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<th>Making Markets Work in Health Care: What Does That Mean?</th>
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| **Stuart Guterman**  
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HealthAffairs
There are two types of markets in health care:
• The market for health care services
• The market for health care coverage

The two markets are interdependent
Both of those markets are broken:
• Lack of usable information
• Adverse incentives
• Disconnect between purchaser and user
Both markets are becoming more consolidated:

• Providers
• Insurers

This trend is both good news and bad news
What are the implications for policy?
• Aligning payment incentives with system goals: paying for what we want
• Making markets work
  – What does this mean?
  – Is it possible?
  – The role of antitrust policy
Balancing competition and regulation

- Narrow networks
- Tiered networks
- Reference pricing
- Benefit design
- Price regulation
- Fixing the infrastructure of the market—markets and market forces
Getting The Product Right: How Competition Policy Can Improve Health Care Markets

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Health Affairs
The Neglected Product

• The US wastes roughly $1 trillion each year because the health care system is inefficient
• We do not spend our money on the health care that people value most, and we do not produce health care at the lowest possible cost
• The payoff from market consolidation is efficiency; the risk is market power
• However, antitrust enforcement is only a partial solution
• A long history of regulation and subsidy distorts competition in health care, including the “products” the health care system buys and sells
• Price, quality, and even innovation mean little if one is buying and selling the wrong things
Professionally Defined “Products”

- Most health care “products” are defined by physicians, whose ordering decisions account for about 2/3 of health care expenditures.
- Professional traditions equate products with inputs and workflow.
- With traditional fee-for-service payment, health care providers first devise a process step and then create a way to bill for it.
- Suppliers do the same with inputs.
- There is little incentive for productive efficiency because few products are assembled.
- Providers understand their revenue (“reimbursement”) much better than their costs of production, and mainly collect the information they need to collect in order to get paid.
“Products” Defined by Insurance

- Other health care “products” consist of health insurance for a set of covered benefits.
- For a few insurers (e.g., prepaid group practices), coverage means comprehensive care for medical needs during the premium year.
- For many insurers, however, coverage merely aggregates professional process steps and inputs.
- When insurers negotiate with providers, it is often over these faux products, and antitrust law doesn’t add much value by facilitating that.
- Managed care was supposed to accomplish more.
Competitive Products

• Competitive products are saleable units that consumers understand because they deliver both intuitive and measurable value

• Competitive products must be assembled and can be warranted for quality and safety
  – Warranty risk is not insurance risk (i.e., the opposite of fee-for-service is not capitation)

• A variety of competitive products exist based on clinical need and consumer demand
  – Packaged diagnostic work-ups
  – All-in treatment for an acute condition
  – Periodic maintenance care for a chronic disease
Next Steps for Competition Policy

• Coordinating antitrust and regulation
• Focusing payment and transparency reforms on competitive products
• Removing regulatory barriers to entry by new competitors
• Scrutinizing provider-insurer agreements that perpetuate faux products and deter entry
• Linking “clinical integration” to specific products with measurable benefit
• Protecting the emerging competitive space upstream of current markets (e.g., mHealth)
Addressing Increasing Provider Leverage

Paul B. Ginsburg, Ph.D.

Presentation to Health Affairs Briefing: Provider Consolidation in Health Care, May 19, 2014
Powerful Trend towards Provider Consolidation (1)

• Driven by “fear” as well as “greed”
  – Highly challenging environment for hospitals and physician practices
    • Future is coordinated/integrated care
      – Push for ACO-like and bundled payment contracting
    • Report and be judged on quality
    • HIT requirements
• Physician lifestyle another factor
Powerful Trend towards Provider Consolidation (2)

- Hospital mergers, physician group mergers
- Hospital acquisition/affiliation with physician groups
  - Distinct additional challenges
    - Interferes with steering of patients to high-value inpatient or outpatient facilities
    - Prevents emergence of competition in ACO/risk contracting market
Approaches to Address Provider Consolidation

• Market approaches
  – Steps that purchasers and plans can pursue
• Government efforts to facilitate market approaches
• Direct regulation of prices
Better Information on Price and Quality for Enrollees

• Online tools for enrollees
  – Customize to enrollee’s product and deductible/account
    • Recent Massachusetts requirements for insurers
  • Opportunity has grown with increasing deductibles
    – But most opportunities on outpatient side
      • Few incentives on inpatient provider choice in high-deductible plans
Some Public Price Transparency Initiatives Misguided

- Publication of prices that are not relevant to most patients
  - CMS release of charges from Medicare claims
- But data on prices to private insurers can influence employers and policy-makers
  - Massachusetts AG reports on negotiated prices
- Downside of transparency in concentrated markets
Limited Networks

• Leads to lower prices in two ways: steering and increased leverage
  – Potential for stimulating provider efficiencies
• Public more receptive now than in 1990s
  – Affordability challenges are larger
  – ACA exchanges create ideal incentive structure
    • Also avoid “one size fits all” requirements
• Potential regulatory obstacles from network adequacy
Tiered Networks (1)

- Potential for broader appeal than limited networks
  - Point of service rather than annual decisions
  - Experience with drug benefit design
- Steering patients and gaining additional discounts
- Obstacle of refusal to contract by prominent hospitals
  - Massachusetts legislation barring practice
Tiered Networks (2)

- Physician high-performance networks
  - Limited by numbers of claims each insurer has access to
  - Longstanding push to release Medicare claims data to insurers, consumer groups
    - Bolster sample size of physician claims
      - Future versions of recent release could accomplish this
      - Potential application for “all-payer claims databases”
Reference Pricing

- More aggressive approach to tiered networks
  - But applies to smaller share of spending
- CalPERS experience with joint replacement
  - Successful but hard to do
- Works best with discrete outpatient procedures
  - MRI, colonoscopy
- Carriers divided on priority compared to alternative use of resources to contain costs
Fostering Physician Organizations (1)

- Medical groups, independent practice associations
- Potential upside
  - More competitive hospital market
    - Reduce attractiveness of hospital employment
    - Incentives under shared savings to steer patients to higher-value hospitals and specialists
  - More effective ACOs due to clearer incentives
Fostering Physician Organizations (2)

- Financial/technical assistance to practices
  - CareFirst BCBS global incentives and pods for PCPs
- Policy options
  - Loans/grants to establish infrastructure
  - Eliminate higher Medicare payments for physician services in hospital outpatient departments
    - Artificial incentive for hospitals to acquire practices
Anti-Trust Policy

• Need to develop policies on hospital acquisition of physician practices
  • Recent FTC success in Boise not based on vertical combination issues
    – But other plaintiffs raised them
Price Controls

- Activity at state rather than federal level
- Limits on charges when patients have no choice
- Broader limits on charges where competition is highly limited
- State rate setting
  - Maryland pioneering how to evolve its approaches given movement to provider payment reforms
Concluding Thoughts

• Upside in developments in financing and delivery has downside in increasing consolidation
  – Proceed with developments and address the consolidation

• Many opportunities for market approaches to offset growing provider leverage
  – Important government role in fostering these market approaches
  – Rate setting is a “stick in the closet” if the market cannot do the job
Pogo:

We have met the enemy and he is us
The Schizophrenia of US Healthcare

• We believe in the “free market”- but most government regulations actually encourage oligopolies, monopolies and price fixing
  – Long patent periods for new drugs and devices
  – Legislation restricting ability of largest customers to negotiate prices (Medicare, Health Plan-AWP)

• We believe in access to healthcare to all- but can’t seem to define to what you have access to-or how it should be paid for going forward
The Vicious Cycle of Costs

The Trillion Dollar “Tax” on Health Care

Health Care Costs in Excess of GDP

High Clinical Provider Prices

Endless Supply of “half-way” Technologies

High Prices of Suppliers (Labor-Drugs-Devices)
Thoughts on moving forward

• Top 10 list

1. Actively support development of physician ACOs especially in already consolidated markets
2. Remove or greatly diminish differential pay for hospital based procedures
3. Rapidly expand reference pricing of procedures
4. Enforce anti-trust related to both vertical and horizontal consolidation that restricts rather than promotes competition
5. Remove regulations that restrict narrow network if access is adequate
6. Move rapidly to global payment wherever possible
7. Shorten drug and device patent periods
8. Restrict anti-competitive practices of drug companies buying out—or paying off-potential competitors
9. Restrict anti-competitive plan practices such as “most favored nation” arrangements
10. Fund studies to illustrate areas where competition is working in spite of presence of large integrated practices and studies of organizational changes that appear to enhance quality and reduce cost-without adding monopolistic tendencies
Competition Policy in Health Care

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*The views expressed here are those of the author alone and do not necessarily represent the views of the Federal Trade Commission or any of the Commissioners.
Consolidation and Competition in Health Care Markets

- There is a great deal of change happening in health care markets.
  - New organizational alignments and forms.
    - Some new and innovative.
    - Some offer little improvement or may be harmful.
  - New Policies.
    - ACA, Medicare, States, ...
- The US relies on markets for the delivery and financing of health care.
  - The success of health reform depends on how well these markets function.
- Competition policy key to making markets, and health reform, work.
  - Federal antitrust agencies – FTC, DOJ
  - Other federal agencies – CMS, FDA,...
  - State governments – legislatures, regulators,...
Consolidation

• Surge in hospital mergers.
  – Over 1,000 deals since mid-90s.
  – Most urban areas dominated by 1-3 large systems.

• Increase in physician practice acquisitions by hospitals.
  – 32% increase in # of doctors employed by hospitals over last decade.
  – 20% of physicians now employed by hospitals.
Consolidation

- Majority of mergers/acquisitions benign or beneficial.
  - FTC challenges very few.
- There may be benefits to consolidation.
  - Reduced duplication/excess capacity
  - Costs
  - Quality
  - Clinical integration/coordination
  - IT
  - Risk bearing
- But, little evidence that consolidation achieves those benefits.
- Questions
  - Is consolidation necessary, or sufficient, to achieve benefits?
  - Are joint negotiations with payers necessary to achieve benefits?
Competition

• Consolidation can harm competition.
  – Competition leads to lower prices.
    • Mergers in concentrated markets (most of US) can drive prices up by 20%, 40%, 50%.
  – Competition and quality.
    • Heart attack mortality for Medicare beneficiaries 1.46 percentage points lower in most competitive vs. least competitive markets.
  – Not-for-profits behave no differently than for-profits.
  – No evidence of cost savings.
  – No evidence of increased charity care.

• Increased prices get passed on to consumers dollar for dollar.
Competition Policy

• Goals
  – Static: protect consumers by protecting competition.
  – Dynamic: keep open opportunities new innovative forms for delivering care to enter and compete.

• Role of antitrust
  – Enabling markets, and policies, to work.
    • Antitrust does not, and should not, take the place of the market.
  – Once competition is gone, it’s extremely difficult to get back.
  – Innovative policies/organizations can’t succeed if there’s no competition.
    • Transparency, Narrow networks, Tiering, Reference pricing.

• Policy coordination/harmonization
  – Requires mutual recognition of policy dependence by federal and state governments.
Paradigm Lost: Provider Concentration And The Failure Of Market Theory

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ENOUGH IS ENOUGH

$113 BILLION\(^1\) of new hospital cuts added to $320 BILLION\(^2\) in ACA cuts since 2010

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1. Backstop (bad debt) included in Middle Class Tax Relief and Job Creation Act of 2012 (MCTRCA), offset for 2 Midnight policy included in FY 2014 IPPS Final Rule; LTCH policies included in Bipartisan Budget Act of 2013/Continuing Appropriations Resolution, 2014 (H.J.RES.56); 3-day window cut included in the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010; Medicaid DSH cuts included in MCTRCA, American Taxpayer Relief Act of 2012 (ATRA), and H.J.RES.56; MS-DRG coding cuts included in ATRA as well as CMS regulations (estimate of excess cuts based on hospital analysis); and sequestration amounts included in Budget Control Act of 2011 and H.J.RES.56 (estimate based on hospital analysis).

2. CBID letter to Speaker Boehner, July 24, 2012.
MEDICARE MARGINS DRIVEN TO ALL TIME LOW

HOSPITAL OVERALL MEDICARE MARGINS

-3.0%  2003
-7.3%  2005
-5.4%  2008
-6.0%  2012
-8.0%  2014

-6.0%

WITH SEQUESTER

-8.0%

3 Medicare Payment Advisory Commission FY2014 is a projection.
4 MedPAC estimate including the sequester, Jan. 2014.
Health care prices increased just 1.1% from December 2012 to December 2013, the 2nd lowest increase in the past 50 years

Year-Over-Year Growth Rates in Health Care Price Index (2009-2013)

*Note: annual growth rates calculated from December to December of each year.*
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