The Colorado Purchasing Alliance

"Purchasers Leading Market-Based Health Reform"

Friday, November 13th, 2020

EMPLOYERS' FORUM OF INDIANA

Addressing the challenges of the local healthcare marketplace

"If you want something new, you have to stop doing something old."

– Peter Drucker

The Colorado Purchasing Alliance

a CBGH Affiliate

”A problem well-defined is a problem half-solved.” Chas Kettering

When it comes to Healthcare in the U.S.

Three empiric statements we CAN make based on evidence...

- It is inconsistently effective.
- It is consistently inefficient.
- It is increasingly and ***unjustifiably expensive*** (unrelated to quality of cost of care).

What we CANNOT say and which mis-diagnoses the problem…

- It is “***broken***.”

”Every system is perfectly designed to achieve exactly the results it gets.”
Don Berwick, MD

Insights from Peter F. Drucker's 1994 HBR article….

The Theory of the Business

"What underlies the malaise of so many large and [previously] successful organizations world-wide is that their ***theory of the business no longer works."***

"Some theories of the business are so powerful that they last for a long time. But ***eventually every single one becomes obsolete."***

From the September–October 1994 Issue
https://hbr.org/1994/09/the-theory-of-the-business

When it comes to how we purchase healthcare…

Is our theory/framework obsolete?

"The theory is that only the surrogates [e.g., the health plans] have enough knowledge to control excess care, enough market power to discipline rising prices, and enough vested interest in our health to drive greater safety and quality. ***But the experience of the past 50 years suggests the theory is wrong***: ***the surrogates themselves create many of the incentives for bad behavior in health care***."

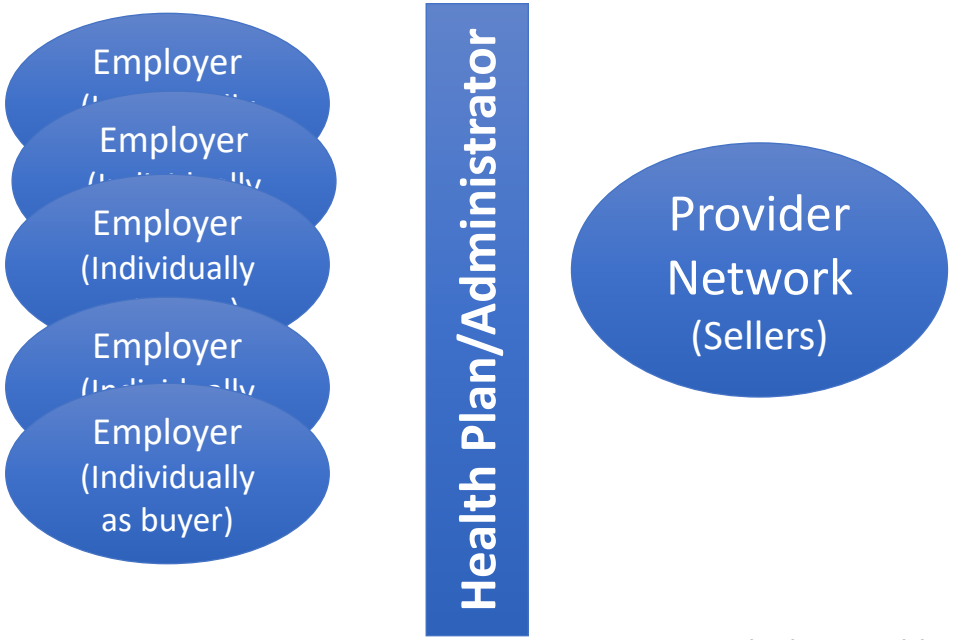
David Goldhill, ***Catastrophic Care: Why Everything We Think We Know About Health Care is Wrong***

Changing dynamics for a more effective, efficient marketplace:

What *market-based health reform* looks like:

Traditional Purchasing

- Health plan functions as ***surrogate*** purchaser.
- No interaction between buyers and sellers.
- Employer has ***negligible purchasing power.***



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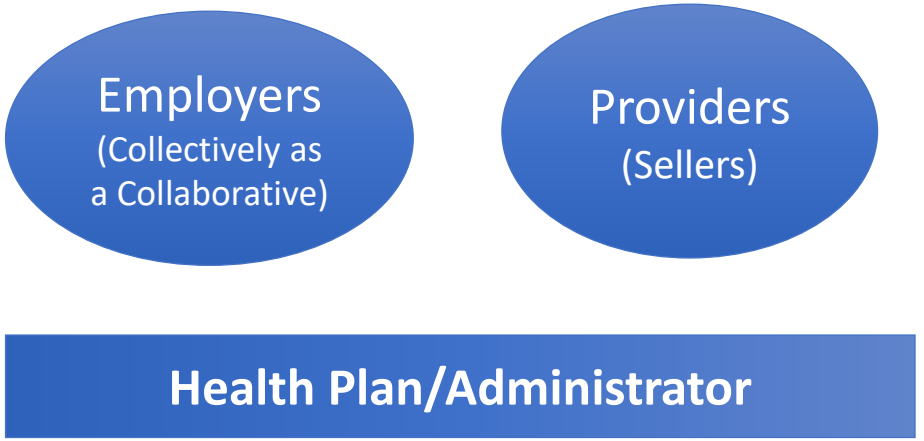
- Purchasers pool their purchasing power as authorized under Colorado Revised Statute.
- Employers (as buyers) and providers (as sellers) directly ***negotiate price and improve performance***.



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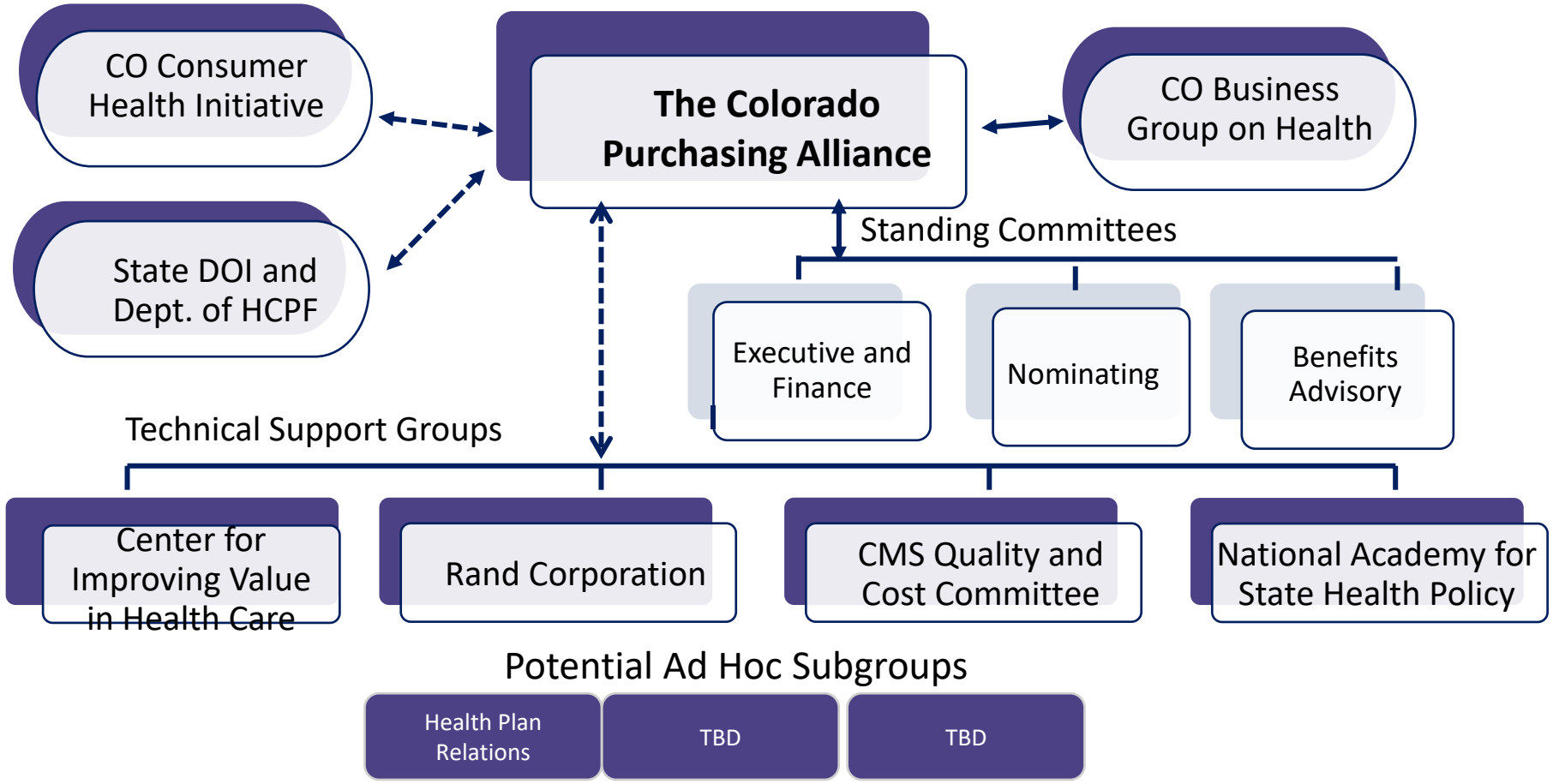
A Colorado Not-for-Profit Purchasing Coop Authorized Under CRS 10.16.1001

Organizational Structure



Disrupting the Dynamics that WILL Create
Meaningful, *Market-Based* Health Reform

Legacy Approach

- **Purchasing Care.** ***Insurers/third-parties contract*** for health care:
  - Typically as a discount from facility charges.
  - Employers sub-let networks, typically without conducting due diligence or transparency.
- **Providing Benefits**. Enrollees access care ***without regard to value*** – either in terms of quality or cost. High deductibles discourage appropriate use
- **Delivery System**. Market is oligopolistic with over-compensated hospitals consolidating to increase pricing without improvements in quality.

Re-envisioned Model

- **Purchasing Care.** ***Employers collectively and directly contract*** for healthcare:
  - Using a multiple of Medicare as the reference point.
  - Employers apply the same due diligence to health care used to purchase other goods/services.
- **Providing Benefits**. Enrollees access care with incentives to use ***primary care, higher quality specialists, and lower-cost sites of care***, creating competition based on value.
- **Delivery System**. Purchasers create competition using payment and plan designs to increasingly create ***a physician-directed market,*** shifting revenue to clinicians.

Driving Market-Based Change: The Quintessential Role of…

Value-Based Plan Designs

Multi-Year Value-Based Benefit Design Plan

3-Year Value-Based Purchasing Plan

Essential for…

- Negotiating most fair, reasonable pricing
- Assuring employees receive best care and price
- Deriving full value from contracts for purchaser/patient
- Creating incentives to be "good" (not just big)

Essential for…

- Negotiating a fair referenced-based price
- Introducing alternative payments/accountability
- Establishing quality expectations

Outcomes of an in-depth financial analysis of
35 Colorado (Front Range) Hospitals

- **Cost to Charge Ratio (CCR):**
  - **Measure:** Total hospital costs divided by total hospital charges for services provided.
  - **Finding:** Overall, CCR run 20-25% - e.g., charge master prices are ***4x to 5x times greater than actual costs of care.***

- **Profit/Loss on Government Programs:**
  - **Measures:** Total charges and costs are allocated between specific payers, for calculation of profit/loss by payer.
  - **Finding:** Medicare (26% of patient mix) at **-11%;** Medicaid (21% of the patient mix) is at -32% loss.

- **Profit Margins on Commercial:**
  - **Measures:** Charges and costs for patients not covered by a Government Program, including commercial insurance, employer self-funded plans, Veterans Association, Federal Employee Program, etc.
  - **Finding:** Commercial payers average 50% of the payer mix, with ***average profit margin of 46%.***

- **Break Even Requirements:**
  - **Measures:** Commercial payments (calculated as a percent of Medicare) to allow hospital to break even.
  - **Finding:** Average commercial breakeven requirement is **153% of Medicare**.

    NOTE: The RAND 2.0 study reported these 35 hospitals averaged 312% in commercial allowed amounts.

Responses from the Largest Health Systems
(Particularly interesting when juxtapositioned with mission statements)

- **Universal:** Pursuing the quadruple aim is all well and good but what do we get in return for reducing our pricing (from >250% of Medicare)?
- **Classic Quotes**:
  - *"Since everybody is **fat and happy**, the payers and providers don't want to change…Basically, no one wants to disrupt the market." P. Banko, CEO, Centura, Colorado Times Recorder. 3/20*
  - "We reserve the right to price to what the market will bear." (System "A")
  - "We have no interest whatsoever in discussing either risk-based contracting or reference-based pricing." (System "B")
  - "Don't bother calculating our costs of care. We'll tell you the price we'll accept. Negotiations would not be a good use of our time." (System "C")
  - "We'll negotiate price in exchange for steerage but won't discuss quality issues for at least one year." (Despite having seen outcomes in the bottom decile of scores nationally – which the Chief Medical Officer "suspected.")

An Evolving Contracting Approach

- **Barriers**:
  - Hospital market fits the classic market definition of an ***oligopoly;*** largest systems see little gain in or advantage to competing based on value.
  - Even health systems that could significantly gain by working with us are ***afraid of the "business risk***." (Loss aversion principle on steroids.)
  - ***National health plans have national strategies*** and realizing historic profits; little interest in "one-offs" or disruption; fear being marginalized.
  - ***Post-COVID,*** CEOs have withdrawn from the discussions, abandoning strategic approach. Discussions with CFOs and contracting folks has been "transactional."

- **Opportunities:**
  - Independent, community hospitals
  - Advanced primary care practices
  - Free-standing centers

- **THE Success Factor: The will, resolve, and the courage of purchasers to create a market that rewards value!!!!**