TABLE of EXPERTS

PARTNERS IN HEALTH CARE

The *Albany Business Review* hosted three executives to discuss the future of a single-payer system and the rising costs and rapid transition of health care. The discussion was moderated by Sierra Kehn of the *Albany Business Review*.

With the health care market in a period of rapid transition, can you talk about what it means for providers, payers and patients?

Robert Iseman: We certainly are in a period of rapid change. There's some debate about how quickly the change is occurring. My personal view is that it's not only occurring, but accelerating, toward a business environment in which providers will be asked to take a greater risk in providing care for their patients. All this is really being driven by the fact that the health care system is broke. People sometimes ask me why this trend toward requiring providers to take risk is different than it was in the '90s. The difference is the health care system is truly broke this time.

There has been a lot of activity by the federal and state governments to find ways to deliver health care services more efficiently to the Medicaid and Medicare population by creating greater value through greater efficiency. Those changes are being applied in contracts with commercial payers. That is changing the way in which providers are being paid.

Your planning and your budgeting and your infrastructure, the way you train those who work for you, your IT systems are all developed and maintained towards supporting the way in which you get paid. Now we are moving toward a value-based payment system that is changing infrastructure. I think it's going to be to the benefit of patients, but it presents enormous risks for providers and even payers.

In managing that transition on behalf of our clients, we identify the change, see where it's going, and get out in front of it. We advise clients on how to take advantage of the changes that are happening, but we're also very mindful of the enormous risks that need to be managed.

Kelly Smith: We are seeing a trend, moving from fee-for-service into more of a fee-for-value basis, where we are potentially perceived not necessarily in an adversarial manner with our provider network. We're certainly moving more along the lines of developing partnerships. We're working with our provider network on a daily basis to really identify gaps in care, to provide them with data, to help them make business decisions on where they can maximize revenue opportunities. You really are starting to see payers moving into a space where they truly are partnering with their provider network.

Barry McNamara: From an employer perspective, we spend 18 percent of the gross domestic product on health care. The number is not going down. The question we get asked most often is, "How are we going to account for this 'sea change,' both on the provider side and the payer side?" Moving to pay for performance, if I can call it that, on the provider side. Consolidation is a concern of employers. From our perspective, the more competition, the better. On the local health care scene, we're not concerned, but we watch carefully what's going on with consolidation. There are four local payers here and two other national companies, Aetna and United Healthcare. We don't want to see six turn into three.

We talked about industry consolidations a little bit and the movement from the fee-for-service to the pay-per-performance model. Why are health care costs still going up in multiples in general?

McNamara: There are a number of factors. Baby boomers utilizing more services than millennials. Just the cost of doing business. Regulations and mandates. Those are just three that come to mind. There's probably half a dozen more. I think the challenge is to come out the other end, whenever that occurs, with better outcomes and lower total costs. That would be the ultimate goal, but getting there is going to be the challenge. I don't know if we will in the balance of my career. It's not going to happen tomorrow.

Smith: There was a lot of focus on the Affordable Care Act and giving the ACA probably more credit than it deserved for "health care reform". When we look at the ACA and really what it has accomplished, it was payer reform. It really wasn't health care reform. I think what we have ahead of us now is truly talking about health care reform and the manner in which health care in this country is consumed and expected. I think we need to move into a world of transparency so that consumers get a better understanding of what they're paying for, how they're paying for it, and how those services are being provided, and the different cost elements that go into receiving care.

Is a single-payer system in our future?

Smith: Well, we already have single-payer, right? Medicare. There's a lot of talk about Medicare for all. I personally don't think it's going to be in my future in this country. When you look at other countries that have single-payer, our consumer behavior is one of entitlement and one of feeling like we work hard and we deserve the best care when we need it and how we need it. I just don't see that pendulum swinging so far to the other side.

Barry touched on how important competition is in this space. I think there was a study released recently that showed that the cost of health care when there were no more than two players in a marketplace was significantly more. Double-digit rate increases are significantly more costly than it is when you have multiple carriers that are competing in the same space. That flies in the face of single-payer. Then when you talk about a government-run entity, we're into a whole other power station.

Iseman: A single-payer system is not something I favor personally, but I think it is in our future. Right now, depending upon the state, and how many are Medicaid-eligible, you have percentages that are above 40 percent of combined Medicare and Medicaid recipients. And so you may have 40-45 percent of people covered by a government payer.

The emphasis for reform is really being driven by the value-based payment methodologies, particularly in the Medicaid program, that are spilling into the commercial world – pay-per-performance contracts and other arrangements moving along a continuum toward greater risk being assumed by the providers.

I think we will always have a private insurance market – the people who can afford to have private insurance over and above the taxes they may pay to support a public system.

Back when Hillary Clinton was trying to create Hillary Care, there were proposals that said it should be a crime to privately contract outside the single-payer system. They were trying to force everyone into a single-payer, government-run system. They were saying that even if you wanted to contract with providers outside the public system, you couldn't.

Now in New York we have a single-payer bill that's

passed four years in a row by the Assembly. Never been taken up by the Senate. California has passed a single-payer bill for two years in a row. In the state Senate, you can't tell who's caucusing with the Democrats and who's caucusing with the Republicans and who's an Independent. But if the Democrats ever have a workable majority in the Senate, and it may happen next year, there's going to be a single-payer bill passed in New York.

McNamara: I keep coming back to cost. I've never seen a model where single-payer, statewide or nationally, is less expensive than the system we currently have. The system we currently have is broken and expensive. I think my children or my grandchildren might see it, but only if it addresses the cost issue. We just can't increase taxes to pay for a system that was broken before we create a different system.

What are the pros and cons of these association health plans (AHPs)?

McNamara: The list is probably longer than the list of what's driving health care costs. Locally, that challenge has already been raised by New York state and 11 other states. The fight is going to be over how AHPs, if at all, are allowed to combine small groups to make them a large group. I think that's where the battleground is going to be.

There's a long history of problems with self-funded multiple employer welfare arrangements. In particular, insolvency. I think that the unintended consequences of AHP regulations would be the impact on the small group market. Destabilizing the small group market. For that reason, I don't think it's a good idea. There's

Kelly Smith, left, Barry McNamara and Robert Iseman.

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MEET THE PANELISTS

ROBERT H. ISEMAN

Partner
Rivkin Radler Attorneys at Law

Robert H. Iseman has represented institutional and individual health care providers and health insurers for more than 40 years.

Bob provides a full range of legal services for multi-provider health care systems, accountable care organizations, hospitals, physician practice groups and third-party payers. Areas of representation include corporate governance and compliance, internal compliance investigations, fraud and abuse, integrated health care delivery systems and related antitrust issues and medical staff relationships.

Bob has led many internal compliance investigations, prepared and submitted self-disclosures to regulatory agencies, and defended False Claims Act cases. Bob has the distinction of being listed in the peer-rated Best Lawyers in America for more than 25 years. He is listed in four separate categories of legal practice (health care law, commercial litigation, antitrust litigation, and regulatory compliance litigation), as well as being the recipient of the Super Lawyers designation for health care in upstate New York for many years.

RIVKIN RADLER LLP
ATTORNEYS AT LAW

BARRY MCNAMARA

President
Benetech Inc.

A 1974 graduate of SUNY Oswego, Barry has spent his entire career in the employee benefits business.

He joined Benetech as vice president of sales and marketing in May of 2003, and was named president in 2005. Prior to joining Benetech, his positions (in reverse chronological order) included VP/large group sales and service for Blue Shield of NENY; Regional Sales Director for UICI Administrators, a national TPA; territorial sales director, national sales VP and VP of marketing for MetLife; and, group underwriter and client service manager for Union Labor Life.

Barry oversees Benetech's client contracting and regulatory compliance activities, including all external communications. He also serves as executive consultant to some of Benetech's largest clients and is actively involved in the design, development and implementation of the company's strategic initiatives.

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KELLY K. SMITH

Vice President, Sales
MVP Health Care

Kelly K. Smith has enterprise-wide responsibility for commercial sales at MVP Health Care. In this capacity, she is responsible for identifying and growing MVP's new commercial business opportunities. Kelly joined MVP in August 2015 as director, new sales and exchange solutions. During her tenure at MVP, she has implemented sales strategies for commercial products in eastern New York, Hudson Valley, and Vermont. She also has worked with national and regional consultants, brokers, and employers as MVP has taken a lead role in developing private insurance exchanges.

Prior to joining MVP, Kelly was a senior member of the New York Health Benefit Exchange, publicly known as NY State of Health. Kelly is currently participating in the AHIP Executive Leadership Fellowship Program and is a member of the National Association of Health Underwriters. She is a graduate of the Leadership Institute through the Rensselaer County Regional Chamber of Commerce. Kelly is on the board of directors for Girls Inc. and the Colonie Chamber of Commerce.

MVP® HEALTH CARE

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a whole bunch of structural issues, including selling across state lines.

Smith: MVP Health Care has been in the association health plan business for many years. We've seen it ebb and flow. We had a couple of very large statewide associations prior to the ACA that had pretty significant enrollment. We've seen that enrollment decline over time as the state-based marketplace and more competition in the small group market has created a competitive, quality playing field where small group, self-proprietor and individuals can purchase health care. With everything that's coming down the pike with association health plans, we're feeling as though New York is pretty well prepared to deal with it. The look-through provision that currently exists, we think, is going to hold up.

I think there's value in associations. If you were to look outside of health care, there's value that associations bring to the market. We're not opposed. I'm just not sure that we have quite figured out what new value in health care they're going to bring to a market that already seems to be stable and working well, for the small group, self-proprietor market today.

How have payer/provider relationships shifted over the years?

Smith: We talked a little bit about capitation and how capitation existed in the mid- to late- '80s and '90s. It was a bad word. Capitation with risk adjustment has come back around. One of the things that we're seeing, again more because of the data that's available and the data that's shared, is that we're able to go into provider offices and make reimbursement adjustments based on the makeup of that practice. If we have a provider that has a higher-age population or a sicker-age population, or a practitioner who specializes in adult onset of diabetes or congestive heart failure, those types of risk adjustments and reimbursements are helping them care for those patients.

In the old days, you had a capitation, which was basically a per-head reimbursement from the payer. Practitioners could figure out that the more times they saw a patient, or the more sick a patient was, the less their reimbursement over time. Now, you're starting to see providers that are cultivating more complex types of practices because they can see it as a way to increase their revenue stream. One of the biggest changes is the transparency and the willingness of the carriers to share data with the providers and the providers to share data with the carriers.

We had a real-life case where a practice was focusing on a gap in care related to maternity cases. They were putting in some resources and hiring full-time employees to really look, to really focus, on this maternity care issue that they have. When we went in, we looked at their referral patterns. They had a very high ER referral utilization. We worked with them to shift the focus away from where they thought the problem was, and more to what the data was showing the problem was. They ended up opening urgent care hours on Saturday. They solved their problem. They got their ER utilization down to normal. They were able to generate additional revenue by being open an additional day a week.

Iseman: I think the word partnership is a little bit too much on the, "We're all in it together, we're going to be very cooperative" end of the relational spectrum. While there are elements of cooperation, when you have a provider network that may be contracting with MVP or any other payer, these remain adversarial transactions. You want it to be win-win. You want it to have the feel of the partnership, but these arrangements are negotiated hard and continue to have many features that are adversarial in nature.

I can assure you that a lot of the physician groups are apprehensive about having the payer march into the office and say, "Let me see your data," because it's going to determine how much they get paid. The payers don't want to pay more than they have to pay. They have an interest in paying as little as they can pay. The provider groups, they have an interest in showing that the data supports a greater payment to them.

There's a term now in the health care market place that is very important. It's called SDOH. That stands for the "social determinate of health," and it has driven the Medicaid reform effort nationally and on a statewide basis. It says that for particular patient cohorts, there are going to be social factors and emotional and mental factors that are going to get in the way of delivering health care. Perhaps the person suffers from mental illness and is not going regularly to the mental health clinic. Perhaps the person is homeless. Perhaps there's domestic abuse in the home. Perhaps there's not access to transportation.

One of the things that the Medicaid reform effort has focused on is how to create a partnership with the payers and the providers to manage these real impediments to care, so the care can be delivered more effectively. This need to address SDOH has resulted in very innovative relationships.

If the providers can reduce the amount that the payer has to pay on behalf of the Medicaid patient, then that amount can be split. If it costs more or they don't reduce the cost, then they don't get paid as much. There's a socially beneficial effort at work now to identify these barriers and to break them down. The relationship, while it is one you like to think of as a real "partnership," is a partnership in air quotes. They remain business relationships to both sides.

Smith: Social determinates of health and the impact is a primary focus of MVP Health Care. Our data shows that 80 percent of people with a behavioral health issue will visit their primary care doctor at least once a year. Fifty percent of behavior health issues can be treated at the primary care level. One of the things that we're working on is providing resources and skill development at the primary care level so that providers feel more comfortable handling behavioral health. What we were finding was that many times the practices are just not equipped. The addition of nursing staff or mid-level providers that have a specialty or have some additional training in dealing with mental health and behavioral health issues is something that primary care practices are seeing become quite successful and comfortable with.

I think Bob's point is spot-on that we are moving out of treating the disease state to looking at our members holistically.

McNamara: Well, I want to go back and pivot on something Bob said: that partnership is one of the main drivers of consolidation on both sides, payers and providers. The larger your organization, the more leverage you have in negotiations. Again, we're not seeing that locally on the payer's side, but on the provider's side. Nationally, some of the proposed mergers, it's all about critical mass. Whether it be how big is the hospital system or whatever. Integrated systems and how big is the payer?

Do you see these consolidations and mergers continuing to unfold throughout the country?

McNamara: Yes, absolutely. Yes.

Iseman: There's some schizophrenia going on in the regulatory scheme, however. Barry's right. I've used for years this term "critical mass" to describe organizations that will be big enough to deliver a full continuum care and financially big enough to take risk. The cost of maintaining duplicated services in various hospital systems, or health care delivery systems, is enormous. However, the counter consideration is competition and the anti-trust laws.

So you have all these pressures to create critical mass. Then you have the anti-trust regulator saying we don't want you to eliminate duplications because we want to have competition. This is a very difficult thing in the health care marketplace because you find mixed messages. Government policy makers are saying, "We want you to form clinically integrated networks. We want to make it more efficient. We want to avoid duplication." Then the anti-trust division of the Department of Justice, Federal Trade Commission or the Attorney General oppose the consolidation under the anti-trust laws.

One of the things the anti-trust regulators want to see is if there's a consolidation through pro-competitive efficiencies. What does that mean? That means the cost is going to go down. Here's a true story. I went to see the Attorney General about a merger that we were handling. They said, "Tell us about the pro-competitive efficiencies." So I anticipated that. I'm going down the list of pro-competitive efficiencies. They smiled and said we were being a little bit too efficient.

I said, "Why's that?" They said we don't want any employees to lose their jobs. The biggest part of any health system's budget is personnel. It's human resources. Then you say, "Well, how about if we do this by attrition?" Then they say, "With attrition, do you really have the pro-competitive efficiencies that are going to support this?" It is schizophrenic public policy.

McNamara: Drives some interesting potential partnerships, like Walmart and Humana. Humana is primarily a Medicare Advantage company. They do sell ancillary benefits, but they're primarily a Medicare Advantage company. Their goal would be to put clinics inside of Walmart's to deliver care and that which fragments the delivery. I stop seeing my PCP. I go to the Walmart "minute clinic" to get my care.

Similarly, how could Amazon's entry into the arena impact the current delivery model?

McNamara: I don't know that it would extend to the delivery of care, but I think it could easily extend to the delivery of materials like diabetic supplies and durable medical equipment, and drugs.

Iseman: And pharmaceuticals. Did you see what happened to the stock market when Amazon said they were going to get into the pharmacy business? The market reaction was unbelievable.

With regard to telemedicine and telehealth, Kelly, you had mentioned that MVP is really promoting consumerism. Can you define what consumerism means to MVP and how this technology comes into play?

Smith: We're seeing a movement and we have been over the last couple of years. I think some of the state-based marketplaces, as well as some of the private exchange work that's been going on nationally as well as regionally, is supporting some of this. I also think the shift on the employer level of moving group-sponsored coverage into high-deductible plans, where people are no longer insulated. It's not a copay first plan where they're going to the doctor and paying $25. A lot of people have pretty large deductibles on the front end of their plan that they're paying for it out-of-pocket. They're starting to see the true cost of the health care services that they're receiving. They're starting to sit up and say, "Do I really want to have to pay $2,500 for that MRI? Maybe I'm just going to go and have some physical therapy. If my knee doesn't get better, then I'll go back to the doctor."

Consumerism, from MVP Health Care's perspective, means working very hard to have an educated consumer. We do a lot of work around putting information out in the marketplace. Whether it's on our member portal, working with our broker distribution channel, working with employers directly on what are the types of things consumers need to understand before they receive health care and after they receive health care. Then, what are the types of tools that they need to help them be better consumers?

Telemedicine is a tool. There was some concern in the beginning when telemedicine came out with the minute clinics. Is it going to fragment the care continuum? Are people going to start moving in a direction where the primary care providers won't have that ability to provide that holistic care that we all talk about? I think it's a convenience factor. I personally have used telemedicine. I think it's great when you have a sniffle or a sick child that you know probably just needs a strep test. It's extremely effective for someone who just wants that quick doctor visit.

Iseman: There's a difference between telemedicine and telehealth. The traditional telemedicine approach was where there would be some connection, video connection or otherwise, between the provider and the patient. Telehealth is a different matter, where the patient remotely provides data back to the doctor.

This is recognized by the Federal Government as being very important. This year, for the first time, the Medicare physician fee schedule announced by CMS last June said that Medicare will now pay for physicians to interact with their patients when the patients don't visit the office, but they remotely report data. Telemedicine will be important, but telehealth will be perhaps more important.

McNamara: In the commercial market, we're clearly at the telemedicine phase. We try to encourage our clients to consider plan design when considering telemedicine, copay changes. Not so much a PCP copay change, but to separate the telemedicine copay amount from the PCP copay amount. Then maybe increase the urgent care and emergency room copays. Financially, telemedicine makes sense just because of the way it's costed out. How do we engage employees and how do we influence them? Through sensible plan design changes. Start trying it. I think they'll like it once they do.

How do you see the developing role of electronic medical records and what are the practical implementation issues?

Iseman: Certainly, everyone wants to be in a position where regardless of where you go in the world, your medical history will follow you in a safe and secure way. All of that is obviously a perfect world. The implementation of that is more challenging. Hospitals, more and more, are acquiring physician groups to create critical mass. They're hiring and employing the physician groups. Now, some health systems may employ 500 doctors. They'll bring with them their own legacy IT systems. The health system has been thinking, "We've got to have our own EMR system so that we can function as a clinically integrated network." That means we have to get all the data from all these doctors. The doctor says, "I'm not going to do it." The doctor's a particularly important doctor, brings a lot of business. So the health system says OK.

The implementation of this initiative creates big problems. Even where you have major hospital systems merging together to create critical mass, one system may be on one EMR system, one system may be on another. They've invested hundreds of millions of dollars in those systems. Now they have to create a so-called crosswalk so they can talk to one another.

McNamara: The cost of these crosswalks is measured in the millions, if not tens of millions, especially the larger the system. That's certainly an obstacle.

Iseman: In order to create critical mass the health care delivery systems hire doctors as employees. The average hospital loses about $200,000 a year on employed physicians on a profit and loss basis.

So why are the hospitals employing doctors at a loss and how can this be sustained economically? The difficult answer is that hospitals need the referral stream to support their hospital services. But paying a doctor for patient referrals is illegal, even if the doctor is employed, and provides a basis for substantial liability under the False Claims Act.

Among the hospital employees may be potential whistleblowers who can receive approximately 30% of the amount the government receives from False Claims Act recoveries.

The False Claims Act was originally passed during the Civil War in 1863 to deal with the fact the Army was being sold guns that didn't shoot, uniforms that dissolved in the rain, and rancid meat. There are nightmarish stories of responsible community leaders who sit on health system boards and act honestly and in absolute good faith. Their reputations were ruined all because the Federal Government, which recovered in 2017 $3.7 billion. ■

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