EXECUTIVE SUMMARY

1: Health Care Costs Continue to Rise

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

Today, health care expenditures account for nearly all projected structural deficits at the federal level1-2 and for a major – if not the major – component of state budget outlays each year.3 Despite a slowdown in health care spending in 2009 and 2010, recent projections by the Congressional Budget Office show spending on health care services will increase to 20% of Gross Domestic Product (GDP) by 2020. This has implications that extend beyond health care, including impacts on the U.S. debt, wage growth, and unemployment. Excessive growth in health care expenditures will have serious economic consequences for the country, with the ultimate burden falling on those who use and pay for health care services.4

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

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

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

Numerous recent studies have shown that the increase in unit prices – defined here as the cost of hospital and physician services, including medications – in both inpatient and outpatient settings is the single biggest driver of health spending increases. Recently released data from the Health Care Cost Institute (HCCI), a nonprofit research entity that has private insurance claims data accounting for more than 40% of the private market from four large private insurers, substantiate this conclusion.6

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

Health care economists broadly agree that provider consolidation is a major driver of price increases, and is also associated with the significant payment variation across and within markets for both hospital and physician services.7 Consolidation in the health care sector is ubiquitous. And despite the potential benefits, there is also fear – based on well-documented historical trends – that unless we manage it carefully, massing provider market power will lead to even higher prices and revenues. And, this excessive growth in health care expenditures is expanding toward unsustainable proportions without correlated improvements to quality.
In addition, many researchers have pointed anecdotally to the rise of managed care in the 1990s as the primary factor driving hospital consolidation. More recently, researchers theorize that continued merger activity may be a result of the worsening economic situation and declining volumes of stand-alone hospitals due largely to the recession. Some believe that for hospitals to survive in this economic environment, more mergers are essential. Others believe, however, that the mergers are an attempt to gain the leverage to block insurers from redirecting patient flows or to slow the adoption of tiered networks.

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

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

MARKET-BASED APPROACHES

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

Network Strategies:
• Tiered, Narrow, and High Performance Networks
• Centers of Excellence/Direct Contracting
• Managed Care/Managed Competition Strategies
• Entry of New, Lower-Cost Competitors
• Strategically Seed the Supply Side
• Oversight of ACO Development
strategies that can impact competition, segmented into two groups: those utilizing consumer engagement and those utilizing provider networks. Additional detail below illustrates how each intervention can promote competition among providers in a health care market.

1. **Consumer Engagement: Price and Cost Transparency** Many believe increasing the transparency and usefulness of data on the performance of providers (including compliance with evidence-based standards, health care outcomes, and cost) can increase market competition. Allowing consumers, who are paying an increasing share of the costs of care, to select providers based on quality and cost would motivate providers to compete in those domains, akin to how other non-health care markets function. With price variation as high as 700% for selected services in some markets and significant differences in quality, access to information must be available to those who need to make decisions or who guide consumers in doing so (e.g., health coaches, nurses, and primary care physicians). This information is also the basis for benefit designs that build on information-only support for consumer decision making with financial incentives for consumers to select providers with the best combination of quality and affordability. Transparency can also inform employers working to build long-term strategies to improve value.

   Some stakeholders voice concern that price transparency – alone or in combination with performance data—could lead to provider collusion and increased prices, or that it may confuse or mislead consumers. While theory suggests the potential for such effect, there is little empirical evidence on the impact.

   Efforts to create meaningful and consistent metrics in a useful context to inform consumer decision-making are still in their infancy. Some states collect and publish data on private sector prices and provide some limited information on provider quality and utilization patterns. See [www.catalyzepaymentreform.org/Price_Transparency.html](http://www.catalyzepaymentreform.org/Price_Transparency.html) for CPR’s specifications for consumer price and quality transparency tools.

2. **Consumer Engagement: Consumer Directed Health Plans (CDHPs)** In health insurance, there is an inherent tension between reducing a person’s exposure to financial risk and the drawback of reducing a patient’s sensitivity to differences in price and quality among providers. Patients with comprehensive health insurance naturally tend to consume more services without much attention to value, which contributes to rising costs.

   Many benefit experts believe we could draw greater value from the health care system with plan designs that create the proper balance of incentives, information, and/or more restricted or higher-value provider networks. One of the primary consumer engagement strategies being used to support this goal is the Consumer-Directed Health Plan (CDHP), which typically pairs a health savings mechanism (e.g., HSA, HRA, etc.) with a high-deductible health plan. However, consumers alone may not be able to drive market share shifts or change the balance of market power between providers and payers. In the case of higher cost services where the consumer has already met a deductible, incentives to shop based on both quality and cost fade away. CDHPs do, however, introduce the concept of consumer price sensitivity into the mix which can begin to support the fundamentals of a competitive marketplace.

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

   The challenge with VBID is constructing benefit packages that provide strong incentives to consumers to be more cost conscious, while avoiding negative clinical effects and shifting too much risk to them. To date, VBID has largely been used in pharmaceutical benefit design to encourage use of lower-cost, equivalent therapies or to incentivize compliance with a specific drug regimen that supports better health through use, such as diabetes maintenance drugs. There has been limited use of VBID for other services, provider selection, or network strategies.
4. **Consumer Engagement: Reference and Value Pricing** Reference and value pricing live at the intersection of consumer engagement and provider contracting. Unlike VBID, reference pricing establishes a standard price for a drug, lab test, procedure, service, or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. This creates the incentive for the plan member to use the preferred provider or the preferred class of services or therapies. Value pricing is similar, but it also includes consideration of quality and/or performance in the equation determining the price point or preferred list of services or providers.

Even though reference pricing has yet to wield sufficient volume to affect the overall pricing behavior of providers substantially, reference and value pricing have shown some promise when applied to high-cost and high-volume procedures such as joint replacements. As with VBID, reference and value pricing can introduce consumer sensitivity to the price for high-cost services as well as where they seek such services.


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

6. **Network Strategy: Centers of Excellence/Direct Contracting** Most major health insurers use Centers of Excellence (COEs) in a limited set of clinical areas (e.g., transplants, bariatric surgery, cardiac, orthopedics) to direct patients to facilities that have demonstrable strengths – better clinical outcomes, fewer complications and readmissions – for certain high-risk and/or high-cost procedures. More recently, several of the nation’s large employers (and some insurers) have begun to pursue direct contracting with COEs as a way to regain control over the costs of employee health care benefits. As a result, provider competition for direct contracting arrangements may well increase in the near term. And in some cases, direct contracting of this nature may be the beginning of efforts by some employers to circumvent private insurers. For the short term, COE contracting represents a way of injecting some competition into the market place while saving employers money and maintaining or potentially improving quality.

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

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

8. **Network Strategy: Entry of New, Lower-Cost Competitors** The systematic investment in, development, and marketing of a “lower-cost” alternative is a relatively new development in a couple of regions characterized by high prices and substantial consolidation, such as Boston and Pittsburgh. The entry of a well-capitalized outside group in one instance and a private insurer in the other indicates that some see a market opportunity to undercut monopoly pricing strategies. Employers and insurers should look for ways to encourage this type of strategy in other extremely consolidated markets.
9. **Network Strategy: Strategically Seed the Supply Side**  
This generally involves the following strategies: 1) Encouraging the entry of new providers that can compete directly with entrenched and consolidated health systems (see above); 2) Encouraging entry and expansion of new practitioners by opening up more medical school slots to train more physicians and reducing or removing restrictive licensing or certification requirements that govern the type of care nurses, nurse practitioners, and physicians (as well as other personnel) can provide; 3) Developing new cost-reducing technologies and innovative approaches that can compete directly for both acute and ambulatory care (such as telemedicine and hospital-at-home delivery system approaches); 4) Encouraging the expansion of existing, more productive services that can compete directly with hospitals on a cost-effective basis (such as urgent care centers, retail clinics, and specialty hospitals); and 5) De-emphasizing regressive policies that act as a barrier to entry – such as certificate-of-need policy and regulation, which is often politicized and aimed at protecting existing competitors rather than protecting competition.

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

10. **Network Strategy: Oversight of ACO Development**  
Employers can communicate their expectations to their insurers/third-party administrators regarding how they will contract with and monitor the impact of Accountable Care Organizations (ACOs). Providers receive considerable antitrust exemptions under the provisions of the ACA and could use health reform as cover for additional consolidation and integration with the aim of increasing their market power. If they are not at the table, employers could be left with little leverage.

View CPR’s Action Brief on **Accountable Care Organizations and Ensuring Competition** for more detailed information.

**COORDINATED PUBLIC AND PRIVATE ACTIVITIES**

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

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

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

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

**COORDINATED PUBLIC AND PRIVATE ACTIVITIES:**

- Antitrust Activity: Monitoring and Pursuing Injurious Mergers
- All-Payer Claims Databases
- Alignment of Public/Private Payment Structures
- Episode-Based and Bundled Payments
- Accountable Care Organizations
- Global Budgets or Population-Based Payment Models
- Increased Emphasis on Primary Care
- Pay for Performance (P4P)
- Monitor Inappropriate Use and Health Care Fraud
3. **Alignment of Public/Private Payment Structures** Alignment of public and private payment strategies would have the benefit of providing more consistent incentives to hospitals and physicians and would likely reduce variation in prices and costs. Medicaid programs and private payers could consider aligning their payment methods with those of Medicare and assess where there is greater flexibility to consider those policies as a platform upon which to innovate further. There could be further alignment with, for example, episode-based and bundled payments, shared savings, global budgets or population-based payment models, payments that emphasize the value of primary care, pay for performance initiatives, and the monitoring of inappropriate use of services and fraudulent practices.

4. **Episode-Based and Bundled Payments** Recently, Medicare has experimented with payment systems that broaden the focus of physicians, hospitals, and other providers from delivering piecemeal, individual services to patients to providing the care a patient needs for an entire episode of illness or that an entire population needs over time. While bundled payments alone do not enhance competition among providers, they bring with them important incentives for providers to improve quality and contain costs.

5. **Accountable Care Organizations** The Centers for Medicare and Medicaid Services (CMS) has defined ACOs as a way to create incentives for health care providers to work together to treat an individual patient across care settings while making care more affordable. Despite the potential risks of enhanced market power for providers, some policymakers believe it is vitally important that reformers continue to encourage increased alignment of incentives. But it’s important to monitor whether these lead to more market power for providers and higher prices as a result.

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

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

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

9. **Monitor Inappropriate Use and Health Care Fraud** There are estimates that savings from reducing health care fraud can be as much as 5% of total health spending. Consequently, both public and private payers have invested resources in identifying and remediating fraudulent claims and inappropriate patterns of care. This approach could help to counteract some of the increases in health care costs due to provider consolidation. Despite its considerable potential, public and private entities appear unwilling or unable to devote sufficient time and money to this activity at present.
REGULATORY INTERVENTIONS/APPROACHES

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

1. Improving the Accuracy of the Medicare Physician Fee Schedule  The current Medicare fee schedule for physicians appears to have many distortions in payment levels, causing some medical services to be highly profitable and others to be less so. It clearly rewards specialty procedures at the expense of primary care services, causing too many patient procedures and too little primary care interaction and care management. This drives higher than necessary volumes and adds to the overall cost of health care for both public and private payers. Because most Medicaid departments and private payers benchmark their fee schedules off of the Medicare fee schedule, changes to it have enormous potential to influence the entire payment system.

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

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

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

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

5. Limits on Emergency Care Pricing  Acute emergency care is inherently monopolistic since patients in an emergency situation have very limited ability to decide where they seek care. When they can, such as when patients receive care out-of-network, providers often charge patients much more than what the providers accept from Medicare or private insurers with an established contract.
Most state legislatures are reluctant at present, but establishing a Maximum Payment Obligation as a percentage of Medicare payment levels could reduce cost shifting, re-establish negotiating balance between hospitals and payers, and generate cost reductions. It could also help patients without insurance who obtain emergency services.

6. **Active Purchasing Strategies by State Health Insurance Exchanges** State-based health insurance exchanges, an important component of the ACA’s plan to expand access to coverage, are both a gateway for people to purchase subsidized health insurance and a means to help organize insurance markets for more effective competition among health plans and providers. Many states have been reluctant to begin work to implement exchanges – first because they were waiting for the Supreme Court decision on the ACA and then because they were awaiting the outcome of the 2012 presidential election with its implications for health reform. However, by consolidating individuals and small groups, potentially aligning with large purchasers’ strategies to encourage value-oriented consumer shopping, exchanges could encourage long-term delivery system changes that help improve quality and curb the current growth in health care costs.

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

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

5. **Monitoring Market Competition and Market Power**

Today, we have a limited line of sight into the true impact of provider consolidation and market power because of a lack of systematic and comprehensive oversight. Until now, monitoring of provider consolidation and the identification of instances where mergers might lead to injurious price increases has primarily been in the domain of those charged with identifying and pursuing cases that might violate antitrust provisions.

However, given the growing awareness of the impact of increased provider negotiating leverage on rising health care expenditures, the appetite to develop a mechanism to monitor more broadly and rigorously the impact of provider consolidation on price may be at an all-time high. Representative health care claims data are also increasingly available, which could make such monitoring possible.

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

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

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

About this Report

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

About Catalyst for Payment Reform

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

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