

State Approaches to Addressing the Effects of Provider Consolidation at

Healthcare Consolidation: Winners, Losers, and Policy Implications

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The Consolidation Frame

- Many frame the pricing power problem as consolidation, supported by evidence that finds that beyond a fairly low threshold, additional size does not improve quality or efficiency – may actually make them worse
- But this frame:
 - ignores that there are high prices enjoyed by “must haves” as well in non-consolidated markets and which don’t M&A
 - ignores the reality of “have nots,” which are price takers, rather than price makers, and have relatively low payments
 - points to antitrust policy as the prime antidote, rather than as just one tool to address pricing issues
 - and slides over strong views about the concept of ACOs as a community-based entity of some kind featuring collaboration

Leverage Factors Unrelated to Concentration/Consolidation

- While concentration is the main story (and a major consideration re ACOs), other factors contribute to growing provider market power over prices and contract “terms and conditions”
 - Employer rejection of narrow networks
 - Reputation
 - Geography
 - Leveraging particular “monopoly” services – sometimes fostered by understandable regulatory exclusion of market competitors

Have and Have Nots

- MedPAC reports that in aggregate, hospitals contract at about 140% of Medicare, but anecdotally, it is clear that many “must haves” obtain >250% of Medicare, and as high as 600%
- Physicians at about 120-125% of Medicare overall but in Miami some are at 60-70% and in a mid-west city as high as 900%
- Classic multispecialty group practices – prototypical ACOs – reportedly negotiate at levels of must have hospitals - >250% of Medicare -- but now for both physician and hospital services

Competitive ACOs or Community ACOs?: a Rarely Engaged, but Real, Disagreement

- Many ACO advocates favor a non-competitive context for ACO development (although rarely addressing how a community-wide effort addresses governance or the potential for exercise of market power), whereas mainstream economists and antitrust experts naturally want competing ACOs – “integration and rivalry”
- Further, there is no settled view on whether vertical integration in health care is generally pro- or anti-competitive, although a few recent papers suggest that formal hospital-physician integration raises physician prices significantly

“The Evolution of Integrated Health Care Strategies” by Evans et al.

- Reviews 25 years of academic literature *Advances in Health Care Management*
- Shifts in integration strategies over the period. From:
 1. a focus on horizontal to vertical integration
 2. acute care and institution-centered models to a broader focus on community-based health and social services
 3. economic arguments for integration to emphasis on improving quality and value
 4. evaluations of integration using an organizational perspective to an emerging interest in patient-centered measures
 5. a focus on changing organizational structures to changing ways of working and influencing underlying cultural attitudes and norms
 6. From integration for all patients within defined regions to a strategic focus on integrating care for specific populations

Why Antitrust Policy Focused on Consolidation Can't Be the Primary Focus

- Consolidation, esp. if clinical integration and risk taking, may improve quality and efficiency in particular situations -- and also lead to market power with increased prices as a derivative of the new arrangement
- Many local markets can't readily support competition among major health care providers
- There are many reasonable, practical reasons for consolidations to take place – yet, pricing power can ensue

“While the antitrust agencies’ efforts to promote and protect competition in health care markets is commendable, it is also the case that the antitrust law has little to say about monopolies legally acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in hospital markets and a growing number of physician specialty markets, it is particularly important other measures that promote competition.”

-- Professor Thomas (Tim) Greaney, Testimony to the Committee of the Judiciary, House of Representatives, May 18, 2012

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

A Report of the National Academy of Social Insurance

April, 2015

NASI Report Policy Options on a Continuum from Market-oriented to Classically Regulatory

- Encouraging market entry of competitors
- Greater price transparency
 - Collecting and reporting all-payer claims data
 - Supporting price conscious consumers
- Limiting anticompetitive health plan-provider contracting provisions
- Harmonizing network-adequacy requirements and development of limited provider networks
- Active purchasing by public payers

Policy Options (cont.)

- Improved Antitrust Enforcement
 - Scrutiny of hospitals and insurers with market power
 - Active review of vertical mergers
 - Conduct remedies and post-merger monitoring
- Additional public oversight and review
- Regulating Premium increases thru rate review
- Limiting out-of-network provider charges
- Setting upper limits on permissible, negotiated rates
- Expanding the use of all-payer and private-payer rate setting

Classification of State Policies Addressing Provider Market Power (From Catalyst for Payment Reform)

The report produced a catalogue of laws to enhance market competition or substitute for it

- Antitrust related laws
- Laws and regulations:
 - encouraging transparency on quality and price
 - encouraging competitive behavior in health plan contracting
 - implementing the monitoring or regulating of prices
 - around the development of ACOs
 - expanding the authority of Departments of Insurance
 - facilitating or reducing barriers for new entrants to the market

State Examples

- CA prevents providers' ability to suppress price information
- MA has created the Health Policy Commission which among other things conducts a "cost and market impact review" to monitor material changes by provider organizations
- MA bans carriers from entering contracts that limited tiered networks or guarantees a provider's participation
- MI (and other states) explicitly bar insurers from using "most favored nation" clauses in provider contracts

State Examples (cont.)

- RI Office of the Insurance Commissioner has been granted broad authority to hold health insurers accountable for fair treatment of providers, and to direct insurers to promote improved accessibility, quality, and affordability, giving them the ability to review and approve payer-provider contracts
- Texas defines a “health care collaborative” (ACO) and requires them to obtain a certificate of authority from the DOI and AG concurrently. The latter reviews whether the ACO is likely to reduce competition and whether it should be permitted