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# *Industry* ROUNDTABLE

# HEALTH CARE

PRESENTED BY: Hodgson Russ LLP ATTORNEYS | 200 BICENTENNIAL CELEBRATION

The health care industry is about 1/6th of the nation's economy. It's also one of the largest employment sectors in the Capital Region. Law firm Hodgson Russ and the *Albany Business Review* hosted a panel discussion with six experts in the field on what changes in law might mean for the industry, employers and consumers, among other topics. Cindy Applebaum, *Business Review* publisher and market president, moderated the discussion.

## ▸ MEET THE PANEL

**NORMAN DASCHER JR.**
**Title:** CEO, Samaritan and St. Mary's Hospitals, vice president, St. Peter's Health Partners

**BETHANY GILBOARD**
**Title:** CEO
**Company:** Innovative Health Alliance of New York (IHANY).

**JOAN HAYNER**
**Title:** CEO
**Company:** CapitalCare Medical Group

**DAVID HOGAN**
**Title:** Senior vice president
**Company:** USI Insurance Services

**KURT JAEGER**
**Title:** Executive vice president
**Company:** Jaeger & Flynn

**PAUL MILTON**
**Title:** CEO/president
**Company:** Ellis Medicine

**Some 23 million people are projected to lose their coverage if the House health care bill becomes law. Is this an improvement on the Affordable Care Act or are we going in the wrong direction?**

**NORMAN DASCHER JR.:** I would much rather see it modified than repealed. I was down in Washington about a month ago. We met with nine Republican members of the House of Representatives over the course of a day. And it was disappointing, the lack of true understanding that they had about the topic and what the solutions would be. One of the biggest flaws of any of it is it's really expensive to insure 46 million people. And coming up with a plan that you think you're going to be able to maintain that level of insurance for less money is a bit of a stretch.

In New York, we have a particularly difficult problem, much more so than any other state, because so many people are currently covered by Medicaid. In New York, about one in three people receive some type of benefit from Medicaid now. It used to be one in four, now it's one in three. The Medicaid expense in New York state far exceeds that of almost any other state. One of the reasons for that is Medicaid as a health insurance plan is very rich. When Medicaid was first passed, there was a menu of items. And there were certain items that were mandated, and there was a list of other items that were options. Well, New York went down and very generously checked all of the options. So people actually moved to New York state to take advantage of the Medicaid program. If we were to do some type of block grant program in New York, the funding just wouldn't be there in order to insure all the people in New York. The governor has already sent out an email to all of us saying that if the House bill passes, those cuts, he's just going to pass on to providers. He's not going to modify the Medicaid program. And those cuts are just not sustainable.

**KURT JAEGER:** Twenty-three or 24 million Americans pick up health insurance. If the cost containment doesn't happen first, all you've done is increase cost. Obamacare, for or against it, added essential benefits, added a lot more mandates to the coverage. None of that was free. So, you increase the cost in the programs, you focus on giving more Americans healthcare coverage – and I believe everybody should be covered – but when you do it in that order, how do you maintain it? There's got to be some compromise somewhere.

**JOAN HAYNER:** I have a pretty cynical view right now about the whole political environment. I think if we're looking to a political solution, we're not going to solve the problem. Everything done at the national level is for political expediency, and it's not taking into account what is actually happening out in the field. I feel our best solution is to focus on what we can do locally, and I think we have a great opportunity locally.

Providers like CapitalCare, we have a choice. We're not required to participate in Medicaid, but we make a choice to participate. By doing that, it helps the system: It helps for access, it certainly helps the patients, and I think it helps keep costs down. The problem is, when Medicaid cuts come in, if we continue to choose to participate and care for Medicaid patients, our only choice is to go to all of our commercial payers and demand more money. So, either we get out of the Medicaid business and we create an access issue, or we stay in and we cost shift. We've done nothing to reduce costs in that situation. But that's the reality.

**PAUL MILTON:** In our business, 65 percent of our revenue essentially comes from government between Medicare and Medicaid, so it's hard to avoid the fact that it's not in this political arena somehow. So, how do you get it out of that political arena and run it in some other way that makes a little bit more sense? With a little bit of a plug to Joan's firm, they've done some innovative things in this total cost of care, where they've worked with some of the insurance companies, whether it's commercial or others. This is what some of the others like us are trying to do.

Even though it's frustrating, the government kind of knows what it's doing, whether it's state or federal, whether it's block grants and we don't like them, or whether it's these deals that say here's so much to

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**Back, left: Bethany Gilboard, Kurt Jaeger, David Hogan and Joan Hayner. Seated, left: Paul Milton and Norman Dascher Jr.**

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an ACO, figure out to how to take this money, $10,000 per head. We end up thinking like insurance companies a little bit.

**BETHANY GILBOARD:** We have a huge prevalence of chronic disease in the Northeast that has to be managed, and we need to figure out how to align our payment systems with the care that's necessary. The conversation should be around, how are we going to create an environment here where the payment strategies align with the care delivery system? I don't see it happening here. I see an environment that still perpetuates a volume-based approach to healthcare as opposed to a value-based, outcome-based, patient-centric care system.

**DAVID HOGAN:** I think the ACA, as it is right now, really isn't sustainable in terms of the financial levers that are supposed to fund it. It's not politically expedient for the excise tax, the Cadillac tax, to actually take place ever, so it's been pushed out. And a lot of the levers which would be creating the revenue sources to pay for all these new participants on insurance have been either pushed back or are possibly going away. From the vantage point of the benefit consultant that looks not just at the Capital Region, which is a vibrant insurance market, or downstate, where we have good competition, we do see in parts of the country that don't have a single health insurance company, or might have just a single provider. The Affordable Care Act is really a reform of health insurance and a way to have people covered in this "affordable way," which many times the employees of our customers don't actually have real-world affordability with their payroll deductions, or $10,000 deductibles for their medical plans if you're working poor. That's not affordable. I think any reform to the current situation is good.

**President Trump and the Republicans say the ACA, also known as Obamacare, will implode if nothing is done. What are your opinions on that?**

**GILBOARD:** The insurance side of the market is the piece that's the most complicated and I think the one that is the least understood by consumers in general. And that's the area that I think needs fixes. It's the financial part of it. It's not the services that are being delivered or the people that are receiving those services. And I don't think there's enough of a distinction made.

**HAYNER:** Prior to the ACA, the health insurance market at that time and the language that was used at that time didn't feel as much inflammatory as that we were headed towards a financial cliff. It was an unsustainable system. The fee for service, pay-per-click payment strategy was not working. And costs were rising at a pace that, at that time, I believe in 2008, the prediction was that there was only about 10 years left for that system to be sustainable. You've got to change the reimbursement system to incentivize and align with what you want, and that's reduced cost with better outcomes. We've got to find the adults in the room to have the conversation.

**DASCHER:** One of the problems with Obamacare that we encountered as a provider was that you have the different levels of payment and the different cards and the least expensive program so that people could get insurance for a very reasonable premium. The problem is, they had very high deductibles. People would come in and have a procedure, they would slide their insurance card across the table and say, "I've got insurance." And the registration person would say, "Yes, but you have a $4,000 deductible." And the person would say, "If I had $4,000, I wouldn't have this level of insurance. I'd have insurance like everybody else has." People didn't get that. Our bad debt doubled. So that part of Obamacare didn't work out so well. That being said, at least it was a framework to build on as opposed to just poof and have this dry spell with nothing in between.

People without insurance don't go for doctor visits. Then they show up in the emergency room and say, "Oh, I have this little bleed." No, you don't have a little bleed. You have Stage 4 colon cancer. And then the cost of that is just remarkably more expensive than an annual office visit. Our law in New York state is, when somebody enters our emergency room, we have to see them. A lot of people have figured out, I don't need insurance. I'll just go to the emergency room. We haven't figured out how to create the incentive for people to keep themselves healthy.

**GIBOARD:** I think that's going to change. Because, depending on how things roll out with insurance plans, not just with public payers, there are going to be more high-cost deductibles to make premiums more affordable for the consumer, for employers. And I think consumers are going to start shopping around. And when they go to see an orthopedic surgeon, after the second MRI, they're going to finally say, "What are they doing?" Or, is it cheaper for me to have an MRI in a freestanding facility versus going to a different kind of facility? And people are going to start looking at their hospital bills, their EOB – their Explanation of Benefits – much more carefully. Because the reality is, there is no relationship between what a provider charges and what they get paid for by the insurance company. And people will look at a bill and say, "Oh, my God, $5,000?" They only got paid $200. There's a tremendous disconnect between lack of understanding in terms of what something costs, what somebody charges, and what a payer will reimburse.

**JAEGER:** The real problem is a lack of transparency. And the biggest lack of transparency is on big pharma. There's a pharmacy cliff coming and it's coming fast. Fifty percent of all drug spend is going to be made up of specialty drugs by 2019. They're saying close to 50 percent of all medical spend is going to be from the prescription drug market. We do a lot of self-funding. I look at self-funding reports on a daily basis. In the last couple weeks, I've seen a $600,000 drug hit one of our spend reports. Twelve injections a year, $600,000. And as that child increases in weight,

so does the dosage. We project in four years it's going to be over a million dollars spent to one company. Big pharma, the lobbying that happens down in Washington, has to stop. The pharmacy companies are making a ton of money and we need to take some of it back. Providers took it on the chin with Obamacare. Carriers took it on the chin with Obamacare. Consultants took it on the chin with Obamacare. I'm looking at big pharma and they seem to be doing just fine. People really have to focus and start talking about that.

**MILTON:** It's this whole issue of is it a federal issue? Is it a state issue? Some states, mostly in the Midwest, probably in the West, don't want to be told by the federal government what to do. If they want to get Stage 4 colon cancer and not have insurance, they think that's their right to do that. They'll die. That's their choice. I think we live in a little bit different area up here in the Northeast. There is a federal/state issue. It's kind of skin-in-the-game right now. Basically, the more you do, the more you get paid. So we're all kind of under that incentive. And at the next level down for a patient, there's not a big incentive yet. You're starting to see $5,000, $10,000 deductibles come into play. As a patient, if I have a high deductible, I'm going to think differently if I have more skin in it. Whether I'm a CEO or I'm on welfare or Medicaid, if everybody had something in it, they're going to think differently about the care and where they're going to get it. I think that's going to fundamentally change the system.

**Do consumers have some type of input into this as business owners and as leaders in the health care industry? You're talking to each other, you're talking to government officials. Who is talking to consumers?**

**DASCHER:** Two years ago, we started a group called the Patient and Family Advisory Council. We invite former patients, those that have had good experiences as well as those who have had not as good experiences, and their family members, and we meet once a month in an open forum. We invite them in and we talk about what we can do better. It's not always uplifting, but it is certainly enlightening.

**MILTON:** The conversation is really not happening, because they're really not that engaged. If all of us here have insurance and then something happens to us and we get sick, we have a mindset of being entitled. If I sit around with my parents and all of their Medicare friends, they feel very much, I paid for this. I'm now going to get what I need out of it. God forbid my parents got cancer. No one's having that conversation. Oh, by the way, this is going to cost 70 grand. It's going to give you four more months of life. What do you think?

**GILBOARD:** In 2005, my dad, who was 94 at the time, had congestive heart failure in New York City, and didn't have a primary care physician. He kept using his cardiologist as his primary care doctor, and was in and out of the hospital and emergency room. Here I am in managed care, I'm smart, I know what we should be doing. I'll never forget the day when the cardiologist came in and said we really should replace that pacemaker that he had for 25 years. It was a company that they could no longer support telephonically. And the alternative would be he'd have to go to the doctor every other week to have it monitored. And I'm thinking to myself, that's kind of an inconvenience. He's 94, and what did I do? I hemmed and I hawed with my mother and I said go ahead. Put it in. And he died two months later, not from the procedure, but just because of his condition. Knowing what I know today, I would never ever have allowed that to happen. Because one, it cost the system god knows how much money. The physician, whatever he made. And did it add anything to the quality of life of my father? Absolutely nothing.

**DASCHER:** We actually have a full-time nurse whose title is nurse conversationalist. She has those discussions. It's been a dramatic help for our families and our patients. All that being said, nobody ever thinks it's going to happen to them. When you're standing over the bed and your mother has had a stroke, and there's a DNR order and they look at you say, "Are you sure you want us to just let nature take its course?" It's really easy to talk about it, but when you're on the front line, it's a very difficult thing to do. And some studies show a vast majority of Medicare money is spent on last year of life. How much of that is really a good investment from a consumer as well as a provider relationship?

On a related note, we've got some fee-for-service contracts and we've got some value-based contracts, and it's a very awkward transition about where we are, because, as much as we all want to go towards value-based, you still got to make payroll. There needs to be a defining point where the switch flips and it's all value-based, and you'll see utilization drop like a rock.

**GILBOARD:** In the small community of Albany, there isn't a lot of a burning platform to change. This is a relatively small employer market in the Albany area. You've got a population of a million people, not necessarily growing, and you've got very few real insurance plans, with one that dominates the market. And when you have one player that dominates the market, it's very difficult to kind of move the needle and change behavior. And even with New York state being the largest employer, I haven't heard this burning outcry from employers saying, "Reduce my premiums, reduce

my premiums." Because if they were really screaming loud enough, and you as brokers hear it from your clients, what are the insurance plans doing to help move that needle? The only way they can reduce premiums is if they realign their payment mechanism with providers so that everybody is in sync and you're really paying for things that need to get done. You're really putting the consumer at the center of the platform, and you're really focused on, how can we improve outcomes? How can we improve health care? How can we improve the quality of what we're delivering and make it a better experience?

**JAEGER:** I think a lot more employers are starting to take measures into their own hands. Wellness-based programs six, seven years ago, were looked at very differently than they are today. More and more employers are starting to buy into those wellness programs. Employees are actually getting to be better consumers, but it's taken a lot of time to get there. When we take a look at the organizations we're working with, we're finally getting the CEOs, the executive VPs, the COOs, the CFOs and HR at the table to talk about claims-avoidance types of discussions. It takes everyone. Everybody has got to have some skin in the game. It takes everyone actually taking an active role. I do think it's happening, it's just not happening quick enough.

**HOGAN:** The bigger point is that when we encourage that primary care physician relationship, we catch those chronic illnesses in the early stage. And while we might not be in a society, at least around this roundtable, that wants to "Medicaid" every potential chronic illness, sometimes a very low cost solution exists to keep someone healthy and return someone to health, rather than the out-years of huge expense.

**MILTON:** If you look at the Medicaid spend per person per year, the Capital Region is actually a good- to high-performer. We could always do better, but it's very, very good. And, so I think, in this community of these large physician groups, having probably a good-minded way to take care of the community and not-for-profit insurance companies, with many of these physicians sitting on those boards over the last 15, 20 years, they have really kept this community in balance overall in terms of the care that's provided.

**HAYNER:** One of the things that we haven't talked about, that is sort of threaded through many of these conversations, is how are we addressing the social determinants of health. What we're doing and what is being done in lots of areas, is taking those additional dollars that come in, either the Medicaid expansion dollars through DSRIP activity, or the Medicare dollars, and using them to embed our own care management organization. We were a primary care practice. We now have RN care managers. We have social workers. We have clinical pharmacists on staff. We are now recruiting for clinical psychologists. We have collaborations with Rensselaer County in embedding clinical psychologists into our pediatric practices to deal with adolescent behavioral health issues. All of the social determinants of health are not things that the doctors were trained on, but they're things that impact the patient's ability to be and stay well.

It's not just about that 15- to 30-minute appointment one to four times a year, but finding out what's going on in their life, recommending that they get a PCP but then understanding they have a transportation issue. Poverty and housing and unemployment may be the first three things on their list even though they have HIV. It's number four because they're dealing with the first three all of the time. And how we as a society can start figuring out how we use dollars that are designated towards health to help keep people well. We started to see some of our greatest gains in terms of bringing costs down and improving outcome when we started spending some of our dollars on these other things that are not necessarily about what the physician does.


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**MILTON:** The Schenectady City Mission and all of these other community-based organizations have such a big impact on the delivery of care in the community overall.

**DASCHER:** We just started an interesting program in partnership with the Interfaith Partnership for the Homeless in Albany. We took a portion of St. Mary's Hospital which used to be inpatient beds that we were no longer utilizing, and established a program called the "Medical Respite." When a patient comes through the emergency room, they've been in the hospital and they're discharged, the social worker who's doing the discharge paperwork says, "Okay, can you confirm your address?" The person looks at you and says, "The park." You know they're going to be back in about a week. They're not going to get the discharge meds. They're not going to be in an environment that helps them recover fully. They don't have a house to go to and they don't have a job.

In Medical Respite, we have a 10-bed unit for people who have nowhere to go, and when it comes time to be discharged, we discharge them to Medical Respite, which is funded in part by DSRIP. They'll be there for about a month. During that month, one, we want to make sure they get their discharge medicines. Two, we get them an appointment with one of our primary care physicians so they can actually follow up, because a lot of these people have chronic conditions: diabetes, CHF, pulmonary. We get them their discharge meds, we get them stabilized, discharge them, get them a physician, and then we work on permanent housing and we try to find them a job. For that population that is coming into the emergency room once a week, I think this could be an interesting experiment.

**Is there a health care model anywhere in the world, in the universe, that would work better than what we have now in America, but that is also politically viable to being implemented?**

**MILTON:** You hear the Netherlands, you hear single payer, it's almost inevitable that it goes down to something like that. The Canadian model, they always score well. They've got reasonable cost per person and good outcomes, and they give it to each of the provinces and they manage a fixed amount of money. Something like that is probably going to have to come into play. And the political part of it has to be removed so that there's an independent body or board.

**GILBOARD:** I think that, as we continue to incrementally see more of that transitioning into alternative payment models and to total cost of care, as providers, as systems, as hospitals, you begin to re-engineer your system, so it really doesn't matter who the payer is. You're just treating your population as such and you've brought down your costs and you've kind of redesigned your system. And any dollars that you save are dollars that you then can reinvest into your own organization to continue to improve the care and hopefully bring down the premium. We do see that happening here in the market of managed care payers.

**We constantly hear stories about pharmaceutical companies charging astronomical prices for life-saving drugs because they can get away with it. Should this be allowed? Is this business as usual in the health care industry?**

**MILTON:** As long as we continue to have direct consumer advertising, whether it's on TV or pamphlets, it's going to be very, very difficult to reign in control. As consumers, everybody wants the greatest – whatever the latest and greatest is out there. I think it's incumbent upon some of these health plans to really reign it in. Of course, as somebody who may be taking a very expensive drug, you don't want to have that limitation. But for the good of the system, I think we really need to have more controls. We were impacted with the EpiPen situation.

**HOGAN:** We have a president who campaigns saying we should be able to import drugs from Canada. We have an FDA that makes it illegal for an end user to do that. But we actually have a lot of mechanisms in place right now. We see a lot of public entities, municipalities and school districts in New York state that are using organizations to import drugs. Their benefit is a significantly less costly version. These are drugs that are manufactured mostly in the UK, Canada, New Zealand, Australia – countries with very similar governing and political approaches to regulating drugs. But right now, there's some question as to whether that could be challenged. There could be issues coming down to the employer. But there's a clear benefit to the employee who's, in most cases, now paying nothing because of the way the mechanism works. The benefit to the employer is that it's a 60-, 70-, 80 percent reduction in the cost of that HIV drug, of that Hepatitis drug. And notwithstanding all the issues of different countries' HIPPA policies and all of that, but that could be right there a very easy legislative fix.

TRANSCRIPT LIGHTLY EDITED FOR SPACE AND CLARITY.