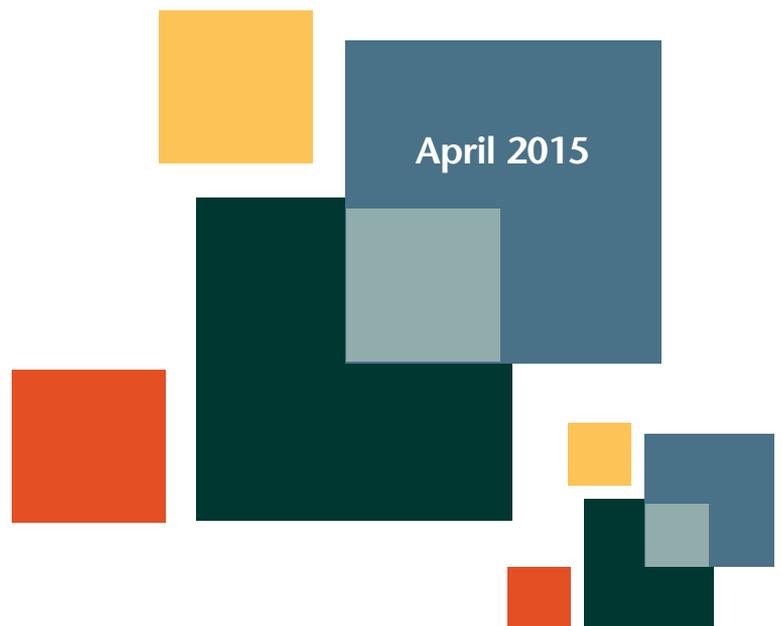


Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets

The Final Report of the Academy's Panel on
Pricing Power in Health Care Markets



NATIONAL
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INSURANCE

The **National Academy of Social Insurance (NASI)** is a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to advance solutions to challenges facing the nation by increasing public understanding of how social insurance contributes to economic security.

Social insurance encompasses broad-based systems for insuring workers and their families against economic insecurity caused by loss of income from work and the cost of health care. NASI's scope covers social insurance programs such as Social Security, Medicare, workers' compensation, and unemployment insurance as well as related public assistance and private employee benefits.

The Academy convenes steering committees and study panels that are charged with conducting research, issuing findings and, in some cases, reaching recommendations based on their analyses. Members of these groups are selected for their recognized expertise and with due consideration for the balance of disciplines and perspectives appropriate to the project.

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April 2015

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In memory of Andrew Hyman, without whose vision, passion, and dedication to social insurance and universal coverage this project would not have been possible.

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Executive Summary

In June 2013, the National Academy of Social Insurance (NASI) convened a diverse study panel of economists, antitrust experts, researchers, and hospital and insurance executives to examine the role and impact of pricing power in the U.S. health care system. While the public sector sets prices administratively, the private sector relies on market-based pricing. In the private sector, pricing power, also known as market power, is defined as the ability of a seller to raise and maintain prices above the level that would prevail if the market were competitive.

Primarily interested in the role of prices and their contribution to spending growth, the panel set out to think systematically about market power and the shifting balance of negotiating power from private purchasers to health care providers over the last 20 years.

Despite spending nearly double the share of gross domestic product on health care as other developed nations, care in the United States is uneven at best and ranks poorly by many critical measures compared to other countries. U.S. spending differs from other developed countries for two main reasons: substantially higher private prices paid for medical care and higher administrative costs related to health insurance.

Concerns about the lack of price competition are longstanding in health care, and the role of market power in the conduct of both health insurers and health care providers is a significant policy issue. Primarily interested in the role of prices and their contribution to spending growth, the panel set out to think systematically about market power and the shifting balance of negotiating power from private purchasers to health care providers over the last 20 years.

Health Care Markets Differ from Other Goods and Services

The market for medical care is different from other markets in at least two significant ways: third-party payment for insured consumers and a fundamental imbalance in information and clinical knowledge between patients and clinicians.

If insured consumers are able to fulfill their cost-sharing obligations, third-party payment often insulates them from the further costs of their health care decisions and removes the primary incentive for them to be price conscious and shop for an acceptable level of quality at the lowest price. Health care consumers also face difficulties in assessing the value of health care services because they typically lack both clinical knowledge and access to widespread, useable health care price and quality information.

While most experts acknowledge that health care is different from other goods and services to some degree, there is a major division between those who think competition can significantly improve the situation and those who think health care is fundamentally different in ways that are likely to thwart attempts to create competitive markets.



The former group believes that reasonably well-functioning markets can be created through greater transparency of performance on quality and costs, relaxed barriers to entry of potential competitors, increased consumer financial responsibility for the health care choices they make, and supported by antitrust or other pro-market regulatory approaches. Those who think health care is fundamentally different emphasize unique characteristics that seem fixed and unamenable to pro-market policies: asymmetry of information between buyers and sellers, inherent uncertainty and variation in clinical decision-making, desirable insurance protection that society wants but that makes patients relatively indifferent to costs, and the intermingling of patient care with other activities that benefit society as a whole, including research, education, and care for the uninsured.

The Shifting Balance of Power Between Health Plans and Providers

Over the last two decades, the balance of power between health plans and providers has shifted significantly, albeit to different degrees in different local health care markets. Following a serious recession and the failure of government health care reform in the early 1990s, managed care emerged as a market-based response to rapidly rising private health care costs. Employers shifted large numbers of workers to managed care products that relied on restrictive provider networks and greater utilization management.

Armed with a credible threat of excluding providers from their networks and the resulting loss of patient volume, health plans gained negotiating leverage over hospitals and physicians and obtained significant price discounts. About the same time, however, hospital consolidation picked up speed through mergers and acquisitions as hospitals tried to reduce excess capacity, cut expenses, and increase their clout with insurers.

By the late 1990s, a significant backlash against tightly managed care developed and, aided by the booming economy and tight labor markets, negotiating leverage began to swing back to providers, particularly dominant hospitals. Focused more on recruiting and retaining workers, employers abandoned cost controls in favor of broad provider networks, denying health plans an important bargaining chip with providers — the credible threat of exclusion from plan networks if provider price demands were too high.

Not surprisingly, spending growth for employer-sponsored insurance accelerated as insurers abandoned narrow-provider networks and tight utilization management controls. Initially, increased volume of services played a larger role in private-sector spending growth, but higher prices ultimately became a greater factor. Lacking support from employers to hold the line against provider demands, health plans in many cases effectively called a truce with providers, leading to the existing environment where higher provider payment rates are passed on to employers — and ultimately to employees — through higher premiums.

Insurer and Provider Market Power

As the intermediary between health care providers and insurance purchasers, insurers with market power can potentially leverage negotiations in both directions. On one hand, insurers with market power have the ability to obtain greater price discounts from providers who need to be in the



dominant insurer's provider network; on the other hand, such insurers do not have to actually use this market power because they do not face effective competition in selling their insurance products to employers. Evidence is mixed on the net impact of these two factors on hospital prices.

While concerns about insurer market power exist, most recent attention has focused on the market power of health care providers — primarily the ability of dominant hospitals and large physician group practices to negotiate higher prices. Growing evidence shows that private insurers pay widely varying prices both across and within local health care markets — sometimes double and triple or more — for the same medical services.

Reasons for Provider Market Power

Market power and negotiating leverage are derived from a number of complex and mutually reinforcing factors, including provider size, reputation, location, and unique service offerings. Despite the complexity of factors contributing to provider market power, much of the policy discussion about negotiating leverage has focused on the size of the provider.

Mergers among hospitals to create a single hospital system — horizontal integration — and/or integration of physician practices and hospitals into larger health systems — vertical integration — recently have garnered attention. Over the last two decades, there has been a steep increase in hospital mergers and in market concentration. The trend toward consolidation in health care markets continues to accelerate and now includes the absorption of physician practices into hospital systems.

Key Emerging Trends and Market Power

Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have also been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular.

Increased scrutiny of high and widely varying prices for health care services, especially hospital care, has helped raise public awareness of the lack of price competition and focus policy attention on the role of provider market power in negotiating prices with insurers. Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have also been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular. The array of emerging trends related to market power includes:

- Fostering consumer price-sensitivity through greater cost sharing and health plan benefit structures that guide patients to more efficient providers;
- Launching payment reforms that move from piecemeal fee-for-service methods that reward volume regardless of quality to methods placing more risk on providers for the cost and quality of care;
- Shifting care from inpatient hospital settings to outpatient care;

- Encouraging health plan competition in the individual and small-group markets through state health insurance exchanges; and
- Intervening in markets through state and federal regulatory and antitrust enforcement actions.

Policy Principles

With a diverse group of national experts participating, the Academy study panel developed a set of policy principles to provide a starting point for crafting policy that would address market power in health care markets (see Chapter 2 for the complete principles). Substantively, these principles reflect a preference for market solutions and for targeted regulation in markets that lack competition — in some cases because of provider consolidation — or where new competitors are unlikely to enter the market. These principles recognize the need for policy to address broader societal goals — for example, around issues of access and quality — but the panel believes that meeting these societal goals should explicitly recognize the potential impact on prices and competition. Finally, the principles reflect the important role of competition in generating new ideas about institutions and mechanisms for innovative ways to deliver care that can increase both quality and efficiency.

Policy Principles

- Market competition is often the best way to motivate providers to increase efficiency, improve quality, and ensure that health care prices reflect the value of services provided to consumers. Where unfettered market competition is ineffective, public policy can enhance market competition or, if that is not likely to be successful, regulate prices directly.
 - When they work well, competitive markets weed out providers that fail to efficiently deliver services that are valued by consumers. While some inefficient providers may lose business or even exit the market, consumers benefit from the overall improvements in efficiency and quality that emerge from competition.
 - Competitive markets generate prices that reflect the cost and value of services and promote innovations in health care delivery, including the development of new institutional mechanisms for the delivery and organization of care. In the long run, these innovations may provide substantial benefits to patients.
 - Health care markets are local, and policy interventions that address market failures should be tailored to local markets. In many markets, there has been significant hospital consolidation to the degree that unregulated markets are unlikely to generate competition that will lead to efficient prices or innovation.

Policy Principles continued

- There is a broad scope of regulatory interventions to foster competition, including targeting more aggressive antitrust enforcement, prohibiting providers from demanding favorable treatment as a condition of contracting, and directly limiting prices through administrative means.
 - However, all regulation risks so-called capture — or undue influence — by regulated entities. Just as markets may not work in every situation, regulation has costs and benefits that vary by context. Regulatory capture has in some situations led price regulation to be only marginally effective, if at all.
 - Along with care for patients, hospitals and physicians often provide additional services with significant social value, including research, medical training, and uncompensated care. In a competitive market, prices are unlikely to support these public goods. Increased competition leads to the additional need for specific policies to support such activities.
- Greater transparency that provides consumers with accurate and timely information about price, quality, costs, and provider networks likely can help them make better choices and, in some cases, make markets more competitive. Greater transparency also may improve the functioning of markets by exposing market conditions and market behavior to public scrutiny. At the same time, policymakers must guard against providers or plans using price information for collusive purposes.
 - The benefits of emerging payment reforms and delivery systems, such as ACOs and other provider configurations, may improve quality but also can contribute to excessive market consolidation. Policymakers should carefully evaluate known costs and benefits before making exceptions to competition laws to encourage new but unproved payment and delivery systems. Forcing highly integrated systems to divest if they do not deliver value is a formidable challenge.
 - Significant variations in provider prices should reflect real differences in costs related to their missions or to consumer preferences in well-functioning markets, not vagaries of negotiating leverage that might produce inequitable prices of services, placing providers in very different financial circumstances unrelated to their own performance.

Policy Options

Recognizing that no single policy option would be applicable to all local markets — that there is no “silver bullet” to address the lack of price competition — the study panel produced a range of policy options. The policy options assume that laws and regulations can help foster competition by imposing rules of conduct and by addressing barriers to competition.

The policy options should not be seen as either a packaged set or as competing alternatives. Where feasible, policy solutions should be crafted to reflect local health care market conditions. The policy options follow a continuum based on how vigorously they intervene in the market from least to most:

Policy Options

- Policy Option A: Encouraging Market Entry of Competitors
- Policy Option B: Greater Price Transparency
 1. Collecting and Reporting All-Payer Claims Data
 2. Supporting Price-Conscious Consumers
- Policy Option C: Limiting Anticompetitive Health Plan-Provider Contracting Provisions
- Policy Option D: Harmonizing Network-Adequacy Requirements with the Development of Limited-Provider Networks
- Policy Option E: Active Purchasing by Public Payers
- Policy Option F: Improved Antitrust Enforcement
 1. Scrutiny of Hospitals and Insurers with Market Power and the Foreclosure of Markets to New Entrants
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- Policy Option G: Additional Public Oversight and Review
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- Policy Option J: Setting Upper Limits on Permissible, Negotiated Provider Payment Rates
- Policy Option K: Expanding the Use of All-Payer and Private-Payer Rate Setting

CHAPTER ONE

Assessing the Problem of Pricing Power in Health Care Markets

The Role of Prices in Health Care Spending Growth

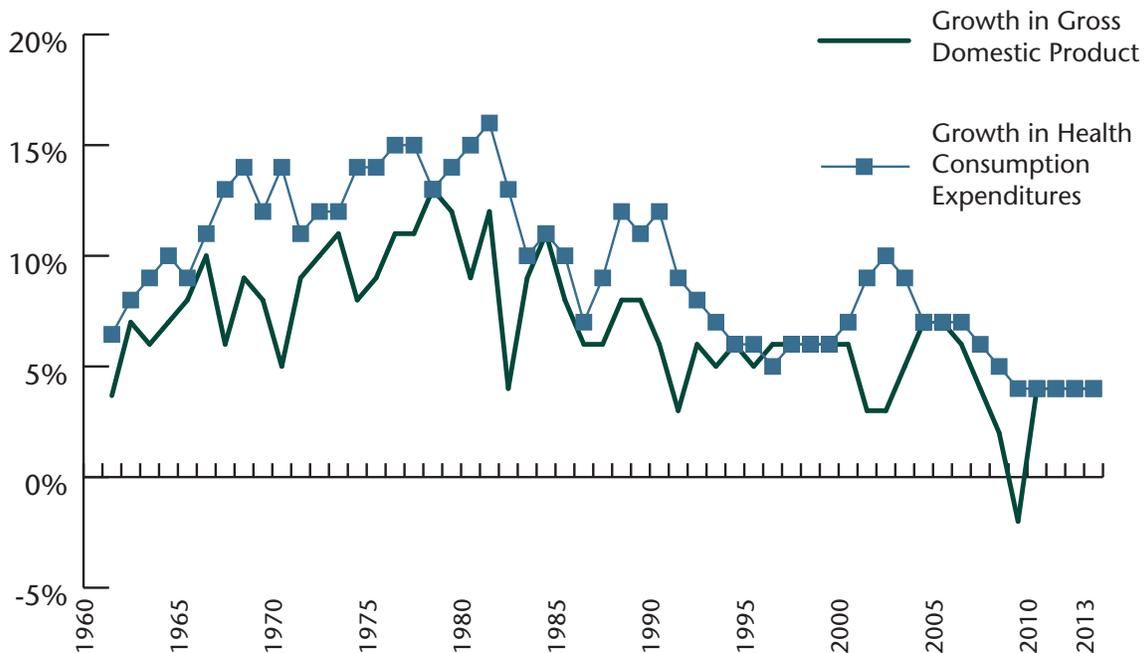
Although U.S. health care spending growth has moderated in recent years, rising health care costs remain a critical domestic policy issue, especially as more Americans gain health insurance. Maintaining the significant coverage gains under the Affordable Care Act (ACA), in large part, depends on keeping health care affordable. In 2011, the United States spent 17.7 percent of gross domestic product (GDP), or \$2.7 trillion, on health care, compared to an average of 9.4 percent of GDP for other developed nations in the Organization for Economic Cooperation and Development (OECD).¹

The United States stands out because of two major factors: substantially higher prices paid for medical care and higher administrative costs related to health insurance.

Higher U.S. spending does not produce better quality care — care in the United States is uneven at best and ranks poorly by many measures. The United States also has fewer hospital admissions and fewer physician visits per capita than most other countries,² as well as a younger population and comparable or lower rates of chronic conditions.³ The United States stands out because of two major factors: substantially higher prices paid for medical care⁴ and higher administrative costs related to health insurance.⁵ Financing of the U.S. health care system is split about evenly between the public and private sectors, with the public sector largely setting prices for health care and the private sector relying on market-based pricing.

On average, annual U.S. health care spending growth has outpaced growth in the overall economy by about two percentage points since 1960 (see Exhibit 1).⁶ Simply put, spending growth consists of two main components: 1) the volume and intensity of services and 2) the price of services. The share of spending growth attributable to higher volume or higher prices shifts over time and is affected by many factors, including levels of insurance coverage, economic conditions, advances in medical technology, the population's health status, and demographics, such as aging of the population. In recent years, health care spending growth has slowed — a turn of events many have attributed to the 2007-09 recession, stagnant incomes, declining employer-sponsored health insurance, greater cost sharing for insured people, and cost-containment efforts by Medicare and state Medicaid programs.⁷ While these are important factors, the NASI study panel is primarily interested in the role of prices and their contribution to private health care spending growth.

Exhibit 1: U.S. Health Care Spending and GDP Growth Trends, 1960-2013



Source: From National Health Expenditure Accounts, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

When spending growth is caused primarily by rising prices for the same services, consumers are worse off because they must spend more to maintain their health. Rising prices may reflect increased resource costs, less competition, ineffective regulation, or costly new technologies. Several studies point to medical prices as significantly contributing to overall health care spending growth, accounting for 50 percent to 80 percent of growth in any given year.⁸

Though health care spending growth in 2013 reached historic lows not seen since 1998, analysts point to spending growth accelerating in the near future as economic growth picks up and more people are insured under the ACA.⁹ Actuaries at the Centers for Medicare and Medicaid Services (CMS) estimate that health spending growth will increase from 3.6 percent in 2013 to about 5.7 percent annually through 2023, when health spending will account for an estimated 19.3 percent of GDP.¹⁰

Several studies point to medical prices as significantly contributing to overall health care spending growth, accounting for 50 percent to 80 percent of growth in any given year.

What is Pricing Power?

In simple economic terms, pricing power — or market power — is the ability of a seller to raise and maintain prices above the level that would prevail if the market were competitive. High prices can be maintained, for example, if there are no substitutes available to consumers or if new firms cannot enter the market. The exercise of market power imposes high costs on consumers and society, resulting not only in higher prices but also in greater inefficiencies. Concerns about the lack of price competition are longstanding in health care, and the role of market power in the conduct of both health insurers and health care providers is a significant policy issue.

Why Health Care Differs from Other Goods and Services

The market for medical care is different from other markets in at least two significant ways: third-party payment for insured consumers and a fundamental imbalance in information, clinical knowledge, and understanding between patients and clinicians. Third-party payment leads consumers to be less sensitive to prices than would otherwise be the case. Standard economic theory holds that when well-informed consumers pay the full cost of services, they will make a conscious trade-off between the price and quality of goods and services and purchase those that provide the best value — or the combination of highest quality and lowest price acceptable to the consumer.

Once insured consumers have fulfilled their cost-sharing obligations, however, third-party payment largely insulates them from the costs of their health care decisions and removes the incentive for them to be price-conscious and shop for an acceptable level of quality at the lowest price. Typically, consumers would respond to high prices by purchasing less, but in health care, insurance allows consumers to continue paying high prices and demand greater quantities of care.

In addition to the effects of third-party payment, health care consumers often face difficulties in assessing the value of health care services for two main reasons:

- The fundamental imbalance in information, clinical knowledge, and understanding between patients and clinicians, coupled with the emotionally laden nature of life-threatening serious illnesses.
- The lack of widespread, useable consumer price and quality information. This lack of information may make consumers less able to judge whether higher-priced services deliver higher quality.

...there is a major division between those who think competition can significantly improve the situation and those who think health care is fundamentally different in ways that cannot and should not be subject to attempts to create competitive markets.

While most acknowledge that health care purchasing is different from other goods and services to some degree, there is a major division between those who think competition can significantly improve the situation and those who think health care is fundamentally different in ways that cannot and should not be subject to attempts to create competitive markets. The former group believes that reasonably well-functioning markets can be created through greater transparency of performance on quality and costs, relaxed barriers to entry of potential competitors, increased consumer financial responsibility for the health care choices they make, and supported by antitrust or other pro-market regulatory approaches.

Those who think health care is fundamentally different emphasize unique characteristics — well articulated in a seminal article by Kenneth Arrow¹¹ more than 50 years ago — symmetry of information between buyers and sellers, inherent uncertainty and variation in clinical decision-making, desirable insurance protection that society wants but that makes patients relatively indifferent to costs at the time of service, and the intermingling of patient care with other activities that benefit society as a whole, including research, education, and care for the uninsured.

Those who think current market failures can be improved or even perfected tend naturally to support public policies that would make markets function better. Those skeptical of market solutions for health care tend to favor more overtly regulatory approaches. And some would see complementary interaction between regulation and competition, for example, regulating prices as a way to promote competition over quality and service use. Regardless of one's viewpoint, current law assumes competitive markets in health care.

The Shifting Balance of Power Between Health Plans and Providers

Over the last two decades, the balance of power between health plans and providers has shifted significantly, albeit to different degrees in different local health care markets. Following a serious recession and the failure of government health care reform in the early 1990s, managed care emerged as the market-based response to rapidly rising health care costs. Employers shifted large numbers of workers to managed care products, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which relied on restrictive provider networks and greater utilization management.

Armed with a credible threat of excluding providers from their networks and the resulting loss of patient volume, health plans gained negotiating leverage over hospitals and physicians and obtained significant price discounts. About the same time, however, hospital consolidation picked up speed through mergers and acquisitions as hospitals tried to reduce excess capacity, cut expenses, and increase their clout with insurers.

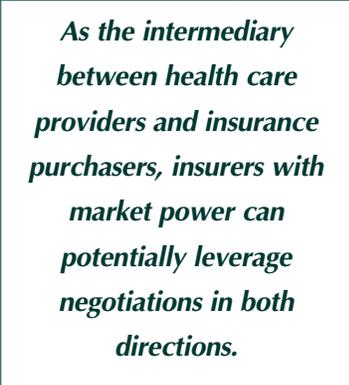
By the late-1990s, a significant backlash against tightly managed care developed and, aided by the booming economy and tight labor markets, negotiating leverage began to swing back to providers, particularly dominant hospitals. Focused more on recruiting and retaining workers, employers abandoned cost controls in favor of broad provider networks, denying health plans an important bargaining chip with providers — the credible threat of exclusion from plan networks if provider price demands were too high.

A wave of health plan-provider showdowns occurred in the early 2000s, with providers threatening to drop out of plan networks unless they received higher payment rates and other favorable contract terms. About the same time, hospitals shifted competitive strategies from a nascent “wholesale approach — vying for managed care contracts — to a retail approach — marketing directly to patients and physicians on the basis of the latest technology and amenities.”¹²

Not surprisingly, spending growth for employer-sponsored insurance accelerated as insurers abandoned narrow-provider networks and tight utilization management controls. Initially, increased

volume of services played a larger role in spending growth, but higher prices ultimately became a greater factor in spending growth. Lacking support from employers to hold the line against provider demands, health plans in many cases effectively called a truce with providers, leading to the existing “pass-through” environment where higher provider payment rates are passed on to employers through higher premiums. In turn, employers have responded to higher premiums by steadily increasing patient cost sharing at the point of service and, more recently, by asking workers to pay a slightly larger share of premiums.¹³

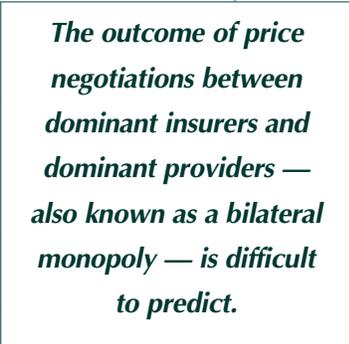
Insurer Market Power



As the intermediary between health care providers and insurance purchasers, insurers with market power can potentially leverage negotiations in both directions.

As the intermediary between health care providers and insurance purchasers, insurers with market power can potentially leverage negotiations in both directions. Insurer market power largely is derived from market share — the number of covered lives — in either the fully insured individual and group markets or in the self-insured market where carriers provide only administrative services to employers.¹⁴ Large insurers typically can obtain greater price discounts from providers that agree to be in the insurer’s network because of the promise of increased patient volume.¹⁵ Insurers also can gain market power by offering products with narrower provider networks.

Historically, the health insurance market has been relatively concentrated, in large part, because of the legacy dominance in many areas of local Blue Cross Blue Shield plans. And, health plan consolidation has increased in the last decade through mergers and acquisitions and as regional and local non-Blue plans became less attractive to national and multi-state employers.¹⁶ As a result, the health insurance market has become more concentrated over time. In 2004, the largest insurers controlled more than half the market in 16 states and at least one-third of the market in 38 states. Between 1998 and 2006, the fraction of health care markets that were concentrated to levels high enough to raise antitrust concerns, according to the U.S. Department of Justice’s Horizontal Merger Guidelines, increased from 68 percent to 99 percent.¹⁷



The outcome of price negotiations between dominant insurers and dominant providers — also known as a bilateral monopoly — is difficult to predict.

Data on the impact of health plan concentration on prices is limited but developing.¹⁸

The outcome of price negotiations between dominant insurers and dominant providers — also known as a bilateral monopoly — is difficult to predict. In theory, an increase in a health plan’s market power may strengthen bargaining power with hospitals and other providers, which may in turn lead to reduced payment rates and reduced premiums. The dominant health plan could more effectively threaten exclusion from the network to negotiate lower prices.¹⁹

But at the same time, increased concentration in the insurer market may allow the merged entity to simply increase premiums to employers.²⁰ There is some evidence to support both arguments. One study found that hospital prices in the most concentrated health plan markets are approximately 12 percent lower than in more competitive markets.²¹ Another study shows that concentration in the insurance market produces a

greater reduction in prices than concentration in hospital markets raises prices — although that result may be skewed because of the particular geographic markets examined.²²

There also is evidence that increased insurance market concentration leads to higher premiums, not lower, even if only by a modest amount.²³ Nonetheless, insurer concentration, while a factor, has not been a driving force of rapid growth in private health insurance premiums.²⁴ One study shows that health plan concentration explained 12 percent of the premium increase among a large set of employer-based health plans.

Provider Market Power

While concerns about insurer market power exist, most recent attention has focused on the market power of health care providers — primarily the ability of dominant hospitals and large physician group practices to negotiate higher prices.

The market power of providers varies across regional and metropolitan markets.^{25,26} One study of 10 markets found hospital payment rates ranged from 134 percent above Medicare to 193 percent of Medicare.²⁷ Another study of eight different markets found that payment rates for inpatient care in 2010 averaged 205 percent of Medicare in Milwaukee and 147 percent in Miami.²⁸ The differential was even greater for outpatient rates, which ranged from 234 percent of Medicare in Cleveland to 366 percent in San Francisco.²⁹

Another study, based on claims data from current and retired autoworkers using 110 hospitals in 10 metropolitan markets, identified private plan prices that ranged from 34 percent above Medicare to 93 percent above Medicare, including adjustments for the facility's case-mix, status as a teaching hospital, and local wages.³⁰ In a few extreme cases, private insurers paid hospitals five times what Medicare pays for inpatient services and seven times what Medicare pays for outpatient care.^{31,32}

In competitive markets, hospitals would not be able to sustain such high prices over time because purchasers would shift to lower-price hospital competitors.³³ Hospitals are unlikely to ever be pure substitutes for one another; their location alone confers some market power based on convenience if nothing else. But if competition in other markets is characterized by a drive to innovate and improve processes to drive down costs and improve quality, then health care is far different.³⁴

Currently, wide price variations exist even within a single geographic area. The landmark report by the Massachusetts Attorney General in 2010 documented the ability of some hospitals and physicians to charge as much as 100 percent more for similar services. These prices did

Another study of eight different markets found that payment rates for inpatient care in 2010 averaged 205 percent of Medicare in Milwaukee and 147 percent in Miami. The differential was even greater for outpatient rates, which ranged from 234 percent of Medicare in Cleveland to 366 percent in San Francisco.

Currently, wide price variations exist even within a single geographic area.

not correlate to quality of care, the acuity of the population served, the payer mix, or status as an academic teaching hospital or research facility.³⁵ Instead, variation among private payment rates was explained by differences in negotiating leverage among regional hospitals and physician groups.

A study of hospitals serving autoworkers found little meaningful correlation between higher prices and quality; higher-price hospitals did much better than lower-price hospitals on reputation-based measures of quality but had a much more mixed record on outcome-based quality measures.³⁶

For physicians, market power may depend heavily on the type of specialty, since prices for specialists vary far more than for primary care. In part that may be due to the complexity of services provided by specialists and surgeons. But it is more likely due to the greater market power of specialists—their smaller numbers in any market and their tendency to form larger single-specialty practices allow them to more easily walk away from negotiations with insurers and command higher prices.

Reasons for Provider Market Power

Market power and negotiating leverage are derived from a number of complex and mutually reinforcing factors, including reputation, location, and unique service offerings. Some hospitals and physicians can demand higher prices based on a reputation for quality, regardless of whether that reputation is correlated with objective measures of higher quality. Others benefit from their prominence as a well-known, research-oriented, academic health center. Insurers often believe that without these so-called must-have providers their networks will not be attractive to employers and consumers.

Hospitals also can command must-have status through their dominance in a fairly isolated or sparsely populated geographic area where access to a broad range of health care providers is limited.³⁷

Likewise, hospitals and physicians can gain market power and higher prices by virtue of offering unique and highly specialized services, such as neonatal intensive care, organ transplants, or specialized cancer care.^{38,39}

The negotiating leverage of these large hospitals and physician practices is reinforced by the reluctance of many employers to adopt benefit structures with limited-provider networks, which weakens insurers' negotiating power and undermines their ability to rebuff provider price demands.⁴⁰

Consolidated Provider Markets

Despite the complexity of factors contributing to provider market power, much of the policy discussion about negotiating leverage has focused on the size of the provider. Mergers among hospitals to create a single hospital system — horizontal integration — and/or integration of physician practices and hospitals into larger health systems — vertical integration — have garnered much attention. Over the last two decades, there has been a steep increase in hospital mergers and in market concentration, as measured by the Herfindahl-Hirschman Index (HHI).

What is the Herfindahl–Hirschman Index (HHI)?

The Herfindahl–Hirschman Index is a commonly accepted measure of market concentration used by antitrust enforcement agencies and scholars in the field. The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20, and 20 percent, the HHI is 2,600 ($30^2 + 30^2 + 20^2 + 20^2 = 2,600$). The HHI takes into account the relative size distribution of the firms in a market. It approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The HHI increases both as the number of firms in the market decreases and as the disparity in size among those firms increases. The agencies generally consider markets where the HHI is between 1,500 and 2,500 points to be moderately concentrated and markets where the HHI exceeds 2,500 points to be highly concentrated. Transactions that increase the HHI by more than 200 points in highly concentrated markets are presumed likely to enhance market power under the *Horizontal Merger Guidelines* issued by the Department of Justice and the Federal Trade Commission.

Excerpt from U.S. Department of Justice. Available at <http://www.justice.gov/atr/public/guidelines/hhi.html>.

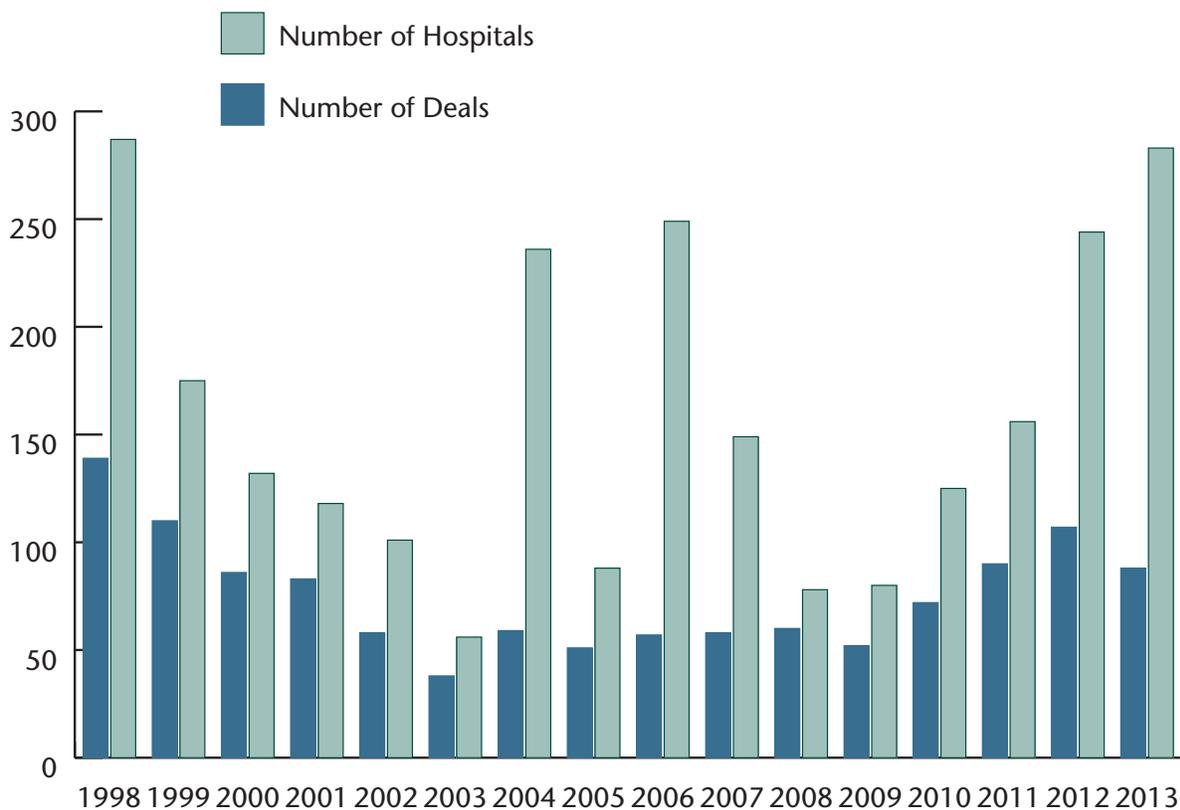
Over the last two decades, there has been a 40 percent increase in hospital market concentration. While much of the merger activity slowed by the early 2000s, the HHI increased from a national average of 2,340 — the level just under where the Federal Trade Commission (FTC) and Department of Justice (DOJ) consider a market highly concentrated — to 3,261 over this time.⁴¹ This is equivalent to a market with five hospitals of equal size becoming a market with three hospitals of equal size.⁴² Moreover, using the HHI as the yardstick, most of the metropolitan statistical areas in the United States are now considered highly concentrated hospital markets.⁴³

Hospital consolidation appears to be accelerating. Between 2009 and 2012, there were 314 hospital mergers, with the number increasing every year within that period (see Exhibit 2). The true volume of consolidation is likely to be greater since this description of transactions does not include affiliations and joint ventures.⁴⁴

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Exhibit 2: Hospital Mergers & Acquisition, 1998-2013



Sources: American Hospital Association (2014) Trendwatch Chartbook, Organizational Trends, Chart 2.9. Available at <http://www.aha.org/research/reports/tw/chartbook/ch2.shtml>. See also A Wave of Hospital Mergers (Business Day), New York Times, August 12, 2013. Available at http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0.

Many of the most significant hospitals in major markets today are not free-standing facilities, but part of Integrated Delivery Networks (IDNs) that also include physician groups, post-acute providers such as home health agencies, and in some cases, health plans. The managements of the entities claim that consolidation is not a strategic market move but rather to further the goal of improving population health. Others note that consolidation may allow smaller hospitals better access to capital and the ability to bargain for higher payment rates by merging with a larger hospital; larger hospitals may be able to invest in new technologies and spread fixed costs over a larger base.⁴⁵ Some providers may consolidate out of fear — of being the last independent provider standing, of needing to adapt in an increasingly coordinated and integrated health care system, or of stagnating margins from Medicare and Medicaid patients.⁴⁶

Consolidation among hospitals may also provide the new entity with bargaining leverage with health plans that might otherwise play hospitals against each other.⁴⁷ Moreover, large health systems may be able to increase the quality of care because there is a clear positive relationship between higher volume and outcomes for many procedures. Thus, consolidation may allow the new entity to increase the volume of specialized services and improve quality. Ultimately, larger health systems potentially could be beneficial, by improving health care quality and reducing costs through improved clinical integration.

However, relatively little is known about the economics of these complex IDNs. To this end, the Academy commissioned a team of researchers led by Jeff Goldsmith and Lawton R. Burns to see what could be learned about IDNs from their publicly disclosed financial and quality information; the researchers focused particularly on the financial role of the IDNs' hospital assets and how their hospital holdings affect their overall performance.⁴⁸ Although publicly available data are scarce and two to three years old, the study found little evidence in the literature of any comparative advantage accruing to providers from forming IDNs. Nor does there appear to be a relationship between hospital market concentration and IDN operating profit. Looking at the performance of the flagship hospital in the IDN's portfolio—either the original hospital that created the system or one that is located in its principal metropolitan or regional market—the study found that they appear to be more expensive, both on a cost-per-case and on a total cost-of-care-basis, than the services of their most significant in-market competitor. Further, the flagship facilities of IDNs operating health plans or having significant capitated revenues are more expensive per case (Medicare case-mix adjusted) than their in-market competitors.⁴⁹

And there is little evidence that integrating hospital and physician care promotes quality or reduces cost. Indeed, there is growing evidence that hospital-physician integration has raised physician costs and the total cost of care. The evidence further suggests that the more providers invest in IDN development, the lower their operating margins and return on capital. Thus there appear to be no economies of scale (savings from being a larger entity overall) and no economies of scope (savings from having different services — health plan, hospital, and physician—delivered by a single IDN).⁵⁰

Most studies find that hospital consolidation is associated with price increases. Evidence also shows that there is strength in numbers: just being part of a system, regardless of whether it is small or large, can help secure higher prices. Hospitals in both small systems and large systems were able to obtain much higher prices than hospitals that were not part of a system (17 percent and 34 percent more, respectively).⁵¹ According to a comprehensive review, consolidation in the 1990s among hospitals in proximity to each other consistently led to price increases that range between 4 percent and 53 percent.⁵² While factors that contribute to increased negotiating leverage in health care markets are complex, the result appears clear: higher prices that bear little relation to the cost of production.

However, others caution that several hospital competition and merger studies are from the 1990s or early 2000s and may not reflect current market realities.⁵³ While the studies may be dated, an important market dynamic remains: insurers still rely on network structures to pit hospitals against one another in price

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negotiations, a strategy that can only work when competition is robust. Another important takeaway from prior studies is that health care markets are local, and that judgments about market power should be made at the local level.

Other Aspects of Provider Consolidation

The trend toward consolidation in health care markets continues to accelerate and now includes the absorption of physician practices into hospital systems.⁵⁴ Physicians who sell their practices to hospitals typically become hospital employees. While most physicians remain either self-employed or work in independent, physician-owned practices, the share of physicians employed by hospitals is substantial and growing rapidly.

Many factors make such acquisitions attractive to hospitals and physicians. Employment of primary care and specialty physicians can help hospitals expand their referral base.⁵⁵ For physicians, hospital employment or affiliation allows them to share the complexity and cost of running a practice — especially the cost of new information technology — and reduces the financial pressure of stagnant payment rates.⁵⁶ Hospital employment also provides a stable salary and a better work-life balance, which is increasingly attractive to younger physicians.⁵⁷

For some physicians, another benefit is higher compensation.⁵⁸ Hospitals often negotiate with insurers on behalf of employed physicians, gaining substantially higher rates than small practices are able to garner. Likewise, larger physician groups may be able to command higher payments from private insurers, while solo or small practices often are price takers.

Generally, most health care competition occurs in local markets. However, large multi-hospital systems operating in different geographic markets also can use size to their advantage. They may seek to negotiate on behalf of the entire health system,⁵⁹ pursuing an “all-or-none” strategy that ensures that all facilities in the system receive higher payment rates.

Though studies have not yet borne this out, the idea is that even system hospitals with relatively small market shares can obtain higher prices because of the cumulative influence of a large system on the network of a particular plan. Thus, these multi-facility hospital systems can use their dominance in a major geographic market (such as the San Francisco Bay Area) as leverage in more competitive geographic markets (such as the less populous Central Valley). Through geographically dispersed mergers, such systems may be able to extend their bargaining leverage even in markets where they do not have significant market share and, therefore, without raising concerns under existing antitrust guidelines.⁶⁰

Market Power and Antitrust Enforcement

Antitrust laws are intended to foster competition, discourage anticompetitive monopolistic practices, and prevent inefficient consolidation. The major pieces of federal law that frame antitrust policy are the Sherman Act, the Clayton Act, and the Federal Trade Commission Act. Briefly, section 1 of the Sherman Act bars cartel behavior, such as price fixing, group boycotts, market division, and similar

collusive agreements; section 2 of the Sherman Act prohibits firms from exploiting monopoly power to stifle market entry or inhibit competition. The Clayton Act prohibits mergers, tying, and exclusive dealing arrangements that lessen competition or lead to a monopoly. Finally, the FTC Act created an independent agency to work with DOJ to enforce federal antitrust laws.

Federal regulators, state attorneys general, and private plaintiffs, including consumers, all contribute to antitrust enforcement. Most actions under federal antitrust law are brought by private parties. While both federal agencies and private parties can bring suit to enforce civil penalties, only federal agencies can enforce criminal provisions.

Because the two federal enforcement agencies are relatively small and litigating cases can be expensive and protracted, considerable emphasis has been placed on preliminary reviews of announced mergers. Pre-merger review under the Hart-Scott-Rodino Act allows the agencies to assess any anticompetitive consequences of a merger before it is consummated.

To specify and clarify when agencies are likely to challenge proposed mergers, both the FTC and the DOJ Antitrust Division have disseminated a variety of materials that offer some enforcement predictability to would-be merging parties: merger guidelines, public statements upon closing investigations where there is no enforcement, advisory opinions, amicus briefs in court cases, and, in the case of health care, a set of Statements on Antitrust Enforcement Policy in Health Care. The Statements outline the types of hospital mergers, joint ventures, multi-provider networks, and information-sharing agreements between physicians and purchasers that are likely to trigger further antitrust scrutiny.

The basics of antitrust doctrine are no different when applied to health care than to other industries, yet certain circumstances of health care — widespread third-party payment that creates so-called moral hazard, or how behavior changes when people are insured against losses; extensive regulation; the large role of government purchasers; and a rapid pace of technological change — make the analysis of competition and monopoly power unique.

Currently, federal agencies operate under the assumption that consolidation among providers is not justified simply to exercise countervailing power in geographic areas where health plans also are consolidated. The agencies have explicitly stated that enforcement against unlawful consolidation of health plans is preferable to permitting providers to accrue market power simply to counter health plans' negotiating power.

Horizontal review includes not only mergers but also such transactions as physician network joint ventures in which competitors collaborate. The inquiry in each of these transactions compares the losses in competition against the purported gains in efficiencies, including clinical efficiencies. Under current guidelines, transactions that involve significant financial risk for patient care, such as global fees, are more likely than other financial arrangements to avoid enforcement. Finally, the agencies pay particular attention to whether transactions lead to joint pricing, which preempts price competition, and whether collaborative pricing is necessary to achieve the proposed efficiencies.

The FTC successfully argued that courts should look at how the merger affects bargaining over networks with health plans, in addition to changes in patient flows.

In recent years, the FTC has aggressively challenged a number of horizontal mergers by hospitals and health systems that substantially reduce competition. Perhaps the pivotal case was *FTC v. Evanston*, in which the FTC not only ended a seven-case losing streak but laid out a blueprint for successful litigation going forward. The FTC successfully argued that courts should look at how the merger affects bargaining over networks with health plans in addition to changes in patient flows.^{61,62} In the last year, the agency successfully blocked mergers in *Pro-Medica Health v. FTC* and *FTC v. St. Luke's* and undid a merger in *FTC v. Phoebe Putney*.

Many local geographic markets are already highly concentrated, with either a dominant hospital system or a small number of competitors that each has pricing power. Even with the courts taking a different view of horizontal mergers, cases are time and resource intensive, and the government is able to challenge few mergers. Consequently, antitrust policy also should consider actions to constrain the exercise of pricing power where providers have achieved monopoly power.

High Prices and Cost Shifting?

One argument for why prices have been rising is that hospitals are simply cost shifting by demanding higher private payment rates to make up for lower payment rates from Medicare and Medicaid. Price differences alone are not evidence of cost shifting because different payers may have a different willingness to pay for services. At issue is whether one set of payers (usually private insurers) is paying more because someone else (usually public payers) is paying less.⁶³

Historically, the evidence of whether and to what extent cost shifting actually occurs in hospitals has been quite mixed.⁶⁴ A review of the early literature by the Congressional Budget Office in 2008 found evidence on cost shifting varies over time, depending on the payment system and competitiveness of the market.⁶⁵ In the early 1980s, there was evidence of cost shifting as hospitals were paid based on their charges, price negotiations with plans were less intense, and there was little selective contracting. But evidence of cost shifting seemed quite weak after that when health plans aggressively negotiated payments and established provider networks.⁶⁶

The notion that high private payment rates are efforts to cost shift assumes that hospitals operate under a structure so that any reduction in payment rates from public programs like Medicare must be made up by increases in private payment rates. There is an alternative theory, advanced by staff at the Medicare Payment Advisory Committee (MedPAC), that hospitals in concentrated markets with high private payment rates have negative Medicare margins as a result of higher costs. Weak cost controls could be caused by the lack of competition in these markets.⁶⁷ In this scenario, higher payments from private payers compensate for higher costs rather than for lower payments from public programs. This MedPAC theory is consistent with findings from the Massachusetts' Attorney General that higher prices for health care in the state reflected the hospitals' higher cost structures but were not necessarily *caused* by them.

This alternative theory advanced by MedPAC is consistent with recent studies demonstrating that private payment rates and market conditions are related to hospital cost structure. Hospitals in markets with less competition appear to be less efficient and thus have higher cost structures; this reduces their overall margins and necessitates higher commercial rates. A study of 61 hospitals participating in the value-based purchasing initiative of the Integrated Healthcare Association demonstrated that hospitals in concentrated markets are more likely to focus on revenue enhancement from private payers — cost shifting — while hospitals in competitive markets are more likely to focus on cost moderation.⁶⁸ A review of inpatient payment rates across hospital markets between 1995 and 2009 found that the hospitals most adversely impacted by Medicare cuts — that presumably had the highest Medicare volumes — did not make up the shortfall with increased prices from other payers, while those affected the least actually increased revenues.⁶⁹ These studies find that what looks like cost shifting may be inefficient behavior related to markets lacking competition.

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Key Emerging Trends and Market Power

Increased scrutiny of high and widely varying prices for health care services, especially hospital care, has helped raise public awareness of the lack of price competition and focus policy attention on the role of provider market power in negotiating prices with insurers. Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular.

Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular.

Understanding emerging trends in health care financing and delivery can help policymakers identify how best to counteract market power and foster price competition in health care markets. The array of emerging trends related to market power includes:

- Fostering consumer price-sensitivity through greater cost sharing and health plan benefit structures that guide patients to more efficient providers;
- Launching payment reforms that move from piecemeal fee-for-service methods that reward volume regardless of quality to methods placing more risk on providers for the cost and quality of care;
- Shifting care from inpatient hospital settings to outpatient care;
- Encouraging health plan competition in the individual and small-group markets through state health insurance exchanges; and
- Intervening in markets through state and federal regulatory and antitrust enforcement actions.

Fostering Consumer Price-Sensitivity

For more than a decade, consumer out-of-pocket costs for health care have increased steadily as purchasers and payers resorted to higher deductibles, coinsurance, and copayments to buy down premium increases. A secondary goal has been to encourage consumers to actively shop among alternative providers based on price considerations and, in some cases, forgo care they don't really need.

Since many insured consumers are insulated to a large degree from high and rising health care prices, they have little reason to care about health care prices if they are able to fulfill their cost-sharing obligations. Increasingly, however, purchasers and payers are trying to raise consumer awareness and knowledge of the prices they pay for their care.

Providing transparent and useful information about provider prices remains a challenge, but recently purchasers and payers have invested in price-transparency tools to raise consumer awareness of wide price variations among providers for the same or similar services and to help them find lower-price providers. And, some purchasers and payers have tentatively turned to benefit structures, including tiered-provider networks, designed to raise consumer awareness of differential prices at the point of service.

Consumer Out-of-Pocket Costs.

Insured consumers face two types of out-of-pocket costs for medical care: contributions toward health insurance premiums and patient cost sharing at the point of service in the form of deductibles, coinsurance, and copayments. Over time, while the average share of premium contributions for people with employer coverage has increased slightly, for the most part, worker contributions have remained relatively stable at about 28 percent for family coverage and 18 percent for single coverage.⁷⁰

...patient cost sharing at the point of services has increased steadily over the last decade or longer. For example, the average general deductible for single employer-sponsored coverage was \$1,217 in 2014 compared to \$836 in 2009. The proportion of workers covered by high-deductible health plans has increased from 4 percent in 2006 to 20 percent in 2014.

In contrast, patient cost sharing at the point of services has increased steadily over the last decade or longer. For example, the average general deductible for single employer-sponsored coverage was \$1,217 in 2014 compared to \$836 in 2009. The proportion of workers covered by high-deductible health plans has increased from 4 percent in 2006 to 20 percent in 2014. In an era of stagnant wage growth for large parts of the workforce, these increases in cost sharing have the potential to significantly reduce access to care. At a time of growing disparity in wealth, these averages may mask even larger increases for workers who have less bargaining power or in sectors where there is greater slack in the labor market.

Limited-Provider Networks.

Emerging payer strategies to counter provider pricing power include developing limited-provider networks that either exclude high-price providers or require greater patient cost sharing to use non-preferred, in-network providers. Narrow-network plans exclude certain providers entirely, while tiered-provider networks

use quality/efficiency metrics to assign providers to cost-sharing tiers, with the goal of directing patients toward more cost-effective providers through financial incentives. A primary goal of limited-provider networks is to motivate providers in non-preferred tiers to reduce prices or improve quality in exchange for preferred status.

By limiting network providers, health plans can bargain with providers for lower prices in exchange for greater patient volume. They potentially can exclude high-price providers entirely. While employers have moved tentatively to offer narrow-network plans, the ACA exchanges have turned out to be the epicenter of this trend, with about half of the plans offered having narrow networks.⁷¹ Ultimately, insurers and employers contend that health plans must have the flexibility to form restrictive networks to balance negotiating leverage with providers and encourage competition on price and quality.

Payment Reform

Experimentation with and adoption of alternative public and private payment methods increasingly is impacting health care prices. This trend reflects the wide recognition that under the existing fee-for-service payment system, providers are rewarded primarily for the volume of care delivered with little regard for quality or efficiency. Many believe this piecemeal payment approach contributes to fragmented care delivery and an emphasis on acute, episodic care rather than care coordination for people with chronic conditions, such as diabetes and high-blood pressure, which if treated improperly contribute to poor quality and high costs.

Many private payers and purchasers, even before enactment of the ACA, were experimenting with and implementing new payment and delivery models, including private versions of accountable care organizations (ACOs), where a group of providers is rewarded for successfully taking greater responsibility for the cost and quality of care of a defined group of patients. The precise payment method adopted affects whether providers have a direct incentive to restrain their prices or not. For example, the most widely adopted approach — shared savings — typically sets targets for an ACO based on the organization's historic spending for patients attributed to the ACO to determine whether the ACO has met quality and spending targets. In short, this approach accepts the baseline per capita spending of the ACO but discourages further price increases. Physician-based ACOs have incentives to create referral arrangements with hospitals and other providers with lower prices to help meet spending targets.

The ACA has also led to a series of initiatives and demonstrations of new payment and delivery models in Medicare, including shared-savings ACOs, bundled payments for particular procedures involving hospitalization, and patient-centered medical homes.

The major provision that potentially affects provider pricing power is encouraging providers to form ACOs. At its most basic level, the ACO program encourages providers to integrate care delivery, and if they are successful in meeting certain cost and quality goals, share a percentage of the savings with the government. ACOs are seen as a positive step toward preparing providers to assume financial risk for the cost of care because they move payment incentives away from fee-for-service methods that reward high volume toward payments based on quality and efficiency. A potential downside of promoting Medicare ACOs is that these bigger, more integrated provider organizations may also command increased bargaining clout that will spill over into negotiations with private health plans.⁷²

Hospital Inpatient Care

The use of hospital inpatient care continues to decline across multiple payers. Between 2006 and 2012, Medicare experienced 12 percent fewer hospitalizations per beneficiary,⁷³ and privately insured individuals experienced similar reductions in inpatient care. While inpatient care has declined, outpatient care has expanded. Medicare visits per beneficiary increased 28 percent from 2006 to 2012. Moreover, from 2010 to 2011 Medicare prices grew modestly, but they grew more for outpatient care than for inpatient care.⁷⁴

Despite the fact that outpatient care has partially offset the decline in inpatient care, Medicare has not been a lucrative payer for most hospitals. Medicare payments are lower than estimated hospital costs, resulting in negative overall hospital margins hovering around -5 to -7 percent since 2007.⁷⁵ More efficient hospitals have performed better and have positive, but small, Medicare margins. In general hospitals rely on commercial payers to sustain their margins and can face significant financial difficulties when they have few commercial patients. Across all public and private payers, hospital profitability has increased because commercial price increases have outpaced those of Medicare and Medicaid.⁷⁶

Hospitals also are affected by the broader shift in health care spending from private payers to public payers. As more baby boomers age into Medicare and as states expand their Medicaid programs, public spending is playing a larger and growing role in financing health care. Consequently, the pressure on hospitals is clear — find and follow strategies to counter loss of service volume and low public-payer margins.

Health Plan Competition

The longstanding lack of health plan competition in the non-group insurance market — the only place a significant minority of Americans can buy health coverage — has been the focus of intense policy intervention to make the market more transparent, functional, and competitive.

By prohibiting medical underwriting — or basing premiums on people's health status — standardizing health plan offerings to some degree, and providing subsidies to make coverage more affordable, the state and federal health insurance marketplaces created under the ACA are designed to stimulate health plan competition to gain the business of millions of uninsured Americans.

More than half of the 17 states and the District of Columbia that chose to establish a state-based exchange for 2014 embraced some form of active purchasing to increase the competitiveness of the local insurance market, including limiting the number of plans an insurer may offer or requiring participating insurers to offer standardized plans through the exchange, including a plan with a limited-provider network. Since the exchanges in particular and the nongroup market more generally account for a relatively small share of American's health coverage, adoption of these strategies to encourage health plan competition would need to be adopted more broadly in employer-sponsored health plans.

Regulatory and Antitrust Interventions

As market forces fail to promote price competition in health care markets, regulators are beginning to intervene, for the most part, in limited ways. Continued merger and acquisition activity, along with other potentially anticompetitive practices, may prompt increased antitrust scrutiny.

State and Federal Regulatory Efforts.

A few states have responded to current market conditions with extensive regulation. Massachusetts, for example, enacted a law pegging statewide health care expenditures to growth in the state's overall economy. The state also created an independent Health Policy Commission to set the health care cost growth benchmark and certify new payment methods and care delivery models. The commission will track and publicly report on provider and health plan performance in meeting savings targets.

On the federal regulatory front, the ACA requires all health plans — not just exchange plans — to report their medical loss ratios, or the proportion of premium dollars spent on clinical services and quality improvement. Additionally, states are required to review premium increases for plans offered in the exchanges, and plans must justify increases greater than 10 percent.

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Antitrust Enforcement.

In recent years, federal antitrust scrutiny of horizontal mergers has increased and is likely to continue. However, there are potentially other areas of antitrust enforcement that could be pursued by federal and state authorities, including prohibitions on anticompetitive contracting terms between health plans and providers.

Generally, these contracting provisions are aimed at thwarting insurer efforts to adopt narrow- or tiered-provider networks or new payment incentives that would encourage lower prices or increased efficiency. Other potentially anticompetitive contract provisions — such as most-favored-nation clauses that require providers to give a plan their best price — can create barriers to market entry by competing health plans.

Overview of Policy Options

In 2013, the Academy convened a diverse study panel of economists, antitrust experts, researchers, and hospital and insurance executives to think systematically about the shift in negotiating power from purchasers to health care providers, particularly dominant hospital systems. Recognizing that no single policy option would be applicable to all local markets — that there is no “silver bullet” to address the lack of price competition — the study panel produced a range of policy options. As a result, the study panel offers these options as a starting point for federal and particularly state policymakers interested in responding to the issue of competition in local health care markets.

Some of the policy options are intended to foster or preserve market conditions that support price competition. These options assume that laws and regulations can help foster competition by imposing rules of conduct and by addressing barriers to competition. Markets need government to set minimal regulations — “rules of the game” — to enforce contracts among parties and to create competition-

The Academy's panel generally favors policy options that support competitive market mechanisms. But when markets fail, the study panel recognizes that other types of policy interventions may be appropriate.

Labels mean different things to different people and there is no broad consensus on how to characterize many policy options.

enhancing institutions. The Academy's panel generally favors policy options that support competitive market mechanisms. But when markets fail, the study panel recognizes that other types of policy interventions may be appropriate.

This report reflects how the panel grappled with a number of analytical challenges, primarily the typology to use for describing the policy options. Labels mean different things to different people and there is no broad consensus on how to characterize many policy options. More aggressive enforcement of antitrust policy, for example, could be seen as preserving market competition or government intervention in the market. For many policymakers, it is difficult to draw bright-line distinctions between these two policy categories; it is easier, and perhaps more useful, to consider a broad continuum of policy options, ranging from policies to foster a more competitive market to those that rely more heavily on direct regulatory intervention that limit market outcomes.

These policy options should not be seen as either a packaged set or as competing alternatives. Panel members believed it was important to offer individual options, knowing that some may work better in combination than individually. They also may interact in ways that increase the effectiveness of each, depending on local market characteristics and the political and regulatory environment. Where feasible, policy solutions should be crafted

to reflect local health care market conditions. No one policy is likely to be optimal in all markets.

The result of this work is a set of policy options that follow a continuum based on how vigorously they intervene in the market from least to most (see box on p.26):

Policy Options

- Policy Option A: Encouraging Market Entry of Competitors
- Policy Option B: Greater Price Transparency
 1. Collecting and Reporting All-Payer Claims Data
 2. Supporting Price-Conscious Consumers
- Policy Option C: Limiting Anticompetitive Health Plan-Provider Contracting Provisions
- Policy Option D: Harmonizing Network-Adequacy Requirements with the Development of Limited-Provider Networks
- Policy Option E: Active Purchasing by Public Payers
- Policy Option F: Improved Antitrust Enforcement
 1. Scrutiny of Hospitals and Insurers with Market Power and the Foreclosure of Markets to New Entrants
 2. Active Review of Vertical Mergers
 3. Conduct Remedies and Post-Merger Monitoring
- Policy Option G: Additional Public Oversight and Review
- Policy Option H: Regulating Premium Increases through Strengthened Rate Review
- Policy Option I: Limiting Out-of-Network Provider Charges
- Policy Option J: Setting Upper Limits on Permissible, Negotiated Provider Payment Rates
- Policy Option K: Expanding the Use of All-Payer and Private-Payer Rate Setting

In addition to the policy options, the study panel also developed a set of principles that identify core policy values to serve as the foundation for policy development. The principles highlight the important role of competition in lowering prices, fostering innovation, allocating resources — and even forcing poor performing providers to exit the market. The principles also recognize that where market competition falters or fails, policymakers must intervene in markets to foster competition and, in some cases, limit or set prices. As with the policy options, the principles are offered as a starting point for the creation of policies for particular market conditions.

CHAPTER TWO

Policy Principles

Crafted by a diverse group of national experts, these principles provide a starting point for a public discussion about addressing market power in health care markets. There is broad agreement among the study panel members that these principles also offer a useful framework for crafting policy. Substantively, these principles reflect a preference for market solutions and for targeted regulation in markets that lack competition — in some cases because of provider consolidation — or where new competitors are unlikely to enter the market. These principles recognize the need for policy to address broader societal goals — for example, around issues of access and quality — but the panel believes that meeting these societal goals should explicitly recognize the potential impact on prices and competition. Finally, these principles reflect the important role of competition in generating new ideas about institutions and mechanisms for innovative ways to deliver care that can increase both quality and efficiency.

- Market competition is often the best way to motivate providers to increase efficiency, improve quality, and ensure that health care prices reflect the value of services provided to consumers. Where unfettered market competition is ineffective, public policy can enhance market competition or, if that is not likely to be successful, regulate prices directly.
 - When they work well, competitive markets weed out providers that fail to efficiently deliver services that are valued by consumers. While some inefficient providers may lose business or even exit the market, consumers benefit from the overall improvements in efficiency and quality that emerge from competition.
 - Competitive markets generate prices that reflect the cost and value of services and promote innovations in health care delivery, including the development of new institutional mechanisms for the delivery and organization of care. In the long run, these innovations may provide substantial benefits to patients.
 - Health care markets are local, and policy interventions that address market failures should be tailored to local markets. In many markets, there has been significant hospital consolidation to the degree that unregulated markets are unlikely to generate competition that will lead to efficient prices or innovation.
 - There is a broad scope of regulatory interventions to foster competition, including targeting more aggressive antitrust enforcement, prohibiting providers from demanding

favorable treatment as a condition of contracting, and directly limiting prices through administrative means.

- However, all regulation risks so-called capture — or undue influence — by regulated entities. Just as markets may not work in every situation, regulation has costs and benefits that vary by context. Regulatory capture has in some situations led price regulation to be only marginally effective, if at all.
 - Along with care for patients, hospitals and physicians often provide additional services with significant social value, including research, medical training, and uncompensated care. In a competitive market, prices are unlikely to support these public goods. Increased competition leads to the additional need for specific policies to support such activities.
-
- Greater transparency that provides consumers with accurate and timely information about price, quality, costs, and provider networks likely can help them make better choices and, in some cases, make markets more competitive. Greater transparency also may improve the functioning of markets by exposing market conditions and market behavior to public scrutiny. At the same time, policymakers must guard against providers or plans using price information for collusive purposes.
 - The benefits of emerging payment reforms and delivery systems, such as ACOs and other provider configurations, may improve quality but also can contribute to excessive market consolidation. Policymakers should carefully evaluate known costs and benefits before making exceptions to competition laws to encourage new but unproved payment and delivery systems. Forcing highly integrated systems to divest if they do not deliver value is a formidable challenge.
 - Significant variations in provider prices should reflect real differences in costs related to their missions or to consumer preferences in well-functioning markets, not vagaries of negotiating leverage that might produce inequitable prices of services, placing providers in very different financial circumstances unrelated to their own performance.

CHAPTER THREE

Policy Discussion

Policy Option A: Encouraging Market Entry of Competitors

The market entry of new health providers and insurers can potentially spur innovation in care delivery and price competition. Encouraging new ways of care delivery that challenge the traditional role of existing providers may benefit consumers. Barriers to provider market entry include licensure and scope-of-practice requirements, certificate-of-need requirements, and facility licensure requirements. Conversely, states may be able to structure health insurance exchanges to promote new entry by insurers.

Licensure and Scope-of-Practice Requirements.

Most states regulate clinicians, including physicians, nurse practitioners, and physician assistants, through professional licensure. These standards are typically set and enforced through autonomous professional boards made up of industry participants — often physicians — with an economic interest at stake.

Many have suggested broadening membership of such boards to include others with a range of social science and health services expertise to reduce the likelihood that the licensure process impedes competition. Research studies have found that tougher licensure leads to higher prices and reduced consumer choice.

Likewise, state scope-of-practice (SOP) laws and regulations dictate the clinical role of nurse practitioners (NPs) and physician assistants (PAs). Motivated primarily by concerns about competency, quality, and patient safety, scope-of-practice restrictions also reduce the supply of health professionals. State SOP requirements vary widely, undermining the argument that restrictive scope-of-practice requirements protect patients. For example, some states allow NPs to practice independently, while others limit their authority to diagnose, treat, and prescribe medications to patients without physician supervision. Removing barriers for nurse practitioners and physician assistants to practice more autonomously would increase the supply of primary care clinicians.

Facility and Other Licensure Requirements.

Over the last decade, both retail clinics and urgent care centers have grown rapidly and appear to offer lower-cost alternatives to physician offices and emergency departments with comparable quality for preventive care and simple acute-care needs.

State licensure requirements can influence the market entry of retail clinics and urgent care centers. For example, most states exempt retail clinics from facility licensure, relieving them of size and other requirements that would raise their costs. Instead, states often rely instead on practitioner licensure by the applicable state board for oversight. The more physician supervision required by the state, which varies by frequency, proximity, and the need for medical chart reviews, the more costly the retail clinic model becomes.

Many states also use licensure requirements to restrict use of emerging technologies like telemedicine. For example, some states bar the use of telemedicine by out-of-state providers or require separate licensing for remote providers, even for peer-to-peer professional consultation. Such a regulatory regime reduces patient access and may add to the cost of care. Advocates have suggested uniform licensing laws and state compacts that provide reciprocal access.

Certificate-of-Need Requirements.

Intended to ensure access, maintain quality, and control capital spending on health care facilities and services, state certificate-of-need (CON) requirements explicitly restrict market entry. Although no longer required by federal law, CON requirements remain on the books in more than 30 states, despite mixed findings about the effectiveness of CONs in controlling the growth of health expenditures. Some research indicates that the CON process is often used by existing providers to protect market share and diminish competition.

State Insurance Exchanges and Policies to Encourage Insurer Market Entry.

States may be able to promote competition and new entry by health insurers in the nongroup and small-group markets depending on how they structure their health insurance exchanges. States can determine how many plans will be offered, whether they must offer standardized plans, and any network restrictions. Early data from a handful of states have found evidence of new entry and greater competition in some states and fewer health insurance competitors in others as a result of how insurance exchanges are structured. Another early study has found that greater competition on the health exchanges leads to lower premiums.

Additionally, states can encourage entry of health plans by reviewing licensure and capital requirements for health plans and discouraging or prohibiting certain contracting provisions, such as most-favored-nation pricing clauses, that discourage entry by new insurers.

Advantages

Eliminating barriers to new entry of competitors is a core tenet of free markets. Existing firms can be disciplined in their pricing behavior by the threat that new competitors will enter when prices are high. While encouraging market entry is a long-term strategy to support competition, it is essential to overcoming the existing market domination by some insurers and provider systems. Licensure, facility, and exchange regulations can be revisited with a keener eye toward their implications for competition and permitting entry. Increasing health care competition based on price and quality can foster innovation and more efficient care delivery.

Disadvantages

Licensure standards are intended to promote quality and patient safety, which could decline if standards are eased. Other ways to assure quality and patient safety potentially might be more or less effective and costly. The cost of monitoring quality and safety must be weighed against the cost associated with otherwise lost competition. In the past, many in health care have pointed out that without price-sensitive buyers, greater competition and new entry by high-tech facilities could lead to a medical arms race and higher prices.

(Sources for this policy option are located on page 49)

Policy Option B: Greater Price Transparency

1. Collecting and Reporting All-Payer Claims Data

A fundamental problem in the U.S. health care system is that pricing for services is both technically complex and seldom disclosed. For example, there are thousands of different codes to describe health conditions and individual medical services and procedures. And, any two payers or providers may have very different prices for the same service. This is in contrast to more transparent goods, such as groceries or gasoline at the pump.

Establishing state-based all-payer claims databases (APCDs) could provide purchasers, payers, policymakers, and consumers with more transparent, consistent, and standardized price information for services delivered by hospitals, physicians, and other providers. Typically, APCDs include information from medical, pharmacy, and dental claims, which are combined with eligibility and provider files from all public and private payers. Rather than provider charges, APCDs include the actual prices private health plans have negotiated with providers, along with information about Medicare and Medicaid payment rates.

...the primary audiences for APCDs are purchasers, payers, and policymakers that can use price and practice-pattern information to identify lower-price, higher-quality providers. Large payers operating in a state may already have sufficient information on prices and quality of providers for most services, but APCDs can benefit potential new entrants.

More than a dozen states have APCDs, and many more are exploring the idea. Most states have initially focused on hospital prices, but APCDs also can be used to identify prices and practice patterns for other providers, including physicians. While some consumers might consult an APCD, the primary audiences for APCDs are purchasers, payers, and policymakers that can use price and practice-pattern information to identify lower-price, higher-quality providers. Large payers operating in a state may already have sufficient information on prices and quality of providers for most services, but APCDs can benefit potential new entrants.

For example, Minnesota has used its all-payer claims data to create a “Provider Peer Groupings” system that compares physician clinics and hospitals on both risk-adjusted price and quality metrics. These publicly reported data can be used by plans and employers to develop provider networks and benefit structures that reward patients — for example, through lower cost sharing — for choosing more efficient providers.

APCDs also can provide useful information about actual prices and assist policymakers in assessing the level of price competition in health care markets and what interventions might encourage competition. Consistent, accurate data about health care prices also can inform policy discussions about large variations in health care prices and spending. However, policymakers also must consider safeguards to prevent APCD data from being used for price collusion among competing providers. For example, access to the information might be limited to specific entities (e.g., purchasers only) or for specific purposes (e.g., to define episodes of care).

APCDs are typically funded through general appropriations or industry fee assessments; in some states, there is an assumption that a portion of future funding will come from data product sales. Efforts are underway to encourage states and health plans to establish standardized data collection practices. Currently, how data are released and to whom varies across states; in some, de-identified, aggregate data are published on a public website, while detailed data files are limited to certain users, such as researchers.

Advantages

By combining data across providers and payers, purchasers, payers, and policymakers have a more complete picture of price competition in health care markets and are in a better position to develop spending estimates for entire episodes of care rather than for individual services. This can assist in developing new payment models. Additionally, shining a public spotlight on health care prices can discourage egregious provider pricing.

Disadvantages

Claims data are costly to collect, analyze, and report, and methodological challenges may hinder meaningful comparisons. Without uniformity of state APCD data collection, payers would incur additional costs through having to comply with state's submission specifications. And, providing greater price information to sellers can potentially harm competition if it discourages providers from cutting prices to gain market share by making it easier for competitors to match prices. Placing more price information in circulation may result in a greater need for antitrust agencies to monitor potential collusive activities.

2. Supporting Price-Conscious Consumers

Most major health plans — and some large employers — provide enrollees with some type of online price transparency tool, whether developed in-house by health plans or through third-party vendors. Typically, these tools are customized to individual enrollee's coverage, including cost-sharing obligations, provider network, and individual claims experience. Consumers can search by condition or service type and are shown the estimated consumer out-of-pocket cost based on their benefit structure and any remaining current-year cost-sharing requirements.

In some cases, states require consumer price transparency. For example, under Massachusetts law, each health plan must operate a toll-free number to provide consumers who request information with estimated prices and cost-sharing amounts for admissions and procedures. The state does not require online access to this information.

This type of consumer price transparency is happening mostly without policy interventions. The role for public policy likely is narrow, for instance, as in the case of Massachusetts mandating a minimum level of transparency. There also may be a public role in developing best practices, as has been done with comparative quality reporting.

Advantages

Payers are in a unique position to tailor out-of-pocket price information to consumers and to make it available at key decision points. Public policies to promote best practices may accelerate diffusion and development of these tools. If consumers switch providers after comparing prices, higher-price providers that are losing market share may lower prices to gain back market share.

Disadvantages

With little compelling quality data for consumers, additional price data could lead some to seek out higher-price providers under the mistaken assumption that higher prices signal higher quality, especially if their benefit design has only weak incentives to shop for price. Despite the guidance of tools, consumers may be overwhelmed by many choices for some services and, consequently, resort to decision shortcuts that are not strongly tied to prices. Such transparency tools may not take into account consumers' individual medical circumstances or help consumers assess treatment alternatives.

(Sources for this policy option are located on page 49)

Policy Option C: Limiting Anticompetitive Health Plan-Provider Contracting Practices

State laws prohibiting anticompetitive contracting practices between health plans and providers can offer a counterbalance to market power. Generally, these practices protect providers from attempts by insurers to adopt narrow- or tiered-provider networks or new payment incentives that would encourage lower prices or increased efficiency. Other potentially anticompetitive provisions protect insurers from new health plans entering the market and may result in excessive provider payment rates.

Anti-Tiering Clauses.

When health plans develop tiered-provider networks, they lower patient cost sharing to encourage patients to use higher-quality, lower-cost providers that are placed on a preferred tier. Sometimes, as a condition of contracting with a health plan, dominant providers demand placement on the preferred tier regardless of their performance on cost and quality metrics. Some states, notably Massachusetts, prohibit providers and plans from relying on such contract provisions.

Most-Favored Nation (MFN) Clauses.

Under MFN contracting clauses, health plans require providers to give the plan their best price and to charge other insurers a higher price. On the one hand, this ensures that a dominant health plan will receive the benefit of any price concessions that a provider extends to other health plans. On the other hand, MFNs may discourage hospital discounts. Moreover, they may be used by insurers with significant market power to disrupt potential rivals, locking in their competitive advantage and preventing

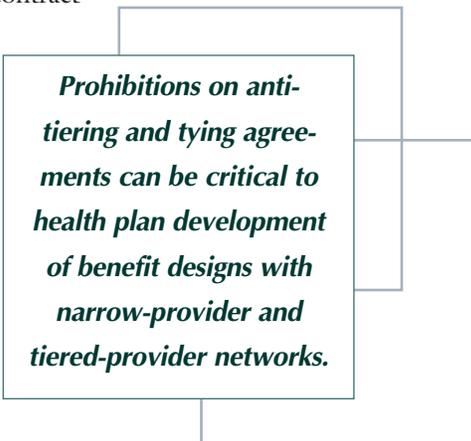
new competitors from entering the insurance market because they cannot attain the same level of provider price discounts. States such as Michigan have reacted to the lack of robust competition in health care by barring MFN clauses sought by health plans.

Tying Agreements.

Many providers require a health plan to contract for all services or facilities as a condition of participating in the insurer's network. For example, a provider might contract for specialized, exclusive services, such as organ transplants or trauma care, only if the plan contracts for the full range of the provider's other services. Another form of tying is when a health plan must contract with all hospitals that are part of a single system. Tying agreements are subject to state and federal oversight, including antitrust actions, but this has largely been an under-policed area of enforcement.

Advantages

Prohibiting anti-competitive contracting practices between health plans and providers may encourage price competition and, in some cases, new market entry. While some contracting provisions can prompt antitrust scrutiny, the antitrust remedies are cumbersome relative to state legislative action to prohibit these anticompetitive contract provisions outright. Prohibitions on anti-tiering and tying agreements can be critical to health plan development of benefit designs with narrow-provider and tiered-provider networks. A number of states have been quite active in limiting anticompetitive contracting practices.



Prohibitions on anti-tiering and tying agreements can be critical to health plan development of benefit designs with narrow-provider and tiered-provider networks.

Disadvantages

In more competitive markets, outright bans on MFNs might interfere with competitive forces by restricting the ability of providers to offer insurers discounted prices. Policymakers may be hesitant to ban contract provisions, since their potential impact depends on the competitive context and can change over time.

(Sources for this policy option are located on page 51)

Policy Option D: Harmonizing Network-Adequacy Requirements with Development of Limited-Provider Networks

Many states have laws to make sure insured consumers have adequate access to covered services. And, some states have laws that prohibit health plans from excluding certain practitioners from provider networks. While designed to protect consumers and practitioners, both types of laws can hamper health plan efforts to exclude providers with practice patterns outside of the mainstream or to develop limited-provider networks.

Network-Adequacy Requirements.

Most states require health plans to meet certain standards — known as network-adequacy requirements — to ensure enrollees have timely and reasonable access to providers and needed services. For

example, state regulators may require plans to demonstrate that enrollees are within a minimum distance or a minimum travel time from hospitals, physicians, and other providers. Plans also may need to demonstrate minimum provider-enrollee ratios or compliance with minimum appointment waiting times.

State standards for network adequacy vary greatly. Some states require health plan provider networks to meet standards set by accreditation organizations, such as URAC, formerly the Utilization Review Accreditation Commission, or the National Committee for Quality Assurance. Other states have numeric network standards, or they use more subjective standards of “reasonableness,” which increase flexibility but create ambiguity. Additionally, some state standards apply only to commercial HMO products, while others include PPOs, potentially contributing to consumer confusion and health plan operational challenges.

As part of the ACA, qualified health plans in the federal and state insurance exchanges must meet network-adequacy standards. Requirements by states for plans outside of exchanges and for Medicaid and Medicare Advantage plans may differ. Plans with very narrow networks draw concern that consumers will be unable to access care at the lower, in-network level of out-of-pocket costs. A key role for public policy is to ensure that health plans provide transparent and accurate information to consumers about which providers participate in each health plan network. Provider networks, however, are dynamic and keeping consumers updated can be challenging.

Any-Willing-Provider Laws (AWPs).

Under AWP laws, plans must include in their networks any provider meeting plan terms and conditions. Historically, AWP laws have served more to protect providers (by including chiropractors and other specific classes of providers in plan networks) than consumers.

Overly broad network-adequacy and AWP laws can limit plans’ ability to trade greater patient volume for price concessions from providers. States will need to balance competing goals of protecting consumers and practitioners and enabling health plans to form limited-provider networks.

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Advantages

Ensuring network-adequacy standards are not overly restrictive can promote price competition by enhancing plans’ ability to bargain with providers over network inclusion to obtain lower prices and, in turn, offer lower premiums to consumers. The presence of AWP interferes with insurers’ ability to obtain lower prices and to steer enrollees toward higher-value providers. Plans are increasingly using broader measures of price, such as spending per episode, and measures of quality to shape networks so overly restrictive network adequacy can interfere with such initiatives. Overly restrictive standards also could preclude insurance networks built around large delivery systems.

Disadvantages

When networks are not adequate, this can interfere with patient access and saddle patients with larger than expected financial burdens. Although the problem may be transitional, health plans have been accused of failing to provide timely and accurate network information to both those considering enrolling and existing enrollees. Regulatory attention may be needed to resolve these transparency issues more quickly than if left to the health plans.

(Sources for this policy option are located on page 51)

Policy Option E: Active Purchasing by Public Payers

Public entities play a role in negotiating with or selecting health plans for a large number of people, including federal, state and municipal employees and participants in state health insurance exchanges. Sometimes public purchasers are proactive in pushing innovations that can benefit taxpayers and employees. In some cases, these innovations can impact health care delivery and payment more broadly, for example, by increasing price competition, so that other purchasers and consumers might benefit. For example, the California Public Employees Retirement System, which provides health insurance for 1.4 million California state and public agency employees, retirees, and dependents, has responded to provider pricing power by experimenting with reference pricing, which caps payment for certain services for in-network providers.

Public purchasers also can encourage health plan competition by limiting the number of plans offered to workers in hopes of stimulating price competition among insurers to gain access to a large customer base. State-based health insurance exchanges are another example of how states can promote health plan competition. Under the ACA, a state exchange can opt for a clearinghouse or open-market model that allows all health plans meeting minimum requirements to participate.

Alternatively, states can create an exchange using an active-purchaser model that relies on selective contracting and price negotiation with health plans with a goal of offering consumers higher-quality coverage and more affordable premiums. Selective contracting also may affect provider pricing because fewer plans on the exchange may give health plans more clout in negotiations with providers over prices. Likewise, states could combat insurer market power by requiring state employees to purchase coverage through exchanges, which would increase the exchanges' market share and clout when negotiating with health plans.

A key health plan tool to counter provider market power and keep costs down is the development of narrow- and tiered-provider networks. States could require health plans to offer a limited-network product to ensure lower cost coverage is available. Massachusetts, for example, requires health plans with at least 5,000 enrollees in the nongroup and small-group health insurance markets to offer either a narrow- or tiered-network plan with a base premium that is at least 14 percent lower than the premium for a similar plan with a broader provider network.

Advantages

Public employers and insurance exchanges that operate as active purchasers can use market forces to foster competition among insurers and providers on both cost and quality. If health plans are concerned about losing market share, they may try to negotiate better deals with providers that may be motivated to accept lower payment rates in return for increased patient volume.

Disadvantages

There is evidence that less competition in insurance markets increases premiums at least modestly. In such markets, the largest insurers are likely to be an insurer that the payer or state exchange needs to ensure adequate enrollee access to a broad range of health care services and geographic areas. Regardless, there is evidence that even if insurance market concentration leads to lower provider prices, a dominant plan may only demand lower prices to the extent that they get a better price than competing health plans.

(Sources for this policy option are located on page 53)

Policy Option F: Improved Antitrust Enforcement

1. Scrutiny of Hospitals and Insurers with Market Power and the Foreclosure of Markets to New Entrants

Federal antitrust scrutiny in the health sector has increased in recent years, as noted previously, and will likely remain a policy priority for federal and state antitrust enforcers. However, many local geographic markets are highly concentrated, with either a dominant hospital system or a small number of competitors with individual pricing power. Consequently, antitrust policy should also consider actions to constrain the exercise of pricing power where providers have achieved monopoly power.

Aside from anti-steering and MFN provisions explained in Policy Option C, hospitals with market power can engage in practices that stifle market entry or constrain the market share of current competitors. Such practices enable hospitals with significant market power to limit price competition.

One such practice by hospitals with market power is to bundle services where they have greater market power with services where they have relatively less market power. This practice, known as tying, is designed by the monopolist hospital to reduce competition more broadly. Through exclusive tying arrangements, monopolist providers can extend their market power and limit entry into health care markets by competitors. Such illegal tying can be challenged under the Sherman Act and Clayton Act, and tying enforcement actions could be effective in curtailing the dominance of hospitals with monopoly power.

Advantages

Scrutiny of dominant hospitals' behavior focuses regulatory attention on those geographic areas where harm to consumers is the most likely and where increasing competition is most crucial. In response to concerns raised by antitrust authorities about MFN clauses, insurers in some areas, such as

North Carolina, have dropped MFN clauses in their contracts with hospitals and other providers. It also targets dominant providers whose practices have the greatest potential to impose anticompetitive harm.

Disadvantages

Antitrust enforcement targeting anticompetitive conduct is costly because the legal standards are difficult to specify and prove empirically. There is little empirical work to support how and when certain agreements, such as exclusive agreements, may foreclose entry by potential competitors, and the legal standards are imprecise. This remains an underexplored area, both empirically and legally.

2. Active Review of Vertical Mergers

Vertical integration involves agreements between entities at different stages of the health care delivery process, including hospitals, physician practices, providers of ancillary services, and insurers. Many hospital systems, including those with market power, have acquired other providers and have articulated a conceptually compelling argument that vertical integration generates efficiencies. First, vertical integration can lower transaction costs between entities, such as improving monitoring, increasing care coordination, decreasing fragmentation, and reducing medical errors. Merging organizations may also achieve some efficiencies by implementing new information systems, instituting new compensation models, reducing medical errors, eliminating redundant services, and reducing fragmentation.

Accountable care organizations are a specific form of vertically integrated health care payment and delivery established under the ACA. Designed for the Medicare fee-for-service population, some ACOs also operate in the private insurance market. For both, the payment method usually contains incentives for the ACO to hold down spending growth.

For example, under the Medicare shared savings model, ACOs are penalized if their expenditures grow faster than an established benchmark. From the ACO's perspective, provider price increases would make lower growth in expenditures more difficult to achieve. Since ACOs do not negotiate rates with Medicare, the main concern is the added market power these organizations will have in negotiations with private health plans. There are also concerns about an ACO locking up a high share of the providers, making it difficult for rival ACOs to form. These concerns are heightened where ventures are exclusive and providers, for example, physicians, are restricted from dealing with payers or ACOs.

The trend of hospitals and physicians jointly establishing ACOs is expected to continue, and ACO formation, encouraged by the ACA, carries with it the risk that health care markets will consolidate further. As the paper by Goldsmith *et al.* that was commissioned by the study panel noted, there is virtually no evidence at this time that vertical mergers and consolidation produces any material efficiencies. Moreover, some have expressed skepticism that hospital-led ACOs will invest the same effort as other ACOs to lower costly utilization, such as emergency department visits or inpatient readmissions, if payment, for example, is based on volume. In fact, there is good reason to suspect that physician-based ACOs are likely to direct their hospital referral patterns toward lower-price

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hospitals and thus are more likely to achieve savings than hospital-based ACOs. Physician-based ACOs might therefore exert market pressures on high-cost hospitals to reduce prices.” If physician-lead ACOs are able to lower costs, this should translate to lower prices, even under standard models of monopoly pricing, assuming all other conditions are held equal.

There are, however, a number of anticompetitive consequences that might follow when a dominant hospital or insurer vertically integrates with other providers. Vertical integration can capture and direct patient flow and referrals. For example, a hospital with market power might instruct the physicians it acquires to direct their patients to that hospital, even if it provides lower-quality or higher-cost care. Vertical integration can accordingly secure revenue and market share for a dominant system, which in turn can foreclose markets to entrants or other competitors. In short, ACO formation through vertical mergers might achieve efficiencies, but they also might introduce inefficiencies and strengthen the position of providers with market power.

Advantages

Vertical mergers potentially can create integrated entities comprised of hospitals and multispecialty physicians groups capable of providing a full continuum of care. Antitrust review can help sort out proposed integration that is designed to achieve efficiencies from integration that could lead to

greater exercise of market power. Communications by the antitrust enforcement agencies are important to educate providers on how to integrate legitimately within the boundaries of antitrust law. Advisory opinions, follow-up letters, statements, and reports permit the agencies to apply the most up-to-date evidence on efficiencies related to financial integration, clinical integration, the role of exclusivity and market shares, and likely competitive effects.

Disadvantages

While most vertical arrangements can be reviewed prior to merger, more lenient criteria sometimes apply to ACOs. Greater effort is needed to monitor integrated entities after the fact, and if market power concerns are raised, it is more difficult and costly for the integrated entities to address them. Much of the evidence on quality and efficiency gains is elusive, particularly for newer integration arrangements, making their potential difficult to assess beforehand.

Moreover, existing empirical studies do not provide sufficient guidance to sort out which clinical and administrative components are necessary to achieve efficiencies — what degree of care monitoring, decision support through health information technology, dissemination of clinical protocols, etc. Despite missing evidence on the best approach to achieving efficiencies, the agencies must make judgments about transactions and whether to challenge them, either before the fact or later when efficiencies do not emerge and higher prices result.

3. Conduct Remedies and Post-Merger Monitoring

One option for supervising hospitals with market power or entities that seek to merge is to impose conduct remedies. Such restrictions might include, for example, creating firewalls that prevent the dissemination of information within the newly created entity; requirements to maintain existing health plan contracts and, for future contracts, to negotiate in good faith with health plans or become subject to binding arbitration; prohibitions on most-favored-nation provisions and anti-tiering and anti-steering provisions in contracts with health plans; prohibitions on hospital-based billing of physicians; maintenance of an open medical staff; and limits on the expansion of services and further acquisitions. The conditions imposed are case-specific and designed to limit the ability of the affected providers to use their market power in various ways that reflect local conditions. Such arrangements can include some form of periodic reporting by the private party and are typically time limited.

Conduct remedies are often implemented through consent decrees that follow an antitrust enforcement action. For example, conduct remedies might be part of a negotiated settlement to a challenged merger, where entities are permitted to merge but must adhere to certain restrictions on their future pricing or market behavior.

Conduct remedies may also follow a suit against a monopolist, such as the Department of Justice's suit against Blue Cross Blue Shield of Michigan, where the insurer stopped certain contracting practices and other anticompetitive conduct.

In the 1990s, several state legislatures used a regulatory mechanism called a Certificate of Public Advantage (COPA) that is similar to conduct remedies in a consent decree. A COPA allows hospitals or other providers to merge or enter into collaborative agreements on the condition of significant state oversight of the new entity, including limits on contracting, employment, and prices. Similar to consent orders signed to settle an antitrust investigation, COPAs also can be a way for a state to encourage consolidation through its health planning agencies, guided by a statutory reporting process. COPAs can shield parties not just from state enforcement but also federal antitrust laws under the doctrine of state action immunity when there is a "clearly articulated and affirmatively expressed state policy to displace competition" and when such agreements are actively supervised by the state.

With Asheville, N.C., for example, the theory was that high costs kept health care services out of rural areas while antitrust laws prevented a merger of hospital competitors that would allow providers to mitigate costs and increase access to services in rural areas. State health planners encouraged a merger because it was believed that the state oversight that followed would impose price discipline on services in lieu of market competition.

The conditions imposed are case-specific and designed to limit the ability of the affected providers to use their market power in various ways that reflect local conditions.

COPAs can shield parties not just from state enforcement but also federal antitrust laws under the doctrine of state action immunity when there is a "clearly articulated and affirmatively expressed state policy to displace competition" and when such agreements are actively supervised by the state.

New York recently passed a COPA law that will extend the state’s antitrust immunity to Nassau Health Care Corp. to collaborate with other health care providers to achieve improvements in clinical outcomes, to share services with the goal of reduced procurement costs and back-office functions, and, finally, to jointly negotiate reimbursement rates with commercial payers. States, such as Pennsylvania and Massachusetts, have entered into consent decrees that were not COPAs but involved significant oversight of the merging entity’s contracting and pricing practices.

Advantages

Mergers that might otherwise be blocked entirely can go forward with consent decrees, allowing providers more freedom to pursue creative integration models while mitigating any likely anticompetitive harm. In some cases, conduct remedies allow providers to preserve the full range of hospital services in geographic proximity to the communities traditionally served by those facilities. Conduct remedies can be entered into with limited judicial oversight since the role of the courts can be limited to specific requirements, such as ensuring that negotiations were adversarial and obligations imposed on the parties were consistent with the public interest broadly, allowing either side to strike a deal quickly when the cost of litigation is too high or too uncertain.

It is difficult to anticipate and prohibit in a consent degree all the ways a provider might exercise market power and raise prices.

...conduct remedies are not a substitute for aggressive efforts to prevent mergers; private parties are significantly more likely to agree to a COPA or other form of consent decree if the state or federal government has a broad theory of what constitutes a transaction that unfairly restrains competition.

COPAs also may provide an advantage to safety-net facilities that otherwise would have little to offer in terms of potential partnership. State antitrust immunity may ensure that these entities grow and that they realize some, even if not all, of the benefits of competition through savings, improving utilization of hospital resources, and avoiding duplication of hospital resources.

Disadvantages

It is difficult to anticipate and prohibit in a consent degree all the ways a provider might exercise market power and raise prices. For example, the entity may avoid price or margin limits in one market by instead imposing price increases in a related but unregulated, market. As a result, the protections for payers — both consumers and insurers — may be limited. Though the state is required to actively supervise the resulting entity, state oversight often relies on self-reporting by the new entity. Neither courts nor other agencies are well-equipped to assess the competitive behavior of health care providers or to evaluate the competitive consequences of mergers. At the same time, it is easy for such agreements, whether consent decrees or COPAs, to become politicized in a way that forces the executive branch to fight a constant rear guard battle for the duration of the agreements.

Regulators seeking to craft a COPA or any other conduct remedy can only guess at what the health care market would look like “but for” the proposed merger. Finally, conduct remedies are not a substitute for aggressive efforts to prevent mergers; private parties are significantly more likely to agree to a

COPA or other form of consent decree if the state or federal government has a broad theory of what constitutes a transaction that unfairly restrains competition.

(Sources for this policy option are located on page 53)

Policy Option G: Additional Public Oversight and Review

Policymakers can lose sight of the cumulative effect of marketplace changes and how market changes relate to one another. An independent commission or board charged with monitoring merger transactions, competition, and overall health care spending could be used to raise public awareness about price and quality changes across health care segments. Such an oversight process can establish the basis for additional policy remedies if voluntary compliance with spending targets is not achieved.

Public monitoring may be viewed as a middle ground between policies aimed at preserving market competition and policies that rely on direct government intervention. By reinforcing awareness of provider and insurer consolidation and rising health expenditures, public monitoring could assist health care purchasers, payers, and policymakers by providing guidance for the development of proposed market-based or regulatory interventions.

One example of public monitoring is the Massachusetts Health Policy Commission (HPC) a quasi-independent entity within the executive branch charged with establishing the annual health care cost growth benchmark and monitoring progress through annual cost trend hearings. Intended as a cost-containment measure, the HPC combines exhortation with regulatory threat. As part of its work, the HPC is required to identify dominant providers that charge comparatively high prices and that have relatively high costs. The Commission also has the power to compel health care entities that exceed the cost growth benchmark to file and implement performance improvement plans and may fine entities that fail to implement them.

With regard to market consolidation, providers must submit proposed transactions to the Commission for review of health care market and expenditure impact. Although the Commission cannot block a proposed merger or acquisition, it has the capacity to analyze such transactions and can, based on its findings, recommend further action to the state attorney general. Finally, the HPC has certain regulatory authority over ACOs and also distributes grant funding for targeted initiatives aimed at delivery system reform.

Massachusetts provides just one example of a commission structure. Clearly, there are many possible ways to structure a public monitoring board and assign its role and authorities. Such monitoring would be informed by, but separate from, existing agency activities, such as antitrust scrutiny or oversight of premiums by state departments of insurance. With the increasing availability of public and private claims data across a broad range of providers and payers, monitoring has become a more viable state strategy.

The powers and authority of a commission can be tailored to fit the political culture and the priorities of the particular states considering such an option.

Advantages

An independent commission should be less vulnerable to political pressures than other state agencies with formal authority to intervene in the market; this appears to be the case even where such a commission has significant analytical capacity and can influence plan-provider negotiations. The powers and authority of a commission can be tailored to fit the political culture and the priorities of the particular states considering such an option.

Disadvantages

While an independent commission may serve a different function, its activities may overlap with operations of other state agencies, potentially creating diffusion of responsibility and possibly conflicting policy positions on specific matters that arise. Moreover, the commission's influence is only as great as the authority it has been assigned. Without credible intervention tools, its impact may be limited. Yet, its presence might serve to preempt consideration of other, possibly more definitive, approaches.

(Sources for this policy option are located on page 55)

Policy Option H: Regulating Premium Increases Through Strengthened Rate Review

In markets with little insurance competition, review of insurers' rate increases may give health plans greater negotiating leverage and increase pressure on downstream provider payment rates. Under the ACA, insurers must publicly disclose and justify rate increases of 10 percent or more for non-grandfathered plans in the non-group and small-group markets. States that have an effective rate review process in place, as defined by federal regulations, have the authority to review rate increases over 10 percent; for states that lack the authority and/or infrastructure to do so, the

U.S. Department of Health and Human Services (HHS) will conduct rate reviews. But HHS reviews are nonbinding, and only states have the authority to reduce rates.

...not all state rate-review processes are created equal. States that have statutory authority to approve or disapprove rates before they are implemented (prior approval authority) are better positioned to negotiate reductions in rates than states that use retrospective authority (file and use regulation).

States could provide their insurance departments with greater authority to review and limit requested premium increases. However, not all state rate-review processes are created equal. States that have statutory authority to approve or disapprove rates before they are implemented (prior approval authority) are better positioned to negotiate reductions in rates than states that use retrospective authority (file and use regulation). File and use regulation often requires only a certification that states meet certain standards and often relies on consumer complaints to identify a problem. Currently, some states may be able to issue a determination that a proposed rate increase is unreasonable but cannot block it since the insurer does not actually need permission to raise rates. In states without the authority to deny excessive rate increases, health plans can raise rates as much as they did before the ACA was enacted.

In addition, states typically have a standard that guides the review and approval of rates. Most states use subjective standards, barring rate increases that are “excessive, inadequate, or unfairly discriminatory.” Only a minority of states requires plans to keep rate increases under a prescribed level. Furthermore, state laws may have limited reach. Some states may exempt some plans from rate review. For example, Pennsylvania exempts for-profit plans, Maine’s rates are deemed approved if they meet medical loss ratio standards, and South Carolina allows the formation of out-of-state “trusts” that allow many plans to bypass rate review altogether.

Strengthened rate review could potentially take several forms. States could provide their insurance departments with expanded authority to review and limit premium increases in tandem with standardized review of requested provider price increases. Rhode Island, for example, has expanded the insurance department’s rate-review authority to include limits on annual price increases for inpatient and outpatient services. States also could regulate the growth of premiums through expenditure growth targets or soft caps. The impact of this effort on prices is evolving.

Advantages

Regulating premiums may give insurers leverage to resist provider price demands that they would otherwise accept and pass on to purchasers and enrollees. It could also benefit consumers by constraining plan margins and lead to greater public discourse over premiums and greater transparency over rate setting methods and insurer justifications for proposed increases.

Disadvantages

Insurers may respond to premium rate regulation by exiting the market. Since insurer margins tend to be low, without regulation of downstream provider payment rates, the potential for significant savings from premium regulation is limited. Although there is anecdotal evidence, for example, from Massachusetts, that regulatory pressure on premiums can lead to lower provider rates, it is unclear whether this approach can be a successful long-term strategy.

Leverage by some providers might actually exacerbate pricing differentials across providers. As price increases are permitted for the more powerful provider systems, the rest of the providers would be left to absorb the overall pricing pressure from limits on premium increases. This could increase pricing disparities between have and have-not providers. Finally, state insurance departments have an obligation to monitor plan solvency as well as focus on premium reduction. Once they are actively engaged, state insurance departments can become subject to political pressures that distort the appropriate “actuarially sound” standard.

(Sources for this policy option are located on page 55)

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Policy Option I: Limiting Out-of-Network Provider Charges

A survey comparing charges billed by out-of-network providers to Medicare fees found that plan members were routinely billed 10 to 20 times Medicare rates for out-of-network care.

An alternative to directly regulating prices is restricting out-of-network provider charges. Physicians, hospitals, and other providers that do not contract with health plans typically bill patients for the full charges of treatment. Depending on their coverage, patients can be responsible for paying the full amount charged if their plan does not cover any out-of-network services, or if they have a plan that covers out-of-network services, they will have to pay any difference between their health plans' allowed amounts for out-of-network care and the providers' full charges. Known as balance billing, the practice leaves consumers at risk of paying significant out-of-pocket costs. A survey comparing charges billed by out-of-network providers to Medicare fees found that plan members were routinely billed 10 to 20 times Medicare rates for out-of-network care.

Limits on balance billing prevent the use of provider market power. Restrictions may be as narrow as prohibiting additional charges for specific services, such as emergency care or other situations where consumers have no ability to choose providers, such as an assistant surgeon or an anesthesiologist.

Alternatively, policymakers might, as the Medicare Advantage program does, generally limit out-of-network rates to a benchmark rate, such as a percentage of the Medicare rate. Such limits would not only protect consumers but would also bolster health plans' ability to negotiate lower payment rates with hospitals and physicians.

Advantages

Limiting out-of-network provider charges would protect consumers from significant out-of-pocket costs, especially when there is no advance notice that a provider is out of network or where circumstances do not allow consumers to pursue in-network alternatives. It also helps consumers accurately assess health plan costs. While the ACA establishes minimal actuarial value for plans sold on exchanges, the value of the plan does not include out-of-network care. Limits on charges would also give insurers more bargaining leverage when negotiating in concentrated provider markets since out-of-network care would be less lucrative. This could be seen as a relatively moderate regulatory approach compared to setting or limiting overall payment rates.

Disadvantages

Such limits create a disincentive for plan members to stay in network, when other reforms to the health system are intended to create more price-sensitive consumers. Such limits also remove the economic rewards for providing higher-quality care.

(Sources for this policy option are located on page 56)

Policy Option J: Setting Upper Limits on Permissible, Negotiated Provider Payment Rates

Across the country, physicians and hospitals negotiate payment rates that are, on average, significantly higher than Medicare rates. Moreover, there is significant inter-market and intra-market variation in those rates. One approach to limiting this variation is to address the highest price providers. For example, policymakers could impose a ceiling on the payment rates negotiated by a health plan and a provider, using Medicare as a benchmark. An upper limit on negotiated prices could be set, for example, at 200 percent or 250 percent of Medicare. The ceiling would apply to all payers, whether individuals who self-pay or insurers. An upper limit on what hospitals and physicians can charge gives insurers important leverage during negotiations, especially when bargaining with dominant providers.

Though an upper limit on provider rates is a form of rate setting, it is intended to focus on the price outliers, not all providers. In applying an upper-payment limit, states could choose a ceiling that takes into account the particular attributes of their local health care markets. If the ceiling were set too high, there would be little impact on health care prices and outliers would remain unaffected. If it is set too low and does not cover providers' reasonable costs, it would jeopardize providers' financial stability and potentially lead to lower quality of care. To implement upper-payment limits, states would need reliable and accurate payment and cost data.

Advantages

Setting an upper-payment limit targets providers that can exercise the greatest market power. It may prod providers to hold down operating costs and even decrease barriers to entry for new health plans, such as ones started by regional physician groups or local cooperatives. Though an interventionist approach, placing an upper limit on provider rates does not require as complex an administrative apparatus as all-payer rate setting or other price-setting approaches. To the extent that upper limits are decided by commissioners or other public officials, there is some measure of accountability.

Disadvantages

This policy option may not be compatible with or may at the least be difficult to reconcile with delivery systems that are based on bundled or capitated payments, which are seen as a way to stimulate integrated and value-based health care systems. This diversity of payment models could make upper limits hard to administer. Like any kind of regulatory price-setting approach, there is the risk that interfering with market winners and losers may prevent providers from having the resources or incentives to adopt new technology, produce societal goods, or provide higher-quality medical procedures. Providers also may not have sufficient capital for new technology or revenue to support teaching and research missions.

(Sources for this policy option are located on page 56)

Policy Option K: Expanding Use of All-Payer and Private-Payer Rate Setting

Rate setting is the policy instrument most industrialized countries use to address cost control and equitable treatment of providers — usually through a form of all-payer rate setting that covers both hospital and physician services. The most common model for rate setting involves a public agency, either in the executive branch or a quasi-independent agency, setting payment rates for providers, including payment rates for patients without insurance. Rate setting may include Medicaid, if permitted under state legislation, and Medicare, if a state successfully negotiates a federal waiver.

During the 1970s and 1980s, seven states enacted some form of hospital rate setting to counter the inflationary incentives inherent in the then predominant cost-based method of hospital reimbursement. All but two states — Maryland and West Virginia — dropped rate setting as the private insurance market moved away from indemnity coverage to managed care plans with provider networks. But some states are reconsidering the approach.

In addition to constraining price growth, rate setting was established to address price discrimination, improve hospital financial stability, ensure adequate and equitable funding for uncompensated care, and improve access to and quality of care for different communities.

In addition to constraining price growth, rate setting was established to address price discrimination, improve hospital financial stability, ensure adequate and equitable funding for uncompensated care, and improve access to and quality of care for different communities. Since hospitals are encouraged to serve all patients in need of medical care regardless of their ability to pay, rate setting ensures that all hospitals participate in funding medical care for indigents as well as other programs aimed at providing a social benefit (medical education, disaster training, addressing population health needs) in a manner that is spread across all payers.

There are different rate setting regimes. One version — the policy originally adopted by Maryland and in effect for over three decades — was to have all hospitals bill approved payment rates for service specific and departmental units. Aggregate payments to hospitals were capped by an average per case rate based on a version of diagnosis-related groups that categorizes patients based on clinically similar conditions, severity of illness and mortality risk — all of which are intended to be a proxy for resource use. Similar caps applied to outpatient facilities. The payment formula also penalized excess volume growth. A different payment regime relying on global budgets was applied to rural hospitals.

It is worth noting that Maryland's new five-year Medicare demonstration that began in 2014 uses an updated version of rate setting to undertake comprehensive coordinated care across different settings; its new focus on population health is based at least initially on global budgets that limit total hospital spending growth per capita to state GDP growth. Under the new approach, Maryland can allow risk-based payment, including the development of ACOs.

Another approach — the policy adopted by West Virginia — applies only to non-governmental payers and imposes annual revenue limits based on the average charge per discharge and inflation; higher rate increases are based on a hospital's ranking against its peers on costs and charges. There are no restrictions on payment methods, but all contract language is reviewed and there is a floor on payments based on costs; approval is required for new services and excess revenue must be returned before the next year's update is approved. The same authority that sets parameters for rates also grants certificates of need required for new facilities.

Several studies have examined the impact of rate setting on cost growth and on hospital quality. These studies suggest that rate setting contained costs during a time when selective contracting was not the norm or not permitted but that in the absence of competition may lead to higher prices. American Hospital Association data indicate that while the ratio of private payer rates to hospital costs has increased nationally, in Maryland it has been fairly steady since the creation of the rate setting system. Maryland's cost per admission dropped relative to other states — from significantly above the national average to just below the national average (although per capita spending on hospital care in a year was high because of higher hospitalization rates). Previous studies found mixed results with respect to the impact of rate setting on patient outcomes and the impact of resource constraints on patient health.

Advantages

In a market where there is no or little competition among hospitals, rate setting may reduce prices and control costs, allowing a public debate over community needs for services and what configuration of hospitals can best meet those needs. Rate setting may reduce hospital competition based on payer mix and provide additional resources to so-called have-not hospitals that serve low-income and uninsured individuals. In communities where there are disparities of wealth, ensuring a more equitable distribution of resources among hospitals, clinics, and other providers can improve access to health care and health outcomes, particularly for individuals who may not have the purchasing power to ensure adequate care. Rate setting also can increase transparency in the health care system by providing extensive and timely data.

Disadvantages

The cost of operating a rate setting system and collecting provider information can be substantial and the effectiveness of such a system without the inclusion of Medicare and Medicaid is likely to be limited at best, in part because a system with just private payers does little to increase the market leverage of public safety-net hospitals. Moreover, rate setting in one sector, such as hospitals, may create incentives for providers to shift care to sites where rate setting is not in effect, transforming care in ways that do not reflect improved efficiency or quality. There also is risk that interfering with market winners and losers may prevent providers from having the resources or incentive to adopt new technology, produce societal goods, or provide higher-quality medical procedures. However, it may be difficult for states to set up a rate setting system that includes Medicare and Medicaid. Waivers are needed that shift significant power to federal authorities and inclusion would mean higher Medicaid costs for most states.

(Sources for this policy option are located on page 56)

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Integrated Delivery Networks: In Search of Benefits and Market Effects

by Jeff Goldsmith, Lawton R. Burns, Aditi Sen and Trevor Goldsmith, February 2015

Any examination of the role that hospitals play in health care cost growth is complicated by the fact that in many large markets, hospitals may be part of integrated delivery networks (IDNs), either vertically integrated

health services networks that include physicians, post-acute services and/or health plans or fully integrated provider systems inside a health plan. Looking at the benefits to society, the authors found that there is evidence that IDNs have raised physician costs, hospital prices and per capita medical care spending; looking at the benefits to the providers, the evidence also showed that greater investments in IDN development are associated with lower operating margins and return on capital. As part of this report, the authors conducted a new analysis of 15 of the largest IDNs in the country. While data on hospital performance at the IDN level are scant, the authors found no relationship between the degree of hospital market concentration and IDN operating profits,

between the size of the IDN's bed complement or its net collected revenues and operating profits, no difference in clinical quality or safety scores between the IDN's flagship hospital and its major in-market competitor, higher costs of care in the IDN's flagship hospital versus its in-market competitor, and higher costs of care when more of the flagship hospital's revenues were at risk.

The authors conclude that the public interest would be served if IDNs provided more detailed routine operating disclosures, particularly the amount of hospital operating profit as a percentage of the IDN's total earnings and the IDN's physician and hospital compensation policies. How IDNs allocate overhead and ancillary services income between the three main lines of business should also be disclosed. It should also be possible to determine from an IDN disclosure if capitated risk is transmitted from the IDN's health plan or risk-accepting organization to its hospitals and physicians. Analysis of societal benefits would also be materially aided by a comprehensive, national all-payer claims database.

State Policies on Provider Market Power

by Suzanne Delbanco and Shaudi Bazzaz, July 2014

Health care economists broadly agree that the market power of certain health care providers is a major driver of price increases, and is associated with significant payment variation across and within markets. This report catalogues the laws and regulations that state governments are using to enhance the competitiveness of health care markets and reduce the ability of providers to use market power in such a way that creates negative consequences for those who use and pay for care. The authors researched regulatory approaches, specifically recent state efforts pertaining to: antitrust; price and quality transparency; competition in health plan contracting; price regulation; the development of Accountable Care Organizations (ACOs); expanding the authority of state Departments of Insurance; and facilitating the entry of new providers into the marketplace.

Specifically, this paper catalogues existing state statutes and regulations that address the contracting practices of health plans and providers likely to reduce competition and lead to higher prices. In doing so, this paper provides insight into the current scope of state authority to regulate and monitor health care prices. In addition, because states may pursue policies that would not be captured in a review of laws and regulations, this paper also explores efforts beyond the legislative realm by states taking an active role to address these issues.



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