The annual Munich Re Healthcare Symposium took place April 3-5, 2016, in Scottsdale, Arizona. Munich Health North America invited their top clients and partners to talk about the future of healthcare. On the following pages we feature excerpts from the speakers at this event.

Table of Contents

Karl Rove & Governor Howard Dean
Debating the future of health reform and the 2016 election
Karl Rove and Governor Dean discuss politics, the economy, and their impacts on healthcare.  

Josh Linkner
Innovation: driving creative disruption
We so often are faced with the risk of trying something new, but we usually fail to contemplate the risk of standing still. What happens if we don’t adapt or innovate?  

Dr. Eric Coleman
An unrecognized key to improving transitional care: feedback loops
How can we keep hospital care providers updated on the status of the former/future patients?  

Bill Copeland
The US healthcare system: innovation as a curative
Innovation is a holistic process that changes the way that we do business. Done right, it’s where you get “More for Less”.  

Secretary Kathleen Sebelius
Healthcare reform – an insider’s view
A progress report on the Affordable Care Act, reviewing keys to the future, and topics on the horizon.  

Dr. Nathan Wolfe
How much epidemic risk are you holding?
Reviewing how our global interconnections make epidemics worse – and how they can make them better.
Debating the future of health reform and the 2016 election

Ives: Do we agree that the Affordable Care Act is now settled law? And, if so, are there amendments and modifications that should be made, and in today’s Congress, is that even possible?

Dean: We are now two years into the bulk of the Act, and we can see what is happening: the creation of Accountable Care Organizations. They may have been an unintended consequence of the Act, but for once, that is a good thing. The ACOs are contributing to the demise of fee-for-service medicine, and that is absolutely critical, so that people stop paying for stuff that they don’t need and doesn’t contribute to their health. This is starting to transform the healthcare industry, where the ACOs attempt to vertically integrate the system and remove fee-for-service. The government, via CMS, started this process, but the private payers, the insurers, are also going to demand an end to fee-for-service medicine. Will there be some changes required? Of course – most agree that the exchanges are in need of modifications. But any changes can only take place with a Republican president, House, and Senate.

Rove: I don’t think that it’s settled law. I think that Howard is right that the unintended consequence of incentivizing things has undermined fee-for-service, and that may be the largest, most consequential result of the Act. But let’s be honest, every single promise used to sell the ACA turned out not to be true: we were told our premiums would go down by 20% or $500 a year; if we liked our doctor, we could keep our doctor; it won’t add to the deficit. Since its passage, 9 million people have lost their private coverage. The real expansion of coverage is through Medicaid, a second-class system. And if this were all that good, we wouldn’t have large insurers exiting on a weekly basis.

Ives: if you were empowered to make one change, what would it be?

Dean: I would accelerate the process and outlaw fee-for-service medicine. True, there are always going to be people with enough money to buy their own and I’d let them do whatever they want, like Concierge medicine.

Rove: I’d extend the tax benefit to the individual, to make health benefits transferrable and transportable, so that people don’t lose coverage just because they change jobs. I’d also limit how much they can deduct for insurance: heck, we limit the size of the deduction for home mortgages, we ought to limit the amount of “free” insurance, because one of healthcare’s big cost drivers is the gold-plated health insurance policies.
Ives: Do you think that there should be some type of government strategy looking at prescription drugs and their cost drivers? If so, what would that program look like and how might we define success?

Dean: I think that some of the most egregious behavior is coming from outliers. Only about 10% of the healthcare outlay is on drugs. And if you look at what they do today, it's pretty extraordinary. When I was a resident 30 years ago, the standard hospital admission time for a myocardial infarction was 10–14 days, but now it's just 2–3 days. People point to the new autoimmune and oncology drugs that might cost $80,000 to $120,000 a year. That's an outrageous amount of money, but when you compare it to what you would have spent on all other treatments, is it too high? And isn't the outcome better? I don't enjoy the rhetoric about how evil drug companies are, and most of that is coming from my party!

Rove: It's ironic, really, that Trump, Clinton and Sanders sound virtually alike when it comes to the drug companies. But I agree with Howard, that if one company raises the price of a pill to $750 then in a matter of weeks another company comes out with a $13 generic pill. The markets have a way of taking care of that. I'd be very careful about creating more regulations for the drug companies and turning them into public utilities, where the government dictates prices and rates of return. If they can do that in one part of healthcare, then they'll do it in other parts as well. We should try to find ways to incentivize competition and add to transparency in pricing. I don't have the answers, but I'd be careful in saying that we should have the government solve our problems. Obviously, this kind of change would stifle innovation. Right now, we are the research and development capital of the world, and one reason is that the drug companies can produce a drug and market it here and then sell it around the world where other countries have price controls. I don't want us to surrender as being the source of innovation.

Audience question: The commercial marketplace accounts for 33% of all hospital admissions, while at the same time accounting for 74% of all of the financial contributions to the provider community. That type of subsidization, or cost shifting, is mostly done with the large Fortune 500 self-insuring plans. Is that kind of cost-shifting model sustainable?

Dean: I think that cost shifting in general is not sustainable, and I hope that is going to be dealt with by the movement to capitated care and away from fee-for-service. Cost shifting is a conscious strategy that basically makes up the difference of the shortfall from the people that you can't negotiate with (the government) and takes it out of the hide of the people that you can negotiate with, which is the private sector. The solution is to not simply add more money to the Medicare and Medicaid reimbursements. We need to put providers at risk instead of the payors. This would reduce the incentive for cost shifting.

Rove: I don't think that you're going to get rid of the incentive for cost shifting until you fundamentally reform Medicare and Medicaid, because you have price controls on that side of the equation, where in many instances, the payments are less than the actual cost of the services. If you had a troubled birth with a lot of time in the ICU, the government is only going to reimburse a fraction of the cost, so the hospital is going to have to make that up by getting money from elsewhere on other procedures that are performed. Until we reform Medicare and Medicaid, we will only be able to nip at the edges of the problems of cost shifting.

Audience question: Do either of you gentlemen have any idea about the FTC's position on the big mergers and consolidations in both the insurance segment as well as in the provider community? In certain geographies we are getting close to monopolies where you cannot do business in a state without doing business with those mega-health systems.

Rove: I think that the FTC is going to approve them, but like you, I worry about competition. I worry about concentrations of these big institutions and I worry about the related lack of transparency. The Bush Administration did a study in Milwaukee where we looked at pricing and outcomes for the 20 most common procedures, and there was no relationship between the outcomes and the pricing, yet the price differentials were jaw dropping! As much as 300% differences in prices at hospitals that were 2 miles apart. So I want more competition and more transparency for the consumers, and all those that help the consumers – namely, their insurers can do a better job of sorting this out. That's one of the things that came out of Medicare Part D, which is the only government health service that is coming in 40% under its estimate.

Dean: Basically, if you're concerned about cost, you have a choice between regulation and competition. In Vermont we have one hospital system that controls about 80% of all healthcare dollars, and all physician groups are tied to either that hospital system or one single ACO. There is no question in my mind that we are going to have to regulate the hell out of them. There is no other way to control costs in a monopoly.
Innovation: driving creative disruption

When you think about risk, especially as it relates to healthcare, there is patient risk and business risk. As for the patient risk, there are “contributing behaviors” that may be beyond the patient’s control, like family history. Clearly, if they are into skydiving and eat bacon-maple-donuts for breakfast, that isn’t quite beyond the patient’s control.

But if you take the time to think about contributing factors leading to negative business outcomes, so often we think about the risk of trying to do something new, but we fail to consider the risk of standing still. What is the risk of complacency?

The world of insurance is changing so quickly that if we aren’t the source of disruption, we run the risk of being disrupted. In a rapidly changing world of increasing complexity and regulatory burdens through the roof, what is the antidote? It might just be an interesting technology called “human creativity”.

A couple of fun things about healthcare innovation and technology:

- The first involves burns. Researchers are borrowing from how urban street artists apply spray paint to city walls. Combining stem cells with a saline solution and spraying thin layers onto the patient, has generated incredible outcomes in a matter of days.

- A new infrared device helps illuminate veins in arms so that healthcare professionals can more accurately draw blood from patients.

- A new bandage reacts to pigment changes based on the detection of bacteria so the healthcare professional won’t need to remove the bandage to check on the status of the wound.

Now you might be thinking to yourself that this is really interesting, but I’m not on the R&D front. I’m responsible for risk and the business aspect of patient outcomes. Well here is my big idea for you – innovation doesn’t only apply to those wearing lab coats. It applies to us all. We can embrace the same creative wonder to the context of our daily work. Everyday innovation, little innovative acts, may not make the cover of a magazine, but may drive real progress for ourselves and those that we serve.

This could be how you run your Monday morning team meeting; how you interview a new job candidate; how you review internal processes to drive more efficiency and reduce patient risk. In this context, innovation applies to everyone.
I wrote two books on the topic of creativity and innovation because I became obsessed with the topic. I kept seeing the same pattern again and again: the most innovative companies and the most innovative people tended to be the ones that enjoyed sustainable success.

My research resulted in some great news – creativity is a gift that all of us have and there is an actual process to put this type of thinking to work on a daily basis. Make creativity a daily habit. This doesn’t mean betting the farm on irresponsible risks. It means running lots of little experiments and allowing your creativity to shine on a regular basis.

I had the chance to interview over 200 thought leaders: artists and musicians, CEOs and billionaires, and non-profit leaders, and military folks. I noticed some very common themes, philosophies and approaches from the most innovative people and companies. It all boils down to the “five obsessions of innovators.”

The first obsession is getting curious. Curiosity is the building block of creativity. How do you do this? You begin by asking a lot more questions. It’s easy to save time and accept the first answer that comes to mind. Ideally, start asking questions about the challenge, using questions that start with “Why,” “What if”, and “Why not”, which will force you to challenge conventional thinking.

The second obsession is what’s next. This can be a real driving force. Since we live in a world with the fastest rate of change in history, this forces you to stop blindly saluting the methods of the past.

The third obsession is defiance. When you see a tradition, challenge it! Ask yourself if another way of doing things could yield a better outcome. Can you take the obvious answer and flip it upside down? Judo-flipping challenges is exactly what the most innovative people do.

The fourth obsession is getting scrappy, which is about grit, determination, tenacity and resilience. Recall how MacGyver could break into Fort Knox with using only a pen, a comb and a toothpick. The idea is solving a problem in an unorthodox way, using limited resources.

The fifth obsession is adapting fast. It’s about how quickly you tweak, evolve and pivot an idea. Using little micro-innovations along the way gives you an advantage, rather than waiting until all the bugs have been ironed out and the bells and whistles have been attached.

I’d like to leave you with a challenge: See if you can uncover one single idea for creative disruption in the next week. Here’s what’s going to happen: ideas are contagious, so one idea becomes seven ideas and before you know it, this new creativity will spill over to those around you. In areas where complexity rules, the stakes are high, and competition is fierce, the opportunities are more profound than ever.
An unrecognized key to improving transitional care: feedback loops

That is a very long title, so let’s deconstruct it. There are two key elements. The first one is “transitional care” and this has to do with that individual requiring care across multiple settings. The most common would be leaving the hospital, and either going home or to a recovery facility. There may be multiple transitions after an episode or illness. The other piece has to do with “feedback loops.” This would include the cues and mechanisms that give us a sense of whether we’re doing a good job.

The ultimate goal is for transitional care to create a match between an individual’s care needs and their care settings.”

Let’s talk about my hypothetical patient, Mabel. She’s been hospitalized four times in the last four weeks for heart failure. This time she’s going home but with no skilled services, no skilled nursing, and no skilled home-care. How often do healthcare professionals go on rounds and try to figure out whether care needs match care settings for a woman like Mabel? Something is clearly failing her. What do we know about Mabel’s self-care capacity? What about her health literacy? What do we know about her cognitive status? Is there a family, and are they involved? What does “care needs match care settings” look like for someone who is returning to the community? And what is our role in addressing this?

We are talking about coordinating care across time and across geography. This is a real gap in our healthcare training.

When it comes to coordinating care across multiple care settings, this is a real opportunity. Part of this involves re-envisioning the “care team.”

So who’s on the team? Everyone names the hospital and the physician, the home care agency, skilled nursing, and sometimes even the health plan. Who else? The pharmacy? Dialysis center? Emergency medical services? Those paramedics can provide a lot of insight into the home environment. How about area agencies on aging? It’s a huge advantage to bring those folks to the table. And adult day care centers and community mental health providers. The truly successful teams invite in real patients and their families.
My colleagues and I have found six points to create effective collaboration across care settings:

1. There has to be a trusted convener. In some communities, it’s the hospital. Having common goals is key and newly formed accountable care organizations and bundled payment entities create a common framework of financial goals. You need shared understanding and site visits.

2. Healthcare professionals are naturally goal oriented. We can capitalize on that action orientation and come up with small, meaningful, quick wins. This is part of the feedback loop. An example would be follow-up phone calls, which are inexpensive and easy to do. The one problem is coordinating who makes them – and does that person have the most current information? This can only happen if we appoint one entity or person who then shares the outcome of the calls with other members of the extended care team.

3. Another area that has contributed to success has been team players shadowing one another. People learn each other’s names and functions and the hassles that they go through on a daily basis. And they begin to see that care is different in different settings. They see challenges and develop ways to work through them.

4. Another powerful strategy is a community transition conference, which really builds on the successes we have had with patient safety. This is a “no blame, no shame” arrangement where we invite different sections of the care continuum to come together and talk about cases that went well, and cases that didn’t go well. Some of the most successful meetings include faith-based organizations, people who provide community resources and transportation.

5. Communication is really a fundamental part of this all coming together. I would love it if people talked before implementing their own solutions, but all too often, the communication is just telling the other end of the line what has already been done.

6. What is the expectation for a transfer or transition? This isn’t about a FedEx package moving from point A to point B. What do you want the ER to do with this 93-year-old Alzheimer’s patient that just fell? Is there a way to create a transfer summary so that your colleague could read your recommendations?

When people are discharged, we supply them with “one size fits none” information. We don’t customize and we try to do it very quickly. So Mabel is back in the hospital. She didn’t do what we asked her to do at home. If I don’t account for the fact that Mabel has low health literacy and cognitive impairment, that makes me non-compliant. Patients get accustomed to us doing things for them in the hospital, and then 15 minutes before they leave, we turn the tables on them and give them a list of what they have to do for themselves.

With a colleague from Mississippi, we came up with the idea of a simulation lab for heart failure patients. This is a way to involve the patients before we send them home. We can road test their home care instructions. We asked what we should tell Mabel to do when she went home. The answer was to weigh herself and write it in a care log. So we asked Mabel to show us how she would weigh herself. Her response was that she can’t do that anymore because she can’t read the numbers on the scale. This might explain why she doesn’t weigh herself any more. Would we have learned this in any other forum? After installing this simulation lab in Mississippi, the hospital reduced readmissions from heart failure from 17% to 13%. Now the hospital wants him to operate simulation labs for COPD and Diabetes.

One of the things that came out loud and clear was that, even if you had the best case manager and a direct line to your primary care doctor, the vast majority of patients were their own care coordinators. And they had to do this without the skills, confidence and tools that they needed. The evidence-based Care Transitions Intervention (CTI)® (available at www.caretransitions.org) was designed to overcome this challenge and has been adopted by over 1000 health care organizations worldwide.

We are comfortable being fixers and doers, but at some point we have to start preparing the patient and family to be able to participate in self-care.

If we do not do this, we will fail. Unless you are planning on moving in with these folks, you have to support them in their self-care capacity.
The US healthcare system: innovation as a curative

So what are we looking to solve with healthcare innovation? First and foremost, why does it cost so much? Go to any other country and see that they have expensive stuff and they have physicians working hard, so why do we cost so much? It’s actually not the number of the services that we provide; it’s the unit cost.

Data from one of my clients shows that 70% (of 19 million people) spend less than $600 for the year in total – of which, 35% actually spend nothing. On the other hand, you have chronic care, trauma, cancer, diabetes, congestive heart failure, where those folks spent more than $26,000 each – almost 60% of the total cost. If you were designing a system, you’d need different strategies for each group. Your chronic care strategy should be way different than your healthy group strategy. But we don’t think about it that way.

There have to be changes in the marketplace. The rules of the game have changed and there is a whole new strategy as to how you apply different assets now because of the Affordable Care Act: how you make money; how you design a product to attract the kind of population that you want to underwrite, how you build a network and how you make that network perform better. And how do you provide transparencies to consumers, who are spending up to 35% out of pocket?

So where do we think innovation is going to come from? The first place is provider-sponsored health plans. Up until the Affordable Care Act, nobody was actively investing in provider-sponsored plans, but all of a sudden, we have the potential for the individual market to be as large as the group market. Medicare Advantage is growing, plus Medicaid expansion, and the federal exchange markets, and a lot of employers on the small group side are getting ready to send their employees to the exchanges. So the individual is set for strong growth. And who serves these individuals? Their local provider system. Those local providers know those patients – and they know how to take care of them. If they want to create a patient experience that is different from their fee-for-service patients or the patients from United of Aetna or Blue Cross, they can make it like the Ritz-Carlton. How’s that for differentiation?

The second hot spot is Remedy Partners. They have been working with voluntary care coordination, also known as the Bundled Payments for Care Improvement (BPCI) initiative for CMS, for the last two years. Under the voluntary bundled payment program, there is a flat payment available to the participants, generally a hospital
that takes the risk. Patients are admitted, have the procedure and, if the hospital spent less than the target, they get to keep 50% of the savings, assuming they passed the quality and service metrics.

What Remedy did was partner up with 1,700 hospitals across the US, to do patient engagement – explaining the process, performing care coordination, sharing the clinical data, developing protocols, agreeing on who was participating from the physician side, agreeing on metrics and then producing a balanced scorecard for every single day and every single patient. In essence, they became a virtual ACO.

A third hot spot is MACRA – the Medicare Access and CHIP Re-authorization Act that was passed last year. They intended to use this to do away with the annual “doc fix”, but they had no idea that this would be as disruptive to providers as the ACA was to health plans. Now all physicians will be scored and their payments will be based on that score. On top of that, if doctors in what they call the “Merit Incentive Performance System” (MIPS) and if they are in their 50s, they are probably going to retire, because are will be measured on utilization, quality, access and cost – and scored against all other physicians in their specialty and geography. And it’s going to be budget neutral. So the people at the top will get a bonus at the expense of the people at the bottom.

So imagine that you are a hospital CEO and you’ve been accumulating doctors as assets for 15 years. You have no idea how good your staff is compared to the rest of the market, and all of a sudden, your physician professional service reimbursement is going down 5% a year for the next five years? What will that do to your bottom line?

As an insurer, if you were building a network and could choose only high quality providers over lower quality providers, you’d see a 60-point swing. Note that all of the MACRA data is publicly available, so there will be something like Consumer Reports on doctors. How disruptive is this going to be?

Ultimately, new care models will emerge where the focus on doing well on the metrics is probably going to get a whole lot more important.
Healthcare reform – an insider’s view

A progress report on the Affordable Care Act, reviewing keys to the future, and topics on the horizon.

Kathleen Sebelius began by summarizing the state of healthcare in the six years since the ACA was implemented. She reported that the United States currently has the lowest uninsured rate in its history: below 10%. And the number of uninsured younger Americans has been cut in half. Despite predictions that the Medicare Trust Fund was going bankrupt, years have been added back to its lifespan. Patient care has also improved, now that CMS has started to pay its Medicare bills differently on preventable readmissions.

Ms. Sebelius reminded the audience that the three major goals of the ACA are: access to coverage, improving patient care, and lowering costs. Today much of the focus has been on the marketplace side. But there are more important aspects under the surface, changing how healthcare is delivered — and how it’s paid for.

“The private market has been moving toward value-based propositions and keeping people healthy in the first place, while the government had been stuck in fee-for-service,” she explained. “But now the government is using $1 trillion of government buying power to accelerate the shift of how care is delivered and paid for, by aligning financial incentives with outcomes.”

Kathleen Sebelius
Secretary of Health and Human Services 2009-2014, implemented the Affordable Care Act; Governor of Kansas 2003-2009

Ms. Sebelius identified these seven keys to the future:

1. Data: Examples of relevant data advances include the conversion to electronic records, an all-system standard of quality used to measure and pay providers, and several cost-reducing initiatives developed by the CMS Innovation Center.

2. Technology: Hospitals are now adopting technology with virtual workforces and remote monitoring. Senior centers are adding devices to prevent falls and provide alerts on drug adherence. Telemedicine frees up time for providers and patients.

3. Science: Unlocking the human genome is allowing the application of precision medications and cutting clinical trial times in half.

4. Patients as consumers: For 20 years, WebMD has empowered patients to question their doctors. Patients can now compare providers, hospitals, and the prices of their medications.

5. New payment systems: Value-based systems are focusing on prevention and disease management. The government is now looking at how to prevent younger people from developing diabetes, heart disease and obesity — and how to better manage these conditions as they occur.

6. Aging: With so many more people living longer, the nation lacks the physical infrastructure for people to “age in place.” This points to the need for more community support systems, transportation and health services.

7. Pandemics: There are no walls to protect the U.S. from H1N1, Bird flu, Ebola, or Zika. Investing in global health security is a must.
How much epidemic risk are you holding?

Reviewing how our global interconnections make epidemics worse – and how they can make them better.

Fifteen years ago people in the Silicon Valley were referring to the internet as the global nervous system. That made me wonder if what the world needed was a global immune system. I realized that academia probably wasn’t the answer, so I started Metabiota, with the objective of making a world resilient to epidemics. Interestingly enough, I now focus a lot on risk transfer.

Dr. Gunter Kraut of Munich Re Life called me about four years ago, after reading my book, and wanted to talk about insurance, because his feeling was that he was holding a lot of epidemic risk. That was the beginning of a long and beneficial relationship.

The epidemic/epidemiology community has no idea about risk and risk transfer. Learning about this has fundamentally changed the way I think about risk transfer events, and how we can best address them. The collaboration has created a lot of subject matter expertise and a new perspective – that epidemics are not similar events. If we look at Zika, Ebola, SARS, MERS, and influenza, you’ll see that these are profoundly different from each other. So we can separate them into different risks with strong historical data and identifiable characteristics. As a result, the amount of risk can be sliced and diced into different categories, and we can think about the most appropriate way to extend transfer to a much wider audience.

And my views of risk have changed. As research scientists, we focus on morbidity and mortality. That doesn’t really work for Zika, because other than microencephaly, there isn’t any mortality or morbidity. But that doesn’t mean that it doesn’t have a cost. Now I think about “holding” risk – and every human, every corporation, and every country on the planet holds risk. Some individual and companies are holding quite a bit of risk and some hold very little. There is risk that is variable and can be pooled and transferred. There is also risk appetite – some organizations can actually take on risk.

We started Metabiota in 2008 and we needed to invest in data scientists and engineers and pull this together in a platform. We needed to create a set of tools that permit people to visualize and understand this risk, and to be able to effectively transfer it.
As an example, an underwriter might want to know what’s going on with a particular event, like MERS. He’d like to get a sense of the case fatality rates in a particular location, what’s the population in that region, and then be able to develop a “sleep easy” cover.

For some viruses, the transportation infrastructure will play a big role in whether it moves from Point A to Point B. In the case of Zika, we’ve been following it for some time. I did research on Zika when I lived in Borneo in the late 90s. It’s been in the old world for ages. The first thing we said was that it was all going to be about microencephaly. And because of that, we knew that it would draw huge coverage from the media. We created a “fear index” for every outbreak – how many people will now demand high-resolution ultra-sounds when pregnant? It doesn’t really relate to the number of infections, but to the amount of interest and fear.

Here is an example that brings it all together – we actually did this with Munich Re. You have an individual and family. The individual has been paying into a pension fund and life insurance policy, and is now retired. The life insurance has reinsurance behind it. Now the big event comes along and the individual dies, and the family no longer collect the pension, but the life insurance and the reinsurance both kick in. Now let’s imagine that this is a really big event and causes serious trouble. We created an instrument that allows the pension fund, which sees little to no risk, to participate in the risk held by the reinsurer. Is this a shell game just moving things from A to B? That’s a naïve view. This model actually provides “breakers” which create resilience.

Overall, this allows us to ask, industry wide, how much risk is there, and what kind of protections do we need?

What I’ve come to realize is that we do have a global immune system – and that it is contemporary risk transfer.