



**CALIFORNIA  
MEDICAL  
ASSOCIATION**

# **HEALTH CARE COSTS, COVERAGE AND POLITICAL OUTLOOK**

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# OVERVIEW



- I. Consolidation in Health Care
- II. Political Pressure
- III. Innovative Market-Based Solutions



# THE PHYSICIAN MARKET

# MARKET CHALLENGES FOR PHYSICIANS

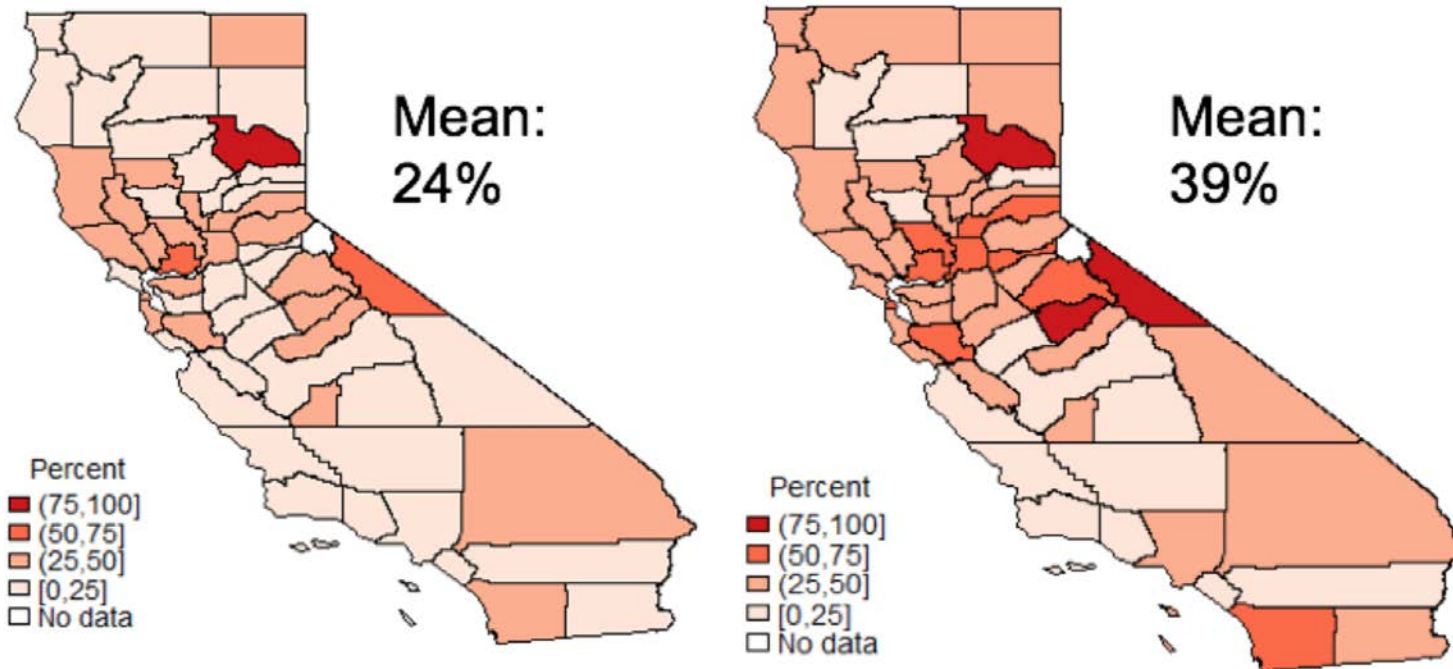
- Rapid consolidation in the marketplace
- Hospital-dominated markets
- Complexity of payment models and regulations
- Limited physician access to capital

# PROVIDER CONSOLIDATION

Percent of Physicians in Each County Who Work for Foundations Owned by a Hospital or Health System

2010

2016



# THE HOSPITAL MARKET



# THE HOSPITAL MARKET

- **California Hospital Systems.** In 2013, the 8 largest hospital systems in CA accounted for 40% of hospitals and beds in the state, with the three largest systems accounting for nearly 25% of the hospitals and beds in the state.

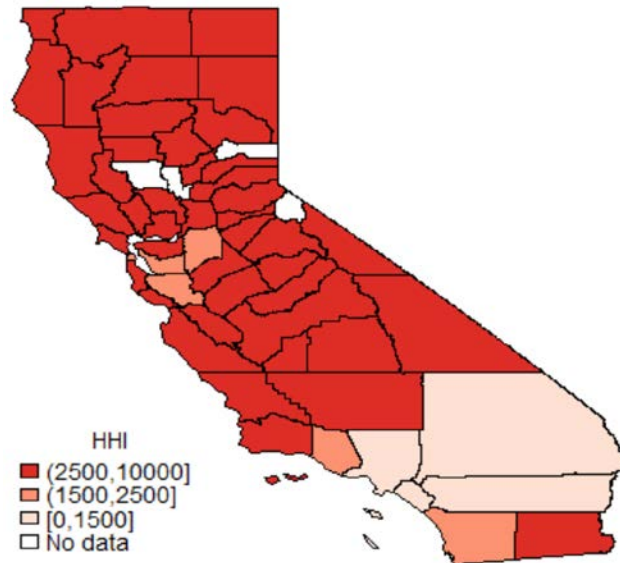
# THE HOSPITAL MARKET

- **Growth of health systems.** 60% of hospitals are part of health systems, up 7 percentage points from a decade ago.
- **Post-acute care health care organizations and services** are also increasingly affiliated with hospitals: 67% of hospitals offer home health services; 37% have skilled nursing facilities; 62% own hospice services; and 15% provide assisted living options.

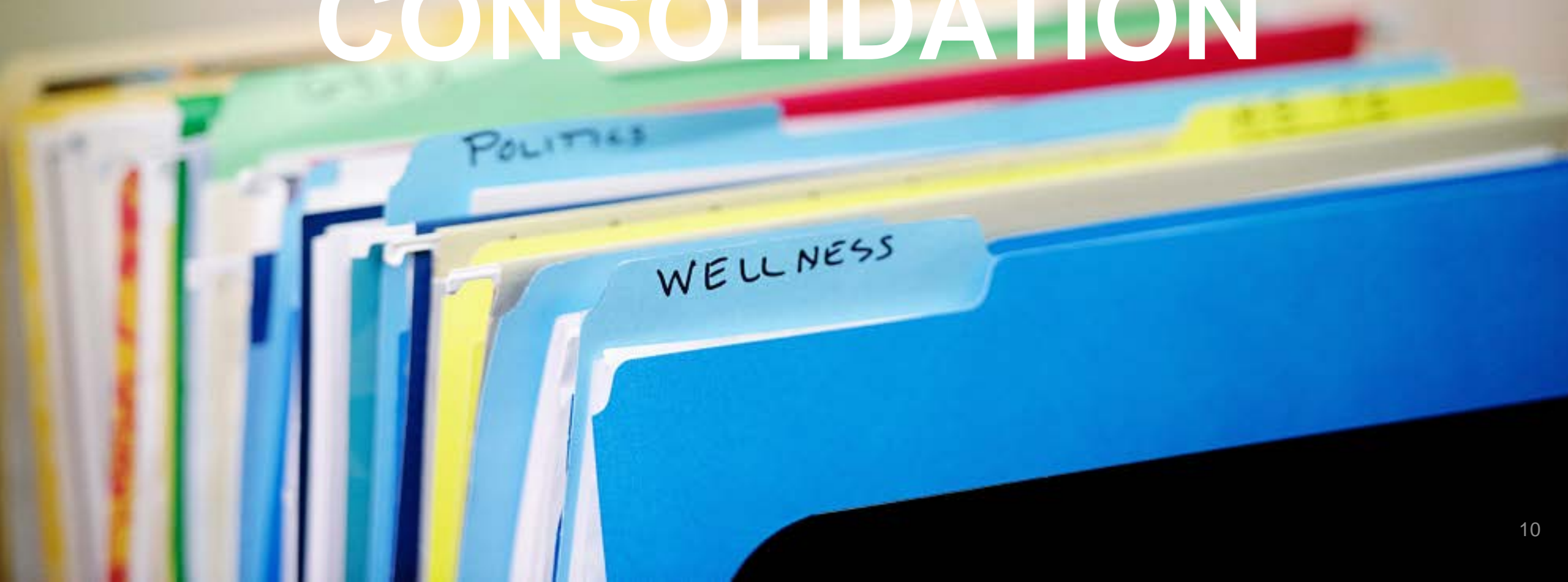


# HOSPITAL MARKETS ARE “HIGHLY CONCENTRATED”

Of the 54 California counties with a hospital in 2016, 44 were highly concentrated markets that warrant concern and scrutiny according to the DOJ/FTC Guidelines .



# DRIVERS OF CONSOLIDATION



# DRIVERS OF CONSOLIDATION

PHYSICIANS	HOSPITALS
<ul style="list-style-type: none"><li>• Lack of Access to Capital</li><li>• Expensive technology (e.g., EHR, Analytics)</li><li>• Leverage in Negotiating with Payors</li><li>• Less administrative hassles</li><li>• Income Stability</li><li>• Decreased business risk</li><li>• Increased reimbursement (i.e., bonuses, guaranteed salary)</li><li>• Medical school debt</li></ul>	<ul style="list-style-type: none"><li>• Leverage negotiating with payors</li><li>• Higher reimbursement for hospital outpatient procedures (e.g. site of service)</li><li>• Increased referrals &amp; hospital utilization</li><li>• Compete with independent ASCs</li><li>• Control quality programs</li><li>• Ease participation in value based payment programs</li><li>• Increase ability to recruit</li></ul>

# PAYMENT POLICIES REQUIRE CAPITAL INVESTMENT THAT DRIVE CONSOLIDATION

## Payment Incentives For Integration

- Promote Value-Based payments
- Push towards new alternative payment models that require collaboration: ACOs, Medical Homes, Bundled Payments, Readmission Reduction Program; Hospital Acquired Conditions

## Delivery Models Require Advanced Analytics

- Encourage integration and care coordination
- Improve population health management
- Promote patient engagement
- Remote access to care
- Reporting on quality and cost

## Information Sharing & IT

- Increase information available to consumers, providers, payors and regulators
- Cost and quality transparency
- Bring electronic health information to the point of care
- Reporting on quality and cost

# SPECIFIC CONCERNS WITH CONSOLIDATION



# MARKET CONCENTRATION AND COSTS

- According to a UC Berkeley studies, market concentration of hospitals, hospital systems and insurers results in higher insurance premiums.
- The studies also found that growth of hospital market concentration correlates to higher premiums rather than physician market concentration alone.
- “The impact of hospital concentration on premiums become larger as vertical integration increases.” (Scheffler, et al.)

# THE WALL STREET JOURNAL.

## Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition

Contracts with insurers allow hospitals to hide prices from consumers, add fees and discourage use of less-expensive rivals

September 18, 2018



**“By the numbers:** For single coverage — a plan that just covers you, no family members — employees are paying an average of about \$1,200 per year in premiums. That’s 65% more than what they paid in 2008.

**The bigger story** is deductibles, which are growing in every way.

The number of employees who have a deductible is up. The size of the average deductible is up — 212% since 2008, to be precise. And the number of employees with above-average deductibles is also up.

The increase in premiums and deductibles both outstrip increases in wages”

# LEGISLATIVE REACTIONS

## 2015

- AB 533 (Bonta): Price Fixing for Out of Network Physician Services at In-Network Facilities

## 2016

- SB 932 (Hernandez): State Regulation of Contracts between Provider and Payers

## 2017

- SB 538 (Monning): State Regulation of Contracts between Hospitals and their affiliation Providers, and Health Insurers
- SB 562 (Lara): Mandates to implement a Single Payer model of healthcare

## 2018

- AB 3087(Kalra): Establishment of a Rate Setting Commission for Providers and health Insurers
- SB 1156 (Leyva): Rate Setting for dialysis providers





# MARKET SOLUTIONS & OPPORTUNITIES

# OPPORTUNITIES FOR SUCCESS

- Foster a Pluralistic Delivery System
- Physician-Payor Alignment Is Critical
- Payors Deploying Capital by Partnering w/ Physicians not by Conquering Them
- Payors Should Help Reduce Physicians' Administrative Burdens (i.e., reduce prior-authorizations, uniform quality measures and reporting, uniform EHR, simplify provider directory updates)
- Hospital physician alignment centered on patient outcomes not economic protectionism

# PHYSICIAN-LED ORGANIZATIONS EXHIBIT LOWER AVERAGE ANNUAL COST OF CARE

- **Multi-Hospital System Owned**
  - Mean expenditure \$4,776/patient
- **Local Hospital Owned**
  - Mean expenditure \$4,312/patient
  - **9.7% less** than multi-hospital system owned
- **Physician Led**
  - Mean expenditure \$3,066/patient
  - **35.8% less** than multi-hospital system owned
  - **28.9% less** than local hospital owned

Annual Savings to Payors: Physician-Led v. Other Models (examples)		
	43,000 Lives	70,000 Lives
Multi-Hospital System Owned	None	None
Local Hospital Owned	\$19.95m	\$32.5m
<b>Physician Led</b>	<b>\$73.53m</b>	<b>\$119.7m</b>

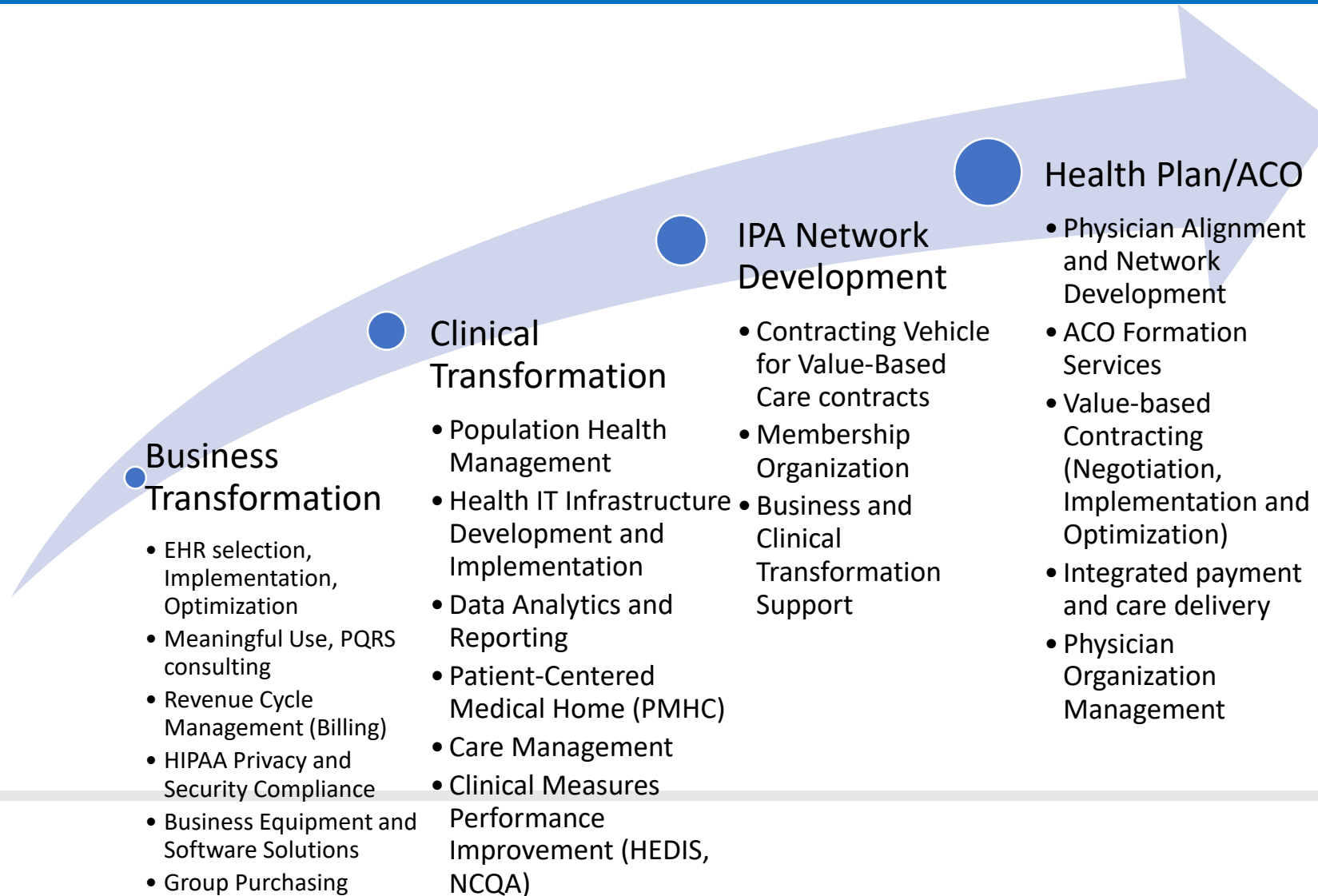
# THE FUTURE OF MEDICINE

- Help physicians build and sustain core competencies in population health management and value-base payment systems.
- Deliver scalable, turnkey solutions that helps providers:
  - Enhance quality of care
  - Improve the patient experience
  - Increase physician satisfaction
  - Tie pay to value
  - Create a sustainable model

# KEY DRIVERS FOR SUCCESS

- Engaged Group of Physician Leaders
- Innovative payment model contract with payors(s)
- Effective Communication with Providers
- Care Management Support
- Quality and Coding Education Programs
- Patient Engagement Strategy
- Integrated IT/EHR Solution Stack
- Real-Time Data Exchange (HIE)
- Data & Analytics Capabilities with Actionable Opportunities

# PAYOR-PHYSICIAN MODEL FOR CLINICAL INTEGRATION WITHOUT ECONOMIC CONSOLIDATION



# PAYOR-PHYSICIAN PARTNERSHIP



*FOR IMMEDIATE RELEASE*

## **Blue Shield of California and California Medical Association Collaborate to Build Health Care Model of the Future**

**SAN FRANCISCO (June 12, 2018)** – Blue Shield of California and the California Medical Association (CMA) today announced a multi-year collaboration to develop and support a new health care model that gives Californians access to quality, comprehensive and sustainably affordable care that improves the health of individuals and their communities.

Blue Shield will invest \$30 million to support the initiative, beginning with two pilot projects in Monterey and Butte counties designed to bring health care into the digital age, tie pay to value and create a patient-centered experience through home- and community-based services. To achieve this, a new technology infrastructure will be built to help physicians focus their attention on care delivery, rather than administrative work. The goal is for Blue Shield and CMA to scale the projects statewide with a focus on supporting independent physicians.



**Thank You**  
**QUESTIONS?**