HEALTH CARE INDUSTRY CONSOLIDATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE

COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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HEALTH CARE INDUSTRY CONSOLIDATION

FRIDAY, SEPTEMBER 9, 2011

U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health Washington, DC.

The subcommittee met, pursuant to call, at 9:34 a.m., in Room 1100, Longworth House Office Building, Honorable Wally Herger [chairman of the Subcommittee] presiding.
[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Herger Announces Hearing on Health Care Industry Consolidation

September 09, 2011

House Ways and Means Health Subcommittee Chairman Wally Herger (R-CA) today announced that the Subcommittee on Health will hold a hearing to examine how private health insurance costs, Medicare spending, and beneficiary costs are impacted by mergers and acquisitions in the health care sector. The hearing will take place on Friday, September 9, 2011, in 1100 Longworth House Office Building, beginning at 9:30 A.M.

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Recent years have seen a large number of acquisitions and mergers in the health care industry. Among typical transactions, hospitals are buying or merging with other hospitals, hospitals are purchasing physician practices, physician practices are merging with physician groups, and large insurance companies are purchasing smaller plans. Industry experts expect regulations and policies contained in the new health care overhaul to exacerbate this trend.

While such consolidation may facilitate greater efficiencies and deliver higher quality services by eliminating duplication and excess capacity, many experts are concerned that some consolidations are being driven primarily by a desire to increase reimbursements. Richard Feinstein, director of the Bureau of Competition at the Federal Trade Commission, warned that provider consolidation "can create highly concentrated markets that may harm consumers through higher prices or lower quality care."

In announcing the hearing, Chairman Herger stated, "While consolidation within the health care industry is not new a phenomenon, all signs point to it accelerating in the coming years. In some circumstances, consolidation produces desirable results like improved efficiency and quality. However, we must ensure that consolidation is not simply used as a tool to increase revenues by driving up Medicare spending and the cost of private health insurance. This hearing will provide members with a better understanding of what is currently taking place, what is expected to occur, and how we can protect America's seniors and those with private health insurance and the employers who offer it."

FOCUS OF THE HEARING:

The hearing will focus on the impact health care consolidation is having on the cost of private health insurance, Medicare spending, and beneficiary costs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you

would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, by the close of business on Friday, September 23, 2011. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

- 1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
- 2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
- 3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at http://www.waysandmeans.house.gov/.

Chairman HERGER. The subcommittee will come to order.

Today we are going to hear from a panel of witnesses regarding consolidation in the health care industry.

Consolidation among hospitals, doctors, and insurance plans has occurred for some time. I recognize that, at least in theory, consolidation can lead to greater efficiencies and improved outcomes. Unfortunately, research has shown that higher prices are more often the result.

Consolidation allows providers to command higher insurance payment rates. As one official at an Ohio hospital that is seeking to merge with another hospital stated in an internal document obtained by the Federal Trade Commission, such a partnership would allow them to "stick it to employers, that is, to continue forcing high rates on employers and insurance companies." Research has repeatedly shown that after hospitals merge the prices they charge to those with private health insurance increase significantly. Unfortunately, research has not shown that such consolidation leads to greater efficiencies or improved quality.

In my own State, a 2010 report conducted by the Sacramento Bee concluded that one California hospital system's large market share has allowed them to obtain "reimbursement rates with 'markups' more than double what it costs them to provide services."

Consolidation also enables providers to receive higher Medicare reimbursements by simply changing their designation on paper. While this increases provider revenue, it results in higher costs for beneficiaries and an increased burden on taxpayers with no discernible community benefit.

When hospitals purchase physician groups, hospitals are able to further increase revenue by controlling referral patterns and creating a situation in which they could pressure their physicians to perform more procedures. Similarly, insurance plan consolidation leaves consumers with fewer coverage options and providers with fewer carriers paying claims.

In many ways, the Democrats' health care law has made a challenging situation worse as all signs point to the law leading to even greater consolidation as providers try to blunt the impact of the law's one-half trillion dollars in Medicare cuts and massive new regulations.

Providers unable to absorb the cuts are prime candidates to be acquired by larger providers who can. Large insurance plans that are able to comply with the new regulations are likely to buy smaller plans that cannot. Providers teaming up in preparation for the ACO program are likely to be able to command higher private insurance rates whether or not their ACO is successful.

Who ultimately pays higher prices associated with consolidation? It is not the insurance companies. They pass it along to employers by way of higher premiums and employers pass it on to their workers by way of reduced wages, higher costs, and benefit cuts. At a time of elevated unemployment, Congress must ensure that it is doing all it can to foster a more competitive environment that promotes growth, not one that adds additional cost burdens and 'sticks it to employers" and, by extension, to their employees.

This hearing will shed light on the important and under-examined issue of consolidation and its implications for health care consumers.

Before I recognize Ranking Member Stark for the purposes of an opening statement, I ask unanimous consent that all members' written statements be included in the record.

Without objection, so ordered.

I now recognize Ranking Member Stark for 5 minutes for the

purpose of his opening statement. Mr. STARK. Thank you, Chairman Herger, for calling this hearing. It is difficult to take on a topic of this breadth with a single panel on a Friday morning, but we can work together, I am sure, to fashion more targeted hearings in the future.

The questions of whether provider consolidation helps to improve the clinical integration of care, how it is balanced against the desire not to create provider giants that can become virtual price setters, the issue of pharmaceutical benefit manager consolidation is also timely, and there is growing examples of new mergers that warrant review.

I think we will hear from our witnesses today a mixed story. Consolidation may indeed be a core strategy in achieving our shared goal of increased integration, but the health care delivery systems that are lauded by Members on both sides of the aisle for their efficiency are ones that are integrated and consolidated.

So we recognize that consolidation could lead to market imbalances and have got to be balanced by a regulatory role that ensures

that consumers are protected.

We know that common perceptions about each of our parties—you Republicans are seen as the party that defends the market-place and the power of competition and we Democrats are perceived as the party that puts regulation ahead of competition. Perhaps what we see today is that these perceptions can be wrong, and the majority raises concerns about competition and how it may result in outcomes that are bad for consumers.

So I look forward to seeing what we can develop today and whether this will lead to future hearings on this topic.

Thank you very much.

Chairman HERGER. Thank you.

Today, we are joined by five witnesses who will discuss the effects of consolidation in the health care industry from overall

health care spending to the impacts at the local level.

Our witnesses in the order they will testify are Martin Gaynor, E.J. Barone Professor of Economics and Public Policy, Carnegie Mellon University; Paul Ginsburg, President, Center for Studying Health System Change; Diane Kiehl, Executive Director, Business Health Care Group; Michael Guarino, Board Member, Ambulatory Surgery Center Association; and David Balto, Senior Fellow, Center for American Progress.

You will each be recognized for 5 minutes. Mr. Gaynor, if you would kick things off.

STATEMENT OF MARTIN GAYNOR, PH.D., PROFESSOR, H. JOHN HEINZ III SCHOOL OF PUBLIC POLICY AND MANAGEMENT, CARNEGIE MELLON UNIVERSITY, PITTSBURGH, PENNSYL-VANIA

Mr. GAYNOR. Thank you very much, chairman and committee members, for giving me the opportunity to address you on this very important topic.

Health care, as we all know, is a very large and very important industry. There has been a tremendous amount of consolidation in

this industry, and this represents a serious problem.

Let me talk about consolidation. I will start with hospitals. We know a great deal about consolidation among hospitals. Most hospital markets in the U.S. are now highly concentrated markets, meaning that market shares are concentrated in the hands of a very small number of hospital firms.

With regard to physician services markets, we don't have nearly as much information. There is some information to indicate that some practices have been growing in size and some information from California that shows very highly concentrated physician

practice markets.

For health insurance markets, we do have more information than we have for physician markets, although not as much and not as good information as for hospital markets. Some recent data show that the large employer health insurance market has grown concentrated over time and became highly concentrated about 2004. The report of a couple of years by the General Accounting Office for the small group market also showed some evidence from recent years that that market is highly concentrated.

With regard to integration between different kinds of providers, what I am calling here vertical consolidation, for example, physicians and hospitals, the evidence is that those forms of integration between doctors and hospitals peaked in the mid-1990s and fall steadily thereafter, with the exception of employment of physicians

by hospitals which has increased steadily over time.

Now, what are the effects of all of this consolidation? Because

this is what we care about after all.

For hospitals, the evidence on prices is very clear. Prices are higher in more concentrated markets. Consolidation leads to price increases, in some cases price increases that are well over 50 percent.

The evidence on quality is as follows. The markets with regulated prices, Medicare, for example, the evidence is that competition enhances quality and vice versa. Consolidation harms quality. For markets where the prices determine the market for the privately insured, the evidence is all over the map. I don't think there is any firm conclusion that can be drawn from those markets.

Cost savings are possible from hospital mergers if the two hospitals really truly do become fully integrated, although the evidence I just cited with regard to prices being passed on to consumers doesn't support the fact that any cost savings actually end

up in the hands of consumers.

Now, who pays for this? Well, as health care prices go up, insurers don't end up paying for it. Employers don't end up paying for it. The evidence is that if there are costs in health benefits for employers, those increased costs get passed on to workers in the form of lower total compensation.

For physicians, we don't actually have much evidence on consolidation and competition in the markets. There is some evidence that

the prices do go up in the absence of competition.

For insurance markets there is more evidence, evidence that premiums are higher in more concentrated markets for large employers specifically. There is some recent work that shows substantial market power in the Medigap, the supplemental insurance market for Medicare beneficiaries, and there is some older research that shows evidence that competition has a large effect on premiums in the Medicare+Choice market, the predecessor of Medicare Advantage.

For integration between physicians and hospitals, there is not much evidence. There are two studies I know of, and they have exactly opposite results. So I don't think we can draw a firm conclu-

sion about impacts on price.

There has been much more work about the impacts of integration, particularly physician hospital organizations, on costs and quality, access, et cetera, and that work turns up little evidence that integration has an impact, that integration at that point in time. Let me now briefly talk about policy options in this industry. The first and most obvious is vigorous antitrust enforcement that can occur over a number of domains. Now, many of these markets are already highly concentrated, so there does have to be some concern about exactly how effective antitrust enforcement can be, although it is important to realize that strong and vigorous enforcement can have effects far beyond the actual cases that are prosecuted because they can have a chilling factor on possible anti-competitive conduct by other kinds of firms.

One thing that is very important is considering safe harbors. The Federal Trade Commission and the Department of Justice have gone to great lengths to establish safe harbors for kinds of integration they think could be efficiency enhancing that extends to the accountable care organizations. That is important, but it is also important not to allow integrations that are sham or integrations that

foreclose the possibility of competition in the future.

In support of that, policies that facilitate the entry of firms in innovation in organizations technology are very important, making sure that it is possible to do that, set policies on the demand side, such as facilitating selective contracting. Making sure that consumers have information that is not only good but they can actually understand and use is very important.

And, last, rate regulation is certainly a policy option as well. As the market becomes too concentrated for other policies to be effective, then rate regulation is a policy option that can be considered.

Thank you.

[The prepared statement of Mr. Gaynor follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:30 AM FRIDAY, SEPTEMBER 9 2011

Health Care Industry Consolidation

Statement before the Committee on Ways and Means Health Subcommittee U.S. House of Representatives

by

Martin Gaynor
E.J. Barone Professor of Economics and Health Policy
Heinz College
Carnegie Mellon University

Washington, D.C. September 9, 2011

1 Introduction

Health care is a very large and important industry. Hospital and physician services are a large part of the U.S. economy. In 2009, hospital care alone accounted for 5.4% of GDP – roughly twice the size of automobile manufacturing, agriculture, or mining, and larger than all manufacturing sectors except food and beverage and tobacco products, which is approximately the same size. Physician services comprise 3.6% of GDP (Martin et al., 2011). The net cost of health insurance – current year premiums minus current year medical benefits paid – was 1% of GDP in 2009. The share of the economy accounted for by these sectors has risen dramatically over the last 30 years. In 1980, hospitals and physicians accounted for 3.6% and 1.7% of U.S. GDP, respectively. while the net cost of health insurance in 1980 was 0.34% (Martin et al., 2011).

Of course, health care is important not only because of its size. Health care services can save lives or dramatically affect the quality of life, thereby substantially improving wellbeing and productivity.

As a consequence, the functioning of the health care sector is vitally important. A well functioning health care sector is an asset to the economy and improves quality of life for the citizenry. By the same token, problems in the health care sector act as a drag on the economy and impose a burden on individuals.

As documented below, there has been a tremendous amount of consolidation among health care providers. Consolidation has also been occuring among health insurers. Consolidation can bring efficiencies – it can reduce inefficient duplication of services, allow firms to combine to achieve efficient size, or facilitate investment in quality or efficiency improvements. On the other hand, consolidation can enhance the market power and lead to increased prices or reduced quality.

The research evidence shows that providers in more concentrated markets charge

higher prices to private payers, without accompanying gains in efficiency or quality. Further, the burden of higher provider prices falls on individuals, not insurers or employers. Even though individuals with private, employer provided health insurance pay a small portion of provider fees directly out of their own pockets, then end up paying for increased prices in the end. Insurers facing higher provider prices increase their premiums to employers. Employers then pass those increased premiums on to their workers, either in the form of lower wages (or smaller wage increases) or reduced benefits (greater premium sharing or less extensive coverage, including the loss of coverage). There is less research evidence on the impacts of consolidation in health insurance markets, but that evidence shows insurers in more concentrated markets charge higher premiums to large employers, and pay lower prices to providers.

This represents a real, and serious problem. The U.S. health care system depends on private markets to deliver health care and for a large part of the financing of care. If these markets are not functioning well due to the exercise of market power this creates problems for the entire system.

2 Consolidation

While not a new phenomenon, there has been substantial consolidation in the health care industry in recent years. There was a large amount of consolidation in hospital markets in the 1990s. Consolidation activity slowed down starting around 2002, but has turned up in the past couple of years.

Figure 1 presents information on hospital merger and acquisition activity from 1998 through the first two quarters of 2011. As can be seen, there were a large number of mergers and acquisitions in the 1990s, with the pace slowing down in the early 2000s, and some pick up in activity in the past couple of years.

Some additional information is contained in Figure 2, which charts the number of hospitals that are members of systems from 2000 to 2009. Members of hospital systems are often jointly owned and operated, so can be considered to be one firm. As can be seen, membership has been increasing substantially over time, thereby diminishing the number of independent hospitals.

The Herfindahl-Hirschmann Index (HHI) is a measure of how concentrated shares are within a market, and is widely employed as a measure of market structure. The HHI is the sum of squared market shares in the market. It increases as market shares are more concentrated among a small number of firms. It reaches its maximum value of 10,000 for a monopoly (the square of the monopolist's market share of 100 percent), and reaches a minimum value when the market is equally divided.

Table 1 presents numbers for the population-weighted, Herfindahl-Hirschmann Index

for hospitals for selected years from 1987 to 2006.\(^1\) Two things are clear from this table. U.S. hospital markets are highly concentrated and have become even more concentrated over time. From the table it is easily seen that hospital markets have become significantly more concentrated. In 1987, the mean HHI was 2,340 and by 2006 the HHI is was 3,161 – an increase of over 900 points. In 1992, the mean hospital concentration levels (2,440) were (barely) below the recently updated Federal merger guidelines' (Federal Trade Commission and Department of Justice, 1992) cut-off point for classifying a market as "Highly Concentrated" (HHI \geq 2,500), but by 2006 the mean concentration level (3,261) rose to well above this threshold. Town et al. (2006) note that mergers and acquisitions are the primary reason for the increase in hospital concentration over this period.

To provide some context for these numbers, a market with 5 equally sized firms would have a HHI of 2,000, 4 equally sized firms would have an HHI of 2,500 and a market with 3 equally sized firms would have an HHI of 3,333. That is, the increase in the HHI over the last 20 years is the equivalent of moving from approximately 5 equally sized firms to a market with between 3 equally sized firms.

While hospital markets are highly concentrated on average, there is also wide variation in concentration. Figure 3 shows a scatterplot of the MSA level market concentration in 1990 and in 2006. This figure displays two phenomena. First, it shows the distribution of HHIs across MSAs. Most MSAs are "Highly Concentrated." In 2006, of the 332 MSAs in the U.S., 250 had HHIs greater than 2,500. Second, it is clear from Figure 3 that the increase in hospital concentration was a broad phenomenon – the vast majority of MSAs became more concentrated over this period. Particularly striking is the number of moderately concentrated MSAs in 1990 that by 2006 had become highly concentrated.

An obvious question is why this wave of hospital consolidation occurred. Fuchs (2007) and others point to the rise of managed care as the principal factor driving this massive consolidation. A cursory glance at Figure 4 suggests this causal explanation. The idea is that the rise of HMOs introduced aggressive price negotiations between hospitals and health plans, thereby giving hospitals a strong incentive to acquire bargaining power through consolidation. The rise of HMOs during the 1990s is widely credited with significantly reducing health care cost growth, primarily through tough price negotiations (see, e.g., Cutler et al., 2000).

Early suggestive evidence is provided by Chernew (1995), who finds that in the 1980s there is a relationship between HMO penetration and the number of hospitals operating in the market. Dranove et al. (2002) examine data from the 1981 to 1994 and find a correlation between metropolitan area HMO penetration in 1994 and the change in

 $^{^1{\}rm The}$ table contains population weighted, averages for all but the largest Metropolitan Statistical Areas (MSA)(based on admissions). The sample is limited to those MSAs with a population less than 3 million in 1990 because it is likely there are multiple hospital markets in MSAs larger than 3 million population .

market structure. However, Town et al. (2007) examine the change in hospital market structure and the change in HMO penetration and find little correlation. Some have suggested that it wasn't the realization of the rise of managed care, but the anticipation (which in some cases may have been in error) that led hospitals to consolidate. Work in progress by Town and Park (2011) provides support for this hypothesis. They find that HMO exit, a measure of the exuberance of expectations regarding the demand for managed care in a location, is correlated with hospital consolidation.

There have also been substantial changes in market structure in U.S. physician markets. Liebhaber and Grossman (2007) report that the percent of physicians in solo or 2 person practices declined from 40.7 percent in 1996-97 to 32.5 percent in 2004-05. Further, the proportion in practices of 3-5 physicians fell over the same period. The proportion of physicians practicing in groups of 6 or more grew from 15.9 percent to 21.8 percent. The number of physicians in other practice settings (primarily employed by others) grew from 31.2 to 36.0 percent over this period. Since the number of physicians per 1,000 persons has not really changed (\sim 2.5) since 1997 (National Center for Health Statistics, 2011), this represents an increase in concentration.

There is no good systematic information on the structure of local physician markets. Those markets, especially for specialized services, may be very concentrated, but there is no information generally available at the national level. Schneider et al. (2008) constructed HHIs for physician organizations in California at the county level for 2001. They find the average county HHI for physician organizations was 4,430, implying a high degree of concentration on average. They found that 17 percent of California counties had a physician organization HHI below 1,800, 33 percent had an HHI between 1,800 and 3,600, and 50 percent had an HHI above 3,600.

Tables 2, 3, and 4 provide information about health insurance market structures for the U.S. This information shows consistently high levels of concentration in health insurance markets.

Table 2 contains measures of HHI for HMO plus PPO markets in the U.S. from reports from the American Medical Association (AMA). They show high levels of concentration (although lower than for hospitals). The numbers show insurance market concentration declining somewhat over time (although not consistently). However, there are some concerns about the accuracy of these numbers (see Capps, 2009; Dafny et al., 2011a).

Dafny (2010) and Dafny et al. (2011b), using data on the large employer segment of the insurance market, also show increasing concentration in health insurance markets. Dafny (2010, Figure 5) documents an increase in the percentage of markets with 1-4, 5-6, or 7-9 insurance carriers in the U.S. from 1998-2005, and a decrease in the percentage of markets with 9-10 or more than 10 carriers. Dafny et al. (2011b) state that the mean HHI in their sample increased from 2,286 to 2,984 from 1998-2006, the median four firm concentration ratio increased from 79 to 90 percent, and the mean number of carriers per market fell from 18.9 to 9.6. They show (Figure 1 in their paper) that 78 percent

of the markets they study had increases in the HHI of 100 points or more from 2002 to 2006, and 53 percent experienced increases of 500 points or more. Table 3 has mean HHIs by year from the data used in those papers. These numbers indicate that the large employer segment of the health insurance market is concentrated and has grown more so over time. These numbers are roughly similar in magnitude to those calculated by the AMA. However they show concentration increasing over time (by about 400 points from 2004-2008), while the AMA numbers exhibit a slight decrease over time.

A recent report by the U.S. Government Accountability Office (Government Accountability Office, 2009) compiled information on the market structure of the small group health insurance market in the U.S. Table 4 reproduces numbers from that report. As can be seen, those markets appear to be fairly heavily concentrated, and increasing in concentration. A recent paper by Schneider et al. (2008) utilizes a unique data source for California to construct HHIs for insurance plans at the county level for 2001. They find an average insurance HHI for California counties of 2,592. They report that 21 percent of counties have HHIs below 1,800², 55 percent had HHIs between 1,800 and 3,600 and 24 percent had HHIs above 3,600. The information from these various data sources seem broadly consistent.

It is worth noting that, based on the data in Table 3 the increase in concentration in health insurance markets appears to occur much later than the increase in concentration in hospital markets. The major increase in hospital market concentration occurred in the mid to late 1990s. Insurance market concentration, at least for large employers, starts increasing in 2002.

In addition to "horizontal" consolidation between firms in the same industry (hospitals and hospitals, physician practices and physician practices), there has been some "vertical" consolidation between hospitals and physician practices. 5 shows the trends in the proportions of hospitals with various kinds of integration with physicians. As can be seen, various forms of integration between physicians and hospitals grew and peaked during the 1990s, and have declined since then, with the exception of physician employment by hospitals, which has increased substantially over this time period.

In addition to information on market structure, there is some information on trends in prices and the contribution of health care prices to overall health care cost growth. Akosa Antwi et al. (2009) document a 100% increase in hospital prices in California from 1999-2006, although they do not find market concentration to be a contributor to the increase. Martin et al. (2011) decompose U.S. health spending growth into growth due to prices versus growth due to nonprice factors (e.g., population, intensity of care). They find that prices account for 60% of the increase in overall spending from 2008 to 2009. The proportion of health spending growth due to prices varies over time (see Exhibit 6 in Martin et al., 2011), but has been growing steadily since 2001.

²The old Federal merger guidelines cutoff for considering a market highly concentrated (Federal Trade Commission and Department of Justice, 1992).

Some recent reports from state governments document growth or variation in health care prices. A report from the Massachusetts Attorney General's office (Massachusetts Attorney General, 2010) finds that price increases caused most of the increases in health care spending in the state in recent years. The report also finds significant variation in prices and that the variation is uncorrelated with quality of care, but is correlated with market leverage. A report on Pennsylvania hospitals found substantial variation in prices for heart surgery, but no correlation of prices with quality (Pennsylvania Health Care Cost Containment Council, 2007).

Overall, the statistics presented here paint a picture of health care markets that are concentrated and becoming more so over time. There is also some evidence that prices are rising faster than quantities, and that price variation isn't related to quality but may be due to market power.

3 Evidence on the Impacts of Consolidation

Most of the evidence on the impacts of consolidation come from hospital markets. Unfortunately there are very few studies of competition in physician markets, mainly due to lack of data.

3.1 Hospitals

3.1.1 Price

There has been a lot of research on the impact of hospital market consolidation on prices paid by private payers. The overwhelming finding in the literature is that consolidation leads to higher prices (see Dranove and Satterthwaite, 2000; Gaynor and Vogt, 2000; Vogt and Town, 2006; Gaynor and Town, 2012, for reviews of the evidence).

Examining the distribution of realized hospital prices (for the privately insured) alone is informative about the functioning of hospital markets. Ginsburg (2010) uses administrative claims data for 8 geographic areas from four large private insurers to construct inpatient hospital prices. He finds that there is significant variation both within and across regions in hospital prices. For example, San Francisco has the highest average hospital prices in 2008, with prices equal to 210% of the Medicare reimbursement rate. The lowest rate is Miami-South Florida with mean prices that are 147% of Medicare rates – the mean price in San Francisco is 43% higher than Miami. Within San Francisco, the interquartile range is 116 percent of the Medicare price. Of course, there are a number of possible reasons for this variation. Cost, quality and demand differences will generally imply price differences. However, it seems unlikely that there is enough variation across those factors to generate such wide variation in price.

There are a number of different methods that have been used to estimate the impact of hospital consolidation on prices. The most direct approach compares price increases at merging hospitals with those at similar hospitals which did not merge (see Capps and Dranove, 2004; Dafny, 2009; Haas-Wilson and Garmon, 2011; Krishnan, 2001; Spang et al., 2001; Sacher and Vita, 2001; Tenn, 2011; Thompson, 2011). The vast majority of these studies find price increases of at least 10 percent due to merger, with some estimates of price increases due to merger of 40 percent or greater.

For example, Haas-Wilson and Garmon (2011) evaluate the Evanston Northwestern and Highland Park hospitals in the northern suburbs of Chicago. They find a price increase of 20 percent due to that merger. Tenn (2011) examines the merger of two hospitals in California: Summit and Alta Bates. He finds that prices at Summit hospital increased between 28 and 44 percent after the merger.

Another source of information on the impacts of hospital consolidation comes from studies which examine the impact of hospital market concentration (measured as the HHI) on price. These studies don't examine the effects of mergers directly, but allow one to calculate the expected impact of a merger based on its impact on market concentration. Vogt and Town (2006) calculate the average estimated impact of a merger of two equal sized hospitals in a five hospital market (a "5 to 4" merger).³ They find that such a merger is estimated to increase prices by 5 percent.

Last, a few research papers have estimated the impacts of hospital mergers using simulation. These papers estimate models of hospital competition, then use the estimated parameters of those models to simulate the impacts of mergers (Town and Vistnes, 2001; Capps et al., 2003; Gaynor and Vogt, 2003; Brand et al., 2011). These papers find estimated impacts of mergers ranging from 5 to 53 percent increases in price. Town and Vistnes (2001) examine mergers among hospitals in Los Angeles and Orange Counties, California, where there are more than 120 hospitals between the two counties. They find that many of the mergers they examine would result in price increases of 5 percent or greater, in spite of the large number of hospitals in these counties. Capps et al. (2003) examine a 3 hospital merger in the southern suburbs of San Diego County, California, and find a price increase due to the merger of over 10 percent. Gaynor and Vogt (2003) find that a three-to-two hospital merger in San Luis Obispo, California (which was attempted, but blocked by the FTC) would have raised prices by over 50 percent. Brand et al. (2011) consider the recent proposed acquisition of Prince William hospital in Manassas, Virginia by Inova health system in Northern Virginia. They estimate that the acquisition would have led to price increases at Prince William hospital of anywhere from 19 to 33 percent.

Overall, these studies consistently show that hospital consolidation raises prices, and by nontrivial amounts. Consolidated hospitals that are able to charge higher prices due to enhanced market power are able to do so on an ongoing basis, making this a permanent

³This results in an 800 point increase in the HHI, from 2000 to 2,800. As reported in 1, the average HHI rose by about this amount from 1997 to 2002, albeit from a higher base.

rather than a transitory problem.

3.1.2 Not-for-Profit Firm Behavior

The hospital sector is characterized by the fact that there is a mixture of firms with different ownership types. Not-for-profits are the most common, but there are substantial numbers of for-profit hospitals and public hospitals. One question that is relevant in this setting is whether not-for-profit hospitals behave any differently with regard to their pricing behavior.

A number of studies (e.g., Keeler et al., 1999; Simpson and Shin, 1997; Dranove and Ludwick, 1999; Capps et al., 2003; Gaynor and Vogt, 2003) have addressed the issue of not-for-profit/for-profit differences in competitive conduct. Those studies do not find any significant differences in pricing behavior. In particular, the effects of consolidation on pricing do not appear to differ depending on whether a hospital is not-for-profit.

A recent study by Capps et al. (2010) examines whether not-for-profit hospitals are more likely than for-profit hospitals to offer more charity care or unprofitable services in response to an increase in market power. The implication is, that if there were such a difference, not-for-profits would be spending their profits from market power on socially beneficial activities. Capps et al. examine 7 years of data on California hospitals and find no evidence of any such differences – not-for-profits do not engage in any more socially beneficial activities than do for-profits when they possess market power.

3.1.3 Costs

It is clear that mergers can result in efficiencies because of economies of scale, increased purchasing power, the ability to consolidate services, or the the transfer of managerial techniques and skill to the acquired hospital. However, mergers also have the potential to increase costs. Larger systems imply larger bureaucracies. In addition, hospital costs are not necessarily exogenous to market structure. Hospitals that are able to bargain for higher prices may have the incentive to use the resulting profits for the benefit of physicians and hospital executives (e.g., through capital expenditures that benefit physicians or increases in executive compensation or perks). This is particularly likely if there is no residual claimant (as is the case for not-for-profit organizations) or monitoring by the residual claimant is costly. Thus, the analysis of cost impacts is central to understanding the impact of hospital mergers. The evidence presented above suggests that, on average, hospital mergers result in increases in price. Consequently if there are significant cost reductions associated with mergers they are not passed onto the purchasers of hospital services in the form of lower prices.

A few studies do directly examine the impact of hospital mergers on costs. Dranove and Lindrooth (2003) examine mergers of previously independent hospitals that consoli-

date financial reporting and operate under a single license post-merger. They find that, on average, these hospitals experience post-merger cost decreases of 14 percent. System mergers in which the hospitals were not as fully integrated (as measured by the use of multiple licenses) did not realize cost savings. These findings suggest that integration of merging hospitals is necessary to achieve meaningful efficiencies. A recent study by Harrison (2010) finds that immediately following a merger costs declined, but eventually rose to pre-merger levels. This finding that is difficult to reconcile with the view that mergers require significant upfront costs but have benefits accrue in later years. The circumstances in which mergers are most likely to result in meaningful cost decreases are those in which the merging facilities operate as a more fully integrated entity. To be clear, however, the presence of any cost savings does not mean that they are necessarily passed on to consumers.

3.1.4 Quality

A number of research studies have examined the impacts of hospital consolidation on various measures of quality, although the most commonly used measure of quality is mortality (adjusted for patient severity of illness). The results in this literature are mixed, although the results are strongest for markets with regulated prices (see Gaynor, 2006; Vogt and Town, 2006; Gaynor and Town, 2012, for surveys).

A number of studies have examined the impact of market concentration on patient mortality for Medicare patients. There are a variety of findings, but the strongest studies find that market concentration significantly increases mortality (Kessler and McClellan, 2000; Kessler and Geppert, 2005).

Kessler and McClellan find that risk-adjusted one year mortality for Medicare heart attack (acute myocardial infarction, or AMI) patients is significantly higher in more concentrated markets. In particular, patients in the most concentrated markets had mortality probabilities 1.46 points higher than those in the least concentrated markets (this constitutes a 4.4 percent difference) as of 1991. This is an extremely large difference – it amounts to over 2,000 fewer (statistical) deaths in the least concentrated vs. most concentrated markets.

The English National Health Service (NHS) adopted a set of reforms in 2006 that were intended to increase patient choice and hospital competition, and introduced regulated prices for hospitals based on patient diagnoses (analogous to the Medicare Prospective Payment System). Two recent studies examine the impacts of this reform (Cooper et al., 2010; Gaynor et al., 2010) and find that, following the reform, risk-adjusted mortality from heart attacks fell more at hospitals in less concentrated markets than at hospitals in more concentrated markets. Gaynor et al. (2010) also look at mortality from all causes and find that patients fared worse at hospitals in more consolidated markets.

The results of studies which examine impacts of competition for privately insured

patients are more mixed. A number of studies find that quality is positively affected by competition, a number find that it is negatively affected by competition, and some find no effect. As a consequence, there is no clear impact of the impact of hospital consolidation on quality for privately insured patients that can be ascertained from the current research literature.

A recent study by Cutler et al. (2010) examines not only the impacts of competition on quality, but also impacts on costs. Cutler et al. use the repeal of entry restricting regulation (hospital certificate of need regulation; CON) in Pennsylvania to examine the effect of entry of hospitals into the CABG surgery market. They find that entry led to increased quality, but that the gains from reduced mortality due to entry are approximately offset by the additional costs incurred by entering firms.

A recent paper by Romano and Balan (2011) attempts to directly assess the impacts of hospital mergers on quality. Romano and Balan study the impact on quality of care of a consummated merger between two hospitals in the Chicago suburbs (Evanston Northwestern Hospital and Highland Park Hospital). This merger was the subject of an antitrust suit by the Federal Trade Commission, and the authors provided evidence on the case. They find no significant impact of the merger on many quality measures, but there is a significant negative impact on some and a few with positive impacts. They estimate that the merger led to heart attack, pneumonia, and stroke mortality going up at Evanston Northwestern Hospital, although not at Highland Park. There was some improvement in quality for some nursing-sensitive quality measures: the incidence of decubitis ulcers (bedsores) fell at both merged entities, as did infections at Evanston Northwestern. Conversely, the incidence of hip fractures rose at Evanston Northwestern. Last, they found increases in some measures of obstetric outcomes (birth trauma to the newborn, obstetric trauma to the mother), and decreases in some other measures. They conclude that overall there is no reason to infer that the merger had salutary effects on quality.

Overall, the research evidence suggests that hospital consolidation can have a negative impact on quality in markets with regulated prices, like Medicare. However, the current research evidence where prices are market determined (the privately insured) does not indicate a clear impact of consolidation on quality in those markets in general.

3.2 Physicians

As stated previously, there is relatively little research on competition in physician services markets, mainly due to lack of available data. There are some studies, however, which shed some light on this topic.

Economics suggests that there is a minimum population necessary for a given area to support a physician of a particular specialty. Further, the smaller the total number of physicians in a given specialty, the larger the population necessary to support a physician.

If the total number of physicians expands, then competition will lead to lower incomes for physicians in larger communities, and physicians will diffuse out to smaller areas, so the minimum population necessary to support a physician will fall. Rosenthal et al. (2005) test this hypothesis by examining communities in states in which the total number of physicians doubled from 1970 to 1999. They find that communities of all sizes gained physicians over this period, but that the impact was larger for smaller communities, implying that competition among physicians did increase due to the increased number of doctors.

Some recent work by Schneider et al. (2008) examines the impact of physician and insurer market concentration on physician prices. They find that physician market concentration is associated with significantly higher prices. A 1 percent increase in the physician HHI leads to 1-4 percent higher physician prices. Conversely, they find that the health insurer HHI has no statistically significant impact on physician prices.

3.3 Insurers

Until recently there has been very little research on competition by health insurance firms. Part of the reason for this has been the paucity of sufficient data for given markets to construct measures of prices or market shares in the U.S. and internationally. For the U.S., there are detailed household level data (the Medical Expenditure Panel Survey, http://www.meps.ahrq.gov/mepsweb/) on health insurance decisions and prices, but these data are from surveys of approximately 4,000 households selected to be nationally representative. As a consequence, they don't fully describe the choices in a given market, or catalog the prices of alternatives, let alone the market shares of sellers. Other data (National Association of Insurance Commissioners, http://www.naic.org) do capture market shares, but at the level of a state. Since the vast majority of health insurance restricts enrollees' choices to a network of providers, most of whom are local, the geographic market for health insurance is often local, and smaller than a state. In addition, there are no comprehensive data on health plans' networks of providers. The most comprehensive data on health insurance markets has been for private insurance associated with the Medicare program (Medigap coverage, Medicare+Choice/Medicare Advantage).

Dafny (2010) is one of the first of some new studies on insurance market competition. Dafny uses data from a benefits consulting firm on the plans purchased and premiums paid by a large number (776) of large employers over the period 1998-2005. While these data are not necessarily complete by market or nationally representative, they do represent the most extensive and comprehensive data set with prices and quantities for the insurance market.

She examines the effect of shocks to employer profitability on the changes in the insurance premiums they pay. The idea is that if insurers possess no market power then the premiums they charge will not vary with employer profitability. Only if insurers

have market power will they be able to price discriminate based on employer profitability. Dafny finds evidence that premiums increase with the buyer's profitability. She also finds that the effect of employer profitability on insurance premiums falls with the number of firms in the market. More precisely, what Dafny finds is that the effect of increased profitability for an employer is to increase premiums in markets with few insurers by more than in markets with a large number of insurers, for the <u>same</u> employer.

It is notable that there are significant effects of employer profitability in insurance premiums even for markets with 9-10 insurers (the effect is insignificant for markets with 10 or more insurers). It seems surprising that insurers would possess market power in markets with 8-9 rivals (9-10 firms total). This empirical result does raise some doubts, but research by Dranove et al. (2003) found patterns in 1997 suggesting there may be market power in HMO markets with up to 6 firms. In any event, Dafny is a contribution that opens a line of empirical research on competition in health insurance markets.

Dafny et al. (2011b) employ the same dataset as in Dafny (2010), but examine how the growth rate of an employer's health insurance premiums is affected by health insurance market concentration (HHI). Initial estimates reveal no significant effect of insurer market concentration on premium growth. Of course, market concentration may be codetermined with premium growth, making it difficult to tease out a clear effect. In order to deal with that problem Dafny et al. examine changes in local market concentration due to a large merger in 1999 between two national health insurers: Aetna and Prudential Healthcare. Using this, they find a significant impact of the predicted change in HHI due to the merger on the change in premiums. They find that the cumulative effect of insurer market consolidation on premiums is approximately 7 percent.

Dafny et al. also recognize that insurers may have bargaining power (market power in a posted price world) with regard to providers. They therefore examine the effect of insurer concentration on changes in earnings and employment for physicians and for nurses as a way of testing for the presence of insurer monopsony power. They find that the merger reduced physician earnings growth on average by 3 percent, while nurses' earnings rose by approximately 6-10ths of one percent. There is no significant effect on physician employment, while nurse employment grows as a result of the merger induced increase in concentration. This doesn't seem to be evidence of monopsony power, but it is consistent with plan concentration leading to downward pressure on physician earnings and ultimately to substitution of nurses for physicians.⁴ Overall, while the estimation results depend crucially on the use of the Aetna-Prudential merger as a driver of changes in local insurance market concentration, they show evidence of a significant relationship between changes in insurer market concentration and changes in premiums, implying a link between market structure and the exercise of market power.

⁴Sorensen (2003) and Wu (2009) find that health plans who are better able to channel patients can extract greater discounts from hospitals. Shen et al. (2010) and Moriya et al. (2010) find health insurer concentration reduces hospital prices, while Schneider et al. (2008) find no effect of insurer concentration on physician prices.

Maestas et al. (2009) document substantial price variation in Medigap insurance markets, even though plans are standardized. They find that insurers have substantial differences in costs, and hence loading fees, which contribute to the observed variation in prices. This conclude that price dispersion is caused by substantial search costs – Maestas et al. estimate an average search cost for consumers in the market of \$72 and a maximum of \$144.

Starc (2010) also examines the Medigap market for insurance, using a model that allows for both adverse selection and market power. She documents that the market is highly concentrated – the national 4 firm concentration ratio is 83 percent (compared to 44 percent for private passenger automobile insurance or 34 percent for life insurance), and two firms (UnitedHealth, 46 percent and Mutual of Omaha, 24 percent) account for almost all of that. Starc documents substantial price dispersion for Medigap policies, confirming Maestas et al., and documents a positive relationship between premiums and market concentration, the same qualitative result as in Dafny et al. (2011b), albeit for a very different market. A one percent increase in the two-firm concentration ratio is associated with a 0.26 percent increase in premiums.

Starc then uses the estimates from her model to find the impacts of adverse selection and market power in the Medigap market. She finds that adverse selection increases premiums by 9 percent and reduces the size of the market (lowers insurance coverage) by 18 percent. Starc goes on to calculate the impact of market power by calculating what premiums would be if they were set equal to costs. This is estimated to lead to large reductions in prices – 44 and 45 percent, respectively. These results emphasize the substantial market power exercised in this market.

Lustig (2010) examines the market for Medicare+Choice plans in 2000-2003. Medicare+Choice are private managed care plans that Medicare beneficiaries may choose as an alternative to traditional Medicare (the current version of this program is called Medicare Advantage). Lustig allows for both adverse selection and market power in his model. He finds that consumers' health risk has no significant impact on insurers' costs. Lustig then goes on to use the model estimates to simulate the gains to consumers and producers when adverse selection is eliminated and compare that to what he actually observes. The gain from eliminating adverse selection is simulated for markets with increasing numbers of insurers to generate effects of competition. Lustig finds that the gains to eliminating adverse selection increase steadily in the number of insurance firms. For example, in one of his simulations Lustig finds that removing adverse selection eliminates 17 percent of the difference in consumer and producer benefits between the observed and socially optimal outcomes where there's a monopoly, while it eliminates 35 percent of the difference in a duopoly, and 50 percent where there are 6 or more firms. This implies that when there is market power most of the welfare loss is due to the exercise of market power as opposed to adverse selection.

A paper by Town and Liu (2003) estimates a model of the Medicare+Choice market,

the predecessor of Medicare Advantage, i.e., the market for private Medicare plans. They use their estimates to calculate the impacts of the program and of competition. They find that the creation of the M+C program resulted in approximately \$15.6 billion in consumer surplus and \$52 billion in profits from 1993 to 2000 (in 2000 dollars), i.e., \$67.6 billion in value to consumers and producers. They also find evidence of competitive effects. Consumer benefit increases with the number of plans in a county, and most of the increase is due to increased premium competition. Comparing monopoly markets versus markets with four firms, they find that 81 percent of the difference in consumer benefit (higher in quadropoly markets) is due to increased premium competition. Of the remainder, 3 percent is from increased product variety and 8 percent from prescription drug coverage.

3.4 Vertical Integration

Vertical integration between hospitals and physicians or insurers and providers can in principle provide efficiencies by aligning incentives, allowing for better coordination of care and joint investments which enhance efficiency or the quality of care. At the same time, integration can potentially harm competition by foreclosing rivals from access to key inputs. An integrated system which has locked up all the orthopedists in town, for example, may make it difficult to impossible for another hospital to offer orthopedic services or for a freestanding ambulatory surgery center to enter the market and compete on orthopedic services. Separately, integration may eliminate competition among previously independent providers. For example, physicians who had previously been in competition all become members of the same firm once they integrate with a hospital system (or an insurer).

There is very little evidence at present on the impact of vertical integration on market power. In part, that is because vertical integration has not been that common in health care. It was quite rare until the mid-1990s, and then declined rapidly thereafter. Integration between hospitals and physician practices peaked in 1996 at approximately 40 percent of all hospitals, and declined thereafter (Burns and Pauly, 2002; Ciliberto, 2005). This pattern was repeated with vertical integration of hospitals into the insurance market, although the extent of vertical integration was never as great as between hospitals and physicians (Burns and Pauly, 2002). This growth coincided with the growth of managed care, and in particular with the perceived growth in managed care organizations' negotiating power with hospitals. Burns et al. (2000) find that hospital-physician alliances increase with the number of HMOs in the market. They infer that providers may be integrating in order to achieve or enhance market power. More recently, Berenson et al. (2010) conducted 300 interviews with health care market participants, and report that increased bargaining power through joint negotiations listed as one of several reasons for hospital-physician alliances.

Certain types of vertical relations in health care have been the subject of significant

antitrust scrutiny — exclusive dealing between physician practices and hospitals (usually for a specialized service, e.g., radiology, anesthesiology, or pathology), and most-favored-nations clauses between insurers and providers, which require the provider to give the insurer a rate as low as it gives to any buyer (see Gaynor and Haas-Wilson, 1998; Haas-Wilson, 2003, for reviews of vertical issues in health care).⁵

In spite of the interest in this topic, there is relatively little evidence on the effects of vertical restraints in health care. Ciliberto and Dranove (2005) and Cuellar and Gertler (2005) are the only two papers (of which I am aware) which examine the competitive impacts of vertical integration in health care. Both papers look at the effects of hospital-physician practice integration on hospital prices. The two studies find opposite results – Cuellar and Gertler find evidence consistent with anticompetitive effects of physician-hospital integration, while Ciliberto and Dranove find no such evidence.

Research on efficiencies from integration does not find much evidence of positive gains from integration. Burns and Muller (2008) review the empirical evidence on hospital-physician relationships. They find little evidence of an impact of integration on costs, quality, access or clinical integration. Madison (2004) investigates the relationship between hospital-physician affiliations and patient treatments, expenditures, and outcomes using data on Medicare heart attack patients. She finds little evidence of any impacts of hospital-physician relationships.

4 Who Pays for Higher Provider Prices?

As mentioned previously, when consolidation leads to providers obtaining higher prices from providers the impact ultimately falls on consumers, not insurers or employers. Research evidence consistently shows that higher health insurance costs for employers are passed on to employees in the form of lower wages (or lower wage increases) (see Gruber, 1994; Jensen and Morrisey, 2001; Bhattacharya and Bundorf, 2005; Baicker and Chandra, 2006; Adams, 2007; Emanuel and Fuchs, 2008). In addition, there is recent evidence that hospital mergers have increased the number of the uninsured. Town et al. (2006) find that private insurance rolls declined by approximately .3 percentage points or approximately 695,000 lives in 2003 due to the effects of hospital mergers, with the vast majority of those who lost private insurance joining the ranks of the uninsured.

As a consequence, even though privately insured consumers typically pay a very

⁵Complaints about exclusive contracts between hospitals and physician practices are the most numerous type of antitrust case brought in health care. One of these cases was decided by the Supreme Court (Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2(1984)), and represents an important legal precedent on exclusive dealing and tying. There have also been a number of cases on most-favored-nations clauses, e.g., Ocean State Physicians Health Plan v. Blue Cross & Blue Shield, 883 F.2d 1101 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990) and Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996).

small share of provider fees directly, they bear the brunt of the impact of higher fees by ultimately receiving reduced total compensation from their employers.

5 Policy

There are a number of policy levers that can be considered to deal with consolidation in the health care industry. They include antitrust enforcement, enhancing supply by facilitating the entry of new providers (including new forms of providers), policies designed to enhance the responsiveness of demand, and rate regulation. These policies need not be pursued in isolation. For example, vigorous antitrust enforcement is likely to be most effective paired with policies that facilitate entry. Even under rate regulation providers compete for patients via quality or other means. Taking steps to maintain or enhance that competitive environment can substantially improve performance even if prices are regulated. Policies that enhance the entry of new providers can ultimately reduce the need for intensive antitrust enforcement or rate regulation.

5.1 Antitrust

The standard approach to the injurious effects of market consolidation is vigorous antitrust enforcement. Antitrust enforcement must be applied judiciously. Consolidation or integration can be efficiency enhancing, and those cases should be allowed and encouraged. However, the evidence does not support efficiency enhancing consolidation in general, at least in hospital markets. While there is some evidence that prices are higher in more concentrated physician and insurance markets, we do not have direct research evidence on the impacts of consolidation on efficiencies or quality in those markets.

Antitrust enforcers should carefully examine proposed mergers and block those they find anticompetitive. This policy can be successfully pursued, but it should be recognized that many markets (especially for hospitals) are already highly concentrated. Another policy is to prosecute cases against consummated mergers, where the merged entities have exercised market power and not realized any substantial efficiencies. In addition, enforcers can pursue anticompetitive behavior intended to harm competition (for example, attempting to prevent entry or force exit of competitors). The enforcement agencies' resources are limited, so there are only so many cases of this sort they can pursue. It is possible, however, that vigorous enforcement against egregious offenders may have a chilling effect on the exercise of market power by others, who fear the possibility of detection and prosecution.

Another aspect of antitrust enforcement is providing safe harbors for integration that

⁶Nonetheless, if prices are higher in more concentrated markets, that is evidence that any efficiencies that consolidated firms may realize are not being passed on to consumers in the form of lower prices.

is considered to be efficiency enhancing. While efficient forms of organization should be allowed to emerge and flourish, care must also be taken to avoid allowing integration that is only a sham with regard to efficiency and is truly for the purpose of enhancing market power. This is true in general, but is currently salient with regard to the Accountable Care Organizations (ACOs) which are part of the health reform law. As indicated previously, integration among hospitals and doctors has the potential to be efficiency enhancing, but can also cause harm to competition, and can potentially make it more difficult for innovative organizations to enter markets. This is a factor which must be given serious consideration.

Last, it is sometimes proposed that allowing firms on one side of a market to acquire market power is an appropriate response if firms on the other side of the market already possess it (e.g., allowing providers to acquire market power if insurers have substantial market power). This is sometimes called countervailing power. The notion is that having a sort of balance of market power on both sides of the market is better than only having market power on one side. This is not necessarily the case. First, it must be true that one side of the market does indeed have market power and it is causing harm. Hard bargaining over price (or other matters) is not in and of itself of harmful market power. Second, the best response is to deal directly with the problem, and try to eliminate or reduce the extant market power. Antitrust enforcement is the most likely tool for this. This is certainly better than creating a situation with more market power. Third, if it is not possible for some reason to deal directly with the extant market power on one side of the market, having market power on both sides does not necessarily improve matters. It can do so, but it can also make things worse. If the only way firms have to increase their bargaining power is by restricting the quantity they sell, then countervailing power will make things worse than market power on only one side of the market.

5.2 Supply Side Policies

Another policy lever are policies that facilitate the entry of new providers, and in particular allow for innovation. It may be that markets (again, hospital markets in particular) have become so concentrated that the effectiveness of antitrust enforcement is limited. That may leave inefficiencies in place in the short run. However, in the long run, as the technology of medicine changes, new types of providers will likely emerge and compete with current organizational forms. We have already seen some of this via the entry of free standing ambulatory surgery centers, retail clinics, and specialty hospitals. In the case of insurance, a key factor governing entry is the ability to field an attractive network of providers. Making sure that providers, particularly those that are perceived as "must-have" providers, are available to potential entrants is a critical factor. Regulation can play a role as well. Relatively few states have retained certificate of need regulation for health care facilities, but such regulation can raise the costs of entry. Insurers have to deal with differing sets of regulations in every state, and are not allowed to pool risk

across states. Such factors may also raise the costs of entry.

Facilitating the entry of new firms, and in particular innovative new forms, can ameliorate or eliminate the effects of current consolidation in the long run. As stated previously, however, care still must be taken to ensure that such entry is possible, and not foreclosed by integration, so antitrust enforcement also plays a key role here. Obviously, such a process will take time, although change can sometimes occur very rapidly.

5.3 Demand Side Policies

Competition can only occur if demand by payers or consumers is sufficiently responsive to price or quality differences across providers, and if there's sufficient choice of providers. Selective contracting by private payers is a mechanism which helps to create an environment where competition among providers is possible. If payers contract with every provider in a market, then they have very little bargaining power. Policies that enhance the ability of payers to selectively contract with providers are important, but they will only be effective if there is sufficient choice among providers.

Transparency, providing information about prices or quality to the public, is a policy that has received substantial attention, and has been implemented by some states. In principle, it seems as more information should be better. However, this is not necessarily the case. Making pricing information public can make it easier for firms to collude. In addition, it's not clear that heavily insured consumers have sufficient incentive to pay attention to price differences. Even consumers who have policies with a lot of cost sharing will not face much of the impacts of price differences if they obtain an expensive treatment. Expensive treatments put most consumers well beyond their deductibles and copays so that they bear little to none of any price differences across providers. Of course, expensive treatments account for the majority of medical spending.

Providing clear and understandable information about products (providers' and insurers') so consumers can understand what they are obtaining can facilitate competition (again, conditional on sufficient alternatives). If consumers have little information or don't understand the information they have, they tend to rely on reputations, brand names, etc. This tends to decrease the responsiveness of demand to prices or other factors and enhances firms' market power.

5.4 Rate Regulation

A possible response to highly concentrated markets is rate regulation. If markets are highly concentrated and there appears little hope of competition, then price regulation

⁷This doesn't mean that being insured against large losses is bad – it isn't. Consumers should be insured against large risks. It just means that it's not realistic to expect them to pay attention to prices in such a situation.

is an economic policy that can be employed. However, moving to a regulated price environment for the privately insured would be a nontrivial undertaking, with all of the issues associated with regulation and bureaucracy. Evidence from state hospital rate regulation programs in the 1970s and 1980s indicates a mixed pattern of success. The setup and administration of the program played a large role in whether they were effective. Nonetheless, there is evidence that finds that mandatory rate regulation program in a number of states did reduce the rate of growth of hospital expenses (by a little more than 1 percent) (Dranove and Cone, 1985; Sloan, 1983).

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Table 1: Hospital Market Concentration, U.S., $1987-2006^{a}$

Year	Mean HHI ^b	Change ^c	
1987	2,340	_	
1992	2,440	100	
1997	2,983	543	
2002	3,236	253	
2006	3,261	25	

^a Source: American Hospital Association. Data are for U.S. Metropolitan Statistical Areas with population < 3 million.</p>

^b Herfindahl-Hirschmann Index. Means weighted by MSA population.

^c Total change from the previous year in the table.

Figure 1: Hospital Mergers and Acquisitions, 1998-2010. Source: Irving Levin Associates, Inc., The Health Care Acquisition Report, Sixteenth Edition, 2010.

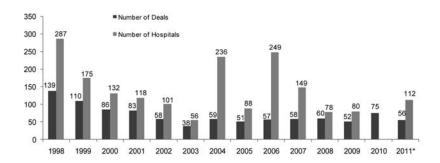


Figure 2: Number of Hospitals in Health Systems, 2000-2009. Source: American Hospital Association.

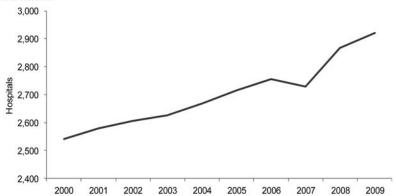


Figure 3: Scatterplot of MSA HHI in 1990 and HHI in 2006

Figure 4: Trends in Hospital Concentration, M&A Activity and HMO Penetration: 1990-2006

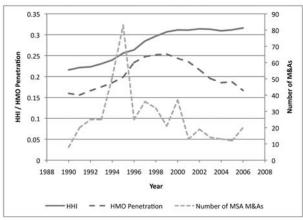


Table 2: Insurance Market Concentration, U.S., 2004-2008 a,b

Year	Median HHI	Change	Mean HHI	Change
2004	3,544	12 23	3,939	
2005	3,748	204	4,077	138
2006	2,986	-762	3,440	-637
2007	3,558	572	3,944	504
2008	3,276	-282	3,727	-217

^a Source: See American Medical Association (2010) for more information on the data and calculations. American Medical Association (AMA) calculations for the combined HMO+PPO markets using January 1st enrollment data from HealthLeaders-InterStudy's (HLIS) Managed Market Surveyors © HealthLeaders-Inter-Study.

^b MSA-level HHIs for HMO+PPO markets.

Table 3: Large Employer Insurance Market Concentration, U.S., 1998-2009^a

Self + Fully Insured Year Mean HHI ^b		Fully Insured C Change Mean HHI			
1000	9.179		2.094		
1998 1999	2,172 1,997	-175	2,984 2,835		
2000	2,175	178	3,092		
2001	2,093	-82	3,006		
2002	2,280	187	3,158		
2003	2,343	63	3,432		
2004	2,519	176	3,706		
2005	2,609	90	3,951		
2006	2,740	131	4,072		
2007	2,873	133	4,056		
2008	2,916	43	4,201		
2009	2,956	40	4,126		

^a Source: These #s were graciously provided by Leemore Dafny. The data are for large multisite employers and do not represent the totality of the insurance market. For more information on the data source, see Dafny (2010).

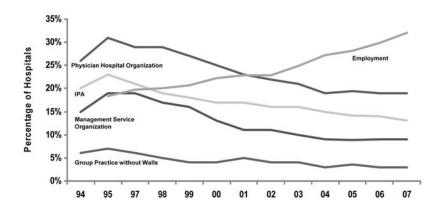
Table 4: Small Group Insurance Market Structure, U.S., $2000\text{-}2003^{\mathrm{a}}$

Year	Median Market Share, Largest Carrier	# of States with 5 firm concentration ratio $\geq 75\%$		
2002	33%	19 (of 34; 56%)		
2005	43%	26 (of 34; 77%)		
2008	47%	34 (of 39; 87%)		

^a Source: Government Accountability Office (2009).

^b Weighted by # of enrollees.

Figure 5: Physician-Hospital Trends, 1994-2007. Source: American Hospital Association.



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Chairman HERGER. Thank you. Mr. Ginsburg is recognized for 5 minutes.

STATEMENT OF PAUL B. GINSBURG, PH.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, D.C.

Mr. GINSBURG. Thank you, Mr. Chairman, Congressman Stark, and Members of the Subcommittee. I am delighted to be able to testify before you today.

I and my colleagues at the Center for Studying Health System Change have been conducting research on leverage between health care providers and private insurers for some time. Much of my testimony is based on the community tracking study site visits which we have conducted in 12 representative metropolitan areas since 1996

There is a striking difference between the period of the early and mid-1990s and the present time. In the 1990s, health plans were able to pressure providers to accept lower payment rates and assume financial risk for patient care. It was a time of rapid growth of managed care enrollment, and employers supported relatively restrictive provider networks. Excess provider capacity existed in

many markets and there was relatively limited provider consolidation, although extensive merger activity was getting under way, prompted partly by plan leverage. Many of these mergers were challenged unsuccessfully by the Federal Trade Commission. Premium increases were very small. In fact, they got close to zero in the mid-1990s.

Contrast with the present time we see substantial provider leverage, and higher prices have been a more important driver of spending trends recently than volume growth. We see a pattern of very extensive variation in prices paid by private insurance as a percentage of Medicare rates both by market and by providers within the market. Some hospital rates are four times Medicare payment rates.

What has changed? Well, part of the story is increased provider consolidation, both through mergers and also by attrition of weaker providers. But the managed care backlash of the mid 1990s led to demands for broad provider networks, and employers have not backed plans in showdowns with providers over payment rates.

Now, we have the notion of must-have providers. Providers who have a reputation for quality, who have a geographic niche or a very large part of the market are able to get much higher rates from insurers because of the inability of insurers to exclude them from networks.

I want to say a few things about this recent development of hos-

pital employment of physicians.

This has developed very rapidly. In some communities, a large majority of physicians are employed by hospitals. Some have perceived this as a step to prepare for delivery reform, accountable care organizations, and bundled payments, but the trend toward hospital employment started before the name "ACO" was even coined.

My perception is that this employment is predominantly to garner more patient referrals, expand hospital specialty service lines, and increase provider market power. This is a highly attractive strategy today under volume-driven, fee-for-service financing. It is also a potential asset for integration, but, to do that, hospitals would need to rework the compensation incentives to focus on volume

Hospital employment of physicians is causing rising prices because hospitals can negotiate higher payment rates for physicians than small physician practices can, and the differences are very large. It may even permit higher prices for hospital services. Also, there is an impact on Medicare and its beneficiaries and the facility charges that begin when physicians become parts of hospital outpatient departments.

Now, there are both markets and regulatory approaches to address provider leverage. The market forces work by engaging enrollees in selecting providers on the basis of price and quality. Some employers have adopted benefit designs to do this, and some evidence is that the poor economy has contributed to this increasing interest. But provider ability to resist the tiered designs by refusing to contract is a serious barrier.

There are things that government can do to support market approaches. One is the development of methods for measuring value

that will be credible to both providers and to consumers. Also, government can limit provider contracting practices that interfere with cost-conscious choices by enrollees. Changing the tax treatment of health employee benefits is another option.

There is a major question about how effective market approaches can be because some markets are already too concentrated, and consumers did not react well to some of these approaches in the mid-1990s, and we need to know how they will react to better-con-

ceived approaches today.

If market forces do not work, regulation should be considered. It could come in the form of rate review or rate setting by a public entity, most likely at the State level, and it could take a loose form like a limits or a review trigger by high rates in relation to Medicare or it can be a much more structured system. The key is to designing such interventions so that they foster or accommodate payment reform for innovations.

Thank you very much.

[The prepared statement of Mr. Ginsburg follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:30 AM, FRIDAY SEPTEMBER 9, 2011

Health Care Provider Market Power

Statement of Paul B. Ginsburg, Ph.D.
President, Center for Studying Health System Change (HSC)
Research Director, National Institute for Health Care Reform (NIHCR)

BEFORE THE U.S. HOUSE OF REPRESENTATIVES Committee on Ways and Means Subcommittee on Health

Hearing on "Health Care Industry Consolidation"

Sept. 9, 2011





Chairman Herger, Congressman Stark and members of the Subcommittee, thank you for the invitation to testify on health care industry consolidation. My name is Paul Ginsburg, president of the Center for Studying Health System Change (HSC) and research director of National Institute for Health Care Reform (NIHCR).

Founded in 1995, HSC is an independent, nonpartisan health policy research organization affiliated with Mathematica Policy Research. HSC also has served since 2008 as the research arm of the nonpartisan, nonprofit National Institute for Health Care Reform, a 501(c) (3) organization established by the International Union, UAW; Chrysler Group LLC; Ford Motor Company; and General Motors to conduct health policy research and analysis to improve the organization, financing and delivery of health care in the United States—www.NIHCR.org.

Our goal at HSC is to inform policy makers with objective and timely research on developments in the health care system and their impact on people. We do not make specific policy recommendations. Our various research and communication activities may be found on our Web site at www.hschange.org.

I and colleagues at HSC have conducted and published research on the issue of leverage between health care providers and private insurers for some time. Much has been based on the Community Tracking Study site visits, a project that has followed 12 nationally representative metropolitan communities since 1996, ¹ and a similar project conducted in six California metropolitan areas in 2008-09.

The Shifting Balance of Negotiating Power

In the early 1990s, health plans pressured hospitals and physicians to cut costs, accept lower payment rates and assume financial risk for patients' care. This phenomenon occurred across the country, albeit to varying degrees in different markets. What prompted health plans to suddenly act so aggressively in their local markets? Ultimately, the broader economic climate emboldened them, as employers got serious about controlling costs during a severe recession, shifting employees into managed care products that had restrictive provider networks and tight utilization management. At the same time, hospitals began a wave of mergers and acquisitions to address excess capacity and to strengthen their clout with insurers.

Just a few years later, perhaps abetted by the economic boom of the late-1990s, a significant backlash against managed care developed, ultimately shifting the balance of power in favor of providers, particularly hospitals. More concerned with recruiting and retaining employees than with controlling health care costs, employers embraced health insurance products with broad provider networks. Without a credible threat of excluding a provider from their networks, health plans lost an important bargaining chip. It's important to note that many physicians, except for

¹ HSC recently completed the seventh round of the Community Tracking Study site visits to 12 nationally representative metropolitan communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. The visits were conducted from March 2010 through October 2010. In each site, researchers interview representatives of major hospital systems and private insurers.

large multispecialty and single-specialty practices, did not experience the same gains in negotiating leverage, but that may be changing as physicians form larger groups or seek employment by hospitals.

When the economy slowed again, employers did not limit provider choice, but instead began to pass responsibility for containing costs to their employees through higher patient cost sharing in the form of larger deductibles, coinsurance and copayments. Provider demands for higher payment rates and other favorable contract terms led to a spate of plan-provider contract showdowns in the early 2000s, when many providers threatened and some actually dropped out of health plan provider networks.²

Higher Prices and Spending Growth

As insurers abandoned tightly managed care practices and moved to create broad provider networks, health care spending for employer-sponsored insurance began accelerating in the late-1990s with increased volume initially playing a larger role in more rapid spending growth than higher prices. In the wake of highly publicized and sometimes disruptive contract disputes in the early 2000s, health plans and providers in many markets reached a "separate peace," with plans—and employers tacitly—agreeing to go along with higher payment rates to get along.

Despite the 2001 recession, employers stayed the course on maintaining broad provider choice, and health care spending continued to escalate. As the adjustment in volume to the looser managed care environment was completed, a larger portion of health care spending growth was attributable to higher prices, particularly for hospitals. At the same time, many hospitals shifted their competitive strategies from a 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. Many hospitals also pursued aggressive specialty-service-line expansion for profitable services, such as cancer, cardiac and orthopedic care.

While health care spending growth has slowed in recent years, it still continues to outpace growth in the economy and wages by 1 to 2 percentage points. Despite the great recession of 2007-09, employers remain reluctant to restrict provider choice and continue to increase patient cost sharing at the point of service and, most recently, by asking workers to pay a larger share of premiums.⁵

Provider Leverage

During HSC's recently completed 2010 site visits, insurers consistently cited higher payment rates to obtain hospital and large physician group participation in health plan networks as a major factor driving higher insurance premiums. Hospitals often acknowledged that private insurance payment rates were rising more rapidly than their costs but attributed the spread to increasingly

² Strunk, Bradley C., Kelly J. Devers and Robert E. Hurley, Health Plan-Provider Showdowns on the Rise, Issue Brief No. 40, Center for Studying Health System Change, Washington, D.C. (June 2001).

³ Kaiser Family Foundation and Health Research and Educational Trust 2010 Annual Survey of Employer Benefits.

constrained Medicare and Medicaid payment rates. However, there is evidence that many hospitals have grown lax about controlling costs and have the market power to demand higher payment rates from private insurers to stay profitable regardless of Medicare rates.⁴ Likewise, previous HSC research examining six California metropolitan areas documented considerable increases in provider leverage over time, resulting in striking differences in payment rates to providers with strong leverage vs. those with little leverage.⁵

Turning to quantitative evidence, American Hospital Association data indicate that the ratio of private payer rates to hospital costs increased from 116 percent in 2000 to 134 percent in 2009. A recent HSC study found wide variation in private insurer payment rates to hospitals and physicians across and within local markets. Looking across eight health care markets— Cleveland, Indianapolis, Los Angeles, Miami, Milwaukee, Richmond, San Francisco and rural Wisconsin—average inpatient hospital payment rates of four large national insurers ranged from 147 percent of Medicare in Miami to 210 percent in San Francisco. In extreme cases, some hospitals commanded almost five times what Medicare paid for inpatient services and more than seven times what Medicare paid for outpatient care.

Variation within markets was just as dramatic. For example, the hospital with prices at the 25th percentile of Los Angeles hospitals received 84 percent of Medicare rates for inpatient care, while the hospital with prices at the 75th percentile received 184 percent of Medicare rates. The highest-priced Los Angeles hospital with substantial inpatient claims volume received 418 percent of Medicare. While not as pronounced, significant variation in physician payment rates also exists across and within markets and by specialty. Those specialties covered in the study received higher rates in relation to Medicare than primary care physicians. Few would characterize the variation in hospital and physician payment rates found in this study to be consistent with a highly competitive market.

Factors Contributing to Provider Leverage

Provider consolidation is clearly a factor behind provider leverage. Consolidation has increased both through mergers and through attrition of weaker providers, especially hospitals. Mergers and acquisitions are subject to antitrust review, while increased consolidation from competitors leaving the market is not. Although recent studies by economists have reported clear results that hospital mergers increase prices, searlier notions that hospital mergers could lower prices through increased efficiency led to many Federal Trade Commission (FTC) setbacks in blocking hospital mergers that might harm the public.

⁴ Ginsburg, Paul B., "Cutting Medicare with a Scalpel, *The New York Times*, (July 11, 2009). Accessed at http://www.nytimes.com/2009/07/12/opinion/12einsburg.html.

http://www.nytimes.com/2009/07/12/opinion/12ginsburg.html.

Berenson, Robert A., Paul B. Ginsburg and Nicole Kemper, "Unchecked Provider Clout In California Foreshadows Challenges To Health Reform," *Health Affairs*, Vol. 29, No. 4 (April 2010).

⁶ American Hospital Association, TrendWatch Chartbook 2011, Trends in Hospital financing, Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1989 – 2009, Chicago (2011).
⁷ Ginsburg, Paul B., Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power, Research Brief No. 16, Center for Studying Health system Change, Washington, D.C. (November 2010).

Nogt, William B., and Robert Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care, The Synthesis Project, Research Synthesis Report No. 9, Robert Wood Johnson Foundation (February 2006).

A recent study by James Robinson provided additional empirical evidence that faced with shortfalls between Medicare payments and projected costs, hospitals in concentrated markets focus on raising prices to private insurers, while hospitals in competitive markets focus on cutting costs.9 This is consistent with earlier Medicare Payment Advisory Commission (MedPAC) findings that hospitals with substantial negotiating leverage do not have to be as efficient and can allow unit costs to increase, which will result in lower or negative Medicare margins, because the hospitals can obtain higher private insurance rates to offset their high costs.

But provider consolidation is not the only factor driving provider leverage. Hospitals can achieve must-have status-meaning health plans must include them in their networks to offer insurance products attractive to employers and consumers-in a variety of ways. Hospital reputation for perceived quality-not to be confused with measured clinical quality-is a particularly powerful factor. Some independent hospitals that do not have large market shares have substantial leverage on the basis of their reputation for quality or their niche within a particular geographic area.

Many respondents in our California study alluded to the high payment rates obtained by Cedars-Sinai Hospital in Los Angeles. Asked why Cedars did not engage in mergers and acquisitions to become a horizontally integrated system, as is common in northern California, a respondent from another area hospital suggested that Cedars can say, "Screw it; we have a strong marketing arm and the [movie] actors, let's grow on campus and they will come to us." As a result, according to another respondent, "Cedars has the highest rates in the world.... The hospitals down the street have no market power. They have to fight for every penny."11

Although Miami-Dade County, Fla., has a relatively unconcentrated hospital market, Baptist Health South Florida reportedly has significant leverage because of its reputation for quality and dominant role in the southern part of the county. Some hospitals have leverage on the basis of highly specialized services, such as transplants and trauma or burn care. Children's hospitals are another example of providers with a particular niche gaining significant market power.

Even in markets with dominant health plans, insurers appear unable or unwilling to constrain payment rate increases, because they can pass along higher provider payment rates to employers.

Hospital Employment of Physicians

While not new, the pace of hospital employment of physicians has quickened in many communities, according to HSC's 2010 site visits. 12 To date, hospitals' primary motivation for employing

⁹ Robinson, James, "Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration," Health Affairs, Vol. 30, No. 7 (July 2011).

Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Washington, D.C. (March 2009).

Berenson, Ginsburg and Kemper (April 2010).

O'Malley, Ann S., Amelia M. Bond and Robert A. Berenson, Rising Hospital Employment of Physicians: Better Quality, Higher Costs? Issue Brief No. 135, Center for Studying Health System Change, Washington, D.C. (August

physicians has been to gain market share, typically through lucrative service-line strategies encouraged by a fee-for-service payment system that rewards volume. At the same time, stagnant reimbursement rates, coupled with the rising costs of private practice, and a desire for a better work-life balance have contributed to physician interest in hospital employment.

While greater physician alignment with hospitals may ultimately improve quality through better clinical integration and care coordination, hospital employment of physicians does not guarantee clinical integration. The trend of hospital-employed physicians also may increase costs through higher hospital and physician commercial payment rates and hospital pressure on employed physicians to order more expensive care.

Also, hospitals routinely charge facility fees for office visits and procedures performed in formerly independent physicians' offices, where the physicians have converted to hospital employment. In short, it is possible for a physician practice to be acquired by a hospital, not change locations or even practice operations, yet the hospital now receives significantly higher Medicare payments. Often, hospitals apply these billing practices to private insurers as well. Hospitals charging facility fees for physician visits not only results in higher costs for payers, but also for patients because facility fees are subject to deductibles and coinsurance.

Options to Address Provider Leverage

Two broad options are available to address rapidly rising provider payment rates to private insurers—market forces and regulation. The market approach involves changes in insurance products to engage enrollees in selecting providers on the basis of price. One recent trend in coverage offered by small employers is insurance products that have a more limited provider network, excluding providers that insurers believe to be most expensive.

A related approach, which may ultimately have more potential, is tiered-provider networks. The essence of the approach is to offer enrollees incentives in terms of lower patient cost sharing at the point of service—lower deductibles and coinsurance, for example, to choose lower-cost providers. This approach may have more potential because consumers appear more willing to accept incentives to choose certain providers over others more readily than absolute restrictions on choice of providers. However, tiered-provider networks have not gained much traction, particularly because dominant hospitals often refuse to contract with health plans unless placed in the most favorable tier with the least patient cost sharing, effectively circumventing any advantage to the approach. Physicians also have opposed these approaches, typically referred to as high-performance networks, because of concerns about the accuracy of methods used to measure their quality and efficiency, which determines whether they are deemed high performing or not.

Government has some opportunities to support these market approaches. Medicare's development of hospital value-based purchasing and value-based modifiers under the physician fee schedule will advance the state of the art in comparing performance among hospitals and physicians. If private insurers follow Medicare's lead and adopt these approaches, it would send consistent payment signals to providers and increase the credibility of these tools. In addition,

regulatory options exist to enhance market forces. For example, Massachusetts has enacted legislation that bans some hospital contracting practices, such as refusal to contract according to placement in tiers. The legislation also bars multihospital systems from requiring that insurers contract with all of their facilities.

Antitrust policy will be an important area where regulation can enhance market forces. In addition to standard reviews of mergers and acquisitions, the Department of Justice and FTC are heavily involved in guiding rules for Medicare accountable care organizations (ACOs) to safeguard against increased provider leverage resulting from greater integration.

Finally, the tax treatment of employer-sponsored health insurance will influence the extent to which market forces can be a countervailing force to provider leverage. Reduced tax subsidies for high-cost health benefits likely will increase the receptivity of employers and employees to insurance products that provide incentives to enrollees to favor lower-cost providers.

The federal and state governments in particular have taken steps to increase the transparency of information on the price and quality of services in hospitals. Much of the available price information is unlikely to have much impact because for insured people, the only prices that matter is what their deductibles, copayments and coinsurance will be if they use different providers.

However, as governments make provider price data available, it is possible that providers with the highest prices will feel public pressure to limit increases. The extensive release of hospital price information by the Massachusetts Attorney General has prompted public scrutiny and perhaps will motivate hospitals, particularly nonprofit hospitals and their trustees, to constrain prices.

The major question with market approaches is how effective they will be. This will depend on the degree to which some markets are already so consolidated that effective competition on the basis of price is not possible. It will also depend on how consumers react to having to focus more on price as they use health care services.

The alternative to market forces is rate review or rate setting by a public entity. This is much more likely to develop at the state rather than the federal level. It could take relatively loose forms, such as a limit based on Medicare payment rates or high rates triggering a review. It could be highly structured, such as the system used in Maryland since the 1970s. A key issue in rate-setting approaches is the extent to which they will foster broader provider payment reforms or accommodate payment innovations.

The topic of increasing consolidation in the health industry is an important one. It certainly has played a role in rising health care spending, especially for services covered by private insurance. But a key role in increasing provider leverage has been broad provider networks and lack of incentives for patients to choose providers that have lower costs. If there is to be a market solution to this problem, it will have to address both the issue of consolidation and engage consumers in ways that they have resisted before.

Chairman HERGER. Thank you. Ms. Dianne Kiehl is now recognized for 5 minutes.

STATEMENT OF DIANNE KIEHL, EXECUTIVE DIRECTOR, BUSINESS HEALTH CARE GROUP, FRANKLIN, WISCONSIN

Ms. KIEHL. Good morning and thank you, Chairman Herger, Ranking Member Stark, and committee members, for the invitation

to speak to you today.

I am here representing the Business Health Care Group of southeastern Wisconsin serving as their executive director since 2004. We are a progressive and very active employer-based health care coalition. We represent over 1,200 employers, including Fortune 500 companies.

I have submitted my full statement to the committee which I ask be made part of the hearing record. I encourage you to review my written testimony for details about my organization's efforts and other health care initiatives in our State, as well as a thorough ex-

planation of provider consolidation in our market.

I have spent 41 years in the health care field both as clinician—I am a registered nurse and clinical lab technologist—and as an executive and business owner assisting employers in managing health care costs. I also serve on numerous health care organizations' boards of directors, as well as various steering committees

dedicated to payment reform and delivery reform.

When I started my health care career many years ago, health care was available based on community need, which minimized costly infrastructure. I am sure many of you remember a time when hospitals specialized in specific high-cost services, and we had a virtual center of excellence care delivery model. As we are all aware, things are very different today. With the current reality of extensive vertical integration of health care providers, most services are duplicated at every system in our region. The emphasis is now on keeping the patient in the system's revenue stream and controlling processes.

In my written testimony, I mention that our remaining 21 full-service hospitals have consolidated into six systems in our six major counties, but I would like to clarify that no county has six.

Two counties have four; the others only have two.

A more serious consequence of consolidation is that doctors report that they are now being expected to meet revenue targets or jeopardize their jobs. Physicians are key to cost control. They need to determine the standards of care and quality metrics regardless

of financial implications to the system that employs them.

First and foremost, I am here to testify our costs is what caused our founding CEOs to form our group, but the continued consolidation is what keeps us going and growing. We believe hospital consolidation will continue and physician consolidation is ongoing. We have seen that consolidation has decreased competition, added excess infrastructure, decreased physician autonomy, contributed to our costs, and decreased consumer choice. Detailed information corroborating our position on the effects of provider consolidation can be found in my written testimony.

The most critical point I would like to make is that provider consolidation has increased provider leverage at the negotiating table, including contractual language that limits what employers can do and still access competitive rates. For instance, we are not able to provide incentives to direct patients based on cost and/or quality.

Additionally, there are significant limits on quality and price transparency, which is a must-have for true health care reform. To allow transparency to work for consumers, providers must be forced to publicly report their contracted rates and all quality measures.

The final point I would like to make is that we do need to provide care efficiently and effectively in a patient-centered model where patients get care according to established appropriateness and by the right provider. Integrated or what once was called coordinated care is the goal, but it does not necessitate consolidation.

We are expecting more consolidation as providers get ready for health care reform and form accountable care organizations. Physicians want to keep their autonomy but feel they have no choice. The fear of the unknown is driving defensive behavior. The race is on to lock up market share.

In summary, as employers, our ability to control our costs is significantly compromised by the provider leverage and control achieved through consolidation. Employers' choices to reduce coverage or workforce are not good choices.

Lastly, we believe in the promise of patient-centered care with full price and quality transparency, physician autonomy and leadership, payment reform, and consumer choice to reform our Nation's ailing health care system.

Chairman Herger, Ranking Member Stark, I would like to thank both of you and the committee for your time and the opportunity to have an employer-based person share their testimony on this very important topic. It is indeed an honor to share my thoughts and experience with all of you. I look forward to your questions and comments.

[The prepared statement of Ms. Kiehl follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:30 AM, FRIDAY SEPTEMBER 9, 2011



Written Testimony

Of

Dianne Kiehl

Executive Director

of

Business Health Care Group of Southeastern Wisconsin

Before the

U.S. House of Representatives

Ways and Means Committee

Health Subcommittee

Hearing on Health Care Industry Consolidation

September 9, 2011

Background

Good morning and thank you, Mr. Chairman and Members of the Committee, for the invitation to speak to you today. My name is Dianne Kiehl and I am appearing here representing the Business Health Care Group of Southeastern Wisconsin, a progressive and actively engaged employer-based health care purchasing coalition operating in Milwaukee, Wisconsin where I have served as the executive director since 2004.

I have spent 41 years in the health care field, with the first 14 spent providing patient care as a registered nurse and clinical lab technologist. For the past 27 years I have worked in a variety of leadership positions assisting the employer community in managing health care costs, including 12 years as a business owner. I also serve on the boards of directors of five organizations, Wisconsin Collaborative for Healthcare Quality, Wisconsin Health Information Organization, Wisconsin Health Information Exchange, Greater Milwaukee Business Foundation on Health and WISHIN, Wisconsin's State-Designated Entity for Health Information Exchange (HIE). WISHIN is responsible for developing HIE capability throughout the state. In addition, I serve on numerous steering committees related to payment reform and other health industry related activities.

I am here today to share with you my own and the organization I represent's experience and perspective on the health care industry's consolidation in our region – specifically, southeast Wisconsin which includes the greater Milwaukee metropolitan area.

When I started my career in health care; and for a good many years after that, health care was available based on community need. For example, this meant, if you had a serious neurological need you went to one facility, cardiac surgery, you went to one of three facilities, and neonatal care was only provided at one of two facilities. This kept costly infrastructure to a minimum. In essence, we had a virtual "center of excellence" model of care delivery for high cost ticket items

Today, with the vertical integration of health care providers, most systems provide virtually every service regardless of actual community need. The emphasis is now on keeping the patient in its integrated delivery system which is intended to protect revenue stream and support the quality of care. This has resulted in an incredible expansion of cardiac, neonatal, orthopedic and cancer units/facilities in our market, including three specialty hospitals; one dedicated to cardiac and two to orthopedic care, and all partially owned by hospital systems.

With the exception of a very few, services are duplicated at every health care system in our region, resulting in increased and unnecessary infrastructure. As health care purchasers, when we question the duplication of services within a system, frequently the answer is that the community wanted it, but does the community know the price tag?

At a time of rampant provider consolidation in our region, consider the following facts:

 In a study by the Greater Milwaukee Business Foundation on Health – using the most recent data available – average southeastern Wisconsin hospital commercial payments have increased approximately 24 percent from 2003 through 2007. Total Medical CPI

- during this same time period for our market was 12.8 percent, so hospital costs escalated at a faster rate.
- Wisconsin's health insurance rates have increased faster than the national average.
 According to Citizen Action of Wisconsin's 2010 Wisconsin Health Insurance Cost
 Rankings, national employer-based single health insurance premiums have increased
 120 percent this decade in Wisconsin, they have increased 179 percent. These
 rankings show that all Wisconsin regions and metro areas have suffered health
 insurance cost inflation above the national average.
- According to a 2004 Government Accountability Office report, health care spending in Milwaukee was about 27 percent higher than the average across all of the Metropolitan Statistical Areas studied in the analysis. A quote from the same report suggests provider consolidation may be a possible reason for higher costs, "We have found some evidence to support the stakeholders' assertion that hospitals and physicians had more leverage than insurers in negotiating prices."

When faced with escalating health care costs, employers have several choices, none of them appealing. They can choose to pass the costs on to their employees in the form of higher premium contributions or higher deductibles. They can limit wage increases. They can try to get by with fewer employees. They can make the decision to no longer offer health insurance benefits. Or they can choose to relocate their operations to a location with more reasonable health care costs.

Business Health Care Group Background

I will provide you with more detail on our experience with provider consolidation in our region later in my testimony. However, I would like to take a few moments to give you some information on the group I represent as well as some important health care cost and quality initiatives that have been organized in our state and have played an integral role in our efforts. The Business Health Care Group of Southeastern Wisconsin or as we refer to it, the BHCG, grew out of the frustration felt by several CEOs of large Milwaukee-based employers concerning health care costs in southeast Wisconsin as compared to their other locations, particularly other areas in the Midwest.

A study commissioned by the Greater Milwaukee Business Foundation on Health found that in 2003, health care costs in southeast Wisconsin were 39 percent above the Midwest average. In 2003 the cost of health benefits for employees in the state rose 14.8 percent to \$6,940 per employee which was 20 percent higher than the national average for workers in businesses with 500 or more employees. The CEOs realized that something needed to be done if our area was going to maintain jobs in our market.

The CEOs also understood that no one employer was large enough to influence the health care market. It would take a number of large employers, speaking with one voice, walking in unison with a common strategy, to impact the costs of health care in southeast Wisconsin and actually move the market. Ultimately, 11 corporations with headquarters in southeast Wisconsin and two other existing coalitions founded the BHCG as a member owned Limited Liability Corporation in 2003 to explore alternatives to contain health care costs in the region. They soon established a goal to get costs at or below the Midwest average within five years.

Our current goal is to enable southeast Wisconsin to become a premier community for health care, recognized for its ability to provide low cost, high quality health care services and promote employee well-being. BHCG member companies are committed, in collaboration with employees and health care providers, to maintain our cost status of being at or below the Midwest average and to achieve ongoing medical cost trend rate at or below the rate of general inflation.

Several tenets were established early on that, to this day, serve us well in advancing our mission. We push for accountability from all stakeholders – this includes health care providers, employers, employees/consumers and our sole health plan administrator. Consumers need to be held accountable for becoming more engaged in their own health and to use information to make more informed decisions. Health care providers need to be held accountable for outcomes, efficiency and to reduce variation in care thereby mitigating cost trend. Employers need to be engaged in coalitions, provide a healthy environment and their total health benefit offerings need to be based on best practices. The administrator needs to meet the needs of the local markets, have the ability to support engaged employers, assist in removing barriers to reforming the market and perform their core activities efficiently and effectively.

One key component to our success is our network strategy which promotes competition through re-contracting with all significant providers at the same time every three years. We also strive to enter into provider contracts with fixed prices as opposed to arrangements with a percentage off charges. Since we have excess infrastructure in our market, our member companies support a narrow network approach which further provides the impetus for the providers to compete in order to be included in the network. Only members of the BHCG can use the exclusive network offered by our sole administrator.

The BHCG is committed to the education of both employers and their employees as a basic principle of our strategy. We believe employees must be motivated through plan design and educated to become better consumers of health care. We develop tools for our employer

members to help make their employees better purchasers of the health care they consume. Our health plan administrator provides online pricing (to the extent allowed under their contracts) and quality information to allow them to make better decisions. The BHCG developed consumer videos focused on key consumer accountabilities that are available to our members. We provide educational forums and support projects that promote best practices for employers to utilize in managing their health care dollars and benefit programs effectively.

We continue to have the active engagement of the CEOs of some of our largest members, providing guidance and direction for our organization. This is a key to keeping the provider community engaged with our group. We meet with the provider community on a regular basis through a provider action plan process established by our group to promote provider accountability and to support increased communication between the provider and business communities.

Our success would have not been possible without a committed employer community who partnered with an administrator that was willing to allow the employer community to drive marketplace change.

Business Health Care Group Successes

Presently, the Business Health Care Group service area includes 11 counties in southeast Wisconsin. Our membership includes over 1,200 employers of all sizes, with over 110,000 employees and their dependents using the network offered by our administrator. In 2006 when we first launched our health plan option, it included 14 employers and 67,000 employees and dependents enrolled in the health plan. Our group includes both fully insured, through our sole administrator, and self-funded member companies.

I am pleased to be able to report that for 2009 – the most recent year that data is available – Business Health Care Group member health care costs were 6 percent below the Midwest average and 13 percent below the average for southeast Wisconsin. Measured another way, we have been able to limit the average annual increase in health care costs for our self-funded employers to 1.4 percent for the past five years.

This is some remarkable success, but it would not have been possible without an enormous amount of hard work from our employer members. To sustain a coalition of diverse employers requires countless hours from membership in the form of serving on numerous committees and work groups. This work on the part of member representatives is in addition to their jobs they perform for their employer. Our employer members have also provided financial support in the form of both start up money and ongoing membership fees.

Strategic Partners

The Business Health Care Group is a formidable force in the community, but other organizations have contributed to the results in our market. In Wisconsin we are privileged to have a number of organizations that work in collaboration to tackle the challenges of improving health care quality and reducing costs. Three organizations deserve special mention. The first is the Wisconsin Collaborative for Healthcare Quality, or WCHQ, a voluntary consortium of provider organizations committed to improving health care quality in the state of Wisconsin.

WCHQ is active in developing and guiding the collection and analysis of health care performance measures. They publicly report performance data and identify and share best practices among their provider members. A recent research project funded by The Commonwealth on WCHQ data showed the following: transparency drives improvement, what gets measured and reported publicly improves faster and provider groups that belong to WCHQ perform at a higher rate than those that do not participate. Better quality removes unnecessary costs. For example, if diabetics are managed according to best practices standards, the potential for complications decrease and dollars are saved.

The second organization is the Wisconsin Health Information Organization (WHIO). WHIO is a voluntary, not for profit public-private partnership with a multi-stakeholder board which includes payers, providers, business and the state government. WHIO has developed a statewide data mart of health care information which can be used to produce comparative analytics on provider performance and evaluate population health. Providers and others use this information to improve value in health care by focusing on quality and resource utilization. All the major payers and the Medicaid data are included in the data mart. However, at this time, the Medicare data set – which is critical to complete the data mart – is missing.

The third organization is the Wisconsin Health Information Exchange (WHIE). In its fourth year of operation, WHIE is a nonprofit organization whose mission is to improve the quality, safety, efficiency and accessibility of health care through the secure delivery of timely, accurate electronic health information to authorized users across institutional boundaries. WHIE's initial initiative involved linking emergency departments to a database that allowed emergency department personnel access to a patient's emergency department visit and treatment history. When medical information is shared in this way, substantial money can be saved by reducing duplicate tests, procedures and unnecessary inpatient admissions. In addition, the patient experience and quality of care is improved. WHIE is one of the nation's leading efforts to improve health care through regional electronic information exchange. The BHCG provides reimbursement to WHIE for paid emergency room visits for which the linked data was used.

A recently released study shows this saves money.

As a result of the efforts of our provider community, these organizations and many others, Wisconsin consistently ranks in the top ten states in terms of health care quality according to the Agency for Healthcare Research and Quality.

Provider Consolidation in Southeast Wisconsin

Southeast Wisconsin has seen extensive provider consolidation in the past twenty years, starting with hospitals merging and acquiring one another. At one time we had 26 independent general hospitals in the metropolitan Milwaukee area in six counties. The bulk of the hospital consolidation took place in the early to mid 1990s. Presently all the hospitals remaining in the area have been consolidated into six health care systems which include 21 hospitals. Nine new hospitals have been built, four of them in just the past two years.

In roughly the past five years, hospital health care systems have begun buying up independent primary care physician practices. In the past three years there has been an uptick in health care systems buying multi-specialty clinics and specialty groups. This is due to the systems currently having a significant number of primary care physicians employed through practices they purchased. They can now control where the primary care physician refers which puts undue pressure on specialists to sell their practices in order to maintain their referral stream.

These consolidations have occurred for a number of reasons. Providers realize that increased market share, especially in specific geographic markets, improves their access to commercial insured versus government funded programs and offers them greater contractual leverage. When health systems purchase independent practices, they can automatically move reimbursement levels to those of the acquiring larger group or system. Based on a third party analysis of physician fees in our market, doctors employed in consolidated systems have fees that are on average 56 percent higher than those of independent doctors. In addition, the more consolidated a community becomes, the less chance of any one provider group or system being excluded from any one network or plan.

The increasing complexity of health care administration and regulations placed upon independent physicians makes overtures on the part of health care systems to purchase them sound appealing. Physicians can sell their practices for lucrative sums and avoid the day-to-day administrative headaches of running a practice.

Providers are also preparing for all the expectations that are included in health care reform. Health care systems believe consolidation is the simplest way to provide coordinated or

integrated care. Integrated care should be the goal, but consolidation is technically not necessary to achieve this goal. It is possible to integrate care through technology, operational processes and collaboration.

A Purchaser Perspective on the Effects of Consolidation

Decreased competition, increased cost

The obvious concerns surrounding consolidation are decreased consumer choice and competition, greater leverage and a physician community that is now locked into a specific system. Not so long ago, doctors had admitting privileges at multiple hospitals. Now those same doctors are employed in practices owned by health care systems and those physicians can only admit to their employers' facilities. This fact is in direct opposition to the contention that consumer directed choice is a key component of the solution to our health care crisis. Since our member companies do business in a heavily consolidated market, we must now hold the provider community accountable to deliver the results promised through integrated care. In addition, we need to escalate the efforts to engage consumers to be a force in the health care market.

In our market, consolidation caused two systems to build three hospitals that opened in the last two years to capture new geographic market share. This was primarily based not on lack of access to services, but to keep patients within their care systems to support their idea of integrated care. This has resulted in four hospitals sharing the market that two used to share, resulting in excess capacity. There was considerable cost incurred that will need to be covered by the promise of integrated care.

We do have examples in our market where costly services are being consolidated within a system and not replicated at each of their facilities. We also have an example where a system is trying to work with their community independent physicians to function as an ACO. I never thought I would see the day where physicians are participating in work groups with employers to come up with solutions but we believe our provider community understands that the "gravy days" for health care are over and they are prepared to work with us to deliver the results we need. But all of this will not end the arms race for market share.

The quality question

Health care systems also maintain that consolidation gives them more control over quality. However, even though we are glad we live in a state that consistently ranks in the top ten states for health care quality, one has to look at what that really means.

For example, chances are good that some of you or your loved ones are diabetics. If you are, you most likely know that good glycemic control is critical to successfully managing your condition. According to the Wisconsin Collaborative for Healthcare Quality's 2009 to 2010 data, southeastern Wisconsin health care systems ranged from a low of 59 percent to a high of 76 percent compliance with the standard of providing diabetic patients with two A1c tests per year which is best practice. Good glycemic control for people with diabetes is cost-effective and improves the quality of life, yet good A1c control for the patients in this same group ranged from a low of 55.7 percent to a high of 65.3 percent. Clearly there is much more work to be done to improve these statistics in our area despite the hoped for effects of integrated care as a result of provider consolidation.

The negotiating table

Health care is a local issue, yet many of our employers are multi-region, multi-state employers who find it tough, if not impossible to equitably offer uniform health plans and influence health care value for all their employees. We represent diverse employers with diverse interests, cultures and market pressures, unlike providers who have the advantage of selling services that are largely necessities and geographically locked. Our member companies have to compete globally and for the most part, our health care providers only have to compete locally. Consolidation creates provider leverage for specific contractual provisions that limit the ability of what employers can do such as shifting care based on price and quality, often referred to as tiering

Provider clout at the negotiating table as a result of consolidation has a deleterious effect on transparency of cost and quality information available to payers and consumers. Provider systems, given their size, are adept at pushing for contract language that severely restricts information to assist consumers in making wise purchasing decisions.

Health care administrators are also not without fault when it comes to restrictions placed on transparency. Administrators treat provider pricing as a core competency when it should not be. We need to hold the provider accountable for their prices, not the administrator. Administrators use their contract pricing to differentiate themselves in the market. If differential pricing disappears, they will need to redefine their value proposition.

To allow transparency to truly work for consumers and payers, providers must be forced to make public their fees. The entity that should be selling their rates to the consumer is the provider, not the administrator. Providers and administrators are making it virtually impossible for consumers to have access to pricing in order to make wise purchasing decisions. We believe this is an extremely important issue for the government to understand. Additionally, the plan I enroll in should not affect what I pay for a certain service at a certain provider.

Going Forward - What Needs to Happen?

It is obvious that we need to provide care efficiently in a patient-centered model where patients get care at the right time, right place and by the right provider. Integrated care is the goal, but it does not require consolidation.

Providers and the health care administrator and insurance community need to take responsibility for the lack of transparency of provider prices. What other services or commodities do you purchase where you don't know the price until after the fact? The BHCG believes full transparency of price and quality is essential to a patient-centered model.

From our perspective, ACOs will further limit consumer choice by locking in market share. Under the current law, new payment mechanisms will be incorporated in which ACOs will be taking some financial risk so they will want to control physicians, which in turn, gives them control over revenue, processes, care delivery and priorities. Will they also provide financial incentives to physicians that support patient-centered care? Not every provider system does everything well, we need to make sure consumers have the choice to use the best provider for their situation.

I believe the Accountable Care Organization concept that promotes patient-centered care is a good one. But in reality, its presence in the current health care reform law has only provided more fuel to the fire for physicians to sell their practices to hospitals and hospital systems to lock up market share, especially the commercial market share. Fear of the unknown is driving defensive behavior. Physicians prefer not to give up their autonomy but see no choice.

In summary, the considerable health care industry consolidation has made our efforts and those of many other similar organizations an absolute necessity if employers are to maintain some control over the cost of their health care benefits. We expect more consolidation to occur in our region, ratcheting up our concerns as well as our efforts. Even though we have seen some improvement, it is not enough to bring trend to a tolerable level.

We will need to see dramatic improvements in quality and significant adoption of best practices and patient-centered care – all key elements called for in the reform of health care in this country. Provider-driven business practices need to be kept in check and balance by a very engaged employer community. Cost and quality information needs to be accessible to consumers and used to drive improvement and competition in this new world.

Mr. Chairman, I would like to thank you and the committee for your time and the opportunity to share my testimony on this very important topic. It is indeed an honor to share my thoughts and experiences with such esteemed company. I look forward to your questions and comments at this time.

Chairman HERGER. Thank you. Mr. Guarino is now recognized for 5 minutes.

STATEMENT OF MICHAEL GUARINO, MEMBER, BOARD OF DI-RECTORS, AMBULATORY SURGERY CENTER ASSOCIATION, WEEKI WACHEE, FLORIDA

Mr. GUARINO. Chairman Herger and Ranking Member Stark, thank you for inviting me to testify on health care consolidation.

My name is Michael Guarino, and I live in Weeki Wachee, Florida. I manage the operations of five ambulatory surgery centers, better known as ASCs, in New York and Florida. I am testifying on behalf of the Ambulatory Surgery Center Association for which I serve as a board member.

I have worked for more than 15 years in the management of ACSs and physician practices, and I manage both single- and multi-specialty centers. I commend you for convening this hearing to explore the impact of consolidation in the health care industry, as I believe this phenomenon has increased recently and may raise overall health care costs.

In theory, consolidation may bring efficiencies to the market by reducing excess capacity and duplication. However, I have seen firsthand that consolidation can also be anti-competitive and may result in virtual monopolies in certain markets where patients are funneled into higher cost settings.

Surgery centers are health care facilities that specialize in providing essential surgical and preventative services in the outpatient settings. Surgery centers have transformed the outpatient experience by offering a convenient, personalized, lower price alternative to hospitals. With approximately 5,300 Medicare-certified facilities, surgery centers perform more than 25 million procedures each year, which constitutes nearly 40 percent of all outpatient surgeries nationwide.

As you may know, on average, Medicare now pays surgery centers about 56 percent of the hospital outpatient department payment rate for providing identical services. For instance, a hospital receives almost \$2,000 reimbursement when a knee scope procedure is performed, while a surgery center only receives nearly \$1,200 for the same service. This means surgery centers are an enormous source of savings to the Medicare program, cutting costs for the program by approximately \$2.5 billion a year.

We stand ready to work with Congress to reduce Medicare outpatient surgery costs even further. For example, if just 50 percent of the cases performed in a hospital setting that are eligible to be performed in a surgery center were moved to the surgery center, Medicare would save an additional \$20 billion over 10 years.

But there is a flip side to this growing disparity in the payment that surgery centers and hospitals receive. Just 8 years ago, surgery centers were paid 86 percent of the hospital rate. As that rate has slipped to 56 percent, there is now a growing payment incentive to treat these patients in the hospital. Indeed, we are now starting to see a number of hospitals acquiring surgery centers and converting them into HOPD. A recent analysis conducted by our Association found that of 179 surgery center closures since 2009, about one-third were purchased by hospitals. The result is that Medicare will pay substantially more for its beneficiaries to receive identical services.

My own experience may also be illuminating. I have been approached by a hospital or hospital system to sell my surgery centers in every market in which I operate. One hospital system presented an economic analysis showing that one surgery center could increase its annual revenue by over \$4 million simply by allowing the hospital to acquire the surgery center. This revenue increase would occur only because we would be paid more by Medicare and commercial insurance for the exact same cases.

In another market, the vice president of operations of a major health care system suggested that I either allow them to purchase my single specialty surgery center or watch as my surgery center became worthless when the not-for-profit hospital system became an accountable care organization.

In my New York market, all three hospital systems have contacted me about acquiring the outpatient surgery center. In addition, virtually all my referring doctors were approached by a hospital system to enter into a management agreement that effectively prohibits physicians from referring cases to any facility not affiliated with their hospital system.

What would be the impact on Medicare when this acquisitions occur? The answer is that the beneficiaries will pay substantially higher copays for the outpatient surgical procedure. For example, a beneficiary's copayment for cataracts would soar from a little less than \$200 to well—if she received the procedure at a surgery center—to nearly \$500 for the exact same service instead provided at a hospital. Similarly, the price Medicare would pay for a colonoscopy and biopsy would nearly double from \$370 to \$647.

What should be done about this phenomenon? Congress has the obligation to ensure the proper incentives to provide high-quality care at the most economical price.

Among the key areas that should be addressed: implement transparent quality and cost-sharing reporting across settings to better inform patients about their treatment options; ensure that ASC payment updates keep pace with the updates from the same services provided in hospitals; surgery centers and hospitals confront the same inflationary challenges of hiring and retaining nursing and purchasing medical supplies; provide vigorous oversight of accountable care organizations to ensure they do not hinder competition and lead to higher costs.

Once again, thank you for inviting me to participate in this hearing.

The prepared statement of Mr. Guarino follows:

THIS TESTIMONY IS EMBARGOED UNTIL 9:30 AM, FRIDAY SEPTEMBER 9 2011



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TESTIMONY FROM MICHAEL GUARINO ON BEHALF OF THE AMBULATORY SURGERY CENTER ASSOCIATION SEPTEMBER 9, 2011 WAYS AND MEANS SUBCOMMITTEE ON HEALTH

Chairman Herger and Ranking Member Stark, good morning and thank you for inviting me to testify at the Ways and Means Health Subcommittee's hearing on health care consolidation.

My name is Michael Guarino, and I am from Weeki Wachee, Florida. I manage the operations of five ambulatory surgery centers (ASCs) in New York and Florida. I am testifying on behalf of the Ambulatory Surgery Center Association, for which I serve as a board member. I have worked for more than 15 years in the management of ASC and physician practices, and I manage both single- and multi-specialty ASCs under a number of different financial arrangements.

I commend you for convening this hearing to explore the impact of consolidation in the health care industry, as I believe this phenomenon has increased recently and may

raise overall health care costs. In theory, consolidation may bring efficiencies to the market by reducing excess capacity and duplication. However, I have seen first-hand that consolidation can also be anti-competitive and may result in virtual monopolies in certain markets where patients are funneled into higher cost settings.

Ambulatory Surgery Centers (ASCs) are health care facilities that specialize in providing essential surgical and preventive services in an outpatient setting. ASCs have transformed the outpatient experience for millions of Americans by offering a convenient, personalized, lowerpriced alternative to hospitals. With approximately 5,300 Medicare-certified facilities across all 50 states, ASCs perform more than 25 million procedures each year, which constitutes nearly 40 percent of all outpatient surgeries nationwide. We remain a major component of the health care continuum and an essential point of access for important preventive procedures, such as colonoscopies that detect colon cancer, and cataract surgeries that repair eyesight. As such, we are dedicated to providing high quality care to our patients at an affordable cost, as well as to private and public payers.

As you may know, Medicare now pays ASCs about 56 percent on average of the hospital outpatient department (HOPD) payment rate for providing *identical* services. For instance, a hospital receives \$2,042 in reimbursement

when a knee scope procedure is performed while an ASC would receive \$1,167next year for the same service.

Medicare and its beneficiaries can achieve substantial savings in ASCs

HCPCS	Description	Patient Copayment		Total Procedure Cost	
	Matthews desired perform	ASC	HOPD	ASC	HOPD
66984	Cataract surg w/iol, 1 stage	\$190.57	\$488.94	\$952.83	\$1,667.18
43239	Upper gi endoscopy, biopsy	\$66.49	\$136.33	\$332.43	\$581.65
45378	Diagnostic colonoscopy	\$73.94	\$186.06	\$369.70	\$646.88
45380	Colonoscopy and biopsy	\$73.94	\$186.06	\$369.70	\$646.88
45385	Lesion removal colonoscopy	\$73.94	\$186.06	\$369.70	\$646.88
66821	After cataract laser surgery	\$44.28	\$104.31	\$221.39	\$387.37
64483	Inj foramen epidural I/s	\$59.89	\$104.80	\$299.46	\$523.98
66982	Cataract surgery, complex	\$190.57	\$488.94	\$952.83	\$1,667.18
45384	Lesion remove colonoscopy	\$73.94	\$186.06	\$369.70	\$646.88
29881	Knee arthroscopy	\$233.47	\$408.52	\$1,167.37	\$2,042.58
63650	Implant neuroelectrodes	\$701.35	\$871.77	\$3,506.75	\$4,358.81
29827	Arthroscop rotator cuff repr	\$384.49	\$804.74	\$1,922.43	\$3,363.71

^{· 2012} proposed payment rates.

This means ASCs are an enormous source of savings for the Medicare program—cutting costs for the program by approximately \$2.55 billion a year. We stand ready to work with the Ways and Means Committee and Congress to reduce Medicare outpatient surgery costs even further. For example, if just 50 percent of the cases performed in an HOPD, that are eligible to be performed at an ASC, were transitioned to an ASC setting, Medicare would save an additional \$20 billion over 10 years.

But there is a flip side to the growing disparity in the payments that ASCs and hospitals receive. Just eight

years ago, ASCs were paid 86 percent of the HOPD rate. As that number has slipped to 56 percent, there is now a growing payment incentive to treat these patients in the HOPD rather than the more economical ASC setting. Indeed, we are now starting to see a number of hospitals acquiring ASCs and converting them into HOPDs. A recent analysis conducted by our Association found that of 179 ASC closures since 2009, about one-third were a result of purchase by a hospital. Further, our research shows that almost 40 percent of the facilities that have closed this calendar year have been purchased by a hospital. The result is that Medicare will pay substantially more for its beneficiaries to receive identical services. While not all of these acquisitions lead to an ASC conversion to a HOPD (20% of the ASC marketplace is a joint venture involving a hospital where the ASC retains its ASC designation), the trend raises serious concerns.

My own experience may also be illuminating. I have been approached by a hospital or hospital system to sell my ASC in every market in which I operate. One hospital system presented an economic analysis showing that one ASC could increase its annual revenue by \$4 million to \$6 million simply by allowing the hospital to acquire the ASC. This revenue increase would occur only because we would be paid more by Medicare and commercial insurance for the same cases.

In another market, the vice president of operations of a major hospital system suggested that I either allow him to purchase my single specialty surgery center or watch as my surgery center became worthless when the non-profit hospital system became an accountable care organization.

That hospital system has started to acquire other outpatient surgery centers and physician practices in the community.

In my New York market, all three local hospital systems (the non-profit catholic system, the state run hospital system, and the non-profit Jewish hospital system) have contacted me about acquiring the outpatient surgery center. In addition, virtually all of my referring doctors were approached by a hospital system to enter into management agreements that effectively prohibit physicians from referring cases to any facility not affiliated with their hospital system.

Similarly, a January 2011 Certificate of Need application by Hartford Hospital for the acquisition of Constitution Eye Surgery Center, LLC, as ASC, noted that under the ownership of Hartford Hospital, the surgery center is expected to produce incremental operating gains of \$5 million in 2011, which would rise to \$7 million in 2012 and every year thereafter.

What will be the impact on Medicare when these acquisitions occur? The answer is that beneficiaries will

pay substantially higher copayments for their outpatient surgical procedures. For example, a beneficiary's copay for cataract surgery would soar from \$191 if she received that procedure at an ASC to \$489 if the same service were, instead, provided in the hospital outpatient department. Similarly, the price Medicare would pay for a colonoscopy and biopsy would nearly double from \$370 to \$647.

The acquisition of ASCs also reflects a broader trend of hospital acquisition across many aspects of the healthcare community, including physician practices, labs and other ancillary services. Between 2005 and 2008, the percentage of medical practices owned by hospitals has soared from 25.6 percent to 49.5 percent, according to the Medical Group Management Association's 2008 Physician Compensation survey. More recently, this physician merger activity has accelerated. According to a report from Irving Levin Associates, physician practice merger activity has increased by 200 percent from the second quarter of 2010 to the second guarter of 2011. This consolidation may limit competition in particular geographic areas, potentially increasing costs to employers and insurers, as hospital-based procedures are often priced higher than those performed in a physician office.

What should be done about this phenomenon?

Obviously, the certificate of need process is controlled at the state level. But as fiduciaries for the taxpayers and Medicare beneficiaries, Congress has the obligation to ensure that Medicare policy and health policy effective in the private sector provides the proper incentives to provide high quality health care at the most economical price.

The ASC industry stands ready to work with Congress and CMS to ensure a better alignment of incentives for care is rendered in the most efficient, cost effective and highest quality setting. Among the key areas that should be addressed are:

- Implementation of transparent quality and cost-sharing reporting across settings which will give all patients access to the information they need to make informed decisions about the quality and cost of their care.
- Ensure that ASC payments updates keep pace with updates for the same services provided in hospitals. Section 2 of the Ambulatory Surgery Center Quality and Access Act of 2011 (H.R. 2108), would tie future ASC updates to the hospital market basket—the measure currently used to update HOPD rates. ASC inflationary challenges of hiring and retaining nurses and purchasing medical supplies are similar to hospitals. Those costs are not reflected in the Consumer Price Index for All Urban Consumers (CPI-U) -- the measure currently used for ASC updates. The CPI-U measures price changes for items like energy, housing and food. Applying the hospital market basket would arrest the widening delta between the ASC and HOPD rates and signal to the health care market that the ASCs can remain viable alternatives for patients.
- Finally, Congress should provide vigorous oversight of accountable care
 organizations (ACOs) to ensure ACOs do not impede competition, lead to
 higher costs or inhibit patient choice of care setting. While ACOs have the
 potential to better coordinate care, safeguards are needed to ensure that
 the model does not simply become a catalyst for greater consolidation and
 monopolization in health care markets.

Conclusion

Once again, thank you for inviting me to participate in the hearing. It is critical to protect patient access to the high quality, cost-effective services provided by Ambulatory Surgery Centers. We appreciate your interest in ensuring this is the case. The ASC industry looks forward to working with the Committee and Congress to lower overall health care costs while improving patient outcomes.

Chairman HERGER. Thank you. Mr. Balto is now recognized for 5 minutes.

STATEMENT OF DAVID BALTO, SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS ACTION FUND, WASHINGTON, D.C.

Mr. BALTO. Thank you, Chairman Herger, Ranking Member Stark, and the rest of the committee.

I am David Balto, a Senior Fellow at the Center for American Progress. My testimony today is based on over 15 years as a government antitrust enforcer at the FTC and the Department of Justice and my experience as a public interest lawyer representing consumers and other groups.

I have a simple message for you today. I applaud you for holding this hearing. Concentration in any market is certainly problematic, definitely in health care markets, and antitrust enforcement plays an important tool here.

Let's start off with health insurance. Unfortunately, because of a complete lack of health insurance antitrust enforcement, almost all health insurance markets in the United States are highly concentrated. You know the results of that—you heard about it in the last congressional session—skyrocketing premiums, consumers harmed by egregious and deceptive conduct by health insurance companies. Fortunately, Congress has enacted the Affordable Care Act which gives us tools to go and help to deal with some of these problems. I know not all of you voted for it, but watch and see. I think it is going to be effective in grappling with many of these

problems.

Fortunately, the new antitrust enforcers at the Department of Justice have set a line in the sand and simply said no more consolidation when it comes to health insurance, and they have gone after anti-competitive practices that stop markets from performing effectively, and that is really important.

Now, an area where the antitrust enforcers have been asleep at the switch are pharmacy benefit managers which play a crucial role in managing drug benefits. Two of the three of them now plan to merge, Medco and Express Scripts. They will have over 50 percent of the large plan market. They will have over 150 million covered lives. They will be phenomenally larger than anybody else.

And I should have said right at the beginning, I represent consumer groups, unions, and specialty pharmacies in advocating

against this merger before the FTC.

This merger will significantly increase the cost of the specialty drugs. For the millions of vulnerable consumers who need specialty drugs, it will deny them the choice they need because these two firms control the two largest specialty pharmacies in the United States.

Hey, this hearing is about providers with too much market power. Go back to your districts. Go look at your community pharmacist. Look him in the eye and you tell me does he have market power. Community pharmacists are the life bone to our drug delivery system. They are there advising patients, helping them deal with their drug benefits, delivering high-quality care. They don't have any market power, but these PBM mergers threaten to drive them out of business by forcing consumers to mail order, which is more expensive and leads to less care.

Finally, for you as members of the Ways and Means Committee, this PBM merger is important. Government programs such as TRICARE, Medicare Part D, and FEHPB rely on these PBMs. You

are going to have only two choices at the end of the day.

Let's turn to the issue of hospital consolidation, which is a big part of this discussion here. There is no doubt that there are economic studies that suggest that these mergers lead to higher costs, but there is a tremendous need for hospital consolidation. There is no doubt that there is overcapacity. There is no doubt that there is a need for certain types of consolidation. Fortunately, antitrust enforcement has been ramped up in this area. The FTC has brought some significant cases and, also, the Department of Justice has gone after anti-competitive practices that prevent other hospitals from being able to effectively compete. The combination of both active antitrust enforcement and greater regulation offers a promise here.

Now, I agree with the other panelists about what the solutions are here. Besides antitrust enforcement, we have to look for market mechanisms to make the market work. Is there adequate transparency so employers get the right price signals, so consumers get the right price signals, so consumers are choosing the health care that is lowest cost and leads to the best quality? We have got to

make sure that there is nothing that prevents that.

And important here could be the possible role of the FTC in helping to go and educate the market to make sure that there is adequate transparency but, also, when there are problems such as the referral power that was mentioned earlier, where you have a group of providers with referral power, the FTC can go after that kind of conduct under Section 5 of the FTC Act.

Finally, if there is a concern about the impact of ACOs, let me make one suggestion to my friends at the FTC and the DOJ. People are concerned that the ACOs will be controlled by dominant hospitals. That is a legitimate concern. It is time for the FTC and DOJ to adjust the antitrust standards so doctors can get together and

form ACOs that are competitive to the ACOs that are controlled by the hospitals. Unfortunately, the standards the FTC and DOJ have been applying are too strict in this area.

My testimony ends with several other suggestions for revitalized antitrust enforcement, and I appreciate the opportunity to appear before you today.

[The prepared statement of Mr. Balto follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:30 AM, FRIDAY SEPTEMBER 9, 2011

Statement of David Balto, Senior Fellow Center for American Progress Action Fund

Before House Committee on Ways and Means, Subcommittee on Health on "Health Industry Consolidation"

September 9, 2011

David Balto 1350 I Street NW Washington, DC 20005 202-789-5424

Statement of David Balto, Senior Fellow Center for American Progress Action Fund¹

Before House Committee on Ways and Means, Subcommittee on Health on "Health Industry Consolidation"

September 9, 2011

Chairman Herger, Ranking Member Stark, and other members of the committee, I appreciate the opportunity to come before you today and testify about health care industry consolidation-a subject of significant concern. As a former antitrust enforcement official who has litigated a number of cases challenging anticompetitive conduct and proposed mergers in the healthcare industry as well as a private practice attorney who has represented insurance companies, hospitals, pharmacies, and other healthcare providers in merger investigations, I have a learned firsthand of the harm of excessive concentration in healthcare markets. Highly concentrated healthcare markets, especially health insurance markets, can result in escalating healthcare costs for the average consumer, a higher number of uninsured Americans, an epidemic of deceptive and fraudulent conduct, and supracompetitive profits. My time at the antitrust enforcement agencies has also showed me that we need to draw a clear distinction between problematic consolidations on the one hand, and the efficient integration of our health system on the other. For antitrust enforcement to serve as a tool for and not an obstacle to improving our healthcare system, we must understand this distinction and realign enforcement priorities to focus on the forms of market consolidation that pose harm to the ultimate consumers.

Three realities that both policy makers and antitrust enforcers need to embrace include:

- Health Insurance Markets Are Broken—more than 90 percent of all metropolitan health insurance markets are highly concentrated. The healthcare debate and countless Congressional hearings have documented how this extreme concentration results in higher prices, millions of uninsured consumers, and a pattern of egregious conduct by health insurers. Greater focus needs to be directed towards consolidation in health insurance
- Aggregation is Distinct from Integration—If there is a competitive problem in healthcare
 markets, it is due to aggregations of market power, such as in health insurance, and not
 because of integration among physicians. Rather than the problem, integration is an
 important solution for improving quality and cost in the fee-for-service healthcare system.
 So as not to thwart the much needed reform of our healthcare system, antitrust resources
 should be directed towards concerns of market power by health insurers, hospitals, and
 specialized physician groups. A lesson to be learned from the Affordable Care Act is that

¹ I am former policy director of the Federal Trade Commission and was actively involved in several health care matters and revisions of the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care in that role. This testimony represents solely my views.

² Antitrust enforcement is shared between the Antitrust Division of the Department of Justice and the Federal Trade Commission. Both agencies investigate healthcare providers, but the DOJ has primary jurisdiction over insurers.

facilitating integration can be used as an effective mechanism to combat the excessive costs and poor health care outcomes often resulting from the lack of coordination among health care providers.

Healthcare markets are distinct and enforcers need to appropriately adapt the antitrust
models used to evaluate them. The price-centric antitrust framework is rather inapt in
healthcare markets where price is often an insufficient mechanism for fully understanding
the impact of a given market structure or business practice. Moreover, the prevailing
perception that insurers are the central customer in healthcare markets creates a framework
for evaluating the healthcare system that ignores the ultimate impact on consumers.
Antitrust enforcers need to amend their approach to healthcare markets to focus on the
impact on the ultimate consumer and not just the payment intermediary.

These realities directly undermine the underpinnings of the current antitrust paradigm in healthcare. That paradigm assumes that healthcare intermediaries, such as health insurers or pharmacy benefit managers (PBMs), are an appropriate proxy for the consumer in healthcare markets. The paradigm assumes that consumers will be better off if health insurers can use their power to drive down reimbursement rates relentlessly. It suggests that it is necessary to harbor deep suspicion over collaboration by doctors. Antitrust agencies appear to prefer a system of autonomous providers, who are fundamentally powerless to deal with insurance companies.

Let's just deal with one of these notions: the belief that the market will perform better with powerful insurers and autonomous and unintegrated providers, especially doctors. If your main concern is the bottom line for health insurers, this notion may theoretically sound appealing. But this paradigm presents two significant problems for healthcare and consumers. First, doctors acting autonomously are unable to effectively coordinate care – the "silo" problem that leads to more costly and less efficient care and delivers poorer health outcomes. The healthcare debate clearly demonstrated that a lack of integration led to more costly and lower quality care. Second, autonomous providers are too weak to bargain with insurance companies leading to increasingly reduced reimbursement and assembly line healthcare. Insurance companies may benefit from lower reimbursement but consumers suffer through more expensive and lower quality care.

In fact, consumers and public welfare as a whole may be better off if providers, especially doctors and pharmacies, can band together to have some level of countervailing power to deal with powerful insurers. Former Republican Congressman Tom Campbell in a series of thoughtful law review articles has demonstrated that permitting sellers of service or good to merge may improve welfare when dealing with powerful buyers. You may recall that a decade ago he called for legislation to grant doctors the ability to collectively negotiate with insurers.

More concretely, countervailing power for doctors and pharmacies may benefit consumers. These providers are often the most effective advocates for patients when insurance companies cross the line and engage in abusive and deceptive conduct. Doctors can use their negotiating power to prevent insurers from implementing "physician gag" clauses which prevent physicians from informing consumers about insurance options. Doctors can use their power to

³ See Tom Campbell, Bilateral Monopoly in Mergers, 74 ANTITRUST L.J. 521 (2007); see also Tom Campbell, Bilateral Monopoly -- Further Comment, 75 ANTITRUST L.J. 647 (2008).

challenge deceptive conduct that harms both consumers and providers. Take the Ingenix case as an example – where United Healthcare's subsidiary deflated usual and customary rates harming millions of consumers.⁴ It was associations of doctors including the AMA that led the charge in exposing these practices, leading to a landmark remedy and over \$350 million in damages to date.

What about the idea that the insurer or the PBM is the consumer? Insurers and PBMs do attempt to control costs for employers and other purchasers of health plans. While these entities may attempt to control cost they are also for-profit entities with an overriding incentive to maximize profits. When there are battles between healthcare providers and insurers, the agencies almost always weigh in on the side of the insurers. But insurers are not the consumers. The endless list of competition and consumer protection cases against insurers and PBMs show that health insurers and PBMs frequently act to harm consumers. The primary goal of these for-profit insurers and PBMs is to serve their shareholders and their profit margins, and not consumers. They are not the representatives of consumer interest.

This was recognized in a decision last fall by the Third Circuit in a case challenging anticompetitive conduct against Highmark, the dominant insurer in Pittsburgh. Highmark attempted to justify alleged anticompetitive conduct that reduced reimbursement to a hospital, arguing that it did not pose antitrust problems because it enabled Highmark to set low insurance premiums and thus benefitted consumers. The Third Circuit rejected that claim:

[E]ven if it were true that paying West Penn depressed rates enabled Highmark to offer lower premiums, it is far from clear that this would have benefitted consumers, because the premium reductions would have been achieved only by taking action that tends to diminish the quality and availability of hospital services.⁵

The court went on to explain that the purpose of the antitrust laws is to ensure a competitive marketplace and that a reduction in competition is not permitted simply because it may appear to lead to lower prices. This can be a profound observation is healthcare where quality of care is a central concern.

It is time for our antitrust enforcers and policy makers to recognize the lessons from healthcare reform and adapt the antitrust paradigm. As I have documented in a Center for American Progress study, the history of healthcare antitrust enforcement in the past administration is characterized by largely misplaced enforcement priorities. Although health insurance markets are plagued by anticompetitive and abusive conduct, there were no competition or consumer protection enforcement actions against health insurers. At the same

⁴ Testimony of David A. Balto, "The Effects of Regulatory Neglect on Health Care Consumers" before the Senate Committee on Commerce, Science and Transportation, Subcommittee on Consumer Protection, Product Safety and Insurance on Competition in the Health Care Marketplace (July 16, 2009).

West Penn Allegheny Health System v. UPMC and Highmark, Inc., 2010 U.S. App. LEXIS 24347, at *40 (3d Cir. 2010).

⁶ Testimony of David A. Balto, "The Need for a New Antitrust Paradigm in Health Care" before the House Judiciary Committee, Subcommittee on Courts and Competition Policy on Antitrust Laws and their Effects on Health Care Providers, Insurers, and Patients (July 16, 2009).

time almost all of the FTC healthcare enforcement actions were against efforts by physicians to collectively negotiate. Physician collaboration has been living as a suspect class and represents the only area where antitrust agencies apply the "per se" label and condemn endeavors without analysis of anticompetitive effects. (The "per se" rule is the legal guillotine of the antitrust laws. Under the per se rule, the government need not demonstrate the conduct has harmed competition or consumers.) The FTC brought 31 cases, all settled, probably because of the high cost of a government investigation. There was little evidence in the complaints filed by the government that these groups actually secured higher prices or that consumers were harmed. In fact, in none of the cases did consumers file any antitrust suits seeking damages for the alleged illegal conduct. (There was only one case filed by an insurer and it lost.)⁷ This disproportionate focus on physician groups was supported by no evidence that higher physician costs were a significant force in escalating health care expenditures.

My testimony today highlights how those enforcement priorities have changed and what else needs to be done to address competitive problems in healthcare markets. It begins with observations about health insurance concentration, certainly the most chronic and severe competitive problem in the market. The testimony describes increased prudent antitrust enforcement aimed at addressing those both the problems of increased consolidation and anticompetitive practices. It then focuses on problems in concentration among healthcare providers, primarily hospitals, and addresses renewed enforcement efforts. It addresses how the Affordable Care Act offers the potential to significantly spur health care competition and closes with several recommendations to strengthen healthcare antitrust enforcement.

This hearing focuses on concentration in the healthcare industry and it is important to recognize that antitrust law is an important but limited tool for fighting concentration. Antitrust enforcement rarely, if ever, can be used to "deconcentrate" a market. Rather, antitrust enforcement can simply prevent further concentration through merger enforcement under the Clayton Act, and can prevent actors in an already concentrated industry from acting anticompetitively through enforcement of the Sherman Act. Thus, antitrust is a limited weapon against the harms of market concentration.

Adapting the Antitrust Paradigm: Focusing on Health Insurance Consolidation

Concerns over healthcare consolidation should focus on the need to prevent increases in concentration by health insurers. Insufficient focus on this area in the past has given way to a very poorly functioning health insurance market. Few markets are as concentrated, opaque, and as conducive to deceptive and anticompetitive conduct. Congress has recognized time and again these markets as lacking in sufficient competition and transparency, so I will not detail the mountain of evidence pointing to their ineffective function, but I would like to highlight why the lack of competition and effective transparency in health insurance markets is so problematic.

⁷ In contrast, in one of the few DOJ cases – a challenge to an association of Arizona hospitals that had agreed to depress the wages of traveling and visiting nurses – there was successful private litigation which led to a proposed settlement of over \$23 million in damages for a class of harm to nurses. (Doe v. Arizona Hospital and Healthcare Association, Case No. 07-cv-1292 (D.AZ.)) I was co-lead attorney for the class of nurses.

There are three necessary components of a functioning market: choice, transparency, and a lack of conflicts of interest. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. Only where these three elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: a recent report by Health Care for America Now found that in 39 states two firms control at least 50 percent of the market and in nine states a single firm controls at least 75 percent of the market. A 2009 AMA study found almost 99 percent of all markets are highly concentrated. Industry advocates claim that many markets have several competitors. But the reality is these small players are not a competitive constraint on the dominant firms, but just follow the lead of the price increases of the larger firms.

In the last session Congress heard from scores of consumers about the harms from this dysfunctional market. The number of uninsured patients has skyrocketed: more than 47 million Americans are uninsured, and according to Consumer Reports, as many as 70 million more have insurance that doesn't really protect them. In the past six years alone, health insurance premiums have increased by more than 87 percent, rising four times faster than the average American's wages. Healthcare costs are a substantial cause of three out of five personal bankruptcies. At the same time from 2000 to 2007, the 10 largest publicly-traded health insurance companies increased their annual profits 428 percent, from \$2.4 billion to \$12.9 billion.

Empirical economic studies have also documented the harm from health insurance concentration. A recent study documented how concentration in various Texas markets led to higher premiums of about 7%. The study also concludes what most of us know as the truth: the increase in concentration has led to lower premiums paid to healthcare providers, and has also contributed to the substitution of nurses for doctors in many markets. Thus, we are seeing concentration negatively impact the economics of the healthcare industry, as well as the quality of care received by the American consumer. ¹⁰

The Express Scripts-Medco Merger

The pharmacy benefit manager, or PBM, market is another example of a highly concentrated intermediary market. I have testified in the past about how this market does not behave competitively and remains the only unregulated segment of today's healthcare market. Just three players—Medco Health Solutions, Express Scripts, and CVS Caremark—dominate

⁸ Testimony of David A. Balto, "The Effects of Regulatory Neglect on Health Care Consumers" before the Senate Committee on Commerce, Science and Transportation, Subcommittee on Consumer Protection, Product Safety and Insurance on Competition in the Health Care Marketplace (July 16, 2009).

⁹ Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry, American Economic Review, forthcoming, at 32, available at http://www.kellogg.northwestern.edu/faculty/dafny/personal/.
¹⁰ Id. at 31.

this market. These big three PBMs have engaged in deceptive, fraudulent, and egregious conduct and limited market competition - in the past 6 years the three major PBMs have settled 5 major cases brought by state attorneys generals resulting in over \$370 million in penalties and fines.

The recently proposed acquisition of Medco by Express Scripts, which is under investigation by the FTC, threatens competition and will lead to significantly reduced competition and higher costs for individual consumers, employers, and Federal programs such as TRICARE and Medicare Part D. The merger will further aggregate this market and create a dominant PBM with approximately 155 million covered lives and over 50% of the large employer market. 12 To put that number in context, a combined Express Scripts-Medco will cover 70 million more lives than the next largest PBM. This merger will significantly limit competition among pharmacy benefit managers and poses harm to consumers, plans, employers, unions, and pharmacies.

A particular concern is for the millions of consumers who depend on specialty drugs to treat their chronic, incurable and potentially life-threatening illnesses. Through vertically integrated models, Express Scripts and Medco also own the two largest specialty pharmacy businesses. This deal would give the joint company over a 50 percent share of the specialty pharmacy market13 and further restrict pharmacy competition which today is based on quality service, clinical support for patients/caregivers and other non-drug, non-price features. Specialty pharmacies provide treatments for our nation's most vulnerable patient populations suffering from complex conditions such as hemophilia, Crohn's Disease, hepatitis C, infertility. HIV/AIDS, and many forms of cancer. The specialty treatments for these conditions are generally very expensive, costing an average \$1,867 per drug14 and often require special handling and control, complex administration, and intensive and consistent patient monitoring. The services provided by specialty pharmacies support the most cost-effective use of these expensive treatments and help to keep these patients healthy and out of hospitals and emergency rooms. This merger threatens these important services provided by specialty pharmacies as well as creates challenges for new, innovative specialty drugs to enter the market. Further consolidation of these markets would significantly harm pharmacies as well as the vulnerable patients that rely on their services, and would hamper any efforts to contain pharmaceutical costs. The FTC should block this merger to protect competition in the PBM and specialty pharmacy markets.

This committee should be particularly concerned about the impact of the merger on government healthcare programs such as Medicare Part D, the FEHBP, and Tricare, for example. These federal programs are heavily dependent on the big three PBMs and competition among the PBMs is crucial to controlling government drug expenditures. The merger will significantly reduce competition for these government programs and threaten to increase the government's

¹¹ Testimony of David A. Balto on Section 408(b)(2) Regulation Fee Disclosures to Welfare Benefit Plans before Employee Benefits Security Administration U.S. Department of Labor (December 7, 2010).

I currently represent several consumer organizations, as well as the Independent Specialty Pharmacy Coalition and the National Coordinating Committee for Multi-Employer Plans (NCCMP) before the FTC on this issue. NCCMP represents 10.4 million participants in defined benefit pension plans and 26 million Americans who receive coverage from multi-employer health welfare plans. This testimony represents solely my views.

¹³ Pembroke Consulting 2010-2011 Economic Report on Retail and Specialty Pharmacies.

¹⁴ Id. at 12.

expenditures in providing drug benefits for employees and retirees. Moreover, it will limit access to high quality specialty pharmacy services for millions of consumers nationwide.

Recent Revitalization in Healthcare Antitrust Enforcement

The Bush administration failed to challenge any mergers or anticompetitive conduct by health insurers during the entirety of its tenure, ¹⁵ but under President Obama we have seen a revitalization of health insurance antitrust enforcement.

Enforcement Actions Against Health Insurers

The record on past enforcement in health insurer mergers was stark. In the past administration there was a tsunami of mergers, leading to further concentration in the industry. There were no competition or consumer-protection enforcement actions against health insurers in the last administration, despite the fact that anticompetitive and abusive conduct plagued some health insurance markets. There were more than 400 mergers and the DOJ required the restructuring of just two of those mergers.

The tide changed in 2010 when the Department of Justice presented the first government challenge to a merger of health insurers when Blue Cross Blue Shield of Michigan agreed to acquire competitor Physicians Health Plan of Mid-Michigan. The Department determined that this acquisition would result in BCBS controlling nearly 90% of the market for commercial Michigan health insurers. It further concluded that this acquisition would result "in higher prices, fewer choices, and a reduction in the quality of commercial health insurance plans purchased by Lansing area residents and their employers." As a result of this concentration and likely anticompetitive results, the DOJ announced its intention to enjoin the merger. Facing this announcement, the parties agreed to abandon their deal, leaving intact competition between the two insurers. This was the first time the DOJ threatened to go to court to block a merger and their willingness to litigate made a difference.

Equally pernicious can be practices by dominant insurers that limit the ability of other insurers to enter or expand in the market. One such practice is a Most Favored Nation clause (MFN), which requires the seller of a service to provide the best price to a buyer. Generally these can be procompetitive, but when used by a dominant insurer they can forestall entry. An MFN requires a hospital to provide an insurer its best price, and can prevent other health insurers from entering into the market. These provisions escalated prices and increased entry barriers in the commercial insurance market. The DOJ sued Blue Cross of Michigan for its aggressive use of MFNs. ¹⁷ According to the complaint, Blue Cross used MFN provisions or similar clauses in its contracts with at least 70 of Michigan's 131 general acute-care hospitals, including many major hospitals in the state. The complaint alleges that the MFNs require a hospital either to

¹⁵ I have testified in the past about the mistaken enforcement priorities under the Bush administration and have listed the misguided actions taken against groups of healthcare providers, typically small and rurally located, with no significant impact on consumers. Please refer to my testimony, "The Need for a New Antitrust Paradigm in Health Care" for more additional information.

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charge Blue Cross no more than it charges Blue Cross's competitors, or to charge the competitors more than it charges Blue Cross, in some cases between 30 percent and 40 percent. In addition, the complaint alleges that Blue Cross threatened to cut payments to 45 rural Michigan hospitals by up to 16 percent if they refused to agree to the MFN provisions.

The effects of these agreements are numerous, including: raised prices for commercial health insurance; restricted competition among health insurer providers; restricted choice by Michigan-area hospitals; and, ultimately, less hospital services available to consumers. Blue Cross lost on its motion to dismiss the case just last month, as the court concluded that the government sufficiently alleged plausible markets, anticompetitive effects, and a legal theory of harm.

The DOJ, assisted by several state attorneys generals, has ongoing investigations of MFNs by dominant insurers in several states.

Enforcement Actions Against Healthcare Providers

Much of the focus of today's hearing is on concerns about market power by healthcare providers – both hospitals and doctors. Although it is easy to generalize concerns, or focus on colorful anecdotes, these concerns should be put in perspective.

- Both the FTC and DOJ devote considerable resources to healthcare and investigate dozens of provider mergers, joint ventures, and other alliances each year.
- As to doctors there have been no enforcement actions brought against mergers by physician groups or exclusionary practices by physician groups. As I discussed before, antitrust enforcement in the healthcare industry prior to the Obama administration focused almost entirely on doctors and on the narrow issue of whether these physician groups were sufficiently integrated to jointly negotiate. None of the cases against doctors demonstrated or even attempted to demonstrate market power. There has never been a case challenging a physician group merger. In fact, the last case brought that alleged exclusionary conduct by a group of physicians was in 1994. This does not mean this area is free from competitive problems, but to date physician group mergers have not appeared to violate the law.
- As to hospitals there has been significant consolidation. But much of this consolidation is justifiable and can be procompetitive. No one can dispute there has been significant overcapacity in hospitals and a tremendous need for consolidation. Moreover, scores of hospitals are in a weakened financial state and consolidation is necessary to keep the hospitals operating, serving the community, and preserving jobs. Finally, hospital merger consolidation can lead to improved services and increased quality of care. Not surprisingly even under the renewed enforcement in the Obama Administration the FTC has only challenged three hospital mergers.

Ultimately there must be a prudent balance that recognizes the potential efficiencies of consolidation in a measured fashion and weighs those efficiencies against potential anticompetitive effects.

Enforcement Actions Against Hospitals

Emblematic of this measured approach is the Federal Trade Commission's law suit to enjoin the merger of ProMedica and St. Luke's Hospital in the first and third largest hospitals in Toledo, Ohio. The FTC alleged that the merger will increase concentration and raise prices in acute-care inpatient services and inpatient obstetrical services. However, the complaint also focused on the loss of quality competition, alleging that competition between the two hospitals had "spurred both parties to increase quality of care" and that these elements would be lost after the acquisition. The focus on both price and quality competition show that the FTC recognizes the need to evaluate both price and quality competition. The matter is still pending before an FTC administrative law judge.

Similarly, in 2009, the FTC ordered the Carilion Clinic of Roanoke, VA, to separate from two recently acquired competing outpatient imaging and surgical clinics. Carilion is the dominant hospital system in the market and these outpatient clinics would have posed a significant threat to its dominance in outpatient imaging and surgical services, leading to higher premiums, and the risk of reduced coverage for these needed services. The FTC's willingness to undo an already consummated merger is further demonstration of the administration's commitment to combating concentration in the industry.

Like with health insurers, the Obama administration has ramped up enforcement against anticompetitive conduct by hospitals. Again, antitrust cannot undo concentration but it can prevent practices that create barriers to competition that would threaten that dominance. In United Regional, the Department brought a Section 2 case against a Wichita, Texas hospital system that allegedly holds 90% market share in the market for inpatient hospital services, and 65% market share in the market for outpatient surgical services sold to commercial insurers. This was the first case brought by Justice or the FTC against anticompetitive conduct by a provider alleged to have significant market power in more than 17 years. This market power means that United Regional is a "must have" hospital for commercial insurers in the Wichita, Texas region. 18

The complaint alleged that United Regional willfully maintained its monopoly power by employing anticompetitive exclusionary contracts with health insurers. The contracts were relatively simple: health insurers are penalized as much as 27% if they contract with competing hospitals. The contracts defined competitors through geographical limitations, but they all encompassed the primary competing facilities. The DOJ alleged that the monopoly-maintaining contracts had the anticompetitive results of delaying and preventing the expansion of competitors; limiting competition over price; and reduced quality for healthcare services. The DOJ ultimately entered into a consent decree with United Regional that prohibits the hospital

¹⁸ United States of America and State of Texas v. United Regional Healthcare System, Complaint, Feb. 25, 2011, available at http://www.justice.gov/atr/cases/f267600/267651.pdf

from entering into contracts that improperly inhibit commercial health insurers from contracting with United Regional's competitors.

The Affordable Care Act and Opportunities for Increased Competition

The healthcare reform debate challenged the underpinnings of the antitrust paradigm in healthcare that has generally characterized the past decade. As I discussed earlier, that paradigm was deeply skeptical of integration by healthcare providers, particularly of efforts by physicians to collaborate. Last year's healthcare debate scrutinized this model, however, and shed light on the opposing conception that increased provider integration could actually lead to more efficient, higher quality care. Insufficient integration, the debate clearly demonstrated, contributes to the "silo" problem between the various levels of healthcare delivery and is a central impediment of containing healthcare costs and improving quality.

The Affordable Care Act offers a number of tools to increase competition in healthcare markets. Let me highlight a few. First, in 2014, for example, competition among insurance companies will be spurred as insurers will compete for business on a level and transparent playing field in health insurance exchanges. Second, as Secretary Sebelius has recently stated publicly, the new cooperatives created under the ACA will also help make health insurance markets more competitive. The provisions of the Affordable Care Act aimed at better educating consumers of their options in health insurance further promote competition amongst health insurers. The Consumer Assistance Program of the Center for Consumer Information and Insurance Oversight, for example, is charged with providing the necessary resources for educating consumers about healthcare decisions and will surely foster greater competition among health insurers by creating better-informed consumers. Finally, the ACA promotes the development of ACOs which should spur greater, more integrated and efficient competition.

Under the new health law, physicians, hospitals, and other healthcare providers are encouraged to reduce cost by, among other things forming ACOs. While ACOs involve collaboration among competitors, which has frequently raised antitrust concerns, skepticism of integration provider groups is misguided. Though, as I have mentioned, the agencies appear to have dedicated the vast majority of enforcement resources to the question of integration of physician-negotiating groups, the most difficult issue the agencies must grapple with in the formation of these ACOs is market power, not integration.

What should be the response of enforcers to the concerns of provider market power in the context of ACOs?

First, to the extent the concern is over ACO competition, it is critical that the agencies broaden the standards for integration, in evaluating proposed ACOs. If hospitals dominate some markets, it is even more important that the agencies provide a clear path for physician-sponsored ACOs to be formed. The agencies should permit ACOs to qualify based on clinical integration, not just financial integration. The current integration antitrust standards may create obstacles to physician-sponsored ACOs and that would reduce competitive alternatives in ACO markets.

Second, the FTC should focus its enforcement resources on market power by hospitals and specialized physician groups. The FTC has done an admirable job in reviving hospital-merger enforcement in the past several years. Recent cases, such as the Toledo hospital merger

and the Carilion Clinic case, have demonstrated the importance of antitrust enforcement in preventing the creation or the improper presentation of market power.

The agencies clearly need to focus greater attention in those situations where physicians may possess market power. The DOJ and the FTC have generally overlooked this area—the most recent enforcement action against a group of physicians for exercising market power was 1994. In that case, the FTC challenged joint ventures by two groups of pulmonologists that harmed the home oxygen-equipment market by bringing together more than 60 percent of the pulmonologists who could make referrals for this equipment. This type of referral power by large groups of specialists can raise prices for many procedures. It is interesting to observe that the case was brought under Section 5 of the Federal Trade Commission Act, which declares illegal "unfair methods of competition." The agencies should use their full range of powers including the FTC's unique authority under Section 5.

Antitrust enforcement is an important solution but a limited one. The DOJ and the FTC have limited resources. In addition, antitrust enforcement does not break up monopolies or oligopolies that have been legally acquired nor does it restrict much of their exercise of market power. While traditional antitrust enforcement should absolutely remain part of the solution, we must also look to legislative fixes and innovative market reforms like ACOs to address the potential exercise of market power. There are several examples worth considering.

Massachusetts passed a law in August 2010 aimed at controlling health care costs. ²⁰ The law requires the Division of Health Care Finance and Policy, or DHCFP, to encourage payers and providers to adopt bundled payment arrangements rather than fee-for-service arrangements. The goal is to implement pilot bundled-payment programs in 2011. The law extends DHCFP's ability to require providers to submit standardized data about their costs and payments. It requires insurers to file all new rate increases with the commissioner of insurance and the commissioner is directed to disapprove such increases if they are "excessive, inadequate, or unreasonable in relation to the benefits charged." Perhaps most importantly, it requires that provider networks with 5,000 or more enrollees offer limited-network or tiered-network plans. The base premium for this plan must be at least 12 percent lower than that of the carrier's "most actuarially similar" plan that does not include such a network. There are also some specific provisions in the law that ensure that the tiered or limited networks will engender cost savings. Taken together, these provisions may make some real impact on containing price increases.

Paul Ginsburg also offers a number of suggestions for decreasing costs as part of his study. He breaks the suggestions down into two categories: a market approach and a regulatory

¹⁹ In the Matter of Home Oxygen & Medical Equipment Co., et al, 118 F.T.C. 661 (1994) (challenge under Section 5 to joint venture of 13 competing pulmonologists in California who formed a joint venture involved in the supply of home oxygen and other related medical equipment, which consisted of 60 percent of the pulmonologists in the relevant geographic area. Because the venture included such a high percentage of the pulmonologists in the area, the FTC alleged, it allowed the specialists to gain market power over the provision of oxygen to patients in their homes, and created a barrier against others who might offer that service (i.e., through patient referrals by the owner-pulmonologists and the resulting inability of another oxygen supplier to obtain referrals from pulmonologists), thereby reducing competition and risking higher consumer prices).

²⁰ An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses, August 10, 2010, available at http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288.

approach. In the market approach, the goal is to provide mechanisms that encourage individuals to obtain lower cost services. The vertical integration of the ACO model provides consumers with an understandable comprehensive cost of care that will then be easier to compare with other provider options. In the regulatory approach, the government may establish a common payment method across public and private payers and set a ceiling on the amount that providers can charge insurers. For example, in Maryland, all-payer rate setting is used for hospitals.

All of these recommendations on potential regulation pose complex issues. It is important to recognize that the ultimate goal of the Affordable Care Act is improved access to improved health care delivery. In assessing the roles of ACOs and potential regulation, there are important tradeoffs to be made.

Recommendations

Ultimately, concerns with health care industry consolidation need to be focused on strong consumer protection and the balanced antitrust enforcement paradigm I have described. Below are some recommendations for building a solid structure for competition and consumer protection enforcement that is supportive of efforts at reform, while protecting competition in healthcare markets.

- Increase coordination among government health and antitrust agencies. A vast
 majority of healthcare expenditures are in government programs and
 maintaining competition in these programs is vital for controlling costs. The
 DOJ and the FTC need to work with HHS and CMS to ensure that taxpayers
 are receiving the full benefits of the most efficient, lowest cost services.
- 2. The Obama administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious, and deceptive conduct by insurers. The structure of the health insurance market is broken and the evidence strongly suggests a pervasive pattern of deceptive and egregious practices. Health insurance markets are extremely concentrated, and the complexity of insurance products and opaque nature of their practices make these markets a fertile medium for anticompetitive and deceptive conduct.
- 3. Reinvigorated enforcement against anticompetitive conduct by health insurers and providers. The FTC should scrutinize anticompetitive conduct and use its powers under Section 5 of the FTC Act. Section 5 of the FTC Act can attack practices which are not technical violations of the traditional antitrust laws, the Sherman and Clayton Acts. Thus the FTC can use that power under Section 5 to address practices which may not be technical violations of the federal antitrust laws, but still may be harmful to consumers. As I have testified elsewhere, the FTC should begin to use that power under Section 5 to attack a wide range of anticompetitive and egregious practices by health insurers and PBMs.
- 4. Conduct a retrospective study of health insurer mergers. I and the American Hospital Association have suggested elsewhere that one approach to this issue would be for the FTC or the DOJ to conduct a study of consummated health insurer mergers. One of the significant accomplishments of the Bush administration was a retrospective study of consummated hospital mergers by

- the Federal Trade Commission. This study led to an important enforcement action in Evanston, Illinois, which helped to clarify the legal standards and economic analytical tools for addressing health insurance mergers. A similar study of consummated health insurance mergers would help to clarify the appropriate legal standards for health insurance mergers and identify mergers that have harmed competition.
- 5. Recognizing that the insurer does not represent the consumer. Although insurers do help to control cost, they are not the consumer. The consumer is the individual who ultimately receives benefits from the plan. It is becoming increasingly clear that insurers do not act in the interest of the ultimate beneficiary. They are not the proxy for the consumer interest, but rather exploit the lack of competition, transparency, and the opportunity for deception to maximize profits.
- Clarify the jurisdiction of the FTC to bring enforcement actions against health 6. insurers. Some may suggest that the FTC lacks jurisdiction over health insurance. I urge Congress to ask the FTC to clarify their position on this issue. Is the claim of no jurisdiction the law or simply an urban legend? As I understand it, there is a limitation in Section 6 of the FTC Act that prevents the FTC from performing studies of the insurance industry without seeking prior Congressional approval. This provision does not prevent the FTC from bringing either competition or consumer protection enforcement actions. There may be arguments that the McCarran-Ferguson Act limits jurisdiction, but that exemption is limited to rate making activity. In addition, some people might argue that the FTC's ability to attack anticompetitive conduct by nonprofit insurance companies might be limited under the FTC Act. The solution to this problem is simple, straightforward and critical. If the FTC lacks jurisdiction in any respect to bring meaningful competition and consumer protection enforcement actions against health insurers, Congress must act immediately to provide that jurisdiction. There is no reason why health insurance should be immunized from the Federal Trade Commission Act.
- 7. Congress should repeal the McCarran-Ferguson Act, exempting insurers from the full range of federal antitrust laws. Eliminating the exemption will make it clear that the Justice Department can bring antitrust cases and the Federal Trade Commission can bring consumer protection cases against health insurers. Repeal of this exemption would improve competition and is necessary for the type of substantial antitrust enforcement that is long overdue in health insurance markets.²¹

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Chairman HERGER. Thank you.

Mr. Gaynor, research indicates that provider consolidation results in higher prices. Who ultimately ends up paying these prices? Mr. GAYNOR. Thanks for the question.

The folks that ultimately end up paying for that are folks who have employer-provided health insurance. There is a lot of research evidence that shows that if health benefit costs for employers go up, those costs get passed on to workers, either in the form of lower pay or pay increases that are lower than they would otherwise

²¹ Testimony of David A. Balto, "Protecting Consumers and Promoting Health Insurance Competition" before the House Judiciary Committee Subcommittee on Courts and Competition Policy on H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009" (October 8, 2009).

have gotten, greater cost sharing for health insurance, or reduced benefits for health insurance, including, in some cases, elimination of the provision of health insurance entirely.

Chairman HERGER. Generally speaking, does consolidation result in improved quality of care or increased efficiency? And please

explain.

Mr. GINSBURG. Consolidation has the potential to do these things, but I think Dr. Gaynor had mentioned the literature—and I don't want to paraphrase him wrong—but I think there is no evi-

dence of a consistent pattern; is that correct?

Mr. GAYNOR. Yeah. For hospitals, again, if a consolidation is actually real, there is real integration, it will keep operating. Say two large orthopedic or oncological centers they consolidate, there can be real cost savings, but the evidence is that prices go up when there is consolidation. So if cost savings are realized those are not being passed on to consumers.

The only other evidence that I know we have on consolidation comes from some hospital organizations during the 1990s, and that does not provide evidence of substantial efficiency gains from that kind of integration at that time. Doesn't improve quality, either.

Chairman HERGER. Thank you.

Mr. Guarino, the difference in Medicare payment for the same procedure when it is done in an ambulatory surgical center versus a hospital outpatient department is striking. Can you walk through an example for a specific procedure so that we are clear on the discrepancy and the cost implication for beneficiaries and the tax-payers who largely fund the Medicare program?

Mr. GUARINO. Yes, Mr. Chairman.

On a knee scope, the hospital would receive \$2,042, where a surgery center would receive \$1,167 for the exact same procedure, and then there would be—the copay would be based on the dollar amount that the hospital would have charged, the higher amount.

Chairman HERGER. Thank you.

Mr. Stark is recognized.

Mr. STARK. Thank you, Mr. Chairman.

As I listen to the witnesses today, it becomes clear to me that Medicare has an advantage in the marketplace because it is a national program and pays defined rates. It doesn't run into negative consequences of consolidation the way that consumers in the private health care system may. I would ask Dr. Ginsburg and Mr. Balto if that doesn't suggest that a Medicare-for-all or an all-payer system might be the best answer for our health care system in the future. It seems to me that with that system we get the advantages of integration, increased efficiency, quality, and reduced waste, without having to worry about price consequences in local communities.

I don't know if you gentlemen would like to comment on that.

Mr. GINSBURG. There certainly are pros and cons of Medicarefor-all or rate setting, but I would say that, one of the pros for both is the ability to prevent consolidation from leading to much higher prices paid by the purchasers of medical care. It can be achieved through a broader Medicare program or, alternatively, in a private insurance system, it can be achieved through a rate-setting mechanism. Mr. BALTO. And I agree with Dr. Ginsburg. I think, you know, a powerful buyer like Medicare can really drive efficiency in the system and you see much greater efficiencies in the Medicare system.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. Reichert is recognized for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman; and thank you all

for being here today.

I have just a real quick question for Mr. Gaynor. In your slide presentation, one of the bullet points states that there is evidence of substantial market power in the Medigap market. What do you attribute the reason for that?

Mr. GAYNOR. Thanks for the question.

I should clarify in a couple of ways.

One, this is a recent study—or, actually, there is a couple of recent studies, so there is not a huge evidence base on this, but the evidence that is out there does point in that direction, one.

Two, there are a small number—or I should say, rather, that market is dominated by a couple of large insurers, and that is prob-

ably the reason for that.

Mr. REICHERT. What is the impact on Medicare Advantage then? Is part of the increase to the Medigap market the cuts to Medicare Advantage, seniors maybe moving to that market, or is it just because we have these two large organizations that have consolidated?

Mr. GAYNOR. Yeah. I think that the main impact is because the Medigap market is dominated by two large insurers offering the product. There may be spillover effects onto Medicare Advantage, for that matter, traditional Medicare as well, but there isn't any research evidence on that directly.

Mr. REICHERT. AARP's role in advertising have anything to

Mr. GAYNOR. It could, it could, but I am not-

Mr. REICHERT. Their special label might have some impact

there, you think?

Mr. GAYNOR. Well, I don't have specific knowledge about that, but the evidence that I am referring to did say that brand name had a lot to do with that, without referring specifically to AARP, to be clear.

Mr. REICHERT. Yes, sir. So this is a question for the entire panel, specifically to the dialysis industry and their consolidation. There is enormous consolidation taking place in that venue. For the past decade that has been happening, and there has been a recent acquisition, as you know, in this past week. Just two extremely large for-profit dialysis companies provide care to over now 65 percent of everyone in this country who require dialysis to stay alive. What impact is that going to have in that specific market on the choices, the price that people will pay, the access that people will have—won't it have the effect of eliminating those smaller neighborhood dialysis centers where people would have maybe better access to—what is the impact on these large consolidations in the dialysis arena?

Mr. BALTO. Congressman Reichert, you are right. This week the Federal Trade Commission acted in the DaVita matter requiring divestiture of I believe 29 centers which the FTC, based on its investigation, believes is going to be sufficient to alleviate the competitive concerns raised by the merger. They looked specifically at a wide variety of geographic markets and in markets that they believed were very concentrated required the divestiture. I am not sure that the FTC's action is adequate. The FTC action leaves very few national players in the market, but their focus was primarily on just these 29 individual markets.

Mr. REICHERT. Any other comments?

How about home dialysis? Any impact on that that you would see, Mr. Balto, or anyone else on the panel?

Mr. BALTO. No. Mr. REICHERT. No?

Mr. Ginsburg, can you talk a little bit about why a hospital might want to purchase a local physician practice? I know you touched on this a little bit, but could you go through some of the

reasons why that might happen again, please.

Mr. GINSBURG. Sure. One of the points that I made—and we published a study about two weeks ago on this—is that even though in theory preparing for integration, accountable care organizations, employing physicians would be helpful, but I believe that much of the current activity is motivated by opportunities in the current fee-for-service system. And, basically, hospital strategies in recent years have been to identify fairly profitable service lines; and sometimes to expand a service line by going and recruiting physicians, prominent physicians. Hospitals are always battling each other over market share, and employing physicians is a way to get market share from one's competitors. Those are the key driv-

Mr. REICHERT. Thank you, Mr. Chairman. My time is expired. Chairman HERGER. Mr. Kind is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman. Thank you for holding

this very important hearing.

I want to thank the witnesses for your testimony today, especially welcome Ms. Kiehl from my home in State in Wisconsin, very fascinating testimony. What is even more amazing is the results you have been able to achieve with the group that has been formed,

the consolidation of the employers.

If I read your testimony correct, you went from moving the insurance rates for your employers from 39 percent above the Midwest average in 2003 to 6 percent below the Midwest average by 2009, which is an amazing transformation; and it seems to me that what you have been able to achieve there through this collaboration of employers is a model we ought to be looking at nationwide. Yet it doesn't seem to be catching on in other areas. Why is that? Why aren't we spreading this model out so other employers can take advantage of what you have been able to establish?

Ms. KIEHL. Well, let me just clarify. We didn't do that singlehandedly. We definitely contributed to the market. We were a force in the market. We do get credit for what we did in the market, but there is a lot of activity going on in Wisconsin, as you probably well

know, Representative Kind.

Mr. KIND. Yeah.

Ms. KIEHL. So we were definitely a force, especially in south-

eastern Wisconsin, which is heavily populated.

The reason why it is hard to roll this approach out around the country is that you have to think about it from an employer's perspective. Let me explain the difficulty that we run into when we try to add more employers to our group. I can tell you I spend many hours in bed at night wondering why doesn't every employer in our market join our group. That would make it really good, and we could really deliver much better results. But the dilemma is that employers are multi-State, obviously global even. So they look at their plan designs and they look at their networks and they look at who serves them best across the country.

We have a very unique model because we did not want to duplicate the infrastructure related to contracting with providers. We chose a strategy of having one sole administrator. So the dilemma is a lot of employers want one administrator and maybe the one we chose is not the one that works for them across the country. They need to change that focus of thinking that health care can be handled across a broad geographic area, and they need to look at what do they need to do in each market to control health care costs because then they would join our group and we would have more

impact.

Mr. KIND. Let me ask you—because my time is limited and I know my colleagues get tired of me talking or bragging about what is going on in Wisconsin, but there are a lot of unique things that we should be talking about to take nationwide. The Wisconsin Collaborative Health Care Quality that you referenced in your testimony, this was voluntary collaboration of health care providers joining forces in order to establish quality measurements to determine what works, what best practices protocols of care that they are sharing amongst each other. The Wisconsin Health Information Organization, the ability for public-private partnership to collect the data for greater transparency in the marketplace, too, things that I think virtually all of you were touching upon.

But as we go forward with this supercommittee over the next couple of months looking for long-term deficit reduction to deal with the structural problem that we are facing, obviously health care costs is the major item. If we don't get a grip on the rising health care costs, virtually anything else we do really isn't going

to matter.

So there are three options the way I see it that we face. We can either go after the providers, asking for deeper cuts, and even though there are some already in the Affordable Care Act, more would be asked to start shifting costs to the beneficiaries and given the state of beneficiaries today that is not a very pleasant option, or we can change the way we pay for health care in this country. And that is something that is being worked on right now under the Affordable Care Act, changing the fee-for-service system to a fee-for-value or a quality-based reimbursement system.

How important do you think that will be as far as the overall health care system is changing how we pay for health care in this country and getting away from these volume payments to pay-

ments based on results, quality, or value? Ms. Kiehl?

Ms. KIEHL. Well, I actually think it is very important, but it is also very difficult. You are trying to change history of how claims and how services have been paid for, and the administrators or the carriers across the country, they have mega systems of IT that is not going to be able to turn on a dime. So it is going to take a long time I think to do this in an efficient way.

Administrators and providers can handhold certain payment reform projects. We are doing some projects in Wisconsin, and we will get collaboration from some providers and administrators to be able to pilot some of these projects. But it will slow down the throughput on auto adjudication. It will take some time to auto-

mate these new payment approaches.

Mr. KIND. I think a hearing on consolidation, the impact that is having on prices is fine, but unless we get a grip on the ultimate payment system, the incentives that are built in, encouraging more volume rather than to focus on value or outcomes, we are going to be spinning our wheels. And you are right. We are not going to change the way we pay for one-fifth of the entire U.S. economy overnight. It is going to require a transition period. I think that needs to be the ultimate goal.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Gentleman from Georgia, Mr. Price, is recognized for 5 minutes. Mr. PRICE. Thank you, Mr. Chairman. I want to commend you for holding this hearing.

I want to thank the witnesses.

The costs in health care are a concern for all. I would respectfully suggest that the major fundamental change that has occurred in health care over the past 2 years has been the bill that was passed by Congress that really does nothing to address the costs in health care, with the exception of the ability of the Federal Government to deny care to recipients.

There is significant evidence that the market is so distorted I believe by rules and regulations from the Federal Government that we are not even talking about market forces anymore. All that I heard from the four to the left here are all the defensive activities that are going on in the market to just try to navigate the system, and what is lost in all of that is the patient, and we have had some allusions to quality care but most of this is talking about cost.

Mr. Gaynor, in your presentation, there is a little line in there that says that regulated prices, especially in the Medicare system, that the consolidation in this area reduces quality of care. Would you expand briefly on that, please?

Mr. GAYNOR. Sure, of course.

So the evidence is as follows: There have been a number of studies in this area. The most prominent one looked at impacts on mortality for Medicare beneficiaries who are suffering from heart attacks, and what they found is that mortality rates were substantially higher for Medicare beneficiaries who had heart attacks who obtained care in the most concentrated hospital markets. Indeed, the mortality rate was on average one and a half percentage points higher for these heart attack patients if they were treated at a hospital in a highly concentrated market as opposed to a hospital in a less concentrated market.

So price is not an issue here. Obviously, prices are set by fiat,

but quality of care is something that is still an issue.

I also can mention some research I have done recently with some colleagues in the U.K. The British National Health Service recently moved to a system where they tried to encourage competition among hospitals and used regulated prices like our Medicare prices, and our evidence is very much like the evidence from the U.S.

Mr. GAYNOR. We find that patients do better when they are served by hospitals that are in less concentrated markets as op-

posed to more concentrated markets.

Mr. PRICE. And I think this really is the major issue. As a physician, I can tell you that the patients are concerned about costs, yes, but they are concerned about quality. And the physicians in this country are concerned about quality, and they believe, many of them, that the quality that they are able to provide is being limited by the rules that are coming out of Washington.

Mr. Guarino, I want to discuss, the evidence is pretty clear that ASCs, ambulatory surgery centers, many of which are physician-owned—provide higher quality care at lower costs. And yet the bill that was recently passed limits the number of physician-owned hospitals—and ASCs fall under this—to any expansion at all. What

is going on?

Mr. GUARINO. I think that is a better question for you guys.

Mr. PRICE. Why do you think anybody would come up with a public policy that wants to do away with facilities that provide

higher quality at lower costs? What is the rationale there?

Mr. GUARINO. You possibly could look at the marketplace, what is being driven in the marketplace regarding with the—who we are in competition with. I know there has been concerns regarding physician ownership in surgery centers like you have said in the past, but it has been proven patient satisfactions are higher, quality, and the savings to the system.

Mr. PRICE. So an ideal public policy then for decision makers here ought to be to expand the kind of facilities that you are representing here, as opposed to limit them. Would that be an appro-

priate statement?

Mr. GUARINO. Yes, it would be.

Mr. PRICE. I want to touch, Mr. Balto, on the comments that you made about antitrust reform for physicians. Noneconomically aligned physicians out there, the mom and pops, the smaller practices have been at the mercy of larger entities, whether it is insurance companies or the government or other provider entities that are much larger. And I think I heard you say that you supported, you encourage the administration to support anti-trust relief for those physicians so that noneconomically aligned physicians could pool together and negotiate with hospitals, insurance companies, and others, is that correct?

Mr. BALTO. Yes, I strongly support that. I testified to that in other contexts. That was actually legislation proposed by former Republican Congressman Tom Campbell, and I think it is something physicians really need to create a balance and better protect

the health care of consumers.

Mr. PRICE. Thanks. I think you are absolutely right and encourage you to continue to champion that in the administration.

Ms. Kiehl, in my very brief moments—in fact, the clock just turned, so I apologize. We will get questions to you on the record.

Chairman HERĞER. Thank you, Dr. Price.

Now Mr. Johnson will be recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

You know, it appears to me, at least in the Dallas area, that physician-owned hospitals versus other hospitals are doing a better job at lower cost. I don't know if you can confirm that or not, Dr. Ginsburg.

Mr. GINSBURG. I don't have any specific evidence to compare

physician-owned with other hospitals.

Mr. JOHNSON. Why would we want—why does a hospital want to purchase physician practices right now? Can you talk to that?

Mr. GINSBURG. Yes. Hospitals are continually competing with each other for—to get more patients, and the way they do this is to try to align physicians with them. And since employing a physician is the ultimate alignment—

Mr. JOHNSON. Well, that is happening all around, but I don't

see any reduction in cost.

Mr. GINSBURG. I wouldn't expect any. For one thing, we know that hospitals are able to negotiate much higher reimbursement rates from private insurers for their employed physicians than physicians are able to obtain in small practices.

Mr. JOHNSON. But that is costing you and me more when we

go to the hospital.

Mr. GINSBURG. Absolutely. It is costing us more when we pay our insurance premiums. And, as Dr. Gaynor mentioned, even when it is employer-paid coverage, the employees ultimately pay the bill.

Mr. JOHNSON. Well, is there a deterioration in innovation and

quality?

Mr. GINSBURG. As far as hospital-employed physicians, if hospitals are going to innovate and integrate delivery, coordinate care, having employed physicians is going to be an asset to them. Because in the traditional staff relationships, hospitals can have a lot of trouble engaging physicians in efforts to improve quality or coordinate care. So it is going to be an asset if the system goes in that direction.

Mr. JOHNSON. Okay. Well, I am told that docs aren't even going to school anymore because it doesn't look like a profitable profession, and they work them too long.

Ms. Kiehl, what do you think the current barriers are to transparency? And is there anything this subcommittee can do to re-

move those barriers?

Ms. KIEHL. Well, I think one of the barriers is that providers contract with all the different plans at varying rates. So they can't even tell—their front office can't tell a consumer what something will cost for that specific consumer. Try some time to find out what your rate would be for a colonoscopy. They really can't tell you. Because they would have to go back to the contract and figure it out. So it is very difficult.

So this varying rate business really interrupts the ability to effi-

ciently provide transparency.

And the other barrier is the administrators, who also don't want their rates to be disclosed because that would give an advantage to the administrator who had the best rate. This is why we believe that providers should be in charge of setting what they charge for something, meaning they should decide what they can afford to charge for something, and they should compete with each other versus competing at a network level where the consumer really has no ability to impact. They can't choose their administrator, the employer chooses.

So are people going to call a prospective employer and first ask them,—do you offer a health benefit plan that has the best prices in the market? Otherwise they just end up getting subject to whatever price happens to be in place with their employer's carrier or their administrator to deliver their service need. So it is just a di-

lemma that we are faced with at this time.

The other thing is that providers don't want to display their rates either, because then everybody will know who does what at the best rate, and there is a lot of controversy on that in the provider community. So there are confidentiality clauses that are in place in the contracts on both the administrator side and the provider side that interferes with transparency.

The consumer is the one who really needs to have access to the rates. They are the purchaser. Where else can you go and purchase something and not know the cost until after it is delivered to you?

It doesn't make sense.

Mr. JOHNSON. Okay. Thank you.

Mr. Balto, you had a comment.

Mr. BALTO. Yes. Sometimes our Federal Government creates impediments to transparency; and, as an example, the Federal Trade Commission has come out in opposition to transparency in the PBM market. Certainly this is an area where there is a desperate need for transparency. PBMs basically play the spread, getting one price for drugs and charging something much greater; and for some very-difficult-to-discern reason the FTC has come out and said transparency is bad. I don't think there is a person in the Halls of Congress that would come out saying transparency is bad.

Mr. JOHNSON. Thank you. Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

I apologize to our panelists and our members. We do have a series of a couple votes followed by a moment of silence. What I would like to do is, before calling on Mr. Pascrell for 5 minutes, to announce that we will-I would ask the members to come back immediately after the moment of silence so we can get in maybe a final half hour of questioning before we adjourn.

But, with that—and we will recess at that time, but Mr. Pascrell is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Balto, you express very particular concerns about the health insurance industry and the results of a private market that hasn't protected the consumer and it has led to a dramatic increase in premium prices. The facts are the facts, Mr. Balto, would you agree?

Mr. BALTO. Yes.

Mr. PASCRELL. While I pointed out earlier this year that when reform is implemented—is implemented—premiums will be reduced by 9.2 percent for American families with employer-based insurance or, to put it better, \$2,000 per family, I don't believe we discussed certain details like the CO-OP Program in health care re-

According to a Commonwealth Fund report of May, 2010, do you know that the CO-OP Program in health care reform will support the creation of a new health plan in every State of the Union? Is that correct, Mr. Balto?

Mr. BALTO. Yes.

Mr. PASCRELL. Do you believe that the CO-OP Program. Section 1322 of the health reform bill, will help infuse competition into this private market which everyone wants to save and says is competitive?

Mr. BALTO. I think the CO-OP Program is important, along with other provisions of the ACA which I have detailed in my testimony. It is going to provide greater transparency. It is going to force the insurance companies to compete at a level that they haven't had to compete up until now.

Mr. PASCRELL. Do you think that there is more that the Federal Government can do, that we can do to protect the consumer

and promote competition in the health insurance market?

Mr. BALTO. Two things quickly. You should repeal the McCarran-Ferguson Act which, for some reason, gives the health insurance companies an anti-trust exemption. The only other people that get it is baseball.

And then, second, the FTC should establish a bureau to deal with consumer protection problems in the health insurance indus-

tries.

Mr. PASCRELL. There haven't been too many Justice Departments, regardless of who the President is, that have recommended that, Mr. Balto. So we shouldn't hold our breath over that.

Mr. BALTO. Actually, the current Justice Department does rec-

ommend repeal of the McCarran-Ferguson Act.

Mr. PASCRELL. Who recommended that?

Mr. BALTO. Christine Varney in testimony in the last session.

Mr. PASCRELL. Somehow that got by us, I guess. We have been talking about this for years. Do you think it is possible?

Mr. BALTO. Yes. It passed by a strong—over 400 Congressmen in the last session voted to repeal the McCarran-Ferguson act.

Mr. PASCRELL. Well, why haven't we done that?

Mr. Chairman, we ought to take a look at that. I think that is critical. I think it is essential to everything that we talk about in terms of health care. Even the good doctor from Georgia agrees with me, right?
Mr. PRICE. Even.

Mr. PASCRELL. Very good.

The Consumer Operated and Oriented Plan, the CO-OP, was created by Section 1322. I think this is very, very important to what health care—it is not a perfect piece of legislation, but I think that this CO-OP is very important in Section 1322. It supports the establishment of nonprofit health insurance plans to compete with plans in the current market. How do you think that is going to fly?

Mr. BALTO. I think it is going to be an important competitive for us. We like to call it, in anti-trust jargon, a maverick, someone whose incentives are going to be totally different, they are going to be very consumer oriented. And if there is sufficient transparency and choice, and the exchanges are going to help ensure that, you are going to see a change and a significant improvement in competition in health insurance markets.

Mr. PASCRELL. Thank you very much.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Again, this committee will recess. We will come back immediately after the moment of silence. Thank you.

[Recess.]

Chairman HERGER. The Ways and Means Health Subcommittee will come to order.

Again, I apologize to our witnesses for the votes we have had. But, before this hearing wraps up, I would like to ask two questions.

Dr. Gaynor, when plans, hospitals, or other brick-and-mortar providers exit a market, it generally puts upward pressure on the prices consumers pay for health care. Are these higher prices transitory or a permanent issue for consumers?

Mr. GAYNOR. Once prices go up, they stay up. Price increases are not rescinded.

So a price goes up this year, it is going to stay high next year and the year after that and so on. If a hospital or a physician practice acquired market power and nothing changes that market power, they will continue to charge high prices.

Chairman HERGER. So do hospitals reenter the market or do

consumers just have fewer choices?

Mr. GAYNOR. When hospitals exit, they don't reenter the market.

Chairman HERGER. And, Dr. Ginsburg, Mr. Balto has suggested that provider consolidation is not a significant problem and that there is no evidence that higher physician costs are a significant driver of escalating health care costs. However, you have noted that consolidation between hospitals and physicians can result in higher costs. Can you describe the evidence you have seen in this point across the 12 markets you have examined?

Mr. GINSBURG. Yes, certainly. First of all, as far as Dr. Gaynor mentioned before, the research on how hospital mergers affect prices is fairly clear that that leads to higher prices. As far as physician—hospital employment of physicians, we know just from our interviews, because we ask hospital executives and health plans how much they pay physicians who are employed by hospitals. And in many large metropolitan areas the payment rates private insurance for small physician practices is not very different from Medicare rates, sometimes a little higher, sometimes lower. But the rates that hospitals can achieve are substantially higher than Medicare rates.

So this is a very recently developing phenomenon. There has been a wave of hospital acquisition of cardiology practices that began in 2010. So there hasn't been an attempt quantitatively to say how much of premium increases is due to greater hospital employment of physicians. But from our qualitative research it is very clear that this is going to be increasing premiums.

Chairman HERGER. Thank you very much.

I would like to ask unanimous consent to enter into the record a new Rand Corporation study released yesterday that shows hospital consolidation, not insurance consolidation, is a leading driver in higher health care prices.

Without objection, so ordered. [The information follows:]

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HEALTH PLANS & PROVIDERS

By Glenn A. Melnick, Yu-Chu Shen, and Vivian Yaling Wu

The Increased Concentration Of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices

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ABSTRACT The long-term trend of consolidation among US health plans has raised providers' concerns that the concentration of health plan markets can depress their prices. Although our study confirmed that, it also revealed a more complex picture. First, we found that 64 percent of hospitals operate in markets where health plans are not very concentrated, and only 7 percent are in markets that are dominated by a few health plans. Second, we found that in most markets, hospital market concentration exceeds health plan concentration. Third, our study confirmed earlier studies showing that greater hospital market concentration leads to higher hospital prices. Fourth, we found that hospital prices in the most concentrated health plan markets are approximately 12 percent lower than in more competitive health plan markets. Overall, our results show that more concentrated health plan markets can counteract the price-increasing effects of concentrated hospital markets, and that-contrary to conventional wisdom-increased health plan concentration benefits consumers through lower hospital prices as long as health plan markets remain competitive. Our findings also suggest that consumers would benefit from policies that maintained competition in hospital markets or that would restore competition to hospital markets that are uncompetitive.

s the long-term trend of consolidation among US health plans continues, providers have voiced growing concern that health plans will acwill be able to depress the prices paid to providers. The American Hospital Association has argued that health plan consolidation leads to "reimbursement to hospitals and physicians that is below competitive levels," thereby threatening both the quality of care and patients' access to it.¹ The American Medical Association has proposed legislation that would allow physicians to bargain collectively with health plans without fear of antitrust prosecution, so as to "level the playing field" in price negotiations.^{7,3}

Despite the importance of these issues, and the growing interest in them, there is limited empirical evidence regarding the relationship between concentrated health plan markets—that is, markets where most people with private health insurance purchase it from one to just several insurers—and the prices that plans pay to providers. There have also been few studies of the relationships among the level of concentration in the market of health plans; the level of concentration in the market of health plans; and the prices that hospital charge. ⁴⁵ This article adds to the literature by studying how both health plan market concentration interact to affect hospital prices in the United States.

The Framework For The Study
The literature on hospital pricing and on bargaining between hospitals and health plans
serves as the framework for our empirical analyses. Health plans compete with each other on
price—the premiums they charge—along with
the quality and accessibility of the providers included in their networks or benefit packages.
Because the cost of hospital care represents
about half of the health care costs that plans must
pay, the prices that they pay hospitals have a
large impact on the premiums they must charge.
Mark Pauly suggests that larger plans should be
able to secure lower prices from hospitals than
smaller plans can. Accordingly, because the
average size of the plans in more concentrated
markets—those with fewer health plans—is
larger, prices should be lower.

However, health plans' bargaining power also depends on plans' ability to send their members to competing, lower-price hospitals for care, rather than having to use a more expensive hospital.\(^{74}\) The ability of health plans to substitute one provider for another to create competition and generate lower prices depends on the concentration of the hospital market in which the plans are buying services. Research shows that in concentrated markets, health plans pay higher prices to hospitals.\(^{9}\)

According to this framework, increasing the market concentration of health plans has the opposite effect on hospitals' prices from increasing the market concentration of hospitals. Thus, the prices that hospitals receive will depend on the relative concentration in the market of both plans and hospitals. Our analyses included plan and hospital market concentration measures to explore how these factors affect hospital prices.

Study Data And Methods

DATA Our sample included all general, acute care hospitals not owned by the federal government that were located in Metropolitan Statistical Areas in 2001 and 2004. Hospital data came from Medicare hospital cost reports, the American Hospital Association Annual Surveys, and a database of multihospital systems provided by Kristin Madison and Sujoy Chakravarty. 10-12

Kristin Madison and Sujoy Chakravarty. 10-12
The federal government's Area Resource File and the Medicare Impact files provided the area wage index, per capita income, unemployment rate, and population data. We obtained managed care data for health maintenance organizations and preferred provider organizations in 2001 and 2004 from InterStudy, a health care data company; these data cover more than 90 percent of the United States.

The final analytical sample contained 4,017

hospital-year observations and included more than 90 percent of all hospitals located in Metropolitan Statistical Areas.

METHODS First, we summarized the distribution of hospitals and Metropolitan Statistical
Areas across different levels of market concentration for both health plans and hospitals. We
constructed multivariate models to explore the
effects of health plan and hospital market concentration on hospital prices. In one model, we
estimated the effects of market concentration of
both plans and hospitals on hospital prices, after
adjusting for other factors that affect hospital
prices. For example, because previous research
has shown that prices can be lower in areas
where more of the population is enrolled in managed care plans, 13 we included the level of managed care penetration in the market as an additional factor.

In a second model, we tested for the possibility that health plan concentration effects on hospitals were much stronger in the most concentrated markets, compared to less concentrated ones, by dividing health plan markets into four categories, based on health plan concentration.

We employed standard statistical methods to adjust for the fact that we used a pooled crosssectional database for our analysis." Finally, we conducted a series of statistical tests to validate our key assumptions and found that our results were unchanged and statistically robust.¹⁵

HOSPITAL PRICES Because actual hospital prices paid by private health plans, such as per diem prices, are not available on a national basis, we constructed our statistical models to produce a valid proxy for hospital prices. Following other researchers, ^{13,16,17} we regressed total hospital not revenue on a set of independent variables that included hospital volume (total adjusted patient days) ¹⁸ and hospital case-mix. Case-mix was measured by the Medicare case-mix index, a measure of patients' level of illness.

Because net revenue equals price times quantity, by including a quantity measure we controlled for and effectively held constant the changes in net revenue related to quantity, while the case-mix measure controlled for changes related to patient severity over time. The total net revenue included Medicare and Medicaid revenue as well as revenue from private payers, so we also controlled for the changes in revenue due to the mix and prices of different payers.

HEALTH PLAN CONCENTRATION We constructed a standard concentration index variable with values that ranged from close to 0 to 10,000. A monopoly market—that is, a market with a single health plan—had a value of 10,000, while a value close to 0 represented a highly competitive, less concentrated market.

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Using Metropolitan Statistical Areas as the geographic market for health plans, we summed the squared value of each health plan's Metropolitan Statistical Area market share. If a health plan offered both health maintenance organization and preferred provider organization and preferred provider organization products in a given metropolitan area, we first added the enrollment in each together and then calculated the market share of the combined products before computing the concentration index.

Other studies have calculated these values separately for both health maintenance organization and preferred provider organization products under the assumption that they serve separate product markets. However, it is more likely that consumers see these two types of plans as similar enough that they are willing to switch between the two. Thus, both types of products should be included in the same market. 78-22

should be included in the same market. 20-32

To measure health plan concentration, we used a standard concentration index, again with values ranging from close to 0 to 10,000. We divided Metropolitan Statistical Areas into four categories, based on their health plan concentration index: less than 1,000, 1,000-1,800, 1,801-3,200, and greater than 3,200. These thresholds were chosen to facilitate comparison with other studies of health plan market concentration and are consistent with the Department of Justice 1997 Merger Guidelines. 22

MANAGED CARE PENETRATION AND HOSPITAL MARKET CONCENTRATION Following previous studies, 3x45 we calculated managed care penetration as the total population of a metropolitan area that was enrolled in either a health maintenance organization or a preferred provider organization in a given year, divided by the total population of that area in that year.

We calculated a hospital-specific concentration index for each hospital's market, using standard methods. 26

control variables Following other studies, 37-38 we included supply and demand variables that might affect hospital prices, including a wage index (as a proxy for input prices); Medicare's and Medicaid's shares of total inpatient discharges (to control for payer mix); hospital ownership (not-for-profit, for-profit, or government); hospital teaching status; hospital system membership status; Medicare case-mix index (log transformed); total adjusted patient days (log transformed); er capita income in the hospital's geographic area (log transformed); and the percentage of for-profit and government hospitals within a fifteen-mile radius.

We also included time variables to control for general trends in hospital prices over time, and geographic variables (including each hospital's census region) interacted with time variables to capture regional differences in hospital prices

LIMITATIONS Although our market concentration data cover the period between 2001 and 2004, our results are likely to remain valid today. Consolidation has continued within both hospital and health plan markets, but increases in market concentration have slowed because antitrust regulations limit mergers and acquisitions that greatly increase concentration in local markets. Our statistical results are generally descriptive in nature, which limits our ability to make strong causal inferences regarding the welfare effects of the relative concentration between hospital and health plan markets.

Study Results

Hospital and health plan market concentration differs across the country (Exhibit 1). Thirty-two metropolitan areas (10 percent) are in the most competitive category for health plans and account for 13 percent of US hospital revenues for 2004. The most concentrated category for health plans contains thirty-five areas and 7 percent of hospital revenues for 2004.

Hospital market concentration varies only slightly across the categories, ranging from 3,204 to 3,661 (Exhibit 1). And only in the most concentrated health plan markets does the health plan concentration divided by the hospital concentration exceed 1.0. These results indicate that hospitals face less competition in their own markets than health plans face in theirs. More than 90 percent of all hospitals (2,111 of 2,276) operate in markets where the hospital market concentration exceeds the health plan market concentration.

Higher health plan market concentration reduces hospital prices, while higher hospital market concentration increases them. For example, a 1,000-point increase in the health plan concentration index is, on average, associated with 2.5 percent lower hospital prices, while a 1,000-point increase in hospital prices, while a 1,000-point increase in hospital concentration values is associated with an 8.3 percent increase in hospital prices. Model 2 shows that health plan concentration reduces hospital prices at a much gradier rate in those areas where health plan markets are the most concentrated but reduces them at a much smaller rate in less concentrated ones (Exhibit 2).

Discussion

Previous research has documented a trend of consolidation among US health plans.³⁸ Provider groups such as the American Hospital Association argue that health plan markets are already

itions Of Health Plans And Hospitals in Metropolitan Statistical Areas (MSAs), 2004

Health plan concentration index	Number of MSAs	Number of hospitals	Percent of total hospital revenue	Average health plan concentration	Average hospital concentration	Health plan concentration/ hospital concentration	Percent of population in managed care
<1,000 1,000-1,800	32 129	326 1.131	13	854	3,204	0.28	57
			51	1,409	3,265	0.46	59
1,801-3,200	122	654	28	2.284	3,570	0.66	57
>3,200	35	165	7	3,977	3,661	1.11	59
Total	318	2,276	99	1,714	3,361	0.52	58

SOURCE Authors' calculations based on data from InterStudy and the American Hospital Association Annual Surveys. NOTES The concentrations, concentration index, and penetration are explained in the text. Percentages of hospital revenue do not sum to 100 because of rounding.

highly concentrated, and that continued consolidation will allow plans to gain additional market power, which will give them too much bargain-

ing power over providers.

Our findings add several new and important insights to this discussion. Our descriptive analyses show that 64 percent of hospitals oper-ate in markets where health plans are not very concentrated, and only 7 percent are in the most concentrated health plan markets (Exhibit 1). These results suggest that contrary to conventional wisdom, very few hospitals operate in mar-kets with only a few dominant health plans.

Our statistical results show that although higher health plan concentration is associated with lower hospital prices on average, this rela-tionship is not constant. In fact, hospital prices are significantly affected only when health plan concentration index values are above 3,200 (Exhibit 2). These findings lend support to the argument that highly concentrated health plan markets can lead to lower provider prices.

At the same time, our results are consistent with previous research^{9,30} showing that hospital prices are higher in more concentrated hospital markets. Higher hospital concentration is asso-ciated in all of our models with higher hospital prices. For example, a 1,000-percentage-point increase in the hospital concentration index raises prices by approximately 8.3 percent

Taken together, our results show that more concentrated health plan markets can counteract the price-increasing effects of concentrated hospital markets.

POLICY IMPLICATIONS Our results have implications for health care policy. Under the Affordable Care Act of 2010, states are beginning to regulate insurance premiums to control costs; our results suggest that restoring competition to hospital markets would have an even larger effect. Regulators should continue to monitor

health plan consolidation to prevent excess concentration, but they should also adopt proactive policies to increase hospital market competition.

Many areas in the United States are dominated by several large local or national hospital systems that negotiate collectively with health plans. This reduces competition and raises hosplans. This reduces competition and raises hospital prices. Because such large systems may provide increased efficiency and quality, we do not recommend breaking them up. But regulators could require hospitals in the systems to negotiate independently with health plans. The Federal Trade Commission recently applied this approach to hospitals operating in Illinois. "And Medicare should be careful not to create concentrated organizations that reduce competition."

Medicare should be careful not to create concentrated organizations that reduce competition when it establishes large, provider-based accountable care organizations.

Increased transparency would also benefit consumers. Providers should be required to share utilization and cost data with payers such a large employers. Currently were for these consumers. as large employers. Currently, many of these employers do not have access to data on how much care their employees are using, and how much they are paying for it.

Changes In Hospital Prices Associated With Hospital And Health Plan Market Concentra

	Percent change in hospital prices			
Concentration Index Hospital (for 1,000-point increase)	Model 1 8.3**	Model 2 8.3 [∞]		
Health plan (for 1,000-point increase)	-2.5°°	_		
Health plan 1,000-1,800	_	-1.0		
Health plan 1,801-3,200	-	-3.0		
Health plan > 3, 200		-12.17**		

SOURCE Authors' calculations based on regression analysis. NOTES Estimates control for other variables. The results for other control variables are given in the online Appendix (to access the Appendix. (to an the Appendix link in the box to the right of the article online). The two models are described in the text " *p < 0.05

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FUTURE RESEARCH QUESTIONS We found that hospital markets, on average, were much more concentrated than health plan markets. These findings depend in part on the definition and measurement of health plan products and markets. We combined health maintenance organizations and preferred provider organizations into a single product market because we assumed that consumers are willing to substitute one for the other and that an insurer offering both products negotiates with providers as one entity. However, others have treated these organizations as separate product markets or used other approaches. 4.29 Assuming that there are separate product markets leads to smaller mar-kets and higher health plan concentration index values. Research is needed to validate these assumptions.

Another question is whether fee-for-service care paid for by Medicare and Medicaid should be included in the denominator when calculating health plan market shares and concentration values. New studies should focus on these important conceptual and measurement issues and examine interactions with other markets-such as physician markets—which may have different underlying structures. We also need further research to extend our understanding of how these and other market structure variables work together to affect the prices that consumers ultimately pay each year to purchase health insurance and medical care.

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- which managed care market characteristics are measured.

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 27 Zwanziger J. Médnick GA, Bancezal A. and officed of selective contracting the part of multi-hospital systems with other members in the same geographic market.

 28 Zwanziger J. Médnick GA, Bancezal A. and officed of selective contracting the part of the part
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ABOUT THE AUTHORS: GLENN A. MELNICK, YU-CHU SHEN & VIVIAN YALING WU



Glenn A. Melnick is

In this month's Health Affairs, Glenn Melnick and coauthors report on their examination of markets in which health plans, hospitals, or both are highly concentrated. Their results show that more concentrated health plan markets can counteract the priceincreasing effects of hospital concentration and that health plan concentration benefits consumers through lower hospital prices as long as health plan markets remain

competitive.

The authors took up their study because lack of competition in insurance markets was cited as a main culprit behind rising health insurance premiums during the recent debate over health reform.

Surprisingly even to him, Melnick says, the study refutes that claim. Melnick says he now hopes that this report will bolster the commitment of policy makers to "strengthening and restoring provider market competition" as a way to better control costs.

Melnick holds the Blue Cross of California Chair in Health Care Finance in the School of Policy. Planning, and Development at the University of Southern California. He is also a resident consultant for the RAND Corporation in Santa Monica, California. Melnick received his doctorate in urban and regional planning from the University of Michigan.



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Daily Report for Executives™

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Health Care Berwick Says Costs 'Most Urgent' Problem for Health Care System

The high cost of health care is the "most urgent" problem the United States faces in its health care system, Centers for Medicare & Medicaid Services Administrator Donald Berwick said Sept. 8.

"Our costs are too high—unsustainably high for our country," Berwick said at a *Health Affairs* journal briefing. "And the value is too low," with problems related to patient safety, effectiveness of care, and equitableness for people with lower incomes, he said.

"The problems of cost and the problems of quality are connected," Berwick noted.

Controlling health care costs through productivity improvements is more difficult than cutting payments to providers, Berwick said. However, he said, "It's just better."

Government, Private Sector Must Be Partners

The government and private sector must be partners in reducing costs and improving quality, Berwick said. The Patient Protection and Affordable Care Act is a "rich toolbox of opportunities and levers and ideas" to improve the health care system, he said.

Berwick cited as an example the Partnership for Patients implemented by CMS under PPACA. Under the partnership, the government is investing \$1 billion to reduce hospital-acquired conditions by 40 percent and to cut hospital readmissions by 20 percent by 2013. The program is "the largest effort, I think, ever undertaken anywhere in the world—certainly in our country—to try to help health care become safer," he said

The program is expected to save Medicare about \$30 billion over its first 10 years, he said.

CMS is implementing direct savings through payment rules and other means, Berwick said. The agency, which spends about \$800 billion a year on Medicare, Medicaid, and the Children's Health Insurance Program, is also implementing indirect savings through efforts such as reducing waste, which are harder to track, Berwick said.

Indirect savings, however, "may be more sustainable over time," he said. "Direct cost levers are always subject to debate and push-back, because we're talking about the amount of money we'll pay," he said. "Indirect changes, because they act through improvements in the care delivery system itself when appropriately managed, stay in place," and they help both public and private payers.

Coordinating care is probably the most effective way to reduce cost, Berwick said. Accountable care organizations being created under PPACA will provide incentives to coordinate care, along with new "bundled payment" systems, in which health care providers are paid for episodes of care, such as heart attacks, he said

CMS's final rule on accountable care organizations will be issued "soon," Berwick said. That means it is "imminent," he replied to a question asking him to be more specific.

Reducing waste could cut health care spending for all payers by more than 20 percent, he said.

Weight-Loss Program Saves \$15 Billion

Medicare could save as much as \$15 billion over the lifetimes of baby boomers, if it made community-based, weight-loss programs available to people age 60 and older who are at risk for diabetes or heart disease, an Emory University health policy professor, Kenneth Thorpe, said at the briefing.

From 1987 through 2008, about two-thirds of the growth in health care spending was due to a rise in the prevalence of treated diseases. Six conditions accounted for about 40 percent of the growth in Medicare, he

said. Diabetes accounted for the biggest increase, 8 percent of the growth in Medicare spending, he said.

"There's an enormous opportunity, I think, for the federal government to reach out earlier to improve the incoming health profile of patients coming in the Medicare program," he said, "both because it'll reduce the incidences of diseases like diabetes, and it has the potential for reducing lifetime spending in the program."

A program that has helped people lose 4 percent to 7 percent of their weight could be offered on a national basis for about \$80 million, Thorpe said. The YMCA program also reduced the incidence of diabetes among participants.

Concentrated Health Plan Markets Reduce Costs

Although concentrated hospital markets lead to higher prices, health plan concentration tends to reduce costs, according to research presented at the briefing by Glenn Melnick. He holds the Blue Cross of California chair in health care finance in the School of Policy, Planning, and Development at the University of Southern California.

Hospital markets, on average, are much more concentrated in the United States than health plan markets, Melnick said. But there has also been a long-term trend of consolidation among health plans, which has raised concerns among providers that health plans may have enough market power to reduce their payments, he said.

If hospital market concentration is increased by 1,000 points under the Herfindahl-Hirschman Index measurement system, prices rise by 8.3 percent on average, Melnick said. If health plan concentration is increased by 1,000 points, prices drop 2.5 percent, he said.

"These two concentration measures have countervailing effects," Melnick said. Under the index, a measurement of 10,000 means an industry has a monopoly in a market; a measurement close to zero means a market has more competition.

Melnick said his study found that the largest reductions in health plan prices were in markets where health plan concentration was the greatest. In 35 markets where health plan concentration was above 3,200, which is a market of about three health plans of equal size, hospital prices were 12 percent lower than the most competitive markets in other parts of the country, Melnick said.

"The implications of this are: More concentrated health plan markets can actually benefit consumers by counteracting the price-increasing effects of our fairly concentrated hospital markets in the U.S.," he said.

But those benefits will happen only "as long as there is sufficient competition remaining in health plan markets to keep the health plans honest and pass on those savings to consumers in the form of lower prices." Melnick said.

There should be less focus on health plan concentration and competition, and more focus on provider market concentration and competition, he said. Provider market concentration "is contributing in large part to the increase in spending and prices that we've seen over the last 10 years."

Melnick noted that private insurers are concerned that accountable care organizations will lead to the creation of larger provider organizations. If that happens, the fear is that "prices are going to rise," he said,

By Sara Hansard

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Chairman HERGER. Again, I want to thank each of our witnesses for your testimony and for your insight. Your participation was integral in helping us understand the history of consolidation, its current trends, and its implications. The issue of consolidation warrants this subcommittee's attention as all health care cost drivers need to be closely examined, especially in this challenging economic and budget environment.

While I believe that market approaches hold great promise for improving the situation, my intent is to use the information we learn from this hearing as a starting point for further assessment of the consolidation issue.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask that the witnesses respond in a timely manner.

With that, the Subcommittee stands adjourned.

[Whereupon, at 11:50 a.m., the Subcommittee was adjourned.] [Submissions for the Record follow:]

STATEMENT

of the

American Medical Association

to the

Subcommittee on Health Committee on Ways and Means United States House of Representatives

RE: Health Care Industry Consolidation

September 9, 2011

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on health care industry consolidation. We commend Chairman Camp, Ranking Member Levin, Subcommittee Chairman Herger, Subcommittee Ranking Member Stark, and Members of the Committee for addressing this important issue. Our comments examine health insurer consolidation, hospital consolidation, and consolidation pursuant to the formation of innovative health care delivery models. We look forward to working with you on these issues.

Health Insurer Consolidation

The Problem of the Dominant Health Insurer

The AMA has long held that health insurer consolidation results in health insurer concentration and increased market power. To gather data on this issue, for the past ten years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country.

The most recently published AMA study, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2010 update)," found that the vast majority of health insurance markets across the United States are highly concentrated and are dominated by one or two health insurers. Specifically, the study found that 80 percent of the metropolitan areas examined were highly concentrated based on the 2010 Horizontal Merger Guidelines, and in nearly half of the metropolitan areas examined, one insurer had at least a 50 percent market share.

¹ U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines. Issued August 19, 2010.

Furthermore, insurer concentration is on the rise: independent researchers recently concluded that the fraction of local markets falling into the "highly concentrated" category increased from 68 percent to 99 percent between 1998 and 2006.² Those fractions were based on the 1997 Horizontal Merger Guidelines.³

The AMA believes that high insurer market concentration is an important issue of public policy because it facilitates insurers' exercise of market power, which may have anticompetitive effects.

Barriers to entry into health insurance markets enable the exercise of market power. Barriers include: brand name acceptance of established insurers; the need to develop sufficient business to permit the spreading of risk; the need to contend with established insurance companies that have built long-term relationships with employers and other consumers; and the cost of developing a health care provider network.

Entry barriers were exemplified in the proposed merger between Highmark Inc. and Independence Blue Shield in 2008. In that case, a report commissioned by the Pennsylvania Insurance Department concluded that it was unlikely that any competitor would be able to step into the market after a Highmark / IBC merger:

[B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas.... On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.⁴

Furthermore, contracting practices used by dominant health insurers exacerbate the harm caused by the exercise of market power. These practices include most favored nations clauses whereby physicians must agree to give the dominant payer at least as favorable a rate as they give to any other insurer, as well as products clauses, anti-assignment provisions, and minimum enrollment assurances. If physicians were to refuse the terms of the dominant buyer, they would likely suffer an irretrievable loss of revenue.

When considering the marketplace for medical services, it is also important to understand that medical services are unique in that they can neither be stored nor exported. This results in a considerable, and prohibitive, financial risk to physicians who wish to terminate a relationship with a health insurer because of low reimbursement rates. To make up the revenue loss, the physician would need to make up lost business by immediately switching to an alternative health insurer, and simultaneously retaining patients who subscribe to that insurer. Where those alternatives are lacking—in most

² Dafny L, Duggan M, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry." National Bureau of Economic Research Working Paper 15434, October 2009.

³ U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines. Issued April 8, 1997.

⁴ LECG Inc., "Economic Analyses of The Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10, 2008.

environments where insurers have market power—a health insurer will have the ability to reimburse physicians at rates that are below a competitive level.

Increased Costs for Patients

In an era of spiraling costs, it is tempting to conclude that anything that drives down medical fees is a good thing for consumers. However, many policy experts have asserted that, in fact, lower fees paid by insurers may result in higher premiums for patients. R. Hewitt Pate, a former Assistant Attorney General of the Antitrust Division, said in a 2003 statement before the Senate Judiciary Committee:

A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from a true economic efficiency that will tend to result in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers. ⁵

This sentiment was repeated at the conclusion of the aforementioned Highmark / IBC hearings. In that case, the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would grant the merged health insurer undue leverage over physicians and other health care providers. The Department released the following statement:

Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers. ⁶

In summary, the AMA believes that health insurer consolidation results in high market concentration and an increase in insurers' ability to exercise market power. Left unchecked, the exercise of market power can have anticompetitive effects such as low reimbursement rates for physicians relative to competitive levels, and increased costs for patients.

⁵ Concerning Antitrust Enforcement in the Agricultural Marketplace: Hearing before the Committee on the Judiciary, United States Senate. (October 30, 2003) (Statement of R. Hewitt Pate, Antitrust Attorney General, Antitrust Division). Available at https://www.justice.gov/atr/public/testimony/201430.htm.
⁶ Statement of Pennsylvania Commissioner Joel Ario on Highmark and IBC Consolidation. January 22, 2009. See also LECG Inc., "Economic Analyses of The Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10, 2008.

Hospital Consolidation

The Committee's review of the issue of hospital consolidation is timely. While our most recent data shows that 78 percent of office-based physicians in the U.S. work in practices of nine physicians or less, and the majority are in solo practices or practices of four or less, ⁷ hospitals are increasingly hiring physicians as employees and acquiring physician practices.

Many physicians cite decreased administrative duties and less time spent complying with regulation as reasons for seeking hospital employment instead of private practice. Whatever the reasons, hospitals have increased their efforts to hire physicians, and the trend of physician employment by hospitals is growing.

Hospital acquisition of physician practices has also grown in the past several years, in large part due to the prohibitive cost for physician practices of implementing health information technology and regulatory compliance. These acquisitions have, in some markets, given hospitals significant market power over both facility and physician markets. Importantly, because each such acquisition is small, this consolidation occurs under the radar of antitrust enforcement.

Hospital mergers also often have negative effects on physicians. For example, consolidation of services can mean the deterioration of the physician / patient ratio, and physicians are likely to lose leverage with, and have their practices more closely controlled by, the hospital. Many physicians reported that, following the "merger-mania" of the 1990s, they experienced an overall loss of practice autonomy and clinical decision-making. Moreover, in regard to anticompetitive concerns, some physicians can be shut out entirely if one hospital becomes "the only game in town."

In all three of these hospital consolidation scenarios—physician employment, physician practice acquisition, and hospital mergers—patient care is increasingly delivered in the hospital, as opposed to the private practice setting. Health policy experts generally agree that hospital care is more expensive for patients, and, in the context of the federal health programs, the taxpayer. The AMA believes that these consolidation issues merit further review.

Innovative Delivery Models

The health care system is currently exploring new payment and delivery models that mean to increase quality and efficiency. The AMA believes that physician leadership in

⁷ The AMA Physician Practice Information Survey (2009). Available at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/the-resource-based-relative-value-scale/physician-practice-information-survey.page?.

these new models is imperative for their success, and that current antitrust law and enforcement, if not revised, will be an obstacle to physician participation.

Value of Physician Participation in Innovative Delivery Models

The AMA has long advocated for physician leadership in new payment and delivery models that focus on quality and efficiency. Physician leadership ensures that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. The AMA believes that clinical decision-making autonomy is best fostered in a physician-led environment.

Physician-led models are also widely believed to lower costs. On average, patients who receive care from a physician practice incur a lower cost than those who receive hospital care for the same condition. In the context of the Medicare Shared Savings Program for Accountable Care Organizations (ACOs), the Centers for Medicare and Medicaid Services (CMS) has recognized that "the savings generated by ACOs, in many cases, are expected to result from reduced inpatient admissions." MedPAC has also observed that, in the context of outpatient care, total payment (Medicare and patient) for a level three visit in a physician's office is \$68.97 compared to \$124.40 in a hospital-owned clinic or hospital-based entity.

CMS has also said that one goal of the new delivery models is to "raise the likelihood of preserving alternatives in the market, ultimately leading to the emergence of better procedures and treatments." ¹⁰ If physicians are enabled to participate, and establish competing models in the marketplace, reduced costs and increased quality will result.

Antitrust Laws are a Barrier to Physician Participation

Generally, under antitrust law, physicians may not collaborate regarding payer negotiations unless they are integrated, either financially or clinically. While some innovative delivery systems have sought and obtained conditional antitrust clearance from the Federal Trade Commission (FTC) pursuant to a showing that they are clinically integrated, the current rules regarding clinical integration are unnecessarily restrictive and ultimately prohibitive to physician participation in new delivery models. The consequence of this is two-fold: physicians will not be able to lead these models or bring about the benefits discussed above, and hospitals and very large health systems will become the only players in the market. The latter consequence will likely exacerbate the problem of hospital market dominance and acquisition of physician practices.

The AMA has advocated that the FTC and the Department of Justice (DOJ) set forth clear and common sense antitrust rules concerning the formation of innovative delivery

^{8 76} FR 19537.

⁹ Available at http://www.medpac.gov/chapters/Jun11_Ch06.pdf.

models so that physicians can pursue integration options that are not hospital driven.¹¹ Physicians should not have to become employed by a hospital or sell their practice to a hospital in order to participate in innovative delivery models.

Conclusion

The AMA applauds the Committee for examining the important issues of health insurer consolidation, hospital consolidation, and antitrust barriers to physician engagement in innovative delivery models. As Congress continues to examine health care delivery, the AMA urges the Committee to be mindful of the vital role that physicians play in patient care. Physicians are critical in efforts to improve quality and to provide coordinated care for patients, and should be supported in these efforts, rather than penalized, by antitrust law and enforcement. We have been encouraged by the FTC and the DOJ's willingness to work with us on these issues, and look forward to working with the Committee to address any questions on our comments.

¹¹ The AMA recently submitted comments to the FTC and DOJ on antitrust barriers to physician leadership in innovative delivery models. Available at http://www.ama-assn.org/resources/doc/washington/aco-antitrust-reform-proposal-comment-letter.pdf. See also https://www.ama-assn.org/ama1/pub/upload/mm/399/aco-comments-27sept2010.pdf.



Statement of Joel White, Executive Director Coalition for Affordable Health Coverage to the Committee on Ways and Means Subcommittee on Health

Hearing on Health Care Industry Consolidation September 9, 2011

Introduction

Chairman Herger, Ranking Member Stark and Members of the Subcommittee, thank you for holding this hearing on health industry consolidation.

The Coalition for Affordable Health Coverage (CAHC) is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a broad range of interests—organizations representing small and large employers, manufacturers, retailers, insurers, brokers and agents, physician organizations and individual consumers.

We are concerned that health coverage has become much less affordable over the last decade—a trend that continues despite the passage of major reform legislation. Runaway medical spending is adversely affecting a range of national indicators, from economic competitiveness, to public sector fiscal balances, to national employment levels, to household living standards. Indeed, correcting what many see as symptoms of national decline requires looking no further than our broken health system.

Consolidation is leading to highly concentrated markets across the country and in your districts, which, in turn, are dramatically driving up the price of health services and the overall cost of care. This is translating into inflated government spending, higher premiums, and inefficient cost shifting. These factors are creating strong head winds in our labor markets, making retaining and hiring workers more difficult and creating a drag on our economy and household finances.

Market Concentration Creates An Unbalanced Playing Field

Studies of price variation show that higher prices reflect provider market power in addition to the quality and intensity of care, population differences, and the prevalence of Medicare and Medicaid patients. Concentrated markets tend to have higher prices and greater price variation. i, ii

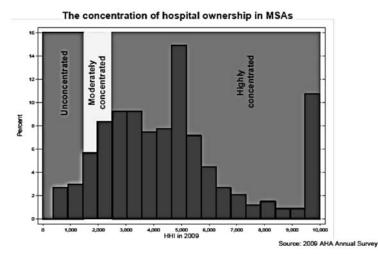
Horizontal Consolidation

Market consolidation takes a variety of forms. The classic example is the horizontal consolidation of hospitals within markets through merger and acquisition. Although these kinds of combinations are the most subject to regulatory scrutiny, antitrust authorities have permitted large numbers to go forward over the years. California alone saw more than 900 mergers and acquisitions during the 1990s.

Currently, the Department of Justice and the Federal Trade Commission use the Herfindahl-Hirschman Index (HHI) to classify the degree of concentration in markets: unconcentrated (HHI below 1,500); moderately concentrated (HHI between 1,500 and 2,500); and highly concentrated (HHI above 2,500). Mergers resulting in unconcentrated markets are

unlikely to have adverse competitive effects and ordinarily require no further analysis from the FTC or DOJ. Mergers resulting in moderately or highly concentrated markets potentially raise significant competitive concerns and often warrant agency scrutiny.

By 2003 almost 90 percent of Americans in metropolitan areas had "highly concentrated" hospital markets, according federal antitrust standards. iii Ten percent of metropolitan statistical areas have only one hospital system—and therefore no realistic prospect of price-competition. The American Hospital Association provides data on the concentration of hospital ownership in MSAs, which is represented below.



Over the 3 years from 2006 to 2009 most MSAs saw modest changes in the HHI, with the average HHI across MSAs increased by 61 points. 30 MSAs saw increases in the HHI of more than 500 points and large increases in the HHI outnumbered large decreases by a 2-to-1 margin.

Hospital mergers and acquisitions have had significant price effects. Estimates of price increases range from four percent to 53 percent depending on the samples and methodologies used. A widely accepted rule of thumb is that prices increase 40 percent when the merging facilities are closely located.^{IV}

Complicating the measurement of price effects is the fact that, when merged entities raise prices, non-merged competitors tend to follow suit. In addition, consolidation across regional markets can increase the price-setting power of hospital systems and physician groups indirectly.

For example, by giving health plans the choice of contracting with all or none of their facilities in multiple markets, hospital systems with a "must-have" facility in one market can drive up prices for their more ordinary facilities elsewhere.

Vertical Integration

A more recent trend in consolidation involves the vertical integration of hospitals and medical practices. Hospitals now employ one in six doctors nationally. The Medical Group Management Association reports a nearly 75 percent increase in the number of doctors employed by hospitals since 2000. Accenture has estimated that only one in three doctors are likely to remain independent by 2013. Joining with hospitals can increase physician bargaining clout with insurers while giving hospitals a guaranteed flow of referrals.

Consolidation has also allowed single-specialty and other clinically integrated medical groups to gain "must have" status. Writing in Health Affairs, Robert Berenson et al. document how clinically integrated physician groups in California have pushed up prices for health maintenance organizations to the extent that, in many cases, HMOs are less economically viable than fee-for-service insurance products. viii

Some providers have also used their market power to negotiate product participation agreements, such as "anti-steering," "guaranteed inclusion" and "product participation parity" clauses, which limit insurers' ability to develop new products and promote value-based consumer choice. These practices may be anti-competitive, but certainly drive up health costs.

Insurance Markets

Finally, there is some evidence that price discrimination—a feature of concentrated provider markets—increases concentration among insurers. The American Medical Association reports that in 60 percent of metropolitan statistical areas, the two largest insurers combined have a 70 percent or higher market share. AMA estimates that 99 percent of health insurance markets are highly concentrated. Yet the prices insurers and providers negotiate tend to reflect their relative market power, with the result that insurers with a large presence in a region are able to obtain lower prices.

Some insurers have sought to cement their market advantage through parity agreements (such as "most favored nation" clauses) that provide an insurer with substantial market share to enter into an exclusive contractual arrangement to get the best discounts offered by a provider in a certain geographic area. This allows the insurer to maintain a dominant market position. Typically the contract language will state that the health insurer or payer will receive the lowest price that has been given to any other health insurer in the market. These types of contracts make it difficult for any insurer other than a dominant carrier to offer competing coverage as an affordable option to consumers.

Implications

The implications of horizontal, vertical and anti-competitive contract arrangements means markets are not as free as some would argue or hope. It is certainly true that markets are becoming more concentrated, and that this concentration is creating un-level playing fields that result in prices that reflect relative market power, and not input costs. When these market situations result in monopolies, there is a significant loss to consumer welfare in the form of higher premiums and less affordable medical care and insurance coverage.

PPACA Does Not Address Core Concentration Issues, and May Make Matters Worse

Because health markets are becoming increasingly concentrated, consumers have fewer affordable choices. PPACA shifts many of the existing costs of consolidation onto taxpayers through new subsidy mechanisms, but PPACA does not address the underlying concentration problems, and may, in fact, make matters worse.

For example, the Medicare Shared Savings Program that seeks to establish Accountable Care Organizations (ACOs) has the potential to lower costs while improving quality. Done well, the program will support higher value in the health system by rewarding superior and more efficient care. Done poorly, however, ACOs hold the potential to further concentrate provider markets and create barriers to competition that will drive up costs for consumers and patients. CAHC is particularly concerned about the potential spill-over impact of the regulations on commercial markets.

The record suggests that unregulated clinical integration envisioned under the ACO model will lead to the greater vertical consolidation of provider markets, which in turn will fuel cost growth, making medical care less affordable. Any integration and concentration that may result from the implementation of ACOs should be closely supervised by the FTC, Justice Department and state regulatory authorities to ensure that clinical integration results in proportional savings to private payers. We encourage the Subcommittee to maintain vigilance over the program's implementation.

Lastly, it is unclear what impact health benefit exchanges may have on market concentration for insurers. Again, done well, exchanges hold promise to expand competition in the insurance market and provide more options for consumers. Exchanges that limit choices through mechanisms such as selective contracting, will not promote expansive choice among competing health plans. Benefit exchanges will do nothing to address provider concentration increase.

Current Enforcement Mechanisms Are Not Adequate

While the FTC and some courts have concluded that market power can be problematic, recent agency activity shows a lack of willingness from enforcers to break up existing merged entities, even in highly concentrated markets. Christine Varney, head of the Antitrust Division at the Department of Justice, noted in a speech in May of 2010 her commitment to maintain open

and competitive markets through enforcement actions. While laudable, the recent consolidation in local markets may point to a lack of resources at the Department to systemically review local market concentration.

Little Transparency

In normal markets, sellers compete on of price and quality, which in turn stimulates innovation. The driving force in this process is price-sensitivity—consumers demanding more for less. In the health sector, these price signals are weak or missing altogether. One off-cited reason for this demand-side disconnect is the prevalence of third-party payment systems, which shield patients from the financial consequences of choosing high-cost providers. Another is that employers, who sponsor the preponderance of private plans, have few incentives to push back on costs: for the most part, they have been able to pass on rising premiums in the form of lower wage increases.

In addition, fee-for-service (FFS) payment systems, which pay sellers of medical services more for doing more, create powerful incentives not to economize. There is also evidence that excessive market power undercuts the business case for reducing costs.

Even in the most competitive markets, the lack of usable information on cost and quality prevents consumers from directing their business to efficient providers. Hospitals have 20,000-30,000 items in their "charge masters," which consist of list prices charged mainly to those patients with the least market power. Health plans generally are able to negotiate much lower rates. While anti-trust guidelines permit health plans to provide comparative data to their members, they prohibit them from publicly posting actual prices, in the belief that doing so would discourage providers from giving secret discounts, thus driving up average prices. In other instances, hospitals have insisted on "gag-clauses" in their contracts that prohibit health plans from disclosing hospital cost and quality information to their members. Removing barriers to transparency will be essential to unleashing the power of consumerism.

Congress Must Take Steps to Address Concentration Issues

Over the past several decades, the argument over free versus managed or government run markets has emerged as a flash point in the dialogue over how to best lower health costs. This misses the point. So long as markets remain highly concentrated, no amount of market reform is likely to succeed. because price fixing by oligopolies or monopolies is just as inefficient as price setting by government regulators.

Congress can take several steps to begin to address health industry consolidation, market concentration and barriers for consumers to obtain information on cost and quality.

a. Require CMS to measure local market concentration. CMS could use its extensive data on providers and billing to develop local measures of provider concentration. Methods similar to those used by MedPAC could lead to measures of propensity to shift costs, by local market.

- b. Enforce existing antitrust law. Congress could require the more rigorous enforcement of existing antitrust standards. FTC classifies markets with a Herfindahl-Hirschman Index score above 2,500 (e.g., four firms with equal market shares) as "uncompetitive." A rule of thumb is that each 160-point increase in the HHI corresponds to a one percent price increase. Rigorous enforcement could prevent future such mergers. Yet FTC has permitted the formation of hundreds of such oligopolies in recent decades—with the result that high degrees of concentration are a fait accompli in most markets. One option would be to de-concentrate markets through the retroactive enforcement of existing standards.
- c. Modify antitrust law. An alternative is to expand the remedies available under antitrust law. One possibility would be to permit the supervised collusion of payers (insurers, employers, consumer organizations) in the most concentrated markets. Writing in the current issue of Health Affairs, Glenn Melnick and colleagues show that greater consolidation on the payer side can constrain the power of monopoly and oligopoly. Finally, FTC prohibits insurers from publicizing the price they pay to specific providers, on the theory that, in today's oligopolistic markets, providers would stop offering secret discounts, thus causing average prices to rise. If pursued in concert with other policies that inhibit cost shifting, eliminating such restrictions could facilitate price transparency and consumer choice.
- d. Prohibit practices conducive to price fixing. As noted above, providers, in some cases with the cooperation of insurers, have used their market power to negotiate product participation agreements, such as "anti-steering," "guaranteed inclusion" and "product participation parity" clauses, which limit insurers' ability to develop new products and promote value-based consumer choice. For example, "gag clauses" prevent insurers from providing price information even to their own customers (e.g., "In no event will [hospital] providers be singled out in a tier, limited network, or other product...") "Most favored nation" clauses prohibit providers from charging rival insurance plans less for their services. Concentration across markets can effectively circumvent antitrust restrictions. For example, by giving health plans the choice of contracting with all or none of their facilities in multiple markets, hospital systems with a "must-have" facility in one market can drive up prices for their more ordinary facilities elsewhere. One recent FTC enforcement action required each facility in merged hospital systems to negotiate prices independently. Congress could ban these practices as detrimental to consumer welfare.

Conclusion

Given the degree of concentration in local markets, necessary and appropriate efforts to limit Medicare and Medicaid reimbursement growth will simply result in higher costs – via costshifting - for the dwindling share of privately insured workers and their dependents, whose rising premiums, like payroll taxes, are deducted from cash wages. The experience of high-productivity providers such as Intermountain Healthcare, Mayo Clinic and Geisinger underscores

that enormous productivity gains-exceeding 30 percent-are well within the reach of American medicine.

Congress ought to take steps to rebalance markets and level the playing field. Doing so should create necessary incentives to lower health costs, which in turn will help improve labor markets and improve our Nation's balance sheet.

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HEALTH PLANS & PROVIDERS

By Glenn A. Melnick, Yu-Chu Shen, and Vivian Yaling Wu

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The Increased Concentration Of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices

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ABSTRACT The long-term trend of consolidation among US health plans has raised providers' concerns that the concentration of health plan markets can depress their prices. Although our study confirmed that, it also revealed a more complex picture. First, we found that 64 percent of hospitals operate in markets where health plans are not very concentrated, and only 7 percent are in markets that are dominated by a few health plans. Second, we found that in most markets, hospital market concentration exceeds health plan concentration. Third, our study confirmed earlier studies showing that greater hospital market concentration leads to higher hospital prices. Fourth, we found that hospital prices in the most concentrated health plan markets are approximately 12 percent lower than in more competitive health plan markets. Overall, our results show that more concentrated health plan markets can counteract the price-increasing effects of concentrated hospital markets, and that-contrary to conventional wisdom-increased health plan concentration benefits consumers through lower hospital prices as long as health plan markets remain competitive. Our findings also suggest that consumers would benefit from policies that maintained competition in hospital markets or that would restore competition to hospital markets that are uncompetitive.

s the long-term trend of consolidation among US health plans continues, providers have voiced growing concern that health plans will acquire such market power that they will be able to depress the prices paid to providers. The American Hospital Association has argued that health plan consolidation leads to "reimbursement to hospitals and physicians that is below competitive levels," thereby threatening both the quality of care and patients' access to it.' The American Medical Association has proposed legislation that would allow physicians to bargain collectively with health plans without fear of antitrust prosecution, so as to "level the playing field" in price negotiations.' ³²

Despite the importance of these issues, and the growing interest in them, there is limited empirical evidence regarding the relationship between concentrated health plan markets—that is, markets where most people with private health insurance purchase it from one to just several insurers—and the prices that plans pay to providers. There have also been few studies of the relationships among the level of concentration in the market of health plans; the level of concentration in the market of hardings are did sto the prices that hospital charge. ¹⁵ This article adds to the literature by studying how both health plan market concentration interact to affect hospital market concentration interact to affect hospital prices in the United States.

The Framework For The Study

The literature on hospital pricing and on bargaining between hospitals and health plans serves as the framework for our empirical analyses. Health plans compete with each other on price—the premiums they charge—along with the quality and accessibility of the providers included in their networks or benefit packages. Because the cost of hospital care represents about half of the health care costs that plans must pay, the prices that they pay hospitals have a large impact on the premiums they must charge. Mark Pauly suggests that larger plans should be able to secure lower prices from hospitals than smaller plans can. 6 Accordingly, because the average size of the plans in more concentrated markets—those with fewer health plans—is larger, prices should be lower.

However, health plans' bargaining power also depends on plans' ability to send their members to competing, lower-price hospitals for care, rather than having to use a more expensive hospital. The ability of health plans to substitute one provider for another to create competition and generate lower prices depends on the concentration of the hospital market in which the plans are buying services. Research shows that in concentrated markets, health plans pay higher prices to hospitals.

According to this framework, increasing the market concentration of health plans has the opposite effect on hospitals' prices from increasing the market concentration of hospitals. Thus, the prices that hospitals receive will depend on the relative concentration in the market of both plans and hospitals. Our analyses included plan and hospital market concentration measures to explore how these factors affect hospital prices.

Study Data And Methods

DATA Our sample included all general, acute care hospitals not owned by the federal government that were located in Metropolitan Statistical Areas in 2001 and 2004. Hospital data came from Medicare hospital cost reports, the American Hospital Association Annual Surveys, and a database of multihospital systems provided by Kristin Madison and Sujoy Chakravarty. 10-12

The federal government's Area Resource File

The federal government's Area Resource File and the Medicare Impact files provided the area wage index, per capita income, unemployment rate, and population data. We obtained managed care data for health maintenance organizations and preferred provider organizations in 2001 and 2004 from InterStudy, a health care data company; these data cover more than 90 percent of the United States.

The final analytical sample contained 4,017

hospital-year observations and included more than 90 percent of all hospitals located in Metropolitan Statistical Areas.

METHODS First, we summarized the distribution of hospitals and Metropolitan Statistical Areas across different levels of market concentration for both health plans and hospitals. We constructed multivariate models to explore the effects of health plan and hospital market concentration on hospital prices. In one model, we estimated the effects of market concentration of both plans and hospitals on hospital prices, after adjusting for other factors that affect hospital prices. For example, because previous research has shown that prices can be lower in areas where more of the population is enrolled in managed care plans, "I we included the level of managed care penetration in the market as an additional factor.

In a second model, we tested for the possibility that health plan concentration effects on hospitals were much stronger in the most concentrated markets, compared to less concentrated ones, by dividing health plan markets into four categories, based on health plan concentration.

We employed standard statistical methods to adjust for the fact that we used a pooled crosssectional database for our analysis." Finally, we conducted a series of statistical tests to validate our key assumptions and found that our results were unchanged and statistically robust."

HOSPITAL PRICES Because actual hospital prices paid by private health plans, such as per diem prices, are not available on a national basis, we constructed our statistical models to produce a valid proxy for hospital prices. Following other researchers, 13.54.77 we regressed total hospital not revenue on a set of independent variables that included hospital volume (total adjusted patient days) is and hospital case-mix. Case-mix was measured by the Medicare case-mix index, a measure of patients' level of illness.

Because net revenue equals price times quantity, by including a quantity measure we controlled for and effectively held constant the changes in net revenue related to quantity, while the case-mix measure controlled for changes related to patient severity over time. The total net revenue included Medicare and Medicaid revenue as well as revenue from private payers, so we also controlled for the changes in revenue due to the mix and prices of different payers.

HEALTH PLAN CONCENTRATION We constructed a standard concentration index variable with values that ranged from close to 0 to 10,000. A monopoly market—that is, a market with a single health plan—had a value of 10,000, while a value close to 0 represented a highly competitive, less concentrated market.

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Using Metropolitan Statistical Areas as the geographic market for health plans, we summed the squared value of each health plan's Metropolitan Statistical Area market share. If a health plan offered both health maintenance organization and preferred provider organization products in a given metropolitan area, we first added the enrollment in each together and then calculated the market share of the combined products before computing the concentration in deep.

before computing the concentration index. Other studies have calculated these values separately for both health maintenance organization and preferred provider organization products under the assumption that they serve separate product markets. However, it is more likely that consumers see these two types of plans as similar enough that they are willing to switch between the two. Thus, both types of products should be included in the same market.²⁰⁻²²

To measure health plan concentration, we used a standard concentration index, again with values ranging from close to 0 to 10,000. We divided Metropolitan Statistical Areas into four categories, based on their health plan concentration index: less than 1,000, 1,000–1,800, 1,801–3,200, and greater than 3,200. These thresholds were chosen to facilitate comparison with other studies of health plan market concentration and are consistent with the Department of Justice 1997 Merger Guidelines.³²

MANAGE CARE PENETRATION AND HOSPITAL MARKET CONCENTRATION Following previous studies.^{24,25} we calculated managed care penetration as the total population of a metropolitan area that was enrolled in either a health maintenance organization or a preferred provider organization in a given year, divided by the total population of that area in that year.

We calculated a hospital-specific concentra-

We calculated a hospital-specific concentration index for each hospital's market, using standard methods.²⁶

CONTROL VARIABLES Following other studies, 37-38 we included supply and demand variables that might affect hospital prices, including a wage index (as a proxy for input prices); Medicare's and Medicaid's shares of total inpatient discharges (to control for payer mix; hospital ownership (not-for-profit, for-profit, or government); hospital teaching status; hospital system membership status; Medicare case-mix index (log transformed); total adjusted patient days (log transformed); per capita income in the hospital's geographic area (log transformed); and the percentage of for-profit and government hospitals within a fifteen-mile radius.

We also included time variables to control for

We also included time variables to control for general trends in hospital prices over time, and geographic variables (including each hospital's census region) interacted with time variables to capture regional differences in hospital prices over time.

LIMITATIONS Although our market concentration data cover the period between 2001 and
2004, our results are likely to remain valid today.
Consolidation has continued within both hospital and health plan markets, but increases in
market concentration have slowed because antitrust regulations limit mergers and acquisitions
that greatly increase concentration in local markets. Our statistical results are generally descriptive in nature, which limits our ability to make
strong causal inferences regarding the welfare
effects of the relative concentration between hospital and health plan markets.

Study Results

Hospital and health plan market concentration differs across the country (Exhibit 1). Thirty-two metropolitan areas (10 percent) are in the most competitive category for health plans and account for 13 percent of US hospital revenues for 2004. The most concentrated category for health plans contains thirty-five areas and 7 percent of hospital revenues for 2004. Hospital market concentration varies only

Hospital market concentration varies only slightly across the categories, ranging from 3,204 to 3,661 (Exhibit 1). And only in the most concentrated health plan markets does the health plan concentration divided by the hospital concentration exceed 1.0. These results indicate that hospitals face less competition in their own markets than health plans face in theirs. More than 90 percent of all hospitals (2.111 of 2,276) operate in markets where the hospital market concentration exceeds the health plan market concentration.

market concentration.

Higher health plan market concentration reduces hospital prices, while higher hospital market concentration increases them. For example, a 1,000-point increase in the health plan concentration index is, on average, associated with 2.5 percent lower hospital prices, while a 1,000-point increase in hospital concentration values is associated with an 8.3 percent increase in hospital prices. Model 2 shows that health plan concentration reduces hospital prices at a much greater rate in those areas where health plan markets are the most concentrated but reduces them at a much smaller rate in less concentrated ones (Exhibit 2).

Discussion

Previous research has documented a trend of consolidation among US health plans.²⁶ Provider groups such as the American Hospital Association argue that health plan markets are already

EXHIBIT 1

tions Of Health Plans And Hospitals in Metropolitan Statistical Areas (MSAs), 2004

Health plan concentration index	Number of MSAs	Number of hospitals	Percent of total hospital revenue	Average health plan concentration	Average hospital concentration	Health plan concentration/ hospital concentration	Percent of population in managed care
<1,000	32	326	13	854	3,204	0.28	57
1,000-1,800	129	1,131	51	1,409	3,265	0.46	59
1,801-3,200	122	654	28	2,284	3,570	0.66	57
>3,200	35	165	7	3,977	3,661	1.11	59
Total	318	2,276	99	1,714	3,361	0.52	58

SOURCE Authors' calculations based on data from InterStudy and the American Hospital Association Annual Surveys. NOTES The concentrations, concentration index, and penetration are explained in the text. Percentages of hospital revenue do not sum to 100 because of rounding.

highly concentrated, and that continued consolihealth plan consolidation to prevent excess condation will allow plans to gain additional market power, which will give them too much bargain-ing power over providers.¹

Our findings add several new and important insights to this discussion. Our descriptive analyses show that 64 percent of hospitals operate in markets where health plans are not very concentrated, and only 7 percent are in the most concentrated health plan markets (Exhibit 1). These results suggest that contrary to conventional wisdom, very few hospitals operate in mar-kets with only a few dominant health plans.

Our statistical results show that although higher health plan concentration is associated with lower hospital prices on average, this relationship is not constant. In fact, hospital prices are significantly affected only when health plan concentration index values are above 3,200 (Exhibit 2). These findings lend support to the argument that highly concentrated health plan markets can lead to lower provider prices.

At the same time, our results are consistent with previous research^{9,30} showing that hospital prices are higher in more concentrated hospital markets. Higher hospital concentration is asso-ciated in all of our models with higher hospital prices. For example, a 1,000-percentage-point increase in the hospital concentration index raises prices by approximately 8.3 percent (Exhibit 2).

Taken together, our results show that more concentrated health plan markets can counter-act the price-increasing effects of concentrated hospital markets.

POLICY IMPLICATIONS Our results have impli-cations for health care policy. Under the Affordable Care Act of 2010, states are beginning to regulate insurance premiums to control costs; our results suggest that restoring competition to hospital markets would have an even larger effect. Regulators should continue to monitor

centration, but they should also adopt proactive policies to increase hospital market competition.

Many areas in the United States are dominated by several large local or national hospital systems that negotiate collectively with health plans. This reduces competition and raises hos-pital prices. Because such large systems may provide increased efficiency and quality, we do not recommend breaking them up. But regulators recommend oreaxing them up. But regulators could require hospitals in the systems to nego-tiate independently with health plans. The Federal Trade Commission recently applied this approach to hospitals operating in Illinois. "And Medicare should be careful not to create concenrated organizations that reduce competition when it establishes large, provider-based accountable care organizations.

Increased transparency would also benefit consumers. Providers should be required to

share utilization and cost data with payers such as large employers. Currently, many of these employers do not have access to data on how much care their employees are using, and how much they are paying for it.

Changes In Hospital Prices Associated With Hospital And Health Plan Market Concent

	Percent change in hospital prices		
Concentration Index	Model 1	Model 2	
Hospital (for 1,000-point increase)	8.3**	8.3**	
Health plan (for 1,000-point increase)	-25**		
Health plan 1,000-1,800	-	-1.0	
Health plan 1,801-3,200		-3.0	
Health plan > 3, 200	-	-12.17**	

SOURCE Authors' calculations based on regression analysis NOTES Estimates control for other variables. The results for other control variables are given in the online Appendix (to access the Appendix (to access the bapendix (to mice Appendix (to mice Appendix)). The two models are described in the text $^{\rm vsp} < 0.05$

HEALTH PLANS & PROVIDERS

FUTURE RESEARCH QUESTIONS We found that hospital markets, on average, were much more concentrated than health plan markets. These findings depend in part on the definition and measurement of health plan products and mar-kets. We combined health maintenance organizations and preferred provider organizations into a single product market because we assumed that consumers are willing to substitute one for the other and that an insurer offering both products negotiates with providers as one entity. However, others have treated these organizations as separate product markets or used other approaches. ^{4,29} Assuming that there are separate product markets leads to smaller markets and higher health plan concentration index

values. Research is needed to validate these asumptions. Another question is whether fee-for-service

care paid for by Medicare and Medicaid should be included in the denominator when calculating health plan market shares and concentration values. New studies should focus on these important conceptual and measurement issues and examine interactions with other markets—such as physician markets-which may have different underlying structures. We also need further re-search to extend our understanding of how these and other market structure variables work to gether to affect the prices that consumers ultimately pay each year to purchase health insurance and medical care.

External funding for this research was provided by the Robert Wood Johnson Changes in Health Care Financing and Organization (HCFO) initiative.

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- which managed care market characteristics are measured.

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ABOUT THE AUTHORS: GLENN A. MELNICK, YU-CHU SHEN & VIVIAN YALING WU



Glenn A. Melnick is a professor at the University of Southern California.

In this month's Health Affairs, Glenn Melnick and coauthors report on their examination of markets in which health plans, hospitals, or both are highly concentrated. Their results show that more concentrated health plan markets can counteract the priceincreasing effects of hospital concentration and that health plan concentration benefits consumers through lower hospital prices as long as health plan markets remain

competitive.

The authors took up their study because lack of competition in insurance markets was cited as a main culprit behind rising health insurance premiums during the recent debate over health reform.

Surprisingly even to him, Melnick says, the study refutes that claim. Melnick says he now hopes that this report will bolster the commitment of policy makers to "strengthening and restoring provider market competition" as a way to better control costs.

Melnick holds the Blue Cross of California Chair in Health Care Finance in the School of Policy. Planning, and Development at the University of Southern California. He is also a resident consultant for the RAND Corporation in Santa Monica, California. Melnick received his doctorate in urban and regional planning from the University of Michigan.



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Yu-Chu Shen is a tenured associate professor of economics at the Naval Postgraduate School's Graduate School of Business and Public Policy. She is also a faculty research fellow at the National Bureau of Economic Research, in Cambridge, Massachusetts. She received her doctorate in health policy from Harvard University.



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Vivian Wu is an assistant professor in the School of Policy, Planning, and Development at the University of Southern California. Her research focuses on health care economics and finance. She received her doctorate in health policy from Harvard University.



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Statement of the National Community Pharmacists Association (NCPA)

U.S. House of Representatives Committee on Ways and Means Subcommittee on Health

Hearing on Health Care Industry Consolidation September 9, 2011

NCPA recommends that Congress:

- (1) Oppose the Express Scripts and Medco Pharmacy Benefit Manager merger.
- (2) Pass H.R. 1946, The Preserving Our Hometown Independent Pharmacies Act of 2011. (3) Pass H.R. 1971, The Pharmacy Competition and Consumer Choice Act of 2011.

Chairman Herger, Ranking Member Stark, and Members of the Committee:

The National Community Pharmacists Association ("NCPA") welcomes and appreciates this opportunity to provide input and suggestions regarding the impact that consolidation within the health care industry is having on the cost of private health insurance, Medicare spending and beneficiary costs. NCPA represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. The nation's independent pharmacies, independent pharmacy franchises and independent chains dispense nearly half of the nation's retail prescription medicines.

Our members are keenly aware of recent efforts toward consolidation within the health care marketplace and are concerned regarding the probable negative impacts for patients and providers should these efforts succeed. Specifically, NCPA is concerned with consolidation within the pharmacy benefit management (PBM) industry. The recently announced proposed merger of Medco and Express Scripts, two major PBMs, will lead to decreased competition in the drug market, increased drug prices to government payers and beneficiaries, decreased patient access to high quality care, and decreased choices for patients. For those reasons, NCPA opposes the merger, encourages the Federal Trade Commission to block the merger and asks Congress to express its concerns and opposition to the merger as well.

In light of the movement towards consolidation within the health care industry, and consolidation of the PBM industry in particular, NCPA urges Congress to pass legislation to provide protection to small business community pharmacies against the negative impacts, which flow from an increasingly concentrated, anti-competitive PBM marketplace. More specifically, NCPA urges Congress to pass H.R. 1946, the Preserving Our Hometown Independent Pharmacies Act of 2011, sponsored by Congressman Marino, as well as H.R. 1971, the Pharmacy Competition and Consumer Choice Act of 2011, sponsored by Congresswoman McMorris Rodgers.

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THE VOICE OF THE COMMUNITY PHARMACIST

Recent History of Anticompetitive Practices within the Pharmacy Benefits Management Industry Related to the Merger of CVS and Caremark

In recent years, the PBM industry has been rife with consolidation. The general result of such consolidation has been higher drug costs, decreased patient access to pharmaceutical care and lower quality of care. For example, in March 2007, CVS, the nation's largest retail pharmacy, merged with Caremark, the nation's largest PBM. The resulting prescription giant operates more than 6,800 pharmacies, holding the number one or two positions in each of the country's top ten markets with respect to retail pharmacy market share. Caremark, which serves as the PBM for the combined company, has a market share as high as 47%, and covers 134 million lives (more than twice as many as any other PBM). The combined company dominates the pharmaceutical services industry, filling or managing more than 1.2 billion prescriptions annually, servicing an estimated half of Americans.

Simply put, the evidence demonstrates that the CVS Caremark merger has had a negative impact on patients. First, CVS Caremark created the ironically named "Maintenance Choice" program that forces consumers to fill prescriptions at CVS stores/mail-order or else pay an increased co-pay to fill 90-day or maintenance prescriptions at non-CVS locations. Second, the merged entity switched Medicare beneficiaries under Caremark's plan to CVS stores with higher co-pays, thus, bringing these consumers to the Part D "donut hole" prematurely. Third, CVS Caremark used confidential patient information collected by Caremark to enable CVS pharmacists to solicit non-CVS customers by phone and mail in order to direct them to fill their prescriptions at CVS stores. Fourth, Caremark-operated Medicare Part D plans reimburse CVS pharmacies at costs that are grossly inflated relative to both the cost of the drug and the reimbursement level received by other pharmacies. Fifth, CVS Caremark requires patients with high cost specialty drugs to fill them only at CVS locations, where patients are given excessive supplies, creating expensive waste. Ultimately, the CVS Caremark merger has decreased patient choice, increased costs and generated waste. The Federal Trade Commission has an ongoing investigation into these anticompetitive and unfair trade practices.

The Proposed Express Scripts-Medco Merger Would Reduce Competition, Decrease Access to Quality Patient Care and Lead to Higher Prescription Drug Costs

Examples of abuses that resulted from the CVS Caremark merger are only the beginning of the potential anticompetitive effects resulting from PBM industry consolidation. NCPA is most concerned about the future, and more specifically, the likely negative impact from the recent proposed merger of Express Scripts, Inc. and Medco Health Solutions. The merger of these two PBMs would create a "mega PBM", specialty pharmacy provider and mail-order pharmacy with market power in all of these markets that are critical to controlling health care costs. The resulting merger will harm patients by reducing choice, decreasing access to pharmacy services and ultimately leading to higher prescription drug costs paid by plan sponsors and consumers. As community pharmacists whose primary concern is patient-well-being, NCPA fervently opposes the proposed merger and asks Congress to do the same.

If the Express Scripts-Medco merger were to succeed, the merger would create a PBM with substantial market power. In fact, the proposed merger is a tipping point in terms of PBM market concentration. The merger will cause a substantial reduction in both price and non-price competition among PBMs, especially in certain defined customer segments. If approved, the "mega PBM" would control over 40% of the national prescription drug volume.

The overwhelming size of this consolidation is enhanced by the fact that large national employers, unions, large health plans without an in-house (captive) PBM, insurance companies and federal and state government-sponsored health plans, are already largely limited in their PBM choices. Moreover, smaller regional, captive, and niche PBMs are simply not viable alternatives when it comes to the size and scope necessary to manage and administer the complex prescription drug benefits for these large national customers.

Post-merger, these large national customer segments will have few drug benefit administration alternatives, which will allow the merged PBM entity to dictate plan design and benefit structures at the expense of purchasers. The merged entity will be able to use their dominance to shift patients to favor their in-house mail operations. This shift in "mix" will force more customers to mail order and deprive consumers of access to their local pharmacies, which provide vital healthcare services. The merged entity may also restrict pharmacy networks by limiting access points. This will reduce patient choice at the outset, and will ultimately impact the economic viability of community pharmacies, leading to a diminution of services in the form of reduced hours, less consult time, and longer wait times.

Beyond the impact of the merger on the overall pharmacy marketplace, the merger would also create a dominant PBM with substantial market power in two specific submarkets: specialty pharmacy and mailorder services. The merger will combine two of the three largest suppliers of specialty pharmacy services, creating an entity with more than a 50% share of all specialty pharmaceutical sales.² entity will have both the incentive and ability to reduce competition and prevent new competition in specialty pharmacy, an increasingly lucrative market.

The merger also likely will force more customers into mail-order. The merger will create the largest mail-order pharmacy accounting for close to 60% of all mail-order prescriptions processed in the U.S. The merged firm will have an increased incentive to force consumers to utilize their mail order business. One misconception perpetuated by the merging parties is that this switch to mail order will lower drug costs for consumers. Evidence demonstrates that mail order pharmacies consistently dispense more costly brand-name drugs and fewer generics than retail pharmacies. Therefore, the shift to more mail order will lower the rate of generic dispensing, ultimately raising drug costs.

¹ Atlantic Information Services ("AIS"), 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill's Guide to Rx Channel – An Investor Handbook, May 10, 2011.

Based on 2009 reported market shares of CuraScript and Accredo to AIS and estimates from Pembroke

Consulting.

³ AIS 2011 data.

The combined Express Scripts-Medco will have an increased incentive to reduce transparency, and thus raise costs to consumers. Transparency into PBM practices has been an important concern of consumers, employers and pharmacies. Vigorous competition among PBMs improves transparency because plan sponsors who encounter or suspect a lack of transparency with their current PBM can switch or credibly threaten to switch to a competing PBM. Absent effective competition there is no guarantee that any hypothetical savings claimed by Express Scripts and Medco would be passed along to consumers or plan sponsors. The far more likely scenario is *increased profits for the merged entity* as a result of rebates, discounts and other spreads that they retain rather than pass though to plan sponsors. This is evidenced by the fact that in recent years the profits of the major PBMs have skyrocketed by 400 percent. That level of profitability for what are essentially middlemen is astounding.

H.R. 1946, The Preserving Our Hometown Independent Pharmacies Act of 2011 will Lead to Increased Quality of Care and Decreased Drug Costs

Independent community pharmacies do not operate on a level playing field with regard to PBMs and in the face of the looming Express Scripts-Medco merger, this playing field will be even more skewed against independent community pharmacy. Not only will the PBM industry be more consolidated and anti-competitive, but the industry remains neither regulated nor transparent. They make large profits by steering patients to the more expensive brand name drugs on which they make the most money on manufacturer rebates, and often hide these profits from plan sponsors, increasing drug costs for patients and plans. Small pharmacies face a "David vs. Goliath" situation with PBMs. Because small pharmacies cannot band together and negotiate with PBMs, patients' quality of care suffers and drug costs are higher than they should be. Allowing independent community pharmacies to negotiate on a level playing field with PBMs will improve patient access and help shift ill gotten gains from PBMs rightfully into the hands of patients.

In light of this "David vs. Goliath" scenario, NCPA urges Congress to pass H.R. 1946. The proposed legislation would allow independent pharmacies (defined as pharmacies representing less than 10% market share of a Part D prescription drug plan region) to band together to negotiate third-party contracts with PBMs. By creating this narrow exemption to antitrust law, H.R. 1946 starts to level the playing field. However, it does so without creating the overwhelming consolidation and anti-competitive concerns likely to result from the Express Scripts-Medco merger. In addition to applying the exemption only to pharmacies with less than 10% of the market share of a Part D prescription drug plan region, the bill also limits independent community pharmacies to forming negotiating entities representing no larger than 25% of all retail pharmacies in a Medicare Part D prescription drug plan region. H.R. 1946 levels the playing field for independent community pharmacies to more effectively negotiate with PBMs for high quality care and low drug costs without raising the specter of harmful anti-competitiveness, such as is raised by the proposed Express Scripts-Medco merger.

H.R. 1971, The Pharmacy Competition and Consumer Choice Act of 2011 will Provide Basic Protections for Consumers, Community Pharmacies and Health Plans to Make Sure Pharmaceutical Dollars are Wisely Spent

H.R. 1971 is another vehicle through which pharmacy can fight back against the PBM-constructed artificial barriers to competition in the delivery of pharmacy services. As outlined above, these anticompetitive barriers increase costs and reduce choice. H.R. 1971 will start to break down some of these artificial barriers by providing a basic level of protection to consumers regarding their choice in where they obtain their prescription medications, saving money by making the inner workings of PBMs more transparent to plan sponsors so they know whether they are getting a good deal, and by curbing burdensome PBM audit practices of independent pharmacies and strengthening fraud protections.

More specifically, H.R. 1971 protects patients from being denied access to community pharmacies, being financially punished for having their prescription filled at a community pharmacy, and from being artificially induced to fill their prescriptions at a pharmacy owned by their health plan's PBM. The bill would also allow any licensed pharmacy willing to accept a health plan's terms and reimbursement rates to participate in that plan, so long as the pharmacy is eligible to participate in federal and state health plans.

In terms of new consumer protections, the bill would prohibit PBMs from selling sensitive patient information without the health plan being notified in advance. Moreover, patients would be shielded from PBM solicitations unless the patient and plan provide written consent.

With regard to reducing wasteful PBM spending and lowering drug costs, the bill would make sure that PBMs work on behalf of plan sponsors and patients rather than padding their own profits. The bill would require PBMs to confidentially disclose certain information to private insurance plans about, for example, whether the PBM is passing along – or pocketing – manufacturer rebates. Plan sponsors would be able to climinate PBM practices that increase costs, such as switching patients to costlier drugs and inflated billings.

Finally, H.R. 1971 contains numerous provisions that would curb burdensome and abusive audit practices by PBMs. First, the bill would prohibit unfair penalizing of pharmacies for typographical/recordkeeping errors, thereby keeping the focus of any audits on the actual pursuit of fraud. Second, the bill would prohibit the practice of extrapolation. Third, it would prohibit forcing patients to use a specific pharmacy (retail, mail, specialty) if the PBM has an ownership interest in the pharmacy (or vice versa). Fourth, it would prohibit PBMs from requiring more stringent recordkeeping than state or federal law/regulation. Fifth, it would allow for a written appeals process and require disclosure of audit recoupment to the sponsor. Sixth, the bill would create a defined audit look back period from the date that the claim is submitted. Seventh, H.R. 1971 would allow pharmacies access to a plan's methodology for determining reimbursement rates (e.g., Maximum Allowable Costs) and require those rates to be updated frequently. Again, in the face of increasing PBM consolidation it is important that H.R. 1971 be enacted to give pharmacy the tools needed to ensure low cost, high quality patient access to needed pharmaceuticals.

Conclusion

In light of the Committee's focus on the impact that health care consolidation has on the cost of insurance, Medicare spending and beneficiary costs, NCPA strongly urges Congress to investigate the anti-competitive dangers of PBM consolidation and oppose the proposed merger of Express Scripts and Medco. Furthermore, NCPA also encourages Congress to enact H.R. 1946 and H.R. 1971 in order to level the playing field for independent community pharmacies vis-à-vis PBMs, so that independent community pharmacies can continue to provide high quality, low cost health care to their patients, as these pharmacies are the backbone of their communities in both rural and urban settings. Thank you for your consideration.

Comments for the Record

House Committee on Ways and Means
Subcommittee on Health

Hearing: Health Industry Consolidation

September 9, 2011, 9:30 AM by Michael G. Bindner The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic. We will leave it to the invited witnesses to take the temperature of the industry on health care consolidation and will focus on possible future sources of health care consolidation and their impact on the cost of private health insurance, Medicare spending, and beneficiary costs.

The key issue for the future of health care consolidation is the impact of pre-existing condition reforms on the market for health insurance. Mandates under the Affordable Care Act (ACA) may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether for constitutional reasons.

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support also will not work if the ACA is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

Resorting to single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related. For example, Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax — which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, and NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

If cost savings under an NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed. The ability to exercise market power, with a requirement that services provided in lieu of public services be superior, will improve the quality of patient care. To the extent that

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Employer provided health care will also reverse the trend toward market consolidation among providers. The extent to which firms hire doctors as staff and seek provider relationships with providers of hospital and specialty care is the extent to which the forces of consolidation are overcome by buyers with enough market power to insist on alternatives, with better care among the criteria for provider selection.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a "balanced budget" rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

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Hearing on Health Care Industry Consolidation Friday, September 9, 2011, 9:30 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.



September 23, 2011

The Honorable Wally Herger Chairman The Committee on Ways and Means Subcommittee on Health 1102 Longworth House Office Building Washington, DC 20515 The Honorable Pete Stark Ranking Member The Committee on Ways and Means Subcommittee on Health 1102 Longworth House Office Building Washington, DC 20515

Re: September 9, 2011 Hearing on Health Care Industry Consolidation

Dear Chairman Herger and Ranking Member Stark:

The Estes Park Institute, a nonprofit, 501(c)(3) organization, is the nation's leading educational forum for hospital executives, hospital trustees, and medical staff leaders. For over 45 years, the Estes Park Institute ("Estes Park") has improved the patient experience around the country through creating better trained and more innovative health care professionals. From the observations and vast experience of the Estes Park leadership, the viability of independent, community not-for-profit hospitals is paramount to achieving high-quality delivery of health care services while holding down costs to the overall health care system.

The Committee should work to foster the existence of independent community hospitals in the light of the historical high rates of consolidation among hospitals around the country. While the hearing on September 9th touched upon the current trends in physician, hospital, and insurance markets, we would suggest the Committee consider three points which provide additional context to the consideration by the Committee on any future policy-making in this area.

First, independent not-for-profit community hospitals form the essential base of many communities throughout America. Along with the local school system, thousands of towns across the country would not exist without the local hospital. Without both adequate schools and access to health care services, communities wither, jobs and businesses leave, and local community leaders cannot recruitment replacements. Good schools and health care are essential to persuade families to come and live in any community.

Further, independent community hospitals play an essential role in providing cost-effective health care to the community. Some out-of-community hospital systems employ a strategy to acquire community hospitals for the main purpose of recruiting patients away from accessing their care in the local community setting and to the higher-cost, tertiary-care hospital setting. As a result, care that could be effectively provided in the community hospital is often more expensive for patients and payors alike in a tertiary or teaching environment. While tertiary care serves a major and essential purpose, all care should be provided in an environment that is less costly and closer to home when it is equally effective to do so. Much of health care need not be concentrated in a single setting but can be available in less costly dispersed settings.

Certainly, patients generally wish to receive care in their own communities, close to home and family. The major reason that many community hospitals exist is for the health, welfare, and quality of life of the public. Large tertiary hospitals in urban settings should exist for these same purposes, not for a business purpose.

Lastly, at present, some community hospitals are affiliating with tertiary-centered health systems – not being acquired. These affiliations can be arranged so that legal control of the hospital remains in the community, and thus that, in the future, hospital care can remain in the community. In fact, achieving population health in a community is not possible without the presence of a vibrant community hospital. There are growing technological and organizational ways to do this – such as telemedicine.

Estes Park exists to assist community hospitals, health care organization boards, and physician leaders in responding to the current and future needs in our country's health care system. We believe that the community hospital must change. Community hospitals must do what they can do best – providing high-quality coordinated care at the local level. Changing how care is delivered is a potent measure for holding down costs. The Committee should encourage the continued independent existence of community hospitals in any way possible.

Sincerely,

John Horty Chairman

Estes Park Institute

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