Setting the Fair Price Standard

Surviving Healthcare in America:

Bending The Will Of The System Without Breaking The Spirit Of Providers

For America's healthcare system to earn the trust of all Americans, it must improve outcomes by lowering the total cost of care and improving the patient experience. Redesign the profit model and the system could heal itself.

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Executive Overview

America's healthcare model was designed to get us exactly where we are.

Congressional actions have supported the 'more is better' American spirit, serving consumers by solving access to coverage, removing pre-existing exclusions, and eliminating claim maximums. These are responsible actions for our society as a whole and good for consumers. But because those with the authority to set prices did not accept the responsibility to price fairly, prices became inconsistent, escalating costs unnecessarily. According to JAMA, this lack of accountability led to waste in price abuse, fraud, and unnecessary care.

Did any good come of this spend? Of course, but the point is that the U.S. built a system that drives profit using the same strategy as every other industry; grow revenue to grow profit. In healthcare, the checks and balances in this formula do not apply because the user (patient) and authorizer (physician) are uninformed of cost and not the ones paying the real cost.

Employers and their people have absorbed the brunt financially, paying what the law required and more, passing on the balance to their people. Yet over the past decade, research from multiple sources shows employee costs increasing at 300% of median wages(1). Other burdens are piling up as well:

1. **Medical debt**: Up to 100 million American's have accumulated up to $1 trillion in medical debt involving 57% of households, making it the leading cause of personal bankruptcy (2)
2. **Chronic Conditions**: A record 60% of Americans now have one or more chronic conditions (3)
3. **Life expectancy**: Twenty-five years of gains have been lost, rolling it back to age 76 (4)

Employers and their people are paying more, and getting less in many aspects of healthcare.

Congress will not intervene substantively. The economic conflicts between costs and benefits are simply too politically conflicted to untangle in today's polarized environment. Further, low Medicare and Medicaid payments have caused so much cost shifting to employers that moving people to Medicare would devastate either the Medicare fund or the hospital systems depending on which took the hit.

What the healthcare system is gradually accepting is that it can heal itself - improving the healthcare experience for the plan member and lowering the total cost of care if the profit model can shift from volume-based revenue to outcome-based revenue. This is the message of Value Based Care (VBC). But the forces holding it back are as strong as the ones moving it forward. It is an epic battle that will last a decade and touch every American.

Nonetheless, change is coming. Years of testing outcome-based payments have encouraged the market. While value is inconsistent, VBC is being positioned to become the force driving cost, unleashing dramatic corporate restructuring and consolidation within the industry. Profit shifting is an inevitable result. The M&A activity in the past five years is revealing this transition and it has only just begun. The worry of the commercial market is that VBC simply becomes a curtain hiding yet another profit center.

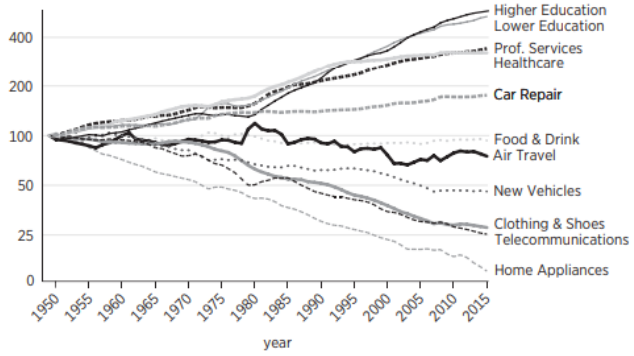
Physicians are at the center of all healthcare because nothing happens until they authorize it. Knowing how their decisions influence the total cost of care is vital to controlling costs. And nowhere is that influence more significant to the cost of claims than in the selection of healthcare facilities. Those decisions are made every day, not just on the annual renewal. Actions to influence those decisions begin with understanding price variability.

The Question

Is the U.S getting enough value from its $4.1 trillion healthcare spend to justify the 19% of GDP cost(5)?

According to JAMA, the U.S. spends almost $1 trillion too much (6) and many countries spend far less as a percentage of GDP and have lower chronic care costs and higher life expectancy. But there is more to this story. As nations prosper the share of GDP spent on healthcare also increases (see graphics and text boxes below). The Baumol Effect(7) explains the limitations of productivity, leading to why inefficiency occurs naturally as societies prosper. For the U.S. healthcare system to overcome this affect, productivity measurements – and financial models - must change from rewarding utilization to improving outcomes that include a better member experience and a lower total cost of care.

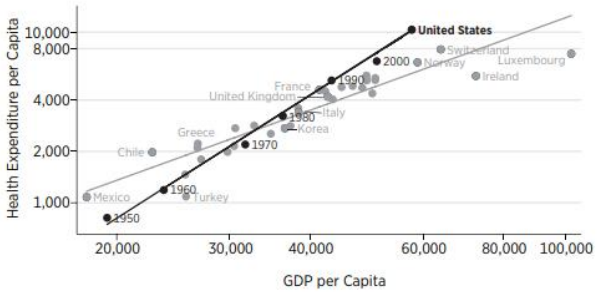
Figure 1. The Real Price of Selected Goods and Services, 1950–2016



Note: Prices normalized to 100 in 1950. Ratio scale.
Source: Bureau of Economic Analysis (BEA), "National Income and Product Accounts."

The Baumol Effect happens in industries such as education and healthcare when real costs go up, but productivity does not increase. For example, physicians can only see so many patients in a day, while automation has increased output for other products and services. Consider a concert. There has been no productivity gain when measuring how long any choir takes to sing Handel's Halleluiah Chorus for nearly 300 years. The gain is in how many people can hear it at once.

Figure 17. Health Expenditures per Capita against GDP per Capita



Note: This figure uses a log-log scale. Lines of best fit indicate that a 1 percent increase in GDP per captia increases health expenditures per capita by approximately 1.4 percent outside the United States (see gray line) and by 2.4 percent in the United States (see black line). Not all countries are labeled. GDP = gross domestic product.
Source: Organisation for Economic Co-operation and Development (OECD), Health Expenditure Financing: Health Expenditure Indicators (dataset), accessed March 19, 2017, https://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics_health-data-en; based on Kaiser Family Foundation Health System Tracker.

Health expenditures are highest in the U.S. However, this graphic shows the similarity of health expenditures in other countries when their GDP per capita is equal to that of the U.S. in a previous year. When America's GDP per capita was $38,000 the U.S. spent the same percentage of its GDP on healthcare as Italy does now – with its GDP roughly the same. As nations prosper, they all spend more on care. That does not make it right, but it does establish similarities.

The Baumol Effect Is Not Excuse – It Is A Warning

Physicians can only treat so many patients in a day, so productivity does not improve in the traditional one-on-one healthcare experience. Gains have to come from previously unmeasured value. Are we healthier? Do we live longer? Has our quality of life improved? These measurements either justify cost increases or force us to realize our system is faltering. The U.S. healthcare system has to accept outcome responsibility if it is to improve productivity.

How We Got Here

We did not intend to, but when the U.S. built a 'fee for service' system rather than an outcome-based system, utilization patterns and risk finance were both set in stone. The commercial healthcare market has tried to stop the escalation ever since, including offering 'skin in the game' solutions like HSA's whose balances now exceed $100 billion. But these do more for high income healthy participants than for modest income chronic care plan members who often have unmet routine needs that result in high-cost procedures, according to VOYA research(8).

Providers do not control cost since their clinical work is done in a price vacuum. Making decisions on cost alone is clearly inappropriate, but the pendulum is now so far to one end that cost relative to benefit is often ignored. Movements to "bundled pricing" for episodic care and transparency notwithstanding, cost blindness is still the rule.

This is not to diminish other obstacles to lowering the cost of care. Structural issues such as social determinants of health, high consumer demand, increasing chronic conditions, abusive price escalations, and inconsistent patient care management have further complicated healthcare. The moral code itself is deteriorating to the point of abdication, with invoices asserting "if they pay it, it must be ethical." All of these examples are by-products of a broken profit model.

What brought us to this costly place of little restraint and mixed patient experience cannot be solved by the current system, nor will going back to exclusions and limitations improve outcomes. Returning to inequity, poor quality, and ultimately higher cost should not be acceptable.

How We Get Where We Need To Go

Recent models are testing the system. Solutions such as bundled services, transparency services, direct contracts, narrow networks, and referenced based pricing have all had some success, along with some disfavor. But to scale solutions going forward, employer plans must change payment methods so that new opportunities are not starved to feed legacy problems. The competing need for profit, a lower total cost of care, and a better patient experience must find a way to align for the greater good.

Capital seeks yield, balanced by the risk taken to achieve it. To attract the capital healthcare changes will require, a market yield will be needed. Most M&A activity is based on consolidation that raises revenue, improving operating efficiencies to increase margin. The emerging model seeks value in alternative care delivery, accepting some risk, using care management efficiencies to take cost out the system, and keeping some of the gain for profit. These two methods are destined to collide. Over the next decade, the winner will be the one that takes cost out of the system while improving the member experience. This system will be a more open system, doing for healthcare what freeways and tollways do for travel now, paying for convenience, or risk sitting in traffic.

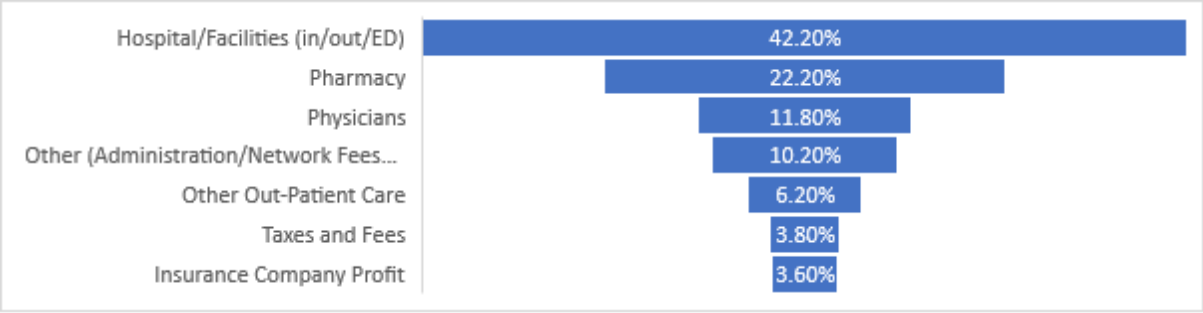
The U.S. needs the lower total cost of care model to win because it is the only one sustainable. It took 15 years for the total cost of healthcare to grow from $2 trillion to today's $4.1 trillion. CMS actuaries project the next $2 trillion increase to take only 7(9). The more this problem is fed, the more other investment opportunities in the greater economy are starved.

In spite of its promise, this new care model remains vulnerable to at least ten market forces. Every aspect of healthcare that ignores these headwinds does so at its own peril.

1. Insurance carriers are making record profits and have a vested interest in the status quo. If the market moves to VBC, they will want to own it.
2. Hospitals have moved from record profits two years ago, to profit vulnerability that will persist for the next decade due to changes in referral patterns, high internal costs, and site of service shifts to better value. Hospitals want to lead change, but most will not have the capital to do it.
3. There will be resistance from providers benefiting from the nearly $1 trillion in waste.
4. Physician authorizations can either lower the cost of care or increase hospital revenue. The compensation plan driving their actions will determine the direction.
5. Patients/plan members trust their physician relationship most. Any model must make physician level trust a priority to achieve consumer acceptance and compliance. Alternatives to clinical visits, such as telemedicine, will need to be integrated with primary care to track outcomes.
6. Employers and their advisors are already dealing with massive challenges inside the administration of every health plan. This makes any change difficult to implement, with plan members easily confused about new ideas. VBC must accept that they will have to compete with semi-established point solutions already in the market.
7. Patient non-compliance with physician care plans adds an estimated $290 billion to the cost of care each year for medication alone(10). Add services such as physical therapy and the cost of non-compliance could double. Will physicians drop non-compliant patients if their pay is cut?
8. If patient non-compliance is due to high out of pocket costs, will the employer be required to pay a higher percentage of the cost?
9. If risk stratification inside VBC adds cost to an employer today for an employee that will work somewhere else when that value is realized, the employer will push back.
10. A “shared savings” approach can only bridge the gap between today’s ‘fee for service’ and tomorrow’s VBC if physician value is tied directly to actions or employers will reject it.

The Money Pit Will Find Solid Ground

To lower cost inside a profit model, there has to be leverage. This is most evident in the relationship between physician fees and hospital fees(11). Physicians receive a fraction of the money hospitals receive, but have indirect control over hospital revenue. If physician compensation is changed to total cost of care outcomes, costs will drop.



To providers, volume mattered more than price, especially with hospitals owning so many physician practices. But now that employer awareness of price variances is increasing, ‘site of service’ matters and is shifting the balance of power to an outcome based lower total cost of care strategy. This shift will shake physician practice ownership to the core.

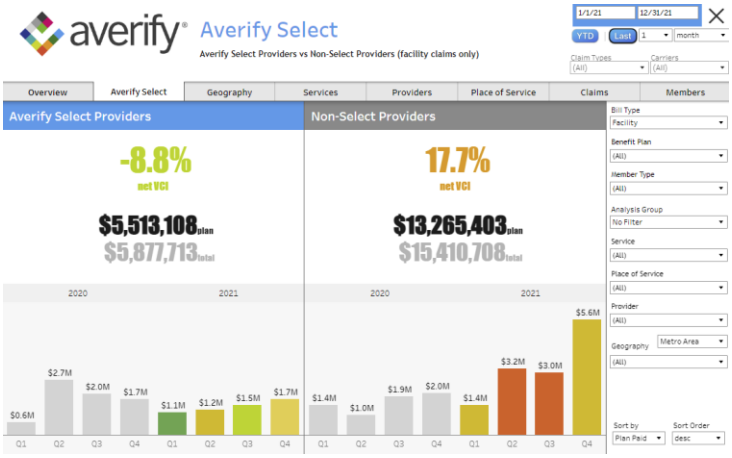
VBC itself will vary, depending on ownership/management. Investment in physician practices by any party with 'site of service' flexibility will deliver value faster than a hospital whose systems may be integrated, but whose prices are excessive.

Aligning The Interest Of Employers Seeking Value With The Facilities Who Deliver It

Already, hospitals are facing reductions in procedure referrals as changes in PCP compensation and responsibility begin to include avoidance and guidance to lower cost 'site of service' facilities. Given the billions of dollars standing ready from Private Equity investors and insurance carriers, recent models hospitals used to grow will not be applicable in the emerging market of VBC. Owners will decide between two paths; charge as much as possible, as long as possible, until the market forces change or improve processes – like more efficient management of business operations, physician surgical schedules, and OR turn-around time. The longer hospitals delay, the more opportunity that exists for physicians, high value facilities, employers and their people to build their own bridges. Change happens slowly and accelerates quickly. Even now, as this jockeying for position just begins, hospital revenue is concentrating in ways few appreciate.

- 6000 U.S. hospitals generate $1.3 trillion in healthcare revenue(12)
- The top 100 hospitals generated $856 billion of those dollars
- The top 10 hospitals received $324 billion of those dollars (13)

There is a reason why United Health Group is aggressively acquiring physician practices and surgical centers, but not hospitals. United is investing in markets in the direction money is moving, and away from the market segments whose revenues are more vulnerable, like hospitals. Coming inflationary pressures will increase variability even more as plans continue to see power struggles that will affect every network and every plan member. And hospital pressure points are happening just as federal regulations are requiring ever greater transparency. In this new environment, the best hospitals will compete favorably. The others will have some difficult decisions to make.



Averify developed the VARIABILITY COST INDEX® to track pricing, measuring whether every claim is paid at a rate that is in excess of, or below the fair market price. Making raw transparency data "readable" and actionable on a plan level, through in-network 'site of service' selection, lowers the total cost of care. Network discounts are legitimate, but for a variety of reasons, such as an employer's desire to have the broadest network possible, they are not consistent. Averify solves this variability.

What opens the window to change is the simplicity of the model. This is why Averify's model aligns the shared interests of hospitals, employers, physicians and the plan members in a simple, facility level guidance approach that is easy for everyone to use and respects relationships that are already trusted. This approach captures higher facility savings because it is easier for the member and their physician.

Financial markets are adjusting as they are accustomed to winners and losers, they just need to know how the economic model works. And employers are willing to adjust, as long as it adds real value without complicating plan administration, employee communication, and HR Department constraints.

Physicians Authorizations Will Always Drive Cost – But Who Will Drive Them?

Physician control, or at least influence, has become so important to the total cost of care that insurance companies and private equity firms are buying practices at a rapid pace. United Health Group's subsidiary, Optum, is now the largest owner of physician practices in the U.S., with over 60,000 physicians, focused on primary care (14). The recent announcement of CVS Aetna to purchase Signify Health shows the depth of this transition, along with record investment from Private Equity companies.

The ownership shift has a double effect on revenue generation control when PCP engagement is included, such as in Direct Primary Care. And in a VBC environment, if a hospital has quality problems, even the procedures from practices they own will shift to facilities that meet quality criteria or the hospital's physician revenue will suffer, forcing clinics to operate at a loss with no place to make it up.

With few exceptions, physician influence will come more through ACO's, Private Equity companies, or Carrier network affiliates than from hospitals in the decade to come. High cost hospitals are the only party vulnerable to fewer procedures if the payment model shifts to outcomes and a lower cost of care. Each ownership structure can design a revenue model that wins by taking cost out of the system, except for high cost hospitals that cannot deliver enough clinical savings to offset their high fees.

Employers Need Clarity to Act

The inevitability of Value Based Care is not assured in the commercial market. Here is why:

1. While the hope of VBC is seen in the 9% of employers already in direct contracts with providers and the 20% considering it (15), carriers have a massive head start.
2. The provider market forgets that employers are buying benefits as an incentive to hire and retain talent, thus they are as sensitive to employee perception as they are about cost.
3. Hospitals and physicians tend to assume that employers are anxiously waiting for VBC. They are not. To employers and their advisors, it is just one of the many options they will consider in a crowded field of "point solutions" that may leave employers too exhausted to understand new alternative delivery models.
4. Since their people see healthcare as a benefit, they want "comfort food" like network names they recognize (the BUCA's), who have a decades long head start on identity.

If there is one point that is universally true about point solutions in general, or VBC specifically, it is this; everyone is trying to add value by keeping people out of high-cost hospitals, except for those hospitals.

Closing Observation

Prudence suggests that to bend the will of the system without breaking the spirit of providers, change must come with precision. The profit model, the member experience, and lower total cost of care will align to stabilize the system. As money moves within the healthcare eco-system to seek a return, the only certainty is that change will affect everyone.

Sources:

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2 50% Of Americans Now Carry Medical Debt, A New Chronic Condition For Millions (forbes.com)

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