



Healthcare Roundtable

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- Dave Gessel, Utah Hospital Association
- Patty Connor, Office of Consumer Health Services
- Jeffrey Kluge, GBS Benefits
- Ronald Ruff, Mountian Medical Imaging
- Blaine Bernard, Holland and Hart
- Brent Bennett, Spectra Management
- Sean Mulvihill, University of Utah Medical Group
- Scott Barlow, Central Utah Clinic
- Mickey Braun, Arches Health Plan
- Jeana Hutchings, Diversified Insurance Group
- Steve Kieffer, Big-D Construction
- Chris Esseltine, Holland and Hart
- Rylee Curtis, Utah Health Policy Project
- Jason Stevenson, Utah Health Policy Project
- Thomas Miller, University of Utah Health Systems
- Steve Bateman, St. Mark's Hospital
- Korey Capozza, HealthInsight

The world of healthcare is ever changing, especially across Utah. From the governor's proposed Healthy Utah plan to new ideas on population health management, industry experts have a lot to keep an eye on in the coming months and years. Our panel also discusses the pros and cons of the Affordable Care Act, consumer engagement when it comes to insurance, and how technology is changing healthcare.

We'd like to give a special thank you to Dave Gessel, executive vice president at the Utah Hospital Association, for moderating the event.

We are in the throes of the second year of open enrollment for health insurance under the Affordable Care Act and the federal/state exchanges. What trends do you see in this new world?

HUTCHINGS: The only concern I have with private exchanges and the whole push toward choice is that are we ignoring cost again. When rates go up and when you have multiple options, those carriers don't have any idea what risk they are going to get. If an employer has a defined contribution, then what happens when the rate goes up? Who gets the cost? The employees? As we are looking two and three years down the road with the exchanges, those increases are much higher than our individual companies are experiencing. That's something we have to balance. If we are all about choice, sometimes we do that at the sacrifice of cost.

CONNER: We were all surprised last year when healthcare.gov had such a failure when they launched in October, and it took a long time to recover from that. What we are hearing from Health and Human Services and CMS is it's going to be better this year, but it's not going to be significantly better. They are saying they have fixed some of the technology problems, but they aren't promising the world, and hoping that people will be patient when they go through the process of doing their insurance.

We are still seeing a lot of businesses, large and small, trying to figure out what their role is. What is it they have to report on as far as the mandate goes? Do they have the right plan designs and the affordability of those plans for the employees? I bet all the consultants in the room can say they are still doing a lot of conversation with their clients on how to direct them to 2015 and how to handle the reporting.

BENNETT: What we are seeing, especially for mid-size employers, is they have consciously made the decision that benefits are here to stay and that's part of our culture. They are looking for more decision tools, whether that is software, private exchanges, resources or education tools. They want to start involving their employees in the decision process rather than the employer pushing things to the employees—to have the employees be stakeholders through education tools.

BRAUN: Large employers don't know what they are supposed to report. There's four or five different ways to count employees. Depending on what piece you are reporting on, you count them differently. That's got to be fixed. As far as where we sit, clearly the public exchange and Avenue H are all options for us, as is the traditional large employer/small employer insurance. Even that definition gets blurred in a year. People that were large employers now become small employers. There's so much uncertainty still.

CONNER: Most of the businesses that decided to continue to do group benefits are the higher income, more professional-type businesses. Their employees really wouldn't get an advantage of the tax subsidies through the healthcare.gov site. They are also the ones competing for talent, and they want to do what they can to attract and retain that talent.

BENNETT: Because of healthcare.gov's failure, more employees fear going out to the marketplace. They are now putting a higher value on their benefits. You hear people for the first time saying, "I love my insurance company." Because of that, a tech company that's got a low employment pool will absolutely have a top-tier benefits package, and they'll use that from

a recruiting standpoint. Somebody in the service industry may be saying, “The economics just don’t make sense for us to continue to offer benefits.” You are really getting a division among employers—those that value benefits and are going to continue to beef those up, and those that are going to look to the federal marketplace to offer their employees benefits.

From the provider side, what are the changes or trends in interacting with insurance?

MULVIHILL: There’s a lot of moving parts to the demand and utilization question. You have market share issues as well as overall demand for services. But the University Medical Group had a record increase in new patient visits this last year to our surprise. It has lots of moving parts because we have increased access for patients as well. The thing that concerns us the most is the slow rise in patient contributions to their overall care. This is going to be a real barrier for some people.

MILLER: One of the concerns we have is the percentage of high deductible plans. With high deductible plans, we get hit on bad debt so we can’t collect on the deductible side.

CONNER: On Avenue H, we have over 74 plans right now between three carriers, and they range anywhere from a \$250 deductible up to a \$5,000 deductible for the individual. Most people are choosing the \$1,000 deductible or the \$500 deductible. We are seeing a different trend in small business than in the individual market. Individuals have a tendency to pick the lowest premium regardless of what the benefit is. Small business will pick a richer benefit, but they are conscientious about what the premium is.

BATEMAN: Last year we predicted a higher level of demand for hospital services. That has not been the case. The demand for most hospital services remains relatively flat. Most hospitals in the state have been about the same or had less inpatient admissions. At the same time, those people have been typically more ill, have stayed longer in the hospital, and have had a severity of illness and acuity level higher than we anticipated.

However, the percentage of people who come to the hospital that are uninsured or unable to pay has not increased. That level is the same or less. We are on the front end of the demand curve still, and the next two or three years will still be an area of increasing demand for hospital services, especially as the population ages.

BARLOW: In our market, particularly in Utah County, we’re seeing some struggles. A large number of people are picking plans for the price, and then coming and wanting services and we’re not empanelled. The education of the consumer of what are they buying, what are they getting, and what they really want is an element that still needs some work.

The second trend we are worried about is the number of employers that are self-insuring and are probably too small to really safely self-insure because the risk of underwriting has changed.

In the grand scheme of things, what does that do to the macroeconomic healthcare industry, where you get people self-funding when they probably aren't credible to do that? It appears to be a price-saving initiative, but is it the right thing to do in terms of risk capture and risk recognition of employers?

The good trends are anything that gets employees involved. We are at the tip of the iceberg with that. We have got to get more people focusing on their own health. There seems to be added activity there.

RUFF: In our hospital practice, which is a large portion of our practice, the growth in inpatient or hospital-based out-patient hasn't been quite what we expected. Imaging has been flat. Government has been suppressing imaging for years now because of the cost equation. But with more people being insured, we expected that to grow.

What we have seen in other aspects of our practice is an increased effect of consumerism. Individuals are more responsible for their healthcare bill. There are more high-deductible healthcare plans and people are shopping. In terms of our out-patient practice, we are seeing a significant effect of people shopping and looking for value. That part of our practice has grown in a way that's outpaced all of our anticipation and projections going forward.

Talk about how you deal with consumer engagement and getting people involved in their own healthcare.

STEVENSON: We are talking about a \$5,000 or \$10,000 deductible. That's a Hyundai. Before, most medical bankruptcies were caused by a \$200,000 or \$300,000 debt. That's a Bentley. The ACA has moved us from a Bentley to a Hyundai. Although there is still a problem, and \$5,000 and \$10,000 might be a big reach for people, we were in a focus group a couple of days ago and a woman mentioned \$80,000 worth of medical debt in one year. That can't happen under those high deductible plans anymore. There is at least a little bit of a stop gap, and a little bit of consumer protection that the ACA has provided.

We are a navigator here in Utah so we actually help sign people up. We had 84,000 people sign up in Utah during the first open enrollment period. That's probably closer to 100,000 now with special enrollment. That's out of a population between 200,000 and 300,000 that could be eligible for subsidies in Utah. There are still a lot of people grandfathering their pre-ACA plans that have not really come into this.

In terms of demographics, we didn't get the Hispanic population signing up at the percentage we thought we were going to. We definitely missed the mark there. The Medicaid expansion issue is playing a role, but at the same time, it's just getting the message out. Primarily the people we had signing up were young, between 18 and 34. We led the country in terms of the percentage of "young invincibles." We also did very well with the 50 to 64 year olds. That is a result of the Great Recession. There are a lot of stories of people in this demographic being supported by their children because they couldn't get back into the workforce. This was a

chance for them to get insurance until they could get on Medicare. So 84,000 was pretty good in Utah. We beat our goal of 57,000 by almost 50 percent.

The Department of Health says 11.6 percent were uninsured in Utah in 2013. Other surveys showed between 14 and 15 percent. Some of that would be the Medicaid coverage gap. Some of that are people who could buy but just don't. We have a high underinsured rate here. We are the second highest state of underinsured people, according to a recent study, like people who had deductibles of \$10,000, \$15,000 or \$20,000 under the old pre-ACA policies.

The market for private insurance in Utah is only 6 percent. When we think of ACA insurance, we think more about the private market, but only 6 percent of Utahns are insured through the private market. Sixty percent get employer-based benefits. Another 15 percent are underinsured. The ACA, at least from the private market or individual market, is focused on 20 percent.

The one thing we are interested in is who is going to be the next wave? Who is going to be signing up for the ACA insurance? During the first sign-up period, we got the people who really wanted it and were probably waiting for years or decades. What it sounds like is if we have businesses dropping their small group coverage and sending their employees to healthcare.gov, we are going to have a lot of employees who are going to be managing their healthcare in a way that used to be managed for them.

CAPOZZA: Jason's group is interested in helping people get insurance coverage. Our group is interested in making sure consumers get the highest value for the healthcare dollar. By some estimates, one-third of healthcare spending is wasteful. That's not a good use of your healthcare dollar. Part of the efforts we have been engaged with consumers in is helping them navigate high-value to low-value care through campaigns like "Choosing Wisely." We have a public reporting website that helps people identify high-quality providers and plans. We are just now getting into the territory of helping them compare providers and plans on the basis of cost and quality.

KLUGE: Education and planning is so critical. High deductibles are clearly here to stay. They are the way to keep costs down better than any other opportunity. The people who look at the cost are the ones that can't afford a \$5,000 deductible. It's just not going to happen. We're making sure we educate the employee or the individual that if they have a \$5,000 deductible, they need to work out a payment agreement with their hospital or provider so they don't get sent to collections.

What is either a real positive or a real negative with the Affordable Care Act?

CAPOZZA: A major benefit has been the moderation in cost increase—whether it's due to things like a shift to value purchasing on the side of the feds or the increased penetration of consumer health plans. It seems like we are not on the same trajectory we were on. Whether we can attribute that to the ACA or not, I'm not sure, but it is an association.

BATEMAN: The assistance that the government and other institutions have provided to the healthcare industry with regard to electronic health records has been substantial. Our industry lagged other industries for years with regard to the adoption of electronic information technology. While very expensive on the front end, on the back end the improvement has been significant.

It would be nice if we could come together better with regards to a uniform platform for electronic health records. The fact that we are on the same system that the University Health System is on is a good thing for us and the community. It would have been a good thing if the rest of the providers could have come onto that same system, at least on the hospital side. That was a missed opportunity.

STEVENSON: Transparency. We describe healthcare.gov like shopping for cereal at the supermarket. All the insurance products are on the shelf. There's nutrition facts on cereal, and you have the deductibles and all that information for the insurance products. We are going to see more transparency for prices. Everything is going to become a little more like Amazon.com. It's a step in the right direction to bring down prices, increase the competition and educate the consumers.

BARLOW: Medicare found that the median activity of a Medicare enrollee is seven different physicians from four different systems in the course of a year. It's multiple systems taking care of people. That's dangerous without coordination. We have to make sure we are coming together in better coordination. The ACA has to have credit for being the catalyst to start having these discussions. We have talked about it for years but now there's real movement to try to come together as a system of care on behalf of the patient.

BATEMAN: On the hospital side, we worry that there's going to be a time soon when the bill will really come due. In the past, the bill has sort of come due on the backs of providers. We are fearful that in the latter part of this decade when the bill comes due, the government or the primary underwriters of these services will not know how to manage the system. I don't say that rudely, but it will be very, very difficult to manage the system.

MULVIHILL: The fundamental problem that we are struggling with is just what Steve said. Are we heading down a path of decreasing the unit price of services to a level that the providers won't be able to maintain the standards that everyone is expecting of us? Or are we going to get a handle on utilization and figure out how we weed out the things that really don't add improvement in health to our patients but are being done today unnecessarily? That transition from volume to value in the system is the key goal the ACA doesn't address very well.

HUTCHINGS: Hopefully technology can help us get to a point where best practices are more utilized than they have been in the past. With the ACA, we have had to become more innovative and also align incentives.

KLUGE: We have seen costs come down for some large employers, but the reality is small groups are getting hammered. I want to make it clear that I don't have a love fest for the ACA on behalf of the small group. I feel really bad for them, and it is going to drive more of the dismantling, pushing to the exchanges, and it's going straight to individuals. The people that were teeter-tottering as to, "Do I continue to offer benefits or not?" are saying "not" in small group.

What do you like or not like about the Healthy Utah plan? What do you think the Legislature or the governor will do and how soon will it go into effect if there's an agreement?

BARLOW: We have a population that has been vulnerable for a number of years and has been made more vulnerable now because now they also have penalties. Despite the political rhetoric, we have to offer something to that population. In the absence of any other solution—and I know there's a lot of legislative resistance to this—we have to do something for that population.

STEVENSON: We recently had a focus group with about 16 Salt Lake County residents. We asked them about the Healthy Utah plan, and there was almost overwhelming support for it. You know what the number one response was? Take the money and run. They want the federal tax dollars that have been set aside for Utah to be used to cover this persistent uninsured Medicaid coverage gap. There were people who were not fans of the Affordable Care Act, but when they were presented with the facts of the plan, they were like, "This is a no-brainer."

Sure, there's a state cost of 10 percent. But they like the idea that it's a three-year pilot, which is what Gov. Herbert's plan is. If it doesn't work out after three years, we can opt out of it or do something different. Study after study and poll after poll have shown Utah voters think this is a good idea. It's finally the chance to close this gap.

MULVIHILL: From the provider's side, we think more people getting coverage is better, because otherwise people like us are paying for that care on the backs of other people who have insurance coverage. We thought expanding to 138 percent of the federal poverty level in the Medicaid program was a preferable solution because that's better for the consumer. It puts them into systems of care in Utah that might lead to improvement in both their health and the cost. The exchanges are going to have the problems around the deductibles and so forth that will be problems for some of those patients, and it will promote this episodic care in a sort of disorganized way. We are in favor of expansion of the Medicaid program, but we understand it's a political, economic and healthcare issue.

BATEMAN: The services for that segment of our population are already being paid for somehow. The way that payment is determined is not very rational. Much of it accrues to the coffers of private industry who are paying for commercial insurance that comes through our system. It's a compelling argument to cover these people in that it will help rationalize the market better. Not only is it a good social solution, but it will also help us in the long run to manage costs better than we have in the past.

STEVENSON: When we talk about the coverage gap, sometimes we think they are another people far away and we don't know them. But 60 percent of the folks in the gap are working, sometimes two or three jobs. These are the backbone of the low-income workforce here in Utah, and getting them health insurance means they are going to be healthier, more reliable, and they are going to show up for work. A medical emergency isn't going to remove them from your workforce. We are getting into a tight labor market where every employee is important to keep.

BATEMAN: There's lots of doctors my age that don't want to practice anymore because of the burden that is on their practice from people who are in this position. They are uninsured and therefore the physician provides the services and is reimbursed for it. In the long run, as that instability increases, what does that do to the overall inefficiency and cost of the system which eventually is paid for by the business community? The governor's plan helps rationalize that—it helps make the path from A to B a little more stable.

CAPOZZA: Getting those people into a system of care also reduces chaos on their end, because what we are seeing is the episodic, emergent, fragmented care with this population. When they are surrounded by a system of care, and they can be connected to preventative services and other services out there, we are going to see long-term cost savings.

In the future, will we have enough physicians to care for a growing and aging population? How do these changes interface with how medicine will change as far as specialties?

RUFF: For chronic disease management or population health management, a lot of it doesn't necessarily require the intuitive skills of a physician. Some of the solution for that problem is going to be—and I might get shot by my physician colleagues for saying this—utilizing alternative healthcare providers or ancillary providers to provide a large portion of that primary care. Wal-Mart just announced they were going try to become the largest healthcare provider in the United States. They are going to employ nurse practitioners and mid level PAs. Some shift in that direction is going to happen.

MULVIHILL: We are grateful to the Legislature for helping us expand the medical school class size. The disadvantage that we face now is it hasn't done anything about postgraduate education. When you graduate from medical school, you can't go out and do anything. You have to have a residency.

We have to have a conversation around the correct balance of specialty services and primary care services in the state, and help direct our trainees into those areas of high need. Right now the debt of our medical students is so high when they finish their medical education that they tend to go off into high-paid specialty services rather than primary care. We need to find a way to incentivize young people to go through primary care services. Out of our medical school, they have around \$140,000 of debt. In private schools, it's \$240,000 to \$250,000 in debt. That's a real barrier.

BARLOW: Rural areas are more difficult to find people to staff those communities. They end up being on 24/7, because even if they aren't on, their neighbor comes and knocks on the door and now they are taking care of a patient.

HUTCHINGS: We have had many of our larger employer groups make a decision to hire their own private physician and have them on site with onsite clinics because they believe in the model of primary care and chronic disease management. The physicians love it because now they get to practice medicine. They don't have to deal with billing and ACA. They get to focus on the patients and their families. If you have enough people in one location, it's been a great model. The employees love it because you get attention. You are not seeing a doc for seven minutes. You are seeing them for 30 minutes.

STEVENSON: One way to tackle the problem of not enough primary care physicians is to look at the 40- to 50-year-old physician range and try to keep them engaged. When I do presentations at med schools, I make the pitch for primary care. I say, "Go into primary care. That's where the ACA is focusing. There's a lot more investment in that." Afterward students come up to me and show me their loans and how much they owe. They are like, "Tell me how I can do this."

There are loan forgiveness programs, but Utah does not have a loan forgiveness program to allow people to go into primary care and serve in rural areas. On the East Coast and in the Midwest, it's a common practice. One solution could be for Utah to develop a pilot loan forgiveness program to encourage primary care physicians to do their residencies and then focus in rural areas.

Where do you see population health efforts going in Utah?

KLUGE: We believe in biometric screenings enough that we recently purchased an interest in a biometric screening company. Population health management is one of the most critical things because you want to keep the healthy people healthy. We have found that a majority of people who have a major issue have four co-morbidities. If we can keep healthy people healthy and remove one of those co-morbidities, you will have an impact on hospitalization and an impact on prescription utilization.

RUFF: We started a mobile mammography unit two years ago because Utah traditionally has one of the lowest screening rates in the country for mammography. This thing has been so well accepted. It goes all over the state. It goes on site to the employers, and it makes it much more convenient for women to go out and get their screening mammography on a regular basis. The acceptance of it and the demand for it is out of sight. If we could promote accessibility in other areas of screening or population health management, it would have a large effect. We can do it at the same cost or even lower cost than in the traditional settings.

MULVIHILL: There's a majority of us in the room that are like the majority of Americans. We are walking around healthy and aren't utilizing many healthcare services. The goal is to keep them healthy and get proper screenings to detect things early. Then there's a middle group that have

early expression of chronic diseases, and that group benefits from proper primary care medical management to prevent them from progressing to more serious illness. The real group you want to focus on are the people with multiple chronic conditions. In Utah that's just several hundred kids and several hundred adults that really are the drivers of 50 percent of all the healthcare costs in the state. A real intense focus on that population really does help reduce hospitalization and cost. That's where we think the benefit of population management is going to be: identification of the individuals, getting them into a system, getting them managed. That really goes beyond a primary care doctor in many cases. It needs a team of physicians across a variety of specialties because many times these people have three, four or five chronic medical conditions that require coordination of care.

BARLOW: We employ about 1,600 people, and with their families we insure over 3,000. We have a lab group that we get incentives with and see if that changes healthcare behaviors. Unfortunately, we have learned that carrots for the employee cause an initial improvement, and then it goes back to the norm. We have learned that sticks seem to have a more long-lasting impact.

STEVENSON: We talk about incentives and how we can actually drive people's behaviors. Some people who end up with these chronic conditions are making an irrational decision to end up very sick. If we think everyone is going to respond to rational incentives, it doesn't work out. My wife is a physician. She had a patient come in who wanted to know the correct dose of iodine to give to her schnauzer in case the Fukushima radiation came over to Pennsylvania, where we were living. Meanwhile, she had uncontrolled diabetes that she would do nothing to rein in. Irrationality is a huge player in our system, and we have to respect that, especially for those that have the chronic conditions.

CAPOZZA: Major health behavior changes are extraordinarily hard. A simple one-time incentive is probably not going to work. One of the exciting things about the ACA is it has shifted the focus off the clinical environment into the community where we can start to address these things upstream through different modes of care.