Oregon Health Policy Commission
Question & Answer
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The questions and answers below are based on questions asked at our presentation to the Oregon Health Policy Commission on June 23, 2004. Most of these questions were asked during formal session and a few were asked afterwards.

We have proposed that state government can help the public maximize its health care value by redirecting health care competition to focus on health conditions rather than tasks or other attributes.

We have organized the Q&A as follows:

ORGANIZATIONAL IMPLICATIONS OF CONDITION COMPETITION?

Would condition competition favor generalists or specialists?

It would favor neither. In contrast to fee-for-service payment methods which tend to cast judgments about the relative value of procedural versus cognitive care, or specialist care versus generalist care, we propose establishing financial incentives that reward superior prevention, diagnosis and treatment of conditions.

What are the implications for organizational structures?

Purchasers and payers that instill condition competition through the use of fee-for-solution payment, provider set reference pricing, and information utilities will transform the basis of competition from task-based to condition-based. The value proposition

would become the superior prevention, diagnosis and treatment of conditions. This is a significant change. Providers that offer demonstrably superior results will be most successful. Undoubtedly, successful delivery strategies will include (Figure 1) coordination of care, preventive care, continuous communication, improving quality, and reducing cost to the consumer. But this does not necessarily favor any particular ownership structure or size. Ownership consolidation or aggregation would not seem to be a winning strategy unto itself, unless it somehow contributed to superior results. Skillful management of relationships, communication and information management would likely be far more important than size for size's sake. Commission members suggested possible structures that may emerge such as the renewal of independent physician associations (IPAs) and a range of partnering arrangements. These seem likely as do others. The key again is to restructure the incentives to align patient and provider interest, and then allow creative solutions to blossom.

Figure 1

DELIVERY MODEL WITH CONDITION COMPETITION		
	Today	**Market**
Organization	Individual	Team
Provider	Physician	Non-physician
Communication	Episodic	Continuous
Intervention	Reactive	Preventive
Information	Paper	Paperless
Technology	↑Revenue	↓Costs/↑Results

What are the implications for routine and preventive care?
The fee-for-solution method is flexible enough to be applied to all levels or care, including routine and preventive care. For example, the preventive services can be bundled into a categories based on gender and age and other relevant clinical factors and the provider would be paid a fixed, lump-sum fee for delivery all those services.

However, there is no requirement to implement fee-for-solution immediately to preventive services. (Figure 2) Fee-for-solution will have its greatest immediate impact on the 15 chronic and acute conditions that account for the majority of health care costs in this country. If fee-for-solution were first applied to these select conditions, the delivery system that could emerge under these new incentives would include a combination of frontline primary care providers paid fee-for-service who would funnel select patients to centers for chronic conditions and complex procedures. Furthermore, catastrophic care could be separated out and tightly managed by the purchaser. Such a system would deliver what most experts have said we need: a combination of highly personalized care that is also deeply based in evidence, tightly linked to a common understandings of quality and that reduces waste and constantly improves results.

Provider Payment Pyramid
Alternative to Full Fee-for-Solution
Figure 2.

QUALITY AND ACCESS IMPLICATIONS OF CONDITION COMPETITION
Would there be an incentive to avoid complex and sick patients?
No. First, condition groupings reflect severity and co-morbidities thereby adjusting payment for risk. In other words, providers get paid more for sicker patients. Second, we

suggest that payers permit providers to set their own prices for each condition, further limiting financial risk. In sum, condition based payment balances risk between providers, patients and payers. Under condition based payment, providers cannot succeed by avoiding, under-treating or over-treating.

Would there be an incentive to avoid low income patients?
Regardless of payment method or other incentives, providers will always act to limit the number of patients in their practice who either do not have insurance or have inferior insurance – be it public or private.

Would "cheap care" be favored over "quality care"?
What we all want is a market where providers compete to deliver superior prevention, diagnosis and treatment of our conditions. It is well known that all providers are not equal. Quality and costs vary. We've specified the methods to make this variance explicit. When deployed, here's what will happen. Providers who under-treat will have poorer results than their peers. They will lose market share and pricing power. However, if it turns out that the inexpensive provider was simply judiciously adopting technology he would gain share and pricing power.

Is condition competition viable in underserved areas (rural or inner city)?
Condition competition will maximize value for purchasers and consumers in rural and inner city communities because it will shift competition from localities to regions. This will initially be most clear for a series of common, complex, costly conditions – particularly those that require procedures. Consumers will be able to compare across geographies if they are inclined, and significantly providers, always sensitive to their standing among peers, will initially act to preserve and enhance their stature and later compete to serve consumers.

One concern may be that rural areas do not have the concentration of specialists or hospitals required for integrated care at a single location. However, condition competition would create incentives that reward greater coordination and accountability of care even in rural areas with widely dispersed providers. The accountability results from a payment for a solution. It doesn't come from having all providers under a single roof in one location. In fact, fee-for-solution could be a very powerful method for expanding access in rural and underserved areas by providing a payment framework that fully supports care delivered remotely (electronically or telephonically) and coordinated care delivered by teams of non-physician providers.

How will quality be defined with condition competition?
The power of fee-for-solution provider payment is that purchasers and payers do not mandate the methods of diagnosis and treatment. That is left to the provider and the patient. Here's how it works. A fee-for-solution claim requests payment for a condition. Therefore, diagnosis, clinical status, treatments, results and costs can be routinely and systematically captured and published in the course of filing claims. This would permit consumers to compare outcomes and costs based on different providers' approaches to care and the consumer's personal interpretation of quality. This would appropriately minimize the role of government or insurer as determiner of billable services and products.

ROLE OF INDIVIDUAL ACCOUNTABILITY

Isn't the real issue today the lack of individual accountability?

It's true that individual accountability is a hot topic today. It's often referred to as consumer-drive health care. Is it mere fad? Or is it a panacea? The answer probably lies somewhere in the middle.

We agree with the individual accountability advocates who argue that the health consumers should consider costs when making care decisions. Cost should be one factor in selecting providers and type of care itself, but should not deter individuals from seeking care altogether.

This is best achieved with "continuous cost-sharing": individuals pay a fixed percentage of all their medical bills up to an income-adjusted annual cap. In this way, individuals are encouraged to be mindful of their decisions while maintaining the financial security required.

For the actuaries among you, the technical description is as follows:

Most health insurance policies pair a low annual out-of-pocket maximum with a deductible and coinsurance. Consider a typical benefit design with a $1000 out-of-pocket maximum and 20% coinsurance. In this case the consumer is cost conscious through $5,000 of total spending: the consumer pays 20% of their costs through $5,000 of total health care spending after which the insurers pays 100%. But remember, the top 5% of spenders, who account for 55% of total health care costs, spend $25,330 or more per year.[1] That means that individuals in the top 5% of spenders will quickly exceed their $1,000 out-of-pocket maximum and enter a free zone. Therefore, coinsurance in current benefit designs primarily affects the 70% of consumers responsible for only 12% of the total spending. That makes no sense.

In contrast look at the scenario where the annual out-of-pocket maximum limit is set at 5% of gross family income. For a single person earning $70,000 per year, the annual out-of-pocket maximum limit will be $3500. Combining this with the co-insurance of 20% means that the member will be cost conscious through $17,500 in total spending. Even the top 5% of high spenders will experience co-insurance cost consciousness through most of their annual average spending of $25,330. By income adjusting, a single person with $100,000 annual income would have a maximum of $5,000 and be cost conscious through $25,000 in claims while an individual with $30,000 in annual income would have an annual maximum of $1500 and be cost conscious through $7500 in spending.

PRICING DYNAMICS

What's to prevent provider-set prices from floating up?

Consider the pricing dynamics when providers set their own fees for caring for a condition, the insurer pays a portion of the fee up to a market-set reference price, and consumers have an appropriate financial incentive. If we assume that there is no price collusion, providers will for the first time manage their price strategically. Providers that cannot command a supra-reference price based on superior results run the risk of losing market share if patients must pay the difference between their price and the reference price. Fear of supra-reference pricing prevents prices from floating up.

[1] M.Berk and A. Monheit, "Concentration of Health Care Expenditures Revisited," *Health Affairs,* (March/April 2001), corrected for inflation.

Even more fundamentally, the provider profit model will shift from production to margin based. Providers will now have the incentive to reduce their cost basis to position their price to maximize share and/or margin, an incentive that does not exist when prices are fixed.

How would providers be expected to incorporate costs beyond their control?
Clearly advantages will accrue to providers with superior cost basis. If there are authentic costs that all providers must incur, those costs will be reflected in all market prices and no particular advantage or disadvantage will accrue to any provider. However, provider organizations will for the first time question all costs, seeing them as opportunities for competitive advantage.

MEDICARE AND MEDICAID
Is condition competition applicable to Medicare and Medicaid?
Condition competition and its components establish incentives that maximize value for any health care dollar, be it public or private. Furthermore, public officials would find setting a reference percentile to be a far simpler budgeting tool than setting thousands of individual fees. Also, since public and private payers share the same providers, any progress toward condition competition by one payer sector would carryover to the others.

COMMERCIAL INSURANCE MARKET
What are the implications of condition competition for the commercial insurance market?
Providers and payers will negotiate the fee for a condition until there is a critical mass of participation at which time payers will phase in reference prices. During this early phase both payer and providers will gain experience with pricing and working a new set of incentives. Over time it is likely, that providers will settle on consistent prices for all payers to maintain a consistent market position.

Would this lead to new varieties of supplementary insurance?
We expect that all insurers will develop and evolve as they move away from being price fixers and price passers and become more market-makers. Insurers may see opportunity in providing supplementary insurance for bills that result from prices that exceed reference prices. However, health insurers will continue to actively coordinate benefits and protect against duplicate insurance and its impact on demand.

PROVIDER REACTION
How will providers respond to condition competition?
We suggest that past performance predicts future performance. Historically, physicians have not initiated health care reforms but have embraced them and then shaped them once purchaser demand convinced them that a particular change is inevitable. Condition competition opens a world of opportunity for not only physicians but also all other health care professionals and we believe they will again rise to the challenge and transform health care.