Provider Market Power and Cost Containment

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Introduction

Since California's swift implementation of the Affordable Care Act (ACA) has significantly reduced the number of uninsured state residents, there is growing attention for the state to turn to what some have dubbed the "second act" of health care reform: cost containment. When the ACA reformed the insurance market to ban discrimination against pre-existing conditions, and financed coverage for millions of low-income and underserved populations, it removed several barriers to accessing care. While more individuals are covered by insurance, the rate of health care cost growth continues to outpace economic growth, resulting in higher premiums and deductibles.

It is imperative to make health care more affordable through structural changes in the way health care is delivered and financed. It is important to note that cost containment efforts are not new. Prior to the ACA, there have been various and ongoing approaches that aim to lower health care costs, such as consumer driven approaches that include high deductible health plans paired with health savings accounts. These approaches have been met with mixed results[1] and illuminate that there is no single panacea to cost containment.

Containing costs ensures that California lives up to the social promise of ensuring its residents have access to affordable health insurance, and one key area to focus efforts on is the prices paid for health care. There are many categories that contribute to health care cost growth, ranging from an aging population to technological advances (e.g., increased utilization of diagnostic imaging procedures). Health care prices are a ripe area to target because there is increasing evidence that higher health care prices are not correlated with higher quality and outcomes. When consumers are not receiving quality care and outcomes that are commensurate with the prices paid for their health care, prices are arbitrary, inflated, and exacerbate the ability of the health care system to efficiently deliver value for consumers.

Because the U.S. has a multi-payer health care system, commercial prices are the result of negotiation between providers and payers. Publicly funded programs (e.g., Medicaid and Medicare), use administratively set prices. In this negotiating process between payers and providers, an increasing body of research links higher health care prices to the leverage providers have in obtaining higher payments from payers, a phenomenon referred to as "provider market power." Provider market power has been linked with increased unit prices for services and higher utilization of outpatient services.[2] When provider market is left unconstrained, this effectively limits the ability of payers to negotiate prices.

Despite the evidence, provider market power has not always received the attention it deserves in health policy discussions. One of the key challenges to shining a light on provider market power is the entrenched belief that higher prices means better care. Fortunately, policymakers can draw many relevant lessons from the nationally recognized work done on price transparency and provider market power by the Catalyst for Payment Reform (CPR), an independent, nonprofit organization working to promote high-value care in the U.S. In 2012, CPR published a report entitled, "Provider Market Power in the U.S. Healthcare Industry: Assessing its Impact and Looking Ahead."[3] The report included a comprehensive review of the evidence that providers have exerted market power to extract higher prices in both consolidated and non-consolidated health care markets. CPR argued that addressing this issue now is consequential for slowing the growth in U.S. health care spending. CPR identified the way antitrust enforcement is an important tool in improving market efficiency through blocking mergers and acquisitions that reduce competition. However, antitrust action is a time intensive process that requires identifying a relevant market size and demonstrating that the merger and/or acquisition resulted in a more concentrated market that produced higher health care prices. Because of a series of unsuccessful state and federal antitrust suits, CPR discussed the way antitrust action cannot be

relied upon as the sole tool to mitigate provider market power.

Provider marker power can also manifest in ways that do not involve ownership (through a merger or acquisition) or meeting the definition of a concentrated market under antitrust law. One example is when insurers effectively have no choice but to contract with certain "must-have" hospitals because employers and consumers demand access to that hospital because of its brand name or reputation. For example, Los Angeles based Cedars-Sinai Medical Center is not considered to have market power under antitrust law, but has considerable "leverage" in its negotiations with insurers because employers and consumers want access to it because of its reputation. Because this type of scenario is not within the scope of antitrust enforcement, policy research groups like CPR articulate the need for additional strategies to foster competition within health care markets. These strategies include market-based approaches, coordinated public and private activities, and regulatory interventions that promote competition as a means to achieve efficiency.

This report will be organized as follows:

- Part 1 presents the California context and the need to address the looming health care cost crisis;
- Part 2 explains the relationship between high health care prices and provider market power;
- Part 3 discusses the regulatory and market factors that are increasing greater clinical integration among providers, the recent wave of provider consolidations at the state and national level, the impact of the St. Luke's case, and alternatives to ownership such as joint ventures;
- Part 4 discusses the four strategies for addressing provider market power: encouraging transparency in health prices and quality, encouraging competitive health plan contracting, monitoring and regulating prices, and establishing a state health policy commission; and
- Part 5 recommends the establishment of the California Health Policy Commission, an independent commission dedicated to developing and implementing policy for cost containment, including better controls on provider market power.

Part 1: The California Context—A Looming Affordability Crisis

This section reviews several concerning trends in health insurance affordability from a recent California HealthCare Foundation (CHFC) report aptly titled, *California Employer Health Benefits: Rising Costs, Shrinking Coverage*, and projections for health care spending growth from the Berkeley Forum for Improving California's Healthcare Delivery System.[4]

According to a California HealthCare Foundation analysis of employer health benefits, trends in cumulative premium growth across 2002-2014 show an alarming chasm between the growth in health care premiums and overall prices (the Consumer Price Index or CPI). During this period, health insurance premiums grew by 202.2% while California's inflation rate only grew by 36.1%, an over five-fold difference.[5] When health insurance premiums outpace the growth in prices, health insurance becomes less affordable and consumes a greater share of employer, individual and family budgets. Similarly, when premium growth outpaces wage growth, employers and employees may pay more or drop coverage because it is unaffordable. Employers have reacted to these trends by shifting rising health care costs onto employees, restructuring plan benefits, dropping coverage, or absorbing costs.

California employees have experienced cost-shifting through increases in premium contributions and deductibles. For small group employers defined as having 3-199 workers, the share of employees with deductibles greater than $1,000 has grown significantly, from 21% in 2009 to nearly one-third (32%) in 2014. In comparison, large employers defined as having 200+ workers, have experienced slower growth in the share of employees with large deductibles, from 6% in 2009 to 14% in 2014. Overall, half of Californians en-

rolled in all plan types (HMO, PPO, Point-of-Service, and High Deductible Health Plans) have a deductible larger than $1,000.

Notably, two thirds of Californians enrolled in a high deductible health plan for single coverage have a deductible larger than $2,000. Within the past eight years, there has been a two-fold increase in the share of employees with deductibles larger than $1,000 for single PPO coverage, from 10% in 2006 to 20% in 2014. When examining family deductibles for all plan types, 60% of covered employees had a deductible greater than $2,000. When examining out-of-pocket limits, nearly one-fifth of workers in family coverage could bear costs up to $6,000.

When drilling down into national employer survey data on changes already made or planned by employers, it shows high rates of change among employers. When looking at all employers in 2013, there was a high level of plan changes in which a quarter (24%) of all employers either reduced the scope of benefits or increased employee cost-sharing. For 2014, a tenth (9%) of all employers reported making such changes. The percentage of small employers (3 to 199 workers) making changes were nearly the same as all employers (24% in 2013 and 8% in 2014). In 2013, a third (36%) of large employers with 1,000 or more employees reduced benefits or increased cost-sharing; in 2014, over a quarter of large employers made such changes. When employers were asked about plan changes for the following year, over half of large employers (57%) stated they are "very likely or somewhat likely to increase the amount that employees pay for health insurance premiums" while two-fifths (40%) of small employers report similar plans.

Since it is the largest source of coverage for Californians, the alarming trends in health care cost growth and higher deductibles pose legitimate questions regarding whether employer-based coverage is maintaining value for consumers. Notably, the data shows that the growth in health care costs is impacting even the largest employers. When benefits are reduced at the same time premiums and cost-sharing increase, consumers are paying more and getting less.

According to a 2014 analysis by the Berkeley Forum for Improving Health Care, between 2013 and 2022, California's health expenditures per capita are expected to grow from $8,398 to $13,061— an increase of 36% over a nine-year period. During this period, health expenditures are expected to have an average annual growth rate of 5.0% while economic growth, as measured by GDP per capita, is expected to grow at an average annual growth rate of 3.9%. Taken together, health expenditures as a share of gross domestic product (GDP) in California, health care expenditures were 14.5% in 2013 and are expected to grow to 16.0% by 2022 (Berkeley Forum, 2014). Given these projected trends in California, it is imperative that payers, policymakers and regulators understand the factors contributing to growth in health care spending and deftly craft solutions to address affordability.

Part 2: The Relationship between Price and Provider Market Power

This section will discuss health care spending and health outcomes, the way higher health care prices are correlated with provider market power, and the way provider market power does not incent lower cost structures. California data will be used whenever it is available, however, any U.S. data or discussion of trends at the national level are also relevant and applicable to California.

High Prices Drive Higher Health Spending and Are Not Linked with Better Health

Despite a recent slower growth rate[a] in U.S. health care spending, an international comparative study

[a] Between the period of 2003-2009 and 2009-2013, the real average annual growth rate slowed from 2.5% to 1.4%, respectively. The slower growth was partly due to the Great Recession, however researchers is unclear how much of the slowdown is attributable to the loss of private insurance or other factors, such as the provider efficiency gains through delivery system reforms, increased

using mostly 2013 data shows that the U.S. still spends more on health per capita and as a percentage of gross domestic product (GDP) than any of high-income Organization for Economic Co-operation and Development (OECD) countries[b] in the study.[6] Similar to its previous studies, the OECD data also dispels the notion that the U.S. health care system supports a higher supply of physicians and hospital beds and the population utilizes a greater quantity of services. In actuality, the U.S. had a lower physician supply in 2013 (2.6 physicians per 1,000 population, compared to the OECD median of 3.2 physicians per 1,000 population). The data also shows the U.S. population had fewer physician visits (4.0 physician visits per capita, compared to the OECD median of 6.5 physician consultations per capita). Additionally, the U.S. population had a lower number of acute care hospital beds (2.5 beds per 1,000 population) and a lower number of hospital discharges (126 per 1,000 population) when compared to the OECD median (2.9 beds per 1,000 population and 164 discharges per 1,000 population).

The OECD data shows that higher U.S. health care spending is linked to two factors: 1) higher prices for pharmaceuticals, office visits, and procedures; and 2) higher utilization of advanced, expensive technology, such as diagnostic imaging. The OECD data showed that the U.S. had the highest prices for pharmaceuticals, hospitals and physician services, and diagnostic imaging. For example, the U.S. had an average price of $75,345 for bypass surgery, while the second highest, Australia, had an average price of $42,130—a difference of over $30,000. The U.S. population also had the highest per capita rates of magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET) exams (e.g., 106.9 MRI exams per 1000 population) when compared to the OECD median (e.g., 50.6 MRI exams per 1,000 population).

With the exception of cancer survival rates, the U.S. population fares poorly on several population health indicators. The U.S. population has a lower life expectancy (78.8 years, compared with the OECD median of 81.2 years) and experiences the highest infant mortality rate among the 13 high-income countries (6.1 deaths per 1,000 live births in 2011, compared to the OECD median country average of 3.5 deaths). The U.S. population also has a significantly higher rate of chronic diseases (68%), when compared to its peers in the U.K. (33%) and Canada (56%). However, one silver lining is that the U.S. health care system may have better outcomes for cancer care than other OECD nations, as indicated by research that shows a significant decrease in the mortality rate between 1995 and 2007. Overall, the conclusions that can be drawn from the data is that the U.S. has the highest health care spending but does not consistently reap the benefit of improved health. As discussed below, a vigorous effort to address the higher prices paid for health care could lower overall health care spending and allow governments, employers, and consumers to invest in other priorities that positively impact health, such as public health and prevention and social services.

Higher Heath Care Prices Are Correlated with Market Power

National Evidence from the Center for Studying Health Systems Change

A study by the Center for Studying Health Systems Change (HSC) found substantial payment variation across and within eight health care markets[c], indicating that providers have significant market power to obtain higher than competitive prices. Because commercial rates are more variable as a result of the negotiation between providers and payers, the researchers compared them with Medicare rates, which are pre-determined, fixed

consumer cost-sharing, and slower development of medical technology and pharmaceuticals

[b] The thirteen high-income countries are: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

[c] The eight health care markets are: Cleveland; Indianapolis; Los Angeles; Miami; Milwaukee; Richmond, Va.; San Francisco; and rural Wisconsin.

amounts based on diagnosis-related groups for inpatient stays. The analysis by HSC compared commercial payment rates for hospitals as a percentage of Medicare payment rates, i.e., 150% of Medicare would indicate that the hospital was receiving commercial rate that was 1.5 times the Medicare rate. (Ginsburg, 2010).[d]

When looking at average inpatient hospital payment rates, HSC reported that four national insurers paid 147% of Medicare in Miami to 210% of Medicare in San Francisco. HSC also noted some extreme outliers in which some hospitals were able to receive 500% of Medicare for inpatient services and 700% of Medicare for outpatient services. Wide variation was also found within markets. In the Los Angeles market, the hospital with prices at the 25th percentile of Los Angeles hospitals received 84% of Medicare for inpatient care while the hospital with prices at the 75th percentile received 168% of Medicare. The Los Angeles hospital with the highest price and considerable claims volume received payments that were 418% of Medicare. What these findings suggest is that these health care markets are not highly competitive markets and the significant price variation is attributable to providers with strong leverage.

State-level Evidence from Massachusetts

In 2008, Massachusetts followed their historic health care reform law by passing "An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care." The law required the Attorney General's Office (AGO) to conduct an annual investigation on the reasons why health care costs grew faster than inflation and can be considered one of the most comprehensive examinations of health care costs at the state level. Its first annual report was published in 2010 and included several noteworthy findings:

A. Prices paid by health insurers to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.
B. Price variations are not correlated to (1) quality of care, (2) the sickness of the population served or complexity of the services provided, (3) the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.
C. Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.
D. Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for risk-sharing providers than for providers paid on a fee-for-service basis.
E. Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.
F. Higher priced hospitals are gaining market share at the expense of lower priced hospitals, which are losing volume.
G. The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

Finding C focused on provider market power and the AGO uses the term "leverage" to describe the clout one side has in influencing the other side during contract negotiations. For providers, leverage was based on the provider's size, geographic location, "brand name," and/or niche or specialty service line. The AGO examined two measures of

[d] The rational given by HSC for this approach is stated as follows: Medicare payment methods are designed to capture cost differences outside of the control of providers through case-mix adjustments, medical education adjustments and input-price indexes. Since payment rates are expressed as a percentage of Medicare rates, these factors, in theory, have been taken into account

leverage: (1) provider size and (2) the relative leverage between insurers and providers in a geographic region.

Market Leverage due to Provider Size

The Massachusetts AGO describes the preferences for consumers and employers to access broad provider networks and this provides large providers considerable leverage in obtaining contracts with insurers. If an insurer did not continue to contract with these larger providers, this could result in significant disruption when consumers must find a new provider or if employers and purchase plans with insurers that do include these larger providers. In measuring provider size, the AGO used two factors as proxy variables: 1) the total revenue paid by the insurer to the provider system; and 2) the total number of enrollees assigned to a primary care physician within the system. The AGO found that hospitals with larger revenues from the insurer and more members had greater leverage and were paid at higher rates compared to hospitals with less revenue or members.

When physician groups care for more members, they also have considerable leverage to negotiate better rates than the standard physician fee schedule. The AGO measured leverage for physician groups by examining if the group was able to obtain a multiplier to the fee schedule (e.g., a multiplier of 1.2 denotes an enhanced payment of 120% of the standard fee schedule rate). It was found that 14 groups were able to obtain multipliers to the fee schedule, with half of them receiving enhanced payments due to their sheer size and the other half due to other factors (e.g., regional leverage due to geographic location or due to providing specialty services). The AGO also found that seven physician organizations also received per-member-per-month (PMPM) payments in addition to receiving a multiple to the standard fee schedule. Of the seven, five physician groups were also among the insurer's 10 largest physician groups.

The Relative Leverage between Insurers and Providers in a Geographic Region

The AGO also found that the relative leverage between insurers and providers in a geographic region interacted to affect negotiated prices for health care services. This finding challenged the common view that prices are a reflection of inputs such as quality of care, patient mix, or the hospital's status as an academic medical center or source of care for disproportionate numbers of uninsured or Medicaid patients. The AGO began this examination with the assumption that all health care is local, i.e., hospitals would compete with one another in a given region. The AGO was interested in comparing differences between relative leverage across geographic regions in the state. To measure insurer leverage, the AGO used a non-scientific proxy for how much the hospital depends on revenue from the insurer.[e] To measure provider leverage, the AGO used a non-scientific proxy that represented the hospital's market position in the region and how dependent the insurer is on the hospital for caring for its enrollees in that region.[f] Then, a ratio of insurer leverage to provider leverage was calculated. When compared to all hospitals within the region, if an insurer had more leverage over a hospital, it was able to negotiate lower reimbursements for that hospital. Conversely, if a hospital had more leverage over the insurer, it was able to obtain higher reimbursements from insurers.

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[e] This examined "the proportion of a hospital's total revenue (or, in the event the hospital belongs to a larger provider system, the total revenue received by all hospitals in that provider system) that came from an insurer."

[f] This examined "the proportion of an insurer's payments to all hospitals within a region that were made to the hospital in question (or, in the event the hospital belongs to a larger provider system, to all hospitals in the provider system).

Strong Market Power Does Not Incent Cost Control

An argument for provider consolidation is improved operational efficiency and greater economies of scales, but data shows mergers may not incentive cost efficiency. Between 2000 and 2012, aggregate hospital payment-to-cost ratios for private payers increased from about 116% to nearly 150% (American Hospital Association, 2012). Meanwhile, aggregate hospital payment-to-cost ratios for Medicare decreased from about 99% to about 86%. What this suggests is that private payments are staying well above cost, but public payments appear to be falling short. In conversation with this topic, a recent study by the Medicare Payment Advisory Commission (MedPAC) finds that hospitals with strong market power have higher cost structures (Stensland et al, 2010). This is an important issue to address because lowering overall health expenditures will require not only addressing the effects of market power on inflated prices, but also promoting cost efficiency in providers.

The MedPAC research found that hospitals with strong market power also had more private-payer revenue sources, which provided greater financial resources for the hospital. Since nearly all hospitals are nonprofits, they can reinvest their profits towards improvements (e.g., capital investments) that help maintain or enhance their status in the market. This resulted in these hospitals having higher cost structures, i.e., a higher cost per discharge. These hospitals could pass along these higher costs by marking up prices in the rates they negotiate with private payers, ultimately maintaining profitability on their private payer payments. On the other hand, because Medicare rates are administratively set and have modest annual increases, these hospitals experienced negative margins from Medicare payments. While the adequacy of Medicaid and Medicare payments is an obvious problem that needs to be addressed, this study provides some evidence to counter the argument that private cost-shifting occurs due to underpayments from public payers.

Part 3: Addressing Provider Market Power in a Post-ACA World

Thus far, provider market power has been described in terms of providers merging to become larger in size in order to have greater leverage with payers. Provider market power becomes more complicated in light of the ACA because it promotes greater clinical integration among providers. This means it does not require financial integration, which would involve ownership as in a merger or acquisition. This section will review the regulatory and market factors that are increasing greater clinical integration among providers, discuss the recent wave of provider consolidations at the state and national level, the impact of the St. Luke's case, and alternatives to ownership such as joint ventures.

Fee-for-Value Increasingly Holds Hospitals at Risk for Quality and Cost

Through its payment and delivery system reforms, the ACA is shifting the health care system away from fee-for-service payments that drive volume of services to a new fee-for-value paradigm in which payments to providers are linked to performance on quality and cost. For hospitals that participate in Medicare, there are three major value-based care programs: Hospital Readmissions Reduction

Types of Organizational Integration

Horizontal integration involves the same types of entities integrating for the purposes of improved efficiency, greater economies of scale, or better care coordination. For example, horizontal integration can involve the merger of medical groups or the merger of hospitals.

Vertical integration involves different types of entities integrating, such as medical group merging a hospital. One of the best examples of a vertically integrated organization is Kaiser Permanente, which comprises a health plan, a medical group, and a hospital.

Program, Hospital Acquired Condition Reduction Program, and the Hospital Value-Based Purchasing (VBP) Program. Respectively, the first two programs primarily use payment reforms in the form of financial penalties for unnecessary readmissions (for specific conditions due to lack of appropriate discharge instructions and follow up care) and non-payments for harmful patient care (e.g., adverse events). The Hospital VBP is a broader program that rewards hospitals with enhanced payments if they demonstrate improved performance on several measures for clinical care, patient experience, outcomes, and cost effectiveness.

In addition to these set of programs, the federal Department of Health and Human Services announced that 50% of Medicare payments are expected to shift to value-based by 2018.[7] Because virtually every hospital in the U.S. accepts Medicare, and Medicare represents roughly a third (28%) of net patient revenue for the average California hospital, hospitals finances will be increasingly linked to performance on quality and cost.

The ACA's Delivery System Reforms Promote Clinical Integration

The delivery of health care is fundamentally fragmented because the prevailing FFS payment system did not consistently incent various providers (physicians, hospitals, ancillary providers) to coordinate with one another for patient care (e.g., preventing avoidable hospitalizations through ambulatory care). The ACA includes three major provisions that aim to increase collaboration among providers: bundled payments, patient-centered medical homes, and accountable care organizations (ACOs). In this report, we focus[g] on ACOs, which are clinically integrated delivery networks that require providers to meet certain cost and quality targets in order to share in financial savings with a payer. Under clinical integration, the shared financial risk incents greater collaboration among providers across the continuum of services (ranging from primary and preventive care to inpatient care to palliative care) to improve quality and outcomes, enhance patient satisfaction, and reduce costs.

In California, the ACO model has proliferated, resulting in the state currently leading the nation in the number of lives covered by an ACO. This trend is due to the ACA's encouragement of ACOs for Medicare beneficiaries enrolled in Part A (hospital care) and Part B (outpatient care) through the Medicare Shared Savings Program as well as the Pioneer ACO demonstration. In parallel, the commercial market has also implemented ACOs for members covered by private insurance. During a two year period, the number of both commercial and Medicare lives covered by ACOs in California increased 78%, from 514,000 lives in 2012 to over 915,000 in 2014.[8] It is estimated that 1.3 million Californians will be covered by ACOs by February 2016, which represents a 48% increase from February 2014.[9]

Potential Risk of Provider Market Power by ACOs and other clinically integrated networks

What is unique about ACOs is that they do not require providers to merge because the clinical integration can be accomplished through contractual arrangements. In contrast, when providers undergo a merger (e.g., a hospital acquires a medical group), they are effectively financially integrating under one corporate structure which may trigger antitrust review. ACOs are an example of the way provider market power can manifest in ways beyond the traditional idea of market power under antitrust law. As will be discussed in the St. Luke's case below, when clinical integration (or ACO formation) occurs through a merger (e.g., a hospital acquiring a physician group), antitrust enforcers must parse whether complete financial integration via a merger was necessary to achieve the clinical integration. Essentially, the question is whether the same efficiencies achieved in clinical integration can also be obtained through other

[g] For more information on bundled payments and patient-centered medical homes, see ITUP's report, "A Vision for Payment and Delivery System Reform: Moving from FFS to Improved Quality, Better Health, and Cost Containment."

means that don't involve ownership and the associated risk of higher costs due to reduced competition in the marketplace.

To be clear, ACOs are a relatively new concept and there have not been studies that demonstrate their anticompetitive effects. However, trends in California before the ACA may provide some applicable lessons. In 2010, Berenson et al reviewed the shifting landscape in California, beginning with the dominance of managed care in the early 1990s that was successful in using insurer leverage to contain costs through selective contracting with providers[10,h]. The researchers found that between the mid-1990s and the early 2000s providers were overall successful in regaining their leverage. This was accomplished through consolidation of independent practice associations and multispecialty medical groups, the strengthening of alliances between physicians and hospitals, and the increased consumer preference for broader provider networks following the managed care backlash of the mid-1990s. Providers increased their leverage by negotiating higher prices with payers, which in some cases resulted in payments to hospitals and physician groups reaching or exceeding 200% of Medicare rates. Through "must-have" hospitals or "all-or none" contracting provisions for groups of providers or health care systems, Berenson et al argue that providers can exert greater bargaining clout in ways beyond the traditional sense of market power under antitrust law. Because ACOs promoted integrated care, they encourage providers to integrate—whether through mergers or contractual agreements. Berenson et al warn that the ACO concept can also results in providers having greater leverage in the prices they negotiate with commercial health plans.

[h] Employers during this time were increasing shifting their employees into HMO plans due to rising premium costs. HMOs were then able to limit rate increases from providers by using their leverage to exclude certain providers.

State and National Trends in Provider Consolidation

National Mergers and Acquisitions

According to an analysis of hospital mergers at the national level by the California HealthCare Foundation, between 1998 and 2012, there were an average of 74 hospital acquisitions and mergers per year.[11] Within the 1998 and 2012 period, provider consolidations peaked in the late 1990s, but moderated during the 2000s. Within the span of a few years coinciding with the passage of the ACA, mergers grew from 52 in 2009 to 100 in 2012, an upward trend similar to the levels observed in the late 1990s. Some have attributed this uptick to the ACA's emphasis on increased care coordination among various providers.

Under the ACA's new landscape of value-based care payments, hospitals have increased risk for quality and cost, as well as face increased pressure to make the necessary health information technology investments, such as electronic medical records, that enable sharing of information for care coordination. Although many of the recent provider consolidations may coincide with the ACA, it is important to note that the ACA is one factor and that hospitals also face other market and economic pressures. For those hospitals and medical groups that financially struggle, a merger with a well-resourced hospital or hospital system is an attractive option because the larger scale eases the burden of investing in expensive health information technology, facilitates the standardization of care protocols, and enables greater bargaining power to drive down supply costs.

One of the largest provider consolidations occurred in 2013 when multiple hospital systems consolidated under Ascension Health's corporate umbrella. Ascension Health was already the nation's second largest health system by revenue, when it purchased regional health systems in Kansas, Oklahoma and Wisconsin. The acquisition added 32 hospitals to its system and $4 billion in additional revenue, resulting in the consolidated entity having $15.3 billion in patient revenue for 2013. Another similar consolidation of health sys-

tems occurred in 2013 as well when Trinity Health and Catholic Health East merged to become CHE Trinity Health, a deal which resulted in more than $12 billion in combined operating revenue and status as the fourth largest health system.

State Mergers and Acquisitions

In California, there is less publicly available information on mergers and acquisitions because antitrust reviews are not always made public and not every transaction requires review by the Attorney General. With the exception of one transaction, the reviews of hospital mergers by the Attorney General in 2013 and 2014 revealed that they all involved at least one hospital that was in a dire financial situation or at high-risk for closing[12]. Although hospitals that are financially struggling can use a "failing firm" defense in litigation that challenges the merger, this defense is not always used or validated to confirm if the hospital is truly failing. But both the California Attorney General and the FTC have permitted mergers to go forward when they involved a financially struggling hospital or a hospital that was critical to preserving access for community residents.

The most recent newsworthy transaction in California was Prime Health Care's attempted acquisition of the three financially struggling Daughters of Charity nonprofit hospitals, which primarily serve low-income residents in the South Bay.[13] Collectively, the Daughters of Charity hospitals were losing 10 million dollars a month. This type of transaction triggered review by the California Attorney General's Office, Charitable Trusts Section, which is responsible for examining the impact on a community's access to health care services when a nonprofit hospital is sold or converted to for-profit. Interestingly, the reviews by the Charitable Trusts Section focus less on anticompetitive effects and the Attorney General is empowered to place conditions on the transaction in order to protect the public interest. The Prime Health Care deal pitted two of the state's major labor unions on opposite sides, with the California Nurses Association supporting the acquisition and the Service Employees International Union opposing it due to concerns about service cuts, layoffs, and reductions in worker's salaries. Because the Attorney General ultimately placed conditions that would have required operating the Daughters of Charity as-is for the next 10 years, Prime Health Care withdrew its bid because they found the conditions too restrictive in making the hospitals financially viable. Ultimately, the six facilities were acquired by the Blue Mountain Capital Management Group with the same conditions that Prime had concluded were too restrictive.[14]

There is also a growing trend of hospitals increasing their affiliation with medical groups. In some cases, a hospital purchases a medical group, but in other cases a hospital can more tightly align with a medical group without ownership. For example, in July 2014, three San Diego physician groups combined into one physician network that comprise a wide range of specialties and primary care physicians.[15] Although this transaction was not reviewed for antitrust implications, the physician network then partnered with the Scripps Health hospital system for the expressed purpose of streamlining the consumer experience and increasing provider choice at the regional level. These types of physician and hospital partnerships could very well be part of an effort to expand the ability to coordinate care across the continuum, better manage population health and succeed in value-based payments. However, when there is high risk for higher prices resulting from such transactions, regulators should vigilantly enforce antitrust law.

The St. Luke's Case

The 2014 case of *St. Alphonsus Medical Center – Nampa v. St Luke's Health System* is significant because it was the first FTC challenge to a hospital acquisition of a physician group[16]. Although St. Luke's acquisition of the Saltzer Medical Group appears to be a vertical merger, it was treated as a horizontal merger because of the way the acquisition increased St. Luke's market power in primary care services in Nampa, Idaho. The plaintiffs were two competing health systems, St. Alphonsus Health System and Treasure Valley Hospital (a surgical center), the FTC, and the Idaho Attorney General. St. Alphonsus and Treasure Valley Hospital

claimed that patients at Saltzer would be steered towards St. Luke's, which would result in significant losses in revenue that would have to be balanced with service cuts, layoffs, and reduced choices for consumers. The FTC and the Idaho Attorney general argued that antitrust laws were violated because the merger would result in St. Luke's controlling 80% of the market for physician services in the Nampa. The principal concern was that this acquisition increased the risk that St. Luke's could use its leverage for higher reimbursements.

To demonstrate that an antitrust violation occurred, the relevant product and the geographic markets need to be defined. Both the plaintiffs and the defense agreed that the relevant market was physician services, but they disagreed on the geographic market. St. Luke's used a patient flow analysis to make the argument that the geographic market is much larger, which supports lower market shares for the merged entity. However, the court sided with plaintiffs who were able to demonstrate that the appropriate geographic market was the city of Nampa. They were able to use data from wide array of market participants to show that patients prefer seeking primary care within the city of Nampa and that health plans were interested in having Nampa's PCPs as in-network providers. Through the merger analysis, the plaintiffs were able to show that the HHI measuring market concentration increased from 4,612 to 6,219, which was well above the HHI threshold of 2,500, along with an increase in the HHI by 200 points following the merger.

Because it was the first time a federal court deemed a hospital's acquisition of a medical group to be unlawful, the key takeaway was that the integrated care models promoted under the ACA do not permit mergers and acquisitions that violate antitrust law. The court found that while the greater integration could improve care delivery, there were other avenues to achieve these effects without a merger that increased risks for higher costs and reduced competition.

In the St. Luke's case, the evidence showed that consolidation often also results in higher payment rates despite the aim of integrated delivery systems to improve efficiency.[17] Patients are referred for services at higher cost hospital outpatient departments, which include the addition of facility fees for procedures performed in physician offices. In public programs where prices are relatively fixed, such as Medicare and Medicaid, market power can still exert its effects on the non-price dimensions of access, quality, and amenities. Reductions in competition have been linked to erosion of quality in Medicare and the National Health Service.

Guidance to Health Care Providers

In 2010, the FTC and DOJ jointly issued new Horizontal Merger Guidelines (also referred to as the "2010 Guidelines") that included a new analytical framework for evaluating mergers. The 2010 guidelines serve as an important tool for providers contemplating mergers. The 2010 Guidelines revise what constitutes a market and includes updated definitions and criteria for market concentration, merger specificity and efficiencies provisions. Compared to previous guidelines, the 2010 Guidelines are more flexible because they do not require defining a market as a precondition to evaluating the merger. Market concentration is measured by the Herfindahl-Hirschman Index (HHI), a formula that is based on the sum of the squares for each merged firm's market share. The new guidelines also direct enforcement agencies to examine whether the merger increases the risk for "coordinated effects," which is when the merged entity and its remaining competitors increase their market power through coordinated, accommodating, or interdependent behavior. Because there are a lower number of competitors in the market, it becomes easier for the merged entity and the remaining competitors to raise their prices in tandem. Similarly, the new guidelines also prompt enforcement agencies to more closely examine whether the merger increases the risk for explicit collusion or "parallel conduct," which refers to more subtle agreements on pricing or terms of sale that dampen competition choices for consumers.

Thus, the potential cost savings and quality improvements from greater coordination among providers could very well be undermined if the behavior of dominant providers is not actively reviewed and regulated.

A Growing Number of Joint Ventures to Compete with Kaiser Permanente

Providers are also increasingly engaging in regional joint venture partnerships to compete with Kaiser Permanente. One major joint venture in northern California is the Bay Area Accountable Care Network (BAACN), a partnership between UCSF Medical Center, an academic medical center based in San Francisco, and John Muir Health, a two-hospital health system based in Walnut Creek and Concord.[18] Because it is a joint venture, UCSF and John Muir Health, do not merge but remain independent health systems. Through the joint venture, they manage a third company that develops a Bay Area-wide provider network serving the Bay Area and northern California. The goal of BAACN is to recruit providers to create a broader constellation of providers in addition to those at UCSF and John Muir Health. UCSF and John Muir Health have also applied for a restricted Knox-Keene license[i], which permits BAACN to accept global payments from health plans to manage population health across the care continuum.

In Southern California, Anthem Blue Cross and seven health systems (Cedars Sinai, Good Samaritan, Huntington Memorial, MemorialCare, PIH Health, Torrance Memorial Medical Center, and UCLA) have partnered together in a joint venture that is an HMO insurance offering known as Vivity. Because Vivity members can receive care at any of the seven health systems, the value proposition of Vivity is a far broader provider network than offered by Kaiser Permanente as well as the narrow networks in other health plans. Vivity has offered lower priced premiums than Kaiser Permanente, and only requires that its members pay a co-pay (there are no deductibles or co-insurance). Though the scope of Vivity does not concern provider market power, it does address cost containment. All participates in the joint venture can only share in any profits if they achieve certain cost targets through better population health management. Although time will eventually tell if Vivity is successful, it is an encouraging that an insurer and providers are collaborating together to increase competition in the marketplace, rather than out leverage each other.

Part 4: Strategies to Mitigate Provider Market Power

This section will review strategies to mitigate provider market power.

Option 1 would require enactment of state laws and regulations that increase the transparency of price and quality information, including aggregating data through an all payers claims database and posting meaningful information on a public website.

Option 1: Encouraging Transparency in Health Care Prices and Quality

Because market power allows providers to raise their prices, one challenge to obtaining greater value in health care is to overcome the entrenched belief that higher prices means mean higher quality. Given the signification variation in prices, the way prices are not correlated with quality, and that price and quality can even have an inverse relationship, there is a growing health care transparency movement. This calls for purchasers and consumers to have greater access to price and quality information to support value-based decision making at the provider level.[19] The Commonwealth Foundation has identified the im-

[i] California has an extensive history of HMOs delegating financial risk (via capitated payments) to medical groups for outpatient care. A restricted Knox-Keene license is broader because it permits a provider to assume full financial risk for both institutional services (i.e., hospital care) and physician services. However, the entity with the restricted Knox-Keene license would not be considered an insurance plan because it does market itself as one.

portance of health care transparency for the following reasons:

1. Assist providers in benchmarking their clinical and financial performance against other providers;
2. Provide public and private payers the information to identify and reward high quality and efficient providers; and
3. Empower consumers with easily understandable decision tools so they can become more active in their health care decisions.

Background on Quality Information

Across both commercial and public insurance markets, there is increased emphasis on quality data. Generally, health care quality is measured across four categories: 1) *process:* whether a clinical service was provided that has demonstrated improved health status (e.g., administering aspirin shortly after a heart attack); 2) *outcome:* an outcome that suggests the health care intervention is having an effect (e.g., reductions in 30-day mortality); 3) *patient experience:* whether consumers report satisfaction with the care they receive (e.g., if consumers report they were promptly attended to by their providers); and 4) *structure:* the human and material resources that support health care delivery (e.g., electronic medical records). Many quality measures derive from the National Quality Forum, a nonprofit organization that has developed several families of measures for the federal government and private sector to use in accountability and payment programs. For example, the federal Center for Medicaid and Medicare Service's (CMS) has implemented hospital and physician quality measures and publicly reports them through the Hospital Compare and Physician Compare websites. Additionally, the CMS Value Based Purchasing Program is also increasingly linking Medicare hospital payments to quality performance.

The commercial sector is also active in the reporting of quality information. The most prominent example in California is the Integrated Healthcare Association California Value-Based Pay-for-Performance (P4P) program[j], which involves 200 physician groups and 35,000 physicians that serve 9 million Californians enrolled in commercial HMOs and point of service products.[20] The IHA Value-Based P4P focuses measuring performance across the following four areas: 1) clinical quality; 2) patient experience; 3) meaningful use of health information technology; and 4) resource use and total cost of care.[21] For clinical quality, there are six priority areas: prevention, cardiovascular, diabetes, maternity, musculoskeletal and respiratory conditions, and includes process and outcome measures based on available standardized national measures. As rising health care premiums has increased the attention to demonstrate value in terms of improved quality and cost efficiency, the Value-Based P4P program may provide some applications for addressing containing costs. The Value-Based P4P program's "total cost of care" measure encompasses actual payments made to cover the enrollee's care, including professional, pharmacy, hospital, and ancillary care, and consumer cost-sharing, including administrative payments and adjustments. Because the incentive structure shares savings between the plan and the medical group caring for the member, each medical group can compare their cost and quality performance against a benchmark and make changes accordingly.

While the goal for transparency quality information is for consumers to use comparative data to be selective in the providers they seek care from, a review by Faber et al found little evidence that consumers actually use quality information when selecting a provider.[22,k] Faber et al noted barriers for consumers include a lack of awareness about publicly available information and difficulty un-

[j] The P4P program initially began as physician incentive program to demonstrate that managed care plans are evaluated on a standard set of quality performance measures.

[k] The literature review had a strong study design that only included randomized control trials, controlled before-after trials or interrupted time series. However, it was cautioned that small number of studies (14) limits the strength of the conclusions.

derstanding information if it is not presented in a meaningful format. Some recommendations by CPR for consumer engagement quality information tools are that they show only quality measures that matter to consumers and reflect the latest evidence.[23] CPR also notes the need to better delineate patient satisfaction and patient's experience with the care they receive. The former refers to the customer service received during care, such as waiting times or front office communication while the latter refers to the patient providing information about the care they received, including their received discharge instructions or their functional status. More importantly, CPR recommends that consumer engagement tools allow for side-by-side comparisons of price and quality so that consumers can clearly see which provider is lower cost and high quality.

Background on Price Information

Compared to quality information, price information is more difficult to obtain because insurance companies and providers consider it a trade secret and generally do not disclose it for fear of losing their competitive advantage. Because employers are increasingly shifting costs onto employees through higher deductibles, it is expected that more consumers will comparison shop for health care based on price information. Higher cost-sharing obligations such as deductibles are partly intended to make consumers more sensitive to prices and thereby more motivated to search for affordable providers for routine, non-emergency health care. In order to truly succeed in consumer driven health care, price transparency tools (usually via web or mobile device) are needed to make price information readily available and meaningful to consumers so they make informed decisions in selecting lower-cost, high quality providers. However, a recent study found little evidence for employees using price comparison tools.[24] Instead, cost savings from high deductible health plans was primarily due to employees forgoing care, including necessary care when they were sick.

Even when states have laws on price transparency, they may not be all that effective in making information readily available and meaningful for consumers. When CPR graded all fifty states based on their analysis framework (described below), California, along with 44 other states receive a failing grade of "F."[25] Three states were mentioned as potential models for others states to replicate: New Hampshire, which received an "A" grade, and two states that received receiving a "B," Colorado and Maine. CPR has provided a framework for analyzing the relevance, adequacy, and usefulness of state laws and regulations on price transparency: 1) the source of the price information being reported — from providers versus or payers via an all-payer claims database (APCD); 2) the scope of price information available to consumers (charges vs. paid amounts); 3) the scope of service information reported (inpatient, outpatient, or both, as well as most common services); 4) the scope of providers reported (hospitals, physicians, or both); and 5) varying levels of public access to price information (on a public website, and/or available by patient request, and/ or available in a public report. This report will further discuss the source of price information being reported and the scope of price information.

The scope of information available to consumers is usually provided in two forms: (1) "charges" or (2) "paid amounts." Paid amounts are more reliable because it reflects what the health plan or consumer actually paid for health care services. Charge prices are listed on standard documents referred to as charge masters, which list undiscounted dollar amounts that uniformly apply to all types of payers. The full charge price is not actually paid by payers because providers contract with payers (i.e., the health plan) for negotiated fixed prices or set reimbursement levels as a percentage of charges. The charge prices billed to the uninsured may be reduced if the hospital has charity care policies, but the uninsured often end up being billed the actual charge price. A research study by Christensen et al finds that while charge prices may not reflect the true cost of health care, in lieu of paid amounts, charge prices may provide a basis for comparing the competitive standing of the provider in the marketplace.[26] For example, it has been documented that providers often look at the publicly available charge masters of their competitors

as a reference for establishing their own charges.

All Payers Claims Data Base: The Ultimate Price Transparency Tool

When it comes to the source of price information, CPR concludes that an all payers claims database (APCD is much more stable and accurate since information comes directly from the payer. Under the APCD concept, a state mandates the participation of multiple payers, public and private, in submitting claims data for medical, provider, pharmacy and dental claims, along with supplemental eligibility and provider files, to a centralized database. Because an APCD consolidates commercial, Medicaid, and Medicare health claims data it allows for analysis of the costs associated for services and particular providers and facilities. This allows data analysts to examine the frequency in which services are utilized and what settings they are delivered in (e.g., physician offices, ambulatory surgical care centers), as well as if practices are following appropriate clinical protocols. Information from an ACPD can also produce more meaningful information for consumers because it can longitudinally report the cost of a treatment episode across multiple settings and providers (e.g., total knee replacement, birth). Conversely, when price information comes from a provider, it is usually the hospital providing price information for only one component, such as the inpatient stay (e.g., it may not include the cost for associated physician services).

In addition to providing consumers transparent information, an APCD can provide policymakers and regulators more complete data to ascertain whether prices correspond with improved quality and outcomes. Because the data would include diagnosis dates, procedures, care locations, providers, and payments this would also allow for policymakers and regulators to establish a baseline for monitoring trends, including "hot spots" for when prices dramatically increase or services are utilized more often. As providers exert market power, information from an APCD may provide for more effective regulation that promotes competition and lower health care costs.

New Hampshire's Success with an ACPD

The latest evidence on the effectiveness of an APCD to promote cost-consciousness in consumers and foster competition among providers comes from New Hampshire, which received an A grade in CPR's 2015 review on state price transparency laws.[27] In 2003, New Hampshire enacted legislation authorizing implementation of one of the first APCDs in the nation. Since 2007, New Hampshire has used claims data from its APCD to establish a public website called HealthCost that lists bundled prices for both facility and physician payments for 30 common, mostly outpatient services, as the typical costs for office and emergency visits. In their review of the website, CPR provides HealthCost high marks for its consumer friendly format. For example, consumer can enter details about their health plan, co-insurance and deductible and HealthCost returns meaningful information for consumers that provides provider-specific, insurer-specific median amounts paid for each service.

Although HealthCost initially showed limited effectiveness, it is increasingly becoming more effective and a model for other states to follow. A previous 2009 evaluation by the Center for Studying Health System Change found no evidence that HealthCost led to reducing provider leverage or impacting price variation for the 2 years since its launch. A 2014 analysis by the California HealthCare Foundation and the Robert Wood Johnson Foundation found that HealthCost only experienced a moderate uptake by consumers and has not achieved its intended purpose as a consumer-shopping tool.[28]However, the same review finds that HealthCost may be a more important tool for policymakers and other health care stakeholders such as payers to identify variation between hospital outpatient departments and free-standing facilities, as well as among different hospitals. For example, when it was revealed that Exeter Hospital in New Hampshire had 50% higher rates than its competitors, Anthem Blue Cross and Blue Shield threatened contract termination. Eventually, Exeter acquiesced under public pressure. [29]

California's APCD Activities

California has a voluntary APCD known as the California Healthcare Performance Information System (CHPI).[30] It began collecting data in 2013 and covered 12 million lives as of December 2015. The current payers participating are: Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare of California. As incremental progress, a voluntary APCD falls short because there is no state law mandating payers to continuously submit claims data and the benefits of aggregated data accrue through a larger participation of payers. While a voluntary effort is admirable, there are concerns that it may not be sustainable in the long-term. To avoid duplication of effort, a preferable course of action for California may be to pursue a joint venture with CHPI to gain the participation of a more complete set of payers.

Option 2: Encouraging Competitive Behavior in Health Plan Contracting

In an effort to both promote competition among providers and foster value, this strategy would involve enacting state legislation that: (1) limits "all-or-none" contracting for hospital systems; (2) removes restrictions on tiered networks; and 3) limits most favored nation clauses.

Limit All or None Contracting for Hospital Systems

According to Berenson et al, the hospital systems, Sutter Health, Catholic Healthcare West and the University of California, have adopted an "all-or-none" contracting strategy in which they are able to negotiate for higher rates that apply to all hospitals within the system. Because the hospital system covers a wide geographic area, this approach also allows them to also avoid antitrust litigation, which reviews the use of market power within a defined local market. Even if a health plan is interested in contracting with an individual hospital, it must now include all the hospitals that are part of the system in the provider network. All-or-none contracting would also link the rates of other hospitals in the system to the payment rates of the flagship hospital. This limits the ability of the health plan to incorporate value-based insurance designs that include selective networks. When states enact legislation that prevents such contract provisions, it would effectively allow plans to competitively negotiate contracts with each hospital based on cost and quality, rather than the entire system.

Remove Restrictions on Tiered Networks

Selectively contracting is a strategy used by insurers to increase value in health care by partnering with lower cost, high quality providers to form selective networks (also known as limited or narrow networks) or tiered networks within a health plan. Selective contracting allows insurers to create more affordable health insurance products for premium sensitive customers as well as implement incentives for enrollees to seek care at lower cost, high quality providers within the network. Because certain providers may be excluded for higher costs and or lower quality, some providers have been successful in including contract terms that limit the ability of the insurer to establish tiered networks (e.g., the contract terms guarantees the provider to be included in the tier or requires all enrollees assigned to a medical group to be placed in the same tier). Because states can enact legislation that forbids contract provisions such as these, it would effectively promote competition among providers based on cost and quality.

Limit Most Favored Nation Clauses

"Most favored nations"[1] (MFN) contract clauses guarantee the buyer the lowest price for a product or service during the contract period; essentially, the seller would treat the buyer as its most-favored customer by giving them the best price. For example, an insurer includes a MFN clause in its contract with a hospital. If another insurer were to negotiate a lower rate with that same hospital, the first insurer would be guaranteed to also receive this lower rate. Typically, large insurers with substantial covered lives have the clout to demand

[1] MFNs are also referred to as "most favored customer clauses," "prudent buyer clauses," or "nondiscrimination clauses."

MFN clauses from providers during contract negotiations. A MFN clause would include language similar to the following:

> "Provider represents and warrants that it has not agreed to accept from any other payer a reimbursement rate that is less than what is offered by Payer under this contract. If Provider offers a better reimbursement rate to any other Payer, the Provider must provide prior written notice of such an offer to Payer and give Payer the option to accept the reduced reimbursement rate. Thereafter, at Payer's option, Payer may accept the reduced reimbursement rate or it may terminate the contract immediately upon written notice to Provider." [31]

Supporters of MFN claim that it provides assurance to the insurer that the rates it pays providers is no greater than the rates paid by its rivals. Others discuss MFN within the context of the transaction costs for discovering the price of a good or service, such as when a new pharmaceutical drug enters the market. Once a market price for a good is settled, a MFN clause can protect the buyer by allowing for the contracted price to be updated; this is especially beneficial for long-term contracts. A 2014 analysis by CPR finds that 16 states have banned MFN clauses from contracts. Although there is limited empirical evidence on the effects of MFN clauses on competition, the problem with MFN clauses is that they provide a disincentive for providers to negotiate lower prices with one payer if it means they have to lower it to the same price for a payer protected by the MFN clause.

Antitrust Concerns for Most Favored Nation Clauses

MFN clauses will be challenged by the federal agencies if there is sufficient evidence that the terms violate antitrust laws. There are two theories for why MFN clauses harm competition and they differ in the whether the insurer or provider is using the MFN clause to their advantage. The use of the MFN clause will depend on the respective market power of the insurer or provider, essentially, which has more leverage or dominance over the other at the bargaining table. Overall, both of these theories finds problematic that MFN clauses raise prices above a competitive level and forestall the opportunity for negotiations that can lower prices.

Facilitated Coordination among Providers

Under the first theory, MFN clauses facilitate tacit price coordination in situations where a dominant provider has greater leverage over the insurer requiring the MFN clause. Similar to the collusion that occurs in a cartel, the dominant provider can (1) maintain a price above the competitive level by limiting the ability of other providers to reduce their prices and (2) prevent the entry of new providers into the market because these providers know they cannot negotiate for lower prices to obtain a competitive advantage.

Dampened Competition

Under the second theory of "dampened competition," the insurer is not controlled by a dominant provider and uses the MFN to prevent its rivals from obtaining lower rates from hospitals and providers. The provider does not have the incentive to lower their prices in negotiations with other insurers because they would have to extend that same discount to the dominant insurer with the MFN agreement. Because providers are essentially limited in their ability to enter into competitive negotiations, rival insurers cannot bargain with them for lower prices. Rival insurers effectively become price takers and if their costs substantially rise it reduces their ability to compete. Under dampened competition, the marketplace does not support buyers and sellers coming together to competitively negotiate; instead, buyers are only concerned about not paying more than others.

Option 3: Monitoring and Regulating Prices

This strategy would involve enacting legislation to establish a governing body or board that monitors and/or regulates prices. The board can monitor and analyze variation in prices, and if given the authority, can regulate how payments are set.

The most prominent example of a regulatory board that has achieved cost savings is Maryland's Health Services Cost Review Commission (HSCRC), which implements an all-payer rate

setting strategy for Maryland's hospitals. When Maryland enacted legislation to establish the HSCRC, it had three primary goals: 1) limit hospital cost growth; 2) support the financial ability of hospitals to provide efficient and high quality care; and 3) increase the fairness of hospital financing. Since the 1970s, HSCRC has engaged in all-payer rate setting where both public and private payers pay the same inpatient rate (i.e., the Medicare payment per inpatient admission) to the same hospital.[32] Because commercial, Medicaid, and Medicare all participate this effectively eliminated cost-shifting to other payers. However, because of differences in a hospital's level uncompensated care, medical education expenses, and cost structures, each hospital still receives a unique inpatient rate established by the HSCRC. The all-payer rate setting also includes the participation of Medicaid and Medicare, programs that have administratively set rates. Maryland was able to get approval of a federal waiver that requires Medicaid and Medicare to pay HSCRC-approved rates. Between 1976 and 2007, Maryland observed the second lowest increase in cost per hospital admission for any state; this amounts to an approximated savings of $40 billion during this time period.[33,34]

In 2014, Maryland revamped its approach to all-payer rate setting through a new Medicare waiver with CMS. Instead of an inpatient rate that is based on Medicare payment per inpatient admission, the new waiver is modelled on hospital cost growth rates.[35] Effectively, there are cost growth targets set for all-payers and Medicare. During 2015-18, Maryland is required to limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent, which is the 10-year compound annual growth rate in per capita gross state product. Simultaneously, Maryland must also limit annual Medicare per capita total hospital cost growth to a rate lower than the national annual per capita growth rate for each respective year in the 2015-18 period. In addition to the growth targets, Maryland is also required to achieve quality improvements in readmissions, hospital acquired conditions, and on various population health measures.

At the time of the waiver's approval in January 2014, Maryland was estimated to save $330 million in Medicare savings during a five year period. As of June 2015, the Maryland Hospital Association reports that it has achieved $100 million in cost savings during the first 18 months through several changes in care delivery.[36] These included improved care coordination between primary care and nursing facilities and better follow up care after discharge through more in-home visits for disease management patients. For vulnerable populations with chronic disease, free or reduced cost care was provided at clinics. Nurse advice lines were also implemented to provide patients with communication options beyond the hospital. In the arena of quality, there were dramatic improvements from baseline. Readmission rates fell faster than the national average (an avoidance of 5,000 readmissions) and hospital acquired conditions were reduced by a quarter. Overall, the Maryland waiver provides compelling evidence that an all-payer rate setting strategy that caps cost growth rates is a viable option for states to consider.

Option 4: Establish a State Health Policy Commission

When Massachusetts enacted universal coverage prior to the ACA in 2006, it effectively provided a blueprint for the ACA as well as relevant lessons to other states. Since then, Massachusetts has shifted from coverage expansion to enacting cost containment legislation in 2012. For these reasons, Massachusetts is a model for California to examine closely as the next logical step in health reform is to contain costs and thereby improve affordability.

While Massachusetts has been a pioneer in health policy, it is important to note that Massachusetts, compared to California, had the following advantages prior to expanding coverage: relatively high incomes per capita[m], a high rate of insured[n],

[m] According to the 2012 Census, Massachusetts was the fifth state with the highest median household income based on a three-year average of 2010-12.

and a fairly homogenous population. These factors, along with having enacted health reform legislation eight years earlier, have contributed to Massachusetts having over 95% of non-elderly adults having health insurance—the highest of any state prior to the ACA's coverage expansions in 2014.[37] Because the state already had a high rate of insured, the problem of the uninsured in Massachusetts was narrower in scope than in California, where nearly one-fifth of the population was uninsured prior to the ACA.[38] For this reason, California's first act of health care reform—expanding coverage—is a far more complex and nuanced, including the unique challenges of conducting outreach and education to California's ethnically and linguistically diverse population.

Despite the Massachusetts's accomplishments in near universal coverage, the state has the third highest health expenditures per capita at $9,278—well above the national average of $6,815.[39] The impact of these higher health care costs at the individual and family level is illuminated by the Massachusetts Health Reform Survey (MHRS), which reports that achieving affordability for Bay State residents remains an ongoing challenge.[40] The most recent survey is effectively a baseline for measuring progress in cost containment because it takes place one year after the effective date of Chapter 224 and one year prior to when many of the ACA's major provisions took effect in 2014. Overall, the survey reports that the findings for 2013 are unchanged from 2012, including "nearly 40 percent of adults with coverage all year had reported that health care costs had caused financial and/or nonfinancial problems for them and their families over the year, with lower-income adults and adults with non-ESI coverage more likely to report such problems." (Blue Cross Foundation, 2014).

Further, the 2013 MHRS reports that "almost one-third of adults in the state who had insurance for all of the past year reported unmet need for health care (29.8 percent)" and "almost half of those with unmet need overall reported the cost of care as a reason (13.8 percent)". The MHRS findings reiterate that despite the benefits of expanded insurance coverage, rising premiums and deductibles challenge delivering the ACA's promise of a "culture of coverage," where financial burdens are no longer an obstacle in seeking high quality care. The applicable lessons that California can draw upon from Massachusetts is that a vigorous pursuit of cost containment is essential to ensuring that California truly guarantees that its residents have access to affordable health care.

An Independent Commission that Develops and Implements Cost Containment Policy

Through Chapter 224, Massachusetts established the Massachusetts Health Policy Commission (HPC), an independent commission that develops and implements policy to reduce health care cost growth and improve the quality of patient care. By not being part of the executive branch, the goal is that the HPC will be more insulated from politics and less subject to regulatory capture, a phenomenon in which the regulatory agency advances the interests of the industry instead of the public interest. The key activities of the HPC are to monitor the performance of the health care system, analyze the impact of health care market transactions on cost, quality, and access, set the health care cost growth benchmark, and invest in community health care delivery.[41]

Setting Targets for Health Care Cost Growth

Under the 2012 law, Massachusetts has set a goal that health care costs should grow no faster than the rate of growth for gross state product (GSP).[42] During 2013-17, the benchmark is the rate of growth for GSP but eventually the benchmark will be adjusted to below the rate of growth for GSP. For 2013-2015, the health care cost growth benchmark was set to 3.6%. If successful, the state approximates that it will save $200 billion in the next five years. For 2013, the HPC's Center for Health Information and Analysis reported that health care costs grew by 2.3%, or 1.3% below the

[n] In 2006, Massachusetts had a 93.6 rate of health insurance coverage for non-elderly adults.

benchmark. For 2014, health care costs grew by 4.8%, exceeding the benchmark by 1.2%. The CHIA gave potential reasons for the state missing the benchmark, including increased spending due to expanded eligibility for MassHealth and higher prescription drug costs.

Analysis and Reporting of Cost Trends: Provider Price Variation

Similar to the findings by the AGO, the HPC shed additional light on price variation in its 2015 Provider Price Variation Report.[43] The report findings include:

1. Provider prices vary extensively for the same sets of services
2. Provider price variation has not diminished over time
3. Unwarranted price variation contributes to higher health care spending due both to the prices and to the larger share of volume at higher-priced providers
4. Higher hospital prices are not generally associated with higher quality or other common measures of value; market leverage continues to be a significant driver of higher prices
5. Unwarranted price variation is unlikely to diminish over time absent direct policy action to address the issue

Addressing Provider Market Power: Cost and Market Impact Reviews

With respect to provider market power, the HPC receives notification if any material changes that include mergers and acquisitions impact the commonwealth's ability to meet cost benchmarks. The transaction cannot occur until the HPC conducts a cost and market impact review (CIMR). The HPC does not have authority to stop the transaction from happening, but the CIMR is released as a public report with a recommendation. In compiling their recommendation, the HPC assesses whether the transaction will increase health spending, reduce competition, or increase premiums for employers and consumers. The report is also forwarded to the Attorney General's Office for antitrust review. In 2014, the HPC completed a CIMR for the proposed Partners' takeover of South Shore Hospital and affiliated Harbor Medical Associates and found that it would result in higher costs and reduced competition.[44] While the Attorney General allowed for Partner's acquisition of South Shore Hospital to proceed with temporary limits on price increases, this agreement was eventually reversed by a state judge that found it lacked sufficient protections to constrain Partner's market power.[45]

Part 5: The California Health Policy Commission

In compiling research and analysis for this report, it became abundantly clear that policy development and implementation for health care cost containment does not have a "home" within California's public policy framework. If policy development and implementation for Medi-Cal beneficiaries' lives with the Department of Health Care Services while HMO plan regulation lives with the Department of Managed Health Care, where do health care cost containment efforts reside within state government? When considering cost containment with respect to provider market power, and the ways it can manifest in ways outside of antitrust litigation, it is also unclear which state agency would develop and implement policies to mitigate its effects.

In part, cost containment policy is distributed across California's public policy framework. The California Health and Human Services Agency (CHHSA), managed the Governor's Let's Get Healthy Taskforce, which developed a 10-year plan and recommendations that included a focus area on lowering costs. Although the taskforce included relevant subject matter experts, it was advisory and had no formal authority to implement its recommendations. California policymakers may want to strengthen the steps they have already taken by implementing an agency with dedicated staff resources that can execute the cost

containment goals of the Let's Get Healthy Task Force.[o]

In addition to the CHHSA, the California Legislature's Senate Health Committee has been very active in discussing the drivers of rising health care costs and the impacts on employers and consumers during hearings that took place in 2014 and 2015.[46] In crafting legislation to address cost containment, the Legislature may have access to staff experts, the Legislative Analyst's Office or the California Health Benefits Review Program. But the Legislature would immensely benefit if there was a dedicated agency that continuously analyzed health care cost trends and presented actionable recommendations to the Legislature, the commercial sector, and the public.

As discussed above, the Massachusetts Health Policy Commission has successfully shed light on cost trends and price variations and developed actionable recommendations for legislation and regulation. This report argues that California too needs a single body that is responsible for policy development and implementation of cost containment efforts. California should replicate the model in Massachusetts by implementing an independent, quasi-governmental agency known as the California Health Policy Commission. To address cost containment, including provider market power, the California Health Policy Commission would serve as a centralized body that implements the following recommendations organized under the categories of regulatory interventions, coordinated public and private activities, and market-based approaches.

Recommendations:

Regulatory Interventions

1. Advance consumer-driven health care to promote competition among providers and health plans by requiring reporting of meaningful cost and quality information on a public website
2. Publish reports that monitor cost and quality variation in California, including by service lines (e.g., orthopedics)
3. Set health care cost growth caps for California that are benchmarked to the rate of growth for gross state product
4. Implement cost and market impact reviews to better evaluate the potential for transactions to drives prices upward without increasing value. These CIMRs will be used by the California Attorney General in any antitrust reviews.
5. Develop and recommend a strategy for an all-payer model for California's hospitals if health care costs grow faster than a specified benchmark (i.e., a conditional trigger).

Coordinated Public and Private Activities

6. Through a joint venture, facilitate broader participation of payers, including Medicaid, into California's voluntary all-payers claims database known as the California Healthcare Performance Information System.

Market-based Approaches

7. Enact competitive health contracting legislation through limiting MFN clauses, and banning all-or-none contract clauses and provisions that prevent plans from creating tiered products.

[o] In 2012, the Governor issued an executive order to establish the Let's Get Healthy California Task Force within the California Health and Human Services Agency. The Task Force has developed a 10-year plan for California to address population health, improve care quality, and lower costs, including the development of measures to track health care spending. However, because the Task Force was created by executive order and includes the participation of health care leaders and stakeholders on a voluntary basis, it has long-term sustainability issues. There is also minimal staff dedicated to the project.

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Appendix: Existing Federal and State Antitrust Enforcement Laws

	Sherman Antitrust Act	**Clayton Act**	**Federal Trade Commission Act**	**Cartwright Act (California)**
Description	Sections 1 and 2 are typically used to review anticompetitive behavior in health care. Section 1 "prohibits contracts, combinations, and conspiracies in restraint of trade" while Section 2 prohibits conduct by a single company, or sometimes two or more companies working together, to sabotage competition in order to gain or keep a monopoly.	Section 7 is used to prohibit mergers or acquisitions where the effect "may be to substantially to lessen competition, or to tend to create a monopoly."	Prohibits unfair methods of competition (the same as those described under the Sherman Antitrust Act, but may be more expansive) in interstate commerce. Section 5 prohibits "unfair methods of competitions and "unfair or deceptive acts or practices in commerce" and gives the Federal Trade Commission (FTC) broad powers to cope with new threats to the competitive free market."	Similar, but not identical to the federal Sherman Antitrust Act. Covers certain types of anticompetitive actions, such as price fixing and market division schemes, which are agreements between competitors to divide markets, products, customers, or territories among themselves (e.g., one hospital agrees to focus on bypass surgery while the other will focus on orthopedics). Does not cover mergers, which are reviewed under federal merger laws.
Authority	Violations of the Sherman Antitrust Act can only be criminally prosecuted by the U.S. Department of Justice, but state attorney generals can bring civil actions through authority granted to them under the Clayton Act. The DOJ generally takes the lead on reviews involving insurers.	Enforced by the U.S. Department of Justice – Antitrust Division and the FTC. Grants authority to state attorney generals to enforce antitrust laws and permits consumers and other private parties harmed by antitrust violations to bring their own actions.	Establishes the Federal Trade Commission to police violations. The FTC generally takes the lead on reviews involving providers.	Used by the California Attorney General.
Penalties	Civil and criminal penalties	Civil penalties	Provides for civil remedies, but carries no criminal penalties	

Adapted from the following 2015 California HealthCare Foundation report: Antitrust Principles in Health Care: Implications for Consumers and Health Care Organizations.