

# The Shifting Health Care Landscape | Day 1

The Consumer Experience and State Policy Responses

June 11, 2020  
12:00 – 1:30 PM



Support for this two-day series is provided by the Endowment for Health

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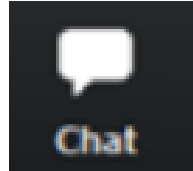
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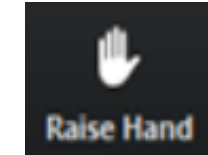
- IHPP Staff:
  - Bridget Drake
  - Molly Umana
  - Devan Quinn

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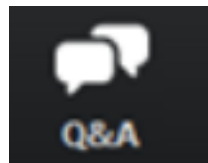
## Comments

You can access **chat** by clicking the icon on the control bar. Use for comments to the host, panelists, and attendees.



## Need Something

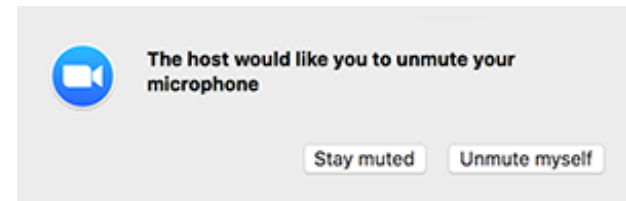
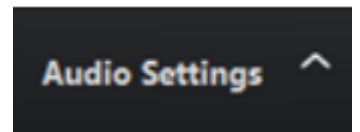
Click the **Raise Hand** icon to indicate that you need something from the host. This should be used during the discussion session at the end of the webinar if you have a question and would like to speak.



## Questions

Open the **Q&A** window to ask questions to the host and panelists. They can either reply back to you via text in the Q&A window or answer your question live.

**Unmute/Mute:** If the host gives you permission, you can unmute and talk during the webinar. All participants will be able to hear you. If the host allows you to talk, you will receive a notification.



# Today's Agenda

- Introduction to 2-day event and Polls
- National Consumer Perspective, Lynn Quincy
- State Policy Perspective, Trish Riley
- Q&A from Audience
- Wrap Up and Poll

# Housekeeping

- Please type your name and organization into the chat box.
- We will have 15 minutes for discussion from the audience.

You can ask your question two different ways:

- Use the **Q&A** option to submit your question in writing. You can choose to submit a question anonymously or submit your question with your name. We will read these questions out loud for our panelists to answer.
- **Raise Your Hand** if you want to be unmuted and ask your question directly. Let's practice raising hands!

# Objectives

- Learn what consumers of health care services are experiencing
- Identify key pain points in our healthcare delivery system
- Discuss the opportunities for responding to these challenges from a policy perspective in New Hampshire

And now, a few polls for the audience!

# Welcome Lynn Quincy



Director of Healthcare Value Hub  
at Altarum



# Lynn Quincy – Healthcare Value Hub

Lynn Quincy is Director of the Healthcare Value Hub at Altarum, a company that creates and implements solutions to advance health among vulnerable and publicly insured populations. At Altarum, the Healthcare Value Hub monitors and synthesizes evidence to help consumer advocates work on health care cost, quality and equity issues. Via their free resources, in-person trainings and webinars, the Healthcare Value Hub provides a comprehensive view of the health care system, and deploys evidence and the power of consumer voices to achieve a health system that is equitable, patient-centered, allocates resources wisely and delivers uniformly high health outcomes.

More generally, Ms. Quincy works at the federal and state levels on a wide variety of health policy issues, with a particular focus on health care costs, transparency, consumer protections, and consumers' health insurance literacy. Ms. Quincy serves as a policy and consumer expert in myriad ways, including speaking professionally, policy development, as a reviewer, consumer testing and more.

Prior to joining Altarum, Ms. Quincy held senior positions with Consumers Union, the policy and advocacy arm of Consumer Reports; Mathematica Policy Research, Inc.; the Institute for Health Policy Solutions and Watson Wyatt Worldwide (now Willis Towers Watson). She holds a master's degree in economics from the University of Maryland.

# National Consumer Perspective

## Lynn Quincy

# Let's Nail This Down: What Patients Really Want

Lynn Quincy, June 11, 2020

@HealthValueHub @LynnQuincy

healthcarevaluehub.org



# Altarum

A 450-employee, nonprofit health services research organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.



## The Hub got its start at *Consumer Reports*



**Consumers  
Union®**  
POLICY & ACTION FROM  
CONSUMER REPORTS



# What IS the Healthcare Value Hub?



*With support from the Robert Wood Johnson Foundation:*

- We review evidence to identify the policies and practices that work best to reduce healthcare spending, improve affordability for consumers, improve outcomes and reduce disparities.
- We create FREE resources--accessible for a wide variety of audiences--to help YOU work on these healthcare value issues.
- We support and connect consumer advocates across the U.S., providing comprehensive, fact-based information to help them advocate for change, and connect them to researchers and other resources.



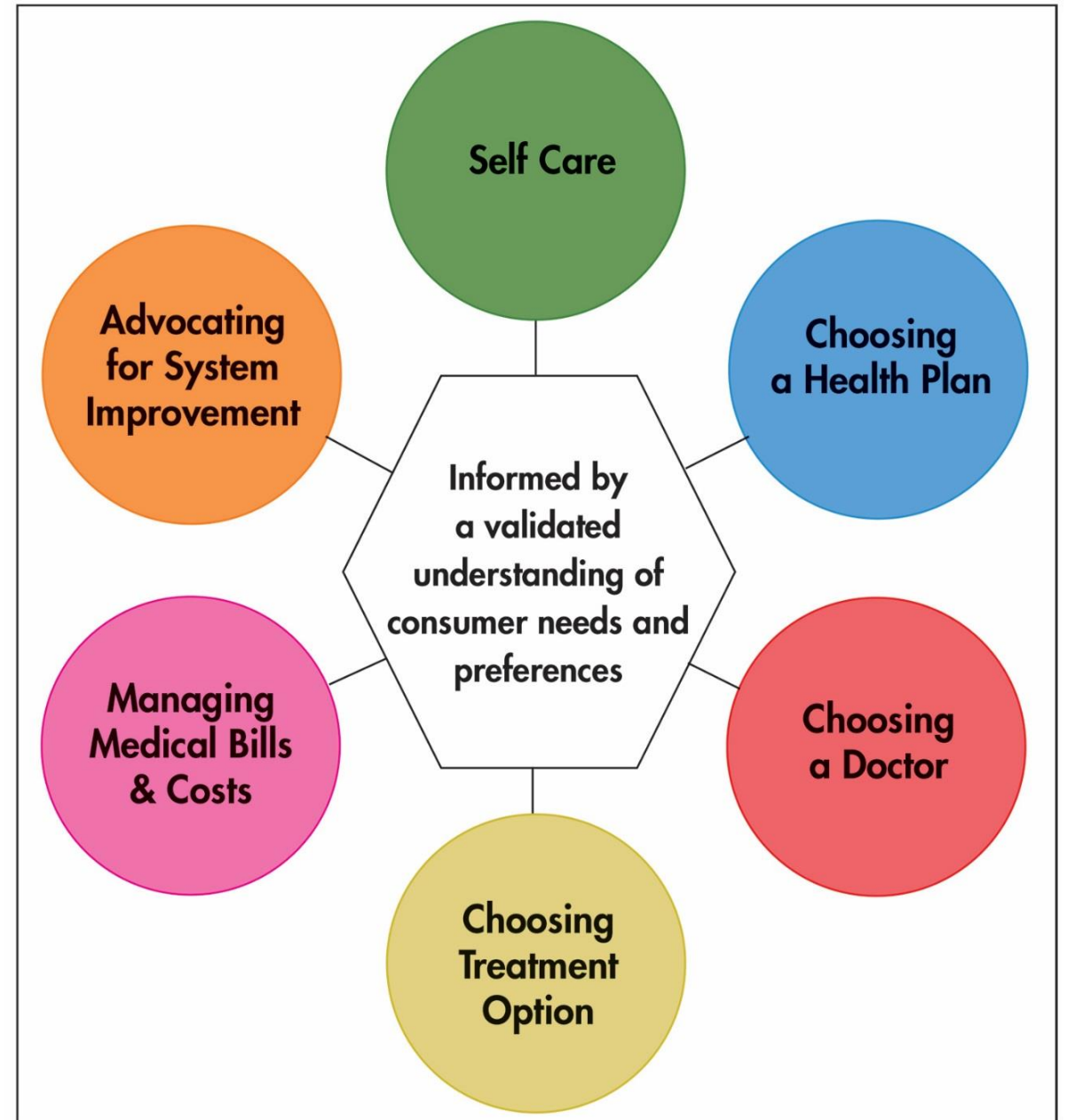
Sign up to be notified about upcoming events, new publications, state news or *Research Roundup* at:  
**[www.healthcarevaluehub.org/contact/stay-connected/](http://www.healthcarevaluehub.org/contact/stay-connected/)**

# What do patients truly want?

... what we knew pre-COVID



The way people  
experience healthcare  
is broader than  
just the  
clinical setting





We know a LOT about  
patient preferences and  
values

..but we rarely cater to these preferences and values

One-size fits all

**-Not!**

# Humanizing healthcare means tailoring our approaches to different types of patients



- ▲ Approaches to self-care are often **culturally based**
- ▲ **Recently arrived immigrants** are often used to health systems that are differently organized and administrated than the U.S. health care system
- ▲ Compared to men, **women** use more health services, are more likely to take prescription medication, and are more likely to experience problems paying medical bills or forgoing needed health care because of the cost
- ▲ **Trust** of the health system varies by population

TRUST  
is critical

# Role of Trust



- ▲ Patients highly value being able to trust their healthcare providers
- ▲ Healthcare Outcomes:
  - Trust influences a patient's decision to **seek care**
  - Patients who trust their **doctors** are more likely to follow treatment plans
  - Trust influences whether an enrollee stays with their **insurer** and whether they would recommend that insurer
  - Trust in **public health institutions** influences whether or not recommendations are followed

# People's trust depends fundamentally on three questions:



- ▲ Do you know what you're doing?
- ▲ Will you tell me what you're doing?
- ▲ Are you doing it to help me or help yourself?

# Trust varies based on socio-economic status, race, and level of interaction with the healthcare system



- ▲ Young vs. old
- ▲ Low-income (“bad” insurance) vs. high-income (“good” insurance)
- ▲ Spanish speakers
- ▲ Black Americans are much less likely to report trust in their physicians and hospitals

Sources: *To Improve Health Care, How Do We Build Trust And Respect For Patients?*, HealthAffairs Blog, September 26, 2017; *Overcoming Lower-Income Patients’ Concerns About Trust And Respect From Providers*, HealthAffairs Blog, August 11, 2016

# RESPECT

Patients who feel disrespected by doctors are far less likely to trust doctors overall and are less likely to take their prescription medications as directed.

*Overcoming Lower-Income Patients' Concerns About Trust And Respect From Providers, HealthAffairs Blog, August 11, 2016*

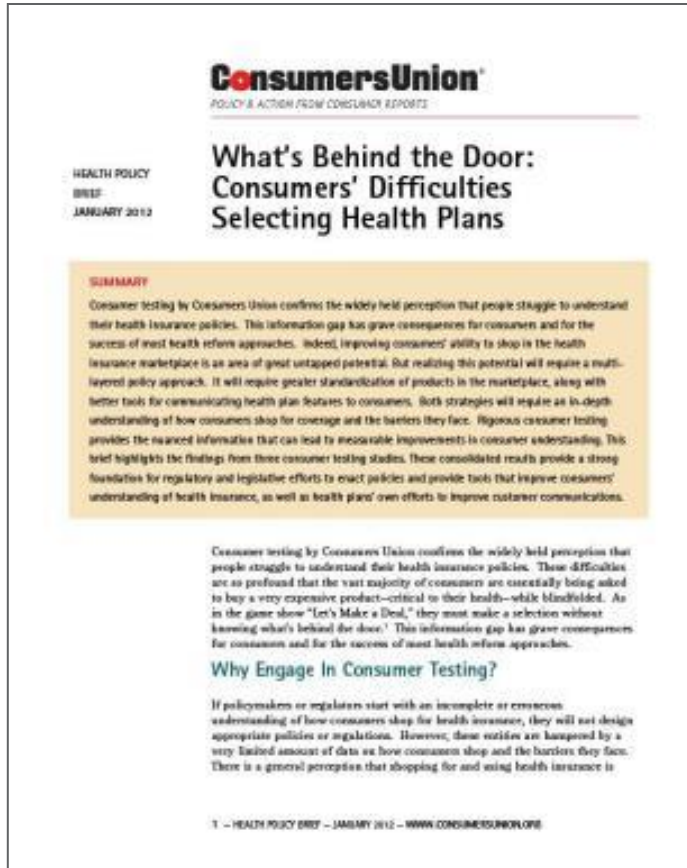


# Choosing and Using a Health Plan

# 2011 Consumer Testing New Insurance Disclosures Revealed...



...consumers HATE health insurance shopping.



# To put this into perspective...



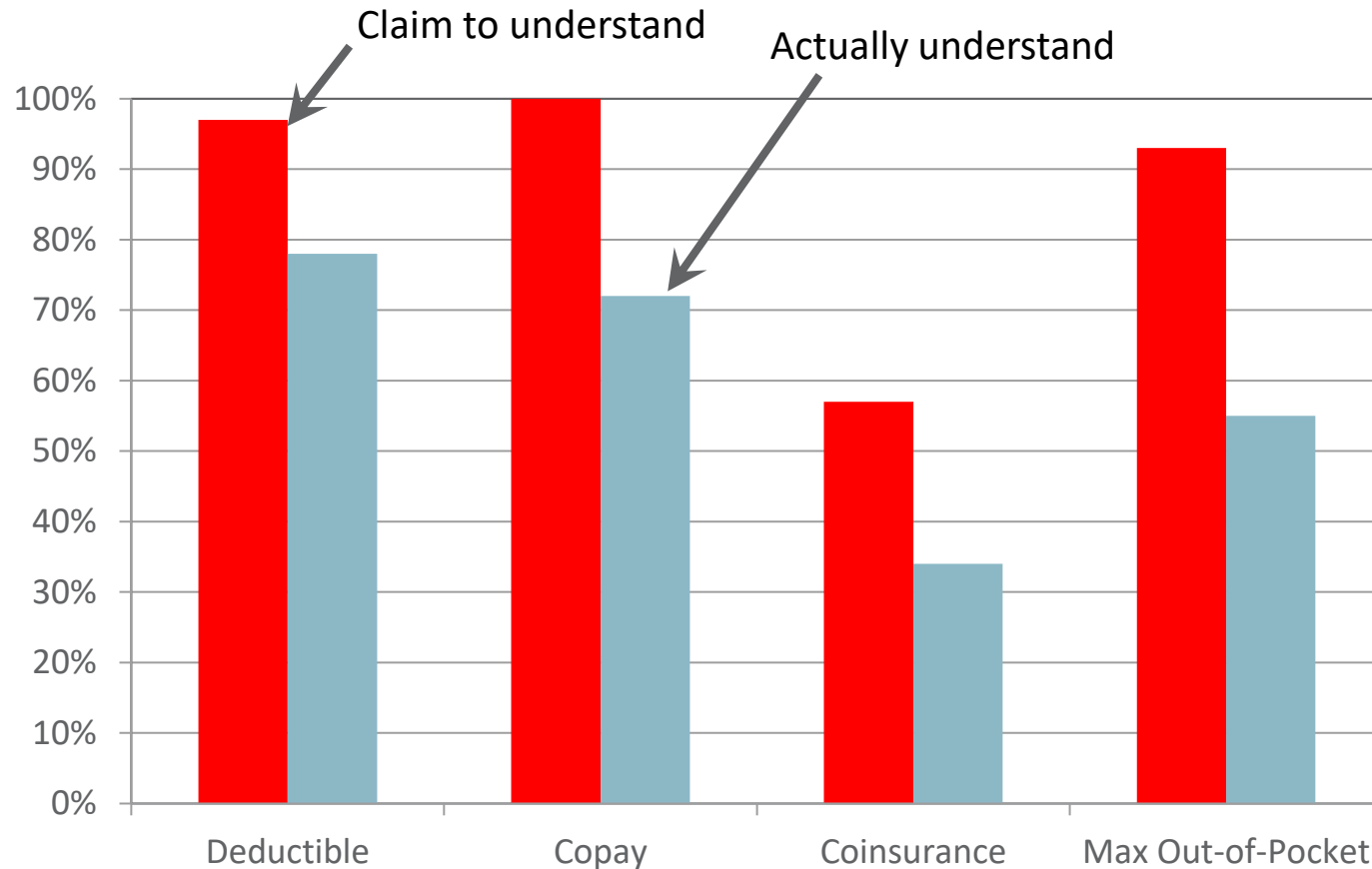
...consumers would prefer to:

- go to the gym or
- pay their taxes

....rather than shop for health insurance.

Source: ehealth, Inc., “New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology,” Jan. 3, 2008, available at [http://www.insurancenewsnet.com/article.asp?a=top\\_news&id=89712](http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712)

# Cost-sharing is the hardest thing Consumer Confidence > Skills





Source: [Loewenstein et al., JHE, 32\(5\):850-862, 2013](#)

# 2018 Focus Group: Overarching Views on the Health System



- **High Costs:** the dominant concern “*expensive,*” “*skyrocketing,*” “*astronomical,*” and “*out of control*”
- **Complexity:** the challenge of navigating health care frustrated nearly all participants
- **Fairness:** dismayed by systemic inequities and disparities regarding access to quality care



FOCUS GROUP FINDINGS | SEPTEMBER 2018

## Engaging Consumers in Health System Transformation: Key Takaways from Focus Groups

If we are to engage consumers and give them a voice in efforts to transform our health system, we must meet them where they are and anchor our communications in their experience of the health system.

This report summarizes the key takeaways and actionable steps from qualitative research by Lake Research to help advocates and others seeking to communicate effectively.

### BACKGROUND

To better understand people's attitudes and perceptions of the healthcare system, Altarum's Healthcare Value Hub contracted with Lake Research Partners to conduct focus groups in Philadelphia, PA, on June 27, 2018 with African American women and white men, and in Richmond, VA, on June 28 with white women and African American men. The goal of these conversations was to explore people's experiences with the U.S. healthcare system and better understand their perceptions of healthcare value, and the components of value—quality, outcomes and costs—to enhance advocates' ability to communicate and engage consumers to enact policy changes. Participants were recruited to reflect a mix of educational attainment, partisanship, parental status and age (between 25 and 65). For full findings, see Lake Research Partners' *Focus Group Findings on Healthcare Value* available at [www.HealthcareValueHub.org/Consumer-Engagement](http://www.HealthcareValueHub.org/Consumer-Engagement).

### WHAT WORDS MEAN TO PEOPLE

When it comes to healthcare, participants care about high costs, access, fairness, quality and having options to receive the care they need. Understanding how people perceive these terms can inform how we engage with consumers.

### COSTS

When asked for general impressions of our healthcare system, high costs emerged as the dominant concern among participants. Cost is a key component of healthcare access—if someone cannot afford care, they do not get the care they need.

People's dominant description of the healthcare system included “expensive,” “skyrocketing,” “astronomical” and “out of control.” The high cost of healthcare generated strong frustrations across groups. Many people felt as though they are overcharged. They think the focus in healthcare is too often on money instead of quality and outcomes. They frequently brought up greed as a force within the system and lamented that it is “too much of a business.” Participants believed that greedy business considerations spill into and affect political decision making.

Results from Lake Research Partners Focus Groups

# Changes Wrought By COVID



## ▲ Concerns about the **safety** of healthcare settings:

- Driving more interest in telemedicine, such as virtual visits and remote health monitoring
- Many are postponing healthcare
- Perception of safety is a function of trust.
- *Exception:* Forty-nine percent feel “very comfortable” picking up a prescription from their pharmacists.

## ▲ Fear of **losing coverage**

- ▲ Among those with one or more chronic conditions, just one in 10 respondents was very confident that the federal government could prevent a nationwide outbreak.

What Health System  
Changes Are Needed?

# Make Health Insurance Less Complex (Pre-COVID)



- ▲ NO surprises v/v uncovered services;
  - Surprise Medical Bill protections
  - Discourage plans that don't cover essential health benefits (like STLD plans)
  - Comprehensive approach to network adequacy
- ▲ Require adherence to Standard Benefit Designs:
  - Use copays instead of deductibles and co-insurance;
  - Remove cost-barriers (and other barriers) to high-value care
- ▲ No under-insurance
- ▲ Make it easy to enroll/no wrong door



# COVID opened these doors:

- ▲ **Eliminate copays and deductibles** while also guaranteeing coverage for Covid-19 testing costs\*
- ▲ Better access to the **provider workforce**:
  - Coverage of telemedicine services
  - Relaxing licensing across states
  - Easing scope of practice rules
- ▲ **Easier Medicaid and ACA enrollment** (some states); no new requirements leading to Medicaid disenrollment.
- ▲ **Surprise Medical Bill** protections
- ▲ Perhaps COBRA subsidies...

\*requirement does not apply to short-term, limited duration health plans

People want to know that someone is “minding the store” so the health system works when they need it.

# Healthcare Affordability State Policy Scorecard

Polling data repeatedly shows that healthcare affordability is the number one issue that state residents, on both sides of the political aisle, want their policymakers to work on. This scorecard identifies areas where New Hampshire is doing well and areas where it can improve.

STATE:

**NEW HAMPSHIRE**

RANK:

**17**

out of  
42 states  
+ DC

New Hampshire has relatively high healthcare spending per person, yet the percentage of residents reporting affordability problems is slightly lower than the national average. High recent spending growth suggests that policymakers need to bring a broad focus addressing affordability.

	POLICY SCORE	OUTCOME SCORE	RECOMMENDATIONS
<b>EXTEND COVERAGE TO ALL RESIDENTS</b> 	<b>3 OUT OF 10 POINTS</b> Medicaid coverage for childless adults extends to 138% of FPL.	<b>8 OUT OF 10 POINTS</b> In 2018, NH was in the top third of states in terms of covering the uninsured, ranking 14 out of 50 states, plus DC, for this measure.	<i>NH should consider options that help families that earn too much to qualify for Medicaid, like Basic Health Plan, reinsurance or supplementary premium subsidies. The state should also consider adding affordability criteria to its insurance rate review.</i>
<b>MAKE OUT-OF-POCKET COSTS AFFORDABLE</b> 	<b>5 OUT OF 10 POINTS</b> NH has some protections against skimpy, confusing STLD health plans and comprehensive SMB protections.	<b>7 OUT OF 10 POINTS</b> NH surpasses many states in reducing healthcare OOP affordability burdens, although 33% of adult residents are still burdened. NH ranked 10 out of 49 states, plus DC, for this measure.	<i>NH should consider stronger protections against STLD health plans and strategies that lower the cost of high-value care.</i>
<b>REDUCE LOW-VALUE CARE</b> 	<b>2 OUT OF 10 POINTS</b> NH requires some forms of patient safety reporting, but performs below average for hospital antibiotic stewardship and has not measured the provision of low-value care.	<b>6 OUT OF 10 POINTS</b> NH ranks 26 out of 50 states, plus DC, in terms of reducing C-sections for low-risk mothers and 15 out of 50 states, plus DC, in terms of per capita antibiotic prescribing.	<i>Curtailling low- and no-value care is a key part of a comprehensive approach to affordability. NH should use claims and EHR data to identify unnecessary care and enact a multi-stakeholder effort to reduce it. NH should also stop paying for 'never events,' use other techniques to reduce medical harm and increase efforts to address antibiotic overprescribing.</i>
<b>CURB EXCESS PRICES IN THE SYSTEM</b> 	<b>4 OUT OF 10 POINTS</b> NH has an APCD, but is otherwise a middle-ranked state with a few policies to curb the rise of healthcare prices.	<b>6.5 OUT OF 10 POINTS</b> NH is among the most expensive states, with private payer prices well above the national median. The state ranks 36 out of 42 states, plus DC, for this measure.	<i>Year-over-year increases in healthcare prices overwhelmingly drive state healthcare spending. NH should consider establishing a health spending oversight entity and health spending targets.</i>

APCD = All-Payer Claims Database FPL = Federal Poverty Level EHR = Electronic Health Records OOP = Out-of-Pocket Costs SMB = Surprise Medical Bill STLD = Short-Term, Limited-Duration

See state notes on page 2.



Full report and additional details at [www.HealthcareValueHub.org/Affordability-Scorecard/New-Hampshire](http://www.HealthcareValueHub.org/Affordability-Scorecard/New-Hampshire)

# Reduce the burden of interacting with the health system



## ▲ Office of the Healthcare Advocate:

- Direct assistance with insurance issues, *regardless of type of coverage*
- A trusted and powerful representative to guide policymaking



RESEARCH BRIEF NO. 25 | APRIL 2018 (updated May 2018)

### The Office of the Healthcare Advocate: Giving Consumers a Seat at the Table

As healthcare recipients and payers (through premiums, taxes and out-of-pocket costs), consumers are the most important stakeholders in our healthcare system. Yet, all too often, healthcare policies are made without sufficient consumer input, resulting in a system that does not reflect patients' wants and needs.<sup>1</sup>

Consumers' difficulty understanding and using their health insurance is a primary example of our system's failure to put patients first. In theory, health insurance is designed to protect consumers. But consumers are harmed when they are unable to understand coverage options or use their plans once they are enrolled. Consumers are also burdened by denied claims and confusion over the appeals process. To make matters worse, they often don't know where to turn for help.<sup>2</sup>

Most states offer some form of consumer assistance to help people navigate the health insurance landscape. For many consumers, these programs are vital to decreasing otherwise insurmountable barriers to coverage and care. But consumers' needs extend beyond just-in-time assistance. They also need a powerful representative to help policymakers understand how they can make the healthcare system work better for consumers.

A few states, like Connecticut, are leading the way by establishing offices that not only assist consumers with their immediate needs, but advocate on their behalf to create long-term improvements as well. This brief highlights Connecticut's Office of the Healthcare Advocate and explores best practices from five other high-performing states—California, Maryland, New York, North Carolina and Vermont (see Table 1). The information presented in this report was collected from ten discussions with consumer representatives from these six states.

#### SUMMARY

*Consumer assistance offices that help people find and use their health insurance are vital to decreasing barriers to coverage and care. But consumers' needs extend beyond just-in-time assistance. They also need a powerful representative to report pervasive problems to policymakers and recommend solutions. Some states address this by establishing offices that not only assist consumers with their immediate needs, but also advocate on their behalf to create long-term improvements. This brief profiles high-performing consumer advocacy offices and offers best practices for states looking to increase protections and strengthen representation for consumers.*

#### Consumer Assistance is Vital, but has Limitations

Undeniably, consumer assistance is vital to achieving better healthcare value. But it largely serves as a "band-aid fix," helping consumers navigate a complex and, at times, dysfunctional healthcare system once problems arise. Consumer advocacy offices can take consumer assistance further in two ways:

- Looking across the spectrum of healthcare consumers (private and publicly insured) to understand how they are experiencing the healthcare system.
- Attempting to influence policy to prevent pervasive problems and bring about large-scale change.

In many states, consumer assistance resources are highly fragmented. For example, it is common for a

# COVID Concerns:

- ▲ Loss of revenue may lead to fewer small, independent practices and a more concentrated marketplace
- ▲ Delays in getting care may mean more severe illness down the road
- ▲ State budget short-falls



## Preventing Healthcare Consolidation: Strengthening State Antitrust Laws

Federal antitrust laws aim to preserve competition by prohibiting anti-competitive behaviors, however these laws are often under-enforced.<sup>1,2</sup> For a variety of reasons, federal regulators have been reluctant to proceed, forcing generalists to halt those that are potentially anti-competitive.

In the healthcare sector, antitrust laws are primarily focused on mergers between single market (a.k.a., horizontal mergers) and mergers between organizations at different stages of the supply chain (i.e., vertical mergers). However, evidence suggests that cross-market mergers can also have negative implications for competition. Given the increasing prevalence of mergers, policy experts have identified the need to strengthen anti-trust enforcement in the healthcare sector.

### Strengthening Oversight: Vertical and Cross-Market Mergers

While the majority of state antitrust laws resemble federal law, some states have enacted legislation that permits increased scrutiny of mergers, including vertical and cross-market mergers. For example, Connecticut, for example, requires

[HealthcareValueHub.org](https://www.healthcarevaluehub.org)



## When Antitrust Fails: Limiting Consumer Harm from Healthcare Consolidation

Competition in healthcare, while increasingly rare, helps control prices, encourages the delivery of high-quality products and services, and promotes consumer choice. However, antitrust laws designed to preserve competition have been largely ineffective since the 1990s, and persistent consolidation among providers and insurers has contributed to high (and rising) healthcare costs. As a result, states have relied upon alternative approaches to mitigate anti-competitive effects after mergers occur. This brief describes these efforts and identifies additional strategies to prevent future consolidation.

### What are Antitrust Laws and Who Can Enforce Them?

Antitrust laws aim to preserve the benefits of competition in healthcare markets by prohibiting certain anti-competitive behaviors. Federal antitrust laws prohibit three categories of conduct that undermine competition:

- agreements by two or more businesses not to compete, or to limit competition;
- efforts by one or more companies to undercut competition by others in order to secure a monopoly; and
- mergers (or acquisition of business assets) that would significantly reduce competition.

Each of these categories has specific requirements and limitations reflecting the interpretation of the law by the courts. These laws can be enforced by the U.S. Department of Justice, the Federal Trade Commission

and by states' attorneys general. Most states also have their own versions of antitrust law, enforced by the state attorney general.

### What Happens When Mergers and Acquisitions are Allowed to Proceed?

Studies have found that antitrust laws are generally under-enforced. For a variety of reasons, many mergers and acquisitions are allowed to move forward, forcing regulators to grapple with the subsequent anti-competitive effects.

In the healthcare sector, antitrust activity primarily focuses on mergers between competitors in a single market (a.k.a., horizontal mergers). However, evidence is mounting that mergers between organizations in different markets (i.e., cross-market mergers) and mergers between organizations at different stages of the supply chain (i.e., vertical mergers) can also have negative implications for consumers.

### Current Evidence on Healthcare Consolidation



Healthcare organizations typically argue that mergers improve efficiency and create economies-of-scale, improving quality and reducing costs. Yet little reliable evidence supports this claim. In fact, ample evidence demonstrates that healthcare mergers increase prices and that less competition may lead to lower quality. Mergers may also negatively affect other important aspects of the healthcare system, such as the healthcare workforce, health systems' responsiveness to community concerns and access to care.

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# Health System Oversight By States





RESEARCH BRIEF NO. 20 | NOVEMBER 2017

## Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.<sup>1</sup> Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.<sup>2</sup> While all states have well-defined roles for certain segments of their health

system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

### SUMMARY

*It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.*

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising healthcare costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

### Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.<sup>3</sup>

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.<sup>4</sup> States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in “upstream” approaches that lead to healthier communities. Research shows that just 10-20 percent

*It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture.*



# Potential Duties of the Oversight Entity



- ▲ Monitor spending, in total and unwarranted variation
- ▲ Monitor quality, outcomes, patient safety, inequities
- ▲ Monitor system efficiency and capacity
- ▲ Develop recommendations
- ▲ Convene stakeholders
- ▲ Align payers and/or aggregate purchasing power
- ▲ Ensure that Public Health, Social Services and Health Systems care for the population in an integrated fashion

To truly claim the mantle of being consumer-centric, stakeholders must:

- meet consumers where they are,
- recognize the limitations and barriers consumers face, and
- actively work to reduce the consumer's burden of interacting with the health system.



# Thank you!



Contact Lynn at [Lynn.Quincy@Altarum.org](mailto:Lynn.Quincy@Altarum.org) or any member of the Hub team with follow-up questions.

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# Welcome Trish Riley



Executive Director of the National  
Academy for State Health Policy  
(NASHP)

# Trish Riley - NASHP

Trish Riley is Executive Director of the National Academy for State Health Policy and president of its corporate Board. She helped build NASHP as CEO from 1988-2003.

Previously, she was a Distinguished Fellow in State Health Policy at George Washington University and taught in the graduate program at the Muskie School of Public Service, University of Southern Maine.

From 2003-2011 she served as Director of the Governor's Office of Health Policy and Finance, leading the effort to develop a comprehensive, coordinated health system in Maine including access to affordable health insurance. She chaired the Governor's Steering Committee to develop a plan to implement the Affordable Care Act in Maine. Riley has also held appointive positions under five Maine governors – directing the aging office, Medicaid and state health agencies, and health planning and licensing programs.

She served as a member of the Kaiser Commission on Medicaid and the Uninsured, and serves at the Institute of Medicine's Board on Health Care Services, the National Academy for Social Insurance where she co-chaired the Study Panel on Medicaid and the Culture of Health, Board of Directors of Maine's Co-Op insurance plan. She was a founding member of the Medicaid and CHIP Payment and Access Commission (MACPAC), served on the Institute of Medicine's Subcommittee on Creating an External Environment for Quality and was a member of the Board of Directors of the National Committee on Quality Assurance. Riley holds a B.S. & M.S. from the University of Maine.

# State Policy Perspective

## Trish Riley

# The Shifting Health Care Landscape and How States Can Respond

1

**UNH INSTITUTE FOR HEALTH POLICY AND PRACTICE**

**JUNE 11, 2020**

**TRISH RILEY -EXECUTIVE DIRECTOR  
NATIONAL ACADEMY FOR STATE HEALTH POLICY**

**TRILEY@NASHP.ORG**



# Who IS Minding the Store??

46

- ❖ Consumers: A trusted source to assure affordability , simplicity and accountability...WHO?
- ❖ Doctors and Hospitals = most trusted but vested interests
- ❖ Employers – Incentive but not in the health care business
- ❖ Feds or States? -Public institutions dead last on “trust” but...


# What Do Consumers Want?

3

- ❖ Affordable, simple, accountable
- ❖ High bar: “Choice is not critical” – but ONLY if the health system meets individual need and there are no bad providers

# The Policy Question

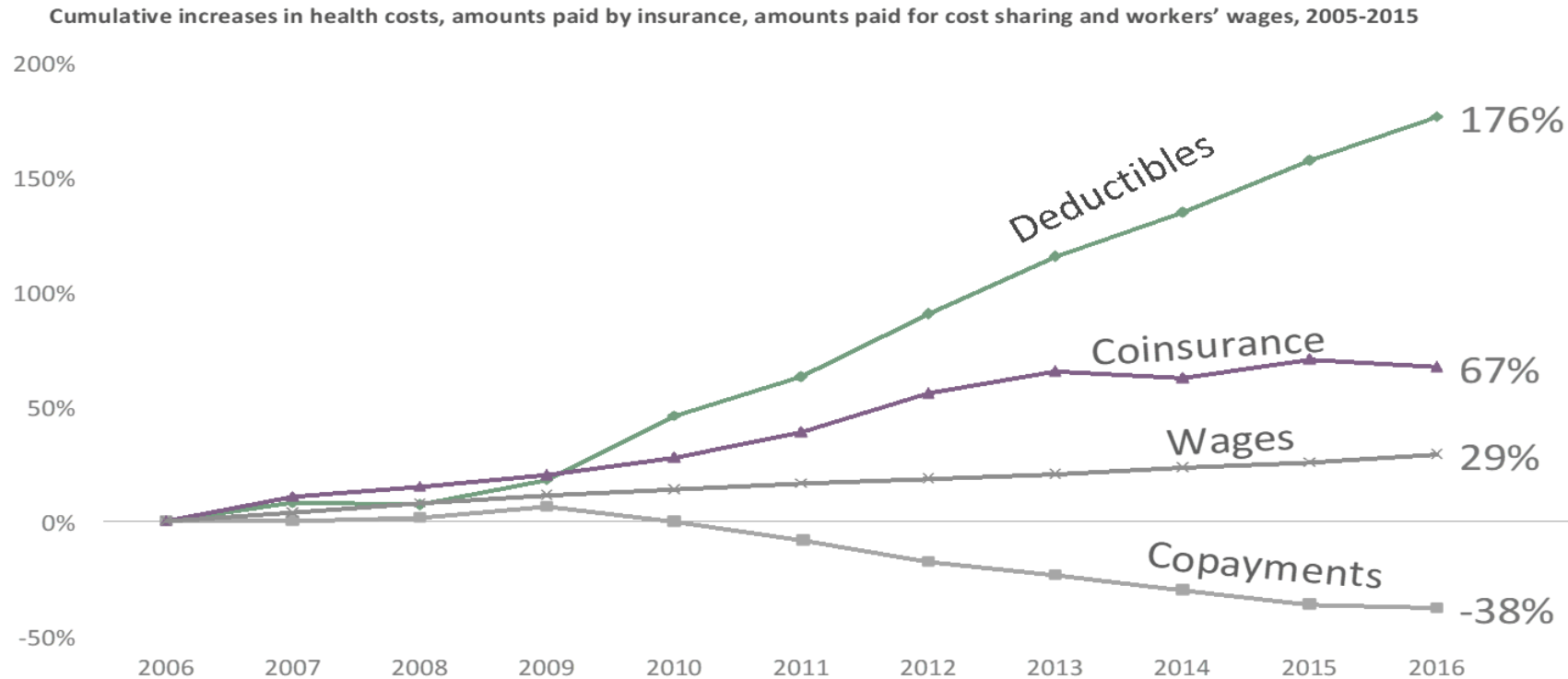
4

- ❖ AT WHAT COST?
- ❖ Consumers want affordability but, affordability  cost
- ❖ Affordability strategies often just shift cost
  - ❖ Subsidies for coverage
  - ❖ Limiting OOP
  - ❖ Outlawing Surprise billing



# Spending on deductibles and coinsurance have far outpaced wages, while copayments have fallen

49



Source: Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2005-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2006-2016 (April to April).

Peterson-Kaiser  
**Health System Tracker**

# Costs Drive Premiums Up; What Drives Costs?

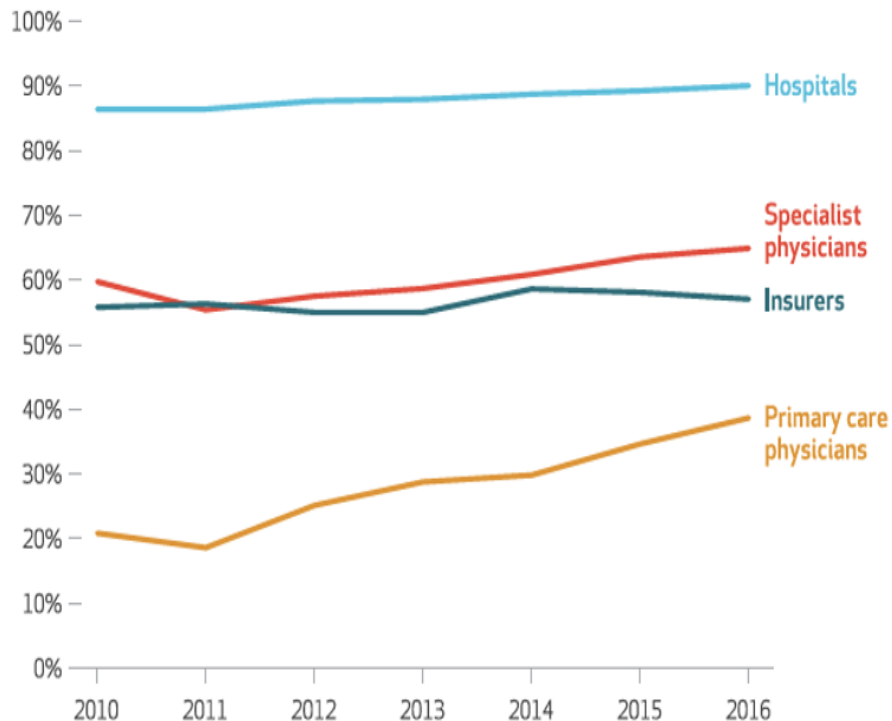
50

- ❖ Prices – Hospital and Rx
- ❖ Consolidation – horizontal and vertical
- ❖ Misplaced priorities –e.g. under-investment in SDOH; primary care
- ❖ Medical education costs/provider debt (see price increase)
- ❖ Uninsured and Underinsured

# Health care consolidation trends

EXHIBIT 2

Percentages of Metropolitan Statistical Areas (MSAs) whose Herfindahl-Hirschman Index (HHI) was above 2,500 for hospitals, physician organizations, and health insurers, 2010-16



% of markets that are highly concentrated:

65% of specialty physician markets

57% of insurer markets

39% of primary care markets

Source: Fulton, BD. Health Care Market Concentration Trends in the United States: Evidence and Policy Responses. Health Affairs. 2017;36(9):1530-1538.

# Hospital Consolidation → Higher Prices

Hospital consolidation leads to significantly higher prices in concentrated markets.

Estimated price increases: 20-40%

Author/Year	Result
Dafny (2009)	Merging hospitals had 40% higher prices than non-merging
Haas-Wilson, Garmon (2011)	Post-merger, Evanston NW hospital had 20% higher prices than controls
Tenn (2011)	Summit/Sutter prices increased 28% - 44% compared to controls

Source: Gaynor M, Town R, The impact of hospital consolidation – update, Robert Wood Johnson Foundation, The Synthesis Project, ISSN 2155-3718 (June 2012).

# Consolidation and Quality

- Patient outcomes are worse in more concentrated markets, where hospitals or physicians face less competition (Gaynor et al. 2013, Koch et al. 2018)
- Hospital ownership of physician practices led to higher readmission rates and no better quality measures (McWilliams et al. 2013, Neprash et al. 2015)

Against the mounting evidence that consolidation raises prices, there is a noted lack of evidence that consolidation improves quality or reliably generates cost savings through reduced utilization or improved efficiency.

# States Can “Mind the store”

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## ❖ States have many roles

- ❖ Purchaser
- ❖ Payer
- ❖ Bully pulpit / convener / educator
- ❖ Regulator/licensing/quality

# Many Levers of State Action

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- ❖ More facile than Federal government to respond to shifting landscape
- ❖ Laboratories of Experimentation – Can inform federal action



# How DO States “Mind the Store”?

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- ❖ 1970's – Federal/State /Community Health Planning/CON Replaced by Market Solutions – managed care
- ❖ Growth of alternative payment models /ACOs  
Policy Commissions/ Government oversight
- ❖ Medicaid/ Public Purchasers – Set Payment rates



# Transparency

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- ❖ First but inadequate step – Follow the money
- ❖ Track hospital or system or both?
- ❖ APCDs – N.H's Health cost website
- ❖ States have enacted hospital transparency laws – new model law pending from NASHP
- ❖ 8 states have RX pricing transparency

# Broad Oversight/Accountability

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## Total Cost of Care/Cost Growth Benchmarks

MA, VT, RI, DE, OR, WA, CT, CO

- ❖ Builds on status quo
- ❖ Enforcement?
- ❖ Stakeholder engagement v. capture

## ❖ State Health Planning ?

# OVERSIGHT

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- ❖ MD Health Services Cost Review Commission
- ❖ VT Green Mountain Care Board – Global Hospital budgets
- ❖ MD Drug Affordability Board (stay tuned for new NASHP model law)
- ❖ Insurance rate review – RI hospital spending growth cap
- ❖ CO Office of Saving People Money in Healthcare

# Consumer Protection/Affordability

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- ❖ Surprise billing with reference-based fees
- ❖ Facility fees
- ❖ All or Nothing contracts
- ❖ AG and /or CON review of consolidation
- ❖ Provider licensing/scope of practice
- ❖ COPA
- ❖ Hospital community benefit

# Rural Hospital Initiatives

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## ❖ PA Rural Hospital Sustainability

- ❖ All payer- CMS awards \$25 M
- ❖ Global budget
- ❖ Rural Health Transformation Plan – delivery reform/invest in primary care
- ❖ Projected Medicare savings
- ❖ Limits hospital cost growth

# State as Purchaser

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## Consolidate purchasing clout

- ❖ WA. Health Care Authority (Medicaid, State employees, teachers)
- ❖ OR. Health Care Authority (Medicaid, municipalities, state employees, teachers)
  - ❖ Covers 1:3 Oregonians
  - ❖ Includes sustainable growth cap for providers

**Montana State Employees** — Based hospital reimbursement as % of Medicare

**State Based Insurance Exchanges**

**Public Option**

# State Actions to Improve QHP Affordability/ Choice

63

- ❖ **Reinsurance programs** (AK, CO, DE, MD, ME, MN, MT, ND, NJ, OR, RI, WI)
- ❖ **Additional state subsidies** (CA, MA, VT)
- ❖ **State individual mandate** (CA, DC, MA, NJ, RI, VT)
- ❖ **Regulation of short-term plans** (CA, CO, CT, DC, DE, HI, IL, MA, MD, MI, MN, ND, NH, MN, NM, NV, NJ, NY, OR, SC, SD, VA, VT, WA, WY)
- ❖ **Limitation or prohibition of association health plans** (AK, CA, CT, DC, IA, IN, KS, MA, MD, MI, NY, OR, PA, RI, VA, VT, WA)
- ❖ **Extended open enrollment period** (CA, CO, CT, DC, MA, MN, NY, RI)
- ❖ **Public option** (WA)

## 17





# Simplify the Insurance Shopping Experience

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- ❖ States have considerable flexibility in oversight of health plans
- ❖ Common standard plan requirements
  - ❖ Standard copayments and coinsurance (e.g., lower co-pays for generic drugs)
  - ❖ Deductible-exempt services (E.g., a set number of physician visits before the deductible)
  - ❖ Provider tiers: Single in-network provider tier
  - ❖ Drug formularies: Limited prescription tiers (generic, preferred brand, non-preferred brand and specialty tier) / Waste Free formulary

# SBMs Innovate Consumer Shopping Experience

20

## **Direct to Broker or Assister Tools**

- ❖ CA “Help on Demand”: web-based tool to connect consumers with an enrollment assister in <30 minutes
- ❖ CO: >7,600 consumers used the tool to make appointments with assisters during the 2020 OEP

## **Plan comparison tools or calculators**

- ❖ MN: Nearly 300K “sessions” of using plan comparison tools in 2020
- ❖ WA: Smart Planfinder used by >54,000 enrollees
- ❖ RI: Use of tools doubled after a revamp of plan comparison tools for 2020

# Pain Points: The Politics of Reform

67

- ❖ One person's cost savings is another's income
- ❖ Health care a significant economic engine and powerful lobby
- ❖ Consumers may want lower costs, less complexity and more fairness...they also want their local hospital

# Post- COVID?

68

## ❖ Lessons:

- ❖ Weakness in system readiness-
- ❖ Impact on hospitals – revenue losses and CARES Act and other Federal funding- Some health system “windfalls”
- ❖ MORE CONSOLIDATION LIKELY
- ❖ Roll backs of many regulatory levers e.g. telehealth, licensing, scope of practice, new entry, grace periods
- ❖ Severe economic impact – state budgets walloped as revenues decline

# Never Let a Crisis Go to Waste

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- ❖ Opportunity for innovation and collaboration
- ❖ Raging incrementalism works – if you have a vision  
of where you want to go

# Q&A Session

# Concluding thoughts

## Lucy Hodder

In one word, what is the  
biggest challenge for  
**consumers** in  
New Hampshire's healthcare  
system post-COVID  
emergency?



In one word, what is the biggest challenge for **the state** in New Hampshire's healthcare system post COVID emergency?