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20th Annual ITUP Conference

Health Industry Consolidation

Prepared by Linnea Koopmans | February 9, 2016

Moderated by Howard Kahn, ITUP Board Chair

Summary: Three Health Industry Consolidation Session Takeaways

1) Organizational integration used by health entities for consolidation. Health entity consolidation occurs in three primary ways: integrating with another provider of a similar service in the same geographic region; acquisition of a new type of service or geography; or, a joining together of entities that buy and sell services between one another. The California Department of Managed Health Care is responsible for overseeing almost all health plan consolidations, ensuring that the market remains stable, and that consumers retain their healthcare rights.
2) There are both positive and negative potential impacts on health services and consumers as a result of consolidation between health entities. Possible positive impacts include improving the quality of care, increased team-based care and care coordination, and unified purchasing. However, possible negative impacts of consolidation include creation of inefficient bureaucratic systems, a higher cost-sharing burden for consumers, and unnecessarily moving care to higher-cost settings.
3) Trends in California have shown that both employers and consumers are opting for lower premium, higher deductible plans. As a result, consumers often switch to lower-priced providers and, in the future, providers will need to be more transparent about pricing and the cost of services. However, lower cost care needs to be rewarded or incentivized, and currently this market reward does not exist for dominant plans or providers.

Opening Remarks by Moderator

- Questions for consideration:
    - What is consolidation?
    - Is consolidation necessary? Is it inevitable? Is it beneficial or detrimental?
    - What are the types of consolidation?
    - What are the implications for various players? Implications for safety net?
    - What is the impact of consolidation on consumer?
    - Is there the possibility for IT consolidation?

Panelist Presentations

James Robinson, UC Berkeley School of Public Health – Organizational Integration: Enhanced Efficiency and/or Market Power?

- Is integration productive and does it support quality care, or is it to the detriment of the consumer?
- Three forms of integration:
    - Horizontal – two providers offering the same service in a similar geographic area.
    - Diversification – process by which an entity acquires a new geography or type of service.

  - Vertical – two entities that buy and sell from one another (e.g., an insurance company that buys a provider or vice versa).
- Possible positive and negative impacts:
  - Positive – can lead to economies of scale and/or enhanced quality.
  - Negative – can decrease efficiency because entities can become large and bureaucratic. Often lower prices aren't passed onto the consumer and cost-savings gets reinvested back into the healthcare system.
- Integration between hospitals and physicians is of particular importance.
  - Can include improvements such as team-based decisions on patient care, care coordination, and unified purchasing.
    - Large systems can do this (ex. Kaiser).
    - Orange County demonstrated savings via integration in spine surgery, joint replacement, and cardiac rhythm management.
  - However, a possible negative impact is that care can go from low-cost settings to high-cost settings (ex. from community-based clinics to university or research based settings).
- Impacts on cost of care:
  - Competitive markets demonstrate significantly lower prices for care than non-competitive markets.
    - Ex., CalPERS paid between $500-8,000 for the same procedure depending on location within CA
  - Total cost of care can be higher for consolidated organizations.
- Employer and consumer trends in health care spending:
  - Employers are moving toward higher deductibles.
  - Consumers of Covered California plans are also choosing the higher deductible plans (silver and bronze).
    - However, many don't have to pay their portion because they're eligible for cost-sharing subsidies (not just subsidies for the premiums).
  - The consolidations push more cost-sharing to the consumer.
    - Consumers switch to lower-priced facilities when spending their own money (reference pricing).
    - Lower-priced providers are not necessarily lower quality.
- Looking ahead:
  - Price and quality transparency is part of the future.
    - Higher cost providers will need to convince the consumers that the higher price tag is worth the money.

Shelley Rouillard, California Department of Managed Health Care – A Regulatory Perspective on Consolidation

- New plans are entering the marketplace and large mergers and consolidations are occurring across providers and medical groups.
- The California Department of Managed Health Care (the Department) oversees plans that cover 25 million people in CA (96% of people who have coverage) and anticipates this number will grow.
- General roles and responsibilities of the Department:
    - Protect consumer rights and ensure a stable market.
    - Operate a help line for consumers.
    - Regulate 121 different health plans (full service, vision, dental, behavioral health) in both large and small markets; Medi-Cal managed care plans; and some Medicare plans (mostly for financial solvency).
    - Oversee mergers and ensure compliance with consumer protections and with Knox-Keene.
        - Blue Shield and Care 1st merger that occurred last year.
        - Overseeing three other large mergers, and holding public meetings (including the Anthem-Cigna merger).
    - Quarterly financial solvency meetings
        - Report on impact of mergers on competition concludes there will be minimal impact on Medi-Cal. See *www.healthhelp.ca.gov* for presentation on impact of mergers
- The Department's role in mergers includes ensuring that enrollees retain their healthcare rights; it evaluates:
    - Organizational and administrative changes.
    - Utilization management changes.
    - Clinical decision making changes.
    - Healthcare delivery system changes (changes in networks, cost-sharing, and tiering).
    - Product or subscriber contract changes.
    - Financial viability of plan.
    - Determine a plan's necessary undertakings
        - These are areas for improvement that are required when mergers happen, which are determined by the Department.
            - An example from the Blue Shield-Care First merger undertakings – improve quality of care performance, increase access to specialty network, and improve health literacy.
- The Department looks for ways to maximize health plan value.
    - Encourage new market entries (ex. Oscar Health Plan, United Health Group).
    - Evaluate proposed rate increases in small group market

        - Don't approve or deny rate increases, but negotiate with plans.
    - Starting in fall of 2016, health plans will have to file price data on large group products.
- The Department evaluates access to care in relation to geography and timeliness.

Greg Buchert, California Health and Wellness Plan – The Rural Perspective on Consolidation

- California Health and Wellness Plan is in 19 rural California counties
    - The rural market is not competitive, especially when compared to more urban areas of the state.
    - The plan is in the process of acquiring Health Net.
        - Will transform plan from 186,000 members in 19 counties to more than 3 million members in the state (Health Net has 3 million members throughout CA).
- Consolidation is good or bad depending on how the new, larger entity uses its new "power"
- Reasons for expansion/consolidation:
    - Increased revenue base, allows for more innovation and creativity.
    - Increases incentive to make investments in the community.
    - Potential for larger community impact.
    - Increased influence on the market.
    - Opportunity to improve coordination
        - Coordination activities are complex and consume a lot of resources. Consolidation may help align coordination and makes it more efficient.
    - Investments in infrastructure are easier to accomplish (EHR and IT capabilities).
    - Diversification and vertical integration increase accountability because everyone is serving the same members, so there is incentive to work together for quality and transparent care.
- The plan's philosophy is to transform the care of communities. This will involve expansion of managed care and the services provided.

• Moderated Discussion

- *In comparison to the many changes in the healthcare environment, there have been few changes to the regulatory environment. Is the current legal structure antiquated considering the new environment?*
    - Shelley Rouillard – any changes to regulations will need to go through the Legislature
    - Greg Buchert – the intensity of regulation on the plans is not always apparent to the members. More could be done through both regulation and changes in contracting.
    - James Robinson – a policy solution should be suggested with caution.
        - New policy is not always needed to solve a social problem and often creates its own problems.
        - The healthcare system is already too complicated; new reforms or proposals layer the system even more, and increase its complexity.
        - Need to determine if there are also regulations that can be removed.

- There is a role for regulation, but there are both risks and positive aspects that should be considered.

Audience Q&A

Will mergers have any impact in the two-plan model counties?

- Shelley Rouillard – where Health Net exists, Centene will be the company managing the care.
  - May see increased competition on the commercial side.

Question to James Robinson: It seems there is a great potential to get better quality via consolidation. However, a risk of consolidation is that the price efficiencies may not be reflected back to the consumers. Is this a correct understanding of the evidence?

- If there are anti-trust concerns, there may be a way of doing clinical coordination with fewer mergers/acquisitions via two different mechanisms
  - Changes in contracting.
  - Make a market reward for low-cost healthcare.
    - Currently this market reward does not exist, especially for dominant plans/providers.
      - Ex., in LA the market is competitive but in the rest of the state, there are often single dominant plans and care is much more expensive.
    - The direction we're headed is consumer cost-sharing. Consumers will almost always choose high cost-sharing rather than high monthly premiums.

Question to James Robinson: How could changes in contracting (versus acquisitions/mergers) work for private, disproportionate share networks that have limitations on hiring and staffing if just using contracts for a mechanism for change? In other words is the bar on corporate practice of medicine a bar to efficiency?

- Medical foundations can sometimes circumvent the law regarding the restrictions placed on hiring physicians.It is doable, but involves complicated legal processes.
- Commenter's thought restated: if hospitals employ doctors, they will have more influence over them as employees rather than contractors.
  - However, all hospitals will need a physician strategy to attract and keep doctors, regardless of hospital structure