AFFORDABLE CARE ACT: Where are we now?

PANELISTS

Tim Cappel
The Christ Hospital Health Network

Caitlin Clipp
UnitedHealthcare

Kathleen M. Crawford
Bailey & Company Benefits Group

Burt Huber
Employee Management Services
A Staffmark Company

SPONSORED BY:
Q: Please go around and introduce yourselves.

HUBER: I'm Burt Huber, and I run the Employee Management Services’ division of Staffmark. We’re a professional employer organization, we work with smaller businesses who manage a lot of their administrative tasks. We co-employ the employees so we have skin in the game. We have liability for HR compliance, and payroll and payroll taxes, which gives business owners piece of mind to run their companies - the reason they went into business in the first place.

CLIPP: I'm Caitlin Clipp. I'm vice president of sales and account management for UnityHealthcare here in Southeast Ohio, and I lead the office in trying to both attract new customers and retain our current customers so we can help people live healthier lives here in Cincinnati.

CAPPEL: I’m Tim Cappel. I’m the executive director of population health for The Christ Hospital. What that means is that I’m in charge of helping to redefine the patient value proposition for The Christ Hospital. We do that through a variety of ways. One would be working with large employers for chronic disease management and also Center of Excellence offerings.

CRAWFORD: I'm Kathleen Crawford, and I am a benefits consultant with Bailey & Company Benefits Group. I have been in the business for 11 years, and my role is to advise employers of mid- to large-sized companies on how to maximize the return on their employee benefits investments so they can attract and retain quality employees which can give my clients a competitive advantage.

Q: How has the ACA changed the healthcare landscape just in the past year as opposed to when it was first enacted?

HUBER: 2015 was kind of a “free-pass” year where a lot of things had to be put in place, and we had all had to add infrastructure to make sure that we could support our customers. A lot of the mandates and penalties weren’t fully enforced this year, but they will be next year, so now that we’ve had one year under our belt, we have to get it right.

Q: What has the last year meant for the rest of you as opposed to two, three years ago when you were trying to prep for things?

CLIPP: In preparation, there was a lot of education that needed to happen, so that people understood and had clarity around what this meant for them. But also bringing other opportunities and solutions to the table, such as Burt’s PEO (Professional Employer Organization) and other associations or plans out there to help people have options and not feel like this is something being done to them but something they can have some choices in. We’ve seen a lot of groups transition to self-funding to take some more ownership into what they might be doing. There’s been a lot of education around the different avenues to deal with the ACA.

CAPPEL: From a provider’s point of view, I would concur that we’re also seeing more companies that are self-funded as costs continue to rise, so I think that’s really changed the dynamic. Also from a provider’s standpoint, we’re finding more providers doing direct contract, so we’re talking more directly to large employers about where the cost drivers are and what we can do to help partner with them to get those costs under control.

CRAWFORD: This was a busy year for everyone involved. But it has been interesting, for lack of a better term, to see how the ACA has changed the landscape in the past couple of years. The public exchanges and the consumer-run health insurance cooperatives, known as co-ops, aren’t the answer that everyone thought they were going to be. You see some of the large insurance carriers actually pulling out of the public exchanges and the underco-ops, are being shut down. I think the frustration has been that employers are helping subsidize those government funded programs and they’re failing, so, to Caitlin’s point, they’re looking to self-insured arrangements in order to avoid ACA fees that apply only to insured plans as well as more closely manage their healthcare spend. Ultimately, employers are...
THE AFFORDABLE CARE ACT: Where are we now?

Q: The gap between how people use healthcare and how it was paid for used to be the Grand Canyon, right? Is that fair to say? If you ask anybody how much that little bottle of pills they take costs, they would have no earthly idea other than their co-pay. You’re all talking about the idea that transparency is a part of that equation?

PHOTO: MARK BEALER

CAPPEL: One comment, though. I think what’s important as companies go to self-funding is that they now own the risk, and so that creates a profound change in the attitude of their employee population. And I think it really introduces this idea of population health because now, instead of just trying to negotiate the best deal possible – as you would in a fully insured environment – you really own the risk. So I think now there is more understanding around creating cultures of wellness and understanding their population and applying the right solutions.

CLIPP: Sometimes we call that “renters” and “owners,” and it’s such a great analogy to bring the whole feeling to life because, really, in the past it was a one-year fix – that’s all people were looking for – and, sometimes, a Band-Aid approach. Now, groups are really saying, “This is my population of employees. I need to help them get help here. I need to help them be the best and most productive workforce I can.” And that’s changing a community.

Q: Who needs to understand this that maybe didn’t need to understand this five years ago?

HUBER: I think the business owners have much, much more interest. I deal with them every day, and they’re always looking at how to control the costs. They’re saying: “Healthcare’s a big expense because labor’s my largest expense, so how do I control these costs?” It’s not always just dollars and cents. It’s what kinds of changes can I make so they’re not going to the emergency room for a cold? What kinds of wellness programs can we implement so our employees get to a better place? So, I think there are a lot of avenues programs can we implement so our employees get to a better place? So, I think there are a lot of avenues.

CLIPP: And it goes back to what your employer cares about. What is their mission and vision for the

DISCUSSION, CONTINUED ON PAGE 4B

So, I think that’s the challenge: How do we get true transparency around those three elements?

CLIPP: That whole quality-first aspect of it that Tim referenced is so key because, truly, cost and price don’t matter if you don’t understand the quality component. Can this be done well and correctly and the first time without the readmissions that sometimes make something much more costly on the backend, even if, upfront, it’s less expensive?

We try to think about cost a little differently and think more about efficiency over a total cost of care for an entire episode, from beginning to end, because that’s, really, what a consumer’s looking at as they go through a patient experience.

Q: The gap between how people use healthcare and how it was paid for used to be the Grand Canyon, right? Is that fair to say? If you ask anybody how much that little bottle of pills they take costs, they would have no earthly idea other than their co-pay. You’re all talking about the idea that transparency is a part of that equation?

CAPPEL: I think transparency’s an important part of the equation, but I would define transparency a little more broadly. I think when many people think about transparency, they’re first thinking about price transparency, but we can have transparency all we want around MRI costs, but that’s really not going to move the needle. Not to say that it’s not important because it is – we have to get better at understanding costs. But I think what’s equally or more important is quality. What are the outcomes? At Christ Hospital, we strive for exceptional outcomes. That’s what we do every day. And we also can’t lose sight of patient satisfaction because that’s also an important part of the healing – if you can remove those stresses, you’ll make the entire experience better.

We’re seeing a big uptick in our wellness business as companies evolve their cultures to a culture of health.”

– Tim Cappel, The Christ Hospital

Reds’ Homers Score a Brighter Future.

When the Reds light up the scoreboard, they also bring in donations to promote healthy kids.

For each Reds’ home run this season UnitedHealthcare gives to organizations working to improve children’s health in greater Cincinnati.

Serving mid-sized businesses to publicly traded companies, Bailey and Company provides an unmatched range of advisory services for employee benefit programs.

bailey&company BENEFITS GROUP
An Affiliate of McGohan/Brabender, Inc.

www.baileyandco.com  513-579-9800
organization that the employees typically care about, as well? So, it goes back to the culture of health that Tim referenced and others have spoken about to say that if this is part of our everyday lives, we really can make changes.

CAPPEL: It’s a paradigm shift for employers because they’ve been conditioned to understand just the financials; so, they understand premium versus claims, and they might understand the discounts in terms of how the claims are priced, but what they don’t understand is what the return on investment is that they’re getting for those dollars where they’ve invested. For example, if you call someone’s home phone, how many times do they pick up? Not very often. No one has a home phone anymore. So, we had to develop ways to get to where they’re having to deal with readmissions and infections. Hence our journey toward what we call “fee-for-value.” That’s moving from “fee-for-service” where you’re paid by the piece and making more by doing more to, really, being rewarded for producing exceptional outcomes and the finest patient experiences.

CRAWFORD: Employers are an integral part in changing the way health insurance is delivered as well as the way health insurance is offered. Because employers represent a large portion of consumers, much of what comes about in the way of innovation in the delivery model stems from employer initiatives.

I agree with Tim that the current—and dominant—“fee-for-service” model is definitely not working. In addition to paying for repetitive services, this model also favors the more expensive specialty care compared with primary care services and supports a fragmented delivery system. The focus needs to be more on care coordination which is necessary for overall health management.

There also needs to be more transparency tools available to employers. In the past, what employers did is shift the costs of higher and higher deductible plans to their employees, but simply raising their deductible doesn’t make for a better consumer if you don’t give them the tools. When employers are able to make an informed decision based on what an employer gets for a reasonable limit on how much they are willing to cover for certain procedures in a geographical region, and then the consumer is responsible for costs above that.

Q: Is this something that has been a pretty smooth journey in actual information-based decisions? I have made hundreds of zero-information decisions—where an employer sets a reasonable limit on how much they are willing to cover for certain procedures in a geographical region, and then the consumer is responsible for costs above that.

CRAWFORD: The tipping point is coming. Employers had the pressure of offering affordable and sustainable benefits to their employees well before the ACA began. With the enactment of the ACA, I think it started to push them over the edge. Now, they are looking to move to a self-funded arrangement or variations of it. While we have been educating employers for years on the benefits of self-funding, it has been easier for some employers to be fully insured and just accept the increases year over year.

I like to equate the funding of an employer sponsored medical plan to building a home. When you’re fully insured, you’re buying a house off the MLS. You pay an upfront cost. The thinking has been done for you. It might not be the right thing you would have selected and it might cost more, but you know what you’re getting. When you’re self-funded, you’re creating a custom home and thoughtfully selecting the different components to create that home, and you can install cost-control measures and build it as you see fit—customized to your population. The key is then to educate your population on how to best use the features selected.

For the employers that have ‘had enough’ and are willing to engage in the healthcare buying decisions, they know ultimately they need to involve their employees—indeed, that are making the daily buying decisions.

Huber: By self-funding, you become the general contractor. You have a big say in what costs are going to be incurred. As a PEO, we have a fully insured model, and it’s still medically underwritten but that’s attractive to small- and medium-sized businesses that really don’t have any inclination toward managing that risk. They don’t have the infrastructure to do that properly or the time or inclination to think about it.

Q: Especially with small- and medium-sized businesses that we talk to and the big questions they’re asking us, they barely have enough time to build a profitable business, let alone take this entire 80-pound gorilla on.

Crawford: It’s among the top two or three expenses of a company so it’s become more of the focus.

Clipp: And where you focus, you can make changes. It’s just like manufacturing and their safety requirements, they have been able—once you put a focus to it and a plan around it and have a strong strategy and business plan—to make changes.

We saw the same thing with healthcare years ago when pharmacy became more transparent and people started making changes within what drugs they take. The skin in the game definitely helps. When people pay out-of-pocket for things or have different benefit levels, they’re going to pay more attention.

But, also, in today’s changing landscape, you have some people who want to do it all online, some people who want to call someone on the phone, some people who still want to talk to someone face to face. We have to hit all of those customer segments with ways to teach them how to be better healthcare consumers today too, and that’s a daunting task for any employer.

Cape: I agree with all of that, but I also think there’s an opportunity for employers. Rob just said it: Most people assume quality when it comes to providers, and in many cases they are quality but in many cases they’re not. There can be huge differences in outcomes, and it can be based on the technology they have available to them, it might be their skill levels, it might be the number of procedures that they do.

We’ve attacked it from an employer perspective because we think an employer can really have an influence on employees’ thinking and understanding of the fact that there can be differences. It’s really why we developed our Center of Excellence program, which is a bundled payment initiative where we go to medium- and large-sized employers and give them a fixed price for procedures, a single bill, a warranty for the outcomes and, also, a report back. What I think Huber is meaning as we talk to employees is that we’re beginning to track productivity. So, again, there can be big differences in terms of how quickly people can get back to work. We’ve structured it within a narrow panel of surgeons, and we have risk in this environment so we’re all on the same page. It helps the employer send a message of quality to their employees.

Crawford: I love what Christ Hospital is doing. Employers are looking for cost-containment strategies that also ensure quality, and what Christ is doing is a great option. There is absolutely no correlation between cost and quality. In fact, the inverse can be said: where a poor quality procedure actually results in the higher cost.

For an example, we had a self-funded client who had an employee with a knee surgery that was botched and had to go back and have a second surgery with another doctor. They paid twice. How many products or services do we buy where we pay multiple times for the same thing? So, what Christ is doing with a set price and one-year warranty and everything covered under that makes sense.

Huber: For a small business owner who is self-funded, that could hit their business hard.

Clipp: That’s the concern as you see more people entering the self-funded arena. They aren’t necessarily prepared for all of those things, so you need a lot of that protective umbrella to make sure it’s safeguarded.

Q: So they can’t make three or four mistakes and get away with it?

Crawford: The costs have always been there. They just didn’t take notice until now. Now, they’re starting to pay attention.

Q: What are some of the advances in healthcare technology that feed into what we’re talking about now with quality?

Clipp: At UnitedHealthcare, we love technology because we are trying to get to that end user of health insurance, it’s been hungry for this.

For example, if you call someone’s home phone, how many times do they pick up? Not very often. No one has a home phone anymore. So, we had to develop a way to connect, and that’s the phone in your pocket that you have with you all the time. So, we developed an app that’s very easy, that you register with your thumbprint so you don’t have to remember another password, and that can do all of the things you need within your healthcare. It has your ID card. It has your cost-transparency and quality-transparency tools embedded. It can GPS you to the nearest minute clinic or a PCP. It can keep all of your records. So, we’re trying to make healthcare easier and simpler while still getting some of these harder messages out to people. That’s been an exciting change in technology.

I think the other way a lot of folks are changing is making sure you’ve got Tim and I and we’ve tried to do that, as well, with our customer service model. It’s now very much geared toward that end user and trying to triage them to possibly even a nurse the first time they call so they’re not having to go through an automated system. Either better than that, though, you can actually sign up to have customer service call you when you’re available. Those are the kind of unheard-of things that all of us are having to approve in the healthcare pool.

Cape: From a provider’s standpoint, there are a few things that are happening that I think are exciting. Certainly, the mobile apps — there are great applications there, especially with continuous glucose monitoring, which I think is a great thing for diabetics—telehealth and some of the other technologies around imaging clarity are all major advancements.

Then, the other thing I would say, too, is that there are also some advantages to the investments that are made to facilities and improving surgical techniques and devices. For instance, around the country 75 percent to 80 percent of hip replacement surgeries are done using a posterior approach, which is, basically, a very invasive approach that is from behind and takes the muscle off the bone. That’s versus an interior approach, which you’re back on your feet in four hours. The driving now has gone from 30 years to 10. And, frankly, we made a big investment in our Joint & Spine Center. We truly have state-of-the-art technology, and surgeons have everything they need with great care teams to produce exceptional outcomes.

Crawford: From the employers’ perspective—telehealth has been a brilliant solution. For a set price, it allows employers that have an acute condition, such as a sinus infection, to save the trip the doctor’s office and avoid waiting in a room exposed to others’ illnesses. Employers also appreciate that their employees do not have to leave work, instead they can just sneak away and FaceTime with a doctor, if you will, and get a prescription sent to a pharmacy, if needed.

Huber: On the business side of the Affordable Care Act and some of the infrastructure—I know everybody here on this panel has invested a lot of time and energy into their technology to support the compliance end of ACA. A lot of things that have been put in place in 2015 now have switched over to more of a monitoring and an evaluation task rather than a creation task.

**THE AFFORDABLE CARE ACT:** Where are we now?

“The skin in the game definitely helps. When people pay out-of-pocket for things or have different benefit levels, they’re going to pay more attention.”

— Caitlin Clipp, United Healthcare
THE AFFORDABLE CARE ACT: Where are we now?

Q: How is that being done?

HUBER: In our environment, we’re monitoring the number of full-time equivalent employees. We’re monitoring the applicable large-employer status. We’re looking at the coverage and the affordability of that coverage; what plan designs are being offered by the employer, and, of course, the contribution that those employers are making to those plans.

A lot was made of the pay-or-play scenarios. I think most businesses have decided that they can’t afford not to play. If the long-term success of their company is attracting and retaining the right people, they’re going to have to do that not just through cost, not just through salary, but also through the benefits and all of the other things that they offer as well. So, I think from our standpoint, we offer that compliance, that piece that the business owner wants no part of.

There’s been a lot of infrastructure that’s been built, I think, over the last couple of years, and now, it’s going to get a lot easier because we have that in place and we can make smarter decisions to really understand the impact on the business. That’s a key point now.

Q: How concerned should employers be about the "Cadillac tax"?

CRAWFORD: Based on the current tax, they should be concerned. The “Cadillac tax” was touted as a way to target lavish, costly health plans by applying a 40 percent excise tax on plans valued over certain thresholds. The reality is that the excise tax is not targeting plans based on level of benefits, so the actual impact will be felt by common health plans that have more of a "Cherry" style plan. So, while the “Cadillac tax” has been delayed until 2020, we’re still working with employers to implement strategies that mitigate the tax. With the upcoming election of a new president, of course, combined with the fact that unions are going to feel the biggest impact, this is going to be a hot topic, so things could change, but the challenge for Congress will be that getting rid of the tax altogether will create a sizable hole in the budget.

Q: How hard is it to get companies to plan for something that’s four years away?

CLIPP: Most companies are saying we’ll wait and see what happens because there’s a lot of expectations that it could change again; however, many companies want to be very aware and educated so they know what could potentially happen and have almost a plan A and a plan B because they can’t wait until the last minute.

CRAWFORD: We are doing projections for our clients to see if they’re approaching those thresholds and proactively making changes. It all depends on the company. Some have taken the wait-and-see approach, but the ones that know they’re going to hit the threshold or the ones that I said have hit the tipping point in the past, they’re ready to make changes because they don’t want to pay any more taxes than they have to.

CAPPEL: More progressive employers are starting now, I think. We’re seeing a big uptick in our wellness business because I think what’s happening is that it takes awhile to change the culture of a company to a culture of health. So, you can’t decide in 2019 that your company is going to be healthy now; it’s a journey. I think that the earlier point about self-funding in combination with this has really created a different dynamic. I think there is increased awareness around creating meaningful wellness programs and engage-ment strategies to begin to bend that cost curve.

Additionally, I think it’s also chronic disease man-agement. How do you get your diabetics engaged in their condition 12 months out of the year, as opposed to two weeks before they go see their doctor for their annual checkup? That’s the challenge. I don’t think any of us has solved that, but I do think there are some creative solutions out there now to figuring out how to do that, to see what’s working and, also, to understand people’s readiness to change. You have to meet them where they are with targeted programs. It’s going to be a journey, but I think the smart employers are engaging now.

CRAWFORD: Wellness programs are where employers, especially if they’re self-funded, can reap the rewards because they can begin to manage the risk in their population and control or reduce their costs. One way employers are doing that is through onsite and near-site clinics to where they can actually place a physician on staff, if you will. When integrated with a worksite wellness program, an clinic can help create a culture of health in which employees are motivated to improve their health habits—which is the best way to manage long-term health care spending.

HUBER: Own instead of rent.

Q: Is customized benefits something you’re hearing more about? And is this something that could make financial sense?

CLIPP: I think there isn’t a one-sized-fits-all, so you’re absolutely correct—employers are trying to recruit and retain top talent by having plans like that that really fit people where they are.

We saw a lot of this with some of the consumer-directed plans like HSAs—they weren’t the solution for everyone but they were very attractive to some of the folks who wanted to put money away for later. But, on the other side, there were concerns among the higher-aged workers who couldn’t put as much money into them. So, there’s always been a need to have some options, but there’s a fine line—depend-ing on your size—of having too many options, so you have to keep it simple with your available options.

I think what we’re trying to bring to the table is to bring new, innovative solutions that you could offer as an option alongside what you currently have. An example of that is that we rolled out a kids-first plan, which covers all children under 19 so that all of their PCP or pediatrician visits are covered at 100 percent, regardless of whether it’s sick or well. For a company that’s paternalistic or dedicated to family and health and wellness, we put those in so they can say to their employees: “Don’t ever have cost be a reason not to take your child to the doctor. We want them to be healthy.” And it creates that feeling of support and helping people where they need it. So, for companies with a young workforce and young families, that’s really a good fit. But then we have solutions for companies that have a workforce that only go to the doctor once or twice a year and don’t really use the rest. So, we talk about putting a high deductible out there and then having a couple of free or very-low co-pay PCP visits and virtual visits—two or four per person per year—because...
THE AFFORDABLE CARE ACT: Where are we now?

Discussion, from page 5c

cause some people would never use more than that, and it gives them a really nice solution as another avenue to recruit folks.

CRAWFORD: I think employers that truly want to offer the pick-and-choose strategy that you talked about would offer a private exchange strategy. Where it’s like Amazon for employer benefits buying with an intuitive interface that asks you questions about your risk tolerance, and from there will tell you how rich of a deductible or co-pay plan might be the best fit for you.

So, an employer might choose to offer eight health plans – two dental plans, some critical illness or accident plans among other benefit offerings – to supplement a high deductible, but that truly gives employees the choice. The employer then provides a set amount of money similar to offering a gift card – employees go online and shop. If what the employee selects exceeds the amount you allotted, they’re paying out of pocket. A private exchange provides the employers with enough options in order to create a package that best fits their needs, and allows the employer to easily define their budget.

Q: What are the most common frustrations you’re hearing right now from businesses?

HUBER: Obviously, the costs associated with affordable care – that’s probably the first one. I don’t think anyone or any of the business owners I’ve talked to, at least, feel it got any more affordable with some of the legislation. I think the other thing that they’re frustrated with is just change and unknowns.

Let’s face it, we’re coming into an election year and legislators legislate, so there’s going to be change. Change is the only constant we know. Quite honestly, business owners don’t want to have to deal with it. This is something that’s been thrust on them, and I think that’s the frustration. They want to go and be successful and grow their business. They don’t want to worry about whether or not their young employees are getting hit really hard through community rating or by new pricing put into place. They want to make sure these people have good, solid benefits and that it’s an attractor, not a detractor.

Q: What do you guys think? What are the common frustrations you’re hearing?

CAPPEL: I think my conversations would be around cost, but I think there’s also a feeling of a lack of accountability and effectiveness with the current model. I think there’s an understanding that things have to change, so if the ACA has done anything, it’s really put us off of the perch to say we finally decide to do something different. That starts us on this journey toward value.

But, to go back to the accountability piece, that’s where my conversations with employers are. They’re around having an accountable partner who will provide data around patient experience and around quality. At Christ, we talk about how to get people back to their pursuit of life. Through our patient interactions, we work to understand what their goal is, and then, how do we get them back so it’s not only clinically successful but also personally successful? If they’re back to a good state of health, that also gets back to this idea of well being. It starts to feed on itself. To me, that’s the most dynamic change that’s happening in healthcare and that’s what we’re having a lot of conversations with employers around.

CLIPP: And it all leads back to transparency. This has been an area that was kind of behind the black curtain, and people didn’t ask and didn’t tell. It was a very big problem. To pull that curtain back, though, has caused frustration on all levels, among providers, insurance carriers and customers. They’re asking, “What’s really going on here and what can we do about it?”

And I think it hasn’t been a smooth journey to where we are today, but now we’re all on the same page in saying that we want to continue this process, we want to improve this process, especially here we want to do more with what we have, and I think that then allows for more competition, and that’s a good thing in this area. If we start to have hospital systems competing, insurance carriers competing, employers competing for top talent, it really raises everyone’s bar, and it raises the bar of healthcare.

CAPPEL: I think the decision tree has changed a little bit, too, for self-funded employers. It used to be all about the discounts. The carrier and the service levels and some of the innovation they’d bring to the table, but at the end of the day, what’s your discount?

CRAWFORD: And it’s an arbitrary number.

And it’s an arbitrary number. But it fed into this volume issue. And that’s not to say it’s not still important because it is, but I think two things are now being inserted into the equation that are more sophisticated in terms of how to manage cost over time.

CLIPP: And, having that shared accountability back because United Healthcare will actually take on risk if we miss that claims target, so rather than doing a discount, we’re saying, “Here’s what we think your claims are going to be and, if we’re wrong, we’ll pay you back what you paid us and share that risk with you because we feel like we’re a self-funded partner to you. We should have that shared accountability.” Those would have been unheard-of things to say five, 10 years ago.

CRAWFORD: I think employers are feeling very helpless. The model today almost feels similar to a specialty because they know they have to get onto the next one. They have a set amount of time to meet with each patient. So, what you’ve seen is fewer physicians going into primary care practice, but we have more people in the healthcare system now with the development of the ACA. So, you’re seeing retail clinics popping up at grocery stores, convenience stores, etc. But what happens is, there’s no continuity of care, so, while they solve the short-term acute issue, there’s no overall health management.

It is concerning how many employees do not have a designated primary care physician. So, we are seeing employers offer financial incentives through their wellness program to encourage employees to establish a relationship with a PCP. This is important for two reasons, employees obtain an annual physical but it also increases the likelihood of them using that physician versus the emergency room in the future for non-life threatening issues.

The shortage of PCPs is another factor in the development of onsite and near-site clinics that I talked about earlier, a model that is beneficial to all parties involved. Providers in a clinic setting have a smaller number of patients and therefore develop stronger relationships – employees love the concierge like feel and convenience - and the employer realizes a savings because they’re paying a reduced amount for care. There are various clinic models that the majority of clinics are actually shared, which allows companies of smaller sizes to pull together and start a clinic.

HUBER: It comes back to the right cost of care, so they’re not going to the emergency room for a cold or a runny nose. They need to be more thoughtful and intentional in terms of those choices and decisions, and it’s not easy.

Q: What do you think about the population of doctors – not just here in Cincinnati but nationally – and how does Christ Hospital look at this?

CAPPEL: We’re always looking to add more PCPs to our group, so it is a concern of ours, but I think we have a pretty robust group and there are other ways and I think some of that comes from having clinicians work at the highest level of licensure. From that I mean, more and more practices have nurse practitioners to handle the running noses, etc., and, additionally, we see many medical homes offer care managers to help organize everything that has to happen for the person, so often that looks like they’re providing help. There are more access points, so although there is some disconnection between retail clinics and their primary medical home, I think there are more access points through that and through telehealth, and I think over the next few years, we’re going to see telehealth really take off. It may be a generational thing. We might find more adoption from the millennials on that, but it will provide better access to people at more places.

We think that’s one of the reasons people are not compliant with their chronic disease conditions. They have to be out of work for two hours to go see their doctor. Imagine if you could close the door to your office and schedule an office visit at 10:15 and it happens, virtually, at 10:15? It lasts 10 minutes and the prescription is sent by the end of that process.
Q: The baby boomers are now in their 50s or 60s. Is the healthcare industry, in general, set up well enough to handle this big bulge of older — and, in many cases — sicker people?

CLIPP: Do you have a glass ball? Whether or not we’re ready, it’s coming.

CAPPEL: It’s an interesting question. We’ve talked a lot about affordability and part of our mission statement is providing affordable care, so we’re very cognizant of this, as well. While there’s a lot of Christ Hospital building going on around the community, there are outpatient, ambulatory centers and physician offices. They’re not hospitals, not inpatient facilities. So, our idea is to have one facility where you have care teams that do this day in and day out together and manage costs and produce exceptional results, but you have to get out into the neighborhoods and provide access, as well. So, our model is to say let’s get out where the people are. Access to care is not a problem, but also, again, being cognizant of the cost of that big surgery and if you need something more intensive, you drive downtown.

CRAWFORD: That’s a great model — the hub and spoke — because you can staff your most quality physicians at one hospital and be the center of excellence rather than trying to staff multiple hospitals. Being the best at everything at every hospital is not possible.

Q: Explain what a PEO is, Burt.

HUBER: We’re a professional employer organization, so our relationship with the employer is based on a co-employment, and that’s different from most models. They’re actually your employees, too, and, for that, we become the administrative employer; and for that reason, we can offer benefits programs and workers’ comp insurance and other products and services that perhaps you couldn’t get otherwise, that the business would have to get on their own. And we buy for more than 7,000 employees for a company that may have 50 or 100 employees, so our buying power is a lot different.

Q: What does a CEO have to surrender or give up?

HUBER: They’re still the operational employer. It’s still their company. A small business never went into business to become an employer; that’s something they had to do. So we wake up every morning doing those HR compliance, payroll-related tasks, administering benefits and helping them with their claims costs. We do that every day, and we do it for 105 companies right now, so it’s, basically, us plant ourselves inside our company to take over all of those administrative tasks so they can focus their attention on running their business and growing it.

CLIPP: We have so many small employers who don’t have an HR team, or their HR team is also their controller and finance person and answers the phone. People wear a lot of hats in small businesses.

HUBER: And every one of our HR people is certified. If a small business went and tried to buy that, they’d spend easily $80,000 on salary plus loaded costs — they’d be way into six figures — and we have that.

CLIPP: And then with ACA, you’re taking on all of that and making sure they’re compliant, which is another huge headache for people who don’t want to have to deal with all of that.

HUBER: That’s the value proposition of a PEO.

Q: Tim, what are one or two of the biggest changes Christ Hospital has been able to state that have had the biggest impact on the quality and the numbers — the amount of readmissions?

CRAWFORD: It all depends with whom you’re meeting with and what their concerns are. We have an extensive list of consultative services that help employers achieve their goals. I believe the biggest differentiator for Bailey & Company is our unique account management model. Our clients look to us to be quarterback for all things ACA and benefits related so that they can prepare in advance for any future implications of the ACA. We pride in getting to know each client’s goals and their company culture before offering a customized strategic plan. We are all about integrating ourselves into a client’s executive, financial and human resource teams. In order to do that effectively you can manage 60 clients and be involved with every client on the level we need to be. Instead, our account teams manage approximately 20 clients per account management team rather than the typical 40-50.

With this model we are able to focus on educating employers about trends in our industry, and discuss if the various cost containment solutions such as the ones we discussed today are a fit for each client. As mentioned earlier, there are options for clients regardless of their size. But this is the year self-funding is starting to resonate with some of our clients that were reluctant in years past. They are fed up with the current system and want more control. In the self-insured world, ‘building the house’ takes more thought and effort for all parties involved, but if done right, it’s worth the reward. Ultimately, I want to see my clients have a successful business and be able to protect one of their biggest assets — their employees.

CLIPP: Kathleen’s correct. Obviously, there’s a different trigger for every customer you meet, but one that comes to mind for me is everyone in the world, it seems like, faces pre-diabetes and diabetes issues. It’s a known issue. It’s always in the top three causes of clinical issues. But, sometimes as an insurance company, going into talk to someone about pre-diabetes or diabetes, their eyes gloss over, so you have to make it really relevant.

We had a customer that we were talking to about wellness. It became a bit of a droning conversation. What we found out finally for this trucking company is that for their employees to keep their certified driver’s licenses, they can’t be insulin-dependent and diabetic, so that was their trigger. They said, “Oh, we have to fix this problem.” It took that moment of how this could impact me and my population? We had to change our message and show them what it could do for their population. And that’s more than just health and wellness and benefits, that becomes policy. They had guys who were out lifting and as they got promoted, they got to drive in the truck. Well, guess what happened? They still ate McDonald’s for lunch and weren’t as active, so they were promoting them into this unhealthy lifestyle.

Being able to bring a solution that maybe has been there the whole time but really tie it to something that matters to them? That makes healthcare personal.

CAPPEL: I mentioned earlier the Center of Excellence. I think that would be our real differentiator. It’s an experience that’s fixed price — so you know in advance what the price will be — but also the accountability that affords it, if it’s changing the game being the best place in the country that people can travel to for other areas to have these procedures done. So, now, we’ve contracted with many companies that are now doing Center of Excellence work. A good percentage of them may be located outside of Cincinnati but because they need this service around the country, they will provide a travel incentive, in addition to waiving out-of-pocket expenses. It’s a different model. These have been around for awhile but haven’t really been utilized. What we’re doing is different. It has some real teeth in it. So, people are coming in from out of the area. In fact, we just enrolled a company from out of state. They have 40,000 employees up there, and they’re now sending people to Cincinnati for knee, hip and spine surgery.

CRAWFORD: And that concept is actually taking off nationally. It’s great that we have Christ Hospital in our backyard and what they’re doing is phenomenal. We’ve partnered with a company that has solutions for bundled pricing similar to what Christ is offering for joint replacements, but for more than 80 episodes of care and doing so across the nation.

Q: Did we miss anything?

HUBER: I think the bottom line is — at least among the employers I work with — they’re just looking for a trusted adviser and partner. They just don’t want to go it alone. It’s daunting. The compliance issues are not straightforward and they’re ever-changing, so you need a trusted adviser. You need someone you can sit down with to come up with the right solution. We partner with everybody here.

CLIPP: I think that’s probably one of the biggest changes I’ve seen is so much more collaboration within healthcare. In the past, insurance companies were at odds with providers, and there was a line you didn’t cross in terms of sharing too much information between consultants and insurance companies, and employer groups didn’t trust insurance companies. There was just more animosity and tension. And, now, people are saying, “We’re in this together. We’re in to solve it together.”

HUBER: We’d better innovate.

CAPPEL: I think this is really around innovation and, for the reasons you just said, those barriers are broken down and we all know we have to work together. We meet with carriers now on a regular basis about our strategy and we want to know their strategy. And a lot of our contracts now have risks with meeting certain clinical goals, and we’re meeting with larger employers, too, about taking risks around the chronic disease population, so there’s new stuff that’s starting to happen that gives us hope that the trajectory can change.

CRAWFORD: Being a consultant, I love that there are more tools in our arsenal now. More things have come about and our role as a navigator, if you will, has become even more imperative because all of the different solutions that have come out aren’t fit for everyone and you want to focus on the one or two that is.

THE AFFORDABLE CARE ACT: Where are we now?

“I think at the end of the day we’d all agree that although the ACA has been sort of thrust upon the business community, innovation will come out of this, and the resilience of all the industries coming together and coming up with new options is the good news. That’s the silver lining in all of this.” — Burt Huber, Employee Management Services

What are some of the changes you guys have made that have had the biggest impact?

CAPPEL: We start from a pretty strong position. Christ Hospital has been ranked a top 50 hospital for 16 straight years by U.S. News & World Report, and, to put that in context, that puts us in the top 1 percent nationally. It’s a rich tradition there. What we’ve continued to do is to make investments in technology and in people.

So, for instance, we have been first in the nation, first in the world and first in the state in probably 25 to 30 cardiovascular procedures. There are more clinical trials happening at Christ Hospital than at the Cleveland Clinic. Being able to provide this community with access to high-quality cardiologist is a real asset. We track the outcomes, we meet with clinicians on a regular basis. We’re now sitting down in surgical groups and service-line groups to look at the outcomes and look at the variation, and when we find outliers, we do some investigation. It’s more around using evidence-based guidelines to produce more predictable outcomes. That’s the main thing, and then around the patient experience. That’s really our calling card. We really take that seriously.

For 20 years, we’ve been the most preferred hospital in Cincinnati. We partner with others to make sure that experience is absolutely exceptional. We reflect that in our facilities — they’re bright and airy. It doesn’t feel like a hospital. It feels more like a campus.

It also comes down to hiring the best physicians to produce the best outcomes. They all run in support of each other.

Q: Kathleen and Caitlin, what do you feel like is your biggest ace in the hole? What do you feel like differentiates you and gets a company to listen to you?

CRAWFORD: It all depends with whom you’re meeting with and what their concerns are. We have an extensive list of consultative services that help employers achieve their goals.

What do you feel like differentiates you and gets a company to listen to you?
Stay on top of local health business with editor-selected daily news stories and blogs from Cincinnati.

Get it delivered to your inbox every Tuesday, sign-up at: www.cincinnatibusinesscourier.com/healthbiz