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HOSPITAL REVIEW

Government Intervention: Boon or Burden for Healthcare? CNN's David Gregory and Executives From Banner, Northwestern, Prism Weigh In

By Akanksha Jayanthi and Emily Rapple

The Affordable Care Act is perhaps one of the greatest legacies of the Obama presidency. It turned the healthcare industry on its head — and was marked by many successes, but also its fair share of unresolved issues. As our country gears up for the next president and a new Congress, both governmental and healthcare leaders continue to wrangle with unanswered questions left in its wake.

Are the changes the ACA spawned sustainable? Will the risk pool on the ACA's exchanges diversify? Can consolidation eliminate inefficiencies and drive down costs? What policies still need to change?

David Gregory, former moderator of NBC's Meet the Press and current CNN political analyst, asked those questions of a panel of healthcare executives at the Becker's Hospital Review 7th Annual Meeting in Chicago. The panel was sponsored by national healthcare consulting firm Prism Healthcare Partners and included:

- **Kathy Bollinger,** executive vice president of Banner University Medicine (Tuscon, Ariz.)
- **John Orsini,** senior vice president and CFO of Northwestern Memorial Healthcare (Chicago)
- **Mukesh Gangwal,** president and CEO of Prism Healthcare Partners (Chicago)

Here is how they responded.

Editor's note: Panel discussion has been edited for length and clarity.

David Gregory: I would argue that no matter who is president, Obamacare is here to stay. And the fundamental political calculus is, who wants to get into that morass and try to get that thing either replaced or reformulated? I can imagine them tinkering with it over time, but the thing about entitlements is once you give something to the public, politicians are loathe to take it away. Given that, what is this healthcare environment in which you're operating?

Kathy Bollinger: I would agree with you, it's here to stay. The ACA certainly isn't healthcare reform; it's payment reform, and it's getting us directionally moving down different paths. Very good things are happening as a result of it: More people have insurance, we have different kinds of partnerships, we have our focus on...doing the right thing. Incentives are beginning to be aligned, you're getting paid for value, and outcomes are becoming important. While it's certainly not the be-all and end-all, it has nudged the industry down the path it needs to go.

John Orsini: I think it's here to stay, and I also think it's a good thing. The part that gets lost on Obamacare is the insurance reform. I think [there are] some

really good things in terms of limits that were eliminated and [coverage for] sicknesses that were not covered. The Medicaid expansion has been very good for healthcare and the communities in which those [enrollees] live. I do think the challenge though [is] we're now seeing the end of high-deductible health plans. They've been pushed about as far as they can go. We're now seeing $10,000 to $12,000 deductibles. People may or may not have the ability; they just don't want to pay. We are seeing people shop more for services. It's going to be interesting to see what the next evolution of payment will be for the healthcare system.

DG: For Obamacare to work on a sustained basis, we have to have a more diverse pool of the insured. Are we seeing enough young and healthy people get into insurance market to sustain everybody else?

Mukesh Gangwal: No, David, not really. What we see is the concept in insurance called adverse selection. Adverse selection relates to a population of sick people with chronic diseases buying cheap insurance to take care of their health on an interim basis, and they jump from one insurance company to another. With the removal of pre-existing conditions, with the [limits] of age enhanced to 26 years for dependent coverage, there is a movement in the market where the sicker patients are buying insurance from these exchanges. Then you can see a whole slew of insurance companies...losing hundreds of millions of dollars. The problem really is not insurance. The problem is the cost of providing care.

If you look across developed world, we spend probably two to 2.5 times [on healthcare] compared to England, France and other western European countries. Our child mortality rate is probably the highest [among other wealthy nations]. To address costs through financial risk management, which is what an insurance company does, is not the answer. What we have to do is bring cost of care down, and address the very old, the very sick… in the last three years of their lives, which consumes probably one-third of the cost of healthcare in the U.S. Those are the harder political issues that need to be addressed.

DG: Given the way the government is intervening in the healthcare economy, do we yet fully understand the impact?

KB: We understand enough to get started and look at disparities and redundancies in our care. If half or 60 percent of our business is zero margin, there have to be some dramatic changes. We need to generate a 4 to 5 percent margin, as a nonprofit organization, to continue to reinvest in ourselves. Absolutely we have large cost drivers, but we have to figure out the right and best way to take care of a disease process and do that consistently. That involves very smart people that have trained for a very long time to practice medicine in a way that they're comfortable with becoming more open to standardization and seeing that as a positive thing — not as a constraint on their critical decision making.

DG: One of the big realities in your industry is a lot of mergers and acquisitions, a lot of consolidation. How do you look at that from quality of care perspective as well as economic efficiencies?

MG: Bigger is better. Size matters. But consolidation of inefficient environments doesn't result in better outcomes. If this were the steel industry or auto industry, you would have massive bankruptcies and the elimination of companies that are not cost-effective. How many hospitals declare bankruptcy? Almost none. The reason for that is there's so much excess capacity and inefficiency in an industry that is heavily, heavily regulated. Automating inefficiency doesn't take you anywhere.

DG: Where have some of these merged systems worked well? What are the positive aspects?

MG: Consolidation itself is not an evil word. Consolidation with

a purpose to provide better, more cost-effective care for your community and a channel of good clinical care is critical. New YorkUniversity, Mount Sinai Health System (New York) and Barnabas Health (West Orange, N.J.) have been responsible for much of the consolidation in the Northeastern market. If you look at the statistics, more people are getting care; costs generally haven't gone up. The Federal Trade Commission hasn't stepped in trying to stop those mergers. I think the evil of consolidation is when only size matters, when you are just trying to get bigger and bigger without doing it efficiently and without a clear strategy. What that results in is, ultimately, you have to pay the piper.

JO: What we say at Northwestern [is] bigger is not better, better is better. Every hospital does something better than somebody else. It's your job as a manager to figure out what they do well and harness that and transplant [those skills] to hospitals that can learn.

DG: If we see in the next Congress and the new president a desire to take the question of healthcare up again, where would you like them to start? What modifications do you think would be helpful?

MG: I would say three things would help. First, having a healthcare system that doesn't have a political axe over it. Fifty percent of the dollars in healthcare come from Washington and from states. [Everything has] political residue behind it, and part of the problem with Obamacare is the polarization. No matter what one party would choose, the other party would shoot it down.

The second part is putting some cost [mechanisms] in place. It's completely hearsay for me to talk like that in the United States, but we have to have ceilings on drug costs. We have to have ceilings on exotic care that accounts for 2 percent of disease, but consumes 18 to 19 percent of costs. There have to be some cost ceilings — not across the board, but in certain strategic areas.

Third is the reimbursement mechanism, which is a person's right to get good clinical care and the person's ability to pay for that clinical care; there is complete misalignment. I [should be able to] walk into Northwestern or Banner Health with not a single penny in my pocket and demand the same care as a millionaire. We need some sort of mechanism where there's alignment between a person's need and right to clinical care and state and federal government's responsibility to pay for it. That synchronization and convergence has to happen for long-term survival and viability of the system.

JO: I would love to see the government take on advanced directives and end-of-life [care]. If you want to have insurance, you have to [facilitate palliative care], period. The area where we struggle in healthcare is having difficult conversations with patients.

And then there's the whole Medicare payment aspect. They use the payment mechanism to drive policy. Just simplify it. Just pay us 'X,' put us on the hook. This whole observation thing is a Rube Goldberg contraption. If they could simplify that, it would take some real cost out of the system.

KB: A lot of the cost of healthcare doesn't contribute any benefit at all to patients, and a lot of regulation around billing is part of that. The government could absolutely create a different schema that would do perhaps what John is suggesting, or just reduce a lot of the red tape. Dollars could go right to the bottom line of taking care of patients.

The second point is, at end of the day, most patients want everything that is possibly available when it comes to managing our own health. As we get more involved in preventive medicine and early screenings, we identify more conditions that may or may not have any impact on an individual's health but do send us down a path of biopsy, testing and incurring healthcare expenses. We have to reconcile consumer expectations and rational thinking.■