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## I. Overview and Context of Report

It is projected that Americans spent \$265 billion in out-of-pocket medical expenses in 2007, expenses not paid by public or private insurance. This “patient portion” is a complex problem that is beginning to wreak havoc for both patients and healthcare providers in the coming years.

Hospitals, patient advocacy groups, government agencies and even financial services companies have each brought forward their own way of dealing with these expenses. But each “solution” is only addressing a part of the problem, often at the expense of another stakeholder. In the end, a comprehensive and effective solution will require the input, and eventual buy in, from each of these sectors, and possibly more.

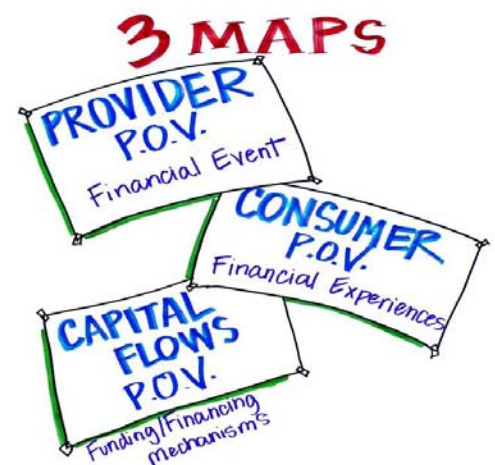
With funding from the Rockefeller Foundation, Criterion Ventures and their partners, the Access Project, Hudson TG and Good Capital, are running Healthcare\_Uncovered for an eight-month period to analyze the problem, explore solutions, and draw up a detailed plan ready to be implemented by the participants.

We formally began the project in October, 2007 and since then have engaged over 85 individuals across multiple industries and disciplines. We did a survey of the field, identified blocks and opportunities, and sought to identify the core principles for a solution. We engaged players from the following sectors:

- Providers – Executives at large provider systems and other healthcare innovators
- Advocates – Both patient advocates and asset and community development specialists
- Finance – Executives from the financial services industry, capital markets and revenue cycle specialists
- Government – Representatives from national and state agencies involved in healthcare funding

On December 8, 2007, we convened a group of key thought leaders at the Rockefeller Foundation offices for a Mapping Summit. The two days of meetings were driven by the following objectives:

- Create a mapping—a shared representation—of the scope and impact of the patient portion of medical costs on patients, families, healthcare institutions, and society
- Identify points of leverage in the system that may lead to possible opportunities to mitigate the negative impacts



In the coming months, we will shift our attention to design, leading up to a Design Summit in March, 2008. We hope the Design Summit will generate solutions, scenarios and questions which will drive the testing, development and grounds for building broad agreement among stakeholders. In the end, we will turn the vision into a concrete model with an implementation plan, including a timeline, a work plan and a budget for launching pilots.

This report provides an overview of the first phase of the work leading up to and including the December Mapping Summit. It does not yet suggest a particular solution but begins to draw out themes and points of leverage within the system.

This report should not be read as a formal research summary but rather an open discussion, an attempt to convey snapshots of the system. Many of the graphics are drawn from the Mapping Summit and the graphic facilitation of the meeting. They represent ideas in process rather than a finished product.

This report is structured as follows:

**Frame for Healthcare\_Uncovered.** Through this initiative we have reframed several intersecting issues in healthcare through the lens of patient costs – costs not covered by public or private insurance. This summary outlines the uncovered costs briefly; for additional information, we refer you to previous Healthcare\_Uncovered documents.

**Terms of the Conversation.** We recognize the importance of technical language as we are talking across several disciplines. This quick glossary highlights the terms we find most used, as well as those most contested in the conversation.

**Emerging Themes.** While we are still in the middle of a process, we are beginning to see several aspirational themes emerge. These themes include:

- Integration across perspectives
- Predictability
- Shared Risk

**Insights into the System.** We are not defining the whole system or attempting an analysis of root causes of uncovered costs. Rather, we draw a set of insights from the Mapping Summit and previous conversations that makes sense of a complex system from the lens of Healthcare\_Uncovered.

We hope this report both orients individuals and institutions as they engage in Healthcare\_Uncovered and spurs additional conversation as we continue to cast and recast these ideas over the coming months.

## II. Participants in the Mapping Summit

We would like to extend our thanks to the participants in the Mapping Summit. In addition to those named on this list, we want to thank all who have participated in shaping this thinking through interviews, resource sharing and informal conversations.

### **Mapping Summit Participants**

Enrique Balaguer, Executive Director, RealBenefits

Stephen Bolles, Consultant, Open Health Media

Richard Clarke, President and CEO, Health Care Financial Management Association

Richard Eskow, CEO, Health Knowledge Systems

Jose Garcia, Senior Research and Policy Associate, Demos

Wendy Goldstein, President, Lutheran Health Care

Melinda Hatton, Senior Vice President & General Counsel, American Hospital Association

Michele Kahane, Clinton Global Initiative

Fran Kelleher, President, Kelleher Consulting

Michael Klozotsky, Analyst, Kaulkin Ginsberg Company

Dr. Robert Levine, Founder, Growth Philanthropy Network

George Miller, Regional President, Community Mercy Health Partners

Len Nichols, Director, The New America Foundation

Karen Quigley, Chief Operating Officer, Community Catalyst, Inc.

John Rother, Director, Policy and Strategy, AARP

Kim Simensen, Simensen & Associates

Irene Skricki, Program Manager, The Annie E. Casey Foundation

Maria Beylin, Public Health Fellow, Rockefeller Foundation

Monica SanMiguel, Research Associate, Rockefeller Foundation

Margot Brandenburg, Research Associate, Rockefeller Foundation

Marsha Gold, Senior Fellow, Mathematical Policy Research

### **Healthcare\_Uncovered Team**

Catherine (Cathy) Dunham, Director, Access Project

Tim Freundlich, Founder and Managing Principal, Good Capital; Director of Strategic Initiatives, Calvert Foundation

Ben Geyerhahn, Principal, Hudson TG

Claudia Machaver, Consultant

Robert Mittman, Founder, Facilitation, Foresight, Strategy

Mark Rukavina, Executive Director, Access Project

Michael Tobman, Principal, Hudson TG

Dana Wright, Founder, Take Action, Inc.

**Criterion Ventures Team**

Joy Anderson, President and Founder

Jacqueline VanderBrug, Partner

Andrew Greenblatt, Partner

Anne Marie Bellevance, Relationship Manager

John Chamberlain, Operations Manager

### III. The Frame of Healthcare\_Uncovered

One of the important outcomes of the summit was a validation that the frame of the uncovered costs of healthcare provides important insights into the dynamics of the system today. Currently, approximately 15% of the \$2 trillion per year in healthcare costs are not covered by private insurance, Medicare, or Medicaid. These bills often become a great burden for patients and their families, or are never paid and must then be borne by providers. This uncovered portion – or patient portion – has a profound effect on the way medical care is delivered in the United States, as well as having effects far beyond the delivery of healthcare.

One way to look at this is the scale of impact on individuals and families. A significant portion of Americans report problems with medical bills and medical debt:

- One-fifth (21%) of working-age adults, both insured and uninsured, currently have medical debt they are paying off over time and more than two of five (44%) of these individuals are carrying \$2,000 or more in debt.
- More than one-third (34%) of adults ages 19 to 64 either had medical bill problems in the past year or were paying off accrued medical debt. Problems include: not being able to pay bills, being contacted by a collection agency about unpaid medical bills, or having to change their way of life to pay bills.
- Three 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.
- More than half (51%) of uninsured adults reported medical debt or bill problems. Of those, nearly half (49%) used up all their savings to pay their medical bills. Two of five were unable to pay for basic necessities like food, heat, or rent because of medical bills.<sup>1</sup>

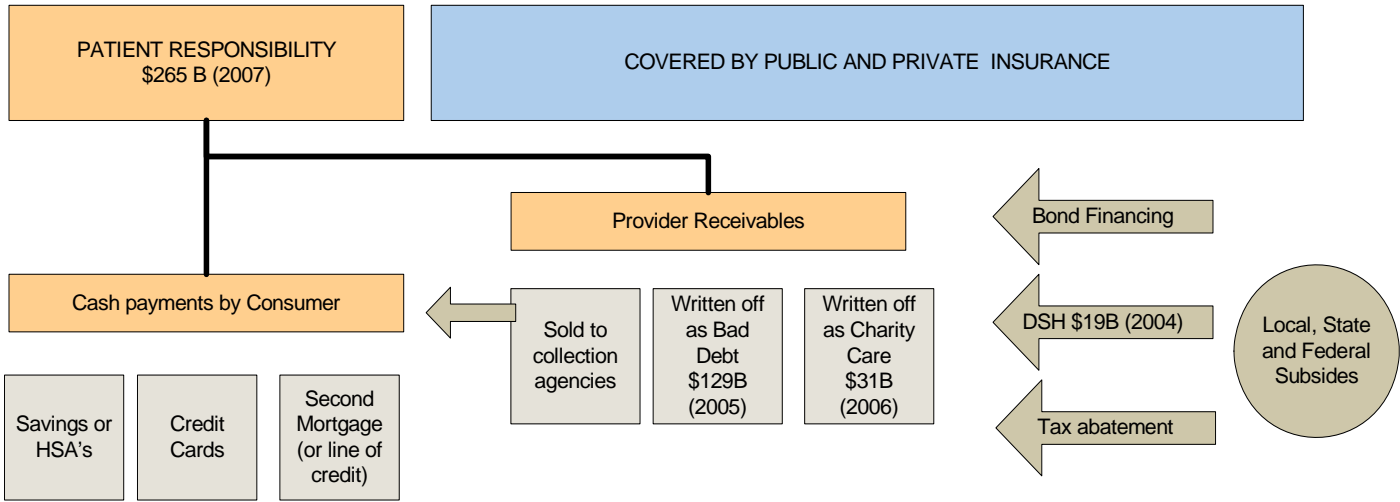


Uncovered costs represent a particular lens into the healthcare system. This cost of medical services not covered by public or private insurance can be broken down into two basic categories: 1) payments made by patients, and 2) provider receivables that they may or may not collect on over time.

The graphic below demonstrates the dynamic among consumers, government and providers as they manage their uncovered costs.

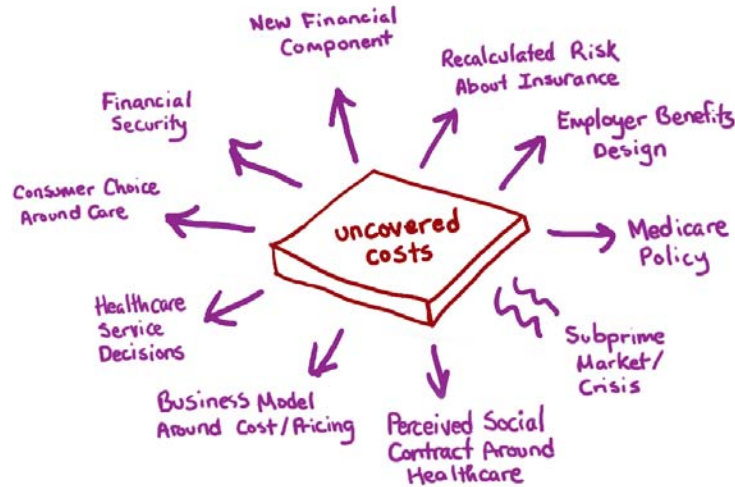
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<sup>1</sup>"Gaps In Health Insurance: An All-American Problem - Findings from the Commonwealth Fund Biennial Health Insurance Survey"; The Commonwealth Fund; [http://www.commonwealthfund.org/usr\\_doc/Collins\\_gapshtlins\\_920.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Collins_gapshtlins_920.pdf?section=4039); pages viii, ix.



These uncovered costs represent the outgrowth of many trends and changes in the healthcare system and are themselves generating far-ranging consequences.

As a result, providers must consider whether certain services will be covered by the insurance companies, and not just whether offering the service would be in the best interest of their patients. Some large providers serving poorer populations are even closing their doors, consumers unable to pay their bills delay or defer treatment.



Consumers often deplete their savings trying to pay medical bills and end up turning these bills into debt of various kinds, most notably credit card debt and second mortgages. This debt can then snowball; it has been found to be a factor in approximately half of all personal bankruptcies. This financial instability affects consumers' ability to pay mortgages, keep up with their bills, and plan for their futures.

The financial services industry has been working with both providers and consumers to find new ways to address this problem. It is not clear how successful these services are, either for consumers or providers.

#### IV. Terms of the Conversation:

Healthcare\_Uncovered intersects many technical fields within healthcare and finance. In each of these contexts, language conveys meaning and imparts power.

The way the current system tracks data and makes decisions is determined or described by terminology. What is measured matters because it is granted power within the system and because it is the lens through which questions can be answered. In conversations about solutions, terms become shorthand for the organizing principles that shape definitions of the problem.

The following terms have played an important role in conversations to date. We provide the most common usage and name the perspective from which the term originates.

<b>Terms</b>	<b>Usage</b>	<b>Perspective</b>
uncompensated care	Care given to the patient, for which the provider is paid less than the cost borne by the provider for the care. Often used when discussing Medicare or Medicaid reimbursement amounts.	provider
cost shifting	Being able to charge more for one kind of procedure, item, or service to cover losses incurred by providing another kind of procedure, item, or service.	provider
high deductible plans	A health insurance policy where the consumer covers the first several thousand dollars of medical bills in a year before the plan begins to reimburse any costs.	employers and insurers
consumer driven healthcare	Refers to health insurance plans which couple personal Health Savings Accounts (HSAs) or similar medical payment products that allow members to pay routine healthcare expenses directly with a high-deductible health insurance policy. This system of healthcare is referred to as "consumer driven healthcare" because proponents believe it gives patients greater control over their health.	employers, providers and insurers
managed Care	A series of techniques employed by payment intermediaries such as insurance companies and HMOs to regulate and manage the delivery of care.	employers, providers and insurers
charity care	Charity care is healthcare rendered to patients	providers

	unable to pay in whole, or in part, with the provider choosing to bear the costs rather than seeking payment.	
reimbursements	Fees paid by insurance companies or Medicare/Medicaid for procedures, items, or services provided to covered patients.	providers and insurers
adjudication	The process by which insurance companies determine if and how much they will pay for a claim.	providers and insurers
receivables	Bills issued by providers that have yet to be paid.	providers
consumer medical debt	Any kind of debt incurred by a consumer to pay a medical bill including direct financing, credit card debt, or second mortgages.	consumers
securitization	Securitization is a process in which assets from multiple sources are combined and then distributed into various risk pools, and offered as collateral for third-party investments.	financial services
collective buying power	Involves using the purchasing power of a large group to negotiate lower prices for goods and services.	employers
risk pooling	Involves bringing together individuals or small groups into an insurance pool to mitigate the effect of a single or small number of high cost events through sharing the risk across the entire pool.	insurers
revenue cycle management	The process of managing receivables from initial billing to final disposition. This includes: filing claims, billing, collections, writing off bad debt, etc.	providers and financial services

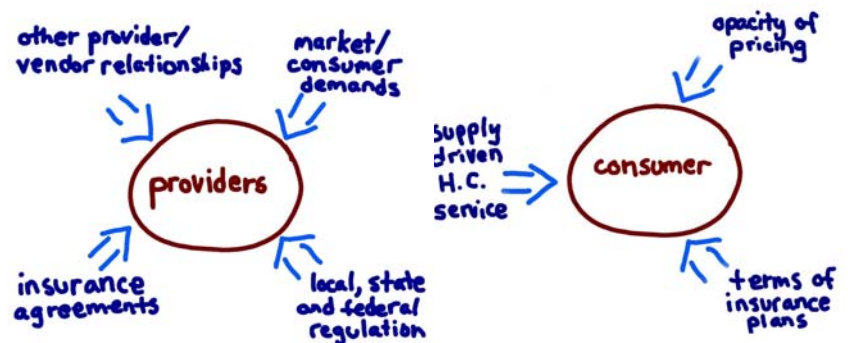
## V. Emerging Themes

### ***Integration across Perspectives***

Throughout our conversations we have heard about the delineation of roles and distinctions between perspectives. Healthcare is an industry that is viewed in radically different ways depending upon where you sit.

In general, this heterogeneity of experience leads to summative statements about complexity. “The American healthcare system is complex.” True enough. But in the context of Healthcare\_Uncovered we are looking for integration across perspectives. From that vantage point we will find new opportunities.

Providers play out a fragmented set of relationships with those seeking care. They: define/diagnose the need, provide the care, set or submit the price, collect on payments past due and finally remediate unpaid bills in court, all of which occur in different chronologies and ways by site of service. In each of these relationships, the logic, the drivers, is not transparent to the other party.



In most cases, transparency and clarity increase trust. In financial markets, intermediation can play a key role in building clarity and trust. But in the healthcare industry, intermediation through third-party administrators, insurers and collectors reduces transparency and trust. Intermediation distorts perspectives.

The result of this fragmentation is that it is not uncommon for various players to shift the burden. Providers, patients, employers, and insurers, at times, shift costs or liabilities to other players in the system.

Is there another possibility for intermediation that would increase trust? Can intermediaries bring common interests of the stakeholders to the attention of those stakeholders?

The divergence of perspective is the reason we will organize the report according to the various stakeholders: providers, consumers, employers and other aggregations of consumers, government, and the financial industry.

## **Predictability**

In a system where so much is at stake, multiple, divergent perspectives create an environment of opacity which leads to unpredictability. In the case of uncovered expenses, the consumer does not know what a procedure or service will cost and who will be responsible for it, or they have incurred an involuntary expenditure brought on by an unanticipated crisis. A bewildering flurry of bills and notices then begin to arrive, some labeled “this is not a bill.”

Providers, too, face a high degree of unpredictability. They don’t know what the outcome of an insurance company’s adjudication will be in many cases. If they are left with unpaid receivables they must then enter into the murky world of billing directly to the patient. Here the ability and willingness of a patient to pay may be unclear, leading to a lack of predictable cash flow. These unexpected, unmanaged expenses cause friction throughout the system, in multiple relationships.

At the same time, the very nature of healthcare rests on the randomness of when need will arise. No one plans to have a heart attack today, or to get hit by a bus tomorrow.

The opacity of the system and the randomness of the need both lead to a high degree of unpredictability. At a core, we need to find a way to balance what is expected and what is a surprise. To achieve this we must focus on reducing opacity through simplicity and transparency. We must also reduce the impact of the randomness inherent in healthcare by finding better ways to pool risk and spread the burden of unexpected (though inevitable) health events over time and/or populations.

## **Shared Risk**

The American healthcare system is going through a period of rapid change in which risk is being shifted to smaller and smaller pools, and ultimately to the individual consumer. Each player is now seeking to limit his or her own risk as much as possible.

At the same time, those left holding the risk are less and less able to efficiently plan for the worst-case scenario. Not everyone is able to maintain sufficient reserves to cover the rare catastrophic medical bill.

The current way the risk is spread, in particular for individuals and small groups, is no longer effective. Public and private insurance are not covering the costs of medical care in America. At the same time, providers, individuals and employers are suffering extreme economic hardships when medical expenses exceed their ability to pay. Further, by simply viewing “risk” as a short-term and sporadic economic problem, solutions that look to limit the risk of actually getting sick (or increasing health) in the first place are overlooked.

When designed and deployed correctly, a new model would serve to manage risk across multiple parts of this complex system. It would create standards and terms of engagement that allow each player to feel he or she is being fairly dealt with.

To achieve this we need aggregation mechanisms that leverage new collectives both for reducing costs and pooling multiple kinds of risks more effectively. These new models will have to step out of the current supply and demand dynamics.

## VI. Insights into the System:

Many have ventured into the task of mapping the complexities of the American healthcare system and some have succeeded. Our goal in this mapping process was to seek ways to understand the causes and effects that surround the uncovered costs of healthcare.

In our discussions over the past several months two issues were raised again and again. The first issue is that the healthcare system is very complex. Numerous variables come into play whenever a patient and provider come together. Is this procedure covered by insurance? Has a yearly deductible cap been reached? Was the adjudication process fair and accurate? Can the patient afford to pay his share today? Over time? Never? Are Medicaid reimbursements for this procedure enough to cover the costs? And what, exactly, is counted when one is determining costs?

A second issue revolves around the broad spectrum of interactions that take place within the healthcare industry. Providers, from small medical practices to enormous hospital systems, have vastly different billing systems and capacities to deal with insurance companies. Patients have significant variety in their insurance coverage and their ability to pay any bills that may come their way. Different physicians may order entirely different batteries of tests and treatments for the same set of facts. And, of course, there are ailments whose treatments vary and last anywhere from a short period of time to the rest of a patient's life.

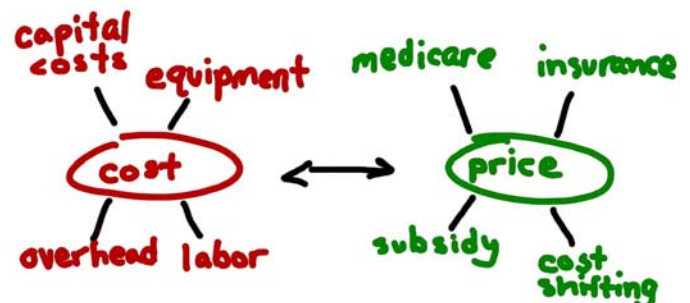
These related problems of complexity and variety have vexed previous attempts to see effective, far-reaching reforms. In this report, we attempt to see past the haze of complexity and variety and look instead for patterns and commonalities that may point toward possible paths to change. What is presented below is a series of insights into the current system, drawn from these patterns and commonalities. We have organized these insights according to various perspectives: providers, consumers, financial services, employers, government and society.

*Note: Many of the drawings included in this section are taken directly from graphical recording of the Mapping Summit.*



### **Providers:** cost and price

The pressures of increasing costs, standard practices of cost-shifting and revenue maximization lead to an opaque system where accountability is illusive. "Real" costs and the price that is relayed to the public insurer, private insurer or the individual can appear independent.



One of the befuddling elements of the uncovered costs lies in the dynamic relationship between cost and price. Pricing of healthcare is determined by a wide range of factors. Insurance companies reimburse a single procedure at different rates for different hospitals. Hospitals service very different populations. While hospitals charge individuals the same fee, what they expect to be reimbursed is different, contingent on whether patients are uninsured or insured and the nature of their plan. There is room for negotiation where providers discount based on a variety of factors. For the individual patient, there is no logical reasoning behind pricing.

As in most businesses, cost and price in healthcare are in dynamic tension. Providers testify to increasing costs in the face of multiple constraints on price. And they compensate by **cost shifting** among different procedures. A procedure may be profitable either because the provider can seek high reimbursement or because the insurer or patient is willing to pay. Over time, through cost shifting, healthcare institutions have embedded an informal taxing system into the pricing system.

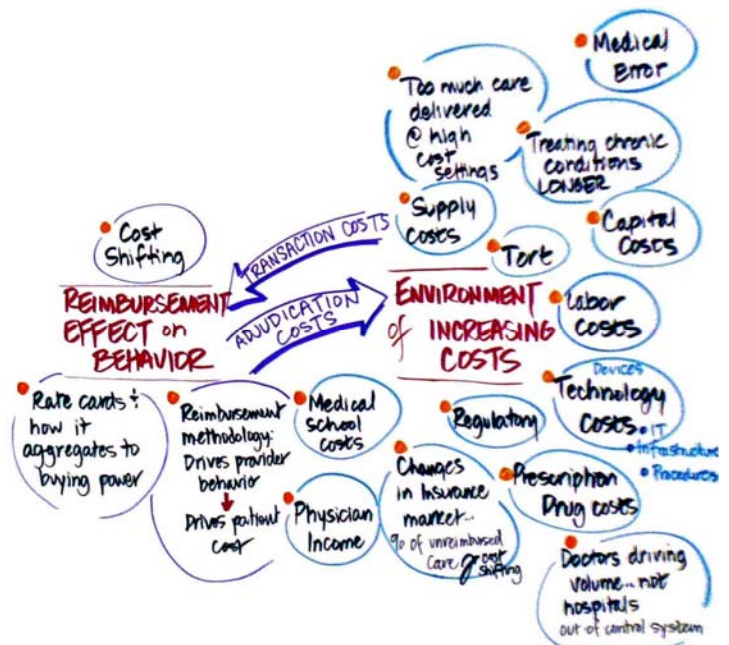
Today, rack rates bear no consistent relationship to the cost of service. Many payers (including the employers who in the end purchase the plans) are increasingly intolerant of cost-shifting and are beginning to demand better information on the cost of services. For example, Medicare publishes rates quarterly and uses costs to push efficiency and factor reasonable reimbursement costs.

The current visibility of the uncovered costs of healthcare pushes the questions of cost and price, what is fair to pass on to

the consumer. Over the past years, increases in health costs have wildly outstripped growth in family income.

If an individual is going to go into substantial debt to pay for healthcare, then we elevate the question of the reasonable price.

In general, though, these questions are asked in isolation. The individual consumer experiencing an individual bill is granted a very limited insight into a system intermediated by many systems pressuring pricing and reimbursement rates.

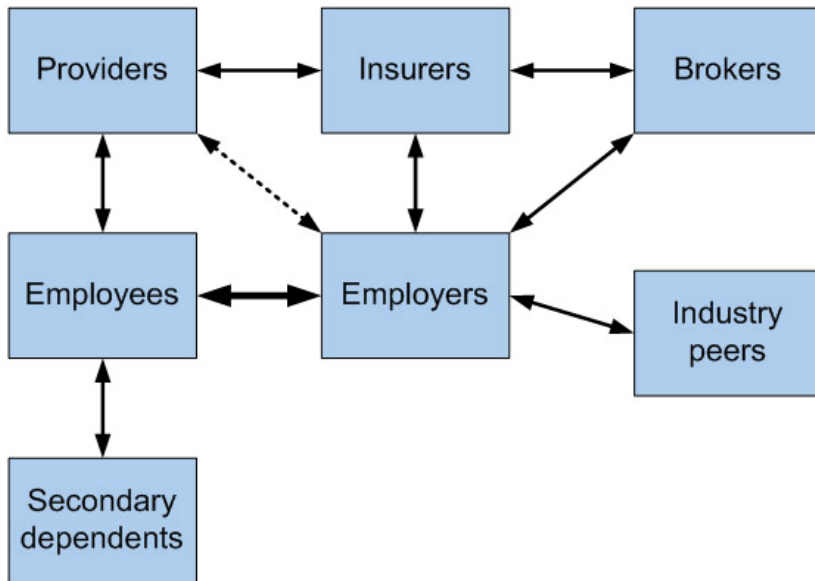




## Providers: intermediated by reimbursement

In the end, providers set prices in the context of complex reimbursement systems. This intermediation, while it brokers and standardizes relationships among patients, providers and insurers, also contributes to unpredictability.

At some point we imagined a scenario where the insurer stands as the broker, the risk pool, to rationalize unpredictable events and extraordinary costs. You just don't know when the heart attack will hit. That is the purpose of insurance.



Over years of adaptation, these systems have layered fixes on top of systems on top of complexity, and ended up with a web of nearly incomprehensible relationships and dependencies. We have moved beyond a “broker” who manages risk and smooths out payments, to a place where neither the providers nor the patients are clear on which bills the insurers will pay. This lends to a feeling of being out of control.

Reimbursement amounts (primary revenue drivers) appear out of provider control.

- Providers are greatly affected by the **patient mix** of their local population).
- Payment rates for Medicare and Medicaid vary by geography and specialty.
- Negotiating better deals with insurance companies requires provider power – some have it, others don't.
- Physician decisions drive the vast majority of medical expenses, while in some health systems, provider administrators may set usage limits on expensive treatments and procedures.
- Powerful employers can negotiate better rate cards.

Laws, rules, and regulations cover everything from what care can be offered, how much Medicaid or Medicare payments will be, how collections can be done, when you can turn away a patient, etc. These regulations also vary from state to state and sometimes from county to county. Some of these regulations have unintended consequences, like the fact that EMTALA prevents hospitals from informing patients what procedures will cost in the emergency room, fearing that this will intimidate people seeking care.

Reimbursement from Medicare, Medicaid, SCHIP and other public funding is an important source of revenue. While many providers feel that reimbursement from public programs is not sufficient, very few choose not to participate in these programs (with the possible exception of Medicaid in some states or among some sub-specialties).

Providers expend significant energy in the adjudication process to maximize their reimbursements, yet adjudication remains a somewhat mysterious process.

One interesting adaptation within the system: delayed billing to avoid payments as *deductibles*. Providers cannot know whether the charge that they send to the insurer will be reimbursed or will fall within a patient's deductible. If the charge is billed to the individual there is, in general, less likelihood that the provider will be able to collect. While this practice is not necessarily widespread, some providers delay billing until later in the year, increasing the likelihood that a family has maxed-out their deductible.

It is interesting to note that determination of eligibility for charity care, in general, happens prior to the adjudication process. Calculations of what underinsured patients can afford to pay falls outside of the determination.

These are additional layers added to a complex system of reimbursement and determination of reasonable expectation of payment.

- ADJUDICATION COSTS ... ADMINISTRATIVE COSTS**
- \* IT/Technology
  - \* Staff/Labor
  - \* Hidden costs (reimbursements)
  - \* Re-submitting of bills
  - \* Coding
  - \* Inter-payer variation  
↳ increases transaction costs
  - \* Volume of transactions
  - \* Regulations to adhere to
- process by which a provider works w/ payer*



**Providers:** mechanisms for optimizing revenues

As an industry, healthcare has become a more and more complex and risky business proposition. Providers struggle to optimize revenues and engage multiple practices to manage revenue cycles and sustain margins.

As businesses, providers operate in a challenging environment – uncovered costs are part of their reality and are increasing. They need to maintain margins to fulfill their mission.

Because of this, providers engage multiple mechanisms available to optimize revenues. These include:

- DEMOGRAPHICS that FEED PROVIDERS**
- \* Providers are attempting to influence demographics thru advertising
  - \* "offering Mix" options based on what will make \$\$\$ (e.g., orthopedics, cardiac)
- No Margin - No Mission**
- \* Negotiating w/payers
  - \* Change payer mix through mergers
  - \* Academic medical centers: costs are less  
→ BUYING POWER → "SEXY"

- Cost shifting between services from high and low reimbursements or from elective services to emergent care
- Raising money through philanthropy
- Income from foundation capital (particularly proceeds from the sale of a hospital)
- Tax benefits from charity care and community benefits
- Out-of-pocket payments by consumers
- Securitizing “fungible” insurance receivables
- Changing the mix of services rendered to include those that are more profitable

Providers manage risk by scale. Mergers and acquisitions are common, with innovative methods employed to obtain financing for growth. Scale can overcome the challenge of geography – allowing access to a more profitable market, for instance. Physicians form chains where the only shared element is administrative costs. Smaller scale makes the vicissitudes of healthcare more direct. Higher volume also allows them to

- Absorb administrative costs;
- Exercise leverage with insurers; and
- Manage complexity.

And yet, providers don’t want to end up with volume without margin – leading to losing more money at volume. Hence, service balance and cost shifting between services are essential.

And like any business, overcapitalized and unprofitable hospitals end up on a path to bankruptcy, often resulting in significant impact on the neighborhood and residents’ access to healthcare. For instance, hospitals employ 70,000 Bronx residents. In many cities hospital systems are one of the top five employers in the community. The economic viability of the hospital is important to the community from multiple angles, often creating competing pressures.



### **Providers:** collector role and financial intermediaries

Providers have been historically uncomfortable in their role as collector. Some providers are shifting to take on a more direct role and others are employing multiple strategies to intermediate their role in collecting payments for services.

To focus on their core competencies and avoid the tension between the patient-provider role and the creditor-debtor role, healthcare organizations often outsource their collections.

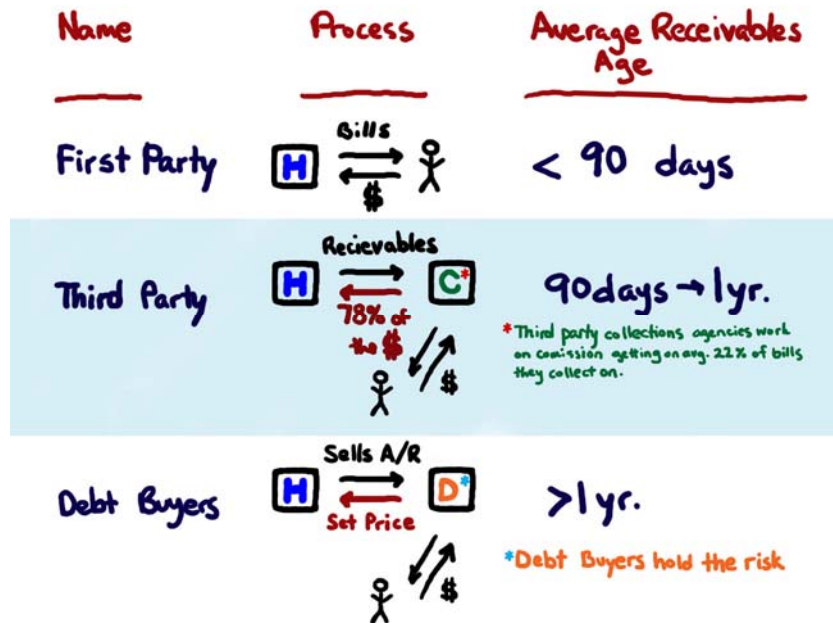
Current realities require sophistication and excellence in collections:

**COLLECTION / DEBT**

- \* Debt sales will go up in coming year... provide immed. (??) cash Rise of 3rd party receiv.
- \* Collect @ Point of Service
- \* **ILLEGAL** to tell ER. patient cost until they've been seen by doctor & stabilized (or alternatives ... e.g, clinic, doctor's ofc.)
- ↳ **SORTING: "Financial Triage"** SORTING & FRAGMENTING
- \* Revenue Cycle World **VERY** fragmented

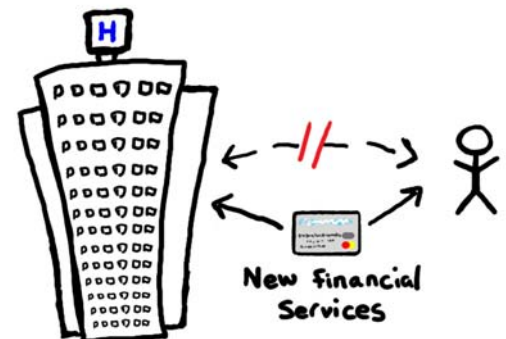
- Providers typically collect only a fraction of what they charge self-pay patients
- Bad debt as a percentage of revenues is increasing by 10 to 20% per year
- Cost of collecting is 15% rather than 2% in the general retail world<sup>2</sup>

Providers choose from a proliferation of new accounts receivable programs and firms offering revenue cycle management services. Three primary categories for receivables (A/R) collection, first party, third party and debt buyers, dominate the landscape, but most providers use creative combinations of the three.



Providers have learned that outsourcing does not eliminate their accountability, as time and time again tactics of aggressive collectors reflect negatively on the provider. They look for other ways to avoid the collections game, including offering a variety of financial products and services to patients:

- Traditional pay out agreements, often with a discount for prompt payment
- Branded credit cards
- Regular credit cards offered within the hospital
- Lines of credit offered by the provider or a for-profit subsidiary of the provider
- Lines of credit offered by third parties – in these arrangements the third party usually gets the debt at a discount



<sup>2</sup> The McKinsey Quarterly, June 2007, "Overhauling the US Healthcare Payment System"; page 2, 3

Significant and increasing regulations govern collection practices. Federal minimum standards were set under the Fair Debt Collection Practices Act, and four states passed laws in 2007 to address late payment and interest fees, charity care and discount payment policies, property liens and governance.

Simultaneously, advocates at the local level have mobilized to address the injustices they see in individuals' bills. Programs which train patients how to question coverage and negotiate for discounts have succeeded in reducing bills by up to 90%. While these solutions do not necessarily scale to a national level, they provide an insight into the risks and opportunities created by the current system's set of financial intermediaries.



### **Consumers:** unpredictable costs and liabilities

The complexity and contradictions in healthcare financing are passed on to the consumer.

As consumers see more costs for their healthcare, the unpredictable nature of such costs and risk sharing becomes more painful. As the cost of insurance increases, employers are dropping insurance plans or modifying them to share more risk with the employee. Therefore, from the experience of many consumers, the nature of insurance has changed.

Plan features make things unpredictable beyond deductibles:

- Co-insurance, where the patient pays a percentage of the cost
- Exclusions or waiting periods as a result of a pre-existing conditions
- Greater fees associated with seeking care from out of network providers
- Tiering within a provider network (where a physician in plan is in "tier 2" and therefore does not have the same level of reimbursement)
- Lifetime limits or limits for particular services or treatments
- Exclusions on procedures and drugs (often driven by evidence-based medicine, other times by standard practice)

In the past, people took out insurance to spread the financial risk associated with the cost of illness or injury. They typically had 12 predictable monthly payments (premiums). Now people experience a shock after receiving medical care and are served a 30 or 60 day demand note in addition to the 12 monthly payments.

Patients receive a confusing array of bills, notices marked "this is not a bill", etc. Sometimes bills arrive months after a procedure. Often patients have no idea what something will cost or whether their insurance will cover it



until long after the procedure is done. Billing systems are set up to deal with insurance and Medicare/Medicaid not to communicate with individuals.

Education levels certainly affect the ability to navigate or understand this new reality. And, as in the case of credit card fine print, being able to have adequate knowledge to know fully what to expect requires more wherewithal than most of us have.

In the end, though, you just don't know when you are going to get sick or how much it will cost if you must seek care.



### **Consumers:** complexity and choice

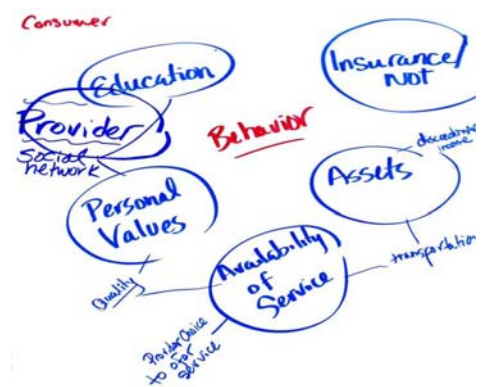
The ideals and the trends toward consumer-driven healthcare have played out as a form of cost shifting and an effort to control premiums.

Consumer-driven healthcare begins with the theory that giving patients more decision-making authority and thus greater control over their health will make them more prudent purchasers of healthcare. Proponents argue that with better information and aligned incentives individuals would make more effective consumption decisions, thereby reducing the overall waste. As a model, it intends to get patients to challenge supply-driven healthcare.

**Supply Driven** → **Patient Driven**

The implementation of patient control has been through high deductible plans and accompanying financial instruments such as Health Savings Accounts (HSAs). Unfortunately, in many cases consumer "choices" actually amount to risk sharing with or risk containment for either the provider or the payer.

A complex set of factors drive consumer behavior – providers, education, personal values, service availability, assets and coverage. Often healthcare purchases defy rational expectations, such as choices of certain procedures or services in spite of having to pay directly for them (full body scans, Lasik and cosmetic surgery). Such choices demonstrate the power of personal values and service availability, and the importance of understanding their impact on behavior.



Consumer-driven health demands and provides individuals with new economic tools. They will continue to destabilize norms and patterns of behavior within the system. They require informed consumers; consumers who appreciate the cost of services and have a sophisticated understanding of

data/information to assist them in making more prudent choices. Currently individuals lag behind the demands of such a system, and appropriate systems are not in place to support them.

Truly giving individuals the benefits of determining their health future will also require other sweeping changes. For instance, one key barrier to the healthcare that begins with the person is to provide individuals with a portable history of their health. In many circles this is seen as a key lever in healthcare reform. While ostensibly tangential to uncovered costs, it is part of a trend toward choice and mobility. Increased patient choice necessitates increased transparency of data, quality and cost, in order for patients to make informed decisions.

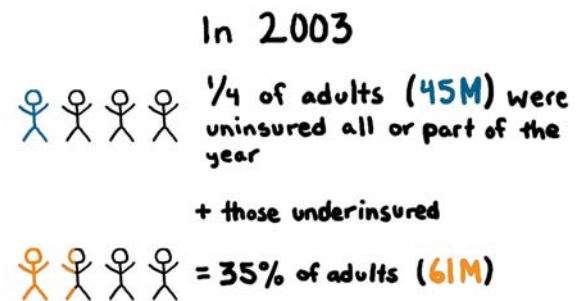


**Consumers:** insured or underinsured or uninsured

Access to healthcare was once equated with access to insurance. That reality has changed, although our reform efforts have not caught up. A third paradigm of the underinsured is rapidly emerging.

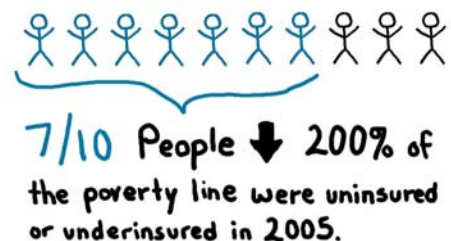
Insurance is about managing risk. It spreads the risk across a pool of individuals, enabling each to contribute minimally to offset the cost of “random” incidents. Reasonably, there are only certain things that are appropriate for insurance.

The design of insurance plans has changed significantly over the past years (as previously discussed) but so has the availability of coverage by employers. We anticipate this trend will continue. In particular, small businesses are more frequently unable to afford the cost of healthcare for employees. Many of these small groups have limited options regarding the quality of insurance that is available to them.



Within an individual family’s calculations, being uninsured can be less risky than being underinsured. Some providers do not extend their financial assistance to patients with insurance, regardless of whether they have high deductibles or other significant cost sharing. This exposes patients to the potential of thousands of dollars in deductibles. A recent study by Towers Perrin suggests a significant exodus from employer-sponsored plans on the part of employees who would prefer to be uninsured than share the costs of increasingly expensive plans.

There is a larger debate afoot about how to define what underinsured means. At a baseline it encompasses insured adults with any one of the following indicators:



- Family out-of-pocket medical expenses exceeding 10% of household income
- Family out-of-pocket expenses exceeding 5% of household income for low income families (less than twice the federal poverty level)
- A deductible that exceeds 5% of household income

According to Families USA, one in four families fit the screen of paying more than 10% of pretax dollars on healthcare. Individuals from these underinsured families have similar health seeking behaviors than the uninsured. Apparently behavior is less influenced by the presence or absence of insurance than by an appropriate, holistic look at the ability to pay for the necessary health services.

For many years now, the state of the American healthcare system has been measured by the number of uninsured Americans. Given the growing number of underinsured Americans, it may be time to look beyond whether one has insurance and see whether the coverage provides adequate protection.



**Consumers:** deploy multiple assets and liabilities to manage risk through life cycles

Health, healthcare, and health cost are factors which exist in the context of a complex set of asset and liabilities which change within a life cycle.

Medical incidents create financial problems for people in several ways. They incur medical bills that they may be unable to pay. Additionally, if a person becomes too ill to work, they lose income. Research done on personal bankruptcy found that nearly one-half of the 1.4 million American families that filed for personal bankruptcy in 2001 experienced medical bankruptcies. More than three-quarters of them had health insurance at the time of the incident.<sup>3</sup>



Higher healthcare costs impact overall household finances. In a recent survey, individuals indicated that increased healthcare costs had:

- Resulted in a decrease in contributions to retirement (30 percent)
- Resulted in a decrease of other savings (52 percent)

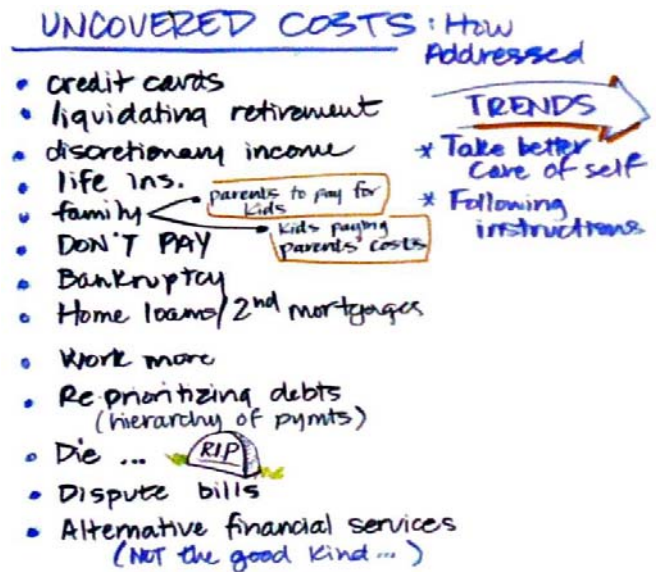
<sup>3</sup> David U. Himmelstein, MarketWatch: Illness and Injury as Contributors to Bankruptcy., Health Affairs, February 2005

- Created difficulty paying for basic necessities (29 percent)
- Created difficulty in paying other bills (36 percent).<sup>4</sup>

In a time of negative savings, the healthcare system and trends ask consumers to make complex trade-offs with little guidance. They may have multiple options to choose from (including retirement funds, second mortgages, credit cards, etc.) but lack a “financial home” with a trusted advisor to figure all this out.

The context of a personal life cycle impacts individual choices. Race, class, gender and medical history factor into relative risk. But the classic story of the individual who builds assets through their youth, depletes them somewhat in the early stages of raising a family but then has a nest egg for retirement, which still drives many of our calculations, no longer represents the wildly heterogeneous experiences across a life cycle. Intergenerational asset shifting (parents pay for kids, adult children paying for the aging parents by cashing in savings), non-traditional families and the loss of “lifetime employment” have altered this permanently.

Asset development and asset protection strategies, including healthcare related strategies, must be retooled for new realities.



**Consumers:** debt shapes care-seeking and decision making

Seeking medical care is another kind of risk management. Patterns of delaying care as a result of debt or lack of insurance increase those risks. Debt, in general, shapes broader realities and therefore determines priorities for families and individuals.

Medical debt impacts care-seeking behavior in negative ways. In fact, those with medical debt have care-seeking behavior which mirrors the uninsured, including inappropriate use of emergency rooms and delaying primary care, which increase overall system costs. Individuals without insurance or with debt avoid seeking care to contain their costs, but also because they are embarrassed and fear they may be denied care.

<sup>4</sup> Employee Benefits Research Institute, “NOTES” [http://www.ebri.org/pdf/notespdf/EBRI\\_Notes\\_11a-20071.pdf](http://www.ebri.org/pdf/notespdf/EBRI_Notes_11a-20071.pdf), Page 1 November 2007

- More than one-third (35%) of uninsured adults who had a chronic condition went to an emergency room or stayed overnight in the hospital in the past year because of their condition—about two times the rate of people with chronic health problems who were insured all year.

Individuals with gaps in coverage are much less likely to get preventative care, and the problem is getting worse.

More than 6 in 10 Americans with health insurance coverage (63 percent) report they experienced an increase in the costs they are responsible for paying under their plan in the past year. Of these respondents, higher costs have caused them to increasingly:

- Try to take better care of themselves (81 percent in 2007; 71 percent in 2005)
- Talk to the doctor more carefully about treatment options and costs (66 percent in 2007; 57 percent in 2005)
- Go to the doctor only for more serious conditions or symptoms (64 percent in 2007; 54 percent in 2005)
- Delay going to the doctor (50 percent in 2007; 40 percent in 2005)
- Not fill or skip doses of their prescribed medications (28 percent in 2007; 21 percent in 2005)

There is a spectrum of individuals impacted by uncovered care that begins with those just beyond the outer reaches of government programs for the poor and ending at somewhere around \$90,000 in annual family income. However, the individuals and families along this continuum are varied, and this is far more complex. There will be some described who have high-quality, low-deductible coverage, but we must assume that most do not.

Within this continuum we imagine three profiles:

The family or individual mired in debt so daunting that their horizon is short-term only. In this posture, individuals and families are concerned with juggling credit card balances and minimum payments, not repaying the debts generated either by general spending or by a medical event. At some point it doesn't matter if you have a coupon for twenty-five cents off a grocery item when the whole A&P bill is going on a near maxed-out high-interest credit card.

The family or/and individuals who have little or no savings, but successfully manage their debts and are perhaps contributing something to their long-term economic security. These are individuals and families who count on a positive tax return to pay for holiday gifts, but who are counting on social security and, maybe, an employer-funded pension to finance their retirement.

Also consider the family or individual who has created positive but marginal savings. These are families and individuals who are building assets, but for whom a significant

disruption in spending patterns (forced or self-imposed) could have a substantial negative impact and perhaps push them into one of the less secure categories above.

The contextual and comingled reality of debt in the life of an individual or a family shapes a broad range of decisions and priorities.



### **Financial Services:** target market for financial services

The financial services industry is responding to changes in the healthcare system by offering new products and services to consumers.

The ways that Americans pay off their uncovered healthcare costs (and possibly the cost of their health insurance premiums) varies. For Americans with medical debt or billing problems, approximately 39% - or an estimated 23 Million people - use up their savings trying to pay their medical bills, and 11% - estimated to be 6.5 Million people - have taken out a mortgage against their home or have taken out a loan. And 13.5% of all Americans - or an estimated 8 million people - have taken on credit card debt in order to pay off medical debt.<sup>5</sup>

The financial services industry has responded with a number of new offerings that allow consumers to turn bills into debt. Besides typical credit cards, the financial services industry has introduced two variants: healthcare credit cards that can be used for certain types of medical care, and credit cards co-branded with providers that can be used for nearly any expense incurred with that provider. Large financial services companies are also working with providers to offer lines of credit directly to consumers to pay off their bills. Some companies are even offering credit card healthcare reward points to pay medical bills.

The rise of Health Savings Accounts has also led to a rise in lines of credit to cover any shortfalls a consumer might face.

All of these offerings are either offered directly to consumers or are marketed through providers. But either way, they have the affect of shifting receivables off the provider's books and onto the creditor's books. Many states offer consumers protection in terms of how

### **PRIVATE SOURCES: CONSUMERS**

- \* Secondary mortgage mkt
- \* Providers themselves  
(financing debt ... charity care)
- \* GE Financial - branded for consumer healthcare financing etc.  
↳ points/rewards that can be used to pay for healthcare  
↳ linked to banks getting into HSA's
- \* HSA's ... FSA's (pre-tax vehicles)
- \* Discretionary income
- \* Employers buy down premium by self-insuring

<sup>5</sup> Sara Collins, et al, Gaps in Health Insurance: An All-American Problem The Commonwealth Fund April 2006

medical bills can be collected. Moving debt to a credit card or other line of credit reduces these protections and distances the provider from the collections process.

Significant players are entering this field. GE Money's Care Credit card, for example, had an expected loan volume of \$5 billion in 2007 and U.S. Bank currently loans \$24 million/year to cover patients' healthcare costs.<sup>6</sup> Other large players include Bank of America and American Express Bank.

If structured appropriately, debt offers can help smooth out the expenses that arise from the unpredictable nature of health crisis. Currently, much of this debt simply prolongs and makes more expensive the process of reaching the conclusion that this bill can't be paid.



### **Financial Services:** providers as capital consumers

Healthcare providers, like all businesses, need multiple kinds of capital, often in sizable amounts. Their receivables play into those financing structures in complex ways.

Providers, like any business, use capital to buy buildings and equipment, finance growth in staff and services, and smooth out the problems of cash management. But unlike most businesses, the healthcare industry has limitations, legal and otherwise, on what they can do with their receivables, especially those that spring from patient billing.

Healthcare receivables themselves are rarely if ever repackaged and sold into a secondary market. This secondary market is stymied by two facts:

- 1) hospital receivables are regulated much more strictly than other receivables (such as car payments), and
- 2), hospitals negotiate the right to buy the debt back to avoid any instances that could potentially hurt the hospitals' reputations.

Unlike other receivables purchases (e.g. leases, consumer credit cards), healthcare receivables have buy-back provisions, whereby the sellers always have the right to buy back the receivables.

This last point has grown in importance since a series of scandals involving aggressive collection tactics led to bad press, a series of hearings in the U.S. House and Senate, and class action lawsuits that targeted non-profit hospital billing and collection practices. Even in states

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<sup>6</sup> Brian Grow and Robert Berner, "Fresh Pain for the Uninsured," *Business Week*, 11/21/07  
[http://www.businessweek.com/bwdaily/dnflash/content/nov2007/db20071120\\_397008\\_page\\_3.htm](http://www.businessweek.com/bwdaily/dnflash/content/nov2007/db20071120_397008_page_3.htm)

with little oversight, providers are often non-profits or at least seen as providing a community benefit. An ugly scandal with an overly aggressive collections agency can hurt a reputation and jeopardize a non-profit status or the chance of getting a favorable municipal bond.

Despite the restrictions on collections practices of receivables, there is still a large industry that either does this as a contractor for providers, or by purchasing receivables outright. Some examples of larger companies that have purchased receivables include CarVal Investors, MedCLR and West Asset Management, which purchased \$1.2 billion of debt from Tenet for \$16MM. However, there are hundreds of small buyers of this paper.

Providers do find other avenues to getting credit for capitalization of expansion or cash flow management. One hospital administrator told of getting a HUD mortgage partially collateralized with revenue from future receivables expected from the new facility. The delay in reimbursements from Medicare and Medicaid are often smoothed out with short-term cash flow loans backed by these future payments.

Providers are also able to borrow against assets like existing buildings or the expectation of future earnings. But given the highly regulated nature of this industry, the forms of financing available drive what is actually done. The introduction of consumer credit directly into the mix is opening new doors for providers, though with the potential for serious negative consequences for consumers. Still, the possibilities for securitization of this debt and the creation of other vehicles could bring much-needed capital into the system.



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**Employers:** shifting risk pools to individuals

Employers are increasingly shifting costs and risks to individuals by redefining the mix of benefits they provide.

Over the last decades the insurance industry moved from large community-based risk pools to smaller “puddles” of risk usually connected to an employer. Employers are now moving the risk down to people, namely their individual employees.

The shift toward “employee-centric” benefits is increasingly emphasizing consumer choice and consumer

responsibility, as well as shifting risk from the employer to the employee. This is seen most clearly with the growth of voluntary employee-paid benefits beginning in the 1990s, the shift in employer-sponsored retirement plans from defined benefit plans to defined contribution plans, and the rise of consumer-driven health plans.

*Pools to Puddles to People.*

In general, employers are moving toward a defined contribution rather than a defined benefit approach in healthcare, mirroring the trend that has increased the use of 401(k) plans rather than traditional pension funds in retirement programs. With a defined contribution plan, the employer provides a specific amount (their contribution) for health insurance rather than paying a certain percentage for the insurance premiums.

Given ever-escalating healthcare costs, this is a strategy for employers to limit their obligation. Employers are better able to manage their costs by agreeing to a defined contribution and having the employee bear the cost of future increases.

This system also reflects a cultural bias toward the ideal of individual choice in making healthcare decisions. A defined contribution plan gives employees more choice over the mix of pay and benefits. Even if the new choices put them in a worse position, it may be easier to swallow a cut in benefits if it is your "choice."

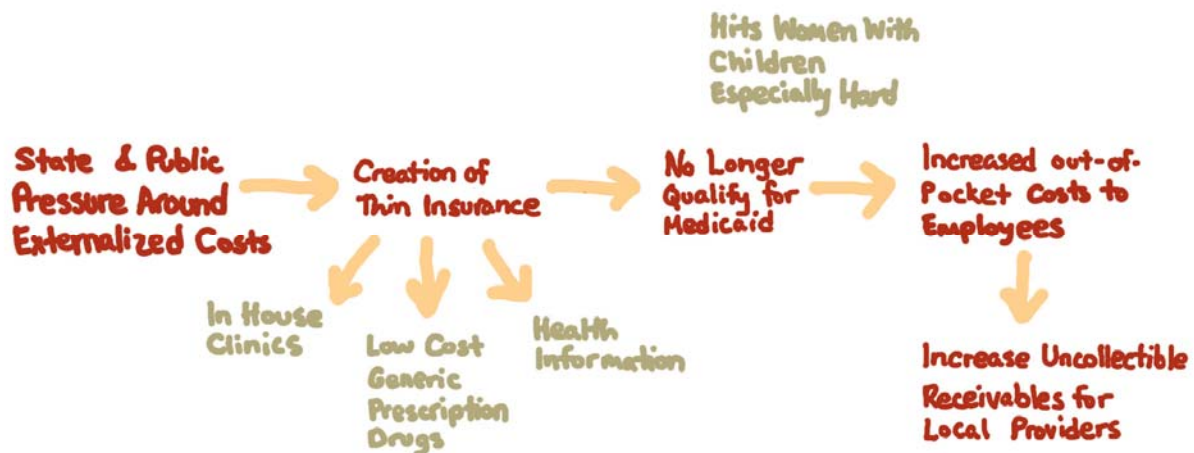


**Employers:** internalized and externalized costs

Wal-Mart provides an intriguing case study, in broad strokes, that lays out the unintended consequences of a significant change in the system.

Activists in Maryland were able to pressure Wal-Mart to provide healthcare coverage for many of their low income employees. This led to many unintended consequences that were both positive and negative.

Wal-Mart responded by providing thin insurance for these workers. This insurance was



enough to count as coverage, but didn't meet the needs of the workers. Many employees, especially women with children, were now no longer eligible for Medicaid, a more comprehensive coverage. Instead, they were now responsible for large increases in

uncovered medical costs, increasing their out-of-pocket expenses. Since they were unable to pay these costs, local providers, who were formerly reimbursed by Medicaid, now saw sharp increases in uncollectible receivables.

One of the arguments used by activists pressuring Wal-Mart was that taxpayers should not have to bear the costs of healthcare for Wal-Mart employees. In the end, some of these costs were shifted to Wal-Mart, but others were shifted to the employees themselves and finally to local providers.

This was also the period of time when Wal-Mart began requiring more positions to have a physical component, such as collecting wagons in the parking lot. These more strenuous tasks allowed the company to weed out less healthy employees and applicants, thus driving down their costs.

Despite these negative consequences, Wal-Mart did do some innovative things to help lower healthcare costs, increase the health of their employees, and improve productivity. They began offering in-house health clinics and distribution of health information. They began using their bulk buying power to lower the costs of drugs, especially generics. For example, they were able to buy flu vaccine at a cut rate and inoculate their employees at work.

Individuals being thrust into the healthcare purchasing world have much less purchasing power on their own. But Wal-Mart has shown that joint action and collective purchasing can drive down costs and improve the delivery of healthcare.



### **Government:** healthcare as a regulated industry

Government is a significant player in healthcare. They are the 300 lb gorilla as both the largest payer through Medicare/Medicaid and as an extensive regulator. Those regulations define the choices individuals, providers and insurers have available to them.

Healthcare is a highly regulated industry. Laws, rules, and regulations cover everything from what care can be offered, how much Medicaid or Medicare payments will be, how collections can be done, when you can turn away a patient, etc.

We do not always know which of the regulations protect people with regard to uncovered costs and which exacerbate the problem. For example, EMTALA prohibits hospitals from telling patients arriving in their emergency rooms what their care will cost ahead of time. This was designed to protect patients who couldn't afford care from feeling pressured to leave. But this law also increases the opacity of the system and can lead to sticker shock when a bill does arrive.

Regulation can also be used as an excuse for inaction by stakeholder in the system. Conversely, changes in regulations can drive rapid and widespread change throughout the system. For example, half of all healthcare payments are set by Medicare and Medicaid. Funding formula changes, typically controversial and rarely simple, can drive a lot of change.

The broad reach and slow rate of change of regulations also adds an element of predictability to the healthcare system.

Considering all this, it is imperative to keep in mind the power of regulations to both help and thwart any reform efforts. The healthcare system is complex, and rife with high-stakes, big-dollar conflicts.



### **Government:** Disproportionate Share Hospital (DSH) payments

Disproportionate Share Hospital (DSH) payments are a placeholder for the problem of inadequate reimbursement within the healthcare system for treating low-income patients without insurance or covered by Medicaid.

The largest government program targeting the shortfall caused by unpaid medical expenses is the Medicaid program known as DSH payments. It began as modest program designed to give states greater flexibility in helping providers deal with the problems caused by unpaid medical expenses. This flexibility, however, led to multi-billion dollar abuses by certain states who devised schemes to misuse these funds. In one widely used scheme, states transferred federal DSH funds to hospitals and then taxed that money back into state coffers for use in the general fund. Reform efforts finally made these and other schemes illegal.

These reform efforts were successful in reining in the abuses, but left the system less flexible and locked in place much of the disproportionate funding between the states. Still, the program does remain a significant outlet for innovation in the form of Section 1115 waivers, and several states have used these waivers to expand coverage or in other ways increase the impact of their use. And the DSH program remains by far the single largest pool of money targeting the problem of uncovered healthcare costs.



### **Healthcare Industry:** as a public good

Americans have an idiosyncratic relationship with our healthcare industry. We live in a paradox expecting a public good from a largely private system.

Americans have a paradoxical relationship with the healthcare industry. We don't place the same kinds of expectations on any other private industry. The food industry doesn't have to feed the poor who can't afford to buy what they need. Landlords routinely evict families who can't keep up with the rent. But every emergency room in America must treat anyone who walks in the door even if they know they'll never get paid.

This example reflects the two contradictory views we have toward healthcare. On the one hand, we want the system to remain private and full of choice for consumers. The specter of "the post office running the healthcare system" killed the effort to reform the system on a national scale. At the same time we view healthcare as a public good that must be available, at least in emergencies, to all.

Even beyond the case of emergencies, we expect hospitals to provide a large amount of charity care, whether non-profit or for-profit. We are appalled when we hear stories of people who have reached the limit of their insurance and are expected to pay the services they continue to receive.

In the past this ideological tension was kept at bay because the problem of uncovered care was small enough so providers could manage it and most of the care was given to the poor. But as the impact grows and the effects push higher into the middle class we may be forced to confront it more directly.

One potential outcome of this confrontation is an increased understanding of the problems between stakeholders. Communities do not want to see their hospitals close and leave populations underserved. As a result, consumers may begin to view providers more as partners straining under the burden of uncovered costs right along with them. This may provide an opening for new models based on shared burdens and increased trust.



### **Society:** new alliances

Health-seeking activity and the current fragmentation of the healthcare environment are creating new, dynamic opportunities for alignment and redefinitions of constituencies.

Consolidation of providers, insurance companies and employer purchasing power (Leapfrog) are creating a landscape with decreasing fragmentation. Consolidation is also pooling power in ways that may be leveraged; for example, Leapfrog has the power to push for its adoption around the country.

We are finding local examples of pooled charity care or primary care such as Project Access in Buncombe County, Church Health Center in Memphis, the Indigent Care Collaborative in

Austin, Texas and the Three-Share Program in Muskegon, Michigan, to name a few. There are hundreds more across the nation, many funded by the federal government and others through private philanthropy.

One intriguing example of a new alliance is Working Today, which has created a benefits system through the Freelancer's Union that provides portable benefits to independent workers in New York. The independent worker is an interesting category which includes, for example, both the cab driver and the artist. This is at times a vulnerable group left out of the larger risk pools of employers.

We find on the internet multiple social networking sites which are intended to draw together multiple, divergent communities around a shared interest in information sharing (trusera.com as one example). These social networks, along with an emerging consumer market around health and lifestyle products and services, are beginning to unsettle traditional loci of control within the healthcare system.

## VII. Conclusion

The patient portion of healthcare costs is having a profound effect on the way medical care is delivered in the United States, as well as having effects far beyond simply the delivery of healthcare. Traditionally, discussions about the uninsured have dominated this field, but the growing size of the underinsured is pushing the problem into new demographics.

As the Healthcare\_Uncovered project moves forward, we will be exploring working models for alleviating the medical, social, and economic impacts of these uncovered costs. We believe that any successful program will have to encourage integration across perspectives, increase predictability, and find new and more effective ways to share risk.

There are models of reform working in small pockets around the country, and there is a growing community committed to finding solutions that move beyond the status quo. During the next phase of this project we will look to them for components that can be configured into a scalable model that can have a deep impact throughout our healthcare system.

For more information or to find out how you can get involved in Healthcare\_Uncovered, please contact Joy Anderson, e-mail [Anderson@CriterionVentures.com](mailto:Anderson@CriterionVentures.com), or phone 860-345-3520.

