THIRD WAY

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Stop Hospitals from Dumping Patients

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Takeaways

Hospitals are threatening to dump patients' insurance networks as a negotiating tactic to raise prices. This "hostage-taking" strategy puts individuals at risk of losing access to their local hospitals, hurting patients and employers by increasing premiums and out-of-pocket costs.

Health plans and employers who provide insurance coverage are stuck between a rock and a hard place—either accept hospitals' outrageous price increases or risk patients losing access to care. Because of that, Congress should create a level playing field between patients' health plans and consolidated hospital systems. In this piece we lay out how to do so in three steps:

1. Eliminate unfair pricing advantages from hospital consolidation.
2. Prevent future hospital consolidation through increased antitrust enforcement.
3. Ban hospitals from using anticompetitive contracting terms.

Hospital systems are increasingly dumping patients, or threatening to do so, as they demand higher prices. Recently, there have been numerous high-profile disputes between hospitals and patients' health plans, where tens of thousands of patients risk losing access to their local hospitals and the doctors they employ. In 2021, 70,000 Houston residents lost access to St. Luke's Health, a system of 19 hospitals across Texas, after another 100,000 lost access to eight Houston Methodist hospitals in 2020. [1] This past March, 70,000 patients in New York watched in distress as the Mount Sinai Health System was threatening to dump their coverage. [2] These hospital systems are not the first to leverage this out-of-network tactic to raise their prices, and will not be the last.

Although it is routine for hospital networks to change, hospital consolidation limits free and fair negotiations. As a result, hospitals are increasingly threatening to dump patient coverage. There were 21 standoffs in the third quarter of 2023, a 91% increase from the previous year. [3] Now it's common to see hospital consultants openly bragging about raising prices for patients. Ensemble Health Partners, a "revenue cycle management" consulting firm, bragged "two of our clients recently leveraged an out-of-network strategy that ultimately resulted in contract rates double the standard annual increase of 2%-3% for each year of their agreement." [4]

Lawmakers must put a stop to this predatory tactic and hold hospitals accountable. To protect patients from losing access to care, especially for those with chronic conditions, Congress must put reasonable constraints in place to promote a fair negotiation between hospitals and health plans. Below, we examine how hospitals are dumping patient networks, how patients are caught in the middle, and a variety of policy solutions.

This report is part of a series called Fixing America's Broken Hospitals, which seeks to explore and modernize a foundation of our health care system. A raft of structural issues, including lack of competition, misaligned incentives, and outdated safety net policies, have led to unsustainable practices. The result is too many instances of hospitals charging unchecked prices, using questionable billing and aggressive debt collection practices, abusing public programs, and failing to identify and serve community needs. Our work will shed light on issues facing hospitals and advance proposals so they can have a financially and socially sustainable future.

The Problem: Hospitals are dumping patients.

Most Americans have insurance coverage through the private sector, whether it's an employer-provided plan or the Affordable Care Act marketplace. Private plans must negotiate prices with doctors and hospitals individually to have them included in coverage networks. Most patients in government-run health programs have coverage through the private market too. Over half of seniors and Americans with disabilities have coverage through Medicare Advantage, and three-quarters of low-income Americans in Medicaid have coverage through managed care plans. [5]

In a competitive market, health plans can choose from several hospitals and doctors when constructing a network of providers. This allows employers and health plans to get the best quality for the lowest cost. Unfortunately, health care markets aren't working that way. Over three-quarters of hospital markets are "highly concentrated", and half of physicians are hospital employees. [6]

This means that health plans often have little or no choice about which hospitals and doctors to include in their coverage networks if the health plan is seeking to provide coverage to its members in a specific geographic area. As a result, health plans often have to accept whatever prices a hospital system charges to keep the providers within the coverage network. If they do not, the hospital system can dump the health plan, resulting in loss of coverage and access to care for the covered employer and its employees. Standoffs where hospitals threaten to leave the coverage networks are becoming more common. In the third quarter of 2023, there were 21 public contract disputes between health plans and hospitals, nearly double the amount from 2022. [7] For patients covered by Medicare Advantage, contract disputes in 2022 increased by 115% compared to 2021, and experts warn this trend will continue. [8]

This trend is especially troubling for employers. Over 178 million Americans receive coverage through their employer. As hospital systems become more consolidated, employer negotiating power decreases, and they must accept hospitals' demands for high prices or risk losing in-network access. For example, when the Houston Methodist Hospital system terminated coverage for employers contracting with United and their 100,000 covered patients, the CEO of The Woman's Home said, "It's going to mean significant changes for me and my staff and all of our families." [9]

Patients in public programs are vulnerable to these hostage-taking negotiating tactics too. Last year, the Bon Secours' Mercy Health system terminated contracts with patients enrolled in Medicare Advantage in Ohio and Medicaid Managed Care in Virginia. [10] At the same time, Bon Secours was cutting services for safety net hospitals and investing in other hospitals in wealthier, and less diverse communities. [11]

Patients are caught in the middle.

Losing access to a hospital and doctors can disrupt patient care. Hospitals may choose to suddenly dump the network in the middle of negotiations with health insurers to increase their leverage. To protect patients in the short-term, state and federal continuity of care laws require plans to cover hospital costs on an in-network basis for up to 90 days or for the end of specific treatments like pregnancy, nonelective surgeries, and some others. [12] However, that may not be enough protection for pressing treatments like chemotherapy for cancer patients or treating patients with complex chronic or rare diseases for whom continued care via a well-integrated team of diverse specialists familiar with the patient's history is truly vital.

Even for patients not receiving ongoing treatment, switching medical providers can be incredibly burdensome. For patients with several providers (such as a primary care doctor, gynecologist, allergist, physical therapist, etc.), the process of finding new doctors who are in network can be extremely taxing. When Mount Sinai threatened to leave a network impacting 70,000 patients, the New York Times reported, "It was especially stressful for cancer patients at Mount Sinai or pregnant women who had planned to deliver at one of the system's hospitals, doctors said." [13]

Consolidation hurts fair negotiations and inflates costs.

As hospital markets become more consolidated, fair negotiation between hospitals and employers or health plans often breaks down. Hospitals' primary purpose for consolidation is to increase their negotiating power with health insurance companies. Because three-quarters of hospital markets are highly consolidated, patients with private insurance pay hospitals over two and a half times the amount Medicare pays for the same services. [14]

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If a hospital's price demands are too high in an ideally competitive market, employers and plans would simply not include that hospital in their networks, which is sometimes the case. However, health plans must abide by "network adequacy" laws, meaning that their network must cover enough providers within a given distance. [15] While these laws are intended to protect patients' access to doctors and hospitals, they create an environment where hospital systems consolidate to set their prices as high as possible—with employers and health plans having no other option but to meet hospital demands.

For employers, higher premiums have significant spillover effects on their employees. Recently, the Small Business Majority conducted a poll of small business owners to examine the effects of rising health care costs. [16] The poll found that the most common outcomes of high prices were increasing employee premiums and moving to more limited coverage options. Other less common options include cutting employee benefits outside of health care, dropping coverage, raising their prices for consumers, and eliminating/reducing wage increases.

While charging higher prices, hospitals can also require employers and health plans to limit how to operate their networks. When insurance plans manage networks, they often will give their patients incentives to get the highest value care (higher quality for lower cost) through lower copayments. However, as a condition for joining a network, consolidated hospital systems will often use their market power to include four common tactics in their contracts that further suppress competition: [17]

Hospitals use anticipative contracting tactics to suppress competition.

- **All-or-nothing contracting,** which require a health plan to contract with all providers in that hospital system or forgo contracting with any of them.
- **Anti-tiering clauses,** which require insurers to place all providers from a health system into the most preferred tier of providers even if they do not meet the requirements for that tier (usually related to lower costs and higher quality).
- **Anti-steering clauses,** which prohibit insurers from using cost-sharing incentives, such as reduced out-of-pocket costs, to direct enrollees to providers who offer higher-value care.
- **Most-favored-nation clauses,** in which a hospital or health system locks in prices with a health insurer and agrees not to offer lower prices to any other health insurer.

Source: A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts." National Academy for State Health Policy, 12 Apr 2021. https://nashp.org/a-tool-for-states-to-address-health-care-consolidation-prohibiting-anticompetitive-health-plan-contracts/. Accessed 10 June 2024.

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All-or-nothing contracting can be especially detrimental to competition. If one hospital leaves a patient's network, they can take the rest of the hospital system with them. This creates an unlevel playing field as hospitals negotiate with health plans for rate increases.

The Solution: Address hospital consolidation to protect patients.

It's time to limit hospitals use of predatory "hostage-taking" strategies. The best way to do that is by addressing the root cause of the issue: consolidation. Below, we outline three actions Congress

should take to stop consolidation in hospital markets which will protect patients from big price hikes:

First, eliminate unfair pricing advantages from hospital consolidation. Because consolidation allows hospitals to engage in anticompetitive negotiating tactics, Congress must take steps to eliminate the incentives that encourage hospitals to consolidate for the wrong reasons. [18] Since Medicare pays hospitals more than physician offices for the same services, hospitals are incentivized to buy up those practices, resulting in higher Medicare rates and additional fees on patients. Congress should reduce Medicare's overpayment for outpatient services safely delivered in physician offices which would limit hospitals' use of add-on facility fees that inflate price. Lawmakers should also require transparency in hospital billing. [19] Finally, Congress should also reduce costs for low-income patients visiting hospitals that receive discounts through the 340B Drug Pricing Program from drug manufacturers by mandating minimum levels of charity care. Hospitals receive billions of dollars a year in additional funding from 340B drug discounts, and they are incentivized to consolidate further to increase revenues. [20]

Second, prevent future hospital consolidation through increased antitrust enforcement. Federal antitrust agencies lack sufficient resources to prevent hospitals from running amok and increasing their market concentration. The result of this means patients have fewer choices for care. Despite modest increases in funding, antitrust agencies need additional resources to tackle hospital consolidation as mergers and acquisitions have grown. [21] Congress should increase the budget of the Federal Trade Commission and Department of Justice Antitrust Division and allocate that new funding towards curbing consolidation in hospital markets. [22] Congress can also end the prohibition on the Federal Trade Commission's ability to investigate tax-exempt hospitals, which account for half of US hospitals.

Third, ban hospitals from using anticompetitive contracting terms. Contracting provisions such as all-or-nothing, anti-tiering, anti-steering, and most-favored-nation clauses restrict the ability of health plans to incentivize patients to seek care from lower-cost, higher-quality providers. Several states already have bans in effect, and Senators Mike Braun (R-IN), Tammy Baldwin (D-WI), and Congresswoman Michelle Steel (R-CA) introduced the Healthy Competition for Better Care Act to ban these practices at the federal level. [23] Last year, the Senate Health Committee passed legislation to ban these practices as well. [24]

Conclusion

As hospitals use a hostage-taking strategy by threatening to leave patients' networks, employers and health plans must choose between increasing costs or limiting access for patients. As health care costs continue to soar for patients and employers, Congress must step in and create fair negotiations with hospitals to secure patient access and affordability.

TOPICS

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