HEALTH CARE ROUNDTABLE

The Experts Discuss the Current Healthcare Landscape

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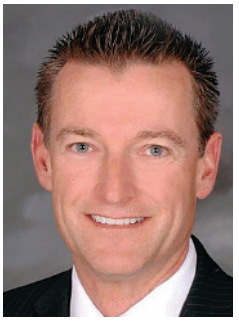

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As the various sectors within the health care industry continue to evolve and adjust as a result of health care reform, many questions remain regarding the state of the industry and how our businesses and local population are affected. To help answer some of those questions, the San Fernando Valley 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. Below is a series of questions the Business Journal posed to these health care stewards of the Valley 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 San Fernando Valley.

HEALTH CARE ROUNDTABLE

'Two things are certain. First, the demand for primary care providers will outstrip supply in coming years, particularly as baby boomers enter retirement. Second, non-physician providers can provide excellent quality and service when properly placed within a limited scope of practice.'
KEVIN A. ROBERTS

◆ Has there already been an economic impact caused by the Patient Protection and Affordable Care Act (ACA)?

ROBERTS: Yes. The early impact on local hospitals has been significant reductions in reimbursement. For most hospitals (Glendale in particular), the MediCare disproportionate share hospital (DSH) supplemental payments were drastically reduced. Overall, California was worst hit by this ACA policy. Additionally, last July, a pilot program went into place that consolidates coverage of MediCare/MediCal enrollees into managed healthcare plans. This will also likely reduce payments to hospitals and some physicians. There has been little relief from these cuts related to the "newly insured" but we are hopeful that this will come to pass soon.

KENNEDY: One can certainly argue that there has been an impact. The bottom line is that the legislation is imposing a whole host of new requirements on employers. Now, to be fair, I think they did a decent job of setting the various parameters within levels that most companies are already complying with—for example minimum plans at a 60% actuarial value—but there is still a tremendous cost in the manpower involved in finding times to set down whatever other work you're doing and educate yourself on the bill. Additionally, we are certainly seeing employers weigh the cost of reducing employees' hours down below 30/week so as not to need to extend coverage to as many staff—which has its own, obvious, economic ripples.

◆ What changes are occurring in the small business health insurance marketplace this year?

PATTON: Small businesses have more options to give their employees greater control over their coverage, making it easier to choose plans that employees will use. This year, Covered California is introducing a dual-tier model for the Small Business Health Options Program (SHOP) marketplace, allowing employers to provide employees with more choices to pick coverage that meets their needs. The dual-tier option is available for coverage starting on or after October 1, 2014. With this new option, employers select their contribution level and reference plan as before, but now they can pick two metallic tiers to offer their employees instead of just one. The employee decides which plan from the two tier options provides the best coverage at the most affordable price. Because employees have the opportunity to compare health plans at a variety of price points, the result is greater employee choice and coverage that is more closely tailored to individual needs, all without additional cost to the employer.

HUNN: Small and large employers alike are looking at the cost of health care for their employees and continue to evaluate the best options for their businesses. Employers are looking for year-over-year 'cost-predictability.' We reach out to employers routinely to advise them on how best to keep their employees on the job and safe – for the good of the individual and to benefit the productivity of the business. We encourage employers to meet with health system representatives, just like they do with providers of health plans, to better understand how to manage both the health coverage and costs of providing employer sponsored insurance. We encourage the business owner to participate in the dialogue along with human resources – the owner, CEO, or president must be involved to make the best decision. The employees are counting on all of us to get this right.

KENNEDY: "Grandmothering" was finalized in early July of this year and basically allows certain small groups an opportunity to keep non-ACA compliant plans for another year. It's important to note that the law allows it but it doesn't mandate it. In other words, it's going to be up to each insurance carrier to decide on whether or not they want to write plans reflective of this "Grandmothered" allowance. For groups that do fall into this, the nice thing is that 10 essential health benefits is one of a few of the ACA provisions you can stave off—including that somewhat vexing

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'The implementation of the ACA has put greater emphasis on the role of the agent in assisting consumers with acquiring health coverage. Consumers now need more trusted advisors, particularly because many consumers are either purchasing health insurance or navigating multiple coverage options for the first time.'
CHRIS PATTON

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pediatric dental. Another major change is in the way we quote small group plans—we need a lot more information now, so be prepared to produce demographic info, like birthdays and genders, for not only all of your employees but also their dependent spouses and children.

◆ How will SB 1446 affect the small business community? What new opportunities will this bill create?

PATTON: SB 1446 allows small businesses with less than 50 employees an extra year to find coverage that is compliant with the ACA. Over the coming year, the bill gives small businesses the opportunity to renew their existing coverage, regardless of whether that coverage meets the ACA "essential benefits" requirement. All non-ACA compliant plans will now expire at the end of 2015. Small businesses are not currently required to offer health insurance; however, if an employer currently provides and chooses to continue offering coverage, they will have an additional year to find options that are ACA compliant at a cost they can manage. Ultimately, SB 1446 offers small businesses a longer transition period with more time to research coverage options and a chance to better prepare for the future. Covered California's Small Business Health Options Program (SHOP) is interested in reaching the 300,000+ currently uninsured small businesses that are not affected by SB 1446. These are businesses that do not currently offer health coverage to employees but may be considering SHOP coverage to take advantage of federal tax credits and/or to recruit and retain industry talent. Covered California SHOP will also be prepared to assist those small businesses that are seeking ACA-compliant coverage in 2015 when existing plans expire.

◆ How has Covered California impacted providers?

HUNN: It's too early to measure actual impacts on providers, but one thing we do know is that the Affordable Care Act cut the number of uninsured residents in California by half to 11 percent. More than 1.2 million are newly insured, with the largest gains in the comparatively healthy 19- to 34-year-old age group. We expect the new access to affordable health care to increase the number of primary care visits to physicians that are health exchange providers. It also will increase the number of referrals to specialty care. Moreover, we expect to see more patients coming in for health screenings such as mammograms and colonoscopies.

REBAY: Many providers (at least those who have done the analysis) are experiencing reduced revenue as people previously insured through other means migrate to the exchange. However, even though many providers elected not to participate because of what the health plans were offering in contracts, they aren't reporting lost patients because of it. Patients follow their physicians for the most part. Narrow network strategies that get between patients and doctors are rarely successful, and many physicians appreciate that. All that said, in California we have a lot of large groups that have worked well with the plans and are very sophisticated when it comes to bringing quality and efficiency. It's how they've been successful in the prepaid model for decades. We see them participating and making it work.

◆ How can physicians survive and increase their revenues as reimbursement is reduced?

REBAY: For reasons of personal preference, many physicians and physician groups continue to resist adding more physician assistants and nurse practitioners. After all, most physicians want to see patients, not oversee someone else's work. But when margin is shrinking, you have to increase volume to enhance or maintain profitability—and that means increasing capacity. Bringing on MD partners doesn't always

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'The most important thing consumers can do is to work with their physicians to determine the best health care options for their particular needs. Age is important, as are pre-existing conditions.'
MICHAEL HUNN

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translate into more money for an owner physician. But hiring someone to see the sore throat and earache patients so you can expand the number of patients you can see is good business.

HUNN: Physicians must be open to innovative change to stay ahead as government and health plan reimbursements are reduced and or when new reimbursement methods include rewards for managing the care efficiently. Partnerships and affiliations with medical groups and health care organizations are surging as physicians see the value in shared management services, equipment and overhead. Providence has two affiliated physician groups – Providence Medical Group and the Providence Facey Medical Group, serving over 350,000 patients a year here in Los Angeles. Providence also participates in accountable care initiatives to better manage care of populations and to coordinate care between physicians and health delivery networks.

◆ What has been the impact of the reduction of uninsured patients to hospitals as a result of the ACA?

REBAY: It's important to remember that many states rejected Medicaid expansion, which is supposed to provide the bulk of coverage expansion. Further, the appellate court decision striking down the federal government's ability to provide subsidies puts any measurable impact to date at least somewhat at risk. The Census Bureau pegged the uninsured at 48 million, or 15.4 percent, in 2012, and the National Center for Health Statistics released 2013 estimates of 44.8 million uninsured, or 14.4 percent. That would indicate an improvement, but, according to the report, it comes from groups labeled "poor" and "near poor," which would indicate the improvement is due to expansion of social programs and not necessarily the exchanges. What hospitals are really seeing is a decrease in inpatient business overall, which is of greater concern. For those that rely on significant subsidization (such as disproportionate share funding), the moving buckets of funding have executives on edge.

◆ How is the Affordable Care Act changing the way hospitals, clinics and employer groups work together? Are the benefits to consumers "as promised?"

ROBERTS: It is too early to tell whether the promises of the ACA will become a reality, though the increase in insured citizens appears to be materializing. Regarding provider/employer cooperation, some metropolitan areas of the country are having better success than others. Los Angeles/San Fernando are large complex economies and it will take more time to develop these synergies with employers. Once a few successes emerge, then it will replicate rapidly.

HUNN: Employers, hospitals, clinics and physicians all desire the same thing, excellent care at an affordable price with a patient experience that is second to none – the ACA has definitely highlighted and prompted a robust dialogue among the key stakeholders to achieve these goals. Those dialogues have also resulted in a renewed focus on wellness and prevention. It has encouraged employers to educate themselves on how best to craft employee benefit plans to help workers adapt to higher deductible insurance plans and co-pays. And it has created a new urgency by the employee/patient/consumer to better manage their care through health savings accounts (HSAs) and health reimbursement accounts (HRAs). By creating select networks and other customized options, health care providers are strengthening their consumer bases. For Providence that means continued growth, more capital to keep up with the latest technology in diagnostics and treatment and the ability to sustain a workforce of approximately 15,000 in the Los Angeles Area. Consumers are benefiting on a variety of fronts – primarily because hospitals are competing for the newly

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'Bringing on MD partners doesn't always translate into more money for an owner physician. But hiring someone to see the sore throat and earache patients so you can expand the number of patients you can see is good business.'
KARL REBAY

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insured and know they must provide the best possible patient experience. Health care reform also has brought a new transparency to the industry and consumers can make more informed choices.

REBAY: Consolidation was occurring among providers prior to the ACA. What the ACA does in part is put focus on care coordination and therefore primary care, which hasn't been a traditional focus for hospitals employing physicians. Employer organizations are purchasers, whether they're buying traditional coverage for their employees or are self-funded. Realizing that they're providing a mandatory benefit to employees at a cost that's out of control has changed the level of interest, to put it mildly—not unlike the government's interest because of the unsustainable costs associated with Medicare and Medicaid. What we see are providers and employers working more closely to address the cost problem. Large employers are working with larger health systems to provide more effective and efficient care—we're seeing this with Boeing's relationship with Providence and Walmart's with the Cleveland Clinic, to name two high-profile examples.

◆ What are the predominant legal issues that physicians need to focus on when entering into managed care contracts today?

REBAY: One of the most critical items we've seen in the years since the ACA was first being discussed in detail was how capitation payments would be paid from Medicare Advantage plans to hospitals and groups. We've seen contract language that specifically allows for the inclusion of any taxes, fines, levies, penalties—anything that comes from the government—as reductions to capitation payments. Sometimes it shows up in the definitions section, and sometimes it appears more prominently. The intent of the medical device, pharmaceutical, and health plan fees and taxes in the ACA wasn't to pass them on directly to providers or to increase cost to employers or patients. But that's what's happening. Frankly, it's surprising there hasn't been more of an uproar over this, given thin provider margins.

◆ Where do health care entities need to focus their limited resources in today's market?

KENNEDY: I think a top priority for the health care entities would be to continue the track they are on with creatively examining cost reduction strategies. The innovation is really astounding. We are seeing everything from successful Accountable Care Organizations, which rate and bonus providers based on performance, to literally mobile Kiosks that set up in offices and allow technology like Skype and telecommunication with doctors from inside the private booth placed at the employer's office—so there are some great cost reduction strategies out there that we really applaud and hope to see expanded. Furthermore, we all see and sell the "high-low" benefits package, or some variation, but I think there's a way to have plan families with even lower cost choices in them—even if the doctor selection was highly localized, I still think there are some consumers out there that it would be a fit for.

ROBERTS: First we must always focus first on meeting our mission to the community. Without that "true North" sense of purpose, we'll wander, falter and fail. Operationally, we must succeed in meeting the triple aim of healthcare: clinical quality, service quality, cost efficiency/ value. Assuming these fundamentals are sound and reliable, then we must invest strategically in whatever we believe the future will be. Most are expecting the development of strong networks and alliances of historical competitors. This will be good not only for business by reducing duplication and increased contracting leverage, it should help create the heretofore elusive seamlessness of communication, electronic records, and sharing of best practices.

HUNN: Forming strategic partnerships, seeking innovation, inspiring employees and embracing young talent are key. Many of the larger hospitals offer high-level specialties that others do not. For example, Providence Saint Joseph Medical Center has a very successful neuro-interventional program, one we share via a telehealth network with four other hospitals in the San Fernando Valley, three of them unaffiliated with Providence. At Providence Holy Cross Medical Center, a team of oncologists from City of Hope brings that center's expertise to our community. By sharing rather than duplicating we find all of our patients are better served. Oftentimes, suggestions for improving upon excellence come from our employees, inspired to play larger roles. We must nurture that to ensure we sustain our ministry of health care into the next generations.

◆ Has the role of agents changed since the implementation of the ACA?

PATTON: The implementation of the ACA has put greater emphasis on the role of the agent in assisting consumers with acquiring health coverage. Consumers now need more trusted advisors, particularly because many consumers are either purchasing health insurance or navigating multiple coverage options for the first time. Agents help consumers navigate plan costs and options, help consumers find the right coverage, file and submit consumer applications and assist consumers with application or coverage changes. Agents are equipped to help make applying for coverage as quick and painless as possible, particularly in the Covered California marketplace. Covered California's Certified Insurance Agents have received training on our system and products, which builds upon their own industry experience. Certified Insurance Agents help take the guesswork out of the process. They are there to provide assistance, at no additional cost, to employers and individuals navigating the new health insurance marketplace.

KENNEDY: Our industry has faced countless legislative changes throughout the years and the truth is that while this is a historically big test, we've been conditioned to face adaptation by the very nature of our highly regulated industry. There was a fairly large shift in the scope of service packages within the last 15 years or so that a natural, competitive market created and it forced a lot of brokers to look at the value they bring to the table. Now, not only are we being looked at for our services, we are being looked to for consultation more than ever. The knowledge our clients need today surrounds new laws that are changing all the time and new plan ideas that are just as fluid as the legislation because of a carrier base trying to innovate within the new normal they exist inside of. It's a very exciting time.

◆ We are reading a lot about health systems working to give individuals, employers and employees more options. In light of this, what should consumers be looking at when making healthcare decisions?

ROBERTS: As a healthcare professional, I encourage enrollment in health plans/programs that expect something from the enrollee and create incentives for healthy behaviors. At Glendale Adventist, our 2600 employees are offered two plans, Basic and Engaged! The price is less for the Engaged! plan and it also requires personal involvement in health (biometric screening, tracking/posting activities, setting health goals, etc.). The vast majority of our employees opted for the Engaged! plan and there are many testimonials of people taking better care of themselves, identifying hidden chronic diseases, and enjoying healthier lifestyles! Personal involvement plus accountability go well together to create innovative, attractive and lower cost health care programs. I remind people that we are in "health" care and should set a great example for our customers!

HUNN: The most important thing consumers can do is to work with their physicians to determine the best health care options for their particular needs. Age is important, as are pre-existing conditions. Then they must pay careful attention when choosing their insurance plans. Ask questions. Make sure your preferred physicians, clinics and hospitals are a part of the plan you choose, and double-check copays, premiums and prescription drug coverage.

KENNEDY: Options are great but there is also something called "the tyranny of choice" that basically describes a scenario where too many options can be as debilitating as too few, so I do believe we need to strike a balance in the volume we throw into plan offerings. That said, I think consumers need to be sure in their conversations with their consultant that they have a comfort in the person's acumen. Group coverage and the individual market are very different, but you saw with Covered, CA this year how much confusion about networks and plan designs can result even when people looked to enrollers for assistance. Consumers want to be sure their consultant really understands the available choices so he or she can really counsel them on the best decision from the available options.

PATTON: Employers should be looking at health care models that are simple, cost-effective and give employees the most options. We encourage consumers to reach out to certified Covered California experts—free of charge—to walk them through a process and manage much of the paperwork involved. Covered California offers employers free support through the help of a Certified Insurance Agent or service center representative to help choose a plan that works for them within their budget. Their employees can also easily choose from multiple coverage options that meet their needs at the right price.

◆ Today more than ever before, businesses and practices in the healthcare industry are challenged with accounts receivable, including patient co-payments and reimbursements from a range of insurance providers. Are there any innovative ways companies can master cash flow management to overcome this challenge?

REBAY: First and foremost, stay on top of the basics. Time and again we hear horror stories from clients who implemented a new system or redesigned a department but dropped the ball operationally. Health care isn't making Barbie dolls. It's a complicated, highly regulated industry with relatively thin margins, so every dollar counts. Never lose sight of things like

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'Our industry has faced countless legislative changes throughout the years and the truth is that while this is a historically big test, we've been conditioned to face adaptation by the very nature of our highly regulated industry.'
TOBIAS KENNEDY

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charge structure and charge capture, and make sure not to cut corners in the coding department. With respect to patients, a relentless focus on up-front cash collection isn't just good practice anymore—it's imperative. Have your admitting people work with your collections people and communicate with your elective-service patients the clear expectation that amounts are to be paid ahead of time. With respect to outsourcing, make sure you're not just coughing up a percentage that adds to the cost. Make them prove how good they are, and get guarantees.

◆ With the advent of electronic medical records, what are some emerging issues that consumers should be aware of?

ROBERTS: The potential for electronic medical records (EMRs) to transform healthcare is amazing…but it's still a work in progress. The biggest challenge is healthcare information exchange, the ability of systems to talk to each other. This will work itself out over time, but it will take time. The next big issue is security/privacy of this delicate information especially with the plethora of devices available today. Consumers should be involved and maintain copies of their medical information. If your provider offers an electronic copy of your record, take it. If they don't, make hard copies. The more the consumer is involved in their health, the better off they will be.

HUNN: The positives far outweigh the single negative, but it is the latter that is of most concern to the health care industry. EHR systems can be subject to computer hacking, so Providence has been vigilant about system security now and in the future. EHRs improve quality of affordable care by allowing for better coordination by care teams and by giving patients access to their records. Providence believes patients should be partners in their care and is pleased that by the end of July, we had registered 123,000 patients in MyChart, Providence's online electronic health record system for patients. We will continue to promote this program, encouraging patients to access their records.

◆ Can large employers reduce costs through direct contracting with physicians or other health care entities?

KENNEDY: To the contrary, carrier executives have reached out to us to let us know they need us more than ever. With the carriers' administration cost restrictions, the broker community is really the extension of the service arm that they truly need to most effectively manage their business. The value of a broker extends to not only consulting on the benefits but to things like HR compliance and, perhaps most importantly, thoroughly marketing your pricing to all carriers on an annual basis for rate control. In the perpetually changing world we live in today, this is probably the worst time in our country's history of group benefits to try to go without a good consultant. The system really is set up to have us as the delivery channel, now more than ever, and without a broker you simply can't get the support you otherwise would.

ROBERTS: Direct contracting is the likely scenario of the future. As with any system improvement, the less layers you have between the provider and consumer, the less wasted cost. However, building these systems is not easy. Health insurance companies have huge reservoirs of intellectual capital and systems that provide their products to consumers. I envision evolving cooperation and experimentation with the current healthcare entities that deliver value, including lower cost to employers and citizens.

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

KENNEDY: Before a company self-funds their medical they really need to know what plan structure they're moving to and understand how that fits within their size and their risk. Remembering also that California is such an HMO rich world, moving to the PPO-only structure may cause some confusion within your population as well. At times, plans can look good on the spreadsheet, but may inaccurately reflect expected claims, stop loss, or a host of other mechanisms built in. Be really sure you understand the risk. For our part, we will sometimes recommend products that are level funded—meaning built on a self-insured chassis, but billed in a manner similar to fully insured—or even self-funding products like dental and vision that carry less risk as a first foray into that type of arrangement. It's important to consider all of your options so you aren't taking on inappropriate risks you didn't foresee.

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

HUNN: The single best strategy for all employers is to encourage a work-life balance and to stress preventive care. A healthy, happy workforce is an effective work force. Providence has hosted Weight Watchers meetings, provided employees with pedometers to encourage walking both on and off the job and stressed the importance of family as part of its wellness focus. The organization also provides financial incentives for all employees to have annual physicals and provides basic health care checks annually.

KENNEDY: Within the self-funded arena you have great options for bending down the cost curve and managing the long-term trend. First and foremost, look at your self-funded arrangement for appropriately set plans, contracts and stop loss limits including an examination of the plan's lasering, tail, and the windows for claims to be incurred in, billed in, and paid in. Beyond that there are things like pharmacy benefits, timely filing frames and even the network discounts you're getting to explore if there is a carrier with stronger contracts in their network for you to rent. Once you've really vetted your product, then you should seek to tackle your utilization. The positive to self-funding is the claims data. You can get a wealth of data and experience to really do a lot with insofar as implementing targeted and strategic wellness campaigns and altering plan designs for steerage into more fiscally sensible habits.

◆ What issues do health care providers need to address as they become more retail-minded? Are there any specific issues that health care providers who partner with retailers need to be aware of?

HUNN: Shared dedication to quality is the No. 1 issue as health care providers expand to new methods of delivering care by partnering with retailers. These partnerships lend the expertise of health care professionals to the retail enterprise, providing for intriguing options for consumers. For the not-for-profit, mission-focused Providence, we must carefully discern whether we are comfortable with the reputation, values, employee relations and community standing of any potential partners.

◆ With all the new clinic options for consumers, such as Walgreen's, CVS, Zoom and Minute Clinics, what should consumers be aware of when visiting these clinics?

HUNN: Quality, price, delivery of care, medical history and much, much more. These new retail clinic options provide for convenient care and less of a wait as some communities see declines in primary care physicians. Some of the concerns that have surfaced, however, including a disruption in a patient's continuity and coordination of care when these clinics are not connected with the patient's primary care doctor. Consumers also should be cautioned to check their insurance coverage because often times preventive care, such as a flu shot, is free from their physicians, but not retail clinics.

◆ How is concierge medicine affecting the health care market? Might concierge medicine be an alternative for physicians who wish to avoid today's market pressures and reduced reimbursement?

ROBERTS: First, I haven't seen significant impacts on the healthcare market related to concierge medicine. Secondly, I've got a "wait and see" perspective on this. Two things are clear: understandably, physicians desire to mitigate the financial impacts of health reform on their practices; and, some people can afford more concierge type care. As systems improve and the value proposition for quality/cost materialize, people may be less likely to pay extra.

REBAY: Concierge medicine works well in certain markets for certain physicians. But sometimes concierge physicians end up with the same issues as other providers—they're just collecting from people instead of insurance companies. You can take your pick on which is better. We don't see it having a significant impact on the health care industry overall, at least in the near term. Patients who can navigate and afford it love it, although it can be complicated when bringing in specialists and coordinating care. From a physician perspective, the market pressures are reduced only if you have a good patient list (and a critical mass of those patients who will follow you wherever you go and whatever you charge them) or if you're a young physician who joins an established concierge practice. It's not for everyone.

◆ Where do allied health/non-physician providers fit into today's health care market?

REBAY: Physician assistants and nurse practitioners are playing an ever-increasing role in the delivery system. They're going to be the ones that relieve the pressure on primary care physicians. In the United States we have a big shortage of primary care physicians—and an even bigger shortage coming—and a lot of people are saying that PAs and NPs are going to be the answer. You see it already to a large extent

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in walk-in clinics, where PAs and NPs are providing basic care and treating people with a certain level of illness.

ROBERTS: Two things are certain. First, the demand for primary care providers will outstrip supply in coming years, particularly as baby boomers enter retirement. Second, non-physician providers (sometimes called "mid-levels") can provide excellent quality and service when properly placed within a limited scope of practice. Physician assistants, nurse practitioners, nurse anesthetists, etc. are wonderful supplemental resources to the healthcare system and should be embraced within reasonable and rational policies.

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

REBAY: Yes. Some primary care doctors, especially those who have been in practice for a long time and are accustomed to a different era of health care, don't want to be "sitting around signing off on charts all day," as they'd put it. But they can't argue with the fact that there aren't enough primary care physicians to care for our expanding and aging population. So we have to change the focus to preventive care. And if you don't have enough primary care docs, who's going to treat people? Physician assistants and nurse practitioners are a viable solution. That said, how much this is going to reduce costs is hard to say, but it helps extend the capabilities of the primary care physician, and that can enhance efficiency.

ROBERTS: Physician assistants, nurse practitioners, nurse anesthetists, etc. are wonderful supplemental resources to the healthcare system and should be embraced.

◆ Outside of the usual suspects (benefit structure changes, wellness programs), what other tactics are employers using to reduce their healthcare expenses?

KENNEDY: The truth is that we are living in an age of creativity like none we've ever seen before. Average costs have constantly risen and the market has demanded action. Gone are the days of renewing your same plan because a broker was able to get the 15% down to 11%. We are seeing everything from self-funding ancillary products like dental and vision, to playing with high deductible or HRA options for plan design changes that lower premium but allow employers to reinvest some of that savings to neutralize the impact on employees. We have had accounts use worksite Gap plans to offset plan changes by moving to a higher deductible product (and thus saving premium) and installing a Gap plan to mitigate the liability to employees. A good, creative broker/consultant can find some real gems in strategy for you and your employees who also have more skin in the game.

◆ What are effective models to analyze hospital departments for revenue enhancement?

HUNN: Hospital leaders must recognize the contributions and talents of the "boots on the ground" in the constant quest to improve upon excellence. Physicians and employees throughout Providence are urged to voice their suggestions on how to make our services more valuable and more efficient. They are our eyes and our ears, talking daily with consumers and seeking to understand their needs.

REBAY: Revenue challenges related to specific hospital departments come in two forms: accuracy and completeness. But the difference makers aren't always just good forms and a complete charge description master. Department managers who understand the relationship between charges, net revenue, and cost for their departments and who communicate the importance of charge capture with staff regularly are the real secret sauce. Everyone has access to an effective tool (whether a comprehensive charge ticket or a fancy EMR system), which means what you have left to work with is human capital. Equip department managers with the right knowledge—and let them know how important charge capture, coding accuracy, and timeliness are—and they can do a much better job for you.

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

HUNN: Quality ratings based on patient surveys and patient outcomes will increase as forces in driving patients to – or away from – health care providers. Consumers have so many choices within reasonable distances. It is up to providers to ensure they are providing the best possible experiences from admission to discharge because deviations in quality will be part of the public record – and, more importantly, because it's the right thing to do. Disclosure of costs is a far more difficult issue. Hospital pricing is very complex and we as an industry are trying to simplify it, but the truth is hospitals must cover extensive overhead, maintain top quality equipment and, in the case of faith-based organization, to care for the poor and vulnerable in our communities.

ROBERTS: Transparency is already having huge impacts on healthcare. I have always been passionate about quality, service and cost…but I'm now even more passionate because it's "out there"! Just like personal accountability in health makes a difference, public transparency of provider data makes a difference. One good thing is that, over time, the systems of comparison are becoming more reliable, so we can prove when we're better…or not. But the BEST part is that the true winners of this "quality competition" are our patients.

◆ How are the quality and review websites (Healthgrades, Yelp, etc.) influencing consumers today? Are these sites delivering on the promise they make to consumers? How can consumers really know if the sites are providing accurate information?

HUNN: There is a wide range of these websites, and Healthgrades and Yelp! are at opposite ends of that spectrum. Healthgrades is strictly devoted to health care and uses data collected by regulatory agencies to rate hospitals and physicians. Yelp! features oftentimes anonymous reviews from participants commenting on everything from cupcakes to open heart surgery. Consumers have come to understand as more and more review sites pop up that some provide fair, balanced and professional recommendations. Nevertheless, regardless of the sources, reviews must be recognized as a public voice and thus a tool to help us continue to improve upon the quality of the patient experience we provide.

ROBERTS: I'm a little less bullish on these accountability vendors than on the overall transparency movement because many of these sites have economic drivers that taint the reliability of the data. For instance, many will score a provider and if you have high marks will charge substantial fees to allow you to publish their results. Therefore, consumer beware! Surprisingly to some, the government websites are the most reliable (i.e. hospitalcompare.gov) because they have high statistical reliability and no economic incentives that can blur the value of the disclosure.

◆ Are there laws specific to California that restrict the growth of business and innovation in the health care industry?

ROBERTS: Yes, the "corporate practice of medicine" law is clearly the most restrictive statute. This prohibits any entity other than a physician from employing a physician. California is one of only a few states where this limitation still exists. For hospitals, the seismic requirements for existing and new buildings have increased costs dramatically while also increasing safety. In general, regulatory intervention of healthcare in California is more than most states.

◆ What are the challenges that health care business that operate outside of California face when trying to enter the California market?

REBAY: The business of care, from both the provider and payer perspective, is different here. Capitation, reviled elsewhere, has met with huge success in California. Providers have weathered the financial storm around it and realized two things: that healthy people are cheaper to care for and that to survive they had to become more efficient. While capitation exists in many other states, providers in California get their own downstream contracts and pay claims—whereas in other states the health plans manage these details. Plans that haven't been here for a while or have never operated in California can struggle with this, damaging their reputations along the way. Large national plans have been brought to their knees at times by the medical establishment in California because of a "my way or the highway" attitude. Thoroughly understanding and being respectful of a new market is important in any industry. This one's no different.

◆ What do you think will be the "new frontier" in health care for the future?

REBAY: It's going to involve a more aggressive fight between free-market health care and monopolistic yet effectively coordinated health systems. We're starting to see lawsuits arguing that certain provider consolidations, especially in rural areas and smaller cities, are anticompetitive and would raise health care costs in their region. At the same time, a lot of the new models of care delivery are built around greater consolidation and coordination of resources. People like choice, but to properly manage care you've got to have network coordination. If you let patients go to any provider, they can say they're going to the Mayo Clinic. But if I'm the payer (a health plan or a self-funded employer) and I don't have a contract and some clinical connectivity with the Mayo Clinic, the benefits that come from integration and care management can be lost, and I'm paying a huge surcharge.

HUNN: Telehealth. Most larger hospitals have signatures specialties – stroke care, pediatric, interventional cardiology, substance abuse, psychiatry and more – and it isn't feasible to entrench communities with those services. Partnerships that allow shared expertise via telecommunications technology are part of the future. Today, specialists can diagnose and treat patients by robot at distant hospitals, helping to limit costs and improve outcomes. This will be especially important for hospitals in rural communities that don't have next-level care nearby. For example, a NICU specialist at Providence Tarzana can use this technology to save the life of a newborn in stress hundreds, if not thousands, of miles away!

ROBERTS: Population health holds the most promise for America's health future. This concept, which we should have been doing all along, holds that we must focus more on society's health as a whole instead of just individual illnesses. In practical terms this will help the "most sick" to have better management of their diseases and help the "well citizens" stay healthy. This means reducing the prevalence of gateway diseases such as diabetes and reducing risky behaviors such as smoking. When we take better care of ourselves then all of society benefits.