THE FUTURE OF HEALTH CARE
PRICE TRANSPARENCY IN CALIFORNIA
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Provider (and Health Plan) Pricing Power and What to Do About It

ROBERT A. BERENSON, M.D., F.A.C.P.
INSTITUTE FELLOW, THE URBAN INSTITUTE

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Prices Are Now the Main Driver of Health Care Costs Increases

The Health Care Cost Institute published results for 2010-2011 spending -- claims from Aetna, United, and Humana. (KP also part of HCCI)

Prices drove health care cost increases

- Inpatient – unit prices increased 5.9%, intensity level decreased 0.3%
- Outpatient – unit prices increased 3.5%, intensity 1%
- Professional services – price increased 3.7%, intensity decreased by 0.4%

Just Published HCCI Study Expands Findings

Herrera et al. *Health Affairs,* Oct 2013

- 4.5 million medical and Rx claims paid between 2007 and 2011.

Here, controlled for changes in intensity of care

- Per capita medical expenditures up 5.3% with utilization up 1.7% and prices up 3.5% on avg

Intensity adjusted unit prices grew faster than intensity: inpt: 5.2%; outpt: 2.9%; professional: 2.2%

Trends in Payment to Cost Ratios

Aggregate hospital payment-to-cost ratios for private payers has increased from about 115% in 2000 to about 135% in 2010

-- Avalere analysis of AHA Annual Survey Data, 2010, for community hospitals, AHA Trendwatch Chartbook, 2012

Prices Are a Major Reason US Spending Exceeds the Rest of the World

- Whether as per capita spending or as percentage of GDP spent on health care
- "It's the prices, stupid: why the United States is so different from other countries." – Anderson et al., *Health Affairs*, 2003
- *Accounting for the Cost of Health Care in the United States* – McKinsey Global Institute, 2008

  "Input costs – including doctors' and nurses' salaries, drugs, and other medical supplies, and the profits of private participants in the system – explain the largest portion of additional spending… [the $650 billion extra the US spends compared to world norms]

But there is Evidence of Recent Moderation in Hospital Price Growth

Altarum Institute Price Brief, October 2013 –
Price growth near historic lows (from ‘90)

- Aug, 2013 prices 1.0% higher than Aug, 2012; 12 month moving avg. was only 1.5%
- Hospital price growth only 1.5% (lowest since 1998)
- Physician prices up only 0.3%
- Medical CPI below 2% (from 4.1% Sept, ‘12)

2013 May Be Way Different in Other Ways from 2011

- In FY ‘11, many large health systems were reporting operating cash flow margins of $500M to $1B. Hiring like crazy. Increased M&A activity (from ’10-’12)
- Now, reportedly, margins and retained earnings for major not-for-profit hospital systems are down dramatically, with reduction of capital expansion and major reductions in workforce.
- Altarum reports health sector job growth flat for first time in a decade

Some Important Papers and Reports Addressing Pricing Power

- Massachusetts Attorney General. *Investigation of Health Care Cost Trends and Cost Drivers.* Preliminary Report, Office of Attorney General Martha Coakley, Jan 29, 2010.
- Berenson, Ginsburg, and Kemper. “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” *Health Affairs*, 29:2010, 2010
- Office of the Health Insurance Commissioner State of Rhode Island. V*ariations in Hospital Payment Rates by Commercial Insurers in Rhode Island.* Jan. 2010
- Vogt and Town. *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Research Synthesis Report 9, RWJF, 2006, updated 2012.
- Catalyst for Payment Reform (Murray and Delbanco). *Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead*, 2012

The Role of Consolidation

Many frame the problem of pricing power as resulting from consolidation in health care markets

There is strong evidence that consolidation raises prices

But framing as a problem of consolidation ignores that there are high prices as well in non-consolidated markets

Further, focus on consolidation and resulting high prices ignores the problem of “Have Not” providers, which are price takers, rather than price makers. Also, the record from the 1990s in California suggests prices can be too low under some market conditions?

“The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed”

-- Berenson, Ginsburg, Christianson, and Yee,

Health Affairs, May ‘12

The Community Tracking Study

- Conducted since 1996 by the Center for Studying Health System Change. Reporting on Round 7 findings. Interviews in 2010.
- Based on dozens of in-depth interviews in each market using a structured interview protocol
- Combination of ongoing “tracking” and round-specific and site-specific questions
- Contracting leverage has been one of the ongoing issues of interest in the CTS

CTS Sites

Boston
Cleveland
Greenville, SC
Indianapolis
Lansing, MI
Little Rock
Miami
Northern New Jersey
Orange County, CA
Phoenix
Seattle
Syracuse

Leverage Factors Unrelated to Concentration/Consolidation

While concentration is the main story, other factors contribute to growing provider market power over prices and “terms and conditions”

- Employer rejection of narrow networks
- No longer oversupply of beds and docs, with some exceptions (some Miami docs accept 70% of Medicare fees)
- Reputation
- Geography
- Provision of particular clinical services
- Regulations (in a couple of places)

Market Variations in Hospital Leverage

- Overall recent trend favoring hospitals (in commercial products, not Medicare Advantage, which pay at or near Medicare rates, not contracted commercial rates)
- “Must have” hospitals with clout have long existed in some markets – Boston, NNJ, Greenville, and Cleveland.
- Market respondents refer to hospital tiers on clout – “must haves,” those with some clout for a particular reason, and those which have little if any leverage. The “Haves and Have Nots” is the phrase commonly heard

“We have clout not because of our size but…who we are. Am I supposed to apologize for that?”

-- executive of an academic health center

Various Forms of Provider Consolidation

- Multi-hospital health care systems
- Larger single specialty physician groups
- Hospitals employing physicians
- Multispecialty group practice and IPAs (but no recent growth pre-ACA)
- Hospital mergers within a service area

Differences Between Mergers and Systems

- In multi-hospital systems, two or more hospitals in same or nearby markets have common ownership, but maintain separate facilities, do business under separate licenses, and keep separate financial records

- With a merger, hospitals have common ownership, a single license, report unified financial records, and may or may not consolidate some physical facilities

- And then there are Alliances, which are currently springing up -- do not involve common ownership

Examples of Terms and Conditions Affected by Leverage

- Rejecting “tiered networks” in benefit design or, placement of all or some systems’ hospitals in a disadvantageous tier.
- Outlier policy such that per diems or case rates revert to % of charges for high cost patients
- Veto P4P or, more recently, gain incentive payments outside of negotiated rates
- “Most favored nations” clauses to charge higher prices if plan contracts with competitors

The Health Plan Market

- Terms like “truce” and “détente” used to describe current plan-provider climate.
- Plans frustrated by lack of support by large employers when contract negotiations have become contentious in the past

Some Markets with Dominant BCBS Plans

- Have >60% of commercially insured lives

  -- Boston, Greenville, Lansing, Little Rock, Syracuse (not-profit BCBS plans) and Indy (Anthem/Wellpoint)

- These plans could “dictate prices” but don’t. Prices have increased far more than medical inflation in recent years

“Blue Cross has this deep and abiding truce with hospitals – ‘you take what we give you and we won’t make your life difficult’”

-- Lansing respondent

Why a Monopsony Purchaser Doesn't Use Its Market Power?

- Dominant insurers do obtain modestly lower prices than other insurers.
- However, study respondents point to holding back on potential – it only needs to have an advantage over its smaller competitors, which it can achieve either by formal (Lansing) or informal "most favored nations" approach
- Consensus is that powerful payers and providers need each other
- "[Blue Cross] has the leverage, but we get double digit price increases..." – Little Rock provider

Will ACOs Help the Situation or Make it Worse?

- “Unchecked Provider Clout In California Foreshadows Challenges To Health Reform” -- *Health Affairs*, 2010, by Berenson, Ginsburg, and Kemper
- California has long featured ACO-like organizations, suggesting that greater efficiency and pricing power can co-exist
- Risk-taking, although an antitrust safe harbor, does not assure entities will not exercise market power
- Mass. BCBS’s Alternative Quality Contract findings confirm that risk-bearing provider groups shop on price, perhaps changing the locus of market power from hospitals to medical groups?

Economists Differ On Whether Vertical Integration is Pro-competitive

- FTC/DOJ guidelines promote the concept of clinical integration, with hospitals and physicians
- Some envision competing ACOs (“integration and rivalry”), whereas others see larger ACOs that somehow become the core of accountability for community’s health
- The reality is that prototypically excellent ACOs get high prices as “must haves”

Concerns Raised by Exercise of Market Power in Plan-Provider Negotiations

- Inflated and rising prices increase spending
- Exacerbation of provider haves and have nots
- Leads to distorted/defensive behavior – e.g., hospital mergers for leverage not efficiency or quality, hospitals employing physicians for the wrong reasons

  -- no evidence for net economies of scale in hospital services, access to capital based on financial performance not size, early evidence does not show improved quality

An Initial Listing of Approaches to Address Provider Market Power

On a continuum from market-oriented to regulatory approaches –

- More ambitious antitrust theory and more active enforcement
- Price transparency with consumer education
- Reference pricing
- Benefit design renewal of narrow/tiered networks
- Spotlighting/jawboning/self-regulation/cost targets

Moving Toward Regulation

- Rely more on competing, risk-bearing physician groups to discipline hospital prices

- "Pro-competition" state-based regulation of plan-provider contract provisions that:
  - -- prohibit gag clauses (that prohibit disclosure of pricing information)
  - -- prohibit "most favored nations" clauses
  - -- prohibit "anti-tiering" clauses
  - -- prohibit "all or none" contracting

More Traditional Regulatory Approaches

- Limit health plan premium increases, indirectly pressuring provider prices
- Place upper limits (e.g., % above Medicare) on permitted negotiated rates
- State regulation of hospital rates for commercial insurance products – W.V.
- State-based all payer hospital rate setting - Maryland

Rarely Discussed Approaches – But Worth Putting Into the Mix?

- State action immunity (certificate of public advantage) requiring state to have an articulated policy and "active supervision" to displace competition and the application of antitrust enforcement

- Voluntary or mandatory dispute resolution, such as baseball-style arbitration (can't split the difference) -- John Bertko at MedPAC