move to, or remain in, a tier with lower cost sharing. Clinic informants reported that price reductions alone are not scalable. They sought greater transparency in tier assignment and increased data sharing to help them reduce costly or unnecessary utilization.

CONCLUSIONS: Managers of primary care clinics respond to a tiered benefit design that holds them accountable for total cost of care. They respond by offering price discounts and expressing interest in reducing costly referrals and unnecessary use of services.

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Insurance Program (SEGIP). We define tiered total cost of care systems as those in which the primary care provider or clinic is assessed for total cost, including specialist, inpatient, and pharmaceutical costs, even if they did not provide the services themselves. The SEGIP design is distinct from other forms of tiered designs that individually tier hospitals, pharmaceuticals, or individual services.

SEGIP has been in operation since 2002 and covers approximately 130,000 employees and dependents, as well as a small number of retirees. The benefit design is relatively simple from the consumers' perspective. Plan members make only 2 choices each year: a primary care clinic and 1 of 3 administering health plans. The primary care clinic then coordinates all their patients' care, including referrals to specialists and hospitals. The SEGIP program reviews the clinics' historical data on the mean annual risk-adjusted total cost of care and places the clinic into 1 of 4 cost-sharing tiers for the coming year.

This analysis focuses on the response of primary care gatekeeper clinics to tiered cost sharing. The clinics' response depends, in part, on the response of consumers to tiering, and so we provide a brief summary of the consumer response data. We then examine the steps that clinics have taken when faced with pressure to lower prices.

Program Description

SEGIP is one of the longest-running tiered cost-sharing systems in the country. State employees are spread across the entire state, including densely populated urban areas and remote rural areas. SEGIP assigns all primary care clinics that participate in the SEGIP program to 1 of 4 tiers based on their per capita risk-adjusted annual total cost of care for members from the prior year (or 2 years for smaller clinic groups), divided by the mean risk-adjusted cost for all SEGIP members. Tier 1 has the lowest-cost clinics and lowest cost sharing and tier 4 has the highest. Currently, total risk-adjusted per capita health care spending for the highest-cost clinic in tier 4 is roughly 80% greater than that for the lowest-cost clinic in tier 1.

TAKEAWAY POINTS

Tiered total cost of care health care benefit designs may significantly reduce overall spending and offer advantages over other health care reform initiatives. In this study, we find that:

- ▶ Assessing primary care clinics for total cost of care put them in the positions of gatekeeper and coordinator of care.
- ▶ Consumers demonstrate an ability to choose a gatekeeper clinic and prefer clinics in tiers with lower cost sharing.
- ▶ In response, clinics reduce prices by an estimated 10% to 20%.

Large employers or managed care decision makers may want to consider such consumer choice approaches along with payment reform, reference pricing, pay to shop, and other initiatives.

As shown in the [Table](#), annual deductibles in 2020 ranged from \$150 to \$1250 for single coverage and \$300 to \$2500 for family coverage. Office visit co-pays ranged from \$30 for enrollees who select a tier 1 clinic to \$85 per visit for enrollees who select a tier 4 clinic. Maximum out-of-pocket spending, ranging from \$1200 and \$2400 for single and family coverage, respectively, in tier 1 to \$1600 and \$3200 in tier 3, increases to \$2600 and \$5200 in tier 4. The maximum consumer out-of-pocket cost-sharing amount, along with all aspects of the tiered cost sharing, are set through collective bargaining.

The members' health insurance claims are processed by 3 health plans: HealthPartners, Blue Cross and Blue Shield of Minnesota, and PreferredOne. The member's out-of-pocket premium is the same across the 3 administering health plans, so the member's incentive to choose a lower-cost clinic is based only on their point-of-purchase cost sharing.

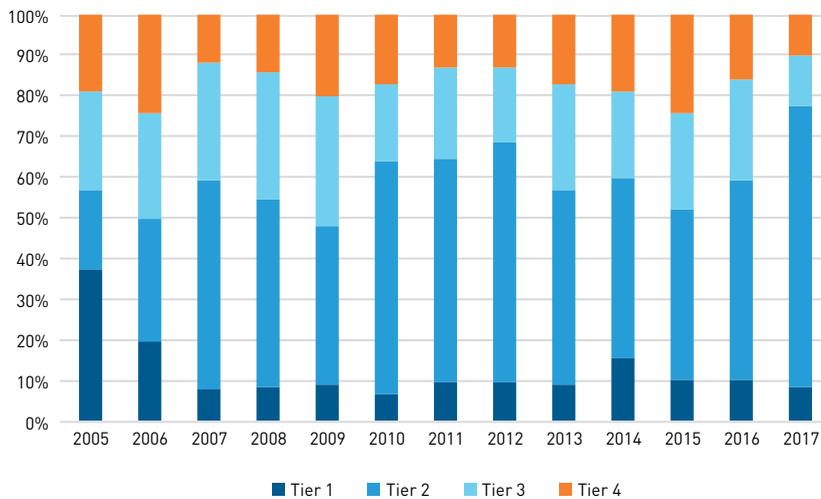
Members choose a primary care clinic that acts as a "gatekeeper" and directs the member's access to specialists and hospitals. Each family member can choose a different clinic, including pediatric and obstetrics and gynecology clinics, but all family members must choose the same health plan.

Clinics can influence their tier placement in 3 ways: (1) reducing their use of avoidable utilization and low-value care relative to other clinics; (2) prospectively reducing their reimbursement price schedule for the SEGIP program by an amount required to achieve a certain tier; or (3) participating in a risk-sharing arrangement with

TABLE. Consumer Cost Sharing by Tier

Service	2020 cost sharing by tier			
	Tier 1 (single/family)	Tier 2 (single/family)	Tier 3 (single/family)	Tier 4 (single/family)
Preventive care services	\$0	\$0	\$0	\$0
Annual first-dollar deductible	\$150/\$300	\$250/\$500	\$550/\$1100	\$1250/\$2500
Office visits	\$25/\$30 co-pay	\$30/\$35 co-pay	\$60/\$65 co-pay	\$80/\$85 co-pay
Emergency care	\$100 co-pay	\$100 co-pay	\$100 co-pay	25% coinsurance
Inpatient hospital care	\$100 co-pay	\$200 co-pay	\$500 co-pay	25% coinsurance
Outpatient surgery	\$60 co-pay	\$120 co-pay	\$250 co-pay	25% coinsurance
Maximum out of pocket (Rx)	\$800/\$1600	\$800/\$1600	\$800/\$1600	\$800/\$1600
Maximum out of pocket (everything but Rx)	\$1200/\$2400	\$1200/\$2400	\$1600/\$3200	\$2600/\$5200

Rx, prescription drug.

FIGURE 1. Primary Care Clinic Tier Placement, 2005-2017

1 or more of the administering health plans. In the third option, a portion of the reduction to achieve a desired tier may be placed at risk via a target set with the SEGIP administration. The price reduction option was introduced in 2004, and the risk-sharing option was introduced in 2013 and phased out in 2019 because of a lack of adoption among clinics.

METHODS

Study Design

We designed a qualitative study using nonprobability, purposive sampling. Our sampling strategy included first identifying, from SEGIP administrative annual data, those clinics in the prior year that had sought and been assigned to a lower-cost tier than calculated cost experience for annual total cost of care data defined by SEGIP and its Deloitte partner. With rare exceptions, every clinic that participates in the SEGIP program is included in each of the 3 administering health plans, and in 2017 there were 2786 such clinic-plan combinations. Of these, 700 (25.1%) had agreed to a specified fee reduction to move to a lower tier or retain their current tier for the coming year. We then stratified these clinics by geography and size, as measured by number of primary care physicians, to include contrasts in the sample. Finally, with help from SEGIP administrators, we selected a sample of key informants (CEOs, chief operating officers, chief medical officers, or contracting officers, hereafter referred to as “clinic managers”) from 7 clinics from across various regions, both micropolitan and metropolitan areas of the state, and various clinic sizes. We also interviewed selected key informants at each of the 3 administering health plans who are responsible for the SEGIP business. We were successful in recruiting all the informants to participate in interviews.

Data Collection

We created an interview guide ([eAppendix A](#) [eAppendices available at [ajmc.com](#)]) based on concepts from the literature to include core questions for all respondents and additional specific questions for each type of key informant. Questions were designed to explore clinic understanding of, experience with, and response to the SEGIP program; health plans were asked about fee reductions or risk-sharing arrangements and perceptions of experiences of clinics in their networks. We recruited individuals for participation in interviews by email in May and June 2017. Two investigators (T.M., K.M.W.) conducted telephone or in-person, 60-minute semistructured interviews with 13 key informants between July and October of the same year. A listing of the professional titles of the informants is included in [eAppendix B](#). Interviews were audio recorded and transcribed for analysis.

Data Analysis

Two investigators (T.M., K.M.W.) independently coded the transcripts using a codebook derived from the interview questions and inductively from the responses. Investigators met to compare coding and resolve differences through review and further discussion. Key themes were identified from the systematic, iterative review of the coded material and notes were made of emergent concepts heard during the interviews.^{19,20}

RESULTS

Figure 1 shows clinic placements in tiers from 2005 to 2017. From years 2005 through 2016, between 49% (in 2006) and 68% (in 2012) of clinics were in tiers 1 and 2, with an uptick to 78% in 2017, reflecting a higher number of clinics electing to reduce their prices after initial tier placement.

Consumer Choice of Clinic Tiers

Figure 2 shows consumer choices of clinics from 2005 to 2017. These data suggest a strong preference by consumers for clinics in the lower 2 cost-sharing tiers. From 2005 to 2017, consumer choice of clinics in tiers 1 and 2 ranged from 78% in 2008 to 91% in 2017. During this 13-year period, the mean portion of clinics in tiers 1 and 2 was 59%, and the mean portion of consumers choosing clinics in tiers 1 and 2 was 85%.

Clinic Responses to Tier Placement

As described earlier, clinics can change their tier placement in 3 ways. The first is to reduce avoidable utilization of health care services and low-value care, thereby establishing a lower base of total annual risk-adjusted cost of care for the next 2 years' tiering.

The second is to voluntarily reduce their prices. The third is to place a portion of their revenue at risk. After clinics receive their initial tier placement in June, SEGIP contacts the clinic and gives them the option to reduce their prices or participate in risk sharing.

Figure 3 shows that over time an increasing number of clinics have voluntarily reduced their prices—up to 25% of clinics by 2017. The required price reduction for a primary care clinic to move to a lower tier is calculated in a 2-step process. First, analysts at Deloitte compute the amount that a primary care clinic’s costs would need to be reduced to improve its overall cost efficiency to the threshold for the tier that the clinic is seeking. Then, price reductions are applied only to the costs incurred by the clinic, not to referrals or prescription drugs. Deloitte computes the price reduction data for SEGIP and reports that the typical required fee reduction for clinics is between 10% and 20%. For example, if the total cost of care attributed to a primary care clinic is 5% above its goal tier and it is determined by claims analysis to control 50% of its total cost of care (the other 50% of cost being for care provided by specialists or prescription drugs), the clinic would need to reduce its own prices for the SEGIP population by 10%.

Risk sharing was introduced by program officials in 2013. Figure 3 shows that in 2013 and 2014, 8% and 10% of clinics, respectively, entered into risk-sharing arrangements. After some initial popularity, the risk-sharing option became less popular over time as clinics substituted price reductions, and it was eventually phased out by SEGIP in 2019. In our interviews, both clinics and health plan administrators reported that price reductions were administratively simpler than risk sharing.

Rationale and Decision Process for Lowering Prices

Respondents described 2 rationales for lowering prices to prevent movement to a higher-cost tier. The first was concern over developing a reputation as a high-cost clinic—a “reputation” effect. The second rationale was more directly economic, centered on potential loss of patients due to higher cost sharing.

When asked about the implications of substantial price reductions for SEGIP members, the clinics reported they did not do special analyses to determine their costs for caring for SEGIP members, and 1 clinic informant noted that their discounted prices may create an economic loss for their clinic, but considering the limited patient

volume, this was tolerable in the short term. When asked what would happen should a larger portion of their total patient base be in a SEGIP-style tiered benefit design, multiple clinic respondents stated that expansion of discounted prices to a larger portion of their patient base would be unsustainable.

Clinic respondents reported that they would need more data on cost drivers to improve efficient use of resources. “We cannot just continue to discount prices without understanding where we can intervene to manage total cost of care,” one clinic stakeholder said, but the lack of information on the effects of specific types of utilization on tier placement makes improvement difficult. All clinic representatives except one, who was part of an integrated system,

FIGURE 2. Consumer Choice of Primary Care Clinic by Tier, 2005-2017

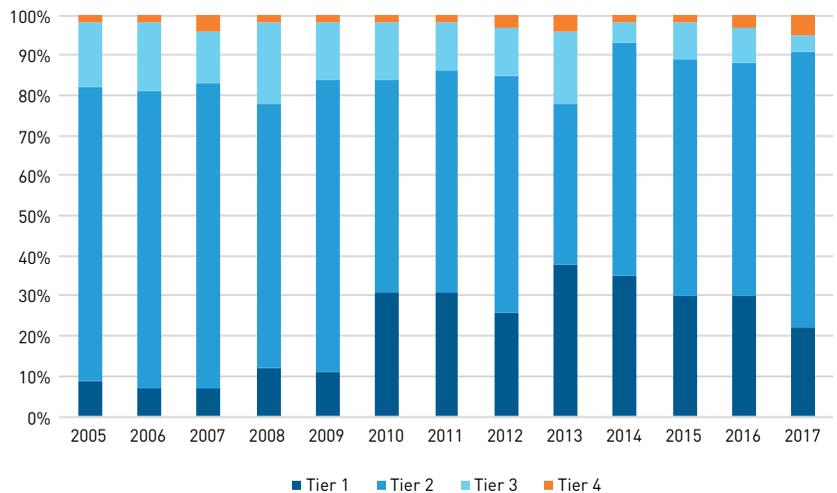
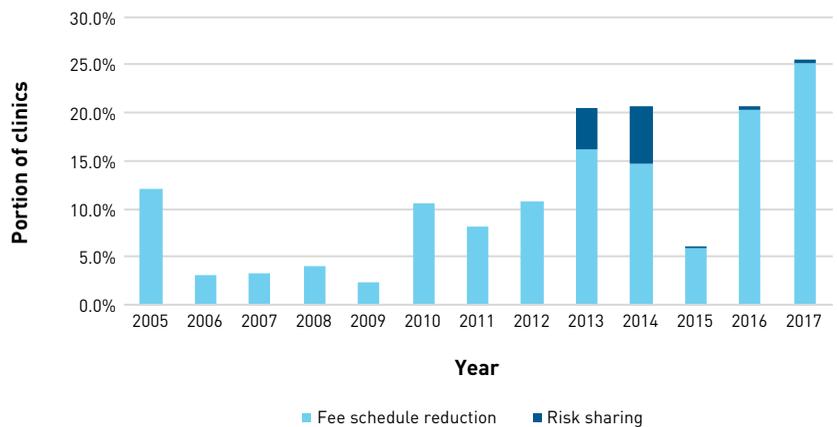


FIGURE 3. Prospective Clinic Actions to Move to Lower-Cost Tier, 2005-2017



reported that they did not know which specialists and hospitals are higher cost, and thus base their referrals on intuition rather than data. “They are kind of a gut feel...We don’t know how those patients are utilizing so we don’t know...where those high-cost referrals are going,” one said.

All key clinic informants noted that decisions to lower prices were primarily made by clinic managers in the contracting departments, reflecting the relatively small portion of the book of business for the 7 clinics chosen. In some clinics, senior leadership was involved with the clinic’s response to the SEGIP design.

Clinic Perceptions of Member Price Sensitivity

Clinic respondents reported that they believe that state employees are price sensitive, consistent with our findings from administrative records. One clinic informant stated, “Members in the state health plan are very competitive [price sensitive]. So you have to watch that tiering pretty close; really close.” Respondents said they hear from members if they have moved to a more expensive tier. “The only thing they [members] don’t like is when a facility [moves to] a [higher] tier. If you are a tier 2 one year and next year you’re a tier 3, they give you some feedback,” one respondent said.

Views of Health Plan Administrators

The 3 health plan administrators generally were satisfied with the program and believed that they have an innovative partnership with the state, but a common critique was that the program is resource intensive to administer because the primary care gatekeeper model requires running 4 plan designs, 1 for each tier.

DISCUSSION

Opportunities exist for improvement to the SEGIP program design. Currently, the tiers are constructed using a measure based solely on total cost of care, and quality is presented to plan members through a link leading to the Minnesota Community Measurement website. Literature on consumer decision-making suggests a positive relationship between consumer use of information and the ease of accessing it.²¹ Clearer and more direct inclusion of quality measures at the time of tier selection or incorporating quality metrics into tier design could improve the utilization of information and incent clinics to improve care.

Limitations

There are 2 sources of limitations to discuss. This study did not differentiate responses by clinic type. The SEGIP program includes a range of primary clinic types from independent small primary care clinics to large, integrated systems with their own health plans. Large care systems such as multispecialty groups with hospitals are tiered as a single system, but they also have a higher ability to control their own costs. Future research should investigate these differences, which may provide further insight into clinic actions and motivations.

The interviews reported in this study did not include care providers, SEGIP members, or labor leadership. The study would be strengthened by expanding the sample and speaking with a range of stakeholders at each clinic. Practicing physicians may have different views on tiering, pricing, and the gain or loss of patient volume depending in part on the type of clinic and degree of physician leadership and involvement in contracting decisions.

CONCLUSIONS

We investigated a state employee benefit program that employs a tiered total cost of care benefit design that places primary care clinics into tiers with different levels of consumer cost sharing based on total cost of care. We find that both consumers and clinics respond to participation in the tiered system. In 2017, 91% of consumers chose clinics in the 2 lowest-cost tiers and 25% of clinics chose to lower their prices for the SEGIP program by a reported typical range of 10% to 20% to avoid being moved to a tier with higher consumer cost sharing.

Clinics cited 2 motivations for their response to the possibility of being moved to a higher consumer cost-sharing tier: concern over reputation and economic concern about the possible loss of patients. Clinics reported that continued price reductions are not sustainable and they wanted better information to help them to understand how to reduce unnecessary utilization.

These findings contribute to the literature on consumer engagement and clinic incentives and to the emerging literature on tiered insurance systems. The SEGIP members’ response to a clinic’s tier is consistent with advances in measurement and information technology to improve presentation of information to consumers²² and is related to the literature on physicians’ “intrinsic” incentives.²³ Easily understood, publicly available information on the total cost of care for primary care clinics compared with their competitors combines both intrinsic self-assessment and extrinsic demand-related incentives for improvement. ■

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TYH, CMW, BD); statistical analysis (TM, TYH, BD); obtaining funding (TM, BD); administrative, technical, or logistic support (BD); and supervision (TM, KMW, BD).

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eAppendix A

Interview Protocol

State Employee Group Insurance Program (SEGIP) Project Interview Protocol

Questions for Clinic Leadership Key Informants

We are interested in your organization's experience working with the *Minnesota Advantage* plan; whether it has an impact in how you do business and how it compares to other forms of payment reform or insurance design; and what your impressions are of the program overall.

Questions:

- a. Tell us about your organization's history with the Advantage program. How does the program work within your organization? Has that changed over time and if so, how?
- b. About what portion of your patient panel is in Advantage? About what portion for the overall clinic/system?
- c. What is your impression of the Advantage program? How would you say it is perceived overall in your clinic? By members? What impact, if any, do you think it has had on your organization?
- d. Have you made any changes in response to being part of Advantage? What kind of changes have been made? (For example to referral process, such as fewer referrals or referrals to a more concentrated group of providers; or to care management; Or to care processes, e.g. for prescribing, ancillary tests, or how you organize and otherwise manage care?) Briefly describe these.
- e. Are you aware of who the lower-cost referrals are?
- f. In your opinion, how does the tiered network approach compare with other approaches that payers are trying to take, such as shared savings or bonus payments tied to quality metrics, etc.?
- g. Do you believe that physicians within your organization know about Advantage and how it works?
- h. Do you feel like you have a say in how your clinic makes decisions regarding Advantage participation, tiering decisions, program recommendations or other aspects of participating in the SEGIP program?

Questions for Health Plan Key Informants

We are interested in your experience with SEGIP, as one of the administering plans – what the experience has been like, your assessment of the effect of the program on your members and on clinics and providers, and what changes, if any, you would recommend.

Questions:

- a. Tell us about your organization's history with the SEGIP program. How does the SEGIP program work within your organization? Has that changed over time and if so, how? How difficult or easy is it for you to administer the SEGIP program?

- b. About how many of your members are in SEGIP? What proportion does that represent?
- c. What is your impression of the SEGIP program? Of how it is perceived overall in your company? By members? What impact, if any, do you think it has had on your organization?
- d. Have you developed any special arrangements with clinics, such as risk-sharing, that were proposed to the state for moving the clinic to a lower tier? If you did, what was the thought process? How were they formed and how are they structured? How are they performing?
- e. Have you made any additional changes in response to being part of SEGIP? What kind of changes have been made? Briefly describe these.
- f. How does the tiered network approach compare with other approaches that payers are trying to take, such as shared savings or bonus payments?

eAppendix B

Professional Titles of Key Informants

Plan Interviews

Senior Account Manager

Director of Market Strategy

Director, Special Government Accounts

Principal Account Manager

Clinics and Provider Interviews

Vice President, Revenue and Contracting

Director, Revenue and Contracting

Vice Chair, Contracting and Payment Relations

Vice President, Payer Strategy and Contracting

Payer Relations and Contracting

Supervisor of Reimbursement and Contracts

Chief Operating Officer

Vice President Health Information

eAppendix C

Data Tables

Primary Care Clinic Tier Placement (Table)

Tier	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
T1	38%	19%	8%	9%	9%	7%	10%	9%	9%	15%	10%	10%	9%
T2	19%	30%	51%	46%	39%	57%	55%	59%	48%	44%	42%	49%	69%
T3	24%	26%	29%	32%	32%	19%	23%	19%	26%	21%	24%	24%	12%
T4	19%	24%	12%	14%	20%	17%	13%	13%	17%	19%	24%	16%	10%
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Consumer Choice of Primary Care Clinic by Tier (table)

Tier	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
T1	9%	7%	7%	12%	11%	31%	31%	26%	38%	35%	30%	30%	22%
T2	73%	74%	76%	66%	73%	53%	55%	59%	40%	58%	59%	58%	69%
T3	16%	17%	13%	20%	14%	14%	12%	12%	18%	5%	9%	9%	4%
T4	2%	2%	4%	2%	2%	2%	2%	3%	4%	2%	2%	3%	5%
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Prospective Clinic Actions to Move to Lower-Cost Tier (table) (2005-2017)

Year	Price Reduction	ACO
2005	12%	
2006	3%	
2007	3%	
2008	4%	
2009	2%	
2010	11%	
2011	8%	
2012	11%	
2013	16%	4%
2014	15%	6%
2015	6%	<1%
2016	20%	<1%
2017	25%	<1%