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An Updated Health Policy Role for State Government:

Redefine Competition to Maximize the Public's Value

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I. Introduction

Ladies and gentlemen of the Oregon Health Policy Commission, thank you for inviting us here today. We are physicians who spent much of the past decade co-founding two health care information technology companies. Since late 2002 we have devoted our efforts toward helping develop a modern health care system in Oregon. We spent over one year conducting research and analysis. We then developed that research into a ballot petition we called HealthOregon. While much of what we proposed in the ballot petition is clearly out of sync with Oregon's voters in 2004, our underlying premise is gaining currency among thought leaders. For example, the title article in the current issue of *Harvard Business Review* is an analysis of health care by Michael Porter that mirrors our findings to a word. So for today, while we share with you the hope for a far better health care system and harbor some big ideas about how to get there, we thought that we might best serve you by focusing on the big levers rather than on big ideas. The big levers are those seemingly small steps – perhaps they don't cost much and aren't headline stories – that pack a large potential positive result.

Today we specifically address the question 'How should we organize the delivery of health care to maximize the value for our health care dollar?' We do not address the question 'How should we finance our health care system to maximize access to care?' Needless to say, these questions are interdependent and we hope to have the opportunity to continue the discussion we begin today.

Our premise is that competition in health care today takes place over all the wrong things – lives, technologies and tasks – rather than over what we really care about, namely the effective and efficient prevention, diagnosis and treatment of our health conditions. We suggest that for policymakers working in an era of incrementalism, reshaping health care competition offers the largest return on investment. Without any new funds, and working within a relatively non-controversial, centrist concept of government, we can be on the way to getting far more value for our health care dollar for taxpayers, for the middle class with employer-based insurance, for those with public insurance and even for the uninsured. Our presentation will be divided into five sections: (1) we will first introduce the rationale for condition competition; (2) then we will describe the ingredients required for condition competition to thrive; (3) next we present the implications for stakeholders; (4) then we examine a case study; (5) and we

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conclude by proposing a policymaker's practical roadmap to condition competition.

For the sake of disclosure, let me state our private interests. We have neither operational nor governance connection with our previous companies. All of the material we present here was developed over the past year and a half on our own time and without compensation or financial support from any other parties. We have no proprietary interest in any of the concepts presented here.

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II. The Problem: Overview of Condition Competition

To us it seems self-evident that the fundamental economics of health care are driven at the level of conditions. In turn, the underlying costs, quality and health outcomes of health care occur between doctor and patient.

But if this doesn't ring true to you, call a stock broker and ask for a recent analysis of the health insurance industry. You will find that most insurers consistently consume 10% of premiums and pay out 90% in claims for physicians, hospitals, drugs and other services. In fact, the Wall Street analysts refer to insurers as "financial intermediaries" and often praise their business model of medical inflation trend arbitrage. In other words, insurers operate far from the care we care about. We must go to the source.

Let's think of ourselves as patients. All patients have three simple objectives: 1) to prevent conditions, 2) to diagnose our conditions, and 3) to resolve our conditions. Now, let's think about those medical bills we receive in the mail; they are for things like office visits, laboratory tests, consultations, x-rays and on and on. What are these items but mere tasks? What do our bills have to do with our health objectives? Well, nothing really. Everyone knows that we pay doctors and hospitals regardless of results, regardless of patient health. In this way, the health care enterprise operates like a business that pays employees to answer phones, type memos, make copies – not for solving clients' problems. And importantly, as long as we pay for tasks we will never ever be able to understand the relationship between care, costs and health.

We find ourselves in this predicament because as in all things, we do what we are paid to do. Incentives are the issue. Today's predominant provider payment method, fee-for-service, absolves providers of responsibility for cost and quality. As such, the power of competition is spoiled over trifles – amenities, location and baseless reputation. For a brief period in the 1990s capitation was a common payment method. In the lingo of the day, competition was over lives, and providers were rewarded for avoiding the sick and restraining treatment. Fee-for-service and capitation are extreme payment methods that create incentives that reward counterproductive behavior.

And to make matters worse, fee-for-service rates tend to be fixed by public insurers or are essentially fixed by private insurers through the use of market standard conversion factors. With fixed prices, providers have no incentive for reducing their cost basis to maximize market share and profits. The only way to maximize profits is through increasing output of tasks.

And by the way, a consequence of decoupling payment and results is that both sides often find themselves unpleasantly surprised by the bill and results – and find themselves in court.

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As patients we want to be aligned with our providers. We want them to be rewarded financially for what we want: to prevent, diagnose and treat our conditions. What we want is condition competition. We want providers to compete to demonstrate superior effectiveness at condition prevention, diagnosis and treatment. Policy analysts continue to be baffled at why physicians haven't adopted best practices and clinical information systems. They will do so – and do so aggressively on their own dime – when and only when they must organize to compete over conditions.

In light of the previous presentation, let me say a few words about the hypothesis that individual financial accountability is the best way to control costs and improve quality. Individual financial accountability has its place. But let's be explicit about its limits. First, the majority of costs will continue to be generated by a relatively small number of people who incur very high bills which will far exceed their ability to participate in sharing the costs, particularly for the large number of people with limited means. Therefore, the insurer's method of provider payment will remain the primary method for establishing provider incentives. Second, even advocates for greater individual financial accountability recognize that without a provider payment method that transmits price and quality signals, the individual has no means to evaluate and select care more judiciously, and providers have no incentive to modify their practices.

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III. A. Solution: Ingredients Condition Competition

Let's now consider the key ingredients for reshaping incentives to drive condition-based competition (Figure 1).

Market Competition Elements

Figure 1.

	TODAY	MARKET
Product	Fee-for-Service	Fee-for-Solution
Seller	Fee Schedule	Provider Set with Reference Price
Buyer	First dollar cost-sharing	Continuous cost-sharing
Information	Word-of-Mouth	Information Utility

The first and foremost ingredient is the need to begin paying providers for results rather than tasks. Since the condition is the epicenter of health care – it makes sense to pay based on conditions. We call such a payment fee-for-condition or fee-for-solution. In exchange for a fee-for-solution, a provider would be expected to deliver all the services and products required to diagnose and/or treat a condition. Examples include all the products and services required to diagnose and treat a slipped disc in the neck, including physician services, facilities – including inpatient and rehab – and home care, medications, physical therapy, radiology, and laboratory services. This is fee-for-solution: the solution being the comprehensive diagnosis and care of a condition across all care settings for a single fee. Compare this with the way the same condition is currently organized and paid for - by individual tasks (Figure 2).

Product

Figure 2.

FEE-FOR-SERVICE	
Service	***Allowed fee***
Office visit	$90
Cervical spine X ray	$70
Radiologist	$30
Cervical spine MRI	$660
Radiologist	$120
Neurosurgeon consult	$300
Physical therapist	$130
Total	**$1400**

➡

FEE-FOR-SOLUTION	
Diagnosis	***Price***
Cervical spine C6-C7 disc herniation	**$800**

Please note that the specific prices used in this example and all other examples in this presentation are strictly for demonstration purposes.

The second key ingredient for condition competition is market-set pricing (Figure 1). Today government and insurers equalize prices across the market. This absolves the provider of responsibility and locks them into a behavior of simply lobbying for a higher fee year after year. To enable the development of a mainstream market, providers must be accountable for both price and quality. This can only happen if providers send the market both price signals and quality signals. This means providers must set their own price. By letting providers set their own price, we force them to defend price increases with evidence of incremental increases in quality and health outcome.

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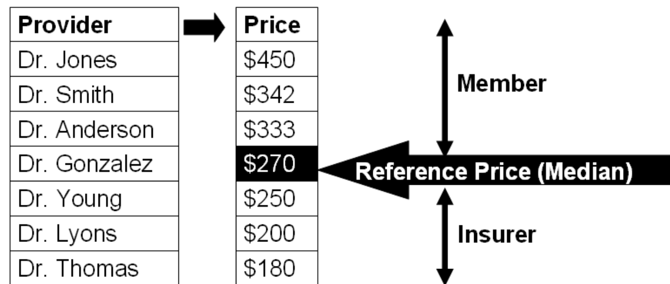
If providers set their own price, the risk holder would have unknown and unlimited liabilities. This wouldn't be sustainable. We advocate *reference pricing*. (Figure 3) Reference pricing is the concept of setting a maximum price which the insurer will pay and allowing the consumer to pay the difference to see a more expensive provider. It is the best way we have found to stimulate a mainstream market while still using insurance as the payer of most expenses. The reference price may be determined by the insurer or, as we advocate, the reference price can be set by the market at some percentile of all prices for a condition. In this case the reference price is set at the 50th percentile of all prices in the market. The insurer pays up to this price, but a consumer is at liberty to go to more expensive providers and pay the difference out of pocket.

Reference Pricing

Figure 3.



The third key ingredient (Figure 1) is transparent price and quality information. Readily accessible price and quality information controls inflation and stimulates quality by restraining unmerited price increases. Providers must justify price increases by demonstrating improved or superior results. Barriers to transparency are structural and cultural. Fee-for-service obscures price and quality and makes transparency nearly impossible. Furthermore, transparency is never voluntarily embraced by sellers. Sellers always go to great lengths to control their information. Health care providers are no exception. The health care industry has vigorously defended its control of information and resisted efforts at systematic measurement of performance. Providers will be able to effectively stem calls for transparency until payment is connected to clinical results, as it would be with fee-for-solution.

III. B. Solution: Condition Competition Implications for Stakeholders

Of course, for condition competition to emerge insurers and administrators must assume a new role. Whereas today's insurers are price passers or price fixers, they must become market makers. Some insurers are already beginning to make the transition. For example, we've recently heard insurer CEOs begin to speak of their companies as health care storefronts. While this is directionally right, they will soon confront a harsh reality. It's difficult enough to just pay claims at 10% of premiums. Wait till they try to bundle ten thousand codes into an unlimited set of clinical permutations in real time and then match them with currently non-existing clinical data. That's what it would take to create a consumer-relevant health care store under fee-for-service. So while insurers will understandably resist new claims methods, they will find that fee-for-condition represents massive code

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consolidation and therefore simplification. Furthermore, fee-for-condition is the only realistic way to capture and integrate payment and clinical data. Insurers are most likely to go down this path by maintaining fee-for-service payment for primary care and adopting fee-for-condition for the dozen chronic and acute conditions that account for half of health care costs.

The role of the consumer will also evolve with condition competition. Until now, purchasers have engaged in blunt and often counterproductive cost-shifting maneuvers like high deductibles. Since 90% of the costs are incurred by 10% of the population who incur high costs, it's more important to keep those individuals – the high spenders - engaged financially for as long as they can afford it by minimizing deductibles, applying a modest coinsurance and maximizing the coinsurance ceiling by adjusting it by ability to pay. This is "continuous cost-sharing" (Figure 1) and it is an authentic consumer incentive defining method as opposed to today's more common first dollar cost-sharing.

The implication of condition competition for providers is best expressed through an example.

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IV. Case Study: Condition Competition in Action

Let me tell you a story about medical care today compared with how behaviors would change if competition were based on conditions.

I am a physician at OHSU and part of my work involves the care of people with diabetes, one of the most common chronic diseases and among the most expensive to treat. I have done research and have helped implement a new approach to diabetic care that could have major advantages for patients. I am part of a practice focused solely on caring for diabetic patients. The practice is organized around a team of non-physician providers: a medical assistant checks the patient in, reviews the laboratories, does a focused physical exam; a pharmacist reviews the medications and makes changes based on protocols; a registered nurse provides diabetes-specific education including instruction in self-management; and a registered dietician provides diet and exercise instruction focused on weight control. I as the physician monitor the care through a database we invested in. And of course I am available for consultations. Electronic communications with the patients enable adjustments of medications and monitoring of sugar levels remotely. Research indicates that this system will dramatically improve the health of diabetics, reduce hospitalizations, reduce the need for intensive specialty care, and reduce the need for dialysis, laser eye surgery and even medications. Even apart from preventing complications, I can reduce the cost of caring for diabetics by eliminating physician visits and making use of automatic referrals and electronic communications.

This system as you already know will not be enthusiastically adopted. That is because I and my institution make money through office visits, hospitalizations, and operations. An increasing portion of my compensation is based essentially on the number of patients I see in a clinic session. In fact, if I don't physically see the patient, I lose the most lucrative part of the practice. In short, reducing costs disproportionately reduces my revenue and profit. There is no incentive to do this. When one is paid based on a unit output of service – in my case paid per office visit – there is no incentive to reduce the production of that visit.

Case

Figure 4.

PROFIT MODEL		
	Today	Fee-for-solution
Cost	$1000	$700
Price	$1200	$1000
Margin	$200	$300
Patients	1000	1250
Net	$200,000	$375,000

Now look what happens in a fee-for-solution system. (Figure 4) The "health care delivery organization" made up of physician, and hospital, laboratory, etc, is paid a fixed, lump-sum fee for providing all the care for diabetes for a patient over a period of time. Let's say that I can provide all that care for on average $1000 per year. And let's

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say the reference price is around $1200 and that is what I set my price at. Now the incentives are dramatically different. I now have a powerful incentive to lower my cost basis. If through the organizational changes I described, I lower my cost basis to $700 I increase my profit per patient from $200 to $500. Alternatively, I can now lower my price from $1200 to $1000 to maintain my profit and expand my market share. The difference is that I am now making money on the margin instead of the unit output. Now the advantage goes to providers who organize themselves to coordinate care to improve outcomes. The implications reverberate throughout the health care system. Consider technology adoption. Under fee-for-solution, technology would be adopted for one of two reasons: it either lowers the cost of delivering care or it improves the outcome measurably enough to merit a price increase. Compare this to today, where the criterion for technology adoption is simply whether a product has been approved for billing.

It is our conviction that if this system were applied state wide, it would restrain medical inflation and improve the quality of care.

The lesson here is that the payment and pricing mechanisms make the market, and everything else is probably supportive, secondary, or frankly peripheral. And until we address how providers – physicians, hospitals and others – are paid, I suspect that we are dealing with the peripheral.

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V. Plan: Policymaker Roadmap to Condition Competition

Our message to you today is that if Oregon is to have a modern health care system it must go to the source, the delivery of care itself, the doctor-patient environment. Now there are many reasons to avoid going to the source but unless we understand it, master it and shape it for the public good, what poses for reform is sound and fury signifying little. The care is it; it's where the quality, the costs and the health reside.

We are proposing that to get the care we want at prices we can afford, we must redirect private sector competition away from meaningless tasks and towards conditions, the epicenter of care. What we all really aspire towards is for that magnificent entrepreneurialism that uniquely characterizes American medicine to be re-channeled toward competition for superior prevention, diagnosis and treatment of conditions.

Our state government has an important role to play in bringing about this desired future. We call it "Operation Translucent Hand". It's neither laissez-faire nor big brother; it's more referee bearing carrots and sticks defining the rules of competition by refining supply and demand.

Let's consider the available demand-side approaches:
First, we should use the power of public purchasers, for example the Public Employees Benefit Board and Medicaid, to obtain:

- prospective price estimates for conditions and procedures for their members
- consolidated bills for a set of chronic conditions and complex procedures
- public transparency of price, experience and results for a set of chronic conditions and complex procedures down to the physician level

Public purchasers should also take the lead in provider payment reform by seeking insurers and administrators working with fee-for-solution provider payment.

Second, we could, through a Consumer Rights Bill, grant all health consumers the very same information rights I just stated. This would be a powerful stimulus to condition competition and may be worth considering. Other states are moving in this direction.

Let me just pause and make an editorial about transparency – a topic of great interest to all today. Transparency is always good. But we tend to conceive of blunt applications for it. Or else we moralize around it. Instead, let's use transparency very strategically, to not just understand *current* behavior but to shape *desired* behavior.

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The third demand-side approach would be for public purchasers to issue RFPs for health care delivery organizations willing to be paid fee-for-solution, particularly those capable of delivering care for chronic conditions and complex procedures.

From the supply-side perspective, we should foster competitive pressure on the existing delivery systems by inviting into the state existing delivery organizations that are focused centers of excellence for chronic conditions and complex procedures that are prepared to be paid fee-for-solution. These organizations are on the West Coast and elsewhere.

Lastly, we should support a controlled study of the care of common, complex, costly conditions provided by delivery organizations working within a condition competition framework versus those working under business as usual. This could be a useful tool to refine our market-making strategies and to strengthen the case for this approach.

In conclusion, by stimulating condition competition through Operation Translucent Hand, Oregon's leaders and policymakers would effectively bend the market to the public's will and do so in a way that would find wide bipartisan support.

Thank you.

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