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Seeking Lower Prices Where Providers Are Consolidated: An Examination Of Market And Policy Strategies

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ABSTRACT The ongoing consolidation between and among hospitals and physicians tends to raise prices for health care services, which poses increasing challenges for private purchasers and payers. This article examines strategies that these purchasers and payers can pursue to combat provider leverage to increase prices. It also examines opportunities for governments to either support or constrain these strategies. In response to higher prices, payers are developing new approaches to benefit and network design, some of which may be effective in moderating prices and, in some cases, volume. These approaches interact with public policy because regulation can either facilitate or constrain them. Federal and state governments also have opportunities to limit consolidation's effect on prices by developing antitrust policies that better address current market environments and by fostering the development of physician organizations that can increase competition and contract with payers under shared-savings approaches. The success of these private- and public-sector initiatives likely will determine whether governments shift from supporting competition to directly regulating payment rates.

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Consolidation within the health care industry is a double-edged sword: The integration of hospitals, physicians, and others across care settings has the potential to improve clinical quality and increase efficiency, but the consolidation of practices can also increase providers' market power and thus their ability to command higher prices.¹ Even before the enactment of the Affordable Care Act (ACA) in 2010, the tendency for health care providers to merge and affiliate with each other was increasing.² Since then, the pace of consolidation has quickened. The ACA's payment reform provisions, such as those related to accountable care organizations (ACOs) and bundled payment, have sent strong signals to providers to pursue clinical integration. Some of the desired integration

can be achieved without mergers. Nonetheless, hospital mergers in 2010–12 increased by 25 percent, compared to 2007–09.²

This article takes the perspective that moving the health care delivery system away from volume-based, fee-for-service payment is critical and that additional consolidation is inevitable. We examine both strategies that private purchasers and payers can pursue to combat providers' leverage to increase prices and opportunities for governments to either support or constrain these strategies. We also review options for governments to limit consolidation or regulate prices directly. The online Appendix summarizes the approaches considered in this article.³

Consolidation And Prices

Health care spending growth has moderated in recent years, primarily because of slower growth in the use of health care services. But providers' prices have continued to rise, and price increases now account for most spending growth for people with private insurance. For example, the Health Care Cost Institute, which monitors spending by private payers, reported that in 2012 per capita spending for inpatient care increased by 2.4 percent overall, with a 5.7 percent increase in unit prices, a 3.1 percent decline in use, and a small increase in intensity of care.⁴

Increasing employment of physicians by hospitals also contributes to growing market clout for providers. If a hospital employs physicians, it increases its leverage in negotiating with health plans for payments for both hospital and physician services.⁵ The advent of ACOs has fueled even greater hospital interest in acquiring physician practices to pursue clinical integration. In theory, engaging physicians in coordinated care works better with employed physicians than with those whose relationship with the hospital consists only of admitting privileges.

Other forces pushing providers to consolidate include regulatory and market requirements that hospitals and physicians report quality measures and meet meaningful-use criteria for information technology. Complying with these requirements is likely to be very challenging for physicians in small practices and for small independent hospitals, because the fixed costs are large in relation to these providers' revenues.

In addition, there is intense concern about reimbursement, particularly among physicians—whose rates have been constrained under the frequent “fixes” applied to the Medicare Sustainable Growth Rate formula. Likewise, hospitals face substantial downward pressure on Medicare payment rates under the ACA. Numerous conferences reflect the beliefs of many hospital and physician leaders that the future will require extensive capabilities to coordinate care; report on its quality; and conduct highly complex contracting with payers, including assuming some financial risk for the efficient delivery of patient care.

There are growing concerns among private purchasers and payers about the link between provider consolidation and rising prices. Nonetheless, we believe that if the United States is to achieve more efficient and higher-quality delivery of care, some additional provider consolidation is necessary. We believe that the nation must pursue these changes while limiting the degree to which the accompanying consolidation leads to higher health care prices.

The challenge is to maximize the positive ben-

efits of clinical integration while minimizing the negative effects of consolidation. Acknowledging that provider consolidation is likely to accelerate, we examine eight strategies to promote greater competition on price and quality via private-payer initiatives, bolstered where necessary by various types of regulation. These approaches are summarized in the online Appendix.³

It is common for free-market economies to be regulated in such areas as product quality, enforcement of contracts between private parties, disclosures, fraudulent behavior, and price fixing. People may disagree about how extensive regulation should be. However, the necessity of regulation in market economies was outlined years ago by the noted conservative economist Milton Friedman: “The existence of a free market does not of course eliminate the need for government. On the contrary, government is essential both as a forum for determining the ‘rules of the game’ and as an umpire to interpret and enforce the rules decided on.”⁶

Thus far, the market response to the increase in providers' leverage has been limited and largely ineffective. Most current health insurance benefit designs undermine market responses to high prices by diluting or eliminating incentives for consumers to seek providers that charge relatively low prices.

Even the proliferation of high-deductible plans appears unlikely to lead patients to choose in-network hospitals that cost less than others, because the total cost of most hospitalizations will exceed the deductible. Thus, a high deductible may discourage some elective hospitalizations or procedures. But it is not likely to be effective in influencing consumers' choice of hospitals for inpatient care. Instead, high-deductible plans are more likely to influence the choice of providers for outpatient procedures. For example, patients may prefer freestanding imaging centers or surgical centers to more-expensive hospital outpatient departments. But for this to happen, enrollees will need information on prices specific to their health plan and perhaps information on quality as well.

Insurers' Information On Provider Price And Quality

Major national private insurers are developing information systems that can provide patients with “real time” estimates of out-of-pocket costs for a given service based on their benefit structure.⁷ Armed with the status of their deductibles and other cost-sharing requirements, patients may become more price conscious when choosing providers for routine care. Some large employers are making efforts to inform their em-

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ployees about network prices for providers in the area. Massachusetts has gone a step further by requiring insurers serving state employees to have real-time price information for each network provider available to enrollees.

Effective approaches to price transparency must also include better information on provider quality. Studies indicate that in the absence of information about quality, patients tend to use price as a proxy for quality and act on the belief that higher prices imply higher quality.⁸

Limited Provider Networks

During the 1990s many insurers limited provider networks, especially for health maintenance organization (HMO) products, to obtain lower prices. This approach was abandoned in response to consumer backlash. Limiting consumers' choice of providers as a cost control strategy is returning. However, insurers are now using more sophisticated measurements of cost (focused on broader units of output and with better adjustments for case-mix) than in the past. The measurements also incorporate quality, typically by requiring providers to achieve a specified level to be included in the limited network.

The experience with Medicare Advantage plans is instructive. Many of these plans have limited networks. Nonetheless, more than one in four Medicare beneficiaries are in one of the plans, primarily because their benefits typically are more generous than those in traditional Medicare and premiums are generally lower than those for a supplemental policy.

Insurance products with such limited networks can offer lower premiums both because they exclude high-price providers and because they can negotiate lower rates with some providers. Indeed, many insurance plans being sold through the ACA's insurance exchanges, or Mar-

ketplaces, offer limited provider networks because many people who purchase coverage in the exchanges will be very sensitive to differences in premiums.

However, the potential savings from limited-network products could be limited if either exchanges or state agencies regulate network adequacy in an overly aggressive manner. The wide choice of plans that many exchanges offer would argue for less stringent regulation than is the case with employer-sponsored coverage, where there tends to be limited or no choice of health plans. However, regulation will still be required as a basic consumer protection and to prevent any attempts by plans to discourage people with chronic illnesses from enrolling by making the network unattractive to them.

The extent to which consumers who choose limited-network plans are happy with their choices after the fact will also help determine how large a role this approach plays in the future.

Point-Of-Service Incentives

Patient incentives relating to provider choice can occur at the point of service (for example, through differences in deductibles or copayments by provider) or at the point of enrollment (as is the case with limited-provider networks). Plans that provide incentives at the point of service are designed to appeal to consumers who place a high value on broad choice of providers. People who enroll in plans with point-of-service incentives avoid limited-network plans' lack of access to some providers for a full plan year.

TIERED BENEFITS Prescription drug benefit design has long emphasized the point-of-service approach. Tiered formularies—in which all drugs within a therapeutic class are covered, but in which each tier has different cost sharing—are far more popular with employers and employees than closed formularies—in which drugs not in the formulary are not covered at all. Similarly, in point-of-service plans for medical services, hospitals, physicians, and other providers can be put into tiers according to their costliness and level of quality, with different patient cost sharing for each tier.

This approach can be refined. For example, hospitals might be assigned to tiers not for all services but for different service lines. Thus, a hospital might be in a more desirable tier for cardiac procedures than it is for orthopedics. Because many quality measures apply to specific service lines, such as hospital infection rates for different types of surgery, this arrangement would increase patients' opportunities to make use of information about providers' quality. Needless to say, assigning hospitals to tiers on

the basis of service lines would increase the challenge of effectively communicating the relevant information to consumers.

Compared to limited-network products, tiered benefit designs impose less restriction on patients' choice of providers but have not become as prevalent for hospital services. Multiple factors might be behind this trend, including the additional complexity of designating which hospitals are in which tiers and communicating this information to enrollees; the larger premium reductions that limited-network plans can offer, compared to tiered benefit plans; and hospitals' resistance to contracting with insurers under these terms. Numerous insurers have reported to me that prominent hospitals or those that fill critical geographic or specialty service niches have demanded to be placed in preferred tiers for all services as a condition of contracting with a plan. To the degree that high-cost hospitals must be included in the preferred tier, the approach is not workable.

Responding to hospital systems' refusal to contract with insurers because of their tier placement, Massachusetts enacted legislation in 2010 that prohibited the practice.⁹ Subsequently, Blue Cross Blue Shield of Massachusetts modified a product for the small-group market—generally defined as the market for companies that have fewer than a hundred employees—by including variable hospital deductibles of \$0, \$500, or \$1,000, depending on a hospital's tier. The highly regarded but high-price Massachusetts General Hospital was placed in the least-preferred tier.

REFERENCE PRICING A more aggressive and focused version of tiered benefit designs is reference pricing. This approach identifies specific procedures, such as hip or knee replacement or imaging studies, and designates which providers have met the pricing requirement (the reference price) and quality criteria so that additional payments—beyond applicable patient cost sharing according to the benefit design—are not required. Enrollees who choose other providers for these services are responsible for amounts above the reference price.

The California Public Employees' Retirement System, in conjunction with Anthem Blue Cross, is using this approach for hip and knee replacements and for selected outpatient procedures—colonoscopy, cataract surgery, and arthroscopy—that are commonly performed in both free-standing facilities and hospital outpatient departments.¹⁰ Patients treated in hospital outpatient departments pay the difference if the hospital price is higher than that paid to free-standing facilities.

APPLYING POINT-OF-SERVICE INCENTIVES Tiered designs and reference prices can be sup-

Steering patients to providers with lower prices generates savings directly for the purchaser or health plan, but there could be market-level impacts and savings as well.

ported by sophisticated analyses of claims data by insurers or large employers, which then draw conclusions about the relative cost and quality of each provider. For example, they can measure spending per episode instead of using unit prices for services.

However, some medical societies have complained that providers' assignment to tiers has not been sufficiently refined.¹¹ Tiered designs present relatively simple incentives to patients and are less transparent, but potentially more useful, than providing them with extensive lists of negotiated providers' prices for many different services.

Steering patients to providers with lower prices generates savings directly for the purchaser or health plan, but there could be market-level impacts and savings as well. For example, some providers will be at risk of losing significant volume to their lower-cost competitors. This could lead to competition over price among providers. And in markets where there are fewer insurers, this additional impact is more likely to be achieved because providers would risk larger losses of patients.

All-Payer Claims Data On Providers

Private insurers' assessments of individual providers' cost and quality are often hindered because the insurer has too few claims per provider. This can make the assessments unreliable and lead to the assessments' loss of credibility with providers.

Insurers, consumer advocates, and journalists have long pushed for Medicare to give the public access to physician claims files that identify the provider, but not the patient. Combining Medi-

Some private payers are fostering the development of physician organizations that are capable of risk-based contracting.

care claims data with private-payer claims would allow more-meaningful assessments of providers' performance on quality and cost metrics. The ACA directs the Centers for Medicare and Medicaid Services (CMS) to provide Medicare data to "qualified entities." However, implementation of this provision has been very restrictive: Only seven qualified entities have been designated to date. Recently, however, in response to a judicial decision, CMS announced that it will shortly provide payment data from identified physicians to the public—potentially a major step in this direction.¹²

A number of states are developing all-payer claims databases and requiring insurers to submit data. In theory, these databases could allow payers to access additional provider claims data, which would permit them to make more-robust assessments of providers' efficiency and quality. But only a few of those states developing the databases have the technical capability to provide such access, and few of them actually provide it (Deborah Chollet, senior fellow, Mathematica Policy Research, personal communication, 2013 May 7).

Supporting The Development Of Physician Organizations

Organizational change is another way to expand the potential for provider payment reform. Whether physicians deliver health care through medical group practices or independent practice associations or as employees of hospital systems can have major effects on prices. Physician organizations that assume risk and contract directly with payers are potential competition for hospital-led ACOs. In addition, these organizations have stronger incentives than hospital-employed physicians have to limit hospital admissions, admit patients to lower-price hospitals instead of

higher-price ones, and steer patients who are having outpatient procedures to less-expensive freestanding facilities instead of to more costly hospitals.

PRIVATE PAYERS' ACTIONS Perceiving the implications for prices, some private payers are fostering the development of physician organizations that are capable of risk-based contracting. Payers' efforts have ranged from providing advice and financial assistance to such organizations—for example, subsidizing the implementation of electronic health record systems by medical practices, especially primary care practices—to purchasing large physician practices. The type of approach is market-specific and depends on a plan's market share and the organization of physician practice in the community.

For example, Maryland-based CareFirst Blue-Cross BlueShield operates in a market in which large, regionally dominant hospital systems are actively acquiring physician practices. Through its patient-centered medical home initiative, the insurer is seeking to build independent networks of primary care physicians by raising payment rates for participating practices and by offering additional incentives for quality improvement and overall cost reductions.¹³

A novel feature of this upside-only incentive is that small primary care practices are encouraged to form "pods" of ten or more physicians who can share data on quality (such as mammography screening rates) and cost (such as adjusted cost per case). Physicians in a pod receive financial bonuses when the pod's overall performance on total cost per patient improves. The opportunity to receive such bonuses makes it more attractive for physician practices to remain independent of hospitals—which, in turn, makes it more expensive for hospitals to acquire those practices.

Other insurers have used grants, loans, and contract modifications to encourage physician practice integration, especially among primary care physicians. In many cases, plans foster information sharing by assisting in the development of health information exchanges. For example, in selected areas, Blue Cross Blue Shield of Michigan, UnitedHealth Group, and Aetna either have implemented or support organizations that engage in data sharing and have provided incentives for improvement in quality and efficiency and for physician group development and participation in data-sharing programs.¹⁴

GOVERNMENTS' ACTIONS Governments can also encourage physician organizations to contract as ACOs. One such approach—the CMS Advance Payment ACO Model¹⁵—allows selected practices that qualify for the Medicare ACO shared-savings program to apply to receive advance payments that the practices can then in-

vest in infrastructure and efforts to improve care management. The advance payments can be repaid over time from future earned shared savings.

Because obtaining credit is often a challenge for physician organizations, governments could provide either direct loans or loan guarantees to such organizations that seek to contract as ACOs with public or private payers. A precedent for this is the federal government's support of fledgling HMOs in the 1970s, which likely played an important role in developing those organizations. A more recent example is the ACA's authorization of no-interest loans to nonprofit insurance co-ops so that they can offer plans on the insurance exchanges.

However, a different long-standing Medicare payment policy inadvertently encourages hospitals to employ physicians. Medicare generally pays higher rates for physician services delivered in hospital outpatient settings, compared to services provided by independent physician practices. This is because hospital practice expenses are generally higher than those of independent practices, even though many hospital-employed physicians practice outside of the hospital grounds. One noteworthy example is Medicare's payment for physician-administered drugs, in which markups are highly constrained in independent medical practices but less so in hospital outpatient departments.

The Medicare Payment Advisory Commission, which has long recommended that payments for nonemergency physician visits to hospital outpatient departments should not exceed the rates in the physician fee schedule, recently expanded its recommendation to cover a broad range of nonemergency services.¹⁶

Limiting Increases In Provider Consolidation

A key factor that influences the extent of provider leverage is the extent of consolidation. Market forces are encouraging consolidation because providers see a direct connection between it and increased leverage, and because they perceive some types of consolidation as being integral to achieving increased clinical integration.

BENEFITS OF CONSOLIDATION In general, antitrust enforcement actions that prohibit certain mergers and price fixing can lead to more favorable market outcomes for consumers. But with the growing emphasis on clinical integration as a way to improve patient outcomes and increase efficiencies, providers have made powerful arguments to the antitrust authorities about the societal benefits of mergers.

Reflecting the trend toward advances in mea-

The Federal Trade Commission will need to develop additional policies related to hospitals' acquisition of physician practices.

asuring quality and cost at the level of a geographic area, some analysts have advocated conditional approvals of consolidation that are subject to demonstration that the public has benefited through reductions in costs or improvements in quality.¹⁷ But mergers later judged not to have benefited the public are difficult to undo. Therefore, such performance criteria may have to be accompanied by state monitoring of mergers' impacts and the potential for regulation of rates in cases where mergers have not delivered the expected benefits.

The Federal Trade Commission will need to develop additional policies related to hospitals' acquisition of physician practices. The traditional approach to such an acquisition is to examine the impact on the degree of concentration in the physician market. But such consolidations, as discussed above, also have implications for hospital prices and competition and the potential for payment reforms to increase the value of care.

JOINT CONTRACTING An emerging issue in antitrust policy is the regulation of joint contracting between multiple health care providers and a single payer. For example, since the 1990s the Federal Trade Commission and the Department of Justice have offered a "safe harbor" from prosecution for price fixing to physician organizations that are "clinically integrated" but do not share risk. This means that selected independent practice associations can contract on behalf of their member physicians with payers on a fee-for-service basis.

But this policy may be too permissive in today's environment. Since the safe harbor policy was established, the degree of provider consolidation has increased substantially. In addition, opportunities for providers to contract with payers under approaches that involve limited risk, such as ACOs and bundled payments, have mushroomed.

Some analysts have recommended limiting the safe harbor to contracting arrangements involv-

Many analysts doubt that market approaches will manage to constrain spending sufficiently.

ing providers that bear risk and that report cost and quality data to the Federal Trade Commission.¹⁷ Continued protection under the safe harbor would be contingent on demonstrated benefits in terms of quality and costs.

Limiting Charges For Using Out-Of-Network Providers

Governments also have acted to limit physician and hospital charges in situations where consumers are not likely to be able to choose their providers. For example, West Virginia prohibits additional charges to HMO enrollees for emergency care (both hospital and physician charges), with the HMO responsible for paying only the network rate.¹⁸ Some analysts might consider such regulation to be contrary to market forces. However, we view it as a regulation that supports network contracting between providers and insurers by reducing incentives to providers to eschew network contracts.

Government limits on charges for out-of-network care could be applied more broadly. CMS has long applied such limits to Medicare Advantage, prohibiting hospitals and physicians outside of a plan's network from charging enrollees higher rates than are permitted under traditional Medicare.¹⁹ These limits on charges for out-of-network care bolster the plans' ability to contract with hospitals and physicians at rates that are not greatly in excess of traditional Medicare payment rates.

Governments could use a similar approach to address situations in which health care markets are too consolidated for market approaches to be very effective. Out-of-network payment rates could be limited to a percentage of Medicare rates—for example, 150 percent. The limit would not apply to contracts between insurers and providers but would have an important influence on rates negotiated in those contracts.

In some cases, this approach would require a major change in mind-set on the part of some state governments. For example, in an attempt to

protect consumers, New Jersey requires insurers to pay substantially higher rates for out-of-network care than they pay for network care.²⁰ A ceiling on what providers can charge for out-of-network care likely leads to lower in-network rates. However, a floor for out-of-network rates undermines providers' incentives to participate in the network, which negatively affects consumers.

Another approach that may increase payers' leverage over providers is regulatory constraints on health insurance premium increases in the small-group market. Massachusetts has imposed stringent limits on such rate increases since 2010. Observers believe that this led to increased payer resistance to providers' demands for rate increases.²¹ Rhode Island also has pursued this approach.

Direct Regulation Of Payment Rates

To the degree that competition fails to increase in response to the measures discussed above, policy makers—most likely at the state level—may consider regulation in the form of provider rate setting. An important policy in a number of Northeastern states in the 1970s, rate setting is in force today only for hospitals in Maryland and West Virginia.²² Maryland regulates rates for all payers, including Medicare (through a waiver from CMS). West Virginia, which adopted its policy in the 1980s, regulates only hospital rates charged to commercial payers.

Studies have provided strong and consistent evidence that rate setting slowed aggregate total hospital spending in Maryland, Massachusetts, New Jersey, New York, and Washington.²² However, most states abandoned the policy in response to at least three trends: Medicare's implementation of its inpatient prospective diagnosis-related group payment system, which constrained hospital costs; the rise of managed care; and a broad philosophical shift toward deregulation.²³ A national rate-setting policy may not be politically feasible at this time. However, rate setting could surface in those states more inclined toward regulation and where provider market concentration is highest.

Rate setting is a highly complex activity because of differing cost structures of hospitals and differing burdens of uncompensated care. Applying rate setting to all payers involves dealing with one complexity that was far less significant in the 1970s: namely, sharply different rates paid by commercial insurers, Medicare, and Medicaid. For rate setting to be feasible, such differences across payer types would have to be narrowed only over a very long period, if not maintained indefinitely.

Another challenge for rate setting is that provider payment reforms seek to incorporate services from multiple providers, including hospital outpatient services, physician services, post-acute services, prescription drugs, and inpatient care. But rate setting has tended to be limited to inpatient and outpatient hospital services, and expanding its reach to additional services may not be politically feasible in most states.

Maryland began to address this problem by welcoming ACO and bundled-payment contracting and offering speedy reviews of such contracts to ensure that hospital payments were in compliance with rate limits.²⁴ Presumably higher revenues could be allowed if they were achieved through shared savings, meaning that they were coming from lower rates of admission or from less use of postacute care.

Maryland will be pursuing further payment reforms as part of its recent agreement with CMS on an extension of the state's Medicare waiver, which allows Medicare payment to follow Maryland's rules. According to a recent press release, "Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate. Maryland will limit all-payer annual per capita hospital growth, including inpatient and outpatient care, to 3.58 percent, below historical trends. Maryland will also limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year for 2015–2018."²⁵

The challenge facing Maryland will be to transform a regulatory system that has historically focused on unit prices so that it achieves reductions in overall per capita spending on hospital services. Physicians will be important in achieving this goal, but their rates are outside the jurisdiction of the program.

Next Steps

With provider consolidation likely to continue, policy makers will need to pursue more vigorously either market approaches bolstered by regulation or direct regulation of prices—or some combination of the two—to counteract provider pricing power. This article devoted more attention to market approaches than to direct regulation because policy makers appear inclined to pursue the former before contemplating the latter. Many market approaches are nevertheless highly intertwined with public policies.

How effective market-oriented approaches will be at mitigating provider price increases is uncertain. Their effectiveness will undoubtedly vary because of market structure, degree of plan and provider concentration, the nature of state regulation, and their acceptance by employers and consumers.

Consumers tended not to respond favorably to limits on their choice of providers during the 1990s. However, a number of factors could lead to a more favorable reaction now. For one thing, the approaches are more sophisticated and give greater weight to consumers' ability to choose and to their preferences. Another factor is that the cost of health insurance—both premiums and out-of-pocket spending for covered services—is now much higher in relation to personal incomes than in the 1990s, so the luxury of eschewing cost containment is now out of reach for more people. The sluggish economic outlook and softer labor markets today, compared to the late 1990s, also could foster greater acceptance of limits.

However, many analysts doubt that market approaches will manage to constrain spending sufficiently. Should these approaches fail to mitigate the effects of provider consolidation, more overt forms of government intervention, including rate setting or direct provision of coverage, will be likely. ■

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