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Cost, Quality & Alignment: A Step-Wise Plan to Reform and Transform Healthcare

ECONOMIC & INNOVATION DRIVERS FOR HEALTHCARE POLICY

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EDITOR'S NOTE: This paper is the first formal "policy perspective" published by healthcare venture capital firm Psilos Group. Psilos has been investing in private-sector healthcare reform since 1998, with a defined focus on reducing costs, improving quality and aligning incentives payers, providers and patients. The firm's partners have more than 135 years experience transforming healthcare from the inside out as company managers, investors and consultants. This paper is intended to inject fresh thinking and ideas into the U.S. healthcare debate from an investment, innovation and healthcare economics perspective.

It's been a long hot summer of debate and, dare we say it, discontent.

Over the past six months, Americans have watched with anticipation and increased trepidation as healthcare reform details slowly emerge. President Obama has appropriately led the charge to alert Americans about the crisis and the need for change. At this point we all know our current healthcare "system" does not work *and* we have all seen plenty of evidence detailing the symptoms and root causes of healthcare's failure.

It's now time to develop a ***realistic*** plan for change. We need to understand that we are attempting to fix an extraordinarily complex problem and it will require the best of all parties to accomplish that. Creativity and quality ideas are the essence to build a lasting solution. Reckless expedience, in this case, may serve a political purpose but is unlikely to serve the public interest. Thoughtful deliberations do not mean we do not move forward, but rather, that we move forward with good ideas on a reasonable and achievable time schedule.

If you consider the means by which large corporations make quantum shifts in strategy, it is rarely an overnight endeavor. Rather, leadership adopts a multi-year strategic plan and takes a series of phased actions over time towards achieving the ultimate objective. Leaders garner consensus and demonstrate results along the way so fine tuning of the plan can take place and mid-course corrections can occur based on early learnings. The goal of creating value for the shareholder is the ultimate objective, with leaders focused on their fiduciary responsibility to ensure that each step along the way delivers the value expected from a major strategic undertaking.

By contrast, government too often drives policy shifts in the context of election cycles rather than strategic planning. Policy-makers and pundits talk about healthcare reform in terms of who's winning in Washington, framing the debate as a "once in lifetime" opportunity that leads politicians to push with increased intensity for an all-encompassing "swing for the fences" act – rather than set out objectives and advance towards them step by realistic step. This is a mistake. In the instance of healthcare reform, American citizens are the "ultimate shareholders." Our leaders' fiduciary responsibility is not just to

deliver good policy, but also to build the right alignment, strategic plan and tactical actions that ensure the desired outcomes for patients as well as providers and payers.

Based on our experience in public- and private-sector healthcare reform, we urge policy-makers to take three immediate steps as they work through the details: 1) SLOW DOWN and develop a focused step-by-step plan with clear goals; 2) BUILD ALIGNMENT to make sure a large majority of stakeholders in the system are on board, not just that there are enough votes to pass legislation; and 3) SHIFT THE FOCUS from "who pays" for reform to "how much" we should pay for healthcare – and how do we strengthen its value proposition to ensure good value for quality care.

This last issue is ultimately the one that vexes American families, small businesses, large corporations, healthcare providers and all levels of government. Debating "who pays" is simply a political comfort zone that stokes traditional liberal versus conservative passions and fuels talk show rhetoric. However, it does nothing to actually cover the costs when bills are due. Addressing "how much" is a more complex economic issue that needs to move front and center, especially when healthcare costs are growing at double or triple the general inflation rate – and are expected to consume 19.5 percent of GDP by 2017. This issue is even more contentious today due to our weakened economy and increasing debt.

Clearly, it's time for fresh thinking and transformational solutions that deliver President Obama's targeted cost savings in order to cover healthcare for 47 million uninsured Americans. Fortunately, private sector "reformers" have tackled these issues for years, and many have proven it's possible to cut costs ***and*** improve quality at the same time. Indeed, with a few smart bets on healthcare technology and service innovations already available, we believe healthcare reform can literally pay for itself.

A Realistic Vision and Real Savings—the Prerequisite for Good Policy

Businesses start their strategic planning with a clearly defined set of objectives. Those may be as simple as "earning profit for our shareholders" or "providing good jobs for our employees," but the objectives need to be defined with clarity and measurable targets in order to align people to ensure success.

So what are the clearly defined objectives for healthcare reform? We have heard much about providing coverage for the uninsured and some about coverage for those who have had insurance denied based on pre-existing conditions. These are very important objectives but are not all-inclusive of what it takes to ensure a healthy system. We have heard far less about transforming the underlying economics and using innovation and investment to drive a sustainable healthcare economy for the long term.

Moving forward, it's critical that our leadership lays out a broader set of realistic and measurable goals if we are to achieve lasting and positive reform. Specifically, we would recommend the following goals:

- Reduce healthcare inflation to less than 3% within 10 years.
- Enable insurance access for all and reduce the number of uninsured to less than 2%.
- End prior condition refusals for insurance and policy cancellation for sick people.
- Extend solvency of the Medicare Trust Fund well beyond the current estimates of 2017;

- Dramatically reduce the number of medical errors, redundant procedures, unnecessary hospitalizations and re-admissions, and costly "defensive medicine."
- Improve healthcare quality to get more from our $7,290/person annual investment[1], and improve our quality ranking from #35 in the world to top five.
- Stimulate a vibrant healthcare economy which invests in the long-term health of our citizenry through adoption of new technologies that improve quality and lower costs.
- Ensure the methodology of reform costs equal to or less than the current system, not more. Reform should be, at least, a zero sum game.

This last point is an important one. All of the key experts acknowledge that one third of the $2.4 trillion we spend per year does not contribute to improved health, and in fact, has the opposite effect resulting in medical mistakes and redundancy. Unfortunately, there has been little discussion to date among the policy makers about how, specifically, to reduce it. In fact, all of the rhetoric and projections about savings that have been offered are not based on "real" savings, but rather have been projections that are calculated as reductions against future inflation.

Based on our real-world experience, there is ample room for substantial savings by eliminating waste and error as a matter of public policy. It's the proverbial low-hanging fruit that can be achieved through modest investment in broadly deploying innovations that have already demonstrated significant results on a smaller scale. These technologies and systems can deliver dramatic reductions in waste and error, and the savings can then be used to fund coverage for those who have none while also enabling the delivery of far better, evidence-based medicine than is often practiced today.

We ultimately recommend a phased approach to both reform and transform healthcare. Let's not just fix the basics, but also restructure the system so it delivers good value to all Americans.

Phase 1: Immediate and Short-term Actions for Healthcare Reform

Step 1. Let's admit it will take us 10 years to fix the problem. This is not an excuse for not starting, but neither is it a reason to be careless or overzealous. It is a reason to begin with a well thought out plan. Americans are concerned about a massive government-engineered change that is done too fast and which may have unintended and negative consequences. Don't call opponents names because they are nervous. Lead them and give them a long-range plan that they can understand and believe. Then give them a means to measure that plan and hold government accountable.

Step 2. Focus on innovation, beyond government mandates and reimbursement limits, to drive costs out of the system while improving quality of care. Technology and service innovations have proven to be fundamental productivity drivers in all other industries over the past 20 years, and they are now critical to "bending the curve" on inflation in healthcare. Looking globally, very little new medical innovation comes from countries where healthcare has been nationalized, like England or Germany. Today the vast

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[1] Total health expenditure per capita, US$ Purchasing Power Parity (PPP)
http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html

majority of healthcare innovation across services, IT and devices emanates from the U.S. If we focus too heavily on limits and mandates to cut costs, innovation will suffer and the U.S. could join the ranks of countries that rely on others for innovation.

Step 3. It is continually repeated that we *waste* money in healthcare. Let's attack the low-hanging fruit now and replace current approaches with new, higher-quality, lower-cost approaches. Then, use the cost savings and increased revenues to subsidize insurance for those who need subsidy. Everybody understands a pay-as-you-go approach. There are several specific things we can implement now based on technology and programs that have proven successful but are still in very limited use:

- *Embrace "Accountable Care" for chronic illness:* We need to directly and honestly address management of chronically ill patients, which is currently expensive, inefficient and uncoordinated. Chronic illness currently represents the biggest load on Medicare – including 15 million people who have four or more chronic illnesses costing $350 billion per year. If we include those with three chronic illnesses, the cost expands to more than 80% of Medicare. Chronically ill patients not only need ongoing care management, but they also contribute to runaway costs from preventable hospital readmissions.

  This important population of healthcare consumers can be better served and more efficiently managed through the use of Accountable Care Organizations (ACOs) and Virtual Accountable Care Organizations (VACOs). The latter model has demonstrated significant quality-of-care improvements and cost reductions in projects run by the Center for Medicare & Medicaid Services[2] and reported by the Veterans Affairs[3]. Estimated savings over 10 years by adopting ACOs and VACOs throughout the system could be in excess of $750B, and $100 billion per year in the out years.

- *Use technology to eliminate hospital-based errors:* Hospital-based errors result in more than 100,000 deaths per year, which should be enough on its own to drive reform action. Annual Medicare reports reflect more than 1.5 million medication administration errors. Countless studies have demonstrated that approximately 19% of all medications delivered at the bedside to patients are delivered in error, accounting for $7B to $10B annually in excess Medicare costs. Other avoidable errors such as hospital-acquired infections and surgical mistakes add billions in cost to the tally.

  This, too, can be effectively addressed with broader deployment of existing innovations. Several U.S. companies now have products that significantly mitigate or remove these errors, savings their customers princely sums and helping them avoid damaging and costly malpractice litigation. As one example, bar codes can be used effectively to check patient medications at hospital bedside, ensuring proper doses and patient matches for millions of medication administrations every day.

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[2] Jan 13 2009 CMS Public Affairs MEDICARE EXTENDS DEMONSTRATION TO IMPROVE CARE OF HIGH COST PATIENTS AND CREATE SAVINGS Care Management for High Cost Beneficiaries Demonstration (CMHCB)

[3] Jan 23,2009 Health Hero Network Says Recent Successes of Deployments with Medicare, VA Signal New Era of Telehealth. Successful Multi-Year Trials at VA, Medicare Show Telehealth-based Health Care Interventions Can Improve Care, Reduce Costs.

If we can legislate adoption of electronic medical records (EMRs), as we did through the recent stimulus package, we can certainly legislate adoption of error reducing technologies that run on top of or alongside EMRs – and which ensure that the ROI in both life and dollars is readily counted. The process of setting policy around these errors has begun in a small way—CMS has recently decided to stop paying hospitals for certain avoidable errors—but this policy can be strengthened by subsidizing broader deployment of innovations that would yield significant payback for patients, providers and payers alike.

- *Reform "Defensive Medicine" practices:* Physicians often say that they must give certain tests or provide various services, even when they know them to be excessive or redundant, because the failure to do so can result in their being sued for malpractice. The excessive use of redundant medical imaging is a prime example of this: our nation has experienced a doubling of imaging procedures over the last five years but not a commensurate doubling of diagnostic accuracy or better outcome.

  Policy-makers have suggested reform in this area will be key to success, and they are right. We must establish incentives to provide the right medicine and tools that enable physicians to rapidly understand each patient's condition in order to apply evidence-based medicine. Again, many tools exist today to enable these activities, but they are not satisfied simply by the adoption of EMRs. Rather, we must require the adoption of the applications that sit on top of these EMRs which deliver the decision-making data directly to physicians and nurses at the point of care. Combined with legal reforms, we can then free physicians from fear of unwarranted lawsuits and ensure that they are properly incented to do the right thing.

Step 4: Generate additional revenue to pay for insurance for the uninsured through a series of actions:

- Set a minimum floor for employer-sponsored healthcare: Require all employers to provide at least a minimum health benefit to their employees and, if they fail to provide the insurance, charge them a fee for non-compliance tax. This has been proposed in several policy proposals and health reform bills released so far by the Senate Finance Committee and the House, Health , Education and, Labor and Pensions Committee (HELP).[4]
- Elimination of tax deductions for "Cadillac" healthcare benefits: Tax deductions should be limited to plans which meet minimum basic criteria and be capped so companies do not dis-proportionally benefit from "over-insuring" their employees.[ibid]

By implementing these "simpler" reforms, we can move quickly toward a smart bi-partisan plan that **immediately** delivers savings and new revenues. It is reasonable to expect these near-term revenue enhancements and systemic cost saving efforts could initially drive $50 billion in annual savings. Policy-makers can then take these easily identifiable sources to establish a dedicated Universal Care Fund that delivers broader coverage for uninsured Americans. Depending on the level of subsidies required, this could increase coverage to 20 million more people—not everyone, but a great start. The Universal Care Fund would see additional increases over time as cost savings continue to grow, yielding a potential $100 billion per annum in year 10 without increasing the federal budget. If we only spend what we save

[4] Health Care study Report- Lewin_9.9.09, HR 3200 requires employers to offer insurance or pay an 8% payroll tax on the wages of workers not covered.

as we save it, this would go a long way to eliminate the great fear of deficit expansion and demonstrate consistent proof that reform is delivering on its promise.

Phase 2: Longer-Term Actions for Healthcare Transformation

Now we need to attack the harder problems. Under Phase 1, the country gains the experience and tools that we can leverage to address some of the harder tasks – those on which people agree in principle on the outcomes, but which require wide systemic change and investment where it is more difficult to reach consensus on specifics. However, with some positive experiences under our belt from Phase 1, we should have some additional comfort that successes are possible and repeatable.

Key actions required to achieve comprehensive health reform in Phase 2 include:

- *Replace "fee for service" with performance-based reimbursement:* Results from the chronic care reform initiative (above) will illuminate us on this approach. The new reimbursement system could center around expanding ACO and VACO models, which reward outcomes and clinical results rather than reimburse providers based on the number of procedures they perform. Reducing incentives to over-treat while not withholding care is a complicated balance to strike, but is critical to aligning incentives across patients, providers and payers by using market forces to ensure a functioning healthcare economy. By expanding the VACO model to a broad cross-section of the population, not just Medicare, our goal would be to reduce the trajectory of health care cost inflation by 200 basis points, equal to 2 percent.

- *Provide incentives for healthier lifestyles and behavior:* Healthier lifestyles are universally recognized as key to reducing costs and improving healthcare delivery. We recommend directing the cost savings from healthcare reforms to purchase *only* those health insurance plans that are designed specifically to achieve this goal for uninsured and under-insured Americans. These "value-based" health plans incentivize patients to take care of themselves through preventative wellness actions such as immunizations and screening tests and following treatment regimens. Several health plans already take this approach to cover chronic illnesses, such as diabetes, where people benefit from reduced copayments, reduced deductibles, and higher levels of coverage when they agree to take care of themselves in accordance with generally accepted medical best practices (e.g., take their prescribed medicines, check their glucose levels regularly, see an eye and foot doctor annually).

  Value-based health plans use a "carrot," conveying immediate financial incentives for doing the right thing, which aligns well with good public policy. This recognizes that Americans are highly incentivized by rewards – the "Cash for Clunkers" program being one recent example. It's time to expand and incent these health insurance plans which give rewards for healthier and compliant living. We will need legislation to allow this in governmental programs, but some large self-insured corporations are already rapidly migrating to such a model. These programs can save individuals as much as $500-$600 per year and reduce insurers' cost per covered beneficiary by potentially thousands per patient per year, translating to billions in system savings nationally every year.

- *Enable broad deployment and use of Personal Medical Records*: Beyond simply digitizing hospital records, a "personal medical record" provides patients with an integrated view of their healthcare information along with value-added recommendations and advice. Integrated PMRs not only improve personal understanding and accountability for health decisions, but can be used at the point of care to dramatically reduce medication errors and redundant testing.

  We understand that Americans are slow to adopt electronic medical records because of privacy fears. However, we can use technology to solve this problem, similar to how we use technology to address privacy and security issues with our personal banking, credit cards and other records. If we also ensure insurance access regardless of age and regional community ratings, our fear of insurance denial for prior conditions should disappear.

  Beyond privacy, we are currently on path to experience a "trough of disillusionment" with electronic medical records, since generic EMRs only ensure that providers capture their data electronically – but don't necessarily deliver that data in relevant or valuable ways to front-line doctors and nurses or to patients themselves. Instead, Personal Medical Records (PMRs) are designed around the individual person as a central organizing principle, not the provider. This approach delivers an integrated 360-degree view of a person's health records, allowing them to get real-time health insight and advice similar to what they experience from other "self-service" activities online. PMRs would also enable an ecosystem of patient-focused and provider-focused applications to emerge that improve the healthcare experience, similar to the proliferation of iPhone and Facebook applications that have revolutionized mobile phone and social networking experiences.

  A few examples bring this to life. One is a next-generation search engine that makes it easier for doctors to understand a patient's entire relevant medical history in a readily digestible way – and rapidly identify potential errors or redundancies of treatment, especially when the patient sees multiple doctors. Another is the use of codified best practice systems that enable physicians to keep up with new innovations and discoveries – and identifies for them when such a best practice or new development in their field is specifically relevant to an individual patient, at the point of care.

  Again, such systems do exist today but are in limited use. Where they have been deployed, there has been a marked reduction in medical errors and a commensurate increase in the application of evidence-based medicine. Current trials have shown savings of $100 per year for commercial patients and $500 per year for Medicare patients – which could yield $500 billion over 10 years if applied to all Americans.[6]

The additional savings from these Phase 2 reforms are more challenging to achieve and require deeper alignment that will take time to build. Combined with Phase 1 reforms that can be implemented now, they are sufficient to achieve most if not all of the healthcare reform goals outlined above.

Conclusion: Slowing Down Policy to Speed Up Reform

Healthcare reform is essential and the tipping point is here. For the first time since Medicare was established in 1995, all eyes are on healthcare and we have our best opportunity in years to create momentum for meaningful change. However, a step-wise approach that keeps cost front and center is essential to ensuring a durable success. By taking measured steps and using cost savings to fund other reform goals, we can still seize the day for effective and sustainable healthcare reform that is characterized by:

- Significant cost savings driven by waste reduction, delivery efficiencies and new innovations;
- Improved healthcare quality, insurance access and elimination of coverage denials;
- Meaningful incentives to align the behavior of patients, payers and providers towards wellness, prevention and evidence-based medical practices.

This last point is key to transforming healthcare. It's the basis for bringing a market-based economy to American healthcare, which has long been absent. We need to re-connect the concept of value for dollar spent to healthcare and put consumers front and center in understanding what services cost. We need to create a structure where consumers and providers of care operate according to rational market principles to unlock the concept of value for the dollar spent.

Realistically, reforming and transforming healthcare will take time. Americans will exercise patience as long as they believe we are on a sound path to succeed. While our healthcare economy is clearly entering unchartered waters, many of the ideas above have been tested on a small scale and delivered real results – demonstrating that cost, quality and alignment are indeed achievable goals. Now it's time to "convert these innovative models into successful programmatic change."[7] By combining the promise of early successes with true political will and a focus on the greater good, we can and should deliver a sustainable reform that improves healthcare costs, quality and access for all Americans

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Dr. Waxman has more than 40 years leadership experience as an entrepreneur and investor in the healthcare industry, fueled by a particular focus on driving down costs, improving quality and aligning incentives across payers, providers and patients. As the CEO and founding partner of Psilos Group, he and his firm have funded and developed more than 38 innovative companies dedicated to this vision, including ActiveHealth, Click4Care, Definity Health, ExtendHealth, OmniGuide and SeeChange Health.

Prior to founding Psilos, Dr. Waxman was a successful CEO at several healthcare companies. He most recently served as Chairman and Chief Executive Officer of Merit Behavioral Care and its predecessor companies, American Biodyne and Medco Behavioral Care, growing the company's revenues to more than $800 million and managing successful IPOs, acquisitions and buyouts with Merck and KKR. Dr. Waxman previously founded and served as President, Chairman and CEO of Diasonics, Inc., one of the first medical companies to provide ultrasound and magnetic resonance imaging in the U.S.

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[6] Active Health Management, Qual-Choice Study, The American Journal of Managed Care, Vo. 11, No.2, February 2005.
[7] Testimony statement of Douglas W. Elmendorf, Director CBO March 10, 2009