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Industry ROUNDTABLE

HEALTH CARE

PRESENTED BY: Hodgson Russ LLP ATTORNEYS

How do you improve the quality of care and still bring down costs? What can the industry do to fully engage consumers? Are current health care models sustainable? These are three of the weighty questions discussed at a recent panel called together by the law firm Hodgson Russ and the *Albany Business Review*. Below are highlights from the roundtable, which included seven industry leaders, from health insurance CEOs to heads of hospitals.

▸ MEET THE PANEL

DR. JOHN BENNETT
About: President and CEO, CDPHP, a health insurer based in Albany

DR. ANN ERRICHETTI
About: President and CEO, St. Peter's and Albany Memorial hospitals, both part of St. Peter's Health Partners

DENISE GONICK
About: President and CEO, MVP Health Care, a health insurer based in Schenectady

JOAN HAYNER
About: CEO, CapitalCare Medical Group, a physician group with offices throughout the region

BARRY McNAMARA
About: President, Benetech, a health care consultant and brokerage in North Greenbush

DR. KIRK PANNETON
About: Regional Executive and Medical Director, BlueShield of Northeastern New York, an insurer

DENNIS WHALEN
About: President, Healthcare Association of New York State, a nonprofit representing hospitals and health networks

WHAT ARE THE KEY THINGS TO CONSIDER AS WE LOOK AHEAD TO THE NEXT COUPLE OF YEARS? WHAT ARE SOME OF THE LESSONS LEARNED FROM THE PAST COUPLE OF YEARS?

DR. KIRK PANNETON: We've always been responsive to employer groups and government. Now, with the onset of the ACA and the exchanges, our focus is now on the individual consumer. Looking ahead, it's going to be interesting for us as health plans, not only from a customer service standpoint, making sure we're responsive to the individual, but developing plans that meet their needs, and also educating them for the first time, really, on what it means to buy health insurance.

DR. ANN ERRICHETTI: All of us are experimenting with alternative kinds of reimbursement, whether it's accountable care organizations or bundled payments or value-based purchasing. Whatever the change is, we still need to put the needs of the patient first.

DR. JOHN BENNETT: One of the things we're seeing is that we're crossing lines. Some providers are starting to do some things that payers used to do; payers are starting to do some things that providers used to do. So the line is blurred. And I think we have to do that in a partnering way so that we can begin to partner with payers, partnering with providers. As long as the focus is the patient, I think we'll win.

DENNIS WHALEN: For a long time, we had permanence, and that's no longer going to be the rule, but be flexible. Accountability is now more a [currency] than it has been in the past. We have government and other payers who want to understand what their investment is yielding. Patients want that, too. What's happening on the technological side is a major driver. The empowered patient with the technological tools is going to drive these changes toward this more accountable, more transparent system.

JOAN HAYNER: Partnering and looking at where the skills reside and who is the best sort of purveyor of any particular service is how we're going to gain efficiencies, and bring the better outcomes from the patients. One other thing that's very different is, we are starting to have conversations directly with employers now. The conversations with employers were around premiums and their medical spending, and that was between employer and health plan. But now, there's conversation again: How can we partner in improving the health of your employees? And those conversations now are going directly to the providers of care.

DENISE GONICK: Flexibility is going to be key, and a greater-than-normal tolerance for failure, because not all of these things are going to work. And so for all of our organizations, we have to be smart about it, of course. We probably all tend toward the conservative on these things. But we're in a position now where I think we have to take advantage of the disruption and be willing to take more risk than we might have in the past.

BARRY McNAMARA: As employers, the challenge is going to be how we manage chronic care. Bottom line: Can I offer a level of benefits that allows me to track and retain valued employees? And what can health care as a collective do to manage care to reduce cost and get better outcomes and help me manage what is a significant part of their annual budget?

In health care, there are a lot of regulations. How much creativity is there? How can you take advantage of disruptions and have that appetite for failure wherein you still have to maintain margins and make enough to support the organization?

DENISE GONICK: We're having conversations that, even if you wanted to have them in the past, I'm not sure you would have had that same setting or that same

DONNA ABBOTT-VLAHOS

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Left to right: Dr. Kirk Panneton, Barry McNamara, Denise Gonick, Dr. Ann Errichetti, Joan Hayner, Dennis Whalen and Dr. John Bennett.

opportunity. Some of the payers certainly have been involved in risk transfer in the past, but what's different now is, you have more of a regulatory framework that's encouraging it. You have increased cost pressure where you have a market that's not going to tolerate paying what it's paying much longer. So that's really what's on us now: Whether we can use that information to actually create these new models.

BARRY McNAMARA: The opportunity caused by technology disruption is tremendous. Just telehealth, telemedicine, and the discussions around the Upstate Revitalization Initiative and population health management and wearables, there's a tremendous opportunity.

DR. JOHN BENNETT: Innovation in our state will be different and more difficult than a lot of other industries. This idea that you develop a disruptive innovation, but you fail fast, fail cheaply, fail often, is very difficult in health care. It will be extremely difficult to innovate. That's not to say we're not doing it, but we're doing it within confines. We have premiums regulated. We have a prior approval process, which has really wrought havoc with the upstate plans. So that has limited the ability to invest in innovation. The state has gotten very interested in innovation. That's a good thing. The problem is, the state will tell you, "Innovate this way." And we're about to see that. I think that's somewhat of a danger.

DENNIS WHALEN: New York remains different and a little bit behind. We are being pressured to forge into the 21st century and to innovate. But we are constrained by 20th century rules, regulations and biases. Something's gotta give.

I don't think there's a great tolerance in New York from the regulatory perspective of innovation and failure. They have this penchant for control. At the same time, the rest of the world is pushing us to a different place.

DR. ANN ERRICHETTI: I'll speak from the hospital side. We're in a hybrid world. We all know we need to move from volume to value, but the question all of us face every day is, how quickly, how far, how soon.

What Dennis was saying is true. There is a catch-up in New York. Until now, there haven't been really strong enough incentives to force practitioners to think and act differently. I think about length of stay, which historically has been high in New York and [this region]. That's been a major initiative for us. That's an example of how we have to act and think differently and have physicians evolve in that same way quickly.

Some of the early things we've done for certain types of post-operative patients, instead of staying in the hospital for the duration of your recovery, is to partner with skilled nursing facilities. It's a less expensive site of care. It has good outcomes and is better in terms of the patient experience. But it does require educating patients and families. What remains to be determined is what it means in terms of profitability.

> *'Consolidation is not necessarily a bad thing, but we have to be cautious of unintended consequences.'*
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> **JOAN HAYNER,** CEO, CapitalCare Medical Group

DENNIS WHALEN: Taking Ann's example of services outside the hospital setting, look at Presbyterian in New Mexico, which has an ICU At Home program. If you hit one of the five diagnoses, live within a certain area of the hospital, they send the bed out to you. You are monitored back to the hospital, you get a daily visit, telehealth. You would think if the state is really interested in innovation, they would be promoting that instead of targeting it.

DR. JOHN BENNETT: Then there's the thought that one part of the state government is trying to push one thing, but then it costs another. If we're designing a benefit or a payment model for our enhanced primary care program, we get approval from the Department of Health, then an attorney in the basement of the [finance department] says, don't do that.

There are a lot of laws that cover benefit design and administration in New York that are complicated and have not changed with the times.

DR. KIRK PANNETON: I'm going to underscore something that Denise [Gonick] touched on: transparency. The day has come where we all have to be more transparent with cost. Historically, everybody keeps their cards close to their chest, be it the facility, be it the payer, be it the provider. We really have to start sharing this information because the public's going to demand it.

IS IT POSSIBLE TO BE TRANSPARENT?

JOAN HAYNER: I think you can be. A lot of people in the industry don't really understand when you're talking about cost. Are you talking about a premium? Are you talking about how much I charge for a service? Or are you talking about the underlying cost of providing a service? This brings us back to big data questions. Everybody's got their own information systems. Even though there are efforts underway to make information systems talk better to one another, they still don't very well.

ON CONSOLIDATION: GOOD OR BAD FOR THE INDUSTRY?

JOAN HAYNER: Consolidation is not necessarily a bad thing, but we have to be cautious of unintended consequences. It is impacting the ability for independent physicians to stay independent.

I'm very concerned in this region that the independent physician group is slowly becoming a dying breed. I think they're very vulnerable. They're being told they need to innovate, but the payment system is not aligned for them. They're not part of a large health system that has other streams of income that can help fund that innovation, or they're not part of the health plan. They have to kind of take that money out of their own pockets. Unless they have the ability to do that,

they're going to end up being acquired by a hospital. I don't think that will bode well for our success down the road and allow us to cut into costs.

DR. JOHN BENNETT: That is a very important point. I reflect back to 1984 when CDPHP was formed. CDPHP was formed by physicians in private practice, so we kind of hold that as one of our main values. There is great promise of provider consolidation. But you have to be realistic. Despite the best intentions, if you look at the hard literature on what happens when providers consolidate and cross hospital lines and when hospitals acquire physicians, health care costs rise. That's a great challenge. I said this seven years ago at a forum like this, and it's still true today.

DENNIS WHALEN: The other thing I'd say, though not exactly a counterpoint, but hospital costs have been low over the past several years. And the drive for consolidation that you see in the hospital side is about scale.

The market forces in some way are driving that. My concern about that is, the market does not always make the best decisions for the patient and population.

I think there are only about 30 hospitals now in New York that are not part of a system. It is definitely a trend. And part of it is New York. The hospital margin for New York – we've improved to like 48th place in terms of hospital margin. So you can imagine the pressure to get technology and to do this investment.

I worry about those places, because they are in areas where you need a hospital, where you can't drive 60 miles if somebody's been in a car accident.

DENISE GONICK: It really does speak to unintended consequences for the market and not really having thought through that end game and where it's going to go to.

The other point that is really important, and this speaks to the regulatory side: There's the failure of Health Republic [a Chicago-based plan]. They came to New York and were charging what all of us in the market thought were artificially low rates that were not sustainable. And now, it has failed as an insurer. That created an incredible amount of pressure for everyone else to either bring their rates down or see membership move away, not in a truly competitive fair market, but in this sort of artificially depressed market. Then what does that do? How much money got wasted in that process where you have people enrolling in a plan that was never sustainable? And what does that do for the rest of us who have to pick up the pieces?

That's the cognitive dissonance of government regulation. They let that happen.

JOAN HAYNER: You can draw the same analogy about hospital acquisitions and the independent practices because, in large part where that's happening, physicians who have been independent for years are being offered above-market compensation to come into the hospital system – and it's unsustainable. So over a period of time – and we saw this back in the '80s, the '90s, and we're seeing it again, where physician dissatisfaction begins to rise, when compensation needs to be scaled back to a more reasonable, sustainable rate, and it creates so much unnecessary disruption. That disruption is not beneficial to the market.

DR. ANN ERRICHETTI: I'll be happy to comment on consolidations and mergers, which have been very active in this market after not being active. It looks and feels like a frenzy.

I came out of the Chicago market before coming here, and that had been something happening over a period of time. I actually grew up and practiced in an era of capitation at a time when there were a lot of hospital acquisitions, so it feels like a '90s redux. [*Note: capitation was a system, popular in the 1990s, in which providers were paid a set amount for each patient assigned to them.*]

It's a little different this time, at least from my experience. There was a mania then because of capitation, as in Massachusetts. In that market, there have been lessons learned from that – overpaying practices and not having aligned incentives. This time around, the proof will be in the actual doing.

I do think there's some generational differences and lifestyle differences. And that does drive physicians into looking at employment. And that employment could be as part of a hospital system; it could be part of a large multi-specialty group. Some physicians are concerned about being left out, are concerned about being able to afford continuing in practice. That drives a lot of decisions. Within this market, we see that more on the primary care side than on the specialty side.

WHAT ELSE DO YOU SEE COMING THAT WILL ALTER THE LANDSCAPE?

DENNIS WHALEN: There are other disrupters coming. Retail medicine is one. You have Walgreens, Walmart, CVS all wanting to get into this game. I don't know many places that can compete against a Walmart $40 primary care visit, [where patients can] park outside, walk in without an appointment and get seen.

Another dynamic in New York is cross-border relationships, where it used to be about all within New York. So now you have the University of Vermont that is at a number of hospitals across the North Country and liable to go further. You have Guthrie Health System from Pennsylvania with a couple of hospitals that

they manage in New York.

The other thing is, there's going to be a trend in specialties or places with brand names reaching further in geography. I think of North Shore-LIJ, which has done a deal with Cleveland Clinic. If you get your cardiac bypass graft surgery at North Shore, it's the equivalent of having gone to Cleveland Clinic. We share clinicians, we share protocols, all this stuff. And the reason North Shore pursued it was that Walmart went to Cleveland Clinic and said, OK, any Walmart employee that needs a cardiac bypass graft can get it at Cleveland Clinic.

I look at Memorial Sloan Kettering, which has opened infusion centers around New York City. They recently did a relationship with Lehigh Valley in Pennsylvania and one in Hartford, Connecticut. The reach of places is going to be another dynamic to contend with.

DR. JOHN BENNETT: You mentioned Memorial Sloan Kettering. You got me fired up.

This employer buying of centers of excellence is a great thing in concept. The problem is, the leverage is in the wrong place. The leverage is not with the consumer. What we've been dancing around with in this discussion is really the cost of health care.

I'm not really sure that the public understands that the price of the premium really only reflects the price of the health care. But as an insurer, you can't pay out more in claims than you take in in premiums. It doesn't work.

So we have to get to the fundamental cost structure. When you're dealing with the Cleveland Clinic, for instance, or Sloan Kettering, you have this enormous brand recognition. What we have to ask as payers is, why are you worth that? And that's why I want to come back to what Kirk [Panneton] raised, which is so very important – it's the transparency issue.

Cleveland Clinic has a great reputation. But where is the data that shows that if I have a heart valve operation, that I'm going to do better than somewhere else? And what is the margin that they're going to be allowed to charge because of that? And what do they charge? And I'm assuming that Walmart was able to get a deal, right?

In your own health plan, if you have an MRI at one of several different centers, it might cost you different amounts. You don't know that until after you ask because you can't do all the shopping. It's very difficult to do that per payer, to set that up, to configure that, to structure that.

The other issue is the imbalance. We talked about cost and said, 'Well, where's the cost going to come out of?' A lot of it has to come out of the hospital setting. We are over-bedded, over-tested, and over-operated on in America. And we are over-drugged. Big pharma [is] our single biggest driver of cost today. And we expect that to continue for the next three to five years at least. That is a totally wild west environment, and there's no transparency around their pricing structure.

DR. ANN ERRICHETTI: Cost means different things to each of us. As payers, that might be what you think of when the word is spoken – what we're paying out is the cost.

Our focus in the hospital is our human cost, which is not necessarily translated directly to you. Hospitals in particular have a lot of catch-up to do. Having accurate cost accounting systems, there hasn't been the incentive to really do that. All of us are moving in that direction and making progress.

And I do think that one of the biggest stressors for you all as payers, for physicians, for hospitals, and for any of us as we are continuing to evolve, is going to be drugs. Look at most health plans. That's their biggest driver. It's not just the cost of the pharmaceuticals themselves, but it's even just preparing ourselves for kind of a new wave of pharmaceuticals, and how we've all adapted to that.

DENNIS WHALEN: If we were presented with all of the requirements today, we would never invent the system that we have for delivering care. It doesn't make any sense. If you want to stand in front of the freight train of transparency, you are welcome to do so, but this is happening. It's going to be driven by empowered consumers. They want the equivalent of, where can I get my knee replacement at the highest quality for the lowest price? That's just the way folks are acclimated. And we are going to get there with that.

BARRY McNAMARA: Just two thoughts. Considering where we are and where we're headed, change has to be closer to revolutionary than evolutionary. It speaks to a period of time we may not have. Secondly, I can't understate the over-importance of setting patient expectations. We as a population have come to demand the very best. And changing that dynamic is something we're all charged with.

JOAN HAYNER: In parts of the industry, we have to deal with the marketing aspect of everything about health care. Mostly what the patients understand about pharmaceuticals is what they're being marketed about pharmaceuticals, not necessarily what the best thing is for them. It's very, very common that patients will present to the office and say 'I'm here to get my whatever,' not because it's something that they're on for their condition. But it's something they heard about on TV. So along with transparency, there has to be a tremendous effort around education. We can't forget the patient and the process. If the ultimate consumer doesn't buy into it, we're not going to be successful.

'Transparency and payment reform. Those are the two things that have to be addressed going forward.'

DR. KIRK PANNETON, Regional Executive and Medical Director, BlueShield of Northeastern New York

DR. KIRK PANNETON: Joan brings up a great point. If we sit back and wait for regulation, we might as well be waiting forever. Education is where it's at. We've got to sit down educate people that just because it's new doesn't make it better.

DENISE GONICK: This is, in a way, the great challenge for all of us as we shift more into retail, and this idea of an empowered consumer. And some of the challenges we have around the transparency is that you're not always comparing apples to apples. So even if you want to be comparing costs, it's hard to do. And then that doesn't take into account the point earlier about quality transparency.

DENNIS WHALEN: A common area of interest for all of us should be trying to come up with a reasonable data set, because right now, there are just so many. It's totally confusing for me, let alone a patient.

JOAN HAYNER: I'd just like to follow up on that and say, OK, then once you have that information, what's the best way of delivering that information to the patient?

We very rarely spend much time talking about the good things out of the ACA. But one of the good things that was created out of the ACA was CMMI. It's the acronym for Center for Medicare and Medicaid Innovation.

One of the things that was called for under that initiative was improved inpatient engagement. The way you were going to do that was either through a survey tool or through creating something called Patient Family Advisory Councils. All 10 of our practices decided to put together these Patient Family Advisory Councils. They meet quarterly. They speak directly to patients.

So these sort of dialogues with patients is the best opportunity to be able to convey these very, very difficult concepts.

IF YOU WERE PRESIDENT FOR A DAY OR A WEEK OR A MONTH, WITH CONGRESS AND REGULATORS THAT WERE TOTALLY COMPLIANT, WHAT WOULD BE ONE THING YOU WOULD DO TO GIVE THE COUNTRY AND THE STATE THE MOST EFFICIENT OR BEST HEALTH CARE SYSTEM?

DR. JOHN BENNETT: You know what I would say? I would regulate big pharma, which would take their lobbying money.

DENISE GONICK: I would continue movement to a more value-based system that focuses on outcomes. The more we can do to align the financial incentives and focus on outcomes, that's where we want to get.

BARRY McNAMARA: I would agree with both, but how do we get there? How long is it going to last? So is there some target to get us to make that progress?

DR. KIRK PANNETON: The two things you've heard today are transparency and payment reform. Those are the two things that have to be addressed going forward, along with big pharma. John, I'll be your VP.

DR. ANN ERRICHETTI: In addition to pharmaceutical costs and sales, I would move from state to state variations in allowances. It sounds simple, but everyone has to be insured with a certain minimum of benefits and subsidies for people that need subsidies. And health plans would still be in a position of competing based on service, price, and what other things you might want to add.

DR. JOHN BENNETT: We talked about transparency. I think it starts with pharmaceuticals and how pricing is arrived at. Often what we hear is, they need it for R&D money. We need to first shine a light on what they're spending on R&D. We know there are rises in prices that are totally unrelated to R&D. Everyone sees that. And what a lot of people don't realize, too, is that a lot of those R&D costs have not been incurred by the person selling the drug. I believe we need to have some kind of pricing that's related to how much R&D actually went into the drug. Otherwise, you're going to have this dichotomy where the average standard operating margin of a health insurer, even the for-profits, is only about 3.2 percent. Hospitals nationally are running about 3.7 percent. Pharma, 20.8 percent. So you can't have that asymmetry. It's going to lead to this inversion where you're controlling premium prices but you're not controlling any of the drivers of premium prices.

DENNIS WHALEN: If I were president, I would impose a requirement that government regulation is going to be subject to a logic and consistency test.

DR. JOHN BENNETT: Now you're asking too much.

DR. KIRK PANNETON: You only got 24 hours.

DENNIS WHALEN: We'd have a lot less chaos going on.

JOAN HAYNER: I would continue to emphasize dollars being funded for innovation. And I would try to insure that innovation labs are not just really large health systems. Because if we need to find creative ways to get to where we want to go – which is really meeting the triple aim of outcome, patient experience, and reduction in cost – we probably need to do those experiments in smaller labs where there's a chance to actually get things done. It's much easier to turn a small ship than to turn a huge ship.