Provider Consolidation and Price Variation: A National Perspective

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The Presentation Will:

- Establish the importance of prices as a primary driver of excessive spending
- Explore consolidation as one -- but not the only – reason for pricing power and price variations
- Review the evidence about the impact of consolidation on cost and quality
- Present an overview of policy options to address high and variable prices, with emphasis on states
- Discuss whether payment reform is part of the problem or part of the solution

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]"

Trends in Payment to Cost Ratios

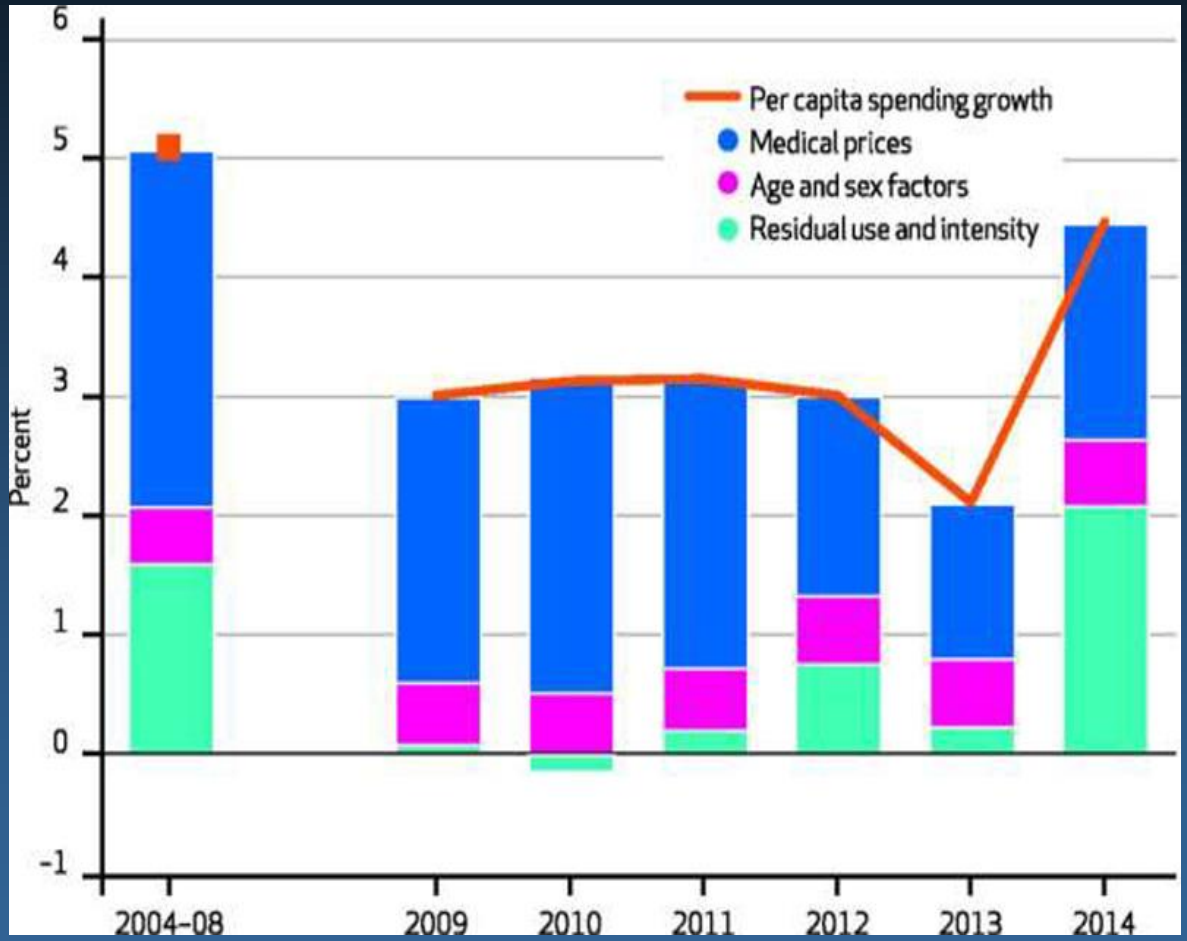
- Aggregate hospital payment-to-cost ratios for private payers increased from about 116% in 2000 to 144% in 2014 (was up to 149% in 2012 from 135% in 2011)

  AHA Annual Survey Data for Chart 4.6, for 2014, *AHA Trendwatch Chartbook,* 2016

- Some evidence of a slowdown in price increases in recent years, although some discrepancy in data sources used, i.e., whether Medicare Advantage is included
- "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."

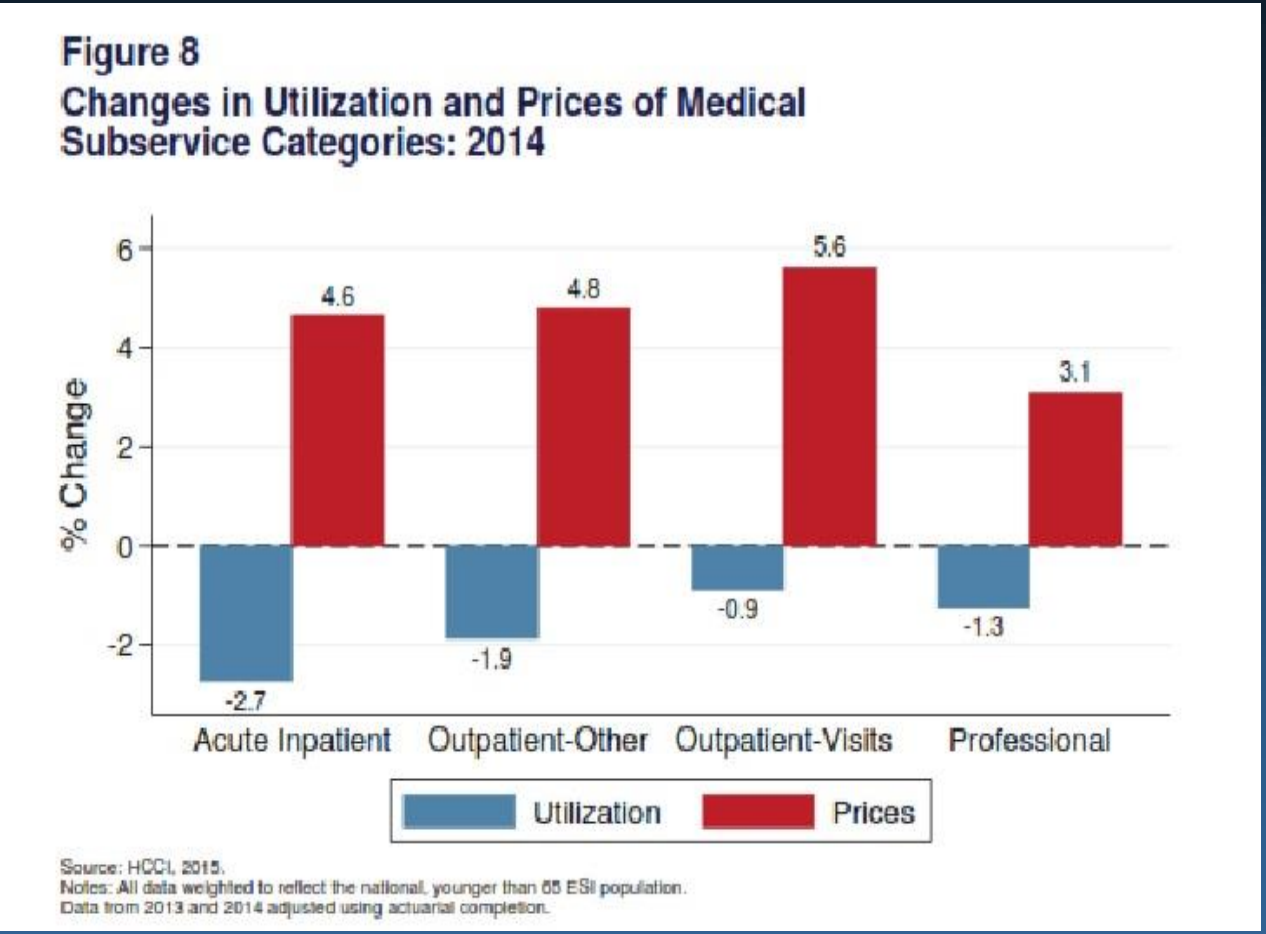
Selden et al., Health Affairs, Dec. 2015:2147

Factors Accounting for Growth in Per Capita National Health Expenditures, 04-14



Martin AB, Hartman M, Benson J, Catlin A; National Health Expenditure Accounts Team. "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending." *Health Aff (Millwood).* 2016 Jan; 35(1):150-60

Changes in Utilization and Prices of Medical Subservice Categories: 2014



"2014 Health Care Cost and Utilization Report." ***Health Care Cost Institute, Inc.,*** **Oct. 2015. Available online at: http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report**

The Price Variations Are Huge and Persistent

- 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. "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 priced for inpatient services and >100% more for outpatient
- In 3 markets, the highest priced got >2X's lowest priced for inpatient care

  White, Bond, and Reschovsky. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." Center for Studying Health System Change Research Brief no. 27, 2013.
- MA Commission found hospital price variations consistent since 2010 and increased somewhat for physicians since 2009

"The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured"

Using HCCI data based supplied by Aetna, Humana, and UnitedHealth (27.6% of those with ESI), Cooper et al (Dec 2015) found:

- Per capita spending varies by a factor of 3 across 306 Hospital Referral Areas, 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 are 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

Haves and Have-Nots

- While hospitals receive 175% of Medicare on average, anecdotally, it seems clear that many “haves” obtain >250% of Medicare, and as high as 500-600%
- But other hospitals accept even less than Medicare rates, because they have few commercially insured patients and are rarely if ever must haves in commercial insurance networks
- MedPAC finds that commercial insurance physician fees are at about 120-125% of Medicare overall but, anecdotally, in Miami, Las Vegas, and other places, physicians are “price takers,” accepting 60-70% of Medicare fee schedule rates, while in an unnamed mid-west city rates can be as high as 900%

The RWJF Synthesis Project

The Impact of Hospital Consolidation– 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 fast increasing (although for various reasons, including to take advantage of FFS payment rules, not only to form ACOs able to receive population-based payments)

Why Antitrust Can't Be the Only or Even the Primary Policy Lever

- Many local markets can't readily support competition among major health care providers
- There are often justifiable, 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
- The horse is out of the barn, after two major eras of hospital merger "mania"

"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

Or other public policies that are more regulatory in nature

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
  - Eliminate scope of practice restrictions, AWP laws, CON
  - Policies to support telehealth adoption, alternative sites of care
- Greater price transparency (and quality)
  - Two different purposes: 1) to shine a spotlight on the problem, 2) to facilitate consumer choice when significant out-of-pocket payment obligations
  - Collecting and reporting all-payer claims data (now made more difficult because of Supreme Court's Gobeille ruling)
- Active purchasing by public payers
  - With hoped-for spillover to other product markets

Policy Options (cont.)

- Limiting anticompetitive health plan-provider contracting provisions
  - e.g., anti-tiering, all-or-none contracting, most favored nations clauses
- Harmonizing network-adequacy requirements with development of limited provider networks
  - While addressing out-of-network “surprise” bills
- Improved Antitrust Enforcement
  - Scrutiny of hospitals and insurers with market power
  - Active review of vertical mergers, based on recent evidence of anticompetitive effects
  - Conduct remedies and post-merger monitoring?

Policy Options (cont.)

- State-based oversight
  - Across the states doing this, there is significant variation in what state commissions are doing and whether they have regulatory authority
- Formal insurance rate review
  - Moving from “file and use” to “prior approval” and medical loss ratio requirements
  - Variations across states in which insurance products subject to review
  - Unsettled whether this approach creates necessary leverage for plans or whether also need direct authority over plan-provider (hospital) contracts, esp. re prices

Policy options (cont.)

- Limits on out-of-network billing as a way to constrain negotiating leverage between plans and providers
- Setting upper limits on permissible, negotiated rates
  - Or focus regulatory limits on health systems that exceed a threshold of consolidation
- Expanded use of all-payer or private payer rate setting, a la Maryland and West Virginia, respectively

NASI Did Not Include Payment Reform As One of the Options

- The greater concern is that some payment reforms would increase pricing power and price differentials
- "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,"
  Berenson, Ginsburg, and Kemper. *Health Affairs,* April, 2010
- Indeed, policy analysts, such as Michael Porter, argue that "focused factories" receiving bundled episode payments for treatments and conditions are preferred over integrated systems receiving population-based payments, partly because of less concern about market power raising prices

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 if health status adjustments are included
- But private insurance prices vary by far more than 20-30% -- perhaps 100% between the 10th and 90th percentile in many markets
- 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 can even exacerbate wide price disparities between "haves" and "have-nots."

How Payment Design Can Affect Prices in Commercial Market Products

- Essentially, whether or not providers' historic costs are the basis for target spending
  - In calculating benchmarks for determining whether shared savings
  - In setting hospital global budgets a la Maryland, where there actually is substantial price variation by hospital, but much less so by patient and payer
  - In pricing a bundled episode
- Using historic costs without adjustments "bakes in" historic pricing differentials, but some approaches to updates can narrow differences over time

Options for Balancing Provider Specific, Historic v. Community Average Prices

- Medicare ACOs get an absolute dollar rather than a percentage trend update (so higher cost providers get a lower percentage update)
- Blend and transition benchmarks from historic toward the average -- but maybe not all the way
  - In Medicare IPPS, 4 yr. transitional blend from actual cost per case to national, standard cost per case
  - In Medicare Advantage, there are 4 different benchmarks based on level of per capita spending in traditional Medicare
  - All-payer rate setting states in ‘80s had transitional blends
- Can vary shared savings percentages in relation to the level of historic, baseline spending

Classification of State Policies Addressing Provider Market Power

(Catalyst for Payment Reform, for NASI)

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

Examples of State Actions to Address Consolidation and Pricing

- 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, and 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

Some Useful Papers and Reports

- Gaynor and Town. *The impact of hospital consolidation—Update.* The Synthesis Project. Robert Wood Johnson Foundation, June, 2012. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261
- Office of the Health Insurance Commissioner State of Rhode Island. V*ariations in Hospital Payment Rates by Commercial Insurers in Rhode Island.* December, 19, 2012. Available at: http://www.ohic.ri.gov/documents/Hospital-Payment-Study-Final-General-Dec-2012.pdf
- Delbanco and Bazzaz. *State Policies on Provider Market Power.* National Academy of Social Insurance, Washington, D.C., July, 2014. Available at: https://www.nasi.org/sites/default/files/research/State_Policies_Provider_Market_Power.pdf
- NASI Panel on Pricing Power in Health Care Markets. *Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets- The Final Report.* National Academy of Social Insurance, Washington, D.C., April 2015. Available at: https://www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf
- Berenson. *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust.* Journal of Health Politics, Policy and Law, Vol 40, No. 4, June, 2015. Available at: http://jhppl.dukejournals.org/content/early/2015/06/09/03616878-3150026.abstract
- Murray and Berenson. *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* The Urban Institute, Washington, D.C., November, 2015. Available at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000516-Hospital-Rate-Setting-Revisited.pdf
- Cooper et al. *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured.* The National Bureau of Economic Research, NBER Working Paper No. 21815, December, 2015. Available at: http://www.nber.org/papers/w21815

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