



Strong-Form Products

What Providers Should Do Regardless of Reform Efforts



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EXECUTIVE SUMMARY

After long discussion and debate, healthcare reform seems to be moving forward. However, what began as a major overhaul of the system has devolved into a more limited-scope effort to aggressively expand coverage (without increasing deficits), ban or modify some long-standing insurance industry practices, and build key enablers for future waves of change. The major long-term issue for the industry and the nation is cost—and the key is healthcare costs, not insurance costs. The focus of future waves of change/reform will place providers front and center. Working with doctors and insurers—and understanding consumers better—will be vital. And “strong-form” products that address the broadest possible set of clinical conditions and treatments, not just the most serious and expensive, are likely to play a major role. Exciting developments in Florida and elsewhere are pointing the way to a more cost-effective and outcome-driven model for care and payment that providers can implement to meet the coming challenges.

REFORM IS PROGRESSING, BUT COSTS KEEP RISING

After long discussion and debate, healthcare reform seems to be moving forward. However, what began as a major overhaul of the system has devolved into a more limited-scope effort to aggressively expand coverage (without increasing deficits), ban or modify some long-standing insurance industry practices, and build key enablers for future waves of change.

The major long-term issue for the industry and the nation is cost—and the key is healthcare costs, not insurance costs. The focus of future waves of change/reform will place providers front and center. The good news is that many of the strategies already being pursued by most providers—such as major IT investments and integration of physician practices—will serve them well. Furthermore,

several elements of reform have been explored in a variety of forums—beyond federal legislation—for some time now.

- “Comparative effectiveness research” will continue, evolving into best practices through the continued development of evidence-based medicine (EBM) approaches, especially for high-volume and high-cost procedures.
- Bundled pricing—to include both facility and physician charges—will increasingly become the norm. Providers that consolidate these two components under one umbrella will be well positioned, both for managing care and for avoiding undue haggling among the parties.

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- Indemnity-like, episode-specific pricing is likely to evolve, partly to control costs, but primarily to provide an avenue of accountability for providers. Under such an approach (most likely for major interventions), providers would be paid a single amount for, say, a hip replacement to cover everything from surgery to rehabilitation.

Strategies already in motion, such as physician integration, centers of excellence, protocol development, and clinical IT enhancements are steps in the right direction, but a bolder approach is needed.

No one strategy or insight can constitute a robust response to the changing world of healthcare insurance, regulation, and economics. A full arsenal of initiatives will be needed—many

building on the momentum of programs already under way at most leading providers. There is no reason to abandon or slacken efforts focused on revenue-cycle management, blocking-and-tackling cost reduction, and striving to meet higher levels of customer service. That said, a vision of a fundamentally different end game for healthcare delivery is overdue—and is needed for context, rationale, prioritization, and resource commitments driven from the very top level of the organization. We, and a set of our clients, believe that moving toward a true retail marketplace and a consumer-driven model of healthcare delivery is the right way to go. It can form the backbone of an enterprise-wide strategic vision of a more cost-effective and patient-friendly way of doing some of the nation's most important work.

A carefully crafted experiment is under way in Florida, where several providers (nonprofit and proprietary) and one large payor have joined forces to fundamentally change the paradigm of care delivery. It seeks to invert the traditional proportion of customized vs. routinized care from 80/20 to 20/80—focused on the goals of better outcomes, better customer experiences, streamlined operations, and lower costs. By involving doctors, hospitals, ambulatory providers, insurers, and consumers, the initiative seeks to leapfrog the traditional boundaries of centers of excellence—transforming both care delivery and the customer experience. In the process, the role of the payor is also transformed—from a risk aggregator and wholesaler for group sponsors to a retailer and fair broker for consumers.

PRODUCTS WORTH WANTING AT A PRICE WORTH PAYING

The holy grail of improved healthcare delivery is hardly a mystery. The vast majority of providers would agree that consumers have every reason to expect the following:

- The best science brought to bear on their conditions—not the anecdotal experience of a single provider
- Seamless and transparent delineation and coordination of care and services by providers—not via trial and error by patients and their families
- Accountability for results within expected bounds
- Up-front knowledge of the financial consequences of the entire episode—and a simple bill or two that conform to the prediction (this was mentioned by 80 percent of consumers in surveys and focus groups)
- Access to extra amenities (home visits, for example) on an integrated basis at reasonable and predictable cost

Despite decades of initiatives to transform healthcare delivery—especially in hospitals—very little has actually changed, especially from the consumer's point of view.

Though healthcare is far more complicated, some comfort (and maybe embarrassment) can be drawn from the example of automobile body shops (along with their insurance company partners), most of which now meet the very requirements we should expect from the provider sector. Despite decades of initiatives to transform healthcare delivery—especially in hospitals—very little has actually changed, especially from the consumer's point of view. While a handful of integrated systems show promisingly different results, for the great majority of providers and their customers, healthcare is an expensive, unpredictable, hassle-ridden experience—often with unjustifiably varying outcomes.

The cornerstone of the new model—Healthcare of the Future (HOF)—is the transformation of services and activities into real products. These so-called strong-form products are integrated consumer-centric offerings that bundle world-class care from diagnosis through rehabilitation, provide simplified billing and payment, improve customer service, and give consumers real choice. The goals go beyond a clinical and marketing focus on high-profile

services (hearts, maternity, cancer, etc.)—that is, they seek more than what can be achieved through traditional centers of excellence.

Strong-form products combine the best features of traditional approaches, while adding new capabilities for an improved customer experience and greater coordination—from prevention and disease management to diagnosis, treatment, and rehabilitation. Just as important, though, is HOF's use of strong-form products to drive a fundamental change in how providers think about their day-to-day operations. For the long term, HOF seeks nothing less than a complete inversion of the traditional paradigm of hospital operations—moving from a world where roughly 80 percent of all services are delivered on a “customized” basis, to one where as much as 80 percent of care is delivered under state-of-the-art protocols driven by EBM. Not only will this action improve outcomes and standardize care, it will also create opportunities for breakthroughs in how hospitals operate. While nothing will ever make all aspects of diagnosis and treatment predictable, the tools are now available (and improving) to do

a much better job for patients—and providers as well.

The notion of “products” has been on the scene for a while—proposed and championed by such prominent commentators as Michael Porter and Regina Herzlinger. HOF takes the basic idea of products and pushes it to another level by involving payors and consumers. Payors are critical to the concept of strong products because without their cooperation there is little potential for steered volumes and simplified payment and billing approaches. Steering patients to EBM providers with strong products is critical to the concept—not just to reduce costs and reward superior providers, but also to improve clinical care and outcomes. In addition, if billing isn't made more simple, transparent, and predictable, one of consumers' major needs will be unmet. And finally, the goal of HOF is to address the broadest possible set of clinical conditions and treatments, not just the most serious and expensive. Without that broader focus on more common treatments, it will be nearly impossible to transform hospitals' operations away from the dominance of “custom-built” activities.

THE FLORIDA EXPERIMENT

The Healthcare of the Future experiment has been under way now for more than two years. It currently involves three of the system's major structural sectors—consumers, plans, and providers. It also has the potential to integrate high-tech suppliers and pharmaceutical companies. The project addresses some of the system's biggest cost components: current and downstream costs of complex conditions such as cancer and big-ticket acute interventions. (In its initial stages, HOF does not address chronic disease or end-of-life costs.) Its leaders are moving deliberately, thoughtfully, and quietly to develop new programs, protocols, structures,

and relationships that will fit into a reformed pluralistic system, or even into a more radical national system.

The cast of characters driving the HOF concept and initiative includes Blue Cross and Blue Shield of Florida (the state's largest health plan provider), along with a not-for-profit regional medical center with a leading cancer treatment facility, a large community hospital and its doctors, a for-profit hospital system and its physicians, and a large group of consumers who have taken part in in-depth surveys and interviews. (During this early stage, the names of most of the participating institutions

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have not been made public.) To varying degrees, the participants share a set of beliefs and hypotheses about what ails the healthcare system and what could be done to control costs and improve outcomes. Based on these foundations, a vision is emerging about the characteristics that a transformed insurance and delivery system should have.

In this vision, the variability of both treatment decisions and the delivery of care would be dramatically reduced. In the selection of care, the best offerings would be given preference, regardless of a particular hospital's full service line. Because strong-form products include prevention and disease management (not just big-ticket acute care), smaller hospitals and rural providers would have more opportunities to attract consumers. With more insurance plans involved, healthcare could become a true retail marketplace—and bundled payments for doctors and hospitals would mitigate the “do more, bill more” mentality of many providers. In short, healthcare services would mimic other retail markets. Consumers would have a better idea of the costs, timing,

billing arrangements, and expected events and outcomes in advance—a feature of great value to surveyed consumers.

After two years of analysis and consumer research, the HOF players are planning to move forward with three pilot programs, each representing a different but crucial product type to demonstrate efficacy.

The first example is an *ambulatory program for managing cardiac risk*. The program focuses on outpatients, managing risk factors and undertaking interventions for diagnostic catheterization, angioplasty, and electrophysiology (for example, ablations). The goal is better outcomes at lower cost, primarily achieved by avoiding bypass surgery where possible, and the program builds on a large regional provider's strength in cardiac services.

A second program, designed for inpatients, involves *surgery for hip and knee replacement*—an area that would clearly benefit from greater standardization, continuity, and predictability of outcomes and

costs. The product spans diagnosis through rehabilitation. Again, a strong regional provider team is the foundation of the clinical side. The third pilot program is for *lung cancer treatment, drawing on the clinical strengths of a world-class oncology brand name*. Experience and efficacy are keys to this product, since the variability of treatments and outcomes for this disease is far greater than for many other clinical interventions (such as cardiac bypass). Like the knee and hip replacement product, this program is aimed at inpatients; the scope of services begins immediately after diagnosis and continues through treatment and rehabilitation.

As important as these three service-specific pilots are for proving HOF's efficacy, it must be emphasized that the long-term vision is for the broadest possible spectrum of services to be developed as products (including normal deliveries, various common surgical procedures, and even routine outpatient care). Without this broader vision, the concept's potential for bringing about fundamental change is very limited.

CARROTS, STICKS, AND PRECEDENTS

If producing more standardized care from best-science protocols were all that these efforts hoped to achieve, the concept would be laudable, but the reality would amount to little more than traditional centers of excellence on steroids—i.e., high-quality healthcare services with little or no influence on the larger system. What sets HOF apart—and may provide a model for federal initiatives—are the structural innovations and incentives that involve plans and patients in new relationships with healthcare providers.

Products and services, for example, are priced to be all-inclusive—encompassing everything from diagnosis and treatment to rehabilitation and final disposition. Providers are paid a set amount to cover facility costs, devices, drugs, and professional fees. This not only makes large-scale costs more predictable for plans and sponsors, but gives consumers a clear picture of their obligations at the beginning of treatment, not after months of claims adjudication and confusion. Such an approach clearly favors providers who have already integrated their hospital(s) and their physicians—either through ownership arrangements or, far more commonly, through employment arrangements. In fact, as employment of physicians increasingly becomes the dominant business model and such programs as pay-for-performance proliferate from Medicare and others, HOF should find itself in the mainstream of most national reform measures.

The best healthcare services, based on the best available medical science, are not much use if they aren't embraced by large numbers of patients. Thus, HOF offers financial and service

incentives to encourage consumer participation. Reduced or forgiven deductibles and co-pays, combined with added amenities, are used as carrots.

The HOF approach may ultimately incorporate some sticks as well, perhaps placing nonparticipants in a more generic major medical plan whose premium reflects the fact that they have moved themselves into a higher-risk group. This form of “prescriptive insurance”—allowing patients to opt out of best-science approaches for a cost—is akin to requiring motorcyclists to wear helmets and charging them more for their insurance if they choose not to.

This undertaking is both more significant and more difficult than other reform efforts to date because it seeks to align incentives across the entire structure of healthcare finance and delivery—far more than just encouraging the use of a handful of high-profile, costly inpatient procedures. HMOs have done this as well, but they lack several key features that stand in the way of a truly consumer-centric marketplace: Relatively few consumers have access to a fully integrated HMO, and such ventures are hard to start; HMOs, no matter how good, will almost certainly not achieve best-of-breed status for all their clinical products, and patients therefore will not have service-by-service choices; and consumers really make only one choice in an HMO system (whether or not to participate). HMOs will have a place in a post-reform healthcare world, but HOF-type approaches could very likely achieve a higher level of consumer choice and satisfaction while lowering overall costs.

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GETTING STARTED

The concepts, consumer research, operating models, and partnership arrangements for strong-form products under HOF are in place and being implemented and refined. The waves of reform (or state-by-state, payor-by-payor cuts and rollbacks) we are likely to see during the next decade give forward-thinking providers the opportunity for a running start on the more draconian pricing and demand-side measures that can be expected over the next few years. The move toward strong-form products is not the only strategy for providers to pursue while waiting for the next shoe to drop, but it may well be the most important and differentiable.

The ongoing political vagaries of reform and the implementation of pilot programs will be taking place simultaneously in real time. For the participants in HOF, the good news is that the program's concepts align

well with most reform scenarios and they will benefit from already-enacted incentives for health IT (under the American Recovery and Reinvestment Act) and various ongoing experimental programs such as pay-for-performance. Even if we see years of scattershot price and demand controls, strong-form products provide the best hope of sustainable cost reduction. Furthermore, the major structural change in healthcare over the past decade or two—hospitals and systems employing more and more physicians—is in the strike zone of both HOF and most assumptions about the healthcare system inherent in the reform debate. Finally, there is good news for smaller and rural providers under HOF—they can use the concepts to address service and cost issues on basic hospital and ambulatory programs. So, while HOF is politically subordinate to the healthcare reform effort, it is not dependent on it. It offers real hope for transforming our patently outmoded operating model of healthcare—trading today's mass customization and confusion for integrated, end-to-end care with more predictable results and lower cost.

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