Changes in the Health Care Marketplace: How Can Communities and Locals Respond?

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Agenda

1. Introduce Community Catalyst
2. Unpack ways consumers—your patients, and you—may be impacted by market changes
3. Identify ways consumer advocates—our “base”—and locals can mobilize in response

Community Catalyst

Who We Are

Community Catalyst is a national non-profit advocacy organization that works with national, state and local consumer organizations, policymakers and foundations to build consumer and community leadership to improve the health care system.

We support consumer advocacy networks that impact state and federal health care policy, and ensure consumers have a seat at the table as health care decisions are made.

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Health care: It’s a tug of war out there.

Payers (Insurers)

Providers

Market Concentration

Hospital Markets

- 49% highly concentrated (in English, this means there's not a lot of competition or choice)
- 32% moderately concentrated
- 19% unconcentrated

Insurers

- 72% highly concentrated
  - (Note that the degree of insurer concentration can vary by market segment—Medicare Advantage; non-group; small group)

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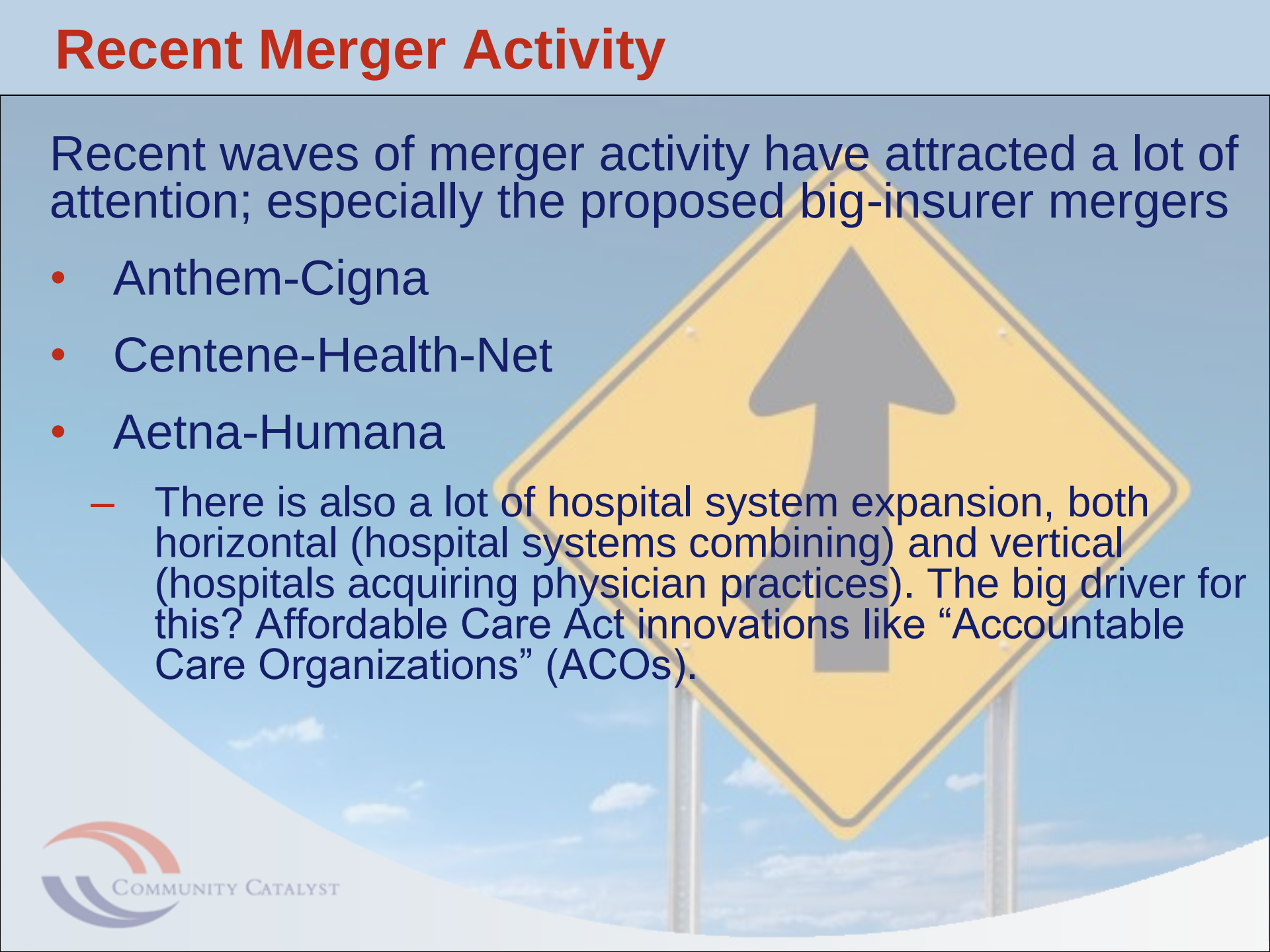
Recent Merger Activity

Recent waves of merger activity have attracted a lot of attention; especially the proposed big-insurer mergers

- Anthem-Cigna
- Centene-Health-Net
- Aetna-Humana
  - There is also a lot of hospital system expansion, both horizontal (hospital systems combining) and vertical (hospitals acquiring physician practices). The big driver for this? Affordable Care Act innovations like “Accountable Care Organizations” (ACOs).



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What does all of this mean for consumers???

Making the Case for Competition

Benefits of Provider Competition

- Lower prices
- More responsive patients

Benefits of Insurer Competition

- Choices of plans
- Lower premiums

But…competition isn’t always enough to protect us.

Problems With Provider Competition

- Historically has taken the form of a medical arms race, not lower prices
  - Payment reforms included in the ACA (like accountable care organizations) could change this but could also encourage competing providers to engage in the same kind of risk-selection that insurers have historically done
- Hamper efforts to take concerted actions to address community health
  - Each provider system is only responsible for a small and shifting share of the population
- Many communities are not large enough to sustain competing delivery systems so regulatory approach needed

Problems With Insurer Competition

- Excessive administrative cost of US health system largely a function of insurer competition
  - about $90-$150 billion/ year
- Competing insurers with relatively small market share cannot bargain effectively with providers for good prices
- More actors can mean bad actors
  - Because they have few other tools, most small insurers rely on "anti-social" approaches to keep costs in check
  - Example: discriminating against sick people in benefit design or network design (they used to just keep "those people" out but ACA doesn't allow them to do that anymore)

What We Know And What We Don't Know

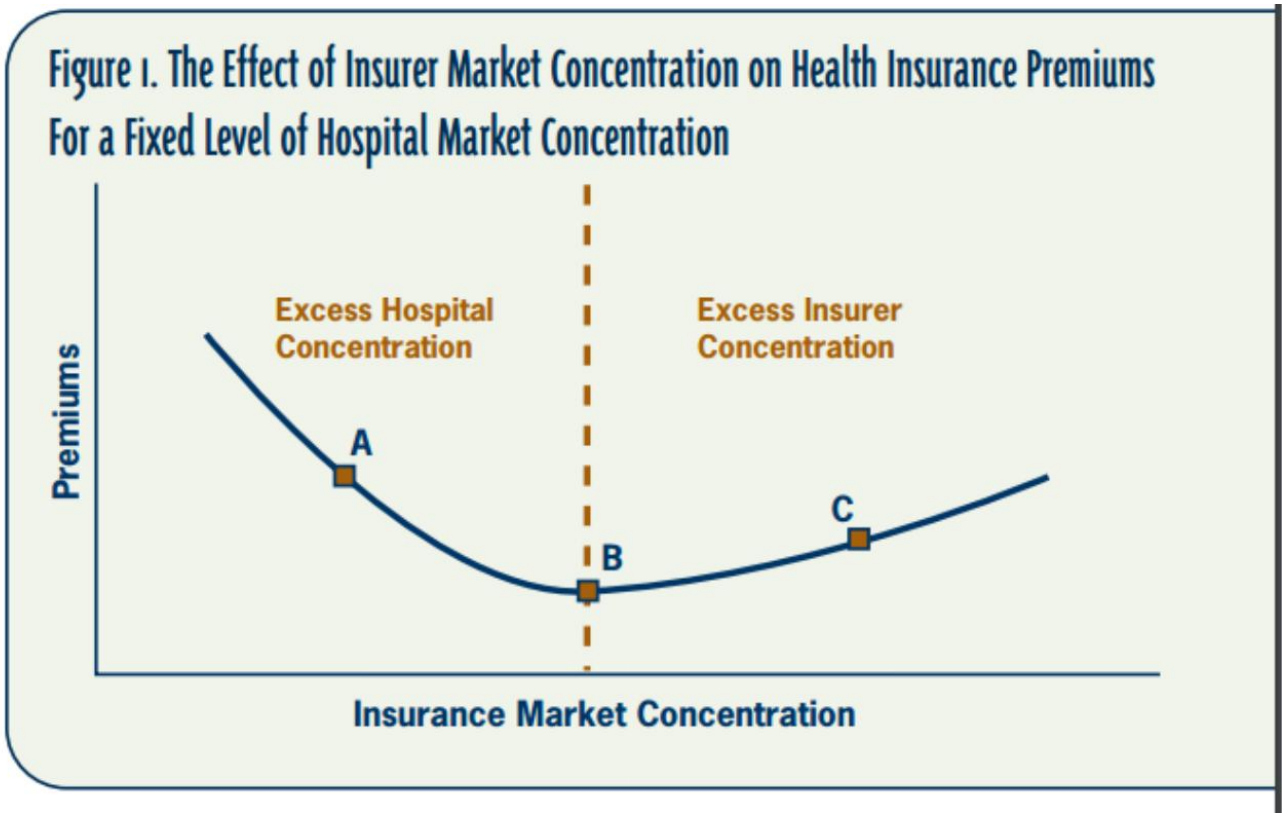
- Evidence suggests that provider market concentration leads to higher prices
- Evidence suggests that insurance market concentration holds down provider prices, but may not translate to lower premiums.
- Recent evidence from exchanges suggests that having more carriers in a Marketplace leads to lower premiums but there are some weaknesses in this evidence.
  - Specifically, not clear that first year premiums reflected cost of enrollees.
- Evidence from Medicare Advantage is that plan mergers raise premiums

Insurer Market Concentration

The Future of Health Care Costs:

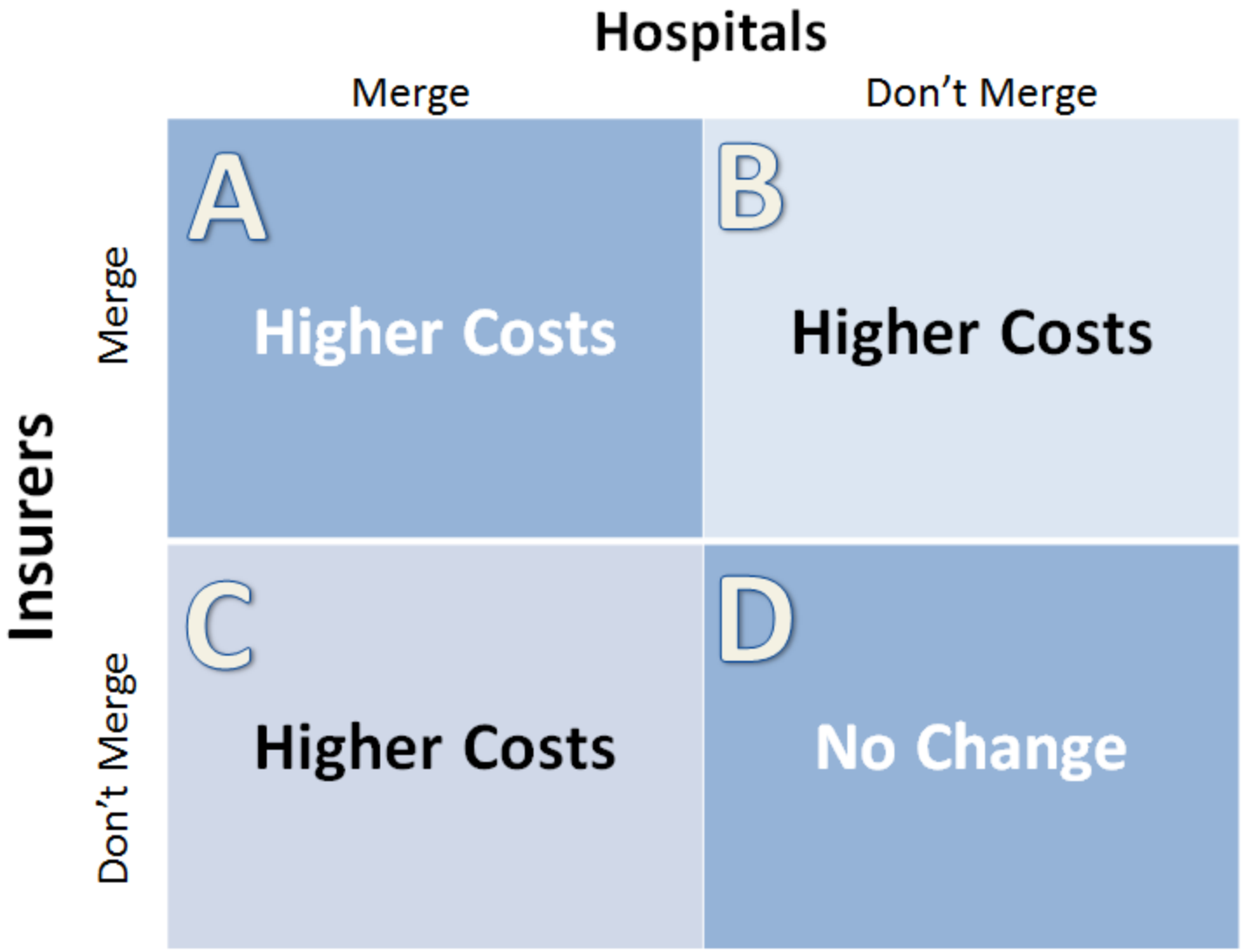
Hospital-Insurer Balance of Power

Austin Frakt, PhD, Health Economist, Department of Veterans Affairs and Assistant Professor, Boston University



Probably not a linear relationship between more plans and lower cost

What We Know


Hospitals
Merge
Don't Merge
Insurers
Merge
Don't Merge
A
Higher Costs
B
Higher Costs
C
Higher Costs
D
No Change

How Should Advocates Respond?

Just say no?

Perhaps not….

Why not?

What Will Happen?

How do we imagine efforts to control health care costs will work over the long run if we block potential innovations to integrate care and reform pay incentives?

Do we *really think* competition between plans and between providers will hold down health spending?

- Only US relies heavily on competition to contain health care spending
  - How well is that working out for us?
- Generally other countries use strong purchasing/ price regulation/set a health care "global" budget
  - A few states are experimenting w/ this approach--MD, MA, VT

Most Of The Damage Has Already Been Done

- Markets are already highly concentrated
- No evidence of willingness or ability to unwind previous mergers
- Blocking insurance mergers without blocking hospital mergers doesn't reduce consumer costs

Source: www.quora.com

A Final Dilemma: Political Power

Even though regulating fewer big entities becomes easier technically, do giant insurers and providers amass so much political power that they are able to capture or discourage regulators and legislators?

The Good Old Revolving Door…

WASHINGTON POST

"Drinks, junkets and jobs: How the insurance industry courts state commissioners"
October 2, 2016

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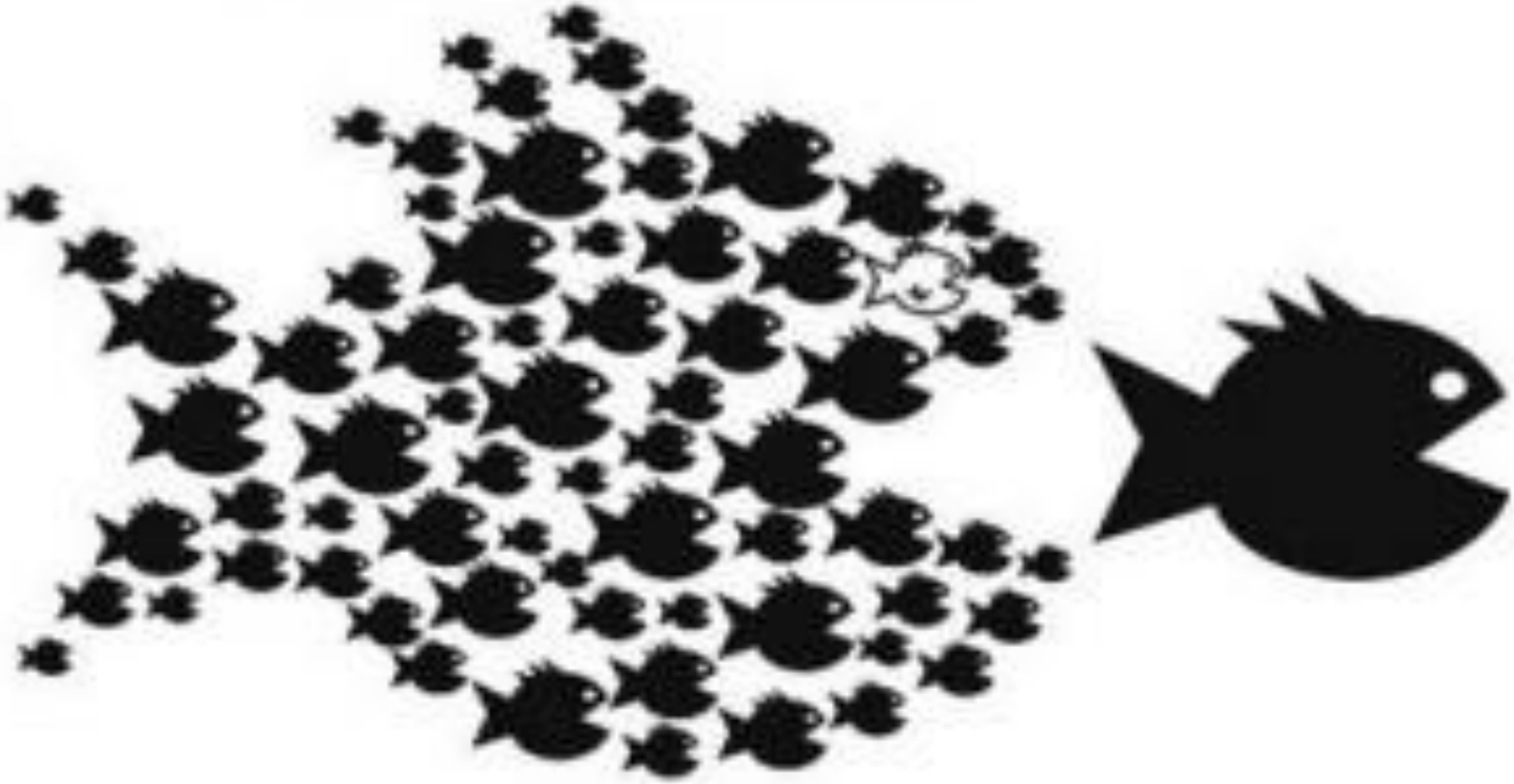
Okay…so what's a local to do??

Don’t mourn.



ORGANIZE!

In the Short Run…

- Use the merger transaction to extract concessions
  - (Insurers) commitments around network adequacy or how out-of-network bills will be handled
  - Limits on premium increases or agreement to stepped up oversight/ enforcement by Department of Insurance
  - (Hospitals) commitments around financial assistance and community benefits and community engagement
- Work with community partners to ID common goals
  - Locals may have access to people, data and relationships, especially on provider side, that community groups can use
  - Community groups may already know the public policy terrain, especially on the insurance side

Build a Strategy (Consumers Union)

- Gather information
- Assess feasibility – and know your strategy and goal (opposing a merger? proposing a remedy?)
- What's clear, measurable, and *enforceable* in your state?
- Can you target a remedy to meet an existing need?
- Develop a broad list of remedies knowing some will lose
- Comments to regulatory agencies – "flooding the zone" with complaints

Six Specific Activities (Consumers Union)

- Testify at hearings (and ID policyholders who can)
- Submit written statements explaining concerns or highlighting problems
- Meet with regulators to explain concerns and discuss remedies
- Enlist support of state legislators at various points in the regulatory process
- Reach out to community members to engage them and hear their concerns and ideas
- Educate the media about prior mergers and what's at stake

Concessions (from Consumers Union)

- Conduct/behavioral remedies
  - Pricing restrictions (really turn on state regulatory environments and access to data)
  - Require insurer to expand to new markets to increase competition and consumer choice (e.g. Florida)
  - Tie to quality and performance improvement
  - Invest in health infrastructure (rural health, consumer assistance, data collection, health sector employment)
  - Charitable giving requirements
  - Require corporate presence to stay or create in-state jobs

Consider community benefit as an “evergreen” opportunity to address high costs and community health needs.

Hospital Billing & Financial Assistance

- Percentage of collection accounts on credit reports attributable to medical debt: 52
- Americans with a medical account in collections: 43 million (CFPB)
- Percentage of the population impacted: 13 (at least)

This little piggy is underwater.

Credit: Shutterstock

ACA Requirements

1. **Financial assistance and collections policies** – written out, board approved, available to the public in multiple languages

2. **Fairer charges** for those who qualify

3. Better protections against aggressive **debt collection**

4. Regular process for assessing **community health needs** and driving strategies to address SOME of the needs (with community input – labor mentioned)

FINE PRINT: This does not apply to for-profit hospitals or other types of medical providers.

What's the Problem?

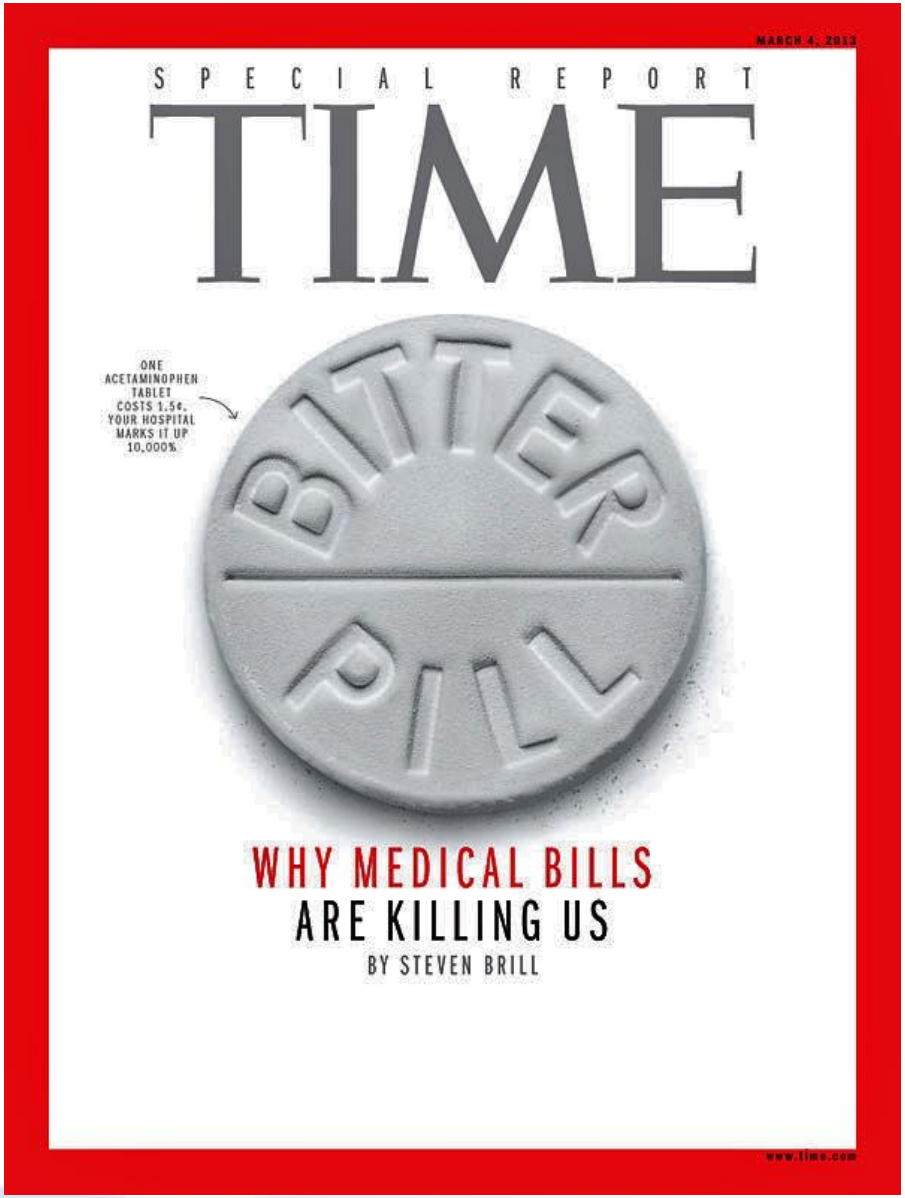
The Washington Post

50 hospitals charge uninsured more than 10 times cost of care, study finds

CFPB Study Finds Medical Debt Overly Penalizes Consumer Credit Scores

The Charlotte Observer

Prognosis: Profits



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A contributing factor in the recession…

"I was told that in order to have the surgery, I would have to pay half the amount. Not knowing what else to do, I gave them my credit card, and it was charged $4,000.00. […] I am now months behind on my mortgage."

- Daisy, unemployed, Orlando

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NJ Markups: 500-600% of costs

Gross patient service revenue – what hospitals would make if they were paid at the rates they charge

- **Charge =** hospital's "sticker price"
- **Cost =** what the hospital spent to provide the service

Net patient service revenue – what hospitals actually collect, after subtracting:

- **Financial assistance (charity care)** to patients unable to pay
- **Contractual rates** negotiated with insurance companies, Medicare, Medicaid

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So, how are hospitals doing?

- Noncompliance
- Don’t address the underinsured
- Charity care numbers are down, bad debt numbers are up
- Unclear whether staff are being trained effectively to share information on financial assistance with patients in a timely way
- Unclear whether hospitals are really changing contracts with third-party debt collectors and debt buyers
- Language access to financial assistance and billing information is poor

And how are *New Jersey* hospitals doing?

2013 New Jersey not-for-profit hospitals' community benefits and economic impact analyses

Table 1. Hospitals' benefit to the community, by type of benefit
Millions of dollars

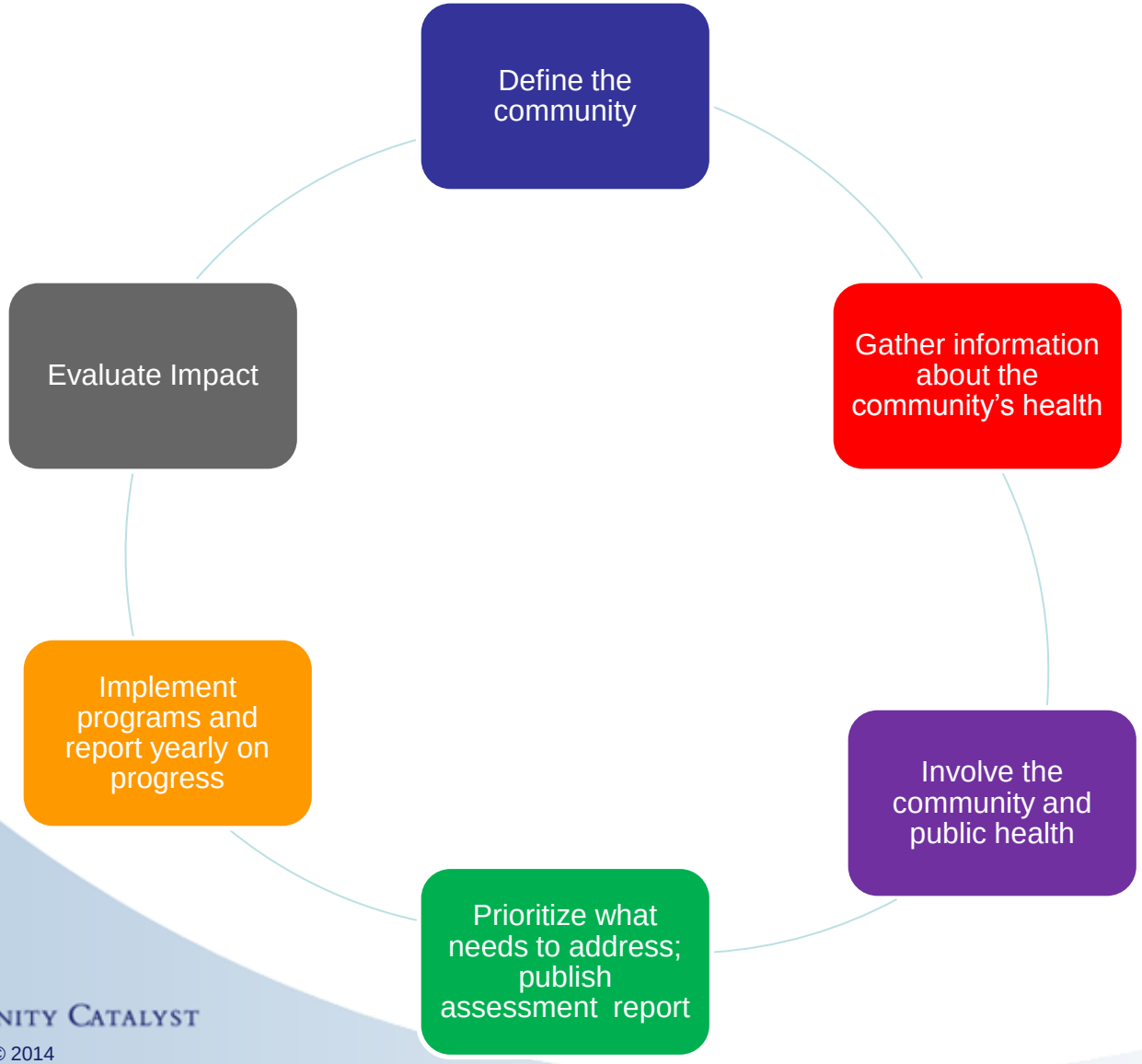
	Net Expense	Percent of total expense
7a Financial assistance	$ 612.8	3.5
7b Medicaid	$ 376.6	2.1
7c Other government means tested	$ 36.5	0.2
7d Financial assistance and means tested	$ 1,025.9	5.8
7e Community health improvement	$ 61.6	0.3
7f Health professionals education	$ 229.5	1.3
7g Subsidized health services	$ 154.4	0.9
7h Research	$ 21.0	0.1
7i Cash and in-kind contributions	$ 8.2	0.0
7j Total other benefits	$ 474.5	2.7
7k Total Financial assistance, means tested, and other benefits	$ 1,500.4	8.5
Part II Community building total	$ 8.0	0.0
Part III 3 Bad debt attributable to financial assistance	$ 234.7	1.3
Part III 7 Medicare shortfall	$ 620.9	3.5
Total benefit to the community	**$ 2,364.0**	**13.4**

Note: Figures may not appear to sum due to rounding.
Source: EY tabulations of New Jersey hospital Form 990, Schedule Hs, 2013.

Ripe for the picking…

- Secret shopper, staff training
- Surveying local members and community members about medical debt
- Hiring bilingual and multilingual staff
- Getting involved in next round of community benefit planning
- Getting data (if possible) on contracts with third-party collections
- Including standards for collections, community health priorities in contracting
- Push for state laws that go beyond the ACA (applicable to all providers, address underinsured)

What the Hospital Community Benefit Process Looks Like



Resources

- Community Catalyst, “Health Market Consolidation”
- Consumers Union Health Care Value Hub, “Advocates Guide to Health Insurance Mergers”
- Merger Watch, “When Hospitals Merge”
- Community Catalyst, Hospital Checklists (financial assistance policies and community health needs assessments)

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Questions?

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Thank You