Chapter Five

Someone Needs To Be Accountable for Implementing the New Business Model for Care or It Will Not Happen

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Cash flow is king. The last two chapters of this book have described how the cash flow we use to buy care sculpts the way care is delivered in this country.

If we really want to change the business model we use to buy care in this country. We need to change that flow of cash. To change the flow of cash, we need someone who generates some significant portion of that cash making real changes in the way we buy care. Real money needs to be involved. Changes in the business model we use for purchasing care in this country can and will only happen if those changes are made by someone who is functionally upstream now in the actual flow of cash that we use today to buy care.

So who actually is upstream in the flow of cash in this country today?

Who in the current massive flow of the $2.8 trillion dollars[215] that is used to buy care, has the sufficient leverage, motivation, capabilities, and functional abilities to actually make changes that can effectively rechannel enough of that cash flow to achieve any or all of the goals that we need to achieve to improve care?

We need to figure out who has the leverage to change the flow of cash and we need to have clear sense of how that flow can and should be changed. This chapter is intended to help answer both of the questions.

For starters, we obviously have four very clear sources for the money that is used to buy most of the care in this country today.

The Patients, The Employers, The Health Insurers And The Taxpayers Are The Key Sources Of Cash

The four significant parties who are actually upstream in the flow of cash in this country today are:

1) the patients, themselves,
2) the employers -- who provide health coverage and health benefits to their employees,

3) our health plans and health insurers, and

4) the government.

Those are the four basic sources of the actual cash that is used to buy care in this country today. If we are going to change that flow of cash, and if we want to use any of that money to buy better and more affordable care, then we will need one or more of those upstream cash sources to make significant functional changes in the way they buy care.

How can that be done?

Who among those four sources of cash actually has the leverage, the expertise, the motivation and the tool kits that are needed to modify and enhance the way we buy care and -- in the process -- to change the business model of care delivery for at least some caregivers? It's a good idea to look at the strengths, weaknesses, and relative flexibility of each of the four sources of cash to figure out what might be our best strategy for using cash flow changes to achieve our care improvement goals.

Consumers Have Very Limited Leverage Today

Consumers cannot do that job. Caregivers are not going to be the cash flow change agents we need to transform either care or the business model we use to buy care.

It would be nice at several levels if the consumers of care in this country could be the change agents who improve the way we buy care. That is not at all likely to happen, however.

The truth is -- with the exception of some selective individual care purchasing decisions and some personal health-related behavioral decisions -- the individual patients in this country basically have no significant economic power and no relevant individual purchasing leverage that can be used to change the current business model of care.

The sad truth is -- at this point in time -- consumers have very little market power in health care.

Consumers have too little individual impact on provider business unit cash flow, and consumers have too little information about key issues related to care to function as either collective or individual agents of change. That is a shame. We clearly could benefit from involving

consumers more in making informed choices about both caregivers and care. We definitely should put a business model in place that can allow meaningful consumer impacts on care delivery to happen to a much greater degree in the future.

If we set the new business model of care up well, the consumers in this country could ultimately have a rich array of informed choices. If we design the health care market model well, we could put in place a model where informed consumer decisions could, would, and should steer the actual delivery of care. But today, at this point in time, individual patients simply do not have enough individual purchasing power to either change the model of care delivery or to cause their caregivers to change the way they produce, provide, deliver and coordinate care.

Consumers can make a few meaningful choices today about both care and health today.

Consumers can and should actually make individual choices to become healthier. And -- in some market settings -- consumers can actually make some choices between competing health plans and between competing care systems.

In an increasing number of settings, consumers who have very high deductible health plans also have health insurers who are beginning to give the consumers information about the prices changed by each available provider for a given set of services.

When a consumer has a $2,000 deductible plan and has to pay for the first $2,000 in care each year, then the difference between two care sites that change very different fees for their office visits can be relevant to the consumer.

If one site charges $75 for a basic visit and another site charges $125 for that same visit, -- if the consumers have tools to know what those price differences are -- that knowledge can drive some choices, and it has the potential to create price competition for some areas of care that cost less than the deductible amount.

As noted earlier, once the deductible amount is paid, prices become irrelevant to the consumer. But as deductible get higher -- moving from $500, as it did a few years ago to $2,000 or more in many

care sites today -- that can make predeductible prices relevant to some consumers.

In some settings, consumers get to choose between competing health plans. That can be an important and highly influential choice.

The opportunity for consumers to make choices between competing care systems doesn't happen as often as it should in this country today -- but it does happen in some settings, and those consumers choices can improve local care when they happen and when consumers can make informed choices based on good and relevant data about the comparative performance of plans.

Medicare has set up a very robust set of choices with their Medicare Advantage Plans. In any given market, consumers can choose between several plans. Prices vary and care service levels and quality vary. Medicare makes quality and service data available -- and consumer choices for those products do influence care delivery and local markets for care.

High levels of voluntary enrollment by seniors in Medicare Advantage plans sends a clear message from the consumers to even local care market and care infrastructure. Plan selection choices that are made by consumers can actually help to structure local markets for care. But individual consumer purchasing choices, by themselves, generally have no significant impact on either the cost of care or the quality of care as we have currently structured both the marketplace for care and the infrastructure of care.

Employers Have More Leverage -- Much of It Indirect

Employers obviously have significantly more clout than individual consumers. Employers channel a lot of cash to the purchase of care.

Employers who provide health coverage to their employees and their families are also very clearly and directly upstream in the cash flow for care in this country. A lot of money flows from that source of cash into purchasing care. As a consequence of that cash flow, many employers have more leverage over care delivery than the individual consumers have. Employers clearly can have collective influence over care

delivery and some of the larger employers can have significant direct and individual leverage over both the delivery of care and the financing of care in some local care settings. But even larger employers still tend to be relatively small in volume as a percentage of the full set of patients who get care from any caregiver in any relevant market setting or local context. Individual leverage by even large employers over significant areas of care is hard to achieve. Individual employers -- like individual patients -- tend to have insufficient leverage to change the basic delivery of care in most settings.

Collective employer leverage over care delivery, however, does exist and collective employer leverage can have a significant and extremely important impact on the delivery of care.

Many employers, for example, use the current NCQA ratings of health plans as part of their specifications for selecting health plans. NCQA is the National Committee for Quality Assurance. The NCQA has created a formal systematic process that measures the quality of care and the level of service for health plans in this country, using about four dozen performance categories.[216] Employers can have a significant impact on the quality of care in their markets by insisting that the health plans they contract with for their employee coverage go through the NCQA reporting and accreditation processes.

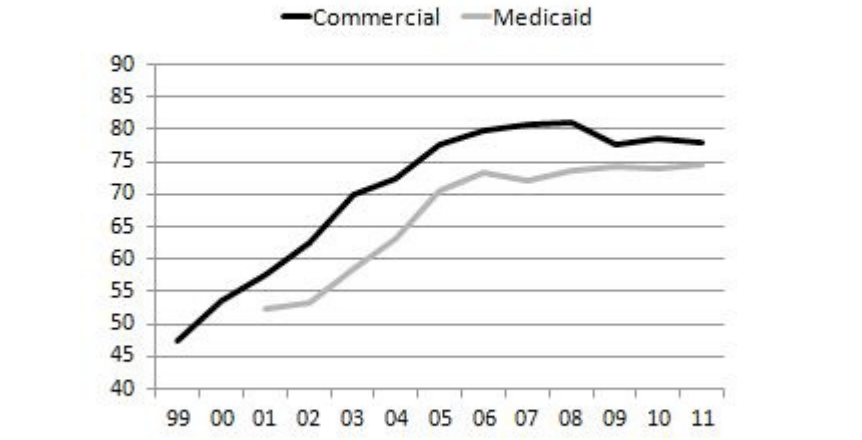
That use of NCQA reports by employers actually does change the way care is delivered in this country. That requirement to use NCQA changes care because cash flow is involved for health plans based on the potential loss of revenue for plans that are not accredited. When employers use NCQA ratings as a purchasing factor as they are making their decisions about which health plans to use, then health plans who want to serve that employer as vendors and who want to get cash from that employer will do the work that is needed in areas of targeted quality improvement both to be NCQA certified and to earn higher NCQA ratings. Care is significantly better in a number of areas in this country because of that indirect but cash flow related employer influence on care delivery through that market process and though the health plans who have an impact on care.

Indirect Employer Influence Changed Immunization Rates for America

As one example of the impact that NCQA measurement can have on care delivery, before NCQA started measuring the childhood immunization rates for each of the health plans, immunization rates were a lot lower. NCQA required the use of that measurement, compared the results in performance between plans and then reported the differences in immunization rates between health plans to employers. When that measurement process started, this entire country had amazingly and embarrassingly low rates of immunizations. When NCQA started tracking and reporting immunization levels by health plans, every health plan that was evaluated by NCQA set up their own set of individual approaches to work with their contracted caregivers to increase the number of immunized children in their customer base.

The United States was far below almost every country in the world on immunizations when NCQA began to exert their leverage through health plans and their provider networks on that issue. The next chart shows the progress that has happened in immunizations in this country over the past decades, since the NCQA measurement of that particular procedure was introduced.

Figure 5.1



SOURCE: National Committee for Quality Assurance (NCQA), The State of Health Care Quality 2012, Childhood Immunization Combination 2 for Commercial and Medicaid HMO

When NCQA started measuring the rate of immunizations, barely half of the kids in this country were immunized. Health plans made that particular area of care delivery a priority and now the numbers for those plans are closer to 80 percent. That is a major improvement -- created in part because the employers exerted collective influence on care delivery by tying their own cash flow to NCQA certification requirements. Similar results have happened for several other NCQA measurement areas -- including blood pressure control, diabetes care follow-up, and follow-up for mental health care. Those are all areas where care for the entire country has gotten better over time because health plans have been focused on those directions by the NCQA measurement process.

So, even though it is clearly hard for any single employer to directly influence any individual performance area for care delivery -- like changing the immunization rates for children in any specific geographic setting -- employers can collectively influence the quality of care and the overall immunization rates by using NCQA and their certification processes as a tool to make those measurements relevant to the cash flow realities of health plans.

Employers have also bonded together to create an organization called the Leapfrog Group that has created safety measurements for hospitals. The Leapfrog Group measures results and has publicized differences in those safety and performance levels between hospitals. The Leapfrog Group has done some very good and informative work. The influence of that process on all relevant hospitals has been somewhat less effective than the NCQA impact on health plans primarily because most of the buyers who are involved in the Leapfrog effort have not directly connected the hospital performance variations to hospital cash flow by only using hospitals with good Leapfrog safety ratings. The hospital safety reports are informative and useful -- and many hospitals are improving their safety levels because of the Leapfrog measurements and safety advocacy -- but the standards have not had a direct business impact on the actual cash flow of hospitals.

Employers Can Have Major Influence on Providers Through Health Plans, However

It is difficult for employers to have a direct impact on care delivery, but employers can have a very powerful indirect impact on care delivery through the health plans they use to either insure the care for their employees or to administer the health coverage for their employees.

Employers hire plans to run their employee health benefits.

Health plans are businesses. Cash flow is also king for the health plans. Health plans very much want cash flow from employers. So health plans tend to pay very close attention to their customer base -- and employers are usually the bulk of the health care insurer customer base for any health plan.

Health insurers sell services to employers. Health insurers survive if they have customers. Plans who want to keep their customers tend to listen to their customers… particularly their large customers. So employers can change the cash flow for care by literally changing the health plan they use as a channel for their cash. They can also influence care by mandating that the plans they hire to administer or insure their coverage deliver a care product that meets care delivery specifications

created by the employer. That set of levers -- focused on specifications about care delivery -- can be fairly effectively used by employers to influence care through the health plans they hire.

If buyers tell their health plans for example, that they want the plans to support and institute the care improvement reforms that are described in this book, that insistence on that support for those care improvements can have massive impact on the priorities and the actions of their health plan vendors. In other words, employers can often significantly extend and increase their own leverage and their own influence over the actual provision of care through their health plan vendors by getting their health plans to do particular things in ways that subsequently influence provider behavior in the community. Employers who use their leverage through the health plans skillfully can have more indirect impact on care delivery than direct impact, and that subsequent indirect impact can be -- in some cases -- both powerful and significant.

Well Leveraged Employers Can Insist That Their Vendor Achieve Those Reforms

As one easy and clear example, employers can insist that the health plans they hire work with patient centered medical homes. Employers can also insist that their contracted health plans work effectively with appropriate palliative care programs. Employers can easily insist that health plans provide data to individual patients about the heart surgery mortality rates of the hospitals that the health plans use. If buyers insist on that data about death rates being provided, plans can make it available. Employers can insist that the health plans they hire should give their employers access to either a full and complete electronic medical record or to some form of electronic patient profile support tool that provides care support data care data to caregivers. Plans can use their claims databases and their own systems expertise to support that work when full EMRs are not available at the care sites.

Plans will do all that work and will create those data flows to support care if the employers demand that work be done by the plans and by their contracted caregivers.

At a very basic level, buyers can insist that plans report important data about care, and buyers can require health plans to make key pieces of information available to patients. The plans who want to be the vendors for the employers will generally be influenced in significant ways by those buyer demands and buyer specifications. If they are well written, the influence of those buyer specifications will spill over very effectively to the actual delivery of care.

Buyers Have More Leverage Than They Know

Buyers today actually can have a lot more leverage on care delivery in that indirect way than they usually appreciate. That wasn't always true -- but it is true now. The tools exist to do that work now -- and they will be used if buyers insist that they be used. Purchasing of health care and coverage doesn't need to be a passive process for employers. Purchasing of care also does not need to be passive and inert process for our government agencies relative to care improvement requirements. Buyers and the consultants they hire to help them manage both their self-insurance vendors and their insured health plan vendors can build specifications for health plans that specify and insist on better performance in important areas like team care. If buyers insist that the health plans they hire must support team care, the odds are very good that team care will be supported.

Most Health Plans Will Welcome The New Specifications

The time is perfect to do that work.

The truth is -- many health plans and many health insurers in today's health coverage marketplace will welcome a set of requests from their key buyers to have a more effective impact on care delivery. The value of doing that work is becoming increasingly clear to everyone in the health care financing business. In today's world -- at this point in the history of both care delivery and health care financing -- many health insurers are already highly likely to be competing in those areas, and many health plans are working hard on very ambitious care improvement

agendas and tool kits today. A great many plans already are intending to build care improvement approaches -- very often in partnership with various aligned caregivers. In many cases, the better and more enlightened health plans have already decided that team care, coordinated care, and even more accountable care should be a key part of their portfolio of benefits and services. Many of those insurers are working hard now to create effective programs and services in those areas and many insurers see the clear value of doing that work in partnership with mutually supportive caregivers. Some of those approaches to align health plans with caregivers to create better coordinated and more accountable care are discussed in more detail later in this chapter. They are clearly a step in the right direction for better, more affordable and more accountable care.

Self-Insured Employers Can Also Use Their Influence Relative to Health Plan Performance

So employers have a hard time directly changing care -- but employer can clearly do their part by becoming better buyers of services from the plans they utilize. That is true whether the employer buys insurance from their health plans or whether the employer is self-insured and buys basically an array of administrative services from their health plan vendors.

Those data supported team care agendas need to be applied to patient care for both insured and self-insured employer groups. The fact is most major employers in this country are now self-insured. Those self-insured employers directly absorb the costs of care rather than paying a premium and then having an insurer absorb those costs. That self-insurance status for employers doesn't change the employer's ability or need to use health plans as a useful leverage tool to improve care. Almost every single self-insured employer currently hires a health plan vendor -- usually under a very clearly defined contract -- to administer their self-insurance plan. Those health plans who administer self-insurance for those employers also usually sell their own insured products to other buyers. Those plans and typically have a broad array of contracted

provider relationships that serve a broad customer base that includes insured and self-insured employers.

So intelligent purchasing by both insured and self-insured buyers to change the delivery of care -- primarily using the leverage they exert through health plans -- is not only possible -- it is desirable.

This book has outlined several ways that care delivery should change to make care better. Buyer specifications can make those care delivery enhancements real for their health plan vendors.

Buyer Specifications Should Be Used More Effectively As A Tool

Specifications are a key tool to achieve those goals.

Buyers can use their own purchasing specifications to simply and directly require their health plan vendors to use care networks that include care teams, medical homes, care registries, electronic medical libraries and the functionality of electronic medical records. Most businesses that buy other supplies or and other services from a wide array of vendors already use and impose detailed purchasing specifications in their relationship with those other vendors. Health care coverage and delivery purchasing that has been done by businesses, by contrast, has been almost specification fee.

Specifications Can Strengthen Care Purchasing

That can easily change. It should change. Buyers should begin to specify a few key points -- like team care and safety reporting -- for their health plan vendors. When buyers set standards and create specifications for those particular performance issues, plans tend to respond well. Plans then need to do the work to be in alignment with those purchasing specifications.

So when you look at the four sources of cash that we use to buy care in this country, it is clear those consumers actually have relatively little leverage relative to using their purchasing power to change the infrastructure of care. But buyers can and do have some leverage…and buyer leverage at this point in time tends to be most effective when it is

channeled through the health plans that buyers use as vendors for their health coverage benefits.

We Need to Optimize The Value Of Health Plans

That realization points us very directly to the third source of cash for health care in this country -- the health plan or health insurer.

We clearly need to use health plans as functional change agents and cash flow modifiers. Health plans are the third source of cash used to buy health care listed at the beginning of this chapter. The government is the largest single source of cash that is used to buy care, but health plans clearly have the second highest cash flow volume. Plans may have a more immediate and effective cash flow leverage in the country relative to the cash flow of care. Health plans clearly have the most flexibility relative to cash flow. The opportunities to have an impact are becoming increasingly clear and many health plans are now building the needed tool kits and provider relationships they can use to change their individual cash flow for the purchase of care.

Health Plans Have The Second Most Powerful Impact On The Flow Of Cash Used To Buy Care

Health plans cover a lot of people in this country. That number of covered people is projected to grow as we roll out the next stages of this country's health care reform agenda. Health plans today channel a lot of cash to caregivers in this country. Those massive health plan steams of cash create their own obvious, high-leverage opportunities for the plans to have an impact on the delivery of care. In fact, health plans in this country not only have the opportunity to have an impact on the delivery of care -- American health plans should have an obligation to have a significant impact on making care better and more affordable.

Sixty to seventy percent of the people who will have health care coverage in America will have coverage that is either insured by private health plans or administered by private health plans.[217] That doesn't count the major role that some health plans now play as the intermediary

administrators who do the key administrative work and functions for the Medicare program.

Health Insurers Should Be Held Accountable for Using that Cash Flow Well

A key point of this book is that we will need the health plans of this country to do some well-structured and highly effective heavy lifting if we want to restructure the cash flow for care and make care both more affordable and better. The opportunity for the plans is huge. Health insurers channel massive -- even staggering -- amounts of money to providers of care. We need to use that fact of economic life to make care better. Health insurers ought to add real value to care delivery in multiple ways.

We need to start with affordability. Being affordable is actually one of the key ways for health plans to add value. The entire next chapter of this book is about health plan and premium affordability. The basic whole approach that we are now using as a country calls for us to use our health plans to provide coverage to two-thirds of Americans. That strategy will fail if the coverage offered by our American health plans isn't affordable.

How can plans be affordable?

Being Affordable Needs to Be a Top Priority

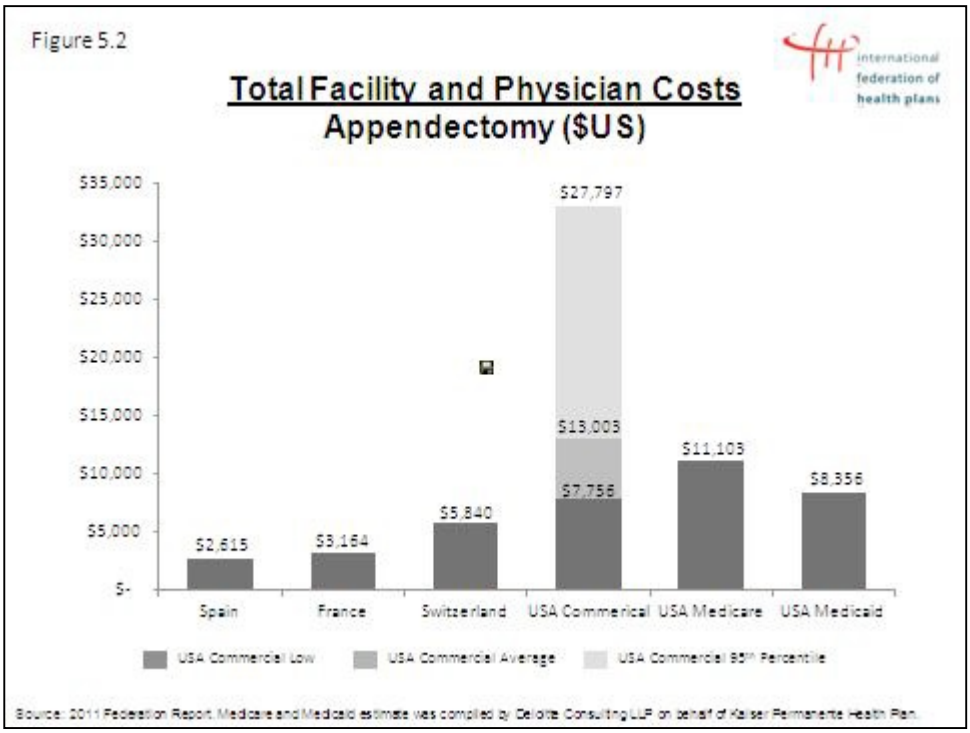
Since health care premium is very directly and purely arithmetically based on the average cost of care for insured people, insurers clearly need to do smart things to bring down the average cost of care for the people they insure. The logic of that need for insurers to effectively bring down the cost of coverage is painfully clear. This whole pathway to universal coverage will fail for us as a country if premium is, in the end, unaffordable.

One of the ways insurers can add value and bring down the average cost of care for the people they insure is to use their volume purchasing power to get better prices for each piece of care they buy. When we pay for care by the piece, bringing down the price of each piece of care is a

basic, fundamental, almost logistically crude tool that needs to be used more effectively. The price chapter of this book was very clear about how the pricing model we use now to buy units of care works today in this country. The comparative price charts are pretty clear. We have the highest unit prices for care in the world. We also have -- by a huge margin -- the widest range of unit prices of any country in the world. The charts in chapter three show the price differences between us and the rest of the world. One of those charts is shown below to make the point that we pay more for each piece of care than all other countries, and there is a very wide range of prices being paid in the U.S. for each service. The premiums that are charged by each insurer in this country are now based -- by law -- on the average cost of care for the people who are insured by each insurer. Prices paid by each insurer for each piece of care obviously create the average cost of care and the premium -- for each insurer.

The arithmetic is clear. Lower prices result in lower premiums. Plans who fail to do their price-negotiating work well will basically fail their customers. Price negotiations need to be a key skill of health plans. Plans need to very effectively negotiate prices for all pieces of care. If all health plans simply paid the full retail prices that are listed by care sites for care in this country, that level of payment to providers of care at full retail prices would create extremely high premium levels, as chapter three also pointed out fairly clearly.

The next chart shows the prices paid for an appendectomy. The chart shows the amount paid in other countries, the price range in the U.S., and the amount paid for that procedure by both Medicare and Medicaid in this country. We clearly pay a lot more in the U.S.



As the chapter on prices pointed out, the prices that are paid by consumers who don't have health plans or the government negotiating fees on their behalf are not even on this chart. They are much higher than the $27,797 number. Those charts do not include the pure "chargemaster" prices that are charged by many health care providers to people who don't have insurance of any kind. Those "chargemaster" prices are sometimes so high as to be cruel.

Health insurers obviously need to do a very effective job of negotiating provider prices on behalf of their customers in order to keep their premiums affordable. Being able to negotiate lower prices with caregivers on behalf of plan members creates a stunningly direct and very immediate benefit relative to premium affordability. A health plan that gets a 50 percent discount on all retail prices paid for all pieces of care would have a premium level that is literally half of the premium that would be charged to those same customers by a plan that pays the full retail prices for each piece of care. A fifty percent discount cuts the premium in half. People who buy health insurance in this country would obviously prefer the lower premium level. Plans clearly need to negotiate low prices in order to have lower premiums levels.

Price Negotiations Are Not Popular With Providers Of Care

Those unit-priced negotiations that are done by the health plans with providers are not particularly popular with the actual providers of care in many cases. Some care sites, in fact, bitterly protest the price negotiation process. The fairly consistent pattern has been that a number of caregivers will complain with some passion to their patients about the price negotiations that happen with health insurers. The providers of who are complaining to the patients tend not to mention that the prices they charge actually create the health insurer's premiums. In any case, when you look at the price levels shown on those charts, it's pretty clear why those price negotiations are needed by the health plans. It is equally clear why skillful price negotiations by plans directly benefit the people who actually have to pay the premium.

So the absolute first truth to look at relative to health plans and their cash flow impact is that negotiated provider prices clearly bring down premium levels.

We need affordable premiums if we are going to cover most of the people of this country using the tool of private insurance to pay for people's care.

We Also Need To Change The Way We Buy Care

Discounts are not enough.

Simply negotiating lower fees for various pieces of care will not be enough to make premiums better and more affordable. We have been doing those negotiations for years and prices are what they are. We now need a better way of buying care. Lower fees that are negotiated in the context of a piecework business model still leave us buying care by the piece. The last chapter pointed out many of the flaws, the dysfunctional outcomes, and the suboptimal consequences that far too often result from buying care by the piece. The last chapter also pointed out the savings, the care improvements and the care safety enhancements that can happen when plans and consumers buy care well by the package. The data on both points is clear. Health plans clearly need to have a positive

impact on that cash flow issue. The piecework model of buying care is badly flawed.

Like the eye surgery and the heart transplant examples in the last chapter, we need the health plans in this country to be really good at buying packages of carefully defined care from care providers in order to bring total costs down and improve quality and outcomes for those aspects of care. This is important work. It needs to happen. It will not happen on its own.

Buying care by the package will not happen until someone who is part of the cash flow for buying care makes it happen. Who can do that work? The truth is that only the health plans and the key government agencies currently flow enough cash to make a better purchasing model happen.

If health plans -- or the government -- do not make a real and relevant conversion of money to that package purchase of care cash flow model, there is no other element of the care delivery infrastructure of economy that really has the flexibility, the cash flow volume, or even the motivation to use that set of tools to accomplish those goals. We can give all of the speeches we want about buying care by the package and not by the piece -- but if the insurers and the government programs who channel most cash to care don't actually start buying more care by the package, than that purchasing tool will not have much traction and it will not be a factor in the real world of care delivery.

Ideally, a modified cash flow from the private health insurers to buy care more effectively can be set up in harmony with similar agendas being set up by Medicare and Medicaid to optimize the total impact of those purchasing agendas. The next two chapters deal with those issues. In any case, the health plans should now accept the accountability for doing major portions of the work that is needed to create the new business model for care, and people who do policy thinking should be figuring out how best to use health plans to do that work.

Health Plans Need to Support Caregivers Who Want To Set Up Accountable Approaches

So what can and should health plans actually do at this point in our history to make care better and more affordable other than just negotiate lower prices with providers of care?

There are several important things that plans can do. We need to look at the role that plans actually play as a pure function of being really plans. Plans tend to be a major connector between the patient and the infrastructure of care. Plans are natural, functional, in place, fully operational conduits for both cash and data. Plans should improve their role as a channeller of cash and as a channeller of data -- setting up data flow approaches that can improve consumer choices about both care delivery and about providers of care, and they provide data to caregivers that can help them improve care. Health plans can and should tee up and enable a much more robust consumer choice agenda.

As noted earlier, that set of data related plan functions should be included in the buyer specifications that are used by buyers to select and manage their health plans. Health plans should be required by the buyers to help facilitate choices by patients. Each plan can come up with creative ways of doing that work. Buyers should require that work to be done.

That's not the only business model element we can and should change through health plans in their role as a conduit for cash. Safety and adverse outcomes should also become much more relevant to the way we buy care. No other industry creates a cash reward for vendor screw-ups and no other industry has vendors who make more money when their customers are damaged. That is a very strange business model. It is entirely unique to health care. It should be fixed. It can be fixed. Health plans need to achieve that fix.

Cash flow needs to be channeled away from rewarding mistakes, errors, and inept care.

Health plans clearly very much need to change both their benefits and their payment rules to stop rewarding care delivery screw-ups. Patients with pressure ulcers should not be a source of both revenue and profit for the care sites where those ulcers were created. Having multiple

patients with pressure ulcers should result in some kind of financial penalty for the care site and care team -- not a financial reward.

Changing the payment model to address those issues can be done. Simply not paying any additional money for hospital acquired infections is one very simple benefit change that can be implemented by health plans as a better way of buying care.

Medicare has begun to make those kinds of payment decisions about hospital infections, and that is a very good and responsible thing for Medicare to do.

Another very reasonable change in the business model is to say that if a hospital patient has sepsis, the hospital will not be paid additional money for the care of that patient unless the hospital has a formal and functional sepsis response process in place. We can't blame hospitals for patients getting sepsis. Many sepsis patients get that disease in nursing homes or even in their own homes. The payment model for sepsis shouldn't penalize hospitals for simply having patients with sepsis. The payment model should, however, penalize hospitals who don't have a fully organized care team response in place for patients with sepsis.

Sepsis is the number one cause of death in American hospitals.[218] Those care teams can cut the death rate for the number one cause of death in American hospitals in half -- and the right care done quickly can also result in half as many of the surviving sepsis patients from suffering lifetime damage and pain from that disease.

Similarly -- for pressure ulcers -- as noted several times in this book, some hospitals have over 10 percent of their patients with those ulcers.[219] The national average is now 7 percent.[220] Each of those ulcers generates an average of $40,000 in hospital revenue for non-Medicare patients.[221] As was also noted earlier in this book, the very best hospital systems have less than 1 percent of their patients with those ulcers.[222] Some very high performing hospitals have not had a single pressure ulcer in years. Not entirely coincidently, as the prior chapter pointed out, the American hospitals that have had zero ulcers success levels have been hospital care sites that have been prepaid for a complete package of

hospital care. There is no additional revenue in those prepaid hospitals for any patients if a pressure ulcer happens and needs to be treated.

In other hospitals that are paid entirely by the piece, those same ulcers can generate a lot of revenue. Health plans and buyers can change that payment model. Our payment model for buying hospital care should reflect the need to reduce the number of those ulcers and not pay more when ulcers happen. Simply setting up payment standards that cap payment in some way for hospitals if more than 5 percent of the hospital's patients have those ulcers would give every hospital in America the needed incentive to put processes in place to make care a lot better for those patients. All patients in those care sites would benefit from the quality gains that would result from better processes for those patients. Better care is definitely possible -- and the cash flow we use to buy care needs to be channeled by the health plans to selectively create better care in targeted areas for patients.

Health plans and the cash flow they channel need to be in the heart of the solution set for those issues.

In each of those cases, at a bare minimum, health plans can and should stop rewarding care misfires with rich streams of cash.

Health Plans Can Enrich The Flow of Data

We also clearly need data to make care better. Health plans can also obviously play a key role in bringing better data into existence. Data support should be another key function we expect health plans to play. Health plans need to create and utilize data flows that support the delivery of care.

Health plan and health insurer databases tend to have a lot of care-related data in them now. Health plans have that care-related data now because all providers need to file claims with each insurer in order to be paid for their care. The claims that are filed with the insurer today describe each patient's diagnosis. The claims also are required to specifically list each of the care procedures that were done for each patient in order for providers of care to have their claims paid for that patient. Because that payment process and that data flow exist, health

insurer claims databases actually have rich veins of care based data in them now.

That rich set of data is not usually used in any way to improve care. Health plans should be using that data to help caregivers deliver and improve care.

Helping caregivers provide better care should be a major priority for health plans at this point in our history. Some health plans are already tightly allied with care systems. The health plans that are also care systems having great success in both care quality and care costs. We now need to extend that care improvement and data sharing work well past those few fully integrated systems to create similar services and similar data support tools for a broad array of consumers and health plans.

Plans Should Now Help Providers Sell Care By The Package

The most useful and most immediate way that health plans can help to improve care at this point is probably for the plans -- as payers and administers -- to create cash flow options and approaches that support the caregivers who want to set up team care, data-based care, continuously improving care, and to support the care sites who want to deliver packages of care.

Start With Team Care

We need to begin with a very practical and functionality-focused look at the opportunities we have in front of us.

The biggest opportunity we have for making care better and more affordable is to focus on the patients who have chronic care needs.

As this book has noted a couple of times, those patients who have chronic conditions currently drive more than 75 percent of the costs of care.[223] Health insurers should be required by their buyer customers to recognize the obvious need for team care for all of the patients in this country who have those chronic conditions. There should be a particular focus on patients with chronic conditions and co-morbidities. We should expect our health plans and our health insurers to work with the

infrastructure of care delivery in America to create, support, and build team care in various approaches that can make care better and more affordable for those patients.

Health plans need to be more effective channellers of their vast flow of cash relative to team care. Insurers should be paying providers to set up care linkages and insurers should be paying providers for team care infrastructure support. The current payment approach penalizes providers who stray from the current rigid and inadequate list of approved services that are included and defined on the standard piecework fee schedules that insurance company claims examiners administer today. We should demand that our health plans face up to that task of creating and supporting team care and should modify the way they pay providers in ways that cause team care to happen.

In exchange for the right and privilege of being a licensed health plan in America, health insurers should support needed levels of care improvement data flow and continuous improvement work done for health care and should help create and support accountable care by creating cash flow approaches that fund and reward accountable care.

Plans Need To Work In Collaboration With Caregivers

Selling care only by the piece should end.

To achieve that top-priority goal of continuously improving fully accountable care, health plans should set up various kinds of purchasing arrangements with various caregivers that allow the caregivers to sell care by the package -- with full transparency relative to the quality and the outcomes of the care that results from that approach.

This is clearly an area where employers can be a major catalyst for change. Buyers should insist that the vendor health plans they hire do this work and buyers should define those requirements clearly in their purchasing specifications. Experts exist who can help the buyers build those specifications.

If buyers very clearly have plans to create care teams and if buyers require health plans to use their benefit design capabilities to channel patients to the care teams that functionally can coordinate care, most

health plans can now do that work and many will also do it quickly and very well.

A few years ago, those kinds of requests by buyers for more aligned caregiving relationship and levels of team care by their health plans would have been much harder to achieve then they are today. Most health plans could not do that work a few years ago. A decade ago, most care business sites also resisted any threat at any level to their piecework payment cash flow approach. As recently as three years ago, the provider business unit resistance to any change of cash flow in those areas was significant. Today, however, many providers of care are ready and even eager to do that work of changing the way they sell and deliver care.

Care Providers Are Seeking Ways Of Aligning To Improve Care

Hospitals, medical groups, community caregivers, and even pharmacy chains are all now recognizing that our current piecework-centered business model is too flawed to get us the optimal results we want for both quality and affordability.

Care delivery is changing. Some of the boundaries between insurers and caregivers are blurring, blending and co-mingling in interesting ways. Caregivers are now beginning to understand that the next generation of care delivery should be more patient focused and better coordinated. Insurers are beginning to understand that simply being passive conduits for cash is not going to be a successful business model for the next generation of health plan competition. The care delivery goals and vision that was outlined in chapter two of this book are being embraced by a growing number of caregivers and care business units as well as by a growing number of health plans. Hospitals are working to figure out ways of becoming more aligned and better integrated with the physicians who give them patients. Physicians in many settings are looking for linkages that can help create continuously improving care for their patients. Health plans and health insurers can and should build on that new intent, that new interest, and that growing provider momentum… and that new set of priorities should enable the

cash flow that is now channeled by the insurers to function as a key tool in core patient-focused care alignments and realignment processes.

New Levels Of Alliances And Collaboration Will Be Useful

Some very creative work is being done. At one end of the collaboration continuum, some health care insurers are now buying actual care delivery organizations. Some very traditional, financially-focused health plans are becoming both health insurers and direct providers of care.

At the same time, some of the larger health care delivery organizations are beginning to create the functionality of health plans and some are looking to get insurance licenses to compete with the traditional health plan entities. At both ends of that collaboration continuum, organizations are being created that look in many respects like the classic Kaiser Permanente, Health Partners, or Group Health Plans -- with the goal being to build integrated care delivery and care financing models.

Buying care sites is one possible way for insurers to link tightly with care delivery and to enhance collaboration with the provision of care. Those health insurers simply become caregivers as well as insurers. Likewise, forming insurance companies is a very direct way for large caregivers to gain the full advantage of the entire upstream flow of cash from the buyers and government programs. Those care sites simply become insurers and they then collect premiums instead of fees. It can be extremely liberating for those care sites when there is enough cash flow to fund more innovative ways of defining and delivering care.

Both of those approaches create new challenges. Both approaches can be a very difficult way to succeed unless the entity can acquire an adequate, upfront volume of patients. But both approaches can be done and some organizations are going down those new integrated roads today.

Contractual Alliances Can Create Virtual Integration

Another way of moving in that same direction to achieve new and improved levels of collaboration between health plans and caregivers is to create direct contractual alliances. Contracts are much easier to do than acquisitions or mergers. It's a lot easier to contract with a hospital than it is to buy or build a hospital. Very creative organizations are developing a whole range of very interesting new contractual arrangements between health insurers and providers of care. Pioneering work is going on. This is a time for creativity and learning in many sites for both health care delivery and care financing. There are several versions of those kinds of aligned strategies now being put in place in multiple settings across the country. Health insurers in multiple areas are working with care delivery business units -- often with major hospitals or with hospital systems and their aligned medical providers -- to create a variety of contractual relationships that will allow the caregivers to benefit financially by taking accountability for key aspects of care.

Those same approaches will allow the insurers who are part of the new collaborative effort to have lower premiums because the average costs of care will be lower for the insured people who get their care from those more efficient, process-enhanced, team-focused care delivery models.

The Federal Government has included provisions in the Affordable Care Act for care sites to set up new organizations to do exactly that work for Medicare patients. The new organizations are called ACOs -- or Accountable Care Organizations. The intent of the law is to help set up a new set of contracting caregivers that will be able to achieve many of the same coordinated and cash flow rechanneling functions for Medicare patients as the old Group Health, Health Partners and Kaiser Permanente fully-aligned care and financing approaches have achieved.

Some Providers Want To Be Accountable Care Organizations (ACOs)

"ACO" is actually a very popular and frequently used name and label in health care circles right now. The use of the phrase and the

concept now extends well beyond the Medicare -focused ACOs that were initially teed up by the new law.

There are an amazing number of current efforts to create aligned care teams in multiple settings for private insurers as well. Many of the new collaborative provider organizations that are being built in the private insurance market are also being labeled ACOs or Accountable Care Organizations. At this point in time, the ACO term is being used to describe a wide range of provider-anchored and provider-centered alliances, collaborations, and organizational models that intend to sell packages of care to health insurers and the government. That alignment agenda is a step in the right direction. The basic underlying concepts of the ACO agenda have real value and are very directionally correct. Each of the three words in that label has significant significance, and each is worth a brief discussion.

Accountable -- Care -- Organizations

The term "organization" in ACO indicates that the care will be organized and not just will not be the haphazard piecework, unconnected, and unlinked approaches to care delivery that have been our norm now for this country for a very long time. Organization implies functioning in an organized way -- rather than just creating isolated incidents of care delivery.

"Accountable," as a term, implies a sense of purpose, responsibility, and -- yes -- accountability that also goes beyond just treating isolated incidents of care as isolated instances of care. Accountable for the full care needs of an entire patient is a concept that is new to most of health care -- because most care delivery in this country is incident focused and not "accountable" for the entire care needs of a patient. That -- accountability -- for an entire patient obviously creates a whole new way of thinking about patient needs and pieces of care.

The third basic term, "Care," is an indication that the primary function of an ACO is to deliver care and not just to provide insurance or coverage. ACOs are not intended to be simply care financing tools. ACOs

are intended to focus on actual care -- using an organizational approach to delivery that care that involves being accountable for the entire process and for the results of care for each patient.

ACO means, in other words, an organization focused on care delivery in an accountable way. That is clearly a good thing to achieve and a great aspiration to have.

Many Care Sites Aspire To Be ACOs

Most major care sites in America are currently thinking about how they can each succeed in an ACO-relevant world.

Health care entities all over America are building a general sense and greater understanding at this point relative to the kinds of team-based care delivery approaches that they can set up, design, or create to deliver care in an organized and accountable way for population of patients. The ACO thinking is very much a learning process for those care organizations. It is also a discovery process. The exact nature of the alliances, alignments, and functional processes that will create a new generation of aligned care approaches is in a state of exploration, flexibility, creativity, and learning. That is a good thing. We don't have the final solution for ACO functionality or success yet. We are inventing the best solutions in multiple settings. There are many variations on the ACO model in this country today, and we can learn from each of those variations.

As noted above, Medicare began the process by creating its own very definite set of initial ACO regulations for one version of the ACO approach.

That set of specifications for Medicare ACOs was derived directly from the Affordable Care Act law. The learning process about ACOs was at an early stage when the law was written, so those initial specifications are not perfect. The initial Medicare ACO work needs to be enhanced, as we learn more about how to build and use ACOs.

The good news is that there are now very flexible ways of building even Medicare ACOs because the ACA law gave Medicare the ability to do

some experimentation. Medicare is using that ability to learn to be somewhat flexible, at this point, relative to ACO pilot program design.

The full Medicare ACO rollout process also now includes the design and creation of what Medicare calls “pioneer ACOs.” The new pioneering ACOs are encouraged and allowed by Medicare to use variations on ACO approaches for care delivery and care funding that varies from the defined model that was embodied in the initial Medicare ACO regulation set. Some of those plans are doing interesting and worthwhile work and could become models for this country.

As noted earlier, Kaiser Permanente already functions as an ACO -- Accountable, Organized, and grounded on the delivery of care. That model works well, and it anchors one end of the ACO continuum -- an ACO on steroids. That model will not be the one that is used in a number of settings because it is not easy to achieve that level of full integration everywhere.

Some of the new ACO’s will look like Kaiser Permanente clones, but many will use other ways of creating both organization and aligned accountability.

ACOs Are Intended To Create Team Care

Some of the best new ACO designs, at this point, will probably not be the ones designed by Medicare. Many of the best ACO designs will probably be the ones that are being put together by private health plans and by various alliances of motivated and organized caregivers. In all of the public and private care settings, and in all of the financial variations, the new ACOs are being formed to create a kind of integrated provider team that can focus on -- and be accountable for -- the care needs of a defined population of patients. The new generation of ACOs actually have a variety of owners, funders, and coordinators.

Cash flow will be key. Access to data will be essential.

At this point in the ACO process, it appears that the ACO models that will be most likely to succeed over time will probably be the ones who are linked most effectively to an existing payer -- to Medicare, Medicaid, or to a private insurer -- who has the tools, patient-volume,

data tools, motivation, and the real and existing cash flow that is needed to make the approach successful.

Most of the ACOs that have been designed up to now typically have hospitals at their core -- or they at least have hospitals as a key partner. The first generations of ACOs also tend to include a full array of aligned physicians -- with primary care physicians usually at the core of the care team. That primary care based model is fundamentally sound. In many ways, moving to a care delivery model that is built around team care and anchored by primary care has some obvious merit relative to making care both better and more affordable.

Medical Homes Also Create Team Based Care

ACOs are getting most of the publicity right now, but another extremely important care delivery enhancement approach that may actually have a bigger impact more quickly for more patients than the ACO agenda is the creation in many care settings of patient-centered "medical homes." America obviously needs better team care. This book has made that point multiple times. Patient-centered medical homes are an approach to team care that can create a direct care team for each patient. The medical home approach almost always has primary care at its core, and it generally is supported with systems that provide basic care delivery information about each patient to each care team.

That very practical patient-focused approach has been proven to work really well in many care settings.

There are about 400 ACOs that are either being formed or that are already operational as this book is being written.[224] There are now more than 10,000 care sites that are currently functioning and being paid with real cash to be patient-centered medical homes.[225]

Medical homes are growing so rapidly in so many places in this country because they are relatively easy to set up and they fill a huge gap in the usual splintered and unconnected approach to care delivery in this country. Many health insurers and health plans love medical homes because they are a relatively easy and fairly quick way for the health

insurer to positively impact care...particularly for patients with chronic conditions.

Medical homes aren't, of course, actually homes. Medical homes are team care models that are set up to create coordinated care for individual patients in a very local and focused setting. By contrast, the full scale ACOs that are being created in most settings tend to be larger, more complex organizations that can involve multiple levels and multiple layers of caregivers. Medical homes are usually much less complicated. They tend to be a very local, nicely-focused, primary care-anchored team care approaches that are usually set up to create and deliver patient-focused care in a very local context. Remember the data cited earlier about most health care costs in this country coming from patients with chronic conditions and co-morbidities. More than 80 percent of the care costs come from patients with comorbidities.[226] We usually do a very poor job in this country coordinating and linking care for our chronic care patients and we do an even worse job when the patients have more than one medical condition. Medical homes are intended to help solve that problem.

The best medical homes are set up with the tools needed to provide a set of linked and coordinated services to the people who elect to use them as patients. Those tools are intended to give each patient who needs team care a care team.

Most medical homes are anchored in primary care physician practices. In essence, medical homes tend to be small teams of caregivers with primary care physicians at their core. The teams generally use nurses, therapists and other related health care professionals to deliver a full package of care. The more successful medical homes have already shown that they can improve care, and many have shown that they can also bring down the total cost of care in the process. They bring down the cost of care because the medical home patients tend to have fewer care crises and they generally have significantly lower needs for inpatient hospitalizations.

Medical home patients who get primary-care-focused team care also need emergency rooms less often. The best medical homes are resulting in a major reduction in needed hospital admissions for their

patients.[227] Private insurers and Medicare and Medicaid programs that pay for hospital care all love having fewer hospital admissions. In various settings, each of those payers has encouraged and supported a whole array of new medical homes to exist and function in various ways. Money is a key success factor.

The primary key ingredient and functional encouragement factor that enables and supports the creation of those medical homes is -- very simply – cash flow. Cash is king. Payers who support medical homes need to create the cash flow that medical homes can use for their full set of care coordination and care-linking activities. The homes exist and succeed because that real world cash flow exists. Because the cash flow exists in those care settings to actually support team care, team care actually happens in those settings. As always, we get what we pay for.

Both ACOs And Patient Centered Medical Homes Can Improve Care

Why do we believe that medical homes and ACOs might have a positive impact on the cost and quality of care? Both approaches are new for most segments of this county's health care delivery infrastructure, but the basic approach they are both trying to achieve relative to delivering coordinated, data rich, patient-focused team based care had been tested, modeled, and proven to work in integrated settings like Kaiser Permanente HealthPartners, and Group Health Plan of Seattle for many years.

Kaiser Permanente, Health Partners and Group Health of Puget Sound, among other similarly organized care sites, have all been leaders in reducing diabetic care complications, asthma attacks, congestive heart failure crises, and the need for emergency room use for quite a few years. Those organizations have very robust sets of tools in place to deliver patient-focused team care, and those care teams have proven over time that patient-focused team care actually works.

Other care sites in this country who have sold care entirely by the piece have not had those same tools to coordinate care. The sad fact is that most other care sites have not had collaborative payers who were willing to pay for coordinated, patient-focused team based care. But that

basic cash flow reality is changing. Many other payers are now willing and even eager to buy coordinated, proactive, team based care. The existence of that new cash flow is causing medical homes to be a growing and highly relevant point of care delivery…because the medical homes have the tools to make care better in those key areas of performance.

Both ACOs and medical homes represent a significant modification in the usual business model for care that health plans need to support. The role of the health plan or government payer as a source of cash is essential to the success of both of those care agendas.

It is an issue of sheer practicality. Cash flow is king.

To succeed, the new care approaches need patients and they need cash flow. A medical home or an ACO with no patients and no money is simply and purely empty, nonfunctional, and irrelevant -- for obvious reasons. So both medical homes and ACOs need both the patients and the logistical support that can only be provided by a payer. They need the cash flow that is channeled by the health plans or by the government to succeed. Health plans and health insurers can and should now provide patients, cash flow, systems support, investment and needed levels of data support and real-time data that are needed to make both medical homes and Accountable Care Organizations viable economic functions.

Medical Homes Are Very Useful Care Coordination Tool

Process engineering and reengineering is a toolkit that tends to be used well by the most successful medical homes.

Those care sites have a package payment cash flow that at least partially frees them from the standard rigidly enforced fee schedule list of services. That package payment allows the medical homes to use their lump sum payment per patient to design care delivery around the needs of the patient.

Medical Homes Tend To Be Anchored In Primary Care

Those care teams can use that cash flow to generally work closely with their nurses and other therapists to provide coordinated

interventional and preventive care to the patients who select those doctors and those caregivers as their care anchor.

Most Medicare patients who have multiple medical conditions -- co-morbidities -- have upwards of seven separate doctors.[228] One study of hospital patients found that 75 percent of the patients with multiple medical doctors were unable to name anyone when asked to identify the physician in charge of their care.[229] As this book has pointed out several times, those doctors who share patients typically are not linked in any way. They don't share medical information. They don't share information about the drugs they prescribe. They don't share their care plans with each other for their shared patients.

Remember the numbers cited above. More than 75 percent of the costs of care come from patients with co-morbidities,[230] and those patients typically have to wend their own precarious and complex way through their own confusing thicket -- even forest -- of care sites and solo caregivers. We too often see many patients who are trying to bring their own basic care data on pieces of paper from one care site to another to keep their entire set of caregivers informed.

That really is a stupid and unfortunate way to deliver care. It is dangerous, dysfunctional and completely unnecessary with modern computer technology. So a major role of a well-functioning medical home is to give each patient a primary care doctor -- or a medical home centered care-appropriate specialist -- who has all of the information about each patient in a computerized care registry and who can coordinate all of the care for the patient. Most patients love that level of support. Care is better. Complications of care are reduced. Safety is improved.

That lump sum payment usually pays for all medical home related services -- including phone calls from non-physician caregivers or emails from the doctor to the patient. Most traditional care sites use email rarely or not at all. By contrast, medical homes often email their patients to gain or share information. Patients tend to like being connected by email to their caregivers.

Emails, e-visits, e-coding and various level of e-connectivity between doctors and patients all make huge sense. That e-connectivity tool kit was discussed in Chapters Two and Four of this book.

Care Sites That Sell Care By The Package Do Millions Of E-Visits

Patients like the convenience and the connectivity that can be created by e-visits. The best vertically integrated care systems that already sell care by the package and not by the piece currently do millions of e-visits with their patients. Their patients love that level of convenient electronic connectivity. As noted earlier, Kaiser Permanente alone did more than 12 million e-visits last year.[231] Kaiser Permanente also sent about 30 million lab results to their patients, electronically.[232]

But most care sites in this country today do no e-visits. None. They do no e-visits simply because they can't bill for those visits without committing billing fraud relative to an approved fee schedule. Cash flow is important to caregiver business units. Care sites all need cash to succeed as a business and even to survive as a business. American care sites can't afford to deliver care to their patients for free, so they tend to turn each patient encounter into a billable face-to-face contact instead of a non-billable e-visit so the encounter can legally generate cash.

The prior chapter of this book made the point that the business model of care clearly defines both the infrastructure of care and the functionally of care. That is very true for the new levels of care connectivity tools. E-visits happen today in care sites when the business model of care allows and rewards the use of that tool. They do not happen when the business model of care does not pay for -- and even penalizes -- the use of that tool. It is very basic economic reality. Health plans in this country need to figure out how to create the cash flow reality for care sites that makes e-visits a widely used tool rather than a tool that the caregivers avoid because it reduces revenue. Both medical homes and ACOs can set up cash flow approaches that encourage and incent the use of e-visits.

Reengineering, Repricing and Repackaging Are The 3 R's

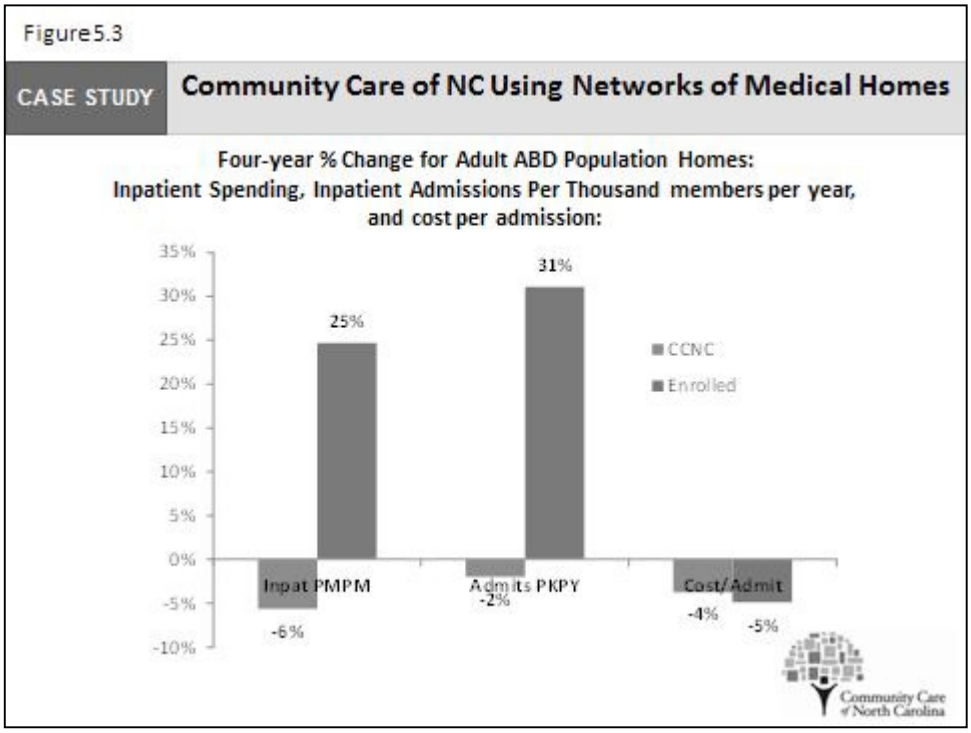
The key to achieving an industrial revolution that improves care and makes care more affordable is to put in place a business model for the purchase of care that encourages and rewards the 3 R's of industry evolution. We need a business model for care delivery that encourages reengineering, rewards repricing, and benefits from the right levels of repackaging. Reengineering works for healthcare when it is done well. Remember the examples from the last chapter of this book of the cost savings that have already been achieved by reengineering care delivery. We cut the cost and price of heart transplants and the cost and price of eye surgery in half in this country by reengineering care for those procedures. That reengineering happened in each case because the infrastructure of care was rewarded for doing process improvement by the business model we used to buy that specific category of care.

Delivering Care As A Package Cut The Death Rate By 50 Percent

This isn't a hypothetical supposition or pure economic theory. As noted earlier, Kaiser Permanente very directly sells care by the package and not by the piece. Kaiser Permanente delivers care from its own care system to more than 9 million people.[233] In the prepaid Kaiser Permanente care system, the reengineered processes that were enabled and rewarded by the business model of selling a package of care instead of selling pieces of care have reduced stoke deaths by 40 percent,[234] reduced HIV deaths to half the national average,[235] reduced broken bones in seniors by over a third,[236] and improved the cancer survival rates for breast cancer and colon cancer patients to some of the highest levels in the world.[237] The model works. Kaiser Permanente has cut sepsis deaths by two-thirds, cut pressure ulcers by over 80 percent; and as noted earlier, the KP hospital system actually has some hospitals that haven't had a single pressure ulcer in over a year. Other hospitals average 7 percent of their patients with those ulcers[238] and those hospitals charge the health insurers $40,000[239] -- on average -- for each case. Care can be a lot safer when you buy it as a package.

The model of selling care by the package works. All health plans need to be figuring out the very best ways of buying packages of care from aligned care teams.

Chart 5.3 below shows the reductions in hospital use that were achieved in North Carolina when that state started using patient-centered medical homes to support care for their Medicaid patients. Care got better. Care costs went down. Those gains could not have been achieved without the medical homes of North Carolina.



That model works well when it is done well. We need the new medical homes and the new Accountable Care Organizations to build on the best features of those existing prepayment models and we clearly need our health insurance plans motivated and enabled to work closely with the medical homes and with the new ACOs to help them succeed. We also -- as this chapter pointed out earlier -- need to stop paying more when care is bad. The benefit redesign strategies were listed earlier in this chapter. Buyers should insist those benefit changes be made by the health plans they use for their employee coverage.

Prices Need To Become Relevant -- Not Just Transparent

We clearly need health plans to support approaches that will make care better and more affordable. As part of that total agenda, we need health plans to address the issue of care prices at a couple of levels. Earlier in this chapter, the role of plans in negotiating price discounts was discussed. That is good work for plans to do -- but it is not sufficient to really create a difference and better market environment for care prices in this country.

Prices Need To Be Relevant -- Not Just Visible

Some people believe that we can have a positive impact on prices by making more prices transparent -- visible -- easily knowable by the consumer. They believe people will invariably choose to buy lower priced care if prices were known for each piece of care. The people who believe that are wrong. As noted earlier, simply creating price visibility is not enough. Visible, by itself is inadequate. Visibility can even have perverse consequences.

We need prices to be relevant -- not just visible.

Relevant is the goal and relevant is the key word to keep in mind relative to prices.

Prices create huge costs overall, but because of the way we usually pay for care through our deductible insurance plans -- prices are simply not directly financially relevant to individual caregivers for most of our care expenses. Deductibles do make some front end prices relevant for some pieces of care. It is a very good thing for patients to know what those prices are for pre-deductible expenses. Prices are, however, only relevant for any patient with deductible insurance until the deductible is met and then they become completely irrelevant for that patient.

Look at the actual spending levels and the distribution of costs. The obvious truth is that the expensive ten percent of the population who used eighty percent of all care costs in this country last year blew right by their insurance deductible almost as soon as their care began. A thousand dollar deductible might pay for one CT scan. Then the

deductible makes other prices irrelevant. That thousand dollar deductible pays for one third of one day in the hospital. Then prices become irrelevant for hospital care. In the real world, no one buys hospital care by thirds of days. It is also very rare that the first piece of care that a patient will face in a year is a CT scan.

Once each person's deductible is met, prices become both invisible and completely irrelevant to most patients in this country.

Some People Confuse Visibility With Relevance

As noted above, some people do believe that the major price issue we need to address in this country is price visibility and not price relevance. Those people believe that keeping prices for pieces of care visible to the patient even after the deductible is met will still cause people to be price conscious in a productive way. The people who hold that position believe the pure awareness of price differences will result in consumers choosing less expensive care.

The truth is -- once the deductible is met for any given patient, if prices for any further pieces of care actually do become visible, patients who know multiple prices often prefer to use the higher priced care vendor. Higher prices seem to indicate higher quality. Many patients prefer to get their care from the surgeon who charges $20,000 for a surgery instead of the one who charges only $5,000 for the same surgery. As one speaker at a policy seminar said, "I really don't feel like I want to have a $4,000 appendectomy when there are $20,000 appendectomies available. I want first class care. Not discounted or cut rate care. My appendix is worth the extra money."[240]

That speaker seemed to have no clue that there is a high likelihood that the higher cost care site for that particular surgery might well have more post-surgical infections, more pressure ulcers, and more surgical redos. Studies have shown that the care sites that charge the most for sepsis care tend to have the highest death rate from sepsis.[241] That piece of information is invisible to consumers, and it certainly isn't how people usually think about prices. Prices very much do not link to quality in this country for care delivery. But patients don't know that, and they are

somewhat more likely to select the higher priced site if the price difference isn't going to have an actual cash impact on the patient.

Also, the truth is that the patients who do see those high prices for that procedure usually do not know that the same site that is charging $20,000 for patients who have that patient's specific insurance coverage for that particular procedure is probably charging $5,000 or $10,000 for the same exact procedure to another patient who has different insurance coverage.

There clearly is no linkage between quality and price in those settings. The range of prices that are used for each service inside each care site is often amazing. As noted in the chapter on prices, the prices charged by the caregivers at each care site tend to vary by payer, not by patient. So even if you do know some prices as a patient, that information doesn't help you figure out anything real about quality at that site, and it doesn't even tell you very much about the actual prices that are being charged to other patients for care at that same site.

We clearly need to do more than make prices transparent. We need our health plans that pay for care by the piece to make prices relevant. We also need to give consumers value-related care data about each piece of care wherever we can add that data to the design process.

Our health insurance companies need to build much better benefit plan structures and approaches that make both prices relevant and visible when unit prices are the way we pay for our care. Buyers should insist that the health plans they use to administer their coverage should put benefit designs in place that will make unit prices both visible and relevant to both patients and caregivers.

The French Set A Baseline Payment Level

As noted in the price chapter of this book. The French actually have figured out a very nice way to deal with the price relevance and visibility issue. The French don't use front-end deductibles. They use a kind of reverse deductible. The French set a fixed price to be paid from their national health program for each and every individual procedure. So every French citizen actually has first dollar -- or first euro -- coverage for

every procedure. That approach doesn't cap prices in France. It sets up a price base payment for each procedure. Doctors in France can then charge patients more than that base payment amount if they want to charge more -- but payment of any additional amount for that care comes from the patients and not from the taxpayer.

The French also insist that each patient pay first for each piece of care. They make people pay first for their care and then the patient must file a claim for that expense -- with each claim paid at the basic benefit level set by the national plan. The French government clearly wants the French people to know what each piece of care costs. They want everyone to have health insurance and they want every citizen to know how much money care costs. The French decided to offer first dollar coverage -- with a payment approach that makes every patient aware of every price. We do just the opposite in this county. We insulate patients from most care prices. The French make all of their prices naked to each patient

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Doctors Will Compete On Price When Price Is Relevant

Doctors in Paris who do want to charge French patients more than the base fee can simply say to the patient -- "The government fee to deliver a baby is five hundred euro. I charge eight hundred euro to do that work. If you want me to deliver your baby, you will have to pay me the difference between the five hundred euro base fee and eight hundred euro price."

It is a very simple payment approach and a very clear price setting method.

That French approach obviously makes prices relevant. It makes prices both highly visible and definitely relevant. That approach creates market forces for care in a very direct way. The French doctor has to convince the patient that the doctor's service levels or the doctor's expertise or the doctor's office décor or charm or convenience and access levels to care are sufficiently superior in some way to make spending the additional money a smart thing for the patient to do.

The French Model Pays Up Front for Chronic Conditions

If that exact model were used in the U.S. for key pieces of care, and if we also decide that we will simply continue to purchase care by the piece and not by the package, using that French approach here would do several very useful things. It would very much make prices visible. It would make prices relevant. It would create a new market model for a wide range of care that would probably work very much like the market model for eye surgery described in the prior chapter. That new payment approach would enable caregivers in this country to improve their business success levels by having competitive prices.

It also would serve the lovely dual ethical and economic benefit and function of not simply shifting the cost of one patient's expensive care site decision directly to all other patient's monthly premium. In the U.S., we actually -- when all the money is moved around -- simply shift the cost of that higher priced care to other people's money. That high average cost of care is then calculated and collected as a premium that is charged to insured people.

That French approach creates a nice relevance for prices relative to decision making about caregivers by patients. It also has a nice intellectual elegance to it. A number of health insurers in this country are beginning to use variations of that model to design their benefits for some procedures.

First Dollar Coverage Is Good For Chronic Care Patients

Another good point to keep in mind in thinking about benefit design is that the French payment approach can offer a very nice additional benefit feature for many patients with chronic conditions. That is true because the French model pays up front for all services -- including chronic care -- instead of having a deductible that causes people to pay for their initial services for their chronic condition each year until their personal deductible is met. Chronic care patients in France don't need to pay a deductible before getting benefits. Not having an up-front deductible is a particularly good thing for chronic care

patients. Remember where most of the costs of care in this country are -- with chronic care patients. We very much want patients with chronic conditions to refill their prescriptions and we want those patients to have their blood tests and other follow-up care done. When chronic care patients in our country have to pay an upfront deductible each year, there are often delays in getting needed care early in the year. Studies show that the higher deductibles often create financial barriers to some chronic care follow-up for some American patients.

The French model eliminates that barrier by paying first for that level of care without a deductible. The French model might only pay twenty euro for a blood test and a French doctor might charge thirty euro for that test. The patient can either find a doctor who will do that specific test for twenty euro or the patient can pay the difference out of pocket.

Both prices are less than a typical American deductible.

Even if the patient decides to pay out of pocket for the price difference, ten Euros paid out of pocket is still less money than the patient would pay for that service with an American deductible plan where the full thirty euro fee paid would then be charged to the patients and then paid directly by the patients until the deductible is met for that patient for each year.

We Need Better Benefit Design When We Buy Care By The Piece

That is another issue for buyers, employers, and health plans to consider in setting up the cash flow we use to buy care.

Deductibles are actually a highly imperfect payment approach that tends to have multiple perverse and entirely unintentionally negative impacts. Those unintentional perverse impacts can often be avoided as part of the benefit package design when a given insurer's approach to financing care involves buying care by the package and not by the piece. Those perverse impacts can also be avoided by having a fixed first dollar benefit schedule to buy care instead of using a pure up front deductible for all care before payment for any care.

Insurers need to do a better job of designing benefit packages around patient needs -- with chronic care patients having benefit plans

that facilitate patients receiving right follow-up care. Insurers also need overall care strategies to improve care. Insurers need to support better care plans and better care approaches to achieve premium affordability rather than simply using increasingly high deductibles to shift increasing levels of costs to patients to keep premiums lower.

We need to get the insurance mechanisms right. We need to do smart things relative to health insurance if we want to make appropriate changes in the actual delivery of care.

The Political Power of Health Care Is Huge

Some basic business model changes are needed -- but in some ways -- for some segments of the current health care infrastructure, those changes will not be easy to do.

We spend nearly two point eight trillion dollars on care in this country.[242] The infrastructure of care in this country is very protective of that cash flow. It results in jobs, health careers, significant local cash flow, and wealth.

The political power and the political connections that result from all of those local jobs and from that local economic strength is massive. Politicians often bemoan the total cost of care but politicians seldom bemoan caregivers. When the political world does look to attack someone for the total cost of care, the usual politically correct target of the cost-related attack tends to be health insurance companies.

This book calls for insurance companies to be a significant positive factor and a major asset in the agenda of making care more affordable in this country. That isn't the role that most people believe that health insurers play today relative to health care costs.

Blaming The Speedometer For The Speed Of The Car

Surveys tell us, in fact, that a significant number of people in this country who are unhappy about care costs actually blame insurance companies, themselves, for the high cost of care. Several surveys have shown that belief to be widespread. A high percentage of people literally

believe that premiums, themselves, create health care costs. When you understand how premium levels are actually calculated, that's actually a bit like blaming your thermometer for your fever -- or blaming the speed of your car on your speedometer.

But surveys show that the number one factor at the top of most lists when people are asked what causes health care costs to be high in this country is the health insurance industry. Insurers tend to be rated by caregivers to be the top driver for health care costs in this country.

Blaming Your Thermometer For Your Fever Isn't Accurate

In the real world, health insurance premiums are very basically the average cost of care. In the context of true functional economic and arithmetic reality, those premiums are simply the speedometer for runaway health care costs. As this book has stated several times, premiums are based on the average cost of care for any given covered population. When the cost of any insured piece of care goes up, the average cost of care for the insured people goes up. The average cost of care is key. When the average cost of care for any given insured population goes up, insurance premiums for that insured population go up. It is a very direct and almost immediate linkage.

So why do so many people blame insurance companies for the high cost of care? That perception is widespread, in part, because a number of political leaders have chosen to ignore the issues of provider costs and to completely duck any mention of provider prices in the cost debates and to focus instead in a very public and focused way on the issues and visible events that relate to insurance costs.

The New Insurance Laws Make Some Old Practices Illegal

How did politicians come to that conclusion? Why do politicians offer that assessment as the primary cost driver for care? They reached that conclusion, in part, because most political leaders have not wanted to challenge the political power of the caregiver community. Political leaders also reached that conclusion because that sense of insurers,

themselves, directly triggering excessive cash flow used to have some situational truth for some insurance companies in some settings.

It is true that some health insurance companies in the past in some market settings did very visibly take some excess profits from some subsets of the health insurance marketplace. The health insurance industry, overall, actually has a lower average profitability level than almost any other industry. The total profit margins for the health insurance industry typically run lower than 5 percent overall. The public -- when asked -- tend to believe the profit margins of insurers exceed 10 percent. That 10 percent number is not true. Two and three percent margins are not uncommon.

Some insurers did, however, make much higher margins in past years -- and some of those margins were visible to the public and policy makers. Those margins are no longer legal.

So it is true that the rules about how insurers calculated premiums were much looser in some settings before the new Affordable Care Act law was passed. Those days of insurer spending very low percentages of the total premiums they collected on actual costs of care are now gone for everyone. To the extent that some insurers actually used those business models, those practices have been ended. The new truth is that the new insurance premium setting laws have simply made those old profit-taking practices and those very low percentages of premium spent on care illegal for insurers. Insurer profits and insurance administration costs are now functionally and legally capped as a total percentage of premiums.

The new law specifies the minimum portions of premium that must be spent by insurers to pay for care. The new maximum loss ratio laws that exist today now define and constrain the calculation of health insurance premiums. So any insurers who might have done any kind of abusive or excessive premium pricing in the past now face strict and rigidly enforced loss ratios laws that keep excessive profits and high administrative cost from being charged to insured people. Those days are gone. They were ended by the new loss ratio laws.

So now, premiums are the thermometer -- not the fever.

Premiums Are Directly Based On The Average Cost Of Care

The basic arithmetic reality today is that health insurance premiums in this country are based on the average cost of care for insured people. That is true here and it is true in every other country that also uses private insurance as the key mechanism to make other people's money available when that money is needed to buy care for sick people. The ACA law directly bases the cost of today's premium on the current and actual cost of care for insured people. So the truth is, care costs create premium costs and premium costs do not create care costs.

Another key truth is -- we do need to make premiums affordable at this point in history. This book argues that the best way of making premiums affordable is to bring down the average cost of care for each insured person. As noted above, we can do that in several ways. We can do it by negotiating lower fees -- we can do it by buying care by the package and not by the piece -- we can do it by delivering better care (that has fewer complications and fewer crises) -- and we can do it by improving the health of the insured population.

Those are all important things for health plans to do. As we try to bring down the total cost of care in this country and as we work to make premiums more affordable, all four of those agendas need to be part of the health plan agenda for the country.

U.S. Premiums Could Drop By Over A Third If We Paid Canadian Prices

Some people argue that the administrative cost burden charged in the health insurance premiums today are still too high. Some people argue that we could make care costs a lot lower in this country if we simply used the Canadian single-payer insurance model...and more than one speaker has said that the difference in costs between the U.S. and Canada is actually the difference in expenses that is created by the health plan administrative costs in the U.S. versus the lower costs that exist for administration in Canada.

Is that accurate?

Are the administrative cost components of the Canadian national health insurance model the primary reason Canada spends so much less money on care than we do?

No. Those administrative costs in Canada are lower -- but they are not the primary reason Canada spends less than 12 percent of their GDP on care while we spend almost 18 percent of our GDP on care.[243]

That belief is, in fact, partially accurate. We do spend more money on insurance administration than the Canadians spend, but the total cost impact is not as high as people believe it to be. Look at actual numbers.

The relative impact of those administrative costs and the relationship between care costs and insurance costs can be seen pretty easily if we compare the key elements of health care costs in the U.S. and Canada. Remember the chapter of this book on care unit prices. Look back at those price charts. Canada spends a lot less on each piece of care. If we used actual Canadian care unit prices to buy each piece of care here, and if we kept our entire private insurance plans intact, our insurance premiums in this country would actually drop overnight by about 40 percent overnight.[244]

Premiums are based on the average cost of care.

The average cost of care purchased by American insurers would be a lot lower if American insurers paid Canadian prices for each piece of care. Look again at the prices for pieces of care in Canada that are shown in the price chapter of this book. Check the chart for Canadian care prices. That forty percent reduction insurance premium in this country would happen with no change in the amount of care delivered in this country if we just paid for each piece of care using Canadian prices. That lower premium level would happen because the American insurers simply could pay for each piece of care using Canadian prices.

How much of that difference is due to the difference in administrative costs?

If we moved to the Canadian single payer administrative costs model and if we eliminated all insurance company administrative expenses for this country and if we replaced them with Canadian administrative costs that they incur for running their program, we would replace an average 15 percent[245] insurance company administrative

charge in this country with the 7 percent total administrative expense level that is now charged in Canada.

The numbers are clear. Replacing our 15 percent with their 7 percent would reduce our total health insurance premium levels by 8 percent.

Eight percent is a big number -- but it is a lot smaller than the 40-percent reduction that we would get if we paid for care using the Canadian fee schedule.

The Canadian government fees for each piece of care are all set by the government. They look very much like the fees we pay when our fees are set by our government. As noted earlier several times, states set the Medicaid fees in this country. Those fees in some states are very close to the fees that are set by some of the Canadian provinces.

It probably is not coincidental that when government legislative bodies in each country have to decide whether to set low fees for pieces of care or raise taxes to pay for that care, the decision that results from the political process and the government officials is to set low fees on both countries.

If that is actually why Canada spends so much less money on care, why don't we simply follow the Canadian model and have our own government impose its own set of prices on all care?

That is the logical final question in this chapter on using the business model to change the way we deliver care. Setting fees by government edict is clearly a business model option we can consider.

Why isn't it the recommendation of this book?

The answer to that question was given at the end of Chapter Three. We would financially destroy the health care infrastructure of this country if we used Canadian fees to buy all care here.

We would also be continuing to buy care by the piece.

Chapter Three also explains how dysfunctional it would be for us to cut prices and also to continue buying all care by the piece. So even though that solution would work at one arithmetic level, it would be disruptive, damaging and even destructive at multiple other levels.

We have better solutions. We may want to write some pricing laws that do prevent providers from using truly abusive pricing for uninsured

people. We may want to set up pricing rules that say people without insurance could cap their payments at prices that are double or even triple what Medicare pays for a piece of care. That could end some obvious pricing abuses. But we do not want to have the government simply set all prices because the consequences of doing that would keep us from continuously improving care.

We Will Not Use A Canadian Fee Schedule Or Insurance Plan

If we are going to change the way care is delivered in this country, we need to change the flow of cash that goes to the infrastructure of care in some important ways.

There are four major sources of cash in this country that create that flow of cash. The four sources are patients, employers, health plans, and the government. This chapter explained why the consumers currently have relatively little leverage in changing the way we buy care -- and it explained that employers clearly have better leverage than individual caregivers. It also explained that the two best mechanisms for charging the flow of cash are the health plans and the major government programs that buy care.

Chapters seven and eight of this book explain what Medicare and Medicaid can do to bring down the cost of care.

This chapter has basically focused on the role that health plans need to follow to help caregivers improve the way care is delivered.

As we look at the total business model of care to see where we could make changes that can help bring down the cost of care and reduce the premiums that are needed to pay for care, it is clear we need health plans to serve as the tools we use to get that job done. We know that health plans need to be buying care more by the package and less by the piece. We know that health plans need to modify the benefit design to make prices more relevant when prices are the way we pay for care. We know that health plans need to support caregivers who are reengineering care to make care both better and more affordable. That approach of working with caregivers and using the cash flow of health plans to modify

the way we deliver care is a very useful strategy that has a high probability of actually succeeding if we do it well.

That entire agenda will fail, however, if we don't make the premiums that are charged by the health plans affordable. Premium affordability is the topic of the next chapter of this book.