

# Social Enterprise Leadership Forum: The American Healthcare Landscape in 2014





## Featured Speakers

*In order of agenda*

### **Ray Fisman**

Lambert Family Professor of Social Enterprise  
Co-director, Social Enterprise Program  
*Columbia Business School*

### **Mark McClellan**

Director of the Engelberg Center for Health Care Reform  
Senior Fellow in Economic Studies  
Leonard D. Schaeffer Chair in Health Policy Studies  
*Brookings Institute*  
Former Administrator  
*Centers for Medicare and Medicaid Services*

### **Tom Scully**

General Partner  
*Welsh, Carson, Anderson & Stowe*  
Former Administrator  
*Centers for Medicare and Medicaid Services*

### **Bob Kocher**

Director  
*McKinsey Center for US Health System Reform*  
Former Special Assistant to the President for Healthcare  
and Economic Policy

### **Michael Dowling**

President and CEO  
*North Shore-LIJ Health System*

### **Thomas D'Aunno**

Professor of Health Policy and Management  
*Mailman School of Public Health, Columbia University*

*Written by Jennifer Itzenson  
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Ray Fisman, the Lambert Family Professor of Social Enterprise and co-director of the Social Enterprise Program at Columbia Business School, introduced the Social Enterprise Leadership Forum and the event's speakers.



## Introduction

By Professor Ray Fisman

The passage of the Patient Protection and Affordable Care Act in 2010 has caused dramatic shifts in the healthcare debate in America. The law's impact remains uncertain, and indeed, the extent to which political forces will even allow its principles to be translated into practice is very much an open question. The purpose of our second Social Enterprise Leadership Forum was to provide the New York community with insights on how these and other reforms in Washington are likely to translate into healthcare practice in the local market.

The forum, held on April 28, 2011, brought together leaders from the local and national healthcare community to discuss both what healthcare will look like and what we should aspire to in healthcare delivery in America.

The participants represented views from a range of backgrounds—from investment banking to medicine—and across the political spectrum, with both Republican and Democratic policymakers presenting their ideas. While

there were of course differences in opinion, much more striking was the commonalities in their views on the budgetary and organizational challenges that lie ahead in bringing affordable care to all Americans.

These discussions helped to shed light not just on the implementation of one critical piece of legislation, but the future of healthcare in America in general. Perhaps not surprisingly, the discussion also provided the audience with as many new questions as answers to consider on what is needed to make affordable healthcare universally accessible.

## Keynote Presentation: The Pathway to Accountable Care

In March 2010, the Obama administration signed the Patient Protection and Affordable Care Act, a set of measures designed to reform the health insurance industry, into law. These reforms will affect nearly every American—from healthcare providers and insurers to policyholders and the millions of uninsured. We can preview the changes set to take place by looking at markets where major steps toward reform are already being put into practice. The most promising trend is the model of accountable care, said Mark McClellan, director of Engelberg Center for Health Care Reform at the Brookings Institution, in his keynote presentation.

“Accountable care means paying more for better care at a lower cost,” said McClellan. “And paying for this care explicitly, and with measurement.” Accountable care organizations, or ACOs, attempt to reduce costs while improving the quality of care. Unlike the fee-for-service model that is the current standard among healthcare plans, which critics say encourages providers to perform excessive testing, ACOs offer incentives for focusing on patient outcomes, rather than testing or other expensive healthcare inputs.

Many organizations are already experimenting with accountable care principles, such as the Medicare Physician Group Practice Demonstration, the Brookings-Dartmouth Accountable Care Organization pilots, and private health insurer ACOs (see figure 1).

One of the best-known examples of a successful ACO is Kaiser Permanente, which has long emphasized preventive care as a way to reduce healthcare costs, and whose doctors receive salaries, rather than fees-for-service. The organization also limits costs by providing appropriate care through outpatient clinics rather than in hospitals, which have significantly higher costs.

“You should not view ACOs as something that’s ‘out there,’ apart from everything else that’s going on in healthcare reform,” said McClellan, who is also the former head of the federal agency that administers Medicare and Medicaid. “The basic concept of paying more to prevent unnecessary costs is something that’s integral to a lot of reform efforts.” In fact, the Centers for Medicare and Medicaid Services in April released a long-anticipated proposal to allow ACOs to receive financial incentives for decreasing Medicare costs. The Medicare proposal, if approved, will go into effect in 2012.

The growing popularity of accountable care is being driven by many factors, such as technological improvements that make it easier to measure healthcare outcomes, McClellan explained. There’s also a sense of urgency to develop proven ACO models, driven by the rising cost of healthcare—for individuals, for businesses that subsidize insurance for their employees, and for the federal government. With the deficit increasing by more than \$1.4 trillion a year over the last two years, the Affordable Care Act was designed in part to relieve financial pressures on Medicare (see figure 2, page 3).

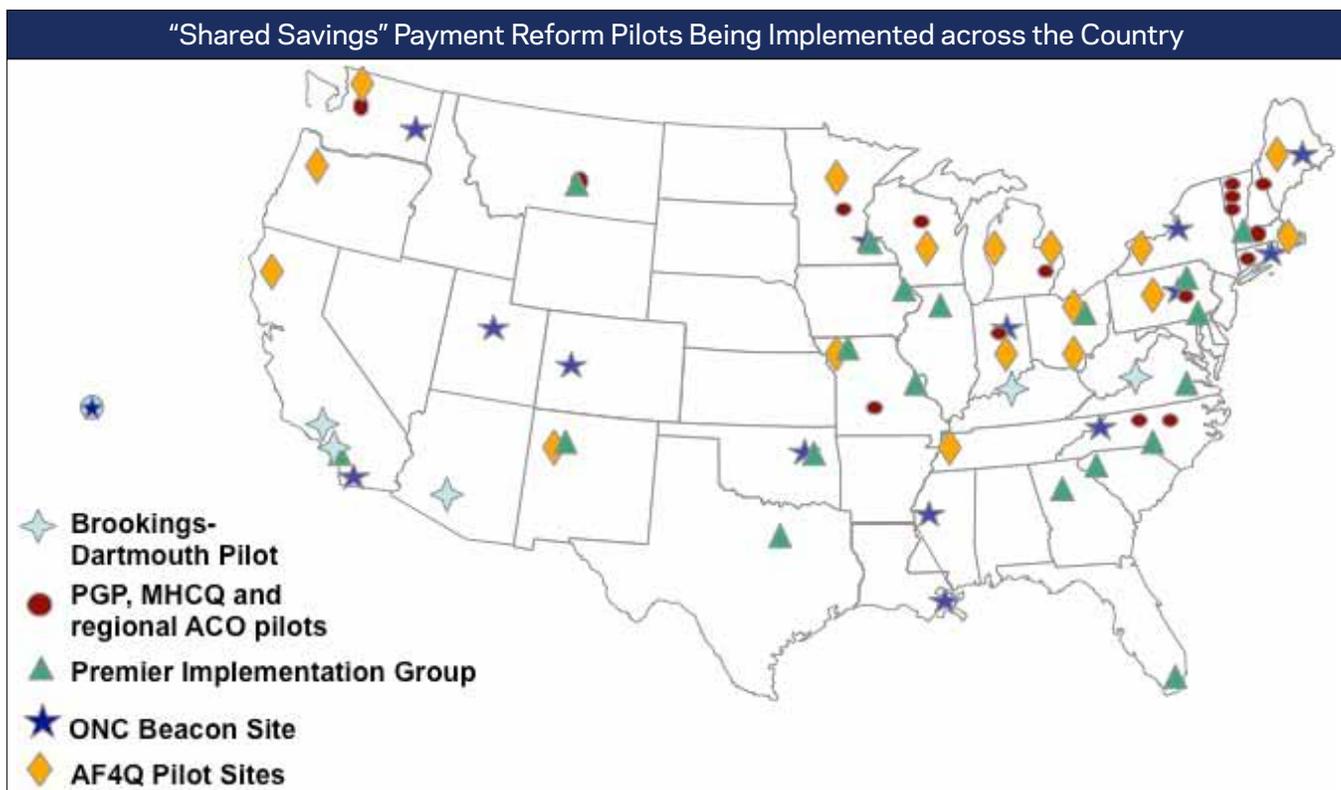


Figure 1: From the presentation by Mark McClellan, director of the Engelberg Center for Health Care Reform at the Brookings Institute.

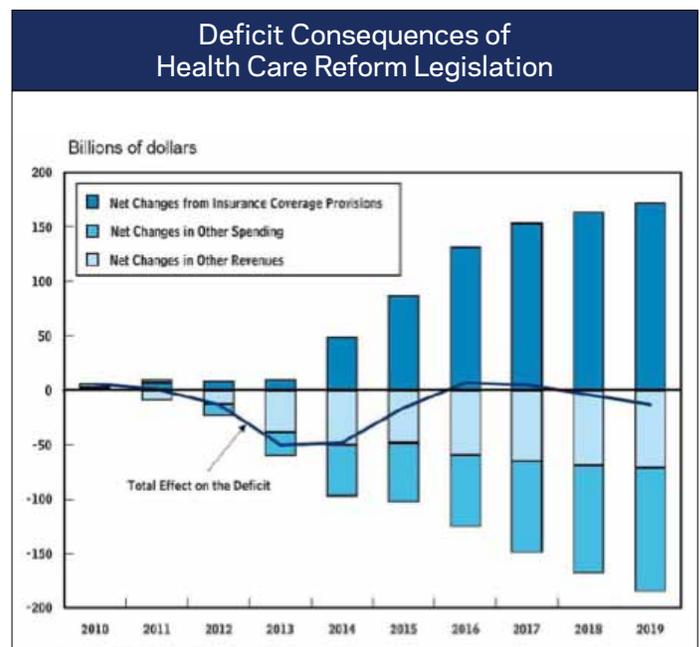
“There will be substantial healthcare reform legislation in the year 2013 or beyond,” McClellan said. “And it’s going to be focused on deficit reduction.” Indeed, the debt-ceiling crisis of 2011 may foreshadow the budgetary debates we are likely to face after the next election. True healthcare reform requires introducing a sense of fiscal accountability into the healthcare system, McClellan argued. “Expanding insurance coverage and squeezing prices won’t do it. Better quality and lower costs requires accountability—system-wide.”

McClellan discussed his own experiences in implementing Medicare Part D, which he described as an accountable care model for prescription drug coverage. As a result of the policy’s competitive design, many individuals enrolled in Medicare now participate in tiered benefit plans, in which they pay much lower prices for generic drugs than for brand-name drugs. “From a consumer standpoint, the real difference is you get a lot more of the savings when you switch to a less costly drug that meets your needs.” Since the program went into effect in 2006, usage of generic drugs by Medicare beneficiaries has climbed to 80 percent, McClellan said.

It is through these types of behavioral changes that we can reform the healthcare system. “Consumers need to become more sensitive to the overall costs of coverage, and therefore get into plans that are more efficient,” McClellan said. “And we need to drive provider decisions toward delivering value. Fee-for-service and open-ended benefits don’t steer us in the direction of making efficient choices.”

In the 21st century, medical advances are leading us toward more personalized, targeted treatments. “That means knowing more about combinations of treatments that work extremely well for smaller groups of patients,” McClellan said. To benefit from these advances, we need a more personalized payment model, not blunt restrictions on coverage. We also need measures of what we want healthcare to deliver. “And that’s not the number of hospital visits and MRI scans, but some reasonable assessment of the quality of healthcare provided to a population of patients.”

The Affordable Care Act has a lot of potential, in part because it gives Medicare broad authority to explore new models of payments like accountable care. “Most people don’t want radical change,” McClellan said. “We like our doctors, we like our care.” And that is why accountable care may be surest route toward creating a sustainable healthcare system. “We’ve done about all we can to lower prices in the short term, and that’s not a strategy to get more efficiency in the healthcare system,” he said. “An environment for healthcare delivery that emphasizes value is where we need to go. It’s just a question of how long it will take and how hard it will be to get there.”



**Figure 2:** Chart source: Goldman Sachs, based on CBO estimates. Note: Figures exclude the effect of education provisions in the Reconciliation Act of 2010 (Public Law 111-152). Source: Congressional Budget Office Presentation to the Institute of Medicine, May 26, 2010. From the presentation of Mark McClellan, director of Engelberg Center for Health Care Reform at the Brookings Institute.

Tom Scully, general partner at Welsh, Carson, Anderson & Stowe and former administrator at the Centers for Medicare and Medicaid Services, spoke about the future of healthcare investment.



## The Future of Healthcare Investment

As policymakers face the implementation of the Affordable Care Act, investors are trying to assess the economic impact of the legislation. Who are the financial winners and losers of healthcare reform?

"The Affordable Care Act puts us on track to having universal coverage, which is great," said Tom Scully, general partner at Welsh, Carson, Anderson & Stowe, a private equity firm that specializes in healthcare. "But it's not a reform plan; it's an access expansion plan." In his view, this is good news for almost any investor in the healthcare industry—at least until the next election, when the realities of the deficit will lead to a second wave of healthcare legislation that could bring much of this spending to a halt.

The act extends access to millions of Americans who currently lack insurance. "Essentially, this massive expansion is funded by some additional fees and some cuts in Medicare payments," said Scully, who is also a former administrator of the Centers for Medicare and Medicaid Services. "In historical terms, these cuts are almost nonexistent."

Hospitals are the biggest winners, Scully argued. The act virtually exempted hospitals from spending cuts and reforms, yet hospitals receive 40 percent of Medicare's

spending. Under the act, Medicare will provide coverage for an estimated 1.9 million new beneficiaries; reducing the ranks of the uninsured directly benefits the hospitals that treat these patients. "For hospitals, this is the deal of the century."

Surveying the rest of the healthcare industry landscape, Scully predicted that other big winners would include providers operating in the post-acute sector, much of which seemed to dodge any significant reform, if only by luck. Rehabilitation clinics will see only a minor reduction in payments. Hospices—an industry that Scully described as having the "most nonfunctional payment system in all of Medicare"—were left almost untouched, and seem likely to remain off the radar for years. Dialysis providers—the "low-risk tortoise of healthcare"—were largely shielded, having experienced earlier reforms in 2008. The impact for labs is limited to a productivity adjustment.

For other providers, the outcome is more complex, particularly for those in the home-health field, Scully said. Fairly or not, policymakers see margins in this industry as too high, which puts providers at risk for spending cuts in the near future. Device manufacturers face a similar, if lesser, risk; the next two years may bring many new customers, which could in turn bring unwanted attention in the next round of legislation.

## The Future of Medicare: Implications of the Affordable Care Act and Fiscal Imperatives

For insurers, the changes will be relatively modest. Private plans will expand as consumers take advantage of the new health insurance exchanges. These insurance exchanges will mean the end of insurance agents, but also encourage new entrants to break into consolidated markets. "The market will be more efficient," Scully said. "And we'll see major new smaller markets, through the exchanges, for individuals and small groups." By 2014, there will likely be 150 state exchanges and sub-exchanges, and increased federal and state regulation of insurers.

The strategies of risk adjustment will fundamentally change. "Right now, insurance companies chase a high-risk, 98-year-old, \$50,000 patient," Scully said. "If they can manage that patient's care for \$42,000, they make \$8,000. What we'll find in the future is that insurance companies will seek out sick patients, and manage them, rather than avoiding the sick. And that's exactly what you'd hope would happen with insurance reforms."

Some of these positive changes may be very short-lived, Scully warned. If hospitals are the biggest winners from the legislation, taxpayers—who inevitably bear the burden of the deficit—are the biggest losers. Just as the debate over lifting the debt ceiling made the deficit a matter of national urgency, budgetary pressures will almost certainly lead to a second round of significant healthcare legislation in 2013. "There will have to be some radical changes," Scully said. "Receipts are ridiculously low, and outlays are ridiculously high. The act is enormously expensive and sets up a huge battle over entitlement cuts and tax increases." Spending 25 percent of GDP on healthcare, and collecting only about 15 percent, is simply not sustainable. In Scully's opinion, Medicare's Part D drug benefit program would never have passed in 2003 if policymakers had anticipated the extent of the deficit.

Scully estimated that the act will cost \$940 billion in the first 10 years, while the impact on the deficit will be \$124 billion in net reductions through cuts and taxes. "Theoretically, the act saves money." But if the deficit makes access expansion impossible, its implementation will be pushed into the future, he said. "In the real world, when you get to 2013 and it's time for actual spending to kick in, along with a lot of other fees, the spending will be delayed. The simplest and most significant way to reduce the deficit in 2013 is to delay the healthcare bill."

Investors in healthcare have little to fear in the next two years, but in the longer term, significant change is unavoidable, Scully concluded. However, the relative outlook for the investment sector remains positive. "The safest place to be in the investment world in the last 30 years has been healthcare," Scully said. "And the safest place to be in the next 30 years will be healthcare. The reality is, people want to consume healthcare."

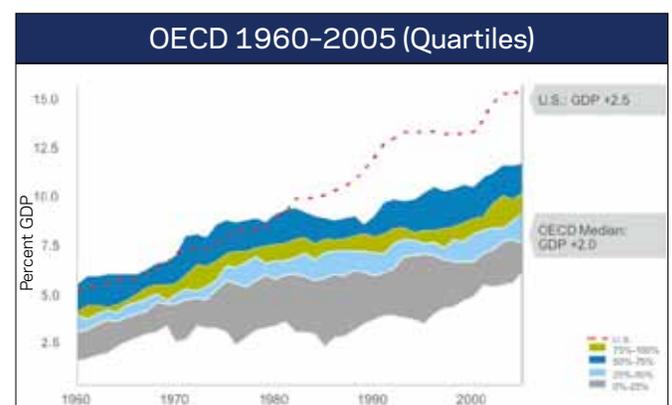
In the next decade, the question of affordability will be the fundamental challenge facing the US healthcare system. Does the Affordable Care Act do enough to slow spending? "The legislation has accelerated an environment for change," said Bob Kocher, director of the McKinsey Center on US Health Reform and nonresident senior fellow at the Brookings Institute, in his presentation on the future of Medicare. "But ultimately, budget constraints will force policies that achieve slower Medicare and Medicaid cost growth."

The US spends \$630 billion a year more on healthcare than it should, based on its wealth, Kocher said. "Healthcare spending is growing faster than the economy." (See figure 3.) By reducing unnecessary variation in the system and enacting incentives that are aligned with patient outcomes, we can dramatically improve the productivity, performance, and affordability of the healthcare system, he argued.

"When you look at the policy ideas coming out of the best think tanks in Washington, there aren't many choices, and I think we can predict how healthcare will evolve," Kocher said. "What's uncertain is the timing. But what's certain is that we will be creating a lot more productivity in the healthcare sector."

In fact, the major reform policies coming from across the political spectrum have a lot in common, Kocher said. They all support an integrative system of care to manage risks and deliver outcomes. All imply increased productivity through team-based care. All promote transparency of data to help consumers shop more effectively. And all are designed to cut costs.

The Affordable Care Act (ACA) will slow spending on healthcare from GDP plus 2.5 percent to GDP plus 2.25 percent, according to the Congressional Budget Office. However, this reduction is simply not enough, and the country's debt will eventually force spending on healthcare to become more in line with economic growth, Kocher observed. As Tom Scully emphasized in his presentation,



**Figure 3:** Historically healthcare has grown globally at GDP +2.0 percent and at GDP +2.5 percent in the United States. Source: OECD 1960-2005 (pub. 2007).

Bob Kocher, director of the McKinsey Center for US Health System Reform and former special assistant to the President for Healthcare and Economic Policy, spoke with Forum attendees.



in a just few years the debt ceiling and budgetary pressures will make significant changes to the healthcare system unavoidable. “Which baseline scenario we’re in—in terms of an economic recovery—will determine how quickly we’ll have to tackle the problem,” Kocher said. But even in the most optimistic of projections, the nation’s “tsunami of debt” will soon be impossible to ignore in the debate on healthcare reform.

The ACA had three primary goals: to increase access to care, to reduce the cost of care, and to improve the quality of care (see figure 4). “We spend more on healthcare each year than the entire domestic Chinese economy consumes,” Kocher said. “And on quality, we do far worse than you’d think.” He cited estimates that 100,000 people die each year in the United States from medical errors alone.

The implementation of the act will be staggered over several years. “In theory, 2014 is when the coverage expansion begins,” Kocher said. “The ‘popular’ provisions go into effect first—though some of these aren’t as popular as we’d hoped. The premise is by the end of these phases, healthcare will not be the preferred form of compensation for high-wage workers.” (See figure 5, page 7.)

The insurance exchanges will make it much easier for everyone to switch plans. “Unlike today, when insurers just try to price correctly, the act creates a model that’s

a lot like those used by cell phone providers, in which a company tries to keep the profitable customers and churn out the bad ones,” Kocher said. “The market will become very large, and we predict a lot of moving around and shopping by consumers. That creates a lot of volatility.”

In response, insurers and providers are already taking action to position themselves for the new market. The act

US Healthcare Reform		
Access	Cost	Quality
<b>50 million</b> Americans uninsured	<b>2x</b> The personal consumption of China is spent on healthcare each year	<b>100,000</b> Americans die each year due to medical errors
<b>Goals:</b> <ul style="list-style-type: none"> <li>▪ Extend coverage</li> <li>▪ Protect consumers</li> <li>▪ Increase choice</li> </ul>	<b>Goals:</b> <ul style="list-style-type: none"> <li>▪ Affordability</li> <li>▪ Productivity</li> <li>▪ Deficit reduction</li> </ul>	<b>Goals:</b> <ul style="list-style-type: none"> <li>▪ Step change in outcomes</li> <li>▪ Population health</li> <li>▪ Liberate data</li> </ul>

Figure 4: US healthcare reform was designed to increase access, reduce costs, and improve quality of care.

forces hospitals to increase productivity, and hospitals are hiring more physicians to reduce costs. “How efficiently hospitals manage their medical cost risks will make a huge difference in their performance,” Kocher said. “As for insurers, every health plan in the country agrees that we have to get away from fee-for-service reimbursement as fast as we can.”

And this, Kocher said, highlights the challenges faced by the healthcare system: “If you ask me what’s the biggest change we need to make, it’s changing the way we pay. What do we do every year? We do more stuff. Providers make all the money from testing, from outpatient diagnostics—MRIs, X-rays, phlebotomies, and so on—rather than from achieving clinical outcomes. That leads to a lot more activity and extra costs.”

There is a growing consensus that fee-for-service leads to “excessive” consumption. And as providers and insurers try to fix the system, we end up with hybrids such as accountable care organizations, Kocher said. Some insurers are working on ways to incorporate accountable care and bundled payments, or seeking agreements from hospitals in which the insurers will pay more but will not be held financially responsible for complications.

“These are interesting experiments, but none are at scale,” Kocher said. “We’re terrified that there’s going to be the grandmother somewhere who sees a doctor who performs unethically, and something horrible happens. And because of the imprecision in measuring quality, the lag in data, and the fragmentation in terms of being able to manage risks, all of these experiments are relatively small steps.”

Under the Affordable Care Act, healthcare plans will favor doctors over hospitals. “The easiest way to save money today in American healthcare is to prevent patients

from making unnecessary trips to the emergency room.” Doctors can easily do this by increasing hours on nights and weekends. A second way is to avoid elective use of hospital technology and, when tests are necessary, to use tools that direct patients to lower cost, but equal quality, providers.

A final possibility is reduced hospital readmissions. “About 20 percent of Medicare patients are readmitted within 30 days for the same condition,” Kocher said. “You can cut that at least in half—and possibly almost to zero—if you do two things: see patients within a week of when they leave the hospital and focus on drug adherence.”

The new laws include incentives for making these changes. However, the extent to which the incentives will mean improvements in cost, access, and quality is uncertain. “So what happens if the Affordable Care Act doesn’t solve all of our problems?” Kocher asked. He predicts we will see balanced budget acts in 2013 or 2016. “There’s no question that if Medicare keeps growing at the current rate and if our GDP growth is 2.5 percent less, there will be price controls,” he said. “It’s the easiest thing for Congress to do.” Should that fail, he predicts there will be renewed interest, particularly on the political left, in bringing back a public plan. Whether this would receive more widespread support in a second round of healthcare legislation remains to be seen.

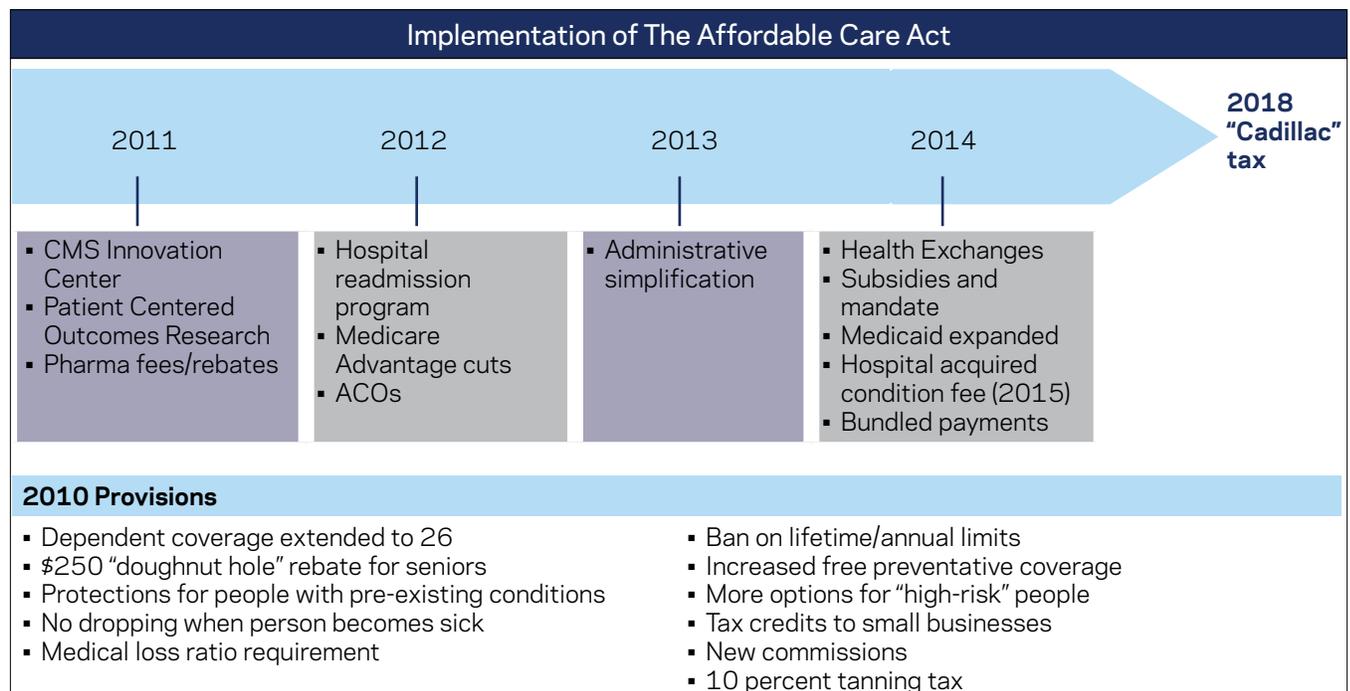


Figure 5: Implementation of the ACA is phased over several years.



Bruce Usher, co-director of the Social Enterprise Program and executive in residence at Columbia Business School, spoke with Thomas D'Aunno professor of health policy and management at Columbia University's Mailman School of Public Health.

## Impact of National Reforms on Local Health Services

The world is full of healthcare pessimists. Providers worry not just about new legislation from Washington, but from state governments facing economic pressures. "But not everything is wrong with the US healthcare system, and if you have any experience with healthcare systems in other parts of the world, you long for the creativity and innovation that exists here," said Michael Dowling, president and CEO of the North Shore-LIJ Health System. "We're suffering not from failure, but from a crisis in success."

Part of the reason that the cost of care is increasing is that medicine has done so well at keeping people alive longer, and that end-of-life care can be extraordinarily expensive. "We tend not to calculate the benefit side of that equation," Dowling said. "If someone stays healthy for another 10 or 15 years and works for another five or 10 years than they would have otherwise, that's progress."

At the same time, we need to recognize that we are entering a period of austerity and transformation, one that is likely to last for at least the next decade. "We have to think about recalibrating our expectations," as we did during previous times of economic contraction, Dowling said. Healthcare costs are unlikely to go down, despite

reform efforts. "The best we can hope for is that costs will increase at a slower rate."

He agreed with earlier speakers that the cost of care is driven, to some extent, by inefficiencies in the system. However, much of the growth in spending can be attributed to the baby boomers who are becoming part of Medicare's caseload, Dowling observed. About 8,000 people turn 65 every day. A more troubling cost derives from lifestyle choices, Dowling argued. "Who will reform healthcare? It's all of us. It's how we eat and how we exercise and how we take care of our kids. If we really want to reduce healthcare costs, we need to reduce the obesity epidemic."

Dowling described having to purchase chairs for a pediatric waiting room that are large enough to hold two healthy adults, but are intended for a single overweight child. The obesity epidemic is easily recognizable, and its harmful effects are clear, but confronting it will mean incurring additional costs. If accountable care organizations seek to encourage healthier lifestyles, for example, what will this mean for employers? How many will be willing to give their employees a few hours of weekly time off to go to the gym? "The idea behind an ACO is you take a population and you figure out how to make it healthier," Dowling said. "But if you can't do that for employees, how will you do it for a community?" These questions extend well beyond the realms of insurers and

Michael Dowling, president and CEO of North Shore-LIJ Health System, spoke about the impact of national reforms on local health services.



providers. “We’re talking about our societal responsibility. But we don’t like to be told what to do. We want it all.”

Like the other speakers, Dowling felt that the Affordable Care Act should not be seen as a radical reform; many of its initiatives have been tested and proven to work in many areas of the country. While its expansion of coverage is a positive change, he cautioned that coverage and access are not the same. “This is a significant problem we’re facing in New York State,” he said. “We don’t pay doctors enough to take Medicaid patients.”

In New York, he predicted, there will be far more consolidation among providers of emergency care. “There are hospitals that, based on any business analysis, should close,” Dowling said. “But given their location and population, and the lack of services in their area, some of them should not be allowed to close. They should be taken over by more successful healthcare systems.” Healthcare reform will bring more focus on quality of care and patient outcomes in hospitals, but hospitals and doctors should not have to strive toward an ever-shifting set of metrics, he said.

Dowling agreed with the consensus that it will be necessary to move away from a fee-for-service system. “Fee-for-service produces incorrect incentives in so many arenas,” he said. “Providers get paid for doing things one way when they know they should be doing them another

way.” Instead, hospitals, doctors, and insurers should integrate and align their agendas. And, to a greater degree, the healthcare system needs to take an active approach toward communities. “We’re relatively good at taking care of individuals when sick. But we need to address our massive community pathologies.”

Dowling nonetheless remains optimistic about the future of healthcare. “Let’s selectively forget the past, and do things differently in the future, and start from the premise that the system can be changed,” he said. “We shouldn’t create unrealistic expectations, whether about ACOs or lowering costs. These issues will challenge our creativity and innovation and intellect. It’s an extraordinary time to be in healthcare.”

In concluding remarks, Thomas D’Aunno, professor of health policy and management at the Mailman School of Public Health at Columbia University, discussed the surprising amount of agreement in the reform debate. “As Michael Dowling and others have pointed out, there’s actually been a fair amount of consensus for a long time,” D’Aunno said. “What I worry about is the implementation. The more we emphasize the what, the more I worry about the how.”

Policy experts say we need to integrate, we need more teamwork, we need to change our modes of payment. “But what we need to emphasize is the role of local leadership and management in making these changes happen,” he said. “In the end, all healthcare is local.”

D’Aunno voiced concern that uncertainty in the coming years will lead to a chill from entrepreneurs. “We need innovation,” he said. “But not in the way we’ve had it before—from the pharmaceutical industry and medical-device manufacturers—but on the low-tech end, on implementation.”

Like Dowling, he stressed the contributions that all of society must make toward reform. “Healthcare systems alone can’t change our health,” D’Aunno said. “We need to invest if we want to make our society healthy.”

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