

2015

The ACA, Provider Mergers and Hospital Pricing: Experimenting with Smart, Lower-Cost Health Insurance Options

Susan A. Channick
California Western School of Law, sac@cwsl.edu

Follow this and additional works at: <https://scholarlycommons.law.cwsl.edu/fs>



Part of the [Health Law and Policy Commons](#), and the [Insurance Law Commons](#)

Recommended Citation

Susan Adler Channick, *The ACA, Provider Mergers and Hospital Pricing: Experimenting with Smart, Lower-Cost Health Insurance Options*, 6 *William & Mary Policy Review* 1 (2015).

This Article is brought to you for free and open access by CWSL Scholarly Commons. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of CWSL Scholarly Commons. For more information, please contact alm@cwsl.edu.

THE ACA, PROVIDER MERGERS AND HOSPITAL PRICING: EXPERIMENTING WITH SMART, LOWER-COST HEALTH INSURANCE OPTIONS

Susan Adler Channick¹

This paper addresses the issue of whether the recent significant uptick in provider mergers and the implementation of the Affordable Care Act have a particularly adverse effect on provider pricing in the commercial insurance market. Uncompetitive provider markets exacerbate already existing high cost issues such as lack of transparency in provider pricing, patient behavior that conflates reputation and quality, and payers' inability, or at least reluctance, to exclude high-price providers from their networks. The ACA's incentives for providers to coordinate patient care and hospitals' revenue losses from reductions in Medicare reimbursement create further rationales for consolidation. The burden of finding solutions to high non-transparent provider pricing is on all stakeholders who should be experimenting in earnest with remedies for the harms that high health care costs create for patients. But no stakeholders have more incentive to find solutions than those who ultimately pay for health care: the insurers, the employers, governments and individuals. The recent literature is replete with payer experiments in insurance design that are intended to provide smart, lower-cost options for consumers and may influence provider behavior as well. More experimentation with remedial measures is warranted and appears to be ongoing even among providers who also see the proverbial handwriting on the wall. The ACA promises health care security by creating near-universal, affordable, adequate health care. The work continues to achieve these goals.

I. INTRODUCTION

In the past four years, hospital merger and acquisition activity has again been on the rise after a period of relative quiescence. The anticipated effects of the Affordable Care Act on hospital reimbursement and the impact of an already consolidated payer market are pushing both for-profit and nonprofit hospitals toward consolidation in order to survive.² While the hospital market had already experienced a wave of consolidation in the early 1990s in response to the power of private payers to negotiate high-risk, low reimbursement managed care contracts,³ the current provider reimbursement environment is creating additional downward pressures that have

¹ Professor, California Western School of Law; B.A., Cornell University; J.D., California Western School of Law; M.P.H., Harvard University

² Chris Myers and Jason Lineen, "Hospital Consolidation Outlook: Surviving in a Tough Economy," Hospital Financial Management Association, November 2009, http://www.navigant.com/~media/WWW/Site/Insights/Healthcare/Hospital%20Consolidation%20Outlook_Healthcare.ashx.

³ Gerald Adolph et al., "The Coming Surge in Health Provider M&A: How Historical Forces and Healthcare Reform Will Combine to Drive Activity," Strategy& (formerly Booz & Company), 2012.

affected hospitals' bottom lines.⁴ The ACA's new reimbursement models reward providers for developing coordinated patient care models to replace the fragmented, fee-for-service reimbursement model that has been the hallmark of Medicare since its inception. Both Medicare and commercial payers are reimbursing providers for integrated care providing an impetus for both horizontal and vertical provider integration in order to achieve economies of scope as well as scale.⁵

While mergers could be a boon for hospitals by creating efficiencies of scale and scope, mergers have been shown to lead to higher prices for consumers. Studies on hospital pricing suggest that expensive hospitals are often the result of patient demand for the "must-have" hospitals that are usually either part of a large consolidated health system or have a university affiliation, or offer unique Level I services.⁶ A number of studies have demonstrated that the imbalance in power between consolidated providers and payers leads to higher health care costs for consumers.⁷ Martin Gaynor, professor of economics and health policy at Carnegie Mellon University, has testified before the House Committee on Ways and Means Health Subcommittee that, "The research evidence shows that providers in more concentrated markets charge higher prices to private payers, without accompanying gains in efficiency or quality."⁸ Higher-priced concentrated provider markets appear to be a result of hospitals consolidating in order to provide coordinated, integrated care at greater efficiencies.⁹ For legislation that seeks to bend the health care cost curve, the incentives of the ACA may actually be driving the costs of health care higher. And, if Professor Gaynor's data are accurate, higher prices do not result in any value added for the patient or for the system.

Recent studies have also shown an increase in hospital acquisitions of physician practices in order to be prepared for the coming integration of the health care delivery system.¹⁰ A 2011 report found that "[m]ore than half of practicing physicians are now employed by hospitals or integrated delivery systems, a trend fueled by the intended creation of accountable care organizations (ACOs) and the prospect of more risk-based payment approaches."¹¹ From a health care delivery perspective, this trend toward vertical integration supports the goal of coordinated care; from a market perspective it is troubling because it further consolidates the provider market,

⁴ Jeff Goldsmith suggests that forces other than the ACA are at work. Cuts in Medicare reimbursement as well as a concerted push by Medicare to reclassify sub-acute admissions as observation stays increasing observation stays by 34% and decreasing acute admissions have by almost 8%. Jeff C. Goldsmith, "Can Hospitals Survive? Part II," *The Health Care Blog*, March 13, 2014.

⁵ Laura Summer, "Integration, Concentration, and Competition in the Provider Marketplace," 2010, https://www.academyhealth.org/files/publications/AH_R_Integration%20FINAL2.pdf.

⁶ Robert A. Berenson et al., "The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed," 31 *Health Affairs* 973 (2012).

⁷ Martin Gaynor and Robert Town, "The Impact Of Hospital Consolidation – Updates," Robert Wood Johnson Foundation, June 2012, summarizing hospital concentration studies since 2006 for an association between hospital concentration and prices.

⁸ *Health Care Industry Consolidation: Hearing before the Subcommittee on Health of the House Committee on Ways and Means*, September 9, 2011, (statement of Martin Gaynor) http://waysandmeans.house.gov/uploadedfiles/gaynor_testimony_9-9-11_final.pdf.

⁹ Martin Gaynor, "Competition Policy In Health Care Markets: Navigating the Enforcement and Policy Maze," 33 *Health Affairs* 1088 (2014).

¹⁰ Scott Baltic, "Monopolizing Medicine: Why hospital consolidation may increase healthcare costs," *Medical Economics* (2014).

¹¹ Robert Kocher, M.D. and Nikhil Sahni, "Hospitals' Race to Employ Physicians – The Logic behind a Money-Losing Proposition," *The New England Journal of Medicine* 364, 19 (2011): 1790.

creating market power that converts into less competition and higher prices for payers who are ultimately individual purchasers and employees.¹² While there is little argument in the health care community that integrated care can be value-added, the fear that provider integration will become market concentration seems well-founded.¹³

The question that this paper addresses is what can be done to remediate the effects of both existing and future market concentration on the price of health care. Antitrust legislation can often prevent illegal market dominance, but it cannot prevent integration that is lawful, nor can it prohibit the legal monopolist from charging whatever prices it can obtain from its market dominance.¹⁴ In addition, antitrust law generally is ineffective in undoing monopolistic transactions that have already created high-priced health care markets.¹⁵ Ensuring affordable health care is essential not only to the success of the ACA but also to the success of the United States in constraining the growth of health care spending. Although there are many variables to health care spending, there is little doubt that provider pricing is key.¹⁶

II. HEALTH CARE SPENDING AND THE ECONOMY

Health care spending is a key component of any industrialized country's economy. The benefits of a robust health care system are many, most importantly ensuring healthy and productive lives for its population.¹⁷ Mature health care systems are costly but none as costly as the U.S. health care system.¹⁸ The 2013 spending for the United States both in the public and private sectors was \$2.9 trillion, accounting for 17.4% of gross domestic product, as reported by the Centers for Medicare and Medicaid Services.¹⁹ Unlike other sectors of the U.S. economy, a large portion of this spending is publicly funded, i.e., the federal government and the states bear at least some portion of the costs of health care. The burden of high health care costs has already had a powerful impact on state and federal budgets in the public sector²⁰ and on employers, employees, and individuals in the private sector.²¹ Health economists have long recognized the need to "bend the cost curve" by controlling the rate of health care cost growth.

¹² Diane Kiehl, *Driving Meaningful Changes*, Hearing before the Subcommittee on Health of the House Committee on Ways and Means, September 2011 (statement of Diane Kiehl) http://waysandmeans.house.gov/uploadedfiles/kiehl_testimony_9-9-11_final.pdf.

¹³ David Balto, *Health Industry Consolidation*, Hearing before the Subcommittee on Health of the House Committee on Ways and Means, September 2011, (statement of David Balto) http://waysandmeans.house.gov/uploadedfiles/balto_testimony_9-9-11_final.pdf.

¹⁴ Martin Gaynor, "Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze," 33 *Health Affairs* 1088 (June 13, 2014).

¹⁵ *Id.*

¹⁶ Gerard F. Anderson et al., "It's The Prices, Stupid: Why The United States Is So Different From Other Countries," 22 *Health Affairs* 3 (2003): 89.

¹⁷ David A. Squires, "Explaining High Health Care Spending In The United States: An International Comparison Of Supply, Utilization, Prices, And Quality," 2012, <http://www.commonwealthfund.org/publications/issue-briefs/2012/may/high-health-care-spending>.

¹⁸ OECD Health Data 2012, "U.S. Health Care System From An International Perspective," 2012, http://www.oecd.org/unitedstates/HealthSpendingInUSA_HealthData2012.pdf.

¹⁹ Centers for Medicare & Medicaid Services, "National Health Expenditures 2013 Highlights," 2014 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

²⁰ Susan A. Channick, "Taming the Beast of Health Care Costs: Why Medicare Reform Alone is Not Enough," 21 *Annals of Health Law* 89 (2012).

²¹ Karen Pollitz et al., "Medical Debt Among People With Health Insurance," 2014, <http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/>.

The Affordable Care Act, enacted primarily to expand access to affordable, adequate health care to almost all Americans, also includes a number of initiatives intended to slow down the rise in health care costs. Many of these measures either directly or indirectly target reimbursement to providers, particularly hospitals.²² In addition, the recent federal budget compromise continues the two percent cut to Medicare reimbursement rates as a result of the 2012 sequester.²³ Whether or not measures in the ACA that were included to affect the future cost of health care will provide a permanent solution to rising health care growth rates is, as yet, an unanswered question. To a large extent, the answer to this question requires more complete implementation of these measures and an examination of the cost outcomes data. However, hospitals, feeling the immediate or anticipated reduction in revenue, are making structural changes to their budgets to ameliorate the effects of reduced revenue.²⁴ They are also taking steps to aggregate market power in order to prevail in reimbursement negotiations with commercial payers by engaging in both horizontal and vertical integration measures.²⁵

Structural changes to budget may be required in difficult economic times, but market consolidation is not a strategy that is efficient in many markets.²⁶ The question is whether health care provider consolidation should be encouraged for its coordination efficiencies or constrained because of the likelihood of market consolidation inefficiencies. While the goal of integration, particularly horizontal integration, is to increase efficiencies by economies of scale and scope, a not-so-unintended consequence may be a concomitant rise in health care costs as a result of market concentration. The policy of the ACA in favor of delivering coordinated care invites different levels of providers like hospitals, physician groups, and clinics to integrate in order to create health care delivery efficiencies. These vertical integrations are thought by some to add to the provider market concentration problem. As has been previously noted by some health policy experts, “It appears that the main purpose of health care entities in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen negotiating power over purchasers in the private sector.”²⁷

The findings of the IOM that post-hospitalization costs drive Medicare cost variations strengthens the arguments in favor of more coordinated care for Medicare and perhaps Medicaid where the payers set the price.²⁸ Indeed, the IOM report advocates in favor of the adoption and more wide-spread use of various payment reforms such as value-based payments that should incentivize coordinated care with improved outcomes rather than fragmented care and overuse,

²² Donald Sjoerdsma, “The Affordable Care Act Ushered in Billions in Provider Payment Cuts,” *The Medicare Newsgroup*, March 22, 2013, <http://www.medicarenewsgroup.com/context/understanding-medicare-blog/understanding-medicare-blog/2013/03/22/the-affordable-care-act-ushered-in-billions-in-provider-payment-cuts>.

²³ Paul Sisson, “Hospitals Fight Budget Deal’s Medicare Cuts,” *San Diego Union Tribune*, December 15 2013.

²⁴ Toby Cosgrove, “The Great Consolidation Begins,”

<https://www.linkedin.com/pulse/20130311203646-205372152-the-great-consolidation-begins>, March 11, 2013.

²⁵ Julie Creswell and Reed Abelson, “New Laws and Rising Costs Create a Surge of Supersizing Hospitals,” *New York Times*, August 12, 2013.

²⁶ Because the health care market is so different from other markets, the policies of consolidation are not so easily dealt with. In other markets such as retail and Internet, anti-competition policy sets the boundaries for monopolistic behavior. In the health care market, where provider consolidation has been determined to have real value, should the growth of hospital systems continue to be encouraged? David M. Cutler and Fiona S. Morton, “Hospitals, Market Share, and Consolidation,” 310 *JAMA* 1964 (2013).

²⁷ Barak D. Richman and Kevin A. Schulman, “A Cautious Path Forward on Accountable Care Organizations,” 305 *JAMA* 602 (2011).

²⁸ Joseph P. Newhouse et al., “Variation in Health Care Spending: Target Decision Making, Not Geography,” *The National Academies Press* (2013).

underuse and misuse of health care resources.²⁹ Surely a more clinically integrated health delivery system should be the goal in the private payer sector as well. But, as the IOM report on variation in health care spending demonstrates, cost of care variation in the private sector is driven more by financial integration and market power than by lack of clinical integration. Indeed, financial integration and market power is a common response of many private providers, particularly hospitals, to the current assault on their bottom lines by provisions in the Affordable Care Act that were enacted for the purpose of reducing unnecessary health care costs.³⁰ The particular conundrum posed by the ACA's incentives toward delivery and reimbursement systems reform is that Accountable Care Organizations, particularly those that are hospital-based, will serve both Medicare and commercially-insured populations. Health policy makers will need to consider both the value of coordinated delivery modalities to provide better outcomes at lower costs and the potential for mischief by concentrated provider markets to increase prices and raise costs.

The question of whether reduced competition really drives up costs is difficult to assess in a complex market like health care where the consumer is generally indifferent to the price of services because of the effect of a third-party payer, the insurer, and the real cost of the service is unavailable to the consumer because of the lack of transparency of health care pricing, particularly hospital pricing.³¹ However, recent studies indicate that hospital prices are higher in concentrated health provider markets.³² Payers in such markets lack sufficient bargaining power to say no to “must-have” hospitals whose size and reputation create demand for their inclusion in provider networks. One of the fears about consolidated markets is how continued provider leverage with payers will affect the ACA's mandate to provide less expensive, higher quality care through coordinated delivery methods. If hospital pricing continues to rise, higher prices for health care services may simply offset any savings that can be achieved by coordinated provider care models.³³

While promising cost control measures have been attempted in the past, none has had a permanent effect on the rate of rise in health care costs. In the wake of the late 1990s Managed Care backlash, which had successfully controlled costs for a limited time, the average yearly growth rate of real health spending again began to rise.³⁴ In the decade from 1998 and 2008, the average annual rate of growth of total health care expenditures (NHE) was seven percent. In 2007, coincident with the Great Recession, the rate of growth dropped to six percent, and in 2008, to 4.4 percent.³⁵ The CMS Office of the Actuary reported recently that from 2009 – 13, the rate of growth of NHE remained stable at somewhere between 3.6 – 3.8 percent annually, making the

²⁹ *Id.*

³⁰ *Id.*

³¹ Recently, HHS has disclosed both hospital pricing and physician reimbursement based on Medicare billing data. Margaret D. Tocknell, “CMS Releases Hospital Pricing Data,” *Healthleaders Media*, May 9, 2013; Christopher Weaver, “Small Slice of Doctors Account for Big Chunk of Medical Costs,” *Wall Street Journal*, April 9, 2014.

³² Gaynor and Town, *supra* note 7.

³³ David Dranove, “Viewing Health Care Consolidation through the Lens of the Economics of Strategy,” March 2010, <http://www.academyhealth.org/files/publications/HCFORreportMarch2010.pdf>.

³⁴ The average growth rate is stated in terms of real health spending deflated by the GDP deflator published by the National Bureau of Economic Analysis. Amitabh Chandra et al., “Is This Time Different? The Slowdown in Healthcare Spending,” 2013 <http://www.nber.org/papers/w19700>.

³⁵ Robert Pear, “Health Spending Rises in 2008, but at Slower Rate,” *New York Times*, January 5, 2010.

growth in the past four years the slowest ever recorded in the fifty-three-year history of the National Health Expenditure Accounts.³⁶

Therefore, it is somewhat ironic that as the ACA is being fully implemented, both the growth rate of health care costs and the rate of health care price inflation are the lowest in decades with predictions of continued moderation for the next decade.³⁷ Some economists like Peter Orszag, the former director of both the Congressional Budget Office and the Office of Management and Budget during President Obama's first term, attribute at least some of the decline in the health cost curve to the ACA.³⁸ There is not, however, unilateral agreement on this interpretation of these data and the reason for the declines remains an open question. Other health care economists attribute the drop in growth to the recent slowdown in the economy, an interpretation that means that the growth rate may start rising again as the economy recovers.³⁹ And in a recent article in the journal *Health Affairs*, the authors conclude that “most of the recent slowdown in health care spending, at least among the working population, can be attributed to the economic slowdown and not to other factors such as early responses to the ACA.”⁴⁰

Still others argue that the rise in health care spending has really not changed at all, arguing that health care expenditure growth has always represented a remarkably stable 30 percent of GDP growth.⁴¹ While it seems unlikely that the ACA has had sufficient time to significantly impact health care costs, proponents of the ACA-connection theory like Orszag argue that proposed changes to reimbursement may be sufficient in themselves to drive down the rate of growth of health care costs.⁴² In other words, providers are becoming fiscally leaner and meaner in response to the fear and reality of diminishing reimbursement from payers in both the public and private sectors.

The decrease in NHE growth rates is, of course, good news to a country that spends a significant portion of GDP on health care. They are particularly good news in the public sector where the money to finance health care costs is finite. As has been explained in past literature, Congress allocates a relatively set share of GDP for federal spending, usually no more than 18 percent, of which Medicare's share for 2014 is calculated to be 16 percent.⁴³ With an assumed 2014 federal budget allocation of \$3.8 trillion, the CBO's 2013 budget projection of Medicare's share is somewhere in the range of \$600 billion, surely not an insignificant expenditure.

³⁶ Gary Claxton et al., “Health Benefits in 2014: Stability in Premiums and Coverage for Employer-Sponsored Plans,” *Health Affairs Online* (2014), <http://content.healthaffairs.org/content/early/2014/09/05/hlthaff.2014.0792>; Anne B. Martin et al., “National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year,” 33 *Health Affairs* 67 (2014).

³⁷ David M. Cutler and Nikhil R. Sahni, “If Slow Rate of Health Care Spending Persists, Projections May Be Off By \$770 Billion,” 32 *Health Affairs*. 841 (2013).

³⁸ Aaron Task, “Obamacare Working Even Better Than Peter Orszag Expected,” *The Daily Ticker*, September 9, 2013.

³⁹ *Containing Health Care Costs: Recent Progress and Remaining Challenges: Hearing before the S. Comm. on the Budget*, July 30, 2013, (statement of Joseph Antos), http://www.budget.senate.gov/democratic/public/_cache/files/46057500-e051-4074-80ab-afc01b9d230f/07-30-13-antos-sbc-containing-health-costs.pdf.

⁴⁰ David Dranove et al., “Health Spending Slowdown is Mostly Due to Economic Factors, Not Structural Change in the Health Care Sector,” 33 *Health Affairs* 1399 (2014).

⁴¹ Charles Roehrig, “Further Thoughts on the Recession and Health Spending,” *Health Affairs Blog*, May 7, 2013, <http://healthaffairs.org/blog/2013/05/07further-thoughts-on-the-recessions-and-health-spending/>.

⁴² Louise Radnofsky, “How the ACA May Affect Health Costs,” *Wall Street Journal*, February 23, 2014.

⁴³ Joseph P. Newhouse, “Assessing Health Reform's Impact on Four Key Groups of Americans,” 29 *Health Affairs* 1719, 2010.

However, compared to the \$700 billion CBO 2010 projection for 2014 Medicare spending, a \$100 billion reduction in spending is a remarkable savings.⁴⁴ While Medicare spending over time is certain to rise because of the baby-boomer increased utilization effect, the CBO 2013 projection predicts a rise in Medicare cost growth rate of only .04% holding 2020 Medicare spending to approximately \$850 billion compared to the 2010 projection for Medicare spending of \$1 trillion.⁴⁵ As health care journalist Sarah Kliff says, “If that cost growth persists, it could make all the difference for Medicare: The entitlement program would, by 2085, make up 4 percent of the economy instead of the previously projected 7 percent.”⁴⁶ Lower Medicare spending means more available revenue for discretionary spending and a decreased possibility of large deficits, scenarios that positively affect federal debt. It is also good news to seniors whose out-of-pocket health care spending could be lowered.

Private sector spending has also decreased since the recession to a rate of 3.6 percent.⁴⁷ The real question is why. Has the cost curve really flattened or is reduced spending in the private sector an artifact of lower demand attributable both to a slow-growth economy and structural changes in the health care system including the design of insurance products?⁴⁸ The shifting of costs from employers to employees and the burden of high deductible insurance on individuals is blamed for a reduction in health care utilization, particularly in lean economic times, and concomitantly lower rates of health care spending growth.⁴⁹ As the economy improves, the question remains whether a more robust economy will also raise health care utilization. A number of economists have demonstrated that, while Medicare spending growth appears untethered to GDP growth, private health insurance is very strongly associated with GDP growth.⁵⁰ As the economy continues to improve, employers and employees with more discretionary dollars may again be willing to absorb the burden of higher commercial health insurance costs resulting in increased utilization, perhaps higher health care price inflation, and an upward tick in NHE.⁵¹

The \$2.8 trillion question is whether this exceptionally low growth rate is sustainable. While, as previously noted, it is yet unclear what effect the ACA has had on health care costs, Medicare reimbursement is more likely to have already been impacted by changes made by the

⁴⁴ Congressional Budget Office, “Updated Budget Projection: Fiscal Years 2013 To 2023,” May 2013; Congressional Budget Office, “The Budget and Economic Outlook: Fiscal Years 2010 to 2010,” January 2010.

⁴⁵ *Id.*

⁴⁶ Sarah Kliff, “Want to Debate Medicare Costs? You Need to See This Chart First,” *Washington Post Wonkblog*, March 15, 2015, www.washingtonpost.com/blogs/wonkblog/wp/2013/03/15/want-to-debate-medicare-costs-you-need-to-see-this-chart-first/.

⁴⁷ The most recent findings by the Kaiser Family Foundation survey of employers’ health benefits just reported that employer-sponsored health insurance premiums rose only three percent from last year but employee deductibles rose. How much of the decrease in premiums is due to containing health care costs versus higher deductibles is the real story here. Kaiser Family Foundation, “Employer Health Benefits 2014 Annual Survey,” 2014.

⁴⁸ There is substantial controversy over identifying causes of the recent slowdown in health care spending as between the recession and structural changes to the health care system. Jordan Rau, “2 Studies Assert Lower Spending Growth is Due to Structural Health Changes,” Kaiser Family Foundation, May 6, 2013.

⁴⁹ *Id.*

⁵⁰ Andrea M. Sisko et al., “National Health Expenditure Projections, 2013–2023: Faster Growth Expected With Expanded Coverage and Improving Economy,” *Health Affairs Online* (September 2014), <http://content.healthaffairs.org/content/early/2014/08/27/hlthaff.2014.0560.full.pdf+html>.

⁵¹ Even with an improvement in the economy, employers may not be willing to finance rich health plan costs as they have done in the past, particularly if plans back up against the so-called Cadillac plan excise tax. Julie Piotrowski, “Excise Tax on ‘Cadillac’ Plans,” *Health Affairs Health Policy Briefs* (January 7, 2013).

ACA than any other sector. As reported by Kronick and Po, the Affordable Care Act contributes significantly to the reduction in Medicare cost inflation “and is the primary cause of the projections of continued slow growth of Medicare spending over the next decade.”⁵² If the Medicare cost projection assumption is true,⁵³ and if price inflation in the healthcare private sector can be correlated with the Medicare sector, there is some reason to believe that this time really is different. However, economists generally agree that Medicare spending and private commercial health care spending are not correlated; spending in the commercial sector is affected by other factors such as economic growth and the change in health insurance design, neither of which affect Medicare spending.⁵⁴

In fact, there is substantial confusion about whether health care spending is continuing to trend downward or is starting to drift upward again after 14 years of relatively low growth. A recent article in the journal *Health Affairs*, reporting on low growth in the rate of health spending, argues that the relative stability of growth since 2009 primarily reflects the lagged impacts of the recent severe economic recession with the Affordable Care Act having minimal impact.⁵⁵ The article reports an uptick in personal health spending based on data from the CMS Office of the Actuary of .04% from 2011 to 2012 influenced primarily by hospital services for which spending increased 4.9 percent in 2012 compared to 3.5 percent in 2011.⁵⁶ Since the publication in *Health Affairs*, others have reported similar upticks in health care spending driven primarily by an increase of \$8 billion in hospital revenue in the fourth quarter 2013, more than in the past four quarters combined.⁵⁷

The Altarum Institute Center for Sustainable Health Spending reports data that support the conclusion that health care costs are again rising. Its report demonstrates that NHE in January 2014 grew 6.2% year-over-year, and February 2014 growth was 6.7% year-over-year, the highest growth rate observed since March 2007.⁵⁸ Altarum believes that this uptick in spending is not the result of the newly insured under the ACA; its data has spending growth rising well before January 2014 when the applicable provisions of the ACA went into effect.⁵⁹ Hospitals and prescription drugs experienced the highest growth rates year-over-year from 2013 – 2014; hospital spending grew by more than eight percent and prescription drug spending by 9.3 percent.⁶⁰ What effect the ACA will have on health care spending requires more data that specifically reflects ACA initiatives, and is yet unknown, but the uptick in prices prior to implementation of the ACA suggests that other forces may be exerting upward pressure on spending.⁶¹ Altarum has since moderated its predictions for rising national health spending from 6.2% year-over-year to 4.8% based on revised spending data from the Bureau of Economic

⁵² Richard Kronick and Rosa Po, “Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows,” Department of Health & Human Services, 2013.

⁵³ Adrianna McIntyre, “Orszag: It’s time for some optimism about health care spending,” *Vox*, June 27, 2014, <http://www.vox.com/2014/6/15/5807046/orszag-its-time-for-some-optimism-about-health-care-spending>.

⁵⁴ *Id.*

⁵⁵ See generally Martin, *supra* note 36.

⁵⁶ *Id.* at 69.

⁵⁷ Paul Davidson, “Health care spending growth hits 10-year high,” *USA Today*, April 1, 2014.

⁵⁸ Altarum Institute Center For Sustainable Health Spending, “Spending Brief #14-04: February 2014 Data,” 2014.

⁵⁹ *Id.*

⁶⁰ *Id.* at 2.

⁶¹ *Id.*

Analysis. Although spending is growing more moderately than earlier predicted, there are still indicators that the health care cost curve is likely to rise more steeply in the near future.⁶²

PricewaterhouseCoopers (PwC) released a report that similarly predicts continued health care spending growth, predicting 6.5% in 2014 and 6.8% in 2015.⁶³ PwC attributes a higher growth rate to a stronger economy, rising pharmaceutical pricing because of advances in very expensive specialty prescription drugs, physician employment by hospitals, and, of course, increased utilization of health care services as a result of increasingly larger pools of people who are insured as a result of the ACA. Higher utilization is then compounded by the effect of higher hospital pricing in markets that have become uncompetitive due to hospital market concentration. In such a situation, the only ways to lower health care spending is to disincentivize usage or find ways to reduce the price of health care.

These predictions of an upswing in health care spending were predicated based on early estimates by the Bureau of Economic Analysis of 2014 first quarter health care spending. Initially, the BEA had estimated a 9.9 percent increase in health care spending in first quarter 2014; in its final estimate, health care spending declined by 1.4 percent in the quarter.⁶⁴ The BEA attributed this unusually large discrepancy to the fact that Commerce Department does not release its QSS for first quarter, the BEA's main health care spending survey, until June, and noise created by the expansion of the insurance coverage under the ACA in first quarter 2014.⁶⁵ The unexpected drop in health care spending is primarily responsible for the 2.9 percent decline in GDP, three times steeper than the Department of Commerce's first quarterly GDP estimate.⁶⁶

There are a number of different takes on the decline in health care spending. While the BEA's Jason Furman attributes the slowdown in part to the ACA,⁶⁷ the Wall Street Journal decries "ObamaCare's role in nearly sending the economy back into recession."⁶⁸ Closer to the truth is that no-one yet has a real handle on how the introduction of the ACA has affected health care spending, a forecast that requires multiple data points to resolve. The BEA's second quarter estimate of health care spending was flat at .07 percent increase with a 1.8 percent in health care prices.⁶⁹ While these numbers seem promising, the CEA's Furman warns that they could be subject to massive changes as more data is available. A recent study in the journal *Health Affairs* finds that approximately 70 percent of the slowdown in health spending is explained by the economic slowdown rather than by any structural changes to the health sector including components of the ACA.⁷⁰ If indeed the state of the economy is primarily responsible for recent low health care spending, then a period of steady economic growth should correlate with higher health care spending in the private sector. The question, later addressed in this paper, is whether

⁶² Altarum Institute Center for Sustainable Health Spending, "Anticipated acceleration in health spending seems to be delayed," 2014.

⁶³ PricewaterhouseCoopers Health Research Institute, "Medical Cost Trend: Behind the Numbers," June 2014.

⁶⁴ Jason Furman, "Third Estimate of GDP for the First Quarter of 2014," Council of Economic Advisers, June 25, 2014, www.whitehouse.gov/blog/2014/06/25/third-estimate-gdp-first-quarter-2014.

⁶⁵ *Id.*

⁶⁶ California Healthline, "Unexpected Drop in Health Care Spending Causes 2.9% Decline in GDP," June 26, 2014, www.californiahealthline.org/articles/2014/6/26/unexpected-drop-in-health-care-spending-causes-29-decline-in-gdp.

⁶⁷ Furman, *supra* note 64.

⁶⁸ Opinion, "GDP's ObamaCare DownGrade," *Wall Street Journal*, June 26, 2014.

⁶⁹ Brett Logiurato, "This Chart Shows How Healthcare Spending Estimates in GDP Reports Are A Disaster," *Business Insider*, July 30, 2014.

⁷⁰ David Dranove et al., "Health Spending Slowdown is Mostly Due to Economic Factors, Not Structural Change In the Health Care Sector," 33 *Health Affairs* 1399 (2014).

payers, that is both insurers and employers, have the will to rein in costs caused by excess utilization and high provider pricing and to innovate in ways that do not unfairly shift the costs of health care to the consumer.

III. HOSPITAL PRICING

Of late, the health care cost spotlight has been on hospital pricing. Examining health care pricing is not new but, since prices have recently been identified as the fundamental driver of health care costs, the scrutiny of hospital pricing has become more rigorous and high-profile.⁷¹ In May 2013, the CMS released for the first time hospital pricing data by making public chargemaster data for the 100 most common Medicare DRGs.⁷² The New York Times followed up with a series of articles by Elizabeth Rosenthal on hospital pricing.⁷³ These efforts unveil information strongly associated with the extraordinary cost of health care in the United States. First is simply the exposure of price information; until recently, hospital chargemasters have been closely-guarded secrets not shared with consumers.⁷⁴ In the commercial health insurance world, prices negotiated by providers and insurers are often not transparent because of hospitals', particularly "must-have" hospitals, ability to insist on the inclusion of gag clauses that prevent disclosure of the negotiated prices.⁷⁵ Device makers may also insist on gag clauses in their contracts with providers so that many physicians choosing the appropriate device for their patients have no knowledge of its price.⁷⁶

In addition to the lack of price transparency, the prices themselves are staggering and explain much about why the U.S. spends significantly more on health care than other first-world nations. Adding to high, non-transparent pricing is the triple threat of tremendous variability in pricing which is not just inter- or even intrastate but within the same geographic location. While such a pricing scheme seems inexplicable, there are a number of possible explanations. The "must-have" hospital or health system phenomenon which gives these hospitals extraordinary bargaining power as well as lack of competition because of hospital market concentration and lack of price transparency are some of likely explanations for pricing variability.

Hospitals often argue that chargemaster prices are irrelevant because those prices are rarely assessed or collected.⁷⁷ Medicare and Medicaid payments are set administratively and patients cannot be liable for any "unpaid" balance. Those with commercial insurance benefit from the negotiating power of the insurer and are subject only to negotiated fees.⁷⁸ Only the uninsured or underinsured may be subject to chargemaster pricing. While the number of uninsured may be shrinking because of the insurance requirements of the ACA, the number of

⁷¹ The Dartmouth Atlas of Health Care has, for 20 years, examined the relationship between health care spending and outcomes using data from the Centers for Medicare and Medicaid Services. These data have demonstrated wide variations in regional health care spending in relation to the quality of patient outcomes. *But see* Joseph J. Doyle, "Returns To Local Health Care Spending: Evidence From Health Shocks To Patients Far From Home," 3 *American Economic Journal* 221 (2011).

⁷² "Medicare Provider Utilization and Payment Data," Centers for Medicare and Medicaid Services (2013).

⁷³ Elizabeth Rosenthal, "The \$2.7 Trillion Medical Bill," *New York Times*, June 1, 2013.

⁷⁴ Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us," *Time*, February 2013.

⁷⁵ Maura Calsyn, "Shining Light on Health Care Prices," Center for American Progress, April 3, 2014, <https://www.americanprogress.org/issues/healthcare/report/2014/04/03/87059/shining-light-on-health-care-prices/>.

⁷⁶ *Id.*

⁷⁷ Brill, *supra* note 74.

⁷⁸ Of course, provider concentration gives providers leverage over payers in negotiating prices resulting in both higher health insurance premium costs and higher out-of-pocket costs. *See* text accompanying notes 6-8.

underinsured is increasing due to changes in employer health plan designs that shift the burden of rising health care costs onto the employee.⁷⁹ Enrollment in high-deductible plans has tripled since 2009, a trend that disincentivizes health care utilization by consumers who are the ultimate payers.⁸⁰ The shift in insurance design may tamp down health care costs because of underutilization by consumers who cannot afford it, but at what cost to health?⁸¹ Consumer directed health plans may bring down health care spending as described above, but they will do little to reduce prices or incentivize greater efficiencies unless payers, including consumers, become active purchasers of health care. Otherwise, such plans simply shift the cost burden to consumers who then may opt to forego valuable health care services.

Few facts about hospital pricing seem unambiguous. One factor that seems consistent both to Medicare and commercial insurance is that hospital outpatient departments are the most expensive venues for the delivery of care. Medicare reimbursement for services performed in an outpatient department of a hospital is 80 percent higher than it would be if it had been performed in a physician's office. In 2010, Medicare paid hospitals \$1.3 billion more for just two services – evaluation and management visits, and echocardiograms – than it would have paid if these services had been performed in a physician's office. And in 2011, that number rose to \$1.5 billion.⁸² Location is also a cost imperative for commercial insurance. As noted by a recent study, the result of a collaborative effort by the National Institute for Health Care Reform (NIHCR) and the former Center for Studying Health System Change, “average hospital outpatient department prices for common imaging, colonoscopy, and laboratory services can be double the price for identical services provided in a physician's office or other community-based setting.”⁸³ According to the research brief, hospitals justify the higher payments because of higher overhead costs related to stand-ready capacity for emergencies and additional regulatory requirements imposed by legislation such as EMTALA, the Emergency Medical Treatment and Active Labor Act.⁸⁴ MedPAC estimates that a move toward establishing a single-payer rate for the service regardless of the location of its delivery could save Medicare an estimated \$1 billion to \$5 billion over five years.⁸⁵ Hospitals, whose revenue would be threatened by a fee reduction for hospital out-patient care, are responding as they are to all reimbursement reductions: by acquiring physician practices so that the delivery of health care is done by employed physicians in the

⁷⁹ According to PricewaterhouseCoopers' 2014 Touchstone Survey, 85 percent of employers have already implemented or are considering an increase in employee cost sharing through plan design changes. Eighteen percent of employers now offer a high-deductible health plan as the only insurance option for their employees. PricewaterhouseCoopers, “Medical Cost Trend: Behind the Numbers 2015,” (2014).

⁸⁰ Jay Hancock, “More High Deductible Plan Members Can't Pay Hospital Bills,” *Kaiser Health News*, August 12, 2013.

⁸¹ Amelia Haviland, et al., “Growth of Consumer Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save \$57 Billion Annually,” 31 *Health Affairs* 1009 (2012).

⁸² MEDPAC, “Report to the Congress: Medicare Payment Policy,” Medicare Payment Advisory Commission (2014) at 3.

⁸³ James D. Reschovsky and Chapin White, “Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services,” 16 *National Institute for Health Care Reform* 1 (2014).

⁸⁴ EMTALA, the Emergency Medical Treatment and Active Labor Act, requires that all hospitals with emergency departments that are Medicare providers must screen and stabilize all patients with a medical emergency regardless of their ability to pay. *Keeping the Promise: Site-of Service Medicare Payment Reforms: Hearing before the Subcommittee on Health of House Commission On Energy and Commerce*, May 21, 2014, (statement of the American Hospital Association), available at www.aha.org/advocacy-issues/testimony/2014/140521-testiteneutral.pdf.

⁸⁵ See MEDPAC (2014), *supra* note 82 at 54.

more expensive HOPDs. The NIHCR report states that such practices simply increase growing provider market concentration and exacerbate an already intractable health care pricing scheme.⁸⁶

IV. FRAGMENTATION VERSUS CONSOLIDATION AND THE EFFECT ON HEALTH CARE COSTS

One of goals of the ACA is to effect changes in the delivery and reimbursement of at least those insured by public programs, Medicare in particular, by changing the methods of health care delivery and reimbursement. While experimentation with value-based payment programs has been ongoing for at least a decade prior to the adoption of the ACA, the Act offers financial incentives to providers that adopt delivery system changes that strive for better patient outcomes at lower cost.⁸⁷ Accountable care organizations and other similar delivery models are new delivery paradigms utilizing value-based payment (VBP) that are included in the ACA. These delivery paradigms are intended to incentivize provider coordination in the provision of health care to a defined population and reimbursement on a value-based payment system with shared savings between the providers and the payer.⁸⁸

Under the ACA model, providers receive a global fee for coordinating the patient's care, hopefully resulting in a better outcome for the patient and better value for the payer.⁸⁹ Correlatively, providers may assume a collective risk for fragmented, uncoordinated care that result in higher costs to the payer; in such ACOs, providers have a downside risk but their upside reward is potentially higher than in the traditional ACO.⁹⁰ Through the Medicare Shared Savings Program, providers can share savings that accrue to Medicare as a result of the coordination of the patient's care by the ACO. The promise of increased revenue has incentivized the enrollment of 250 Medicare ACOs as of January 10, 2013 in the MSSP. Already as many as four million, or approximately 10 percent of Medicare beneficiaries, are now covered by an ACO.⁹¹

Although prior experimentation with VBP models has yielded only very modest success in both outcome and cost savings, CMS elected to use the VBP paradigm to achieve the three-pronged goal of the ACA: better health outcomes for patients, healthier populations, and

⁸⁶ Reschovsky and White, *supra* note 83.

⁸⁷ See e.g. "Better, Smarter, Healthier: Health Care Payment Learning and Action Network kick off to advance value and quality in health care," March 25, 2015, <http://www.hhs.gov/news/press/2015pres/03/20150325b.html>.

⁸⁸ The term "Accountable Care Organization" is slippery; it can be broadly or narrowly interpreted. The Putnam Research Associates defines an Accountable Care Organization as a group of health care providers in a care delivery system who agree to accept joint responsibility for the medical care and management as well as the cost and quality outcomes of a designated population of patients to achieve shared goals of better care at a lower total cost. Kevin J. Gorman, "Cutting Through the ACO Confusion," Putnam Associates, 2013. Oliver Wyman defines an ACO as a catch-all term for providers participating in population-oriented, value-based care delivery and reimbursement models. This definition includes only provider organizations that are working under value-based shared savings or risk arrangements on the total cost of care for one or more sets of attributed patients. Niym Ghandi and Richard Weil, "The ACO Surprise," Oliver Wyman, 2012.

⁸⁹ Harold Miller, "The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher-Value Health Care," Network for Regional Healthcare Improvement, April 2015.

⁹⁰ Charles Fiegl, "Medicare pioneer ACOs save money but lose physicians," *American Medical News*, July 2013.

⁹¹ David Muhlestein, "Continued Growth of Public and Private Accountable Care Organizations," *Health Affairs Blog*, February 2013, <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/>.

decreased health care costs.⁹² Starting in 2013, the ACA mandates enactment of the “Hospital Value-based Purchasing Program,” a program that directly ties hospital performance based on a number of key metrics, both clinical and patient satisfaction, to reimbursement rates for Medicare patients.⁹³ Pursuant to the program, Medicare has reduced its payments to all hospitals by one percent but gives hospitals the opportunity to “earn back” the lost revenue if they meet certain metrics.⁹⁴ According to Kaiser Health News, in California in 2012, 44 percent of hospitals received a bonus under the program while 56 percent were penalized.⁹⁵ By 2017, VBP will increase its penalty or bonuses to two percent, and in 2015, the value-based purchasing program will apply to physician groups of 100 or more and to all physicians by 2017.

Commercial health insurers have also jumped on the bandwagon of coordinated care and value-based payment methods.⁹⁶ A recent Blue Cross Blue Shield Association survey of BCBS companies reveals a diverse portfolio of more than 350 locally-developed, value-based programs in 49 states, Washington, D.C., and Puerto Rico making BCBS a market leader in developing and executing VBPs.⁹⁷ So strongly does BCBS believe in the efficacy of payment reform from fee-for-service to value-based purchasing that its 37 independent companies have spent more than \$65 billion – about one in five medical claim dollars – in programs that provide “incentives for better health outcomes for patients while reducing costly duplication and waste in care delivery.”⁹⁸ The value-based purchasing measures “range from medical homes, where doctors may receive an additional fee to better coordinate patient care, to accountable care organizations, or ACOs, where a larger health system shares some of the savings if it can manage patients’ health for less money.”⁹⁹

The so-called accountable care organization model of delivery and reimbursement is designed to shift from a traditionally fragmented system to a more coordinated one that not only improves outcomes but also reduces waste and drives down costs.¹⁰⁰ Commercial insurers recognize that the cost of health care has become intolerable to the ultimate payers - employers, employees and individuals. Employers have increasingly been shifting the cost of health care to their employees, both directly in the form of increased premium and out-of-pocket costs for the employee, and indirectly by paying the increased cost of health insurance in lieu of raising

⁹² Cheryl Damburg et al., “Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions,” Rand Health, 2014.

⁹³ Dan Verel, “Hospitals Adjust to ‘value-based’ Medicare,” *North Bay Business Journal*, February 18, 2013.

⁹⁴ Measuring outcome success for the purpose of hospital payment utilizes twelve clinical metrics including the effectiveness of treatment on heart disease, hospital-borne infections, pneumonia, and diabetes. Seventy percent of the scores are based on clinical measures, while thirty percent will be determined by patient satisfaction surveys including emergency room wait times and physician responsiveness. *Id.*

⁹⁵ Jordan Rau, “Nearly 1500 Hospitals Penalized Under Medicare Program Rating Quality,” *Kaiser Health News*, November 14, 2013.

⁹⁶ Even prior to the introduction of Medicare Pioneer ACOs, 150 commercial accountable care organizations were already in operation and the number has grown. *Id.*

⁹⁷ Blue Cross Blue Shield Association, “Blue Plans Improving Healthcare Quality and Affordability Through Innovative Partnerships with Clinicians,” *Blue Perspective*, 2014, www.bcbs.com/healthcare-news/press-center/BP-and-Quality-and-Plan-Innovations.pdf.

⁹⁸ “Blue Cross and Blue Shield Companies Direct More Than \$65 Billion in Medical Spending to Value-Based Care Programs,” Blue Cross Blue Shield, July 9, 2014, <http://www.bcbs.com/healthcare-news/bcbsa/bcbs-companies-direct-more-than-65b-in-medical-spending-to-value-based-care-programs.html>.

⁹⁹ Reed Abelson, “Health Insurers Are Trying New Payment Models, Study Shows,” *New York Times*, July 9, 2014.

¹⁰⁰ Katherine Baicker and Helen Levy, “Coordination versus Competition in Health Care Reform,” 369 *New England Journal of Medicine* 9 (2013).

employees' compensation. It has long been recognized that increased employer contributions to Employer-Sponsored Insurance (ESI) result in a stagnant compensation system for many workers who, as a result, have been excluded from sharing in the growth of the economy for at least the past decade.¹⁰¹ Recognizing that the costs of health insurance are bumping up against the payers' appetite to pay should drive commercial insurers to find ways to reduce health care costs and concomitantly lower the cost of health insurance.

While it is too soon to make any statistically significant projections on the success of commercial ACOs, there are reports of some success stories. For example, Illinois' largest provider group and health insurer, Advocate Health Care and Blue Cross & Blue Shield of Illinois, joined forces three years ago to form the first and one of the largest commercial ACOs in order to better align financial incentives between the two entities and provide more coordinated care for the participants. In a recent story, Advocate reported data that demonstrated the advantages of coordinated care in reducing the number of hospital admissions and lengths of hospital stays of ACO patients versus patients whose care was managed in a more traditional manner.¹⁰²

The caveat about provider coordination is that, although the ACA and commercial insurers are pursuing ACOs as a pathway to lowering health care costs,¹⁰³ as this article has argued, it has become well-recognized that coordination often generates incentives for consolidation that can reduce competition among providers particularly in ACOs led by hospitals. As has been noted previously in this article, the ACO model contains the potential for a policy conflict. Nudges toward provider consolidation to better provide coordinated patient care have the potential to create a more concentrated provider market. Greater market share has been demonstrated to suppress competition and give large providers a much stronger bargaining position than payers. Providers, led by hospitals, are particularly incentivized to consolidate for the purpose of creating market power against payers in an environment where provider reimbursement is under attack.¹⁰⁴ Coordination can have a perverse effect: while intended to improve outcomes at reduced costs of care, coordination that translates into concentrated markets is known to instead drive up the costs of care.¹⁰⁵ Given the data that posit a rise in health care costs as an unintended consequence of consolidation, the policy and regulatory levers incentivizing coordination should be used carefully and with full awareness of such an outcome.

Fragmentation in the U.S. health care system is pervasive.¹⁰⁶ Access to and financing of health care has always been fragmented - a conglomeration of social insurance, welfare, and private markets. Medicare, the federal insurance program enacted in 1965 that provides health insurance to all eligible American citizens and legal residents 65 and older and the permanently disabled, is a single-payer system that in 2012 provided health insurance at a single price without

¹⁰¹ Harriet Komisar, "The Effects of Rising Health Care Costs on Middle-Class Economic Security," AARP Public Policy Institute, 2013.

¹⁰² Melanie Evans, "Reform Update: Advocate Health Sees Progress with ACO," *Modern Healthcare*, March 26, 2014.

¹⁰³ Shared savings programs now account for two-thirds of Advocate's hospital revenue. *Id.*

¹⁰⁴ Gerald Adolph et al., "The Coming Surge in Health Provider M&A: How Historical Forces and Healthcare Reform will Combine to Drive Activity," *Booz & Co.*, 2012; Julie Creswell and Reed Abelson, "New Law and Rising Costs Create a Surge of Supersizing Hospitals," *New York Times*, August 13, 2013.

¹⁰⁵ Cory Capps and David Dranove, "Market Concentration of Hospitals," Bates White Economic Consulting, 2011.

¹⁰⁶ Einer Elhauge, *Fragmentation of U.S. Health Care: Causes and Solutions*, Oxford Press, 2010.

regard to health status, usage or age to approximately 15.7% of Americans.¹⁰⁷ In the United States, only the elderly and permanently disabled can participate in a public social insurance system. In the same year, Medicaid, the joint federal /state health insurance program for the deserving poor, provided very low-cost or no-cost health insurance to 48 million or 16% of Americans.¹⁰⁸ For populations that constitute the deserving poor, government provides health insurance based on a welfare model. For more than 30% of Americans, health insurance is less a commodity and more a human right.¹⁰⁹ However, for a large portion of the remaining population, private markets, largely regulated by the states, are the source of health insurance which is bought by employers or individuals and sold by private insurance companies, most of which are organized as for-profit entities.

In addition to the fragmentation of access, delivery and provider reimbursement models tend to perversely disincentivize collaboration and cooperation among providers, leading to less efficient and efficacious outcomes.¹¹⁰ The current encounter-based, primarily fee-for-service payment system, which pays providers for what they do, not for what they accomplish, has a distinct tendency to reward unbundling and inefficiency.¹¹¹ While Medicare, the single-payer system for health insurance for the elderly and disabled, sets a unit price for covered services, it traditionally has done little to control the volume of services or make outcome a predicate for payment.¹¹² By paying for each unit of disaggregated service, Medicare reimbursement provides no incentives for providers to coordinate their treatment of the patient. As nicely described by the prestigious Institute of Medicine:

The health care Medicare beneficiaries receive is often fragmented as patients among multiple physicians and across different care settings (e.g., hospital to home care). As a result, patients do not always receive timely care best suited to their needs. Fragmentation is reinforced by the failure of the current payment system to recognize and pay for care coordination.¹¹³

Under the Medicare Shared Savings Program, providers are paid a global fee for patient care. This change in reimbursement is clearly intended to aggregate reimbursement for care across the patient's providers rather than paying each provider a separate disaggregated amount for his or her services. The added nudge to coordinated care is that ACOs that meet quality benchmarks can share in any savings to Medicare from the coordination of care. Unless an ACO is a Pioneer ACO, there is no disincentive for not providing aggregated care. Commercial ACOs

¹⁰⁷ Jennifer Cheeseman Day, "Medicare and Medicaid, Age and Income," U.S. Census Bureau, September 17, 2013.

¹⁰⁸ *Id.*; Medicaid has provided insurance to certain categories of people thought to be the deserving poor: pregnant women, children, parents of covered children, and the aged, blind and disabled whose income and assets have been determined to be categorical poverty. Under the Affordable Care Act (ACA), states may expand their Medicaid programs to include any citizen or legal resident whose income is less than 133% of federal poverty level. At the time of this writing, one-half the states and the District of Columbia have expanded their Medicaid program. Rachel Garfield et al., "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Kaiser Family Foundation, April 17, 2015.

¹⁰⁹ Since Medicare is incomplete insurance, many of those eligible will purchase private supplemental insurance known as Medigap insurance. Such insurance is priced by comprehensiveness of coverage rather than actuarial health statistics. WEBMD, "Medicare: What are Medigap Plans," <http://www.webmd.com/health-insurance/insurance-basics/medigap>.

¹¹⁰ Elhauge, *supra* note 106.

¹¹¹ *Id.*

¹¹² But *see*, Jordan Rau, "Medicare's Pay-For-Performance Effort Begins, Targeting Quality and Readmissions," *Kaiser Health News*, October 1, 2012.

¹¹³ Institute of Medicine, "Rewarding Provider Performance: Aligning Incentives in Medicare," (2007).

have a similar though less restrictive structure and, like Medicare ACOs, they are required to meet a quality benchmark to achieve full payment through shared savings. Although most early ACOs were led by health systems, the recent growth in commercial ACOs is predominantly due to physician rather than health system initiatives.¹¹⁴

While a rational reimbursement system that promotes both provider coordination and better outcomes seems intuitively persuasive, the question of whether ACOs will be successful in achieving these ends is hardly answered. The ACO model had existed prior to the passage of ACA as part of the Medicare Physician Group Practice Demonstration, which studied ten participating organizations from 2005 – 2010. The demonstration showed only a modest decrease in the cost of care, much of that attributable to groups with populations of the dually eligible.¹¹⁵ Despite the increasing numbers of ACOs since 2010, shifting from a disaggregated fee-for-service system to an aggregated global fee system will not be easy.

One of the more fundamental flaws of many current ACO models is that they do not reject the fee-for-service reimbursement structure; instead, payers continue to pay ACOs on a fee-for-service basis for services provided by members of the clinical team. Indeed, provider fees are no different than the fee that providers have received in the past for the same services. Instead of a real redesign of the fee-for-service reimbursement structure, the ACO approach simply adds another layer of payment for those ACOs that provide quality care less expensively than the benchmark.¹¹⁶ This fact can create significant challenges for providers. As Harold Miller of the Center for Healthcare Quality and Payment Reform explains,

Having two or more providers participating in a shared savings arrangement creates a version of the prisoner's dilemma: if provider #1 makes a good faith effort to reduce unnecessary services but provider #2 does not, provider #2 would "win" by maintaining its own fee revenues while also potentially receiving part of the savings generated by provider #1.¹¹⁷

Miller suggests that ACOs could be substantially more effective by eliminating the fee-for-service reimbursement scheme entirely and substituting for it a payment system that truly incentivizes the coordination of care among the participating providers. Such true payment reform as episode-of-care bundled payments create a win-win-win environment benefiting payers whose costs are reduced, patients whose outcomes are improved, and providers whose margins are better.¹¹⁸ The question is not whether provider coordination is good for health care but whether the ACO reimbursement model will create enough of the right incentives to align the needs of providers, patients, and payers.

¹¹⁴ Muhlestein, *supra* note 83.

¹¹⁵ Carrie H. Colla et al., "Spending Differences Associated with the Medicare Physician Group Practice Demonstration," 308 *JAMA* 1015 (2012).

¹¹⁶ Harold D. Miller, "Ten Barriers to Healthcare Payment Reform and How to Overcome Them," Center for Healthcare Quality & Payment Reform, 2012.

¹¹⁷ *Id.* at 2. For example, if better coordination of a patient's care can avoid an emergency room visit or hospital admission, the hospital will lose all of the revenue for that visit or admission but it will still have to cover the costs of maintaining an emergency room or having a hospital bed available.

¹¹⁸ *Id.* at 4.

V. “IT’S THE PRICES, STUPID”¹¹⁹: WHAT FACTORS DRIVE THE PRICING OF HEALTH CARE GOODS AND SERVICES?

The majority of Americans will continue to buy health care through employment or individually in greatly expanded and much more heavily regulated private markets.¹²⁰ Correlatively, insurers and providers will continue to sell health care in these markets. Both insurers, mostly for-profit entities, and providers, mostly nonprofit entities, are profit-seeking. For-profit entities seek profit on behalf of their owners, either private or public, to whom the entity owes a fiduciary obligation. Nonprofit entities seek profit for mission¹²¹ but also to survive a marketplace where reimbursement from public programs such as Medicare and Medicaid has and will continue to diminish, and reimbursement from commercial insurers is subject to ever-increasing downward pressures from private payers such as employers, employees and other individuals purchasing health insurance.¹²² Hospitals are particularly vulnerable to downturns in revenue. As hospital revenue is projected to decrease, hospitals are also experiencing overcapacity due to excessive competition among particularly nonprofit hospitals to build bigger and better specialty care facilities to attract well-insured patients.¹²³

The last two decades have seen escalating health care spending both in the public and private sectors.¹²⁴ The reasons for this rise have been hotly debated: usage, payment incentives, the aging of the population, waste, fraud and abuse and high prices throughout the system. In the recent past, there seems to be general agreement that high prices lie at the heart of the health spending problem in the United States.¹²⁵ Prices for many health services suffer from the lack of either regulation or real competition, use of global budgets, transparency, and geographic variation.¹²⁶ As a number of recent studies have demonstrated, the more concentrated the provider market, the more successful their price negotiations with insurers particularly in markets where one insurer is dominant and has the ability to steer patient volume to providers included in their provider market.¹²⁷ Insurers, unable to prevail in price negotiations with dominant providers, adapt to the non-competitive environment using such tactics as “most-favored nation” clauses guaranteeing providers will charge the same high price to other payers thereby exacerbating the rise in health care prices. As one commentator posits, why would providers seek out innovative ways to absorb risk and deliver high-value health care when anti-competitive behavior is so reliably profitable?¹²⁸

¹¹⁹ Anderson et al., *supra* note 16.

¹²⁰ Regulations are particularly stringent in the individual market and include bans on an insurer’s right to refuse coverage because of preexisting conditions and an insurer’s right to cancel an individual’s policy because of high usage. *See generally* Patient Protection and Affordable Care Act, 42 U.S.C. sec. 18001 et. seq, 2010.

¹²¹ It is their so-called charitable mission that entitles nonprofit entities to income and property tax exemptions.

¹²² Jeff Goldsmith, “Can Hospitals Survive, Part II,” *Health Affairs Blog*, March 14, 2014, <http://thehealthcareblog.com/blog/2014/03/14/can-hospitals-survive-part-ii/>.

¹²³ Ha Tu et al., “San Diego: Health Care Providers Expand Capacity as Competition Increases for Well-Insured Patients,” *California Health Care Almanac* (2013).

¹²⁴ Diane Archer, “No Competition: The Price of A Highly Concentrated Health Care Market,” *Health Affairs Blog*, March 6, 2013, <http://healthaffairs.org/blog/2013/03/06/no-competition-the-price-of-a-highly-concentrated-health-care-market/>.

¹²⁵ Health Care Cost Institute, “2012 Health Care Cost and Utilization Report;” Anderson, *supra* note 16.

¹²⁶ Uwe Reinhardt, “The Culprit Behind High U.S. Health Care Prices,” *New York Times*, June 7, 2013.

¹²⁷ Chapin White et al., “High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power,” Center for Studying Health System Change 4 (2013).

¹²⁸ Archer, *supra* note 124.

During the managed-care era of the 1980s and 90s, payers were able to capitalize on their market power and negotiate lower payments to providers who tended to be independent physicians or smaller physician groups not necessarily associated with hospitals.¹²⁹ Much of the price reduction was due to the insurers' ability to negotiate advantageous risk contracts with providers where providers received monthly or annual capitated payments which required them to provide all health care regardless of the amount of care the patient required during the capitation period. Provider market power, whether of health plans or provider groups, is thought to be the key to price negotiations between the two groups. When the market power of insurers exceeds that of the providers as in the managed care era, commercial provider reimbursement is likely to decrease. Hospitals particularly experience slowed growth to which they must respond or risk extinction.

One of the responses of hospitals in times when revenue is threatened is increased merger and acquisition activity. The response to the threat of managed care in the mid-1990s drove a frenzy of hospital M&A activity, a wave that peaked in 1997 and experienced zero growth until 2010, the year the ACA was enacted.¹³⁰ One of the reasons for the decline of hospital M&A activity may be that most deals failed to live up to financial expectations. A Strategy& (formerly Booz and Company) examination of hospital and health systems M&A deals made between 1998 and 2008 found that only 41 percent of the acquired hospitals outperformed their market peer group.¹³¹ In addition, from the late 1990s to 2007, hospitals experienced rapid growth of seven percent overall, dampening the demand for mergers and acquisitions that often did not improve profit margins.¹³² M&A activity did not recover in 2008 and 2009 due to the Great Recession; in 2010 hospital merger and acquisition activity started to increase nudged by both the passage of the ACA and availability of more capital.¹³³

The Affordable Care Act, which took effect on January 1, 2014,¹³⁴ makes a number of changes to Medicare and Medicaid payments particular to hospitals. Congress is even seriously contemplating a permanent solution to the sustainable growth rate, the formula by which Medicare reimbursement to physicians is supposed to be calculated.¹³⁵ One of the changes made by the ACA is a 1.1 percent reduction in the annual increase to Medicare reimbursement made to hospitals to account for the growth in health care costs. The ACA also authorizes states to

¹²⁹ In California, where the Kaiser Permanente group-model HMO was providing a real competitive threat to fee-for-service healthcare, physicians formed medical groups and IPAs as early as the 1980s. In a parallel development, health insurers developed HMO products that delegated responsibility for provider network development to medical groups and IPAs.

¹³⁰ Sanjay B. Saxena et al. "Succeeding in Hospital & Health Systems M&A: Why So Many Deals Have Failed, and How to Succeed in the Future," Booz & Company, 2013.

¹³¹ Molly Gamble, "Is Bigger Always Better? Exploring the Risks of Health System Mega-Mergers," *Becker's Hospital Review*, March 18, 2013.

¹³² Avik Roy, "Hospital Consolidation: The Biggest Driver of Health Costs That (Almost) Nobody Talks About," (presented at the MAHP Annual Conference, November 19, 2011).

¹³³ *Ibid.*

¹³⁴ There are certain provisions of the ACA that will not go into effect until 2014. Some of these provisions are the result of a very clumsy rollout of the health insurance exchanges, particularly HealthCare.gov; other changes target the large employer insurance mandate and the small business health insurance exchanges. Timothy S. Jost and Simon Lazarus, "Obama's ACA Delays – Breaking the Law or Making it Work?" 370 *New England Journal of Medicine* 1970 (2014).

¹³⁵ Fred Dews, "Reforming Medicare Physician Payments- aka the 'Doc Fix,'" Brookings Now Blog, November 20, 2013, <http://www.brookings.edu/blogs/brookings-now/posts/2013/11/reforming-medicare-physician-payments-doc-fix>.

expand their Medicaid populations; potentially changing the mix of hospital patients to include more Medicaid patients for whom reimbursement is notoriously low when compared with commercial and even Medicare reimbursement rates.¹³⁶ Medicare has already instituted a non-reimbursement policy for patients readmitted to hospitals within 30 days of discharge. And, under the ACA, Medicare reimbursement is shifting from fee-for-service to value payments, a change that will take a period of adjustment before becoming profitable.¹³⁷ The question for hospitals is how to survive.

Some hospitals will not survive the end of a long run of uninterrupted revenue growth, both from in-patient care and more recently from very expensive ambulatory care.¹³⁸ Some will survive by reducing operating expenses, particularly salaries and benefits, by reducing their work forces or a combination of these policies. The Cleveland Clinic, ranked as one of the best hospitals in America and a model of health care innovation, announced in late September that it is reducing its payroll in response to the ACA.¹³⁹ Still others, particularly the “must-have” providers who are able to extract from commercial insurers prices that are significantly higher than nearby competitors and multiples of what Medicare pays hospitals for similar services, will not only survive but may thrive.¹⁴⁰ But even “must-have” providers recognize that there may be limits to what payers are willing to forfeit and that even the providers will have to innovate to sell their products to payers who no longer are willing or able to be complicit in the extraordinary prices of U.S. health care.¹⁴¹

Surviving an unfriendly market is not new to providers, particularly California providers accustomed to the severe rate cuts of the early 1990s managed care market. Employer resistance to rising health care costs and a response to competition from Kaiser Permanente gave health plans a dominant position in the health care sector resulting in greater bargaining leverage for private insurers. In response to the collapse in payment rates in the late 1990s, California providers started to consolidate, and merger and acquisition activity in the health system sector rose.¹⁴² Much of early M&A activity in the health care sector was horizontal hospital integration, the result of hospitals acquiring other hospitals. The goals of such acquisitions were not only economies of scale and scope that can result in a reduction in costs, but also increased market power with respect to private insurers that can have the effect of driving up the cost of care.

¹³⁶ Prior to the ACA expanded Medicaid program, hospitals that provided care for a disproportionate number of low-income people who were either uninsured or were Medicaid beneficiaries received payments from one or both Medicare and Medicaid Disproportionate Share payment programs. These DSH payments will slowly dry up starting in 2014 as Medicaid insurance becomes available to an expanded population. Cory Davis, “Q&A: Disproportionate Share Hospitals Payments and the Medicaid Expansion,” National Health Law Program (2012).

¹³⁷ Hospitals continue to suffer from negative aggregate Medicare margins of -5.4 percent in 2012 and a projected -8 percent in 2014, although some relatively efficient hospitals have generated positive overall Medicare margins. These negative margins are due to reduced demand for inpatient care. To counter the downward pressure of negative margins, the Medicare Payment Advisory Commission (MedPAC) recommended in its 2014 report to Congress that hospital reimbursement increase by 3.25 percent. MedPAC also recommended that Medicare payments for outpatient services by HOPDs and other locations, like physician offices, be aligned at the lower other location rate. MEDPAC, “Report to the Congress: Medicare Payment Policy,” (2014).

¹³⁸ Goldsmith, *supra* note 4.

¹³⁹ Andrew Evans, “Obamacare’s Structure Leading to Hospital Cuts, Experts Say,” *Washington Free Beacon*, September 2013.

¹⁴⁰ White et al., *supra* note 127.

¹⁴¹ See text accompany notes 202-06 *infra*.

¹⁴² Joanne Spetz et al., “Changes in Hospital Ownership in California,” Public Policy Institute of California (1999).

M&A activity peaked in 1997 as providers responded to reductions in Medicare provider payments brought on by the Balanced Budget Act.¹⁴³ The purpose of the Act – to reduce government spending on public health insurance and balance the budget by 2002 – was accomplished by reducing Medicare reimbursement to hospitals and physicians in order to extend the life of the entitlement program.¹⁴⁴ M&A activity started to fall off in the late 1990s and continued to flatten out through the Great Recession. Then in 2010, M&A activity began to rise with 100 deals completed in 2012, more than double the number from three years earlier.¹⁴⁵ The analysts at Stragey& (formerly Booz & Co.) attribute this rise to a number of factors that are “...powerful, complex, and interconnected. Federal healthcare reform is changing the reimbursement mix for Medicare and Medicaid, deep budget cuts are occurring at the state level, and commercial payers are successfully holding the line on costs.”¹⁴⁶ As in the late 1990s, providers are reacting to reimbursement cuts by consolidating to lower costs, raise capital, and better coordinate care.

Hospitals are also attempting to offset losses in the in-patient market by buying up physician practices and offering ambulatory services, formerly performed in the physicians’ offices, at HOPDs for higher hospital reimbursement rates.¹⁴⁷ However, as noted earlier in this paper, the most recent provider reimbursement policy recommendation by MedPAC would align prices for ambulatory services performed in HOPDs and physician offices at the lower physician office rate in a modest attempt to bring uniformity to the pricing of health care services, regardless of location.¹⁴⁸ While many hospitals are currently involved in both horizontal and vertical mergers, these are questionable long-term strategies that come with steep opportunity costs.¹⁴⁹ As has been noted by at least one Wall Street analyst, “it’s either make deals or run the business. It’s pretty much impossible to do both at once.”¹⁵⁰

The price variability and lack of transparency of health care and particularly hospital pricing is a well-known phenomenon. Recently, the Institute of Medicine commissioned a blue-ribbon panel led by Harvard’s Joseph Newhouse to confront a problem which has long been well-recognized but not easily explained, that is why does it cost more to treat patients in some areas of the country than in others? The panel found first that the variability in health care spending in Medicare and the commercial insurer sectors do not parallel each other. The panel found that while most Medicare variation was due to spending in post-acute services such as nursing facilities, home health care and long-term care hospitals, variation in the commercial market was due, in large part, to higher prices negotiated by hospitals, doctors and other medical providers.¹⁵¹ This finding is corroborated by an analysis by Michael Chernow, a Harvard economist, who determined that 70 percent of commercial spending variation is due to different prices set by hospitals and doctors in different markets. The IOM panel noted this is “most likely reflecting varying market power of providers.”¹⁵²

¹⁴³ Saxena, *supra* note 130.

¹⁴⁴ Marilyn Moon et al., “An Examination of Key Provisions in the Balanced Budget Act of 1997,” Commonwealth Fund (1997).

¹⁴⁵ Saxena, *supra* note 130.

¹⁴⁶ *Id.*

¹⁴⁷ Goldsmith, *supra* note 4.

¹⁴⁸ MEDPAC, *supra* note 137.

¹⁴⁹ Goldsmith, *supra* note 4.

¹⁵⁰ *Ibid.*

¹⁵¹ See generally Newhouse, *supra* note 28.

¹⁵² *Id.*

For more than three decades, experts at the Dartmouth Institute for Health Policy and Clinical Practice have documented the regional variations in Medicare spending and found that higher spending does not correspond to better outcomes.¹⁵³ But little research has been done to examine the relationship between hospital pricing in the commercial market and value added. Expensive hospitals tend to have more prestige and brand-name recognition, giving them greater bargaining leverage with payers.¹⁵⁴ There are, however, few studies on the correlation between price and value. While normal market behavior would dictate that quality and cost are often related (first-class seats on an airplane are much more expensive than coach but also much more comfortable), health care is not a normal market. The correlation between prices and value has been particularly difficult to study because of a lack of price transparency in hospital chargemaster pricing and, more importantly, negotiated pricing between hospitals and private insurers.¹⁵⁵

A study recently published in the health policy journal *Health Affairs* examines the relationship between hospital prices and quality of care and finds high-price hospitals' performance on outcome-based quality measures mixed; their performance compared to low-price hospitals was dependent on the outcome metric. The study found that variation in hospital pricing is supported by two different narratives: first, that high-price hospitals have special missions and unique characteristics that increase their costs and for which they should be compensated; and second, that some high-price hospitals have market power that allows them to negotiate high prices with private health plans and operate under little pressure to control costs.¹⁵⁶ As discussed earlier in this paper, the finding's second narrative is likely to be the more common reason for high pricing if the ACA's preference for enhanced coordination in care leads to more concentrated and less competitive provider markets. The question is whether more concentrated provider markets will make it impossible for payers to negotiate with or exclude mega brand-name high-price health systems from their provider networks. And if market forces do not drive down costs, will states resort to regulatory action such as antitrust litigation or all-payer systems?

VI. WHAT HAPPENS WHEN LONG-TERM RELATIONSHIPS GO BAD: THE END OF A DEAL

In Western Pennsylvania, patients insured by Highmark Blue Cross Blue Shield will be excluded from the University of Pittsburgh Medical Center provider network pursuant to the termination of a long-term contract between the area's dominant insurer, Highmark, and its dominant provider group, U.P.M.C.¹⁵⁷ Prior to Highmark's 2013 acquisition of the ailing West Penn Allegheny Health System, the vertical integration of insurer and provider was beneficial to both groups with Hallmark providing a large patient population and U.P.M.C. the "must-have"

¹⁵³ "Reflections on Variation," *The Dartmouth Atlas of Healthcare*, Dartmouth Institute for Health Policy and Clinical Practice, accessed June 12, 2015, <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=1338>.

¹⁵⁴ Berenson, *supra* note 6.

¹⁵⁵ Daniel Chang, "Health Care Prices: Many Moving Parts Veiled by Confidentiality Agreements," *Kaiser Health News*, September 15, 2014.

¹⁵⁶ Chapin White et al., "Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs," 33 *Health Affairs* 324 (2014).

¹⁵⁷ The market dominance of U.P.M.C., which has grown in annual revenue from \$797 in 1992 to some \$9 billion today with a 58% market share, is responsible for the withering of West Penn Allegheny that had been its main rival. Anna Wilde Mathews and John W. Miller, "Health-Care Rivals Battle For Patients in Pittsburgh," *Wall Street Journal*, March 27, 2012.

provider networks. While such an arrangement between dominant insurer and dominant provider is somewhat different from the more traditional hospital consolidation model, it results in the same type of consolidated, non-competitive and expensive health care market. U.P.M.C. responded to the Allegheny transaction by labeling Highmark as a competitor and a threat to its financial sustainability and refused to renew the current contract with Highmark that terminates at the end of 2014.¹⁵⁸

The result of the “divorce” is that U.P.M.C. hospitals will be available to Highmark customers only at “out-of-network” rates, some of the highest in the country, bad news for all payers, particularly the beneficiaries of previously generous provider rates negotiated between Highmark and U.P.M.C. The end result will no doubt be the creation of a tiered network of providers available to patients with employer insurance covering only less expensive in-network care, or, alternatively, a reference pricing scheme by which insurance only pays a reference price for any procedure and the patient picks up the balance.¹⁵⁹ However the price conundrum is solved, the divorce between the dominant provider and the dominant insurer may decrease the dominance of the provider, U.P.M.C.

This divorce threatens not only the market power of U.P.M.C. but also the dominance of Highmark, which, without the “must-have” provider in their provider networks, may have lost its ability to dominate the health insurance market. What is yet unknown is the extent of Highmark’s vulnerability to the defection of Highmark customers to other insurers offering products that include U.P.M.C. as an in-network provider including U.P.M.C. that has a health insurance component of its own. If Highmark customers do defect, it will be because other insurers are offering less expensive health insurance products because of increased competition. This outcome is highly dependent on whether consumers shop for provider value or reputation. However, since employer decisions have an impact on so many health insurance customers, ultimately the market outcome in this situation depends on the employers’ taste for and tolerance of expensive employer-sponsored health insurance.

This break-up between two monoliths will have collateral effects as well. One of the most poignant is the loss of a trusted provider by patients currently undergoing acute treatments for illnesses, the disruption of which could threaten the patient’s health care security.¹⁶⁰ Under a consent agreement negotiated by the Pennsylvania governor and state attorney general, U.P.M.C. has agreed to allow such patients to continue using its doctors and facilities at in-network rates.¹⁶¹ The end of the relationship between the two dominant health care entities in Pennsylvania could be the proverbial canary in a coalmine. The fallout from this breakup may provide a road map for the behavior of other providers and insurers in highly consolidated markets. In the meantime, more effort must be made on a policy level in order to both prevent health care consolidations that are monopolistic, and to mitigate the negative effects of those consolidations that have already occurred.

VII. REMEDIAL POLICIES TO MITIGATE THE EFFECTS OF PROVIDER PRICING

The remedies to curb escalating provider pricing depend, of course, on the reasons for high prices. One of the chief questions of this article is whether merger and acquisition activity

¹⁵⁸ Theresa Brown, “Out of Network, Out of Luck,” *New York Times*, October 12, 2013.

¹⁵⁹ See text accompanying notes 180–90 *infra*.

¹⁶⁰ Marc Levy, “UPMC, Highmark Settle Bitter Standoff,” *Associated Press*, June 27, 2014.

¹⁶¹ *Id.*

in the health care sector chills competition and drives up prices.¹⁶² As has been discussed, the level of provider concentration in the market will be a determinate of how powerful providers are relative to payers. The role of both state and federal antitrust agencies in protecting competition in health care markets has been broadly discussed in the literature and is beyond the scope of this piece.¹⁶³ However, as many antitrust experts have noted, it has historically not been an easy task for either the FTC or state attorneys general to prevent even patently suspect mergers through antitrust litigation. And if it is difficult to block patently worrisome transactions, it is unlikely that the agency will have the time, money or person-power to investigate activity where the potential anticompetitive effects are unclear.¹⁶⁴

The recent play by Partners HealthCare, Massachusetts's largest hospital and physicians' network, to acquire South Shore Hospital and Hallmark Health Systems, may be a cautionary tale for the future of potentially anticompetitive transactions. A review of the merger by the Massachusetts Health Policy Commission¹⁶⁵ found that the merger would increase medical spending by \$23 - \$26 million each year due to increases in physician prices and increased utilization of Partners and South Shore facilities.¹⁶⁶ The Commission also found that the Partners system would have more leverage to negotiate prices with private payers. Notwithstanding a finding that the transaction would drive up health care costs and adversely impact the cost of insurance premiums, the Massachusetts State Attorney General Martha Coakley, with knowledge of the Commission's findings, reached a conduct settlement with Partners. This settlement would allow the transaction to be completed subject to some conditions, such as limiting future price increases to the rate of general inflation through 2020.¹⁶⁷ The settlement agreement also prohibited Partners from consolidating its negotiating power to leverage higher prices from payers.¹⁶⁸ Since the deal was blessed by the Attorney General's office, there has been significant backlash from the courts, the Commission and a coalition of non-Partners health care providers who ordinarily compete with each other, as well as with Partners for business.¹⁶⁹

This is not Massachusetts' first experience with hospital consolidation. Partners HealthCare is the culmination of a 1994 merger of Massachusetts General Hospital and Brigham and Women's Hospital, both affiliated with Harvard University.¹⁷⁰ Investigations by the state attorney general's office have documented that the merger gave the hospitals enormous market

¹⁶² Text accompanying notes 6-11, *infra*.

¹⁶³ Paul Ginsburg and Gregory Pawlson, "Seeking Lower Prices Where Providers Are Consolidated: An Examination of Market and Policy Strategies," 33 *Health Affairs* 1057 (2014); William M. Sage, "Getting the Product Right: How Competition Policy Can Improve Health Care Markets," 33 *Health Affairs* 1076 (2014).

¹⁶⁴ Leemore Dafny, "Hospital Industry Consolidation – Still More to Come?" 370 *New England Journal of Medicine* 198 (2014).

¹⁶⁵ The Massachusetts Health Policy Commission is an entity formed by Governor Deval Patrick's 2012 health care cost control law. "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation," Massachusetts General Laws ch. 6D, sec. 5 (2012).

¹⁶⁶ "Cost and Market Impact Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital (HPC-CMIR-2013-1) and Harbor Medical Associates (HPC-CMIR-2013-2)," *Commonwealth of Massachusetts Health Policy Commission*, December 18, 2013.

¹⁶⁷ *Commonwealth of Mass. vs. Partners Healthcare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp.* No 14-2033 (Mass. Filed June 24, 2014).

¹⁶⁸ Commonwealth of Massachusetts Health Policy Commission, "Review of Partners' Healthcare System's Proposed Acquisition of Hallmark Health Corporation, Preliminary Report," July 2, 2014.

¹⁶⁹ Molly Gamble, "15 Things to Know About the Deal Between Partners HealthCare, Massachusetts AG Martha Coakley," *Becker Hospital Review*, July 18, 2014.

¹⁷⁰ Editorial, "The Risks of Hospital Mergers," *New York Times*, July 6, 2014.

leverage to drive up health care costs in the Boston area.¹⁷¹ A recent New York Times editorial entitled “The Risks of Hospital Mergers,” elucidates the continuing tension between provider concentration and provider collaboration:

As this case moves forward, it will be important to find an appropriate balance between two concerns that tug in opposite directions. The Affordable Care Act has incentives that encourage hospitals and doctors to integrate their operations and collaborate to control costs and improve care, and Partners has been a leader in doing that. At the same time, such collaborations must not be allowed to accrue such market power that they stifle competition and drive up prices, as seems to have happened in Massachusetts in past years.¹⁷²

If antitrust litigation is often unsuccessful, are there other policies that can effectively prevent or mitigate the power of certain providers to drive prices? Uwe Reinhardt recently addressed the chaotic, private health care sector price system in his New York Times blog.¹⁷³ Commenting on a series of articles written by New York Times reporter and physician Elizabeth Rosenthal about health care costs,¹⁷⁴ Reinhardt roundly criticized the sloppy purchasing practices of employers in their role as purchasing agents for their employees. Says Reinhardt in support of his condemnation of the employer-sponsored health insurance system so prevalent in the United States:

For more than a half a century, employers have passively paid just about every health care bill that has been put before them, with few questions asked. And all along they have been party to a deal to keep the chaotic price system they helped create opaque from the public and even from their own employees. . . . One reason for the employers’ passivity in paying health care bills may be that they know, or should know, that the fringe benefits they purchase for their employees ultimately comes out of the employees’ total pay package.¹⁷⁵

One peripheral question that Professor Reinhardt’s comment raises is whether employers’ passivity toward prices should be more broadly construed as price indifference to providing group insurance at all. If health care costs continue to rise and the state and federal health insurance exchanges succeed in providing affordable and adequate insurance to individuals, employers will not feel much compunction about paying rather than playing.¹⁷⁶ Ezekiel Emmanuel, one of the architects of the Affordable Care Act, predicts that by 2025 only 20% of employers who currently offer health insurance to their employees will still be doing so.¹⁷⁷ His

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ Uwe E. Reinhardt, “The Culprit Behind High U.S. Health Care Prices,” *New York Times*, June 2013, <http://economix.blogs.nytimes.com/2013/06/07/the-culprit-behind-high-u-s-health-care-prices/>.

¹⁷⁴ Dr. Elizabeth Rosenthal has written a series of articles under the umbrella title of “Paying Until it Hurts” on the issue of why the U.S. spends \$2.7 billion on health care. She does this by comparing the prices of assorted medical procedures and pharmaceuticals in the United States with the price of the same procedures in other first-world nations with well-developed health care systems. Elizabeth Rosenthal, “Paying Until it Hurts: A Case Study in High Costs,” *New York Times*, June 1, 2013.

¹⁷⁵ Reinhardt, *supra* note 173.

¹⁷⁶ Julie Appleby, “Expect to Pay More for Your Employer-Sponsored Health Care Next Year,” *Kaiser Health News*, December 20, 2013.

¹⁷⁷ See generally, Ezekiel J. Emanuel, “Reinventing American Health Care: How the Affordable Care Act Will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System,” *Public Affairs* (2014).

prediction is based on assumptions about well-functioning health insurance exchanges that give individuals opportunities to express their purchasing preferences rather than relying on their employers to act as relatively ineffective proxies, as well as increases in compensation to make up for the loss of ESI.¹⁷⁸ Of course, neither of these predicates is a certainty.

There are others who take the opposite view. In a recent study published in *Health Affairs*, the authors hypothesize that the answer to the question of continued employer sponsored insurance under the ACA depends, in large part, on why employers provide insurance in the first place.¹⁷⁹ There is general agreement that employers, particularly large employers, provide health insurance first to give themselves a comparative hiring and retention advantage, second because the cost of health insurance is borne primarily by workers rather than employers in the form of lower compensation and, more recently, insurance plan designs that shift the burden of rising costs to the employee, and third because ESI reflects workers' demand for coverage.¹⁸⁰ The study attempts to predict the behavior of employers to the various incentives of the ACA based on the outcome of various microsimulation models.¹⁸¹ These models predict that the ACA will cause little change in the number of Americans covered by ESI. If that's the case, employers will need to take steps to rein in the cost of health insurance for themselves and for their employees in order to defy Uwe Reinhardt's condemnation of employers as sloppy purchasing agents for their employees.

Professor Reinhardt's assertion that employers have been relatively indifferent, and indeed complicit, in the rise in health care costs is further borne out by analysis from other health economists. At the very least, employers' response to higher prices has been limited and ineffective in incentivizing consumers to seek providers that charge relatively low prices. While, as discussed above, employers have not had much incentive to rein in the costs of health care, their role in rising costs has been limited by both the lack of transparency of health care pricing and its extreme variability. Both of these factors are, at least partly, the result of the negotiating power of providers vis-à-vis payers, that is insurers and employers. Even the proliferation of high-deductible plans appear unlikely to lead patients to choose less expensive providers such as hospitals because the total cost of hospitalization exceeds the consumer's deductible, a situation that discourages many elective procedures.¹⁸² Ginsburg et. al. conclude that while high deductible health insurance may not nudge consumers to the less expensive in-network hospitals, it may incentivize them to choose a yet less expensive option – an outpatient facility – where the price of the procedure is lower than any inpatient procedure, whether in or out of network.¹⁸³

¹⁷⁸ Emanuel admits that both of the above are predicates for his prognosis of ESI and that the failure of either would create a barrier. He also admits that whether or not the exchanges become attractive markets that individuals prefer over ESI will depend on the products that are offered; correlatively, the products that are offered will depend on the demand for them so the interplay is a bit of a chicken/egg conundrum. Robb Mandelbaum, "Ezekiel Emanuel Further Explains His Prediction That Employers Will Drop Health Insurance," *New York Times Blog*, April 7, 2014, http://boss.blogs.nytimes.com/2014/04/07/ezekiel-emanuel-further-explains-his-prediction-that-employers-will-drop-health-insurance/?_php=true&_type=blogs&_r=0.

¹⁷⁹ Thomas Buchmueller, et al., "Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?" 32 *Health Affairs* 1522 (2013).

¹⁸⁰ *Id.* at 123.

¹⁸¹ Various organizations have modeled employers' behavior with respect to the continued provision of ESI. This includes the Congressional Budget Office, the Urban Institute, the RAND Corporation, the Lewin Group, and the Office of the Actuary of the Centers for Medicare and Medicaid Services. *Id.* at 179.

¹⁸² Ginsburg, *supra* note 163.

¹⁸³ *Id.*

Such a choice presupposes adequate information about the price of the procedure in an outpatient facility. Given the state of provider price transparency, this information may be difficult to access.¹⁸⁴

Frustrated by high premium costs, employers are starting to take steps to reduce the cost of health care to themselves and their employees.¹⁸⁵ At the same time, both providers and insurers are starting to recognize that many employers will no longer tolerate inexplicably high prices. While providers may come later to the fair than insurers, they too are considering innovative ways to provide health care more effectively at lower costs.¹⁸⁶ Insurers, on the other hand, are much more likely to collaborate with employers because of their mutual, aligned interests. Like employers, insurers are payers too and experience first-hand employers' intolerance for high premiums. To some extent, the success of innovation depends on overcoming the resistance of those who have benefitted from an existing regime; here the analysis focuses on not only insurers and providers but also patients who believe that expensive, highly reputational health care is better than less expensive health care delivered in hospitals or in out-patient facilities.¹⁸⁷ Certainly disruptive innovation that includes limiting health care choices to those that are less expensive but higher quality is going to take some amount of persuasion as evident in the current backlash against narrow provider networks in the state health insurance exchanges.¹⁸⁸

In the face of consumer and provider dissatisfaction with narrow provider networks in the federal and state exchanges, CMS has proposed some regulation of the adequacy of provider networks. One of the values of limited networks is to give insurers some negotiating power over providers by threatening to exclude the expensive provider from its network. Network adequacy regulation would require the inclusion of more providers in any insurer's network with a concomitant increase in provider negotiating power diminishing the ability of the insurer to control provider pricing and keep the costs of health care in check. While network adequacy regulation seems pro-consumer, it can result in higher prices, more expensive insurance policies, and greater expense to consumers.¹⁸⁹

In order for innovation to be acceptable, it should benefit not just the payer but the insured as well. Many of the recent changes in insurance product design frequently adopted by employers have simply shifted the cost of health insurance to their employees through limits on employer contributions to the purchase of health insurance, or limiting the type of health insurance available to their employees so that the preponderance of the burden of the cost falls

¹⁸⁴ But see Sze-jung Wu et al., "Price Transparency for MRIs Increase Use of Less Costly Providers and Triggered Provider Competition," 33 *Health Affairs* 1391 (2014). This study used Blue Cross/Blue Shield claims data for employees of participating employers to make available to the employees price information about advanced imaging procedures in order to facilitate value-based provider choices. The study found a greater reduction in imaging costs in the participating cohort than the non-participating cohort; it also found that some high-priced facilities reduced their prices in order to retain their market share.

¹⁸⁵ Katherine Baiker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," 24 *Journal of Labor Economics* 609 (2006).

¹⁸⁶ See text accompanying notes 202 -06 *infra* on Anthem Blue Cross' new joint venture, Vivita, with seven Los Angeles hospitals that are competitive with each other.

¹⁸⁷ Clayton Christensen et al., "Will Disruptive Innovations Cure Health Care?" *Harvard Business Review* (2000), <https://wiki.umms.med.umich.edu/download/attachments/118335374/disruptive-innovations-cure-health.pdf>.

¹⁸⁸ Paul Demko, "Providers, Insurers, Grapple with Narrow-Network Backlash," *Modern Healthcare*, July 21, 2014.

¹⁸⁹ David H. Howard, "Adverse Effects of Prohibiting Narrow Provider Networks," 31 *New England Journal of Medicine* 591 (2014).

on the employees. According to PricewaterhouseCoopers' 2014 Touchstone Survey, 44 percent of employers across all industries are considering high-deductible health plans as the only insurance option for their employees.¹⁹⁰ Health insurance with high out-of-pocket costs to the insured tends to depress utilization particularly during recessionary times where under- and unemployment tends to be high. PwC's prediction of health care cost trends for 2015 illustrates the effect of high out-of-pocket costs on health care spending, a net 4.8 percent, two full percentage points lower than the gross 6.8 percent rate of growth.¹⁹¹

The effect of high out-of-pocket spending may seem to bend the cost curve but this result is illusory. Consumers with high out-of-pocket health care expenses may elect to forego sometimes necessary or preventive health care because they cannot afford the burden of high out-of-pocket costs. While this outcome may drive down NHE because of lower utilization, it is neither effective nor efficient.¹⁹² As the RAND Health Insurance Experiment of the 1970s and 1980s demonstrated, health care utilization is surprisingly price sensitive often resulting in perverse underutilization of health care, a result that makes the system less effective for consumers.¹⁹³ And while cost shifting may be a rational response of employers to rising health care costs, it does little to change provider behavior with respect to either prices or costs. Cost shifting simply transfers the burden of high-priced services from one payer to another without affecting the price of the service. On the other hand, higher out-of-pocket costs may encourage more prudent purchasing by consumers who, by necessity, become more cost-conscious.¹⁹⁴

However, notwithstanding some efforts to reveal provider pricing, lack of meaningful information about prices creates substantial barriers for individuals wishing to make better value-based purchasing decisions.¹⁹⁵ Because the majority of Americans still access health care through ESI, cost-consciousness may be best achieved by employers who adopt smart purchasing policies that enable employees to make choices that balance quality and cost.¹⁹⁶ This includes price transparency as well as good counseling by employers or insurers on calculating possible out-of-pocket expenses. Even smart purchasing policies, such as reference pricing, can involve cost-sharing burdens for the insured unaware of the potential for insurance design and regulatory pitfalls.¹⁹⁷ This is particularly true since the U.S. Dep't of Labor, in its January 2014

¹⁹⁰ "2014 Health and Well-Being Touchstone Survey Results," PricewaterhouseCoopers (2014), <http://www.pwc.com/us/en/hr-management/publications/health-well-being-touchstone-survey.jhtml>.

¹⁹¹ "Slight uptick in expected growth rate ends five-year contraction" PricewaterhouseCoopers (2015), <http://www.pwc.com/us/en/health-industries/behind-the-numbers/>.

¹⁹² Elise Gould, "Increased Healthcare Costs Sharing Works as Intended: It Burdens Patients Who Need Care the Most," Economic Policy Institute (2013).

¹⁹³ Joseph Newhouse et al., "Rand Health Insurance Experiment," Rand Corporation (1971–1986).

¹⁹⁴ Don McCanne, "Disturbing PwC Report on Employer Medical Cost Trends," *PHNP Blog*, July 25, 2014, <http://pnhp.org/blog/2014/06/25/disturbing-pwc-report-on-employer-medical-cost-trends/>.

¹⁹⁵ Sze-jung Wu, *supra* note 184.

¹⁹⁶ As has been previously discussed, the price of health care isn't always a proxy for quality so equating higher prices with higher quality can result in unnecessary medical expenditure with no concomitant outcome benefit.

¹⁹⁷ Jonathan Cohn, "A New Obamacare Detail That Could Save You Some Money – Or Cost You Even More," *New Republic*, May 19, 2014. This article speaks to federal guidance on how out-of-pocket costs paid by the insured in excess of either a plan's allowed reimbursement amount or reference price set by the employer or insurer can be treated for the purpose of computing limits on out-of-pocket spending set by the ACA. The federal guidance clarifies that a plan may but need not count out-of-pocket spending of out-of-network services toward the plan's annual maximum out-of-pocket limit. If a plan chooses not to count the employee's OOP expenses toward the OOP limit, the insured will pay the entire balance of the bill without any limit. United States Department of Labor, "FAQs About Affordable Care Act Implementation (Part XVIII)," January 9, 2014.

guidance, blessed employers' discretion to count employees' coinsurance amounts for out-of-network balance billing toward the ACA out-of-pocket spending limits.¹⁹⁸

Insurance that is designed to incentivize value-based purchasing of health care can work in a number of ways. One way is to offer health insurance for all or just elective services that exclude the higher-priced providers by the use of limited provider networks.¹⁹⁹ The experience of Medicare Advantage has been instructive; while MA plans all have limited provider networks compared to fee-for-service Medicare, 30 percent of Medicare beneficiaries enroll in a Medicare Advantage plan because benefits are more generous and premium costs are lower.²⁰⁰ Health plans sold in the new health insurance exchanges also take advantage of limited provider networks to drive down costs although there has been much complaint about narrow provider networks and it is surely possible that states will respond to these complaints by expanding networks with, a concomitant rise in health insurance premium costs.²⁰¹ For Medicare beneficiaries, limited networks result in access issues; for the commercially insured, limited networks increase the risk of higher health care costs for the insured because of the need to go out-of-network to find specialists who are unavailable in a narrow network.²⁰² Providers who have not contracted with payers with regard to reimbursement can and do bill the patient for the balance of the bill for their services not paid by the insurer. Balanced billing for non-emergency services is becoming a more prevalent problem for patients as insurers narrow their provider networks and the patient is uninformed about a provider's network status.²⁰³ The ACA provides some assistance to patients who receive emergency services from an out-of-network provider by requiring that the payer reimburse the out-of-network provider in an attempt to prevent the provider from balance billing the patient.²⁰⁴

Other less blunt and perhaps more palatable possibilities are tiered-provider networks and a reference-pricing system. Both of these models work similarly; the insured can elect a higher price provider or tier and pay the out-of-pocket difference between the provider's price and the reference price. Tiered pharmaceutical benefit formularies where many drugs in a therapeutic class are covered but with different cost-sharing requirements are common in private and public health insurance design. Tiering providers is a much more complex process than tiering pharmaceuticals and often more powerful hospitals refuse to negotiate with payers who use this

¹⁹⁸ *Id.*; unfortunately more recent administration guidance about whether out-of-pocket limits apply to balance billing for in-network providers for care subject to a reference price is unclear. As a result, patients seeking guidance about their balance billing liability if they choose an in-network provider whose price exceeds the reference price will not be certain as to whether their excess spending will apply to the out-of-pocket limit. See Jon Glaudemans et al., "Reference Pricing and Network Adequacy Standards: Conflict or Concord?" *Health Affairs Blog*, <http://healthaffairs.org/blog/2014/09/18/reference-pricing-and-network-adequacy-standards-conflict-or-concord/>.

¹⁹⁹ But see text accompanying notes 201-06, *infra*.

²⁰⁰ Recently, private insurers participating in Medicare Advantage have been narrowing their provider networks in response to Medicare provider reimbursement reductions. While CMS is requiring that insurers provide advance notice of network reductions to CMS and plan beneficiaries, the narrow network policy may cause MA enrollees to move back to fee-for-service Medicare. Christopher J. Gearon, "Health Plans Shrink Choice of Providers," *Kiplinger's Retirement Report*, May, 2014; "Medicare Advantage loses its advantage", *Managed Care*, January 2013, www.managedcaremag.com/archives/1301/1301_medicareadvantage.html.

²⁰¹ Brett Norman, "Obamacare: Anger Over Narrow Networks," *Politico*, July 22, 2014.

²⁰² Jon Healey, "The Ugly Surprise of Out-Of-Network Doctors and 'Balance Billing,'" *Los Angeles Times*, September 22, 2014.

²⁰³ *Id.*

²⁰⁴ 29 C.F.R. sec. 2590.715-2719 A (2010).

process unless they are part of the preferred tier.²⁰⁵ Although HDHI and limited networks are blunter instruments used to attain savings, because they are easier to administer and more cost effective for the payer, they are much more frequently utilized. However, they are much less effective in pushing back against market power of high-priced providers.

Reference pricing may be a different story. There is evidence both in the U.S. and Europe that reference pricing not only incents the choices of the insured, but can also have a positive effect on the pricing conduct of high-priced providers.²⁰⁶ Reference pricing is used most commonly for standardized, non-urgent services such as orthopedic surgery, arthroscopy and cataract removal surgery, and imaging and laboratory services that have fairly uniform care-delivery protocols and quality outcomes, but high price variability. Purchasing such services from high-priced providers is considered low-value because comparable services can be purchased for less.²⁰⁷

The employer electing to use reference pricing designates a ceiling or cap on insurance coverage for a procedure – the reference price – and consumers can choose between a provider who charges the reference price or less and incur no cost sharing or, alternatively, choose a more expensive provider and pay the difference.²⁰⁸ Clearly reference pricing requires that employees have information about the prices and quality of services. While reference pricing and tiered-networks have not gained much traction in the commercial markets because of the market power of dominant providers to drive the transaction with payers,²⁰⁹ reference pricing has recently been used to lower the costs of care.

The California Public Employees' Retirement System (CalPERS) discovered that 7.5 percent of their \$7 billion health care budget was due to joint and muscle condition procedures. It went to Anthem for advice on how to reduce the cost of hip and knee replacements and Anthem suggested reference pricing.²¹⁰ In response to a variation in hospital pricing for replacement surgeries with a spread of \$100,000, CalPERS, partnering with Anthem, adopted a value-based purchasing design system.²¹¹ It set a \$30,000 limit, the reference price, on what it would pay for the procedure. The reference price was based on a claims data supplied by Anthem that showed a sufficient number of California hospitals performed high-quality hip and knee replacement

²⁰⁵ Anna D. Sinaiko, "Tiered Provider Networks as Strategy to Improve Health Care Quality and Efficiency," National Institute for Health Care Management (2012), www.nihcm.org/images/stories/EV-Sinaiko-2012.pdf.

²⁰⁶ Panos Kanavos and Uwe Reinhardt, "Reference Pricing For Drugs: Is it Compatible with U.S. Health Care?," 22 *Health Affairs* 16 (2003).

²⁰⁷ Catalyst for Payment Reform, "From Reference to Value Pricing," (2013).

²⁰⁸ Although the intended purpose of reference pricing is to reduce the average cost of the procedure per insured, the CalPERS study demonstrated that reference pricing also had an effect on hospital pricing. While some of the lower-priced providers raised their prices to the reference price, many higher-priced hospitals lowered their prices in order not to lose business.

²⁰⁹ Paul Ginsburg, *Health Care Provider Market Power: Hearing Before the Subcommittee On Health of the House Committee on Ways and Means*, September 9, 2011, (statement of Paul Ginsburg), http://www.nihcr.org/Ginsburg_WaysMeans_Testimony.

²¹⁰ Anthem Blue Cross provided preferred provider plans to CalPERS employees and therefore had access to CalPERS claims data. Amanda E. Lechner et al., "The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer," Center For Studying Health System Change (2013).

²¹¹ The impetus for the study was a variation in pricing for hip and knee replacements surgery from \$20,000 to \$120,000. James C. Robinson, "Comparison Shopping for Knee Surgery," *The Wall Street Journal*, October 29, 2013.

surgeries for the reference price or less to insure access for CalPERS 1.3 million members.²¹² Not only did reference pricing result in a 19 percent reduction in costs for hip and knee replacements,²¹³ it also incentivized a change in pricing strategy from the high-price providers, half of whom made significant reductions in their pricing.²¹⁴ The reference pricing experiment saved the state of California \$6 million.²¹⁵ As James Robinson, health law and policy professor at UC Berkeley says, “Reference pricing won’t be a solution to all the ills of the U.S. health-care system. But it can make a contribution.”²¹⁶

As noted above, the key to the success of value-based purchasing is that the reference price is set so that the patient has sufficient access to high quality care. In Europe, value-based cost-sharing policies are established by national governments, or in the case of competing health insurers, by purchasers, but limited by parameters of a national framework. In the U.S., private purchasers seem to be the sole determinants of value rather than the government as part of public health insurance programs such as Medicare and Medicaid.²¹⁷ The surprising outcome in the CalPERS experiment was that reference pricing not only saved money for both the state of California and its employees, but also had a competitive effect on pricing among higher-priced providers. Soon after CalPERS rolled out its reference pricing program, hospitals that had not been designated as value-based renegotiated their contracted prices with Anthem in order to retain their CalPERS patients. CalPERS’ size – 1.3 million members – may well have been the reason for the price negotiation.²¹⁸ It may be that the success of reference pricing in increasing provider competition will need to start with large employers with sufficient numbers of employees to give them leverage in pricing decisions.

Hoping to expand on its success with reference pricing, CalPERS has recently rolled out an online comparison shopping tool for medical care, calperscompare.com, for its employees who select Anthem preferred provider network plans.²¹⁹ These patients are the optimum group to get this information because they have the most discretion in provider choice. The new shopping tool gives PPO employees information about a number of factors including price, quality, patient satisfaction, and convenience. It will surely be interesting to see if reliable transparency is sufficient, without reference pricing, to incent value-based purchasing by employees. On a larger scale, the Health Care Cost Institute, on May 14, 2014, announced a joint initiative with three large health care insurers – Aetna, Humana, and UnitedHealthcare – to provide a free, secure, online tool to provide to health care purchasers timely relevant information such as cost and

²¹² Setting the correct reference price is key to the success of reference pricing. The value-based purchasing design is based not on what the patient/consumer thinks is sufficient but what the employer deems sufficient for good quality care. Austin Frakt, The Incidental Economist, “Is reference pricing a good deal,” *AcademyHealth Blog*, May 23, 2013, <http://blog.academyhealth.org/is-reference-pricing-a-good-deal/>.

²¹³ Mike Miesen, “Bending the Cost Curve With Reference Pricing,” *The Health Care Blog*, June 27, 2013, <http://thehealthcareblog.com/blog/2013/06/27/bending-the-cost-curve-with-reference-pricing/>.

²¹⁴ Robinson, *supra* note 211.

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ Sarah Thomson et al., “Value-Based Cost Sharing in the United States and Elsewhere Can Increase Patients’ Use of High-Value Goods and Services,” *32 Health Affairs* 704 (2013).

²¹⁸ Lechner, *supra* note 210.

²¹⁹ Kathy Robertson, “CalPERS rolls out online comparison shopping tool for medical care,” *Sacramento Business Journal*, August 8, 2013.

quality to be used by employees, employers and regulators for value-based purchasing of health care services.²²⁰

In a May 2, 2014, FAQ, the administration essentially blessed reference pricing for large or self-insured employers including, for prescription drug coverage, the use of a generic drug's price to set the reference price.²²¹ The FAQ clarified that the excess cost of an employee's provider choice in a plan that used reference pricing would not, at least for the moment, be counted toward the cap on employees' cost sharing.²²² There are mixed reactions to the policy; health economists and policy experts applaud the move toward reference pricing to slow health care spending while consumer advocacy groups fear that it is likely to make health insurance even more complex and could expose unwitting consumers to thousands of dollars in out-of-pocket costs.²²³

Private employers have been experimenting for some time with the defined contribution approach to health insurance. Having had much success in converting employees' defined benefit pension plans to defined contribution 401k plans, employers are using the same concept with health insurance. Instead of guaranteeing the benefit, the employer provides a contribution toward the purchase of a plan. One form that defined contribution health insurance has taken is health savings accounts funded by the employer's defined benefit that the employee can use to purchase a health insurance policy. A second kind of defined contribution health insurance tactic is a private health insurance exchange. Employees use the employer contribution to purchase health insurance from a private market of health insurance plans established by benefits managers. The excess cost of the plan over the amount of the defined contribution is paid for by the employees.²²⁴ The value of the private exchange is that it facilitates the migration from defined benefit to defined contribution while retaining the employer's involvement in its employees' health insurance choices.²²⁵ Large employers like the private exchange model because they get the reputational benefit of offering their employees health insurance without having to manage the insurance offerings themselves.²²⁶ However, if convenience to the employer is the only benefit of private exchanges, employees may soon catch on.²²⁷ History has taught us that all innovations must benefit the employee as well as the employer or risk obsolescence.

²²⁰ "Major US Health Plans Agree to Give Consumers Free Access to Timely Information About Health Care Prices to Foster Greater Transparency," Health Care Cost Institute, May 14, 2014, <http://www.healthcostinstitute.org/news-and-events/major-us-health-plans-agree-give-consumers-free-access-timely-information-about-health-care-costs>.

²²¹ U.S. Department of Labor, "FAQS About Affordable Care Act Implementation (Part XIX)," May 2, 2014.

²²² *Id.*; Timothy Jost, "Implementing Health Reform: Third-Party Payments and Reference Pricing," *Health Affairs Blog*, May 22, 2014, <http://healthaffairs.org/blog/2014/05/22/implementing-health-reform-third-party-payments-and-reference-pricing/>.

²²³ Julie Appleby, "7 Things You Should Know About the Next Big Benefit Change," *Kaiser Health News*, May 28, 2014.

²²⁴ Paul Fronstin et al., "Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits," Employee Benefit Research Institute (2014).

²²⁵ Akshay Kapur et al., "The Emergence of Private Health Insurance Exchanges Fueling the "Consumerization" of Employer-Sponsored Health Insurance," Booz & Company (2012).

²²⁶ Either insurance companies or benefits managers manage the private exchanges; offerings can be a single-carrier exchange or a multi-carrier exchange. In any case, the offerings must conform to the ACA adequacy requirements. Rosemarie Day et al., "The Evolution of a Two-Tiered Health Insurance Exchange System," *Health Affairs Blog*, 2014, <http://healthaffairs.org/blog/2014/08/13/the-evolution-of-a-two-tier-health-insurance-exchange-system/>.

²²⁷ Paul Demko, "Private Insurance Exchanges Attract More Employers," *Modern Healthcare*, June 7, 2014.

Providers are starting to become involved in cost-conscious, high quality choices. The innovative Cleveland Clinic has entered into a number of direct contracting agreements with employers such as Wal-Mart to provide cardiac surgery for employees and dependents for a negotiated bundled payment. The Clinic's Program for Advanced Medical Care finds great opportunity in directly contracting with employers skipping the typical payers – the insurers – entirely.²²⁸ As Michael McMillan, the Clinic's executive director of market and network services says:

We believe that employers and providers working together directly creates an opportunity for innovation and to create new ways not just to address the needs employees have when they are sick but also how to keep employees healthy.²²⁹

Direct contracting is a relatively new market solution to achieve value-based purchasing that seems to be a good answer but it is far too early to evaluate whether it will succeed in the long-run. Providers have many well-honed skill sets but managing actuarial risk has traditionally not been one; a full-risk contract with an employer could be very risky for an inexperienced provider.²³⁰ A limited risk contract, at least at the outset, may give the provider the necessary time to scale the learning curve challenge that direct contracting requires. While the success of direct contracting is quite unpredictable, it is one more innovation that may achieve cost-conscious high value health care purchasing using the market model that Americans seem to prefer.

The most recent market-based, value-based purchasing strategy is a joint effort of one California insurer and a number of “fiercely competitive” Los Angeles hospitals.²³¹ In an effort to balance the upside value of health care coordination with the downside of provider market consolidation, the organization structure is a joint venture between Anthem Blue Cross, a powerful California insurance company, and seven Los Angeles hospitals. These companies have been competitors for the business of selling health care to the insured, and create a new H.M.O. insurance plan, Anthem Blue Cross Vivity, with a narrow but AAA provider network.²³² Unlike high deductible insurance products that have been the product of health care reform heretofore, the new H.M.O. model will provide health insurance for premium and co-payments only with no deductibles or coinsurance.²³³ The goal of the venture is to provide the level of coordinated, high quality and efficient care that has previously been associated with a handful of health systems such as Intermountain Healthcare in Utah, Geisinger Health System in Pennsylvania, and, most importantly, Kaiser Permanente in California for an affordable price.²³⁴ The success of the new HMO will depend on participating hospitals' willingness to find ways to deliver high quality affordable health care.

In California, Vivity will be trying to accomplish what Kaiser Permanente has been doing for decades, but with at least some hospitals with big brands like UCLA Health and Cedar

²²⁸ Helen Adamopoulos, “Working Together to Contain Costs: What Hospital Leaders Need to Know for Successful Direct Contracting with Employers,” *Becker's Hospital Review*, June 27, 2014.

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ Reed Abelson, “Hospitals and Insurers Join Forces in California,” *New York Times*, September 14, 2014.

²³² Narrow provider networks are often problematic because they present the insured with not only fewer provider choices but fewer still name-brand provider choices because name-brand providers are expensive. *Id.*

²³³ Bob Herman, “Reform Update: Will Anthem's Vivity gain traction among large employers,” *Modern Healthcare*, September 18, 2014.

²³⁴ *Id.* The hospitals in the joint venture are UCLA Health, Cedars-Sinai, Good Samaritan, Huntington Memorial, MemorialCare Health, PIH Health and Torrance Memorial Health.

Sinai. The collaboration of providers and insurers is so unusual that it has taken the health care market by surprise. But the question really is: why has it taken so long? As Jonathan Gruber, health economist and architect of the Affordable Care Act, puts it, “for years, the question has been why hasn’t this happened?”²³⁵ Undoubtedly, health care prices and costs have incentivized providers and payers to try to compete with Kaiser on Kaiser’s turf. “The move by Anthem and health systems to compete with Kaiser Permanente suggests that rising healthcare prices have ‘reached the breaking point.’”²³⁶ To demonstrate their dedication to the principle of affordable high quality health care, the principals in the joint venture will share both profits and losses of the endeavor.²³⁷ The question is whether seven different health systems can agree on a single plan for the success of the venture. Vivity is different from Kaiser in that seven already successful and entrenched health systems are trying to find a single road to collaborative, affordable health care, which could be hard.

If market solutions fail to be effective in reducing prices, there are regulatory options such as banning certain hospital contracting practices, including hospitals’ refusal to contract according to placement in tiers.²³⁸ Antitrust policy is another important area where regulation can make a difference although the DOJ and the FTC have not been particularly successful in antitrust litigation against hospital and health system merger and acquisition activity.²³⁹ But states like Massachusetts have given authority to the agency charged with the task of bringing down the costs of health care to oversee provider merger and acquisition activity.²⁴⁰ How successful its efforts will be remains to be seen.²⁴¹ At the federal level, the FTC and the DOJ have committed to closely monitoring activity of ACOs participating in the MSSP for anti-competitive effects using data provided by CMS.²⁴² Initially, the MSSP proposed rule mandated an antitrust review for certain collaborations as a condition of entry in the Shared Savings Program but the final rule eliminated the review requirement.²⁴³ This compromise surely reflects two competing policy issues raised by the fostering of ACOs by the ACA: coordination of care and market concentration.²⁴⁴ Again, how successful this dual-purpose enforcement policy will be in ensuring a pro-competitive provider environment remains to be seen.

²³⁵ Melanie Evans, “Reform Update: Anthem’s Vivity alliance with seven L.A. systems aims at Kaiser,” *Modern Healthcare*, September 17, 2014.

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ Ginsburg, *supra* note 209.

²³⁹ Robert Pear, “F.T.C. Wary of Mergers by Hospitals,” *New York Times*, September 17 2014; Barak Richman, “Antitrust and Nonprofit Hospital Mergers: A Return to Basics,” 156 *University of Pennsylvania Law Review* 121 (2007).

²⁴⁰ Wendell Potter, “Massachusetts Tackles Next Phase of Health Care Reform: Controlling Costs,” *The Center for Public Integrity*, February 3, 2014.

²⁴¹ Recently, the Massachusetts Health Policy Commission authorized by Massachusetts’ 2012 legislation aimed at controlling health care costs reviewed a proposal by Partners HealthCare System to acquire the South Shore Hospital and physician group and concluded that the transaction would raise costs without affecting quality of care. The transaction will now go before the Office of the Massachusetts Attorney General. Melanie Evans, “Partner’s South Shore Bid Would Raise Costs, Not Quality, Panel Says,” *Modern Healthcare*, February 19, 2014.

²⁴² 76 C.F.R. sec. 67,026 (2011).

²⁴³ 76 C.F.R. sec. 67,802 (2011).

²⁴⁴ Robert Leibentutt, “The ACO Antitrust Policy State: Antitrust Enforcement Meets Regulatory Rulemaking,” *The Antitrust Source*, December 2011, www.hoganlovells.com/files/Publication/f6599f51-7d6b-4896-8b21-aa5a3270511e/Presentation/PublicationAttachment/76171d07-5384-44c9-bac1-ab926d2f5c26/Leibenluft%20ACO%20article%20in%20Antitrust%20Source.pdf.

Finally, if provider pricing power cannot be mitigated by a less constrained regulatory environment, some form of price regulation may afford the best solution. As a threshold consideration, regulations setting hospital prices for certain procedures or establishing global spending budgets do not sit well with Americans who are more familiar and comfortable with private market pricing schemes. But states are starting to experiment with all-payer systems, global budgets for health care, and databases that seek to create transparency in hospital pricing.²⁴⁵

Massachusetts' 2012 legislation seeking to improve health care quality and reduce costs²⁴⁶ sets targets for growth in health care spending; over the next five years, the new law sets a target for state health spending equal to the long-term average annual growth of the state's economy.²⁴⁷ For 2013, the growth cap was 3.6 percent. Given that projected growth of national health care spending for 2013 was 6.3 percent, containing growth to 3.6 percent is a really aggressive goal.²⁴⁸ The legislation also authorized the establishment of an eleven-member independent Health Policy Commission whose job it is to oversee the actual spending of provider groups and require those with above-target spending to take corrective action. While there is little enforcement authority in the legislation, the fact that a state has the political resolve to make a long-term commitment to a multi-faceted approach to controlling health care costs speaks to its commitment to the goal.²⁴⁹ Though the plan may ultimately not work, Massachusetts again is the "canary in the coal mine" with respect to health care reform and its success or failure may provide a map to the way forward for other states.

Maryland is a state that has always been very innovative and proactive about health care costs by focusing on pricing. Since the mid-1970s, Maryland has set hospital prices at a single-rate using an all-payer system made possible by a 36-year-old Medicare waiver that allows the state to set the Medicare hospital rate rather than the federal Medicare program.²⁵⁰ Maryland is the only state to have adopted a non-discriminatory all-payer system.²⁵¹ Under the original waiver, Maryland's prices could not grow faster than the prices set by the Medicare program but growth in health care cost made it difficult for Maryland to meet spending benchmarks.²⁵² The CMS recently approved a Maryland proposal to continue to set hospital prices while capping hospital spending growth to 3.58 percent (the anticipated overall growth of the state economy) for the next five years. Instead of paying hospitals for volume, the new pricing system will pay based on value. This experiment in European-style price regulation will either serve as a model to other states or as a cautionary tale, but Maryland had little choice.²⁵³ It was in jeopardy of

²⁴⁵ Glaudemans, *supra* note 198.

²⁴⁶ Massachusetts General Laws ch. 224 (2012).

²⁴⁷ Robert E. Mechanic et al., "The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation," 10 *Health Affairs* 1, October 2012.

²⁴⁸ *Id.*

²⁴⁹ *Id.* at 7-8.

²⁵⁰ "Maryland All-Payer Model," Centers for Medicare and Medicaid Services, January 10, 2014, <http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>.

²⁵¹ In the free market, the rates paid to hospitals by commercial payers are negotiated between the providers and payers. The market dominance of one of the parties often determines the negotiated rates. Medicare and Medicaid pay the rates established by the federal government or the state. Payer reimbursement rates for services vary depending on whether the payer is a commercial insurer, Medicare, or Medicaid. In an all-payer system, hospitals are paid a single-rate regardless of the status of the payer. *Id.*

²⁵² Sarah Kliff, "Maryland's Plan to Upend Health Care Spending," *Washington Post*, January 10, 2014.

²⁵³ *Id.*

losing its Medicare waiver; an event that would have an annual financial impact of \$1 billion in lost Medicare reimbursements for uncompensated care.²⁵⁴

The U.S. is just embarking on a journey of unprecedented changes to our health care access, payment and delivery systems. These changes may ultimately improve access and bring down the numbers of uninsured by creating additional pathways to affordable health insurance but even this fundamental goal of the ACA is uncertain. It is dependent on a number of factors among which are the extent and success of the expanded Medicaid program; the capability of the state health insurance exchanges to both motivate prospective buyers and offer them affordable insurance products within the coverage requirements of the ACA; and, the potential of delivery and payment system reform to drive prices and costs down while improving quality. Those hurdles are themselves a herculean task.

What clearly has not changed is our preference for and reliance on a market model. The few mandates included in the ACA to make health insurance accessible and affordable to virtually all Americans have been met with heavy resistance from an assortment of contingencies and, with the postponement of the large employer pay-or-play mandate until 2015 and 2016,²⁵⁵ it is unclear whether the ACA's fundamental shared responsibility model will be realized. While there seemed to be quite strong public agreement in 2009 that the U.S. health care system needed major reform, there seems to be little appetite for a more regulated market, at least with regard to the amount of money that is actually spent on care including expensive interventions that do not improve outcomes. That preference is notwithstanding data from other OECD countries that demonstrate that regulatory measures can exercise a downward pressure on prices.²⁵⁶ It is also notwithstanding the findings of much current research on the correlation between cost and quality in the U.S., some of which has been discussed above. Americans may be so entrenched in the existence of a positive correlation between price and quality in other markets that its nonexistence in the health care market is cognitive dissonance. It is simply too difficult for us to delink price from quality.

Given our preference for the free market as the mechanism for the buying and selling of health care, the job of bending the cost curve will require policy changes that nudge both providers and consumers toward less wasteful, more efficient and lower cost health care. To quote a distinguished group of health policy experts, "Although many in the health industry perceive that it is not in their interest to contain national health spending, *it is a fact that what cannot continue will not continue.*"²⁵⁷ As in Maryland and Massachusetts, eventually intolerable circumstances will force change. At the top of the list of systemic changes advocated by the panel of health law experts is the promotion of payment rates with global targets. Recognizing variations in pricing as an artifact of concentrated provider markets, the panel suggests a private market approach to Maryland's all-payer system.²⁵⁸ "Under a model of self-regulation, public and private payers would negotiate payment rates with providers, and these rates would be

²⁵⁴ Jay Hancock, "Maryland's Bold Hospital Spending Plan Gets Federal Blessing," *Kaiser Health News*, January 10, 2014).

²⁵⁵ Juliet Eilperin and Amy Goldstein, "White House Delays Health Insurance Mandate for Medium-Size Employers Until 2016," *Washington Post*, February 10, 2014.

²⁵⁶ "OECD Health Data 2013: Health at a Glance," Organization for Economic Cooperation and Development (2013).

²⁵⁷ Ezekiel Emanuel et al, "A Systemic Approach to Containing Health Care Spending," 367 *New England Journal of Medicine* 949 (2012) (emphasis added).

²⁵⁸ *Id.*

binding on all payers and providers in a state.”²⁵⁹ These all-payer rates would be subject to a global spending target for both public and private payers set and enforced by an independent council of experts representing all parties with an economic interest in a sustainable health care system. It is the hope of this author that the recent flurry of experimentation with solutions to the problems raised by this paper is not just a momentary toe in the water but a serious effort to solve the cost-quality conundrum. It is certain that what exists today is, in the end, a zero-sum game which cannot and will not continue.

²⁵⁹ *Id.*