MAKING HEALTHCARE COMPETITIVE

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Economists have long known consumers benefit from market competition. Competition incentivizes organizations to become more innovative, lowers their prices and increases the quality of their goods and services, which result in more value for the consumer.

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Today, organizations across industries recognize the importance of choice and transparency in competing for consumer loyalty. BookIt.com and Expedia enable consumers to seamlessly curate their own vacation experiences. Outdoor retailer Patagonia created the Footprint Chronicles which provides detailed information on the company's global supply chain. When it comes to healthcare, however, competition in the industry pales in comparison.

Consumers have fewer choices in what healthcare goods and services they pay for and they have little transparency into how much those goods and services cost. These factors reduce health literacy, or a consumer's ability to find information and make informed health decisions. Healthcare organizations can make themselves more competitive by addressing the barriers to choice and price transparency, positively impacting consumer health literacy.

Lack of Choice

One way today's consumers have little choice in managing their healthcare is the lack of control over when, where and how they receive care. Many consumers rely on private, employer-sponsored healthcare coverage. This reduces the cost of a health plan for employees, but at the expense of choice: the employer determines what bundled services to cover and negotiates the corresponding prices, rather than the individual covered by the health plan. In this structure, the quality and cost of coverage is dependent on the employer and their goals — not the consumer's.

While public health plans have increased access to healthcare for many, they still haven't increased choice. Medicaid coverage, a federally mandated program that is state funded, varies by state. As of 2019, 17 states have chosen not to expand Medicaid, adding to the disparity in coverage. For states that have expanded the program, not all providers accept Medicaid. Many consumers also find coverage through the Healthcare Marketplace. While the numbers have improved from 2018 to 2019, insurer participation in the program is unstable: 25% of enrollees have access to plans from only two insurance providers while 17% have access to only one. Insurer participation also varies from state to state, from county to county and even from city to city: rural areas tend to have

fewer insurers while urban areas tend to have more. In this structure, the quality and cost of coverage is dependent on where the consumer lives — not their specialized needs. A lack of standardization within and across state lines impedes health literacy, making it harder for consumers to understand their options.

Consumers are also limited in their choice of providers. For public and private insurance, the plan issuer determines which providers to include in its network, reducing the consumer's options for where to seek care. Networks vary according to the plan provider and consumers may not always have access to a specific healthcare facility in their area or the organization that best fits their needs. Additionally, consumers with rare cancers, autoimmune disorders or sports-related injuries may not have access to the potentially life-saving care of specialists who can better treat specific conditions. While consumers are technically free to choose care out-of-network, many consumers can't afford the surge in costs, and the availability of plans that cover out-of-network care are dwindling: from 2015 to 2018, the amount of private health plans with out-of-network benefits dropped from 71% to 64%. Out-of-network coverage in public plans dropped from 58% to 29%.

Lack of Transparency

If a consumer was looking to buy a used car and asked for the price, you wouldn't expect the seller to respond, "We won't know how much it will cost until you've driven it off the lot." Unfortunately, this concept is all too familiar for consumers trying to find price information for healthcare services.

One reason for the lack of transparency in pricing is that neither payers nor providers know what to quote consumers. For example, a consumer asks their health plan provider for the cost of a CT scan. The provider gives them a quote but says the final price will depend on where they receive care and if they've met their deductible. The consumer finds two hospital systems in network and again asks for a price. Both systems provide quotes but indicate the final price will depend on what insurance the consumer has; for private insurance, they quote one amount and for public, another. Not knowing what to expect financially further diminishes health literacy and may present consumers with an impossible decision: whether to pay the bills or get healthy.

In addition to the cost of healthcare services, consumers must also account for their health plan premium. Premiums for the same plan can differ dramatically in price depending on where the consumer lives. For a single person on an employer-provided health plan, annual premiums for 2018 ranged from $675 in Hawaii to $1,747 in Massachusetts. For family plans, premiums ranged from $3,646 in Michigan to $6,533 in Delaware.

Becoming Competitive: Removing the Barriers to Choice and Transparency

The factors that limit choice and transparency in our healthcare system are not easy to fix. However, there are things healthcare leaders can do to address these problems within their organizations, making themselves more competitive and better serving their consumers now and in the future

Create more choice by developing innovative care delivery models centered on the consumer.

The future of healthcare belongs to organizations that put the consumer first. That means developing and implementing care delivery models that strengthen health literacy and enable consumers to seek and manage care how they want.

When thinking of how to design care delivery models with the consumer in mind, healthcare leaders should look for ideas that solve multiple challenges. For example, if a health plan ran a health system, the model could remove barriers to care such as pre-authorization or having to find providers in-network. This would also eliminate

the need to call the insurance company to manage claims or obtain price information, as both the payer and the provider are aligned in what they're offering and how much it will cost.

While each care delivery model will be unique to the organization, there are a few things all leaders should consider in designing a new model:

- **Link revenue to outcomes:** By making profit contingent on the value delivered — not the amount of services rendered — organizations incentivize physicians to improve outcomes instead of ordering excessive services
- **Prioritize convenience:** Find ways to reduce the number of visits to treat the consumer and collaborate with local pharmacies and medical supply organizations to make filling prescriptions easier.
- **Leverage technology:** Patient portals make it easier for consumers to do everything from order prescription refills to manage appointments. Telehealth programs that connect consumers to a live nurse allow consumers to get answers to common health questions that may not necessitate a formal visit, thus saving on the price of the visit. Intermountain's telehealth program for example, is affordable to use and if consumers need to come in for a visit, they are only charged for the visit, not the call.
- **Make it personal with predictive analytics:** Personalization makes it easier for consumers to learn about themselves. When combined with predictive analytics, it can better prepare consumers for their care needs now and in the future. Weight loss aps such as MyFitnessPal and LoseIt collect and analyze user data to determine when a consumer will reach their weight loss goals, empowering the them to maintain healthy behaviors. Healthcare organizations could apply this concept to patient portals, empowering consumers to stay on track by informing them of when they will reach their cholesterol goal, for example.

Increase consumer access to price information by thinking holistically about transparency.

While the Centers for Medicare and Medicaid Services (CMS) mandated all hospitals to make their prices public at the start of 2019, many in the industry are doubtful of the impact this mandate alone will have on price transparency. Healthcare organizations must go beyond the requirements of the mandate and adopt a holistic approach to transparency — how can information boost health literacy and improve the consumer experience across the care continuum?

UC Health is one organization that is exceeding expectations of the CMS price transparency mandate. The health system created a price estimation tool that considers the patient's insurance to determine the expected cost of a procedure or visit. Consumers can access this tool via a patient portal, a mobile app or a call center. They also have access to financial counselors who can guide them through the complex web of copays and deductibles.

While many factors make total price transparency hard to achieve, healthcare leaders can adopt several changes to significantly improve access to price information at their organizations:

- **Talk about it:** Encourage physicians to address pricing during patient visits to help consumers understand the cost of the services, what their health plan will cover and what the consumer will be expected to pay.
- **Use historical data to predict cost:** Call upon aggregated historical data to provide consumers a predictable range for common services.
- **Incentivize preventative visits with reduced cost:** Offer discounted preventative services for consumers who can pay their bill ahead of receiving care. This encourages consumers to maintain their preventative checkups and eliminates reimbursement risks for the most commonly performed services.

- **Prioritize consumers in cost-cutting measures:** When exploring ways to reduce administrative or operational costs, think of ways those savings can be routed to the consumer.
- **Structure care in bundles:** The types of care consumers will seek can be predictable; for example, a consumer seeking prenatal care will require access to ultrasounds and screening tests. They may also need a nutritional counselor for gestational diabetes or a maternal-fetal medicine specialist if the pregnancy is considered high-risk. By bundling services consumers are likely to use in succession, healthcare organizations can provide a reduced price.

By focusing on ideas that promote health literacy, improve transparency and increase choice, healthcare organizations can facilitate better outcomes and capture consumer loyalty to become more competitive.

Key Takeaways

Healthcare organizations can counteract the effects of a noncompetitive market by creating more opportunities for choice and price transparency from within. Healthcare leaders must:

Think differently.

Reassess your organization's current care delivery model from the perspective of the consumer and identify complexities that can be eliminated.

Plan differently.

Maximize the impact of technology by making it both a reliable source of information for consumers, an enabler of transparency and a tool for collecting actionable data.

Act differently.

Restructure payment models to be intuitive and redirect cost savings back to the consumer.

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