CATALYST FOR PAYMENT REFORM

Ensuring Competitive Markets For Health Care Services

Action Brief

INTRODUCTION

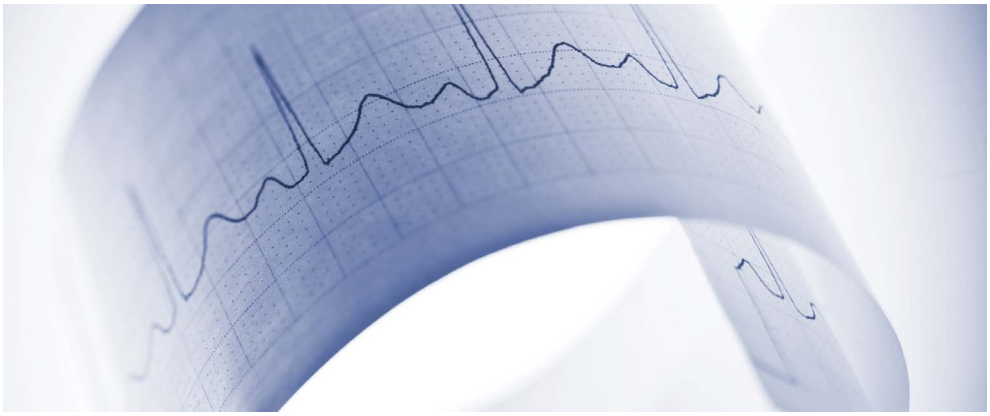
Basic economic theory predicts that competition—occurring when many parties sell similar goods and services—lowers prices and improves quality, as sellers must compete against one another. In cases where no competition exists and there is one dominant seller, a monopoly, or in cases where little competition exists, such as an oligopoly, prices are generally higher and the seller can essentially set and control the price. Despite a slowdown in health care spending in 2009 and 2010, recent projections by the Congressional Budget Office show spending on health care services will increase to 20 percent of Gross Domestic Product by 2020.[i] With employers footing the bill for the nearly 50 percent[ii] of Americans enrolled in employer-sponsored insurance today, representing approximately 21 percent[iii] of the nation's overall health care spending, the unsustainable growth of health care costs is a critical concern. Employers and others who purchase health care are interested in seeing sufficient competition in health care markets among doctors, hospitals and other providers, to help ensure the price of care remains in check while maintaining or ideally improving quality.

IS THERE SUFFICIENT COMPETITION AMONG HEALTH CARE PROVIDERS IN THE U.S.?

Health care markets throughout the United States are becoming less competitive as health care providers continue to consolidate.[iv] Over the past two decades, hospitals in the United States have become highly concentrated as they have shifted away from independent status and merged with other competing facilities, or integrated with multi-hospital systems. By 2006, over 75 percent of U.S. metropolitan statistical areas (MSAs) had experienced enough provider consolidation to be considered "highly consolidated."[v] From 2007 to 2012, 432 hospital mergers and acquisition deals were announced, involving a total of 835 hospitals.[vi] The U.S. health care market has become less competitive as consolidation among health care providers has increased, leaving the market vulnerable to increases in prices by dominant providers without a corresponding increase in quality.

IS THERE EVIDENCE THAT LACK OF MARKET COMPETITION LOWERS VALUE?

Consolidation of providers *can* result in improved efficiencies by eliminating duplication of activities and personnel, creating economies of scale, and integrating care. There is little to no evidence supporting the claim that these efficiencies result in lower health care cost or better quality. However, analyses consistently show that highly concentrated



Nationwide, payments to hospitals on behalf of the privately insured are an estimated 3 percent higher than they would be, absent hospital consolidation.

health care markets experience a greater increase in prices than less concentrated markets.[vii] Numerous recent studies have shown that the increase in unit prices—defined here as the cost of hospital and physician services, including medications—in both inpatient and outpatient settings is the single biggest driver of increases in health care spending. This is supported by data released by the Health Care Cost Institute (HCCI).[viii] A recent study conducted by researchers at UC Berkeley determined that per patient spending for multihospital-owned physician groups was 19.8 percent higher than that of independent physician groups. While multihospital-owned physician organizations had mean expenditures of $4776 per patient, physician-owned physician organizations had mean expenditures of $3066 per patient.[ix] Other studies took a retrospective look at the impact on price of hospital mergers in already in concentrated markets, and determined that further consolidation increases prices significantly[x]—ranging from 20 percent[xi] to 40 percent.[xii] Most health care economists agree that provider consolidation is a major driver of price increases, and is associated with the significant payment variation across and within markets for both hospital and physician services.[xiii] Nationwide, payments to hospitals on behalf of the privately insured are an estimated 3 percent higher than they would be absent hospital consolidation.[xiv]

A number of studies have examined the impact of hospital consolidation on various quality of care measures;[xv] consolidation historically has tended to reduce the quality of care. The research is not yet sufficient,[xvi] but is strongest when examining populations that fall under regulated pricing, such as Medicare.[xvii, xviii] Risk-adjusted one-year mortality for Medicare heart attack patients is significantly higher in more concentrated markets, amounting to more than 2,000 fewer deaths in the least concentrated markets.[xix]

WHAT IS CAUSING INCREASED PROVIDER CONSOLIDATION AND MARKET POWER?

Experts hypothesize that there are several causes behind the increases in provider consolidation and market power. Foremost, researchers theorize that continued merger activity may be a result of the worsening economic situation and declining volumes of stand-alone hospitals due largely to the recession; some believe that for hospitals to survive in this economic environment, some mergers are essential.[xx] Others believe, however, that the mergers are an attempt to gain the leverage to block insurers from redirecting patient flows or to slow the adoption of tiered networks.[xxi] Typically, employers have responded to employees' desire for broad provider choice, and are often reluctant to remove "brand name" provider systems from networks, giving these providers "must-have" network status and subsequent leverage in price

negotiations. Finally, lack of consumer access to information about provider price and quality allows some provider systems to continue to command market power, even when they have higher prices with no demonstrably better quality.

BUT DON'T WE NEED CONSOLIDATION TO ACHIEVE HIGH-VALUE, COORDINATED CARE?

There is no evidence as of yet that consolidation improves care coordination. To the contrary, the last wave of hospital mergers in the 1990s led to substantial price increases with few or no measureable benefits.[xxii] Similarly, a recent study comparing costs and quality in large integrated delivery systems with those in small independent practice associations (IPA) in the Midwest found that the "large complex structures might increase costs with no gain in quality."[xxiii]

Although scant evidence exists to suggest that consolidation results in coordinated, high-quality care, significant evidence demonstrates that providers can effectively coordinate care without tight financial integration. For example, the Intensive Outpatient Care Program (IOCP) provides coordinated, patient-centered care [xxiv] through care management teams including various disciplines that support patients with chronic conditions in adhering to their care management plans. This program produced an approximately 20 percent drop per unit in price-standardized per capita spending, primarily due to lower spending for emergency department ("ED") visits and hospitalizations.[xxv] These results did not involve hospital-employed physicians; rather, these improvements were secured "by three organizationally diverse physician groups, including an IPA composed of many small physician practices."[xxvi]

WHAT STEPS CAN EMPLOYERS AND OTHER HEALTH CARE PURCHASERS TAKE TO ENSURE CARE REMAINS AFFORDABLE IN THE FACE OF GROWING CONSOLIDATION?

Broadly speaking, purchasers can implement or support three different approaches: market-based, public-private, and regulatory.

Market-based Approaches

1. Support price transparency for consumers

   Allowing consumers, who are paying an increasing share of the costs of care, to select providers based on quality and price would motivate providers to compete in those domains, akin to how other non-health care markets function. With price variation as high as 700% for selected services in some markets and significant differences in quality, price information must be available to those who need to

MARKET-BASEDAPPROACHES

Consumer Engagement:

- Support Price Transparency
- Support Consumer Engagement with Benefit Design

Network Strategies:

- Support Tiered, Narrow, and High Performance Networks
- Support Centers of Excellence/ Direct Contracting
- Support Managed Care/ Managed Competition
- Support Oversight of ACOs

Market-based Approaches, continued

make decisions or who guide consumers in doing so (e.g., health coaches, nurses, and primary care physicians).[xxvii] Price transparency can also inform employers working to build long-term strategies to improve value. Some states collect and publish data on private sector prices and provide some limited information on provider quality and utilization patterns. A recent CPR Report Card on State Price Transparency Laws examined laws in all 50 states and concluded most were insufficient in ensuring that consumers had access to the information they need. Employers can help ensure any tools their health plans or third-party vendors provide meet consumers' needs by assessing them against CPR's Specifications for the Evaluation of Consumer Transparency Tools. Additional ideas are available in CPR's Action Brief on Price Transparency.

2. Support consumer engagement with benefit design

Patients with comprehensive health insurance naturally tend to consume more services without much attention to value, which contributes to rising costs. Many benefit experts believe we could draw greater value from the health care system with plan designs that create the proper balance of incentives, information, and/or more restricted or higher-value provider networks. One of the primary consumer engagement strategies being used to support this goal is the Consumer-Directed Health Plan (CDHP), which typically pairs a health savings mechanism (e.g., HSA, HRA, etc.) with a high-deductible health plan.

Value-Based Insurance Design (VBID) represents another attempt by employers and private insurers to engage consumers in making informed decisions about their care based on the identified cost, quality, and overall value of a specific drug or other medical therapy, service, or provider, while still retaining choice.

Reference and value pricing live at the intersection of consumer engagement and provider contracting. Unlike VBID, reference pricing establishes a standard price for a drug, lab test, procedure, service, or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. This creates the incentive for the plan member to use the preferred provider or the preferred class of services or therapies. Value pricing is similar, but it also includes consideration of quality and/or other performance measurement in the equation determining the price point or preferred list of services or providers. Even though reference pricing has yet to yield sufficient volume to affect the overall pricing behavior of providers substantially, reference and value pricing have shown some promise when applied to high-cost and high-volume procedures such as joint replacements. See CPR's Action Brief From Reference Pricing to Value Pricing for more details.

3. Support tiered, narrow and/or high performance networks

   Private payers somewhat successfully employed selective contracting—the use of limited networks of providers offering more favorable pricing—during the managed care domination of the 1980s and 1990s, and it is slowly gaining renewed attention. Despite having suffered from the backlash against managed care largely due to the lack of quality information in the development of managed care networks, renewed employer willingness and resolve to demand narrower networks could bolster health plans in their ability to negotiate with dominant and higher-cost providers in a particular area. A renewal of these strategies could foster competition among providers if coupled with appropriate quality and performance information, employee benefit designs, and decision-making support.

4. Support Centers of Excellence and direct contracting

   Most major health insurers use Centers of Excellence (COEs) in a limited set of clinical areas (e.g., transplants, bariatric surgery, cardiac, orthopedics) to direct patients to facilities that have demonstrable strengths—better clinical outcomes, fewer complications and readmissions—for certain high-risk and/or high-cost procedures. More recently, several of the nation's large employers—most notably Wal-Mart Stores, Inc.—have begun to pursue direct contracting with COEs as a way to regain control over the costs of employee health care benefits.[xxviii] As a result, provider competition for direct contracting arrangements may well increase in the near term. And in some cases, direct contracting of this nature may be the beginning of efforts by some employers to circumvent private insurers. For the short term, COE contracting represents a way of injecting some competition into the market place while saving employers money and maintaining or potentially improving quality. Meanwhile some employers have begun direct contracting arrangements with provider systems. For example, technology giant Intel is pursuing a pilot program working directly with a provider system in New Mexico focused on creating medical homes for employees.[xxix]

5. Support managed care and managed competition

   While deep suspicion about the concept among providers and consumers remains, if it had been handled differently, managed care might have evolved into a successful competitive health care financing and delivery system. According to health policy expert Alain Enthoven, to achieve its potential, certain market failures such as the absence and asymmetry of information must be addressed and benefit and enrollment practices must be structured to help create price-elastic demand. Many health policy researchers remain fans and there are examples, such as in the Netherlands, where this approach had some success in controlling costs while

Public-private Approaches, continued

PUBLIC-PRIVATE APPROACHES

- Align Public-Private Payment and Learn From the Public Sector
- Support All-Payer Claims Databases
- Support Pay For Performance (P4P)
- Increase Emphasis on Primary Care

preserving a choice of providers. In an era of expanding health insurance exchanges, which have the potential to create more competitive models, both managed care and managed competition may once again be considered by purchasers as a means to improve competitiveness in health care.

6. Support oversight of ACOs

   While many believe that consolidation or joint ventures are required to form an Accountable Care Organization (ACO), studies show that mergers may actually lead to substantial increases in prices with few or no measureable benefits.[xxx]

   Instead, in providing oversight of ACOs, employers can communicate their expectations to their insurers/third-party administrators regarding how they will contract with and monitor the impact of ACOs.

   For example, expectations could include: payment rates should reflect cost decreases; reaping savings should be contingent on improved quality; ACO providers will not engage in exclusive contracts; steerage can occur across and within ACOs; and enrollees should be given comparative information on provider performance, regardless of steerage.

   Providers receive considerable antitrust exemptions under the provisions of the ACA and could use health reform as cover for additional consolidation and integration with the aim of increasing their market power. If they are not at the table, employers could be left with little leverage. View CPR's Toolkit on Accountable Care Organizations for more detailed information.

Public-private Approaches

Employers and other purchasers of health care can also team up with public sector leaders to support a variety of strategies to combat the negative effects of increased provider consolidation and market power.

1. Align public-private payment and learn from the public sector about new payment approaches

   Alignment of public and private payment strategies would have the benefit of providing more consistent incentives to hospitals and physicians and would likely reduce variation in prices and costs. Medicaid programs and private payers could consider aligning their payment methods with those of Medicare and assess where there is greater flexibility to consider those policies as a platform upon which to innovate further. There could be further alignment with, for example, episode-based and bundled payments, shared savings, global budgets or population-based

payment models, payments that emphasize the value of primary care, pay for performance initiatives, and the monitoring of inappropriate use of services and fraudulent practices.

The private sector can often learn from and emulate the public sector when it comes to success with these and other payment approaches. For example, recently, Medicare has experimented with payment systems that broaden the focus of physicians, hospitals, and other providers from delivering piecemeal, individual services to patients to providing the care a patient needs for an entire episode of illness or that an entire population needs over time. While bundled payments alone do not enhance competition among providers, they bring with them important incentives for providers to improve quality and contain costs.

Several private payers and the states of Maryland and Vermont are experimenting with the development of new versions of full- or partial-risk, population-based reimbursement arrangements for hospitals and their employed physicians. Like bundled payment, this payment method does not inherently enhance competition among providers. But these experiments hold promise for improving quality and containing costs as long as the state approaches can accommodate one of Medicare's existing payment methodologies or experimental alternative payment approaches (such as ACOs).

Private employers can also learn from Medicaid's payment reform efforts. For example, private employers and health plans have expressed interest in learning more about South Carolina's Birth Outcomes Initiative, a new payment reform program that combines patient and physician education with non-payment for unwarranted early elective deliveries. Organizations like CPR can help summarize the methods and outcomes of payment reform pilots in both sectors to facilitate cross-sector learning.

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2. Support All-Payer Claims Databases

Comprehensive and timely All-Payer Claims Databases (APCDs) are necessary for the development of payment models using global budgets or shared-savings arrangements relating to a defined population. These data are necessary to perform a Medicare-like attribution of patients to multi-payer ACOs or Patient Centered Medical Home (PCMH) models. They also can be used to assess, make more transparent, and help integrate the highly disparate components of a state's health care financing and delivery system. APCDs can give employers and health plans better access to information about payment and quality variation, which can support value-based insurance design and a stronger negotiating position with providers.

REGULATORY APPROACHES

- Influence ACO Regulations
- Support the FTC's Efforts
- Influence Other Federal Regulations
- Support State Oversight
- Support Active Purchasing by State Health Insurance Exchanges

3. Support Pay For Performance

   The Agency for Healthcare Research and Quality defines pay for performance (P4P) as a strategy to improve health care delivery that, depending on the context, refers to financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payers, and improved quality and patient safety. Initial pilots by CMS and others have generated mixed results. Though limited to date by inadequate metrics and data, the continued development of useful and more meaningful metrics on care quality and patient experience of care, could help P4P initiatives have a large positive impact on both quality and cost. Consistency across P4P initiatives nationally, however, remains problematic and alignment of public and private strategies could help.

4. Increase the emphasis on primary care

   Evidence suggests additional emphasis on primary care and substantial increases in reimbursement for primary care providers (PCPs) can help reduce costs and improve quality for patient populations,[xxxi] particularly for Medicare and chronically ill patients. More attention needs to be paid to giving PCPs the time and financial incentive to help engaged patients make the best referral decisions. Rebalancing payment between primary and specialty care can also put competitive pressure on specialists to demonstrate their value and to improve the appropriateness and quality of the care they deliver.

Regulatory Approaches

Regulatory approaches to provider market power can also be effective. However, state antitrust action is costly and involved and the likely success of each case is unpredictable. And while there are a wide range of strategies states can employ to promote competitive markets, there is an increasing trend toward regulatory and legislative provisions allowing providers to consolidate in the name of improving the coordination of patient care without being subject to antitrust regulations. Health care purchasers can support a variety of regulatory efforts to combat the ill-effects of consolidation, including:

- Influencing the development of federal ACO regulations to help ensure ACOs foster enhanced affordability and quality and don't stifle competition;
- Supporting FTC efforts to monitor, and when appropriate, challenge consolidation;
- Influencing the development of federal regulations, such as improving the accuracy of the Medicare physician fee schedule; and improving the Medicare Inpatient and Outpatient Prospective Payment Systems; both help ensure appropriate volume and improved affordability;

- Supporting expanded Department of Insurance oversight and capability to intervene when providers exercise excess market power and engage in price fixing, to help maintain competition and affordability at the state level and/or all-payer rate regulation as in Maryland; and,
- Supporting active purchasing strategies for state exchanges to foster quality, affordability, and competition.

WHAT DO WE EXPECT FOR THE FUTURE?

There is currently a great deal of market consolidation occurring. Frenzied efforts to form ACOs appear to be driving some of this change. Today, we have a limited line of sight into the true impact of provider consolidation and market power because of a lack of systematic and comprehensive monitoring. Given the growing awareness of the impact of increased provider negotiating leverage on rising health care expenditures, the appetite to develop a mechanism to monitor more broadly and rigorously the impact of provider consolidation on price may be at an all-time high. Representative health care claims data are also increasingly available, which could make such monitoring possible.

Efforts to improve price and quality transparency for consumers are proceeding at a slow pace and many purchasers have been hesitant to introduce radical changes in benefit design, especially when it comes to limiting networks. But given how greatly provider consolidation and market power are shaping the health care landscape, purchasers and others concerned about getting good value for their spending on health care will need to explore and implement strategies that create an environment conducive to improving the quality and affordability of care.

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.

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