# The Cash Market in Health Care: A Community-Based Approach

***Joy Anderson and Andrew Greenblatt***
*Criterion Ventures*

This article describes a new discovery in the health-care reform debate in America: the health-care market is not a single market. Rather, it is two markets, a dominant insurance market and a stunted, irrational cash market. The dysfunction of the cash market is an issue that affects all consumers in the health-care market but has a disproportionate impact on those in our society who are the most economically vulnerable. We also suggest a community-based approach to rationalizing the cash market intended to increase the value of the cash dollar in health care and thereby ensure access to services at appropriate prices and create the financial services that have an impact on the financial health of individuals and families.

The research and approach presented here comes from Criterion Ventures and the initiative, Healthcare_Uncovered, that we began four years ago to look at the costs of health care not covered by public programs or private insurance. Criterion Ventures is a firm that launches social ventures that respond to complex social systems. Supported in part by grants from the Rockefeller Foundation, we spent nine months in research and design and another year in feasibility and development of the launch of a new venture that facilitates a community-based approach to providing appropriate financial services in local health-care markets to increase the value of the dollar in the cash market of health care.

## Background

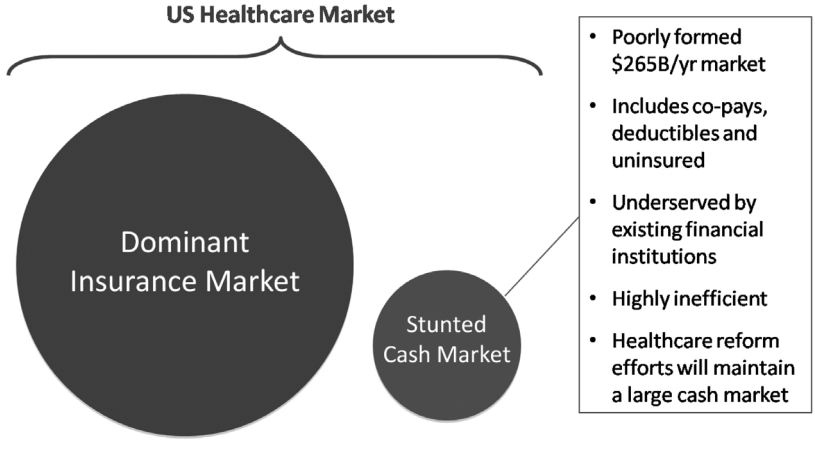
Cash expenditures have always been a component of health care, but it has been viewed as an "exception" to the broader insurance market rather than being effectively and efficiently developed into a market of its own. This has led to inefficiencies and unintended consequences that return less value per cash dollar spent on health care today with particularly detrimental impacts in poorer communities. We offer suggestions on how to create a more effective and efficient market and consider what impact this might have.

Hundreds of billions of dollars are changing hands outside private and public insurance, yet the systems and structures that manage these "uncovered" costs are relatively incomprehensible even to those inside health care. These out-of-pocket expenses are treated as an exception to the insurance market, which makes their tracking and management complex. Receivables management, bad debt, charity care, collection agencies, and health-care card services each represent systems of pricing and payments that add to this complexity.

For many Americans, particularly low-income families, these costs become debt. One in five Americans has medical debt; this debt is one of the leading contributors to bankruptcy, and it causes people to access health care late and in forms that are much more costly and disruptive to their lives, to providers, and to society as a whole. And medical debt is not just a problem of the uninsured. In a recent study by the Access Project, three out of five (62 percent) of all adults with medical bills or debt problems said they or their family members were insured at the time the debt was incurred.[1]

In the end, the players in the system treat the portion of health care paid outside public programs and private insurance as an exception to the norm, an aberration in an insurance-dominated market. And yet the exception represents 15 percent of the health-care market. In financial systems, exceptions create inefficiencies and friction and therefore cost more. However, they also represent market opportunities.

While dwarfed in comparison by the insurance market, the cash market in health care is large in absolute terms. It encompasses $265 billion paid out of pocket, $70 billion in unpaid bills, and $27 billion in alternative medicine and more.[2]




In many respects, the cash market in health care is irrational. It operates with dysfunctional and unbalanced intermediation largely because the insurance market dominates the health-care industry and intermediation was designed to serve insurance, not cash payers. In addition, the capital flows in the cash market are fragmented and complex, which leads to

1 R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, "Gaps in Health Insurance: An All American Problem," The Commonwealth Fund, April 2006.

2 Agency for Healthcare Research and Quality, 2003: HUhttp://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/state_expend/2003/table2.htmUH; The Commonwealth Fund, 2005: HUhttp://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876UH; The Access Project, 2006: HUhttp://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876UH H Institute of Medicine, 2005: HUhttp://www.iom.edu/CMS/3793/4829/24487.aspxU.H.

confusion and distrust of the system. Rational and efficient markets require common definitions, transparent practices, and greater information sharing, each of which is missing in the cash market for health care. Imagine walking out of a grocery store not knowing how much your food will cost. Instead, in the coming weeks and months, you received a flurry of bills from Kraft, the local baker, and others, along with another series of confusing letters prominently telling you that "this is not a bill." Go through that enough times and you might consider avoiding grocery stores all together. But when it comes to getting health care, people do not have a choice, so these inefficiencies, which would be appalling in more transparent and competitive markets, have festered.

A more effective cash market will increase the value of a dollar in the cash market, value defined ultimately in terms of both access to care generally and access to the appropriate care specifically. This value can be improved through decreased cost of financing, optimized intermediation, and competitive pricing. In addition, developing and executing the changes in the cash market will lead to new ideas and opportunities for reforming the entire health-care system.

## Characteristics of the Cash Market

The current cash market for health care is comprised of health-care bills not covered by either public or private insurance, excluding the costs of catastrophic care. This includes charity care and other expenses written off by providers as well as the bills actually paid by consumers. Large bills incurred for catastrophic care by the uninsured or underinsured should not be part of the cash market. They are better understood as a failure in the insurance market.

What does remain—primary care, urgent care, co-pays, and deductibles—is a market that is ill-formed, with opaque pricing structures, confusing billing, few helpful intermediaries, and few appropriate financing options.

**THE EFFECTS OF A POORLY FORMED MARKET**

| Poorly Formed Markets | | Well Formed Markets |
|---|---|---|
| ∆ High and erratic prices | → | ∆ Lower, consistent pricing |
| ∆ Lack of transparency | → | ∆ Transparency |
| ∆ Inefficient payment systems | → | ∆ Efficient payment systems |
| ∆ Inappropriate and expensive financing | → | ∆ Appropriate and reasonable financing |
| ∆ Lack of buyer-seller trust | → | ∆ Predictable buyer-seller behavior |
| ∆ Little innovation | → | ∆ Innovation can flourish |
| ∆ Weak attraction of workers | → | ∆ Workers attracted and retained |

Why don't we simply fix the systems that are creating the irrational cash market and work to limit or eliminate cash completely by advocating for a Canadian-style single-payer system? There are two answers. First, this change is not on the political horizon. The cash market is here and it is not going away any time soon. We write this article as Congress debates one of the most significant health care reform bills in recent history. As a whole, this is an insurance reform effort that will have an impact on the cash market but not eliminate the issue we describe here. Second, because of the nature of cash and the relative size of the payments, there is the possibility for innovation in pricing and payment mechanisms. As financial services push into the area of health care in the wake of the subprime mortgage crisis, we have a responsibility and an opportunity to define standards of practice that will sustain an effective, rather than predatory, market.

Understanding the cash market in health care requires an understanding of the overall capital flows. Funds to cover medical expenses incurred by consumers come from a variety of sources. Private insurance covers a significant portion, approximately $750 billion. Government subsidies, including Medicaid and Medicare, cover another $750 billion.[3] Hospital charity care and other philanthropic sources cover about $50 billion of the costs. The remaining $265 billion is paid by the patient.[4] This amount is either paid in cash, put on a credit card, or paid through other lines of credit.

In terms of the provider, cash flows into the system from two primary sources: insurance and patient receivables. Patient receivables can be broken into three sources: actual cash paid by the consumer or a credit institution, charity dollars or write-offs made by the provider, and debt or money still owed to the provider.

To better understand how these cash flows work, it is helpful to look at three market functions: (1) the pricing of goods and services, (2) delivery systems, and (3) financial services and intermediaries that support payments.

### *Price for the good or service*

A typical cash market includes immediacy in pricing and payment. Most of the capital flows in health care, however, are determined by prepayment to an insurance company (or to company reserves in the case of self-insurance) and then delays in subsequent payment to the providers. The insured pay a premium now for services in the future. The insurance company, in turn, employs a lengthy process of payment and adjudication that slows the outflows of cash. The time delays throughout this process stretch the transaction over months or years. What is not paid is often then dumped into the cash market. In contrast, typical cash markets, such as a grocery store, have payment at the time of the transaction

3 We believe government programs such as Medicaid can also be viewed as part of the cash market since the government is paying cash for services, not insuring against risk. This is analogous to food stamps, which are rightly considered part of the cash market for food.

4 http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

and therefore require clear pricing and on-the-spot-payment systems. Hospitals and other providers are moving toward collecting payments as the patient enters the building–in other words, up front, before the service is provided, reflecting these more traditional cash-market transactions.

In the health-care industry, there is not a single price for a service, nor is it clear what percentage of the price the consumer will be responsible for. Rather, the consumer experiences multiple types of payments–premiums, co-pays, deductibles–all for a single medical event. This fractured system makes it difficult to understand costs, to plan for expenses, and to make informed decisions about care. Currently, it is difficult to understand (or even see) the cash market because it is often scattered in bits and pieces across the insurance market. Because the cash market in health care is so opaque, the consumer is almost always confused or uncertain about the amount he or she will be responsible for paying.

### *Delivery systems that respond to price and create access*

Insurance companies use a number of methods to increase patient responsibility (deductibles, co-pays) as a means to cut down on utilization. The theory is that when there is no patient responsibility, the patient tends to overuse or misuse the system. As intended, the result is decreased use of the system. Unfortunately, in many cases this decrease has gone too far or come in the wrong places. People are not accessing health care when they legitimately need it because of the cost barriers. This often leads to more dire consequences that ultimately result in costlier interventions down the road.

New systems are beginning to emerge that more effectively respond to the needs of the cash market. For example, the rise of urgent care offices (sometimes called a "Doc-in-a-Box") in Wal-Mart or in storefronts reflects this trend. These settings offer lower-priced care for basic services with transparent pricing and payment systems. They cannot and should not offer more expensive catastrophic care, but by offering services such as flu shots and strep-throat tests, they can perform an appropriate service in the cash market.

One goal of creating an effective cash market is to make sure consumers have access to the most appropriate care they need at any given time. For example, consumers should stop seeking primary care in emergency departments (where at least they can be assured access to care) and seek clinics that specialize in this type of service. Many local governments have set up these kinds of clinics in the hope of catching patients before they end up in an emergency department, but there are significant limits on this delivery system. While consumers can access primary care for little or no cost at these clinics, they usually cannot get access to diagnostics and specialized care without making large cash payments.

### *Financial services and intermediaries that support payments*

Today, consumers have several choices to cover out-of-pocket medical costs, including credit cards, health finance cards, health savings accounts, and flexible savings accounts. These payment options vary in their costs and complexity to the consumer in accessing

them, making them more or less effective. They also tap various sources of capital. For example, GE has provided over $5 billion in direct financing to consumers to help them cover their medical expenses. In the end, financing medical costs is big business, and our discussions with financial services and capital-market participants suggest that investors are looking for ways to get into this market in a larger way.

An essential element to a more effective cash market will be more effective forms of intermediation that go beyond what is available today. These new intermediaries will need to bring capital to bear at rates consumers can afford, which may mean finding ways to adjust risk downward through the use of subsidies, risk pooling, etc. New intermediaries also will be able to provide financial services that link savings options to credit offerings and that aggregate buying power to negotiate transparent prices that are lower and billing systems that cut through the current opacity in the system.

## Social Consequences of the Current Cash Market

The irrationality and inefficiency of the cash market have significant social consequences. It affects one's ability to seek appropriate care, and it drives the delivery of service and the financial incentives of the system. For instance, with the lack of payment structures set up between primary-care facilities and specialists, patients often find themselves utterly mystified about costs when seeking a specialist. By creating a cash market with transparent pricing and billing that utilizes appropriate delivery systems and offers consumers effective financing and payment systems, we will be able to lower the overall cost of care within the cash market. This will not only save consumers and providers money but will allow greater access to care overall. The current system leads to dangerous and expensive delays in seeking care, as shown by statistics from a Kaiser Family Foundation report, "Medicaid Debt and Access to Health Care":[5]

- Those with medical debt are more than twice as likely to report being in only fair or poor health, and they are almost twice as likely to have an ongoing or serious health problem compared to others with private coverage (38 percent vs. 21 percent);
- Those who were privately insured but were also carrying medical debt were more than twice as likely to have failed to fill a drug prescription due to cost (24 percent vs. 9 percent; 27 percent for the uninsured);
- Those who were privately insured but were also carrying medical debt were four times more likely to postpone care due to cost (28 percent vs. 6 percent; 29 percent for the uninsured).

An alarmingly high proportion–59 percent–of uninsured adults who had a chronic illness, such as diabetes or asthma, did not fill a prescription or skipped their medications

5 KFF, 2005: HUhttp://www.kff.org/uninsured/upload/Medicaid-Debt-and-Access-to-Health-Care-Report.pdfU.H.

because they could not afford them.[6]

To illustrate how the cash market touches all parts of the health-care industry and crosses social strata, we profiled the following iconic groups: undocumented workers, seniors on Medicare, middle-class workers with a large employer, small businesses and their employees, and low-income wage earners (part-time and full-time). Below, we look at the particularities of the impact of the cash market on these iconic groups:

**Undocumented workers** have a hard time accessing care in the current health-care system. These workers do not have social security numbers and fear contact with government officials. Thus, they have little to no access to the systems of public and private insurance. Many have cash and are willing to pay for their health care. However, they encounter provider systems ill-equipped to handle noninsurance payments, and they end up paying much more for their treatment than an insured person would.

**Seniors on Medicare** have experienced increased out-of-pocket expenses with the passage of Medicare Part D in addition to their premiums and deductibles, which continue to rise. In fact, nearly a quarter (23 percent) of the elderly Medicare population faced financial burdens from health care exceeding 20 percent of their income.[7] Supplemental insurance is expensive and still entails deductibles and co-pays.

**Middle-class workers** are faced with more out-of-pocket expenses as their employers shift to higher-deductible plans to offset increasing health-care costs. With higher deductibles, family medical expenses add up quickly, particularly if there is some sort of medical event, even if it is minor. As bills mount, the patient becomes embarrassed to go to the doctor for follow-up or additional care. The embarrassment of having unpaid bills impedes access to care.

**Small businesses** are crumbling under increased demands not only to provide health insurance but also to shoulder more of the financial burden through new cost-sharing benefit structures. Importantly, many small business owners and their employees are uninsured. For the small businesses that provide health insurance to employees, they pay more for their health care simply because they lack the buying power that larger employers have.[8]

**Low-income wage earners** often cannot afford their co-pays and premiums. Further, many low-income workers are part-time and therefore do not have access to insurance. Without insurance, it is difficult to maintain a relationship with a primary care doctor. This population is reliant on health clinics, which often are not available or, in many communities, are inferior. In addition, because low-income wage earners

6 Commonwealth Fund, 2006: HUhttp://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876U.

7 KFF, 2005.

8 National Conference of State Legislatures, 2008.

live paycheck to paycheck, their cash flow cannot handle unpredictable events (i.e., someone suddenly gets sick and needs care). Because of the lack of relationships with primary care providers and often the lack of health-care clinics, they end up in the emergency room for treatment that would be more appropriately handled elsewhere.

The cash market is here to stay and is growing in scope and impact within the broader health-care industry. The social impact of the practices in this market are measured in terms of access to appropriate health care and the impact of those costs on the overall stability of an individual's financial well-being. In the end, the cash market has a disproportionate impact on those most vulnerable within our society. Therefore, any efforts to ensure universal access to health care need to address the products and practices that shape this market.

## A Community-Based Approach to Building a More Rational Cash Market

New markets are constantly emerging and being rationalized. Some may arise as a result of government action, such as the creation of carbon credits in Europe. Others arise from the introduction of a new technology, such as online advertising. Still others coalesce when new standards, benchmarks, and rating systems emerge in existing markets, such as the introduction of standard ratings for corporate bonds, which created a thriving commercial paper market.

Rationalizing the cash market for health care will similarly take the introduction of new products, services, and other innovations. Some of this work will need to take place nationally. But since health-care markets are currently very local in nature, much of the work needed to shape these markets will have to happen locally.

First, at the national level, thought leaders will need to introduce common ideas and even definitions to discuss this market. Second, common models for distribution of services will also need to coalesce at a national level, though implementation will probably need to stay local for the foreseeable future. Third, consumers will need support as they begin to navigate this newly invigorated market.

Criterion's market analysis led us to community-based innovations that can help shape a well-functioning cash market and therefore increase the value of the cash dollar in health care. If the cash dollar carries more weight, we will be able to shape delivery systems to increase access to primary care, in particular through aggregate buying power to shift pricing patterns and strip out costs associated with current inefficiencies. This effort will ease the financial burden on cash payers for health care and increase their access to quality health care—all with existing funds. Individual arrangements are made with each provider system, and care is sought in one's own community. For the most part, it is not a global market in that one cannot go online and order health care from any provider. Health service requires face-to-face contact and thus must happen locally. Further, provider systems tend to be local, from the smallest doctor's office to city-based hospital chains. There are a few large regional providers, such as Tenet Healthcare, but no dominant national brands.

Because of the need to build the kind of power needed to have an impact on the current

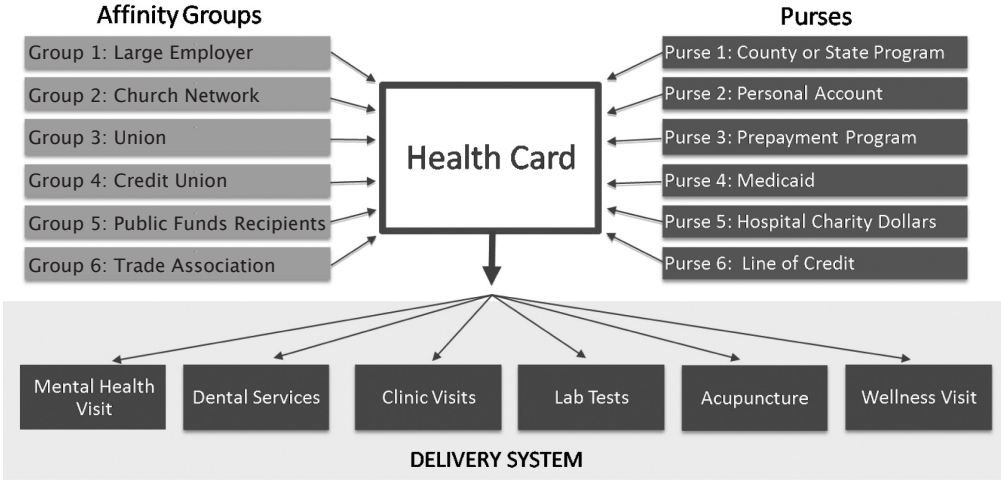
dysfunctional cash market, the solution cannot be to target products and services that will be made available one consumer at a time. Rather, we must use existing affinity groups (like church networks or unions) as a way to build power, and be able to negotiate with the large local health-care providers who currently dictate the nature and price of health-care delivery.

Criterion has been experimenting with introducing a new suite of financial products and services into communities as part of the project we call Healthcare_Uncovered. We use these cutting-edge financial services to organize the existing assets within a community. Behind this product offering is a sophisticated rules engine that can be tied to a standard VISA debit card. This rules engine allows us to tie a single card to different accounts. The rules engine then draws from each of these different accounts at the appropriate time depending on where the consumer is and what they are using the card for. For example, a visit to an asthma specialist may be paid for out of an account the local county has established to serve children with asthma, while a dentist's appointment would come out of the card holder's Health Savings Account. Other accounts on a single card might include an employer-sponsored fund, a union trust, or a philanthropic program. Healthcare_Uncovered is designed to sustain itself by charging small monthly fees to the cardholder (or other sponsors of the card) and by receiving small transaction fees every time the card is used.

A card-based electronic payment services platform with a rules engine allows for access to multiple funding allocations, or "purses," with funder-defined eligibility requirements. The solution relies on existing infrastructure and processes by moving transactions through VISA or MasterCard debit systems to providers, thus allowing for swift implementation and impact. With the first program in a community, we create a platform for capital, access to that capital, and dignity to those in need.

**BUILDING THE CASH MARKET**

**Community organizing to set up purses and identify affinity groups for the health card**



Over time we will be able to aggregate the work we are doing with each affinity group in the community to bring about larger changes to the local health-care system. We will be able to use the combined buying power to tie consumers and providers together into a "cash network" similar to the preferred provider networks currently in place in the insurance market. This network will create the foundation needed for transformational changes. Within this network we will be able to negotiate lower prices, have a rational billing system, and provide appropriate access to care. To achieve this level of influence over the market, we will need to organize consumers across the economic spectrum, but our intent is to have the greatest impact on the lives of lower-income workers. If we organized only these consumers, however, we would, ironically, fail to reach the scale needed to help them since they represent a minority of any community's population and have a disproportionately low portion of the local buying power.

As we work around the country, standards for the market will emerge in various localities as different entities adopt and adapt products and adjust to operating in the cash market. However, these standards will need to be integrated and disseminated broadly. While driven at the local level, there is a need to deliver a coherent message and standardization across the emerging network to make the cash market less frightening and more recognizable and integrate solutions into national reform efforts.

### *Naming the cash market in the local health-care economy*

We have engaged with dozens of counties, municipalities, and state health-care leaders to test a process of dialogue and organizing. We began with an initial field trip that was designed to identify issues and opportunities and provide a context in which we can meet the key players already working to improve health outcomes for the community. We work with trusted connectors to reach out to the major health-care stakeholders in a given city or region to see what problems they face and what resources are at hand.

Organizing and shaping the cash market within a community requires the cooperation of multiple actors, including large health-care delivery systems, banking institutions, government funders, employers and other affinity groups, philanthropic institutions, and small providers. Each actor has a role to play in the market. Some, like small providers, may simply need to accept a more transparent form of receiving payment from patients. Others, like government funders, may be called on to use their might as a single large cash payer to support new initiatives that create platforms that reduce market fragmentation.

The first step in creating an effective cash market in a community is to properly name the problem and identify a vision for the future. Few actors within the cash market even recognize its existence as a separate market, yet when it is properly named they tend to have that "ah ha!" moment that leads them to want to engage quickly and collectively. By giving this hidden market a name, we frame the problem in a way that each player can connect to, giving them a way to understand their role and identify the common problem from which their individual challenges emerge. Having this common name creates initial cohesion and

affiliation among all the various and often disparate players in the market we are building.

For some, naming the problem and the vision for the future leads to skepticism. The problem seems too big to tackle. Others, however, see the potential of trying entirely new strategies to solve problems they have struggled with for decades.

Naming a big goal up front enables actors who at times see their work as quite different to understand a broader picture and creates a way to discuss the impact a well-formed cash market could have on all of their work. For instance, providers can see the cost savings to their system by working in a market where consumers pay on the spot in an efficient manner. Funders see new efficiencies in making payments using systems and intermediaries designed to handle cash payments and the new ability to experiment this would create. Banking institutions see a new role in the health-care market aligned with their core skills of moving and managing funds.[9] Customers see the benefits of clear negotiated prices and an easy way to pay them.

Identifying the cash market in a community allows these disparate players to see their role in the current cash market and how working collectively to reform that market would serve them while also serving the larger community. Creating this shared vision is a time-consuming up-front effort, but it is crucial to the success of the project. We achieve this naming portion of the process through written documents defining the cash market, one-on-one and in community meetings, and engagement of thought leaders and other validators within the community who serve as respected emissaries. This initial naming phase builds awareness of the cash market, engages key players and stakeholders by illuminating their role in the cash market, and reveals potential elegant starting points in creating the nexus of the organized system.

### *Map the assets, relationships, and challenges within a community*

As we enter a community, we map the existing assets, relationships, and challenges relating to the cash market. Health-care delivery in the United States is very localized and each community has a different set of experiences. Common to them all, however, is the fact there is already a cash market in place, though it may be poorly formed and opaque. Bringing the key players together to describe their experiences allows us to map out how the cash market functions in a particular community. To understand this, we seek answers to the following key questions:

- What are the key health-care delivery systems within a community that often define the market? Some communities are dominated by one or two large hospital systems that control enough of the market that a change in the way they handle the cash market could define that market. In many localities, the local government plays an

9 Banks currently tend only to offer products like Health Savings Accounts that react to the insurance market. A few banks see the cash market as a new field where they can offer unique products designed specifically to serve that market.

enormous role in funding small dollar medical care. We have also found that poorer communities tend to have a disproportionate share of the cash market due to a high percentage of people with no insurance or insurance with high deductibles and co-pays. Providers tend to shun these markets, flocking instead to wealthier neighborhoods and the relative security of the insurance market, where they feel they have a better chance of getting paid.

- What are the key financial assets supporting the cash market? Government and philanthropic funders tend to play the lead roles in terms of organized resources to support the cash market. But a large percentage of cash market transactions happen between small providers and individuals and are not tied together in any formal way. This atomization of the cash market disempowers these purchasers and creates the inverse of a typical market, where a cash buyer is more coveted and powerful.
- What are the relationships among the key players? Most communities have been struggling with ways to deliver better health care for decades. These projects have created common tables bringing together government, for-profit providers, nonprofit providers, philanthropies, and the faith community. These points of connection have created trust relationships that can smooth the way as key actors work together to create a local cash market.

Once the initial systems map is created, we can ascertain the key leverage points that can be used to move the larger system. For example, a robust local government health system may be leveraged to create a payment system on a platform that it could open up to the broader community, tying cash payers together and building a rational market. Alternatively, a dominant private system might be in place that could play the same role.

The act of creating the systems map of the local cash market illuminates new possibilities and affects the goals first described in the naming exercise.

### *Invitation*

Both naming and mapping require a third task: an effective invitation process. Organizing a new cash market requires powerful players to sign on to the mission and agree to take particular steps. This may mean accepting lower fees in exchange for ease and guarantee of payment, using the power of pools of money a funder controls to link together affinity groups, or a bank offering a set of financial processing tools that the local community can draw on.

Bringing these key players together requires a local presence respected within the community. This must be someone who has the ability to navigate between disparate and often competing organizations while maintaining the respect of each one. The individual must be trusted to bring in good ideas and use their time effectively. This role can be played by a leader in government, a powerful executive in the health-care sector, a visionary nonprofit leader, or a respected academic. This role can almost never be played by an outsider.

It is important to understand that the invitation is not just to come and listen, but to come and be a part of creating something new. Each participant brings his or her own assets, relationships, and insights to the table. Participants will be moved to action only when they feel their voice will matter, that they can make a difference, and that they share in the desired outcomes they help create. Furthermore, this is the only group of people who can create a local cash market. No outside actor will have the depth of knowledge or the persuasive power to force the necessary changes.

As the process continues, the importance of early genuine invitation becomes more important. Partners in social enterprises often find quick alignment in visions and goals. All parties want to see a social problem solved, a pain alleviated, or funds created. As the enterprise develops and faces choices, however, more subtle differences in motivations and priorities surface, forcing partners to compromise and challenging communications and cohesion. In creating a cash market in health care, these differences usually arise over questions of who will add new money to the system. All agree that a well-functioning system tomorrow will save all actors money tomorrow. But today some actors need to take the first steps to build the market.

For example, a community may see the benefit of having a single system in place that ties together health-related checking and savings accounts and allows providers to draw from those accounts using debit card technology. When a critical mass of the local community uses the system, all the participants benefit. Providers get a quick and easy method of payment, consumers have a reliable way to tie together the myriad public and private programs they may qualify for to augment their own savings, and funders have a cost-efficient way to roll out their programs and connect to consumers.

In a classic market-formation dilemma, difficulties arise in attracting early adopters. Banking institutions may not want to offer the products that few people are using. Providers may not want to go through the administrative hurdles of accepting a form of payment few customers will be using, and consumers may not bother signing up for a card that few doctors accept. In all of this is a free-rider problem: all of this will be cheaper and easier for me to adopt after enough other people have already signed up and taken the initial risk.

Effective invitation early in the process helps deal with the early adopter problem. If key actors feel genuine ownership of the process and understand the long-term value of the early, costlier steps, they will be more likely to take them. Having key leaders work in concert can also shorten the time needed to get through the early stages. To secure early adopters, players should work together through invitation to create an incremental approach. The objective is to minimize risk and up-front capital requirements by establishing a broader dynamic network that can grow and yield additional benefits from scale.

### *Execute through a network to shape a market*

Achieving the vision of an efficient market requires getting disparate actors within communities to work together to create a dynamic and interconnected network of relation-

ships. The process mitigates implementation risk by establishing initial connections among players that will deliver immediate benefit to participating community members and establish a nexus for expanding the network, which achieves additional benefits through scale.

In the end, this entire process will only be as successful as the final execution. Market formation is an arduous process that requires managing relationships and assets over time. In a given community, this will mean rolling out an intermediation that is rapidly adopted by the key players within that community. Getting this done will require a certain stamina and willingness to deal with uncertainty among all the players. The rationalization of the market itself will create new problems and new opportunities.

One key to successful execution will be to find a durable source of revenue during the early period. Eventually the cash market needs to find a new, more efficient equilibrium that can sustain itself. But the period before then will see the creation of new entities designed for the coming market but struggling to survive in the existing one. An infusion of capital will be required, either in the form of philanthropic support or risk capital.

Over time the market will become more rational and disparate players will shift their roles to take advantage of new opportunities. Lower prices, greater ease and efficiency, and increased predictability will entice more actors to join this market.

## The Impact of Intervention

If the cash market for health care is rationalized, we believe costs to consumers and providers will decrease, the value of the cash dollars spent in health care will increase, and coverage for those most in need will expand.

As with any new venture, an influx of capital is needed to jumpstart development and implementation. With an influx of capital, innovative products can be developed and introduced, providing increased definition to the market. New products will create a demand that will increase the sense of possibility within the health-care system of what can happen inside the cash market as opposed to the insurance market. As products that address this opportunity become available and as more affinity groups organize themselves to make use of these products, the market will become more defined.

We can look to the insurance market in health care and other established markets to imagine what a well-formed cash market in health care could bring. Bringing consumers together into large buying pools could allow them to leverage their buying power to negotiate lower prices and press for more appropriate delivery systems. Providers, attracted to a better functioning market and the ease of payment it brings, will offer new services in neighborhoods they previously shunned. Financial and government institutions will see this new market as a fresh place to innovate as they look for new business or try to find new ways to reform the health-care system.

Over time and through replication, the market will standardize. Standardization of the market will enable it to scale up to a national level. At such a scale, a broad impact on access to appropriate health care, the cost of health care, and health outcomes is possible. As this

impact becomes visible, more investors will contribute capital to the products and services that enable the market to function efficiently.

As the cash market becomes increasingly recognized and acknowledged, a paradigm shift will occur. The cash market will no longer be treated as an exception to the insurance market but rather as a separate functioning entity with its own operating procedures. With this paradigm shift in how people view health care will come corresponding policy changes, which in turn will increase the scale of the impact.

Rationalizing the cash market could have unintended consequences. The most obvious is that this market could expand, caused by employers' simply shifting more of the health care cost burden onto employees. We believe, however, that the opposite will happen: by making the cash market more manageable, employers and others will be more likely to help consumers deal with the cash portion of health care by offering subsidies and services that complement their insurance offering. It is also important to note that if the cash market expanded because it offered cheaper and more appropriate care, patients would benefit. The question of whether a larger cash market is good or bad depends on who pays, not on the value of the dollar spent. More value is always better; using that increased value as an excuse to shift the burden is not.

As with any large reform program or any new market, unforeseen consequences will arise. We and others will need to monitor these changes closely as we move forward. The potential for unintended consequences should not paralyze us. If the cash market is not rationalized and it remains an exception to the insurance market, then the current issues surrounding transparency, financing, and overall value of the cash market will only get worse. Consumers will be continually saddled with various and differing forms of medical expenses. They will continue to be unaware of costs and what financial situations they might be getting into as a result of a medical condition. And we know from current studies that financial hardship limits people's access to care.

## Conclusion

The market for health care in the United States is actually two markets: a dominant insurance market and a stunted cash market. Treated as an exception to the insurance market, the cash market is ill formed with opaque pricing structures, confusing billing, few helpful intermediaries, and few appropriate financing options.

The inefficiencies of the cash market are highlighted by looking at three features: how services are priced, how prices affect the delivery system, and the financial services that intermediate the process of payment. Currently the consumer is faced with a fragmented and opaque pricing system (co-pays, deductibles, stop-losses), which is a result of intense negotiations between insurance companies and providers. The resulting fractured pricing system, however, makes it difficult for the consumer to understand costs, to plan for expenses, and to make informed decisions about care. These results have a disproportionate impact on those most vulnerable in our communities, those disenfranchised from

banking services, unable to access insurance, and ineligible for the cost savings created through bulk purchasing agreements.

By creating a cash market with transparent pricing and billing that uses appropriate delivery systems and offers consumers effective financing and payment options, we will be able to lower the overall cost of care within the cash market. This will not only save consumers and providers money but also will allow for greater access to care overall.

To rationalize the cash market, action will be necessary across many local areas because the local level is where health care takes place. The work of local groups will be important as a way to manage risk, build power, and negotiate. Working at the local level will require organizing a broad array of individuals who bring with them their own assets and relationships. By rationalizing the cash market for health care, we will be able to increase the value of the cash dollar, empower consumers to make wiser choices, and lay the groundwork to support new and innovative delivery systems.

*Joy Anderson is the president and founder of Criterion Ventures and a founder of Good Capital. Criterion's venture work is currently focused on the development of solutions to help form and rationalize the cash market in health care, an effort funded by the Rockefeller Foundation. Joy holds a BA from Wesleyan University and a PhD in American History from New York University.*

*Andrew Greenblatt is the director of products and innovation at Criterion Ventures. He has started numerous social ventures, including Pride Diamonds and a real estate holding company that works with charities. He graduated cum laude from Harvard Law School and is an adjunct assistant professor at NYU's Wagner School of Public Service.*