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BURDA ON HEALTHCARE

No, It's *Your* Turn to Throw *Me* Under the Healthcare Bus

By David Burda
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Everyone knows what's wrong with healthcare. Well-honed business practices by incumbent industry sectors and organizations make care less affordable, less accessible and less safe for patients because maintaining the status quo enriches incumbent industry sectors, organizations and their executives.

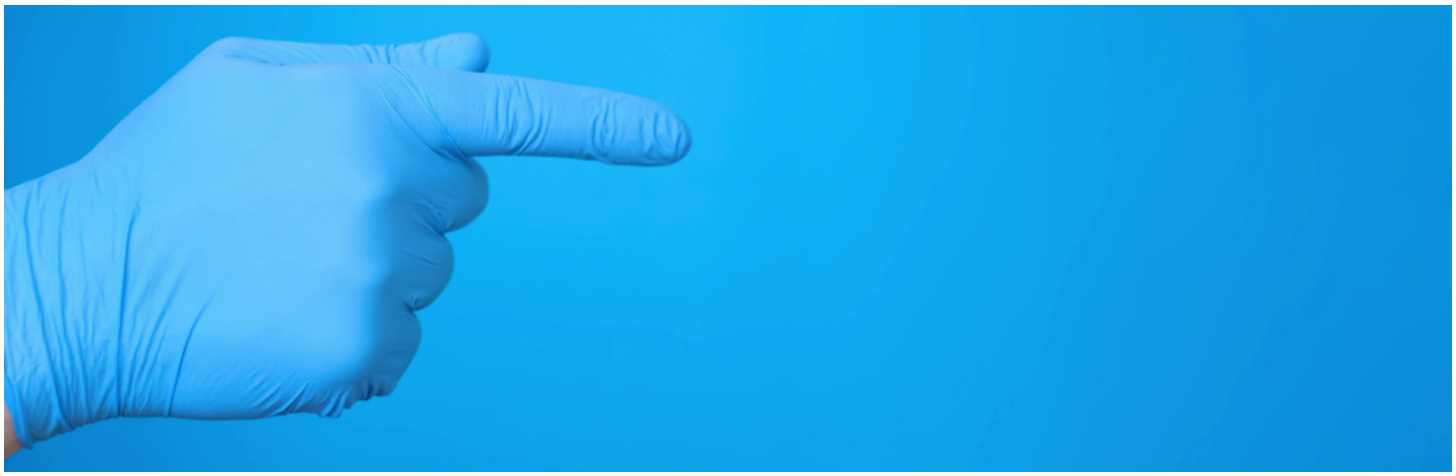
One well-honed business practice is blaming the other guy for the problem. The healthcare blame game makes compelling copy for healthcare business journalists and writers like me. But it really does nothing for consumers. If it's always the other guy's fault, the buck never stops anywhere. Like an endless game of musical chairs in which the music never stops. By continually blaming each other, nothing changes. They always win, and consumers always lose.

The dynamic I described above is nothing new to long-time industry observers. What is new is what one sector is accusing another sector of doing and recommending how to fix it. Here are a few new examples that caught my eye.

WHO HOSPITALS BLAME

Hospitals blame insurers for the medical debt crisis and want health insurers, not healthcare providers, to collect unpaid bills from patients.

In June, the American Hospital Association (AHA) released a two-page fact sheet on medical debt. We all know that the root cause of medical debt incurred by patients is the unaffordable prices that hospitals and other providers charge for care. But the AHA blamed the health insurance sector for the problem.



Specifically, the AHA blamed high-deductible health plans, or HDHPs, that "subject many Americans to cost-sharing they cannot afford" and "skinny" plans that "provide inadequate benefits and frequently lead to surprise gaps in coverage."

More interesting is the AHA's list of ways to solve the problem. The solutions include selling HDHPs only to people who can afford the deductibles and lowering maximum out-of-pocket cost limits for patients. The most interesting solution is this: The AHA wants health plans, not providers, to collect money from their members who owe copays, deductibles and other uncovered out-of-pocket expenses. Hospitals would no longer be in the patient billing and collection business. The target of their revenue cycle operations would be payers, not patients.

The responsibility and blame for aggressively shaking down patients for every last unpaid dime for their care would move from hospitals, health systems and medical practices to commercial insurance carriers and their health plans. Talk about your paradigm shift. The public and the media would stop hating on hospitals and start hating on insurance companies more than they do already.

WHO INSURERS BLAME

Health insurers blame hospitals, health systems, private-equity firms and kidney dialysis companies for rising healthcare costs.

Also in June, AHIP, formerly known as America's Health Insurance Plans, released a five-page letter that it sent to the Senate Finance Committee. The letter blamed the lack of competition in health system and drug manufacturer markets for escalating healthcare prices faced by consumers.

In the letter, AHIP singled out four specific problems that need fixing by lawmakers and regulators:

- Health system consolidation in many geographic markets gives a handful of dominant health systems the market leverage to arbitrarily raise prices for care and limit competition.
- Acquisitions of air ambulance companies, emergency room staffing firms and medical specialty practices by private-equity firm increases, which arbitrarily raise prices and lower costs to drive short-term profitability.
- Monopolistic pricing practices by two companies that AHIP said control nearly 75% of the kidney dialysis business across the country.
- Hospitals that add facility fees to outpatient services when they're performed in hospital-owned settings versus an independent or physician-owned setting, which doesn't charge facility fees.

For each problem, AHIP recommended a host of what it called "market-based solutions." That's market as in heavy-handed government interventions to straighten out these problem children, not market as in free market figure it out for yourself and let the chips fall where they may. Big difference.

AHIP's wishlist includes more aggressive federal antitrust oversight; a new federal legislation addressing anticompetitive health system contracting practices; the U.S. Department of Health and Human Services (HHS) to make private equity (PE) contract transparency a Medicare Condition of Participation; direct the Government Accountability Office to study PE deals in healthcare; new federal legislation to expand access to home dialysis treatments; and adopt a site-neutral Medicare payment policy for outpatient services.

"Every patient deserves access to the care they need at a cost they can afford," AHIP said.

Who'd argue with that?

WHO DOCTORS BLAME

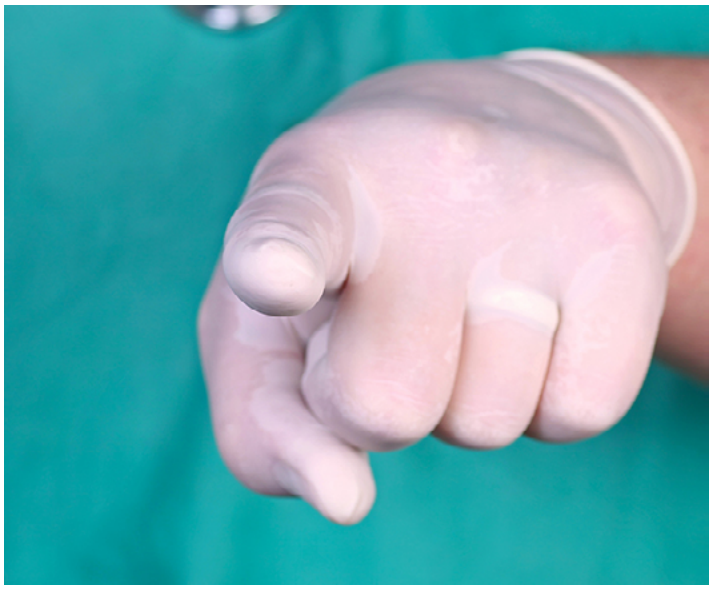
Doctors blame health insurers for delaying necessary care to patients through burdensome prior authorization requirements.

Doctors don't like to be told what to do by anyone. They think they're the sharpest knives in the drawer. Not dissimilar to reporters who don't like to be told how to do their jobs by editors or by publishers who have zero knowledge of the industry they're covering, journalism, journalism ethics or even publishing or selling advertising and sponsorships for that matter. But enough of my PTSD flashbacks.

In March, the American Medical Association released the results of a survey of 1,001 physicians on how prior authorization (PA) requirements from their patients' health insurers affected the doctors' ability to care for their patients. Here are the unpleasant results:

- 89% said PA had a "somewhat" or "significant" negative impact on clinical outcomes.
- 56% said PA "always" or "often" delayed necessary care to patients.
- 33% said PA has led to a serious adverse event for a patient in their care.
- 28% said PA "always" or "often" resulted in patients abandoning their recommended course of treatment.

Meanwhile, in May, the Medical Group Management Association released the results of a survey of executives from 601 medical practices specifically on PA requirements from Medicare Advantage (MA) plans. Here, again, are the unpleasant results.



- 97% said PA requirements from all types of payers are delaying patients' access to medically necessary care.
- 84% said PA requirements from MA plans specifically have increased over the past 12 months.
- 46% said PA requirements from MA plans are the most burdensome of any other type of payer (commercial health plans were second at 32%).

Payers can use PA for good, i.e., questioning costly unnecessary or low-value care to patients, or for bad, i.e., perfunctory denials of necessary and high-value care to patients to avoid paying claims. The latter is proving to be truer than the former, based on credible media accounts.

WHO PHARMACY BENEFIT MANAGERS BLAME

Pharmacy benefit managers blame drug companies for rising drug costs.

We all know that pharmacy benefit managers, or PBMs, are blood-sucking healthcare middlemen who add rather than subtract costs from the healthcare system. Much like group purchasing organizations (GPOs) and distributors. Nonetheless, PBMs, whose business practices are under intense scrutiny from federal and state regulators, are more than happy to throw someone else under the bus for exorbitantly high and rising drug costs. That someone is Big Pharma.

I didn't know that until the other day when I was scrolling through my daily morning edition of Axios Vitals. I noticed that the newsletter is sponsored by the Coalition for Affordable Prescription Drugs. I'm for affordable prescription drugs. Then I noticed an ad from the Coalition for Affordable Prescription Drugs poorly disguised as a Vitals news brief. The headline was "Congress should focus on the real cause of high drug prices — Big Pharma." So, I clicked on the ubiquitous learn more link.

To my surprise but not shock, the Coalition for Affordable Prescription Drugs is an advocacy group for PBMs. Kind of like the Better Medicare Alliance being the advocacy group for Medicare Advantage plans, another industry sector ripping off the government and us taxpayers.

Anyway, the Coalition's website is brimming with statistics, research, surveys and more about how it's the business practices of drug companies, not PBMs, that are fueling higher and higher drug costs. And it's the PBMs that are on the frontlines fighting hard to stop drug companies from screwing consumers.

WHO HOSPICES BLAME

I think I've proven the point about the long tradition of one sector of the healthcare industry throwing another sector under the bus, but let's do one more just for fun.

Not-for-profit hospices blame for-profit hospices for rising end-of-life costs.

In June, the National Partnership for Healthcare and Hospice Innovation, or NPHI, released a 33-page report called "People Over Profits: A Values-Based Movement for Declining Health." The NPHI is a special-interest group that represents more than 100 not-for-profit "community-integrated" hospice and palliative care providers.

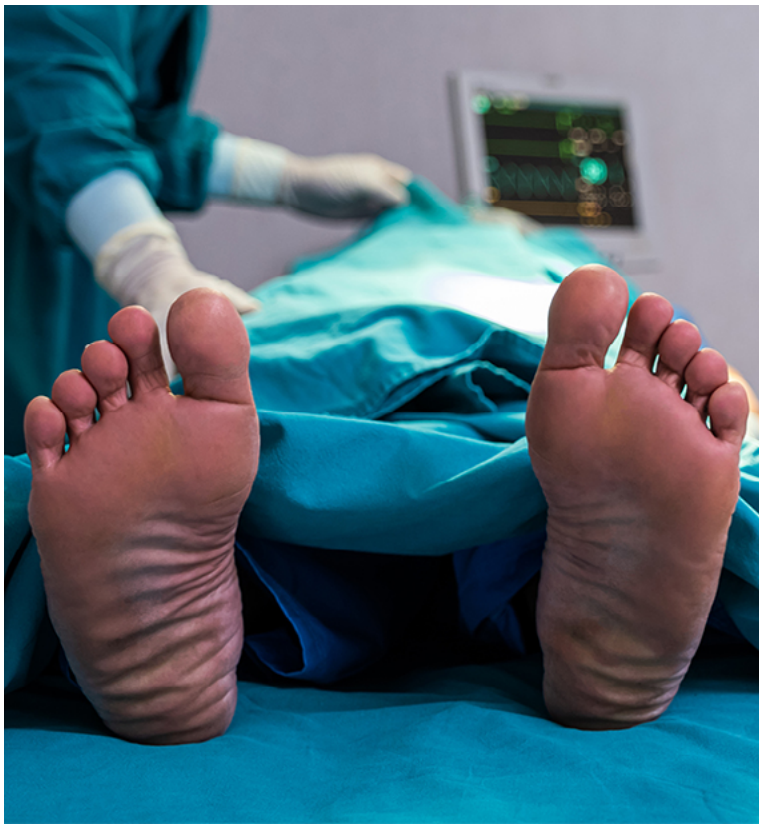
"Many of the factors that drive high costs and poor outcomes could be managed effectively and efficiently," the NPHI said in the executive summary of the report. "Instead, our fractured healthcare system often stands in the way of coordinated, comprehensive, human-centered care."

Who'd disagree with that? Not me.

Who do you blame?

At the top of the NPHI's list is the "proliferation" of for-profit, private equity-owned hospice providers.

"These types of business models are designed to benefit from high-profit margins within the Medicare hospice benefit, and there have been several instances of bad actors putting profits over people," the NPHI said. Further: "The rapid growth of the for-profit industry has coincided with even more alarming trends like outright fraud and abuse targeting both the Medicare hospice benefit and patients."



The NPHI made 12 recommendations in its report to fix the situation, including reforming Medicare's hospice payment formula to reward providers for patient outcomes and to eliminate opportunities to "game the system."

"Shifts in payment structure are critical to reducing the incentives that currently facilitate profiteering at the expense of patient wellbeing," the NPHI said.

AS USUAL, IT'S PATIENTS WHO GET THROWN UNDER THE BUS

Wow! Ownership subsectors throwing daggers at each other! What's next, for-profit hospital chains going after not-for-profit health systems? Not-for-profit nursing homes ripping on for-profit skilled-nursing facilities? Independent doctors critiquing employed doctors? PPOs jumping on HMOs? Where does it all end?

I guess that's the point. It never ends. By endlessly criticizing each other, nothing ever changes.

Especially for the industry's customers.

Thanks for reading.

AUTHOR

David Burda began covering healthcare in 1983 and hasn't stopped since. Dave writes this monthly column "Burda on Healthcare," contributes weekly blog posts, manages our weekly newsletter 4sight Friday, and hosts our weekly Roundup podcast. Dave believes that healthcare is a business like any other business, and customers — patients — are king. If you do what's right for patients, good business results will follow.

Dave's personnel experiences with the healthcare system both as a patient and family caregiver have shaped his point of view. It's also been shaped by covering the industry for 35 years as a reporter and editor. He worked at Modern Healthcare for 25 years, the last 11 as editor.

Prior to Modern Healthcare, he did stints at the American Medical Record Association (now AHIMA) and the American Hospital Association. After Modern Healthcare, he wrote a monthly column for Twin Cities Business explaining healthcare trends to a business audience, and he developed and executed content marketing plans for leading healthcare corporations as the editorial director for healthcare strategies at MSP Communications.

When he's not reading and writing about healthcare, Dave spends his time riding the trails of DuPage County, IL, on his bike, tending his vegetable garden and daydreaming about being a lobster fisherman in Maine. He lives in Wheaton, IL, with his lovely wife of 35 years and his three children, none of whom want to be journalists or lobster fishermen.

Visit **4sight.com/insights** to read more from David Burda.