Annals of Health Law

Volume 25
Issue 2 *Summer 2016*

Article 2

2016

Speculating About the Impact of Healthcare Industry Consolidation on Long-Term Services and Supports

Marshall B. Kapp

Speculating About the Impact of Healthcare Industry Consolidation on Long-Term Services and Supports

Marshall B. Kapp, J.D., M.P.H*

Many aspects of the healthcare industry in the United States today are caught up in a vigorous `get big or get out_[1] trend characterized by significant consolidation of healthcare providers and insurers.[2] The current health industry consolidation movement promises to exert an important and powerful array of effects on numerous different population groups seeking or receiving health services in a variety of different healthcare settings. The other articles in the present Symposium issue of the Annals of Health Law address several of those groups and settings.

Particularly regarding the potential impact of health industry consolidation on individuals contemplating, seeking, or obtaining long-term services and supports (LTSS), little is known but much may be plausibly speculated. This article joins in that speculation, but attempts to advance the constructive consideration of the topic by offering some suggestions for a research agenda to investigate specific empirical questions about consolidation˜s impact on LTSS and thereby generate evidence and knowledge that can be used to either reduce or prevent negative aspects of consolidation for LTSS, on one hand, or foster and facilitate the achievement of positive effects, on the other.

For purposes of the present analysis, LTSS (the modern term that largely has replaced the earlier, more narrowly construed term `long-term care_)[3] refers to ongoing individualized assistance with activities of daily living

* Director, Florida State University Center for Innovative Collaboration in Medicine and Law and Professor, FSU College of Medicine and FSU College of Law.

1. William A. Brandt, Jr. & Andrew M. Troop, Health Care Financing Trends: What Do They Foreshadow?, 33 AM. BANKR. INST. J. 18, 19 (2014).

2. See generally Bara Vaida & Alexander Wess, Health Care Consolidation, ALLIANCE FOR HEALTH REFORM (Nov. 2015), http://www.allhealth.org/publications/Consolidation-Toolkit_169.pdf.

3. This change in nomenclature is reflected in both academic literature and government programs. See, e.g., Long-Term Services & Supports, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Long-Term-Services-and-Supports.html (last visited Apr. 13, 2016).

(ADL)[4] and instrumental activities of daily living (IADL),[5] regardless of the physical location where such assistance is provided.[6] LTSS settings may include, among others, nursing homes, assisted living facilities, continuing care retirement communities, and the private home of the service recipient[7] or that of the recipient˘s family member(s) or friends.[8] LTSS may be delivered by many different types of individual, institutional, and agency actors, and LTSS service delivery among multiple actors may occur in either a coordinated or disjointed manner.[9] `About 70 percent of those aged 65 and older are likely to need long-term services and supports at some point in their lives, for an average of 3 years. Twenty percent will need that care for at least 5 years._[10]

Following this brief introductory section, the article outlines the basic nature and forms of consolidation currently in progress or active discussion among various healthcare providers and third-party payers, including long-term care insurers. The ensuing section delineates potential general impacts, both detrimental and salutary, of health industry consolidation, with a

4. Mary Grace Kovar & M. Powell Lawton, Functional Disability: Activities and Instrumental Activities of Daily Living, 14 ANN. REV. GERONTOLOGY & GERIATRICS 57, 61-63 (1994) (self-care tasks including functional mobility, bathing and showering, dressing, self-feeding, personal hygiene and grooming, and toilet hygiene).

5. M. Powell Lawton & Elaine M. Brody, Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living, 9 GERONTOLOGIST 179, 180-81 (1969) (activities that allow an individual to live independently in a community, including housework, preparing meals, taking medications, managing money, shopping, use of telephone or other form of communication, and transportation within the community).

6. Laura D. Hermer, Rationalizing Home and Community-Based Services Under Medicaid, 8 ST. LOUIS U. J. HEALTH L. & POL˘Y 61, 61 n.2 (2014).

7. For purposes of the present discussion, I indulge my own bias and henceforth refer to persons who need and attempt to receive LTSS as LTSS `consumers._ Marshall B. Kapp, The Ethical Foundations of Consumer-Driven Health Care, 12 J. HEALTH CARE L. & POL˘Y 1 (2009). I do this despite the controversy that sometimes attaches to the use of `consumer_ in the health care context. See generally Carl E. Schneider & Mark A. Hall, The Patient Life: Can Consumers Direct Health Care?, 35 AM. J.L. & MED. 7 (2009); see also Mark A. Hall & Carl E. Schneider, Patients as Consumers: Courts, Contracts, and the New Medical Marketplace, 106 MICH. L. REV. 643 (2008); see also Kristin Madison, Patients as `Regulators_?, 31 J. LEGAL MED. 9, 9-10 (2010).

8. Graham D. Rowles & Pamela B. Teaster, The Long-Term Care Continuum in an Aging Society, in LONG-TERM CARE IN AN AGING SOCIETY: THEORY AND PRACTICE 3, 18 (Graham D. Rowles & Pamela B. Teaster eds., 2015); see generally ROBYN I. STONE, LONG-TERM CARE FOR THE ELDERLY WITH DISABILITIES: CURRENT POLICY, EMERGING TRENDS, AND IMPLICATIONS FOR THE TWENTY-FIRST CENTURY (2000).

9. See Robert B. Hudson, The Aging Network and Long-Term Services and Supports: Synergy or Subordination?, 38 GENERATIONS 22, 28 (2014); see also W. Thomas Smith, An Overview of Long-Term Care Services and Support in America, 29 MISS. C. L. REV. 387, 387-88 (2010).

10. U.S. GOV˘T ACCOUNTABILITY OFF., GAO-15-190, OLDER ADULTS: FEDERAL STRATEGY NEEDED TO HELP ENSURE EFFICIENT AND EFFECTIVE DELIVERY OF HOME AND COMMUNITY-BASED SERVICES AND SUPPORTS 5 (2015).

particular focus on application of those potential impacts to LTSS. Section III then identifies specific groups of LTSS consumers according to the most important piece of the story´ their primary source of payment for services´ and speculates about the ways that individuals within each of those groups may be affected by the health industry consolidation trend. This section also weaves into the discourse a modest health services research agenda to test some of the speculation presented in the previous section about the tangible impact of health industry consolidation on LTSS consumers. The expectation is that the fruits of future investigators pursuing bits and pieces of the suggested research agenda will become a useful part of the continuous information feedback loop helping to reinforce the positive aspects of health industry consolidation and reduce or eliminate the negative aspects.[11]

I. HEALTH INDUSTRY CONSOLIDATION IN THE UNITED STATES

There has been a strong trend in the U.S.[12] over the past several years involving the consolidation of key players in the healthcare industry.[13] Problems with maintaining profit (or excess revenue)[14] margins, growing revenue, and meeting the cost of doing business are strong drivers of consolidation, including in the post-acute (shorter-duration, rehabilitation oriented long-term care) and LTSS (longer-duration, maintenance oriented long-term care) space of the healthcare industry.[15]

---

11. For background on the evolutionary process of quality improvement in the health care context, see John A. Anderson, Evolution of the Health Care Quality Journey, 31 J. LEGAL MED. 59 (2010); see also Kristin Madison, Donabedian˘s Legacy: The Future of Health Care Quality Law and Policy, 10 IND. HEALTH L. REV. 325 (2013).

12. Although this article concentrates on the consolidation trend in the U.S., the U.S. is by no means alone in this trend. See, e.g., Andreas Schmid & Volker Ulrich, Consolidation and Concentration in the German Hospital Market: The Two Sides of the Coin, 109 HEALTH POL˘Y 301, 302 (2013).

13. DELOITTE, THE GREAT CONSOLIDATION: THE POTENTIAL FOR RAPID CONSOLIDATION OF HEALTH SYSTEMS 1 (2014), http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-great-consolidation-111214.pdf; Hearing on Health Care Industry Consolidation Before the Subcomm. on Health of the Comm. on Ways and Means, 112th Cong. (2011) (statement of Paul B. Ginsburg, Ph.D., President, Center for Studying Health System Change, Washington, D.C.).

14. `Profit_ is a term ordinarily applied in the proprietary or for-profit sector, whereas `excess revenues_ is the preferred terminology in the not-for-profit universe. See James W. Martin & Nancy Saint-Paul, í 25:4 State Nonprofit Corporation Laws, 29 WEST˘S LEGAL FORMS, SPECIALIZED FORMS (2015). In the U.S., the majority of LTSS providers are organized as for-profit corporations, but a significant percentage of providers fall into the not-for-profit category. See NAT˘L CTR. FOR HEALTH STATISTICS, U.S. DEP˘T OF HEALTH & HUMAN SERVS., LONG-TERM CARE SERVICES IN THE UNITED STATES: 2013 OVERVIEW 12 (2013), http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf.

15. Jason Oliva, Healthcare Industry Executives Expect Massive Consolidation Ahead, SENIOR HOUSING NEWS (Aug. 10, 2014), http://seniorhousingnews.com/2014/08/10/healthcare-industry-executives-expect-massive-consolidation-ahead; Justin Fengler, Post-

Additionally,

> Even if some of these mergers and acquisitions were inevitable, and some of these trends were underway prior to passage of the ACA [Affordable Care Act], that law envisioned that providers would consolidate. The ACA was predicated on the kinds of changes unfolding in the way healthcare is delivered. They are a necessary precursor to many of the ACA˜s constructs.[16]

Consolidation is taking place in three distinct but intertwined parts of the healthcare industry: health services providers;[17] healthcare products manufacturers and sellers;[18] and third party-payers for health services and products.[19] Although there are countless organizational and financial permutations, consolidation among health service providers has primarily resulted in mergers and acquisitions,[20] providers going out of business[21] or amending their business lines, or joint ventures involving multiple

---

Acute Care Sector Consolidation: Are We Seeing Trends Emerge From Deals Announced in 2013?, TRIPLE TREE BLOG (Feb. 3, 2014), http://www.triple-tree.com/blog/2014/02/03/post-acute-care-sector-consolidation-are-we-seeing-trends-emerge-from-deals-announced-in-2013/.

16. Scott Gottlieb, The State of Competition in the Health Care Marketplace, AM. ENTER. INST. (Sept. 10, 2015), https://www.aei.org/publication/the-state-of-competition-in-the-health-care-marketplace; see also Terry L. Corbett, Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?, 12 IND. HEALTH L. REV. 103, 150-51 (2015) (discussing health care industry consolidation resulting from the ACA); but see Thomas Greaney, Examining Implications of Health Insurance Mergers, HEALTH AFF. BLOG (July 16, 2015), http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers (arguing that the ACA was meant to promote competition rather than consolidation).

17. Zack Budryk, Consolidation in Healthcare Will Continue in 2015, FIERCE HEALTH FIN. (Jan. 14, 2015), http://www.fiercehealthfinance.com/story/consolidation-healthcare-will-continue-2015/2015-01-14.

18. Andrew Ward, Arash Massoudi & Ed Hammond, Medical Device Makers in a Race to Merge, FIN. TIMES (June 16, 2014), http://www.ft.com/intl/cms/s/0/fa3061ba-f565-11e3-91a8-00144feabdc0.html#axzz45jvbqP5C.

19. Robert Laszewski, Health Insurer Merger Mania ¯ Muscle-Bound Competitors and a New Cold War in Health Care, FORBES (July 27, 2015, 2:55PM), http://www.forbes.com/sites/robertlaszewski2/2015/07/27/health-insurer-merger-mania-muscle-bound-competitors-and-a-new-cold-war-in-health-care/#38919fff2647.

20. Michael E. Porter & Thomas H. Lee, Providers Must Lead the Way in Making Value the Overarching Goal, 91 HARV. BUS. REV. 51, 58 (2013) (`Most hospitals and physician groups still have positive margins, but the pressure to consider a new strategic framework has increased dramatically. Market forces are driving increasing numbers of hospital mergers and acquisitions_); see Stephen T. Moore, Orchestrating Successful Mergers and Acquisitions of Health Care Providers, ASPATORE, 2013 WL 2729766
(May 2013); see also Neal T. Goldstein & Deborah Gordon, Health Care M&A: Legal and Business Trends and Issues, ASPATORE, 2013 WL 2729772 (May 2013).

21. Melissa Newton, Home Health Care Providers Worry State Might Force Them Out of Business, CBS (Mar. 25, 2011, 5:01 PM), http://dfw.cbslocal.com/2011/03/25/home-health-care-providers-worry-state-might-force-them-out-of-business.

providers.[22]

First, we have seen extensive planned or completed consolidation of health service providers nationally,[23] in addition to providers simply closing their doors and walking away.[24] Consolidation has occurred or is being contemplated both horizontally[25] and vertically. Accountable Care Organizations (ACO) of the type promoted by the Affordable Care Act (ACA)[26] would be an example of vertical integration. As stated by one observer, `Those who follow long-term care closely have been noticing the trend toward convergence for a while. Major nursing home chains have added hospice and home care to their array of services, along with short-term rehabilitation and other types of care._[27]

Second, consolidation has occurred and is likely to continue among producers and sellers of healthcare products.[28] A number of pharmaceutical

---

22. See Steven H. Pratt, Hospital-Physician Joint Venture Relationships: A Useful Tool to Improve Hospital Services, 4 IND. HEALTH L. REV. 241, 244 (2007).

23. Jennifer Bauer, Life After Consolidation: How LTC Leaders Can Assimilate, MCKNIGHT'S LONG-TERM CARE NEWS (Mar. 21, 2014), http://www.mcknights.com/guest-columns/life-after-consolidation-how-ltc-leaders-can-assimilate/article/338094; Sara O. Marberry, Industry Consolidations Shape Future of Healthcare Design, HEALTHCARE DESIGN (Mar. 6, 2013), http://www.healthcaredesignmagazine.com/article/industry-consolidations-shape-future-healthcare-design.

24. Stewart McClintic, Poor Care, Finances Close Rural Arizona Hospital, SILVER CITY DAILY PRESS (Aug. 25, 2015), http://www.scdailypress.com/site/2015/08/25/poor-care-finances-close-rural-arizona-hospital/.

25. Horizontal integration entails one entity owning or controlling multiple similar providers, such as one corporation owning multiple hospitals or multiple physician practices. See Carey Thaldorf & Aaron Liberman, Integration of Health Care Organizations: Using the Power Strategies of Horizontal and Vertical Integration in Public and Private Health Systems, 26 HEALTH CARE MANAGER 116, 118-19 (2007).

26. See Corbett, supra note 16, at 149; see Bill Aseltyne et al., Accountable Care Organizations´ Physician/Hospital Integration, 21 HEALTH LAW 1, 3 (2009) (`Under this model, the hospital and physician networks would be responsible for the quality of care delivered to patients and would receive bonuses for providing high-quality, low-cost care; penalties would be imposed for delivering low-quality, high-cost care._). However, the successful future of Accountable Care Organizations is anything but assured. Comments on Medicare Second Year ACO Results, NAT'L ASS'N ACOS (Aug. 25, 2015), https://www.naacos.com/pdf/NAACOS2014ACOResultsPressRelease082515.pdf (asserting in 2015 that `In total, 241 ACOs will receive no return on their investment [for 2014] . . . [and] will struggle to stay in the program. We estimate that 40-50 ACOs will leave the program this year [2015]. We understand the ACO program is in its infancy and redesigning healthcare is a long-term commitment that we intend to continue supporting; however, we believe CMS or the Congress needs to take major steps to improve the program._).

27. Liza Berger, Hospice-Home Health Merger to Affect Long-Term Care, MCKNIGHT'S LONG-TERM CARE NEWS (June 3, 2010), http://www.mcknights.com/daily-editors-notes/hospice-home-health-merger-to-affect-long-term-care/article/171634.

28. See Michael J. de la Merced & Hiroko Tabuchi, Walgreens to Buy Rite Aid for $9.4 Billion, N.Y. TIMES (Oct. 27, 2015), http://www.nytimes.com/2015/10/28/business/dealbook/walgreens-rite-aid-deal.html (`As companies throughout . . . the health care industry accelerate the pace of consolidation, two of the biggest drug store chains have agreed to

companies,[29] retail pharmacy chains,[30] and biotechnology firms[31] have recently explored or contemplated mergers and acquisitions or joint ventures. For instance, in July of 2015, Israeli drug maker Teva Pharmaceuticals Industries Ltd. agreed to buy the generic drug manufacturer Allergan Pic for approximately $40.5 billion in cash and stocks.[32]

Third, there has been consolidation in the third-party payer marketplace.[33] Not only have general health insurers been active in mergers and acquisitions, but the giants of the industry are also consolidating.[34] For example, one can look to the 2015 purchase of Cigna Corp. by previous rival Anthem Inc.,[35] and Aetna˘s acquisition of previous competitor Humana.[36] As summarized by one analyst, `[d]eals among the nation˘s largest health insurers in recent weeks have been almost head-spinning. But whatever the details, if the combinations are finalized, the result will be an industry dominated by three

---

combine . . . _).

29. See Robert Dominguez, Major Pharmaceutical Companies Start 2015 with Mergers, N.Y. DAILY NEWS (Jan. 12, 2015), http://www.nydailynews.com/news/national/major-pharmaceutical-companies-start-2015-mergers-article-1.2075360; see also John L. LaMattina, The Impact of Mergers on Pharmaceutical R&D, 10 NATURE REVS. DRUG DISCOVERY 559 (2011) (discussing `the era of large mergers in the pharmaceutical industry_ and its negative impact).

30. See PengCheng Zhu & Peter E. Hilsenrath, Mergers and Acquisitions in U.S. Retail Pharmacy, 41 J. HEALTH CARE FIN. 1 (2014) (identifying recent trends to merge retail pharmacy chains), http://healthfinancejournal.com/index.php/johcf/article/view/20/22; see Daniel Weiss, FTC Approves Express Scripts-Medco Merger, PHARMACY TIMES (Apr. 3, 2012), http://www.pharmacytimes.com/news/FTC-Approves-Express-Scripts-Medco-Merger (discussing the merger of Express Scripts and Medco, two prominent retail pharmaceutical chains).

31. See generally Farah H. Champsi, Biotechnology Mergers and Acquisitions, 16 NATURE BIOTECH. 61, 61-62 (1998), http://www.nature.com/bioent/2003/030101/full/nbt0598supp_61.html (contemplating the benefits of mergers and acquisitions in the biotech industry).

32. Chitra Somayaji, Teva to Buy Allergan˘s Generic-Drug Business for $ 40.5 Billion, BLOOMBERG (July 27, 2015, 3:34 AM), http://www.bloomberg.com/news/articles/2015-07-27/teva-to-buy-allergan-s-generic-drug-business-for-40-5-billion.

33. See Robert Pear, House Hearing on Insurers˘ Mergers Exposes Health Care Industry Divide, N.Y. TIMES (Sept. 10, 2015), http://www.nytimes.com/2015/09/11/us/house-hearing-on-insurers-mergers-exposes-health-care-industry-divide.html (discussing the differing opinions over increasing consolidation in the health care provider and insurer markets).

34. See e.g., Jos¶ R. Guardado et al., The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra, 1 HEALTH MGMT. POL˘Y & INNOVATION 16, 18 (2013), available at http://www.hmpi.org/pdf/HMPI%20%20Guardado,%20Emmons,%20Kane,%20Price%20Effects%20of%20a%20Larger%20Merger%20of%20Health%20Insurers.pdf (referring to the United-Sierra merger).

35. Contingent on approval by federal and state regulators. See Anna Wilde Mathews & Liz Hoffman, Anthem Agrees to Buy Cigna for $48.4 Billion, WALL ST. J. (July 24, 2015, 6:55 PM), http://www.wsj.com/articles/anthem-agrees-to-buy-cigna-for-48-billion-1437732331.

36. Contingent on approval by federal and state regulators. See Humana Inc., Proxy Statement (Schedule 14A) (Aug. 10, 2015), http://www.sec.gov/Archives/edgar/data/49071/000119312515285879/d67897dprem14a.htm.

colossal insurers._[37]

The `head-spinning_ pace of health insurer consolidations has been explained by one set of commentators in the following terms:

> There are good reasons why these consolidation moves are happening now. Five years after the passage of the Affordable Care Act, and in the wake of the Supreme Court˜s recent decision to uphold the use of federal tax credits to subsidize the health insurance costs of poorer Americans [in King v. Burwell, ´ 576 U.S.´ (2015)], uncertainty about the implications of the new law is dissipating. Companies now know the basic outlines of the future health insurance marketplace, and they are looking to position themselves competitively in the fast-evolving health care ecosystem. What˜s more, easy access to cheap debt and high market valuations make the prospect of deals financially attractive to buyers and sellers alike. These trends are exacerbated by the shared fear that if any particular company doesn˜t move fast enough, it risks being left without a `dance partner._[38]

Private LTSS insurers marketing individual policies directly to consumers have been energetically involved in similar consolidation activity.[39] Moreover, the LTSS insurance industry has seen several important industry actors exit the marketplace or restrict their business activities in this arena.[40] In addition, certain LTSS providers are beginning to consolidate the provider and insurer roles, eliminating the need for separate insurance companies.[41]

---

37. See Reed Abelson, Bigger May be Better for Health Insurers, but Doubts Remain for Consumers, N.Y. TIMES (Aug. 2, 2015), http://www.nytimes.com/2015/08/03/business/bigger-may-be-better-for-health-insurers-but-doubts-remain-for-consumers.html?_r=0; but see John Graham, Health Insurers˜ Merger Mania on Hold?, FORBES (July 22, 2015, 7:44 AM), http://www.forbes.com/sites/theapothecary/2015/07/22/health-insurers-merger-mania-on-hold (suggesting that investors˜ enthusiasm for health insurer mergers may have cooled because of concerns that `risk lies in the regulatory and political realm_). The third giant, besides Cigna and Aetna, is UnitedHealth.

38. Jon Kaplan et al., The Promise of Payer Consolidation for U.S. Health Care, BCG PERSP. (July 8, 2015), https://www.bcgperspectives.com/content/articles/health-care-payers-providers-post-merger-integration-promise-payer-consolidation-us-health-care/.

39. See Shakeout Continues in the Individual Long-Term Care Market, SCI. LETTER (Apr. 26, 2005), http://go.galegroup.com/ps/i.do?id=GALE%7CA267769613&v=2.1&u=tall85761&it=r&p=AONE&sw=w&asid=88ef9f9f3ca28c7daabb4aa709fb6fd5 (`conservative pricing and stricter underwriting standards, which, in many cases, resulted in underpriced business_ has led to trends in acquisitions and mergers).

40. See David Gregg, The New Face of Long-Term Care Insurance, NAIFA˜S ADVISOR TODAY, http://www.advisortoday.com/archives/article.cfm?articleID=357 (last visited Apr. 15, 2016) (`It˜s definitely a time of reshuffling and some consolidation in the LTCI industry._); see also Terri Cullen, Long-Term-Care Insurers Jolted by Profit Slump, Consolidation, WALL ST. J. (Aug. 12, 2004, 12:01 AM), http://www.wsj.com/articles/SB109162728478582717 (`Dutch insurer Aegon put out the word that it plans to stop selling long- term-care policies in the first half of 2005 through its Transamerica Occidental Life Insurance, Life Investors Insurance Co. of America and Monumental Life Insurance units._).

41. See generally Gary Ahlquist & Minoo Javanmardian, Healthcare Providers Take on

One of the nation's largest nursing home companies has recently become a `provider-sponsored organization,' or a provider group that accepts full financial risk for its consumers[:] care in exchange for a fixed monthly payment.[42] In sum, consolidation of major players in the health industry constitutes an important force to be reckoned with, and the LTSS sector is centrally involved.

II. GENERAL POTENTIAL EXPECTIONS OF CONSOLIDATION

This section sets out, in very barebones fashion,[43] the most salient general potential expectations of consolidation in the healthcare industry. Consolidation may produce either positive or negative effects, and the specifics of both types are exceedingly difficult to predict accurately.[44] Section III applies these general potential expectations, both positive and negative, to specific groups of LTSS consumers, laying the groundwork for proposed research agenda elements.[45]

A. Negative Potential Impacts

Consolidation in any industry ordinarily generates expectations of reduced competition in the marketplace of goods and services available for consumers.[46] A reduced number of competitors vying for the business of

---

the Payor Role, STRATEGY& (2015), http://www.strategyand.pwc.com/media/file/Healthcare-providers-take-on-the-payor-role.pdf (describing the concept of integrated delivery networks `as a model for a fully integrated system that employed the doctors and owned the hospitals and the insurer').

42. Emily Mongan, Nursing Home Giant Signature Healthcare Pushes into Insurance Industry, MCKNIGHT'S LONG TERM CARE NEWS (Aug. 18, 2015), http://www.mcknights.com/news/nursing-home-giant-signature-healthcare-pushes-into-insurance-industry/article/433418.

43. Obviously, the present discussion neither aspires nor pretends to substitute for a comprehensive economics text. For a concise summary of basic concepts in economics, see generally TODD G. BUCHHOLZ, FROM HERE TO ECONOMY: A SHORTCUT TO ECONOMIC LITERACY (1995).

44. `[Consolidation's] precise impact on the evolution of the health care ecosystem will be anything but straightforward.' Kaplan et al., supra note 38. Regarding the uncertain implications of hospital consolidation specifically, see Tim Xu et al., The Potential Hazards of Hospital Consolidation: Implications for Quality, Access, and Price, 314 JAMA 1337, 1337-38 (2015).

45. Regarding a research agenda, see generally H. Stephen Kaye & Charlene Harrington, Long-Term Services and Supports in the Community: Toward a Research Agenda, 8 DISABILITY & HEALTH J. 3 (2015).

46. See generally Graeme K. Deans et al., The Consolidation Curve, HARV. BUS. REV. (Dec. 2002), https://hbr.org/2002/12/the-consolidation-curve (discussing the industry consolidation life cycle, including decreased competition during stage 3).

consumers´ approaching or reaching monopoly[47] or oligopoly[48] conditions´ generally translates into less or non-existent choice for those consumers. This comes as a result of the unavailability of alternative providers of goods and services and the likelihood of organizations steering consumers toward particular service or product providers in whom the steering organization itself has a financial or other type of interest.[49]

For example, `Monopolies tend to keep their prices and profits high by restricting the supply of a good._[50] As a result, monopolies often leave consumers in a regime of lower quality products at higher prices.[51] Consumer advocates have voiced concerns that consolidation among health insurers will result in higher premiums.[52] The American Hospital Association recently

47. `A monopoly exists when one firm is the only seller of a good or service._ BUCHHOLZ, supra note 43, at 80. A monopoly is the reverse of a monopsony, a market situation in which the product or service of several sellers is sought by only one buyer.

48. See Letter from Reid B. Blackwelder, Board Chair, American Academy of Family Physicians, to Congressional Leaders (July 27, 2015), http://www.aafp.org/dam/AAFP/documents/advocacy/legal/antitrust/LT-CON-Consolidation-072715.pdf [hereinafter Blackwelder 1]; see also Letter from Reid B. Blackwelder, Board Chair, American Academy of Family Physicians, to Hon. William J. Baer, Assistant Att˜y General (July 28, 2015), http://www.aafp.org/dam/AAFP/documents/advocacy/legal/antitrust/LT-DOJ-Consolidation-072715.pdf [hereinafter Blackwelder 2]. The American Academy of Family Physicians referenced a 2014 report from the American Medical Association to support their efforts:

> `Competition in Health Insurance: A Comprehensive Study of U.S. Markets_ found that a single health insurer had a commercial market share of 50 percent or more in 17 states. Furthermore, the report found that in 45 states, two health insurers had a combined commercial market share of 50 percent or more. In our opinion, these numbers suggest that a lack of competition clearly exists today and speaks loudly against any further consolidation in the health insurance industry. Blackwelder 2.

49. The practice of organizational steering of consumers toward particular providers may raise serious antitrust concerns, but analysis of those issues is beyond the scope of this article. See John J. Miles, í 14.12 Diversification and Section 2 of the Sherman Act´ Steering as Predatory Conduct, 2 HEALTH CARE & ANTITRUST L. (2015).

50. BUCHHOLZ, supra note 43, at 80; see also RICHARD A. EPSTEIN, OVERDOSE: HOW EXCESSIVE GOVERNMENT REGULATION STIFLES PHARMACEUTICAL INNOVATION 45 (2006) (`Under classical economic theory, the single monopolist raises price and cuts output in order to maximize his private gains; in so doing he reduces overall social welfare._).

51. See RICHARD A. EPSTEIN, supra note 50, at 80 (`It bears stating one more time that the adverse effects of any system of price controls are not only felt by pharmaceutical houses, their shareholders, employees, and suppliers. It is born in part by the public which will see the supply of new products dry up._).

52. Abelson, supra note 37 (explaining that to be competitive, plans must offer affordable premiums); Leemore S. Dafny, Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience, COMMONWEALTH FUND 4-6 (Nov. 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf (`the premium increase was not limited to the merging insurers; rival insurers raised premiums as well (in areas where the merging firms had substantial overlap)._).

warned Congress:

> The market concentration threatened by the pending insurance deals is large and durable, and consumers and providers are at risk if the deals are allowed to move forward. The two deals [Anthem/Cigna and Aetna/Humana] promise fewer choices for consumers for commercial insurance and Medicare Advantage (MA) plans, narrower networks of providers in what few choices remain, and higher premiums and/or out-of-pocket costs, among other things. Even if these insurers make good on their promise to reduce costs if they are permitted to consolidate, insurers have a dismal track record of passing any of those benefits on to consumers . . . [53]

Along with these apprehensions about insurer consolidation, a study conducted in the first part of 2015 found that the cheapest provider-owned health plans sold on ACA marketplaces were 12 percent more expensive than the cheapest plans not owned by providers.[54] Other studies of health organizational consolidation[55] and physician practice competition[56] appear to support the hypothesis that connects reduced competition among providers to higher prices and expenditures.

Competition and quality are related. `Understanding the relation between competition and quality is a central issue in economics in general. Economists are interested in understanding the optimal level of competition in a market. Moreover, the link between competition and quality is central in

53. State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act˘s Impact on Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary 114th Cong. 34 (2015) (statement of Richard J. Pollack, President, American Hospital Association), https://judiciary.house.gov/wp-content/uploads/2016/02/114-46_96053.pdf; see also, U.S. Gov˘t. Accountability Office, GAO-15-710, Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy (2015), http://www.gao.gov/assets/680/672236.pdf. But see State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act˘s Impact on Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary, 114th Cong. 21-23 (2015) (statement of Daniel Durham, Executive Vice President, Strategic Initiatives, America˘s Health Insurance Plans) (contending that consolidation of health insurers may foster pro-competitive effects).

54. Kev Coleman & Jesse Geneson, Cheapest Healthcare Provider-Owned Insurance Plans Still 12% More Expensive than Cheapest Insurance Plans not Owned by Providers, Health Pocket (Aug. 20, 2015), https://www.healthpocket.com/healthcare-research/infostat/fee-for-service-and-provider-health-plans.

55. James C. Robinson & Kelly Miller, Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California, 312 JAMA 1663, 1663-69 (2014).

56. Laurence C. Baker et al., Physician Practice Competition and Prices Paid by Private Insurers for Office Visits, 312 JAMA 1653, 1653-62 (2014).

designing antitrust and other regulatory policies._[57] Surgeon and health policy essayist Atul Gawande opines:

> I think there are actually two major concerns´ one is that monopolies raise prices, and the second is that monopoly means you also lose the pressure on quality of care. When patients don˘t have elsewhere to go, the pressure on the system to ensure they have quality is also just as affected as the prices.[58]

Some economists remain skeptical about the degree to which increased competition brings about the optimal level of quality in health services delivery in the first place.[59] Certainly, reliable empirical research findings on the competition-quality relationship in the LTSS arena specifically, are quite sparse, as most of the limited research in this arena has concentrated on hospitals. Moreover, usefully evaluating the quality of LTSS is a complicated proposition.[60] Besides measuring descriptive performance,

> [W]e should find ways to measure and systematically collect information on adequacy and appropriateness of care and the consumers˘ level of integration, control, participation, and general well-beingŭ .It is essential that we also assess the impact of LTSS on :quality of life˘ (e.g., comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy, individuality, spiritual well-being, and functional competence) as well as its ability to promote a sense of safety, security, and order.[61]

Another aspect of quality of care concerns continuity, a matter of particular importance to those many LTSS consumers who use the services of multiple providers in multiple care settings.[62] The American Academy of

---

57. Gautam Gowrisankaran, Competition, Information Provision, and Hospital Quality, in INCENTIVES AND CHOICE IN HEALTH CARE 319, 343 (Frank A. Sloan & Hirschel Kasper, eds., 2008).

58. Robert A. Berenson, Is Bigger Better? The Implications of Health Care Provider Consolidation: An Interview With Atul Gawande, ROBERT WOOD JOHNSON FOUND. 4 (Oct. 2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf415751.

59. See FRANK A. SLOAN & HIRSCHEL KASPER, Summing Up, in INCENTIVES AND CHOICE IN HEALTH CARE 357, at 358-59 (explaining that more research is necessary before economists will be able to generalize about the relationship between competition and the quality of care).

60. See generally Gary Claxton et al., Measuring the Quality of Healthcare in the U.S., PETERSON-KAISER HEALTH SYSTEM TRACKER (Sept. 10, 2015), http://www.healthsystemtracker.org/insight/measuring-the-quality-of-healthcare-in-the-u-s/?utm_campaign=peterson.

61. Kali S. Thomas & Robert Applebaum, Long-Term Services and Supports (LTSS): A Growing Challenge for an Aging America, 25 PUB. POL˘Y & AGING REP. 56, 60 (2015).

62. See generally Paul Saucier et al., Consumer Choices and Continuity of Care in Managed Long-Term Services and Supports: Emerging Practices and Lessons, AARP PUB. POL˘Y INST. (2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/consumer-choices-report-full-AARP-ppi-ltc.pdf.

Family Physicians predicts that consolidation, especially among health insurers, may create `mass disruptions in continuity of care due to changing and narrowing networks of_ providers.[63] Narrow provider networks may be problematic for consumers for a large number of reasons.[64]

B. Positive Potential Impacts

By contrast, it is arguable that increased coordination among LTSS providers and insurers may result in greater systemic efficiency;[65] according to this view, it `will make possible the elimination of considerable administrative costs, as new combinations render current systems and operations redundant._[66] Enhanced operational efficiency should, in theory, lead to lower prices[67] and better coordination and continuity of care, the lack of which has been described as what `may very well be the missing link of the healthcare delivery chain_[68] and which often is a very serious problem for contemporary LTSS consumers.[69] Operational efficiencies that ultimately will benefit consumers, as well as employers who subsidize health insurance for those consumers, are enthusiastically predicted by health providers and insurers participating in consolidation activities in their arguments against vigorous government antitrust scrutiny.[70]

There are a few factors that might even support the claim that consolidation in the LTSS industry actually will contribute to an enhanced

---

63. Blackwelder 1, supra note 48; see also Blackwelder 2, supra note 48.

64. See generally Valarie Blake, Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform, 16 MINN. J.L. SCI. & TECH. 63 (2015) (key concerns being higher out-of-pocket expenses for consumers and reduced patient access to tertiary care).

65. See generally Roger D. Blair & D. Daniel Sokol, Quality-Enhancing Merger Efficiencies, 100 IOWA L. REV. 1969 (2015).

66. Kaplan, supra note 38.

67. Id. Lower prices should result from insurers˘ stronger bargaining power to negotiate lower payment rates with providers and insurers˘ increased ability to positively impact clinical management. However, `health insurance mergers also may contribute to increased hospital consolidation. . . due to hospitals seeking greater leverage in negotiating with a dwindling number of health plans._ James Swann, Insurance Industry Consolidation Could Mean Higher Premiums, BLOOMBERG BNA (Aug. 5, 2015), http://www.bna.com/insurance-industry-consolidation-n17179934363/.

68. Barbara Johansson & Jane Harkey, Care Coordination in Long-Term Home- and Community-Based Care, 32 HOME HEALTHCARE NURSE 470, 473 (2014).

69. See generally Richard Browdie, Why Is Care Coordination So Difficult to Implement?, 37 J. AM. SOC˘Y ON AGING 62 (2013); AHIMA Staff, Lack of Acute, Long-Term Care Continuity Harming Patients, J. AHIMA (June 25, 2014), http://journal.ahima.org/2014/06/25/lack-of-acute-long-term-care-continuity-harming-patients.

70. Abelson, supra note 37. For an argument in favor of vigorous antitrust scrutiny as the best means to assure a competitive marketplace, see Thomas Greaney, Examining Implications of Health Insurance Mergers, HEALTH AFF. BLOG (July 16, 2015), http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/.

quality of service.[71] Fear of exposure to potential direct (corporate)[72] and/or vicarious liability[73] (under either an apparent agency[74] or a non-delegable duty[75] theory) claims should encourage LTSS entities to exercise greater oversight and control regarding the quality of services being offered and delivered by the various providers who make up the larger enterprise. So, too, should the need to compete against other fewer, but still competitive, surviving providers for consumers˘ lucrative business keep LTSS entities on their toes regarding their service packages.[76] In addition, recent changes in regulations implementing ACA[77] provisions regarding Medicare reimbursement give hospitals a strong (and perhaps even an excessively strong) financial incentive to avoid too-fast hospital readmissions after discharge.[78] Thus, hospitals have a strong financial incentive to do better discharge planning and follow-up, including selecting and carrying on business with LTSS providers who are more likely to provide higher quality care that is less likely to result in a quick hospital readmission.[79] Furthermore, consolidation among disparate providers, each of whom is involved at some point in the care of the consumer, may facilitate better sharing of that consumer˘s pertinent health and social information within the single parent service delivery entity. Such sharing of information, in turn, is

71. Browdie, supra note 69, at 64-65.

72. Strubhart v. Perry Mem˘l Hosp. Trust Auth., 903 P.2d 263, 269 (Okla. 1995); see generally Whitney Foster, Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians, 31 U. ARK. LITTLE ROCK L. REV. 321, 327-28 (2009).

73. Foster, supra note 72, at 328-30.

74. See generally Jane Elaine Ballerini, The Apparent Agency Doctrine in Connecticut˘s Medical Malpractice Jurisprudence: Using Legal Doctrine as a Platform for Change, 13 QUINNIPIAC HEALTH L.J. 317 (2010).

75. See generally Ryan Montefusco, Hospital Liability for the Right Reasons: A Non-Delegable Duty to Provide Support Services, 42 SETON HALL L. REV. 1337 (2012).

76. Id.

77. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119, í 3025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

78. See generally Qian Gu et al., The Medicare Hospital Readmissions Reduction Program: Potential Unintended Consequences for Hospitals Serving Vulnerable Populations, 49 HEALTH SERVS. RES. 818 (2014); Michael W. Sjoding & Colin R. Cooke, Readmission Penalties for Chronic Obstructive Pulmonary Disease Will Further Stress Hospitals Caring for Vulnerable Patient Populations, 190 AM. J. RESPIRATORY & CRITICAL CARE MED. 1072 (2014).

79. See Ronald Winters, LTCHs: Restructuring and Industry Consolidation Ahead, AM. BANKR. INST. J. 34 (2015) (speculating that changes in Medicare reimbursement may impact the relationship between acute care hospitals (`ACHs_) and long-term care hospitals (`LTCHs_)).

expected to enhance consumer care.[80] Presumably (albeit not guaranteedly),[81] the problems with failure of interoperability of electronic health record (EHR) programs that have impeded timely, efficient, and accurate record sharing among disparate providers thus far[82] would be eliminated when all parts of the single parent provider entity are using the same program.[83]

III. EFFECTS OF LTSS CONSOLIDATION ON PARTICULAR POPULATION GROUPS

The preceding section set out, at an exceedingly broad and general level, some of the main expectations that might be reasonably foreseen as natural results of consolidation within the healthcare industry. In this section, I try to apply these general possibilities to particular distinguishable categories of people who might comprise the current universe of LTSS consumers in the U.S. Also in this section, I tentatively suggest a smattering of research questions that could be pursued to test the speculative possibilities identified here concerning the consolidation-LTSS relationship. The results of some the suggested empirical investigations should importantly inform the ongoing development of LTSS practice and policy.

A. Completely Self-Pay Population

Most Americans do a rather poor job of estimating, and planning effectively for, their future healthcare expenditures.[84] Nonetheless, some individuals pay entirely for their own LTSS out of their own pockets, either using personal pensions, savings, investments, and reverse mortgages[85] or by

80. See generally Nicolas P. Terry, Certification and Meaningful Use: Reframing Adoption of Electronic Health Records as a Quality Imperative, 8 IND. HEALTH L. REV. 45 (2011); Brian Rothman et al., Future of Electronic Health Records: Implications for Decision Support, 79 MOUNT SINAI J. MED. 757 (2012).

81. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-530, ELECTRONIC HEALTH RECORDS: OUTCOME-ORIENTED METRICS AND GOALS NEEDED TO GAUGE DOD'S AND VA'S PROGRESS IN ACHIEVING INTEROPERABILITY (2015) (reporting on EHR interoperability problems within two federal agencies).

82. See Marie-Pierre Gagnon et al., Barriers and Facilitators to Implementing Electronic Prescription: A Systematic Review of User Groups' Perceptions, 21 J. AM. MED. INFORMATICS ASS'N 535 (2014); Carrie Anna McGinn et al., Comparison of User Groups' Perspectives of Barriers and Facilitators to Implementing Electronic Health Records: A Systematic Review, 9 BMC MED. 46 (2011).

83. See Deth Sao et al., Interoperable Electronic Health Care Record: A Case for Adoption of a National Standard to Stem the Ongoing Health Care Crisis, 34 J. LEGAL MED. 55, 57-59 (2013) (explaining the efficiencies of the VA's comprehensive EHR integrated infrastructure).

84. Allison K. Hoffman & Howell E. Jackson, Retiree Out-of-Pocket Healthcare Spending: A Study of Consumer Expectations and Policy Implications, 39 AM. J.L. & MED. 62 (2013).

85. See generally Jean Reilly, Reverse Mortgages: Backing Into the Future, 5 ELDER L.J.

relying on family members who voluntarily or involuntarily[86] support them financially. People who fit within this category are true consumers, the beneficiaries of economic empowerment that both permits and compels them to exercise choice and control over the who, what, where, when, and how details of their own LTSS plan. The power of the purse allows the consumer (or a surrogate who is making decisions on behalf of a decisionally impaired individual) to hire, fire, and direct the actions of their LTSS providers.[87] Sometimes, particularly when there is significant geographical distance between a cognitively impaired LTSS consumer and the consumer˘s family, a private professional care manager is paid to assist in arranging and monitoring the LTSS planning and implementation details.[88]

For LTSS consumers in the self-pay, consumer-direction category, health care industry consolidation may exert a fairly limited impact. Many self-pay LTSS consumers are able to remain in home environments (`age in place_)[89] by purchasing full- or part-time health care, companion, or homemaker services provided by individual, independent, self-employed private caregivers.[90] Alternatively, aging in place may entail relying on care from family members whom the consumer agrees to monetarily compensate[91] or who provide those services without any material compensation (`informal caregiving_).[92] Some individuals are able to stay at home through a

17 (1997); Annie E. Nelson, Reverse Mortgages: Changes Brought About by the Housing and Economic Recovery Act, 13 N.C. BANKING INST. 337 (2009).

86. Regarding involuntary family financial support for LTSS, see generally Twyla Sketchley & Carter McMillan, Filial Responsibility: Breaking the Backbone of Today˘s Modern Long Term Care System, 26 ST. THOMAS L. REV. 131 (2013).

87. See Marshall B. Kapp, Health Care in the Marketplace: Implications for Decisionally Impaired Consumers and Their Surrogates and Advocates, 24 S. ILL. U. L.J. 1 (1999).

88. See Jerome Ira Solkoff, í 1.25 Geriatric Care Managers, 18A WEST˘S LEGAL FORMS, ELDERLAW (2015) (for an example of a service to locate a professional care manager); see also Find an Aging Life Care Expert, AGING LIFE CARE ASS˘N, http://www.aginglifecare.org/ALCA/About_Aging_Life_Care/Find_an_Aging_Life_Care_Expert/ALCA/About_Aging_Life_Care/Search/Find_an_Expert.aspx?hkey=78a6cb03-e912-4993-9b68-df1573e9d8af (last visited Apr. 13, 2016).

89. See Rebecca C. Morgan, What the Future of Aging Means to All of Us: An Era of Possibilities, 48 IND. L. REV. 125, 131-34 (2014); see also Kristina L. Guo & Richard J. Castillo, The U.S. Long Term Care System: Development and Expansion of Naturally Occurring Retirement Communities as an Innovative Model of Aging in Place, 37 AGEING INT˘L 210, 218-219 (2012).

90. Companion care services fall under the broader employment categories of `home health aides_ and `personal and home care aides._ See Jeffrey A. Eisenach & Kevin W. Caves, Economic and Legal Aspects of FLSA Exemptions: A Case Study of Companion Care, 63 LAB. L.J. 174, 175-76 (2012).

91. See Sheena J. Knox, Eldercare for the Baby-Boom Generation: Are Caregiver Agreements Valid?, 45 SUFFOLK U. L. REV. 1271. 1272-73 (2012); Marshall B. Kapp, For Love, Legacy, or Pay: Legal and Pecuniary Aspects of Family Caregiving, 14 CARE MGMT. J. 205, 205 (2013).

92. See AARP PUB. POL˘Y INST. & NAT˘L ALLIANCE FOR CAREGIVING, 2015 REPORT:

combination of private, paid caregivers and family caregivers. The healthcare industry consolidation trend examined in this article is unlikely to substantially affect the availability, affordability, or quality of private, independent, self-employed LTSS caregivers whom consumers seek to hire with their own funds,[93] although certainly there will be other challenges to the retention and expansion of an adequate number of unaffiliated direct-care workers.[94]

Similarly, consolidation should have little impact on paid or informal family caregiving for consumers who need LTSS at home, neither lightening nor worsening the availability of family caregivers to LTSS consumers.[95] Confronting the LTSS system˘s extremely extensive dependence on informal caregiving is a matter of grave and immediate public policy concern.[96]

> It is estimated that informal caregivers voluntarily provide three quarters of all long-term care to elderly friends and family members. In 2009, the unpaid care that was provided by 42 million family caregivers was valued at approximately $450 billion dollars. However, the configuration of the modern family has made caregiving an ever more challenging activity. In addition, family caregivers are no longer solely assisting in instrumental activities of daily living (preparing meals and paying bills) and activities of daily living (helping to bathe and feed); rather, many are providing complex medical care to their older loved ones.[97]

The adverse effects of family (and even more pointedly, female)[98] caregiver burden (physical, mental, and financial) must be addressed on an

---

CAREGIVING IN THE U.S. (2015); Sketchley and McMillan, supra note 86.

93. `According to the Bureau of Labor Statistics (`BLS_) estimates, nearly a quarter of personal and home care aides in 2008 were self-employed. This figure is undoubtedly an underestimate because national databases do not adequately capture this segment of the market._ Robyn I. Stone & Natasha S. Bryant, Educating Direct Care Workers on Transitions of Care, 31 ANN. REV. GERONTOLOGY & GERIATRICS 167, 169 (2011).

94. See generally Lori Simon-Rusinowitz et al., Expanding the Consumer-Directed Workforce by Attracting and Retaining Unaffiliated Workers, 11 CARE MGMT. J. 74 (2010); see also Candace Howes, Love, Money, or Flexibility: What Motivates People to Work in Consumer-Directed Home Care?, 48 GERONTOLOGIST 46 (2008).

95. See generally A. E. Benjamin et al., Retention of Paid Related Caregivers: Who Stays and Who Leaves Home Care Careers?, 48 GERONTOLOGIST 104 (2008) (reporting on a study of the caregiving careers of `related workers_ (families and friends of the LTSS consumer)).

96. See Allison K. Hoffman, The Reverberating Risk of Long-Term Care, 15 YALE J. HEALTH POL˘Y, L. & ETHICS 57, 62 (2015); see generally Michael Poku, Letter, Be Mindful of the Caregiver, 63 J. AM. GERIATRICS SOC˘Y 1723 (2015); see also Bridget Haeg, The Future of Caring for Elders in Their Homes: An Alternative to Nursing Homes, 9 NAELA J. 237, 240-41 (2013).

97. Thomas & Applebaum, supra note 61, at 57.

98. See Mercedes Martinez-Marcos & Carmen De la Cuesta-Benjumea, How Women Caregivers Deal with Their Own Long-Term Illness: A Qualitative Study, 70 J. ADVANCED NURSING 1825, 1826 (2014).

urgent basis.[99] Caregiver stress is an established predictor of nursing home placement and an independent risk factor for the caregiver's morbidity and mortality.[100] However, health industry consolidation by itself is unlikely to exacerbate or mitigate the policy challenges surrounding caregiver burden, unless consolidation results in reduced or total unavailability of formal, professional LTSS providers in a particular geographic location.

To the extent that self-pay consumers need or choose to use institutional or agency LTSS providers in whole or part for companion care or specific services requiring specialized training and licensure, the effects of current consolidation in the healthcare industry may be positive or negative. On the positive side, greater efficiency (if indeed facilitated by consolidation of providers) could result in better coordination and continuity of care for self-pay consumers who employ multiple institutional or agency LTSS providers; that development should then translate into enhanced quality of care. On the negative side, if consolidation means a smaller number of institutional and agency LTSS providers are vying for each consumer's business, that may mean less consumer choice and hence less incentive on the providers' part to compete on the basis of price or quality. Self-pay consumers, whose interests are not represented by a government agency or private insurer, are left to their own bargaining power and acumen in negotiating deals with providers for their care, potentially placing them at a disadvantage. By the same token, because LTSS providers may perceive self-pay consumers as affluent, and therefore desirable, they may be more flexible in negotiating the terms of a relationship with such consumers than they would be in negotiating service or compensation details with insured consumers or their third-party payers.

The surmises presented here are, to some degree, susceptible to either empirical verification or disproof. A health services research agenda concerned with LTSS could investigate the impact, if any, of health industry consolidation on the availability of unaffiliated direct-care workers and institutional and agency services for self-pay consumers, as well as changes in the price and quality of LTSS available to and received by those consumers.

---

99. Ranak Trivedi et al., Characteristics and Well-Being of Informal Caregivers: Results from a Nationally-Representative US Survey, 10 CHRONIC ILLNESS 167, 171-73 (2014); Susan Reinhard et al., Valuing the Invaluable: 2015 Update, Undeniable Progress, But Big Gaps Remain, AARP PUB. POL'Y INST. (July 2015), http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf. But see David L. Roth, Lisa Fredman, & William E. Haley, Informal Caregiving and Its Impact on Health: A Reappraisal from Population-Based Studies, 55 GERONTOLOGIST 309 (2015) (discussing potential benefits realized by family caregivers).

100. Thomas & Appelbaum, supra note 61, at 59.

B. Consumers Paying for LTSS Through Private Health Insurance Policies

A second category of consumers consists of people who need LTSS such as inpatient or outpatient rehabilitative care, medication, or equipment management for a short period of time following an acute illness or procedure.[101] Such care is not intended to be custodial or maintenance,[102] but rather is intensive enough that it is expected to get the consumer to a point at which hospital readmission[103] and further LTSS are unnecessary. Not surprisingly, people with no insurance coverage often experience significant barriers in accessing post-acute care,[104] but many people in the paradoxically-named short-term LTSS category have health insurance policies obtained through present or past employment or individual purchase that will pay for all or part of those prescribed short-term LTSS consented to by the consumer.

The various general possible impacts of health industry consolidation outlined in Section II, supra, are possible for this consumer population. Additionally, as health insurers consolidate into a smaller number of competitors, researchers should particularly investigate whether those insurers begin to reduce their benefits for short-term LTSS by refusing to cover previously-covered services, reimbursing providers at lower rates, and/or shifting more of the associated costs to the consumer through increased deductibles or co-insurance[105] contractual obligations. If such changes in health insurance coverage for post-acute care occur widely, the role of those involved in hospital discharge planning[106] will become even more central for consumers.

---

101. `Post-acute care (PAC) includes rehabilitation or palliative services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home._ Post-Acute Care, MEDPAC, http://medpac.gov/-research-areas-/post-acute-care (last visited Apr. 13, 2016).

102. See Sidney D. Watson, From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid˜s History, 26 GA. ST. U. L. REV. 937, 962 (2010) (`[P]rivate insurance rarely covers personal care._).

103. See generally Maxim Topaz et al., Higher 30-Day and 60-Day Readmissions Among Patients Who Refuse Post Acute Care Services, 21 AM. J. MANAGED CARE 424 (2015) (stating that patients who refuse post-acute care are twice as likely to have 30- and 60-day readmissions).

104. See Courtenay R. Bruce & Mary A. Majumder, The `Permanent_ Patient Problem, 42 J.L. MED. & ETHICS 88, 88 (2014) (`[P]ost-acute care facilities have no financial incentive or legal obligation to accept patients with no insurance or only pending Medicaid coverage._).

105. Coinsurance is defined as `[y]our share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service._ Coinsurance, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/co-insurance/ (last visited Apr. 13, 2016).

106. Hospital Discharge Planning: A Guide for Families and Caregivers, FAMILY CAREGIVER ALLIANCE, https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers (last visited Apr. 15, 2016) (`[D]ischarge planning is :[a] process used to decide what a patient needs for a smooth move from one level of care to another.˜_).

C. Consumers Paying for LTSS Through Private Long-Term Care Insurance

A number of people in the U.S. purchase private insurance that specifically covers all or part of the costs of specified LTSS, although the potential market for this form of insurance is much larger than the actual market saturation achieved thus far.[107] The contractual terms of these insurance products, which usually are lumped together under the heading of `long-term care insurance_ (LTCI),[108] may vary substantially in the details of coverage, eligibility, qualifying conditions for payment, deductibles and co-insurance requirements, inflation protection for benefits, and premium prices, all depending upon the particular policy purchased. As a general matter:

> Long-Term Care Insurance is privately contracted health insurance for long-term care expenses. The coverage is generally activated when the insured needs assistance with certain activities of daily living as defined by the terms of the policy. A long-term care policy generally will provide coverage for: home health care (beyond that covered by Medicare); care offered where one resides in assisted living, memory care, or personal care facilities; and nursing home care. Additionally, a policy may provide coverage benefits for adult day care, respite care, and hospice care (beyond that covered by Medicare).[109]

Traditional claims-based coverage directly reimburses providers for rendered services.[110] By contrast, indemnity-based (`cash-based_) long-term care insurance provides the insured with a check that represents the maximum allowable daily benefit amount stipulated in the policy.[111] The latter form is more consistent with consumer-directed LTSS.[112]

---

107. See, e.g., Peter Kyle, Confronting the Elder Care Crisis: The Private Long-Term Care Insurance Market and the Utility of Hybrid Products, 15 MARQ. ELDER˜S ADVISOR 101, 106 (2013). Compare Enrique Zamora et al., Long-Term Care Insurance: A Life Raft for Baby Boomers, 26 ST. THOMAS L. REV. 79, 102 (2013) (describing LTCI as `a viable option_), with Judy Feder, The Challenge of Financing Long-Term Care, 8 ST. LOUIS U. J. HEALTH L. & POL˜Y 47, 47 (2014) (criticizing private long-term care insurance because it `typically costs a lot, offers limited value, and is subject to premium increases that can cause purchasers to lose coverage they have paid into for years_).

108. Eileen Walsh & Whitney Wilson, An Introduction to Funding Long-Term Care Without Medicaid, 35 BIFOCAL 17, 19 (2013).

109. Id.

110. Joe Tomlinson, Comparing Long-Term Care Alternatives, ADVISOR PERSP. 1 (Dec. 18, 2012), http://www.advisorperspectives.com/newsletters12/pdfs/Comparing_Long-Term_Care_ Alternatives.pdf.

111. Indemnity LTC Policy Provides Consumer-Directed Option, Says Long-Term-Care-Insurance-Planners.com, BUSINESS WIRE (Dec. 9, 2005, 5:32 PM), http://www.businesswire.com/news/home/20051209005538/en/Indemnity-LTC-Policy-Consumer-Directed-Option-Long-Term-Care-Insurance-Planners.com.

112. Id.

Private long-term care insurance companies have encountered substantial barriers to selling their product to potential purchasers.[113] `Although long-term care (LTC) is one of the biggest financial risks facing the elderly today, very few´ 13% of current 65 year-olds´ are insured against this risk._[114] Most prominent among these impediments is a widespread misperception among middle-aged, middle-class people (precisely the group that could benefit the most by having insurance that protects their assets from being dissipated in the event that LTSS are later needed) that they could never become so disabled that they would require LTSS.[115] In consequence, too many people wait until they are old and frail, and therefore, are likely to file claims for coverage within a short period of time, before trying to purchase long-term care insurance.[116] When the only people buying the insurance product are those who are most likely to use it quickly, insurers can only remain financially viable[117] and meet state minimum solvency (reserve) requirements[118] by vigorously screening potential purchasers and excluding

113. See, e.g., Richard W. Johnson & Cori E. Uccello, Is Private Long-Term Care Insurance the Answer?, CTR. FOR RETIREMENT RES. 1, 5-6 (Mar. 2005), http://crr.bc.edu/wp-content/uploads/2005/03/ib_5-29_508.pdf.

114. NORMA B. COE ET AL., NAT˘L BUREAU OF ECON. RESEARCH, FAMILY SPILLOVERS OF LONG-TERM CARE INSURANCE 3 (2015).

115. See, e.g., We Must Address Long-Term Services and Supports (LTSS), LEADINGAGE PATHWAYS 1 (Oct. 2013), http://www.leadingage.org/uploadedFiles/Content/Members/Member_Services/Pathways/WE_MUST_ADDRESS_LTSS.pdf (explaining that the United States˘ `lack of a long-term care financing strategy leaves millions unprotected against the catastrophic costs of . . . physical disability and other chronic conditions that often come with longevity or can strike earlier in life . . . [which] inordinately impoverishes middle-class Americans_) [hereinafter Long-Term Services and Supports]; see also Harriet Komisar, The Effects of Rising Health Care Costs on Middle-Class Economic Security, AARP PUB. POL˘Y INST. 2 (2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/security/2013/impact-of-rising-healthcare-costs-AARP-ppi-sec.pdf (`Expenses for long-term services and supports (LTSS) are a major risk to economic security in retirement for middle-class families, since such expenses are not covered by Medicare and few people have private insurance to cover such costs._).

116. Kyle, supra note 107, at 112˘13.

117. Nimmi Cleve, Long-Term Care Insurance: An Endangered Species, 22 ANNALS HEALTH L. ADVANCE DIRECTIVE 182, 192 (2013) (`The current problem that the LTCI universe faces is precisely this: expenditures are far exceeding funding. Therefore, the LTCI model is not financially viable in its current avatar. In an effort to remedy the situation, the funding needs to increase, expenditures need to decrease, or a combination of both needs to occur._).

118. See, e.g., N.M. STAT. ANN. í 59A-23A-6 (1993) (authorizing promulgation of regulations which `include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, certificates and riders, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, levels of care, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms_).

many of them,[119] and by charging very high premiums to those purchasers who qualify for coverage. Those high prices, in turn, make private long-term care insurance unaffordable for many people who otherwise might be interested.[120]

The other main barrier to the sale of private long-term care insurance policies is the crowding-out effect of the Medicaid program.[121] `The crowding out effect is an economic theory stipulating that rises in public sector spending drive down or even eliminate private sector spending._[122] Because many people incorrectly perceive that Medicare will pay for their eventual LTSS,[123] but correctly perceive that Medicaid ultimately will be available to them as a safety net payment program for LTSS if they fail to save or expend their financial assets, they feel no strong imperative to devote their own current dollars to insurance premium payments for protection they may never use or will use only in the future.[124] As one set of commentators has aptly summarized the situation, `Unfortunately, because the majority of middle-class Americans have failed to plan for their future long-term care needs, Medicaid has in effect become the primary financier rather than a means of last resort for the indigent._[125]

Besides difficulties in selling policies, the insurance industry has at least two fundamental problems: first, a `long-standing one´ buyers are dropping coverage less often than the industry predicted;_ and second, `historically low interest rates are sucking the profit out of the business._[126] As a consequence of this multifactorial economic dynamic, the number of companies offering private long-term care insurance policies for sale to the public has constricted significantly in the last several years.[127] Some of these

---

119. Zamora et al., supra note 107, at 100 (`As these policies are medically underwritten, the older an individual becomes, the more likely they are to suffer medical conditions, which could lead to the insurance company declining the applicant._).

120. Long-Term Services and Supports, supra note 115.

121. See infra Section III.E.

122. Crowding Out Effect, INVESTOPEDIA, http://www.investopedia.com/terms/c/crowdingouteffect.asp (last visited Apr. 15, 2016).

123. See infra Section III.D.

124. See Kyle, supra note 107, at 113¯14; see also Andrew M. Hyer et al., Paying for Long-Term Care in the Gem State: A Survey of the Federal and State Laws Influencing How Long-Term Care Services for Idaho¯s Growing Aged and Disabled Populations Are´ and Will Be´ Funded, 48 IDAHO L. REV. 351, 358 (2012).

125. Zamora et al., supra note 107, at 88; see generally Sean R. Bleck et al., Preserving Wealth and Inheritance Through Medicaid Planning for Long-Term Care, 17 MICH. ST. U. J. MED. & L. 153 (2013).

126. Howard Gleckman, What¯s Killing the Long-Term Care Insurance Industry, FORBES (Aug. 29, 2012, 8:12 PM), http://www.forbes.com/sites#/sites/howardgleckman/2012/08/29/whats-killing-the-long-term-care-insurance-industry.

127. Kelly Greene, Long-Term Care: What Now?, WALL ST. J. (Mar. 9, 2012, 9:46 PM), http://www.wsj.com/articles/SB10001424052970203961204577269842991276650.

companies have ceased doing business altogether, some have stayed and continue marketing their other products but have discontinued their long-term care insurance lines, and some companies have participated in mergers and acquisitions.[128] Thus, the consequences of exit and consolidation in the long-term care insurance industry for consumers so far have proven to be mainly negative, due to both increased costs and diminished coverage scope.[129]

D. Consumers Paying for LTSS Through Medicare

Contrary to popular belief,[130] Part A (Hospital Insurance) of Original Medicare[131] does not provide an open-ended entitlement to payment for all LTSS for eligible Medicare beneficiaries. Rather, Medicare coverage for LTSS is quite limited, not to mention complicated.[132] Medicare Part A covers, generally, up to 100 days per spell of illness in a skilled nursing facility (SNF) for needed nursing services, but only if admission to the SNF is post-acute (meaning that such admission proceeds immediately after a hospital admission which lasted for at least three consecutive days).[133] Part A also pays for certain home health care for homebound individuals so long as those

128. Nancy Anderson, Insurers Are Getting Out of Long Term Care´ Is it Time for You to Get In?, FORBES (Oct. 4, 2012, 9:40 AM), http://www.forbes.com/sites#/sites/financialfinesse/2012/10/04/insurers-are-getting-out-of-long-term-care-is-it-time-for-you-to-get-in; see generally MARC A. COHEN ET AL., U.S. DEP˜T OF HEALTH & HUMAN SERVS., EXITING THE MARKET: UNDERSTANDING THE FACTORS BEHIND CARRIERS˜ DECISION TO LEAVE THE LONG-TERM CARE INSURANCE MARKET (2013), https://aspe.hhs.gov/sites/default/files/pdf/177866/MrktExit.pdf.

129. Long-Term-Care Insurance: Insurers Are Forced to Boost Premiums or Stop Selling Policies, CONSUMER REP. (Aug. 2012), http://www.consumerreports.org/cro/2012/08/long-term-care-insurance/index.htm. For example, consumers who already own long-term care insurance policies, but whose insurers decide to discontinue this product line, may find themselves medically rejected when they apply for policies with the fewer, more selective remaining companies or will be forced to pay substantially more in premiums for the same or lesser coverage.

130. See generally Richard L. Kaplan, Top Ten Myths of Medicare, 20 ELDER L.J. 1, 11˜12 (2012) (`Many Americans believe that Medicare covers the costs associated with these various options. In fact, the most recent survey of Americans age forty-five and over found that fifty-nine percent of respondents thought that Medicare pays for long-term care provided in a nursing home while fifty-two percent thought that it covers assisted living facility care._).

131. 42 U.S.C. í 1395 (2011).

132. See, e.g., Richard L. Kaplan, Desperate Retirees: The Perplexing Challenge of Covering Retirement Health Care Costs in a YOYO World, 20 CONN. INS. L.J. 433, 433 (2014) (explaining that `[i]n virtually every significant aspect of retirement planning. . . change has spawned increasing uncertainty, unpredictability, and anxiety for persons affected_ by changes related to Medicare˜s limited coverage, and the complexity associated with that coverage, and how `retirees and prospective retirees are now the locus of increasing risks relating to retirement security, and the foreseeable trends suggest that this situation will only exacerbate in the future_).

133. 42 C.F.R. íí 409.20-409.30 (2011).

services are provided by a Medicare certified agency, and medically necessary.[134] Medicare Part B also covers medically necessary home health services delivered by Part B providers.[135]

Each year, those eligible for Medicare may choose to opt out of Original Part A and Part B (Supplementary Medical Insurance) Medicare and instead enroll in a Medicare Advantage Plan (MAP) under Medicare Part C.[136] The Medicare Advantage option has been growing in popularity in various parts of the U.S.,[137] despite the overt antagonism of the Obama administration toward this private sector approach, as reflected in the ACA.[138] When an individual selects this option, the Medicare program pays a periodic fee to one of the managed care (Health Maintenance Organization or Preferred Provider Organization) or private fee-for-Service plans operating in the Medicare enrollee˘s geographical area, and in consideration of that periodic fee, the Plan agrees to provide the enrollee or be responsible for the provision of, at the least, all services that would have been covered under Original Medicare.[139] This includes the LTSS that Original Medicare covers.[140] Different MAPs, for marketing reasons, offer different service coverage packages over and above the basics required to match Original Medicare (for example including vision, hearing, and dental care coverage), and similarly may differ regarding deductibles, co-pays, and co-insurance imposed on the

---

134. 42 C.F.R. í 409.42 (2012); see generally VICTORIA WEISFELD & TRACY A. LUSTIG, THE FUTURE OF HOME HEALTH CARE: WORKSHOP SUMMARY (2015) http://www.nap.edu/read/21662/chapter/1. These services may include, for example, part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy.

135. 42 U.S.C. í 1395k (a)(2)(A) (2011).

136. 42 U.S.C. í 1395w¯21 (2015).

137. Robert Pear, As Medicare and Medicaid Turn 50, Use of Private Health Plans Surges, N.Y. TIMES (July 29, 2015), http://www.nytimes.com/2015/07/30/us/as-medicare-and-medicaid-turn-50-use-of-private-health-plans-surges.html?_r=0 ; Medicare Advantage Premiums Remain Stable; Enrollment at All-Time High, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 21, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-21.html; see also Tricia Neuman et al., Medicare Advantage and Traditional Medicare: Is The Balance Tipping?, HENRY J. KAISER FAM. FOUND. 1 (Oct. 2015) http://files.kff.org/attachment/issue-brief-medicare-advantage-and-traditional-medicare-is-the-balance-tipping.

138. See Richard L. Kaplan, Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era, 23 ELDER L.J. 1, 24-26 (2015); Gretchen Jacobson et al., Medicare Advantage 2015 Spotlight: Enrollment Market Update, HENRY J. KAISER FAM. FOUND. 1 (June 2015), http://files.kff.org/attachment/issue-brief-medicare-advantage-2015-spotlight-enrollment-market-update (`Despite concerns that reductions in payments to Medicare Advantage plans enacted in the Affordable Care Act of 2010 (ACA) would lead to reductions in Medicare Advantage enrollment, the number and share of Medicare beneficiaries enrolling in Medicare Advantage plans has continued to climb._).

139. See supra notes 132-134.

140. Id.

consumer.[141] A MAP could offer LTSS benefits beyond those contained in Original Medicare, but such coverage expansion is not common.

Continued consolidation of health insurers is likely to affect the Medicare Advantage Program by reducing the number of competing MAPs available to any particular Medicare-eligible consumer considering this option. Some parts of the U.S. already experience an absence or dearth of MAPs available for selection by local Medicare enrollees,[142] and consolidation can only make that circumstance worse. MAP enrollment is already concentrated among a handful of large insurers. For instance, Humana and UnitedHealth together provide coverage for nearly 40 percent of all people enrolled in MAPs.[143] Some parts of the country that now have one or a few MAPs available may, following mergers and consolidations, have even fewer or no competing MAPs. Those Plans that continue to offer products for Medicare enrollees in a particular area may be able to provide more restrictive provider networks[144] while raising the size of the consumer˘s financial contribution to care as a business practice due to lessened competition for consumers (through imposition of increased premium amount, deductible, co-pay, and co-insurance requirements).[145] Because MAPs today rarely offer LTSS coverage beyond that required to match Original Medicare, the hypothesized effects of consolidation on Medicare Advantage should be minimally felt in the LTSS arena. Nevertheless, investigation of consolidation˘s impact on the availability, affordability, and content of MAP generally, and on LTSS for Medicare beneficiaries specifically, should be placed solidly on the health services research agenda.

---

141. See Rachel O. Reid et al., The Roles of Cost and Quality Information in Medicare Advantage Plan Enrollment Decisions: An Observational Study, 31 J. GEN. INTERNAL MED. 234, 237-38 (2016); see also Paul D. Jacobs & Melinda B. Buntin, Determinants of Medicare Plan Choices: Are Beneficiaries More Influenced by Premiums or Benefits?, 21 AM. J. MANAGED CARE 498, 503 (2015).

142. See Brian Biles et al., Competition Among Medicare˘s Private Health Plans: Does It Really Exist?, COMMONWEALTH FUND 1 (Aug. 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf.

143. See Drew Altman, Amid Merger Talk, A Look at Health Insurers˘ Medicare Business, WALL ST. J. (July 1, 2015, 9:49 AM), http://blogs.wsj.com/washwire/2015/07/01/amid-merger-talk-a-look-at-health-insurers-medicare-business.

144. See Can I Get My Health Care from Any Doctor, Other Health Care Provider, or Hospital in Medicare Advantage Plans?, MEDICARE.GOV, https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans-network-comparison.html#collapse-3306 (last visited Apr. 15, 2016).

145. See Laura M. Keohane et al., Medicare Advantage Members˘ Expected Out-of-Pocket Spending for Inpatient and Skilled Nursing Facility Services, 34 HEALTH AFF. 1019, 1025 (2015).

E. Consumers Paying for LTSS Through Medicaid

The Medicaid program[146] is the primary public payer for both nursing home care and home- and community-based LTSS.[147] `Medicaid is the largest single purchaser of LTSS in the United States, with cumulative spending of more than $130 billion annually on behalf of more than four million individuals. This spending surpasses both Medicare and commercial insurance spending combined._[148]

Historically, with the notable exception of the Department of Veterans Affairs˘ Aid and Attendance and Housebound program,[149] individuals who were dependent on public funding for their LTSS were subject to important choices about the who, what, when, where, and how details of their service plan being determined and directed by the funding agency (usually the state˘s designated Medicaid agency).[150] Institutional´ mainly nursing home´ services were favored for many years under the terms of the Medicaid statute, but in the last couple of decades, an array of home- and community-based (HCB) alternatives have become increasingly available to consumers on Medicaid through a slew of state-specific waiver programs.[151] Although originally the HCB alternatives were built around an agency-directed model, more recently a variety of opportunities for consumer-directed LTSS have been opened up for Medicaid-dependent people, by moving from an

---

146. 42 U.S.C. íí 1396-1396w-5 (2014); see generally Laura Snyder & Robin Rudowitz, Medicaid Financing: How Does It Work and What Are the Implications?, HENRY J. KAISER FAM. FOUND. 1 (May 2015), http://files.kff.org/attachment/issue-brief-medicaid-financing-how-does-it-work-and-what-are-the-implications.

147. Erica L. Reaves & MaryBeth Musumeci, Medicaid and Long-Term Services and Supports: A Primer, HENRY J. KAISER FAM. FOUND. 1 (Dec. 2015), http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer.

148. Dennis G. Smith et al., Proposed Rule Creates Challenges for Managed Long-Term Services and Supports, DENTONS (July 8, 2015), http://www.dentons.com/en/insights/alerts/2015/july/8/proposed-rule-creates-challenges-for-managed-long-term-services.

149. See Pension: Aid & Attendance and Housebound, U.S. DEP˘T VETERANS AFF., http://www.benefits.va.gov/pension/aid_attendance_housebound.asp (last updated Dec. 8, 2015).

150. See KAREN TRITZ, CONG. RESEARCH SERV., LONG-TERM CARE: CONSUMER-DIRECTED SERVICES UNDER MEDICAID 9 (Aug. 31, 2006), http://congressionalresearch.com/RL32219/document.php (comparing agency-directed versus consumer-directed LTSS in terms of program structures and policies); Mary J. Clark et al., A Longitudinal Comparison of Consumer-Directed and Agency-Directed Personal Assistance Service Programmes Among Persons with Physical Disabilities, 30 DISABILITY & REHABILITATION 689, 689 (2008) (`Agency-directed models offer few choices over who is hired, daily scheduling, the types of services to be performed, or how the services are performed._).

151. See generally Hermer, supra note 6, at 62 (`This article examines efforts states are making to expand access to community-based services for elderly and disabled Medicaid beneficiaries and suggests several options that might improve such access nationally._); Molly O˘Malley Watts et al., Money Follows the Person: A 2015 State Survey of Transitions, Services, and Costs, HENRY J. KAISER FAM. FOUND. (Oct. 16, 2015), http://kff.org/medicaid/report/money-follows-the-person-a-2015-state-survey-of-transitions-services-and-costs/.

indemnity model of payment by the government agency to a disability model of empowering the consumer to purchase, pay for, and arrange the specific logistical details of desired services directly.[152] The consumer-directed model is supportive of consumer autonomy, although this model is not without some feminist critics.[153]

Most State Medicaid programs are in a transition period involving a move from the traditional fee-for-service provider payment model to various incarnations of managed care,[154] under which Medicaid beneficiaries participate in private health plans run by insurers.[155] This transition may be understood as follows:

> Managed care differs from the fee-for-service system because the MCO [managed care organization] assumes either full or partial financial risk. Under the traditional fee-for-service system, medical providers issue a fee for each service they provide and are reimbursed by the state's Medicaid program. Fee-for-service providers are only responsible for the specific service they provide . . . . However, under the risk-based approach to managed long-term care, the state's Medicaid program arranges to have a single MCO, also known as a contractor, [or several competing MCOs] provide a package of long-term care benefits. The MCO then contracts with medical providers to render medical services to the beneficiaries within their program. When choosing which medical providers to contract with, the MCO may seek providers known to be cost-effective or it may choose to pay providers a capitated per patient fee.[156]

---

152. See Pamela Doty et al., New State Strategies to Meet Long-Term Care Needs, 29 HEALTH AFF. 49, 49 (2010); H. Stephen Kaye, Toward a Model Long-Term Services and Supports System: State Policy Elements, 54 GERONTOLOGIST 754, 755 (2014). Compare Lori De Milto, Program Results Report – Cash & Counseling, ROBERT WOOD JOHNSON FOUND., http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2015/rwjf406468 (describing the Cash & Counseling concept of consumer choice as implemented in the U.S.) (last updated Feb. 28, 2015), with Barbara Da Roit & Blanche Le Bihan, Similar and Yet So Different: Cash-for-Care in Six European Countries' Long-Term Care Policies, 88 MILBANK Q. 286 (2010) (describing the concept as implemented in the European context).

153. See Daniela Kraiem, Consumer Direction in Medicaid Long Term Care: Autonomy, Commodification of Family Labor, and Community Resilience, 19 J. GENDER, SOC. POL'Y & L. 671, 695-99 (2011).

154. See Sarah Somers & Jane Perkins, Sunshine and Accountability: The Pursuit of Information on Quality in Medicaid Managed Care, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 153, 157-58 (2011) (noting that managed care entities may take several different forms). For a critical perspective on this development, see John V. Jacobi, Medicaid Evolution for the 21st Century, 102 KY. L.J. 357, 363-64 (2014).

155. See Pear, supra note 137; Ctrs. for Medicare & Medicaid Servs., CMS Proposes Rule to Strengthen Managed Care for Medicaid and CHIP Enrollees, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-05-26.html (visited April 28, 2016).

156. Jenna Steffy, Medicaid Managed Long-Term Care: Will It Solve Medicaid's Financial Crisis?, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 72, 76 (2011).

Under traditional fee-for-service Medicaid, the state must permit consumers to obtain services from any provider who is willing to accept the state˘s unilaterally dictated Medicaid reimbursement as payment in full for the particular service(s) rendered. However, when a state enters into a contract with one or more private MCOs to serve the State˘s Medicaid population, the state may obtain a federal waiver[157] or may amend its State Medicaid Plan[158] to mandate that individual consumers make the shift from fee-for-service to managed care. Importantly, though, states ordinarily may not require consumers who are dually eligible for both Medicare and Medicaid to enroll in managed care[159] unless a waiver has been obtained by the state from the Federal Department of Health and Human Services.[160] There is continuing litigation in Florida challenging part of the State˘s Medicaid managed care LTSS waiver that mandates consumer participation, on the grounds that forcing Medicaid LTSS consumers, who are virtually by definition disabled, into this arrangement violates their rights against discrimination under the Americans with Disabilities Act.[161]

The contracts that individual states are in the process of negotiating with MCOs typically include LTSS as part of the comprehensive package of benefits the MCO agrees to provide to Medicaid-eligible consumers.[162] Most of these contracts also include provisions for some form of mandatory care coordination in order to promote the policy objectives of improved continuity and coherence of services, and hence, enhanced quality, expanded access to

157. See 42 U.S.C. í 1396n (b)(2) (2010); see 42 U.S.C. í 1315(a) (2014).

158. See 42 U.S.C. í 1396u-2(a)(1) (2014).

159. See 42 U.S.C. í 1396u-2(a)(2) (2014).

160. See 42 U.S.C. í 1396u-2(a)(1)(A) (2014).

161. Complaint, Parrales v. Dudek, No. 4:15-cv-00424 (N.D. Fla. Aug. 27, 2015); see also FLA. STAT. ANN. í 409.972 (West 2014) (listing various groups of people for whom enrollment in the Medicaid managed care program is voluntary).

162. See, e.g., FLA. STAT. ANN. íí 409.978¯409.985 (West 2011 ¯ 2015); A Snapshot of the Florida Medicaid Long-Term Care Program, FL. AGENCY FOR HEALTH CARE ADMIN. (July 24, 2014), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf; see Rebecca C. Bell, Medicaid Managed Long-Term Care: Is Florida Ready?, 26 ST. THOMAS L. REV. 103, 103¯04 (2013); see also Jean P. Hall et al., Medicaid Managed Care: Issues for Beneficiaries with Disabilities, 8 DISABILITY & HEALTH J. 130, 130 (2015) (`In 2012, 16 states placed at least some beneficiaries using LTSS into Medicaid managed care, with only seven doing so statewide for all LTSS, for a total of about 390,000 beneficiaries nationally. In 2014, 26 states are projected to have managed care programs in place for Medicaid LTSS . . . for a total of more than 1.8 million people._).

services,[163] and more effective cost containment.[164]

At this relatively early stage in the evolution of managed LTSS, it is difficult to predict how this managed care transformation, and particularly the care coordination element, will impact consumer direction in this arena. `A majority of [current managed care contracts with State Medicaid programs] require that all members receive, or at least be offered, care coordination,_ which may range in extent from an annual contact for consumers in low risk groups to more frequent contacts for consumers at higher risk.[165] `Although contracts emphasize consumer choice and preferences in the service planning process, most [thus far] do not address whether members can opt out of care coordination altogether._[166] For many consumers, maintaining elements of consumer choice and self-direction of services is of paramount concern.[167]

It is unclear how, and whether, consolidation in the healthcare industry will affect people who receive LTSS under the different forms of Medicaid. For consumers whose LTSS is subsidized by Medicaid under a traditional agency-directed model, researchers will need to examine the impact on the access and quality of services available to consumers. We will need to collect and analyze data concerning consolidation˘s impact on the number of providers of different types of LTSS and particularly on whether a reduced number of providers in different categories really mean more limited choices for consumers. We will need to investigate whether fewer providers for coordinating agencies to employ will lead to states choosing to increase their Medicaid reimbursement rates[168] or, instead, result in states keeping their

163. See Kimberly A. Opsahl, Using Integrated Care to Meet the Challenge of the ADA˘s Integration Mandate: Is Managed Long-Term Care the Key to Addressing Access to Services?, 10 IND. HEALTH L. REV. 211, 228, 232 (2013) (`Historically, Medicaid Managed Care was used by states as a tool to deliver and finance care for Medicaid enrollees, with the goals of increasing access to care, improving quality, and in some cases, reducing costs._ `[S]tates most often report improved access to care as a result of Medicaid Managed Care_ and `most states report that managed care offered the state improved value related to access and quality._); see also Mary Crossley, Giving Meaning to `Meaningful Access_ in Medicaid Managed Care, 102 KY. L.J. 255, 259 (2014) (stating that `cutting costs while improving oversight and coordination of care, and thus outcomes,_ i.e., improving quality of care, are motivations for states to switch Medicaid beneficiaries into managed care).

164. See generally Paul Saucier & Brian Burwell, Care Coordination in Managed Long-Term Services and Supports, AARP PUB. POL˘Y INST. 27 (July 2015), http://governor.nh.gov/commissions-task-forces/medicaid-care/documents/mm-12-10-2015-care-coordination.pdf (`[S]ome case management providers are re-engineering their practices and business models to become more competitive . . . _); Jane McCahill & Joseph T. Van Leer, The Challenges of Reform for Medicaid Managed Care, 21 ANNALS HEALTH L. 541, 547 (2012).

165. Saucier & Burwell, supra note 164, at 9¯10.

166. Id. at 10.

167. Susan C. Reinhard, What Do Older Adults Want from Integrated Care?, 37 GENERATIONS 68, 70 (2013).

168. See Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378, 1387¯88 (2015)

reimbursement rates constant and either cutting back on quantity or timeliness of services made available to consumers or employing lower quality providers who agree to work more cheaply.

In the dwindling number of states still operating Medicaid LTSS programs on a non-managed care basis, Medicaid-dependent consumers participating in a consumer-directed option probably will be affected by health industry consolidation in much the same way that consolidation may impact consumers who pay out-of-pocket for their true consumer-directed LTSS.[169] The key difference for self-pay consumers, though, is that, depending on their particular financial capabilities, they may be able to offer potential providers more from their own pockets than they could pay them if limited by a Medicaid program voucher or other cash equivalent. Thus, the self-pay consumer may end up paying more for LTSS, but be able to select and hire providers out of a larger pool of willing competitors. Because the Medicaid-dependent but self-directed consumer may, due to financial constraints, have access to a smaller pool of willing competitors from which to choose LTSS providers, that consumer also may be more constrained than a self-pay counterpart in firing unsatisfactory providers or supervising them too closely for fear of alienating them. Researchers should examine empirically whether these surmised scenarios materialize.

Health industry consolidation's impact on Medicaid LTSS managed care consumers could take interesting forms. Even apart from the consolidation effect, one set of commentators examining the shift to Medicaid managed care in Illinois cautions, `[F]ewer providers may participate in the managed care plans than are currently participating in [the traditional fee-for-service] Medicaid program. Fewer hospitals are participating in the managed care plans than are currently participating in Medicaid._[170] With the advent of health industry consolidation and fewer separate providers with whom an MCO may contract for LTSS, the provider network from which a Medicaid LTSS consumer may receive services may shrink even further. Health services researchers should quantify such an effect.[171]

The ramifications of State Medicaid managed care programs on the quality of care available to consumers is a topic of considerable debate.[172] It is

---

(holding that a Medicaid service provider may not sue the state for inadequate reimbursement rates).

169. See supra Section III.A.

170. Elizabeth P. Allen et al., The Impact of State Medicaid Reform on Vulnerable Populations Needing Long-Term Care Services and Supports: An Analysis of Florida, Illinois, and New Jersey, 8 NAELA J. 125, 155 (2012).

171. This task is part of a program evaluation contract awarded in 2015 to the Florida State University Dep't of Behavioral Sciences and Social Medicine by the Florida Agency for Healthcare Administration [hereinafter Evaluation Contract].

172. Compare Robert L. Phillips, Jr. et al., Cost, Utilization, and Quality of Care: An

particularly difficult to predict the effect of health industry consolidation on quality in Medicaid managed LTSS programs. On one hand, because of the enormous size and reach of their Medicaid programs,[173] states exercise near-monopsony, de facto single-payer[174] purchasing power for LTSS. Thus, a provider who wants to become or remain part of the managed Medicaid LTSS network (low reimbursement being better than zero market share) in some states with multiple competing providers may have an incentive´ bordering on coercion[175]´ to be attractive to the state by achieving and maintaining positive ratings and reputation for quality and consumer satisfaction.[176] On the other hand, despite their near-monopsony power, some states may have so few LTSS providers competing to be included in their inadequately compensated, managed Medicaid LTSS provider networks that those states find it necessary to tolerate the inclusion of providers exhibiting a somewhat less than stellar quality of care record. Researchers should investigate which of these hypotheses ultimately gets borne out by the evidence.[177]

Evaluation of Illinois˘ Medicaid Primary Care Case Management Program, 12 ANNALS FAM. MED. 408, 412 (2014) (reporting positive findings concerning impact on quality), with Kyle J. Caswell & Sharon K. Long, The Expanding Role of Managed Care in the Medicaid Program: Implications for Health Care Access, Use, and Expenditures for Nonelderly Adults, 52 INQUIRY 1, 9 (2015) (reporting negative findings regarding quality); see also Diana D. McDonnell & Carrie L. Graham, Medicaid Beneficiaries in California Reported Less Positive Experiences When Assigned to a Managed Care Plan, 34 HEALTH AFF. 447, 447 (2015) (reaching the same conclusion).

173. See John K. Iglehart & Benjamin D. Sommers, Medicaid at 50´ From Welfare Program to Nation˘s Largest Health Insurer, 372 NEW ENG. J. MED. 2152, 2152¯2154 (2015) (examining the evolution of the Medicaid program since its creation under the Social Security Amendments of 1965).

174. See Kristin Peterson, State Medicaid Agencies as Single Payers: An Innovative Approach to Medicaid Expansion Obligations Under the Patient Protection and Affordable Care Act, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 35, 47¯48 (2011) (stating that Vermont applied to CMS to become its own public managed care entity for Medicaid, and if it is approved, Vermont will be a single payer). Regarding the single-payer concept, see generally Kenneth Shuster, Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care, 10 IND. HEALTH L. REV. 75 (2013). Cf. Ann Marie Marciarille, The Medicaid Gamble, 17 J. HEALTH CARE L. & POL˘Y 55, 55 (2014) (`As passed, the ACA transformed Medicaid from an unevenly and underfunded program for the poor and disabled to a program to offer those priced out of commercial insurance markets government-funded health insurance similar to Medicare, the single-payer system for seniors and the disabled._).

175. Cf. Nat˘l Fed˘n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2604¯2605 (2012) (plurality holding that Medicaid is such a large portion of state budgets that the federal government˘s threat to withhold Medicaid funds from a state amounts to unconstitutional coercion).

176. See FLA. STAT. ANN. í 409.982(1) (West 2015) (`Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price._).

177. See Evaluation Contract, supra note 171.

F. Consumers Receiving LTSS Through Membership in a Continuing Care Retirement Community

A significant number of individuals needing LTSS receive them through membership in a Continuing Care Retirement Community (CCRC). By definition,

> CCRCs are generally residential facilities established in a campus-like setting that provide access for older Americans to three levels of housing and care: independent homes or apartments where residents live much as they did in their own homes; assisted living, which provides help with the daily tasks of living; and skilled nursing care for those with greater physical needs. Most residents must be able to live independently when they enter into a contract with a CCRC, with the intent of moving through the three levels of care as their needs change.[178]

There are several general types of contracts that a CCRC might offer to a prospective resident, each varying in terms of required entrance fee and monthly payments.[179] In Type A (often labeled extensive or Life Care arrangements), in return for a substantial entrance fee and reasonably stable monthly payments, a resident is entitled to housing, residential services, amenities, and unlimited health services.[180] The CCRC accepts the financial risk that a resident˘s need for services, and the resource cost to satisfy that need, will increase over time.[181] In Type B (a modified contract), the initial monthly payment is less for the same housing and residential amenities, but only certain health services are included, with the resident paying out-of-pocket for assisted-living or skilled nursing services that exceed the modified contract˘s coverage limits.[182] In fee-for-service (Type C) contracts, the resident˘s lower entrance and monthly fees cover independent living, but the resident is at risk to pay market rates for all health-related services needed.[183] A Type D (rental) contract involves no entrance fee but provides the resident

178. U.S. GOV˘T ACCOUNTABILITY OFFICE, GAO-10-611, OLDER AMERICANS: CONTINUING CARE RETIREMENT COMMUNITIES CAN PROVIDE BENEFITS, BUT NOT WITHOUT SOME RISK 3 (2010) (reporting on a CCRC study, which highlighted the importance of states being vigilant in their efforts to help ensure adequate consumer protections for residents. `GAO was asked to (1) describe how CCRCs operate and the risks they face, (2) describe how state laws address these risks, (3) describe risks that CCRC residents face, and (4) describe how state laws address these risks. To review these areas, GAO analyzed state statutory provisions pertaining to CCRCs with respect to financial oversight and consumer protection, met with selected state regulators, and interviewed CCRC providers, resident˘s associations, and consumer groups._).

179. Id. at 5¯6.

180. Id.

181. Id.

182. Id.

183. Id.

with guaranteed access to CCRC residential and health services, for which the resident pays a monthly fee, the amount of which depends on the living space and services needed.[184]

CCRCs have been experiencing many of the same kinds of financial risks in the past few years that have incentivized other types of healthcare providers to engage in consolidation activities, as well as risks more unique to this sector of the health industry.[185] Notable bankruptcies and restructurings have characterized the CCRC industry over the past decade.[186]

> [Most] successful CCRCs have a mission-based sponsor that also is well-heeled and capitalized. Whether it be a faith-based or a fraternal organization or the beneficiary of some other sponsor, it appears that staying power in the CCRC industry resides with those who independently have the money to continue to support the difficult margins that are being experienced . . . [187]

Consolidation in the CCRC business place might impact actual or potential consumers in a number of ways. The consumer˘s choice of CCRC would be impinged by a smaller number of these providers competing for the consumer˘s business, and access to any CCRC in a particular geographic area might be negatively affected by voluntary or involuntary closings that diminish the total number of spaces available. Scarcer available spaces could lead to less attractive contractual terms (for example, higher entrance fees and monthly payments, or less coverage) for consumers qua purchasers who are forced to compete for those finite but desirable spaces. At the same time, if consolidation puts remaining CCRCs on firmer financial footing and accordingly prevents closings and bankruptcies, the financial interests of consumers who have invested an entrance fee in a CCRC would be better protected.

IV. CONCLUSION

The current, and probably continuing, consolidation of health services providers, producers, and sellers of healthcare products, as well as third-party payers for health services and products, inevitably will exert a variety of impacts on healthcare consumers generally and within specific contexts.

---

184. Id.

185. Id. at 8˘11.

186. See generally George R. Mesires, Lessons Learned from Senior Housing Bankruptcies, 33 AM. BANKR. INST. J. 26 (2014) (describing that certain CCRCs were hit particularly hard by the recession, although the senior housing industry stayed generally resilient, and describing the challenges presented by the current economic downturn to identify and avoid future challenges in a cyclical economy).

187. Brandt & Troop, supra note 1, at 69.

Actual and potential consumers of LTSS, as well as their families, are likely to be affected in unique ways, differing to a large extent depending on the way that respective groups of consumers now finance their own LTSS. Little significant data is available yet regarding such effects, but speculation nonetheless abounds. This article joins in this basically uninformed but plausible speculation exercise but, I hope, adds constructively to the discussion by suggesting the rudiments of a health services research agenda that leads eventually to evidence-informed public policy making and private sector conduct that optimizes consolidation˘s impact on consumers˘ interests in access to, affordability of, and quality received in the realm of LTSS.