CENTER for STUDYING HEALTH SYSTEM CHANGE

Provider Leverage with Health Plans: Evidence from Site Visits

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Policy Context

- Greater provider leverage leads to higher insurance premiums
  - Higher prices could induce supply response
- Accountable care organizations could facilitate greater provider leverage
  - De jure or virtual consolidation

Institutional Context: Process of Establishing Payment Rates

- Creation of contracted provider networks under managed care
- Negotiation with each hospital or system
  - Mixture of per diems, DRGs, discounted charges
- Fee schedule for physicians based on Medicare
  - Negotiation with larger practices

Large Variation in Payment Rates by Community

- GAO study of FEHBP PPO hospital and physician payment rates
  - Adjusted hospital price index
    - Milwaukee-Waukesha: 1.57
    - New York: 0.68
  - Adjusted physician price index
    - Madison, WI: 1.41
    - Washington, DC: 0.75
    - High correlation with HSC site visit results
- MedPAC study of physician payment rates
  - Smaller communities have higher rates

Large Swings in Hospital Leverage over Time

- MedPAC analyses show peak in 1992 and trough in 1999
  - Consistent with HSC site visit results
- Little trend in physician leverage

MedPAC Tracking of Hospital Leverage

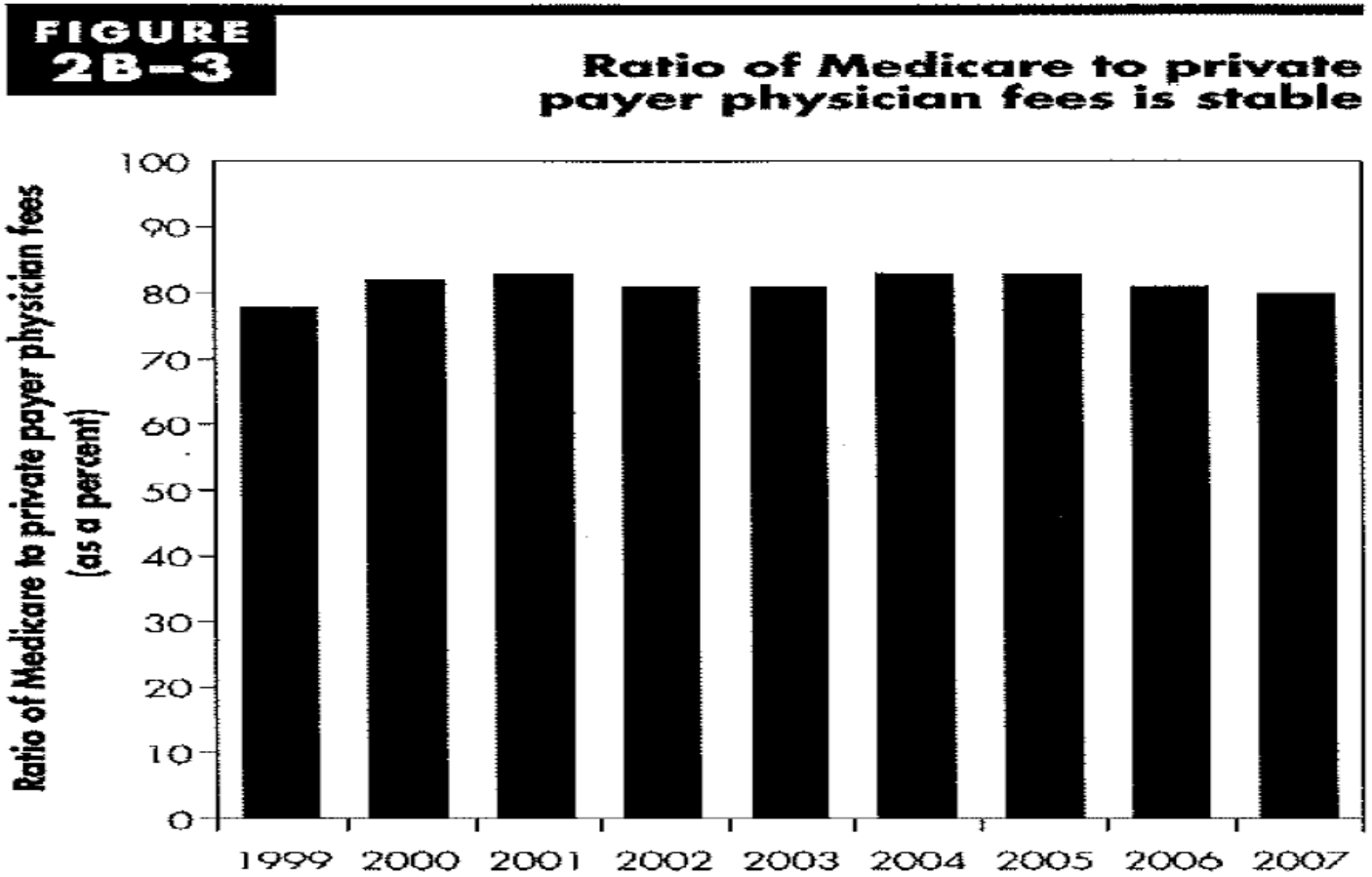
FIGURE 2A–6

Three distinct periods in the private payer payment-to-cost ratio

Note: Private payer payment-to-cost ratios do not include Medicare Advantage patients.

Source: MedPAC analysis of data from the American Hospital Association annual survey of hospitals.

MedPAC Tracking of Physician Leverage



Source: Direct Research, LLC, for MedPAC for 1999–2004 data. MedPAC analysis for 2005–2007 data.

Key Factors in Changing Leverage over Time

- Provider consolidation
- Purchaser requirements for broad provider networks
- Changes in capacity in relation to demand
- Medicaid payment rates likely a factor—at least cross sectionally

Focus on California

- Trends in leverage seen most clearly
  - Swings appear to have greater amplitude
  - Applies to physicians as well as hospitals
- California includes prototypes for ACOs
  - Medical groups, IPAs, hospital foundations
- Recent HSC site visit study for California HealthCare Foundation (CHCF)
  - In-depth visits to six metropolitan areas
  - Community Reports recently published by CHCF
  - Cross-site analyses on compelling topics

Respondents' Assessment of Trends

- Contrast present with 10-15 years ago
- Striking change in leverage
- Little sign of approaching another turning point

Provider Networks

- Demands for broad provider networks
  - Fresno network disruption analysis
- Some recent narrow network products
  - CalPERS
  - San Diego

Hospital and Physician Capacity

- Perception of substantial excess capacity in mid-1990s—hospitals and physicians
- Perception that current capacity is very tight
  - Rapid population growth in some areas
    - Physician shortages most acute in non-coastal areas
  - Seismic standards shift capital from expansion to replacement
  - Lingering effects of plan leverage in 1990s

Regulation

- Department of Managed Health Care review of network changes
  - Permission required to drop a hospital from network
    - Time consuming and usually denied

Horizontal Integration

- Extensive hospital and medical group consolidation
  - Sutter Health: 18 hospitals in Northern California
  - Catholic Healthcare West: 33 hospitals throughout California
- Negotiate for entire system
  - Includes hospitals with differing degrees of importance in networks
  - University of California hospitals now negotiating as system

“Must Have” Status

- Reputation of a hospital or group
  - Cedars-Sinai
- Unique offering of specialized services
- Geographic isolation
- Important to an ethnic group
- Much less leverage for providers without such attributes

Joint Hospital-Physician Negotiation

- Hospitals apply leverage to rates for affiliated physicians
- Growing degree of affiliation
  - Attractiveness to physicians
  - Potential for integration

Larger Medical Groups and IPAs

- Some consolidation resulting from low payment rates in 1990s and opportunities with delegated model
- Substantially higher payment rates than small practices
- Anti-trust policy generally limits IPA negotiation to capitated rates
  - But exceptions for “clinically integrated”

Moderating Influences

- Concern about higher premiums eroding employer-based coverage
- Competition with Kaiser Permanente
- Probably applies only to very largest systems

Outlook for Future

- Continuation of provider leverage
  - Do providers become sated?
- Demand side response
  - Narrow network products
  - Benefit structures incorporate incentives for provider choice
- Policy options
  - More vigorous antitrust enforcement
  - Maryland-style all-payer rate setting

Provider Integration and Impacts on Competition

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Outline

1. Integration – Facts
2. Impacts of Integration
   a. Hospital Consolidation
      i. Efficiencies
      ii. Harm to Competition
   b. Physician-Hospital Integration
      i. Efficiencies
      ii. Harm to Competition

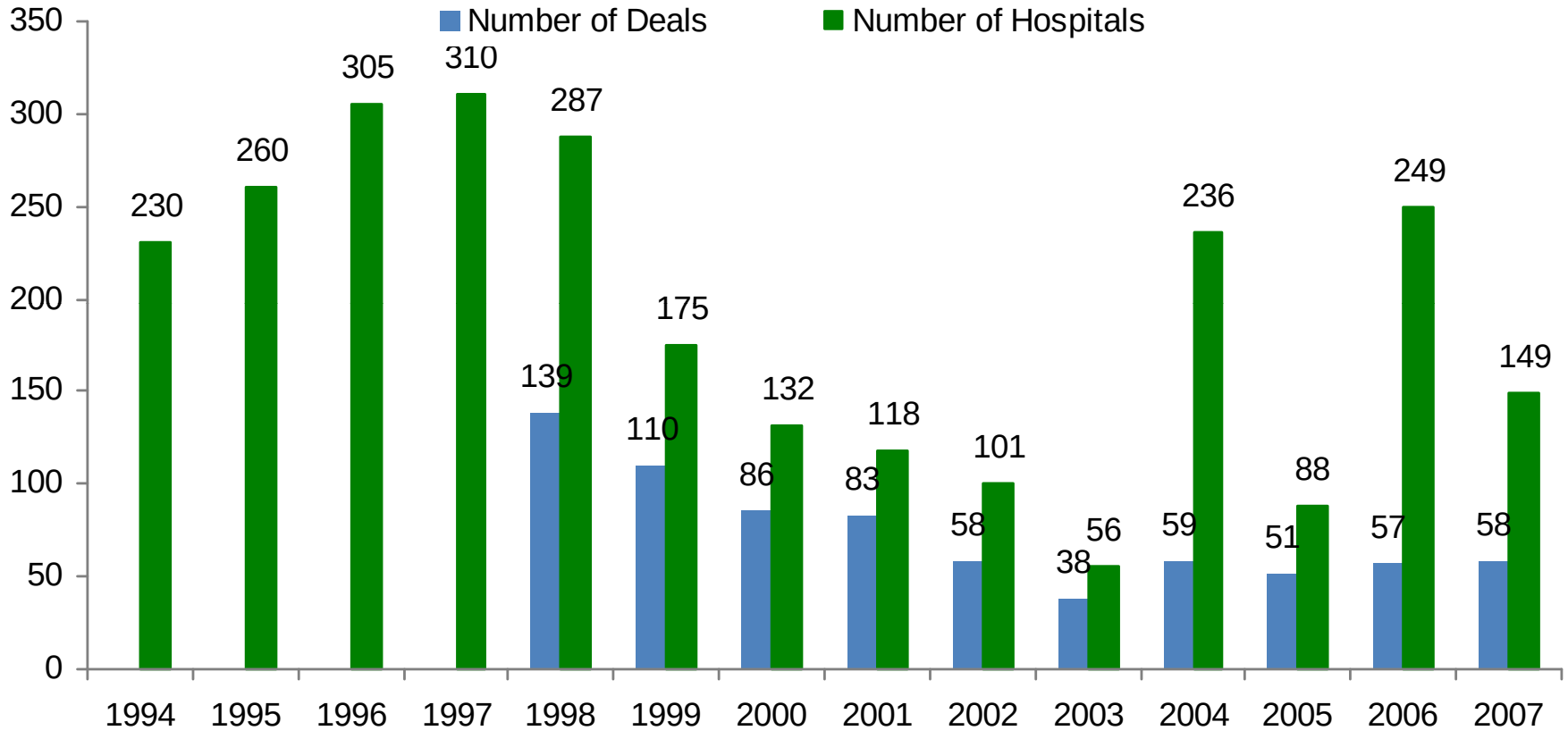
Integration -- Facts

1. There has been a great deal of provider integration over the last 15 years.
2. "Horizontal" – hospital mergers and acquisitions, system membership.
3. "Vertical" – hospital/physician integration.

Hospital Integration

1. 1990s merger wave – 900+ deals from 1994-2000.
   i. Many urban markets now dominated by 2-3 large hospital systems -- 6-12 independent firms used to be typical.
   ii. Proportion system members grew from 40% in 1985 to 60% in 2000.
   iii. By 2003 ~90% of people in larger MSAs faced highly concentrated markets.
2. Trend has picked up again recently.

Hospital Mergers



Source: Irving Levin Associates, Inc., *The Health Care Acquisition Report*, Thirteenth Edition, 2008.

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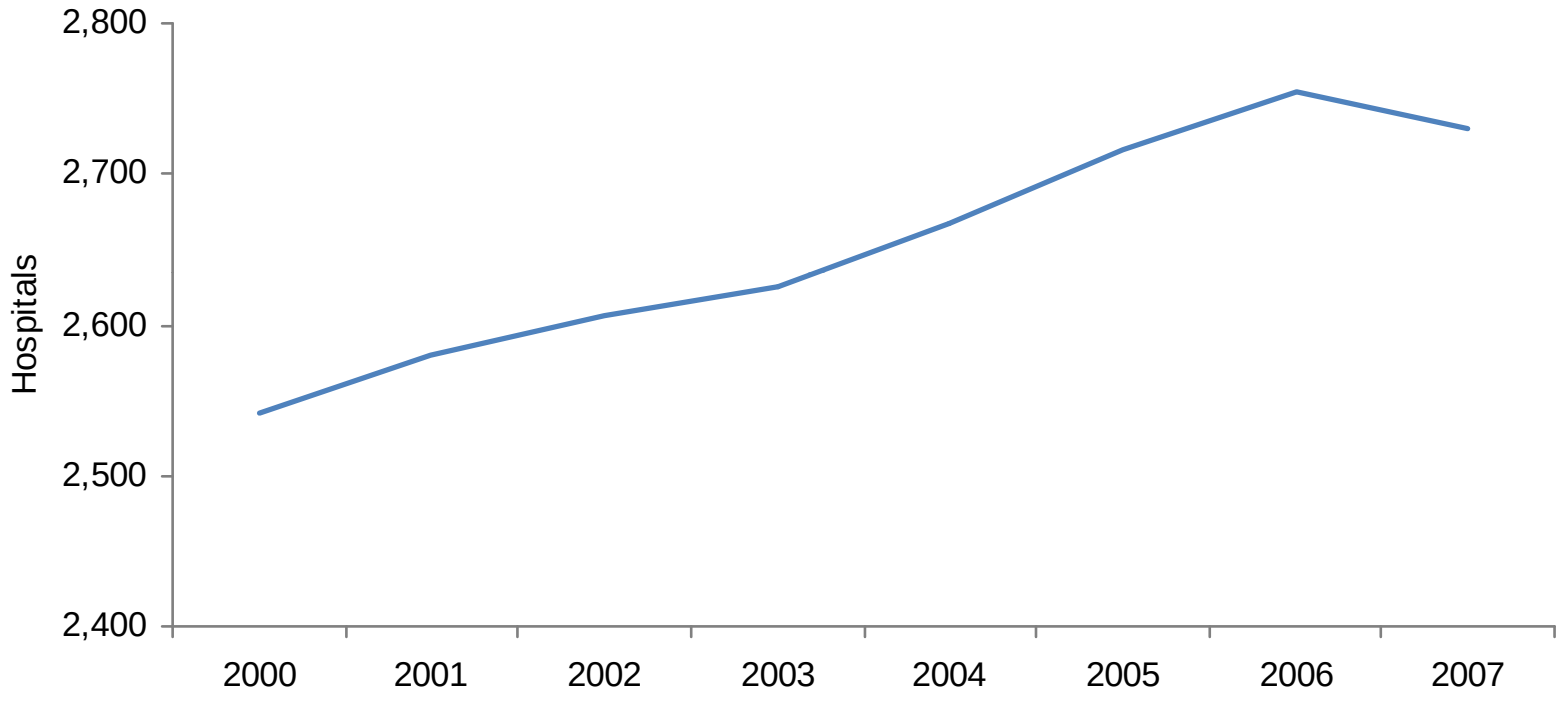
Hospital Systems



Number of Hospitals in Health Systems 2000 – 2007
Source: American Hospital Association

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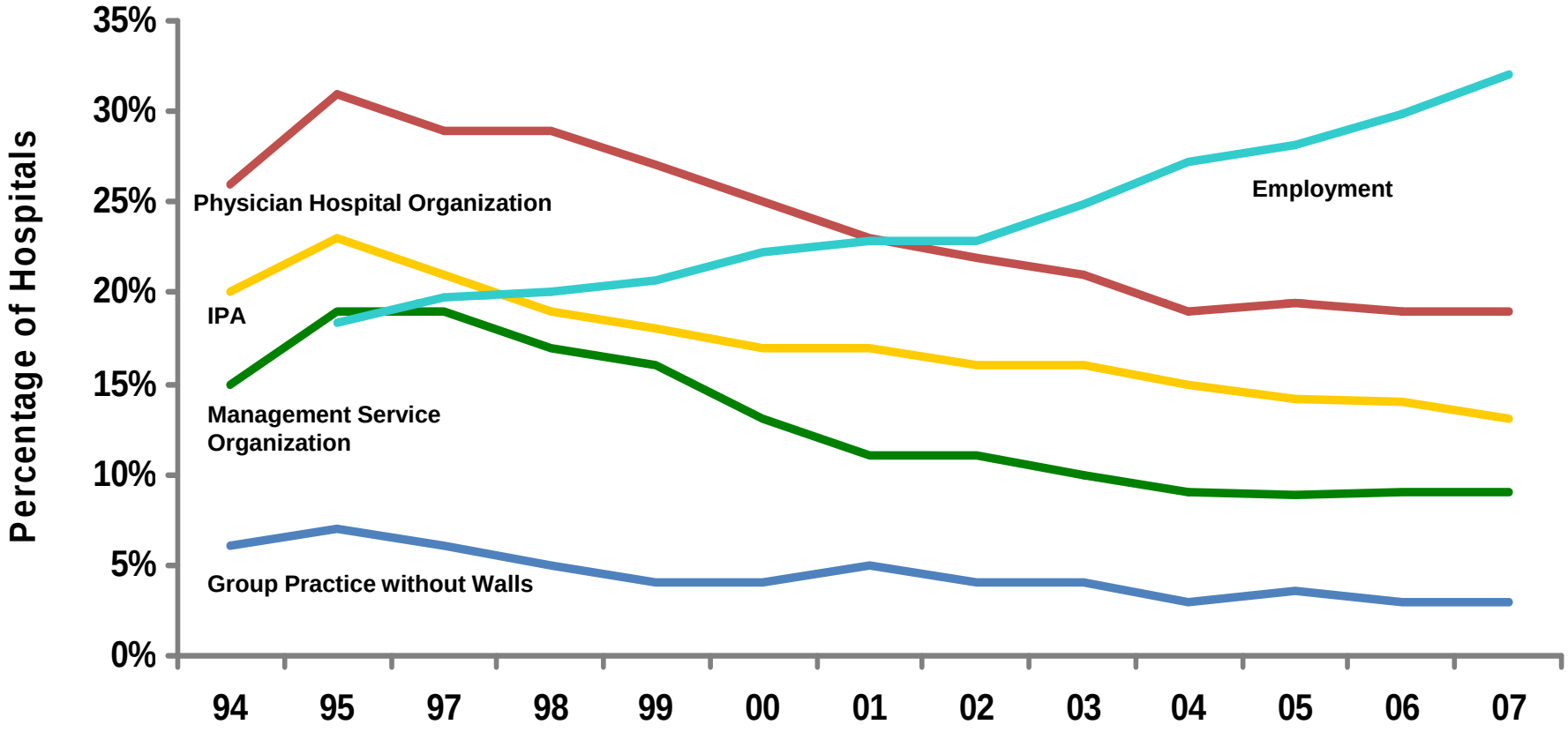
Hospital-Physician Integration

1. Integration between physicians and hospitals grew rapidly from the late 1980s until the mid-1990s, declined, then ticked up.
2. Physician employment by hospitals has been increasing rapidly.

Physician-Hospital Trends



Percentage of Hospitals with Physician Affiliation, 1994-2007
Source: American Hospital Association

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Hospital Integration -- Efficiencies

1. Efficiency gains from integration.
   a. There are potential gains from integration.
      i. Scale economies.
      ii. Eliminating duplication.
   b. Savings realized only if facilities are truly combined.
      i. Consolidate services; close some facilities.
      ii. Ownership integration alone doesn't lead to savings.
   c. Evidence is mixed.
      i. Facility combining mergers result in significant savings.

Hospital Integration -- Competition

1. Harm to competition.
   a. Fewer competitors; less pressure on price, quality.
   b. Evidence
      i. Price – substantial increases due to consolidation
         - 5%+ in markets with many (120) hospitals (LA + Orange counties).
         - 50%+ in markets with few (3) hospitals (San Luis Obispo).
      ii. Quality
         - Medicare – substantial increases in heart attack patient mortality due to consolidation.
         - Private – mixed results.
         - On balance, evidence suggests that consolidation lowers quality.
            - » Evidence is less firm than for price.

Hospital-Physician Integration -- Efficiencies

1. Gains from coordination, collaboration, volume, information, assurance of supply, contracting costs.
   a. Physicians and hospitals coordinating on patient care – lower costs, higher quality.
   b. Physicians and hospitals collaborating on activities to reduce costs, increase quality (long term activities).
   c. Concentrate physicians' patient volumes – improve quality.
   d. Better information about doctors, patients.
   e. Assured supply – both ways.
   f. Reduced contracting costs.

Hospital-Physician Integration -- Efficiencies

1. Evidence
   a. Costs – No impact.
   b. Quality – Mixed results.
   c. IT linkages – Little impact.
   d. Clinical integration – little impact.
2. Bundled Payment
   a. Seems to lower costs, improve quality.
3. Overall, few consistent effects of integration.
   a. Impact seems to depend a great deal on specific form of integration.
   b. Most integration fails to align physician and hospital incentives.
   c. Most integration focused on financial, not clinical factors.

Hospital-Physician Integration -- Competition

1. If both the hospital and physician markets are competitive, then integration can't harm competition.
2. If not, then integration can be anticompetitive.
   a. Foreclose rival hospitals from physicians, or vice versa.
   b. Allow formerly independent firms to collude.
   c. Hospitals (doctors) may have to compete less strongly head to head by integrating with different physicians (hospitals).
   d. If hospital market is less competitive than physician market, then doctors may acquire market power by integrating with a hospital.
3. Integration often seems to be a strategy to increase bargaining power with insurers.

Hospital-Physician Integration – Competition

1. Evidence.
   a. Not a lot of research evidence.
   b. Doesn't seem to be much impact on treatment, outcomes, costs, or prices.
   c. Conflicting evidence on prices.

Antitrust Enforcement in the U.S. for Vertical Restraints in Health Care

1. There has been a lot of antitrust activity concerning physician-hospital relations in health care in the U.S.
2. The antitrust enforcement agencies have been concerned about integration.
3. Courts have not often found integration to be anticompetitive (but that could change).

Summary and Conclusions

1. There has been a lot of integration over the past 15 years.
2. There is potential for improved efficiency and better quality through integration.
3. Those potentials mostly seem to be unrealized.
4. Hospital integration is often anticompetitive.
5. Physician-hospital integration less clear, but there seem to often be anticompetitive motives.