Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust

Robert Berenson
Urban Institute

Abstract Prices are the major driver of why the United States spends so much more on health care than other countries do. The pricing power that hospitals have garnered recently has resulted from consolidated delivery systems and concentrated markets, leading to enhanced negotiating leverage. But consolidation may be the wrong frame for viewing the problem of high and highly variable prices; many "must-have" hospitals achieve their pricing power from sources other than consolidation, for example, reputation. Further, the frame of consolidation leads to unrealistic expectations for what antitrust's role in addressing pricing power should be, especially because in the wake of two periods of merger "manias" and "frenzies" many markets already lack effective competition. It is particularly challenging for antitrust to address extant monopolies lawfully attained. New payment and delivery models being pioneered in Medicare, especially those built around accountable care organizations (ACOs), offer an opportunity to reduce pricing power, but only if they are implemented with a clear eye on the impact on prices in commercial insurance markets. This article proposes approaches that public and private payers should consider to complement the role of antitrust to assure that ACOs will actually help control costs in commercial markets as well as in Medicare and Medicaid.

Keywords accountable care organizations, antitrust, consolidation, cost, insurance, Medicare

High prices have been the dominant reason that US health care is so much more costly than care provided in other countries, as well summarized in a

Funding for this article was provided by the Office of the Attorney General, California Department of Justice; Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California, Berkeley.

Journal of Health Politics, Policy and Law, Vol. 40, No. 4, June 2015
DOI 10.1215/03616878-3150026

Health Affairs article titled "It's the Prices, Stupid: Why the United States Is So Different from Other Countries" (Anderson et al. 2003). Researchers at McKinsey Global Institute put a price tag on the excessive spending resulting from high US health care prices, finding that input costs, including doctors' and nurses' salaries, drugs, and other medical supplies, and the profits of private participants in the system, explain the largest portion of the $650 billion extra the United States spends compared to world norms (Farrell et al. 2008).

Most, although not all, recent analyses have found that price trends were also the leading cause of overall health care spending increases for the first decade of this century. For example, Centers for Medicare and Medicaid Services (CMS) actuaries concluded that the factors associated with price accounted for as much as 60 percent of increases in health care spending until the past couple of years, while other factors, such as population growth and use of medical services, accounted for the rest (Martin et al. 2014).[1] It should be noted that some researchers find that health care prices for hospitals and physicians have moderated substantially in recent years, beginning somewhat later but paralleling the recent slowdown in overall health care spending (Altarum Institute 2014), whereas others find continued high provider price increases, especially for hospital inpatient care (HCCI 2013).

The focus of this article is provider pricing associated with hospital and physician services, which with other professional services represent nearly two-thirds of the 2012 national health spending for personal health care services (Martin et al. 2014). The issue of high and growing provider prices has rightly come into its own as an important policy concern deserving attention from not only antitrust authorities but also policy makers more generally, as this article attempts to justify. In the 1970s and 1980s, a few states implemented modestly successful all-payer, rate-setting programs for commercial health insurance addressing prices and pricing variations (McDonough 1997). However, in the aftermath of President Ronald Reagan's election and the antigovernment sentiment it reflected, and with broad adoption of a health maintenance organization (HMO) strategy that relied on narrow networks and price concessions from providers, state-based all-payer price regulation was dropped, with only Maryland's rate-setting approach continuing. Prices for nongovernment payers as an important policy issue virtually disappeared for more than two decades,

1. Researchers using other methods found that rising prices played an important role in pharmaceutical spending but not hospital and outpatient services during this period (Bundorf, Royalty, and Baker 2009).

despite the occasional academic reminder of the crucial role prices have in driving health care cost increases.

Over the past five years the issue of high and variable provider prices has emerged as an important policy issue, with numerous reports and articles documenting the extent of the problem and offering explanations. Thus far, the market response to the increase in prices resulting from growing provider leverage in rate negotiations has been limited and largely ineffective, although additional efforts featuring increased patient cost sharing, limiting provider networks, and increased price transparency are advancing (Ginsburg and Pawlson 2014).

There is little in the Patient Protection and Affordable Care Act (ACA) that directly addresses the issue of strong and differential provider pricing power, partly because the political narrative accompanying the bill's advocacy typically labeled insurers as the "black hats" and providers as the "white hats." Yet a closer look would likely show that even some of the whitest hats—well-respected, multispecialty group practices and integrated delivery systems pointed to as prototypical accountable care organizations (ACOs)—reportedly are able to obtain among the highest rates of payments from commercial payers, often exceeding 250 percent of the Medicare payment amount.[2]

The Medicare payment level has become the commonly used yardstick to measure the generosity of private-sector payments, especially for hospitals, because Medicare comes close to paying the average costs of hospitals across the country. In comparison to the average cost standard, 250 percent of Medicare in most situations represents what economists refer to as "monopoly rents." And by getting multiples of Medicare rates, these often prestigious organizations are able to set aside huge reserves and compensate their executives quite generously, seeming to behave more like publicly traded companies seeking to increase their stock price rather than not-for-profit health care systems providing community benefits.[3]

Some argue that the new payment and organizational models in the ACA will also address high prices. Unfortunately, while they may change provider incentives, new Medicare payment models do little to address pricing power that provider organizations can exert in negotiating with

2. This assertion is based on confidential interviews I have conducted with large provider organizations and insurers in many US markets as part of research projects and on confidential conversations with insurance company executives.

3. Indeed, with the decrease in the number of uninsured seeking hospital care, one might question the purpose of not-for-profit hospital status, since it has been shown that most of these hospitals' community-benefit-related expenditures are allocated to patient care activities, especially to the uninsured rather than to community health improvement (Young et al. 2013).

nongovernmental payers. Approaches made by CMS to promote ACOs, for example, do not affect how these new creations might affect private markets for health services, especially prices. By granting them Medicare ACO status, Medicare might sometimes unintentionally sanction these ACOs' exercise of market power in their negotiations with other payers. Further, flaws in how many commercial insurers have adapted the ACO payment model for their own use may actually exacerbate the pricing power variations across nascent ACOs.

Given the lack of payment or regulatory policies that attempt to correct for pricing disparities and the high prices themselves, it is not surprising that, as a default, recent attention has focused on the role of the antitrust authorities at the federal level—the Federal Trade Commission (FTC) and the US Department of Justice (DOJ)—and at the state level—the Offices of the Attorneys General. After all, if the problem is the exercise of pricing power, it seems logical to assume that the solution must lie in antitrust enforcement. Indeed, after two decades of mostly failing to prevent anticompetitive hospital mergers, in recent years the antitrust agencies have gotten renewed energy and have had some important wins in blocking anticompetitive hospital and physician practice mergers (Gaynor 2014; Feinstein, Kuhlmann, and Mucchetti 2015 [this issue]).

Nevertheless, I try to make the case that antitrust policy and enforcement can only be one—and not the primary—approach to addressing provider pricing power. I first review research demonstrating that the source of hospital and physician pricing power—or lack thereof—lies not in quality of care, population served, mission, or other tangible aspects of a provider's niche in the health care system or its actual performance but rather in its leverage negotiating contracts with health insurers, leverage that in some cases produces very high prices that in turn become a major source of excessive health care spending. Next, I explain that major variations in negotiating leverage produce *must-have* and *have-not* provider organizations.

I then review the various reasons why consolidation is the wrong frame for considering the pricing problem, which in turn leads to a discussion of why reliance on antitrust policy and enforcement is inherently limited even for addressing consolidation and the resulting concentration, much less provider pricing problems overall. Given the great interest in ACOs as health delivery "game changers," I discuss why ACOs could either promote competition and have a salutary impact on prices or worsen pricing problems. Next I argue that various policy makers and stakeholders actually hold different visions of an ACO-centered delivery system that reflect

fundamentally different viewpoints about the relative roles of competition and collaboration in the evolution of health care delivery. Finally, I suggest that current payment models for ACOs initiated in Medicare but adopted by private health plans could exacerbate the problems of high and variable prices, undermining the potential success of the ACO concept, and suggest ways in which CMS oversight of Medicare ACOs could positively spill over onto ACO prices in commercial insurance markets.

Negotiating Leverage Produces High Prices

As noted, in recent years the issue of provider pricing power has come into its own as an important policy issue, stimulated by the publication of numerous quantitative and qualitative analyses exploring the reasons for and the extent of provider pricing power (Massachusetts Attorney General 2010; Berenson, Ginsburg, and Kemper 2010; Robinson 2011; Vogt and Town 2012). Aggregate hospital payment-to-cost ratios for private payers increased from about 115 percent in 2000 to about 149 percent in 2012, illustrating the substantial increase in hospital prices that have contributed to health care spending growth (Avalere Health 2014: chart 4.6). Further, states' attorney general offices and departments of insurance have used their access to data, which in the former case can include subpoena power, to help establish the nature of the problem (Massachusetts Attorney General 2010).

In particular, the influential 2010 Massachusetts Attorney General report concluded:

> Price variations *are not correlated* to quality of care, the sickness or complexity of the population being served, the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or whether a provider is an academic teaching or research facility. Moreover, price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.
>
> 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 (3–4).

The Rhode Island Department of Insurance found that hospitals affiliated with one of the two major health systems in Rhode Island negotiated substantially higher payment rates than the other, independent hospitals did

(Office of the Health Insurance Commissioner 2010). Others have pointed to the ability of multihospital health care systems to achieve higher payment rates than stand-alone hospitals because of their strategy of "all-or-none" contracting (Berenson, Ginsburg, and Kemper 2010). Other research has demonstrated that contrary to some expectations—and court opinions—for-profit and not-for-profit hospitals exhibit similar price-raising behavior achieved through aggressive negotiating (Keeler, Melnick, and Zwanziger 1999). Various analyses have helped establish that market leverage in the negotiations between health plans and providers is the key to understanding substantial pricing differentials across otherwise comparable health care provider organizations.

Data produced by the Medicare Payment Advisory Commission (MedPAC 2011) demonstrate that average commercial insurance rates are about 25 percent higher than Medicare fee schedule rates for physicians and 40 percent higher than diagnosis-related group rates for hospitals. Providers typically assert that they must receive premium payments from commercial payers to make up for shortfalls in their payments from Medicare and Medicaid, to care for the uninsured, and to cover bad debt.

A simple calculation that accounts for payer mix and payers' payment-to-cost ratios helps explain why substantial rate differences across different payer categories exist. We assume that Medicare, representing about 40 percent of hospital market share, on average, currently pays about 95 percent of Medicare-defined "reasonable" costs, and thus, for purposes of the calculation, we generously assume only 90 percent of actual costs, with disproportionate share hospital (DSH) payments included. Medicaid, until the 2014 expansion in many states, represented about 15 percent market share and also pays about 90 percent of costs, with DSH payments included and with substantial state variation. Uncompensated care and other assorted payers together make up about 10 percent market share—we will assume payment at 40 percent of costs. Doing the math, for hospitals to be made whole—without a positive operating margin—private payers, which pay the remaining 35 percent market share, would have to pay about 130 percent of costs—or about 145 percent of the Medicare payment level, in the same range as MedPAC's empirical data presented earlier (MedPAC 2011, 2014; Avalere Health 2014: charts 4.5, 4.6).[4] For hospitals that do not receive DSH payments, the private

4. Note that this calculation assumes that Medicare reasonable costs are reasonable. Analysis by MedPAC demonstrates that hospitals able to obtain relatively high prices from private payers have higher cost structures than hospitals that have positive Medicare margins because of lower costs with as good measurable quality.

payment levels might approach 170 percent of Medicare to offset the shortfalls from other payer sources.

This math exercise demonstrates why, with the exception of Maryland (the only state that still maintains an all-payer rate-setting program that minimizes payment variations across payers), "price discrimination" is a central part of the US health care system. In short, it is true that for non-DSH hospitals higher payments from nongovernmental purchasers subsidize the payment shortfalls from Medicaid and self-insured individuals, with Medicare close to picking up its fair share.

Price Variations

While the preceding calculation helps explain the important role of price discrimination in financing provider operations, national averages miss the huge variations in pricing both within and across markets. Surveying major health insurers, Paul B. Ginsburg (2010) and colleagues found that across eight major health care markets average inpatient payment rates ranged from 147 percent of Medicare in Miami to 210 percent in San Francisco, but that in extreme cases hospitals negotiated almost 500 percent of Medicare for inpatient care and 700 percent for outpatient care. Variations within markets were also marked. For example, the hospital with prices at the 25th percentile of Los Angeles hospitals received only 84 percent of Medicare for inpatient care, whereas the hospital with prices at the 75th percentile received 184 percent of Medicare rates. This study found similar but not quite as marked variation in physician payment rates within and across markets and by specialty.

A follow-up study analyzed actual claims in thirteen health care markets rather than estimates from a payer survey, finding in most of the markets that a wide gap separates the highest- and lowest-priced hospitals, with the highest-priced hospital being paid 60 percent more for inpatient services than the lowest-priced hospital (White, Bond, and Reschovsky 2013). In three of the markets, the highest-priced hospital is paid well above twice as much as the lowest-priced hospital for inpatient services. Differentials were even greater for outpatient services, with the average differential between highest and lowest varying by nearly 100 percent, with the most expensive hospital in Cleveland negotiating rates producing three times higher than the least expensive one for the same outpatient services.[5]

5. This analysis of course assumes that the services are comparable by not attempting to assess whether quality varies across the hospitals in the studies.

This analysis also examined differentials in negotiated physician prices, finding that variations in primary care services prices were moderate, ranging from 85 percent to 135 percent of the Medicare fee schedule rate, a 60 percent variation, whereas specialists' prices exhibited wider variation, in some markets more than a 100 percent variation. Using a different database of commercial insurer paid claims, Laurence C. Baker, M. Kate Bundorf, and Anne Royalty (2013) found that physicians paid at the high end of the price distribution were paid more than twice what physicians at the low end were paid for the same office visit codes. Similar to the Massachusetts Attorney General's report findings for hospitals, little of the variation in physician payments was explained by patients' age or sex, physicians' specialties, place of service, whether the physician was in the insurer's provider network, or type of plan. Geographic area of the practice explained about one-third of the variation.

Comparable differences in hospital and physician private-sector payment rates have also been demonstrated by MedPAC. Removing high and low outliers, MedPAC (2011) finds for hospitals a nearly 2:1 ratio between the 90th and 10th percentiles with the index value pegged at the 10th percentile of the data values. For physicians the 90th to 10th percentile ratio in payment rates was 1.5:1. The magnitude of these price differences suggests that price variations represent a policy issue because of the likely varying abilities of must-haves and have-nots—and those in between—to provide high-quality access to care. Antitrust policy is less attuned to caring about the have-nots that result from market imperfections, as discussed below.

Consolidation Is the Wrong Frame

Understandably, it is common to analyze the phenomenon of varying and fast-rising, negotiated provider prices through the lens of provider market consolidation. A recent literature synthesis commissioned by the Robert Wood Johnson Foundation on the impact of hospital consolidation found that increases in hospital market concentration lead to increases in the price of hospital care (Gaynor and Town 2012), and there is a good correlation between the growing concentration of hospital markets and rising prices for hospital services.

The Herfindahl-Hirschman Index (HHI) is a measure of how concentrated shares are within a market and is widely used as a measure of market structure (Gaynor 2011). Using HHI trends, studies document

that US hospital markets are highly concentrated and have become more concentrated over time. For example, from 1987 to 2006, there was a 40 percent increase in hospital market concentration such that by 2006 most metropolitan service areas—about 75 percent—were considered by FTC/DOJ guidelines to be "highly concentrated." And over the two decades of the study, many moderately concentrated metropolitan service areas had become highly concentrated (Gaynor 2011). To make this HHI analysis concrete, the increase in HHI concentration over that twenty-year period is the equivalent of moving from about five equally sized hospitals to a market with about three.

Furthermore, the ACA's focus on new payment and delivery models and increased financial pressure on providers in Medicare along with similar interest among nongovernmental payers has produced a marked increase in merger activity. For 2012 alone, 105 mergers and acquisitions (M&A) deals were reported, up from the 50–60 annually in the pre-ACA prerecession years of 2005–7 (Creswell and Abelson 2013).

Increased concentration occurs through consolidation of health care providers via horizontal M&A, and M&A are surely the stuff of antitrust policy. Indeed, the boom in M&A in the 1990s was largely the aggregate effect of hospitals' adopted strategy of merging or acquiring in response to the rise of HMOs, which had engaged in aggressive price negotiations with hospitals to drive their prices *down* (Fuchs 1997). In the heyday of managed care, health plans used their own growing market power—backed by credible threats to move patients away from providers not participating in their networks—to severely limit rate increases, leading in California to the "collapse" in payment rates for medical groups and their many subcontractors and hospitals in the 1990s (Robinson 2001).

In fact, one of the primary reasons for the demise of all-payer rate setting in the few states that had successfully implemented it was the desire of HMOs, then the ascendant insurance product, to use their own negotiating leverage to negotiate lower payment rates in exchange for a directed flow of patients, which was not easily achievable under all-payer rate setting (Atkinson 2009). The appeal to market competition rather than reliance on price regulation after the election of Reagan was natural; initially, insurers that tried were successful at obtaining deep discounts until the hospitals figured out how to counter the leverage of the payers by consolidating, a phenomenon that accelerated through the latter part of the 1990s as a response to managed care.

Pricing Leverage Due to Factors Unrelated to Consolidation

A consolidation lens logically suggests heightened antitrust enforcement as the primary policy solution to addressing the pricing problem. However, although provider consolidation might be the primary story that has resulted in high and ever-escalating prices, numerous other market factors complicate the narrative and put limits on the role of antitrust policy to address the problem.

An essential element of health plan–provider negotiations over price and other contractual terms and conditions is the willingness of consumers to accept narrow or tiered network products that effectively limit their choice of provider to those willing to accept the health plan's pricing. Without a credible threat of either excluding or disadvantaging high-cost providers by placing them in a higher consumer cost-sharing tier, health plans lack an important bargaining chip. Yet in the aftermath of the managed care backlash of the mid- to late 1990s, which included active discussion of "any willing provider" laws that in some forms would guarantee inclusion of high-priced providers, health plans lost leverage, even in nonconcentrated markets.

Another crucial factor elevating the provider bargaining position was the dwindling hospital bed and physician supply in many markets. Victor Fuchs (1997), commenting in the late 1990s on how managed care had been able to obtain substantial price discounts from physicians and hospitals, pointed to the excess capacity of hospital beds and physicians, and expensive technologies like advanced imaging, in many health care markets. Simply, if there are few excess beds in the community, insurers cannot credibly threaten to exclude hospitals from the provider network, again to gain leverage in price negotiations. In response to the ability of managed care to drive prices lower, between 2000 and 2010 hospital beds per one thousand population declined more than 10 percent, from more than 2.9 to 2.6 (Avalere Health 2014: chart 2.2).

Another factor is that it has become common health care parlance to refer to "must-have" providers—especially hospitals—that must be included in a plan's provider network to make the plan marketable to customers. Must-have hospitals, by definition, have pricing leverage over insurers because the plans cannot plausibly threaten to exclude or limit their participation in the insurer's provider networks. Although consolidation with a reduction in competitive choices for the health plans is a major cause of must-have status, so is reputation, lodged either in the

hospital or physician group overall or with particular service lines the hospital brands and actively markets. In fact, some of the highest, anecdotally reported prices are commanded by single, independent hospitals, such as Cedars-Sinai Hospital in Los Angeles (Berenson, Ginsburg, and Kemper 2010). As an executive of a different must-have hospital system succinctly summarized, "We have clout not because of our size but [because of] who we are. Am I supposed to apologize for that?" (Berenson et al. 2012: 975).

To this question, antitrust policy would answer no. Competition theory holds that in competitive markets an organization that achieves pricing power through its reputation for high quality and service deserves those high prices; it certainly should not be the target of antitrust enforcement. Yet payments at 250 or 300 percent of Medicare—or even more for some highly desired, often specialized, hospitals and physicians—pose problems for the health care system and consumers who ultimately pay the bill, whether directly or through pressure on their wages.

Beyond reputation, the assorted other reasons why hospitals can become "must-haves" have little or nothing to do with consolidation, although they are reflected in concentrated market calculations. Providing a unique service, otherwise unavailable in the market, sometimes due to regulatory actions, for example, a designated level 1 trauma center, burn center, or organ transplant facility, gives hospitals the ability to negotiate higher prices for all of its services, not just the unique ones payers need to contract for. Children's hospitals, which in most markets effectively do not have competition for their specialized services, reportedly achieve among the highest prices for their nongovernmental payers, making up for the below-cost payment levels obtained for their patients on Medicaid (Berenson et al. 2012).

Finally, there are service areas that cannot support competing provider organizations because they lack sufficient population to achieve needed economies of scale. In short, these are areas that have provider concentration but not as a result of consolidation. Rural hospitals, for example, often have market power as a result of their geographic isolation (Berenson, Ginsburg, and Kemper 2010); they lack competition, but not because they have actively aggregated the health delivery resources in the area.

Legitimate Reasons for Consolidation

As emphasized by Robert F. Leibenluft (2015) in a companion essay in this special issue, the simple reason that the antitrust agencies have not filed

more challenges is that most collaboration and transactions in the health care sector do not raise significant antitrust issues. There are many good reasons for M&A. An obvious constraint on antitrust action occurs where the market is broad and includes sufficient alternatives such that competition would not be compromised, although, as noted earlier, the majority of metropolitan service areas already are considered highly concentrated. Leibenluft (2013) has proposed a set of successful defenses commonly used by providers to support their M&A. These include the following not uncommon situations:

- No recent merger or acquisition has been reported.
- There is no horizontal overlap—different product or market.
- The acquired provider is failing and therefore does not support competition.
- Entry of other competitors is timely, likely, and sufficient.
- Health plans can constrain price increases.
- The transaction is shielded by state-action exemption.
- Convincing evidence shows that the merger will create significant efficiencies.
- Health plans, employers, and community leaders are generally supportive, or at least not opposed.

The policy concern of course is that although there may be perfectly good reasons to consolidate, including saving failing institutions and producing plausible efficiencies through economies of scale and scope, increased purchasing power with vendors, consolidation of services, transfer of managerial techniques and skills (Gaynor 2011), and easier access to capital for worthwhile clinical and managerial innovations, the merged entity, nevertheless, can find itself in a position to raise prices to levels that overwhelm any savings resulting from the merger. Market power might not have been the primary motivation for the merger but can easily become the result—and persist for years to come.

For their part, the antitrust agencies typically get one opportunity to weigh in on a proposed merger. It is much more difficult for them to take action against a monopolist exercising its market power. This reality was brought home in a case involving Evanston Northwestern, in which the acquisition of Highland Park Hospital by Evanston Northwestern was retrospectively found to have produced a significant increase in prices without improving quality (Romano and Balan 2011). But seven years had passed, making it impossible to order a return of the two

institutions back to the status quo ante, commonly referred to as "unscrambling the eggs" (Baer 1996).[6]

Operational Enforcement Challenges

It is true that successful litigation to prevent an anticompetitive merger can send a chilling signal to others to desist from engaging in similar activities that would be challenged, thereby broadening the impact of relatively few "wins." And although they do provide guidance to market stakeholders regarding permissible behavior, the antitrust enforcement agencies' core tool in their arsenal is to bring actions against entities exhibiting anticompetitive behavior. However, antitrust agencies generally lack the needed resources and lack some of the expertise needed to overcome a range of obstacles (Leibenluft 2015). They must devote substantial time and resources, which are in short supply, to evaluating individual transactions to satisfy the legal standards for challenging them, if deemed appropriate (Dafny 2014).

Probably even more challenging, enforcers must be able to balance the potential benefits that might plausibly result from the merger (and whether there are other means of achieving those benefits), such as reduced costs and improved access and quality, with the potential for cost increasing monopolistic behavior, which could result not only from raising prices but also from other anticompetitive behavior such as using their dominant position to prevent market entry of competitors (Feinstein, Kuhlmann, and Mucchetti 2015). In many cases, an analysis of the worthiness of a proposed consolidation is complex, making it difficult to judge whether to proceed with an action (Leibenluft 2015). If it is hard for regulators to demonstrate why a patently worrisome merger or acquisition should be blocked, it is even less likely that they will investigate or attempt to halt consolidations for which the potential benefits are unclear (Dafny 2014), especially because such antitrust efforts often are very visible and politically charged.

"Have-Nots" Are Not the Focus of Antitrust Attention

As emphasized earlier, the issue of provider pricing power involves not only very high prices that must-have providers command in their health

6. This phrase was used in 1996 to describe the difficulty in postacquisition relief by then director of the Bureau of Competition of the FTC, William J. Baer (1996), who stated, "Once a merger takes place and the firms' operations are integrated, it can be very difficult, or impossible, to unscramble the eggs and reconstruct a viable, divestible group of assets."

plan contractual negotiations but also remarkable variations across and within markets. While many providers may engage in price discrimination, with higher payments from nongovernment payers helping subsidize Medicaid and self-pay patient deficits, some "have-not" hospitals and small physician practices are price takers for all payers and bear the brunt of the insurers' similar need to at least partly compensate for the higher prices demanded by the must-haves.

This proclivity for payers to make up for high prices by ratcheting down on payments to less powerful providers raises the issue of whether there is a role for antitrust policy not only to address anticompetitive mergers and other monopolistic provider behavior but also to scrutinize health insurer consolidation and monopsonistic purchasing behavior. In fact, we do know that insurance markets are even more concentrated than provider markets as measured by HHIs. Between 1998 and 2006, the fraction of health care markets that were raised to levels of concentration high enough to raise antitrust concerns based on the antitrust agencies' *Horizontal Merger Guidelines* increased from 68 to 99 percent (Robinson 2004; Dafny, Duggan, and Ramanarayanan 2009).

From a theoretical perspective, one can argue either way about the likely impact of insurer concentration on prices (Dafny, Duggan, and Ramanarayanan 2009). On the one hand, increases in market concentration, with lack of effective competition, may allow dominant insurers to raise their profit markups, leading to higher, noncompetitive premiums. On the other hand, increases in market share may strengthen insurers' bargaining leverage with providers, which could produce lower provider prices and lower insurance premiums. One market reality seems to be that dominant insurers do not need to achieve low prices in their provider contracts but rather just need to achieve the best prices to maintain an advantage over their smaller competitors and to prevent new market entrants (Berenson et al. 2012). When put on paper, so-called most favored nations clauses are likely illegal and certainly anticompetitive (Complaint, United States v. Blue Cross Blue Shield of Michigan, No. 10-CV-14155 (E.D. Mich. 2010)), but in most markets this expectation about favored, but not necessarily aggressively low, rates seems to be a common and unwritten understanding among dominant payers and providers and thus is tough to prove (Berenson et al. 2012).

It could well be that all of these behaviors are in play, with variations based on different particular circumstances. The net effect of concentration in insurer markets on provider prices and insurance premiums is an empirical question. Unfortunately, there is little empirical data on the impact of dominant health insurers on prices within health care markets. Of the few studies that are part of the literature, there are mixed results

(Dafny, Duggan, and Ramanarayanan 2009; Melnick, Shen, and Wu 2011) and correspondingly little antitrust action directed toward insurers.[7]

For the have-nots, it seems that they often face a compromised financial situation not only because of their payer mix but also because they become price takers with no leverage at all in negotiations with any payers, dominant or not. Indeed, one of the principled objections to reliance on market competition is concern that the competitive game is stacked against those providers that choose to practice as small independent providers serving "unprofitable" populations for sound reasons of mission, for example, serving low-income and poorly insured populations. Antitrust policy to ensure competition is unlikely to address underpaid hospitals—underpaid either because they have many nonpaying or poorly paying patients or because they are price takers, accepting rates often well below Medicare rates for the relatively few nongovernmentally insured patients they do see. For the purposes of this discussion, the practical point is that antitrust policy is geared to addressing the problems of certain forms of consolidation that produce noncompetitively determined, high provider prices but is unlikely to address unsustainably low provider prices.

One of the policy appeals of a regime of state-based, all-payer rate setting is its lack of reliance on price discrimination. In Maryland, hospitals receive comparable payments for care provided regardless of payer source, contributing to one of the purported strengths of this approach—there is no need to discriminate among patients and payers based on insurance status. Other policies, including special government-financed subsidies for market-disadvantaged hospitals that serve as safety net institutions, including DSH payments, are needed to correct for market failure to protect have-not providers.[8]

The Horse Has Already Left the Barn

The late 1990s were characterized by "merger mania." As discussed by Fuchs (1997): "Hardly a week goes by without hearing or reading about a

7. The McCarran-Ferguson Act provides a limited exemption from federal antitrust laws if the activity in question constitutes the "business of insurance," is subject to regulation under state law, and does not constitute a boycott, coercion, or intimidation. In general, states regulate insurer-insured relationships, whereas the interaction between insurers and providers can be subject to federal or state antitrust enforcement.

8. The Maryland all-payer rate review system, first implemented in 1976, has been quite successful at holding down the rate of increase in costs per admission but not in overall hospital admissions and volume. Overall, its performance has been mixed, and it has recently entered into a new Medicare demonstration with altered approaches to all-payer cost control, with less emphasis on prices and more on total costs through the adoption of global budgets for hospitals (Murray 2009; Rajkumar et al. 2014).

major merger or takeover in health care. Acquisitions and mergers of smaller health care organizations are so commonplace they do not receive media attention." In 2014 an economist who studies health care markets, writing in the *New England Journal of Medicine*, referred to the "merger frenzy" of recent years (Dafny 2014: 198). One wonders whether in the aftermath of these merger manias and frenzies there are any unmerged hospitals left.

Clearly, there is a role for the antitrust agencies to protect against two competing hospitals attempting to merge. But in the name of efficiencies and reduction of redundancies we already have passed into a world of hospital system oligopolies, if not overt monopolies in some places.

In short, while antitrust activity to promote and protect competition in health care markets is desirable and commendable, antitrust law has little to say about monopolies lawfully acquired or, in the case of consummated mergers, fully entwined entities that are impractical to successfully unwind (Greaney 2013).

A common misunderstanding among policy makers is that antitrust law provides a reliable counterforce to monopoly (Greaney 2014). With respect to extant monopolies, legally acquired, the opposite is true: antitrust law tolerates the exercise of market power, including obtaining higher prices, reducing output, and, perhaps, lowering quality, and generally intervenes only where the monopolist wrongfully exercises that power to exclude or harm actual or would-be competitors.

Staff from the various federal and state antitrust authorities point to their strong preference for "structural remedies," that is, preventing or unwinding the merger, as much more effective than "conduct remedies" that attempt in essence to regulate the conduct of the monopolist, for example, by providing for binding arbitration to resolve payer-provider price disputes or requiring maintenance of open medical staffs (Brief of amicus curiae the States of California et al. in support of the FTC, St. Luke's v. Federal Trade Commission, No. 03-3674 (9th Cir. Aug. 20, 2014) (Brief No.1:13-CV-00560-BW)). Yet whether called "conduct remedies" implemented by antitrust authorities or "regulations" overseen by health financing agencies more attuned to the complex technical issues that are part and parcel of provider payment, the approaches represent a similar recognition that many health care markets are already noncompetitive and unlikely to evolve in a more competitive direction as a result of usual antitrust activity. Further, nothing in the broad CMS initiatives to move payment from "volume" to "value" by promoting the development of ACOs and other payment initiatives has as an explicit objective lessening extant provider concentration, which is now pervasive (Greaney 2014).

Indeed, commonly used "shared savings" payment models in effect ratify and protect already achieved pricing power, as discussed below.

It is common for procompetition advocates to recommend policy changes that would promote new market entrants as a way to counter concentration. A typical list of such policies includes repeal of certificate of need programs that continue in more than half the states (National Conference of State Legislatures 2014); loosening of state-based scope of practice licensure restrictions on the activities permitted of nonphysician professionals, such as nurse practitioners; and promotion of retail clinics as an alternative to physician offices and hospital emergency rooms for minor ailments. While these are perhaps worthy reforms in themselves, mostly to increase access to needed services, it is hard to see how this rather lean menu of new market entrants would importantly change the domination that increasing numbers of hospital systems currently enjoy in many markets, even if these measures could be implemented over concerted stakeholder opposition.

Even the entry of physician- or venture capital–owned specialty hospitals into a concentrated market may perversely result in increased costs. For example, some insurance executives actually oppose entry of specialty hospitals, for example, cardiac hospitals, even after acknowledging that they would likely promote price competition with the incumbent community hospitals for common cardiac services. They point out that physicians are able to induce demand and referrals to their owned specialty hospital for unneeded procedures, while the general community hospital can simply offset the loss of cardiac business and the price concessions given on cardiac services by raising their payment demands for other services for which there is little price competition (Berenson, Bazzoli, and Au 2006).

Calling King Canute

By legend, King Canute the Great was considered "so great, he could command the tides of the sea to go back." Canute is often referenced to illustrate the futility of trying to stand in the way of the inevitable—Canute was swamped when the seas rolled over his throne set on the seashore (Westcott 2011; Rhodes 2004).[9] Now, antitrust enforcers face what seems to be an inevitable tide of hospital employment of physicians.

9. It appears that Canute was not acting arrogantly and mistakenly to hold back the tides but was actually making the following point: "Let all men know how empty and worthless is the power of kings. For there is none worthy of the name but God, whom heaven, earth, and sea obey" (Rhodes 2004).

To some there seems an inevitability about the development of large, dominant health care systems, featuring physician employment and in some cases full vertical integration that includes not only the full continuum of health services but also the insurance function—akin to California's vertically integrated Kaiser-Permanente system, which owns its own hospitals. A strong impetus in recent years to hospital employment of physicians has been fee-for-service payment incentives and negotiating leverage imbalance. Specifically, for the past decade or longer, hospitals have sought to employ physicians to support service-line strategies for specialty services such as heart, cancer, and orthopedic/spine centers. As part of the service-line branding, physicians often are emphasized in marketing materials and, in some cases, play major management roles in running the service-line product (Berenson, Bodenheimer, and Pham 2006). As a related strategy, hospitals sometimes employ specialists to preempt competition from physician-owned ambulatory surgical centers and hospitals and imaging facilities (Casalino et al. 2008).

In addition, a recent spurt of employment has resulted from the fact that Medicare pays hospitals in total almost twice as much for outpatient physician services provided by hospital-employed physicians as by independent physicians, leading hospitals to entice certain specialists with generous compensation packages to leave private practice to become hospital employees (MedPAC 2014). Further, and consistent with the concern about substantial variation in negotiating leverage, physicians are attracted to employment in hospitals (as well as consolidated, multispecialty groups and single-specialty practices) because these larger entities have greater clout in price negotiations with payers than small practices do. The combination of hospital and employed physicians seems to increase the negotiating leverage—and prices—for both the hospitals and the employed physicians. Hospitals in turn pass along revenue from higher fee schedules to now employed physicians in their compensation packages (Casalino et al. 2008). And important recent research has documented that hospital-owned physician practices incur higher prices from commercial insurers than physician-owned practices do, casting additional doubt on the value of vertical integration to reduce health care spending, at least under prevailing payment models (Robinson and Miller 2014; Baker, Bundorf, and Kessler 2014).

Payment policies might be altered to at least partly address those financial reasons that lead physicians to seek hospital employment. However, other factors seem more fundamental and, perhaps, as inevitable

as the tides. For example, governmental and nongovernmental payers alike are requiring practice enhancements, such as adoption of electronic health records (EHRs) and the ability to meet accompanying EHR "meaningful use" criteria, which necessitate capital that smaller practices lack.

Even more fundamentally, younger physicians seem interested more in financial security, work-life balance, and shelter from an increasingly complex and unstable health care marketplace and are willing to exchange the autonomy that comes from independent, entrepreneurial practice for these advantages (Casalino et al. 2008; O'Malley, Bond, and Berenson 2011). Although the percentage of physicians employed by hospital systems has been somewhat exaggerated by some, there has been a definite trend toward more employment. Overall, about 30 percent of physicians are employed by medical groups that are hospital owned, although estimates vary (Burns, Goldsmith, and Sen 2013). In some markets, well over half the physician workforce is made up of hospital employees. In fact, there appears to be an association between hospital consolidation and physician employment (Casalino et al. 2008). In highly consolidated hospital markets, physicians may feel pressure to align closely with one of the remaining hospital systems; otherwise a hospital will likely bring in other physicians in their specialty to compete with them (Casalino et al. 2008).

The antitrust authorities may favor collaboration between independent physicians and hospitals and can occasionally win cases to prevent incremental employment, as in the recent FTC victory in the St. Luke's Health System of Idaho acquisition case (Feinstein, Kuhlmann, and Mucchetti 2015). But if physicians as a matter of professional preference and financial interest are determined to become employees, it is hard to see how the antitrust agencies can stand in their way to keep them independent for long.

Are ACOs Part of the Problem or the Solution?

Procompetition advocates have made a strong case for ACOs functioning in an environment of "integration and rivalry" (Greaney 2014). Indeed, CMS in its final rule for the Medicare Shared Savings Program (MSSP) that governs ACO start-ups overtly endorses the competition paradigm for ACOs by explicitly linking the need for vigorous private market competition and the interests of the Medicare program. "Competition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care for Medicare beneficiaries and protects beneficiary access to care. . . . Competition among ACOs can accelerate

advancements in quality and efficiency" (Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,801, 67,806 (2012)).

Yet there is a rarely acknowledged but real conflation at the very heart of the ACO concept, in discussing the different uses of the oft-used term *population health*. Douglas J. Noble and Lawrence P. Casalino (2013) point out that the term is used commonly to refer both to the health of the population in a geographic area, usually characterized as the "community," and to the health of a subset of patients associated with an ACO. Similarly, the term *population-based payment* is commonly used to describe what used to be called *capitation*—per-member per-month payments.[10] The term *population-based payment* connotes that payment is not based on activities generated, as in fee-for-service, but rather is a fixed amount based on the number of individuals for whom a provider is responsible, regardless of the actual services provided. In essence, the provider is responsible for a particular group of individuals. Confusion could be avoided by using other terms, such as *global payment*, as an alternative to *population-based payment*.

Competing Visions of ACOs

But the issue is not purely semantic, as the preceding discussion might suggest. Not surprisingly, there are competing ACO visions. A team of early ACO advocates, led by Elliott Fisher, articulated alternative strategic options for how to achieve fundamental payment and delivery system reforms (Fisher et al. 2009). A first strategic option would lodge primary responsibility with insurers accountable for overall costs and quality competing for enrollees. A second—and the authors' own favored approach—would be "to enable providers to become accountable for the *population they serve* and to share in savings created by improving quality and slowing spending growth" (Fisher et al. 2009: w222; emphasis added).

The team also articulated a third way that appeals to many—state governments or regional public-private authorities could be accountable for establishing budgets, overseeing payments, and monitoring performance across all providers, presumably collaborating care for the health of a *geographically based* population. Fisher and colleagues pointed out that this approach is not commonly considered in the United States. They referred to the model of the Rochester Hospital Experimental Payments

10. For Medicare beneficiaries who are not members of a Medicare Advantage plan but rather retain full choice of Medicare provider, they might more accurately be called "per-person per-month" payments.

Program in the 1980s as an example of this community-based or geographically based ACO model, replacing rivalry among ACOs with a focus on responsibility for the health of the population within the relevant geographic area (Fisher et al. 2009).[11]

Thus for many policy experts and providers, an ACO should be accountable for the quality and costs associated with providing health benefits to individuals attributed to it in some way and not for the health of others who live in the community. To the extent that collaborations with social service, housing, other health professionals providing noncovered benefits, and other parties located in the community can improve the health and well-being of the attributed insured individuals, so much the better. But the ACO is not held accountable for the health of the community per se.

For others, population health literally relates to the health of the population, not just to the subscribers of an insurance company or the individuals attributed to an ACO. For example, Donald Berwick (2011: e32), at the time acting administrator of CMS, explained that the purpose of the ACO concept is "to foster change in patient care so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care." Although one could parse the triple aim to mean that one can achieve improved health of populations by the cumulative impact of better care for individuals, the clear implication of the second aim suggests attention to a nonmedicalized definition of health with active attention to social determinants of health that are found in public health agencies, social services, and other community-based support programs. And in a recent editorial titled "Reshaping US Health Care: From Competition and Confiscation to Cooperation and Mobilization," Berwick (2014) explicitly challenged the applicability of vigorous competition to health care.

In some visions, ACOs become community-centered, accountable care systems that link population-wide health services with primary care; alternatively, they can be expected to participate with a broad collaborative that is accountable for the health of the population in a geographic area under the auspices of a community health system, which is given authority to manage a population health budget and allocate resources (Hester and Stange 2014).

Although this tension between ACO visions is mostly unacknowledged, economists Katherine Baicker and Helen Levy argue in "Coordination versus Competition in Health Care Reform" (2013) that the broad-based

11. It is interesting to note that Fisher and colleagues subsequently wrote favorably about moving toward "accountable health communities" (see Magnan et al. 2012).

acceptance of the need to improve coordination among different providers and others, facilitated through integrated organizations perhaps broader than a set of providers, directly conflicts with the strategy of promoting competition in health care markets. Baicker and Levy further argue that the current suite of policies, including promoting ACOs, does not embody a unified approach to reconciling the roles of coordination and competition.

A recent literature review of the evolution of the concept of integrated care as reflected in academic literature over the past twenty-five years suggested a major shift in integration strategies over that period, including the shift from acute care and institution-centered models to a broader focus on "community-based health and social services," accompanied by a coincident shift in emphasis from a focus on horizontal to vertical integration (J. Evans et al. 2013: 125).

Recently, Vermont has actively pursued ACOs supported by a mix of shared savings payments. One in particular, OneCare Vermont, is a statewide, public-private ACO that employs over three hundred primary care physicians and includes all of the state's fourteen hospitals. The governance of OneCare Vermont consists of a governing body with provider and consumer representation. To determine and discipline prices, Vermont would logically have to move in the direction of Maryland's all-payer hospital rate regulation, rather than market negotiations. In short, Vermont, albeit a rural state without much hospital or health plan competition, envisions an ACO model built on provider and community collaboration rather than on competition, possibly with prices disciplined within a regulatory framework, although those details are yet to be worked out.

Integration and rivalry is a well-developed concept and provides clear policy guidance to antitrust, if not easy implementation, on what this strategy is trying to protect—meaningful competition. In contrast, community ACOs and related concepts, such as collaboration and coordination across providers and the community, remain much less well articulated. Many of the elements necessary for community-based solutions, such as governance, financing, payment, and other issues, are mostly not addressed, although some initial efforts at providing a governance model and a funding stream have been advanced (Fisher and Corrigan 2014). It is quite possible that the community ACO concept really is about exhorting competing ACOs to collaborate, sometimes with each other, but primarily with noncompeting public health, social service, and other entities to improve the care for the individuals for whom they are responsible.

State Action Immunity

Practically speaking, there may be situations, such as in Vermont, in which integration and rivalry may not be the right paradigm for population health management; rather, something closer to true community-based accountability is envisioned. In bona fide situations in which state or local policy makers seek to make a policy choice that supplants competition, the antitrust perspective, as enunciated by the Supreme Court in the Midcal case, would require the state, as a sovereign, to have both a "clearly articulated" alternative policy to competition and to provide in some way for "active supervision" of actions to the articulated alternative policy (California Retail Liquor Dealers Ass'n v. Midcal Aluminum Inc., 445 U.S. 97, 102–7 (1980)). Advocates of vigorous competition supported by vigorous antitrust enforcement tend to be skeptical of state action, probably with good reason, given the potential for lack of antitrust agency expertise in the nuances of payment, inadequate resources, lack of necessary follow-through over a period of years, failure to adjust to altered circumstances, and the potential for regulatory capture by those subject to the state oversight (Havighurst 2006).

Nevertheless, like it or not, both the reality of extant monopolies and the legitimate vision of the community ACO call for a willingness to consider state supervision through active oversight and, likely, price regulation and conduct remedies for the many markets where a competitive environment simply does not exist or is rejected. State approaches, such as those embodied in legislative vehicles called certificates of public advantage (Bovbjerg and Berenson 2015), or conduct remedies usually developed and imposed by state attorneys general offer alternatives, usually in consent decrees with powerful provider systems trying to expand (Brief for the States of California et al. as Amicus Curiae). The conduct regulation approach is certainly not the one most desired by competition advocates attempting to address the problems created by the inevitable exercise of market power by dominant provider organizations. How to address pricing power by already empowered and sanctioned provider monopolies needs to be a central issue in the national and state-based policy agenda.

High Prices Eat Low Service Use for Lunch

As noted earlier, some of the most prestigious and respected provider organizations are viewed as prototypical ACOs. The right idea is that under robust, risk-bearing payment approaches, these organizations would

overhaul their business models such that reducing the use of clinically inappropriate imaging, procedures, and other costly services and increased attention to care coordination for the growing cohorts of patients with multiple chronic conditions would become financially desirable and in line with excellent health care delivery. Decades of important research from Dartmouth health researchers and others have confirmed that in Medicare, service use varies across the country with no apparent systematic differences in quality and access. In short, in aggregate, more care does not produce better quality (Sutherland, Fisher, and Skinner 2009; Zuckerman et al. 2010).

A MedPAC (2011) analysis found a substantial 30 percent spread in service use across geographic areas between the 10th and 90th percentiles, once health status and payment differences were adjusted for. In contrast, the prices negotiated between providers and health insurers, as demonstrated earlier, can easily vary by 100 percent or more, such that prices, not service use, correlate with total spending differences (Chernew et al. 2010). With variations in prices far greater than even substantial variations in service use, it is not surprising that studies have found that service use is often inversely correlated with total spending in commercial insurance markets, although there are differences based on the degree of competition in both the insurance and provider markets (McKellar et al. 2014).

Integrated provider organizations built on well-established multispecialty group practices—prototypical ACOs—reportedly are able to command rates of 250–300 percent of Medicare benchmarks for their physicians and hospitals. Not even the latest iteration of "new math" can explain how exemplary care delivery producing as much as 20 percent below average service use can offset 100 percent (or more) higher prices for services.

Flaws in the Dominant Payment Model for ACOs

The MSSP seeks to encourage formation of integrated delivery systems capable of receiving payments that include incentives to restrain spending. Although the ACA provided authority to CMS to employ capitated payment models, the agency chose not to do so (Greaney 2014). Instead, the MSSP maintains reliance on fee-for-service payment models for hospitals and physicians while providing bonuses to ACOs if their attributed patients' spending is below a projected target amount based on recent historic spending of providers in that ACO (Medicare Shared Savings

Program: Accountable Care Organizations, 76 Fed. Reg. 67,801, 67,806 (2012)). That is the shared savings.

The program's financial incentives are designed to provide "training wheels" for providers whose culture and business models are based on fee-for-service and to reduce transition uncertainties in other ways as well (Greaney 2014). Acknowledging that the bonus-only shared savings payment model is a transition model, CMS has laid out a schedule for movement to two-sided risk to reflect the desire to move affirmatively away from volume-based payments. In response to ACOs' concerns that they were not ready to assume risk in the current program structure, CMS has issued revised regulations permitting ACOs to continue a one-sided risk agreement for three additional years but at a lower shared saving percentage (Medicare Program; Medicare Shared Savings Program: Accountable Care Organization, 80 Fed. Reg. 32,692 (Jun. 9, 2015) (to be codified at 42 C.F.R. pt. 425)).

But even with two-sided risk, the payment model is flawed for its near total reliance on an ACO's historic costs as the basis for determining spending targets on which bonuses and penalties are based. The payment flaw certainly exists in Medicare, both for MSSP ACOs and for Pioneer demonstration ACOs. However, in the case of Medicare, it is a less serious problem because Medicare's payments are based on standardized prices. The problem is worse when private insurers use the same shared savings approach because historic costs reflect not only differences in service use, as in Medicare, but also price differences resulting from historic differences in pricing power. There is logic to the approach of basing benchmark targets on an ACO's historic costs for beneficiaries attributed to the ACO, then trended forward. Those ACOs with higher base spending surely have lower "hanging fruit" to pick off in the form of unneeded services and failure to coordinate care to generate savings than lower-spending organizations do. In the very short term, the case for programmatically rewarding the "fat" and ignoring the "lean" can be made. From a payer's budgetary perspective, disproportionately rewarding ACOs with higher base spending makes sense; after all, the low-spending organizations are benefiting the payer without having to pay rewards for previous gains (Weissman et al. 2012).

However, the approach is inherently unfair and certainly contrary to well-established Medicare payment policy, which bases primary payment for providers on input cost-adjusted national averages (hospitals, physicians, other providers) or local community averages (Medicare Advantage), not on the provider's historical spending. Relatively low-spending

ACOs leaving the Pioneer ACO demonstration have pointed to this inequitable payment approach as a reason for withdrawal (Morrison 2013; M. Evans 2014). In effect, these ACOs receive no credit for previous performance demonstrating relative efficiency and have to watch higher-spending organizations achieve bonuses (Beck 2013), a perfect application of the saying "Let no good deed go unpunished."

The ACA adopts a useful approach to marginally correcting the inherent unfairness of basing bonuses on an ACO's historic spending by providing fixed dollar, rather than fixed percentage, increments for medical trend. So assuming a national 4 percent trend update to determine the target for each ACO, a fixed dollar update would provide perhaps 3 percent to a high-spending organization and 5 percent to a low-spending one, at least not exacerbating the dollar differences in spending targets on which shared savings bonuses and penalties are based. Yet the historic spending differences remain, and the potential for achieving shared savings is unequal.

The inequitable payment issue gets worse in commercial insurance ACO implementation, mostly because of the pricing problem in provider concentrated markets discussed in this article. Any ACO's base payment is built on the large provider price variations that in turn are a function of pricing power in negotiating leverage. The shared savings payment model based on historic spending, whether one-sided or two-sided, accepts these price variations as a given. Further, commercial insurance payers have to negotiate ACO contracts with providers that can resist any adjustment in the update method that the ACA included. Commercial insurers often provide a common percentage increase to all of their ACOs, thereby providing higher dollar increases to the already higher-priced organizations.

In theory, basing payments to ACOs on community norms—inherent in global payment or percentage-of-premium approaches—would directly take away any pricing advantages enjoyed by must-have providers. The negotiated pricing variations across providers with different pricing power, in place of fee-for-service payments, would disappear with straightforward global payment based on community norms. It is of course a reason why many provider-based organizations would not voluntarily agree to engage using this approach.

However, it is possible to improve the current approach to shared savings to address the inherent unfairness. For example, shared savings targets could be a blend of historic and normative spending amounts with the percentage of normative contribution to the blend increasing over time. In year 1, the blend might be 90:10, with the major contribution based on an ACO's historic spending and with the update for inflation based on a dollar,

rather than a percentage increase, as Medicare does. Over time the blend would include a large contribution from the relevant national or regional average. Adding even more precision would involve making Medicare-like adjustments for variations in input prices for wages, graduate medical education, case mix, and other factors.

Medicare's Possible Role in Constraining ACO Pricing Power

Will ACOs contribute to moderation of prices and spending in private insurance markets or actually increase prices and spending? The outcome hinges on whether transformation by ACOs rewards lower spending and higher quality or, in effect, sanctions consolidated organizations that gain market power and raise prices more than they lower service use. The focus on this question typically devolves to the role of antitrust to permit or limit ACO configuration.

However, there are also opportunities for CMS to adopt approaches to Medicare ACOs that would have a positive impact on the dynamics of commercial insurance markets. Suggestions for CMS to consider include a major commitment to testing ACO models that do not involve joint ownership of all assets, because joint ventures would be easier to unwind than mergers, if that proved necessary (Dafny 2014). As it happens, various contracting models are well represented in the MSSP and the Pioneer program. Despite expectations that hospitals with employed physicians would be a dominant form of ACO applicant, about half of Medicare ACOs are physician organizations, and many of these are primary care–based ACOs (CMS 2014b).

Or, more ambitiously, CMS could be explicit in its own performance monitoring of Medicare ACOs to counter the interest of some ACOs in raising or sustaining out-of-line prices to private-sector payers, resulting from their existing or newly empowered market position to demand higher prices (Greaney 2014). The obvious performance metric that would capture this concern would be per-person per-month spending for private payers. But this core metric is the mechanism for global payments and resisted by ACOs, whether in Medicare or in the private sector. Applying this "all-payer" performance measure to ACOs that also have commercial insurance contracts would seem an especially heavy lift politically, but it would clearly signal CMS's intent to promote more competitive markets outside Medicaid and Medicare. A practical impediment is that overly

ambitious program administration with heightened performance expectations would likely produce even greater reluctance of providers to participate as Medicare ACOs, which remains a voluntary choice (J. Evans et al. 2013). In addition, private health plans may be reluctant to provide their data to CMS to permit a multipayer per-person per-month calculation.

Final Thoughts

To reiterate, with respect to extant monopolies, legally acquired, antitrust law tolerates the exercise of market power and generally intervenes only where the monopolist wrongfully exercises that power to exclude or harm actual or would-be competitors. Many integrated delivery networks have market power to raise prices without raising any antitrust concerns, much less enforcement action. Again, the reasons for must-have status are numerous, and most would qualify as being legally acquired.

In some cases there might still be opportunities to inject competition into markets with dominant provider organizations and achieve the vision of competing ACOs—perhaps a new physician medical group or independent practice association entering the market to compete with a powerful integrated delivery network based in a powerful hospital system. Nevertheless, for many situations, new market entrants will not appear or may be dissuaded from entering because the powerful hospital system not only can command high prices from insurers but also can use other techniques to frustrate market entry of would-be competitors in ways that typically do not give rise to antitrust action.

In these common situations, public policy—dare I say it—should more aggressively pursue regulatory approaches to limit unreasonably high prices (NASI 2015). These regulatory approaches need not try to reproduce all-payer rate setting given Maryland's mixed performance and new efforts with as-yet-untested approaches in a new demonstration project. Rather, regulation could be directed toward placing price ceilings on negotiated rates that come out of insurer-provider negotiations and upper limits on billing to consumers, beyond the negotiated rates insurers agree to pay, set as a percentage above the Medicare yardstick. Setting upper limits would bound the prices, while permitting market negotiations to focus on selected networks with discounting and with new payment models—market approaches that can be difficult to preserve in a full-fledged all-payer rate-setting environment. Also, placing upper limits on balance billing—even quite generous ones—would directly address the epidemic of physicians and hospitals in some cases purposefully remaining out of

network to charge either the insurer or the unsuspecting consumer outrageously high amounts—such as $117,000 for an assistant at surgery (Rosenthal 2014a, 2014b).

Prohibiting these indefensibly high charges could actually help fortify the insurers' move toward narrow and tiered networks, which is a core market-based strategy to provide insurers some additional leverage in their contract negotiations with providers over prices. In short, sometimes regulation—even price regulation—can help support a competitive market if targeted and carefully constructed.

■ ■ ■

Robert Berenson is an institute fellow at the Urban Institute. He recently completed a three-year term on the Medicare Payment Advisory Commission, the last two as vice chair. From 1998 to 2000, he was in charge of Medicare payment policy and private health plan contracting in the Centers for Medicare and Medicaid Services. Previously, he served as an assistant director of the Carter White House domestic policy staff. His primary research and policy interests are payment reform, provider and plan pricing power, quality performance measurement, and delivery system reform. Berenson is a board-certified internist who practiced for twenty years. He is coauthor, with Walter Zelman, of *The Managed Care Blues and How to Cure Them* (1998) and, with Rick Mayes, of *Medicare Prospective Payment and the Shaping of U.S. Health Care* (2006).

References

Altarum Institute, Center for Sustainable Health Spending. 2014. "Health Sector Economic Indicators: Insights from Monthly Price Indices through June 2014." Price Brief No. 14-06. Washington, DC: Altarum Institute, Center for Sustainable Health Spending.

Anderson, Gerard F., Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. 2003. "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." *Health Affairs* 22, no. 3: 89–105.

Atkinson, Graham. 2009. "State Hospital Rate-Setting Revisited." Issue brief. New York: Commonwealth Fund.

Avalere Health. 2014. *TrendWatch Chartbook 2014: Trends in Hospital Financing*. Analysis of American Hospital Association Annual Survey data. Washington, DC: Avalere Health.

Baer, William J. 1996. "Reflections on Twenty Years of Merger Enforcement under the Hart-Scott-Rodino Act." Speech before the Thirty-Fifth Annual Corporate

Counsel Institute, Northwestern University School of Law, Corporate Law Center, San Francisco, October 31. www.ftc.gov/public-statements/1996/10/reflections-20-years-merger-enforcement-under-hart-scott-rodino-act.

Baicker, Katherine, and Helen Levy. 2013. "Coordination versus Competition in Health Care Reform." *New England Journal of Medicine* 369, no. 9: 789–91.

Baker, Laurence C., M. Kate Bundorf, and Daniel P. Kessler. 2014. "Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending." *Health Affairs* 33, no. 5: 756–63.

Baker, Laurence C., M. Kate Bundorf, and Anne Royalty. 2013. "Private Insurers' Payments for Routine Physician Office Visits Vary Substantially across the United States." *Health Affairs* 32, no. 9: 1583–90.

Beck, Melinda. 2013. "Mixed Results in Health Pilot Plan." *Wall Street Journal*, July 16.

Berenson, Robert, Gloria Bazzoli, and Melanie Au. 2006. "Do Specialty Hospitals Promote Price Competition?" Issue Brief No. 103. Washington, DC: Center for Studying Health System Change.

Berenson, Robert, Thomas Bodenheimer, and Hoangmai Pham. 2006. "Specialty-Service Lines: Salvos in the New Medical Arms Race." *Health Affairs* 25, no. 5: 337–43.

Berenson, Robert, Paul B. Ginsburg, Jon B. Christianson, and Tracy Yee. 2012. "The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed." *Health Affairs* 31, no. 5: 973–81.

Berenson, Robert, Paul B. Ginsburg, and Nicole Kemper. 2010. "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform." *Health Affairs* 29, no. 4: 699–705.

Berwick, Donald. 2011. "Launching Accountable Care Organizations—the Proposed Rule for the Medicare Shared Savings Program." *New England Journal of Medicine* 364, no. 16: e32. dx.doi.org/10.1056/NEJMp1103602.

Berwick, Donald. 2014. "Reshaping US Health Care: From Competition and Confiscation to Cooperation and Mobilization." *JAMA* 312, no. 20: 2099–2100.

Bovbjerg, Randall R., and Robert Berenson. 2015. *Certificates of Public Advantage: Can They Address Provider Market Power?* Research Report. Washington, DC: Urban Institute. www.urban.org/research/publication/certificates-public-advantage/view/full_report.

Bundorf, M. Kate, Anne Royalty, and Laurence C. Baker. 2009. "Health Care Cost Growth among the Privately Insured." *Health Affairs* 28, no. 5: 1294–1304.

Burns, Lawton R., Jeff Goldsmith, and Aditi Sen. 2013. "Horizontal and Vertical Integration of Physicians: A Tale of Two Tails." *Advances in Health Care Management* 15: 39–117.

Busse, Reinhard, Alexander Geissler, Wilm Quentin, and Miriam Wiley, eds. 2011. *Diagnosis-Related Groups in Europe: Moving towards Transparency, Efficiency, and Quality in Hospitals*. New York: McGraw-Hill.

Casalino, Lawrence P., Elizabeth A. November, Robert Berenson, and Hoangmai Pham. 2008. "Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model." *Health Affairs* 27, no. 5: 1305–14.

Chernew, Michael E., Lindsay Sabik, Amanda Chandra, Teresa Gibson, and Joseph Newhouse. 2010. "Geographic Correlation between Large-Firm Commercial Spending and Medicare Spending." *American Journal of Managed Care* 16, no. 2: 131–38.

CMS (Centers for Medicare and Medicaid Services). 2014a. "CMS Releases New Proposal to Improve Accountable Care Organizations." Press release. December 1. Baltimore: CMS. www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-12-01.html.

CMS (Centers for Medicare and Medicaid Services). 2014b. "Fast Facts—All Medicare Shared Savings Program and Medicare Pioneer ACOs." Baltimore: CMS.

Creswell, Julie, and Reed Abelson. 2013. "New Laws and Rising Costs Create a Surge of Supersizing Hospitals." *New York Times*, August 12.

Dafny, Leemore. 2014. "Hospital Industry Consolidation—Still More to Come?" *New England Journal of Medicine* 370, no. 3: 198–99.

Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan. 2009. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry." NBER Working Paper No. 15434. Cambridge, MA: National Bureau of Economic Research.

Evans, Jenna M., G. Ross Baker, Whitney Berta, and Jan Barnsley. 2013. "The Evolution of Integrated Health Care Strategies." In *Annual Review of Health Care Management: Revisiting the Evolution of Health Systems Organization*, edited by Jim Goes, Grant T. Savage, and Leonard Friedman, 15:125–62. Bingley, UK: Emerald Group.

Evans, Melanie. 2014. "Medicare's Pioneer Program Down to Nineteen ACOs after Three More Exit." *Modern Healthcare*, September 25. www.modernhealthcare.com/article/20140925/NEWS/309259938.

Farrell, Diana, Eric Jensen, Bob Kocher, Nick Lovegrove, Fareed Melhem, Lenny Mendonca, and Beth Parish. 2008. "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More." New York: McKinsey and Company.

Feinstein, Deborah L., Patrick Kuhlmann, and Peter J. Mucchetti. 2015. "Accountable Care Organizations and Antitrust Enforcement: Promoting Competition and Innovation." *Journal of Health Politics, Policy and Law* 40, no. 4: 875–86.

Fisher, Elliott, and Janet Corrigan. 2014. "Accountable Health Communities: Getting There from Here." *JAMA* 312, no. 20: 2093–94.

Fisher, Elliott, Mark McClellan, John Bertko, Steven Lieberman, Julie Lee, Julie Lewis, and Jonathan S. Skinner. 2009. "Fostering Accountable Health Care: Moving Forward in Medicare." *Health Affairs* 28, no. 2: w219–w231.

Fuchs, Victor. 1997. "Managed Care and Merger Mania." *JAMA* 277, no. 11: 920–21.

Gaynor, Martin. 2011. Statement made to U.S. House, Committee on Ways and Means, Subcommittee on Health. 112th Cong., 1st sess., September 9.

Gaynor, Martin. 2014. "Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze." *Health Affairs* 33, no. 6: 1088–93.

Gaynor, Martin, and Robert Town. 2012. "The Impact of Hospital Consolidation—Update." Synthesis Project, Policy Brief No. 9. Princeton, NJ: Robert Wood Johnson Foundation.

Ginsburg, Paul B. 2010. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." Research Brief No. 16. Washington, DC: Center for Studying Health System Change.

Ginsburg, Paul B., and L. Gregory Pawlson. 2014. "Seeking Lower Prices Where Providers Are Consolidated: An Examination of Market and Policy Strategies." *Health Affairs* 33, no. 6: 1067–75.

Greaney, Thomas L. 2013. Prepared statement before U.S. House, Committee on the Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law. 113th Cong., 1st sess., September 19.

Greaney, Thomas L. 2014. "Regulators as Market-Makers: Accountable Care Organizations and Competition Policy." *Arizona State Law Journal* 46, no. 1: 1–40.

Havighurst, Clark. 2006. "Contesting Anticompetitive Actions Taken in the Name of the State: State Action Immunity and Health Care Markets." *Journal of Health Politics, Policy and Law* 31, no. 3: 587–607.

HCCI (Health Care Cost Institute). 2013. "Health Care Cost and Utilization Report." Washington, DC: HCCI.

Hester, James A., and Paul V. Stange. 2014. "A Sustainable Financial Model for Community Health Systems." Discussion paper. Washington, DC: Institute of Medicine.

Keeler, Emmett B., Glenn A. Melnick, and Jack Zwanziger. 1999. "The Changing Effects of Competition on Nonprofit and For-Profit Hospital Pricing Behavior." *Journal of Health Economics* 18, no. 1: 69–86.

Leibenluft, Robert F. 2013. "Possible Defenses to Antitrust Challenges to Provider Consolidation." Paper presented at the Catalyst for Payment Reform "National Summit on Provider Market Power," Washington, DC, June 11.

Leibenluft, Robert F. 2015. "Antitrust and Provider Collaborations: Where We've Been and What Should Be Done Now." *Journal of Health Politics, Policy and Law* 40, no. 4: 847–74.

Magnan, Sanne, Elliott Fisher, David A. Kindig, George J. Isham, Doug Wood, Mark Eustis, Carol Backstrom, and Scott Leitz. 2012. "Achieving Accountability for Health and Health Care." White Paper. Bloomington, MN: Institute for Clinical Systems Improvement. www.icsi.org/_asset/hkt4a4/Accountable-Health-Communities-White-Paper.pdf.

Martin, Anne, Micah Hartman, Lekha Whittle, Aaron Catlin, and the National Health Expenditure Accounts Team. 2014. "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year." *Health Affairs* 33, no. 1: 67–77.

Massachusetts Attorney General. 2010. "Examination of Health Care Cost Trends and Cost Drivers." Report for annual public hearing. Boston: Office of Attorney General Martha Coakley.

McDonough, John E. 1997. "Tracking the Demise of State Hospital Rate Setting." *Health Affairs* 16, no. 1: 142–49.

McKellar, Michael R., Sivia Naimer, Mary Beth Landrum, Teresa B. Gibson, Amitabh Chandra, and Michael E. Chernew. 2014. "Insurer Market Structure and Variation in Commercial Health Care Spending." *Health Services Research* 49, no. 3: 878–92.

MedPAC (Medicare Payment Advisory Commission). 2011. "Variation in Private Sector Payment Rates." Chap. 7 in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

MedPAC (Medicare Payment Advisory Commission). 2014. "Hospital Inpatient and Outpatient Services." Chap. 3 in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

Melnick, Glenn A., Yu-Chu Shen, and Vivian Wu. 2011. "The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices." *Health Affairs* 30, no. 9: 1728–33.

Morrison, Ian. 2013. "Why Some ACO Pioneers Turned Back." *Hospitals and Health Networks Daily*, September 3.

Murray, Robert. 2009. "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience." *Health Affairs* 28, no. 5: 1395–1405.

NASI (National Academy of Social Insurance). 2015. *Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets*. Washington DC: NASI. www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf.

National Conference of State Legislatures. 2014. "Certificate of Need: State Health Laws and Programs." www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx?.

Noble, Douglas J., and Lawrence P. Casalino. 2013. "Can Accountable Care Organizations Improve Population Health? Should They Try?" *JAMA* 309, no. 11: 1119–20.

Office of the Health Insurance Commissioner. 2010. "Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island." Cranston, RI: Office of the Health Insurance Commissioner.

O'Malley, Ann, Amelia Bond, and Robert Berenson. 2011. "Rising Hospital Employment of Physicians: Better Quality, Higher Costs?" Issue Brief No. 136. Washington, DC: Center for Studying Health System Change.

Rajkumar, Rahul, Ankit Patel, Karen Murphy, John M. Colmers, Jonathan Blum, Patrick Conway, and Joshua Sharfstein. 2014. "Maryland's All-Payer Approach to Delivery-System Reform." *New England Journal of Medicine* 370, no. 6: 493–95.

Rhodes, Barrie Markham. 2004. "From Viking Warrior to English King—Canute (Knud) the Great." The Viking Network, viking.no/e/people/e-knud.htm.

Robinson, James C. 2001. "Physician Organization in California: Crisis and Opportunity." *Health Affairs* 20, no. 4: 81–96.

Robinson, James C. 2004. "Consolidation and the Transformation of Competition in Health Insurance." *Health Affairs* 23, no. 6: 11–24.

Robinson, James C. 2011. "Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration." *Health Affairs* 30, no. 7: 1265–71.

Robinson, James C., and Kelly Miller. 2014. "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California." *JAMA* 312, no. 16: 1663–69.

Romano, Patrick, and David Balan. 2011. "A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare." *International Journal of the Economics of Business* 18, no. 1: 45–64.

Rosenthal, Elizabeth. 2014a. "After Surgery, Surprise $117,000 Medical Bill from Doctor He Didn't Know." *New York Times*, September 21.

Rosenthal, Elizabeth. 2014b. "Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not." *New York Times*, September 29.

Sutherland, Jason M., Elliott Fisher, and Jonathan S. Skinner. 2009. "Getting Past Denial—the High Cost of Health Care in the United States." *New England Journal of Medicine* 361, no. 13: 1227–30.

True, Morgan. 2014. "Vermont to Launch Global Budget Pilot for Hospitals." *Vermont Digger*, April 14.

Vogt, William B., and Robert Town. 2012. "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Research Synthesis Report No. 9. Updated. Princeton, NJ: Robert Wood Johnson Foundation.

Weissman, Joel, Michael Bailit, Guy D'Andrea, and Meredith B. Rosenthal. 2012. "The Design and Application of Shared Savings Programs: Lessons from Early Adopters." *Health Affairs* 31, no. 9: 1959–68.

Westcott, Kathryn. 2011. "Is King Canute Misunderstood?" *BBC News Magazine*, May 26. www.bbc.co.uk/news/magazine-13524677.

White, Chapin, Amelia Bond, and James Reschovsky. 2013. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." Research Brief No. 27. Washington, DC: Center for Studying Health System Change.

Young, Gary J., Chia-Hung Chou, Jeffrey Alexander, Shoou-Yih Daniel Lee, and Eli Raver. 2013. "Provision of Community Benefits by Tax Exempt U.S. Hospitals." *New England Journal of Medicine* 368, no. 16: 1519–27.

Zuckerman, Stephen, Timothy Waidman, Robert Berenson, and Jack Hadley. 2010. "Clarifying Sources of Geographic Differences in Medicare Spending." *New England Journal of Medicine* 363, no. 1: 54–62.