State Strategies to Address Rising Prices Caused by Health Care Consolidations

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Rising health care prices may be the most important problem that state policymakers face today. A primary force driving up costs is the wave of health care consolidations that give dominant providers the market leverage to raise prices, undeterred by competitive forces. States are assuming a growing role in managing the threat that health care consolidation poses to health care spending. This paper highlights the problem of rising prices driven by consolidation and explores the policy levers states have to address them.

The Problem: High Health Care Prices

Rising health care costs represent a critical financial challenge for states. States struggle with the budgetary impact of funding Medicaid and Children's Health Insurance Program—CHIP, state employee health coverage, mental health and substance abuse treatment programs, and health care for incarcerated populations, as well as the impact of rising private health care costs on employers, businesses, and citizens.[2] Without effective tools to slow the growth of health care costs, spending threatens public and private resources in every other area, from education and public safety to infrastructure and economic development.

Health care cost containment policy consists of two parts: reducing overutilization and constraining health care prices. Just like going to the grocery store, the bill depends on how many items a shopper buys (utilization) as well as the price of each item. No state can effectively control health care spending without addressing both overutilization and price.

Contemporary health care cost-containment policies largely target health care overutilization and waste. These include most payment and delivery reforms, such as accountable care organizations (ACOs), bundled payments, and value-based purchasing, as well as the shift toward consumerism, which uses higher cost-sharing and high-deductible health plans to give patients incentives to make cost-conscious use of health care services. Health care integration is promoted to improve efficiency through improved care coordination and reduction of fragmentation among providers, and reduce transaction costs between the integrated provider and payers. Perversely, many of the payment and delivery reforms aimed at integrating providers to coordinate care and reduce waste, such as ACOs, encourage health care entities to consolidate into large, powerful health care systems that have the market leverage to increase prices.[3]

In fact, so many of the cost control policies pursued in recent years are designed to control utilization so we often overlook the most significant cost driver—high prices. Our inability to control private health care prices is a problem on a huge scale. The United States has experienced more than a 400 percent increase in total annual health care expenditures since 1990,[4] spending reached $3.2 trillion in 2015 representing 17.8 percent of gross domestic product.[5] In the United States, we pay more for everything in health care. For example, an echocardiogram that cost $1,714 in Massachusetts or $5,435 in New Jersey, would cost less than $100 in Japan.[6] Despite the higher prices we pay, we do not get more or better quality care or better health outcomes.[7]

Why are health care prices so high?

"… The empirical evidence points to this sobering conclusion: Health care market consolidation significantly increases prices without offsetting improvements in quality or efficiency."

The primary reason we spend so much more than in every other industrialized countryies is that our prices are simply higher. It is not that we use more health care, have superior health care, sue our doctors or hospitals more, or are much sicker or heavier than our counterparts in Europe, Canada, or Asia.[8] Our health care spending problem boils down to the famous and blunt conclusion from a group of health economists about our excessive health spending: "It's the prices, stupid."[9]

Health care prices are high because health care providers have the upper hand in setting prices. The Affordable Care Act and other recent policy approaches rely on competition to discipline health care prices. But, due to a rapidly consolidating health care market, competition is disappearing, and there are few systemic checks in place to limit price increases. Consolidation creates an environment where health care markets cannot function as competitive markets should. Moreover, more than other consumer goods, health care consumption often evades market forces because patients under medical duress cannot shop around in an emergency. They rely on the expertise of physicians to select services so patients are shielded from some of the price variations by the presence of third-party payers.

Not only are health care prices high, they are extremely variable. Within the same geographic region, there is a wide range of prices for a given service—up to a 60 percent difference between the highest- and lowest-priced hospitals for the same inpatient service, and a two-fold difference in prices for outpatient services.[10] And these price variations between providers are driven by market power, not by differences in quality, payer mix, or sickness of the patient population.[11] In other words, when we pay more at a high-price provider, we are not getting more or better care, we are simply paying for the provider's market power. The health care pricing problem is a provider market power problem.

Consolidation—The Reason Health Care Prices Are Soaring

Today, we are in the midst of a wave of health care consolidation: horizontal mergers between hospitals as well as vertical consolidation of hospitals and physicians. Here is what the data illustrates us about provider market consolidation:

- **Nearly half of all hospital markets in the United States is "highly concentrated," including nearly all major metropolitan areas (more than 88 percent).** Most rural areas are concentrated because they cannot support more than one major health care provider. No hospital markets are considered highly competitive.[12]
- **Hospital concentration has increased by 40 percent in the past 30 years.**[13] In the 1980s, the average hospital market had five independent firms. That has now decreased to three independent firms (usually one is dominant), drastically reducing the ability of health plans to refuse to contract with dominant, costly providers.
- **Vertical consolidation of hospitals and physician groups has similarly increased,** from 2004 to 2011, hospital ownership of physician practices increased from a quarter (24 percent) to nearly half (49 percent).[14]
- **Providers are also merging across geographic markets** at a rapid pace to form large health care systems that span geographic regions. In the roughly 10 years starting in 2000, one-third to one-half of all hospital mergers were across geographic markets, thus escaping antitrust review.[15]

Health care consolidation is frequently justified by the potential of integration to improve health care quality and efficiency. However, the empirical evidence points to this sobering conclusion—*health care market consolidation significantly increases prices without offsetting improvements in quality or efficiency.*

- **Horizontal hospital consolidation leads to 20 to 40 percent higher prices,** with greater price increases in concentrated markets.[16]
- **Vertical consolidation leads to higher prices.** Hospital ownership of physician practices is associated with higher hospital prices, nearly 14 percent higher physician prices, and 10 to 20 percent higher total expenditures per patient.[17]
- **Geographic cross-market health care mergers have led to 6 to 9 percent price increases,** compared with controls, and is currently unchecked by existing antitrust enforcement.[18]
- **Health care consolidation is followed by substantial jumps in prices without offsetting savings in efficiency or quality.**[19] Despite mounting evidence that integrated providers raise prices, there is a noted lack of empirical data illustrating that integration improves health care quality or reliably generates cost savings through reduced utilization or improved efficiency, undercutting the professed justifications used to support consolidation.

Because of federal antitrust enforcement limits, states are now shouldering the critical task of controlling health care costs driven by consolidation.

In summary, health care markets are rapidly becoming consolidated and consolidated providers in concentrated markets are raising prices. This evidence somewhat contradicts long-held beliefs that the main driver of health spending is oversupply in a "medical arms race." **The reality is that more competitive markets have lower prices and better quality.** The key is that more competition is not synonymous with increasing the number of providers; rather, it means that the providers are not joined into giant corporate entities that negotiate as a whole, but rather operate as independent entities who can compete or be substituted for each other by health plans building their provider networks. **When we lose competition, market forces no longer work properly and there is no systemic check on private price increases that flow from consolidation.**

State Options to Address Rising Costs

Because of federal antitrust enforcement limits, states are now shouldering the critical task of controlling health care costs driven by consolidation. However, antitrust enforcement is only one of a range of policies that can address rising prices driven by health care consolidation.

Federal antitrust enforcement is handled by the Federal Trade Commission (FTC) and the U.S. Department of Justice. These federal agencies can oppose anticompetitive mergers as well as police anticompetitive practices in health care providers' contracts with health insurance plans. But federal antitrust enforcement, though a powerful means to prevent anticompetitive mergers, lacks the resources and capacity to police all health care consolidations occurring across the country. States are uniquely situated to monitor and address their own particular market dynamics and tailor policy responses accordingly. **States have an opportunity and an obligation to assist in health care cost containment to promote the health of their citizens, their businesses, and their budgets.**

The following chart describes a range of policy tools states can deploy to regulate rising health care prices resulting from consolidation:

Policy Approach	Tools
Market-based approaches	• Price transparency • Reference pricing by state purchasers
State antitrust enforcement	• Merger enforcement • Challenging anticompetitive practices
Reducing barriers to entry	• Eliminating certificates of need • Expanding scope of practice, telehealth
Certification and supervision	• ACO certification • COPAs
Insurance regulation	• Insurance rate review • Restricting anticompetitive contracting practices
Rate oversight	• Rate oversight commission • Rate caps • Site-neutral payment • All-payer rate setting and global budgets

Market-based Approaches

Market-based solutions, such as price transparency and reference pricing, rely on competition and market forces to reduce price variations and to allow consumers and purchasers to select lower-priced, higher-value providers.

Price transparency: Price transparency policies counter the existing opacity of health care prices that prevent competitive pressure on high-priced providers. Many states have established all-payer claims databases (APCDs) to collect provider-specific price and quality data from payers to make price comparison tools available to consumers.[20] NASHP and the APCD Council have provided guidance about implementing APCDs and the challenge to APCDs posed by the Supreme Court decision in *Gobeille v. Liberty Mutual*.[21] While state APCDs cannot require self-funded, employer-based health plans to report

data, they remain important tools for consumers and regulators to monitor the effects of health care consolidation on prices and quality.

Reference pricing by public purchasers: Like high deductibles, reference pricing also puts an individual's own dollars at stake, but reverses who pays the first dollar of coverage.[22] Health plans agree to pay the price for a given service charged by a low-priced provider (the "reference price"), and the individual is free to seek care from a range of other providers, but is responsible for the difference between that provider's higher price and the reference price.[23] Proponents say reference pricing makes patients sensitive to the providers' price differences, nudging them toward more cost-effective choices. The increased price sensitivity from reference pricing creates market pressure for high-priced providers to lower their prices closer to the reference price or else lose business.

Public purchasers—such as CalPERS, which covers California's public employees and retirees—have used reference pricing to shift patient choices and reduce prices at high-priced providers.[24] Reference pricing generally only works for non-emergent, standardized procedures where there is wide price variation but little variation in quality, such as colonoscopies or hip replacements.

State Antitrust Enforcement

State attorneys general can use their parallel antitrust enforcement authority under federal and state antitrust laws to prevent and regulate anticompetitive mergers or conduct by health care entities.[25] At the federal level, the Sherman Act and the Clayton Act prohibit anticompetitive mergers, collaborations, and conduct.[26] In addition, 49 states have their own antitrust laws to promote and protect competition.[27]

Given the market-specific information required to bring an antitrust enforcement challenge, state officials are well-positioned to identify integration proposals that threaten to harm competition. State attorneys general can challenge mergers and collaborations and bring enforcement actions both independently and in conjunction with a federal action. Joining with federal antitrust agencies to bring an action can be an especially effective means for states to leverage both the expertise and resources of federal agencies as well as their own knowledge of existing market dynamics.[28]

In addition to reviewing proposed mergers, state attorneys general can police anticompetitive contracting practices by providers and health plans (discussed in Part II.E.2, below) under federal and state antitrust laws prohibiting anticompetitive conduct. While state antitrust enforcement is a useful tool to target some of the most egregious anticompetitive behavior, in many instances it is too blunt an instrument to engage in delicate balancing between encouraging the potential benefits of health care integration and mitigating its risks.

Reducing Barriers to Entry

States may take steps to increase health care competition by reducing barriers for new competitors to enter health care markets.

Certificate-of-need and facility licensure: States may implement policies to reform or eliminate certificate-of-need (CON) laws and facility licensing requirements that pose barriers to entry by new health facilities.[29] CON laws have been shown to increase costs without improving quality.[30] The growth of ambulatory, retail, and freestanding clinics provide options for patients to receive care in lower-cost settings, but restrictive CON and facility licensing laws may limit the ability of new types of facilities to enter the market to compete with established hospitals. A longstanding justification for CON laws is to

ensure adequate supply of health care services—avoiding overutilization driven by oversupply or diminished access due to undersupply of services in rural areas. But research on CON laws shows they tend to worsen concentration and increase prices, without controlling costs or ensuring access.[31]

Scope of practice and telehealth: States may expand their scope-of-practice laws to allow mid-level providers, such as nurse practitioners or physician assistants, to offer a broader range of clinical services, such as diagnosis, prescribing, and treatment, without direct supervision by physicians.[32] Narrow scope-of-practice laws limit the autonomy of mid-level clinicians to only provide primary care services, which can exacerbate provider shortages, limit access, and reduce competition for services.[33] Similarly, states may expand the use of telehealth to improve access to providers, particularly in rural or underserved areas.[34]

Certification and Supervision

ACO certification: Unlike for Medicare ACOs, there is no regime oversight for commercial ACOs. Three states (Massachusetts, New York, and Texas) have established ACO certification programs.[35] With ACO certification, the state can offer a range of regulatory incentives to the ACO, such as antitrust immunity or approval to assume financial risk, in exchange for a more searching antitrust review upon the ACO's formation and continued oversight of price and quality. States that certify ACOs can increase data gathered from ACOs and remove certification if ACOs become anticompetitive, but this oversight will not reach all market actors or all vertically-integrated entities.

Certificates of public advantage: While not without controversy, states can facilitate integration but retain some oversight authority by immunizing health care entities from state and federal antitrust enforcement through the use of state action immunity. At least 13 states have legislative authority to immunize health care entities from antitrust enforcement—three via state action immunity and ten via health-related "certificates of public advantage" (COPA).[36] In exchange for antitrust immunity, consolidating entities must agree to ongoing oversight and restrictions on their potentially anticompetitive behavior, such as price increases, future acquisitions, or payer contracting practices.

In a recent case study of a COPA in Asheville, North Carolina, the authors found it unclear whether the COPA effectively counteracted the loss of competition in the area, but they concluded that COPAs may be an underused resource to gain "light-handed, targeted" oversight over otherwise unregulated, post-consolidation activities of integrated providers.[37] COPAs are not without risks, however. The FTC has expressed strong reservations about COPAs, raising concerns that rather than being necessary to encourage procompetitive integration, the immunity only protects entities engaging in the most anticompetitive behavior.[38]

Insurance Regulation

Insurance rate review: States can utilize the rate review authority held by their insurance commissioners to provide some oversight over both insurance premiums and hospital rates. All state commissioners already have insurance rate review authority,[39] but their powers vary in strength and scope. Insurance rate review focuses on premium rate increases rather than on provider prices, but limiting the ability of insurance companies to raise premiums puts pressure on providers when negotiating with the health plans.[40]

To have the strongest effect, states can grant the insurance commissioner the authority to impose a cap or regulatory limit on provider price increases. The best, and perhaps only, example of this is Rhode Island's insurance commissioner, who limits hospital rate increases for health insurers to the Consumer Price Index – Urban plus 1 percent.[41] This model has the benefit of building on existing institutions, but it also locks in the existing pricing disparities between must-have and have-not providers.[42]

States can pass laws, use insurance commissioners' review authority, and antitrust enforcement to limit or prohibit the use of these anti-competitive contracting practices.

Restricting anticompetitive provider-plan contracting: States can restrict anticompetitive practices used in providers' contracts with health insurance plans. Health plans exert pricing pressure on health care providers by using patient cost-sharing incentives to steer patients to lower-cost providers.[43] However, powerful providers can resist these cost-control efforts by insisting on contractual anti-tiering/anti-steering provisions or engage in "all-or-nothing" contracting, in which a large health system will insist plans contract with all their entities or none at all. On the other side of this negotiation, a dominant health plan can insist on "most-favored nation" (MFN) provisions to extract agreement from hospitals not to accept lower rates from another health plan competitor, thus assuring the dominant plan will receive the best price and preventing price competition from other health plans.[44] All these practices (anti-tiering/steering, all-or-nothing contracting, and MFNs) have potential anticompetitive effects because they allow dominant firms to avoid competition and keep prices high.

States can pass laws, use insurance commissioners' review authority, and antitrust enforcement to limit or prohibit the use of these anti-competitive contracting practices.[45] For example, Massachusetts passed a law prohibiting providers from using anti-tiering and anti-steering provisions in their plan contracts.[46] State and federal antitrust authorities have challenged the use of anti-tiering/anti-steering provisions. Currently 19 states have banned MFN clauses.[7] Similar efforts could be pursued through insurance commissioners' review authority.

Rate Oversight

Rate oversight commissions: Several states have established independent commissions to oversee health care prices. These commissions typically have authority to study statewide health care cost growth and proposed mergers and make policy or enforcement recommendations. One of the most prominent examples is Massachusetts' Health Policy Commission.[48] States can vest their commission with regulatory authority, such as the ability to implement price caps or approve hospital budgets.[49]

A rate oversight commission can institutionalize oversight and health policy expertise to analyze data from across the state and provider types. Such a body, however, must be independent to avoid agency capture by the powerful providers they oversee as well as the political branches of government that may be subject to pressure by powerful providers who are also large employers in legislators' districts.

Rate caps and corridors: An intermediate step between monitoring and setting provider rates is to establish a cap on providers' private health care prices, typically described as a percentage of Medicare rates, such as 125 percent or 175 percent of Medicare rates.[50] Price caps limit the extent of price variation by imposing a ceiling on prices, but they still permit providers to compete below the cap. Price caps are simpler from a regulatory perspective than rate-setting because they set the cap at a percentage of

Medicare rates. But, by building off of Medicare, the cap incorporates all the flaws of the Medicare pricing system, as well as its strengths. Rate corridors work in much the same way, but they also establish minimum payment levels so that providers without market power are not paid below costs, while still reducing overall price variation.[51]

Another variation would establish rate caps only for rates charged to out-of-network patients and non-contracted payers. For example, for out-of-network services, the state could require hospitals and physicians to charge no more than 150 to 175 percent of Medicare or the average contracted rate.[52] In so-called "surprise medical billing" scenarios where the patient inadvertently and involuntarily receives out-of-network care, such as in an emergency or at an in-network facility, states could further limit out-of-network charges and prohibit balance billing and higher out-of-network cost sharing.[53]

Site-neutral payment: Site-neutral payment policies eliminate price differences for the same outpatient services based on the location or "site" of service. Hospital outpatient departments are paid more than physicians' offices for performing the same type of service because hospital outpatient settings can charge a facility fee in addition to the physician's professional service fee.[54] The fact that hospitals can charge an additional facility fee for acquired physicians' services is one of the financial incentives driving hospital-physician integration.[55] This vertical consolidation raises prices and total spending for outpatient services for payers and patients alike, without any additional facility standby capacity or overhead to justify the added facility fee.[56]

Site-neutral payment policy is based on the view that, "if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than another."[57] Effective Jan. 1, 2017, Medicare must use site-neutral payments for outpatient services (other than emergency department services) furnished at any new, off-campus hospital outpatient departments.[58] This means these services will be reimbursed at the same, lower rates as freestanding physicians' offices.[59] Despite some broad exceptions,[60] Medicare's site-neutral payment policy is forecast to save the federal government an estimated $9.3 billion over 10 years.[61]

States can also adopt site-neutral payment for private and state-based payers. For example, Connecticut prohibits hospitals from charging a facility fee for outpatient office visits at an off-campus, hospital-based facility.[62] Although Connecticut's facility fee ban only applies to "evaluation and management" codes used for office visits, not the full range of outpatient services covered by Medicare's policy, Connecticut provides patients with more transparency and notice of facility fees for other types of outpatient services.[63] Other states could implement broader site-neutral payment policies that cover the full range of non-emergency outpatient services.

States can adopt site-neutral payment policies to eliminate the incentives for providers to increase prices through vertical consolidation. Payers should pay the price of the most efficient setting, particularly if there would be no reduction in safety or quality.

All-payer rate setting and global budgets: States can address provider pricing power by directly regulating provider prices.[64] The prototypical system of rate regulation is a Maryland-style, all-payer rate setting under which provider prices are regulated like a utility's and all payers pay hospitals the same rate for a given service.[65] States could also set rates for private and state-based payers, without having to obtain a waiver to include Medicare prices. Rate regulation can effectively counteract providers' pricing power, eliminate unwarranted price discrimination and variation, constrain hospital prices,

and reduce hospital administrative costs. However, it needs to be paired with global budgets or limits on total provider revenues to curtail the incentive to increase volume to make up for lower prices. Even Maryland's rate-setting model has moved from fee-for-service to global budgets and caps on total hospital cost growth, and has generated some promising early results.[66]

Newer rate-setting approaches incorporate global budgets to simultaneously regulate prices, utilization, and provider operating costs by imposing total revenue limits on health systems. Vermont is moving toward a global budget system under a waiver agreement with the Centers for Medicare & Medicaid Services to implement an all-payer model, which aligns payment rates for Medicare, Medicaid, and commercial payers under an all-payer accountable care model to limit statewide per-capita health spending growth to 3.5 percent annually, with a 4.3 percent ceiling.[67] Notably, Vermont's all-payer model would cap spending for all services, including physician and outpatient services and not just hospitals.[68]

Conclusion

Health care consolidation and the concentration of provider market power is leading to uncontrolled increases in health care prices and spending. States have a critical role to play in addressing health care consolidation and rising prices, supplementing federal antitrust enforcement with policies tailored to their particular market dynamics. While states have several oversight models to choose from, state engagement and oversight is critical to address this most pressing health care policy problem—soaring health care prices.

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