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.[3]

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.[6] A recent HSC study found wide variation in private insurer payment rates to hospitals and physicians across and within local markets.[7] 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,[8] earlier 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/12ginsburg.html.

[5] 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).

[8] Vogt, 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.[10]

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).
[10] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, Washington, D.C. (March 2009).
[11] Berenson, Ginsburg and Kemper (April 2010).
[12] 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 2011).

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.