

State Approaches to Addressing the Effects of Provider Consolidation and Market Power

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Prices Are the Major Reason US Spending Exceeds the Rest of the World

- Whether as per capita spending or as percentage of GDP spent on health care
- “It's the prices, stupid: why the United States is so different from other countries.” – Anderson et al., *Health Affairs*, 2003
- *Accounting for the Cost of Health Care in the United States* – McKinsey Global Institute, 2008
 - “Input costs – including doctors’ and nurses’ salaries, drugs, and other medical supplies, and the profits of private participants in the system – explain the largest portion of additional spending... [the \$650 billion extra the US spends compared to world norms]”
- There are inconsistent findings based on categorization

Trends in Payment to Cost Ratios

- Aggregate hospital payment-to-cost ratios for private payers increased from about 115% in 2000 to about 149% in 2012
- Some evidence of slowdown in price increases recent few years

Avalere analysis of AHA Annual Survey Data, 2012, for community hospitals, AHA Trendwatch Chartbook, 2014



The Growing Difference Between Public and Private Payment Rates For Inpatient Care

- “Medical Expenditure Panel Survey” data reveal that standardized private insurer payment rates in 2012 were approximately 75 percent greater than Medicare’s – a sharp increase from the differential of approximately 10 percent in the period 1996-2001.” Selden et al., *Health Affairs*, Dec. 2015:2147
- Note that analyses commonly accept Medicare payment rates as the common reference point for hospital payment. Medicare pays about 95% of “reasonable” cost.

The MA Attorney General Study That Helped Define the Issue of High Provider Prices

“Price variations are not correlated to quality of care, the sickness or complexity of the population served, the extent to which a provider is responsible for caring for a large portion on Medicare or Medicaid, or whether a provider is an academic teaching or research facility. Moreover, price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities. ...

Price variations are correlated with market leverage as measured by the relative market position of the hospital or provider group...”

Massachusetts Attorney General. 2010. *Examination of Health Care Cost Trends and Cost Drivers: Report for Annual Public Hearing*. Office of Attorney General Martha Coakley.

And the Price Variations Are Huge

- Across 8 markets, from surveys, average inpatient rates ranged from 147% of Medicare in Miami to 210% in SF but ranged up to 500% for inpatient and 700% for outpatient care
- Within market variations were marked also – hospitals at the 25th percentile in LA County received 84% of Medicare payment levels while the 75th percentile got 184%

Ginsburg, Paul B. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." *Center for Studying Health System Change* Research Brief No. 16, 2010.

- From review of paid claims in 13 markets, the average highest priced hospital was paid 60% more than the lowest paid for inpatient services and >100% more for outpatient
- In 3 markets, the highest priced got >2X's lowest priced for inpatient care

White, Chapin, Amelia Bond, and James Reschovsky. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." *Center for Studying Health System Change* Research Brief no. 27, 2013.

Health Care Pricing Project (published Dec 2015 and covered in front page *NY Times* article)

Using data based supplied by Aetna, Humana, and UnitedHealth (27.6% of those with ESI), study found:

- Per capita spending varies by a factor of 3 across 306 Hospital Referral Areas in the US, with very weak correlation to Medicare per capita spending
- Variation in providers' transaction prices is the primary driver of spending variation for privately insured
- Large dispersion of inpatient prices and for 7 homogeneous procedures, e.g., hospital prices for lower-limb MRI vary by a factor of 12 across US and on average two-fold within HRRs
- Hospital prices in “monopoly” markets is 15.3% higher than in markets with 4 or more hospitals

The Consolidation Frame

- Many frame the pricing power problem as consolidation, supported by evidence that finds that beyond a fairly low threshold, additional size does not improve quality or efficiency – but may actually make them worse
- But this frame:
 - ignores that there are high prices enjoyed by “must haves” as well in non-consolidated markets and which don’t do M&A
 - ignores the reality of “have-nots,” which are price takers and have relatively low payments, often below Medicare
 - points to antitrust policy as the prime antidote, rather than as just one tool to address pricing issues
 - and slides over strong views about the concept of ACOs as a community-based entity of some kind featuring collaboration rather than competition

Leverage Factors Unrelated to Concentration/Consolidation

- While concentration is the main story (and a major consideration re ACOs), other factors contribute to growing provider market power over prices and contract “terms and conditions”
 - Employer rejection of narrow networks
 - Reputation
 - Geography
 - Leveraging particular “monopoly” services – sometimes fostered by understandable regulatory exclusion of market competitors

Havees and Have-Nots

- MedPAC reports that in aggregate, hospitals in private markets contract at about 140% of Medicare (different from the recent Selden article), but anecdotally, it is clear that many “must havees” obtain >250% of Medicare, and as high as 600% or more
- MedPAC also finds that commercial insurance physician fees are at about 120-125% of Medicare overall but in Miami some are at 60-70% and in a mid-west city as high as 900%
- Classic multispecialty group practices – prototypical ACOs – reportedly negotiate at levels of must have hospitals - >250% of Medicare -- but now for both physician and hospital services

Competitive ACOs or Community ACOs?: a Rarely Engaged, but Real, Disagreement

- Many ACO advocates favor a non-competitive context for ACO development (although rarely addressing how a community-wide effort addresses governance or the potential for exercise of market power), whereas mainstream economists and antitrust experts naturally want competing ACOs – “integration and rivalry”
- Further, there is no settled antitrust view on whether vertical integration in health care is generally pro- or anti-competitive, although a few recent papers suggest that formal hospital-physician integration raises physician prices significantly

“The Evolution of Integrated Health Care Strategies” by Evans et al.

- Reviews 25 years of literature in *Advances in Health Care Management* 15:125
- Shifts in integration strategies over the period have changed from:
 1. a focus on horizontal to vertical integration
 2. acute care and institution-centered models to a broader focus on community-based health and social services
 3. economic arguments for integration to emphasis on improving quality and value
 4. evaluations of integration using an organizational perspective to an emerging interest in patient-centered measures
 5. a focus on changing organizational structures to changing ways of working and influencing underlying cultural attitudes and norms
 6. From integration for all patients within defined regions to a strategic focus on integrating care for specific populations

Many Espouse “Big Medicine” Through Consolidation and Integration

- Atul Gawande, “Big Med” (*New Yorker*, Aug 13, 2012)
- Integrated Delivery Networks as the platform for assuming accountability for population health
 - Economies of scale and scope to lower admin. Costs
 - Improved care coordination and reduction in redundant care to lower cost of care delivered
 - Better access to capital for HIT and other enhancements
 - More stable environment for health professionals
 - Even better if includes the insurer function?

Unfortunately, Despite the Claims,
the Evidence Does Not Support
the Logic and Advocacy for Large,
Consolidated Systems

The Synthesis Project (Robert Wood Johnson Foundation) – Update June 2012

Summary of key findings:

1. Hospital consolidation generally results in higher prices (with new evidence since 2012 confirming these findings)
2. Hospital *competition* improves quality of care
3. Physician-hospital consolidation has not led to either improved quality or reduced costs
4. Consolidation without integration does not improve performance
5. Consolidation between physicians and hospitals is increasing (although for various reasons, including to take advantage of FFS payment rules, not only to form ACOs able to focus on population health)



High Prices Eat Low Service Use for Lunch

- Dartmouth and subsequent analyses suggest that efficient providers have service use profiles perhaps 20% lower than average – in Medicare, MedPAC finds a 30% spread across geographic areas between the 10th and 90th percentile once health status is correctly factored in
- But private insurance prices vary far more than 20-30%
- Only through a pure “bending the cost curve” lens can one consider Shared Savings or Total Cost of Care contracting based on historical costs a win. These approaches basically accept and even exacerbate wide price disparities between haves and have-nots.

Why Antitrust Policy Focused on Consolidation Can't Be the Only or Even the Primary Policy Focus

- Many local markets can't readily support competition among major health care providers
- There are many reasonable, practical reasons for consolidations to take place, and some may improve quality and efficiency in particular situations -- but they can also lead to market power with increased prices as a derivative of the new, worthy arrangement

“While the antitrust agencies’ efforts to promote and protect competition in health care markets is commendable, it is also the case that the antitrust law has little to say about monopolies legally acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in hospital markets and a growing number of physician specialty markets, it is particularly important other measures that promote competition.”

– Professor Thomas (Tim) Greaney, Testimony to the Committee of the Judiciary, House of Representatives, May 18, 2012

Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets

A Report of the National Academy of Social Insurance

April, 2015

NASI Report Policy Options on a Continuum from Market-oriented to Classically Regulatory

- Encouraging market entry of competitors
- Greater price transparency
 - Collecting and reporting all-payer claims data
 - Supporting price conscious consumers
- Limiting anticompetitive health plan-provider contracting provisions
- Harmonizing network-adequacy requirements and development of limited provider networks
- Active purchasing by public payers

Policy Options (cont.)

- Improved Antitrust Enforcement
 - Scrutiny of hospitals and insurers with market power
 - Active review of vertical mergers
 - Conduct remedies and post-merger monitoring
- Additional public oversight and review
- Regulating Premium increases thru rate review
- Limiting out-of-network provider charges
- Setting upper limits on permissible, negotiated rates
- Expanding the use of all-payer and private-payer rate setting

Classification of State Policies Addressing Provider Market Power (From Catalyst for Payment Reform)

The report produced a catalogue of laws to enhance market competition or substitute for it

- Antitrust related laws
- Laws and regulations:
 - encouraging transparency on quality and price
 - encouraging competitive behavior in health plan contracting
 - implementing the monitoring or regulating of prices
 - around the development of ACOs
 - expanding the authority of Departments of Insurance
 - facilitating or reducing barriers for new entrants to the market

State Examples

- CA prevents providers' ability to suppress price information
- MA has created the Health Policy Commission which among other things conducts a “cost and market impact review” to monitor material changes by provider organizations
- MA bans carriers from entering contracts that limited tiered networks or guarantees a provider's participation
- MI (and other states) explicitly bar insurers from using “most favored nation” clauses in provider contracts

State Examples (cont.)

- RI Office of the Insurance Commissioner has been granted broad authority to hold health insurers accountable for fair treatment of providers, and to direct insurers to promote improved accessibility, quality, and affordability, giving them the ability to review and approve payer-provider contracts
- Texas defines a “health care collaborative” (ACO) and requires them to obtain a certificate of authority from the DOI and AG concurrently. The latter reviews whether the ACO is likely to reduce competition and whether it should be permitted