You Want Me to Pay *More*? How Does P4P Fit With What Mainstream Purchasers Seek?

- Problems
- Solutions
- Transformational Tools

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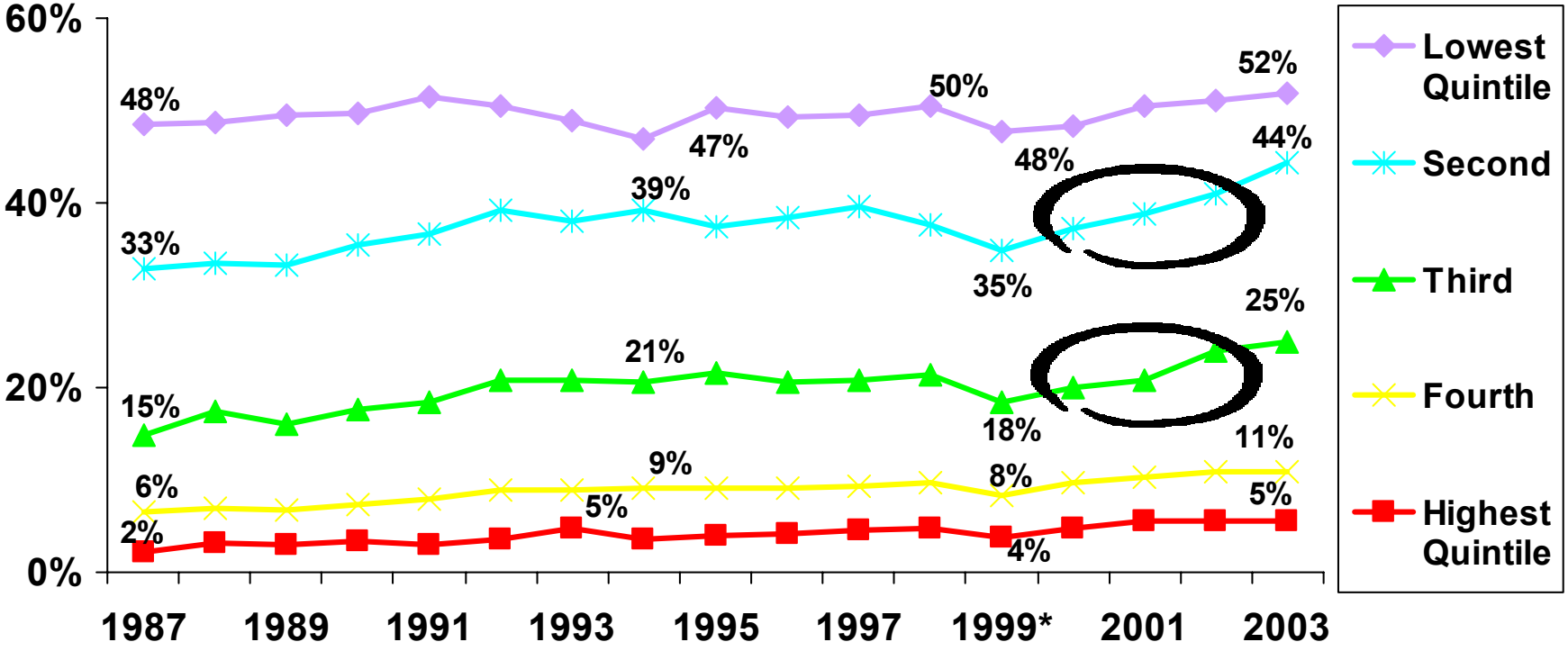
Problem #1: Rapidly Spreading Unaffordability

Percent of working adults *uninsured*, by household income quintile 1987–2003



* In 1999, CPS added a follow-up verification question for health coverage.
Source: Analysis of the March 1988–2004 Current Population Surveys by Danielle Ferry, Columbia University, for The Commonwealth Fund.

Adapted from "A Need to Transform the U.S. Health Care System: Improving Access, Quality, and Efficiency," compiled by A. Gauthler and M. Serber, The Commonwealth Fund, October 2005.

The Human Face of Unaffordability: He Works 90/hrs a Week, Earns $85K and Selected "Thin" Health Insurance Coverage

Arnold and Sharon Dorsett with their children, Dakota, Zachery and Jessica, back. Thinly insured, they had to file for bankruptcy because of Zachery's health care costs.

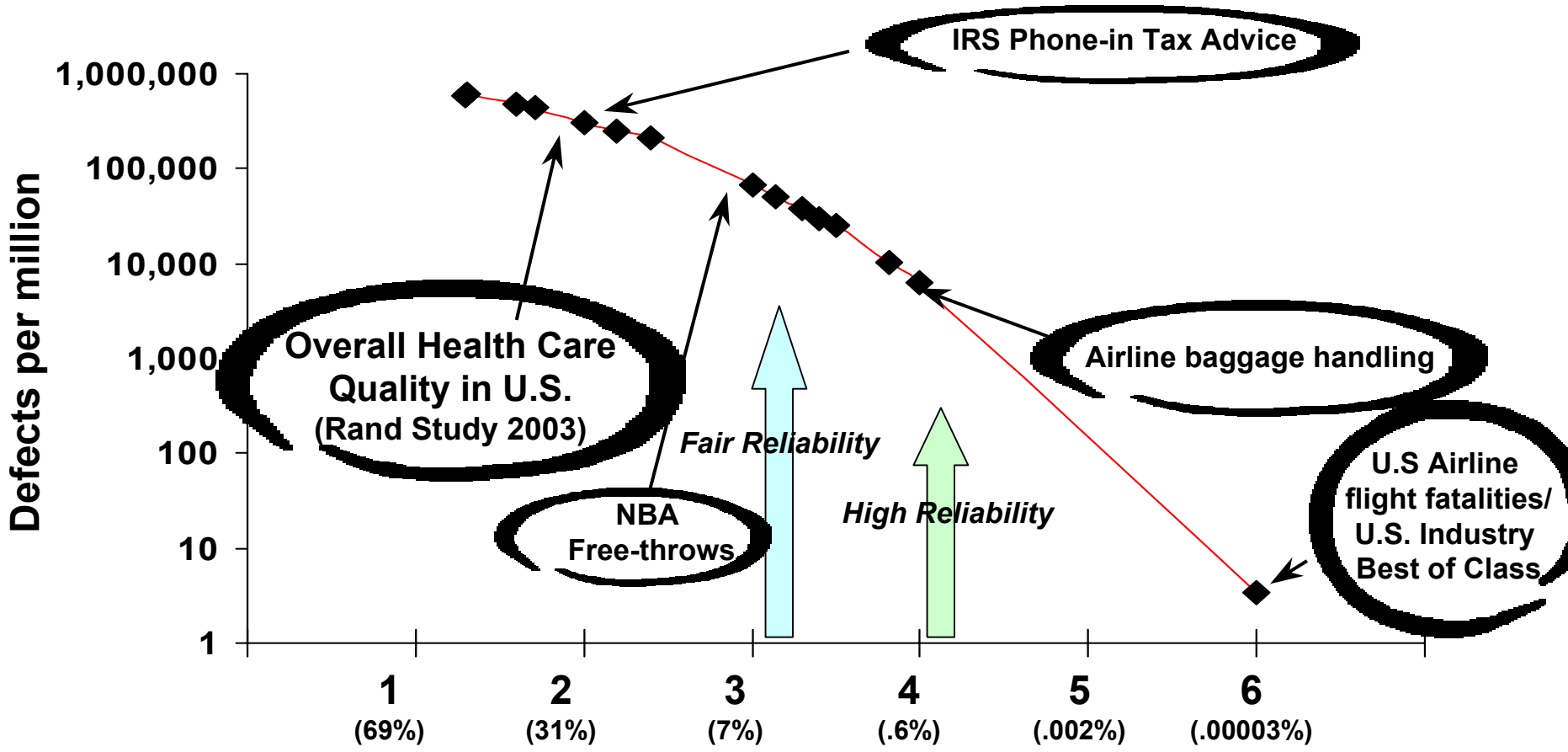
Is Unaffordability Due to Waste? Inventory of Current "Muda"

(Estimates of 3 Major Types of Senseless Waste
As a ~% of Current Total U.S. Health Care Spending)

1. Quality-neutral gap in spending between *lowest spending regions* and all other regions (Dartmouth) (-30%)
2. Quality-neutral gap in spending between *lowest spending providers* and all other providers within lowest spending regions (Regence) (-15%)
3. Quality-neutral gap between *lowest unit cost* care delivery methods and all other methods (National Academy of Sciences) (-20% to -30%)

Problem #2: Untrustworthy Quality of Care

Sources: modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint; & Mark Sollek, Premera



The Human Face of Untrustworthy Quality: (Bring Your Own Bodyguard)

Mary Dotseth, *Minnesota's Senior Policy Adviser for Patient Safety*, was to have a brain tumor removed.

As the surgeon entered the operating room, he announced he was going to remove part of her left temporal lobe, Dotseth recalled.

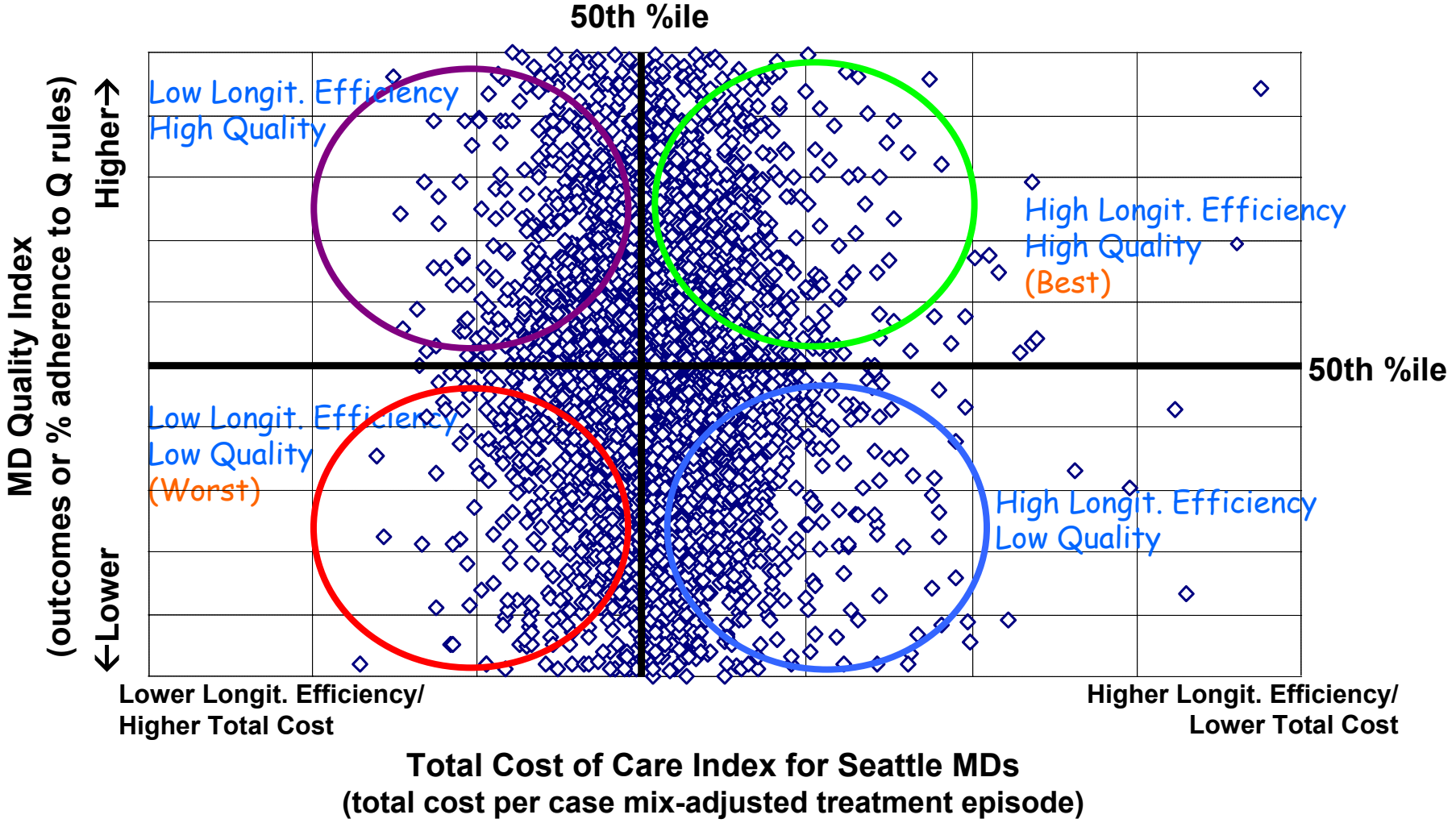
"I cried out, 'No, no, no, it's my right!'" she said.

"He takes the film and turns it over. Everyone just about passed out."

(If she'd been anesthetized a few minutes earlier…)

Provider Total Cost & Quality of Care Are All Over the Map (And Unclear to Providers Themselves)

Wide Performance Spread *Within* a Lowest Spending Region

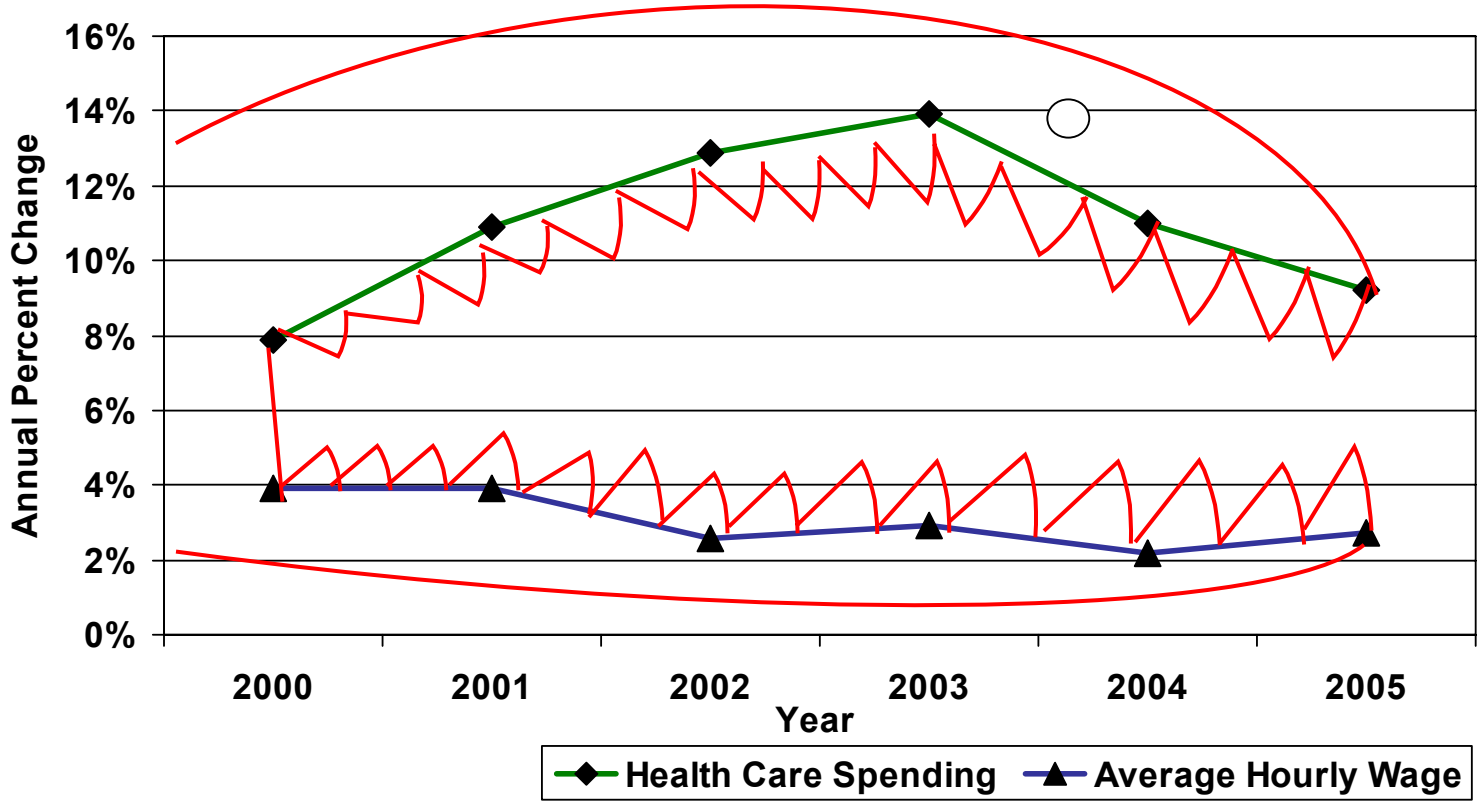


Adapted from Regence Blue Shield

The Continuous Driver of *Both* Main Problems: A Persistent Medical Miracle-Powered Shark

Annually Gain 2.5% in Efficiency or Spend >50% of Employee, Retiree, Taxpayer and/or Shareholder Income on Health Care (N.B. Shark-killing is Prohibited; Shark Adds 5 wks of Life Exp/yr

Annual Percent Changes per Capita in Health Care Expenditures and in Average Hourly Wages for Workers in All Industries, 2000 through 2005



Data from Kaiser Permanente/Health Research & Educational Trust 2005. Dental work by Dr. Milstein.

Solutions: Americans Need Their Health Care Providers to Do Four New "Jobs"

- Eliminate current "muda"
- Make quality *fairly* reliable

➡ Much more rapidly adopt best known care delivery methods

- Perpetually gain efficiency to outswim the medical miracle-powered shark
- Make quality *highly* reliable

➡ Much more rapidly incubate care delivery innovations

Solutions: What "Few Simple Rules" Would Catalyze These Jobs Getting Done by 2015?

- **Rapid and universal performance measurement:**
  measure performance of providers and treatments *much more rapidly and uniformly*
- **Highly performance-sensitive payments:**
  make all enrollee cost-sharing and provider payments *much more performance-sensitive*
- **Faster vetting of cost-saving innovations:**
  much more rapidly measure economic/clinical outcomes of *cost-saving innovations* and cover/reward those *that do not reduce quality*
  - *Expand roles of paraprofessionals and non-professionals*
  - *Use engineers to help redesign IT-enabled care workflows*
  - *Source care globally (e.g., major elective surgery)*

Fee Schedule From a Joint Commission Accredited Hospital in Coastal China: Funnier Than a 1965 Toyota Corona?

ITEMS	CHARGE (U.S. DOLLARS)	
General Registration	$	0.12
Emergency Registration	$	0.25
General Office Visit	$	0.37
Specialist Office Visit	$	0.62
Professional Office Visit	$	0.74
Famous Professional Office Visit	$	3.72
Emergency Consultation	$	1.24
VIP Patient Office Visit	$	12.39
VIP Patient Office Visit (famous professional)	$	24.78
Ambulance	$	6.20
Ward Bed	$	11.13
Suite (capacity: 2 patient per room)	$	47.09
VIP Suite (Single)	$	74.35
Deluxe VIP Suite	$	148.71

Source: Clifford Hospital, Guangdong, Guanzhou, China

Placing "A Few Simple Rules" in Context
(Refreshing a Highly Viral PowerPoint Slide)

↑ ↑ Value Gain by Americans

High

Efficiency of Health Benefits Spending (Health Gain / $)

↑ ↑ Clinical Performance Management

Q ⇧ 50 ppts

$ ⇩ 40 ppts,

then "5 wks" & 2.5 ppts p.a.

↑ ↑ Market Sensitivity to Performance

Faster clinical re-engineering by MDs, hospitals & innovators

↑ ↑ Transparency on Quality & Cost-Efficiency

"Aerobic" professionalism, benefits design, innovation vetting & P4P

Performance comparisons for hospitals, MDs, treatments & innovations

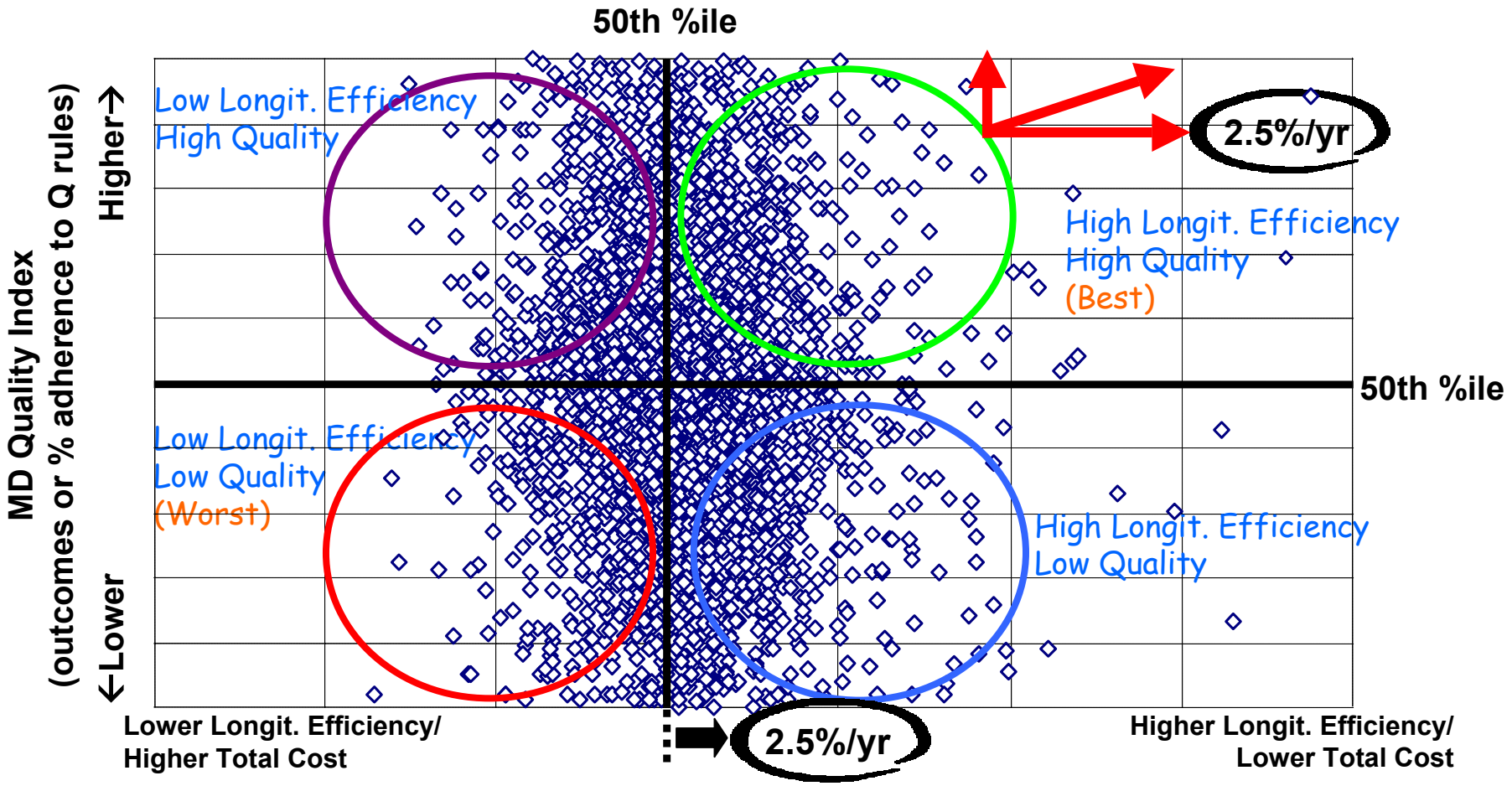
Q = % adherence to evidence-based rules

$ = Per capita health care spending. Includes new investment in IT / industrial engineering capability. Excludes impact of inflation, aging and biomedical innovation

Low

2005 **Evolutionary Path** **2015**

Visualizing an Annual >> 2.5% Gain in Cost-Efficiency, While Improving Quality Reliability



Adapted from Regence Blue Shield

Where to Look for *Perpetual* Gain in Performance
2005 Report On Use of Engineering Tools To Design Innovations in Health Care Delivery

"Unfortunately, the health care system has been very slow to embrace engineering tools and clinical information technologies that could transform it from an underperforming conglomerate of independent entities into a high performance system." (emphasis added)

- Co-chair, National Academy of Science's Committee on Engineering and the Delivery of Health Care

2004 Results from the Engineering Front Lines: 50% Unit Cost Reduction in Specific Processes In Pittsburgh Hospital Departments; Virginia Mason (Seattle) Is Now Combining It With *Major* Reductions In Total Service Volume

A.>10%

B.>20%

C.>30%

D.>50%

A Very Different Provider Message to Purchasers
(Virginia Mason's Refreshing Alternative to "Pay More")

Up to 50% of national corporate health care dollars are wasted on unnecessary variation in diagnosis and treatment, poor quality, inefficiency and failure to apply known "Best Practice."

The current state is unaffordable, unsustainable and is of great concern.

Over the last year you have joined us in applying the innovative principles of the Toyota Way, Evidence Based Medicine, cost accounting and Change Management to improve value *and reduce cost of care.*

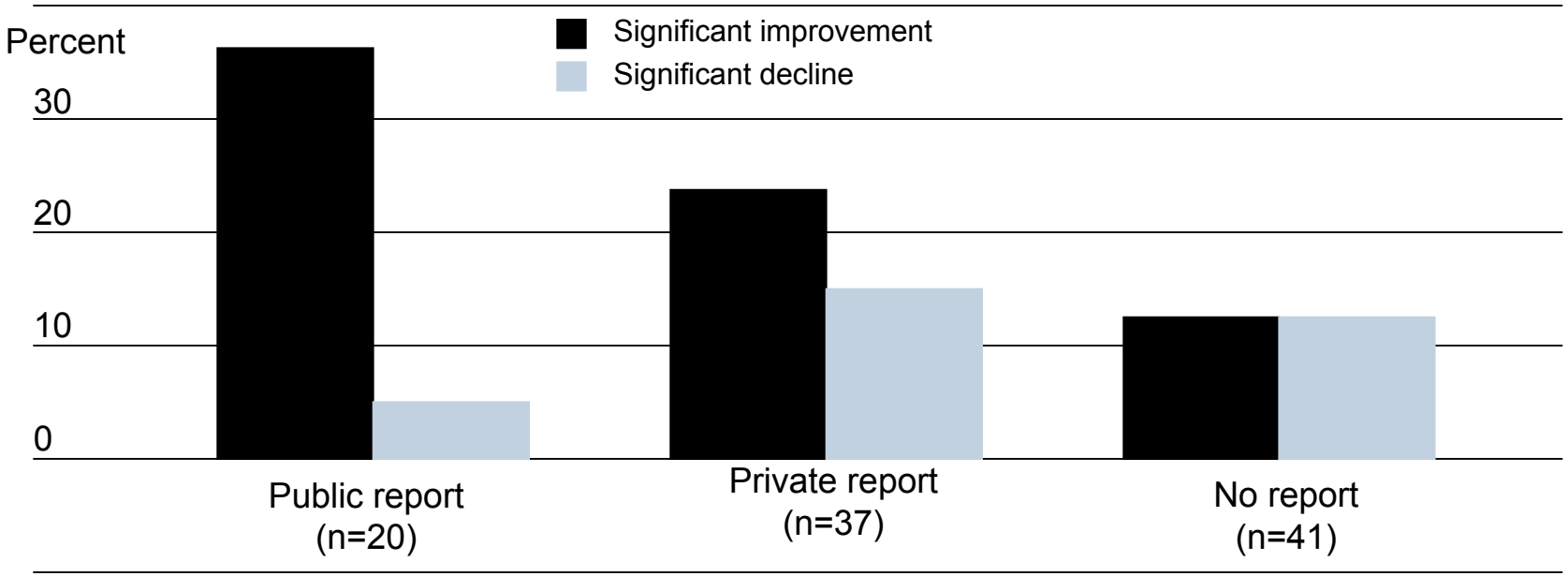
You pay our salaries and we are accountable to you for the care of your employees. This is the report of our progress over the last year.

– Gary Kaplan, MD, CEO
Virginia Mason Medical Center

Tools: *Salient* Transparency Can Be Powerful, Even If Best Available Measures Aren't Precise

(Think Restaurant Hygiene Grading in Los Angeles)

Percentage Of Hospitals With Statistically Significant Improvements Or Declines In Obstetrics Performance In The Post-Report Period (2001-2003)



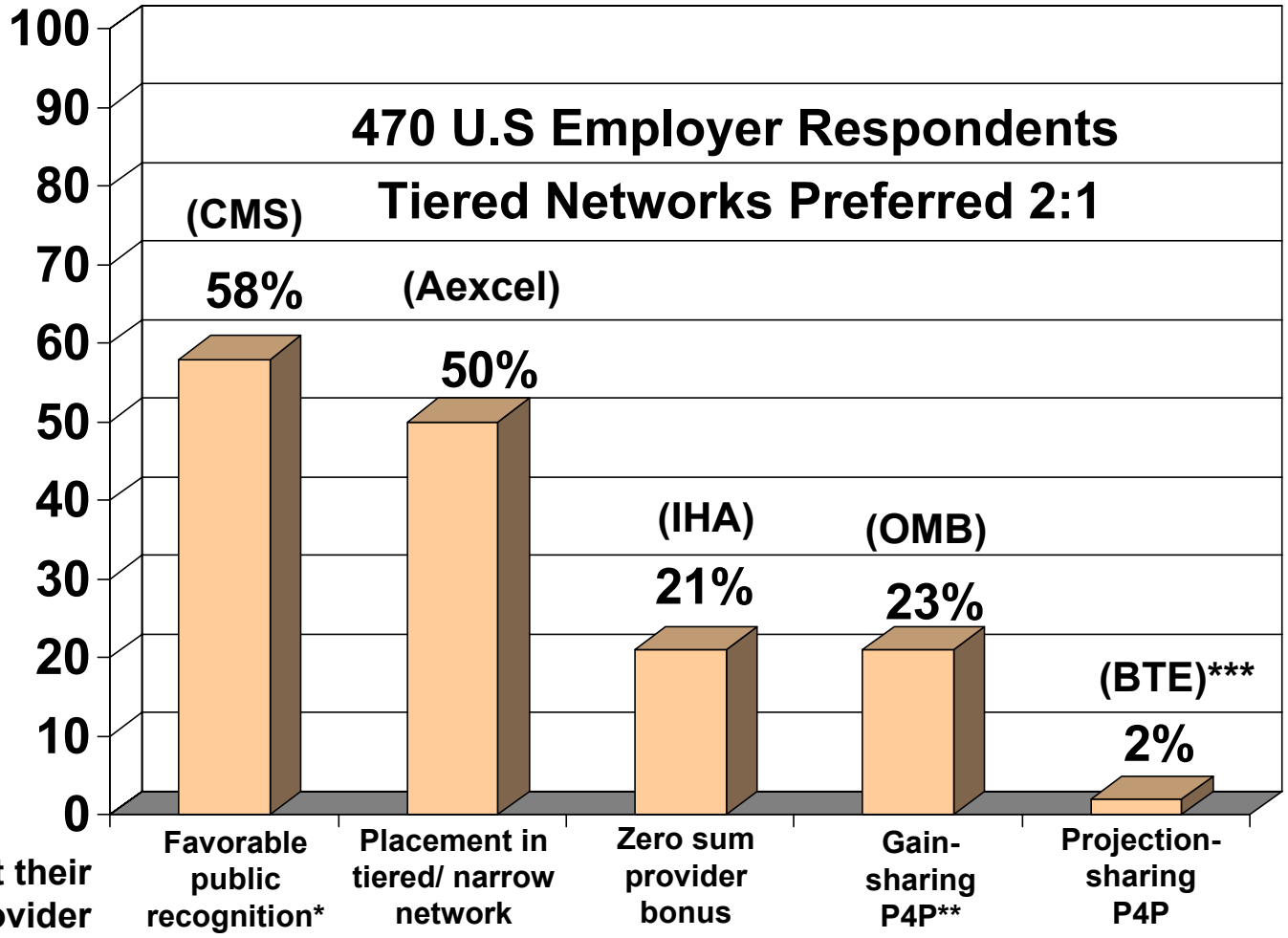
Source: J. Hibbard, et al., Health Affairs, July 2005; and
Wisconsin Bureau of Health Information, risk-adjusted by Medstat.

Tools: Consumers Prefer Narrowed/Tiered Provider Networks To Paying Providers More to Achieve Better Performance (AKA "P4C")

	All Adults
Extremely/Very Interested/Interested in Performance-Selected Provider Networks	67%
Support Strongly/Somewhat Provider Pay for Performance	38%

Extracted by from a HarrisInteractive poll as reported in WSJ Health-Care Poll, May 24, 2005.

Tools: Employers Aligned With Consumers; Sunshine & P4C Preferred 2:1 To Provider P4P



% who would want their plan to reward provider performance with:

Source: Mercer Human Resource Consulting

*Including star designation in provider directory

**Cost savings and/or quality gains demonstrated for the employer's own covered population

***BTE evolving to gain-sharing P4P

Tools: Rating the Useable Horsepower Of Transformational Tools

Tool	Useable Horsepower Rating	Comments
Transparency-Fueled Professionalism	A	Win-win; but doesn't fix baseline payment imbalances
Tiered/Narrowed Networks	B+	Maximizes savings to customers; throughput reengineering an essential co-factor
Zero Sum P4P	B	Useable power limited by losers' resistance
Gain-Sharing P4P	B-	Useable power limited by high baseline levels of uninsurance/underinsurance & purchasers' future financial liabilities
Projection-Sharing P4P	C	Best suited to provider monopolies or wealthy/health industry purchasers
Regulation	D	Few encouraging precedents

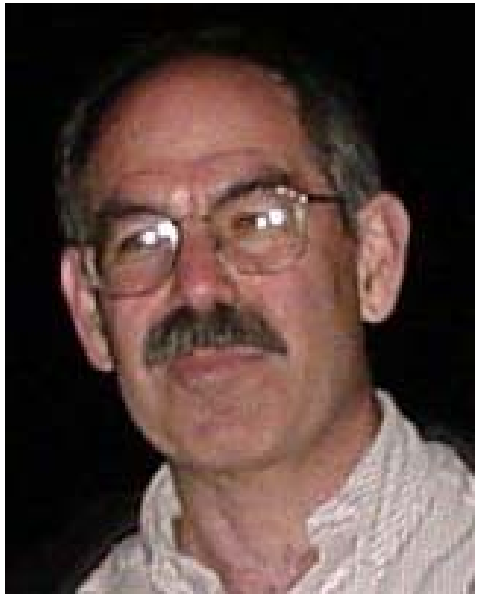
Tools: A Trench-Level P4P Forecast

- P4P is a “medically necessary” symbolic reset
- P4P is likely too constrained by baseline economics and customer/provider resistance to get all 4 big new jobs done quickly enough to shield the middle class (AKA “the voting class”) from ominous medical impoverishment
- Provider payment reform that reallocates spending from procedures and imaging to care coordination will happen, likely under the label of efficiency-based P4P
- Transparency-reenergized professionalism, more sharply value-tiered benefit designs (AKA reference pricing), and faster vetting of cost-saving innovations will create most of the momentum for transformation

What Primary Obstacles Must We Overcome?

Uwe Reinhardt:

“Newman’s Law”



Neil Weinstein:

“Optimistic Bias”

We Are Today's Pilots: Will Our Legacy Be "Survival of the Richest" or >> 2.5% Annual Performance Lift?