Healthcare_Uncovered

CRITERION VENTURES

CREATING SOLUTIONS FOR THE PATIENT PORTION OF MEDICAL COSTS

The Cash Market in Healthcare

June 2008

June 11, 2008

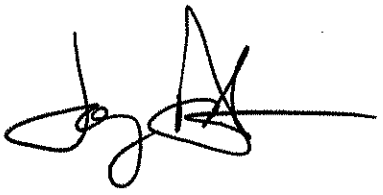
Note to Reader,

Criterion Ventures, along with our partners Good Capital and the Access Project, has led an initiative involving conversation, research, and analysis on the uncovered costs of healthcare, the impact of medical debt, and the cash market in healthcare. This report represents the culmination of these past eight months of work. The views presented here are those of Criterion Ventures.

We owe our gratitude to the Rockefeller Foundation for their generous financial support of the research and development phases of Healthcare_Uncovered.

This report is intended to provide a definition of the cash market in healthcare. The objective of this report is to have you, the reader, test, react, and refine these ideas. For more details about the specific initiatives that are emerging from Healthcare_Uncovered, contact Elizabeth McCance at Criterion Ventures.

Enjoy.



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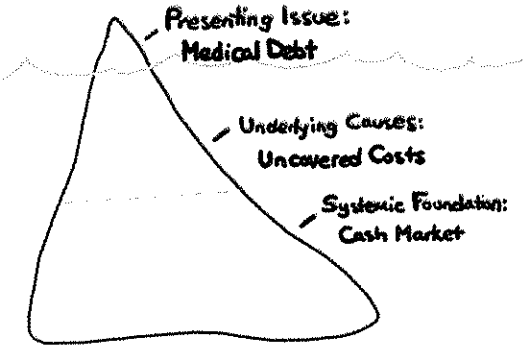
Introduction

This report introduces a new idea into the healthcare reform debate in America: the healthcare market is not a single market but is rather two markets, a dominant insurance market and a stunted cash market. This cash market has always been viewed as an "exception" to the broader insurance market rather than being effectively and efficiently developed into a market of its own. This has led to inefficiencies and unintended consequences that return less value per cash dollar spent on healthcare today.

The report then offers broad suggestions on how a more effective and efficient market might be created and considers what impact this might have.

We began this exploration several years ago by looking at the tip of an iceberg: medical debt. The Access Project and others have researched the prevalence and the impact of medical debt. One in five Americans holds medical debt; this debt is one of the leading contributors to bankruptcy, and it causes people to access healthcare late and in forms that are much more costly and disruptive to their lives, to providers, and to society as a whole. And medical debt is not just a problem of the uninsured. Three out of five (62%) of all adults with medical bills or debt problems said they or their family member were insured at the time the debt was incurred.



However, we discovered that debt is symptomatic of a set of broader issues connected to the uncovered costs of healthcare. While $70 billion in bills was never paid in 2006, a further $265 billion was paid out of pocket by consumers. Billions of dollars are changing hands outside of private and public insurance, yet the systems and structures that manage these "uncovered" costs are relatively incomprehensible to even those inside healthcare. These out-of-pocket expenses are treated as an exception to the insurance market, making their tracking and management complex. Receivables management, bad debt, charity care, collection agencies, and healthcare card services each represent systems of pricing and payments that add to this complexity.

In the end, the players in the system treat the portion of healthcare paid outside of public programs and private insurance as an exception to the norm, an aberration in an insurance-dominated market. And yet the exception represents 15 percent of the healthcare market. In financial systems, exceptions create inefficiencies and friction and therefore cost more but also represent market opportunities.

In short, an underlying systemic issue preventing access to appropriate healthcare is the current irrational characteristics of a cash market within healthcare. This issue affects all consumers in the healthcare market but has a disproportionate impact on those most economically vulnerable in our society. The presenting issue of medical debt began our exploration, but our analysis has led us to see this as a social issue rooted in a broader market failure.

While dwarfed in comparison to the insurance market, the cash market in healthcare is very large in absolute terms. It encompasses $265 billion paid out of pocket, $70 billion in unpaid bills, and $27 billion in alternative medicine,[i] and more, however we don't know the total value of the cash market. Few Americans would be able to spend $100,000 to treat a medical event with cash; therefore we consider catastrophic expenses to be part of the failure of an insurance market and to be outside what we are calling the cash market. Currently, we cannot determine from existing statistics exactly what portion of these dollar figures could be considered as being derived from catastrophic care therefore we cannot determine the total cash flows of the cash market.

There are three features of the cash market that we need to pay particular attention to: how services are priced, how the prices affect the delivery system, and the financial services that intermediate the process of payment. Each of these features is largely determined by the practices of the dominant insurance market, yet there are significant differences that, if the cash market were treated as its own entity rather than a subset of the insurance market, could make a more functional cash- and credit-based system.

The cash market in healthcare is irrational in many respects. It operates with dysfunctional and unbalanced intermediation largely because the insurance market dominates the healthcare industry and intermediation was designed to serve insurance, not cash, payers. Furthermore, the capital flows in the cash market are fragmented and complex, causing confusion and distrust in the system. Rational and efficient markets require common definitions, transparent practices, and greater information sharing. Imagine walking out of a grocery store not knowing how much the food in your bags cost you. Instead, in the coming weeks and months you received a flurry of bills from Kraft, the local baker, and others, along with another series of confusing letters prominently telling you that "this is not a bill." Go through that enough times and you might consider avoiding grocery stores all together. But when it comes to getting healthcare, people don't have a choice, so these inefficiencies, which would be appalling in more transparent and competitive markets, have festered.

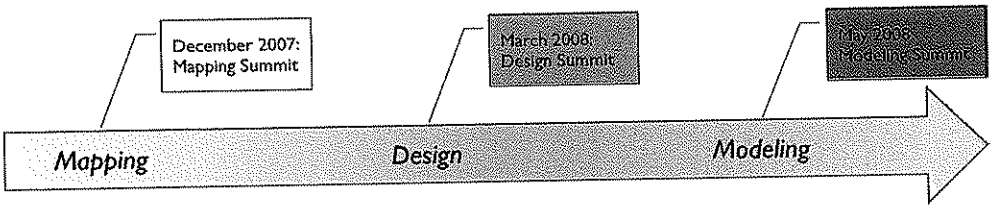
A more effective cash market will increase the value of a dollar in the cash market, value defined ultimately in terms of both access to care generally and access to the appropriate care specifically. This value can be improved through decreased cost of financing, optimized intermediation, and competitive pricing. In addition, developing and executing the changes in the cash market will lead to new ideas and opportunities for reforming the entire healthcare system.

Context for the Argument

The idea of a cash market in healthcare came to us in an informal conversation with an individual from the Brookings Institution who described a project in Rwanda that is working to design an insurance market in the context of a cash market for healthcare. In that moment, it struck us that while the United States has a fully formed insurance market, its cash market is fractured and inefficient. We saw that a rationalization of the cash market in U.S. healthcare would lead to increased access to appropriate care for many segments of healthcare consumers.

We began our explorations several years ago looking at approaches to medical debt in the context of a healthcare reform process. In 2007, the Rockefeller Foundation awarded Criterion Ventures a grant to explore solutions to the impact of the uncovered portion of healthcare. This report is the culmination of this work. The purpose of the report is to present our thoughts about the impact of the cash market and the interventions that will have a positive impact. Separate implementation planning documents present specific plans for those interventions.

Our core team exploring the uncovered costs of healthcare included the leadership of the Access Project (www.accessproject.org), the team at Good Capital (www.goodcap.net), and a several consultants with specific expertise. (See Appendix.) We also held three formal summits that engaged a total of 53 experts and organizational leaders. (See Appendix.) As part of this process, we have also engaged in hundreds of conversations with health economists, financing innovators, credit advisors, social entrepreneurs, hospital administrators, housing analysts, receivables industry experts, doctors, lawyers, community organizers, and educators. Thus, we have created an effective network of engaged players, a network of advocates, reviewers, endorsers, customers, distributors, sponsors, and potential partners.



In these conversations, we initially named the presenting issue as medical debt. Throughout formal and informal conversations, our perspective was reframed and a focus on the cash market of healthcare emerged. Our frame, admittedly, comes from where we sit. We are not inside the healthcare system; we are not policy analysts. We are social entrepreneurs working on large-scale solutions to social problems. We sit closely aligned with the disciplines of the capital markets and enterprises that create business-based solutions to social problems. We value a systems approach but work more in the margins, making unexpected connections visible across traditional sectors. And we see our approach as complementary to other approaches to healthcare reform.

The Healthcare Uncovered team examined structures, models, and capacities required to achieve the venture's goals. To experiment with structures, we have engaged in business planning, assessing resource requirements, evaluating legal and governance structures, and performing due diligence. We looked at hundreds of components of the healthcare system and saw significant potential in combining

these components in new ways. Additionally, certain innovations in the financial services sector create new opportunities to efficiently manage the transactions in the cash market. Finally, new alliances, both online and community based, create new pools of consumers who are actively participating in the cash market.

Early in this process, we mapped the patient portion of healthcare. Our maps conveyed and analyzed the relationships and context of the patient responsibility problem. (See Mapping Report at www.criterionventures.com.) We sought to find patterns in the system and looked for leverage points where we saw the most potential for impact. These leverage points are described later in the report.

In our Mapping Report, we named three patterns that remain relevant:

> ***The entrenched barriers to transparency across the system:*** In healthcare, intermediation through third-party administrators, insurers, and collectors creates fragmentation and opacity. Each player shifts costs and liabilities in the effort to find stability and security, but that complex process results in a spiral of unintended consequences. Transparency becomes a near impossibility as each set of players seeks to preserve its negotiated position.
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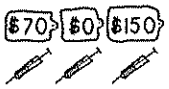
> ***A dependence on strategies that create unpredictability***: Multiple, divergent perspectives create an environment of opacity, and opacity leads to unpredictability. Consumers cannot predict the end price they will pay and often end their healthcare experience with a convoluted flurry of "this is not a bill" statements. Providers cannot predict the relationship between reimbursement and costs. In truth, the very nature of healthcare rests on the randomness of needs. No one plans a heart attack. The dominant systems are geared to manage this reality through public and private forms of insurance. The unpredictability in the system (rather than the unpredictability of needs) is concentrated in the cash market and has a disproportionate impact on the individual consumer.
>
> ***The value of shared risk:*** Insurance is the dominant model of sharing risk across a broad pool. Current health insurance industry trends usually shift that risk into smaller and smaller pools and increase the share of risk borne by the individual consumer and the employer. Aggregation and pooling mechanisms leverage shared interest and reduce costs. Currently, the insurance market primarily services this role, but the cash market is creating new vehicles through financial services and alliances.

These themes—transparency, predictability, and shared risk—became lodestones in our navigation of the healthcare system and our search for where the greatest impact could be found. In a complex system, the potential for impact is found at points of leverage where there is either shared pain or a shared sense of possibility. Through mapping the system, we identified a set of leverage points. Through leverage points, we see the cash market in the broader context of the challenges in healthcare. The leverage points are as follows.

Transparency across multiple pricing and reimbursement strategies: Currently, patients cannot be certain at the time of service the ultimate cost of a service, and providers rarely



know what they will be reimbursed for providing the service. Pricing in an insurance-driven market is determined by the negotiated rate card, and cost-shifting in the system means that the price has no reliable relationship to the costs of the procedure borne by the provider. On the other hand, focusing on the cash market as distinct from the insurance market creates new possibilities for building systems that are more transparent.

Optimizing intermediation between patients and providers: Traditionally, public and private insurance administrators have been the primary and often only intermediation between consumers and providers. Increasingly, consumers are bearing direct costs for healthcare and ostensibly are more engaged in healthcare decisions. While not all optimal, new intermediaries are stepping in to provide financial services, collective purchasing, and information brokering and to empower patients with the ability to access healthcare themselves. These new intermediaries and others that may emerge as the cash market becomes visible reflect an opportunity to realign relationships between patients and healthcare providers.

Realignment of collections practices and risk in the system: Providers have worked for decades to either outsource or professionalize revenue cycle management in a constant quest to turn receivables into cash. New financial services offerings are shifting the risk of nonpayment from the providers to consumers and third parties. Payment at the entrance to a hospital or a doctor's office is becoming the norm. Providers, fearing nonpayment, are limiting their exposure to the cash market by offering credit instruments and cash incentives.

Smoothing the vicissitudes of financial impact on individuals: One theory equates the cash market for healthcare to a similarly priced cash market: "If you can buy a car you can pay for healthcare." Unfortunately, this theory/analogy is flawed, because with a car you know the costs ahead of time, can reasonably predict when you will need to buy another car, can finance the new car easily, etc. Furthermore, you buy a car you can afford and it will still get you around town, but a heart attack is going to be expensive for both the rich and the poor. In the current system, it is difficult to plan and save for healthcare as one does for a car. Tools exist for managing costs in other parts of people's lives; imagine if the same existed for healthcare.

Visible gaps between what insurance covers and the costs of healthcare: In America's past, healthcare financing was offered through employers or government programs. Today, employers are opting out of plans or offering plans in which employees are asked to bear significant amounts of the costs. In the same vein, government programs (Medicare and Medicaid) are increasing their co-payments or reducing eligibility. The amount of uncovered costs of healthcare is growing, increasing the size of the cash market in healthcare, increasing the need for standard and clarifying practices. This gap is not addressed by most universal health coverage policy proposals.

Integrity and accountability in the calculation of risk: As a society, we are responding to the subprime mortgage mess and the subsequent crises in the capital markets with increased attention

to the assumptions behind credit ratings. The idea to rationalize the cash market for healthcare begs several ratings-related questions. Do we have an adequate understanding of the risks currently covered by insurance? How do we rate health-related debt? How do we price the capital behind it? These questions drive the analysis of financial services in healthcare, and the standards and rating systems that drive how they are factored are still emerging.

Potential of alliances to create risk pooling and collective purchasing or action: As employers' role in healthcare diminishes, the door is opening for new alliances to play a significant role. Both traditional alliances (such as trade associations, churches, etc.) and new alliances (such as online communities) may offer opportunities. The cash market presents an entry point for new alliances. These alliances can provide opportunities to pool risk and to negotiate services and prices, offering new ways to access healthcare and lower costs through bulk purchasing, shared risk, etc.

Risk sharing at the micro level balanced against risk management at the macro level: Risk is increasingly moving away from national pools into smaller pools and onto individuals. Placing some risk on an individual may encourage healthier and more cost-effective decisions. Placing too much of the risk on an individual leads to bankruptcy and nonpayment for the provider. Within the cash market, risk is largely managed within the myriad of local, community-based innovations where informal and formal networks come together to ensure access to healthcare in their communities.

Definitions of healthcare as a public good and part of a social contract: Americans have strong and deeply conflicted beliefs about healthcare. Is it a right? A responsibility? Should there be a single payer or a consumer-driven solution? Our ideological views shape our definitions of justice and how we've navigated the cash market in healthcare. Americans don't see the cash market as part of that contract. We can't apply standards of effectiveness to something we haven't yet defined.

Our exploration and prioritization of these leverage points, which began with an inquiry into the uncovered costs of healthcare, ultimately uncovered a cash market in healthcare. These leverage points connect the need and the opportunity to rationalize the cash market to the broader healthcare system. An intervention targeting the cash market for healthcare may address a small portion of the overall system, but it can have a broader impact. We hope the analysis that follows makes the case for attention to the cash market as a necessary lever within broader healthcare reform.

Characteristics of the Current Cash Market and Its Social Consequences

The current cash market for healthcare is made of healthcare bills not covered by either public or private insurance excluding the costs of catastrophic care. This figure includes charity care and other expenses written off by providers as well as the bills actually paid by consumers. Large bills incurred for catastrophic care incurred by the uninsured or underinsured should not be part of the cash market. They are better understood as a failure in the insurance market.

What does remain—primary care, urgent care, co-pays, and deductibles—is a market that is ill formed, with opaque pricing structures, confusing billing, few helpful intermediaries, and few appropriate financing options.

Why don't we simply fix the systems that are creating the irrational cash market and work to limit or eliminate cash completely? There are two answers. First, whole-system change is not on the political horizon. The cash market is here and it isn't going away any time soon. Attention to solutions for the cash market is not only worthwhile but also critical to both access to care and the financial stability of an increasing number of low- and moderate-income Americans. Second, because of the nature of cash and the relative size of the payments, there is the possibility for innovation in pricing and payment mechanisms. As financial services push into the area of healthcare in the wake of the subprime mortgage crisis, we have a responsibility and an opportunity to define standards of practice that will sustain an effective, rather than predatory, market.

Understanding the cash market in healthcare requires an understanding of the overall capital flows in healthcare. Funds to cover medical expenses incurred by consumers come from a variety of sources. Private insurance covers a significant portion, approximately $750 billion. Government subsidies, including Medicaid and Medicare, cover another $750 billion. Hospital charity care and other philanthropic sources cover about $50 billion of the costs. The remaining $265 billion was paid by the patient. This amount is either paid in cash, put on a credit card, or paid through other lines of credit.

In terms of the provider, cash flows into the system from two primary sources: insurance and patient receivables. Patient receivables can be broken into three sources: actual cash paid by the consumer or a credit institution, charity dollars or write-offs made by the provider, and debt or money still owed to the hospital.

The following is a traditional definition of a cash market:

"The cash market is a buying strategy in which the buyer makes an immediate payment that is equal to the current market price for commodities and other types of securities. Upon the receipt of the payment, the seller relinquishes all claims to the property and bestows ownership upon the buyer. In a sense, any type of retail transaction such as the purchase of groceries could be considered a cash market, as the goods are received by the buyer upon rendering a cash payment for the products." (www.wisegeek.com)

To better understand how these cash flows work in healthcare, it is helpful to look at three market functions: 1) pricing of goods and services, 2) delivery systems, and 3) financial services and intermediaries that support payments.

Price for the good or service

The terminology of a typical cash market suggests immediacy in pricing and payment. Most of the capital flows in healthcare, however, are determined by prepayment to an insurance company (or to company reserves, in the case of self-insurance) and then delays in subsequent payment to the providers. The insured pay a premium now for services in the future. The insurance company, in turn, employs a lengthy process of payment and adjudication that slows the outflows of cash. The time delays throughout this process stretch the transaction over months or years. What is not paid is often then dumped into the cash market. In contrast, well-functioning cash markets focus on payment at the time of service and therefore require clear pricing and payment systems to be engaged before the service is rendered. Hospitals and other providers are moving towards collecting payments as the patient enters the building, in other words, up front before the service is provided, reflecting a more traditional cash-market transaction.

There is not a single price for a service, nor is it clear what percentage of the price the consumer will be responsible for. Rather, the consumer experiences multiple types of payments—premiums, co-pays, deductibles, etc.—all for a single medical event. This fractured system makes it difficult to understand costs, to plan for expenses, and to make informed decisions about care. Currently, it is difficult to understand (or even see) the cash market because it is often scattered in bits and pieces across the insurance market. Because the cash market in healthcare is so opaque, the consumer is almost always confused or uncertain about the amount he or she will be responsible for paying.

Delivery system that responds to that price and creates access

Insurance companies have instituted a number of methods to increase patient responsibility (deductibles, co-pays, etc.) as a means to cut down on utilization. The theory is that when there is no patient responsibility, the patient tends to overuse or misuse the system. As intended, the result is decreased utilization of the system. Unfortunately, however, in many cases this decrease has gone too far or come in the wrong places. People are not accessing healthcare when they legitimately need it, because of the cost barriers. This often leads to more dire consequences that ultimately result in costlier interventions down the road.

New systems are beginning to emerge that more effectively respond to the needs of the cash market. For example, the rise of urgent care offices (sometimes called a "Doc-in-a-Box") in Wal-Mart or in storefronts reflects this trend. These settings offer lower priced care for basic services with transparent pricing and payment systems. They cannot and should not offer more expensive catastrophic care, but by offering services such as flu shots and strep throat tests, they can perform an appropriate service in the cash market.

For those who cannot afford access to care, we use government subsidies to help overcome the barriers and get people access to care. When government subsidies directly support a primary care system, we consider that part of the cash market in the same way food stamps are part of the cash market for food. Thus, either through direct payments by the patients or through government subsidies, if patients cannot afford their own expenses, access to primary care has become a cash market. One goal of creating an effective cash market is to make sure consumers have access to the most appropriate care they need at any given time. For example, consumers should stop seeking primary care in emergency departments (where at least they can be assured access to care) and seek clinics that specialize in this type of service. Many local governments have set up these kinds of clinics in the hope of catching patients before they end up in an emergency department, but there are significant limits on this delivery system. While consumers can access primary care for little or no cost at these clinics, they usually cannot get access to diagnostics and specialized care without making large cash payments.

Financial services and intermediaries that support payments

With the increasing demand placed on patients to finance their own healthcare, there has been an influx of financing options. Consumers have several choices to cover medical costs, including credit cards, health finance cards, health savings accounts, and flexible savings accounts. These payment options vary in their costs and complexity to the consumer in accessing them, making them more or less effective.

Supporting the influx of various credit instruments are various sources of capital. For example, GE has provided over $5 billion in direct financing to consumers to help them cover their medical expenses. Our discussions with financial services and capital-market participants suggest that the capital-market participants are looking for ways to get into this market in a larger way.

As we create a more effective cash market, we will need to create more effective forms of intermediation that go beyond collections agencies and credit card offerings. These intermediaries will need to bring capital to bear at rates consumers can afford. This may mean finding ways to adjust risk downward through the use of subsidies, risk pooling, etc. These intermediaries will be able to provide financial services that link savings options to credit offerings and that aggregate buying power to negotiate lower transparent prices and billing systems that cut through the current opacity in the system.

Social impacts

The irrationality and inefficiency of the cash market has significant social consequences. It affects one's ability to seek appropriate care, and it drives the delivery of service and the financial incentives of the system. For instance, with the lack of payment structures set up between primary care facilities and specialists, patients are often finding themselves utterly mystified about costs when seeking a specialist. By creating a cash market with transparent pricing and billing that utilizes appropriate delivery systems and offers consumers effective financing and payment systems, we will be able to lower the overall cost of care within the cash market. This will not only save consumers and providers money but will allow

greater access to care overall. The current system leads to dangerous and expensive delays in seeking care, as shown by the following:

- Those with medical debt are more than twice as likely to report being in only fair or poor health, and they are almost twice as likely to have an ongoing or serious health problem compared to others with private coverage (38 percent vs. 21 percent)..[ii]
- Those who were privately insured but were also carrying medical debt were more than twice as likely to have failed to fill a drug prescription due to cost (24 percent vs. 9 percent; 27 percent for the uninsured). .[iii]
- Those who were privately insured but were also carrying medical debt were four times more likely to postpone care due to cost (28 percent vs. 6 percent; 29 percent for the uninsured)..[iv]
- An alarmingly high proportion—59 percent —of uninsured adults who had a chronic illness, such as diabetes or asthma, did not fill a prescription or skipped their medications because they could not afford them..[v]

The cash market touches all parts of the healthcare industry and crosses social strata. We offer up these five iconic groups: ***undocumented workers, seniors on Medicare, middle-class workers with a large employer, small businesses and their employees, and low-income wage earners (part-time and full-time)***. Below, we look at the particularities of the impact of the cash market on these iconic groups, and then later in the report, we return to them to explore the impact of our proposed solution.

Undocumented workers have a hard time accessing care in the current healthcare system. These workers do not have social security numbers and fear contact with government officials. They therefore have little to no access to the systems of public and private insurance. While some of them are low-income wage earners and have the same issues as this group, not all are. Many have cash and are willing to pay for their healthcare. However, they encounter provider systems ill-equipped to handle noninsurance payments, and they end up paying much more for their treatment than an insured person would.

Seniors on Medicare have experienced increased out-of-pocket expenses with the onset of Medicare Part D in addition to their premiums and deductibles that continue to rise. In fact, nearly a quarter (23 percent) of the elderly Medicare population faced financial burdens from healthcare exceeding 20 percent of their income..[vi] Supplemental insurance is expensive and still entails deductibles and co-pays.

Middle class workers in self-insured plans are faced with more out-of-pocket expenses as their employers shift to higher deductible plans to offset increasing healthcare costs. With higher deductibles, family medical expenses add up quickly, particularly if there is some sort of medical event, even if it is minor. Now the worker has unpaid medical bills. As bills mount, the patient becomes embarrassed to go to the doctor for follow-up or additional care. The embarrassment of unpaid bills impedes access to care.

Small businesses are crumbling under increased demands not only to provide health insurance but also to shoulder more of the financial burden through new cost-sharing benefit structures. Importantly, many small businesses and their employees are uninsured. According to the National Federation of Independent Business, of the 27 million people who are working, 63 percent of them are self-employed or work for a small business..[vii] For the small businesses that provide health insurance to employees, they pay more for their healthcare simply because they lack the buying power that larger employers have..[viii] Small businesses become more exposed to the inefficient pricing in the cash market.

Low-income wage earners often can't afford their co-pays and premiums. Furthermore, many low-income workers are part-time and therefore do not have access to insurance. Without insurance, it is difficult to maintain a relationship with a primary care doctor. This population is reliant on health clinics, which are often not available or are inferior in many communities. Furthermore, because low-income wage earners live paycheck to paycheck, their cash flow cannot handle unpredictable events (i.e., someone suddenly gets sick and needs care). Due to lack of relationships with primary care providers and often the lack of healthcare clinics, they end up in the emergency room for treatment more appropriately handled elsewhere.

The cash market is here to stay and is growing in scope and impact within the broader healthcare industry. The social impact of the practices in this market are measured in terms of access to appropriate health care and the impact of those costs on the overall stability of individuals financial wellbeing. In the end, the cash market in healthcare has a disproportionate impact on those most vulnerable within our society. Therefore, any efforts to ensure universal access to healthcare need to address the products and practices that shape this market.

Building a More Rational Cash Market in Healthcare

New markets are constantly emerging and being rationalized. Some may arise due to government action, such as the creation of carbon credits in Europe. Others arise from the introduction of a new technology, such as online advertising. Still others coalesce when new interventions arise in existing markets. This happened when the Gemological Institute of America introduced a standard system for grading diamonds the 1950s and the Rapaport Diamond Report standardized pricing by grade. Within one generation, an ancient market was rationalized. More recently, the introduction of online sales has pushed pricing transparency to consumers, squeezing out profit margins and system inefficiencies.

Rationalizing the cash market for healthcare will similarly take the introduction of new products, services, and other innovations. To achieve this introduction, action will have to take place at the national level and across many local areas, since healthcare markets are currently very local in nature.

First, at the national level, thought leaders will need to introduce common ideas and even definitions to discuss this market. We hope this report is a first step in that direction. Second, the market will also need to effect ways to rate risk for debt capital, systems at scale for managing pricing and processing payments, etc. Common models for distribution of services can also coalesce at a national level, though implementation will probably need to stay local for the foreseeable future. Third, consumers, too, will need support as they begin to navigate this newly invigorated market.

To understand our approach, it is crucial to understand how healthcare happens at the local level. Individual arrangements are made with each provider system, and care is sought in one's own community. For the most part, it is not a global market, in that one cannot go online and order healthcare from any provider. The service requires face-to-face contact, and thus must happen locally. Furthermore, provider systems tend to be local, from the smallest doctor's office to city-based hospital chains. There are a few very large regional providers, such as Tenet, but no dominant national brands.

One of the significant insights of the Mapping Summit was that risk has been shifted from large pools, such as an insurance plan covering an entire state, to smaller puddles, such as a single employer, and finally to people. We have used this "pools to puddles to people" image quite a bit and employ it now to discuss the size of the group we are targeting to work with as one coherent unit. Because of the need to share risk and build the kind of power needed to impact the current dysfunctional cash market, we will not be targeting products and services that will be made available one consumer at a time. Rather, we will use "puddles" as a way to manage risk, build power, and be able to negotiate with the large local players who currently dictate the nature of healthcare delivery in America. Therefore, to be cost effective, able to carry the right amount of risk, and powerful enough to cause change, a puddle cannot be too small. It can grow quite large, however. A single neighborhood church or small employer is probably too small, but a national membership organization such as the AARP might still work.

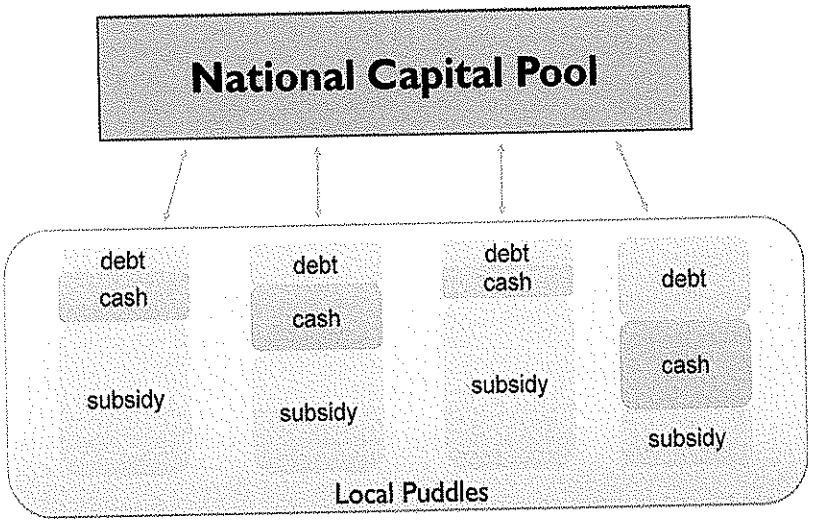
As we work with affinity groups that define these puddles, we will be able to offer them effective financing options (both savings and credit) and payment options that can operate at a national level but be tailored to local needs. These systems can be used as leverage points with existing providers to

negotiate transparent pricing, bulk discounts, and simple payment systems. The new products and services will also create fertile ground for new innovations in healthcare delivery, much as the standardization of grading and pricing information created the fertile ground for online sales in the diamond industry.

As we engage the entities that make up puddles around the country, standards for the market will emerge simultaneously in various localities as different entities adopt and adapt products and adjust to operating in the cash market. However, these standards will need to be integrated and disseminated broadly. While driven at the local level, there is a need to deliver a message of coherence and commonality across the network to make the cash market less frightening and more recognizable.

As stated, our project began by looking at the problem of medical debt. Debt will continue to be a part of the cash market, but we imagine new ways to provide it at lower cost and for longer periods. Currently, debt is arranged on a consumer-by-consumer basis. This both is highly inefficient and eliminates any possibility to share risk and organize ways to lower risk. By working with various affinity groups, we will be able to share risk across puddles and to find first-loss money and other subsidies needed to bring down the overall cost of capital to consumers. But once again, working on the local level won't be enough. Local supplies of capital from employers, community banks, and credit unions will be used up quickly if there is not a national capital to draw from. Fannie Mae and Sallie Mae provide a similar function in the mortgage and student loan markets. To achieve this, puddles will have to structure their credit offerings in ways that create conforming capital flows.

To create conforming capital flows, the market will need to create trustworthy rating models and a way to determine the underlying risk posed by a broad spectrum of puddles. We will then need to craft ways to bring these various puddles in line within a narrower band of risk to allow debt to be packaged and sold to a national capital market. Risk is best evaluated at the local level, by banks or credit unions, but drawing on national, standardized models and data.



Working with puddles will create affiliation-based risk management. For example, workers for a single large employer or in a single union local who are already tied together can be put in a single risk pool. Riskier puddles—say, low-income workers—can then have their risk pool subsidized or otherwise modified with community-based interventions and innovations that understand the subsidies and the unique characteristics of the healthcare delivery system at the local level. Using these local innovations, we will be able to get the debt of each puddle to conform to the national standards needed to create a national capital pool. In

this way, we can create conforming capital flows from seemingly disparate puddles around the country and across income levels.

Adaptation of products and services

Most of the tools we will need have already been created and largely tested. Success requires realignment of components in a fragmented system through the introduction of adapted forms of these tools; this will knit together a market so that the cash market can have the highest value for a dollar. Some of the products and services in place include the following:

Card services: There are a variety of card and related services available at this time. These services include debit cards, which are an alternative to paying by cash or check (although the money is still drawn directly from the individual's account), and healthcare credit cards, which are for nonemergency medical expenses. There are three types of healthcare credit cards: those that look like general credit cards focused on healthcare, those that offer lines of credit associated with Health Savings Accounts (HSAs), and those that use a system of healthcare reward points (incentives) to pay medical bills. Similar to these cards, HSAs tied to lines of credit facilitate payment of medical bills. If the amount is greater than what is actually in the account, a line of credit will be extended with interest rates, final maturity, and other terms based on credit history. The consumer credit rating assesses the credit worthiness of an individual, indicating a probability of paying back a loan. Another savings tool, although one that is currently used for higher education, is the 529 plan, a tax-advantaged savings plan, yet one can imagine something similar for healthcare.

Card issuers are also introducing single cards that can draw from a mixture of credit and savings purses. These cards can draw from one purse until it is empty and then move on to the next—say, drawing on a credit line only after savings have been exhausted. They can also draw on different purses based on what is being purchased. For example, a county program targeting child asthma may create a single purse families can draw on to purchase asthma medication but nothing else. A single consumer could then use one card to buy asthma medication for her child and have that paid for out of the county pot while purchasing an antibiotic for herself paid for out of a savings account.

Group pricing mechanisms: Another group of services in place that can be realigned to rationalize the cash market are a suite of group pricing mechanisms. Some of these are already in place in healthcare, such as bulk purchasing, cost-containment vendors, published-rate cards, and rate regulations. Bulk purchasing allows consumers to lower the costs of a product (such as a drug) by buying a large amount of it. Cost-containment vendors reduce payment costs on behalf of primary payers in the health insurance, workers' compensation, disability, and auto insurance markets by using cost-containment services such as utilization management, provider networks, pharmacy benefit managers, nurse care management, bill review and payment, and carve outs. Published-rate cards, required by some states, ensure that price information is available at the time of treatment. In some cases, the public sector regulates fees for service to make sure necessary services are available to people.

Other group pricing mechanisms exist but are not yet employed in the healthcare market. These mechanisms include cooperatives, fraternal and mutual aid societies, and intermediated cost-savings

programs. Cooperatives are businesses that are owned and democratically controlled by their members. Surplus revenues are returned to members based on use of the cooperative. Organized around ethnicity, religion, occupation, geographical region, or other common interest, fraternal and mutual aid societies support the common interest and often assist the less fortunate members of the group. Intermediated cost-savings programs utilize intermediaries to lower costs to participants and split the savings. Many of these strategies are currently used in the insurance market for healthcare and can be adapted for use by local or national affinity groups.

Subsidies: There are a variety of subsidy types extant in the healthcare market. For starters, there is Medicaid, a government funded, needs-based program for healthcare. There are also community benefit programs in which hospitals provide services to underserved populations as part of their tax exempt status. Often, these programs rely on a sliding scale or progressive pricing model. The sliding scale fees are variable costs for services based on the buyer's ability to pay and the provider's ability to make a variable profit or have the costs subsidized by other means. Disproportionate Share Payments, which are also part of this subsidies group, are federal funds that match state payments to hospitals that finance the additional costs of serving the special needs of a community. Finally, there are government guarantees of debt to reduce the cost of capital for consumers and providers. These government financial guarantees are designed to improve the credit quality of borrowers in order to facilitate their access to debt markets that would otherwise be closed to them or to improve the terms of credit otherwise available to borrowers.

A well-structured cash market would use cash subsidies more efficiently and leverage them to extend the care options beyond those currently served. For example, Alameda County, California, is currently considering using Medicaid dollars to create clinics that can serve Medicaid clients for free and serve other low-income residents on a sliding scale by using the same infrastructure. They think this will be more cost effective for Medicaid patients and offer greater access to the population that falls outside of Medicaid but not inside a private insurance system.

Cash-based delivery systems: Despite the unformed nature of the cash market, there are already two obvious examples of cash-based delivery systems: community health centers and mini clinics (or Doc-in-a-Box models). Community health centers are a network of more than 1,100 centers that provide primary care to 17 million low-income residents. These centers employ a sliding fee scale based on family income and size. A mini clinic is a walk-in medical clinic often based in a retail store. They provide prompt treatment for routine conditions and preventive care for fixed, transparent prices. As savings, credit, and payment systems are rationalized throughout the market, these institutions will be able to deliver their services more efficiently, and new health centers and mini clinics will find it easier to enter the market.

Consumer support: As we transform the cash market, consumers will need support. The most important first step is to ensure that nobody is paying cash for healthcare that shouldn't be, given our existing subsidy programs. Some providers and community-based organizations are already using benefit screening programs such as Real Benefits, the Benefit Bank, or Nets to Ladders to make sure people who qualify for public benefits are getting them. Community-based organizations, such as the

Access Project, are also running patient-advocacy projects that push back against insurers who underpay and providers who overcharge.

Community-based organizations also currently provide financial literacy programs concerning things like budgeting and savings. These organizations and the philanthropies that fund them should ensure that medical financial literacy is included in these programs, since a single medical event can wipe out decades of careful savings.

A more rational cash market will also better utilize the information available through online healthcare interfaces. Consumers may also increase their use of wellness and disease-management programs, the savings and payment systems become easier to use, and the long-term cost benefits become clear to individuals.

Financing structures and services: The world of big finance offers many tools that we can adapt for use by the cash market for healthcare. We have already discussed the need for a national capital pool that can raise money, most likely from a bank syndicate or through floating bonds. Bond issuance will require credit-rating agencies to be engaged, and the reams of data needed to accurately rate these bonds will need to be collected. Many national or local affinity groups will need to find a source of first-loss financing to cover some of the losses that would otherwise drive up interest rates for the capital. Sources of such first-loss coverage could include government subsidies, employer subsidies, mutual aid in settings such as churches or fraternal organizations, program-related investments by hospital-based or independent philanthropic foundations, etc. We can adapt many of the products from the world of debit and credit cards to speed processing of payments and organize an otherwise fractured system of insurance, subsidies, savings, and credit.

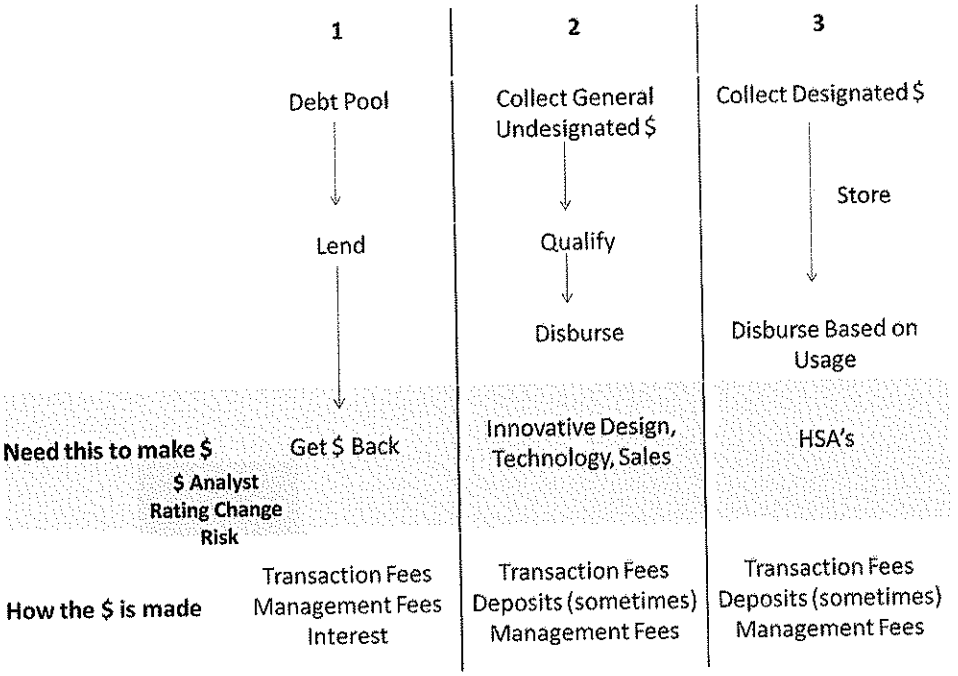
Working with potential partners

In our discovery process, we have found a significant range of potential partners. We have already engaged several potential national and local affinity groups and have begun reaching out to others. To date, nearly every entity we have shared our ideas with has asked to keep the conversation going in the hope that we can bring a suite of products and services to bear on their particular situation. These conversations have included the following:

- Workers' Unions
- Large Employers
- Congregation Networks
- Membership Associations
- Hospitals
- Credit Unions
- Small Business Associations

We have found three common types of financial products that can be used across multiple alliances and local communities. These financial products will be the core of our offering and will allow us to engage affinity groups and their local healthcare ecosystem in other ways that increase value—for example, as a

platform for bulk purchasing of services. Each type of financial product offering will rely on emerging credit and debit card technology that allows a single card to draw from multiple purses and match them to restricted purchasing options. For example, money sitting in a health savings account may be accessed through a Visa-labeled card for purchasing medicines at a pharmacy, but a candy bar would not be approved.



Using this technology, we will offer the members of affinity groups a single card that brings together sources of financing that fall into three categories: lines of credit, individual savings accounts, and prepayment for services designed for a group.

Lines of credit: Capital for these lines of credit may be drawn from employers, local community banks, and even our own risk capital. To keep this money affordable, we will help affinity groups identify appropriate subsidies. For example, a county may wish to subsidize the credit offered to newly employed people who have just left Medicaid but don't have health insurance associated with their job. Or an employer may wish to lower the interest rate offered to employees to pay for deductibles and co-pays.

Individual savings accounts: These pools of money include money saved by the individual in the form of a health savings account, a flexible spending account, or other related medical savings instrument and are designated for use by specific individuals. Alternatively, this money may be set aside by a party connected to the affinity group for the benefit of individuals in the affinity group. For example, an employer may wish to set aside a certain amount of money for use by each employee. Or a county program targeting asthma patients may wish to set aside the funds for up to four doctor visits per patient per year with an accredited asthma specialist.

Prepayment for services designated for a group: In this case, certain government or philanthropic programs pool capital and target a group with a predefined cap on overall spending. This money could sit in a single depository account but be drawn on by any member of the affinity group using the card for a qualified transaction.

Offering this suite of products will allow us to engage with a broad range of affinity groups and help create customized solutions that draw on local resources to address their specific needs. By creating a national platform that maintains flexibility, we address the local nature of most healthcare problems while drawing on the economies of scale that a national product offering can offer. This engagement with the affinity groups will go beyond typical marketing of financial products to include seeking other cost savings through bulk purchasing, shared risk, etc. A common suite of products will, however, ensure that replication is efficient and standards of practice can emerge nationally.

We have used a consultation process to date to work with these various groups to explore the market opportunities. These opportunities can be illuminated most clearly in context. Therefore, we will utilize the same five iconic groups in need of new approaches to healthcare cash economy introduced in the previous section to show how these products could be combined to serve the needs of particular groups.

Undocumented workers: We recently spoke with a community hospital that charges a $15 co-pay for low-income (typically undocumented) patients without health insurance. The hospital explained that it collects on average 2% of this money, but pursued it all through a collections process. This co-pay then becomes a significant barrier to care for people who hesitate to return to the hospital to which they owe money. We can set up a card system tied to a network of churches in that community where each member of the church gets a card tied to a common purse funded with donations from church members, philanthropic money, etc. This card would pay for co-pays at the community hospital. We could then negotiate a reduced rate on the co-pay for this population, since collections would go from 2% to nearly 100% for members of this group.

Seniors on Medicare: Seniors on Medicare could be helped through a variety of offerings. Similarly to the undocumented workers, seniors could be helped through a church or other affinity group where donations and other philanthropic funds are used to help cover medical expenses. These donations and the expenses could easily be handled through a card product. Seniors could also be helped through a per-member-per-month model, in which a certain amount is paid to a clinic each month in return for easy access to primary care. As an aging population, seniors need diagnostics and specialty care. Some states are working towards increased transparency of pricing in these areas and a sliding payment scale. Where these take place, seniors can be helped by linking them to appropriate prices for the care they are receiving. Where the state hasn't intervened, large affinity groups would be able to negotiate their own prices for these services and facilitate payment by using card services.

Middle-class workers in self-insured plans: Large employers have told us of their interest in our products and services to lower costs, help rationalize the payment of care, and steer their employees into healthier care patterns. For example, an employer may wish to raise its current deductible from $1,000/year to $5,000/year but set aside the $4,000 in savings in a separate fund to cover the increased deductible. Changing to a high-deductible plan will save more than the cost of covering the increased deductible and therefore will save the employer money while not costing employees any additional money. Furthermore, employees can set up HSAs to cover their share of the deductible, and all three purses—the HSA, the common pool provided by the employer, and the insurance coverage—can all sit

on a single card, making collections easier for providers and payment easier for consumers. Employers may also wish to add a fourth purse that they fund to pay for wellness programs, such as weight loss or stress management, that increase health and lower overall costs even further.

Small businesses and their employees: By working with small businesses through business associations and the like, we can build larger groups of employees and bolster their collective purchasing power. Bulk purchasing can lower the costs of prescription drugs, common primary care services, and diagnostics. This group could also be offered vehicles for financing the deductible. For example, lines of credit with low interest rates (lower than those typically available on a credit card) could help members manage their finances. HSAs and other stored value instruments could also be used to help workers manage their expenses. Members of this group have an income and for the most part can pay off their debts. However, medical expenses are unpredictable and often hit all at once. Thus, financing instruments that help to spread the burden over time at low costs are significant help in managing household finances.

Low-income wage earners (part-time and full-time): We have been working with a union that organizes workers making less than $8/hour. These workers often have limited or no health insurance. The union has been negotiating with local clinics to provide quality care at affordable prices to their members. The clinics have been concerned that this population won't have the savings to pay for medical care as the need arises, and the union is concerned that its members don't have a savings, credit, or prepayment mechanism to smooth the uneven need for healthcare services its members have. We could supply union workers with a card tied to an automatic savings mechanism that would allow each worker to set aside money on a regular basis to cover the costs associated with their basic primary care. The union could then negotiate favorable pricing with clinics in the area, as well as with associated specialists and diagnostic services. Providers could run the patient's card at the point of service and deduct the fees directly from the savings account associated with that patient. To further expand access and share risk, the union could establish a single joint account that patients could borrow from if their own account runs out of money. The union could then charge these members a reasonable interest rate while the loan is in repayment. By putting these services together on one card, the providers will know they are going to be paid, and the consumers will know they have access to quality care when they need it. This predictability will lower the transaction costs for providers. Consumers will be better able to plan for their needs and therefore will seek care when they need it rather than avoiding care until the situation because more dire—and more expensive.

By adapting tools from other markets, we will be able to offer the products and services needed to rationalize the cash market for healthcare. By engaging groups locally but coordinating them nationally, we will be able to get the cost benefits of scale, share risk locally but manage it nationally, create standards for the entire market, and get to the size needed to create systemic change.

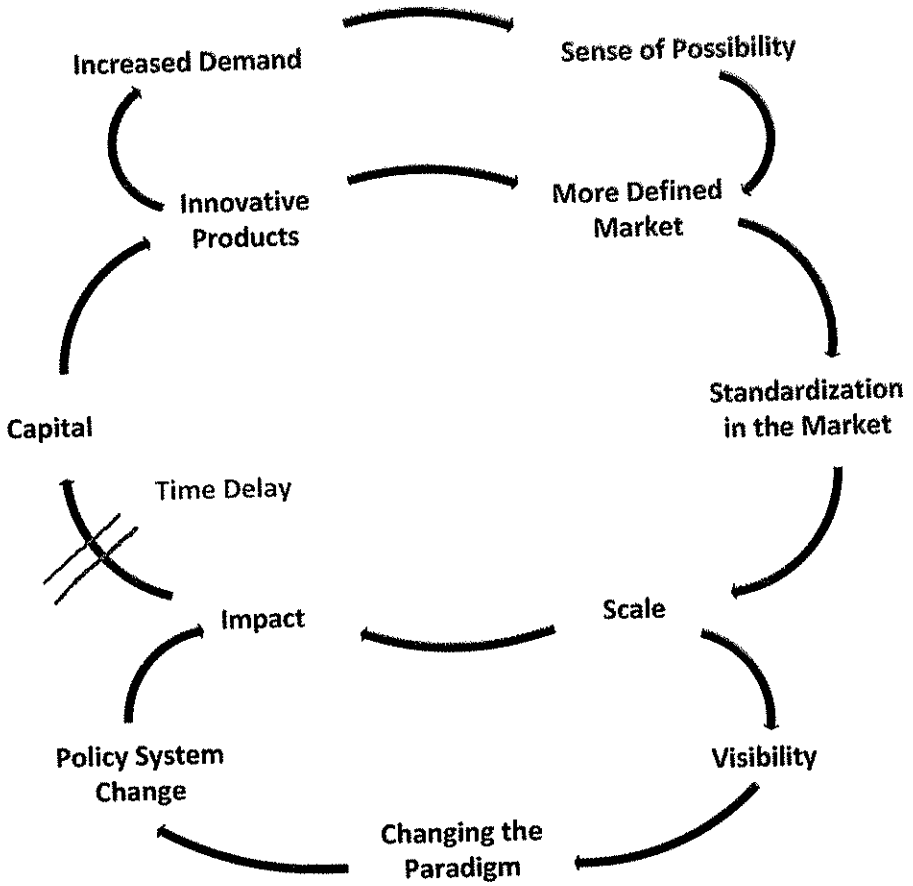
Impact of the Intervention

If the cash market for healthcare is rationalized, Criterion believes costs to consumers and providers will decrease, the value of the cash dollars spent in healthcare will increase, and coverage for those most in need will expand.

As with any new venture, an influx of capital is needed to jumpstart the development and implementation. With an influx of capital, innovative products, such as those described in the last section, can be developed. As these products are introduced, they will provide increased definition to the market. New products will create a demand that will increase the sense of possibility within the healthcare system of what can happen inside the cash market as opposed to the insurance market. As products that address this opportunity become available and as more affinity groups organize themselves to make use of these products, the market becomes increasingly defined.

Over time and through replication, the market will standardize. Standardization of the market will enable it to scale up to a national level. At such a scale, broad impact on access to appropriate healthcare, the cost of healthcare, and health outcomes is possible. As this impact becomes visible, more investors will contribute capital to the products and services that enable the market to function efficiently. As the interventions are brought up to scale, not only will impact increase, but overall visibility of the cash market will also increase. And once the cash market becomes increasingly recognized and acknowledged, a paradigm shift can occur. The cash market will no longer be treated as an exception to the insurance market but rather as a separate functioning entity with its own operating procedures. With this paradigm shift in how people view healthcare will come corresponding policy changes, which will in turn

This graphic depicts how these interventions will shift the cash market for healthcare.



increase the scale of the impact.

This is a particularly important time for people to be working on rationalizing the cash market for healthcare. Several trends exacerbate the problem. These include action by employers to continue to shift more of the burden for healthcare onto their employees and current policy proposals for "universal care," most of which are proposals for universal insurance that still leave the uncovered portion of healthcare—15 percent of the overall healthcare market—unaddressed.

A rational cash market may slow the trend of employers' cutting healthcare benefits and allow more employees to retain access at lower cost to both the employers and themselves.

There may be unintended consequences of rationalizing the cash market. The most obvious is that it may lead to an expansion of this market, caused by employers' simply shifting more of the burden on to employees faster. We believe that the opposite will happen; by making the cash market more manageable, employers and others will be more likely to help consumers deal with the cash portion of healthcare by offering subsidies and services that complement their insurance offering. It is also important to note that if the cash market expanded due to the fact that it offered cheaper and more appropriate care, this would benefit patients. The questions of whether a larger cash market is good or bad are really questions of who pays, not what is the value of the dollar spent here. More value is always better; using that increased value as an excuse to shift burden isn't.

As with any large reform program or any new market, unintended and possibly unforeseen consequences will arise. It will be important for us and others to monitor these changes closely as we move forward.

The fear of unintended consequences should not paralyze us. If the cash market is not rationalized and it remains an exception to the insurance market, then the current issues surrounding transparency, financing, and overall value of the cash market will only get worse. Consumers will be continually straddled with various and differing forms of medical expenses. They will continue to be unaware of costs and what financial situations they might be getting into as a result of a medical condition. And we know from current studies that financial hardship limits people's access to care.

Conclusion

The market for healthcare in the United States is actually two markets, a dominant insurance market and a stunted cash market. Treated as an exception to the insurance market, the cash market is ill formed with opaque pricing structures, confusing billing, few helpful intermediaries, and few appropriate financing options.

By looking through the overarching themes of transparency, predictability, and shared risk, we examined the health care system using leverage points. These leverage points enabled us to identify points of common pain and possibility. They enabled us to see the system more clearly.

The inefficiencies of the cash market are highlighted by looking at three features: how services are priced, how prices affect the delivery system, and the financial services that intermediate the process of payment. Currently, the consumer is faced with a fragmented and opaque pricing system (co-pays, deductibles, stop-losses, etc.), which are a result of intense negotiations between insurance companies and providers. The resulting fractured pricing system, however, makes it difficult for the consumer to understand costs, to plan for expenses, and to make informed decisions about care. These results have a disproportionate impact on those most vulnerable in our communities, those disenfranchised from banking services, unable to access insurance, and ineligible for the cost-savings created through bulk purchasing agreements.

In the current system, people are not accessing needed care because of cost barriers. Insurance companies instituted patient responsibilities to dissuade abuse in the system, but it went too far, and the costly patient responsibilities are now preventing people from seeking treatment when they legitimately need it. This often leads to more dire consequences that ultimately result in costlier interventions down the road.

Financial intermediation is often achieved through collection agencies and credit card companies, which create unnecessary expenses for both providers and consumers.

By creating a cash market with transparent pricing and billing that utilizes appropriate delivery systems and offers consumers effective financing and payment options, we will be able to lower the overall cost of care within the cash market. This will not only save consumers and providers money but also will allow for greater access to care overall. The social impacts of the currently inefficient and irrational cash market as well as how various products and services can bring about positive changes are illustrated through five iconic groups.

Rationalizing the cash market for healthcare will take the introduction of new products, services, and other innovations. Luckily, most of these tools and services already exist and just require realignment and repackaging. Financial offerings will fall into three categories: lines of credit, individual savings

accounts, and prepayment for services designed for a group. Other offerings will focus on delivery systems and aligning types of care with needs.

To rationalize the cash market, action will have to take place at the national level and across many local areas. Work at the local level is needed because this is where healthcare takes place, but also, local groups will be needed as a way to manage risk, build power, and negotiate. Action at the national level is needed to achieve scale in the system and to access national capital. We will need to craft ways to bring various groups in line within a narrower band of risk to allow debt to be packaged and sold to a national capital market.

Of course, there may be unintended consequences of rationalizing the cash market, the most obvious of which is an expansion of the market caused by employers' shifting more of the burden onto employees. However, we believe the opposite will happen. Either way, the impacts in the system need to be monitored closely. We hope to increase the value of the dollar but not shift the burden.

To move forward we are building partnership to be able to offer products and services, adapted from other markets, with the intent of rationalizing the cash market in healthcare. By engaging groups locally but coordinating them nationally, we will be able to get the cost benefits of scale, share risk locally but manage it nationally, create standards for the entire market, and get to the size needed to create systemic change. By rationalizing the cash market for healthcare, we will be able to increase the value of the cash dollar in healthcare, empower consumers to make wiser choices, and lay the groundwork needed to support new and innovative delivery systems.

This report marks a transition from exploration and design into more formal business planning. The next steps in this process include crafting a business plan, forging the necessary strategic partnerships, and creating an ongoing advisory board. We will then be prepared to engage the right partners and launch.

For more information about the Healthcare_Uncovered project, please contact Elizabeth McCance at mccance@criterionventures.com.

Endnotes

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Appendix

Mapping Summit Participants

Enrique Balaguer, Executive Director, RealBenefits
Stephen Bolles, Consultant, Open Health Media
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Louise Malone, Administrator, SEIU
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