2013 MacEachern Symposium:
On a Collision Course? Health Care Integration and Antitrust

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KEYNOTE SPEAKER: JEFF GOLDSMITH
President, Health Futures

"The Future of the Hospital: The Good, the Bad, and the Ugly"

Dranove Good morning and welcome to the Malcolm MacEachern Symposium. I'm David Dranove. I'm the director of the Health Enterprise Management program here at Kellogg. Julie, don't go away. I want to introduce Julie Gertz who's been instrumental in coordinating the program. Those of you who have communicated with us about the program [inaudible, audience clapping]. Also I want to introduce Henry Allen, who will be visible a lot later in the program. Henry's with the American Medical Association and has helped to organize the program.

There are little flyers with detailed biographies of all the speakers and program participants. If you didn't pick one up at the registration desk, you can do so at the break.

Before I introduce our keynote speaker, I'd like to say a few words about Malcolm MacEachern. Malcolm MacEachern was a legendary figure in health care management. Dr. MacEachern joined the staff of the American College of Surgeons in the 1920s to head up their quality improvement efforts. His efforts culminated in the formation of the Joint Commission on the Accreditation of Healthcare Organizations.

Dr. MacEachern also devoted himself to training students at Northwestern University's Hospital Administration program, now Kellogg's Health Enterprise Management program, which he founded in 1943. Ours is the oldest accredited program in the nation and the first to establish itself in a business school.

Dr. MacEachern died in 1956, and his former students started the Malcolm MacEachern lecture in 1976, which, under the leadership of Professor Ed Hughes – who I know is also here – evolved into the MacEachern Symposium that we are all here for today.

Today we honor Dr. MacEachern by continuing to hold this annual event, whose highlights include the MacEachern lecture, which this year will be given by Professor Martin Gaynor from Carnegie-Mellon.

This year's symposium continues our examination of the remarkable restructuring of the health care sector with the emergence of large hospital-led vertically integrated systems. Why is this occurring? What does it mean for cost and quality? And most importantly for today's conference, what are the implications for market competitiveness and antitrust enforcement?

The last question is particularly relevant to Kellogg. As many of you may know, Professor Leemore Dafny is on leave at the Federal Trade Commission, where as the Deputy Director for Economics in the Bureau of Economics, she has responsibility for all health care antitrust investigations. And as Professor Dafny recently stated, "Health care now accounts for half of all the Federal Trade Commission's ongoing antitrust activity."

To explore these questions, we have some of the nation's leading experts on integration and antitrust. To kick things off we're very fortunate to have Jeff Goldsmith. Like all of our speakers, Jeff's bio is available at the registration desk.

I'll just say a few brief words. Many years ago at the start of my career, and not too long into the start of Jeff's, we were colleagues at the University of Chicago. Though our paths have not often crossed since then, I have been an avid reader of his papers and books. Jeff continues to write some of the most thought-provoking articles about the future of health care delivery in the United States, so please join me in welcoming Jeff Goldsmith. [Applause.]

Goldsmith Thank you, David, very much. Good morning to all of you. This is, by my recollection, the very first time I've lectured here at Northwestern, so I'm delighted to be here. David mentioned in his introduction that we were together at the University of Chicago. I was responsible for Planning and Government Affairs at the Medical Center of the University of Chicago from 1975 to 1982, and a lot of my interest in the health care marketplace grew out of that work.

I was part of an internal debate at the university over which part of our decaying physical plant to replace first: our 500-and-some-odd inpatient beds or our ambulatory facilities, which were spread out all over about 15 acres and that were really 1930s relics. I was on the losing side of that debate because my argument was all the growth was going to be in ambulatory medicine and we really needed to replace the ambulatory facilities first.

And when I lost, I assembled all the research materials that I put together to justify the position that I had taken and sent it into the *Harvard Business Review* as an article that was eventually entitled "Can Hospitals Survive?" And that article, which was published in the September/October 1980 edition of HBR, warned about the increasing hospital independence of ambulatory technologies, particularly imaging and surgery, and argued that a huge chunk of what hospitals were presently doing on inpatients would be done in physicians' offices and outside the hospital. This was frightening enough.

But I also warned that health plans, which were rising rapidly, were going to take advantage of their leverage with employers to ration the use of the hospital. These two things would likely have the effect of shrinking the demand for inpatient hospital services over the next decade or two, in contrast to all of the forecasts that we were going to have continued growth in inpatient utilization.

The article predicted a significant decline in inpatient hospital use advocated strategically that hospitals aggressively integrate into ambulatory and post-acute services, and to reach out and control local physician markets.

Well, this article led to my departure from the University of Chicago [laughter], and a nearly 30-year career in health care strategy consulting. Many of the organizations that we are now worrying about hired me to help them build their regional market presences.

The forecasts in "Can Hospital Survive" were accurate. Since 1980, inpatient hospital utilization in the United States has fallen by 1.3 admissions and hospital census by 31 percent in the face of an 80-million person increase in population. And hospitals took my advice about reaching out into ambulatory and post-acute care.

Outpatient services have been where the growth has been in the health system the past three decades, but hospital costs have soared, despite or perhaps because of the shift to outpatient use. The industry has grown from $80 billion in 1978 to $850 billion last year. It's far from clear how much money we've saved by shifting to services with lower intrinsic unit costs.

In 2008, McKinsey analyzed why it is that health costs in the United States are so much higher than you would predict by its per capita wealth. We actually spend $650 billion more in 2006 dollars than our national wealth would predict. McKinsey then decomposed the $650 billion into sectors of spending. For our single-payer friends, I'm sorry to report that only $91 billion of the difference was due to our multi-payer health insurance system and its attendant overheads, and a little less than $100 billion was due to pharmaceutical mark-ups. *Two-thirds* of the difference between what you

would predict the US would spend based on its wealth and what we actually spent was in ambulatory services, both hospital and non-hospital. We actually used 43 percent less days/thousand than the OECD average, so we're astonishingly good on inpatient use control.

A little less than a half of the $436 billion was in the hospital, including both emergency department use and $170 billion elective care. A little more than a third of the difference is in physician office, and that, of course, is not only physician income but also the technical fees that physicians garner from imaging and surgery done in that setting. Other outpatient and ambulatory surgery and diagnostic imaging account for the rest.

So our health cost problem in the United States is really an ambulatory care cost problem. Despite the fact that most hospitals continue to define their core business as taking care of patients in a horizontal position, it is taking care of patients in a vertical position that generates the vast majority of their profits. Three-quarters of hospital profits, according to McKinsey, come from outpatient care and generate an IBIT margin of 35 percent.

So when you think strategically about what hospitals are concerned about, and you're trying to explain their strategy, it really is about controlling their market position in this incredibly lucrative and expensive ambulatory sector of the health system that's the main prize. And unfortunately for them, as you can see, according to the American Hospital Association statistics, it isn't just inpatient utilization growth that's gone to zero but outpatient utilization as well. This has had a dramatic negative effect on hospital top-line growth and on earnings.

So we promised to talk about the good and the bad and the ugly. Here's the good. During the 30-some odd years that I've worked with the hospital community, there has been a marked professionalization of hospital leadership, both on the board side and the management side. You, of course, here at Kellogg made a major contribution to this. You've been turning out bright young people that are applying business tools and perspectives to managing these important societal assets.

It is an increasingly rigorous metrics-based management, too; it's not managing relationships like it was when I entered this field. It really is about performance. It's not just window dressing – the extraordinary energy that's been placed on quality care improvement all across this health system, but particularly in hospitals. One thinks particularly of Accession Health's dramatic reduction in hospital-acquired infections, and, indeed, avoidable deaths. And, believe it or not, after decades of warfare, there has been a slow improvement in hospitals' relationship to physician communities. These are all positives that we can't ignore.

On the not-so-positive side, hospitals have entered what I would call – with apologies – a period of technological menopause. Further, the huge investment in clinical information technology has not apparently generated productivity benefits for society or for hospitals themselves that anyone can measure.

There has also been an unsustainable shift in economic risk from medical communities to hospitals all across the United States. That's creating lots of problems. aAnd frankly a lot of institutions have not addressed their management succession problems. There are an astonishing number of these powerful institutions where the CEOs are older than me – that's pretty old – and where it's not obvious that management is actually building the bench strength necessary to ensure a smooth and thoughtful transition in their leadership.

As a futurist, I'm asked often, "What's the hospital going to look like in ten years?" We make these bold forecasts.. And yet the past 15 years have been a big disappointment for us futurists. The last major new imaging platform in our hospitals was PET, which made its way into active clinical use in the early 1990s; the last major "must-have" imaging tool, 64-slice CT, which entered practice in 1998; the last major advance in interventional radiology and cardiology stents and coils, again in 1998 to 2000. The last major innovation in surgical technology, the Da Vinci robot, which was introduced in 2000. The last major new surgical product line, bariatric surgery, which was introduced around 2000. Our pharmacopeia has been completely outflanked by resistant infections, We are not getting the new antibiotics that we need to cope with this increasingly troublesome challenge from the bacterial world.

The dominant clinical IT platforms in the United States, Epic and Cerner, are 15 years old. Cerner began building its Millennium Suite in 1996, and rolled it out in '98. Epic, which is the dominant provider of clinical information technology for hospitals, rolled out EpicCare in 2000. And the systems that are competing with Epic and Cerner are of comparable vintage. The last major logistical innovation in hospitals, Pyxis, the automated pharmaceutical unit dose management system, was also rolled out in about 2000. The last major clinical productivity breakthrough, the eICU from Hopkins, was also introduced around 2000.

Hospitals used to argue that the reason why they were raising prices was because they were offering a much more improved, technologically advanced product. That argument doesn't have a lot of force now because the product the hospitals are selling at double the cost is essentially identical to the product they were selling 13 years ago.

Don't blame hospitals for the technology drought. I think it's the technology sector and federal regulatory structure (FDA and CMS) that are really

responsible for this lengthening and embarrassing pause in technological progress. But it does raise a lot of questions about the pricing – that is, what is the society getting for the annual increases in prices of hospital and other ambulatory services that they're being charged.

The clinical information technology story is particularly discouraging. Hospitals are spending a fortune on IT: $40 billion last year according to my friends at HIMSS Analytics, , and perhaps $300 billion in the past decade. But actual productivity improvements have been compromised by Windows 95 era user interfaces and serious usability issues that have been largely unaddressed by vendors that are competing rather on feature and function than they are in usability.

There is a full user backlash under way. Talk to a nurse about how they feel about the IT that they are using. They're probably taking his or her charting home in violation of HIPAA to complete the work after hours. There is widespread circumstantial evidence that clinical productivity has declined post-install. The RAND Corporation recently repudiated the study of the societal benefits of investments in health care information technology that they made under industry sponsorship in the mid-2000s.

Can you spot the hospital productivity revolution on this chart? If you adjust the declining inpatient census for outpatient activity, adjusted average daily census in the American hospital has risen about 15 percent since 1980. And yet full-time equivalent employment per adjusted census has risen 62 percent. This may be the only industry in the history of American business that has seen its costs and staffing *rise* as it automated.

And that 62 percent increase does not account for the fact that hospitals have been laying off clerks, coders, minimum wage–level workers, people with no skills, high school educations, and replacing them with $100,000/year database managers to keep the IT up and running, increasingly sophisticated advanced practice nurses and master's-level technicians to run all the machinery. So there has been a steady shift upward in the educational level and skill level of hospital employees that masks the extent of the increase in actual cost of staffing.

Another thing that has been happening has been the role that hospitals have played in the generational transition that's taking place in American medicine. As of 2010, almost a third of the physicians in the United States were over the age of 55, and an additional almost 200,000 or 27 percent between the ages of 45 and 54. So this was the cohort of young docs that was introduced into the medical care system by the big surge in medical school class size that we saw in the 1970s and early 1980s. The US more than doubled medical school class size and introduced this enormous cohort of docs into the medical community who are now nearing their "sell-by" dates.

[Laughter.] The most entrepreneurial generation of docs we've ever seen is nearing retirement.

The 2008 crash destroyed the value both of their retirement savings and their medical real estate holdings, which they had counted on selling to finance their retirements. So when they began looking at the numbers after the carnage in 2008, they realized their options were really limited. They could move in with their kids (if their kids weren't living in their basements).. [Laughter.]

Or they could buy a trailer somewhere up in Waukegan, right? That was about it. I mean they really didn't have a lot of options. They actually began making changes before the crash that kind of accelerated afterward. They postponed retirement; they had to. And they also stopped hiring. So the young docs turning out of medical school with $200,000 in debt and wanting to practice in a community frequently found that the only place that was hiring was the local hospital because the private docs didn't have enough cash flow to be able to take in junior partners.

They also accelerated their withdrawal from hospital practice, meaning that they stopped admitting patients to hospitals, and turned to the hospitals and said, "Would you please hire physicians (e.g. hospitalists) to take care of my patients, because it isn't worth it for me to come to the hospital anymore."

So you actually saw medical communities diverging. You saw a community of people forming in the hospital that never left it – like we had pediatrics for years – but also a community of docs that never went to the hospital because their practices were based in their offices.

One of these older docs said to me, "We just sort of took our foot off the gas." Older physicians were just a lot less aggressive when a patient would call up with a problem, they wouldn't say, "Well, hey, how can I help?" They would say, "Well, go to the emergency room." And they used to say, "I'll meet you in the emergency room," but since there's hospitalists there now they don't have to meet them in the emergency room. In fact, many community physicians cannot find their own patients in the hospital because they don't know who's taking care of them.

So it's really been an interesting transition. I think that withdrawal of the Boomer docs from aggressive practice is one of the factors that's led to the reduction in inpatient use we've seen, particularly in the past five years. Finally, after 30 years of fighting with hospitals, many older docs turned to hospitals either for supplemental income to pay for call pay, directorships, or whatever, or to hire them part-time for a full-time salary as an economic bridge to retirement.

And so a lot of hospital execs [laughter] kind of experienced this (shows photo of the helicopter on the top of the US Embassy in Saigon at the end of the Vietnam War). Some policy types have the idea that hospitals were aggressively out there buying up docs trying to dominate markets. That wasn't really the impetus at all. There were a huge number of refugees from economic risk of independent practice that made their way to the hospital and said, "Hire me or I'll go to work for someone else."

So the idea that we can blame hospitals for the significant rise in physician employment, I think, is wrong. The flight of independent physicians from economic risk of independent practice has clearly had the effect of substantially broadening the hospital's footprint in a new market: the market for physician services.

In contrast to some of the data that you saw in the *New England Journal of Medicine* a couple of years, the Kocher-Sahni article, the percentage of docs employed by hospitals is far less than 50 percent. These are the AHA's survey data on the employment of physicians by their members. If you count full time and part time together, approximately 125,000 physicians were employed by hospitals in 2011.

So, you know, if there were in 2011, maybe 760,000 practicing docs in the United States, hospitals employ a little short of 20 percent of them. The residents aren't in here; there's like about 100,000 residents. And I also didn't include the physicians that have exclusive contracts with hospitals, like the emergency room groups, the hospitalist groups; that is a larger number.

But the people who actually get their paycheck from a hospital, it's about 125,000 docs in 2011. I suspect 135,000 today. It's not going very well. According to the Medical Group Management Association in 2010, the average hospital-employed doc lost the hospital $212,000 in the difference between what they guaranteed the doc in salary and what they actually generated in professional fees. The costs of practice are actually lower for the hospital-based groups, but productivity is 30 to 40 percent below what it is in physician-owned practices.

Those losses apparently narrowed in 2011 to maybe $184,000 a doc. That's still serious money, so if you have a 300-person employed physician group, you're burning what? $50 or $60 million a year. If you have a 1,500-person – well, you do the math.

Moody's actually cited these losses as a near-term threat to hospital profitability in 2011 and, therefore, to hospital bond ratings. Although there has been more recent analyses from Moody's that suggests that all of the ambulatory revenues that these employed docs have brought to the hospital

are actually generating positive cash flow for the institution, despite the losses in the practices. So there's clearly an instrumental benefit to incurring these losses.

And, of course, the first impulse in narrowing the losses is to switch docs back to a fee-for-service type incentive, to put them on RVU comp – or what is inelegantly called by my financial office friends, "eat what you kill" compensation models. This is, of course, poison under shared savings, because you're telling the doc, "Bring us more scans," and then you're turning around and trying to manage down the per capita utilization of your Medicare patients. It's kind of hard to do both of those at the same time without getting either a massive headache or losing money somewhere.

So what hospital systems are doing now is culling their herds and beginning to terminate the bad contracts. One of the reasons why these losses went down in 2011 is because the contracts that were made in the post-crash panic have come up for renewal, and a lot of those are being renewed at lower salary levels. Or hospitals are letting go of docs that were just blatantly unproductive and were just putting their feet up and collecting salary.

So for a lot of my friends in the hospital business, this is the single largest problem that they have–trying to manage down their physician spend as their cash flow declines.

Now this is circumstantial evidence perhaps, but look at these trends in Medicare spending per capita. That is per capita Medicare outpatient hospital spending has more than doubled since 2003, when this most recent employment surge began, and a sharp ($200 per capita) increase from 2009 to 2010, when the upswing was in full force.

Now my finance friends tell me that the typical hospital is losing about 13 cents on the dollar in its Medicare outpatient use. The reason why I show you this is because I want you to think about the gains in the *private* health insurance ambulatory markets that probably closely track these Medicare numbers. I strongly suspect that we've seen more than a doubling of privately insured outpatient business as the result of these acquisitions, and huge earnings leverage from the mark-ups on the cost of privately insured ambulatory business.

So it's not like idiocy that hospitals are losing the money on the practices themselves. They were generating as much as a 3-dollar to 1-dollar return in principally outpatient revenues from pulling people that were formerly managed outside the hospital. But as a society, what we've been doing is trading $700 CT scans for $3,500 ones, which I think is ultimately not a very good trade.

We haven't got to the ugly part yet. [Laughter]. Serious quality and product integrity issues remain in hospital space. Hospital costs have also, at least in this observer's judgment, reached a crisis of disbelief. Market consolidation has unquestionably contributed to this cost problem. And the policy conundrum which we face with the ACO is deputizing hospitals to contain what is largely a hospital cost problem is probably not going to work very well.

Now whenever something reaches the *New Yorker*, you kind of know it's in the zeitgeist. And I love this *New Yorker* cartoon of a few years ago. This is a hospital admissions officer saying to the patient [laughter] "Fill out this tag and attach it to your big toe." There's some issues here.

And I am not discounting the fact that hospitals are taking this problem seriously. Don Berwick really came to the industry's attention through the most marvelous process improvement movement in our health system. And a lot of the things that IHI was trying to do were very prosaic things, you know, rapid response teams, reducing catheter-born infections – but all good; the small but growing footprint of institutions that are using Toyota production system's rigor around sort of factory-floor management and process chains to try and improve health care quality in their institutions.

So Virginia Mason, ThedaCare, The University of Denver Health System, Geisinger's remarkable work in bundled care and warrantying surgical practice, ninety day post-op warranties, the patient centered medical home, all the work around the ambulatory ICU. There are great things going on in hospitals that we should not dismiss, and yet there remains a significant reliability problem.

This is a picture of Sir Edmund Hillary. As someone has pointed out to me, not the first person to climb Mt. Everest, but the first person to return from the summit of Mt. Everest safely, a crucial distinction. The reason for the safe return was his colleague, the redoubtable Tenzing Norgay, his Sherpa guide. Where did Don Berwick's IHI come from? It came from a personal experience with a Harvard teaching hospital, on whose staff he served, that nearly killed his wife, Ann.

I say to people who claim to be, at great insistence, "integrated health systems": "How integrated are you exactly? Is it possible for a patient to simply be admitted to your institution without having to have a relative there 24/7 to make sure that the person isn't harmed?" So to me, we've reached a certain quality threshold when the reliability of hospital processes is sufficiently high that you don't need a Sherpa to come with you to the hospital. If we're paying a fortune for this product, a patient shouldn't have to bring a Sherpa to the hospital with them to make sure that they aren't harmed.

Now, of course, a couple of months ago Stephen Brill unburdened himself of this 45,000-word indictment of the hospital industry in *Time* magazine. How many people read *Time*? You see? It's actually remarkable how few people read this article, except in Washington. If you're a hospital exec, it's probably a relief because this was a broadside at hospital pricing, more than any other single thing.

Forgive the following Reagan-esque anecdote; I've got one. My wife's Pilates instructor, 51 years old, was playing in her backyard with her kid, tripped over a ball and broke her leg. She had a spiral fracture and she went to our local university health sciences center, and her 8-hour visit cost $23,540. The imaging charge of $2,770 was not a CT scan, but an X-ray. It was like of two adjacent body parts – $1,300 apiece. The anesthesia charge did not include the anesthesiologist fee. There was another $3,000on top of the anesthesia and surgical fees. A $26,000 broken leg. She's uninsured, and earns less than $23,000 as a Pilates instructor, so literally, more than an annual income for eight hours to fix a broken leg.

There are political consequences – political consequences, not just economic ones – to dropping enough bills like this. Even a wealthy person with pretty good insurance is going to end up with a couple thousand dollar liability for an emergency room visit like this.

Now, of course, when you're afraid, one strategy available to hospitals is to merge with your competitor. [laughter]That's a Northern pike, and, I think, a lake trout, a soon to be "ex" lake trout that's been engulfed by it. There is no question but one response to the uncertainty – and I think that's what it was – the Affordable Care Act didn't actually change how doctors and hospitals were paid; it just raised this fog of confusion and doubt in the industry. And I think the movement to consolidation, both on the hospital and physician side, was driven more by that fear and uncertainty than by actual changes and incentives in the law.

My colleague, Ken Kaufman, whom you will hear from later and whom I respect tremendously, has been giving a talk around the country about the fact that the consolidation in the hospital industry is inevitable, and that that consolidation is driven by – I love the Moody's quote, "perceived benefits of economies of scale." I also like the Fitch one, "Providers will realize the need for scale and size to drive efficiencies is increasingly important in a tightening reimbursement environment." "Rumor has it. . . "

Ask Ken for the numbers on demonstrated measurable efficiencies and scale economies. When I talked to David Dranove about these this, he said, we don't have a lot of numbers on scale economies in hospital operations, current or otherwise. People haven't studied this recently. They've studied

the effect of mergers on hospital costs post-consolidation. What they haven't studied is whether hospital systems of $3 billion produce a demonstrably more efficient economic product than hospital systems of $1 billion or $500 million. We don't have those numbers. Remarkably, it is something that is merely assumed to be true.

My colleague, Nate Kaufman, a fellow management consultant, has an entirely different thesis. And his thesis is that the secret to hospital profitability isn't production efficiencies; it's unit revenue generation and payor mix (e.g. percentage of patients with private health insurance) that's really responsible for economic performance, not cost efficiency. And he cites data from the Center for Studying Health System Change: the top quartile of most profitable institutions generate almost three times as much bottom line from net revenue per discharge – that is insurance contract–generated revenues – as they do from lower expenses. So a 3:1 ratio of revenue, enhanced revenue generation versus cost reduction. Mergers have been driven, in my judgment, more by unavoidability and by achieving leverage with private insurers than they have by some questioning Walmart-like cost advantage in procuring services. You just cannot talk about those things in public directly, so merger advocates do it in code.

Some observations from a management consultant and colleague of a lot of people that run these places: there are no meaningful economies of scale in hospital services or any other health service. I've just finished writing a 110-page book on physician practice with Rob Burns, chair of the health care management program at Wharton. We can't find them in physician services either. So it isn't just hospital services. There actually is a lot more literature on physician practices than on hospitals. There are no net returns to scale from growing the physician group that we can find or apparent measurable qualitative improvements either.

There are, however, significant diseconomies of coordination in hospital services. A $3 billion hospital system has more layers of management between the CEO and the patient, more expensive management because they pay their people more. Bigger consulting budgets, bigger IT budget, bigger, bigger, bigger…

So it's not clear to me that we're actually saving money by merging smaller institutions into larger ones. We're simply increasing their cost basis and then going to private insurers, particularly the smaller ones, to get more revenue to cover the higher costs.

Since all payer dynamics are local, profitability comes from metropolitan market leverage with payers, not management control. The major operational side effect of mergers is three to five years of operational paralysis as senior management and physicians jockey around to keep their

jobs. And of course, three to five years' worth of changing management reporting systems, accounting systems, refinancing the thing, putting in new IT. I mean it really is not a fun process to go through. There is a thick fog associated with a major merger that really slows the new institution down and prevents it from focusing on its businesses and relationships. It's a great time to go after them if you're a competitor. To paraphrase a colleague in Wall Street, "It's either make deals or run the business. It's really difficult to do both well at the same time."

But, of course, the market leverage pays off. This is from the EMMA database, which is the municipal bond database so that people consult when they're doing financings. These are remarkable 2011 EBIT operating earnings for the major non-profit systems in the country, showing the financial rewards for achieving market dominance. There are some former clients here. Sutter was a client. The Sisters of Providence in Oregon were a client. Advocate Health Care here in Chicago was a client. These health systems worked successfully to dominate their markets, to create the infrastructure that would enable them to be sole-source contractors, and to compete effectively with Kaiser or other integrated health plans in their markets.

Then there's Jamie Robinson's article in *Health Affairs in 2011* that I'm sure a lot of you looked at. His argument is that providers operating in competitive markets are a lot more efficient because they are compelled to reduce their costs. And as a result they generate contribution margins off their fixed payments from Medicare DRGs at the price of significantly smaller operating margins in private insurance.

In concentrated markets, on the other hand, they may lose money on Medicare because there's less pressure to manage their costs, but they are able to juice the private insurers in their markets for significantly higher rate increases.

And there is Paul Ginsburg's data, from his 2010 issue brief on the twelve markets that his center studies. What this shows is where the real hospital markups are in these markets in outpatient services like imaging and ambulatory surgery. Look at the San Francisco Bay area – one of the least competitive hospital markets in the United States – the people in the highest percentile in payment rates have a 700 percent mark-up on Medicare on their outpatient services. We can look at these mark-ups as approximate indicators of the efficiency of hospital market strategy [*chuckles*], in other words, the degree to which you've limited the power of private insurers in your markets. You can see how much higher the mark-ups are for outpatient services than they are for inpatients to return to a theme that we talked about earlier. This is where the real battleground is – ambulatory services costs in concentrated markets.

I think policy makers have made some questionable policy assumptions about where hospital consolidation is ultimately headed. Since the 1980s, hospitals have diversified, that is, spread out along the continuum of care, entered the physician market, entered the financing arena by offering captive health plans. Multi-hospital systems renamed themselves, integrated delivery networks. Therefore, policy makers believe, if you give them enough risk, IDNs will evolve into Kaiser, which is essentially the theory behind the ACO. In other words, Partners or Advocate Healthcare becomes Kaiser. It's not working out that way. Most IDNs treat their health plans as a subsidiary to their health system, not the core business, as a feeder to their hospital and physician groups.

And sure enough, when you look at the STAR ratings for Medicare Advantage plans. These are the 5-star plans. There is one hospital-sponsored plan on this list, Health New England, that's owned by the Bay State Health System in Springfield, Massachusetts, that has 7,000 Medicare Advantage. You go down to 4.5 stars; there aren't any. So if you're using the STAR ratings as sort of an measure of health plan quality, we're not getting the health plan quality that we are perhaps looking for IDNs.

Now, we come to the ACO. Those of you with memories of Mao Zedong will remember in the late 1950s he wanted to compete in the steel business with the United States. So he decreed "Let's build a steel mill in every village." And those are the backyard steel mills that were built during the Great Leap Forward. Starving peasants went out and foraged for sticks and twigs, and the Party would bring them iron ore and they'd make steel in these things. The steel was unusable junk.

That's what we're doing with the ACO. After decades of building buildings and consolidating, and trying to fill the buildings, hospitals all over the US, large and small, are going to morph into Kaiser. We were going to teach our local health care systems to become health care financing vehicles. Because we know they have had great difficulty in the past managing the risk, we're going to give them a no-risk way of getting into the managed-care business.

So to my mind, managed care without the risk, where you're just trying to reduce the rate of increase in cost, is sort of like vegan barbeque, or a gin and tonic without the gin. If you understand managed care, you realize that performance is a function of managing a fixed pool of resources. That if you can't figure out how to deliver care to an enrolled population of people – who, by the way, choose you and give you permission to work with them – then you lose money and everybody gets angry at you.

And the ACO, in, 95 percent of the first wave of ACOs, there was no downside risk at all. A lot of the attractiveness of this idea came from people on the left

wing of the policy community who were convinced that if you could teach hospitals how to manage the risk, then you wouldn't need to contract with health plans under Medicare Advantage. You could just have shift risk inside the Medicare program directly to providers. You wouldn't need those nasty insurers any more. I think this is going to turn out badly.

So a policy conundrum. In 1980 hospitals were 40 percent of the health spending in the United States. Today they're a little more than 31 percent. Yet, through consolidation and vertical integration, hospital systems have come to dominate regional health care markets. The strategy I advocated in "Can Hospitals Survive?" was a successful strategy. Market dominance has led to economic exploitation and unacceptably high costs. Hospital rate review, the solution *du jour* for this problem, is unlikely to solve the cost problem because it grandfathers in absurdly high costs and cost shifts and will be captured by the industry. Paternalistic solutions like the ACO and a new wave of health plan use controls probably won't work either because the facts on the ground are that organizations like Partners and Advocate health care have become unavoidable.

I believe the most likely solutions are likely to involve strengthening the role of consumers and physicians. Isn't that a revolutionary idea? Doctors and patients [laughs], who have been marginalized by the changes that have been taking place in our health system, need to play a central role in controlling and managing cost.

I believe the way you do that is through a reference pricing approach, where when someone becomes sick – I'll say they need cancer treatment – it's not just the two choices defined by hospital mergers that determine where they go. Maybe they have the option of going to Memorial Sloan-Kettering or maybe to a local oncology group.

But the point is to present people with a variety of choices for a fixed contribution. For the people that choose the high-value price – the high-valued bundle of benefits – there's no cost sharing. Or maybe the people that go all the way to the most cost-effective plan, maybe write them a check, in effect rebating back to them a portion of the savings that they're generating for the employer or the Medicare program.

It's something very similar to what Safeway has done with high-priced diagnostic services like colonoscopy in the San Francisco Bay area, and what Walmart is doing with heart care. I think we need to do a lot more of this. And we need to focus the reference pricing on those high-cost, high-margin ambulatory services that everybody's going to be worrying about. So multiple choices with a zero out-of-pocket cost option for consumers. I think we need to expose the high-cost institution to competitive pressures in the high-margin services. You don't need to do it across their entire service lines,

but that $3,500 CT scan, the $7,000 colonoscopy – that's where the profits are; that's where the leverage is to discipline these institutions to bring down their costs, not just to moderate the rate of increase.

More physician risk assumption will help, which why I've argued that we need a new wave of IPAs and physician group-sponsored health plans. I think we need to put resources behind the physicians that do not want to be serfs in hospital systems. We need to give them the market leverage to try to manage populations of people. I think you will find an increasingly receptive audience for this. This was not an approach taken in the Affordable Care Act; It needed to be.

Other policy options, which you'll be talking about: more aggressive antitrust enforcement will also help. It is cheering to learn that half the Justice Department's resources are going into this space after 20 years of failure. It's never too late to get started. But not just mergers – it isn't the percentage of a market that really matters, but the behavior of the high-share entity.

Is the entity using its market power to try and stifle competition and limit choice? So most favored nation pricing deals and exclusion of community-based providers, absorption of competing physician groups into the hospital, and eliminating their ambulatory services – these are the places where antitrust attention needs to be turned, to anticompetitive behavior.

I also think the narrow network exchange products will help. If I can save myself 30 cents on the dollar by having a well-defined and more economically efficient network, I'll be a happy person. I think we're going to see a lot of the products offered under the health exchanges that follow this type of model. We need the PPO to go away, because the PPO was really the point of leverage for market consolidators, who were saying, "you can't not include us."

I also think non-profit status ought to be on the table. A neighbor of mine in Charlottesville was a successful executive in the travel industry went on the finance committee of our local hospital board. He went to a couple of meetings. He was absolutely dazzled by the lack of specificity and focus in the reports that he got. His question was, "Who owns this place?" If the community owns it, well, I'm a member of the community. I don't have any influence here at all. Who really owns this place?

Well, I think the answer is who owns the non-profit institution is the person that has constructive use of the assets and is able to use control of those assets to generate contracts, to generate compensation. We ought to be asking the question – Regina Herzlinger at Harvard asked it 20 years ago – is the community getting a return on the investment that it has made by forgiving these very substantial and successful institutions' profits?

Uwe Reinhardt proposed this years ago: don't just take the non-profit status away; you make all hospitals for-profit, but permit them to credit back against their operating earnings the community contribution that they've made. And maybe if they're generating more contribution than they're generating in profit, there's some form of community benefit that comes back to them in addition to the tax exemption or they can carry forward the net benefit the way we do capital losses on our tax returns. I think we need to think hard about this.

The problem with making the hospital the center of our health care system is that hospitals will always treat the illness that you can do something about as more important than the illness that you can't do something about. And it is those latter illnesses – diabetes, congestive heart failure, etc. – where we are failing. It is the chronic illnesses that are not cured by some magical expensive intervention that are the real problem our society's going to wrestle with as my generation begins falling apart, which could be any day now.

Thank you all very much for having me here.

So we've got a couple of minutes for questions?

Man 1 Yeah, two quick questions. One, can you comment on the future of employer-sponsored health plans? And secondly, how can we get a hold of your deck?

Goldsmith I was a big Wyden-Bennett advocate. I think the employer's role has been a big problem. The employer is where the PPO came from. The employer is where "you can't exclude anybody" came from. I think employer-sponsored plans were directly responsible for creating the situation where you could exert market leverage. So I think employer-based plans need to go away. The Affordable Care Act is going to wipe them out slowly instead of quickly. Wyden-Bennett would have done it all at once. I think we're going to see a significant reduction in the number of people in employer-based covered, particularly for employees under $50,000 in family income because it is so much better a deal for them after tax to get their coverage from the exchange.

Man 2 There has been moderation in health care cost growth over the last three or four years. Is there a solution or partial solution in whatever is driving that?

Goldsmith Well, I mean, I've got a whole separate talk about that. And my argument is, or part of it is the technological menopause thing, the fact that we're not getting the "got to have it" drugs. We're not getting the "got to have it" technologies that were driving cost in the 1980s and 1990s. But I think the bigger part of it is that an increasing number of Americans just can't afford to

use this product. How many people in this room could afford a $23,000 broken leg if you didn't have health insurance?

I could tell you it would be a problem for me, and I'm not underpaid. So I think that a major drag on the growth and demand for health care in the United States has been the expense. And we have pushed the cost of coverage. I mean, only about 20 percent of health plans consider the income of the employee in deciding the level of co-payment. So for 80 percent of the health plans, that person on the loading dock or the administrative assistant may have five times as much of their paycheck at risk when they get sick as a CEO or the HR genius that negotiated the health plan contract. So I actually think that what has slowed down the demand for care more than anything – and it began slowing down before this recession – was the growing number of Americans that just cannot afford to use this health system any more. Our problem isn't the rate of growth in health costs. It's the absolute level of those costs.

Man 3 I see the health care system falling apart. As the costs continue to go up, and as the population ages, and we're not getting a health system where a patient has information and controls the dollars to make decisions based on the cost of quality. With that being said, are we moving to a free-market system in the future or are we moving to the single payer?

Goldsmith Well, the single payer system would have had to been built by the geniuses that wrote the Affordable Care Act. How many people feel positively about the partial movement that we've made towards more government involvement in our health care system? We're not going to have single payer in our lifetime. I think it's a false dichotomy. We need intelligent involvement by government. We need government to be an effective, thoughtful purchaser of health services. We need health insurers to give us choices and help save us money. Is that a market system? The government is all over our health care system and it's not going away. It didn't go away during the Reagan era. We need intelligent government and we're not getting it.

Woman What about the idea that scale is necessary to build the technological and human resources capabilities you need to manage risk and improve quality?

Goldsmith So you need to be a $2 billion health care entity to spend $300 million on Epic, that produces what in the way of ROI? That you need seven layers of bureaucracy between the patient and the CEO to do what? It's not clear to me what capabilities are being created in these multi-billion entities. Let's see the results. Let's see the return to the patient. I don't see it.