



CATALYST
FOR
PAYMENT
REFORM

Provider Market Power in
the U.S. Health Care Industry:
Assessing its Impact and
Looking Ahead

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About Catalyst for Payment Reform

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

Acknowledgements

Robert Murray and Catalyst for Payment Reform would like to thank the following individuals for their valuable contribution to the development of this paper: Shaudi Bazzaz, Robert Berenson, Cory Capps, David Dranove, Anna Fallieras, Dean Farley, Austin Frakt, Chris Garmon, Marty Gaynor, Paul Ginsburg, Stuart Guterman, Steve Jencks, Jeff Lemieux, John McDonough, Mark Miller, Len Nichols, James Robinson, Julie Schoenman, Jeff Stensland, and Anne Weiss.

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November 14, 2012

Dear Colleagues,

As the costs of health care continue to rise at an unsustainable rate with limited to no indication of commensurate improvements to its quality, ensuring high-quality health care at manageable costs is a central challenge for key stakeholders today. Many believe improving the trajectory of health care costs, and with it the overall value of health care, depends on reforming how we pay for health care across the nation. Most experts agree that to do so effectively will require both new forms of payment and corresponding strategies that ensure a competitive health care marketplace.

But for all we can accomplish with payment reform, there are broad trends at play in the health care marketplace that may eclipse its impact. One of these is the two-decade old trend of provider consolidation, which now may be accelerated further by the health care reforms, including Accountable Care Organizations.

Why does provider consolidation matter? Because while it could lead to better care coordination and efficiencies, it could also further concentrate providers in markets where few purchasers or payers have significant negotiating power. Historical data suggest this could lead to higher prices with either a neutral or negative effect on quality. There is deep evidence of this in several studies, including one Catalyst for Payment Reform (CPR) commissioned Paul Ginsburg to conduct that demonstrates significant payment variation within and across markets and suggests that some hospitals have significant market power to negotiate higher-than-competitive prices.

CPR, an independent, non-profit organization providing thought leadership to and coordination among employers and other large health care purchasers, wants to shine the light on this trend, what's known about its potential impact on health care costs and quality, identify possible solutions, and consider how to monitor it going forward.

One might ask why is an employer group concerned with provider consolidation? Employers foot the bill for the nearly 60%¹ of Americans enrolled in employer-sponsored insurance today, representing approximately 21%² of the nation's overall health care spending. And as private payers and providers negotiate prices for health care services, upward pricing is increasingly the result due, in part, to cost shifting and price discrimination by providers. Gaining a better understanding of how rates are determined in the commercial sector, where they are negotiated and not pre-determined by regulation, can point the way to potential solutions to ensure a competitive health care delivery system.

It turns out there is an array of market-based approaches that employers and other health care purchasers could test and implement, such as reference or value pricing and tiered or narrow networks, among others. There are also potential opportunities for private-public collaboration. And of course when these voluntary approaches do not succeed, there are a variety of regulatory options to turn to or to use as a complement to the market-based approaches to ensure the health care market is working efficiently.

As key players in providing access to and purchasing health care for millions of employees and their families, employers have a central role in ensuring that the trend toward provider consolidation and market power lead to greater coordination of services, improved quality and better outcomes and not just increased costs. CPR commissioned this work to inform employers and other key stakeholders, and to begin a thoughtful dialogue about an action-oriented set of strategies that could potentially improve competition, the cost trajectory, and the overall delivery of health care services.

This paper includes a comprehensive assessment of available research as well as the opinions of national health care experts. Thank you to all who lent their insights and expertise to this important issue.

Sincerely,

Suzanne Delbanco, Ph.D.

Executive Director, Catalyst for Payment Reform

¹ Gould E. A decade of declines in employer-sponsored health insurance coverage. February 23, 2012.

² California HealthCare Foundation. US health care spending: a supplement to California HealthCare Foundation's health care cost 101. 2011.

EXECUTIVE SUMMARY

1: Health Care Costs Continue to Rise

Despite many an effort to ‘bend the trend,’ health care costs continue to rise at an unsustainable rate. The broad consensus is that the current health care system does not consistently deliver value – high-quality care delivered efficiently and affordably – and that the most difficult challenge facing stakeholders today is to lower costs or at least slow their growth. In this tough economic time and following passage of the Affordable Care Act (ACA), stakeholders are highly motivated to identify strategies to reign in health care spending in a responsible way.

Today, health care expenditures account for nearly all projected structural deficits at the federal level^{1,2} and for a major – if not the major - component of state budget outlays each year.³ 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% of Gross Domestic Product (GDP) by 2020. This has implications that extend beyond health care, including impacts on the U.S. debt, wage growth, and unemployment. Excessive growth in health care expenditures will have serious economic consequences for the country, with the ultimate burden falling on those who use and pay for health care services.⁴

Some might counter these concerns by noting that the health care sector has been an engine of economic growth and job creation. But, recent research from the RAND Corporation indicates that every new job added to the health care sector results in 0.85 fewer jobs in the rest of the economy.⁵ For every job created, the costs of running this health care system grow and eventually result in layoffs in other sectors unable to manage the growing burden of the cost of health insurance premiums for employees.

2: Price is a Major Driver of U.S. Health Care Costs

Per capita health care spending in the U.S. is nearly twice that of most other industrialized nations, with no evidence of a corresponding increase in quality. The reasons for excessive spending are complex, but multiple analyses indicate that two of the major drivers of costs in the U.S. in the last few years are increased utilization of outpatient services and higher unit prices for all health care services.

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 health spending increases. Recently released data from the Health Care Cost Institute (HCCI), a nonprofit research entity that has private insurance claims data accounting for more than 40% of the private market from four large private insurers, substantiate this conclusion.⁶

3: Behind the Price Increases: Provider Consolidation and Market Power

Health care economists broadly agree that provider consolidation is a major driver of price increases, and is also associated with the significant payment variation across and within markets for both hospital and physician services.⁷ Consolidation in the health care sector is ubiquitous. And despite the potential benefits, there is also fear – based on well-documented historical trends – that unless we manage it carefully, massing provider market power will lead to even higher prices and revenues. And, this excessive growth in health care expenditures is expanding toward unsustainable proportions without correlated improvements to quality.

In addition, many researchers have pointed anecdotally to the rise of managed care in the 1990s as the primary factor driving hospital consolidation. More recently, 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.⁸ Some believe that for hospitals to survive in this economic environment, more mergers are essential.⁹ 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.¹⁰

While consolidation of providers can result in improved efficiencies by eliminating duplication of activities and personnel, creating economies of scale, and integrating care and improving quality, consolidation can also increase provider market power leading to higher prices, less efficient outcomes, misallocation of resources, and lower overall societal welfare.

In addition to consolidation, some hospitals and physician groups obtain “must-have” status, meaning that employers and consumers in health plans demand that they be included in an insurer’s network because they have a well-recognized brand name or provide highly-specialized services not generally offered in a particular region. Hospitals and physician groups alike gain negotiating advantages in areas that are relatively isolated geographically and where bed capacity or other access is still relatively tight.¹³ And to date, employers and consumers have typically demanded unrestricted networks. Thus, private insurers negotiating on behalf of the commercial market lack a credible threat, leaving these providers in a good position to negotiate higher prices.

4: Potential Ways to Improve Provider Competition, Health Care Costs, and Quality

Antitrust action has been the traditional response of those seeking to counteract consolidated market power that can hurt consumers. But a long losing streak in health care antitrust litigation – and other policy concerns – has meant that this approach cannot be the sole solution. Thus, while not ignoring antitrust action as means to counteract the negative effects of provider market power, there are alternative approaches and activities we must consider.

CPR research and discussions identified several options in three categories: 1) market-based approaches; 2) coordinated public-private activities; and 3) regulatory interventions. We can consider each potential solution in isolation or in tandem with the others, depending on the specific market environment. Market-based approaches, while ranging in complexity, are not dependent on coordination with government or changes in public policy. As a result, they are a logical starting place. Public-private coordination could greatly enhance the effectiveness of efforts in either sector. And, while potentially the most challenging and time-consuming to implement, regulatory interventions may be necessary when stakeholders and participants in the marketplace are unable to create a pro-competitive environment through their own actions. Appendix II of this paper contains a more detailed discussion of each.

MARKET-BASED APPROACHES

The market-driven orientation of the U.S. distinguishes it from most other industrialized nations and, when it comes to health care, there is a general preference for market-based activities that address market failures to improve competitiveness. The bullets to the right lists market-based strategies that can impact competition, segmented into two groups: those utilizing consumer engagement and those utilizing provider networks. Additional detail below illustrates how each intervention can promote competition among providers in a health care market.

1. Consumer Engagement: Price and Cost Transparency Many believe increasing the transparency and usefulness of data on the performance of providers (including compliance with evidence-based standards, health care outcomes, and cost) can increase market competition. Allowing consumers, who are paying an increasing share of the costs of care, to select providers based on quality and cost 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, access to information must be available to those who need to make decisions or who guide consumers in doing so (e.g., health coaches, nurses, and primary care physicians).¹⁴ This information is also the basis for benefit designs that build on information-only support

TRENDS IN PROVIDER CONSOLIDATION

Over the past two decades, hospitals in the United States have become highly concentrated as they steadily shifted away from independent status and merged with other competing facilities or integrated with multi-hospital systems. By 2006, over 75% of U.S. MSAs had experienced enough provider consolidation to be considered “highly consolidated.” Nationwide payments to hospitals on behalf of the privately insured are an estimated 3% higher than they would be absent hospital consolidation.

MARKET-BASED APPROACHES

Consumer Engagement:

- Price and Cost Transparency
- Consumer-Directed Health Plans
- Value-Based Insurance Design
- Reference/Value Pricing

Network Strategies:

- Tiered, Narrow, and High Performance Networks
- Centers of Excellence/Direct Contracting
- Managed Care/Managed Competition Strategies
- Entry of New, Lower-Cost Competitors
- Strategically Seed the Supply Side
- Oversight of ACO Development

for consumer decision making with financial incentives for consumers to select providers with the best combination of quality and affordability. Transparency can also inform employers working to build long-term strategies to improve value.

Some stakeholders voice concern that price transparency – alone or in combination with performance data—could lead to provider collusion and increased prices, or that it may confuse or mislead consumers. While theory suggests the potential for such effect, there is little empirical evidence on the impact.¹⁵ Efforts to create meaningful and consistent metrics in a useful context to inform consumer decision-making are still in their infancy. Some states collect and publish data on private sector prices and provide some limited information on provider quality and utilization patterns.

See www.catalyzepaymentreform.org/Price_Transparency.html for CPR’s specifications for consumer price and quality transparency tools.

- 2. Consumer Engagement: Consumer Directed Health Plans (CDHPs)** In health insurance, there is an inherent tension between reducing a person’s exposure to financial risk and the drawback of reducing a patient’s sensitivity to differences in price and quality among providers. 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. However, consumers alone may not be able to drive market share shifts or change the balance of market power between providers and payers. In the case of higher cost services where the consumer has already met a deductible, incentives to shop based on both quality and cost fade away. CDHPs do, however, introduce the concept of consumer price sensitivity into the mix which can begin to support the fundamentals of a competitive marketplace.

- 3. Consumer Engagement: Value-Based Insurance Design (VBID)** Value-Based Insurance Design 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.

The challenge with VBID is constructing benefit packages that provide strong incentives to consumers to be more cost conscious, while avoiding negative clinical effects and shifting too much risk to them. To date, VBID has largely been used in pharmaceutical benefit design to encourage use of lower-cost, equivalent therapies or to incentivize compliance with a specific drug regimen that supports better health through use, such as diabetes maintenance drugs. There has been limited use of VBID for other services, provider selection, or network strategies.

- 4. Consumer Engagement: Reference and Value Pricing** 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 performance in the equation determining the price point or preferred list of services or providers.

Even though reference pricing has yet to wield 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. As with VBID, reference and value pricing can introduce consumer sensitivity to the price for high-cost services as well as where they seek such services.

See http://catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf for CPR’s Action Brief on the topic.

5. **Network Strategy: Tiered, Narrow, and 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.

6. **Network Strategy: Centers of Excellence/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 (and some insurers) have begun to pursue direct contracting with COEs as a way to regain control over the costs of employee health care benefits. 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.

7. **Network Strategy: Managed Care/Managed Competition Strategies** 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 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 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.

8. **Network Strategy: Entry of New, Lower-Cost Competitors** The systematic investment in, development, and marketing of a “lower-cost” alternative is a relatively new development in a couple of regions characterized by high prices and substantial consolidation, such as Boston and Pittsburgh. The entry of a well-capitalized outside group in one instance and a private insurer in the other indicates that some see a market opportunity to undercut monopoly pricing strategies. Employers and insurers should look for ways to encourage this type of strategy in other extremely consolidated markets.

9. **Network Strategy: Strategically Seed the Supply Side** This generally involves the following strategies: 1) Encouraging the entry of new providers that can compete directly with entrenched and consolidated health systems (see above); 2) Encouraging entry and expansion of new practitioners by opening up more medical school slots to train more physicians and reducing or removing restrictive licensing or certification requirements that govern the type of care nurses, nurse practitioners, and physicians (as well as other personnel) can provide; 3) Developing new cost-reducing technologies and innovative approaches that can compete directly for both acute and ambulatory care (such as telemedicine and hospital-at-home delivery system approaches); 4) Encouraging the expansion of existing, more productive services that can compete directly with hospitals on a cost-effective basis (such as urgent care centers, retail clinics, and specialty hospitals); and 5) De-emphasizing regressive policies that act as a barrier to entry – such as certificate-of-need policy and regulation, which is often politicized and aimed at protecting existing competitors rather than protecting competition.

While supply-side strategies can contribute to the competitiveness of the industry, these activities can take a long time to implement and may have mixed success.

10. Network Strategy: Oversight of ACO Development Employers can communicate their expectations to their insurers/third-party administrators regarding how they will contract with and monitor the impact of Accountable Care Organizations (ACOs). 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 Action Brief on [Accountable Care Organizations](#) and [Ensuring Competition](#) for more detailed information.

COORDINATED PUBLIC AND PRIVATE ACTIVITIES

While market-based strategies can improve competition most directly, persistent and pervasive market distortions and failures can forestall efforts to improve the operation of the market. In these circumstances, government, either at the state or federal level, may help clear the way for a more functional competitive environment that protects the needs of those who use and pay for health care. Government activity of this nature should promote market-based efforts and avoid excessive intervention and micro-management. It can be independent of private payers or coordinated with them.

The following section describes activities government can pursue to promote pro-competitive interventions by market participants and/or directly respond to impediments to competition.

- 1. Antitrust Activity: Monitoring and Pursuing Injurious Mergers** More aggressively monitoring and pursuing proposed (or existing) mergers/integration of health providers could greatly support market competition and market-based activities to do so. The Federal Trade Commission and the Department of Justice should continue to pursue vigorous antitrust enforcement in situations they believe are injurious to competition in the health care industry and test the antitrust exemptions associated with ACO formation.
- 2. All-Payer Claims Databases (APCDs)** 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.

COORDINATED PUBLIC AND PRIVATE ACTIVITIES:

- Antitrust Activity: Monitoring and Pursuing Injurious Mergers
- All-Payer Claims Databases
- Alignment of Public/Private Payment Structures
- Episode-Based and Bundled Payments
- Accountable Care Organizations
- Global Budgets or Population-Based Payment Models
- Increased Emphasis on Primary Care
- Pay for Performance (P4P)
- Monitor Inappropriate Use and Health Care Fraud

3. Alignment of Public/Private Payment Structures 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.

4. Episode-Based and Bundled Payments 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.

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5. **Accountable Care Organizations** The Centers for Medicare and Medicaid Services (CMS) has defined ACOs as a way to create incentives for health care providers to work together to treat an individual patient across care settings while making care more affordable. Despite the potential risks of enhanced market power for providers, some policymakers believe it is vitally important that reformers continue to encourage increased alignment of incentives. But it's important to monitor whether these lead to more market power for providers and higher prices as a result.
 6. **Global Budgets or Population-Based Payment Models** 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).
 7. **Increased 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, 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.
 8. **Pay for Performance (P4P)** 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 and scope of P4P initiatives nationally, however, remain problematic and alignment of public and private strategies could help.
 9. **Monitor Inappropriate Use and Health Care Fraud** There are estimates that savings from reducing health care fraud can be as much as 5% of total health spending. Consequently, both public and private payers have invested resources in identifying and remediating fraudulent claims and inappropriate patterns of care. This approach could help to counteract some of the increases in health care costs due to provider consolidation. Despite its considerable potential, public and private entities appear unwilling or unable to devote sufficient time and money to this activity at present.

REGULATORY INTERVENTIONS/APPROACHES

Although regulatory approaches to restore purchasing power are not typically the first choice of experts, they can sometimes provide an important alternative or complement to other approaches. If market-based and limited public interventions are not successful in restoring competitiveness to the health care sector, the U.S. may be resort to more overt forms of price regulation, as implemented by virtually every other industrialized nation in the world.

Examples of such interventions are listed below.

1. **Improving the Accuracy of the Medicare Physician Fee Schedule** The current Medicare fee schedule for physicians appears to have many distortions in payment levels, causing some medical services to be highly profitable and others to be less so. It clearly rewards specialty procedures at the expense of primary care services, causing too many patient procedures and too little primary care interaction and care management. This drives higher than necessary volumes and adds to the overall cost of health care

REGULATORY INTERVENTIONS/ APPROACHES:

- Improving the Accuracy of Medicare Physician Fee Schedule
- Improving the Medicare Inpatient and Outpatient Prospective Payment Systems
- Expanded Department of Insurance Oversight
- Baseball Style Arbitration
- Limits on Emergency Care Pricing
- Active Purchasing Strategies by State Health Insurance Exchanges
- All-Payer Rate Regulation

for both public and private payers. Because most Medicaid departments and private payers benchmark their fee schedules off of the Medicare fee schedule, changes to it have enormous potential to influence the entire payment system.

2. Improving the Medicare Inpatient and Outpatient Prospective Payment Systems Health services research generally supports the proposition that hospital volume levels exceed those required for high-quality, cost-effective care. Therefore, most of the state rate-setting systems that received a Medicare and Medicaid waiver had volume adjustment systems designed to limit incentives to increase inpatient or outpatient volumes. The essential idea is that future rate reductions could capture the marginal revenue in excess of costs that hospitals capture through increased volume. Because most hospitals continue to pursue the strategy of increasing volume where the marginal revenue of each additional case, visit, or test exceeds the marginal cost they face, the industry will likely continue to resist such a change.

3. Expanded Department of Insurance Oversight Several states, including Massachusetts and Rhode Island, are experimenting with new ways of exercising oversight of health plans and their contractual arrangements with providers. These activities can range from applying voluntary targets and goals for insurers (in terms of the structure of payment they use with providers, how much they pay for primary care, and other activities) to more stringent requirements, such as one that enables them to negotiate separately with one hospital within a network instead of taking an all-or-nothing contract for all hospitals in a system.

Despite resistance to perceived overregulation, over time, state departments of insurance may find they will need to increase their level of scrutiny of payer-provider contracting to help eliminate the unjustifiably large differentials in provider rates and engage in other oversight activities aimed at prohibiting or reducing anti-competitive activities by both providers and insurers.

4. Baseball Style Arbitration Baseball arbitration forces the arbitrator to find entirely for one side of a dispute or another, without compromise judgments. The hope is to influence both parties to reach an agreement out of fear of being the loser. It is conceivable that regulators could make payer and provider entry into such agreements a condition of certain safe harbors from regulatory scrutiny.

5. Limits on Emergency Care Pricing Acute emergency care is inherently monopolistic since patients in an emergency situation have very limited ability to decide where they seek care. When they can, such as when patients receive care out-of-network, providers often charge patients much more than what the providers accept from Medicare or private insurers with an established contract.

Most state legislatures are reluctant at present, but establishing a Maximum Payment Obligation as a percentage of Medicare payment levels could reduce cost shifting, re-establish negotiating balance between hospitals and payers, and generate cost reductions. It could also help patients without insurance who obtain emergency services.

6. Active Purchasing Strategies by State Health Insurance Exchanges State-based health insurance exchanges, an important component of the ACA's plan to expand access to coverage, are both a gateway for people to purchase subsidized health insurance and a means to help organize insurance markets for more effective competition among health plans and providers. Many states have been reluctant to begin work to implement exchanges – first because they were waiting for the Supreme Court decision on the ACA and then because they were awaiting the outcome of the 2012 presidential election with its implications for health reform. However, by consolidating individuals and small groups, potentially aligning

with large purchasers' strategies to encourage value-oriented consumer shopping, exchanges could encourage long-term delivery system changes that help improve quality and curb the current growth in health care costs.

7. All-Payer Rate Regulation Under an all-payer rate-setting system, a public body would have the legal authority to establish the prices paid by both government and private health plans to hospitals and other providers for medical services. An all-payer system requires a common unit of payment and, in its purest form, mandates the payment level for a given service at a given provider across all patients. All-payer systems can countervail the market leverage enjoyed by dominant provider groups by establishing the fees for all services and payers and helping to reduce administrative costs, improve system transparency, enhance payer and patient equity, ensure provider financial viability, and be a platform for innovative payment reform.

Most states are reluctant to pursue strategies perceived as highly regulatory and interventionist and, therefore, many see all-payer rate regulation as a strategy of last resort. It is important to note, however, that the U.S. is the only industrialized nation that does not actively reinforce the purchasing side of the health care marketplace through some form of such intervention.

5. Monitoring Market Competition and Market Power

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 oversight. Until now, monitoring of provider consolidation and the identification of instances where mergers might lead to injurious price increases has primarily been in the domain of those charged with identifying and pursuing cases that might violate antitrust provisions.

However, 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.

If developed in a responsible, representative, and timely way, systematic monitoring could serve a variety of purposes, including:

- raising public awareness about the cost and quality impact of non-competitive health care markets;
- understanding the linkage between provider consolidation and rising health expenditures to inform and assist health care purchasers, payers, and policymakers in developing market-based and regulatory interventions;
- assisting governmental agencies in identifying and pursuing antitrust cases and studying the impact of provider consolidation as required by the ACA; and,
- fostering broader awareness of the value of how new entrants can have a meaningful impact on the competitive structure of markets.

Given the increasing availability of both public and private claims data for both hospital and non-hospital providers, one could envision a public-private utility to identify and evaluate the link between provider market power, the growth in health care expenditures, and the impact on quality, cost, and access.

About this Report

Catalyst for Payment Reform (CPR) produced this report to explore provider consolidation and market power and its impact on costs and quality as well as to identify workable strategies to monitor consolidation and its corresponding impacts and to identify both market-based and regulatory approaches that would foster a competitive marketplace. This report reflects both a review of published research and expert input.

About Catalyst for Payment Reform

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

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1: INTRODUCTION

1.1: Time to Rein in Unsustainable Growth in Health Care Costs

In this tough economic time and following the passage of Affordable Care Act (ACA) and the Supreme Court's decision to uphold most of it, many health care stakeholders have taken on the challenge of reducing health care costs with renewed vigor.

Patients, purchasers, health plans, providers, and policymakers all agree today's health care system does not consistently provide value – high-quality care delivered efficiently at an affordable cost. Perhaps the most difficult challenge to achieving value is lowering costs or at least slowing their growth. Most experts believe the current rate of growth is unsustainable and the ACA's planned expansion of health insurance coverage could exacerbate this problem.

Today, health care expenditures account for nearly all projected structural deficits at the federal level^{1,2} and for a major – if not the major - component of state budget outlays each year.³ 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% of Gross Domestic Product (GDP) by 2020.

This has implications that extend beyond health care. The debt to GDP ratio in the U.S. is already high. Continued borrowing will result in higher long-term interest rates and negatively affect the competitiveness of U.S. industry and the country's long-term economic growth. Equally important, employers tend to pass higher health insurance costs on to employees in the form of lower wages, reduced health care benefits, or reductions in employment. Thus, excessive growth in health care expenditures has serious economic consequences for the country, with the ultimate burden falling on individuals and their families.⁴

Some might counter these concerns by noting that the health care sector has been an engine of economic growth and job creation. Data from recent research by the RAND Corporation can be used to estimate that every new job added in the health care sector results in 0.85 fewer jobs on average in the rest of the economy.⁵ For every job created, the costs of running this health care system grow and eventually result in layoffs in other sectors unable to manage the growing burden of the cost of health insurance premiums for employees. As Baicker and Chandra point out in a recent *New England Journal of Medicine*, it may be that continued growth in the health care sector represents at best a “wildly inefficient jobs program.”⁶

1.2: The Link between Provider Consolidation and Rising Costs

Catalyst for Payment Reform (CPR) is an independent, nonprofit organization working to promote high-value health care in the U.S by catalyzing improvements in how we pay for health care services. While setting high expectations for the quality of care, CPR identifies and coordinates workable payment reforms, tracks our nation's progress in this area, and promotes alignment between public and private sector strategies. This work has led CPR directly to examining the effect of provider consolidation⁷ on rising health care costs.

While there are many factors that affect health care costs, among health care economists there is broad agreement that provider consolidation is a major driver, and it associated with significant payment variation across and within markets for both hospital and physician services.⁸ This fact does not receive a lot of attention in policy discussions and or in general public discourse, but with aspects of the ACA encouraging even more

provider consolidation to align incentives and foster clinical integration, it is critical that people understand the potential effect of consolidation on health care costs.

With that in mind, CPR commissioned this paper and began gathering critical insights by convening a discussion of policy and industry experts on this topic in Washington D.C. In large part, the paper focuses on hospital and hospital system consolidation, because that's where most of the available data and research exists. There is also physician consolidation, but little data exists on its extent and impact. And there is insurer consolidation as well, but the best available literature on this phenomenon shows that it generally contributes to lower costs by giving insurers more clout in negotiations with providers.

In short, consolidation in the health care sector is ubiquitous. And despite its potential benefits, there is also fear – based on well-documented historical trends – that unless it is carefully managed, massing provider market power will lead to even higher prices and revenues.

This paper analyzes the historic effect of provider consolidation and outlines steps that can foster a more balanced, competitive marketplace, one that enhances quality without driving untenable costs. The paper is organized as follows:⁹

- The primary drivers of health care expenditures (Section 2)
- Consolidation in the health care provider market, including analysis of the reasons and of its effect on health expenditure growth, hospital operating efficiency, and quality of care (Section 3)
- Options for countering the negative effects of provider consolidation, including market-based, public-private, and regulatory approaches (Section 4)
- Mechanisms for monitoring the extent and impact of provider consolidation, with the goal of a more informed discussion among both policymakers and the general public (Section 5)

2: THE PRIMARY DRIVERS OF HIGH HEALTH CARE SPENDING IN THE U.S.

- Per capita health care spending in the U.S. is nearly twice that of most other industrialized nations with no evidence of a corresponding increase in quality.
- The reasons for excessive spending are complex, but multiple expert analyses indicate that two of the major drivers in the last few years are increased utilization of outpatient services and higher unit prices for all health care services.
- Numerous studies have linked increased utilization and higher unit prices to the increased consolidation and market power of both for-profit and nonprofit hospitals.

2.1: What Drives Cost Increases

Health spending in the United States has consistently been nearly twice as high as that of other industrialized countries, with broad consensus that the increased spending has failed to deliver a corresponding increase in quality, as measured by any number of widely accepted assessments.

Certainly one reason the U.S. spends more on health care is because it has a higher standard of living and higher per capita wealth than most other nations. Many studies show that even when controlling for differences in per capita income, the U.S. is a significant outlier in terms of health expenditures per capita.

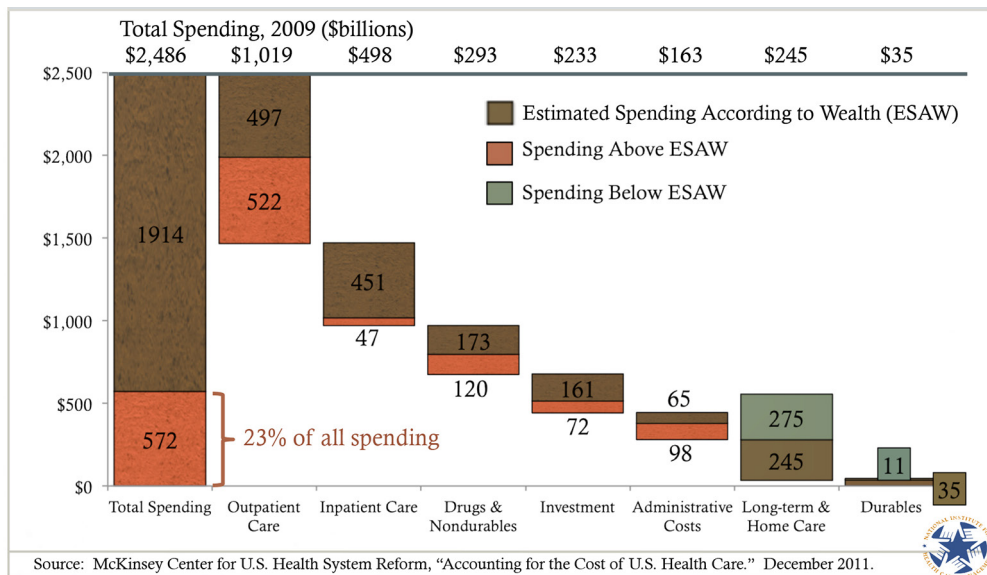
The consulting firm McKinsey and Company performed an analysis that found of the \$2.5 trillion spent on health care in the U.S., \$1.9 trillion of spending is to be expected based on our relative wealth, while \$572 billion – 23% – is higher than expected. According to the McKinsey analysis, the increase is not attributable to greater use of services or a greater prevalence of high-cost diseases in the U.S. Rather, it appears to result from a number of factors, including:

- A more expensive mix of drugs;
- Considerably higher prescription drug costs;
- Higher physician incomes;

- Higher administrative costs due to the complexities of our diverse, public and private financing system
- Greater use of specialists (versus primary care physicians);
- Higher unit prices;¹⁰ and
- Skyrocketing use of outpatient services as technology and payment incentives shifting use away from inpatient settings.

According to McKinsey, outpatient services, including physician services, are the biggest factor in cost increases not explained by per capita income (Chart 1). In the late 1980s and 1990s, movement of procedures from inpatient to outpatient settings, particularly for surgeries, was celebrated as a shift to a lower cost setting of care. Unfortunately, the shift was accompanied by an overall increase in the volume of outpatient procedures that more than offset any savings.

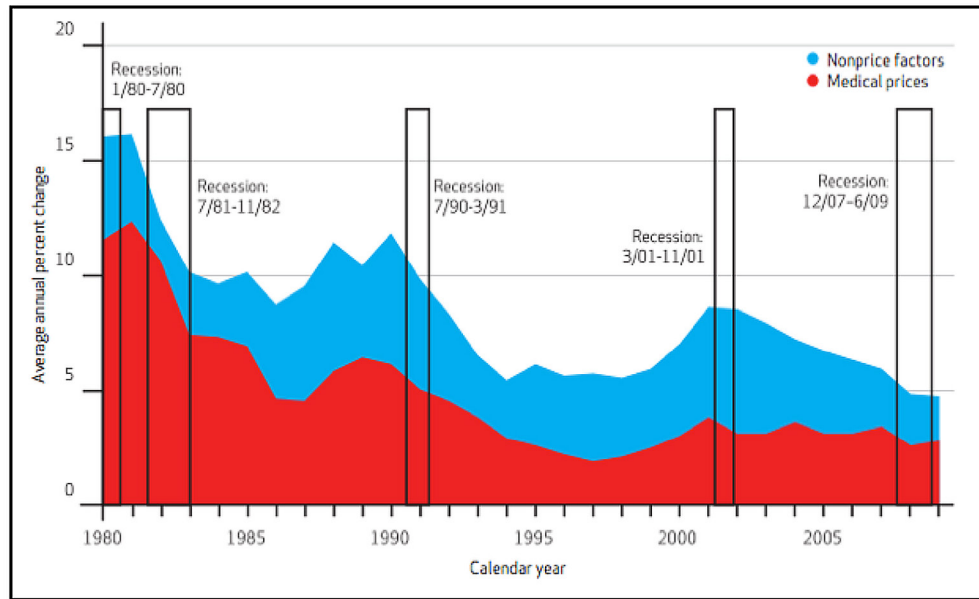
Chart 1 – Total Spending by Category and Estimated Spending According to Wealth, 2009¹¹



Equally important, in recent years numerous 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 health spending increases. Recently released data from the Health Care Cost Institute (HCCI)¹² also show that increased unit prices continue to be a driver of rising health care costs. The HCCI report showed that while utilization of services for this population was generally down, mirroring the trend for the entire population, the increase in per capita expenditures was driven primarily by increases in unit prices, not by the utilization or intensity of services.¹³

HCCI research indicates that increases in per capita spending was driven primarily by increases in unit prices. not but the utilization or intensity of services.

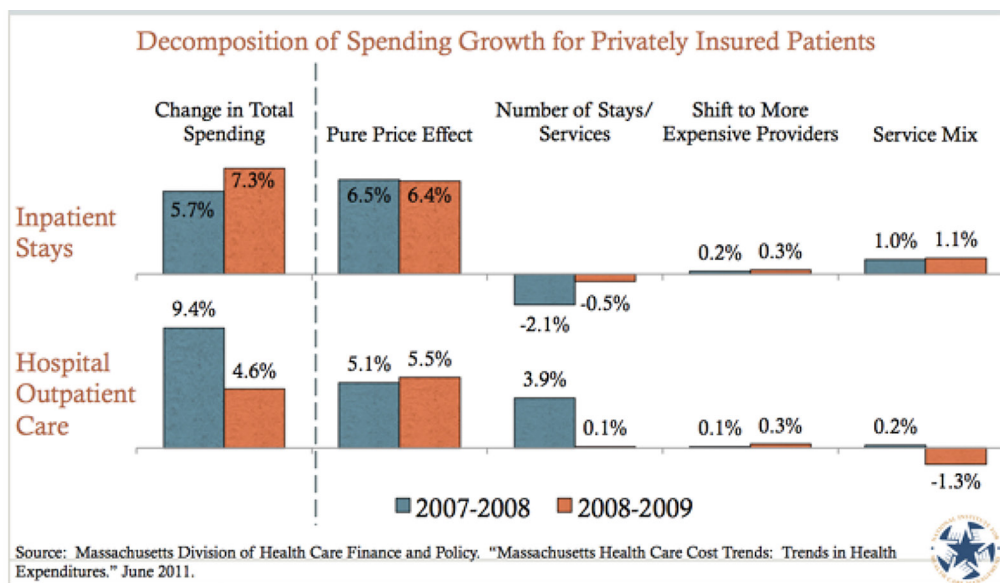
Chart 2 – Factors Accounting for Growth in Personal Health Care Spending, 1980-2009¹⁴



In analyzing the factors responsible for the relatively modest growth in national expenditures in 2009, Martin et al (2011) separated spending increases into price, intensity and quantity. Their analysis showed that prices accounted for more than 60% of the increase in overall spending.¹⁵ The authors also found that while the proportion of health spending growth due to prices varies over time, it has been growing steadily since 2001 (Chart 2).

Studies on hospital pricing from the Massachusetts Attorney General in 2010 and 2011 also identified price increases as the most important factor driving health care expenditure increases (Chart 3).

Chart 3 – Massachusetts Spending Growth by Cost-Driver Category, 2007-2008 and 2008-2009¹⁶



For inpatient services, over the two-year period 2007-2008 and 2008-2009, the shift to more expensive providers and service mix changes largely offset declines in patient volumes, leaving prices to explain nearly all of the increase in expenditures. For outpatient services, prices accounted for 75% of the change in expenditures over two years.

Based on these and other studies, it appears that price increases are 1.5 to 3 times more important than other factors in explaining rising health expenditures.^{17,18} Moreover, there is evidence that higher prices lead to oversupply of some equipment and capital, inefficient use of service capacity, and increased volumes.

For example, Paul Ginsburg has shown that outpatient providers are able to price their services at high levels and still be quite profitable, despite operating at only 50 to 60% of capacity.¹⁹ Evidence of high prices driving utilization comes from the Medicare Payment Advisory Commission (MedPAC), which reports that high prices may explain, in part, the growth in imaging services in the 2000-2008 period.²⁰

Price increases are 1.5 to 3 times more important than other factors in explaining rising health expenditures.

2.2: The Role of Provider Concentration on Higher Unit Prices and Outpatient Utilization

Although a number of factors can drive unit prices and utilization higher, increasing provider concentration and the stronger provider negotiating leverage that results appear to be major factors.²¹ Research (as described in Section 3) clearly demonstrates enhanced provider market power drives prices and revenues higher, as the rate of price increase in consolidated hospital markets typically exceeds the underlying cost contributors, such as drugs or medical equipment.²²

Despite different public images, both nonprofit and for-profit hospitals seem to pursue this price-elevating behavior.²³ Since the early 1990s, hospital consolidation has taken place at about an equal rate for both nonprofit and for-profit hospitals. In the context of many antitrust cases, a number of judges have differentiated between the likely behaviors of nonprofit vs. for-profit merged entities, speculating that nonprofit hospitals would refrain from exercising their market power or that if they did raise prices they would use the extra revenue for more mission-oriented activities.²⁴

A number of studies failed to find any significant differences in pricing behavior between nonprofit and for-profit hospitals post merger.²⁵ For example, Capps et al. (2010) examined seven years of data on California hospitals and found no evidence of any such differences.²⁶

Moreover, the evidence shows that consolidated nonprofit health systems tend to spend their negotiated earnings increases not on mission-oriented work, but on business-augmentation strategies and service enhancements. This includes purchases of new equipment or new medical technology that some evidence indicates may be more of a strategy to attract physicians, increase market share, and drive additional patient volumes than it is a means to improve care quality or efficiency. And in fact, investment in new equipment and medical technology among nonprofit hospitals is another major contributor to rising health care expenditures in the U.S. The primary motivation for this activity appears to be a highly regressive form of non-price competition.²⁷

As Havighurst and Richman argue in their treatise on the dangers of monopoly power concentrated in nonprofit health care systems:

“Managers of nonprofit firms...may intrinsically have incentives to build larger empires to enhance their self-esteem and status in the community and to justify increased perquisites for themselves and their physicians. Such empire building is most easily accomplished by obtaining market power and using it to generate surpluses with which to further entrench and extend the firm’s dominance.”²⁸

Perhaps most importantly, evidence from the Massachusetts Attorney General reports showed that prices for health care services are uncorrelated with either quality or costs. Instead, they are correlated with relative levels of consolidation and market power – and prominent nonprofit medical centers were most responsible for exercising their leverage to obtain these higher prices. Some insurers, such as the Tufts Health Plan, attempted to resist price increases by Partners HealthCare, a large system that includes Massachusetts General Hospital, and tried to assemble networks with Boston’s other hospitals. The report found that Partners launched an aggressive marketing campaign that triggered threats by many of Tufts’ corporate customers to switch insurers.²⁹

Consolidated systems yielding substantial market power negotiate higher private-sector prices, rather than making a rigorous effort to control costs.

Finally, hospitals with enough negotiating leverage to shift costs to private payers tend to have highly negative Medicare margins (i.e., costs much higher than Medicare payment levels). Hospitals facing dominant insurers managed to keep costs lower and maintained substantial Medicare margins.³⁰ The conclusion of MedPAC and others is that large and consolidated systems yielding substantial market power negotiate higher private-sector prices, rather than making a rigorous effort to control costs.

3: THE EFFECT OF PROVIDER CONSOLIDATION ON HEALTH EXPENDITURE GROWTH, HOSPITAL OPERATING EFFICIENCY AND QUALITY OF CARE

- The evidence is clear that for complex reasons, including revenue protection, hospital concentration has increased to monopolistic levels in many medical service areas.
- Accelerated vertical merging is a more recent trend among hospitals and physicians, both for specialty and primary care.
- Private insurers also have consolidated, and this too may increase premiums in certain circumstances, but research demonstrates concentration among payers often has a dampening effect on price increases.
- Theoretically, provider consolidation can result in improved efficiencies and clinical integration, but to date, the evidence indicates consolidation has yielded only price increases, with little improvement in either operating efficiency or quality outcomes.
- The conclusion is that these trends are clearly driven by a significant imbalance between a highly-concentrated provider market and a splintered payer market.

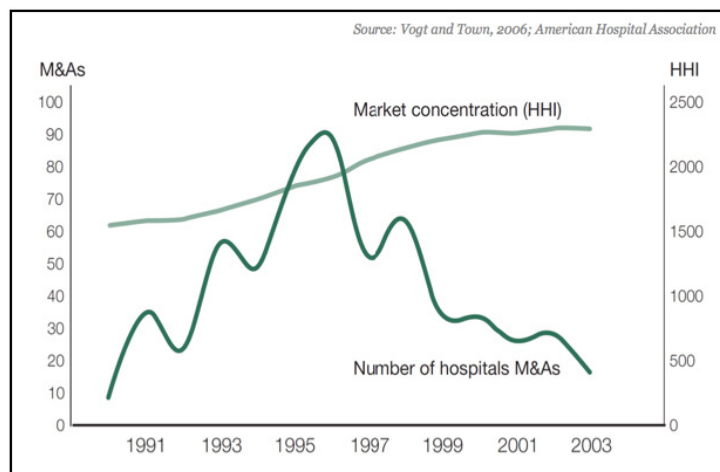
3.0: The Evidence for Hospital Consolidation

Given the clear evidence that higher unit prices are a major driver of health care cost increases, and that large and consolidated systems yielding substantial market power negotiate higher prices, it is critical to establish that there has, in fact, been an inordinate amount of provider consolidation.

The evidence here is also clear. Over the last 20 years, hospital capacity in the United States has become highly concentrated as hospitals have steadily shifted away from independent status and merged with other competing facilities or integrated with multi-hospital systems.

The Herfindahl-Hirschman Index (HHI) is widely employed as a measure of market structure. The HHI is the sum of squared market shares in the market (usually in a Metropolitan Statistical Area or “MSA”). The index increases as market shares are more concentrated among a small number of hospitals. It reaches its maximum value of 10,000 for a monopoly (the square of the monopolist’s market share of 100 percent), and reaches a minimum value when the market is equally divided. The Department of Justice (DOJ) and Federal Trade Commission (FTC) guidelines define a market as “highly-concentrated” if the HHI exceeds 2,500. Chart 4 shows there was a wave of hospital mergers in the mid-1990s with HHIs ticking up rapidly.

Chart 4 – Hospital Concentration increased rapidly in the mid-1990s³¹



Consolidation activity slowed around 2001, but there appears to have been an increase in mergers in recent years as shown in Chart 5. Merger activity has been national in scope. However, increased merger activity was particularly rapid in the southern part of the U.S.³²

Chart 5 – More Recent Hospital Merger Activity

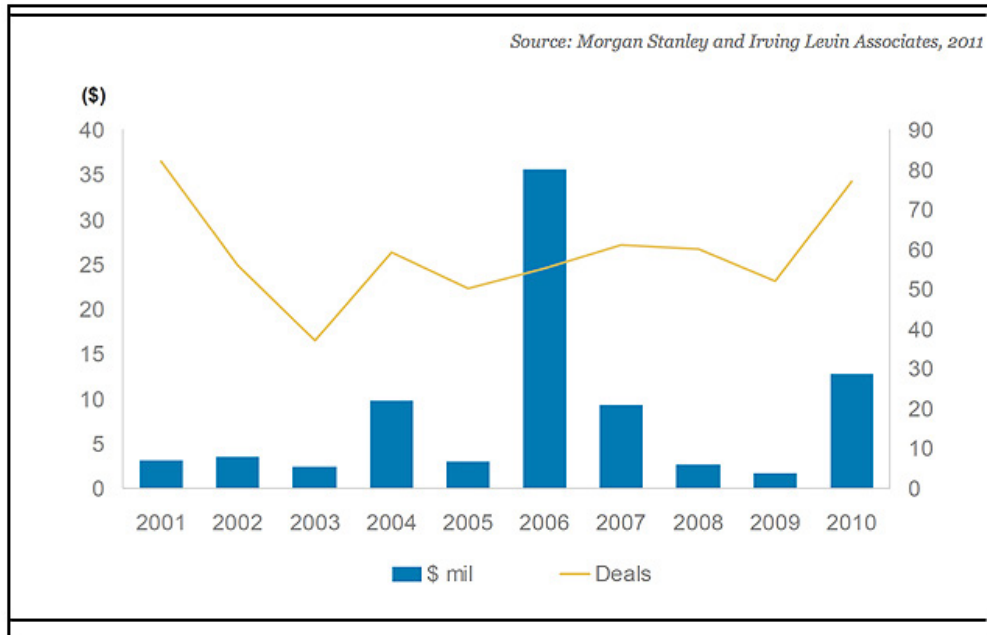


Table 1 presents the HHI for hospitals for various years from 1987 to 2006. The table is further evidence of increasing concentration in hospital markets. From 1987 to 2006 the HHI increased from 2,340, just under the FTC and DOJ recently updated threshold for classifying a market as “highly concentrated” to 3,261, a change of more than 900 points.³³

This rate of increase in a specific market would be comparable to a movement over time from five equally sized hospitals (a market with a HHI of 2,000) consolidating into four (a HHI of 2,500) and then ultimately three (a HHI of 3,333).

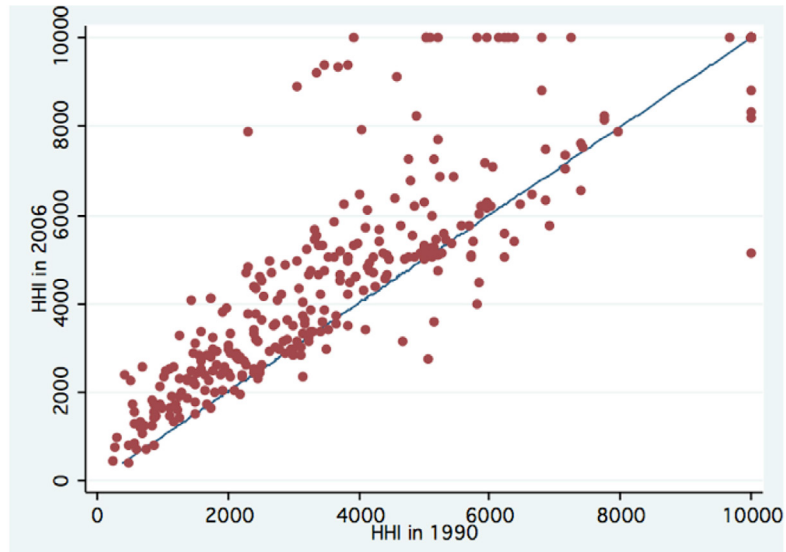
Table 1 – Hospital Market Concentration in the U.S., 1987-2006³⁴

Year	Mean HHI ^b	Change ^c
1987	2,340	—
1992	2,440	100
1997	2,983	543
2002	3,236	253
2006	3,261	25

^a Source: American Hospital Association. Data are for U.S. Metropolitan Statistical Areas with population < 3 million.
^b Herfindahl-Hirschmann Index. Means weighted by MSA population.
^c Total change from the previous year in the table.

Chart 6 (below) shows a scatter plot of concentration at the MSA level in both 1990 (on the horizontal scale) and 2006 (on the vertical scale). The chart shows that the increase in concentration was a broad phenomenon across the vast majority of MSAs over this period and that most MSAs are now highly concentrated. Out of the 332 MSAs in the U.S., 250 had HHIs greater than 2,500 in 2006.³⁵

Chart 6 – Scatter Plot of Metropolitan Statistical Areas (MSAs) by HHI, 1990 and 2006³⁶



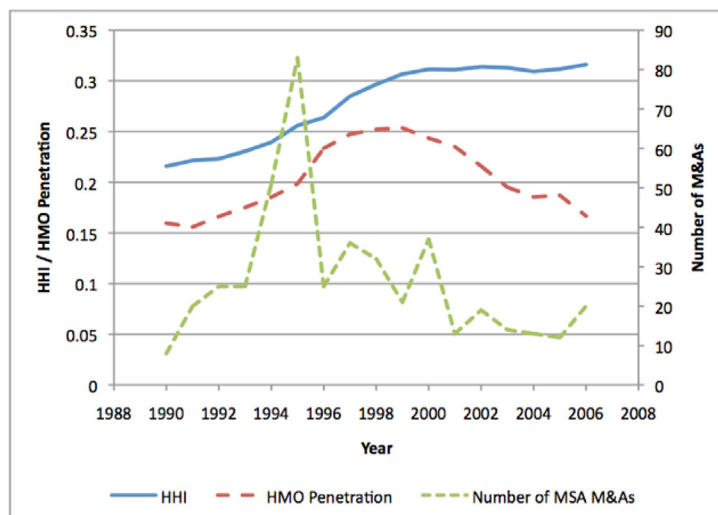
(Note: Points above the line represent MSAs that have become more concentrated over this period)

3.1: Why Hospitals Have Been Merging

The causes of hospital mergers are likely mixed. Economic theory would predict that changes in the competitive environment for hospitals might be the primary reason.³⁷ It's true that hospitals have experienced increased competition from ambulatory surgery centers and other non-hospital providers due to changes in medical technology that allowed certain procedures to be performed in outpatient settings.

In addition, many researchers anecdotally have pointed to the rise of managed care in the 1990s as the primary factor driving hospital consolidation. The theory is that the rise of HMOs, at a time of excess bed capacity, began to put pressure on hospitals through tougher negotiations, thereby inducing hospitals to consolidate to increase their power in these negotiations.³⁸ The trends displayed on Chart 7 show an apparent causal relationship.

Chart 7 – Trends in Hospital Concentration, Merger & Acquisition and HMO Penetration³⁹



Town and Vogt, however, did not find conclusive evidence that managed care was the primary driver of merger activity in the mid- to late 1990s.⁴⁰ Nevertheless, some researchers continue to believe that hospitals' anticipation that managed care would pressure them and compromise many aspects of their operations may have contributed to their decision to consolidate.⁴¹

More recently, researchers theorize that continued merger activity may be a result of the worsening economic situation of stand-alone hospitals experiencing declining volumes due largely to the recession.⁴² Some believe that for hospitals to make the investments to survive in this economic environment, increased merger activity is necessary.⁴³

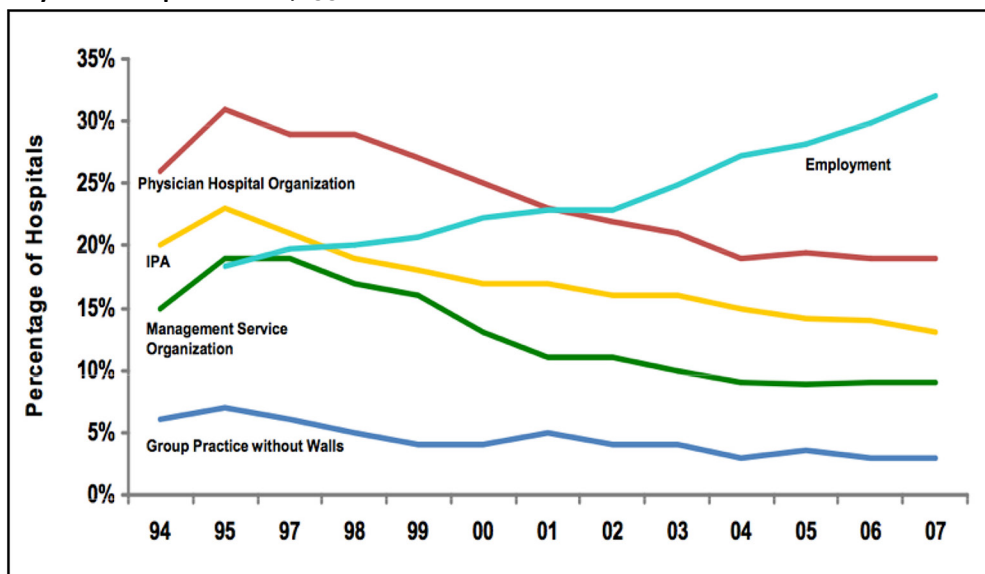
Others believe, however, that the mergers are an attempt to gain the leverage needed to block insurers from redirecting patient flows, or to frustrate the adoption of tiered networks.⁴⁴

Either way, increased size grants hospitals and health systems increased market and political power that they can use to protect and increase their leverage. For example, larger provider groups have been known to pressure local government officials to support efforts through Certificate of Need (CON) proceedings to prevent entry of competing hospitals or non-hospital providers.⁴⁵

3.2: Vertical Integration: Hospital-Physician Mergers

Most of the merger activity discussed in this analysis is about “horizontal” consolidation where hospitals merge with other hospitals. There is also a growing trend toward “vertical” integration between hospitals and physicians. Chart 8 shows the trends in the proportions of hospitals with various categories of arrangements with physicians; direct physician employment is now increasing in all states. This is a result of changing technology, reimbursement, and other environmental and lifestyle factors confronting physicians.⁴⁶

Chart 8 – Physician-Hospital Trends, 1994-2007⁴⁷



Hospitals initially focused on hiring specialists in cardiology, orthopedics, gastroenterology, and oncology. However, hospitals have begun hiring primary care physicians as well to capture referrals to their employed specialists. Today, many physicians – even the specialists who traditionally commanded much higher fees as independent practitioners – seek employment arrangements to avoid the rising costs of private practice and to achieve a better work-life balance.

Plans, providers, and policymakers often tout these arrangements as a positive development because they can align incentives, allow for better coordination and continuity of care, and enable joint investments that

Physician employment, however, is also one of many strategies hospitals use to gain market share by increasing admissions, diagnostic testing, and outpatient services. Most of these arrangements pay up-front bonuses to physicians on the basis of the volume of their billings per month.

enhance efficiency or the quality of care. Related to that, hospitals increasingly view physician-hospital integration as key to preparing for expected Medicare reforms connected to the ACA, such as bundled payments and Accountable Care Organizations (ACOs).

Physician employment, however, is also one of many strategies hospitals use to gain market share by increasing admissions, diagnostic testing, and outpatient services. Most of these arrangements pay up-front bonuses to physicians on the basis of the volume of their billings per month.⁴⁸

In addition, vertical integration can harm competition by reducing competing hospitals' access to key physicians (e.g., locking up all of the orthopedists in a market area can reduce the ability of a competing hospital or freestanding facility to offer that service). Separately, integration may eliminate competition among previously independent providers.

Hospitals also increasingly charge facility fees for office visits and procedures performed in formerly independent physicians' offices. The facility fee can sometimes amount to a significantly higher rate, often two to three times the

original professional fee.⁴⁹

Lastly, hospitals with large numbers of employed or associated physicians (through physician-hospital organizations) will negotiate with health plans on behalf of employed physicians and gain higher rates. In turn, this enables the hospital to offer more attractive compensation than independent physicians could negotiate on their own.⁵⁰

That said, because it is a recent phenomenon, there is relatively little research about the impact of vertical integration on market power or quality and cost. Nevertheless, hospitals with a large percentage of employed physicians in a given market are clearly well positioned to compete under future reimbursement scenarios. If the current fee-for-service dominated financing system persists, large physician networks with a focus on employing specialists will provide hospitals with greater pricing power when they are contracting with health plans. If, however, payment systems move toward more risk-based arrangements, then large outpatient networks will allow a vertically integrated system that includes primary care physicians to shift patients away from higher cost hospital-based care. Systems can also recapture lost revenues as shared savings or capitation surpluses.

3.3: Insurer Consolidation

A recent study suggests that while most hospital concentration exceeds health plan concentration, hospital prices in the markets where health plans are most consolidated are approximately 12% lower than in more competitive health plan markets.

Private insurance companies also have undergone a wave of mergers. This has likely imparted significant market power to the remaining firms and, indeed, health insurance premiums have risen at a very rapid rate since 2000.

With 34% of every premium dollar paid out to hospitals for services, the prices negotiated between insurers and hospitals play a large role in determining the level and growth of insurance premiums.⁵¹ Moreover, economic theory would predict that hospital prices would be lower in the face of more dominant health insurers. Evidence from the post-managed care period seems to confirm the "monopoly busting" ability of large HMOs,⁵² as long as health plan markets remain competitive vis-à-vis employers.

A recent study by Melnick et al (2011) suggests that while most hospital concentration exceeds health plan concentration, hospital prices in the markets where health plans are most consolidated are approximately 12% lower than in more competitive health plan markets.

On the other hand, if health plan concentration gets too great, as middlemen to

the ultimate purchasers of care, these companies can mark up the premiums they charge their customers and keep the cost savings from negotiating lower provider prices. As a result, public policy that systematically shifts the relative market power from one sector of the health care industry to another may have an ameliorative effect in one market and a detrimental effect in another.⁵³

It is difficult to assess the impact of the dynamic between insurers and employers when it comes to insurance plan consolidation. Some studies find evidence that premiums increase with the employers' level of profitability (presumably evidence that less profitable employers negotiate harder over premiums). When there is less consolidation, conversely, the effect of employer profitability on insurance premiums falls.

Overall, the fact that hospital prices are higher in markets with less insurer consolidation should give policymakers pause before advocating policies aimed at increasing the number of insurers in a given market. Melnick et al substantiate this caution. The widely held notion that more insurers in a market area will reduce premiums paid by the insured is not supported by economic theory or empirical research.

The widely held notion that more insurers in a market area will reduce premiums paid by the insured is not supported by economic theory or empirical research.

3.4: The Use of Market Power

Consolidation of providers *can* result in improved efficiencies and quality as a result of eliminating duplicated activities and personnel, economies of scale, and the ability to integrate care. However, as already noted, consolidation can also increase market power, leading to higher prices, less efficient outcomes, and misallocation of resources.

The major concern, therefore, is that hospitals will use enhanced market power to raise prices inappropriately to weaken the effects of or stifle competition.

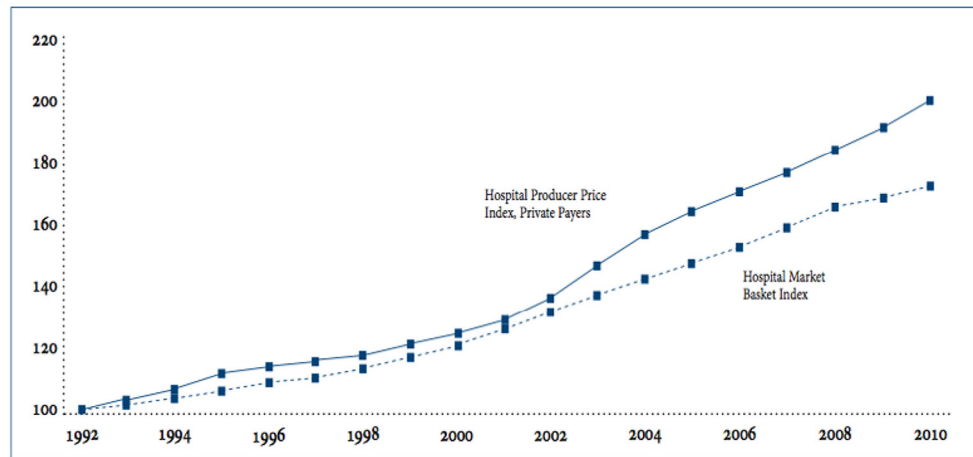
Recent studies on competition document how health systems exercise their market power in ways that would not fall under the scrutiny of federal or state antitrust activities. For example, some hospitals reach “must-have” status, meaning that employers and consumers in health plans demand that they be included in an insurer’s network because they have a well-recognized brand name or provide highly-specialized services not generally offered in a particular region. Hospitals also gain negotiating advantages in areas that are relatively isolated geographically and where bed capacity is still relatively tight.⁵⁴ And in general, employers and consumers demand unrestricted networks. Thus, private insurers do not have any credible threat during negotiations about eliminating a dominant provider from their network.

On prices, we have already cited substantial research documenting the ability of concentrated providers to negotiate increased prices with private insurers.⁵⁵ That body of research suggests that providers with significant market power can continue to negotiate higher-than-competitive prices.⁵⁶

In addition, health systems increasingly are merging with hospitals over a larger region and then are able to extract higher prices for all facilities in their chain and not just those in smaller markets where they are the dominant providers. Multi-hospital systems benefit by negotiating a single contract for all (“all or none” provisions) and obtaining higher prices across the board for every facility.⁵⁷ Again, these facilities can avoid antitrust scrutiny because their mergers do not result in excess concentration in a more localized area.⁵⁸

Moreover, the ability of U.S. providers to extract higher prices appears to be growing. Chart 9 shows the growth in prices paid by private payers for hospital inpatient care and the growth in the hospital market basket index from 1992 to 2010. The “hospital market basket index” (bottom line in the chart) tracks year-to-year growth in the cost of hospital inputs (wages, supplies, utilities, contractual services and capital, etc.). The “hospital producer price index, private payers” (top line) measures the prices hospitals get paid per discharge by private payers. The growing divergence demonstrates that over the past decade hospitals have been using their increasing negotiating leverage to obtain higher prices from private payers, over and above the growth in input costs.

Chart 9 – Growth in Prices Paid by Private Payer for Hospital Inpatient Care vs. Growth in the Hospital Market Basket Index, 1992-2010⁵⁹



Note: The “hospital producer price index, private payers,” measures trends in the price paid per hospital discharge and includes data for patients who are not covered by Medicare or Medicaid (private payers) and who are treated at general medical and surgical hospitals. The “hospital market basket index” measures trends in the prices of hospital inputs (i.e. goods and services such as nurse labor, used to produce hospital care).

Sources: Data for the hospital producer price index are from the Bureau of Labor Statistics (series ID: PCU62211A62211A6). Data for the hospital market basket index are from two different sources. For the years 1992 through 1995, data are from The Lewin Group, *The Balanced Budget Act and Hospitals: The Dollars and Cents of Medicare Payment Cuts (May 1999)*. For the years 1995 through 2010, data are from Centers for Medicare and Medicaid Services (CMS), *Quarterly Index Levels in the CMS Prospective Payment System (IPPS) Hospital 2006 Input Price Index using HIS Global Insight Inc. (IGI) Forecast Assumptions, by Expense Category, 1995-2020 (2011)*.

3.5: The Question of Cost Shifting

Hospital and physician representatives often argue that this trend is a reflection of their need to raise prices to offset lower payments from public payers and uncompensated care, in a process known as “cost-shifting.”

Many economists, however, question two key assumptions that underlie the cost-shifting argument. The first assumption is that cost levels are largely outside hospitals’ control and providers must seek to recover them when payments from public payers grow more slowly. Yet as discussed previously, MedPAC has shown that the ability or willingness of hospitals to control their operating costs is directly related to the level of negotiating power they face from both public and private payers in a given market.⁶⁰ When hospitals have more power, they are less likely to control costs.

The second assumption is that in the course of the normal year-to-year bargaining process, providers intentionally charge payers less than they actually could, given their negotiating leverage. That is, they “leave money on the table” and charge more only when government programs cut their payments. This argument assumes, however, that consolidated providers choose not to use all of their market power out of some sense of public obligation. Although a few may occasionally do just that, the history of provider contract negotiations and most economic theory would argue against it happening very often. Many, if not most, use their market leverage to engage in monopolistic price-discrimination.⁶¹ And as we’ve noted consistently, this dynamic has important implications for underlying hospital expense growth.

Together, various methods of measuring consolidation and the impact on price have found price increases ranging at least 10% to as much as 50% as a result of consolidation.

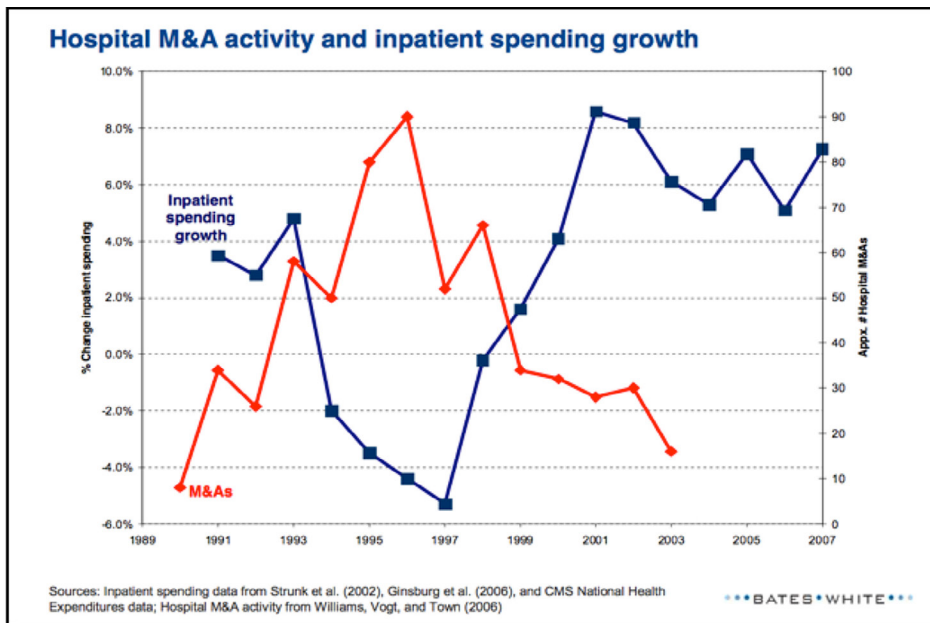
3.6: Impact on Hospital Prices and Spending

There are a number of ways to estimate the impact of hospital consolidation on prices, including the structure-conduct approach (which examines the impact of hospital market concentration, measured as the HHI, on price), the event study approach (such as the Sutter-Summit analysis which considers the impact of single

events), and the simulation approach.⁶²

Together, these methods have found price increases ranging from at least 10% to as much as 50% as a result of consolidation (under a simulated scenario involving a merger of rival hospitals in a particular localized market).⁶³ For example, an evaluation of the Evanston Northwestern and Highland Park hospitals in the northern suburbs of Chicago found a price increase of 20 percent due to the merger. The FTC also found that the merger of two competing Northern California hospitals, Summit and Alta Bates, resulted in price increases of between 28 and 44 percent after the merger.⁶⁴

Chart 10 – Mergers vs. Hospital Spending Increases⁶⁵



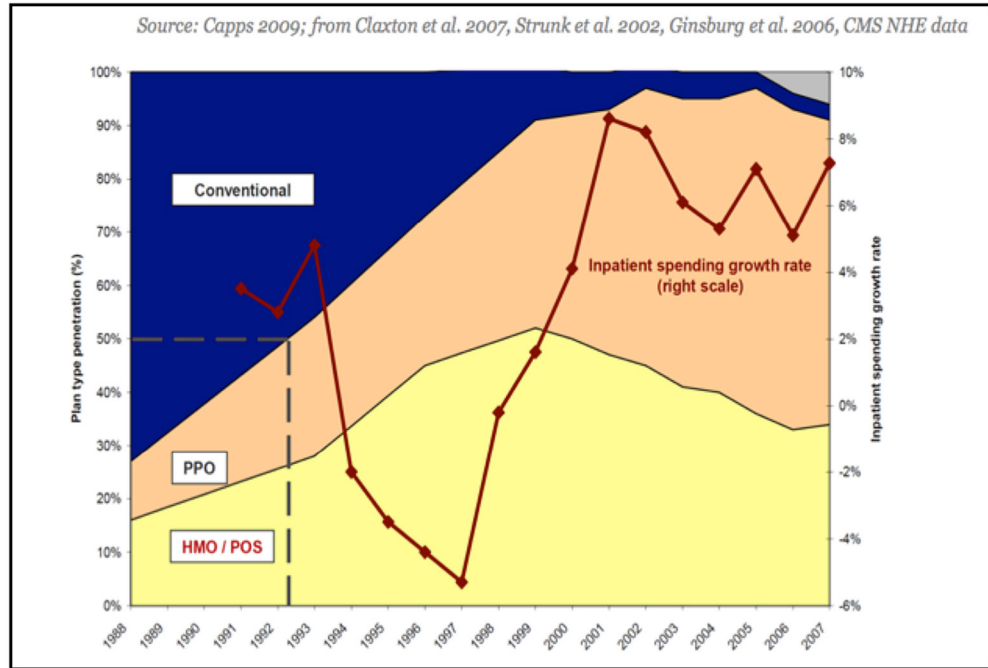
Charts 10 and 11 illustrate the trend in hospital payments and revenues relative to the extent of hospital consolidation and HMO activity over the past several decades, respectively. Chart 11 also illustrates the ameliorating impact managed care had on provider prices during the 1990s.

Extrapolating from the conclusion in an analysis in the Town and Vogt (2006) RWJF survey, Cory Capps, a partner with the economic consulting firm of Bates White estimated the overall impact on national health care expenditures resulting from hospital consolidation experienced as of 2006. Specifically, Town and Vogt estimate that an 800-point increase in the HHI within in an MSA (equivalent to a merger of five hospitals into four) leads to an average price increase of roughly 5%. Applying this finding to the observed levels of concentration in MSAs, Capps concludes that in the 94 most concentrated largest MSAs, privately-insured patients and their insurers pay about 6% more than they otherwise would.⁶⁶

These 94 MSAs account for roughly half of hospital admissions of privately-insured patients – and those patients are paying 6% more as a result of this consolidation. Thus, nationwide, payments to hospitals on behalf of the privately insured are about 3% higher than they would be absent hospital consolidation (i.e., half of private expenditures are 6% higher, so total private expenditures are 3% higher). Given that payments to hospitals by private insurers represent about 13%–15% of total expenditures on health care, total national health care expenditures are roughly 0.4% to 0.5% higher than they would be absent the price increases resulting from hospital consolidation, the equivalent of \$10 billion to \$12 billion annually, in 2006 dollars.⁶⁷

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Chart 11 – Managed Care Penetration and Inpatient Spending Growth⁶⁸



Extreme variation in pricing across different markets and within markets reflects the varying levels of concentration. The CPR-commissioned Ginsburg study used administrative claims data from four large carriers to determine private payment levels as a percent of Medicare for inpatient and outpatient care. The study found significant payment variation both within and across regions. Table 2 provides a summary of the results for the eight geographic areas surveyed.

Table 2 – Private Insurer Payment Rates as a Percentage of Medicare⁶⁹

HOSPITAL PAYMENT	CLEVELAND	INDIANAPOLIS	LOS ANGELES	MIAMI-SOUTH FLORIDA	MILWAUKEE	RICHMOND, VA.	SAN FRANCISCO	RURAL WISCONSIN
Inpatient Payment								
Inpatient Average Payment Rate	151%	198%	149%	147%	205%	192%	210%	169%
25th Percentile	102	168	84	113	167	171	136	144
50th Percentile	128	197	118	136	195	200	210	178
75th Percentile	149	229	168	174	220	238	252	209
Highest Payment Rate, with Volume	232	283	418	284	333	291	484	318
Outpatient Payment								
Outpatient Average Payment Rate	234	307	277	*	267	267	366	240
25th Percentile	158	259	179	*	238	231	268	167
50th Percentile	193	303	243	*	262	275	368	195
75th Percentile	234	336	307	*	304	347	456	291
Highest Payment Rate, with Volume	357	493	559	*	439	495	718	381

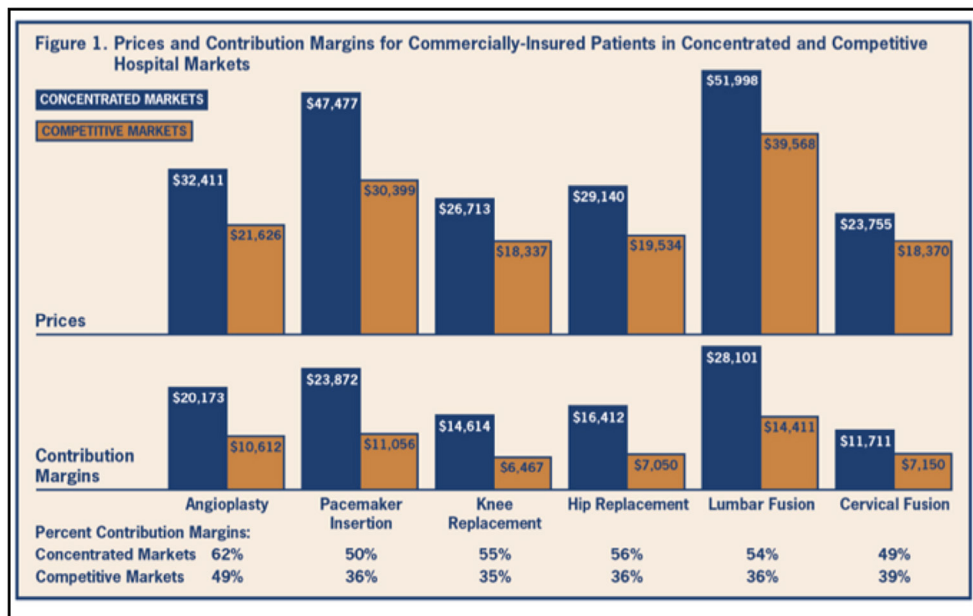
*Fewer than three insurers reported

Source: Author's analysis of hospital payments rates of four large national insurers, Aetna, Anthem Blue Cross Blue Shield, CIGNA, and UnitedHealth Group

While quality differences among providers could account for some of the disparities both within and across markets, it is not likely that differences in quality would be as large as the variation in payment levels.⁷⁰ It appears likely that the primary reason for the differences in payment levels is the different levels of market power wielded by providers.⁷¹

Recently, economist James Robinson presented research that showed the ability of hospitals in concentrated markets to raise prices to private insurers is much higher (Chart 12).

Chart 12 – Prices for Private Patient Procedures and Associated Contribution (“profit”) Margins for Providers in Concentrated and Less Concentrated Market Areas⁷²



Overall, these and other studies consistently show that hospital consolidation raises prices, and often by very large amounts. Consolidated hospitals and integrated hospital/physician systems that are able to charge higher prices due to enhanced market power appear able to do so in the absence of some countervailing force (i.e., exclusion from the provider network of one or more payers, successful antitrust action, or some other intervention).

3.7: Impact on Hospital Operating Efficiency

The next question is whether these higher hospital prices enhance care value, boosting hospitals’ operating efficiency and/or lowering operating costs.

In discussing consolidation in this context it is important to distinguish between two types of mergers: 1) ownership consolidation only; and 2) facilities consolidation. An ownership consolidation occurs when two independent hospitals are now owned by the same overall corporation, but continue to operate independent of one another. Facilities consolidation occurs when an ownership consolidation is followed either by the closure of one of the hospitals or by a significant consolidation of services across the merging hospitals.⁷³

At first, actual consolidation of facilities seems to lower hospital costs, while those not combining facilities produce no appreciable savings in operating costs.⁷⁴ Yet another recent study found that costs declined immediately following a merger, but eventually rose to pre-merger levels. This result and the theory that hospitals with more market power have higher expenses is consistent with MedPAC’s view of how consolidated hospitals behave;⁷⁵ that is, they do not have enough incentives to seek ways to operate more efficiently, with lower costs.

In addition, as noted earlier, there is some evidence that hospitals that generate additional market leverage

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spend newfound revenue on wooing physicians, or on purchasing new technology and equipment to increase their patient volume. They may also increase the salary structure and benefits of hospital management. If there are any cost savings realized by merged hospitals, the evidence indicates that they do not typically pass them on to payers or consumers.

3.8: Impact on Quality

A number of studies have also examined the impact of hospital consolidation on various measures of quality, primarily risk-adjusted mortality. While a majority of these studies show consolidation tends to reduce quality of care, the results do not appear to be conclusive. The results are strongest when examining populations that fall under regulated pricing, such as Medicare.^{76,77}

Kessler and McClellan find that risk-adjusted, one-year mortality for Medicare heart attack (acute myocardial infarction, or AMI) patients is significantly higher in more concentrated markets; patients in the most concentrated markets had mortality that was 4.4% higher than those in the least concentrated markets as of 1991. This amounts to more than 2,000 fewer statistical deaths in the least concentrated versus most concentrated markets.⁷⁸

Some policy experts believe that the merger process itself is disruptive to organizations while it is occurring and they often place quality initiatives on hold for the first six to nine months while the various entities integrate from a legal and operational standpoint. On the positive side, larger and more sophisticated entities can also be more strategic about developing and marketing their quality assurance efforts to insurers and patients.⁷⁹

While the evidence suggests, on balance, that increasing hospital concentration lowers quality, reaching this conclusion is hampered by an absence of reliable quality metrics and other confounding factors. This appears to be an area of research requiring more analysis before a definitive conclusion can be reached.

3.9: An Imbalance in Market Power is the Fundamental Problem

In the 1990s, health policy experts envisioned a more efficient and effective health sector, with managed care plans and integrated delivery systems competing for patients on the basis of how well they could provide care. It may be that the principal roadblock to achieving that vision is a fundamental imbalance between purchasers and providers tied to noncompetitive models of care delivery.

Other countries have adopted public policies that give purchasers more market power, such as Switzerland and the Netherlands. By contrast, policies in the U.S. tend to allow the suppliers of health care services to consolidate and remain strong relative to a highly-splintered purchasing side of the market.⁸⁰

In the private insurance market, which covers roughly half of all Americans, insurance products come in thousands of different variations, each with its own rules and procedures and pricing terms. In 2001, there were an estimated 2,151 private insurance entities operating in the group market and 643 operating in the individual insurance market, with many operating in both.⁸¹

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The U.S. has a highly fragmented and largely uncoordinated public side as well, including: traditional Medicare; Medicare Advantage (the managed care arm of Medicare, operated by multiple types of private plans); the Medicare prescription drug program, which similarly relies on a large array of private insurers; TRICARE for active duty military and their dependents; and TRICARE for Life and the Veterans Administration Health System for non-active military. Government employees receive their insurance through such programs as the Federal Employee Health

Benefit Program or individual state employee benefit programs, which bid their coverage out to a myriad of private insurers. At the state level there is fee-for-service Medicaid and Medicaid Managed Care, which again is bid out to any number of private entities.

This fragmentation weakens purchasers' ability to negotiate rates, and allows providers to price discriminate, resulting in the large increases and considerable variation in pricing, which in turn seems to account for the large variations in practice patterns, use and costs.

A fragmented and disjointed health insurance system also results in huge administrative costs and complexity for providers, plans, purchasers, and patients. Patients have a scarcity of reliable information on prices or other metrics that they can use to assess provider performance and guide their purchasing decisions. Due to this lack of transparency, health care providers possessing market power have greater pricing freedom and are quite vigilant about fighting any attempt to bolster the purchasing power of employers, health plans, and consumers. Such was the case with provider opposition to the Public Plan option proposed as part of the ACA.⁸²

Certainly, the fact that health care is unlike any other product or service – because purchases can literally be a matter of life or death – changes the dynamics of the market. But even allowing for that, the health care marketplace suffers from five basic failures:

1. The general monopolistic nature of hospital activity has given out-of-proportion market power to providers relative to the fragmented and relatively weak market power of public and private insurers.
2. The distorted prices produced by this fragmented and imbalanced system result in huge price disparities that do not reflect cost and resource use. These disparities reflect a huge misallocation of resources, as demonstrated by research showing practice patterns produce wide differences in cost without improving outcomes.
3. The continued lack of actionable data and information on prices for consumers foils their ability to make informed decisions when they shop for care based on value.
4. A lack of alignment of interests and incentives across patients, payers and providers, creates perverse incentives for providers to induce demand unnecessarily.
5. Incentives to consumers implicit in the provision of insurance and the preferential tax treatment of employer-sponsored coverage stimulate excessive consumption.⁸³

These market failures don't just affect costs. Some believe they are part of why there is a shortage of primary care providers and a lack of emphasis on prevention that leads to unfavorable public health trends like our obesity epidemic. This, of course, drives health care expenditures ever higher.

Now, with the Supreme Court upholding most of the ACA, there is concern that for all its good intentions, the new law may exacerbate the fundamental market problem.

- Because reductions in the rate of growth of Medicare payments will largely finance the insurance coverage expansions, purchasers and plans are concerned that providers will raise unit prices for the private insurance sector even further.
- Large Medicaid expansions and the launch of health exchange plans will mean an increased number of low-reimbursement patients for providers, further incenting cost shifting.
- The basic structure of both the Pioneer and Shared Savings Program (SSP) Medicare Accountable Care Organizations (ACOs) are likely to induce losses for hospitals. Some policy analysts have expressed a fear that these providers organizing into ACOs will seek to use their negotiating leverage with private plans to recoup these shortfalls through higher unit prices.
- Additional integration of hospitals and physicians into the ACOs encouraged by the ACA may well accelerate provider consolidation in local markets. Hospitals and physicians are already integrating at a rapid rate, and many policy-experts are asking whether this new evolution of integration will give hospitals and physicians additional negotiating leverage with private payers.⁸⁴

- Finally, with citizens required to have health insurance, market-dominating providers will be somewhat freed from the constraints of consumers' willingness or ability to pay.

All of this could result in a more rigid demand curve, and even more revenue flowing to providers at the expense of the purchasers of care – most significantly the consumer. Thus, the ACA provides an even stronger imperative to address the growing imbalance in market power and other failures of our health care market.⁸⁵

4: POTENTIAL WAYS TO IMPROVE PROVIDER COMPETITION, HEALTH CARE COSTS AND QUALITY

- Antitrust litigation is important, but for a complex set of reasons, it is not enough on its own to slow significantly provider consolidation and its negative impact on the marketplace.
- There are a number of pure market-based interventions that have either demonstrated some efficacy or show potential, but most require purchasers, plans, and providers to cooperate and coordinate at levels that prove challenging. Federal and state governments can work independently or in concert with the private sector to foster a more competitive market. However, many such solutions require purchasers, providers, and plans to change their mindset, but there are some efforts in place that have begun to show promise.
- The last resort in most cases is a more heavy-handed regulatory response. Though there is private-sector resistance today to these approaches, if other approaches fail or are inadequate, this private sector perception may change.

4.0: Antitrust Litigation is Not Enough

Addressing market imbalances and industry consolidation that have grown over time will not be easy.

For one thing, not all consolidation creates negative effects for purchasers and patients. Nevertheless, the historical evidence from 20-plus years of provider consolidation in the U.S. is that consolidation has not benefited consumers, particularly as it relates to hospital care.

Antitrust action has been the traditional response of those seeking to counteract consolidated market power that affects consumers negatively. But a long losing streak in antitrust litigation – and other policy concerns – have led to a level of provider consolidation that has significantly skewed market power toward providers and become a major factor in unsustainable levels of growth in health care costs. Thus, while not ignoring antitrust action, we also must look to alternative approaches and activities to counteract the negative effects of provider market power. Potential solutions fall into three different categories: 1) Market-Based Approaches; 2) Coordinated Public-Private Activities; and 3) Regulatory Interventions. Appendix II contains a more detailed discussion of the proposed solutions.

4.1: A Brief History of Antitrust Actions

Antitrust is the traditional approach taken by government to curtail anti-competitive activities in the marketplace.

Successful antitrust activity effectively draws a line in the sand, articulating explicit and implicit limits on pricing and merger behavior. Officials hope that vigorous enforcement against egregious offenders will have a chilling effect on the inappropriate exercise of market power by others, who fear the possibility of detection and prosecution.

In the 1980s, antitrust activity seemed to create precedents that dissuaded providers from merging or, if already consolidated, from engaging in injurious market behaviors. However, from 1993 to 2006, the Federal Trade Commission (FTC) and Department of Justice (DOJ) suffered a high-profile, six-case losing streak. The cases mostly revolved around the definition of the geographic market area that would be affected by alleged non-competitive activity, but the written decisions seemed to

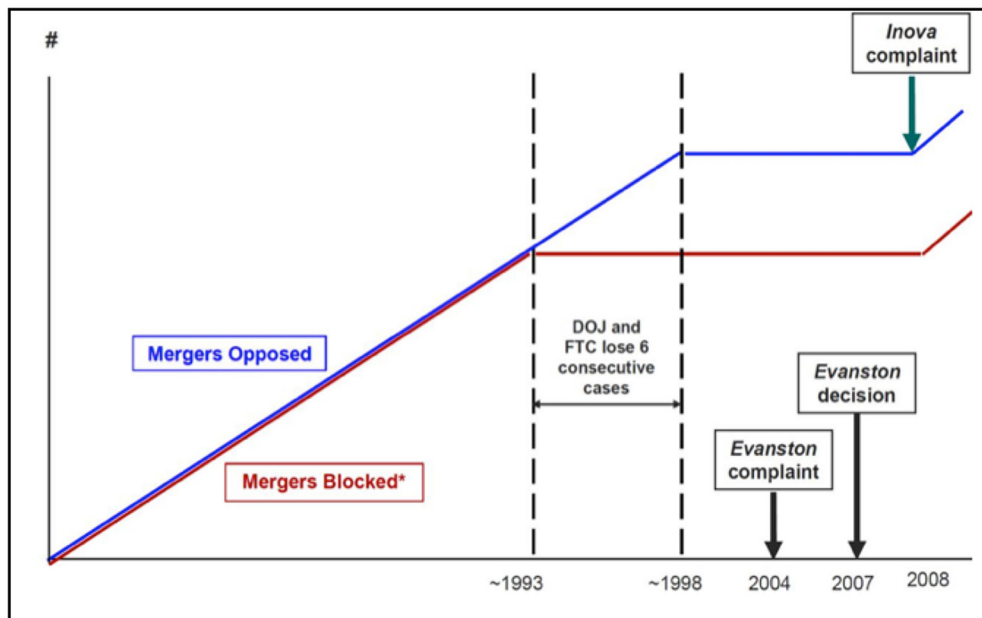
The ACA provides an even stronger imperative to address the growing imbalance in market power and other failures of our health care market.

signal judicial skepticism about the wisdom of applying antitrust law rigorously in hospital markets. This is partly due to the judges' belief that nonprofit hospitals would not exercise their market power to raise prices, or, if they did, would put the extra revenue to charitable use.

As discussed above, that belief has not been borne out by actual behavior and the antitrust decisions paved the way for a number of "naked mergers," particularly in markets like Boston.⁸⁶

One result has been that in newly concentrated markets, some dominant providers have successfully foiled market entry by their competitors. For example, in Virginia, Inova successfully prevented entry by providers like Sentara Healthcare and the Johns Hopkins Health System. This was true too in Northern Virginia and Loudon County where the Hospital Corporation of America's (HCA) bid to enter that market was soundly rejected through a controversial and politically charged Certificate of Need review and decision.⁸⁷ Chart 13 shows this history of antitrust action and highlights the period of unsuccessful challenges from 1993 to 2008.

Chart 13 – Hospital Antitrust Activity: Failure to Block any Mergers, 1993-2008⁸⁸



In addition, as noted earlier, the mergers clearly lead to price increases. In 2007 the Federal Trade Commission (FTC), in a case challenging a merger of nonprofit hospitals on Chicago's North Shore, found convincing proof that following the merger the new entity had substantially raised prices for managed care organizations. The case was unusual because the FTC initiated its challenge in 2004, four years after the merger was consummated. The FTC eventually won a ruling by an administrative law judge that Evanston Northwestern Healthcare's acquisition of nearby Highland Park Hospital violated federal antitrust laws. The Evanston case gave the FTC's staff an opportunity to demonstrate that nonprofit hospitals gaining new market power will use it to increase prices. The remedy, however, only imposed administrative restrictions on the two facilities and did not call for the divestiture of Highland Park.

More recently, the FTC has been experiencing some successes in both pre-merger and post-merger activity. In 2008, the FTC sued to block a merger in Northern Virginia between the Inova Health System and Prince William Health System, estimating that the merger would result in Inova controlling over 73% of inpatient bed capacity (across six facilities) in Northern Virginia with the potential to raise prices substantially for private insurers. The health systems dropped their merger plans in the face of the FTC opposition.⁸⁹

Post-merger, the FTC successfully sued to unwind a consummated merger in Toledo, Ohio in 2011. Hospital representatives justified the merger "as necessary to prepare for health reform."⁹⁰ The regulators rejected that argument on the basis that the merged entity would control more than 80% of the market. They showed that

With cost concerns top of mind, many policy analysts strongly recommend that the FTC pursue egregious antitrust cases with renewed vigor. Given that most major health care markets are already highly concentrated, post-merger action may be all that is left in this regard.

ProMedica Health System (the acquirer) had the highest prices in county, while St. Luke’s Hospital (the acquired facility) had the lowest. The FTC estimated that prices at St. Luke’s Hospital would increase by 38%. The FTC required ProMedica Health System to sell St. Luke’s Hospital within 180 days. This decision, if upheld on appeal, could help slow the pace of mergers and acquisitions.

With cost concerns top of mind, many policy analysts strongly recommend that the FTC pursue egregious antitrust cases like the above with renewed vigor. Given that most major health care markets are already highly concentrated, post-merger action may be all that is left in this regard.

There are, however, potential drawbacks associated with post-merger challenges. The enforcement agency’s resources are limited, so it can pursue only so many cases of this nature. In addition, divestitures can be disruptive to patients and providers and may be politically unpopular.

Nor will it be easy for the FTC to detect and then deflect consolidation strategies. Given the highly-concentrated nature of the provider industry and the fact that in many markets consolidation activities may fall outside the purview of antitrust enforcement, the overall effectiveness of renewed antitrust activities may well be limited.

4.2: Safe Harbor Provisions and Accountable Care Organizations (ACOs)

Another aspect of antitrust enforcement is providing so-called safe harbors for integrations that are expected to enhance efficiency. The safe harbor issue is particularly salient now with regard to the ACA’s expressed intention to encourage the development of ACOs. As indicated previously, the ACO-like integration among hospitals and doctors has potential benefits, but it can also hamper competition. Indeed, by encouraging hospitals and physicians to combine forces to create ACOs, the ACA may actually prompt and enable providers to gain more market power.⁹¹

The New York Times has reported on “a growing frenzy of mergers involving hospitals, clinics and doctor groups eager to share costs and savings, and cash in on the [ACO program’s] incentives.”⁹² Providers appear to be using the reform law as the primary rationale for moving ahead with merger activities, although as in the case of the ProMedica and St. Luke’s Hospital, some providers’ motives in forming ACOs may actually be to strengthen their market power over private purchasers.⁹³

That may be due to the previously noted provider concerns about additional cuts in public payments and a shift to a less favorable payer mix due to the ACA’s insurance expansions. Hospitals are perhaps understandably worried about their financial viability, but if these reform efforts only stimulate new forms of concentrated market power, it seems likely that providers will continue to raise prices at unsustainable rates for private insurers, which in turn will ultimately land on the backs of those paying the premiums: employers and individuals.

In turn, the nation may find it far harder to afford the ACA’s expansion of health coverage to millions of consumers “if monopolists of health care services and products can continue to charge not what ‘the market’ will bear but what insurers will bear.”⁹⁴

That’s why it appears that the U.S. now needs to focus its efforts on other activities and mechanisms to counter the negative effects of provider market power. We describe these briefly below and in more detail in Appendix II.

4.3: Market-Based Approaches

Because the U.S. is largely a market-driven society – a fact that distinguishes it from most other industrialized nations when it comes to health care – there is a general preference for market-based activities to improve competitiveness and address market failures.

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In health care the most prominent market failures include lack of data and meaningful information to facilitate consumer decision-making; price-insensitivity of consumers due to the presence of health insurance; and the overall imbalance in market power between purchasers and providers of care. The following describes market-based interventions to address these failures and promote the normal workings of a competitive market.

1. CONSUMER ENGAGEMENT STRATEGIES – PRICE AND QUALITY TRANSPARENCY

DESCRIPTION: Successful consumer engagement depends on consumer access to actionable information on provider value within an available network.

ASSESSMENT: Increasing the transparency and usefulness of provider performance (value) data is a high priority. Some states have been collecting and publishing data on private sector prices and providing some limited information on provider quality and utilization patterns. But efforts to create meaningful and consistent metrics to inform consumer decision making are still in their infancy. In addition to the transparency tools health plans and other vendors are developing and increasingly offering, improved transparency may mean increased availability of comparative cost and quality data to employers and other parties (such as health care coaches, nurses, and primary care physicians) who are properly incentivized and sufficiently knowledgeable to assist patients in making high-value decisions about their health care. There is also the concern that making raw pricing data widely available could result in provider collusion and increased prices. However, if displayed as the consumer's share for specific health plan patient members according to their benefit design, this concern may be less relevant. If not done well, and in conjunction with quality data, price transparency could also confuse or mislead consumers. Catalyst for Payment Reform has developed [tools](#) to help employers compare the many price transparency tools on the market offered by health plans and other vendors.

2. CONSUMER ENGAGEMENT STRATEGIES – CONSUMER-DIRECTED HEALTH PLANS (CDHPS)

DESCRIPTION: In health insurance, there is an inherent tension between the benefit of reducing a person's exposure to financial risk and the drawback of reducing a patient's sensitivity to differences in price and quality among providers, which stems from the presence of "first-dollar" insurance coverage. When patients receive comprehensive health insurance, they naturally tend to consume more services, which contribute to rising health care costs. However, some believe that if a policy could create the proper balance, and be coupled with the use of more restricted or higher-value provider networks, this could lead to higher-value health care. One of the primary consumer engagement strategies designed to achieve this goal is the Consumer-Directed Health Plan (CDHP), which typically pairs a health savings account (HSA) with a high-deductible health plan.

ASSESSMENT: It may be unrealistic to believe that consumers alone can drive market share shifts or change the balance of market power between providers and payers. There is only so much cost-sharing that can be in effect and still have some form of health insurance in effect. Besides, consumers are hamstrung by the lack of meaningful information that could identify low-cost and high-quality providers. Even if such information existed, it is doubtful that acting by themselves they can use these data to make high-value purchasing decisions. CDHPs can be marginally effective to help younger and healthier patients make wiser and more parsimonious decisions about care options, such as avoiding unnecessary use of hospital emergency rooms. However, care must be taken to structure CDHPs to avoid discouraging patients from seeking necessary preventive and primary care and shifting cost to chronically ill patients who routinely blow through their deductible amount because their care is inherently expensive.

3. CONSUMER ENGAGEMENT STRATEGIES – VALUE-BASED INSURANCE DESIGN (VBID)

DESCRIPTION: Value-Based Insurance Design (VBID) – also referred to as tiered and high-performance provider networks – represents another attempt by employers and private insurers to engage consumers in making informed decisions about their care while still retaining choice of provider. Employer-sponsored insurance has long attempted to direct patients to “preferred” providers based on some set of criteria. In contrast to the 1990s, when HMOs negotiated volume discounts and steered patients to providers in highly-limited networks, health plans today are attempting to provide incentives for patients to seek hospitals and physicians who provide the highest value care. In a tiered network, health plans attempt to sort providers into tiers based on their relative performance on cost and quality metrics. Providers achieving higher scores on efficiency and quality are placed in the preferred tier and patients are given incentives (through lower cost-sharing provisions) to choose these providers. The hope is that by directing patients to high-performing providers, tiered networks will induce providers to compete on the basis of the cost and quality of the care they deliver. Today, most insurers offer a tiered network product and 20 percent of employers include a tiered provider network in their health plan with the largest enrollment.⁹⁵

ASSESSMENT: The challenge with VBIDs is constructing benefit packages that provide strong incentives to consumers to be more cost-conscious, while avoiding unwanted negative clinical effects and excessive shifting of risk to beneficiaries. Some literature has shown that hospitals increase their quality improvement activities in response to public reporting of provider performance data.⁹⁶ Yet there are no formal studies of how providers respond to tiered networks, and only limited empirical work on consumers’ behavioral responses. One study of a tiered network for hospitals found evidence that some consumers switched to preferred hospitals when the price differential between preferred and non-preferred tiers was relatively high (\$400 or greater).⁹⁷ There is other evidence that consumers respond to tiered cost-sharing incentives on prescription drugs.⁹⁸ In areas dominated by a powerful consolidated health system, employers and payers could consider implementing an alternative, more limited network that could offer premiums lower enough to capture the attention of consumers, and, then providers.

4. CONSUMER ENGAGEMENT STRATEGIES – REFERENCE AND VALUE PRICING

DESCRIPTION: Reference and value pricing live at the intersection of consumer engagement and provider contracting. Reference pricing establishes a standard price for a drug, procedure, service, or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. Safeway has applied it for procedures where quality is thought not to vary, such as colonoscopies, labs and imaging.⁹⁹ Straightforward reference pricing can easily be built onto a fee-for-service payment structure. Value pricing is reference pricing that takes quality into consideration and can be applied in many more circumstances, including for procedures and services where quality is thought to vary.

ASSESSMENT: Though they have yet to wield sufficient volume to affect the overall pricing behavior of providers substantially, reference and value pricing have shown some limited promise when applied to high-cost and high-volume procedures such as joint replacements. Patients opting to use a more expensive facility must pay all allowed charges above the reference price. The idea is to create incentives for providers through potential volume gains and to signal that unwarranted payment variation is no longer tolerated. However, patients that have established relationships with providers or are highly influenced by primary care physicians may be reluctant to seek care elsewhere.

5. NETWORK STRATEGIES – ESTABLISHING TIERED, NARROW, AND HIGH PERFORMANCE NETWORKS

DESCRIPTION: 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. Despite having suffered from the backlash against managed care largely due to the lack of quality information in the development of managed care networks, it is slowly gaining renewed attention.

ASSESSMENT: Renewed employer willingness and resolve to demand narrower networks might bolster health plans in their ability to negotiate with dominant and higher-cost providers in a particular area. Some believe 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. Although this strategy is gaining some acceptance, there is a range of approaches that employers feel comfortable implementing: 1) some prefer to obtain and utilize data to improve transparency; 2) others are willing to use these data tied to restructured benefits that provide incentives for patients to use higher-value providers; and 3) others are willing to use data and incentives and simultaneously restrict networks.

6. NETWORK STRATEGIES – CENTERS OF EXCELLENCE/DIRECT CONTRACTINGS

DESCRIPTION: Most major health insurers use Centers of Excellence (COEs) 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. Now several of the nation’s large employers (and some insurers) have begun to pursue direct contracting with COEs as a way to regain control over the costs of employee health care benefits. As a result, provider competition for direct contracting arrangements may well increase. Direct contracting circumvents the traditional third-party relationship between providers and employers and places providers in direct contact with the customer.

ASSESSMENT: Direct contracting of this nature may only be the beginning of efforts by employers to circumvent private insurers. For the short term, COE contracting represents a way of injecting some small degree of competition into the market place while saving employers money. COEs also have the potential both to increase the transparency of health care – by forcing larger providers to post pricing and outcome data as they compete for contracts and volume – and shift volumes away from centers with substantial market power. To date however, COEs tend to be dominant academic medical centers with substantial market power in their immediate markets. These entities are able to discount their already high prices in exchange for additional volume, but it is unclear whether this activity really reduces overall health care costs. Moreover, at present these strategies only work for a limited number of high-volume and high-cost procedures – and if not done through a health plan, direct contracting is only available to employers with a large enough workforce to make the tradeoff between volume and price attractive to providers.

7. NETWORK STRATEGIES—MANAGED CARE/MANAGED COMPETITION STRATEGIES

DESCRIPTION: From the late 1980s into the 1990s, managed care appeared to be exercising significant constraint over growth in health care expenditures. By 1995, 73 percent of those obtaining coverage through employers were in managed care plans compared to just 27 percent eight years earlier.¹⁰⁰

ASSESSMENT: 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 Alain Enthoven, to achieve its potential, managed care needs to address certain market failures such as the absence and asymmetry of information, and benefit and enrollment practices must be structured to help create price-elastic demand. Many health policy researchers remain fans and there are successful models, such as in the Netherlands. 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 included in the arsenal of tools purchasers use to improve the competitiveness of the health care market place.

8. NETWORK STRATEGIES—A NEW MARKET DEVELOPMENT: ENTRY OF NEW, LOWER-COST COMPETITORS

DESCRIPTION: The systematic investment in, development, and marketing of a “lower-cost” alternative is a relatively new development in a couple of regions characterized by high prices and substantial consolidation, such as Boston and Pittsburgh.¹⁰¹

ASSESSMENT: This is a positive development. The entry of a well capitalized outside group in one instance (Boston) and a private insurer in the other (Pittsburgh) indicates that some see a market opportunity to undercut monopoly pricing strategies. Employers and insurers should look for ways to encourage this type of strategy in other extremely consolidated markets.

9. NETWORK STRATEGIES—STRATEGICALLY SEED THE SUPPLY SIDE

DESCRIPTION: This generally involves the following: 1) Encourage the entry of new providers that can compete directly with entrenched and consolidated health systems; 2) Encourage entry and expansion of new practitioners by opening up more medical school slots to train more physicians and reducing or removing restrictive licensing or certification requirements that govern the type of care nurses, nurse practitioners, and physicians (as well as other personnel) can provide; 3) Develop new cost-reducing technologies and innovative approaches that can compete directly for both acute and ambulatory care (such as telemedicine and hospital-at-home delivery system approaches); 4) Encourage the expansion of existing, more productive services that can compete directly with hospitals on a cost-effective basis (such as urgent care centers, retail clinics, and specialty hospitals); and 5) De-emphasize regressive policies that act as a barrier to entry – such as Certificate of Need (CON) policy and regulation, which is often highly politicized and aimed at protecting existing competitors rather than protecting the competitive process.

ASSESSMENT: While supply-side strategies contribute to the competitiveness of the industry and are worth encouraging, absent some set of monumental technological breakthroughs in low-cost alternatives to hospital care that can be broadly disseminated and applied, these activities can take a long time and may never significantly increase the overall competitiveness of the hospital sector.

10. NETWORK STRATEGIES—OVERSIGHT OF ACO DEVELOPMENT

DESCRIPTION: As outlined in CPR's [Action Brief on Ensuring Competition](#), employers can communicate their expectations to their insurers/third party administrators for how to contract with Accountable Care Organizations. Monitoring efforts could include:

- Insist that payment rates reflect cost decreases or increases significantly below historical trend.
- Make the ability of the ACO to reap savings contingent on achievement of improved quality (including safety) relative to measures of importance to employers, and representative of the range of services for which the ACO is responsible.
- Support a patient steering strategy across contracted ACOs and within an ACO.
- Provide enrollees with comparative information regarding provider performance, regardless of whether the employer chooses to use a benefit design with steering.

ASSESSMENT: Employers need to be engaged and understand how the ACO concept is being implemented in both the public and private sectors. 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, leaving employers with little leverage.

4.4: Complementary or Coordinated Activities among Government and Private Payers

While market-based strategies are usually the preferred approach for improving competition, persistent and pervasive market distortions and failures can forestall efforts to improve market operation. In these circumstances, government, either at the state or federal level, may play a helping role in clearing the way for a more functional competitive environment that protects the needs of individuals. Government activity of this nature should promote market-based activities and avoid excessive intervention and micro-management. It can be independent of private payers or coordinated with them.

The following section describes supportive activities that government can pursue to help promote pro-competitive interventions by market participants and/or directly respond to impediments to the competitive process.

1. ANTITRUST ACTIVITY – MONITORING AND PURSUING INJURIOUS MERGERS

DESCRIPTION: Monitor and pursue proposed (or existing) mergers/integration of health providers that the FTC believes are injurious to competition in the health care industry.

ASSESSMENT: FTC/DOJ should continue to pursue vigorous antitrust enforcement activities and test the limits of antitrust exemptions associated with ACO formation – although considerable challenges remain. Most markets are highly concentrated, there has been a surge of mergers post-ACA, these mergers are continuing, and unraveling these mergers can be politically unpopular and disruptive. Nevertheless, additional “wins” by the FTC can help forestall future anti-competitive merger activity and also act as a partial brake on egregious contracting and pricing behavior of consolidated systems.

2. DEVELOPMENT OF ALL-PAYER CLAIMS DATABASES (APCDS)

DESCRIPTION: 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. APCD data can and have been used for the development of VBID in Massachusetts (for the Group Insurance Commission) and the state of Maine (for the state employee benefit program).¹⁰²

ASSESSMENT: APCDs can be powerful tools to integrate and improve the highly fragmented and disparate elements of our health care financing and delivery systems by facilitating payment reform and system transparency. These data also can be used to profile practice and utilization patterns, identify fraud/abuse, and determine overuse of high-cost services. But states will have to overcome significant data gaps and the absence, at this point, of common standards for development.

3. ALIGNMENT OF PUBLIC/PRIVATE PAYMENT STRUCTURES

DESCRIPTION: Medicaid programs and private payers could consider aligning their payment methods with those of Medicare – both the current inpatient payment systems based on diagnostic-related groups (DRGs) and ambulatory payment classifications (APCs). Most Medicaid programs have adopted these payment methods. Private payer payment structures, however, are still very much a mix of DRGs/APCs, per diem payments, and discounted fee-for-service. These disparate payment structures and mechanisms contribute to the extreme fragmentation and administrative complexity of the health financing system in the U.S. and also likely significantly skew resource use in inefficient ways. This alignment could be expanded to coordinated experimentation in new payment models, such as bundled payments and shared savings. Another variant on the theme of aligning public/private payment strategies would be for government – either at a state or federal level or both – to play more of an active role as a convener and coordinator of aligned payment strategies across public and private payers.

ASSESSMENT: Alignment of public and private payer payment strategies would have the benefit of providing more consistent incentives to hospitals and physicians and would likely reduce variations in prices and costs. Aligned payment approaches might also facilitate employers' attempts at Value-Based Insurance Design by requiring that beneficiaries either use facilities that have contracted with the plan at the 150% rate or pay any difference between a provider's price and 150% of Medicare with or without an out-of-pocket maximum. Variations in payment could be made for evidence of substantially better overall quality and outcomes (i.e., a provider with a "Blue Distinction" ranking might receive 160% of Medicare). Such a proposal would help standardize payment relative weights, reduce price discrimination by service, and incentivize consumers to use lower-cost and higher-quality providers.

4. EPISODE-BASED AND BUNDLED PAYMENTS

DESCRIPTION: 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.

ASSESSMENT: These efforts represent promising new developments in the evolution of payment reforms. Some policymakers believe that Medicare should skip the experimentation phase and mandate a methodology for combining hospital and physician payments – and perhaps also some post-acute providers as well – for specific procedures and medical cases. However, bundled payments are administratively complex to design and structure, likely apply to a limited number of procedures, and do not consider the appropriateness of the service performed. Thus, there isn't clear evidence that these approaches will be broadly adopted or when adopted that they will save costs in the aggregate.

5. ACCOUNTABLE CARE ORGANIZATIONS

DESCRIPTION: The Centers for Medicare and Medicaid Services (CMS) has defined ACOs as a way to create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities – and set up the Medicare Shared Savings Program to reward ACOs that lower growth in health care costs while meeting quality of care standards. Private sector providers and insurers are also experimenting with this concept. Some policymakers have advocated for the development of population-based payment structures, including capitation and other ways of assigning a fixed budget to an identified population.

ASSESSMENT: Despite the potential risks of enhanced market power for providers, some policymakers believe it is vitally important that reformers encourage increased alignment of incentives. But it's important to monitor whether these lead to more market power for providers and higher prices.

6. GLOBAL BUDGETS OR POPULATION-BASED PAYMENT MODELS

DESCRIPTION: 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.

ASSESSMENT: These experiments hold promise as long as the state approaches can accommodate one of Medicare's existing payment methodologies or experimental alternative payment approaches (such as ACOs). Another prerequisite for Medicare will be a budget neutrality provision with the expectation that any state-based system will ultimately be able to save the Medicare program money over the long term. States interested in pursuing this strategy may seek to negotiate waivers to allow for the inclusion of Medicare as a participant in a state-based global payment strategy.

7. INCREASED EMPHASIS ON PRIMARY CARE

DESCRIPTION: Evidence suggests additional emphasis on primary care and substantial increases in primary care provider (PCP) reimbursement can help reduce costs and improve quality for patient populations, particularly for Medicare and chronically ill patients. Research also suggests that states with larger numbers of specialists and fewer PCPs tend to have lower quality and higher costs. There are three specific initiatives designed to increase the emphasis on primary care: 1) PCP fee increases; 2) Patient Centered Medical Homes (PCMH); and 3) PCMH incentive payment mechanisms.

ASSESSMENT: There is more awareness now of the need to improve PCP reimbursement, allocate sufficient resources to PCP-driven care programs for chronically ill patients, and draw medical students to primary care, where there is already a shortage. Nevertheless, more attention needs to be paid to giving PCPs the time and financial incentive to help engaged patients make the best referral decisions. New PCMH incentive payment models in Maryland and Massachusetts have the potential to incent PCPs to work more closely with patients and specialists to coordinate care more effectively.

8. PAY FOR PERFORMANCE (P4P)

DESCRIPTION: The Agency for Healthcare Research and Quality (AHRQ) defines pay-for-performance (P4P) as a strategy to improve health care delivery. Depending on the context, P4P 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.

ASSESSMENT: 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. But P4P initiatives must be broad enough in scope, with clear targets, powerful incentives, and consistent incentives across payers. Alignment of public and private strategies can help.

9. MONITOR INAPPROPRIATE USE AND HEALTH CARE FRAUD

DESCRIPTION: Hsiao estimates that savings from reducing health care fraud can be as much as 5% of total health spending. Consequently, both public and private payers have invested resources in identifying and remediating fraudulent claims and inappropriate patterns of care. This has included a CMS effort to move past the practice of paying claims and only later recognizing them as fraudulent and then seeking to recover the lost money. Recently, CMS also announced a relaxation of restrictions on the use of Medicare claims data by “qualified entities,” defined as public/private partnerships at the state or national level that also include other stakeholders, such as provider representatives. Medicare will provide detailed hospital and non-institutional claims data to these qualified entities for analysis and limited reporting purposes. All-Payer Claims Databases (APCDs) can also be a source of information to help state governments and private entities identify inappropriate use and fraudulent billing practices.

ASSESSMENT: Despite its considerable potential, public and private entities appear unwilling or unable to devote sufficient time and money to this activity at present.

4.5: Regulatory Interventions/Approaches

Although regulatory approaches to restore purchasing power are not typically the private sector's first choice, sometimes they provide an important alternative or complement. If market-based and limited public interventions are not successful in restoring competitiveness to the health care sector, the U.S. may be forced to resort to more overt forms of price regulation, as implemented by virtually every other industrialized nation in the world.

1. IMPROVING THE ACCURACY OF THE MEDICARE PHYSICIAN FEE SCHEDULE

DESCRIPTION: The current Medicare fee schedule for physicians appears to have many distortions in payment levels; most notably, it rewards specialty procedures at the expense of primary care. To the extent that the current fee schedule overpays specialists and physicians performing procedures, it drives higher than necessary volumes and adds to the overall cost of health care for both public and private payers. Various proposals seek to provide more efficient allocation of payments and resources.

ASSESSMENT: Because most Medicaid departments and private payers benchmark their fee schedules using Medicare, changes to it have enormous potential to influence the entire payment system, with a consistent focus on incentivizing effective and efficient episodes of care for a broader patient population. Employers and private payers should overcome anticipated resistance and help support current efforts by MedPAC and CMS to correct the known distortions in the Resource-Based Relative Value Scale system.

2. IMPROVING THE MEDICARE INPATIENT AND OUTPATIENT PROSPECTIVE PAYMENT SYSTEMS (IPPS AND OPPTS)

DESCRIPTION: Health services research generally supports the proposition that hospital volumes exceed levels required for high-quality, cost-effective care. Therefore, most of the state rate-setting systems that received a Medicare and Medicaid waiver had volume adjustment systems designed to limit incentives to increase inpatient or outpatient volumes. The essential idea is that future rate reductions could capture the marginal revenue in excess of costs that hospitals capture through increased volume.

ASSESSMENT: The industry will resist, but because the current system is deeply rooted in volume, not value, policymakers should seriously consider a volume adjustment to the IPPS and OPPTS.

3. EXPANDED DEPARTMENT OF INSURANCE OVERSIGHT

DESCRIPTION: Several states, including Massachusetts and Rhode Island, are experimenting with new ways of exercising oversight of health plans and their contractual arrangements with providers. These activities can range from applying voluntary targets and goals for insurers (in terms of the structure of payment they use with providers, how much they pay for primary care, and other activities) to more stringent requirements, such as a requirement that enables them to negotiate separately with one hospital within a network instead of taking an all-or-nothing contract for all system members. A more interventionist proposal advocates a role for a Department of Insurance in reviewing insurer payment arrangements with providers to identify and prohibit excessive levels of price discrimination.

ASSESSMENT: Despite resistance to perceived overregulation, state departments of insurance may find they will need to increase their level of scrutiny of payer/provider contracting to help eliminate the unjustifiably large differentials in provider rates and engage in other oversight activities aimed at prohibiting or reducing anti-competitive activities by both providers and insurers.

4. BASEBALL STYLE ARBITRATION

DESCRIPTION: At a 2009 MedPAC meeting, Commissioner John Bertko proposed that payers and providers enter into voluntary but binding arbitration agreements, using so-called baseball arbitration to resolve disputes about payment levels. Baseball arbitration forces the arbitrator to find entirely for one side of a dispute or another, without compromise judgments. The hope is to influence both parties to reach an agreement out of fear of being the loser. It is conceivable that regulators could make payer and provider entry into such agreements a condition of certain safe harbors from regulatory scrutiny.

ASSESSMENT: It would be difficult for one entity or agency to take on this responsibility particularly across the many different negotiations that take place between providers and health plans every year. Moreover, states may be reluctant to play such an interventionist role at this time.

5. LIMITS ON EMERGENCY CARE PRICING

DESCRIPTION: Acute emergency care is inherently monopolistic since patients in an emergency situation have very limited ability to decide where they seek care. When patients receive care out-of-network, providers often charge patients much more than what the providers accept from Medicare or private insurers with an established contract. Providers also routinely double or triple their prices for uninsured patients or those who are not covered by managed care networks. To protect consumers and help health plans when they negotiate with dominant provider systems, some have proposed the use of a Maximum Charge Level or Maximum Payment Obligation as a percentage of Medicare payment levels.

ASSESSMENT: Most state legislatures are reluctant at present, but Maximum Payment Obligation would help private payers and patients without insurance who obtain emergency services. It might also make sense to impose a limit on the payment obligation for such patients for all services, rather than just emergency services, but this limit would have to be set high enough to induce most persons with the financial ability to buy insurance to do so, rather than pay on an out-of-pocket basis. Legislating a maximum payment level in the case of emergency room care is a pro-competitive strategy in that it removes the pure monopoly pricing power of hospitals and consolidated systems.

6. ACTIVE PURCHASING STRATEGIES BY STATE HEALTH INSURANCE EXCHANGES

DESCRIPTION: State-based health insurance exchanges, an important component of the ACA's plan to expand access to coverage, are both a gateway for people to purchase subsidized health insurance and a means to help organize insurance markets for more effective competition among health plans. Some policymakers have argued that insurance exchanges have the ability to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices through "active purchasing" strategies, such as being empowered to contract selectively with carriers, including setting tougher participation criteria than the federal standards and/or negotiating price discounts. Others believe the best way to serve consumers is to have the exchange provide the broadest possible array of plans, rather than limiting plan participation based on whether their networks meet certain cost and quality criteria.

ASSESSMENT: Again here, most states are reluctant to engage in these strategies at the moment, but by consolidating individuals and small groups, potentially partnering with other large purchasers to align purchasing strategies and encouraging value-oriented consumer shopping, the exchange can encourage long-term delivery system changes that can help improve quality and restrain the current unsustainable growth in health care costs. Once exchanges are up and running and have navigated myriad operational and policy issues, some states may be receptive to pursuing active purchasing strategies.

7. ALL-PAYER RATE REGULATION

DESCRIPTION: Under an all-payer rate-setting system, a public body would have the legal authority to establish the prices paid by both government and private health plans to hospitals and other providers for medical services. An all-payer system requires a common unit of payment and in its purest form mandates the payment level for a given service at a given provider across all patients. Service prices and corresponding payments could, however, vary for different providers, reflecting variations in input costs and the relative illness severity of patients. Given the presence of pervasive market failures in health care, all-payer systems seek to establish a more consistent pricing mechanism and otherwise mimic the operation of a functionally competitive market.

ASSESSMENT: Though challenging to develop and oversee, the U.S. is the only industrialized nation that does not actively reinforce the purchasing side of the health care marketplace through some form of government intervention. All-payer systems can countervail the market leverage enjoyed by dominant provider groups, because fees would be established for all services and payers directly. These systems could: 1) help reduce administrative costs; 2) improve system transparency; 3) enhance payer and patient equity; 4) ensure provider financial viability; and 5) be a platform for innovative payment reform. If antitrust action and the demand and supply-based strategies above do not succeed in curtailing the unsustainable rates of growth in health care expenditures, individual states may well opt for some version of all-payer rate setting.

4.6: What Has Worked So Far?

The current array of reform initiatives, such as Pay-for-Performance (P4P), ACOs, bundled payments, evidence-based medicine, advanced medical homes, and health information technology all have merit. Unfortunately, few experts expect them to have much effect on aggregate spending.¹⁰³

Recent estimates by the Congressional Budget Office (CBO) of the cost savings of these and other initiatives project that these initiatives will not significantly alter the trajectory of rising health care costs.¹⁰⁴ In an issue brief released in February 2012, CBO reviewed the findings of independent evaluators on the outcomes of 10 major payment and delivery reform demonstrations and found that most programs did not reduce federal spending on Medicare.

Looking at 34 disease management programs and care coordination programs, the research found “little or no effect on hospital admissions.”¹⁰⁵ In nearly every program, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered.

Looking at the Medicare demonstration projects for value-based purchasing, “Only one of the four demonstrations of value-based payment has yielded significant savings for the Medicare program.”¹⁰⁶ In that demonstration, Medicare made bundled payments to hospitals and physicians to cover all services connected with heart bypass surgeries, and Medicare spending for those services declined by about 10 percent. Yet there was no check on the appropriateness of procedures performed. The other demonstrations appear to have resulted in little or no savings for Medicare.

4.7: What Might Work?

Looking ahead, to estimate potential savings from ACA-proposed and other initiatives aimed at cost containment, the Urban Institute generated baseline estimates of spending by payer and service for the 10-year period 2014–2023, based on the current law.¹⁰⁷ In addition, the Office of the Actuary (OACT) at the Centers for Medicare and Medicaid Services (CMS) produced aggregate spending projections by payer, reflecting the impacts of the ACA. The actuaries projected spending through 2019 for the following payers: Medicare, Medicaid/ Children’s Health Insurance Program (CHIP), employer-sponsored insurance (ESI), exchanges, and other private health insurance as well as other public, private, and out-of-pocket (OOP) spending.

In addition, since many of the cost containment policies being considered require targeted adjustments to spending by service category, Urban Institute researchers projected spending for hospitals, physicians, and prescription drugs. They also projected spending on other service and administrative costs. Because they used a 10-year window beginning in 2014 and CMS projected through 2019 only, they made additional projections for the years 2020–2023. For each payer (private, Medicaid, Medicare, and out-of-pocket) and each service (hospitals, physicians, drugs, other services, and administrative costs), they assumed that the growth rate for 2019 continues annually through 2023. They then summed up all services and administrative costs, by payer, to get total expenditures for 2020–2023.

For each policy option, they generated estimates of the effects of the policy on the level and rate of growth of spending for targeted populations and services. Such estimates were based on both the available literature and reasonable and conservative assumptions. These effects were then applied to the baseline spending estimates to generate the expected savings from each policy option.

Their results are summarized in Table 3 below. The evidence suggests that all of the options considered could produce some reduction in spending, but that the effects vary considerably.

Table 3 – Total Savings from all Policy Options Measured¹⁰⁸

Policy Option	2014		2023		2014-2023	
	Billions	% of NHE	Billions	% of NHE	Billions	% of NHE
Capping the tax exclusion	-44.9	-1.6%	-73.0	-1.4%	-575.6	-1.5%
Malpractice reform	-2.7	-0.1%	-45.5	-0.9%	-283.3	-0.7%
Disease prevention	-14.8	-0.5%	-31.4	-0.6%	-224.4	-0.6%
Care coordination	-9.0	-0.3%	-46.4	-0.9%	-331.3	-0.9%
End-of-life care	-7.8	-0.3%	-14.9	-0.3%	-110.6	-0.3%
Bundled payments	-1.9	-0.1%	-14.4	-0.3%	-97.9	-0.3%
Strengthening exchanges	-16.2	-0.6%	-46.6	-0.9%	-297.6	-0.8%
Public plan						
Level only	-17.4	-0.6%	-35.1	-0.7%	-266.6	-0.7%
Level and growth	-17.4	-0.6%	-54.4	-1.1%	-338.1	-0.9%
Exchange-based rate setting						
Level only	-23.2	-0.8%	-46.1	-0.9%	-352.8	-0.9%
Level and growth	-23.2	-0.8%	-65.1	-1.3%	-422.8	-1.1%
All-payer rate setting						
No rate increase for Medicaid	0.0	0.0%	-299.2	-5.9%	-1318.2	-3.5%
Rate increases for Medicaid	24.3	0.9%	-300.8	-5.9%	-1187.2	-3.1%

NHE = National health expenditures

5: POTENTIAL MONITORING ACTIVITIES

- Despite stakeholders having a deeper understanding of the link between provider consolidation and unsustainable health care costs, to date their capacity to monitor the extent and effect of provider consolidation has been limited.
- Numerous groups have looked at this issue, but have been constrained by incomplete data. This has made it a struggle to capture an accurate picture of consolidation and its impact for the nation as a whole.
- Now, a combination of learning from past efforts, the loosening of access to Medicare data by CMS and the HCCI’s massive data set from key private payers makes it possible to build a more rigorous and substantive monitoring process.
- Such a process could inform both the public and policymakers and serve as an effective early warning system for all stakeholders, so they can reap the benefits of consolidation without suffering from the ill effects on health care costs.

5.0: Why Monitor?

As this paper has made clear, there is increasing consensus among employers, health economists, and health care policymakers that the level and growth rate of health care prices are at the heart of our health care expenditure problem. Moreover, the ability of providers to drive health care prices ever higher appears directly related to:

- The inherent nature of hospital care (i.e., no close substitutes, inability of patients to shop in the midst of an emergency);
- The presence of insurance which ensures what Alain Enthoven refers to as “cost-unconscious” demand; and,
- The highly consolidated market position of many if not most health systems in the U.S.¹⁰⁹

In the interest of an informed public discussion about restraining health care costs, this section of the paper considers how to monitor and assess the impacts of provider consolidation over time.

Until now, monitoring of provider consolidation and the identification of instances where mergers might lead to injurious price increases has primarily been in the domain of those charged with identifying and pursuing cases that might violate antitrust provisions.

However, given growing awareness¹¹⁰ of the ability of consolidated health systems to force insurers and self-responsible patients to pay excessively high prices – as well as the increased availability of representative health care claims data – it now may be possible to develop a mechanism to monitor more broadly and rigorously the impact of increased provider negotiating leverage on rising health care expenditures. If developed in a responsible, representative, and timely way, such an activity could serve a variety of purposes:

1. Systematic monitoring of health care price increases to private insurers in different markets could raise public awareness about the underappreciated dangers of allowing providers to attain and exercise market power, and could illustrate the larger provider monopoly problem facing today’s insurers, consumers, and purchasers.
2. An understanding of the link between provider consolidation and rising health expenditures could better inform health care purchasers, payers, and policymakers about this issue and assist them in developing market-based and regulatory interventions to forestall or counteract the negative impacts of provider market power.
3. Intelligence gained from such an activity could: a) help the FTC and DOJ in identifying and pursuing antitrust cases; and b) help the FTC study the impact of provider consolidation over the next three years – a task that the ACA requires.
4. General awareness of a market characterized by one or two dominant systems charging excessive prices could serve to alert entrepreneurial firms to the potential to enter a market dominated by high-priced health systems and provide a low-cost and hopefully equal or higher-quality alternative.

5.1: Past Monitoring Efforts

HHI Scores Traditionally, the FTC has measured hospital and health insurer consolidation by calculating and monitoring the HHI for a particular MSA. One difficulty with continuing to monitor and assess concentration based on HHI scores is that nearly all markets are registering HHIs at or above the threshold score the FTC has defined as representative of a highly concentrated market.

All-Payer Claims Database Until recently, there was an absence of aggregated data sets for privately-insured health care claims. Now, a number of states have

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compiled and made public data on the prices paid to physicians and hospitals by private insurers. Many of these states are working actively to compile a single analytic file containing all-payer claims for most health care encounters for state residents. While generally useful and representative of pricing and payment trends within a state, these claims data sets have been used only on a spotty and anecdotal basis to highlight the rate of growth in hospital prices.¹¹¹ Nevertheless, these and other data sources have been used over the past several years to call attention to the large variation and rapid rate of increase in hospital and physician prices.¹¹²

The Massachusetts Attorney General’s 2010 and 2011 Report on Provider Pricing These reports on the level, growth, and variation in provider prices is one of the first examples of a systematic investigation and evaluation of the negative effects of consolidated health systems using their market power to engage in price discrimination and generally drive up the cost of health care. This had powerful implications for the state’s health care marketplace and illustrates how monitoring and periodic reporting on the impacts of provider market power can help call attention to this issue.

In particular, the Massachusetts Attorney General’s reports found that:

- Prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and among providers offering similar levels of service;
- Price variations for hospitals and physicians offering similar services are not explained by:
 - Quality of care differences;
 - The sickness or complexity of the population being served;
 - The extent to which the hospital is responsible for caring for a large portion of patients on Medicare or Medicaid; or
 - Whether the hospital is an academic teaching or research facility;
- Price variations are correlated to market leverage, as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers;
- Variations in providers’ per member per month expenses are not correlated to the methodology used to pay for health care, with expenses sometimes higher for globally paid providers than for providers paid on a fee-for-service basis;
- Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts; and
- The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

These findings continue to influence ongoing policy discussions about how to contain health care costs, reform payment methodologies, and control health insurance premiums while maintaining or improving quality and access.

The report also raised concerns that existing systemic disparities in reimbursement may, over time, create a provider marketplace dominated by very expensive “have” hospitals as the lower and more moderately priced “have not” hospitals are forced to close or consolidate with higher paid systems.

The Attorney General made four specific recommendations to promote value-based purchasing and ensure consumer access to high-quality, affordable health care:

1. Discourage or prohibit insurer/provider contract provisions that perpetuate market disparities and inhibit product innovation;
2. Increase transparency and standardization in both health care payment and quality to promote market effectiveness and value-based purchasing by employers and consumers;

3. Improve market function by: a) adopting payment reform measures that account for and do not exacerbate existing market dynamics and distortions; and b) developing legislative or regulatory proposals to mitigate health market dysfunction and rate disparities to promote convergence of provider rates where there are no differences in quality or other value-based factors; and
4. Engage all participants in the development of a value-based health care market by promoting the creation of insurance products and decision-making tools that allow and encourage employers and consumers to make prudent health care decisions.

In addition, the Attorney General's Office has used its authority to control health care costs and to protect consumers and small businesses facing escalating premiums through actions that include: 1) record recoveries for Massachusetts in Medicaid fraud enforcement actions; 2) consumer protection cases against numerous drug and insurance companies; 3) antitrust review and monitoring; 4) promulgation of new community benefits guidelines; and 5) review of nonprofit executive compensation at major hospitals and insurers.¹¹³

Other Reporting and Analysis of Private Payer Rates Some entities (such as MedPAC, the General Accounting Office [GAO] and America's Health Insurance Plans) have used proprietary databases (such as the Truven "MarketScan" data set) for policy and general monitoring purposes. But it is not clear how broadly representative these proprietary sources are of the private insurance market.

In 2005, the GAO performed an analysis on payment rates for members of the Federal Employees Health Benefits Program (FEHBP) with preferred provider organization (PPO) plans based on claims from several large insurers. The GAO analysis showed that the FEHBP had substantial variation in both hospital in-patient and physician service prices across MSAs.¹¹⁴

Every year MedPAC analyzes private insurer rates in the context of evaluating the adequacy of Medicare fees for both hospitals and physicians. A widening differential between private payer and Medicare rates could start to erode access to care for Medicare recipients. A large differential has also been interpreted as a need for the Medicare program to increase its payment levels. But as we've noted above, when providers face broad constraints from both public and private payers they tend to manage their costs. This demonstrates that Medicare rates are more than adequate for efficient providers. For these and other reasons (such as an interest in how the market power of various providers or insurers affects the variation in the rates private insurers pay providers), MedPAC has an interest in studying private-sector payment levels.

Recently, the Center for Policy and Research of America's Health Insurance Plans (AHIP), the industry trade group, presented private-sector price trends from publicly and privately available data sources in its 2010 report "Recent Trends in Hospital Prices in California and Oregon." The report presented new data from state datasets on the growth of hospital prices in Oregon and California, the only states that systematically report transaction prices for hospital services, by DRG, paid by private insurers over a relatively long period of time. The state of Oregon now publishes the transaction prices for an array of specific hospital services, including joint replacement, removal of appendix, and normal deliveries. Key points from the analysis of price trends include:

- In California, transaction prices for a day in the hospital or a discharge paid by commercial insurers increased by more than 150 percent between 2000 and 2009 – an average annual growth rate of 11 percent per year.
- In Oregon, hospital prices faced by commercial insurers for common discharge categories¹¹⁵ also grew very rapidly between 2005 and 2009. Growth rates in transacted prices for a list of nine common DRGs grew 38% to 69% over that period while the average rate of price inflation over this period was in the 8.4% to 14% range.¹¹⁶

AHIP also recently released a report analyzing MarketScan state-level data showing the rate at which allowed charges grew for 25 different DRG categories. Table 4 presents characteristics of the MarketScan data set. Charts 14 and 15 present some of the results.¹¹⁷

Table 4 – Market Scan Research Databases, 2008 to 2010

MarketScan Data	2008	2010
Number of enrollees in sample (millions)	49.3	45.2
Number of enrollees, weighted to U.S. totals (millions)	163.0	163.2
Total number of discharges in sample (millions)	2.69	2.40
Number of discharges per enrollee	0.054	0.053
Number of days per discharge	4.02	4.01

Dataset Characteristics

- Private sector health data - insured by employer-sponsored plans (i.e., not eligible for Medicare)
- Active employees, early retirees, COBRA continues, and their dependents
- Data provided by approximately 100 payers
- Historically, more than 500 million claim records are available in the full set of *MarketScan Databases*.

Chart 14 – Change in Average Allowed Charges per Discharge (selected DRGs, 2008-2011)

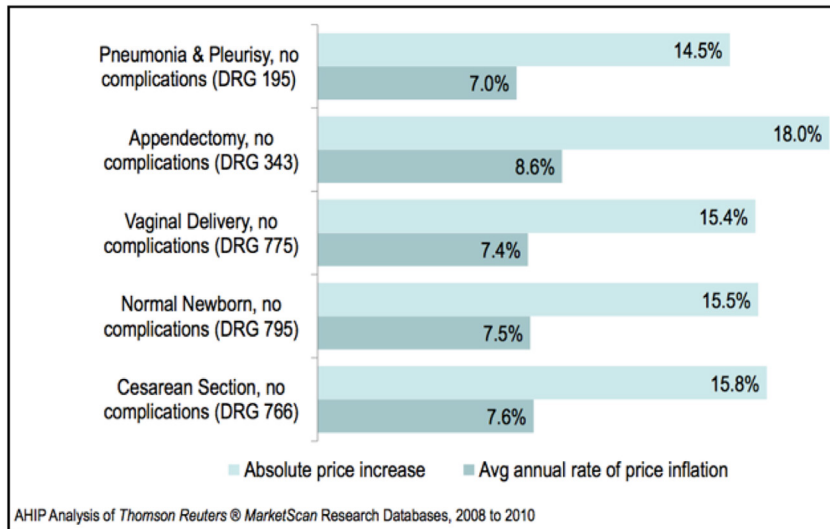
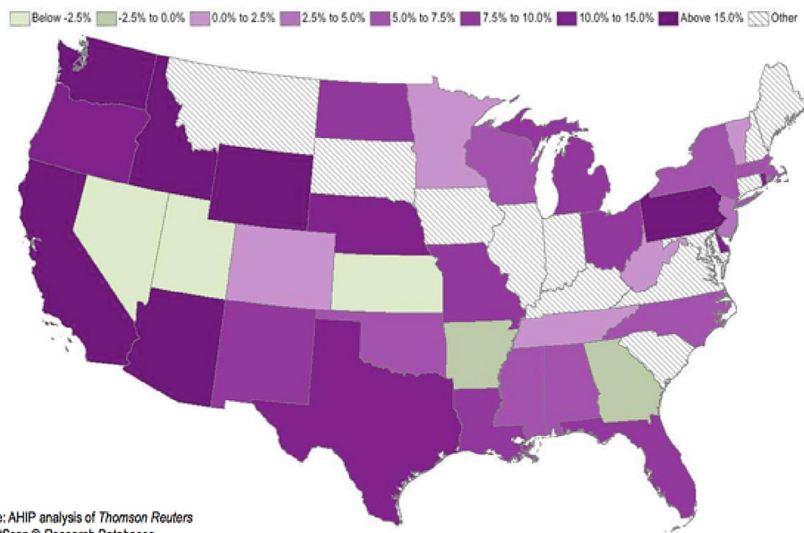


Chart 15 – Coronary Artery By-pass Graft Average Annual Growth in Cost per Admission



Unfortunately, these proprietary data can only be reported on an aggregated basis at the state level and cannot be used to report utilization patterns, price levels, or rates of increase at the individual MSA or other hospital-specific market area.

5.2: Obtaining more Complete Pricing, Utilization and Quality Data

Private Payer Data Sources In addition to the development of state-based All-Payer Claims Databases, other organizations are starting to assemble larger and more reliable datasets of both hospital and non-hospital administrative claims.¹¹⁸

The nonprofit HCCI is an example. Created in September 2010, the HCCI's mission is to provide comprehensive data on health care costs and to promote independent, nonpartisan research and analysis on the causes of rising health care expenditures in the U.S to help policymakers and the public make decisions that lead to more accessible and affordable care.

To further this aim, the HCCI recently secured what is thought to be the largest combined dataset of private payer claims ever assembled. The organization now receives all private payer claims data (including allowed amounts and other data covering claims for "cost-plus" or self-funded plans) from Aetna, Humana, Kaiser Permanente, and UnitedHealthcare, four of the largest carriers in the U.S. This data set includes more than 5 billion claims for 2007 to 2011, representing more than 40% of all private claims in the U.S.¹¹⁹ The HCCI effort represents one of the first opportunities to examine and report on health care pricing (levels, trends, and variation) nationwide, in addition to related topics. The addition of claims data from WellPoint, CIGNA, and all of the Blues plans across the U.S. would make the HCCI data set even more robust.

Eventually, the HCCI expects to pursue funded proposals from public entities for research projects that complement its goals and mission. Given the considerable evidence in the literature of the negative impact of provider consolidation on, among other issues, prices, quality, and provider operating efficiency, this dataset could be a valuable in furthering our understanding of the role of provider consolidation in driving both prices and overall health expenditure growth.

In particular, as noted previously, there is an absence of data on physician services. Policymakers do not know how competitive physician markets are, whether they have become more or less competitive over time, or what the impact of those trends may be for price, quality of care, and other outcomes of import. With this dataset, researchers will have a much better opportunity to examine these important questions. The level of detail in the HCCI claims data may also help to reveal what makes certain health care institutions more successful in containing costs and improving quality.

Increased Availability of Public Data: CMS recently announced it would make its claims database more broadly available to the public to help consumers and employers make better-informed decisions about medical care. The program, called the "Qualified Entity Certification Program," is now accepting applications from "qualified entities" to receive data for the purposes of provider performance evaluation. In a little-noticed provision of the Affordable Care Act, CMS is allowing a new category of organizations to obtain the data: community groups comprising doctors, health insurers, businesses, consumers, and government that work to improve health care at the local level.

These groups, which the agency estimates number about 25 nationwide, will be able to use the data to publish studies, such as report cards on certain procedures, hospitals, or doctors. Although they will have to notify the subjects of their reports 60 days in advance, doctors won't be able to block publication, and patient information will remain confidential.¹²⁰

5.3: Promising Monitoring Efforts Moving Ahead

Given the increasing availability of both public and private claims data for both hospital and non-hospital providers, one could envision a public-private accountability effort with a specific focus: identifying and evaluating the link between the use of provider market power, the growth in health care expenditures, and the

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implications for quality, cost and access.

CPR is interested in the potential benefits of developing proposals for rigorous monitoring – what methodologies could be used, what data would be required, what organizations are in a position to take it on, etc.

Potential analyses and reporting include:

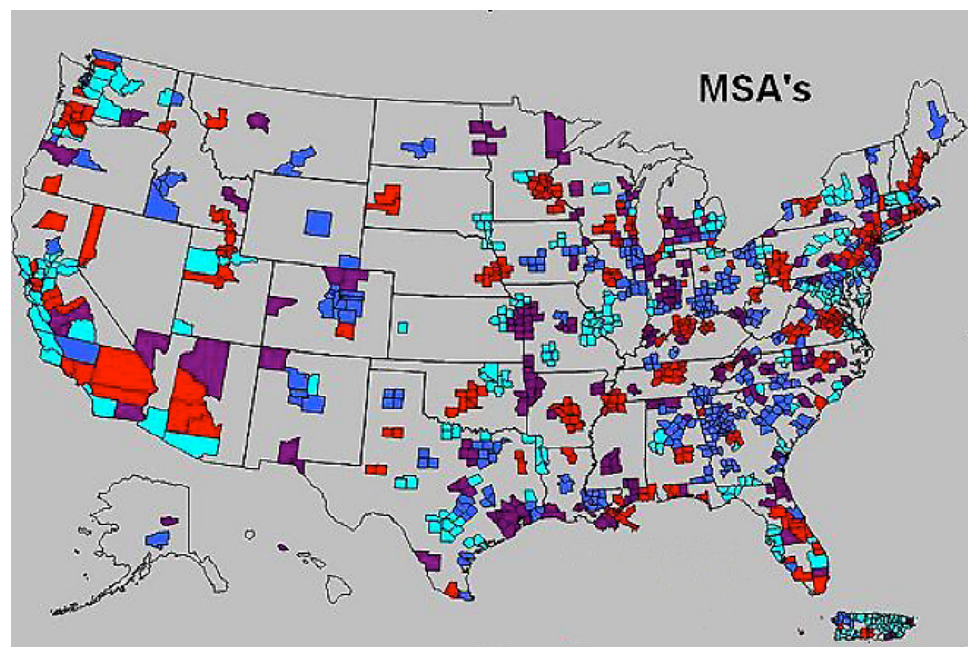
- Identifying known contracting and other activities of consolidated providers, such as “all or none” contracting requirements and most favored nation status provisions with insurers, that may relate to the providers’ ability to drive price increases in a given area;
- Identifying “hot spots” experiencing rapid increases in health care prices broadly speaking or in specific service lines (such as orthopedics, imaging, or emergency room services);
- Identifying areas that provide a market opportunity for the entry of lower cost providers (hospital, ambulatory care, or other);
- Identifying areas where costs are being controlled and quality of care is improving; highlight and analyze the factors associated with these developments; and
- Analyzing the pricing behavior of hospital-based physicians, who commonly hold a monopoly at the hospital where they practice, particularly anesthesiologists and radiologists.

Monitoring and evaluating the impact of market power can:

- Generally help sensitize the public to the urgency of this problem as it relates to a growing lack of affordability of health care for individual citizens;
- Help alert the public when a market is experiencing extreme ill effects associated with the unbridled use of market power in pricing by providers;
- Provide more support for public efforts and possible legislative action to facilitate both market-based and regulatory interventions to forestall the ill effects of provider market power; and
- Be a valuable tool to alert agencies, such as the FTC, to areas ripe for antitrust action, particularly within the physician community for which data on merger and pricing activities has not been readily available to public agencies.

One can conceptualize a periodic reporting tool with results that could be made available to both public agencies and the public at large. It would monitor price changes and other developments indicative of the inappropriate use of market power, which could be represented on a color-coded map such as the one below (Chart 16).

Chart 16 – Map of MSAs in the U.S. (Hypothetical Representation of Potential “Hot-spot” Analysis of Negative Pricing Impacts of Provider Market Power)¹²¹



Such an analysis could be updated on a quarterly basis and provide valuable data.

Identifying inappropriate price activity can trigger other investigatory activity of a hospital or health system, particularly if that entity also has an obligation to be responsive to public and community needs in exchange for its exemption from local, state, and federal taxes. Further public awareness of the excessive use of market power to drive prices higher could also invite additional scrutiny of whether nonprofit facilities are meeting their responsibilities to the public. Data from 990 filings (the recently revised schedule H which requires hospitals to show officer salaries and community benefit and charitable activities provided during the course of a year) to the Internal Revenue Service can also be useful in performing such an assessment.

This type of monitoring can also be useful to public bodies like the Independent Payment Advisory Board and MedPAC given its interest in assessing the adequacy of Medicare payment rates and other related policy issues.

Finally, if successful, a monitoring effort of this nature would help inform members of the business and labor communities and energize these groups and their related organizations to advocate for more aggressive public and private responses to this problem.

While there may be other options, gleaning a better understanding of pricing, quality, utilization and access trends from a comprehensive claims data set might be the most efficient and effective way to monitor the effect of provider consolidation in markets throughout the United States. Given the magnitude of the problem, it seems important to start now.

¹ Blinder AS. "Four deficit myths and a frightening fact." *The Wall Street Journal*. January 19, 2012. Available from: <http://online.wsj.com/article/SB10001424052970204468004577164820504397092.html>. Accessed 8/6/12.

² Johnson S. *White House burning: the founding fathers, our national debt, and why it matters to you*. New York: Pantheon, 2012: 131.

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⁵ Sood N, Ghosh A, Escarce JJ. Employer-sponsored insurance, health care cost growth, and the economic performance of U.S. industries. *Health Serv Res* 2009 Oct; 44:5, Part I: 1449-64.

⁶ Baicker K, Chandra A. 2012. The health care job fallacy. *N Engl J Med* 2012; 366:2433-2435.

⁷ Consolidation is defined as to join together into one whole. Specifically, in the healthcare industry, provider consolidation is the joining of one or more providers (either physicians, hospitals, or any combination of the physicians and hospitals) into one corporate entity with the ability to coordinate its overall business strategy. This consolidation can often influence the level of concentration of firms within a given market. Market concentration is a function of the number of firms in the market and their respective market shares. Most studies of the relationship between competition and hospital prices have found that high hospital concentration (i.e., the market is dominated by one or two hospitals or hospital systems) is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit.

⁸ Ginsburg PB. Wide variation in hospital and physician payment rates evidence of provider market power. Washington (DC): Center for Studying Health System Change; 2010 (Research Brief No. 16). Available from: www.hschange.com/CONTENT/1162/1162.pdf.

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¹² HCCI is a nonprofit research entity that has collected private insurance claims accounting for more than 40% of the private market from four large private insurers.

¹³ Health Care Cost Institute. Health care cost and utilization Report: 2010. May 17, 2012. Available from: www.healthcostinstitute.org.

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¹⁵ Ibid.

¹⁶ Schoenman & Chockley, Understanding health care spending.

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- ⁸⁵ Such a discussion is now occurring in the state of Massachusetts where this dynamic is playing out in advance of the ACA because of the state's growing inability to finance the insurance expansions associated with the 2006 health reform legislation given significant monopoly power on the part of large provider groups in the state.
- ⁸⁶ The Insurance Commissioner in Massachusetts at the time the Partners HealthCare merger was approved described his decision to allow the merger as akin to “throwing a hand grenade down to the other end of a boat and then watching the boat tilt upward and see the grenade tumble back toward you.”
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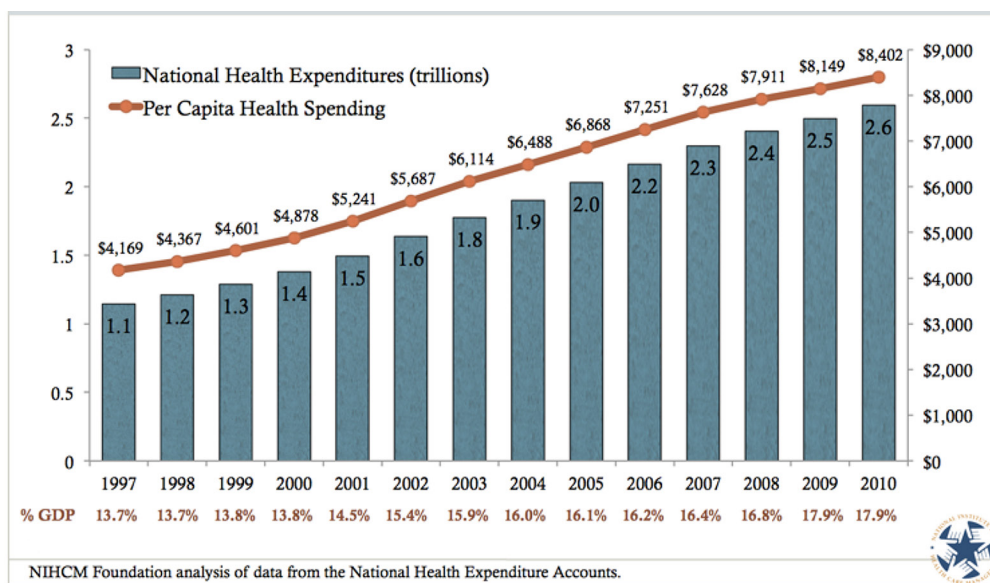
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- ¹¹⁸APCD sometimes are not available to the public (in states like Minnesota, all-payer claims data cannot be released publicly) and these datasets often do not receive data from self-funded plans.
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APPENDIX I The Implications of Health Expenditure Growth for Individuals and the Nation

1: Summary of Recent Evidence on U.S. Health Expenditures and Trends

Despite evidence of a slowdown in health expenditure growth in 2009 and 2010, the amounts spent on health care in the United States continue to rise and are projected to reach 20% of Gross Domestic Product (GDP) by the year 2020.

Chart 1A – Increases in National Health Expenditures (1997-2010)¹

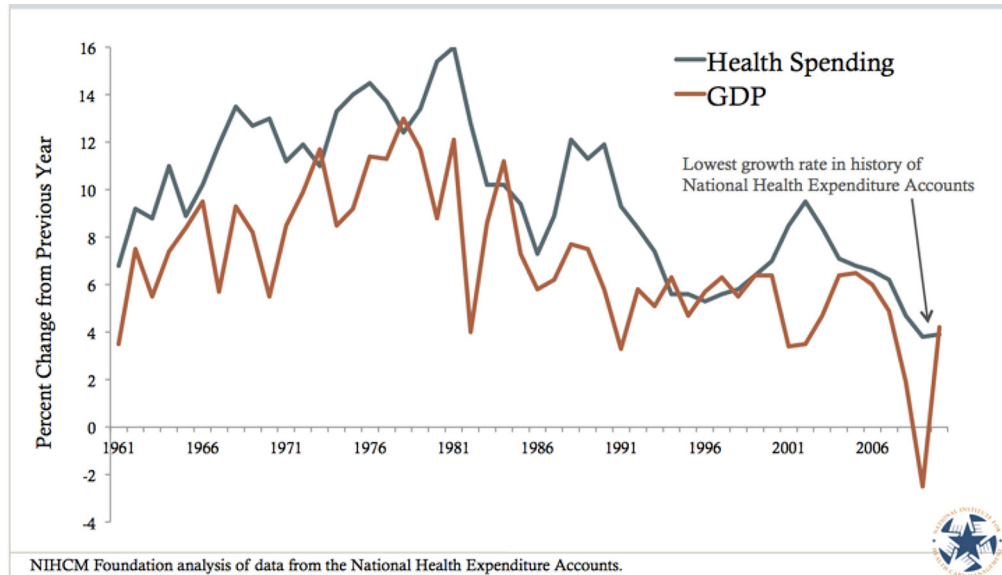


In January 2012, the Center for Medicare and Medicaid Services (CMS) reported that total health spending in the U.S. increased at a rate of 3.9% in 2010.² Chart 1A shows that in 2010 the U.S. spent \$2.6 trillion on health-care-related goods and services. That amounted to 17.9% of GDP or a little more than \$8,400 for each citizen.

Although total national health spending continues to increase, the U.S. spending growth in 2009 and 2010 was the lowest in the 51-year history of tracking national health expenditures. The slower growth in spending was heavily influenced by slower growth in utilization of health care services, likely in response to reductions in private health insurance benefits and enrollment, lower household income as a result of the recession, and future financial uncertainty.³

The spending results did lead many health policy analysts to speculate whether this was evidence of an overall structural shift in key elements of the health care delivery and financing systems that would contribute to more moderate rates of cost growth over the longer term. This observation is consistent with CMS's estimates of lower spending growth over the next decade and the more recent downward trend in health expenditure growth since 2001 (Chart 2A). In addition to reduced use of services, the past several years have also witnessed a number of other developments that may portend more moderate rates of growth in future years.⁴ These developments include single digit growth in the cost of pharmaceuticals, reductions in the rate of growth of imaging volumes and costs, reductions in Medicare and Medicaid payment levels, a restructuring of private insurance benefits to sensitize consumers to excessively expensive care, and shifting physician priorities and practice patterns.

Chart 2A – Real Health Spending vs. Real GDP Growth and “Excess Cost Growth” Gap (1961-2010)⁵

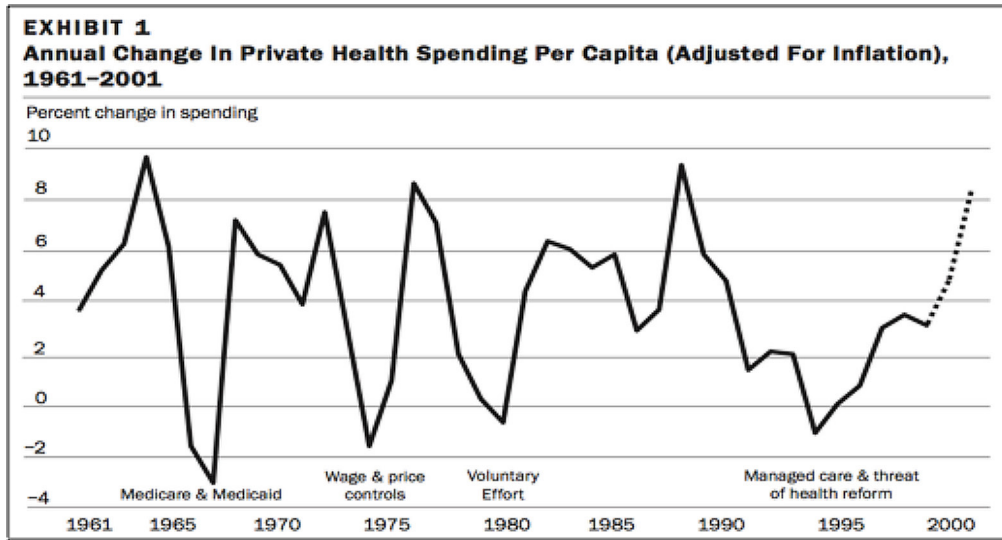


Karen Davis, President of the Commonwealth Fund, speculated in a recent blog that “the tectonic plates underlying the health system are beginning to shift in anticipation of new incentives under health reform or in response to health care leaders’ efforts to transform care over the last decade.”⁶

Although the trend in health care spending does indeed appear to be lower than historical levels, Chart 2A also shows that real GDP growth has also been on a downward trajectory. The more salient question with regard to the long-term affordability of health care is about the trend in the so-called “excess cost growth” – the amount on average that real health spending exceeds real economic growth, represented by the gap between the blue and brown lines on Chart 2A. Thus far, there is little evidence to show that this excess growth gap has permanently descended from the historical average of 1.5 to 2.5% above GDP growth to some more manageable level (e.g., GDP plus 1% or 0.5%).

The U.S. has witnessed similar phenomena of slow-downs in the growth of health expenditures a number of times over the past 40 years and each of these unexpected downturns seems to have coincided with efforts at national health reform. This theory, which was articulated by Drew Altman and Larry Levitt in 2002, posits that over 35 years no approach to controlling costs has had a lasting impact. Each concerted effort at health care reform by government has been accompanied by a sentinel response that inevitably fades, and high rates of cost growth return in succeeding years (Chart 3A).⁷ There’s a reasonable possibility that the Affordable Care Act (ACA) will be added to the list of past reforms that failed to reign in excess cost growth, particularly because many believe that the ACA did not go very far toward fundamentally addressing the key drivers of health cost inflation.

Chart 3A – The Sad History of Health Care Cost Containment Told in One Chart⁷



Notes: Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961-2000 and July-to-July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than fifteen years ago. See J.C. Merrill and R.J. Wassermann, "Growth in National Expenditures: Additional Analyses," *Health Affairs* (Winter 1985): 91-98.

Sources: Henry J. Kaiser Foundation analysis. Private health expenditures per capita, 1960-1999, are from the centers for Medicare and Medicaid Services (CMS). Change in private spending per capita, 2000-2001, is estimated based on average premium increases for employer-sponsored coverage from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

Thus, while we have experienced some positive signs in recent years, it may well be too early to declare, as then secretary of health Margaret Heckler did in 1984 after the implementation of the Inpatient Prospective Payment System (IPPS), that we have "broken the back of the health care inflation monster."

2: Public and Private Health Care Spending

As shown in Chart 4A, government entitlement programs (largely Medicare, Medicaid, and CHIP) accounted for 36% of national health spending in 2010 or approximately \$936 billion – 39% when adding in Department of Defense and Veteran’s Administration spending.

Chart 4A – Government Health Entitlement Programs (36% of Spending in 2010)⁸

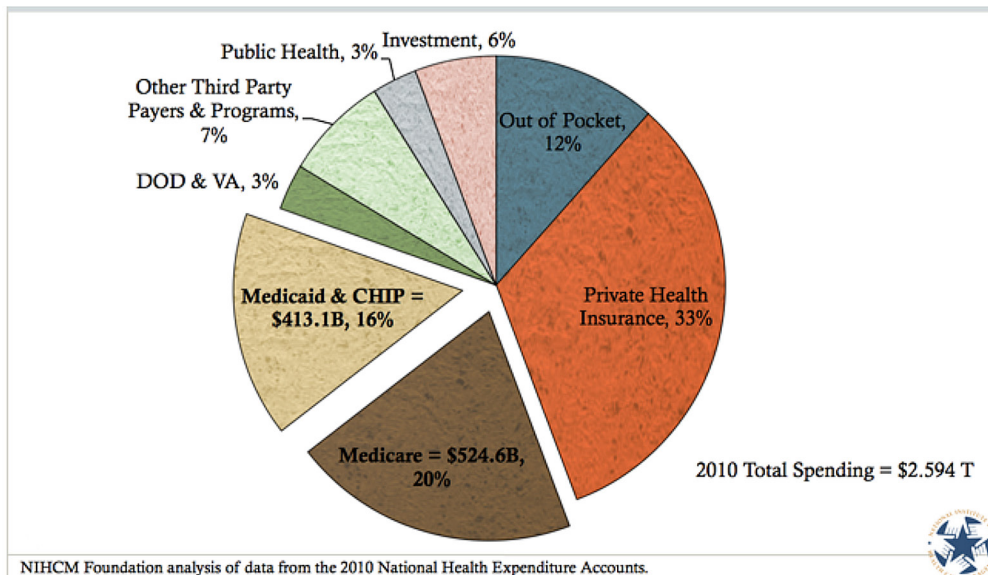


Chart 5A shows the discrepancy in spending relative to the sources of funding, in that 36 cents of every dollar taken in represents additional borrowing. This phenomenon is obviously contributing in large part to our nation's overall long-term debt difficulties. Numerous experts have shown that projected growth in federal spending on Medicare and Medicaid accounts for the vast majority of projected additions to our national debt through the year 2050.⁹

Chart 5A – Government Health Entitlement Programs (21% of Federal Spending)¹⁰

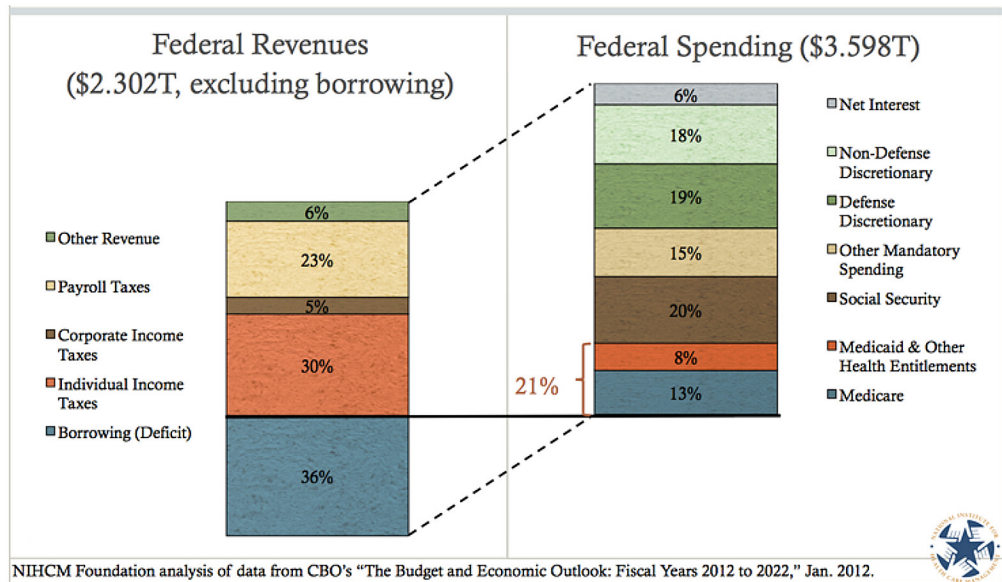
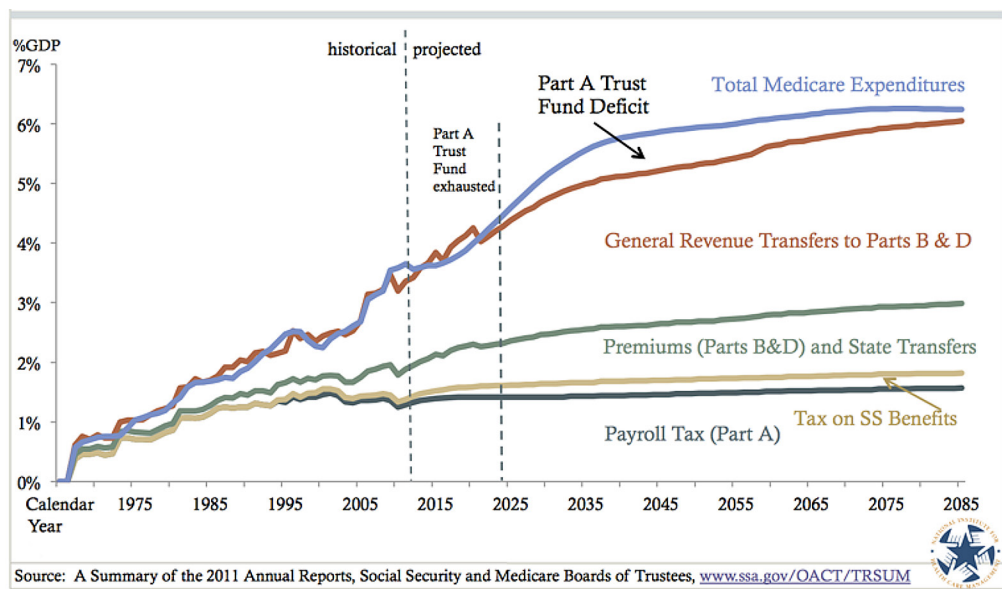


Chart 6A shows where the Medicare program gets its funding and where monies are paid out for various services. It shows that Medicare Part A is financed by payroll tax deductions from current workers and taxes on Social Security benefits. When those incoming revenues are insufficient to cover what is paid out to current beneficiaries, the Medicare trust fund must fund the difference. This of course is what is happening currently and is projected to happen every year in the future until the trust fund becomes insolvent (which is currently projected to be in the year 2024).

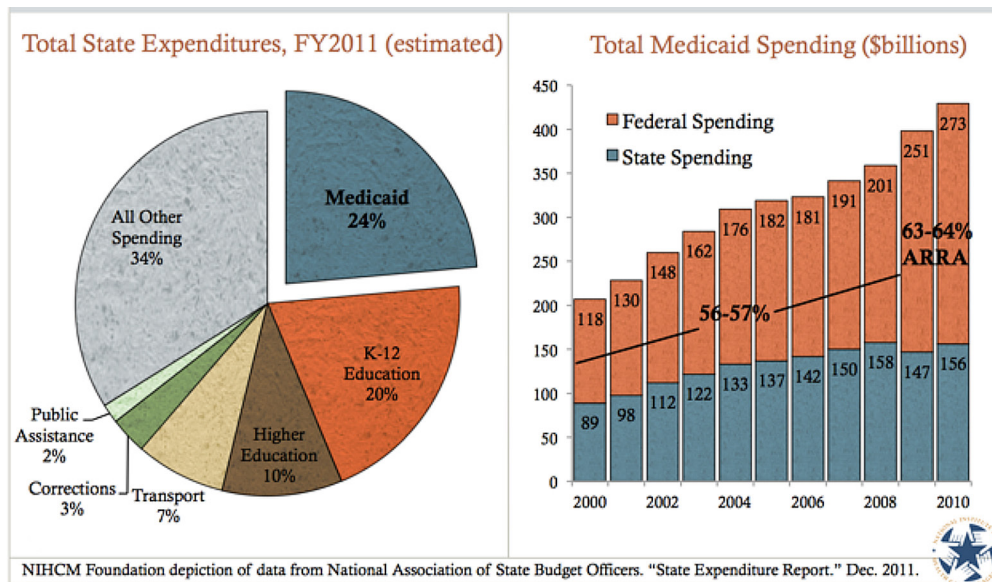
Chart 6A – Sources of Funding and Expenditures for Medicare (1975 - 2085)¹¹



Premium contributions and a small amount of state transfers finance Medicare Parts B and D. Part D premiums have been set by law at 25% of projected spending, with a slight increase in recent years because of the addition of “means-testing.” However, overall the inflow of revenue from premiums for these programs is just a fraction of the total expenditures for both programs.

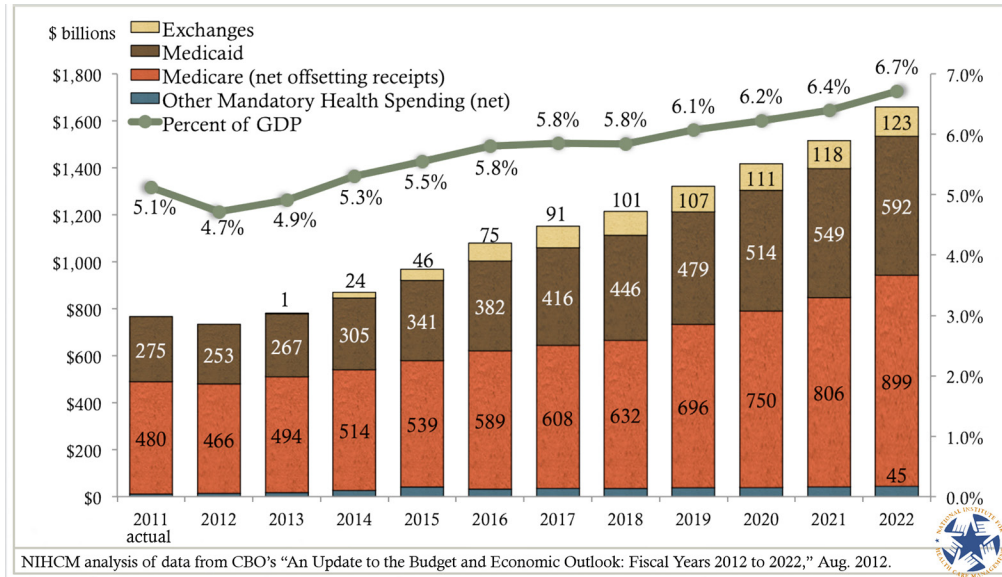
Chart 7A shows that spending on Medicaid at the state level accounts for 24% of state government outlays, always the largest or one of the largest components of state budgets each year. Chart 7A also shows that total Medicaid spending is continually growing from year to year, particularly in recent years given the impacts of the recession. Over time, the federal government has historically matched state expenditures at an average rate of 57%. This matching rate was increased several years ago as part of the American Recovery and Reinvestment Act of 2009 (ARRA), and is also scheduled to increase substantially in 2014 with the planned implementation of the Medicaid expansions associated with the ACA.

Chart 7A – The Picture for Medicaid (Large and Growing State and Federal Burden)¹²



In February of 2012, the Congressional Budget Office (CBO) revised its projections for the federal budget including mandatory federal health spending over the next ten years. Chart 8A shows that these spending amounts are projected to more than double over this period, increasing from 4.8% of GDP to 6.5% in 2022. Roughly half of this trend is driven by the migration of the baby boom population into the Medicare program. The other half is driven by projected increases in spending per beneficiary, although at a lower rate of growth than has been experienced historically. As also shown in Chart 8A, Medicaid expenditures are projected to increase dramatically, especially in 2014 with the planned expansion of the program and enhanced federal match.

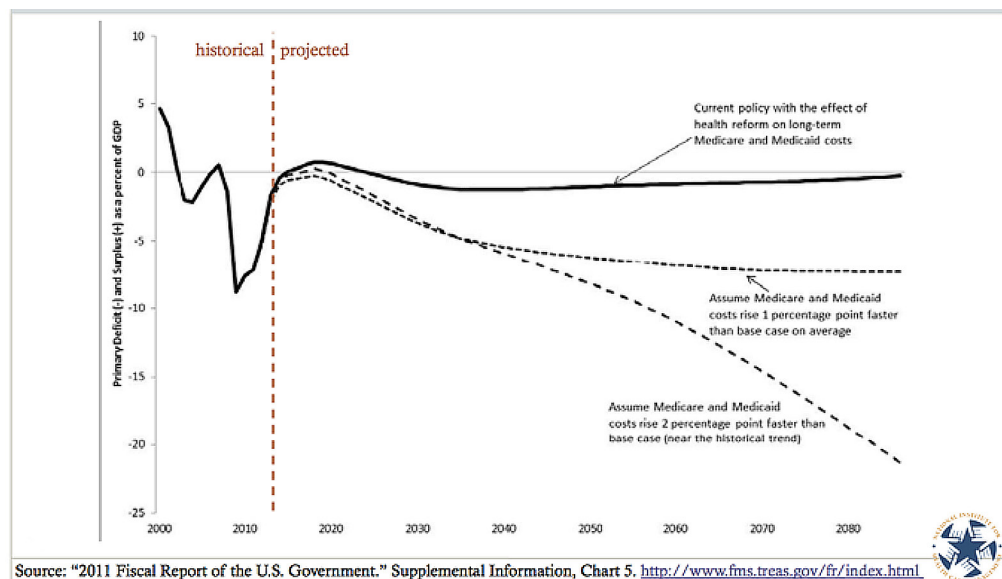
Chart 8A – Mandatory Federal Spending Projection, 2011-2022¹³



The CBO is required to base its projections on the assumption that the current law will be implemented as intended and on what some believe are unrealistic assumptions regarding future events. There are a number of unresolved budgetary issues looming, and any deviation from the current assumptions will likely work toward increasing Medicare expenditures substantially. Foremost on this list are the long-discussed “doc fix” to the Sustainable Growth Rate formula for Medicare physician payments, the sustainability of planned reductions in Medicare fees to hospitals and other providers, and the outcome of the sequestration action scheduled to go into effect in January 2013, resulting from the failure of the so-called Congressional super committee to address the deficit issues before it.

Chart 9A shows how sensitive the projections are to any changes in these assumptions. The darker line, which assumes the implementation of current policy and law, shows a relatively optimistic picture of the future. However, one can see the impact if there is any slippage from projected expenditure trends for Medicare and Medicaid. If these programs rise 1% faster or 2% faster than projected, then the deficit picture will become significantly worse over time.

Chart 9A – Faster than Expected Growth in Health Entitlement Spending will Dramatically Worsen the Projected Deficit¹⁴

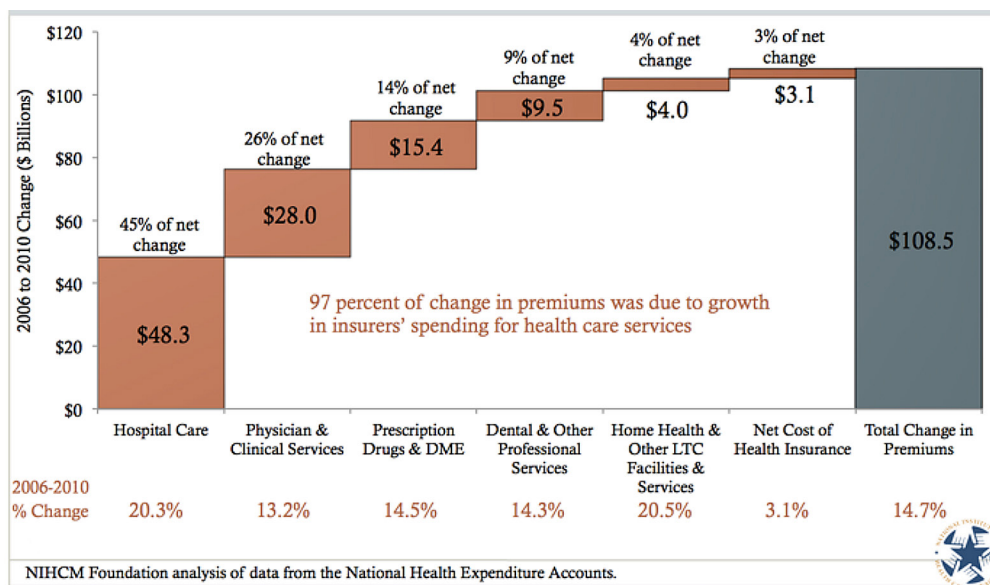


As shown in Chart 4A, private health insurance spending in 2010 accounted for about \$850 billion or about 33% of total health spending. For every dollar of premium income received by insurers, they paid out 88 cents to health care providers to services for enrolled beneficiaries.¹⁵ These expenditures go toward hospital services (34%), physician and clinical services (28%), prescription drugs and durable medical equipment (14%), dental and other professional services (9%), and home health and other long-term care facilities and services (3%). The other 12% is what is referred to as the “net cost of insurance” which is made of administrative and marketing services, rate credits rebated to enrollees, dividends to shareholders, taxes to the government, and operating profit or loss.¹⁶

Recently released data from the newly formed Health Care Cost Institute (HCCI) – a nonprofit research entity that has collected all private insurance claims from 2007 to 2011, which account for more than 40% of the private market from four large private insurers (Aetna, Kaiser Permanente, Humana and UnitedHealthcare) showed that these health plans paid 83.8% of aggregate beneficiary health costs in 2010. Thus beneficiaries paid 16.2% of all health care spending out-of-pocket, compared to 15.6% in 2009. Based on this preliminary report from the HCCI, average total annual per capita health care spending for beneficiaries younger than 65 and covered by employer-sponsored group insurance was \$4,255. This represented only a 3.3% increase in spending over 2009 (just over half the rate of 2009 or 2010), which still outpaced growth in the consumer price index by 1.7%. Utilization of services for this population was generally down, mirroring the trend for the entire population, with the increase in per capita expenditures driven primarily by increases in unit prices and not by the utilization or intensity of services.

As shown in Chart 10A, over the past five years private insurance premium revenue in our health care system went up almost 15% or about \$108 billion. Chart 11A also breaks this down by category of spending, showing the rates of increase for each sector of the health delivery system and the percentage for which that category accounted as a share of the premium increase. For instance, hospital care went up by 20.3% and accounted for 45% of the increase in premium spending. Looking at all categories of spending, 97% of the change in premiums was due to private insurers’ spending on medical services and 3% was associated with the \$3 billion increase in the “net cost of insurance.”

Chart 10A – Private Premium Growth by Health Care Sector (2005-2010)¹⁷

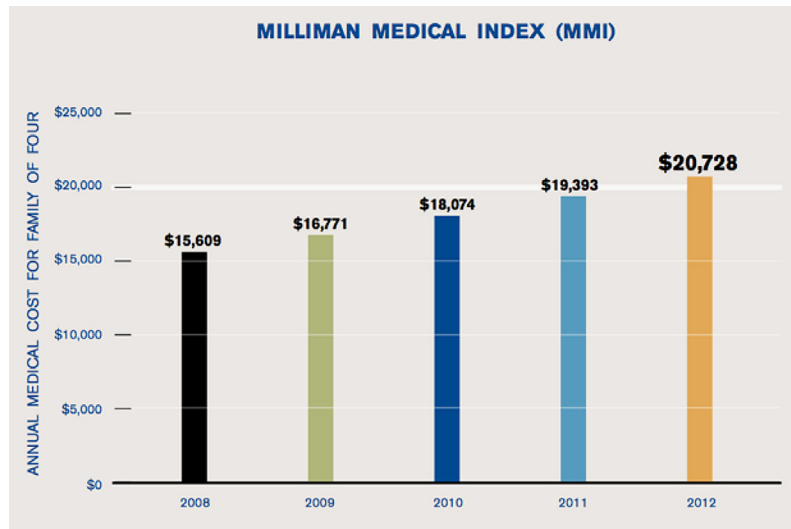


3: Implications of High Health Spending for Individuals

Our much higher level of spending on health care services has major implications both for our overall economy and for the social welfare of citizens. Rising costs combined with more out-of-pocket responsibilities are taking a larger and larger share out of each person’s annual growth in real income. Recently released data from the Milliman Medical Index tracks employer and employee contributions and out-of-pocket costs under a typical Preferred Provider Organization (PPO) plan for a family of four.

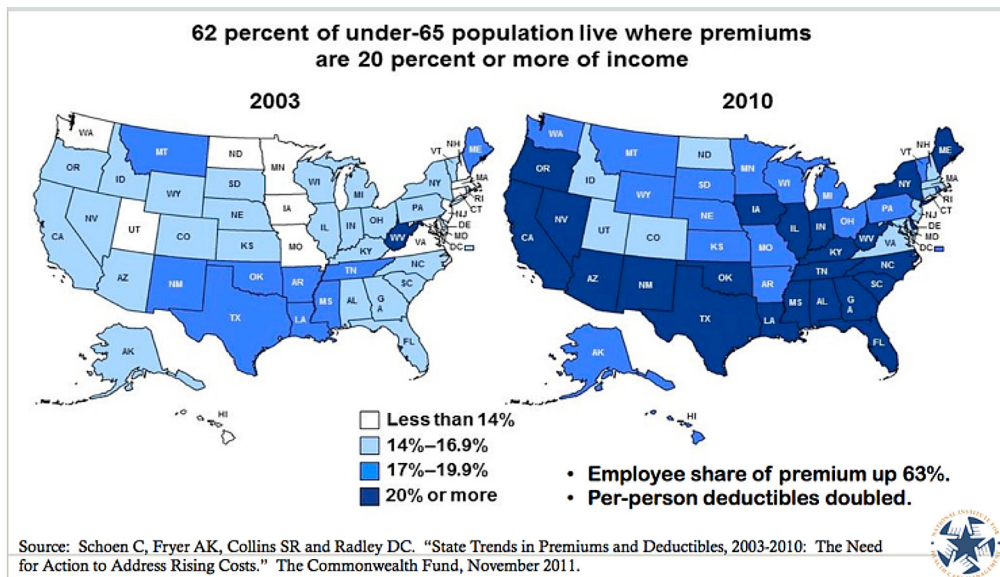
Chart 11A shows that total health care spending was estimated to be \$20,728 per family, which is more than double what it was 10 years ago. Out of this total spending, most goes to physicians and hospitals (\$6,647 and \$6,531 respectively). The balance goes to non-physician outpatient care (\$3,699), pharmacy costs (\$3,056), and “other” (\$795). Again, these are amounts spent on health care goods and services and exclude the “cost of insurance” (administrative expenses, marketing, rebates, taxes, dividends and profit of insurance companies).

Chart 11A – Milliman Index Spending under a PPO Plan for a Family of Four¹⁸



Recent data from the Commonwealth Fund also shows how quickly health care expenditures are growing as a share of personal income. The darker blue states shown in the map on the right side of Chart 12A illustrate this changing picture. Commonwealth now estimates that 6 out of 10 non-elderly people live in states where premiums are 20% or more of income.

Chart 12A – Health Care Premium Growing Quickly as a Share of Personal Income¹⁹

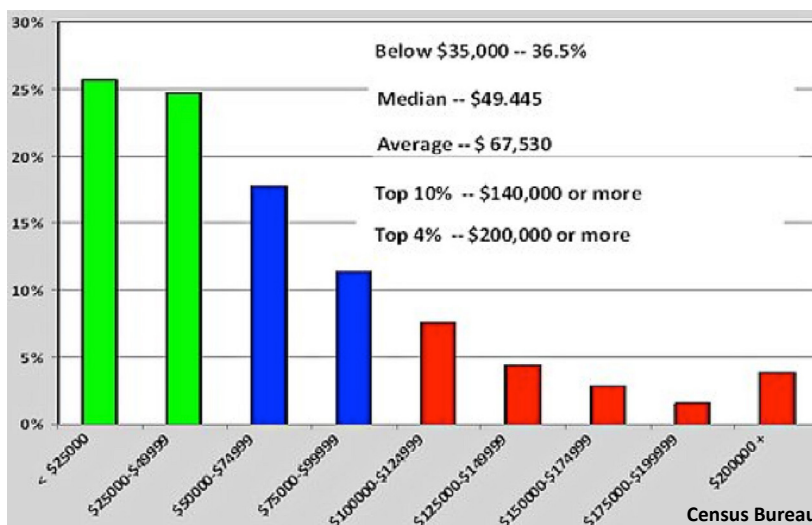


In a recent blog in the *New York Times*, economics professor Uwe Reinhardt juxtaposed the Milliman data with data on the distribution of income among U.S. households. Chart 13A shows that distribution for 2010, taken from the Annual Social and Economic Supplement of the Current Population Survey of the Bureau of the Census.²⁰ It shows that about 50% of households had annual income of about \$50,000 or less (the green bars). Only 10% had annual income of \$140,000 or more and 3.9% had annual income of \$200,000 or more.

Reinhardt raises the question of how even the most self-reliant of families can afford the “ever-larger bites the health care Pac-Man seeks to take out of their budgets.” He believes that in the absence of some larger intervention by the federal government that imposes firm discipline on health care cost growth – not allowing it to grow faster than the growth in GDP – the U.S. will segregate health care into tiers by income class.

Individuals with employer-sponsored insurance generally receive part of their overall compensation in wages and part in fringe benefits. Research consistently shows that higher health insurance costs for employers are passed on to employees through reduced benefits, greater cost-sharing and ultimately lower wages.²¹

Chart 13A – The Distribution of Income among U.S. Households, 2010¹⁹



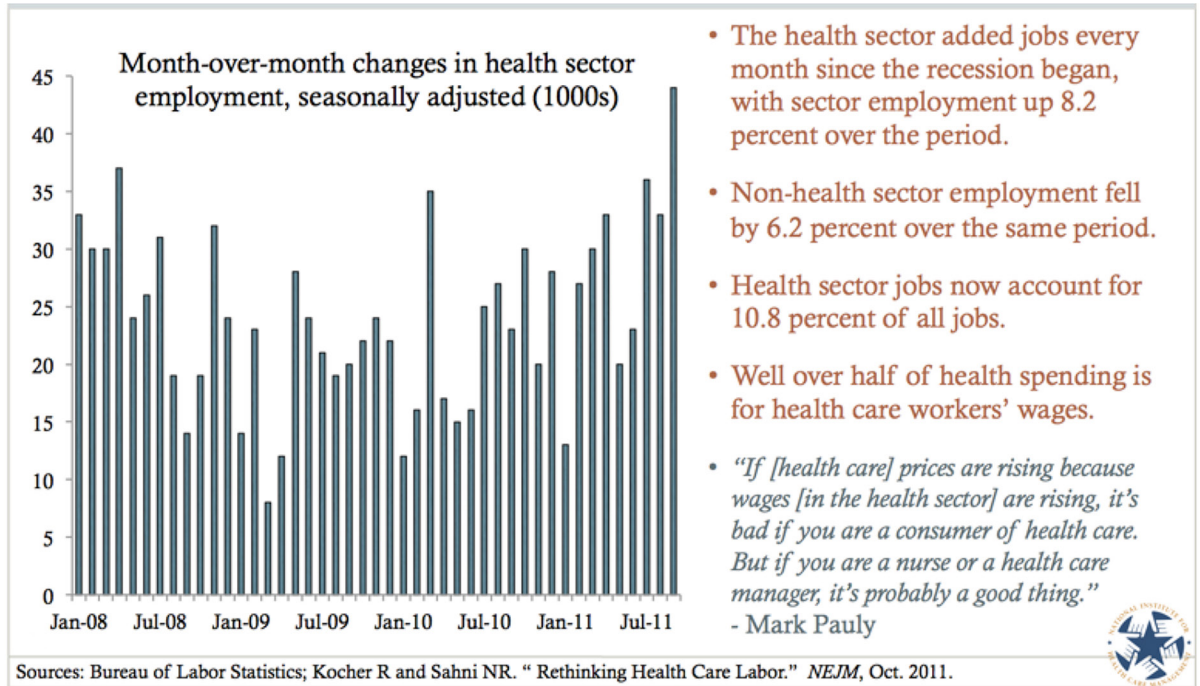
Note: The Y axis represents percent of households accounted for by each category of income.

From the period 1999 to 2009, a median-income family of four with employer-based coverage experienced gross annual income increases of \$23,000 (from \$76,000 in 1999 to \$99,000 in 2009). However, this increase was nearly matched by increased household spending on health care services in the form of higher insurance premiums, out-of-pocket spending, and taxes devoted to health care. After accounting for inflation, this family had only \$95 per month additional income available at the end of this period. Had health expenditures grown at the rate of GDP over this period, the family would have enjoyed an additional \$545 in monthly income, a difference of more than \$6,500 per year.²²

However, as health care costs rise rapidly, employers are generally not able to make broad wage adjustments to their labor forces, so they are left with the option of reducing benefits or cutting employment. In 2009, a RAND analysis showed if health care costs had been 10% higher in 2005, it would have cost 121,000 jobs.²³ The researchers at RAND also projected that if health care spending reaches 20% of GDP (as it is expected to do by 2018), sectors of the economy that provide the most generous employee benefits will face significant employment reductions.²⁴

For those employed by the health sector, rising health expenditures means increased job security. During the recession in 2009 and 2010, the health care industry was adding jobs month over month while the rest of the economy was reducing employment precipitously (see Chart 14A). In addition, while wages fell in other parts of the economy during the recession, health care wages grew at a compounded rate of 3.4% from 2005 to 2010. Currently the health care sector accounts for nearly 11% of all jobs in the economy with approximately 56% of health care spending going to support these jobs.

Chart 14A – Health Sector Job Growth by Month, 2008 – 2011²⁵

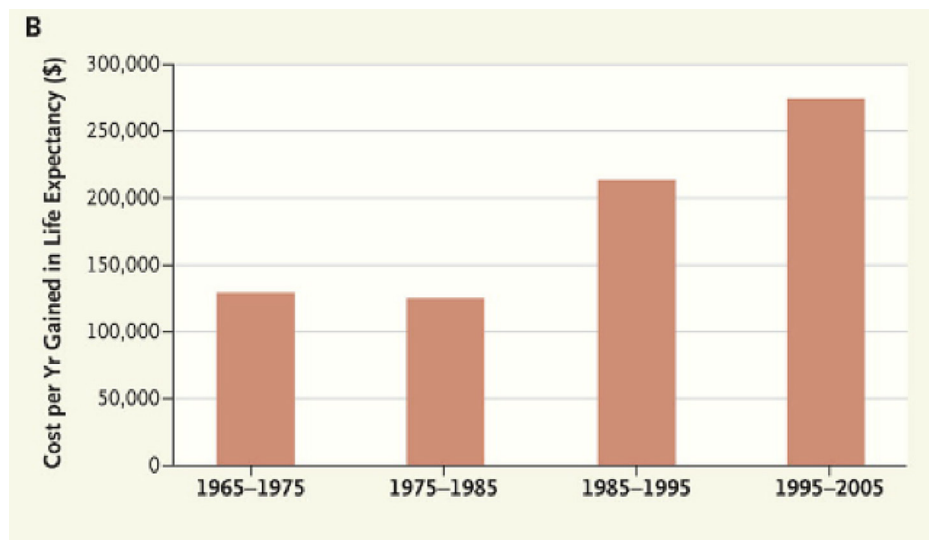


Labor is the largest category of expense because our system is designed to be extremely labor-intensive. However, relative to other sectors of the economy, the health sector ranks extremely low in terms of labor productivity and has experienced no gains in productivity per worker over the past 20 years.²⁶

Also, as Baicker and Chandra point out in a recent *New England Journal of Medicine* article on the implications of job growth in the health care sector, it is tempting to think of rising health care employment as a boon.²⁷ Certainly, at the local level, politicians give much weight to employment opportunities offered by a growing health care sector, which leads them to resist reductions in payment trends or the closing of local facilities.

However, the authors show that given all the money we allocate to the health sector, the cost per year to produce a one-year increase in life expectancy has risen dramatically over time (Chart 15A), exceeding conventional life year cost-effectiveness thresholds.

Chart 15A – Cost per Year Gained in Life Expectancy²⁸



This suggests strongly that these resources could do more good if they were allocated to other things (note that these results depend heavily on the assumed share of health gains attributed to health care spending). Thus, if valid, this evidence shows that incremental health care spending is producing small gains in health at best, mostly at the beginning and not at the end of life. These misallocations are driven by the structure of our current health care system, largely the dangerous dynamic of monopolies and the cost-insulating effects of insurance. Given evidence from Organisation for Economic Co-operation and Development (OECD) countries, it is demonstrably achievable to have the same or better health outcomes with far fewer resources devoted to the health care sector.

In addition, recent research from the RAND Corporation indicates that every new job added to the health care sector results in 0.85 fewer jobs in the rest of the economy.²⁹ So, at best this situation is, as Baicker and Chandra write, “a wildly inefficient jobs program.” At worst it is resulting in a massively inefficient redistribution of wealth from more productive activities in the economy.

At the macroeconomic level, health care is already a large and growing economic drag on U.S. growth and productivity. The historical growth in health care spending cannot be sustained over the long run without reducing the availability of all other goods, services, and investments.

Thus, while the health sector is generally viewed as an engine of economic growth benefiting the short-term economic development of states and local municipalities, the reality is that unbridled increases in the health care industry and the number of people employed in this sector result in longer-term reductions in employment and economic growth in most other sectors of the economy.

4: Implications of Continued Health Care Spending for U.S. Economic and Social Welfare

First, as noted above, continued health care spending has historically had a large and growing direct impact on the income and economic welfare of individuals and families. If health care spending continues to grow at 1% or 2% above income growth, it will take larger and larger bites out of the amount that citizens have to spend

For example, even if health spending grows at only 1% greater than GDP, which is much lower than historical trends, less and less of our new income will be available to devote to other goods and services. That is, up until now an average person has been spending 25% of new income on health care. However under this 1% excess growth scenario, the average person will soon have to devote 40 to 50% of any new income to health care, up from 25% now. If health care spending continues to grow 2% faster than income (closer to the historical trend) more than 100% of the average person’s new income will be devoted to health care spending.³⁰

So rising health care costs will increasingly crowd out spending on other goods and services and take a heavy toll on individual wealth. These stark tradeoffs are occurring also at both the federal and state budget level because total government spending now accounts for about 39% of all health costs. Given the reluctance of Americans to raise taxes, health spending is now pitted against and usually eats into important priorities in public budgets such as education, basic research, and infrastructure investment.

Second, rising health care spending will eventually undermine our prospects for future economic growth as well as our ability to weather any future economic shocks to our system. In 2010, government spending on health care was a little over 39% of all health spending, accounting for about 5% of GDP, but is projected to account soon for 50% of all health care spending. Given current CBO projections, government health spending as a proportion of GDP is projected to rise from 6.5% of GDP in 2022 to over 12% of GDP in 2050. Thus, it is clear that government deficits and debt levels are highly intertwined. As would be expected, deficits tend to fluctuate with the economy. But the U.S. currently has an underlying structural deficit that is large and growing, most of which is accounted for by current and projected increases in federal spending on health care.³¹

If health care spending continues to grow at rates 1-2% above GDP growth, then besides cutting programs, including health entitlement programs, we could try to finance this growth in one or more ways: 1) through tax increases; 2) through increased borrowing (or debt); or 3) through greater shifting of the responsibility of health care spending to individuals through increased out-of-pocket spending, higher premiums, or reduced benefits.

TAX INCREASES

Increasing taxes to finance all new health care expenditure growth, either through progressive income or payroll tax increases, will potentially impose significant “efficiency” costs on our economy. According to a study by Baicker and Skinner, marginal tax brackets could rise to 70% by 2060 depending on the progressivity of future tax changes resulting in a reduction in GDP growth by 11% relative to trend. A proportional payroll tax increase has a less detrimental efficiency impact, reducing GDP growth by 5% relative to trend. Either way, significant increases in taxes can have overall negative economic consequences.³²

INCREASED BORROWING

Conversely, the U.S. could attempt to fund continued health spending through increased debt. As noted, the national debt is currently \$10.1 trillion or 68% of GDP, but projected to increase to 15.2 trillion (77% of GDP) by 2017 and \$18.8 trillion (76% of GDP) by 2022. Others have projected with reasonable assumptions that debt could easily reach 90% of GDP by 2020, 110% by 2025 and 180% by 2035.³³ Most economists and the CBO believe when debt rises to around 90% of GDP there is increased risk of a situation where bond holders lose confidence and start to demand much higher real interest rates, slowing future economic growth.

Prior to the financial crisis in 2007, the debt to GDP ratio in the U.S. was around 20%.³⁴ But as we saw recently in response to the 2008-2009 U.S. banking crisis, things can change very quickly when dealing with large economic shocks. There are also negative economic implications associated with higher debt levels. First, interest payments on the debt, which now exceed \$750 billion per year, will consume an increasing share of income – 1.3% of GDP in 2009 or about 5.3% of total federal spending. Growing debt levels also can push interest rates higher for all borrowers (government, business, and individuals), thus slowing economic growth.

Of course, the U.S. economy is not like most other economies based on our size, historic levels of productivity, and the fact we control our own currency, which is the reserve currency for the rest of the world. While there is likely some debt threshold that could cause investors to turn away from the U.S. as a safe haven, it is likely higher than that for other countries. Nevertheless, reasonable assumptions about our budget show that the U.S. could be on that path after 2022.

Beyond the threat that economic growth will be lower than expected, high levels of debt on the order of magnitude of 70-90% of GDP present the risk of having inadequate fiscal space to absorb another financial shock to the U.S. economy. In the past 12 years, we have witnessed two such shocks, the terrorist attacks of September 2001 and the financial meltdown of 2008-2009. Sufficient fiscal space is important to have to fight any crisis that might occur in the next 10-20 years.³⁵

The bottom line is that policymakers will be forced to respond prior to 2025. Such action is sure to include tax increases and spending cuts relative to projections. And those cuts will likely include significant reductions to health care spending.

INCREASED BENEFICIARY RESPONSIBILITY

Lastly, the U.S. appears to be moving increasingly to a system where the beneficiary pays more and more out-of-pocket. And while it may be useful to engage consumers more in the decision about health care alternatives and costs, there is a real question of how much additional spending household budgets can absorb.

If this trend accelerates without limits, some envision a health care system increasingly segmented into tiers by income class. For higher-income groups we might have self-financed, boutique medicine in which the latest and best care is available, although it is unclear whether that tier would continue to enjoy the tax preference currently afforded employment-based insurance.³⁶

The broad middle class will increasingly face some combination of higher out-of-pocket spending, reduced benefits, and higher premiums.

For publicly-insured, lower-income families, including the elderly, there would emerge a separate, purely public health care delivery system that can be tightly budgeted. There would be public clinics for ambulatory care and budgeted public hospitals for inpatient care – an analog of the Veterans’ Administration delivery system.

Some economists and policy-makers believe that if we move increasingly to a system in which patients

bear a higher share of the costs, this will help solve some of the concerns about rising spending because it will increasingly force people to choose lower cost providers and procedures and to restrict the care they receive.

So an important policy question is: how much will income-related rationing exacerbate disparities and how will voters respond? In the absence of fundamental and comprehensive changes to our overall health care financing and delivery systems, more of the burden of financing health insurance in the private sector will fall on individuals, potentially reducing well-being significantly and distorting demand for other goods and services. Insufficient transparency on prices and other metrics make it difficult for consumers to assess the overall efficiency and effectiveness of providers.

Already, a growing number of individuals, particularly those who have experienced a serious illness within the past 12 months, are concerned about the costs of medical care and are struggling to gain access to the best and most appropriate care, according to new poll released recently by the Robert Wood Johnson Foundation (RWJF), National Public Radio, and the Harvard School of Public Health.³⁷

According to the poll, 87% of those surveyed think that the cost of care is a serious problem for the country. Approximately two-thirds of respondents believe the cost of care has increased over the last five years – and are not impressed with what they’ve received in return. Fifteen percent of individuals seeking treatment for serious illness thought they were given the wrong diagnosis, 15% believed they received tests they didn’t need, and 18% thought they didn’t get the test they did need. More than 25% of patients surveyed thought their care was not “well managed.” And lastly and probably most concerning, of those surveyed and seeking care, 11% were turned away from a doctor or hospital for financial or insurance reasons.

Given the potential fiscal and social consequences of a continued increase in health care spending growth, it is all the more important to consider the root causes of why health care costs continue to increase in an unconstrained way. The lack of competitiveness in the health care sector is, undeniably, at the top of the list.

¹ Schoenman JA, Chockley N. Understanding U.S. health care spending. National Institute for Health Care Management (NICHM) Webinar. February 2, 2012. Available from: <http://nihcm.org/component/content/article/116-research-health-care-reform/583-webinar-controlling-health-care-spending-the-imperative-to-act-and-diverse-views-of-the-road-forward>.

² Martin AB, Lassman D, Washington B, Catlin A. 2012, Growth in US health spending remained slow in 2010: health share of Gross Domestic Product was unchanged from 2009. *Health Aff (Millwood)* 2012; 31(1): 208-219.

³ Martin AB, Lassman D, Washington B, Catlin A. Recession contributes to slowest annual rate of increase in health spending in five decades. *Health Aff (Millwood)* 2011; 30(1):11-22.

⁴ Goldsmith J. Barking up the wrong tree: affordability, not cost growth, is the policy challenge. *Health Affairs Blog* May 7, 2012.

⁵ Schoenman & Chockley, Understanding health care spending.

⁶ Davis, K. Bending the health care cost curve: a new era in American health care? The Commonwealth Fund Blog. January 18, 2012.

⁷ Altman D E, Levitt L. The sad history of health care cost containment as told in one chart. *Health Aff (Millwood)* 2002 Jul-Dec; Suppl Web Exclusives:W83-4.

⁸ Schoenman & Chockley, Understanding health care spending.

⁹ Blinder A. “We don’t have a generalized overspending problem. We have a humongous health care problem.” *The Wall Street Journal*, January 19, 2012.

¹⁰ Schoenman & Chockley, Understanding health care spending.

¹¹ Schoenman & Chockley, Understanding health care spending.

¹² Schoenman & Chockley, Understanding health care spending.

¹³ Schoenman & Chockley, Understanding health care spending.

¹⁴ Schoenman & Chockley, Understanding health care spending.

¹⁵ Schoenman & Chockley, Understanding health care spending.

¹⁶ Health Care Cost Institute. Health care cost and utilization report: 2010. May 17, 2012. Available at: www.healthcostinstitute.org.

¹⁷ Schoenman & Chockley, Understanding health care spending.

¹⁸ Milliman. Milliman Medical Index. 2012 Available from: http://insight.milliman.com/article.php?cntid=8078&utm_source=milliman&utm_medium=web&utm_content=MMI-mktg&utm_campaign=Healthcare&utm_terms=Milliman+Medical+Index.

¹⁹ Schoenman & Chockley, Understanding health care spending.

²⁰ Reinhardt U. “The fork in the road for health care.” *The New York Times*. Economix Blog. May 25, 2012.

²¹ Emanuel E, Fuchs VR. Who really pays for health care? The myth of “shared responsibility.” *JAMA* 2008; 299(9): 1057-1059.

²² Auerbach DI, Kellermann AL. A Decade of health care growth has wiped out real income gains for an average U.S. family. *Health Aff (Millbank)* 2011; 30(9): 1630-1636.

²³ While the number of lost jobs may seem small, it relates to only a small, assumed increase in excess cost growth (the authors assumed health expenditures grew at GDP+2.42% instead of the actual growth of GDP+2.2%). Plus, overall annual job growth per year has averaged approximately 1.2 million jobs per year since 1948. So we are subtracting 10% of our annual job growth for every 10% we grow in excess of GDP growth.

²⁴ Sood N, Ghosh A, Escarce JJ. Employer-sponsored insurance, health care cost growth, and the economic performance of U.S. industries. *Health Serv Res* 2009; 44:5, Part I: 1449-64.

²⁵ Schoenman & Chockley, Understanding health care spending.

²⁶ Kocher R, Sahni NR. Rethinking health care labor. *N Engl J Med* 2011; 365(15):1370-1371.

²⁷ Baicker K, Chandra A. The Health Care Job Fallacy. *N Engl J Med* 2012; 366:2433-2435.

²⁸ Ibid. Note the authors assume (perhaps quite conservatively) that 50% of the gain in life expectancy is due to health care spending.

²⁹ Sood, Ghosh, & Escarce, Employer-sponsored insurance.

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- ³⁰ Chernew ME, Baicker K, Hsu J. The specter of financial armageddon – health care and federal debt in the United States. *N Engl J Med* 2010; 362(12):1166-68.
- ³¹ The term “deficit” refers to the gap between revenues and spending in any given year (currently estimated to be \$1.3 trillion in 2012. National “debt” refers to the accumulated deficits over time (our total stock of debt) which was \$7.5 trillion in 2009 and \$10.1 trillion end of 2011 or about 68% of GDP.
- ³² Baicker K, Skinner JS. Health care spending growth and the future of U.S. tax rates. National Bureau of economic Research Book Series, *Tax Policy and the Economy*, 2011; 25.
- ³³ Johnson S, Kwak J. *White House Burning: The Founding Fathers, our National Debt, and why it Matters to You*. New York: Pantheon Books. 2011: 147-160.
- ³⁴ Federal Register Statistical Release H.15; CBO, The Budget and Economic Outlook, An Analysis of the President’s Budgetary Proposals and The Budget and Economic Outlook: An Update 2008-2011.
- ³⁵ Johnson and Kwak, *White House Burning*, p. 151.
- ³⁶ Reinhardt, Fork in the road for health care.
- ³⁷ National Public Radio/Robert Wood Johnson Foundation/Harvard School of Public Health. Poll: sick in America summary. 2012. Available from: www.hsph.harvard.edu/news/press-releases/files/press_release_blendon_cost_quality_summary_final.5.2012.pdf.

APPENDIX II Potential Ways to Improve Provider Competition, Health Care Costs, and Quality

As discussed in Section 4 of the main paper, antitrust action has been the traditional response of those seeking to counteract consolidated market power that negatively affects consumers. But a long losing streak in antitrust litigation – and other policy concerns – have led to a level of provider consolidation that has significantly skewed market power toward providers and become a major factor in unsustainable levels of growth in health care costs. Thus, while antitrust action remains an important tool in certain circumstances, it is important to examine alternative approaches and activities to counteract the negative effects of provider market power. This appendix looks at the solutions discussed in Sections 4.3-4.5 of the main paper that examine market-based and regulatory approaches.

Market-Based Approaches

Market-based approaches can either manage demand or increase supply. Either approach can help to balance a consolidated provider market by restoring some control to health care purchasers and prompting providers of health care services to innovate to compete on both price and quality.

Consumer Engagement Strategies: Price and Quality Transparency

Many believe increasing the transparency and usefulness of data on the performance of providers (including compliance with evidence-based standards, health care outcomes, and cost) can increase competition among providers. Allowing consumers, who are paying an increasing share of the costs of care, to select providers based on quality and cost would motivate providers to compete in those domains, akin to how other non-health care markets function. Transparency is a building block for purchasers and plans wanting to tie payment to performance, to implement reference and value pricing, to design performance-based narrow or tiered networks, and to designate providers as Centers of Excellence, all of which can enhance competition.

Absent reliable and understandable information, consumers tend to rely on reputations, brand names, and other proxies. This tends to decrease the responsiveness of demand to prices or other factors and enhances provider market power. Thus, successful consumer engagement depends on providing consumers with access to actionable information on the relative value of different providers within (and beyond) the network available to them.

Unfortunately, only a small number of areas in the country provide consumers with useful comparisons of provider cost and quality. For example, New Hampshire and Maine are making use of their state All-Payer Claims Databases to post provider prices on the web for consumers to use when making care-related decisions.

That said, research to date has shown that consumers use such data in a limited fashion. This may be due to a lack of standardization, too much complexity, or other factors.¹ The success of greater transparency depends on the extent to which consumers, employers, and providers have access to standardized measures of cost and quality on providers – as well as the ability to make sense and use of the data. Patient satisfaction and experience of care data may be especially powerful because consumers are accustomed to user-generated ratings in other areas of their lives.

Other barriers to transparency come from health care providers and insurers. There are some providers who negotiate into their contracts with health insurers prohibitions on the release of their negotiated payment amounts. Only a small portion of providers nationwide have such stipulations in place, and many health plans have obtained agreement with some of these providers to share pricing information. But in some markets, where these so-called “gag clauses” are in place for dominant and/or larger providers, consumers may only have access to price information for a small proportion of providers. Some private insurers also

decline to share their pricing data even with their self-insured health care purchaser customers. Not only do insurers fear that making it accessible will undermine their ability to negotiate with providers, but they also do not want other vendors to have the data they would need to compete with health plans' own efforts to create price and quality transparency tools for consumers.

There may, however, be drawbacks to transparency. Some consumers may mistakenly equate price with quality assuming the more expensive the care the better. Making pricing information public can also make it easier for firms to collude and studies have shown that sometimes pricing transparency can result in suppliers in a given industry raising prices.² The good news is that health care providers do appear ready to improve performance in response to published performance data. Therefore, making more of these data available in a clearly understandable format – and raising public awareness – might heighten pressure on providers to bring their costs and quality closer to the norm.

In the end, while increasing the transparency and usefulness of performance data about providers is a high priority, we need further progress in the development of meaningful, consistent, and understandable metrics for consumers. If not presented in a meaningful and intuitive manner, such data could confuse or mislead consumers. Improved transparency may also mean increased availability of comparative cost and quality data to other parties (such as health care coaches, nurses, and primary care physicians) who are properly incentivized and sufficiently knowledgeable to assist patients in making high-value decisions about their health care.

For more information on the topic, see CPR's Action Brief, [Price Transparency: An Essential Building Block for a High-Value Health Care System](#).

Consumer Engagement Strategies: Consumer-Directed Health Plans (CDHPs)

In health insurance, there is an inherent tension between the benefit of reducing a person's exposure to financial risk and the drawback of reducing a patient's sensitivity to differences in price and quality among providers. This stems from the presence of "first-dollar" insurance coverage. When patients receive comprehensive health insurance, they naturally tend to consume more services, which contributes to rising health care costs.

Patient cost sharing is one potential lever for changing behavior and will likely remain an important tool for cost containment. One of the cost-sharing strategies is the Consumer-Directed Health Plan (CDHP), which typically pairs a health savings account (HSA) with a high-deductible health plan. Many of these plans also seek to increase patient responsibility by encouraging greater use of health risk assessments, disease management, and wellness programs.

As health care costs have continued to escalate, CDHPs have become very popular among employers and beneficiaries, increasing from 4 percent of all employer-sponsored insurance (ESI) to 13 percent in 2010.³ Evidence that CDHPs can reduce health care expenditures dates back to the seminal RAND Health Insurance Experiment (HIE) begun in the 1970s.⁴ Enrollment in CDHPs will likely grow substantially in future years, motivating patients to cut back on health care spending and potentially producing savings for consumers and employers over the short term.

There are some caveats to these results however. A recent Robert Wood Johnson Foundation synthesis report summarized some of the existing concerns associated with CDHPs.

- Recent studies tell us very little about how increased cost sharing affects health status or total spending over the long term.
- There has not been a study of the effects of cost sharing on health in a general population in thirty years (since the RAND HIE study).
- Increased cost sharing for prescription drugs leads to increased emergency department and inpatient hospitalization spending by the elderly and the chronically ill.
- Responses to cost sharing differ by income – low-income individuals are more likely to shift the types of service they use, not reduce overall use.
- Cost sharing can reduce use and expenditures for preventative services, prescription drugs, emergency department utilization, mental health care, and substance use treatment.

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- Most patients have difficulty distinguishing between essential and non-essential care.
 - Expensive treatments put most consumers well beyond their deductibles and co-pays so that they bear little if any price differences across providers – thus it isn't realistic to expect them to be price sensitive, so such treatments, which account for the majority of medical spending, will not be impacted by CDHPs.

Many critics of CDHPs believe they are merely an additional way for employers to shift ever-increasing costs to employees. In addition, it may be unrealistic to believe that consumers alone can drive market share shifts or change the balance of market power between providers and payers. There is only so much cost sharing that can be in effect while still having some form of health insurance in place. Finally, consumers are again hamstrung by the lack of meaningful information that could identify low-cost and high-quality providers.

Despite these uncertainties and concerns, it appears that employers will be using CDHPs in conjunction with value-based insurance design (see below) in an attempt to slow the growth of their health care expenditures and induce a higher level of competition among providers. CDHPs introduce the concept of consumer price sensitivity into the mix which can begin to support the fundamentals of a competitive marketplace.

Consumer Engagement Strategies: Value-Based Insurance Design

Value-Based Insurance Design (VBID) – such as tiered and high-performance provider networks – is based on the presumption that patient cost sharing can lead to more efficient resource allocation. Employer-sponsored insurance has long attempted to direct patients to certain preferred providers based on prescribed criteria. In contrast to the 1990s, when HMOs negotiated volume discounts and steered patients to a providers in highly-limited networks, health plans today are attempting to provide incentives for patients to seek out and use hospitals and physicians who provide the highest value care, defined as the highest quality care per dollar of expenditure.

The theory is that VBIDs can engage consumers to make informed decisions about their care while maintaining a choice of providers.⁵ The challenge for employers in using CDHPs and VBIDs is to construct benefit packages that provide strong incentives to consumers to be more cost conscious, while avoiding unwanted negative clinical effects and excessive shifting of risk to beneficiaries.

In a tiered network, for example, health plans attempt to sort providers into tiers based on their relative performance on cost and quality metrics and patients receive incentives – lower cost-sharing provisions – to choose these providers. Part of the hope is that tiered networks will induce the provider industry to compete on the basis of the cost and quality of the care they deliver. Today, most insurers offer a tiered network product and 20 percent of employers include a tiered provider network in their health plan with the largest enrollment.⁶

Some literature has shown that hospitals increase their quality improvement activities in response to public reporting of provider performance data.⁷ Yet there are no formal studies of how providers respond to tiered networks, and only limited empirical work on consumers' behavioral responses. One study of a tiered network for hospitals found evidence that some consumers switched to preferred hospitals when the price differential between preferred and non-preferred tiers was relatively high (\$400 or greater).⁸ There is other evidence that consumers do respond to tiered cost sharing on prescription drugs.⁹

However, it is unclear whether patients will be sufficiently aware of the incentives and able to interpret and respond to them.¹⁰ The other unknown factor relates to the strength of existing relationships between patient and physician. Patients who have established a relationship with one physician or specialist may be highly reluctant to change that care pattern even in the face of additional cost sharing. In addition, different health plans and employers use different metrics to rank providers, often resulting in conflicting assessments of performance.

Again, the challenge is striking the proper balance – sensitizing consumers to the cost implications of their decisions but not shifting so much risk as to incentivize the wrong type of behavior (i.e., forgoing needed care). This balance must be achieved by somehow addressing individual differences in how consumers might respond – no easy task.

Consumer Engagement Strategies: Reference and Value Pricing

At the intersection of consumer engagement and provider contracting is a new movement toward reference and value pricing. Reference pricing establishes a standard price for a drug, procedure, service, or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. Safeway has applied it most recently in areas where quality is thought not to vary, such as colonoscopies, labs, and imaging.¹¹ Straightforward reference pricing can be built onto a fee-for-service payment structure.

When reference pricing takes quality into consideration, it is known as value pricing. Value pricing can be applied in many more circumstances, including for procedures and services where quality is known to vary. The California Public Employees' Retirement System (CalPERS) is now using value pricing for hip and knee replacement, having established a reference price of \$30,000 for a single hip or knee replacement. It found 47 hospitals that met both quality and volume standards and were willing to provide those services at that price. CalPERS will pay up to that level, but patients opting to use a more expensive facility must pay all allowed charges above the \$30,000 reference price. The idea is to incent providers with potential volume gains rooted in consumer choice, and to signal that there is little toleration remaining for unwarranted variation in payment amounts. Depending on how reference and value pricing are incorporated into the overall benefit design, such mechanisms can introduce a sensitivity among consumers to the price for high-cost services as well as where they seek such services.

Network Strategies: Establishing Tiered, Narrow, and High-Performance Networks

Private payers somewhat successfully employed selective contracting – the use of limited networks of providers offering more favorable pricing – during the period of managed care domination in the 1980s and 1990s. But there was a massive backlash to managed care, largely due to the lack of quality information in the development of managed care networks, which included consumers demanding that employers and health plans offer broad access to providers. In the last twenty years, however, it's become clear that broad access undermines the negotiating leverage of health plans that now have no credible threat of excluding higher-cost providers from their networks.

Perhaps in recognition of the need to control soaring costs, selective contracting has begun to reemerge. For example, amid intense scrutiny into why health care costs in Massachusetts are climbing 7.5 percent a year, limited networks have emerged as the most immediate way to control costs. Health insurers are beginning to sell policies that largely bar consumers from receiving medical care at popular but expensive hospitals such as Massachusetts General and Brigham and Women's in Boston. In addition, the Group Insurance Commission (GIC), the agency that oversees health insurance for state employees, required its two largest health plans, Harvard Pilgrim and Tufts Health Plan, to develop restrictive networks. These plans also use network tiering and reference pricing in their benefit design for state employees.¹²

Renewed employer willingness to demand narrower networks might bolster health plans in their ability to negotiate with dominant and higher-cost providers in a particular area. As described above, tiered networks induce consumers to use higher-value providers by lowering their cost sharing requirements for those providers. Narrow (or high-performance) networks are made up solely of high-value providers. Some believe that such strategies could work to foster competition among providers if coupled with appropriate quality and performance information, employee benefit designs, and decision-making support.

Network strategies: Centers of Excellence/Direct Contracting

For some time, health insurers have created special networks that encourage patients or employers to use particular facilities – called Centers of Excellence (COEs) – for certain high-risk and/or high-cost procedures.

For example, insurers have long directed patients to specific hospitals for highly specialized organ transplants. The COE concept takes tiering a step further, sending patients undergoing complicated, expensive procedures to hospitals that do a lot of them. Facilities that frequently perform a certain procedure will have better clinical outcomes, with fewer complications and readmissions.

The purpose is to assure a certain level of quality for a negotiated cost. The COE agrees to provide

discounts in return for the patient volume that gets directed their way. COE contracts are bid out and patients are directed to the winning providers. The lowest-cost pricing does not necessarily win, because access and quality of care also are major concerns, especially for larger employers. To encourage consumers further to use options outside of local geographies, employers may also offer travel benefits for both the patient and a companion.

Though COEs began through health plans, now some large employers have begun pursuing COEs outside of their immediate geographic area and/or are doing direct contracting with providers (usually larger medical center COEs) as a way to regain control over their costs for employees' health care benefits. This could increase competition among providers for direct contracting arrangements, and could also increase local providers' attempts to offer a competitive high-quality, lower-cost alternative.

Firms such as Lowes, Staples, and Wal-Mart are currently using a COE approach with a select number of larger medical centers such as the Cleveland Clinic, the Mayo Clinic, and the Johns Hopkins Hospital for high-cost procedures such as coronary artery bypass surgery and orthopedic surgery. CalPERS first established a center of excellence program for organ transplants. The program was successful enough that CalPERS instituted a similar, although not mandatory, program for coronary artery bypass graft procedures.

If employers, case managers, and the general public are educated about COEs and quality measurement, they may be less likely to focus only on price and have the potential to enhance provider competition on the right mix of cost and quality factors.

Network strategies: Managed Care and Managed Competition Strategies

In the late 1980s and 1990s, managed care was a highly dominant force in the health care sector and for a time appeared to be significantly constraining health care expenditure growth. By 1995, 73 percent of those obtaining coverage through employers were in managed care plans compared to just 27 percent eight years earlier.¹³

Plan provider networks were selective and this allowed managed care companies to gain payment reductions from physicians and hospitals. Many studies have shown that managed care was able to moderate overall spending growth largely by being aggressive on price controls (as opposed to utilization review and control efforts).¹⁴

By the late 1990s, however, physician and consumer dissatisfaction with this model had grown to profound levels. The rapid onset of this so-called "backlash" may have had its roots in the rapid and often times involuntary enrollment of new beneficiaries into managed care plans from traditional indemnity plans.¹⁵

Thus, the vision for vigorous health plan competition under tightly managed HMOs with distinct provider networks competing on the basis of service quality and price did not materialize. Instead, competition had devolved into a state where insurers who had the greatest market share used that negotiating leverage to extract the greatest price discounts in exchange for patient volume. This did lead to lower premium growth for a time, but for the most part the prices negotiated were arbitrarily determined and in some cases put many efficient provider systems out of business. Eventually the discounts subsided as relative market power shifted back in favor of a now-rapidly-consolidating provider industry.¹⁶

The purpose of recounting this brief history of the experience with managed care is to recall that there were highly beneficial aspects of this approach, and that if managed properly, as advocated by Alain Enthoven, the approach could have evolved into a successful model of a competitive health financing and delivery. According to Enthoven, over these past 20-25 years we seem to have lost sight of the fact there can be competition in the health care industry if it is managed. By managed, Enthoven means we address certain market failures, such as the absence and asymmetry of information, and structure benefits in a standardized way to help create price-elastic demand.¹⁷ There are examples of successful systems of managed competition internationally, particularly in the Netherlands. Americans are also familiar with benefit standardization through Medigap policies. These models are not perfect, but they appear to do a reasonable job of combining both public and private forces to promote a more competitive (and managed) health care industry.¹⁸

Many health policy researchers remain fans of managed care and managed competition. But it's an open

question as to whether elements of this phenomenon could now help employers, insurers, and government reinvigorate the competitive process in health care markets. The original basis for managed care organizations came from the concept of industrial sickness funds. Created by employers and their employees, these entities worked on behalf of them and thus not in their own self-interest, as many private insurers are accused of doing today. Is it time that we consider approaches that restore both the competitive dynamic and align the interests of all purchasers in the market place?

Network strategies: A New Market Development – Entry of New Lower-Cost Competitors

In the late 1990s, in many communities physician-owned specialty hospitals emerged as viable and often lower-cost alternatives to entrenched hospital systems. But policymakers saw their proliferation as largely a response to distortions in the Medicare payment system. Public policy to prevent these entities from skimming off lower risk and fully insured patients – as well as Certificate of Need laws – generally acted as a barrier to entry and specialty hospitals did not proliferate.

But today, the excessive price increases driven by highly-consolidated providers in some markets may be stimulating the entry of new providers who seek to deliver a lower-cost alternative. For example, in highly concentrated markets like the Boston and Pittsburgh areas, entities are emerging as potential lower-cost alternatives to large and expensive health systems like Partners HealthCare and the University of Pittsburgh Medical Center (UPMC).

In the Boston area, a new health system recently organized by a private equity firm (Cerberus Capital Management) purchased Caritas Christi Health Care, the region's second largest hospital system, turning a former nonprofit Catholic system of six hospitals into a for-profit system. And a new, less costly health plan in the Boston area is the result of a partnership between Steward Health Care System and the Fallon Community Health Plans, the state's fourth largest insurer. The savings are projected to come from Steward providing care at the lowest-cost community hospitals. The Steward-Fallon product could be priced as much as 20% lower than comparable coverage. In the past, Steward also contracted as a limited-plan provider offered in conjunction with the Tufts Health Plan. The Boston-based company is hoping to develop a model of lower-cost, high-volume patient care that is unlike larger hospital organizations like Massachusetts General Hospital, Cleveland Clinic, and Mayo Clinic. "In a world of Neiman Marcuses, we're OK being Filene's," the president of the system, Ralph de la Torre, told investors.¹⁹

In the Pittsburgh area, the large nonprofit health plan Highmark has agreed to invest as much as \$475 million into the five-hospital West Penn Allegheny Health System, which has been operating at a loss the past five years. Highmark's plan is to convert this system from the traditional fee-for-service reimbursement structure to a model that relies more on primary care physicians and budget-based reimbursement for hospitals and other physicians. The combined entity of Highmark and the West Penn Allegheny Health System is intended to help bridge traditional conflicts and misaligned incentives between the interests of payers and providers. In doing so, the merged entity expects to be a lower-cost alternative to the highly dominant UPMC. In short, Highmark, which has \$14.6 billion in annual revenue and 3.1 million members, is attempting to integrate vertically to circumvent the pricing power and market dominance of the UPMC.

UPMC, a prestigious \$8 billion, 19-hospital health system, currently employs nearly 3,000 physicians and has about 56% of the inpatient market share in Allegheny County. UPMC also owns a health plan with about 1.6 million members. The contract between the Highmark plan and UPMC is up for renewal next year, and it is expected that UPMC won't sign with Highmark after the planned acquisition of West Penn Allegheny goes into effect. Existing plan members would have to pay out-of-network rates for using UPMC, which may cause Highmark to lose membership.²⁰

It remains to be seen how this dynamic will play out. Past efforts to integrate hospitals and payers have had mixed results. It is not clear whether entities such as Steward or Highmark can become credible alternatives to the large and dominant health systems in Boston and Pittsburgh or how these dominant systems might react with health plans that attempt to steer business to these lower-cost alternatives. Plus, there is substantial pricing room in the market for entities like Steward and Highmark to shadow price the

dominant systems, which then would not generate substantial savings for consumers over time.

Yet, in the long run, facilitating the entry of new competitors can help reduce the negative effects of provider consolidation. Reducing regulatory barriers and restrictions that prevent or slow new competitors may facilitate this process.

Network strategies: Strategically Seed the Supply Sides

Supply-side policy approaches seek to facilitate the entry of new providers (as above) and new and competing technologies into the market to increase competition. Policies encouraging entry and expansion of new practitioners by opening up more medical school slots to train more physicians and reducing or removing restrictive licensing or certification requirements that govern the type of care nurses, nurse practitioners, and physicians (as well as other personnel) can provide could facilitate the entry of new providers.

The influence of new competing technologies was seen in the 1980s and early 1990s when technology enabled many procedures to take place in non-hospital, ambulatory settings. Other new forms of competition for hospitals include urgent care centers, retail clinics, and specialty hospitals. The further development and dissemination of new care delivery models should be promoted to compete with hospitals as they are currently organized. Telemedicine is an example of such a technology. Once thought to have great potential to reduce the cost of care previously provided only in a hospital setting, to date telemedicine has not developed as rapidly as expected. This is largely due to the lack of evidence regarding the cost and clinical effectiveness of telemedicine applications and stringent licensing and credentialing requirements.

“Hospital at home” is an example of an innovative model for treating chronically ill patients who have acute medical problems. This concept – which has been adopted in Australia, England, Israel, and Canada – has been shown to be a highly cost- and quality-effective alternative to acute hospitalization. Resistance from Medicare has been the largest issue in preventing the expansion of such programs, due to a concern that proliferation of such services will only add cost to the system. Physicians, too, have been resistant to such a practice approach.²¹

Some hope that the emphasis of the Affordable Care Act (ACA) on enhanced comparative effectiveness research will fill some of the voids in the current state of knowledge regarding the effectiveness of telemedicine and other interventions and will pave the way for further investment in new technologies that can effectively compete with traditional forms of hospital care. More emphasis should be placed on encouraging and expanding comparative effectiveness research, with a particular emphasis on assessing technologies already in use.²²

In addition, there is a need to revisit Certificate of Need (CON) regulation. Originally intended to correct market failures, it appears that in many states the CON process has devolved into more of a protectionist approach designed to prevent additional competition. Protectionist regulatory strategies can be particularly problematic in the health care sector where the presence of health insurance greatly increases the pricing freedom of dominant providers and ultimately imposes the resulting higher costs on unwilling premium payers. In many states CON remains a barrier to entry for new competitors to hospitals because it generally raises the cost of entry and can be heavily influenced by politics.²³

Network strategies: Oversight of Accountable Care Organization Development

As outlined in CPR’s Action Briefs on [Accountable Care Organizations](#) and [Ensuring Competition](#), employers can communicate their expectations to their insurers and third-party administrators for how insurers should contract with Accountable Care Organizations (ACOs). Monitoring efforts could include:

- Insisting that payment rates reflect cost decreases or increases significantly below historical trend;
- Making the ability of the ACO to reap savings contingent on improving quality (including safety) on measures of importance to employers and representative of the range of services for which the ACO is responsible;
- Supporting a patient-steering strategy across contracted ACOs and within an ACO; and
- Providing enrollees with comparative information regarding provider performance within the ACO,

regardless of whether or not the employer chooses to utilize a benefit design that steers patients.

However, 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, leaving employers with little leverage. Therefore, employers need to be engaged and understand how the ACO concept is being implemented in both the public and private sectors.

Complementary or Coordinated Activities among Government and Private Payers

While market-based strategies are usually the preferred approach for improving competition, persistent and pervasive market distortions and failures can forestall efforts to improve market operation. In these circumstances, government, either at the state or federal level, may play a helping role in clearing the way for a more functional competitive environment that protects the needs of individuals. Government activity of this nature should promote market-based activities and avoid excessive intervention and micro-management. It can be independent of private payers or coordinated with them.

Antitrust Activity-Monitoring and Pursuing Injurious Mergers

The Federal Trade Commission (FTC) and Department of Justice should continue to pursue vigorous antitrust enforcement activities and test the limits of antitrust exemptions associated with ACO formation – although considerable challenges remain. Most markets are highly concentrated and there has been a surge of mergers post-ACA. Such mergers are continuing and unraveling them can be politically unpopular and disruptive. Nevertheless, additional “wins” by the FTC can help forestall future anti-competitive mergers and act as a partial brake on egregious contracting and pricing behavior of consolidated systems.

Development of All-Payer Claims Databases

At least thirteen states are currently collecting commercial claims data covering a full range of health care services including primary care, specialty care, outpatient services, inpatient stays, laboratory testing, imaging, dental services, and pharmacy. Ultimately, these 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. They can also be used to assess, make more transparent, and help integrate the highly disparate components of a state’s health care financing and delivery system. APCD data can and have been used for the development of VBID in Massachusetts (for the Group Insurance Commission) and Maine (for the state employee benefit program).²⁴ As such, APCDs can be an important tool to promote positive efforts to reform the delivery system.

Robust and useable APCDs require the development of master patient and provider identifiers. These data sets also must be comprehensive, accurate and reported on a timely basis.

There are many potential beneficial policy applications of APCDs, including the development of episode-based and capitated payment systems; identifying and comparing utilization patterns, costs, and payment levels of providers; surveillance and monitoring of inappropriate care and fraud; the development of disease-specific analyses to assist public health policy initiatives; and the development of quality assessment tools and pay-for-performance incentive systems.

Some states are currently planning additional applications of APCD data:

1. Annual state expenditure and utilization reporting;
2. Reports comparing utilization patterns and costs across payers, including comparisons of Medicare, Medicaid, and commercial populations;
3. Tracking potentially avoidable service use by region, such as potentially avoidable emergency room use, readmissions, ambulatory care sensitive admissions, etc.;
4. Tracking referral patterns, monitoring inappropriate service use, and identifying fraudulent activities;
5. Support for state insurance administration rate review activities;
6. Public reporting on variations in payment levels across providers and reporting to assist in “value-based” benefit design for employers and insurers; and

-
7. Patient attribution methods for assignment of patients and related utilization/expenditure data to specific providers for Primary Care Medical Home and ACO payment models and ultimate evaluation of these programs.

Also, the availability of more standardized claims data across all payers has the potential to save tens of billions of dollars annually as estimated by Hsiao in the context of an all-payer rate system now being discussed in Vermont.²⁵ *The Wall Street Journal* recently demonstrated the power of analytic efforts to identify overuse of services and fraudulent activity.²⁶

Finally, the overall value of APCDs can be greatly enhanced by linking these data sets to other state databases, such as a state's Hospital Discharge Database (HDD) and information generated from Health Information Exchanges (HIEs). These additional databases contain valuable clinical, quality and cost data that can be used to improve both payment and reporting.

Nevertheless, all states creating APCDs face many challenges in assembling a common analytical file that integrates public and private claims in a timely and comprehensive way. Vermont, New Hampshire, Massachusetts and Maine have made significant strides in this direction.

Alignment of Public and Private Payment Structures

For payment reform to become more effective, Medicaid programs and private payers should consider aligning their payment methods with those of Medicare, both the current inpatient payment systems based on diagnostic-related groups (DRGs) and ambulatory payment classifications (APCs). Most Medicaid programs have adopted these payment methods, but private payer payment structures are still very much of mix of DRGs/APCs, per diem payments, and discounted percent of charges. These disparate payment structures and mechanisms contribute to the extreme fragmentation and administrative complexity of the health financing system in the U.S. and also likely significantly skew resource use in inefficient ways (e.g., if prices for a particular service are set too high relative to underlying costs, then providers will overinvest in producing that service, reallocating resources from other services in an inefficient fashion).

If health plans negotiated off of a common DRG basis, it might facilitate a more standardized approach to establishing reasonable payment levels and reducing the intra-market distortions in payment levels that currently exist. For instance, a health plan could attempt to negotiate with a hospital for some multiple of Medicare for all DRGs – such as 150% (Medicare payment levels presumably reflecting reasonable differences in the cost structure of different providers – i.e., teaching costs, labor market differences, and the like).

This approach might also facilitate employers' attempts at Value-Based Insurance Design by requiring that beneficiaries either use facilities that have contracted with the plan at the 150% rate or pay any difference between a provider's price and 150% of Medicare with or without an out-of-pocket maximum. Variations in payment could be made for evidence of substantially better overall quality and outcomes (i.e., a provider with a distinction ranking might receive 160% of Medicare). Such a proposal would help standardize payment relative weights, reduce price discrimination by service, and incentivize consumers to use lower-cost and higher-quality providers. The added benefit of this approach is that it would help create more consistent incentives for providers across multiple payers and rationalize pricing based on Medicare payment relatives.²⁷

There could also be further alignment with 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.

Episode-Based and Bundled Payments

Since 1983, the Medicare program has paid for most inpatient hospital care on a per-case basis, with the episode of care ending when the patient is discharged from the hospital. Medicare currently uses Medicare severity-adjusted DRGs to categorize patients for payment purposes. Medicare DRG payments cover facility services only and do not include physician services, which are paid separately.

There is general agreement among policymakers that both public and private payers need to evolve their payment systems to provide stronger incentives to the health care delivery system to rein in the rapid

increase in health expenditures – and to ensure that providers are paid for quality outcomes, not simply on volume. Recently, Medicare has been involved in the development of 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.

One option getting additional attention is to expand the scope of payment for inpatient care to include readmissions to either the original admitting facility or to all facilities. The Geisinger Health Plan has instituted a version of this payment approach for selected DRGs. The state of Maryland, under its unique all-payer rate setting system, instituted such an episode-based payment system for 31 of its 46 acute care hospitals. Both approaches use a “warranty” structure whereby the hospital is not paid for readmissions above a historical level. Any reductions that hospitals achieve in reducing both cost per case and readmissions generate savings that can be retained in whole or in part by that facility.²⁸

Additionally, the Center for Medicare and Medicaid Innovation (CMMI) is experimenting with bundled payment structures for hospitals and physicians around specific DRGs. Post Acute Care (PAC) can also be incorporated into the bundled payment approaches being tested. While the bundled payment initiative will likely provide some insights and may improve overall incentives of providers to improve efficiency, it is also fraught with complexity in terms of how to package related services, which providers to include and negotiate payment with, and how to risk-adjust payments for the defined episodes of care.

Should these efforts to move toward episode or bundled payment meet some success, Medicaid programs and private payers should consider similarly aligning their payment structures to mirror the new Medicare payment approaches. Aligned payment structures can create consistent incentives for providers and also help reduce price variation and the price-discriminatory practices now the norm in the provider industry. In addition to the technical complexities of bundled and episode-based payment, a challenge with these payment approaches is that they do not inherently provide incentives that will ensure the clinical appropriateness of procedures and episodes. Although each episode or bundled episode would contain incentives to constrain resource use and cost for a given course of care, there is nothing that could induce a provider to reduce the volume of unnecessary admissions or procedures. And such payments also may not incentivize quality, except to the degree that preventing avoidable readmissions is one aspect of quality.

These factors have led policymakers to advocate instead for the development of population-based payment structures. These payment arrangements attribute an overall level of expenditure to a particular population. Traditionally this has been accomplished through capitation (fixed monthly payment) for an enrolled population of patients. Population-based payment structures can, however, be based on other ways of assigning a fixed budget to an identified population.

Accountable Care Organizations

Assigning a fixed budget to an identified population is part of the idea behind the ACA’s ACO concept. Medicare is now implementing this through CMS’s Shared Savings Program (SSP) and the CMMI’s Pioneer ACO program.

In general, both payers and providers have relatively little experience with shared-savings or shared-risk payment arrangements. The Physician Group Practice demonstration, which was the basis for the original ACO concept, only ran for three years with disappointing results; although several entities did generate savings in excess of 2%, it was later determined that much of the gains were attributed to improved coding of risk factors.

There are also considerable concerns about the financial viability of the ACO structure even after Medicare came forward with its revised and substantially relaxed regulations in the fall of 2011. As Medicare itself indicates, the development of a successful ACO will require a significant investment in care coordination infrastructure – between 2-3% of expenditures for a covered population – which could be between \$6-10 million for a population of 40,000 patients. ACOs must also devote a larger portion of any savings to sufficiently incentivizing their physicians under this arrangement. If the ACO is successful and patient volumes drop, it will also have to fund fixed costs of between 40-50% of an institution’s base costs associated with the

volume decline. Given the low potential for financial gain, it may be that entities that have applied to become ACOs believe that if they do lose money they will have sufficient clout to make up these shortfalls by raising prices to the private sector.

In any case, the ACO structure does encourage increased consolidation and integration – primarily vertical integration and alignment of incentives between hospitals and physicians. While vertical integration is likely beneficial in this regard, merged hospital and physician entities have also used their market power to increase physician fees to private insurers.²⁹ More concerning is the tendency for hospitals to be using health reform and the ACO concept as an opportunity to engage in horizontal mergers.³⁰

Some policymakers, however, believe it is vitally important that reformers continue to encourage increased alignment of incentives across providers – hospitals and physicians in particular. Their view is that the potential benefits that could accrue to the country from the development of integrated delivery systems oriented to provide effective and theoretically efficient care to populations is worth the risk of greater provider concentration.

Global Budget or Population-Based Payment Models

Since the backlash against managed care, full-risk or partial-risk arrangements have only been applied on a limited basis to specific services. Now, several private payers and the states of Maryland and Vermont are experimenting with the development of full- or partial-risk, population-based reimbursement arrangements for hospitals and their employed physicians. Private payers are starting to experiment with whole or partial-risk arrangements for enrolled populations, such as planned between a private Anthem/WellPoint ACO and the state of Maine-Maine General Health.³¹

Maryland and Vermont are also experimenting with global budget reimbursement models for hospitals. Maryland operates a unique all-payer hospital rate-setting system governed by the Health Services Cost Review Commission, and Vermont recently passed legislation giving a state agency (the Green Mountain Care Board) authority over private payer rates. Both entities have the ability to establish population-based payment arrangements for hospital expenditures: all patients and payers in the case of Maryland and just private payer and Medicaid in the case of Vermont. Maryland has established ten global budget arrangements – referred to as Total Patient Revenue rate setting – with rural hospitals in the state. The state is also experimenting with extending these types of payment mechanisms to hospitals in suburban and urban settings through patient attribution methodologies, again on an all-payer basis. Vermont is currently in the process of establishing payer-specific, population-based arrangements that may apply to two private payers and the Vermont Medicaid program for two to three of their hospitals.

Global budget arrangements that are specific to an identified population can be transformative in reorienting a provider's delivery system strategy away from a volume orientation toward a population-based health prevention and promotion strategy. Facilities in Maryland under Total Patient Revenue arrangements have already started this process. The global budget arrangements in Maryland and Vermont both have the advantage of applying to multiple payers.

Increased Emphasis on Primary Care

Many believe the current model for primary care in the U.S. is poorly designed, under-reimbursed and in need of reform. Evidence suggests additional emphasis on primary care and substantial increases in the reimbursement of primary care providers (PCPs) can help reduce costs and improve quality for patient populations.

Research has shown that increasing spending for primary care can save costs over the long run, particularly for Medicare and chronically ill patients.³² Research also shows that states with larger numbers of specialists and fewer PCPs tend to have lower quality and higher costs. The reverse is true for states with higher proportions of primary care physicians per capita.³³ Charts 16A and 17A depict the relationships between provider workforce, quality, and Medicare spending.

Chart 16A – Relationship between Provider Workforce and Quality (Specialists & PCPs)³⁴

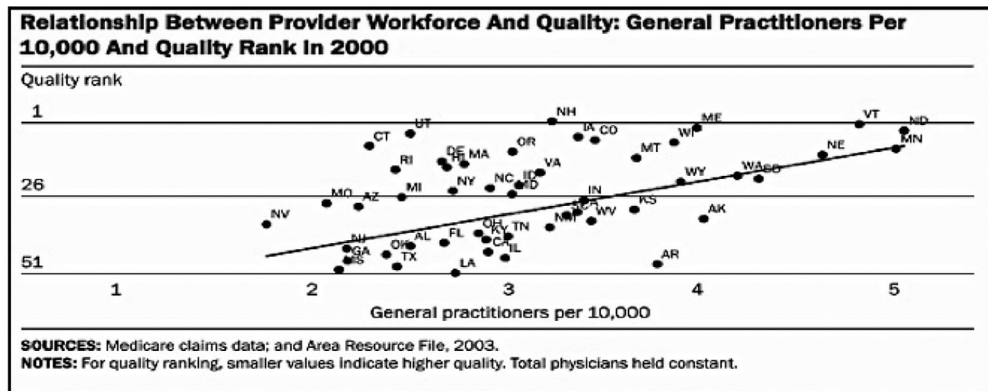
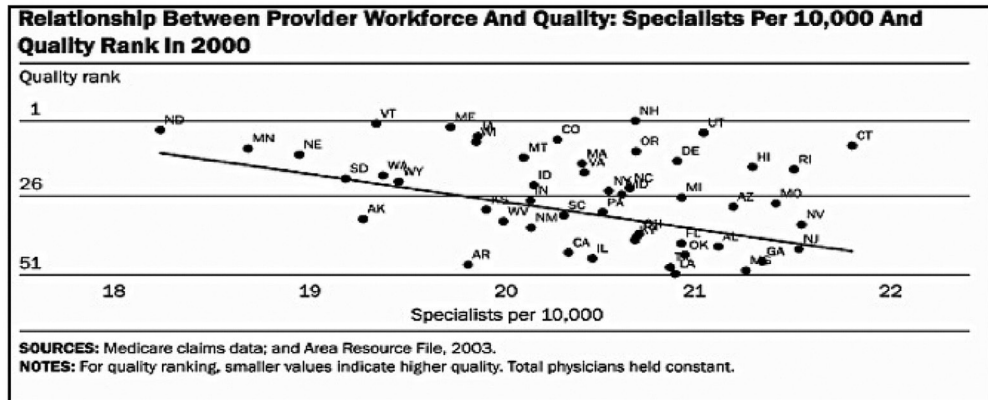
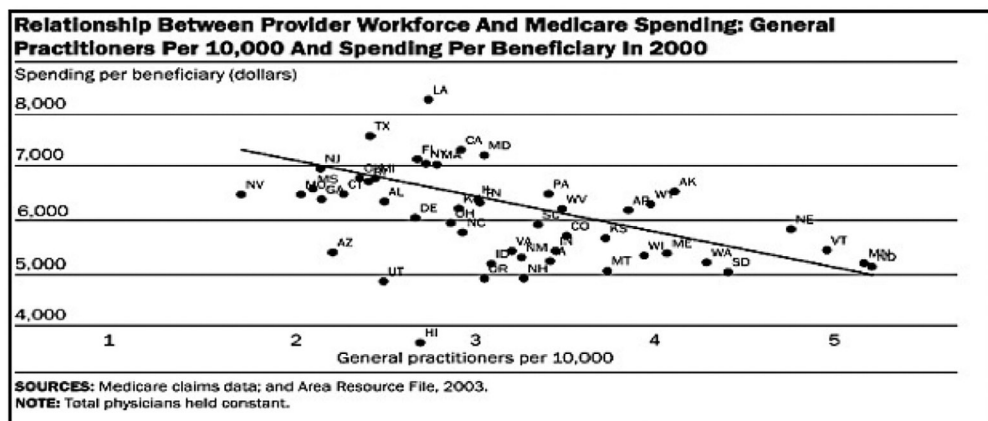
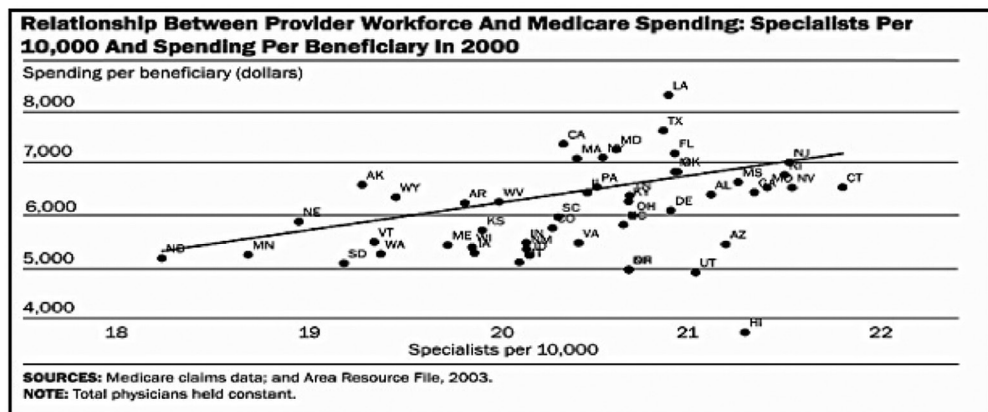


Chart 17A – Relationship Between Provider Workforce and Medicare Spending (Specialists & PCPs)³⁵



Patient-Centered Medical Homes (PCMHs) are a form of budget- and population-based payment that can enhance the emphasis on primary care. This approach designates a physician practice to coordinate patients' care based on their diagnoses and conditions, across multiple settings. PCMH models were developed to enhance the effectiveness of primary care by relying on a team-based approach to coordinate, track, and improve care for patients, particularly those suffering from chronic illnesses. The model also focuses on orienting physicians more toward the individual needs of their patients.

The PCMH concept has taken hold in a number of settings and elements of the ACA are promoting it. The CMMI is currently operating two demonstration projects (the Multi-payer Advanced Primary Care Practice demonstration and the Comprehensive Primary Care Initiative) that seek to identify and expand effective PCMH approaches. Both aim to demonstrate the benefits of the conventional PCMH model when applied across both Medicare and private payers.

These more conventional PCMH models focus primarily on providing and financing an infrastructure of care coordinators and other resources – including access to timely clinical data on patients – for PCPs to help them more effectively coordinate and manage chronic conditions. In most cases, PCPs do not receive substantial (if any) increases in their direct reimbursements.

The absence of enhanced payments to PCPs is a large problem given that a central challenge with primary care delivery in the U.S. seems to be the lack of sufficient and appropriately structured financial incentives for primary care. Currently low PCP payment levels per patient visit require a typical physician to see as many patients as possible during a day to maintain reasonable income levels. The inability to devote sufficient time to patient interactions and care also likely contributes to PCPs making many more decisions to refer than would otherwise be appropriate (i.e., when encountering what appears to be a complex medical issue, PCPs do not have the luxury to spend the time necessary to diagnose and coordinate the necessary care for patients, so it is easier to refer them to specialists).

Although there are signs that both public and private payers are taking steps to increase PCP payment levels, it is important to structure any new payment arrangement to incentivize PCPs to provide more patient-centered care (i.e., spend more time with patients, particularly chronically ill and high-cost patients, and utilize and regularly update care management plans) and to act as the patient's agent in making decisions generally about the consumption of health care resources.

New models of PCMH reimbursement differ from traditional PCMH programs in that they can provide very powerful financial incentives tied to all-inclusive Per Member Per Month (PMPM) target budgets and quality measurements that are designed to motivate PCP panels to work together to raise efficiency and improve quality for their patients. Such an incentive structure places the PCP in the role of “quarterback” to coordinate care and to assist patients in making complex and difficult decisions about their care. In this sense, a PCMH reimbursement model of this nature can address two of the most problematic market failures in health care: 1) the misalignment of the financial interests between patients and providers; and 2) the inability of patients to make effective decisions about their care.³⁶

But PCPs will find it difficult to participate directly in an ACO demonstration – another new model – because of the requirement that in the third year they will bear substantial downside risk. This requirement effectively prevents PCP groups from becoming ACOs because they cannot reasonably be expected to bear financial risk for the Medicare program.

Currently, there are at least two examples of budget-based PCMH models operating in the U.S. (CareFirst Blue Cross of Maryland and one in Massachusetts for PCPs affiliated with the Beth Israel Deaconess Medical Center). Both are structured to: 1) increase PCP fees by at least 10%; 2) organize PCPs into virtual panels of five to fifteen PCPs to achieve actuarial stability; and 3) give PCPs an opportunity to share in up to 30% of savings for improvements in cost (from the budget trend) with additional opportunities for gain if they meet certain quality and patient access targets.³⁷

The “when” and “where” referral decisions that PCPs make are among the most important choices in the medical care system. As noted, there are larger variations in cost performance both within and across markets for both specialty physician and hospital care. Under traditional fee-for-service (FFS) reimbursement there has

been no incentive for PCPs to assess the relative cost and quality performance of hospitals and specialists. One goal of the PCMH program in Maryland is now to arm PCPs with the necessary information about the value of care of different hospitals and specialists, thus enabling them to make more informed decisions about the best care for their patients.

The arrangements also will allow for alignment of PCP incentives with those of hospitals operating under global budget and ACO arrangements. The planned inclusion of Medicare patients into the PCMH panels in Maryland will help amplify the PCMH incentives for participating PCPs. These types of budget-based models, when applied in appropriate ways to different providers, can provide strong incentives to control total cost growth relative to trend and help align both hospital and physician incentives with a common goal of improving total system efficiency and quality.

Pay-for-Performance (P4P)³⁸

Since the release of the landmark studies by the Institute of Medicine, *To Err is Human and Crossing the Quality Chasm*, which created a new paradigm for thinking about quality, pay-for-performance (P4P) has evolved from concept to policy. Although measuring quality of care to a high level of precision still comes with many challenges, P4P initiatives are proliferating in an attempt to determine whether new ways of measuring quality and paying providers can result in increased value for money spent on health care services.

But developing meaningful metrics is not the only challenge. There also is the difficulty of obtaining accurate and consistently reported data upon which to base measurement and questions about who to measure (physicians or hospitals) and what measures to use (process, outcome, life expectancy, etc.).

CMS sparked a broader movement toward P4P when it began to pay hospitals for reporting performance data. The Premier Hospital Quality Demonstration, a voluntary and joint effort with CMS that focused on process measures, followed. Early results were promising, yet a second round of results on the Premier Demonstration raised doubts about the efficacy of the approach. Evidence-based process measures are widely accepted by clinicians and do not require risk-adjustment to normalize performance. Yet since this early period, questions have been raised about whether the so-called value-based purchasing schemes of Premier and CMS really increased quality or led to unintended consequences that forestalled improvement. CMS's move from process to outcome measures has been slow and relatively cautious, favoring very narrowly defined measures. The focus on hospital acquired infections (HAIs) has received criticism from clinicians for being 100% punitive in design and may not have had much impact on care quality or costs because of the focus on a mere 11 conditions that rarely occurred.³⁹

Yet hospital acquired conditions (HACs) are arguably a better gauge of hospital quality than process measures. Examining and eventually measuring and paying for improved readmission rates and 30-day post-hospital mortality rates will also be of value, although there are challenges here as well.

Thus far the major lessons for P4P are perhaps the most obvious ones from past payment reform initiatives: 1) quality measures and methods must be understood and accepted by clinicians; 2) in addition to penalties, they should provide the opportunity for rewards substantial enough to change provider behavior; 3) risk-adjusted rates of performance over larger numbers of cases is a better indication of performance than a focus on a narrow set of relatively infrequent events; 4) there can and will likely be unintended consequences, thus rigorous evaluation is vitally needed; 5) the scope of the initiative is important (can it be applied to all or most all providers and across most or all patients and payers?); and, lastly, 6) consistency of the incentive that providers face can also be influential in changing behavior, hopefully in a positive and substantive way.

The Maryland All-Payer hospital rate setting system likely benefited from capitalizing on several of these lessons, in particular, using its broad rate-setting authority to establish consistent financial incentives. The result was a reduction in preventable complications by more than 20% over two years, with estimated cost savings from hospital operating expenses of more than \$105 million. Clearly, successful P4P programs can improve outcomes, patient experience and reduce cost at the same time.

Consistency and scope of P4P initiatives nationally, however, remain problematic and alignment of public and private strategies could help. The issue of a highly concentrated and dominant provider industry is salient on the

quality front as well. Payment reductions applied by Medicare and Medicaid programs may simply be offset by dominant providers increasing rates to the private sector.⁴⁰

Monitoring Inappropriate Use and Fraud

Hsiao estimates that savings from reducing health care fraud can be as much as 5% of total health spending.⁴¹ Consequently, both public and private payers have invested resources in identifying and remediating fraudulent claims and inappropriate patterns of care. This has included a CMS effort to move past the practice of paying claims and only later recognizing them as fraudulent and then seeking to recover the lost money. Recently, CMS also announced a relaxation of restrictions on the use of Medicare claims data by “qualified entities,” defined as public/private partnerships at the state or national level that also include other stakeholders, such as provider representatives. Medicare will provide detailed hospital and non-institutional claims data to these qualified entities for analysis and limited reporting purposes. All-Payer Claims Databases (APCDs) can also be a source of information to help state governments and private entities identify inappropriate use and fraudulent billing practices.

Regulatory Interventions and Approaches

Improving the Accuracy of the Medicare Physician Fee Schedule

The current Medicare fee schedule for physicians appears to distort payment levels, causing some medical services to be highly profitable and others to be less so. It clearly rewards specialty procedures at the expense of primary care services, causing too many patient procedures and too little primary care interaction and care management. This drives higher than necessary volumes and adds to the overall cost of health care for both public and private payers. There are various proposals to recalibrate the fee schedule, particularly from MedPAC, which seek to rationalize the relative payment weights to provide more efficient allocation of payments and resources.

A revised physician fee schedule for Medicare is also important for other payers because most Medicaid departments and private payers benchmark their fee schedules off of the Medicare system. Thus changes in Medicare’s payment levels for physicians have the potential to influence payments for Medicaid plans and private insurers as well.

Similarly, a realigned physician fee schedule would also support development and possible implementation of broader payment structures that do not incentivize increased volumes of services and instead focus more on providing effective and efficient episodes of care and care to broader populations of patients.⁴²

Improving the Medicare Inpatient and Outpatient Prospective Payment Systems

Most of the state rate-setting systems that received a Medicare and Medicaid waiver had volume adjustment systems that were designed to limit a hospital’s incentive to increase either its inpatient or outpatient volumes of services. These systems included Maryland, New Jersey, Massachusetts, and the Hospital Experimental Payment (HEP) program in Rochester, New York. These volume adjustment systems were designed to discourage volume increases because the health services literature supports the proposition that hospital volumes of procedures and diagnostic tests in particular exceed the levels required for high-quality, cost-effective care.

The essential idea of the volume adjustment systems was to capture the marginal revenue in excess of cost realized by hospitals that increased their volume of services through future rate reductions. Some academics argued that a volume adjustment was unnecessary because a hospital’s variable costs were a very high proportion of its fixed costs. This view was purportedly demonstrated through regression analyses of hospital cost growth associated with volume increases.

In general, hospital chief financial officers (CFOs) or strategic planners do not corroborate these results. Most CFOs, at least those operating hospitals in Maryland, suggest that a hospital’s variable costs are approximately 60% of total hospital costs, which would be equal to approximately 65% of non-capital costs in the absence of the hospital’s facilities. Similarly, a hospital seeking to improve its financial position will frequently opt to expand

its services to include sleep clinics, advanced imaging, pain clinics, and so on with the clear-eyed expectation that the marginal revenue from these services will be well in excess of marginal costs. Economists who studied marginal cost patterns in hospitals prior to the implementation of the inpatient prospective payment system (IPPS) failed to recognize that hospitals are typically nonprofit firms that do not seek to maximize profits. Instead, they seek to maximize services and they spend their marginal profits on service enhancements. Therefore, the cost savings achieved by producing more services at marginal cost below fixed costs never show up as savings.

Both the Medicare IPPS and outpatient prospective payment system (OPPS) operate without volume adjustments. The absence of volume adjustments provides hospitals with powerful financial incentives to increase their service volumes. These incentives are consistent with the FFS incentives of physicians to expand service volumes and amplified by the stringent rate increases allowed by CMS in both the IPPS and OPPS because the hospitals try to generate more volume to maintain targeted profitability. This results in substantial additional costs to Medicare and to the private payers who follow the Centers for Medicare and Medicaid Services (CMS) policy of excluding volume adjustments in their hospital negotiations.

Medicare (and potentially state Medicaid programs) should incorporate a volume adjustment that is designed to reflect these differing proportions of fixed and variable costs. If Medicare adopted a 60% variable/40% fixed cost proportion, then hospitals would only receive 60 cents on the dollar for every dollar of new revenue generated by additional volumes (new cases, visit, ancillary tests and additional intensity). If Medicare wished to provide a disincentive for volume growth it could set the variable/fixed proportions at 40%/60%, allowing hospitals to keep only 40 cents on every dollar associated with volume growth. This policy would effectively penalize hospitals for excess volumes given that their marginal costs are closer to 60%.

In a more competitive market if the quantity of a specific service goes up faster than quantities of other services the former should face more price constraint. In general, greater volume should result in a lower unit price, and lower unit prices would capture efficiencies of production. Lower prices would also discourage excess investment in equipment. To have the maximal effect – and also benefit private payers – volume adjustments of this nature for Medicare should be applied across all volumes at the hospital, not just Medicare-specific volume.

Expanded Department of Insurance Oversight

Several states, including Massachusetts and Rhode Island, are experimenting with different ways of exercising oversight of health plans and their contractual arrangements with providers.

Massachusetts's 2012 health care cost control legislation outlines for a far more interventionist approach oriented at promoting cost control, encouraging better quality, and reducing the market leverage of dominant providers. As passed, the legislation significantly increases the state's capacity to monitor the activities of providers and payers while tracking healthcare spending "aggressive targets" for limiting the overall growth in health spending. The law establishes a Health Policy Commission to monitor spending targets as well as determine the factors contributing to excess spending and developing remedies.⁴³

The Health Policy Commission will monitor overall spending as well as target provider organizations with revenues of \$25 million. Each of these targeted groups will be compared against each other and statewide targets. Groups with above-target spending will be required to submit corrective action plans and be identified publically on the commission's website.⁴⁴

Proposed, but not included in final law, was a provision that allowed health plans to contract with a single hospital in a larger health system on a standalone basis. This would have undermined the strategy that dominant providers use in certain regions forcing health plans to contract on an "all-or-nothing" basis regardless of how expensive certain hospitals are that are part of larger systems.

Though it did not make it into the final law, the Massachusetts House of Representatives had also debated the idea of imposing a luxury tax on hospitals whose prices are 20% above the median level in a particular region for a given service.⁴⁵ Hospitals would have, however, had the ability to justify these higher rates on the basis of providing higher quality. Both the House and Senate bills had provisions to create a separate agency to monitor and either encourage voluntary action on the part of providers or take more direct action to reduce health care spending to a rate of growth approximating the growth in the state's domestic product plus some small fraction.

Some termed this approach a “faith-based initiative” because it largely relied on a faith that providers can and will police themselves.⁴⁶

Another provision that was originally proposed, but not included, addressed payment rate differentials. Legislation proposed in 2011 laid out a plan for the Department of Insurance (DOI) to evaluate each proposed rate structure with the goal of preventing price discrimination rather than directly regulating the absolute level of prices. The review would establish key tests for undue rate discrimination and rules that would govern the degree of pricing variation permitted, while curbing the ability of dominant provider groups to extract higher rates by virtue of their relative negotiating advantage.⁴⁷

The approach would have used the existing Medicare payment rate relationships as the basic guide for ensuring equity across hospitals in private sector payment levels. Medicare establishes an inpatient standard rate with adjustments for labor market differences, teaching and disproportionate share or uncompensated care for each hospital. In the first rate year, the DOI would use these inpatient and outpatient ratios to determine whether or not a health plan’s proposed rate schedule would discriminate against or in favor of a particular hospital. The DOI would require the ratio of the inpatient rates proposed by a health plan for two hospitals to be equal to or within an acceptable range of the inpatient Medicare rate ratios of the two hospitals.

Again with an example of a hospital with a Medicare rate ratio of 2/3 (non-teaching [\$4,000] to teaching [\$6,000]), if a health plan had a commercial rate of \$8,000 for a non-teaching hospital – the contracted price to teaching hospitals must be \$12,000, maintaining the 2/3 relationship that was revealed by the Medicare payment ratio for the two facilities. The DOI would apply this test for discrimination on a prospective basis. Health plans could enter into PMPM incentive-based arrangements with hospitals and their medical staffs as long as the health plan offered the same budget arrangement to all other hospitals in a particular region.

The chief aim of this test of rate discrimination would be to eliminate the unjustifiably large differentials in provider rates that the Massachusetts Attorney General observed. Use of unjustifiably high rates not related to efficiency or quality create distortions in the health care market and allow the highest paid providers to gain market share unfairly and raise the total cost of health care.

Meanwhile the state of Rhode Island has been struggling under the impact of continued cost growth and declines in the number of privately insured individuals (a 10% drop from 2007 to 2009). With little legislative support for payment reform in the Rhode Island legislature, the Governor and the Insurance Commissioner have pursued a strategy of gradually requiring the state’s private insurers to meet a series of affordability and other standards. Thus, the focus is on the activity of private insurers and not directly on provider prices.

To carry out this strategy, the DOI is requiring insurers to: 1) increase their spending on primary care in the state without passing increases on to subscribers; 2) participate in and spread the adoption of chronic care multi-payer medical home models; 3) standardize and facilitate the adoption of Electronic Health Records; and 4) work toward comprehensive payment reform across the delivery system.

The DOI is merely monitoring these efforts and activities relative to pre-established targets for performance. There also is a push for “transparency” and a strong desire to transition gradually away from FFS reimbursement of health care services in the state.

Baseball Style Binding Arbitration

At a Medicare Payment Advisory Commission (MedPAC) meeting in 2009, John Bertko, then a MedPAC Commissioner who is now at CMS, suggested an application of game theory to the problem of creating a fair and reasonable set of payment arrangements between payers and providers. Bertko proposed that payers and providers enter into voluntary but binding arbitration agreements using so-called baseball arbitration to resolve disputes about payment levels. Baseball arbitration forces the arbitrator to find entirely for one side of a dispute or another. No compromise judgments are allowed. Such a system moderates the behavior of both parties to an agreement out of fear of being the loser. It is conceivable that regulators could make payer and provider entry into such agreements a condition of certain safe harbors from regulatory scrutiny,⁴⁸ but it might be difficult for one entity or agency to take on this responsibility, particularly across the many different negotiations that take place between providers and health plans every year.

Limits on Emergency Care Pricing⁴⁹

When patients receive care out-of-network, providers often charge patients much more than what these providers are willing to accept from Medicare or from insurers with whom they have an established contract. Providers routinely double or triple their prices for uninsured patients or those not covered by managed care networks. Mark-ups of this magnitude can only be regarded as taking advantage of market power to charge unreasonable prices that bear little resemblance to actual cost or market value.

To protect consumers from this circumstance and help health plans when they negotiate with larger and dominant provider systems, some have proposed the use of a Maximum Charge Level or Maximum Payment Obligation (MPO), as a percentage of Medicare payment levels.⁵⁰ This could reduce cost shifting, re-establish negotiating balance between hospitals and payers, and generate cost reductions. This is a relatively simple solution that has a clear incentive and a predictable result. Applying it to hospitals would likely save tens of billions of dollars per year, from today's approximately \$800 billion hospital system.

On average, hospital charges for emergency care are in the vicinity of 400% of costs, when they are out of network. Medicare pays hospitals, on average, about 90% of costs and, on average, private payers pay hospitals at rate levels that are approximately 135% of their costs. But if a payer does not contract with a hospital because it deems the hospital's rate demands to be excessive, and its members stop using the hospital except for emergency services, the charges for those services will typically amount to 300% of what the payer would have paid at the typical contracted rates (i.e., $400\%/135\% = 2.96$) for the same care.

This problem could be solved by imposing a limit on the payment obligation of private payers and uninsured persons for emergency hospital services. This limit could be set at, for example, 175% of what Medicare would have paid for the particular services. Payment at this level would amount to approximately 157% of hospital costs (i.e., $1.75 \times 90\% = 157.5\%$) and would thereby give the hospitals a substantially higher margin (i.e., 157% of cost vs. 135% of cost) on these services than they typically earn on all services on a combined basis. At the same time, this limit would restore needed balance to the negotiations between hospitals and private-sector payers. The hospitals would not have the ability to bludgeon the payers into accepting exorbitant rate increases, simply by means of their ability to impose uncontrolled charges on emergency patients, while payers would still have a strong incentive to negotiate with the hospital to try to achieve rates below the 157% of cost level.

Finally, the MPO could be applied to patients without insurance who obtain emergency services. It might make sense to impose a limit on the payment obligation for such patients for all services, rather than just emergency services, but this limit would have to be set high enough to induce most persons with the financial ability to buy insurance to do so, rather than pay on an out-of-pocket basis.

An additional justification to the MPO is based on the logic of implied contracts.⁵¹ The logic of implied contracts applies when a service is performed but there is insufficient time or ability to communicate and execute an agreed price for the service. In this case it is reasonable for the person receiving the service to have an obligation to pay. An implied contract, however, obligates a patient to whatever a prudent patient and provider would have mutually agreed to, given appropriate time and information. The best proxy for this approach would be the rates negotiated by providers and insurers in the marketplace. Another proxy might be Medicare reimbursement rates or some reasonable multiple of Medicare.

Active Purchasing by State Health Insurance Exchanges

State-based health insurance exchanges are an important component of the ACA's plan to expand access to coverage to millions of Americans. They are both a gateway for people to purchase subsidized health insurance and a means to help organize insurance markets and promote more effective competition among health plans.

Some policymakers have argued that insurance exchanges have the ability to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices through so-called "active purchasing" strategies. The logic is that exchanges should be empowered to contract selectively with carriers, set tougher participation criteria than the federal standards, and/or negotiate price discounts. Others believe the best way to serve consumers is to have the exchange provide the broadest possible array of plans (i.e., do not limit plan participation based on whether their network meets certain cost and quality criteria).

The notion of a market sponsor that is also an active purchaser has roots in the concept of managed competition as articulated in 1993 by Alain Enthoven. According to Enthoven, managed competition involves “intelligent, active collective purchasing agents” acting on behalf of enrollees and “connotes the ability to use judgment to achieve goals...to be able to negotiate.” And it uses “rules for competition...to reward...those health plans that do the best job of improving quality, cutting cost and satisfying patients.”⁵²

Health insurance exchanges could be structured to build on this concept by being empowered to act on behalf of consumers and small business owners in a number of ways that would drive value. The Department of Health and Human Services (HHS) has interpreted the law to allow a state to empower its exchange to be an active purchaser, “using market leverage and the tools of managed competition to negotiate product offerings with insurers,” much like a large employer would. And while HHS notes that a state can operate its exchange as a “clearinghouse that is open to all qualified insurers,” the law sets boundaries on how open that clearinghouse can be.⁵³

While the ACA does not mandate that exchanges engage in price negotiations with carriers, it encourages exchanges to monitor rates inside and outside the exchange. At a minimum, all exchanges must review plans’ requested premium increases before they go into effect and take the information they receive in that process into consideration when deciding whether to accept or reject a plan in the exchange. Once plans are selected to participate, the ACA supports the exchange continuing to take an active role in managing the products it offers.

An active purchaser exchange might not only manage the number and quality of participating carriers, but also manage the number and type of products they offer. Many policy experts and administrators of employer and government purchasing programs also believe that the long-term benefits of health insurance exchanges lie not in their ability to negotiate rates with health plans in the short-term, but in helping to align incentives among purchasers and payers to encourage long-term, systemic changes in the way health care is paid for and delivered. With many markets now characterized by a high degree of hospital and physician concentration, some health plans may welcome an exchange that puts requirements on providers that give plans some higher degree of leverage in negotiations. An exchange could aggregate the purchasing power of individuals and small groups to encourage more coordinated and efficient care. Just as CalPERS and Safeway have attempted to implement new reimbursement strategies and value-oriented benefit designs, exchanges might encourage plans to do the same to improve health outcomes and perhaps also reduce the long-term trend in health care costs. Such initiatives might best evolve as part of a long-term strategy, in cooperation with other purchasers.⁵⁴

By consolidating individuals and small groups, potentially partnering with other large purchasers to align purchasing strategies and encouraging value-oriented consumer shopping, the exchange can encourage long-term delivery system changes that can help improve quality and restrain the current unsustainable growth in health care costs.

All-Payer Rate Regulation

In response to increased provider concentration and the corresponding price increases for private insurers, some leading health economists now support a reexamination of all-payer payment systems and the potential cost containment benefits of price regulation,⁵⁵ particularly because private insurers are either unable or unwilling to resist these price increases.⁵⁶

Under an all-payer rate-setting system, a public body would have the legal authority to establish the prices paid by both government and private health plans to hospitals and other providers for medical services. An all-payer system requires a common unit of payment and in its purest form mandates the payment level for a given service at a given provider, across all patients. Service prices and corresponding payments could, however, vary for different providers, reflecting variations in input costs and the relative illness severity of patients. Given the presence of pervasive market failures in health care, all-payer systems seek to establish a more consistent pricing mechanism and otherwise mimic the operation of a functionally competitive market.

All-payer prices and payment levels can be set unilaterally and updated each year, or all-payer systems can include some element of negotiation between payers and providers, as is the case in the Netherlands, Germany, and Maryland. These systems exercise direct control of both the level and the rate of growth of prices, providing

downward pressure on provider revenues and thus inducing higher levels of efficiency.

Policy experts arguing for a renewed focus on the efficacy of all-payer payment systems consistently point to several areas where control of pricing has been accompanied by improvements in system efficiency.

- All other industrialized nations constrain health care pricing and costs through either a single payer or a coordinated all-payer payment system.⁵⁷
- Studies evaluating the effectiveness of managed care to constrain costs in the U.S. show that both successful cost control and the eventual failure of cost control are most directly related to payers' ability to restrain prices.⁵⁸
- Rate regulatory systems such as Medicare, all-payer hospital rate regulation in Maryland and West Virginia's regulation of private sector payment rates, all provide evidence of better constraint of unit prices and costs over time than market mechanisms.⁵⁹

Given the political infeasibility of developing a single payer system and the inability of federal and state anti-trust action to curtail the abuse of market power by providers, the most promising means of constraining prices and costs may ultimately be the development of a mandatory system of coordinated prices. All-payer systems can countervail the market leverage enjoyed by dominant provider groups because fees would be established for all services and payers directly, thus providing the leverage of an oligopsony. Putting all payers on a level playing field with regard to pricing will also mean that private payers will have no reason to oppose cost containment efforts of public payers, as occurred during the ACA debate over the "Public Plan."⁶⁰

An all-payer payment system has numerous benefits. It can simplify billing through the use of a common claim form, promote other administrative efficiencies, and help increase overall system transparency. In particular, the administrative cost that hospitals incur from having to deal with multiple insurers and their chaotic pricing schemes contributes to higher system cost with no corresponding value benefit.⁶¹ The use of more standardized payments has the potential to save tens of billions of dollars annually as has been estimated by Hsiao in the context of an all-payer rate system now being discussed in the State of Vermont.⁶²

A positive byproduct of standard payments and the use of a common claim form would be the public availability of accurate and consistent data on actual prices and payments. The ready availability of these and other data might promote beneficial changes in insurance benefit design, such as network tiering and reference pricing, to encourage the use of more efficient and effective providers.⁶³ With more standardized billing, it would also be easier to keep better records on practice patterns, both to identify providers with extremely high or low resource use, and perform research on the outcomes of different patterns of care. It is estimated that such a system could save as much as five percent of health spending from reduced fraud and abuse.⁶⁴ In general, the experience in Maryland shows that a standardized system of this kind can be a vehicle for achieving transparency in prices, payments, outcomes, and overall provider performance.⁶⁵

Another important advantage of all-payer systems is that more equitable payment levels across all payers can eliminate or substantially narrow the pricing differences across payers and thus remove the financial incentive for providers to treat one class of patient differently from another. There is a significant danger that future cuts to public programs will erode access for both Medicare and Medicaid enrollees.⁶⁶ An all-payer system would protect against this situation because payment levels would be standardized for all patients thus prohibiting the price discriminatory practices that might diminish access for these beneficiaries.

There is also evidence that providers, too, can benefit under a more predictable, stable, and less-complex all-payer payment structure. The literature on all-payer systems demonstrates that (with the possible exception of the New York) rate setting has had a positive impact on hospital financial viability.⁶⁷ Despite profit levels slightly below those of U.S. hospitals, Maryland hospitals routinely receive high bond ratings because of the overall stability and financial predictability of the system. In recent years, Maryland has consistently had the highest proportion of hospitals rated "investment grade" of any state.⁶⁸

As noted, all-payer rate regulatory systems also have a strong track record of unit cost control, both here and internationally. A recent analysis by researchers at the Urban Institute shows that the implementation of all-payer rate setting has the best potential for significant and sustained cost containment.⁶⁹ They estimate

that implementation of an all-payer payment system would reduce health expenditures by 5.9% (cumulatively over the 10-year period) compared to other options such as capping the tax exclusion, disease prevention, care coordination, bundled payments, strengthening insurance exchanges, and implementation of a public plan, which are estimated to generate savings ranging only from 0.1% to 1.6% over the period 2014 to 2023.

The ACA has also generated excitement over the prospect of implementing broader full-risk or partial-risk payment structures. As Ginsburg notes, all-payer systems can accelerate the development of broader payment reforms in an attempt to reverse the counterproductive incentives of FFS payment. Maryland has constructed a system that allows for increasing levels of aggregation of revenue constraint such as 30-day all-cause admission-readmission warranty pricing for 31 hospitals (similar to the Geisinger warranty approach) and fixed global budgets for an additional 10 rural hospitals (similar to the successful Finger Lakes Hospital Experiment of the 1980s).⁷⁰

There is, however, evidence to support the theory that controlling unit costs induces providers simply to deliver more units of care. In response to tight per-case controls imposed by the Maryland rate system in the 1999-2003 period, hospitals increased their admissions by an average of 2.5% per year (vs. 1.0% in the rest of the U.S.) over the period 2001 - 2008. Indeed, because of this dynamic, Maryland has not fared well on per capita cost comparisons in recent years. It was this circumstance that led the Health Service Cost Review Commission (HSCRC) to expand the unit of regulation from the per-case level, to broader episode constraints covering admission and readmissions and global budgets. These payment constraints provide strong incentives to reduce unnecessary volumes.⁷¹ As Ginsburg and others have noted, a key issue in future rate-setting approaches will be the degree to which systems can foster broader payment reform or accommodate other payment innovations.⁷² The Maryland model demonstrates that flexible all-payer regulatory schemes can indeed accommodate and promote innovative market-based payment structures and other mechanisms.

A second major weakness of rate-setting systems is the potential for regulatory failure (i.e., regulatory delays and extreme complexity) and regulatory “capture” by the regulated industry. To avoid both problems a regulatory body must be established to be both politically and legally independent with a flexible statute. The agency must at all costs strictly avoid any real or perceived conflicts of interest. Four states that had previously operated all-payer systems likely experienced some degree of regulatory failure and capture.⁷³

Of course most policymakers see the implementation of rate setting systems as both a second-best and likely “last-ditch” option for the United States. Many more conservative analysts would see it in a far more poisonous light.⁷⁴ However, to the extent that it is a long-term fiscal imperative to control health care costs at a rate close to the growth in GDP to head off what some health policy experts referred to as a health care-induced “financial Armageddon,” an all-payer system will be essential.⁷⁵ Economic research suggests that debt to GDP ratios in excess of 90% lead to substantially higher real interest rates with corresponding limits on long-term economic growth.⁷⁶ A system of uniform and coordinated payments to providers is the best means of averting this impending social and financial crisis. All-payer systems can reduce administrative costs, increase system transparency, and be structured to reward better care coordination and improved quality. However, the principal focus of an all-payer system should be on controlling prices and costs as quickly as possible.

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