

HEALTHCARE ROUNDTABLE

The Experts Discuss the Current Healthcare Landscape



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As the various sectors within the health care industry continue to evolve and adjust as a result of health care reform, many questions remain regarding the state of the industry and how our businesses and local population are affected. To help answer some of those questions, the Los Angeles Business Journal turned to a diverse group of experts with various perspectives, including some of the most knowledgeable and active participants in the regional equation.

Here is a series of questions the Business Journal posed to these health care stewards of the region and the unique responses they provided – offering a glimpse into where health care stands today – from the perspectives of those in the trenches delivering and facilitating health services for the people of the Los Angeles area.

HEALTH CARE ROUNDTABLE

'In a self-insured health plan, the employer sponsor pays for employee health claims as they arise, rather than paying for premium costs to a health insurance plan. Implementing this option can provide better opportunities for the employer to tailor the plan to meet the specific healthcare needs of its employees, instead of choosing from available health insurance plan options. This sort of plan is typically governed by federal ERISA law, rather than several layers of (sometimes conflicting) federal and state laws and regulations, which may potentially reduce regulatory compliance burdens.'

PAUL GOMEZ



'The insurance marketplace continues evolving to respond to rising healthcare costs. Limited physician panels, referred to as narrow networks, have gained more traction as insurers look to provider networks that will deliver greater value. The market is also trending toward high deductible PPO products, as employers look to offer lower upfront costs to employees. These products however, shift a greater portion of cost to employees when medical services are actually utilized. On the insurer side, there continues to be a focus for greater cost predictability.'

VINCENT JENSEN



◆ What are the latest trends taking place in the health insurance marketplace this year?

SIMPSON: We are seeing competitive pricing and add-ons in the large group segment that is catching the attention of HR, CFOs and CEOs. Trend increases are 10-13%, yet carriers interested in retaining business with lower claims experience are offering competitive no-bid strategies, lowering cost to 4-5%. Employers are continuing to seek out benefit enrollment systems that sync with payroll and carriers in efficient, cost-effective ways. Carriers have reduced staff in large group, shifting employees to small group, now up to 100 employees, demanding more from brokers as the 50-100 segment moves into small group, age-rated plans with less carrier service. Benefit brokers are either winning or losing in this push for better systems and service. Our service staff doubled last year, inputting clients' benefits into these technologies, with census enrollments converting to carrier templates, ERISA wraps, ACA reporting and COBRA/TPA services. ACA has brought on tremendous legal compliance and changes.

JENSEN: The insurance marketplace continues evolving to respond to rising healthcare costs. Limited physician panels, referred to as narrow networks, have gained more traction as insurers look to provider networks that will deliver greater value. The market is also trending toward high deductible PPO products, as employers look to offer lower upfront costs to employees. These products however, shift a greater portion of cost to employees when medical services are actually utilized. On the insurer side, there continues to be a focus for greater cost predictability. Capitation (pre-payments to care for a population), bundled payments, and other value-based models are re-emerging as insurers look to align the economic risks and benefits with providers of care. Finally, we see both private and government payers moving toward pay-for-value models. These come in the form of shared savings models or through reimbursement structures that are dependent on achieving quality metrics. The common theme to all of these trends is the market looking to providers for greater accountability in quality and cost.

◆ How do things stand at present with Covered California in terms of impacting business?

JENSEN: We continue to see large insurers make strategic decisions about whether they will or will not offer Covered California products. Some who initially offered ACA products are now reconsidering. City of Hope's focus as a provider is on the opportunity to care for a broader population in need of complex oncology services. We see our efforts to serve members in Covered California as an important part of our mission. As I speak to other healthcare leaders, I continue to see greater adoption of ACA products, despite varying levels of participation at the health plan level.

◆ What about providers? How has Covered California impacted them thus far?

JENSEN: A discussion of healthcare reform prompts differing views from providers around the state. Covered California has generated a necessary focus on prevention and population management for providers who see the ACA as a step toward expanding coverage for important care. Beyond primary care networks, specialties are

also expanding services although the key issue here will be appropriately valuing complex specialty and sub-specialty services under the ACA. There are clearly providers in all specialties throughout the state who have been watching to see how the ACA unfolds before participating. I think history will show however, that delaying the inevitable move to a more value based system will be challenging for those who accept the change too late. City of Hope physicians, for example, are eager to care for Covered California patients and they are actively engaged in discussions around oncology care models and other ways to innovate around oncology.

◆ At this stage in the game, what do hospitals and physicians need to do to offset the fact that reimbursements have been reduced?

KHOURI: We are certainly seeing revenue pressure and it is not going away any time soon. Managing costs is a natural first step and making sure that quality is not harmed is a key balancing measure. Payors are increasingly orienting to pay for quality and pay for value. Pursuing these types of arrangements and seeking to do so in the same way with as many payors as possible may offset or slow some of the revenue pressure we are seeing.

JENSEN: With more patients in need of care, hospitals and health systems will want to be strategic in managing capacity without adding costly infrastructure. This concept is creating market consolidation by way of acquisitions and partnerships at a level we have not seen before. Health systems are asking the important question of whether to build new programs or partner with already existing expertise and capabilities. Within oncology, City of Hope is bringing scientific and clinical programs to its partners that are cost prohibitive or impractical for them to build themselves. On the physician side of the industry, we will continue to see a trend toward large group practices and health system alignments. The concept here is to develop efficiency through shared resources and economies of scale.

◆ In your view, have the "end users" – the patients – benefited from the ACA?

SIMPSON: This is a twofold question that is evolving as expected. Those in industries with higher paid positions are cost sharing more for plans with higher co-pays, deductibles and reduced networks. Those in manufacturing or service industries earning less income are now forced to pay for benefits, unless they qualify for Medi-Cal, which offers benefits to low income individuals, families, seniors, those with disabilities and others with incomes below the 138% of federal poverty level. Covered California offers subsidies to those not offered insurance at work, working from home or not working. The co-pays, deductibles and out-of-pocket maxes are higher for all of us, increasing annually. The cost is not lower for those on employer plans sharing in premium and paying for families. The quality of care is harder on providers with more members obtaining care; however, if more are receiving preventive care in the long run this will pay off.

JENSEN: It's hard to discuss healthcare reform without hearing a multitude of opinions on what could be improved. Having said this, increased access to care has been a pillar of the ACA and for that, patients have benefited. In addition, I see benefit from

the national debate on healthcare and healthcare costs. It has refocused the industry on the need to see patients and employers as important consumers who desire both components of value – quality at a reasonable cost.

◆ What are the pros and cons companies should consider in contemplating going self-insured for their medical/benefits?

GOMEZ: In a self-insured health plan, the employer sponsor pays for employee health claims as they arise, rather than paying for premium costs to a health insurance plan. Implementing this option can provide better opportunities for the employer to tailor the plan to meet the specific healthcare needs of its employees, instead of choosing from available health insurance plan options. This sort of plan is typically governed by federal ERISA law, rather than several layers of (sometimes conflicting) federal and state laws and regulations, which may potentially reduce regulatory compliance burdens. The option generally permits employers to control health plan reserves, enhancing interest income from same. Moreover, the plan may not involve prepayment for coverage and services, which can improve cash on hand and cash flow, and is generally exempt from any applicable state health insurance premium taxes. Self-insurance is not necessarily an option for all employers. For instance, one must have sufficient financial resources to handle what are often substantial healthcare expenditures. Larger employers and those with better cash flow tend to be better able to bear such a financial burden. Employers that implement this option typically obtain appropriate stop loss insurance coverage, which limits, but does not eliminate, potential employer liability. Additionally, the employer should assess whether it can handle the administrative burdens that accompany this option. Many employers contract with a third party administrator (TPA), which is often a health insurance company, to handle these burdens. Such burdens may include, claims processing, claims determinations, payments, appeals, preparation of forms to administer the program, customer service and other services.

SIMPSON: For larger national companies with many more employees in other states than California, self-insurance can pay off and may be recommended. In California, with the HMO market, the self-insured PPO is still a risk that can increase costs. Until we as a nation can get a handle on the increasing prescription costs and lack of caring for our own health, the risk is still unknown. HMOs pay out capitation if a member goes to the doctor or not, helping to reduce costs, offering plans with fixed costs to the members. PPO out-of-network costs are increasing for members as carriers are reducing benefits and placing limits per day on hospital care, increasing deductibles and co-insurance. We are personally not seeing the self-insured model work well for California-based businesses with high penetration in HMOs. Partially self-insured models or level funded plans can possibly assist with costs if companies have a large population of employees out of state. We are just seeing more HSA plans and HRA plans being used for the highly compensated employees who want a PPO with tax savings and freedom of choice.

◆ What strategies can self-insured employers implement to effectively manage their healthcare spend?

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'We have seen through our patients that employers are using health plan benefits design to bring to attention the cost of care. Through increased deductibles and co-insurance, many commercial plans have increased the price sensitivity of patients – leading them to ask questions about price and make decisions that consider their financial liability. We need to support consumers in navigating the complexity of our healthcare system. Inevitably, patients are dealing with such issues when they are being challenged by a health problem. Without assistance from both providers and payors, they will be lost.'

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'We are seeing the C-Level getting more involved in renewals, which is extremely helpful when these executives understand the fine balance between offering best plans and cost-savings. A dynamic Human Resources team and carriers need dedicated partners that are willing to truly understand the needs for their benefit programs, technology, workload and employee education. Brokers that understand their clients' needs are much better at marketing the group to the marketplace, sharing the wellness promoted all year and strategies the company is using to reduce costs through education.'

DANONE SIMPSON

Continued from page 30

GOMEZ: Many employers have expressed dissatisfaction and frustration with costs of healthcare continually rising, as well as the healthcare quality and results obtained for their employees. Similarly, they sometimes express frustration with a perceived lack of transparency and information from health insurance companies and their ability to help facilitate quality care and to contain costs. As a result of the above, an increasing number of employers with self-funded health plans are considering or participating in alternatives to traditional procurement of healthcare benefit products and options, including direct contracting with healthcare providers. These arrangements are sometimes referred to as "direct to employer ACOs" or some other similar label. Such arrangements set forth the range of services to be covered, and require certain quality metrics and standards to be met by the participating healthcare providers. The participating employer and health system may agree to share in any savings achieved to the extent that actual healthcare costs for the employer are less than the agreed upon target spend amount, or also share in any net deficits to the extent that actual healthcare spend for the employer exceeds an agreed upon target spend amount for a given period of time. In addition to potentially better and more convenient care, employee premiums are often less than those of other options that are available, as are cost-sharing obligations, provided that the employee or his or her dependent family members (if they are as enrolled as well) receive care from a provider that is within the defined network. Employers who have pursued certain variations of this option with hospitals and health systems across the country include, without limitation, The Boeing Company, Oracle, Intel, Walmart, United Airlines, Lowe's and others. It is expected that these kinds arrangements will continue to proliferate in the years ahead.

JENSEN: It's critical for self-insured employers to understand where their health spending is occurring. With this data, self-insured employers have powerful tools to help curb healthcare inflation, including the way their benefits are designed around network inclusion, employee cost sharing and how specialty or complex care will be provided. Centers of excellence in pediatrics, orthopedics, oncology, etc., often demonstrate value in specialized services by delivering a healthcare product of remarkable quality with fewer complications. This reduces the overall cost of care. It is important therefore, that self-insured employers see highly specialized centers as an integral part of their network design. At City of Hope, we are working with mid to large sized employers to develop innovative partnerships in oncology. Our network of 13 community cancer centers along with our main campus, allow us the unique opportunity to serve employers with employees distributed throughout the broader Los Angeles region.

◆ **Every large multifaceted organization carries with it a multitude of demands and shifting priorities; how do you define what is most important to your organization?**

KHOURI: We make sure that we are focused on the fundamentals – providing the highest quality patient & family-centered care as cost-effectively as possible. At the same time, we are tracking on where the market is – and as importantly, where it is going. By prioritizing among our strategic initiatives, we are seeking a balance of operational performance and strategic performance.

JENSEN: Remarkable organizations have the unique ability to remain focused on their highest priorities even when the landscape around them changes rapidly. Mission driven organizations do this well. At City of Hope, our commitment for speed to a cure in cancer, diabetes, and other life-threatening diseases focuses us on the development of novel advances to fundamentally change the way the world treats these conditions. We have a remarkable responsibility not only to the patients and families we serve, but patients around the world who look to science and research for answers. Indeed there are many distractions in today's healthcare environment, but as an industry our compass must point to the mission to heal even when the weight of change is significant.

◆ **With the rise of telemedicine and electronic health records – how does technology affect the way your business innovates to meet the needs of patients?**

JENSEN: An electronic health record (EHR) assists physicians in making better decisions and delivering care more safely. It's often hard for a patient to see how this is true, but electronic systems check for medication interactions, provide physicians with important alerts, and update doctors with immediate health information regardless of where he/she might be when a patient is in crisis. Importantly, today's EHR systems are also used for quality reporting which is now essential as pay-for-value models are implemented. Telemedicine is becoming a reliable tool to connect a patient to their physician but we are also seeing a trend for telemedicine to play a role in physician-to-physician interactions particularly for sub-specialty care. City of Hope is looking at ways for specialists to utilize telemedicine to provide real time management of complex cancers when other physicians need us. This will allow us to expand our reach and improve access to complex care.

◆ **Should large physician groups create their own managed care entities?**

KHOURI: This can be attractive to physicians in the short run, but there are risks. Fragmenting the payment system can fragment the care model. Going forward, patients and families along with payors and employers will likely benefit from delivery systems integrating (through partnership and otherwise) managing the cost and quality of care.

◆ **Might concierge medicine be an alternative for physicians who wish to avoid today's market pressures and reduced reimbursement?**

GOMEZ: It may be a viable alternative for some physicians. Generally, concierge medicine involves patients paying physicians directly for a broad array of medical care and enhanced access to their respective physician. Direct primary care is based on the concierge medicine model, but typically focusing more on primary care, lab tests and follow-up visits. Both variations of the model are designed to offer patients more convenience, faster access and generally more time with his or her physician. Although there are variations on the model, concierge medicine generally involves patients paying an agreed upon amount

per month, per quarter or per year directly to physicians in return for often unlimited numbers of appointments, certain amounts of lab tests, certain medications, and follow up visits. This may also involve access to the physician via email, phone, or in person at the patient's home. Among other reasons, some physicians have found this model attractive because the direct to patient payment model has freed them from burdensome insurance-related documentation and paperwork, permitting more time for greater interaction with each patient. This may, in turn, have a substantial, positive impact on the level and quality of care provided, adding obvious benefit to the patient and potentially enhancing career satisfaction for the physician. Physicians and other providers who are considering or who are already active in provision of care through this model must take care not to run afoul of various legal requirements and prohibitions. For example, it is often not clear whether the provision of medical services by physicians based upon a monthly, quarterly or annual fee may constitute the business of insurance, potentially requiring approvals and appropriate licensure from state insurance or managed care regulatory agencies. Appropriate legal counsel should be consulted in structuring such arrangements.

◆ **Can non-physician providers help reduce costs and fill the gap with the insufficient number of primary care physicians?**

JENSEN: New team-based care models often include non-physician providers. These teams frequently have defined structures that include physician leads, nurses, physician extenders such as nurse practitioners or physician assistants, and ancillary clinical staff. In many models patients are assigned to teams based on the skills of the team itself. It may be that one team manages complex and chronic care while another manages well visits. This specialization enhances the experience for the patient. In oncology, City of Hope is advancing new team-based approaches to understand which are most preferred by our patients. We also find that dedicated nurse navigators can be very helpful in guiding patients and families through treatment and healing.

KHOURI: We are certainly seeing a shift to team based care, which means expanded roles for all members of the team, which includes the patient and family. With limited resources and much patient care demand, we have to push everyone to operate at the top of their license and skill sets. This inevitably means that work done by physicians that can be done more cost-effectively (and potentially better) by non-physicians.

◆ **What role do business owners play in improving the health and productivity of their employees?**

SIMPSON: Employee appreciation blended in with health-fairs with purpose, wellness and safety at work themed programs and communications cause more employer appreciation and loyalty, which cuts turnover. When employees feel valued they perform at a higher level and if they are not performing well they naturally get weeded out. Turnover is expensive. However, keeping employees that don't fit your culture is equally costly. When employees commit to the mission of the company, they take ownership over their desks or jobs. When employees are satisfied they want to

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'Healthcare is a competitive industry. Whether provider, payor, or start-up, we often find ourselves competing with others to grow and expand. Just like other industries, we study our competition and try to differentiate ourselves through quality, experience, and cost-effectiveness. Healthcare is very local and on the provider side can be very capital intensive. This is why we often find ourselves challenged in expanding to really large geographies through organic growth, making M&A and affiliation a common practice in our field.'

LARA M. KHOURI



Continued from page 32

commit to company objectives. Employees that are not in sync with the team or work group can upset culture and it takes work to get everyone on track. Human Resources needs support from the C-Level when they are working to inspire programs that promote being active at work, mission education, supervisor/team training, safety, health and wellness.

JENSEN: Wellness programs focused on diet, exercise and work-life balance are trending for employers. These programs not only focus on wellness, but they are often a great way for employees to socialize and collaborate outside of their traditional workspace. Health memberships, yoga classes, ergonomic assessments and nutrition education can be good ways for employers to encourage healthy behaviors demonstrating they care about employee wellness. From a Cancer Center perspective, I would like to see a greater focus nationwide on smoking cessation and nutrition. We know the strong link between smoking and lung cancer. We also now know there are scientific links between body mass index, diabetes and cancer.

GOMEZ: Employers have potential to play an important and effective role in the health and productivity of their employees. In addition to provision of health benefit plans, one of the primary ways that employers can do this is to implement an effective and targeted wellness program. It appears that the more successful wellness programs target a more broad range of key components that make up employees' respective activities and lifestyles. These components include, but are not limited to healthy eating, stress management, financial management, appropriate work environment, fitness club access, smoking cessation or other health-related programs. An effective wellness program can be instrumental in achieving significant benefits for both employers and their respective employees, including reduced medical costs and sick days, reduction in workers' compensation and disability management claims, increases in employee productivity and retention, reduction in employee stress, attainment of healthier lifestyles and greater overall employee satisfaction. Notwithstanding the potential benefits for both employer and employee alike noted above, employers should be mindful of legal requirements and parameters in establishing and operating such programs. Standards, limits and requirements of sometimes conflicting types from a variety of sources, including the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act, HIPAA and the Affordable Care Act, can turn a well-meaning program or participation incentive requirement into a mine field of potential litigation and liability. As a result, employers should consult with appropriate legal counsel in structuring their respective wellness programs to help ensure maximum benefit for both themselves and their respective employees.

◆ What other tactics are employers using to reduce their healthcare expenses?

GOMEZ: Some employers are instituting on-site health clinics. These clinics may range from very basic care services that can largely be provided by nurses and other allied health professionals, to primary care clinics to urgent care clinics. Greater access to and convenience of care from familiar, quality providers can help facilitate earlier and potentially better care to employees, which

in turn may lead to less sick time, less acute care and a happier, more productive workforce. It can also translate to cost-savings for the employer and employees alike. Some employers, and smaller employers in particular, have considered moving away from group health plan options and toward encouraging their employees to obtain individual health plans on the insurance exchanges formed pursuant to the Affordable Care Act. These health plans may be less costly on average to the employee that what his or her previous share of the group plan cost had been in some cases. Moreover, it is possible that even if the employer gives employees a raise or otherwise helps employees to defray part of the costs for healthcare insurance purchased on the exchange that the additional money spent may result in lower out of pocket costs for the employer as compared with what the employer's share of the cost had been under the previous group plan. Employers and employees should continue to monitor the stability of health insurance exchanges in considering this option. Employers are investing in wellness program and other preventative health-related services to contain costs and help keep employees generally healthier. As also discussed, more employers are considering direct to healthcare provider contract arrangements to better manage the health of their employee population. Many other approaches are available, so employers should consult with appropriate and qualified counsel and other advisors in determining what tactics and approaches may make the most sense for them and their employees.

KHOURI: We have seen through our patients that employers are using health plan benefits design to bring to attention the cost of care. Through increased deductibles and co-insurance, many commercial plans have increased the price sensitivity of patients – leading them to ask questions about price and make decisions that consider their financial liability. We need to support consumers in navigating the complexity of our healthcare system. Inevitably, patients are dealing with such issues when they are being challenged by a health problem. Without assistance from both providers and payors, they will be lost.

JENSEN: For those employers who have successfully implemented prevention and wellness programs, they are now engaging in ways to access good primary and secondary care by directing beneficiaries to integrated systems, retail centers and employer-based clinics. City of Hope is working with employers to expand the focus to specialty care. While cancer impacts a minority of the workforce, getting to the right care can have a significant impact on treatment outcomes and lost productivity.

SIMPSON: We are seeing the C-Level getting more involved in renewals, which is extremely helpful when these executives understand the fine balance between offering best plans and cost-savings. A dynamic Human Resources team and carriers need dedicated partners that are willing to truly understand the needs for their benefit programs, technology, workload and employee education. Brokers that understand their clients' needs are much better at marketing the group to the marketplace, sharing the wellness promoted all year and strategies the company is using to reduce costs through education. The 50-100 groups are upset with the changes going into small group. The age-banded rates are difficult to manage for more employees and usually the cost is higher. These rates are non-negotiable. Saving costs comes from sharing costs and finding partners that offer best in class service programs at no extra charge is essential.

◆ How will transparency and the disclosure of costs and quality ratings affect the health care industry?

SIMPSON: With the HMO marketplace and fixed co-pays this is not yet having an impact in California, because it is harder for an HMO member to shop price. They are in an IPA group and can change doctors, but a change of doctors will not impact their costs. PPO members usually prefer their own doctors and are unwilling to change doctors. However, we are very interested in watching how Accountable Care Organizations (ACOs) are evolving. We have quoted a few for employers near Cedars and UCLA with a high PPO population finding them attractive. Providers are sharing in the profits of some of these ACO models and they are highly motivated to offer the best care, and to reduce costs and waste. Going to a doctor in an ACO will prove to provide you with the best care, allowing time to truly manage your wellness and health. These plans are priced a bit lower than a PPO plan, yet higher than HMO plans.

KHOURI: Such a transition will matter most when payors and patients start to pay attention and use these data to inform their decisions. We have seen this occur in pockets across the country. Coupled with increased financial responsibility for consumers, it will be powerful. The real challenge lies in assuring that the information is accurate and reflective of true cost and quality. Getting risk adjustment for clinical outcomes right is a great example. Unless the complexity of patients cared for is accounted for in quality measures, many will challenge their credibility – and they should. But we need to move this way and measurement science should be able to get us there. With this type of information, our healthcare system will be able to demonstrate the real value provided through the care we provide.

◆ What types of issues do businesses in the healthcare sector experience that are similar to or different from those of other businesses when it comes to managing growth or expanding into new markets?

KHOURI: Healthcare is a competitive industry. Whether provider, payor, or start-up, we often find ourselves competing with others to grow and expand. Just like other industries, we study our competition and try to differentiate ourselves through quality, experience, and cost-effectiveness. Healthcare is very local and on the provider side can be very capital intensive. This is why we often find ourselves challenged in expanding to really large geographies through organic growth, making M&A and affiliation a common practice in our field. We are also very heavily regulated across many domains, so growth can be constrained by state law, insurance regulations, and professional services regulations. While not unique to healthcare it can be a real barrier to expansion, especially across state lines.

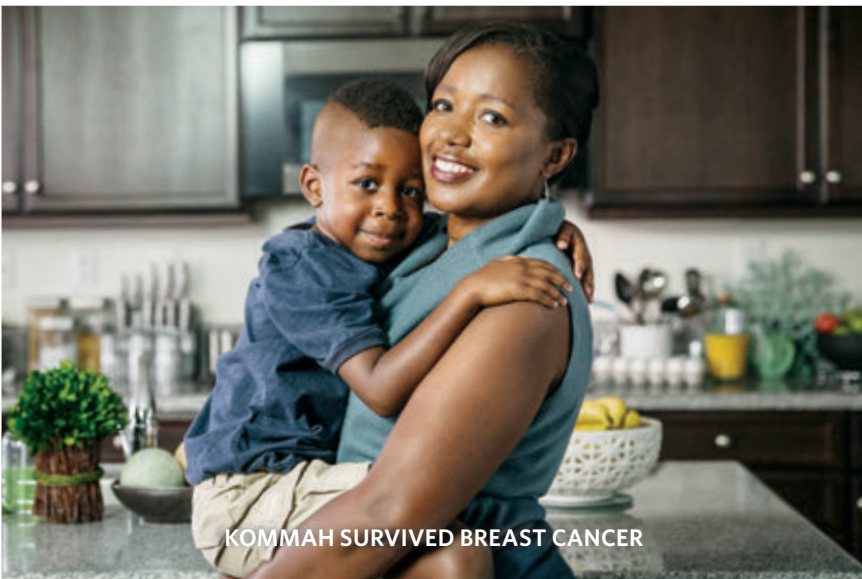
◆ What issues do businesses establishing urgent care centers and other non-institutional facilities face in California?

GOMEZ: Many healthcare providers, healthcare payors, private equity investors and patients are increasingly interested in effective and cost-efficient alternatives to expensive, and sometimes unnecessary trips to the emergency room. Urgent care clinics are

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Continued from page 30

sometimes pursued as a means to help avoid unnecessary emergency room visits. Moreover, urgent care clinics often provide the convenience of extended hours and walk-in service. As a result, they can serve as a welcome alternative to receiving services in one’s primary care physician office, which may involve significant lead-time to get an appointment and longer wait times in the physician waiting room. Moreover, a sound urgent care strategy can provide additional points of access to healthcare and a related health system or other provider, thereby not only improving the convenience of the care but also building the brand of the related healthcare provider at the same time. Notwithstanding the above, certain legal barriers and requirements must be borne in mind. For example, due to California’s prohibition on the corporate practice of medicine, private equity investors, non-medical professionals and lay corporations cannot legally employ physicians to provide the care needed in urgent care clinics. As a result, hospitals and health systems and private equity investors generally must enter into tailored professional services and management contracts for the services necessary to operate the center. Care must be taken in structuring such agreements so that they do not give inappropriate control over clinical decision making to a non-professional or lay corporation. Compensation provisions must also be structured appropriately to avoid violations of Federal and California state fraud and abuse statutes.

◆ **What expertise has your organization sought out (outside of your company) that has helped you make notable strides in growth/expansion? Do you continue to have outside professionals that you consider to be key members of your “team” that provide you with useful guidance/counsel?**

KHOURI: We do. This is a fast-changing market, so we seek to have a mix of in-house resources that identify and chase opportunities for growth along with outside counsel that brings a different perspective. We appreciate that an outside view offers substantial value and we look to supplement our in-house expertise with very specialized consultation that can integrate well with our day-to-day growth planning.

◆ **Any tips for entrepreneurs who have recently started their own small businesses? What’s the best place to start in terms of ramping up health insurance?**

GOMEZ: There are a number of different approaches that the parties may pursue. One such approach involves formation and expansion of accountable care organizations (ACOs), which have proliferated in recent years. ACOs are, broadly speaking, arrangements that provide a mechanism for a range of healthcare providers to coordinate care for defined patient populations across a continuum of care. They involve both government payors and commercial payors. Typically, the parties and the applicable healthcare payor agree upon quality metrics, patient satisfaction and cost targets. Providers can receive greater compensation for achievement of the agreed upon metrics, often agree to share in a certain portion of any achieved savings for the payor, and increasingly, are also sharing in responsibility for any deficits if healthcare costs for a defined patient population

exceed a predetermined target cost level. Centers of Excellence are another model that continues to gain in popularity. In general, a “Center of Excellence” (COE) is an affiliation between a renowned hospital or health system (may be national or regional) that is particularly well known for a very high quality of care for a certain patient service line or service lines and a local hospital or health system partner. The COE partner who has the “brand name” for the patient service lines at issue is usually seeking to improve the quality of care in more local communities, expand the reach of its care network, enhance its brand and reputation for such services, or take an initial step toward a possible, greater affiliation or acquisition down the road. By the same token, the local hospital or health system partner typically hopes that a successful COE affiliation will help it to achieve improvements in performance and patient care by using nationally recognized protocols of a renowned service line leader, improve physician recruitment, and benefit from co-branding of the patient care service line with the COE partner, among other things. In California, non-professional corporations, including most hospitals, cannot employ physicians and certain other healthcare providers, with only limited exceptions. Due in part to these kinds of restrictions, nonprofit medical foundation clinic structures have emerged and proliferated to varying degrees over the last several decades, and markedly over the last ten years. Nonprofit, license-exempt medical foundation clinics contract with a core medical group or groups that meet certain statutory requirements. The contracted medical group or groups are primarily responsible for provision of professional medical care, compensated according to the terms of that agreement and usually have a significant role governing the medical foundation clinics and helping to determine appropriate quality metrics, patient care initiatives and strategic direction of the medical foundation clinic, among other things. The medical foundation clinic typically has primary responsibility to entering into payor contracts for the medical foundation clinic services, provides all space, equipment and non-professional personnel (may also include some non-physician clinical personnel) administrative support, and all other business aspects and costs of operating the clinic business. Medical foundation clinics are widely considered by many in the California healthcare sector to offer close alignment of clinical and financial incentives between health systems and physicians.

SIMPSON: What’s the best place to start in terms of ramping up health insurance? Begin as soon as you can in offering benefits, if even covering 50% of the plan, because when you grow past fifty employees and have not offered benefits, the sticker price will shock owners of startups, sending them to the drawing board to find where else to reduce costs in order to cover these new costs. Covered California is not causing any waves yet in this segment that we have seen due to narrow networks causing new employer groups to lack interest. Find a good broker early on that will take care of you and offer you a great HR package. Sites like www.Simpolicy.com have online options for medical insurance, workers’ compensation and package policies for new employers wanting to get quotes for insurance products. There are still plenty of small group brokers around to assist small businesses.

◆ **We’re seeing more consolidations and more alignments among providers. Does this mean consumers will have fewer choices moving forward?**

JENSEN: It is possible and perhaps likely that we will see fewer choices as health systems consolidate. For this reason, we must focus on transparency and establishing metrics that matter to us as patients. Consumers, employers and individuals must make their needs known to the providers and payers in order to ensure that they are met across the continuum. One provider network or health system might make sense for one family when healthy, but another may be more appropriate as circumstances change. Our system should allow us to make these choices and changes freely. Absent competition and consumerism, we run the risk that the needs of the patient become secondary.

KHOURI: This is a real risk in our quickly consolidating market. We have ways to go until options are as limited as some other major metropolitan areas. And not all consolidation and alignment is bad – we certainly see partnerships in our market that are leading to improved quality, improved access, and services in areas that might not otherwise be financially sustainable for providers. It’s worth noting that in addition to provider consolidation, payor consolidation is presenting challenges to choice for consumers – and is a big influence on provider consolidation at the same time.

◆ **What can be done to ensure quality, transparency in pricing and a reduction in the cost of health care to help consumers?**

SIMPSON: More providers are in accountable care models rated on quality of care and earning profits for higher ratings. Pricing for services is becoming easier for people to find. Providers in PPO networks are still paid out based on their fees-for-service in their service areas and the millions of contracts offer different pricing models making it difficult to understand and manage. HMOs prevail in California more than anywhere in the country, helping reduce costs overall, yet the member cannot negotiate costs. IPA groups are growing larger and larger, negotiating more money to manage care. Carriers are offering reduced networks that are now larger than the full networks; however, as they grow larger, capitation costs increase. Higher co-pays are forcing consumers to ask about costs; negotiating for better pricing by user buyers works in most industries, so time will tell the impact of changing PPO doctors for a better priced surgery down the street.

◆ **Why does health care pricing vary so widely? How can consumers ensure the best value?**

KHOURI: Health services contracting and pricing is a complicated proposition with little transparency. As consumers take more responsibility for their healthcare costs, they are becoming savvier and seeking out resources that explain the quality and cost of services. Users should be careful, as there are many unreliable sources of information. At Children’s Hospital Los Angeles, we work with patients and families to help them understand the potential cost of services that we provide. Our doctors and nurses also share educational information and quality information – as its available – to help inform care decisions. Partnering with trusted physicians and hospitals is a good place to start since the availability of reliable information is still quite limited.

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HEALTH CARE ROUNDTABLE

Continued from page 36

◆ **What can we, as business owners, do to mitigate the rising costs of healthcare?**

SIMPSON: Continue to create a culture of health and safety. These are some of the areas of extreme focus we have continued to expand. We have seen the impact of wellness and so have the carriers. We have reviewed experience factors proving employee education is moving employees toward seeking out preventive care, which controls costs favorably. Prescription costs increased 12.6% in 2014 and are expected to increase 7.3% per year according to government officials, largely due to higher-priced specialty drugs. Carrier management is messaging that these costs are increasing by billions of dollars. Education on RX coverage is not only key, it pays off. I am amazed with every new group of employees how little Americans know about what they are so quick to take as prescribed without asking questions. Consumers cannot continue being highly influenced by advertising. Higher co-pays are demanding better questions from consumers, yet are becoming unaffordable for all.

◆ **Looking to the future, what do you think the health care landscape will look like, say, five years from now?**

JENSEN: The healthcare industry is beginning to see itself as a large and more integrated network. Technology is bringing us together through systems that more seamlessly allow patients to move from one doctor to another or one hospital to another without barriers. This allows us to think differently about how care is best delivered and by whom. The future of healthcare will be through partnerships where each partner brings unique expertise through specialization. Local hospitals for example, will partner with Centers of Excellence in oncology, orthopedics, pediatrics and a variety of other specialties for care in the local community. Local sites will be complimented by highly specialized academic campuses for the most complex chronic

conditions. This structure allows the health system to deliver both standard and highly complex care through one integrated network of partners.

SIMPSON: If we as a people continue in the patterns we are expected to by healthcare professionals, the healthcare of the United States will implode. We are getting unhealthier in many (if not most) states, with diabetes growing rapidly, expected to further impact our children's children. The statistics are frightening – how growing healthcare costs are outpacing the ability for our employers, our government or ourselves to afford. We as a nation, a state, a community, a parent, and each person... have to change our ways. I prefer to look out ten years, because I don't predict a lot of change in our health care landscape in the next five years, except that boomers will need more senior care. The ACA has already caused us much change to deal with. Allowing everyone healthcare is an amazing thing; it is just expensive because we are an unhealthy nation in comparison with other nations. With more pharmaceuticals promising to rid our every ailment, yet not yet abolishing cancer, we have a way to go. However, a commitment to the whole rather than the part is the only way we as Americans are going to pull through our health care needs. We all need to commit to healthier lifestyles.

GOMEZ: Yogi Berra once said that it is tough to make predictions, especially about the future, but here are a few nevertheless! First, we will likely see a healthcare landscape that has become even more immersed in value-based payment models and population health management initiatives than we have now. The U.S. Department of Health and Human Services (DHHS) set a goal of tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models by the end of 2016 (and recently announced that they are ahead of schedule) and 50 percent by the end of 2018. DHHS also set a goal of tying 85 percent of all remaining Medicare traditional payments to quality or value by 2016 and 90 percent by 2018. Second, more healthcare will be likely be provided in outpatient settings, lower

acute care settings, through home health care and in the form of non-medical home care (e.g., assistance with activities of daily living). As the predominant model of healthcare payment shifts to one that is value-based, care in more acute and expensive care settings will increasingly be viewed more as costs centers as opposed to drivers of revenue. Acute and inpatient care will always be essential and needed, but new payment models are further incentivizing many healthcare providers to re-examine whether certain services can be provided just as effectively, or perhaps even more so, in less acute and outpatient settings than in a hospital. Third, there will likely be fewer and larger health-care systems and hospitals five years from now. Like waves of consolidation that occurred in various industries over the last twenty years in the airline, retail, banking and other financial institutions and sectors, more consolidation and affiliations will probably continue among all ranges of healthcare providers. Fourth, like other services and sectors, consumerism generally will continue to drive development and delivery of healthcare. It will also likely drive new entrants into the sector. Healthcare will continue to become more mobile, virtual and convenient. Many retail locations are now partnering with healthcare providers to make certain levels of healthcare available onsite to customers, such as the recent announcement that CVS clinics will be available in certain Target locations. Companies such as Apple, Samsung and others are drawing from their retail expertise to improve effectiveness, connectivity and convenience of healthcare-related services. These include, developments in data aggregation, analysis and mobile health apps that facilitate communication between patients and providers, and permit greater self-awareness and monitoring of certain wellness and health metrics. Fifth, more employers will contract directly with healthcare providers for health services for their employees. Many employers are coming to view this option a better and more effective method to tailor the network of providers, patient care services and geographic areas available to their employees, as well as to potentially better manage and contain costs, for themselves and their employees.



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