NORTHWESTERN UNIVERSITY

Kellogg School of Management

Gauging the future of health care

In a wide-ranging panel discussion as part of Kellogg's MacEachern Symposium, industry experts offer their insight on how major trends in health care will reshape the competitive landscape.

MacEachern Symposium panelists

Dave Burda (moderator)
Editorial director of MSP Communications and former editor of Modern Healthcare

Ed Hughes
Professor of Management and Strategy at Kellogg School of Management and professor of Preventive Medicine, Feinberg School of Medicine

Ken Kaufman
Chair of Kaufman Hall, a consulting firm focused on health care organizations

Michael Sachs
Chairman of SG2, an analytics-driven health care consultancy

Maryjane Wurth
President and CEO of the Illinois Hospital Association

With the implementation of the Affordable Care Act's remaining provisions drawing nearer, health care insurers and providers are working feverishly to be prepared for the new environment. Businesses and consumers are approaching the deadlines with a mixture of curiosity and trepidation for what health care reform will mean for pricing, regulation, and competition.

To offer some perspectives on the future of health care, Kellogg School of Management's Health Enterprise Management program convened a group of health care experts as part of the 31st annual MacEachern Symposium on June 5, 2013. Founded in 1943 by Dr. Malcolm T. MacEachern, a Canadian physician considered to be "the father of modern hospital administration," the Health Enterprise Management program coordinates and promotes groundbreaking education, research, and outreach in both the services and products sides of the health sector. This program is affiliated with the Kellogg Public-Private Initiative.

In a wide-ranging discussion, the panelists shared their views on the health care trends, price transparency, the impact of health IT, and what the industry will look like in the coming years. The following roundtable is an edited excerpt of that discussion.

Pricing Transparency

Dave Burda: *On May 8, CMS released hospital charge data for the 100 most common inpatient admissions and followed that up on Monday of this week with hospital charge data for the 30 most common outpatient procedures. How do you think the release of that data will affect hospital prices in the short and long term?*

Ken Kaufman: Well, I think the publicity around the pricing issues will wind up being a big deal. Over the past three or four years, we've seen where some major research reports are released that provide interesting information that a lot of people hadn't previously focused on. Then three or four months later, it gets picked up by the local media and it gains momentum. So I think we're going to have a lot more attention to the whole pricing structure, how people understand the prices, and what they pay.

But probably the biggest thing that's going to impact prices is nontraditional organizations coming in to provide health care. Those organizations are clearly underpricing the traditional organizations, especially on the outpatient side. That's very likely to produce some significant competition and force doctors and hospitals to rethink how they provide certain primary and secondary outpatient services, because these procedures are just way too expensive for a big facility to compete against Walgreens and other providers.

Dave Burda: *Maryjane, how have your members reacted to the release of data? Have any changed their charge master?*

Maryjane Wurth: Well, let me just say that I think that this is going to continue to be a significant issue. As we have greater transparency, we will begin to change how we approach pricing in the future. Part of the broader question going forward is what's driving the price variation? Is it the practice variations? Is it urban? Is it wage? There's a lot of interest in research seeking to answer that question, because there are many different things that go into it.

Dave Burda: *Mike, do you think prices will be any different a year from now because of what happened?*

Michael Sachs: You can just imagine a hospital board member opening up the New York Times, seeing that information, and then asking the hospital CEO, "Why are our prices so low? Guys, we've been underpricing the market, and look what we could do if we raised our prices."

We've heard reporting on data like this for a long time, and I think in the short term it's actually counterproductive. The negotiating power of the insurance companies has always been: we don't know what the other guy is being paid so we could negotiate. Well, now the pricing is going to be more transparent on the insurance side.

So in the short term, it's actually going to increase prices. We've seen this, by the way, in other industries. When it comes to executive compensation, the compensation consultants go to the

board and say, “Well, your CEO is paid this salary relative to the market, and you should raise him to fair compensation.” You’re seeing the results of that. So the story has yet to play out, but I think the short term is going to be very strong for hospitals’ bottom lines.

Ed Hughes: Michael, you’re right that in the short term there will be higher prices. But in the long term, Ken’s right that prices will fall. It’s right out of Adam Smith: perfect competition requires perfect information. So the more information that you have, the better markets will function. But it’s not going to be immediate. This will take five to ten years to get the powers that be to coalesce, but you will see changes.

Dave Burda: *We know that more care occurs at the ambulatory market. Will physician fees also be disclosed publicly in the marketplace?*

Maryjane Wurth: The world of transparency is here and it’s not going to go away. And it’s happening at a faster clip than I think many would have thought.

Michael Sachs: Data transparency is not anything that’s new; we’ve had hospital comparative performance reporting since 1987. Maybe people don’t remember, but that’s when CMS published, in paperback, the first comparative mortality reports. Now you have Medicare hospital comparisons and a plethora of performance information that’s more than most people can comprehend. And even with the pricing transparency, which is out there, the price that most consumers pay in the commercial market is the same: their co-pay plus their deductible.

So whether you go to the most expensive or the least expensive provider, no matter whether it’s a hospital or a doctor, the price is the same. I’m not really sure in the short term that pricing information is going to change purchasing behavior at the individual consumer level. It may have some commercial implications. But until there are real economic incentives around comparative pricing information that change channels of distribution or purchasing behavior. It’s great publicity and it’s great for journalists, but not for a lot of others.

Maryjane Wurth: To Michael’s point, it’s not just about price. It’s what you’re getting for that price. So the outcomes that are achieved are as much about consumer decision making as price alone. Consumers want to go to providers with very good reporting of quality outcomes at the right price. We don’t know where that exact intersection is, but it’s not just price. It’s about the resulting outcome that’s being achieved in your health care experience.

Ed Hughes: To relate an anecdote that’s relevant to price transparency, I have a daughter who graduated from medical school just two weeks ago, and she’s going to begin a surgical residency in Boston. We are in the process—I say “we”—of buying an automobile. And it’s amazing to me, who grew up in the age of walking into a dealership after looking at the newspapers, how much time my daughter has put into tracking down pricing of different autos on the Web. She knows more about the used-car market than probably any other American. And this CarMax thing is

quite fascinating. They have fixed prices, so you know exactly what a Honda Civic 2010 will cost, for example. I predict that ten years from now, you're going to see more and more of that type of price availability in health care, and people will make decisions in that way.

The Slowdown in Health Spending

Dave Burda: *We are enjoying a period of low growth in health care expenses. Some have attributed it to the ACA's provisions; others to the recession. Is the slowdown based on anything fundamental that would result in a long-term trend downward?*

Ken Kaufman: Well, I've been following this very closely because I think it's a tremendously interesting topic. Charles Roehrig of the Altarum Institute in Ann Arbor built an algorithm and found that 77 percent of the cost declines over the past 40 years were recession related.[1] David Cutler and Nikhil Sahni then came out and said 55 percent of the costs were structural and 45 percent was due to recession and to other changes in health benefit plans.[2]

I'm on the side of the structural changes. I watch this on a day-to-day basis, travel all over the country to meet clients throughout the United States. The amount of work that's going on at the hospital level is impressive. So I don't think that what we're seeing right now is an accident. It certainly perhaps was kicked off by recessionary activities, but it's not being sustained or pushed forward by those activities at this point. It's really thousands and thousands of physicians and thousands of hospitals working incredibly hard to try to take the reform agenda seriously and make a very, very substantial contribution to fixing Medicare and providing higher quality at a lower cost. It's being led by maybe 10, 15, 20 organizations around the country, but everybody's trying to do their part. And I don't think it's any surprise that we keep seeing reports that indicate that there's success in that regard.

So in 2012, we just saw information that readmissions had declined by 70,000. I don't think that's any accident. According to a report covering 2010 to 2012, per-beneficiary Medicare spending grew at 1.7 percent annually, down from growth of 4.3 percent from 2008 to 2009 and 5.3 percent from 2007 to 2008. I don't think that's any accident. CMS just reported that 85 percent of acute care hospitals have EHR technology[3] certified as meeting federal requirements for Meaningful Use objectives in 2012 and nearly 72 percent of office-based physicians used EHRs in 2012,[4] and that's also having a significant impact. So I think we're heading in the right direction. As people continue to do the work they're doing, we're going to see continued progress.

[1] "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending," Henry J. Kaiser Family Foundation, April 22, 2013.
[2] David M. Cutler and Nikhil R. Sahni, "If Slow Rate Of Health Care Spending Growth Persists, Projections May Be Off By $770 Billion," *Health Affairs*, May 2013.
[3] Dustin Charles, MPH; Jennifer King, PhD; Vaishali Patel, PhD; Michael F. Furukawa, PhD, "Adoption of Electronic Health Record Systems among U.S. Non-federal Acute Care Hospitals: 2008–2012," Office for the National Coordinator of Health Information Technology, March 2013.
[4] Chun-Ju Hsiao, Ph.D., and Esther Hing, M.P.H., "Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001–2012," NCHS Data Brief, December 2012.

Maryjane Wurth: You know, I can't overemphasize the amount of work that is being done. And I'll just give you an example: we had all of the hospitals in Illinois three years ago sign a pledge to work together to reduce readmission rates, and it wasn't just rhetoric. We had grants for a federal contractor to send out teams from the association to work with hospitals, diagnose the challenges, and give workable solutions. We are seeing a drop in both readmissions and also hospital-acquired conditions. Is it enough yet? No. But it takes a while to make the systematic changes that you need to ultimately improve quality and drive down utilization.

Hospitals are working very hard on developing care management and coordination to serve people who are at extremes so they get to the right setting at the right time instead of showing up in the ER with a higher utilization and higher cost. All of that is working, but we haven't seen all the results yet. We certainly don't give enough publicity to the very, very hard work and dedication that is going on that will pay dividends—not only for the cost part of it, but for the people who are getting the care.

Michael Sachs: I concur. I think of the shock that the hospital industry went through in 2008 and 2009, kind of double whammy of the slowdown in the economy coupled with the loss of insurance coverage. The financial pain that the market collapse had on hospitals really woke them up. It's not one factor or one particular element, but it's a constellation of elements: the economy, how physicians practice differently now in terms of their notion of what it costs when they order something, a little bit of the malpractice environment, and the ACA incentives for performance. It's the restructuring of the industry. I think there have been some fundamental structural changes that are going to reduce the overall rate of growth at something above the rate of general market CPI—but not the dramatic difference that we've had in the past 25 years.

Ed Hughes: We will see a continuation of this trend, and it's very, very exciting. One of the things that has caused the trend is reduced pharmaceutical innovation. That will be coming to an end. Just last week, at the meeting of the American Society of Clinical Oncologistshad a number of enormously exciting drugs that were profiled. You will see the cost of pharmaceuticals begin to rise because of the new agents, which will contribute to the rise in rates. But on balance, I think we're entering an exciting period where managers and leaders in the health industry are impacting the trends in a positive way. The problem is, society doesn't appreciate it, so you've got to get more attention for how hard providers are working in favor of the consumer, not being opposed to them.

Another positive factor is what I'll call new technology. For instance, there was an article in the New York Times in the past couple of weeks on hand washing. There are now scanners when you walk in and out of a patient's room that will trigger a buzzer if you haven't washed your hands. All of this entrepreneurial behavior is working for efficiency in health care, and that's going to continue. That's only growing in intensity, and very smart people are getting involved.

Ken Kaufman: One fundamental structural change in the market is the health exchange, which will have some impact. There will be a whole set of games around the health exchanges

for the next two or three years. Private exchanges are going develop in very rapid fashion over the next three years, from small employers up to large employers. For the first time, individual consumers will have a conscious price decision to make when they sign up for this narrow network versus that narrow network. That's a fundamental change. So that's where price competition is going to come into the marketplace.

Dave Burda: *Thirty-six states have agreed to expand their programs under the ACA, and 14 say they won't at this point. A few weeks ago, a study out of Oregon showed that when that state expanded its Medicaid program, more people did seek care, but the outcomes didn't change. Is that the future of Medicaid expansion under the ACA or is that an aberration?*

Maryjane Wurth: In most states, one in four individuals are going to be covered under Medicaid. So Medicaid is a major way to access care for a huge population in this country.

To handle it economically, we have to redefine the model and look at managing the population. Back in the 1990s, the focus was on managing costs and utilization. Now we're really trying to say, how do we manage chronic conditions over time? How do we build more outpatient units? How do we make sure that there's wellness and prevention and we get people coverage so that they don't just show up at the emergency room, which is the highest cost option.

Michael Sachs: I think we're going to have to see some fundamental shift in the care model for the Medicaid population—very different, very radical than what we're doing right now. And I'll just leave it at that.

Ken Kaufman: I think ultimately the future of Medicaid is in managed care. It would be fascinating to see if that approach were to be implemented in any major part of the country. You could see some very exciting innovations taking place and the potential for efficiency gains. I don't know if that will happen, but that's also somewhere in the future.

Health IT

Dave Burda: *As noted earlier, CMS has said that 80 percent of hospitals and 50 percent of doctors are using health IT. Kathleen Sebelius used the term "tipping point." Won't it be harder to get that last 20 percent of hospitals or the last 50 percent of doctors if they haven't seen the wisdom of going in that direction?*

Ken Kaufman: I don't think so. I think it's the price of admission. The electronic medical record is only the platform for the revolution in technology and health care. We haven't even seen what's going to happen here over the next five to ten years. It'll make EMR look like we were just playing around.

Maryjane Wurth: I think the whole mobile-health revolution—apps and the ability to diagnosis and send pictures and transfer data just with our little smart phones—is a whole other layer of technology that will fundamentally revolutionize health care.

Dave Burda: *The FDA is considering regulating health apps. Any predictions on where that will go?*

Ken Kaufman: It's a terrible idea. It will slow down innovation in an industry that's already been plagued by slow innovation. Let them roll.

Predictions

Dave Burda: *I'd like to ask each of the panelists to write the big health care headline that will make the front page of the New York Times one year from today.*

Ed Hughes: Health care outcomes continue to improve and dramatically so. People are living longer and will continue to live longer. Read the obituaries in the New York Times.Last week the average age was somewhere like 92. This is not a random event. Health care outcomes will consistently improve—and much better thanwhat the health care industry is given credit for. We can all be proud of what we are accomplishing. That would be the continuing good news topic one year from now, 5 years, 10, or 20.

Michael Sachs: One year from now will be the underrealized potential of the ACA relative to the exchanges. So basically 12 months from now, which will be June 2014, it will be how the health exchanges underperformed and didn't meet expectations.

Maryjane Wurth: The ACA is rated 50/50, that it's a mess—the rollout of state insurance exchanges, expansion of coverage, the impact on providers.

Ken Kaufman: Ten years from now, the hospital industry will be dominated by 250 large companies. We came together to meet market conditions, and it didn't have anything to do with power or price. ■