Virtual Briefing: Examining Proposals for Provider Health Care Competition

December 2, 2020

PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

FAMILIESUSA

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

AGENDA

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PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

The Partnership to Empower Physician-Led Care (PEPC) is dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians through a competitive health care provider market.

We believe that it is impossible to achieve truly value-based care without a robust and vibrant independent practice community.

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FOUR UMBRELLA POLICY AREAS

Physician-Led APMs in Medicare

Anti-Competitive Policies that Level the Playing Field

Physician-Led APMs in Other Markets

Patient-Centric Model Design

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CORE ISSUES EXPECTED TO PERSIST

Consolidations Continues (and Accelerates as a Result of COVID)…

- The share of physicians affiliated with health systems increased from 40 percent to 51 percent between 2016-2018.
- Practice consolidation will accelerate over the next two years due to the financial stress experienced by physician owners during the pandemic.
- As the economy reopens and elective procedures restart, acquisitions of hospitals and practices will gradually resume and then accelerate beginning in Q4 2020 or early 2021.

….Value-Based Care is Path Sustainability If There Are Competitive Provider Markets

- Alternative payment models that use population-based payments are key to building resilience in the health care system, according to LAN.
- Value-based care creates dependable revenue streams that can allow physicians to remain independent.
- Physician-led groups generate more savings with better quality under value-based care models.
- For example, low-revenue ACOs (i.e., physician-led ACOs) in MSSP had net per-beneficiary savings of $201 compared to $80 per beneficiary for high-revenue ACOs.

ADMINISTRATION COMPETITION REPORT

- Executive Order 13813 directed the Administration to facilitate the development and operation of a health care system that provides high-quality care at affordable prices for the American people by promoting choice and competition.
- The Executive Order directed the Departments of HHS, Treasury and Labor to produce a report outlining federal and state barriers to this policy objective.
- The tri-agency report was released in December 2018.
- As identified in the report, opportunities to facilitate more competition in the provider market included:
  - Positively Realigning Incentives Through Payment Reform
  - Certificate of Need/Certificate of Public Advantage
  - Nonprofit exemption from FTC Jurisdiction
  - Employment Agreement Non-Compete Clauses

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ADMINISTRATION COMPETITION REPORT ANALYSIS

PEPC analyzed the report recommendations, highlighting areas of competition in health care that have been enacted at both the federal and state level. The analysis also identifies recommendations that have been partially enacted or have failed to be enacted during the last four years.

Status	Report Recommendation	Level	Action To-Date
	Address Potential Antitrust and Provider Consolidation		
–	The Administration should continue monitoring market competition, especially in areas that may be less competitive and thus more likely to be affected by alternative payment models.	Federal	No public action to-date.
–	The Administration should ascertain the impact of horizontal and vertical integration among provider practices on competition and prices.	Federal	No public action to-date. FTC issued a report in June 2019 providing an overview of its actions to-date in health care services and products, including physician practices, but has not issued a comprehensive analysis of the impact of horizontal and vertical integration among provider practices. DOJ and FTC released new vertical merger guidelines in June 2020, though they are not specific to health care.
	Broaden Scope of Practice		
✓	States should consider changes to their scope of practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.	States	During the COVID-19 state and public health emergencies, states took a multitude of temporary actions to expand scope of practice. More than 40 states temporarily modified licensing requirements and expedited the approval processes to recruit more health care workers. Note, however, that many of the changes made were temporary, for purposes of the public health emergency.
✓	The federal government and states should consider accompanying legislative and administrative proposals to allow non-physician and non-dentist providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care.	Both	In the wake of COVID-19, CMS provided several blanket waivers for health care providers and released several interim final rules with comment, which sought to provide greater flexibility for providers and the health system during the PHE. For example, CMS proposed to expand the types of healthcare professionals that can furnish distant site telehealth services, rolled back certain physician supervision requirements, and certain documentation requirements. In the CY2021 Physician Fee Schedule, CMS proposed to make modifications to certain physician supervision requirements on a permanent basis.

Full report: http://physiciansforvalue.org/administration-competition-analysis/

AREAS TO WATCH IN 2021

- Site Neutral Payments & Other FFS Payment Policies
- Event Notifications & Information Blocking Requirements
- Value-Based Care Models
- Stark/Anti-Kickback Reform
- Surprise Billing & Transparency

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THE VOICE FOR HEALTH CARE CONSUMERS

Addressing Health Industry Consolidation: Policy Solutions in 2021

Sophia Tripoli, MPH, Director of Health Care Innovation, Families USA

Dedicated to creating a nation where the best health and health care are equally accessible and affordable to all

Families USA's Mission and Focus Areas

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We advance our mission through public policy analysis, advocacy, and collaboration with partners to promote a patient-and community centered health system.

Working at the national, state and community level for over 35 years

The Problem

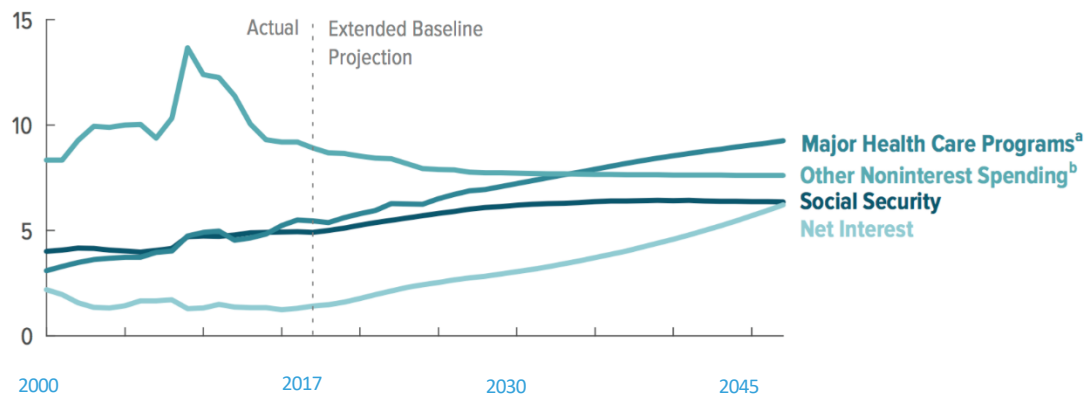
- The cost of American health care is a profound economic problem and an urgent public health problem:
  - **44 percent** of public didn't go see a doctor when they needed to because of cost[1]
  - **30 percent** report medical care interferes with their basic needs (food, housing, heat, etc.) [1]
  - **74 percent** of the public feel that we do not get good value from the U.S. health care system[1]

- In 2019, **U.S. national health expenditures** amounted to an estimated **$3.8 trillion**. [2]
  - And yet, the US has **the highest rates of infant mortality, maternal mortality and lowest life expectancy** compared to other industrialized countries.[3]
  - Over 225,000 people die each year from medical mistakes, making **medical error the third highest cause of death** in the U.S.[4]

Sources:
1. Americans' Views on Healthcare Costs, Coverage and Policy. Conducted by NORC at the University of Chicago. with funding from The West Health Institute Interviews: 2/15-19/2018. Available at: http://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Topline.pdf . 2. Centers for Medicare & Medicaid Services, "National Health Expenditure Projections 2018-2027: Forecast Summary," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf. 3. Alliance for Health Policy, "Chapter 6"; Rabah Kamal, Daniel McDermott, and Cynthia Cox, "How Has U.S. Spending on Healthcare Changed over Time?" Peterson-KFF Health System Tracker, December 20, 2019, https://www.healthsystemtracker.org/ chart-collection/u-s-spending-healthcare-changed-time/#itemhealth-spending-growth-has-outpaced-growth-of-the-u-seconomy_2017. 4..https://www.hopkinsmedicine.org/news/media/releases/study_suggests_medical_errors_now_third_leading_cause_of_death_in_the_us

Federal Health Care Spending to Consume Larger Portion of Federal Resources

Percentage of GDP



Source: Congressional Budget Office, 2017 Long Term Budget Outlook.
The extended baseline generally reflects current law, following CBO's 10-year baseline budget projections through 2027 and then extending most of the concepts underlying those baseline projections for the rest of the long-term projection period.
GDP = gross domestic product.
a. Consists of spending for Medicare (net of premiums and other offsetting receipts), Medicaid, and the Children's Health Insurance Program, as well as outlays to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act and related spending.
b. Consists of all federal spending other than that for Social Security, the major health care programs, and net interest.

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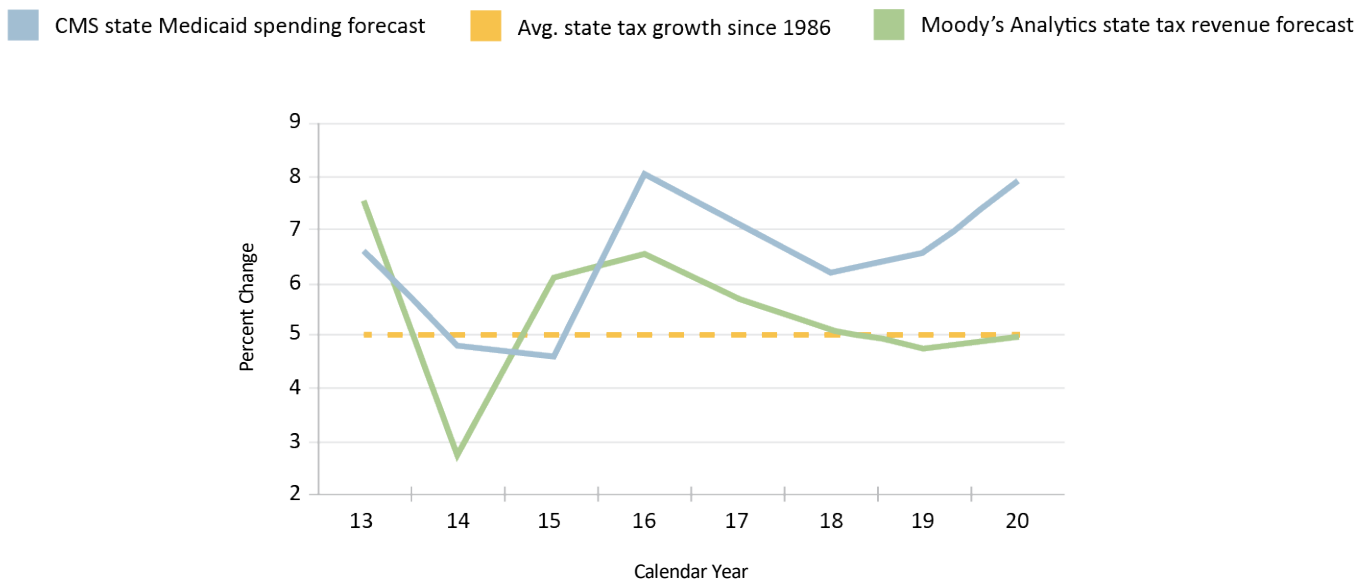
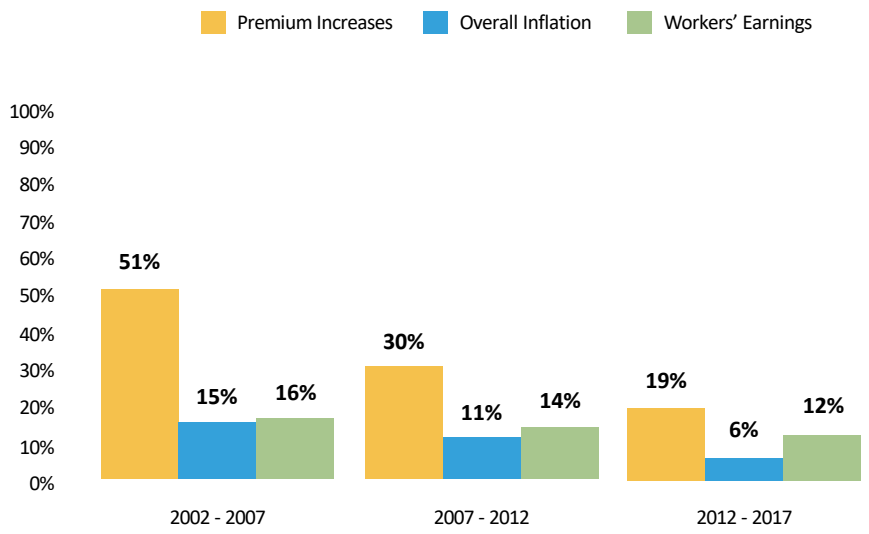
State's Face Similar Dilemma: Medicaid Spending Likely to Outpace Growth in State Tax Revenue



Source: CMS, Census Bureau, Moody's Analytics, 2015.

Family Premiums Increasing Faster than Pay or Inflation

Cumulative Premium Increases for Covered Workers with Family Coverage, 2002-2017



*Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City/Average of Annual Inflation (April to April), 2002-2017; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2002-2017) April to April).

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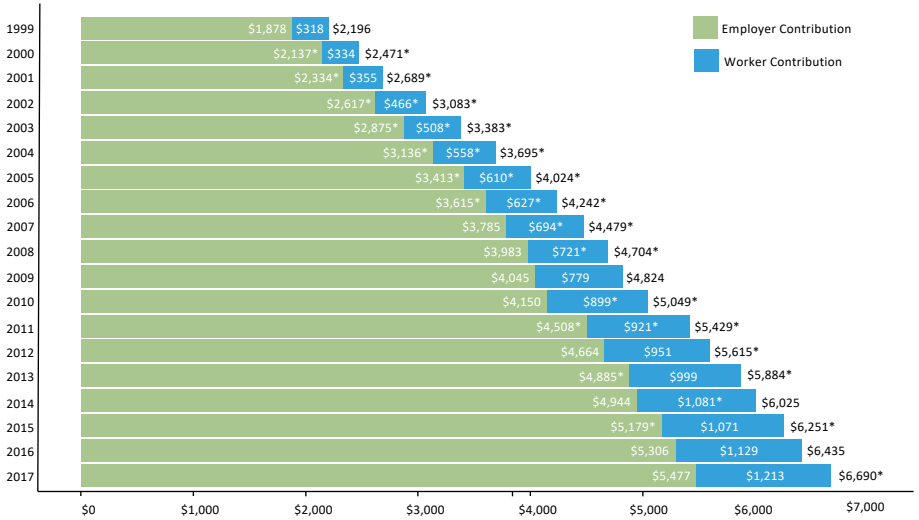
Businesses' and Employees' Income Being Consumed by Health Care Spending

Cost Tripling in 20 Years and Families' Cost Increasing Fastest



*Estimate is statistically different from estimate for the previous year shown ($p < .05$).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017.

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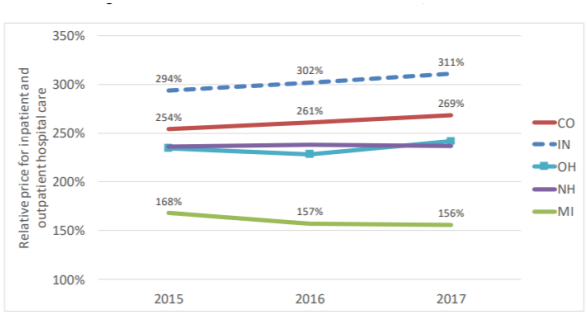
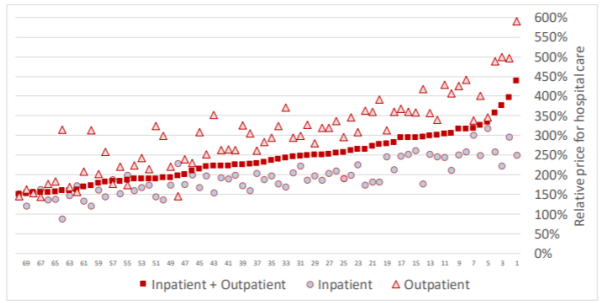
Increasing Health Care Costs:
The Greatest Threat to Coverage and Access

Breaking News on Private Payments for Health Care

Trends in Relative Prices for Selected States, 2015–2017



Relative Prices of Hospital Systems in 25 States, 2015–2017



Source: Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely. Rand 2019. https://www.rand.org/pubs/research_reports/RR3033.html.

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Decades of Research Support High Prices and Health Industry Consolidation as Major Driver of U.S. Cost Crisis

High Prices Drive High Health Care Costs

- Nearly 20 years ago, Uwe Reinhardt and colleagues, *"It's the Prices, Stupid"*
- Irene Papanicolas, Ashish K. Jha and colleagues, 2018, *"Health Care Spending in the United States and Other High-Income Countries."*

Health Industry Consolidation Major Driver of High and Variable Health Care Prices

- Then-Attorney General of MA, Martha Coakley, 2010 Landmark Report. *"Examination of Health Care Costs Trends and Cost Drivers."*
- Paul B. Ginsburg, 2010, *"Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power."*
- Chapin White and colleagues, 2013, *"High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power."*
- New York State Health Foundation, 2016, *"Why are Hospital Prices Different? An Examination of New York Hospital Reimbursement."*
- Michael F. Furukawa and colleagues, 2020, "*Consolidation of Providers into Health Systems Increased Substantially, 2016-18.*
- Christopher M. Whaley, Rand Corporation, 2020 *"Nationwide Evaluation of Health Care Prices Paid by Private Health Plans."*

Consolidation Undermines Ability of US Health Care Markets to Be Competitive

The Race for Market Power

Hospitals and Health Systems

Through horizontal and vertical integration, hospitals and providers consolidate market power to increase leverage over price negotiations with insurers. Other factors that influence hospital and provider consolidation include demographic shifts in Medicare, depressed public sector payments, and new payment and delivery models.

- **There are few competitive health care markets left in US:** 90% of metropolitan statistical areas (MSAs) have highly concentrated hospital markets and 65% of MSAs have highly concentrated specialist physician markets.[1]
- Importantly, consolidation has not produced cost reductions through economies of scale, improved care coordination or quality oversight. Instead, it has produced monopolistic markets that drive high prices without improving quality.[2]

Insurers

Price negotiations between providers and insurers leads to bilateral monopoly, where both parties aggregate market power to negotiate a better price.

- 57% of MSAs have highly concentrated insurer markets.[1]
- Insurers with greater market power are able to negotiate better prices, threaten exclusion from networks or increase premiums to employers, which are shifted to consumers.[3]

Sources: 1. Source: Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs 36, no. 9 (September 2017): 1530–38, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0; 2. Robert A. Berenson, "A Physician's Perspective on Vertical Integration," Health Affairs 36, no. 9. (September 2017): 1585-1590. 3. National Academy of Social Insurance, Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets. April 2015.

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Solutions to Address the Impact of Consolidation on the Health Care System

- A multi-pronged approach is needed to address consolidation and increase market competition across and within U.S. health care markets.

- Key policy reforms should include:

  - **Prohibiting Anticompetitive Contracting** in provider and insurer contracts that limit access to higher quality, lower cost care.
  - **Prohibiting Gag Clauses** in contracts that prevent referring providers, enrollees or plan sponsors from seeing cost and quality data on provider performance, and accessing de-identified claims data protected under HIPPA.
  - **Expanding Site-Neutral Payments** to ensure Medicare and Medicaid pay the same rates across hospital outpatient departments, ambulatory surgery centers, freestanding/non-freestanding EDs, and off-campus offices.
  - **Increasing Price and Quality Transparency** to unveil underlying prices (negotiated rates) and quality data, including the establishment of a national All-Payer Claims Database to analyze where high value and low value care occurs to make informed policy decisions.
  - **Establishing National Data Sharing and Interoperability Standards** including mandatory real-time data exchange across all payers, providers and public health agencies.
  - **Ensure Payment and Delivery System Reform Models** safeguard against inadvertently creating incentives that could further catalyze vertical or horizontal integration.

- Many of these policy reforms benefit from bi-partisan support.
- 78% of Americans think the government should help make sure everyone has access to affordable, quality health care.[1]

Sources: 1. Consumer Reports. Consumer Voices Survey. May 2017.

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About NASHP

The National Academy for State Health Policy is a nonpartisan forum of policymakers throughout state governments, learning, leading and implementing innovative solutions to health policy challenges.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions
- Conduct policy analyses and research
- Disseminate information on state policies and programs
- Provide technical assistance to states

The responsibility for health care and health care policy does not reside within a single state agency or department. At NASHP, we provide a unique forum for productive interchange across all lines of authority, including the executive and legislative branches.

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Risks of Vertical Consolidation

- Rising costs
  - Evidence: vertical consolidation → higher hospital prices, 14% higher physician prices, 10-20% higher total expenditures per patient
  - Cost drivers: facility fees, market leverage in health plan bargaining, captive referrals
- Reduced choice
- No improvements in quality

Why States?

- State action is critical: vertical transactions "fly under the radar" of federal antitrust agencies, leading to unreviewed, incremental accretion of market power.
- States may be unable to prevent more vertical consolidation from occurring.
- States should explore policies to provide robust oversight over the consolidated entities to mitigate the risks posed by vertical consolidation.

State Policies to Address Vertical Consolidation

Policy Approach	Tools
A. Data gathering	• All-payer claims database (APCD) • Hospital financial health transparency
B. Pre-transaction review and approval	• Notice of proposed transactions • Prior review, approval, and conditions
C. Oversight of vertically consolidated entities	• Attorney General enforcement against anticompetitive conduct • Independent health commission • Certificates of need (CON) authority
D. Controlling outpatient costs	• Restrictions on facility fees • Counteracting private equity-backed consolidation • Global budgets

NASHP Resources

- Increase hospital financial transparency
  - Model Act to Ensure Financial Transparency
  - Model Reporting Template: Hospital Financial Transparency Report Template
- Follow federal CARES money
  - Blog: Why States Need to Follow the Federal Money to Hospitals
  - Model Reporting Template: Follow the Money – A Template for States to Track Federal Relief Funds by Hospital
- Control costs through restrictions on facility fees, out-of-network charges, and balance billing
  - Model State Legislation to Prohibit Unwarranted Facility Fees Reporting Requirements
- Negotiate hospitals prices with an understanding of how hospitals are recovering costs
  - NASHP Hospital Cost Tool

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NASHP Resources

- Limit cost increases over time through a total cost of care cost-growth benchmark
  - Chart: Overview of States' Health Care Cost-Growth Benchmark Programs
- Control hospital cost increases through more stringent insurance rate review
- Leverage state payers, including state employee health plans, to address high costs through improved contracts and negotiated rates with hospitals
- Address health care consolidation through AG action, determination/certificate of need programs, transaction approval, etc.
  - White Paper: State Policies to Address Vertical Consolidation in Health Care
  - Blog: Should We Re-Invent State Health Planning and Certificate-of-Need Programs
  - Chart: 50-State Scan of State Certificate-of-Need Programs

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Q & A

Please type your questions into the Q & A box

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Thank You

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