



**Health Care Consolidation: Trends, Impact,  
and Regulation**  
**The Commonwealth Fund**  
**Alliance for Health Reform**  
**November 20, 2015**

The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Okay. Why don't we get started. My name is Ed Howard. I'm with the Alliance for Health Reform and, on behalf of our honorary co-chair, Senator Blunt, and Senator Cardin, and our entire Board of Directors I want to welcome you to today's program on Consolidation in the Healthcare Sector. The high profile part of this issue, of course, is the proposed mergers among major health insurers—Anthem and Cigna, Aetna and Humana—that would, if approved, reduce the big 5 to a big 3. But consolidation is taking place among providers as well. Health systems are merging with and acquiring other health systems. There's hospital physician integration. There are physician practices consolidating with each other, and the pace of consolidation seems to be accelerating as well. It's attracted the attention of both the Federal Trade Commission and the Justice Department Anti-trust Division, which are sensitive to how competition is being affected by these moves.

Today, we're going to take a look at each of these different aspects of healthcare consolidation, their possible impact on the quality and cost of care, and access to it. We're pleased to have, as a partner in today's program, the Commonwealth Fund, a century old philanthropy that is in business to promote the common wheel, or common good, and we're definitely pleased to have, as co-moderator, Dr. Eric Schneider, who's the Senior Vice President for Policy and Research at the Fund and we're going to hear from Dr. Schneider in just a minute. Before we do, let me attend to a little housekeeping. Lots of my usual array of tips you can find on the sheet that was available out front that tells you all about websites and materials and that sort of thing. I will just mention a couple of items. One is, if you would like to Tweet, there is a hash tag HCConsolidation that you can use. It's up on the screen. Wi-Fi is available. The credentials are on your tables, I believe, and on the screen. This, by the way, is going to be the set of credentials for briefings that we do on the Senate side from now on. They've got a new system so you don't have to learn a new set of credentials every time. And, two other things. I want to call attention early to the blue evaluation half sheet in your materials, if you will, which we'd appreciate you filling out before you leave. And, lastly, in those materials you have in your packets there's an updated toolkit on consolidation that the Alliance released today. I want to thank Alex West, our intern, who did the heavy lifting for that update, and it's the one that's not on buff-colored paper in your materials.

Now let's get to the program and we're going to start with a brief overview of the main issues here from Eric Schneider. Dr. Schneider.

ERIC SCHNEIDER: Ed, thank you very much and on behalf of the Commonwealth Fund, thank you to the Alliance for sponsoring this, and it's delightful to see all of you here today. The Commonwealth Fund is dedicated to a high quality and affordable healthcare system which is why this issue of consolidation is so important to us and, as Ed mentioned, this past summer there were two large insurance mergers that are proposed and pending and this could change the dynamic in insurance markets. But I'll start by just asking the question: Why does consolidation matter? And, of course, in other industries large companies facing fewer competitors can raise prices for their products and insurance is no different in that sense. The concern is that these newly merged companies will raise premiums, deductibles, and co-pays and consumers will not be able to vote with

their feet by choosing an alternative competitor. But healthcare is actually distinct from other industries in some ways, like airlines or wireless providers. The suppliers of healthcare services—the hospitals, physician groups, and other providers—have also been consolidating and they are consolidating in two ways that I'll get to in just a moment. These bulked up hospitals and provider groups could potentially use their size, brand, and position in the marketplace to raise prices, and then, insurers have to either absorb these costs or pass them on to consumers in the form of higher premiums. The insurers are arguing that one antidote to this consolidation on the provider side of the market is to take on more market share and gain negotiating leverage over providers through that market share. How big is this problem? How will it affect prices and quality of care for consumers and patients? Is empirical consolidation an antidote to provider consolidation? What are the other remedies?

Today we have an outstanding panel of speakers who will help us to navigate this complex topic but first, I'll set the table with a brief overview of the amount and types of consolidation we're seeing and then our panelists will discuss the topic.

So, the first observation is that there's considerable consolidation in the insurance industry already. This slide, provided by Leemore Dafny, shows that the four largest insurers, and Blue Cross Blue Shield and Anthem are considered one insurer in this counting, now control over 80% of the market nationally and you can see that there's been a trend between 2006 and 2014 in that consolidation and market share control.

And in some markets, the insurance concentration is even higher. This analysis, done at the Commonwealth Fund shows that, at the state level, a remarkable number of states are considered concentrated under the definition of the Hirschman-Herfindahl Index, which is a common measure of competition, and that the majority of states, health insurers are moderately concentrated; only a few states that are considered not concentrated by these measures.

The Medicare insurance market is actually a distinct segment of consumers, and this segment is also quite consolidated, or concentrated. This is work by Brian Biles and colleagues on Medicare Advantage Plans published by the Commonwealth Fund that shows that the percent of all counties nationwide that are highly concentrated is 97%; that the percent of enrollees is 77%; and, beneficiaries—Medicare beneficiaries—is 84%. So these are highly concentrated markets in the Medicare Advantage environment as well.

So let me turn to the provider consolidation side, which is sometimes confusing. So, if this is a typical market represented by some hospitals and some provider groups, marked by stethoscopes and black bags, you can see why this would be a competitive market. Consumers could have choice among these various entities and what we're seeing, or what we have seen historically, is what are called horizontal mergers—hospitals joining with other hospitals to consolidate in these markets, or provider groups joining with other provider groups. And this is the type of merger activity that does set off alarm bells at the Department of Justice and FTC and needs further investigation because, as you can imagine, the competition for hospital services is very low in this type of market. Cost

competition for physician group services is very low as well. And the evidence suggests that hospital concentration is increasing. The dark red, here again, is the highly concentrated areas of the United States in 2011 and you can see that many markets are highly concentrated, or many hospital markets are highly concentrated by this measure.

And we see the same thing in the physician group and large practice area, so between 2009 and 2011 you can see an increasing percentage of the country that's in the red zone, meaning these are physicians consolidated into practice groups of greater than 50 physicians and that seems to be spreading somewhat.

The other type of consolidation that we care about and that is, in some ways, the newest phenomenon, is the consolidation vertically, which involves entities—hospitals and physician groups, just to simplify this—joining together in various ways. So, a physician group may have affiliations with hospitals that may be governed by the physician group. Another typical arrangement is a hospital joining with multiple physician groups, or acquiring them, or merging in some way, and there are even some entities that are sort of mixed physician group-hospital governed entities, and these are important because the Accountable Care Organization policy that CMS has initiated actually is promoting this type of integration in order to promote integration. Now that has several potential virtues. In theory, larger integrated networks, as these are called, can improve the quality of care. They can actually address the complaint that consumers have that care is fragmented, that physician groups in hospitals don't communicate well. They can actually make investments in digital technologies that can improve coordination. They can take on financial risk. There are several virtues and this is the case for accelerating the formation of these ACOs, Accountable Care Organizations.

The next slide shows that physician-hospital arrangements have increased over time. The percentage of physicians in physician hospital ranges is rising relative to other types of arrangements. Part of this was driven by the policy of higher payments to ambulatory practices based in hospitals relative to others. That's a potentially problematic incentive. And, as this slide shows, hospitals have been acquiring physician groups over time. That's the purple bar going from left to right between 2008 and 2011.

So I hope I've made the case that we see consolidation in both insurer and provider markets, and that that trend is increasing. And, for the remainder of the discussion, the panel will address several questions that are critical to the quality and affordability of healthcare. First we'll hear from Tim Greaney, who will discuss insurance consolidation and the current role of anti-trust law, oversight and regulation, and the various tools that are used. He'll tell us about the way that anti-trust law looks at consolidation in the insurance markets. Tim is the Chester A. Meyers Professor and Co-Director of the Center for Health Law Studies at St. Louis University School of Law.

And then next we'll hear from Laurence Baker, who's Professor of Health Services Research and Policy at the Stanford School of Medicine. Lauren will speak to us about the scope and extent of consolidation in the provider market, the research he is doing that

will have more recent data and especially the effects of these consolidations on consumers.

And then we'll hear from Bruce Vladeck, who is Senior Advisor to Nexera, Inc., and has a distinguished history here in policy circles. He'll address the pressures on providers and the role of mergers and acquisitions in restructuring the healthcare industry to effectively meet future needs.

And then, finally, least but not last, Paul Ginsburg, who is the Norman Topping Chair of Medicine and Public Policy at the Schaeffer Center for Health Policy and Economics at the University of Southern California, will address the narrow and tiered networks and implications for pricing and value in consolidated markets. He will indicate that it is much more important whether mergers go through and that mergers won't have much of a positive or negative impact.

So, a variety of perspectives on the panel and, with that, I'll turn it over to you, Tim.

THOMAS GREANEY: Thank you, Eric, and thanks to the Commonwealth Fund and the Alliance for the invitation.

I'm going to give you a cook's tour of how anti-trust law deals with consolidation, focusing, of course, on the insurance mergers that Eric mentioned. I'm going to start with just a look at a couple of things. First, the interplay of the Affordable Care Act and competition policy, and I want to debunk a couple of fallacies that are floating around out there. One is the argument that the ACA is somehow responsible for the excessive consolidation and mergers when, in truth, the ACA really depends on competition and actually promotes it. When you look at the structural changes in the Act—creating exchanges, getting rid of information asymmetries or limiting them, I should say, payment reform, spurs to new delivery systems—they really are designed to work at the market failures that have plagued healthcare competition for many years, namely fragmentation in delivery and a payment system that rewards volume not merit.

So here's a primer on how anti-trust law goes about it. First of all, what's the goal of a merger case? Merger law tries to prevent consolidation, stop them ex-ante before they occur and it's aimed at those mergers that enable the exercise of market power. The mergers are presumed illegal if they exceed certain Herfindahl Indices levels of high concentration and high market share. And there are really four different kinds of arms that come out of mergers. One is coordinated pricing, meaning what economists call oligopoly—too few sellers—and the economic learning is pretty robust on this that in markets with few sellers price tends to go up, outputs decline, and quality decreases. It also addresses the situation which they call unilateral price increases where the two merging firms, because of their special characteristics and brand preference, have the power, after the merger, just between themselves to raise price or reduce quality. A third kind of concern is the flip side of monopoly, which the economists call monopsony, which is the power to depress price of inputs, in this case, depress the prices paid to physicians below a competitive level, and we're talking about pricing that goes below a

competitive level as a buyer. The insurers buy health services from doctors, essentially. And the fourth is an important one that's in the background of these insurance mergers which is potential competition. Anti-trust would try to discourage mergers that would otherwise result in new entry and, to the extent that entry that would have occurred but for the merger is diminished, that's a big concern. And when you reduce the five leading candidates down to three that's a central concern.

And remember, the concern for the consumer is obviously over price, higher premiums on the insurance side, but also over quality. The quality and extent of the networks, the cost settlement claims they do, and so forth. And finally, innovation, whether a merger encourages or discourages innovation and there's a lot of innovation going on in the insurance side.

Okay. So, how do courts and how does the Justice Department go about dealing with mergers? I'm an alumnus, I should confess, of the anti-trust division of the Justice Department, and they're facing a daunting task now, according to the American Hospital Association and American Medical Association. There are as many as a thousand markets in which there are problematic issues raised by these mergers.

The first issue is, what products do they sell? And the argument can be made that insurance in the United States is offered and organized and priced in distinct segments, distinct markets that have different characteristics and should be analyzed separately, so there probably is a distinct market for the individual sales, maybe a separate one for small group markets, a separate one for large groups buying insurance, fully insured products from these insurance companies; a third one from large companies, and this is almost half of the privately insured market in the United States. Large companies don't really buy insurance from insurance companies, they buy administrative services, which are very important but they self-insure, but the insurance companies administer those products and also arrange networks for them. Next, there's a really important market, the Medicare Advantage market, which is almost a third of Medicare beneficiaries are in private plans, sold to them by private insurance companies. And, finally, there is growing markets in Medicaid Managed Care.

Now, almost all these markets are local. The old saying is, "All healthcare is local." Well, health insurance is local, too, because the product you're buying from your insurance company really depends on the network and the networks you buy are local hospitals and local physician care. The exception is for the large national multi-site insurers, which are probably regional or national. Again, as I said, the AMA and AHA claim there are, by using the Herfindahl Indices, literally hundreds and hundreds of such markets.

So the legal presumption attaches, let's assume in many of these markets, what counts on the other side? What counts for rebuttal evidence? Well, the legal test in the case law, not only in healthcare cases and every industry, has been well, prove that the merger will not result in higher prices despite the size and I'm going to go through a few of these and talk about how they may or may not be analyzed in the Justice Department's review—ease of entry, countervailing power, regulatory constraints, and efficiencies.

The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So, the ease of entry defense says, well, the market is really big and concentrated but it's likely that somebody will enter and compete with us in the future. The legal standard really is not just that someday someone will enter the market but that entry will be timely, likely, and sufficient to mitigate harm. And the idea here is that consumers shouldn't have to pay the price over the years waiting for entry. The Department of Justice has brought a number of cases and it has found that significant entry barriers resulting from various factors. One is a new entrant into the insurance market has to assemble a network, and there's sort of a chicken and egg problem that goes on there. Entrants, new insurance entrants, need price discounts from hospitals and physicians in order to be effective competitors and in order to attract customers but, at the same time, hospitals and physicians will only give discounts if they can be assured the entrants will have a good array of customers. So that has proved to be a pretty formidable barrier to entry. Brand recognition is another one.

The experience, since the ACA, has been pretty mixed. You may know the co-op insurers, half of them, the new entrants subsidized by the ACA, have of them have gone out of business. Entry in the health exchanges has been very mixed. Forty percent of the health exchanges have only two companies offering insurance. The average exchange only has three. The possibility of entry into insurance by hospital systems is an interesting phenomenon, and whether that will occur and be effective is an important question for Justice to decide.

And, you know, ease of entry is sort of a slippery slope issue. An interesting question was posed by Senator Lee of Utah to the two insurance executives in the mergers that testified and they both were saying, well, there'll be lots of new competition in the market. And he said, well, if entry is so easy why not enter—those two companies you're acquiring—why not enter their markets, Humana and Cigna, instead of buying them? And, again, there's been mixed results in the exchanges. And those of you who remember the run up to the Affordable Care Act, there was a lot of attention to the so-called public option and the idea of a public option was we needed a public insurance company to shake up these dominated markets, dominated by a few sellers. It didn't pass on the assumption that there would be vigorous new entry spurred by competition.

I'm going to skip over this one. I call this the ACA Made Me Do It defense, the idea that there is so much impetus to concentration that somehow that's a defense. A couple of courts have rejected that in hospital merger cases. Another defense relies on the regulation that's out there, the medical loss ratio regulation which, I think Paul and I disagree on a bit because I don't think it's a very effective – I certainly don't think it's one that will carry the day in court. There's rate regulation, but a lot of this regulation is not a substitute for competition, in my view.

I want to finally turn to my favorite defense, though. I call it the Sumo Wrestler Fallacy. This is countervailing power. And the idea is that, well, okay, we'll have large insurance companies but they're going to be bumping bellies in the middle of the ring with dominant hospitals and dominant physician groups. Won't that redound to the benefit of

the consumers? Should that be a defense looked at in the mergers? And, there's a lot of literature and writing and evidence on countervailing power but, first of all, distinguish it from monopsony where the dominant firm can actually lower the price, competitive price, below the competitive level. That's certainly problematic in everybody's view and that might be even a problem with a dominant hospital because it could lower the prices for other hospitals. But countervailing power is a tricky one, but here's where I come out on it. First of all, there's no question that provider dominance is the major source of cost concern in the country. There's a lot of evidence that that's the major driver of costs. At the same time, there's also evidence that large insurers do get better discounts from hospitals, the bigger insurers get better discounts. On the other hand, there's also evidence that even though they get those discounts they don't pass them on to consumers. So, the evidence from the case law—and there are a number of cases of this sort—is that often the Sumo wrestlers decide to shake hands rather than wrestle and they find strategic accommodations for each other. There's a famous case up in Boston where partners and Blue Cross Blue Shield really reached an accommodation not to drive each other to lower prices. So, that's an example, and there are a number of other examples in the case law.

And I will just mention, the last piece of the puzzle—what kind of remedy can the Justice Department get? In past cases, it is settled for divestitures—spin off, sell the plans where there are large overlaps. Well, there are a lot of problems with that because, going to the second part of this slide, insurance spin-offs are trickier than spinning off a cement plan. You have to find a buyer who's going to operate one of these plans that is capable, not themselves a problem, and able to get favorable contracts and you're going to need ongoing supervision to make sure that the spinoffs work and doing it over hundreds of markets may be problematic. So, my friends at the Justice Department have a big job ahead of them. Thank you.

LAURENCE BAKER: Alright, so my job is provider integration and consolidation—the doctors, the hospitals, all the other providers out there that are merging—and my job is to do that in 10 minutes and so this is a tasting menu, if you will, of things that have been going on in provider markets and a couple key pieces and some of the evidence that's been coming out, I'll show you some evidence from our research at Stanford and we're not the only ones doing it. There are other groups, too, so I've got a couple slides from other people as well.

So this is all set up around the notions and the ideas that Eric talked about at the very beginning where consolidating doctors pretty fast these days into bigger groups, or consolidating hospitals pretty fast into bigger systems into large organizations and we're merging the two of them together to make these large physician hospital organizations and we're doing all this because we think it's going to be good or, at least, we hope it's going to be good for patients. That's one of the arguments. Maybe not everybody is thinking about it that way but, you know, maybe we can hope.

So there's economies of scale that are going to drive down costs. There's better management that comes from larger organizations. You can invest in technologies to drive more efficient utilization of healthcare. Maybe you can drive higher quality so that



outcomes are going to be better. Basically, this notion that we kind of know that doctors who work by themselves, not talking very well to other doctors, not integrated with other hospitals, small hospitals out and about doing their own thing, really probably aren't the best way to deliver healthcare and some sort of integration might help.

So, we hope that that's true. And against that we get the notion that there might also be problems and the biggest problem is you create these large organizations with lots of market power and once they're large they can hire lots of MBA's who know how to use the market power and then they go negotiate for higher prices and we drive up our healthcare costs at the same time.

So those are the two big pieces of the argument, the two sides of the argument, and the question is like what do we know from the literature? So I'll show you some things about prices. That's what we know the most about these days. I'll chat along the way, at least a minute or so, about utilization and efficiencies, and then I'll talk a little bit about quality, which we also don't know that much about. And then I'll try to give you a couple comments at the end.

So, you know, Eric already showed you that there's a trend toward larger physician groups so I'm just going to go right past this one. Almost doubling the share of physicians in practices of more than 100 doctors since the year 2000—huge increases in the high end, in the largest practices. And this goes, then, to questions, so I went too fast past that, but that's the basic story. This thing goes to the amount of concentration that exists in physician markets and you can look at this in a bunch of different ways. Here's a slide from some work that we've been doing that just looks at the Hirschman-Herfindahl Index, which is a measure of concentration in markets for different kinds of specialties in medicine. And so we look at different practices all across the country and, if you look on the left-hand side, there's internal medicine. The median internal medicine practice that we studied in this particular case, a nationwide study, lots of the internal medicine docs in here, we think almost all of them—the median Hirschman-Herfindahl Index—I'm just going to say HHI—the median HHI for them is a little under a thousand. That's reasonably competitive, at least for physician markets. But, if you go out to the other side—radiation, oncology, thoracic surgery, cardiac surgery—median practice HHI is 5,000-6,000. This thing gets higher, you get closer and closer to monopolies. And so these practices are very concentrated by the standards that are normally applied to physician concentration. So, lots of variation across specialties. And I could've shown you a similar one across markets. There are places in the country that are still reasonably competitive but there are places that are highly monopolized—the physicians are extremely concentrated.

So what does this do to prices and utilization and maybe quality? Mostly we know about prices and the answer is the prices are higher when there's more concentration. No economist is surprised by this but, as an economist, I'll tell you I'm a little surprised by the magnitude of it because this is big enough to be important and it's something we should pay attention to.

So what is this graph showing you? This is work that we did a couple years ago, published last year that looks at what happens to the price of common services. This particular figure is for an intermediate office visit; sort of standard office visit for an established patient normally costs about \$75, \$70-\$75 in our study. What happens when you move from the 10th percentile of the HHI to the 90th, which is to say, moving from a pretty competitive practice to a pretty not competitive practice of almost, some cases, monopolized practice, when we get the prices for internal medicine intermediate office visits, intermediate office visits with an internal medicine doc, go up by about \$12. So, on a base of \$70 that's coming up on 20% increase in the price. That's about a 17% increase in the price. Big increases in the price for these services when you consolidate the physicians.

Out on the other side of that graph—orthopedics, ODO, urology—increase is in the \$6-\$7 range, so those are less than 20%, of course, a little closer to 10%, a little bit under 10%, but it's still pretty big increases in prices associated with consolidating physician practices. We're not the only ones that have shown this. This isn't the only paper that shows this. You can see it for different services, you can see it for more complex, more expensive services, and you can see it in different kinds of empirical studies in context, but there's the basic story. Consolidation drives higher prices.

Eric and I got the same slide on hospital concentration. And we thank David Cutler and Fiona Scott Morton for making such an attractive slide that we could both clip out and stick on our slides. But in the interest of time I'll go kind of past this point a little bit quickly, too. What I just showed you for physicians, when you consolidate physicians you get higher prices and meaningfully higher prices. You can do this for hospitals. When you take hospitals and put them together in larger organizations, more powerful organizations, prices go up. They often go up quite a bit. This is a slide from some work by Jamie Robinson from Berkeley that looks at hospitals and more and less consolidated markets. He looked at prices paid to the hospitals for angioplasty, pacemakers, knee replacements, hip replacements, lumbar fusion, and cervical fusion and he finds—you can see the blue bars there—the heuristic here is blue bars = concentrated markets, not very competitive, much higher prices. See those bars are way higher than the orange bars which are the competitive markets, way higher prices paid to hospitals in those markets. We can get into it if we had more time in terms of the specifics and the degree to which the prices go up because there are some studies that'll tell you more and less, but pretty much all of the studies will tell you higher prices that are paid.

Let's quickly kind of go past hospital integration with physicians. This is in our sampling menu. Now we're onto this notion that hospitals are buying physician practices. When the hospitals buy physician practices they get bigger, more powerful, and can they raise prices, too? Answer—yes. And, can we find it in the data? Answer—yes. We see higher prices when these things happen as well, so this is work from our group that just says that let's find hospitals that look like they bought physician practices using the data from the American Hospital Association. On the left, there, if you can read it, there's a tall red bar that's for hospitals that are what they call fully integrated organizations. They own or closely contract with the physicians in a very tight organization. And what this says,

when you increase the share of those kinds of hospitals in your market and, in this case, when you increase it by about 20 percentage points, the share of patients going to those kinds of hospitals in your market, you drive up the price paid to hospitals by 3, 3.5 percent, something like that. Not a huge effect, but then, we spend quite a bit of money on hospitals in this country so if you could reduce it by 3% I'd probably take it. Right? That's still enough money to pay attention to when we're talking about consolidation. This is also consistent with some other work that is coming out of different versions of this kind of study, but these are the kind of magnitudes that you get, sort of medium sized price increases associated with increases in the amount of physician hospital integration.

So, I've just been talking about prices. The thing we know the most about these days is prices. A lot of the work that's been coming out of academia, at least, has been focused on integration, consolidation, and prices and you got the main story now. The question, then, and two other points, is still emerging a little bit. So one of them is what happens to utilization? Do we see any efficiencies coming out of these kinds of bits of integration? Do we see patients getting less care? Do we see things that look duplicative, not being used? And the answer isn't that compelling, or the answer isn't that well defined, I'll say. The evidence isn't that compelling. We're getting there, but there isn't that much evidence that we're getting a lot of the benefits either, and so I'll just make a note that, in this study here, I didn't put the graph in because I figured I'd run out of time, and I was actually right. So, I'm going to go a little bit—I'll just kind of start wrapping up to make sure I get finished.

We don't see any evidence that when you create these integrated physician hospital organizations that there are fewer hospitalizations, that there are things that look like patients are getting the care that they need to keep them out of the hospital, for example, we don't see any of that. We see higher prices and we don't see any changes in utilization that are meaningful, which means higher spending is associated with these mergers.

We also looked in Medicare at what happens to spending for Medicare patients and so I'll just note a couple things from—this is our most recent study where we found doctors, cardiologists, who looked like they were not integrated with a hospital and then got integrated with a hospital. We found some people who changed, a couple thousand of them that changed, and we were able to look at the spending for their patients before they switched and then after they switched and we compared them to other cardiologists who never switched and we just saw if they were more or less expensive than the other cardiologists before and after. So here's a bit of evidence from that. This is for outpatient spending. How much gets spent on the patients of these cardiologists within a 30-day episode, the blue line in the middle is when they switch, and before they switch. The answer is the doctors who are going to eventually switch and get bought by a hospital are a little bit more expensive. At first \$16 more expensive and then they get a little cheaper, then they switch and they become immediately \$60-\$70 more expensive right after the time period that they switched. So this is pretty tightly associated and it is the kind of thing that you'd expect would happen, partly because you can get paid more money once you switch into a hospital and partly—here, and I'll show you for hospitalization—it's probably because you can drive more utilization. And so, this is hospital spending now by

these patients. If your cardiologist gets bought by a hospital what happens to the amount of spending on inpatient care for those patients? Well, before the cardiologist switches and gets bought nothing is really that different. Right after they switch, in the first quarter nothing's different, but then look out a couple quarters. The hospitalization expenditures go up \$200-\$300 per person. And that's basically a function of more of their patients are going in the hospital. So, once the hospitals buy the doctors more patients get hospitalized afterwards. So that's pretty interesting evidence and it suggests that there are not efficiencies associated with less utilization of care, that there are not changes that are coming from maybe more efficient choices about the care that's going to get delivered.

Okay. So, summing up. What do we know about consolidation and prices? Consolidation is positively associated with prices. What do we know about utilization? Evidence is still emerging. Maybe there's no effect, maybe there's a positive effect. I think it does depend a little on how you look at it and we're going to have to work on this a little bit more to give you a really definitive answer but the big thing that you'd hope for there, lots of efficiencies – not really showing up, at least not in big ways in the studies that have been done so far. What about quality? Are we getting patients to live longer? Answer—very limited evidence right now but, again, the people that are looking are not seeing immediate big gains. If you thought this was going to be a huge big obvious thing to find in the data, that's not happening. You know, there might be things out there that are important and we're going to have to look for those, but there isn't a lot of evidence that's really popping out to say quality is improving and there's more work to be done.

A couple of things for interpretation. The organization specifics probably matter and the payment and regulatory environment probably matter. This is all done in kind of a fee-for-service environment and so that may be changing and that might affect how this goes and some of these organizations, there are probably organizations out there that know how to do it—that integrate that don't drive up prices as much, that drive utilization, and maybe we can look to them and find good managers and good techniques and maybe it can be done, but overall, across the country, in the big studies it's not happening.

BRUCE VLADECK: Good morning. [mic not working] ... I don't have any slides today ... [mic not working] ... Now it's on. I think there's been – there's a direct contradiction between what's been the overwhelming consensus in the American health policy community about how to provide high quality care in this country and the tenets of anti-trust theory. Second, I think having a discussion of consolidation in the hospital industry and of the insurance industry in the same meeting overlooks and, perhaps, distorts the radical differences between these industries, particularly at this point in this history, and the direction in which they're going. Third, if you follow that question of the differences between the hospital industry and the insurance industry, after a while you catch onto the fact that hospital systems, after they're non-consolidating and raising their prices 3%, start insurance companies and insurers are directly employing or entering into exclusive contracts with providers at the same time. So the boundaries are shifting, but it also suggests to me that our unit of measurement—and I'll get back to this—is maybe not the right one. And then, again, you've heard this from me before, but the underlying problem here is our continuing insistence on applying conventional marketplace economic

theories to a sector in complete market failure, where we've known all along of the systematic market failure. And I'll elaborate on that a little bit.

One by one, on these points, I've been feeling a real sense—of course, every time I come to Washington I get a sense of cognitive dissonance, but it's been particularly acute today because, again, for the last 30 years every other meeting I've gone to which talks about how do we get to high quality, high performing health systems in the United States, has talked about models like Kaiser Permanente, or Geisinger, or Intermountain and so on and so forth, all of which are integrated systems of hospitals and physicians, many of which are also in the insurance business and, with the exception of Kaiser, most of which are local monopolies.

Now, one of the interesting things about these high performing health systems is they're not cheap. They're not the lowest priced competitors in many of their markets, certainly in the Medicare Advantage market, for example, Kaiser's long been the high priced provider in northern California, but there's some data and, I think a large degree of professional consensus, that this is the way we ought to be getting medical care and now you have healthcare providers sort of trying to do it for whatever reasons, good or bad, and then they get a letter from the Anti-trust division.

On a smaller scale, we also decide the other way to fix the most important part of the healthcare system is by primary care medical homes and I'm a total believer in that, but you can't have a three- or four-man, or person practice and have a primary care medical home. You can't afford the IT. So, for a bunch of qualitative reasons, we're pushing in the direction of innovation and nobody knows where the – of consolidation – nobody knows where the sweet spot is between the two and, again, I think we can argue about the economics for a long time. But if you take seriously that everybody ought to be in a real integrated health system, or that a large proportion of consumers ought to be in an integrated health system that can take care of almost all of their needs within the system, and you do the arithmetic, you figure out that most metropolitan areas in the United States aren't big enough to have more than one or two such systems. If you just do the arithmetic on how many neurosurgeons you're going to need, how many specialty care you're going to need, how much inpatient hospital capacity you need, if you're in a metropolitan area, more than 450,000 people, the ability to support a systematic comprehensive system of healthcare, the arithmetic almost suggests you can afford, at most, 2 or possibly 3 competitors, all of which will be over the anti-trust guidelines, before you have lots of excess capacity running around. And we haven't gotten around this issue.

Second, when we talk about hospital insurance industry consolidation is, though they're the same thing, but there are radical differences that have a lot to do between the hospital business and the insurance business. First of all, when we talk about the hospital business and we talk about measuring consolidation, we generally use inpatient beds as the measure of concentration because that's the way we've always judged hospital capacity but, in fact, inpatient hospital utilization in the United States, not per thousand, but total, even in increasing population, has fallen more than 50% in the last 35 years. This is a

shrinking industry and a large share of all hospital mergers are a way of preserving uneconomically small institutions or dying institutions at least by providing for a more decent process by which they are eliminated rather than bankruptcies and the ugliness of hospital closings without absorption by somebody else. In fact, our systems are our most efficient social mechanism at the moment for taking inpatient capacity out of the system. Now, part of the problem is that inpatient services now account and, for the last 35 years, been accounting for a diminishing share of the revenues of hospitals or hospital systems to the point many instances where they're now 50% or less of total revenues and yet we're still making policy and deciding all these anti-trust cases of counting beds. But, meanwhile, as hospitals increasingly are being expected to assume some degree of financial risk through value-based purchasing or whatever the other phrase of the week is today, they are acquiring and increasing insurance function and many of them are doing that explicitly at the same time. Meanwhile, the number of people with health insurance in the United States has expanded very dramatically in the last 5 years. The Affordable Care Act has accomplished that, although most of the newly insured people are enrolled in Medicaid, but even there, Medicaid has largely been transformed over the last decade from a state government administered system to a system that is administered by contract by private health insurance companies and, in fact, as I understand it, the driving force in the Cigna-Humana merger is not, in fact, the private business, it's Humana's Medicare Advantage business, which is where the profits are for the big national insurers these days. So, I sort of wonder if we know what we're talking about.

The other thing that's very important to the consolidation issues is that, in the insurance side, in about half the states, state regulation really still makes a difference except for national group business, but certainly on the individual and small group markets. You have about half the states where state insurance commissioners still take their jobs seriously and that raises serious questions for how we measure and think about consolidation.

And then, of course, there are the physicians who are a big part of the health system and from an economic point of view in whole 'nother category, a lot of which has to do with the economics of professions which the professionals who study economics tend not to pay a whole lot of attention to.

Third—I sort of slid into the third one about the merging of the hospital and insurance businesses. But I think, in a way, these are all really – our problem, the manifestation is the underlying problem, which is our continued insistence on applying theoretical economic principles to a sector where they just don't fit. I hope you've all read Tom Rice's primer on health economics with his list of the 13 major sources of market failure in healthcare, many of which have gotten stronger in recent years, but since I can't remember 13 different things I think there are two that keep coming back to me with particular force. First of all, we have a market in which half the customers, as defined by revenue for hospitals, for many physicians and for lots of other entities that are involved in the healthcare system, most of which are not part of larger systems at the moment, whether they're home care providers or medical equipment manufacturers or things of that nature, half of the market is government programs with administered prices. So, I

believe even one of Dr. Baker's slides repeated the error that kept the Dartmouth group in business for 20-25 years of confusing Medicare prices with something having to do with an actual phenomenon as opposed to a reflection of a set of particular policy decisions, recognition of graduate medical education, of DSH, of wage index and all that kind of stuff as well.

On the other hand, in the other part of the healthcare market, the relationship between buyers and sellers in healthcare is inescapably distorted by the information imbalance between buyers and sellers and by the emotional valence associated with healthcare issues and health in many other regards. I mean, in that regard, I want to conclude with sort of a personal situation, but a member of my family, two years ago was diagnosed with a relatively uncommon cancer and was treated by wonderful doctors and wonderful people in one of the major academic medical centers in the United States and with a good outcome. However, that major medical center on the island of Manhattan did not have, on its staff, a pathologist who was really capable of reading the slides of her tumor to the point where there was, in fact, a misdiagnosis preoperatively. She probably would've needed the operation anyway. And the aftercare for this particular cancer is determined entirely as a function of the type of cells in the tumor once they're fully analyzed. And the major academic medical center where she had her surgery was unable to make a definitive determination from the slides and so we went, as we should have done in the first place, to the international NCI certified cancer center 30 blocks away where they actually see enough of those cancers so that they have oncologists and pathologists who know what they're doing in dealing with that particular cancer, which was sort of a lesson to me. Because when I saw Dr. Baker's slide about concentrations in cardiac surgery and oncology I said thank goodness. We've known for 30 years that the more cardiac surgical procedures that are performed at a single center the better the outcomes are. We have a significant amount of data in the literature that the more surgeries for a particular kind of cancer are performed at a particular institution the better the results are. We've known also for 30 years that the larger the NICU is the more low birth weight babies survive and yet, in this country over the last 30 years, we have increased the number of NICU's at a far greater rate than we've increased the number of neonates. And the average size of a NICU has gone down in this country over the last 20 years.

So, there is, again, a cognitive dissonance between the evidence on volume and outcomes which continues to amass on the one hand, and the findings that there's no qualitative positive benefit from consolidation, which I think is a function of some of the methodological problems we have in that regard. But all of which, in the area of oncology, of cardiac surgery, of neonatal care and, I would argue, much of the rest of the healthcare system as well, leaves me with the question of the extent to which anyone can suggest significant instances in which increased marketplace competition in the provision of healthcare services has actually benefited consumers and patients. And I think you can find instances, letting optometrists do refractions, that's what I would consider sort of the margins of the healthcare system. But in the core medical surgical services I can think of 50 examples where competition has had bad effects on consumers and costs for every, I would argue, for every 1. But those slides would be too long and so I didn't prepare them for today. Thank you very much.

ED HOWARD: Paul.

PAUL GINSBURG: Thanks. You know, events put on by the Commonwealth Fund and by the Alliance for Health Reform have really just been my favorite events to speak at, so having both of them today is terrific and I appreciate the ability to be here.

My talk has a very different focus because I'm going to say that, you know, our healthcare markets, insurance markets, provider markets are already pretty consolidated and they're getting more consolidated and they would even if there were no more mergers in either case. And there's some solid reasons and some of the things Bruce mentioned were some reasons, that basically, on the provider side, it's becoming an increasingly challenging environment to be a small hospital or to be a small physician practice and so this is why concentration is going to go up.

On the insurance side, it's also a very challenging environment for small insurers today and this changed about 15 years ago, maybe 20, when multi state employers decided that they wanted to get a single national account for all of their employees. So regional insurers have been declining ever since that. And so, in a sense, that's a key reason why the insurance markets are becoming more consolidated. Also, insurers want to pursue payment reforms. You know, they have to be large enough for it to be worth the provider's time to negotiate with them. So, the implications that consolidation will increase even without mergers and I believe that we need public and private sector initiatives beyond anti-trust or in addition to anti-trust to make markets more competitive.

So what can we do to increase competition? And I'm thinking, I would say we, I mean either private sector actors, typically insurers or policy makers. So in the provider markets, I think the key opportunity to make provider markets more competitive is network strategy, basically pursuing narrow or limited networks or pursuing tiered networks. And in insurance markets, I think the key approach to making insurance markets more competitive is insurance exchanges. We now know that we've had, I think, are more competitive environments under the public exchanges, the ACA marketplaces. There certainly are opportunities to make Medicare Advantage more exchange-like if we don't go all the way towards making an it an exchange. And then, we have an unknown. We have a lot of activity and a lot of excitement about private exchanges in the employer sector. They might be very important in a few years, we'll just have to see.

Now, the essence of a network strategy is to shift volume from high priced to low priced providers and there are three potential sources of savings through this approach. The simplest one is if you have a higher proportion of care at the lower priced providers that costs less but you're also going to get price reductions from some of the providers who see an opportunity to reduce their price to qualify to be in the narrow network. And then longer term, if this works, you will see additional cost reduction by providers just from the more competitive environments.



Now, there is potential in these network strategies to use broader measures of price and to incorporate quality. And what's striking to me is the analytic parallels to what we're looking into with alternative payment models. So, for an example, you can create a network based on the cost per episode or the cost per patient over a period of time. The analytics really are the same so they're going in a consistent direction. Also, narrowed limited network approaches give you an opportunity for integration through having provider led plans, or joint ventures between providers and insurers.

I want to make a few comments about narrow versus tiered networks. Narrow networks, I think are a more powerful tool. They have stronger patient incentives for steering and also they, on the exchanges, have been shown to be very attractive because of the large premium reduction and roughly it's about a 15% reduction as measured by McKenzie in the ACA marketplace plans. And exchanges provide an ideal environment to have limited network plans because fixed contributions mean strong incentives to seek lower premiums and also an exchange tosses out the one size fits all constraints that is faced by many employers. If you're going to offer one plan it had better be a plan that most of your employees are fairly happy with. Also, exchanges have potential to ease comparisons of networks along plans. They can be, and they're getting there, a single place to go to truly compare networks in different plans for the consumer to see which is most attractive.

Now, tiered networks ultimately may have even larger consumer acceptance. And, if you think about our experience with managed care over the past two decades, think of the popularity of PPOs over HMOs and think of the popularity of tiered formularies for drugs over closed formularies. So I think the opportunity is there but I think in many areas dominant providers have blocked tiered networks and it's a fascinating case study of Massachusetts, which probably has the greatest mushrooming of tiered plans, that this all got underway in response to 2010 legislation that was passed by the states to eliminate the ability of dominant providers to say unless we're in the preferred tier we won't contract with you.

Now, there's some real challenges for network approaches. Clearly, there's a need for better transparency about networks. And also, that there's this issue of network adequacy requirements. There should be network adequacy requirements because there are some important elements of consumer protection, and these have to be balanced against the cost saving potential of narrow networks. I think where we are today, unlike the '90s where a lot of network adequacy focused on are there primary care physicians close enough to where people might live, I think a lot of the issues today are about sub-specialists. Someone has a retina problem and it's not enough that there are ophthalmologists in the network, there need to be retina specialists. And I think, rather than going into very detailed network adequacy regulation, we really need to use the approach of a very speedy and fair appeals system so that the patient can quickly say, hey, I have a retina issue and there are no retina specialists in the network. Find me one.

Final point I want to make is that the issue of surprise balance bills—these are providers that patients don't choose when they're in network facilities or using a network surgeon

that surprised them with a balance bill. This is an issue for broad as well as narrow networks. It's an issue worth focusing on, but it's really not specific to narrow networks. On insurance exchanges, the way they increase competition is by facilitating consumer comparisons of health plans. They offer comparable information in one place. They standardize benefits, standardize what is covered, and in the marketplace exchanges they standardize, by far, actuarial values. You can go further. California's Act of Purchasing model actually has a uniform benefit design so that if you want a silver plan, all of the insurers in that exchange have the same benefit design for their silver plan. Obviously, this makes it a lot easier for consumers to make comparisons across plans and, thus, increases competition.

Now, to close, I want to just say a few things about policy agenda to promote competition. You know, certainly vigorous anti-trust enforcement is part of that and the anti-trust system still has not really paid much attention to this issue of hospital acquisition of medical practices. Many people don't realize that the challenge in Boise, Idaho to the St. Luke's systems acquisition of a primary care group, was not about vertical integration but the challenge was about monopolization of the primary care market in that area. So this is still an issue on the agenda for the anti-trust authorities.

I think both private plans and governments can do more to support independent hospitals and medical practices and this can level the playing field on payments. And, finally, when we talk about network adequacy and insurance exchanges, we just need further refinements and wise policies. Thank you very much.

ED HOWARD: Alright, thank you, Paul. Let me just get us into the Q&A mode, if we can. There are, as is noted on our little cheat sheet, at least three ways you can engage our panelists. You can come to one of the microphones and ask your question orally. You can fill out a green question card and hold it up. Someone will bring it forward. And you can Tweet to using the hash tag HCCconsolidation and we will be monitoring those Tweets and we'll get those questions up here as well. And, if you do come to the microphone we'd ask you to identify yourself and keep your question as brief as you possibly can.

Paul, I wonder if I could just kick this off—oh, I'm sorry, Laurence?

LAURENCE BAKER: Can I make one comment?

ED HOWARD: Please.

LAURENCE BAKER: It was said that my research has made a mistake by using the wrong data to look at the effects of physician hospital integration and, in fact, it has not. Our research uses private prices when we look at price changes and when we look at Medicare we look at utilization changes so we say that physicians who are acquired by hospitals send their patients to the hospital more often, which is not a price effect and it's a perfectly measurable Medicare effect. I will leave it at that.

BRUCE VLADECK: I stand corrected. I apologize. I didn't interpret the slide that way, I guess.

ED HOWARD: Okay. Let me just follow up with a fairly specific point, something that Paul mentioned. In his last slide on a policy agenda, when you described one of the things that we need to see is greater support for independent hospitals and medical practices are you talking about better subsidies for IT or what kind of support are you talking about?

PAUL GINSBURG: Well, you know, the range is wide. When you talk about the public sector, one thing that CMS has done for its initiatives in Accountable Care Organizations, is it has provided some capital supports and other support for smaller ACOs. I think that's useful. Many insurers have actually subsidized things to physician practices acquisitions of health IT in order to keep them from joining hospital systems, to make it viable for them to be independent. I think many of the initiatives in patient-centered medical homes in the private sector, I think are motivated to – by finding a way to pay primary care physicians more, to make sure that it's still viable environment for them to continue to practice independently.

ED HOWARD: Okay. Eric, you want to use one of our card questions?

ERIC SCHNEIDER: Sure. So, we have a question from the audience. This is to Tim Greaney. What impact will the medical loss ratio requirement of the ACA have, in terms of insuring that insurers pass on savings gained through their better negotiating position?

THOMAS GREANEY: The claim has been made that the medical loss ratio should be taken into consideration because it does, to some extent, control the profits of insurance companies. But, that – the scope and the degree to which it has an effect is somewhat limited. First of all, it doesn't apply to self-insured plans so you have about half of the market not covered. It doesn't really act as a price cap and as Professor Dafny said in her Senate testimony, for it to really control excess pricing it has to bind and if someone is already comfortably within the limits of the MLR it's not going to bind them, they can still raise price significantly. And it's probably gameable, too, in the sense that insurance companies can divert costs on their books to look more like medical expenses and disguise profits that way. So, I don't see it as a control. I think Bruce mentioned the rate regulation at the state level. Unless you really believe transparency makes a huge difference, much of what goes on at the state level is just quote review not rate control, and is really a weak substitute for competition.

Since I have the floor, I will also respond to Bruce just briefly. I'm sure there are a couple of points in his remarks that I agree with but I may have to listen carefully to find them. But, let me just mention a couple things. You seem to believe that there will be some benefit in having mega integrated systems. Okay. Let's seed all of the hospitals, physician practices, to the Vladeck integrated delivery system here in Washington and northern Virginia. What's going to drive them to control cost and improve quality? Indeed, if you look at the experience with dominant hospitals, the must-have hospitals in many states, they are pricing well above their rivals without additional benefits of quality

of care. Even the sainted Kaiser system out in California, which I agree is maybe the best out there, people are writing why is Kaiser still so expensive if it's so much better? Some economists believe that Kaiser engages in what's called shadow pricing. They only have to beat their rival by a little to be popular and they're succeeding on that basis. So I don't have much faith in the solution that we move to monopolistic integrated systems.

Now, I will concede that in many markets there is a limit on how much competition you can have and, to that degree, I agree with Paul. In some areas we really do need a solution. Anti-trust law is really weak tea – really is powerless as to extant monopolies. It really does very little to control them. It certainly does not break them up. So, at that point, some kind of rate regulation or encouragement or subsidizing even new entry may be the solution. So, there are, in some sense, two worlds out there.

**BRUCE VLADECK:** Just a point on competition versus consolidated systems and prices and, again, I felt another sense of déjà vu because back in 2009 or 2010 I was at a health affairs conference in Washington where Tom Rice and I were the only people in 20 papers about health reform that said it's the prices not utilization that's causing the problems of healthcare in the United States and everybody sort of nodded their heads and said you've got a very good point and went back to talking about utilization. But the fact is, I can argue till we're blue in the face about whether it's 4% or 5%, the contribution of a hospital contribution, the rise in prices over a particular period of time in some particular market. I would argue, if you look cross-sectionally, concentrated markets are no more expensive than non-concentrated certainly for private health insurance expenditures. And there's too many other confounding variables is a large part of the problem with that analysis. But the real issue is we got to the problem where, in the United States, not because in the last 10 years prices have gone up 3% faster than they otherwise would have, but because before 10 years ago, in an unconsolidated industry, without any pushback from the insurance industry on the prices that healthcare providers provided and where the residuals of a mentality of cost based reimbursement were still part of many government programs, our prices were twice as high as anywhere else in the world when we had a competitive market for healthcare.

So, that's my point about competition. Yeah, we have a real problem if there are only 3 providers. We have a real problem in northern California because Sutter shadow prices Kaiser and they're both too expensive. I understand that. But if you had 20 competitors in California, our historical evidence would be we'd end up either spending more money or taking the current policy of much of the insurance industry in competitive markets, which is adding the out of pocket expenditures to patients to such a point that they will forego needed care and you will drive the lower middle class out of the healthcare market altogether. That's what real competition in healthcare markets historically has empirically produced in the United States.

**ED HOWARD:** Professor Ginsburg.

**PAUL GINSBURG:** What I would say is that, you know, 10 years ago I think our healthcare markets were less consolidated. I wouldn't say they were more competitive. I

would say, because to have a competitive market you have to have the patients. The consumers have some incentives to look at price when they compare providers.

Comment on California.

BRUCE VLADECK: And, Paul, I would say you can't do that in a humane equitable healthcare system, period. So—

PAUL GINSBURG: Okay – but then that's an argument for single payer price.

BRUCE VLADECK: No, that's an argument for acknowledging that we have intrinsic pervasive market failure in healthcare and we can't use the usual notions like giving patients more skin in the game. God knows we put their whole [expletive] bodies in the game and the last 10 years and people are not getting care as a result.

PAUL GINSBURG: Bruce, this is the reason that my presentation was not about high deductibles and high cost sharing. It was about networks. Because I think, I don't know if you'd call it humane or not, but I think the way that you can engage consumers in a competitive healthcare market is through choosing one provider over another, not by having to pay thousands of dollars before they get any care at all.

But the other point I was going to make is that I've studied California through site visit projects for the last decade and what is striking about the California market is how competitive the private provider market is, including the pressure on Sutter, and it all comes from the pressure of Kaiser Permanente, which is gaining market – even though it's shadow pricing – it is gaining market share over the non-Kaiser private insurers. It's gaining market share over the non-Kaiser Medicare Advantage plans. And this is really leading to some fairly profound changes in California that would be fascinating to watch.

ED HOWARD: Yes, go ahead.

SPEAKER: The question I was going to ask—

ED HOWARD: Would you identify yourself, please.

DR. CAROLINE POPLIN: Oh. I'm Dr. Caroline Poplin. I'm a primary care physician. The question I was going to ask was something that nobody's touched on yet, which is having to change plans every year. It's been in the newspaper, it's been – it was in the New York Times yesterday. If you are healthy, doesn't matter, it's just paperwork, if you're sick and you have a doctor and you have to change every year it's not – it's not like buying a car every year. It's continuity of care is a very important thing in healthcare, not just to the patients but to quality. You keep changing providers, your records are going to get confused, people won't know you, and that will make a big difference. That was the question I was going to ask. The question I want to ask Professor Ginsburg is: Say you're not a professor at Stamford, you're just an ordinary person who's employed sometimes and you try very hard and you work very hard but it's a bad market for you.

The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

And you get an inexpensive plan and you find that you have colon cancer and you need a colonoscopy and, in the tier that you can afford, there's a nice neighborhood hospital with some gastroenterologists and you don't know what their records are on perforations, but you know they don't do very many. Or, say you're in Boston, and the high tier is partners. And it's much more expensive and you don't have the money. What do you do? Do you follow the incentive and cross your fingers and go to the hospital that you've chosen, or – well, what do you do? It's easy to say when you're middle class and you can afford the high tier, or you're in Medicare. But not everybody is that fortunate.

PAUL GINSBURG: Well, my hope is that, as provider comparisons to create networks become more sophisticated, and it's happening very rapidly, that gastroenterologist with the high perforation rates, no plan is going to want that physician in their network because those physicians are too expensive. Their unit prices are low but they cost the insurers too much because they're a higher complication. I'm not saying that we have a panacea and that we're there today but I think that truly the choice is, are you going to go through high deductibles where patients who don't have a lot of money could have no choice but to go to the lowest priced providers, or are you going to go through networks where hopefully more skill over time will go into creating these networks because low quality physicians don't save money for insurers.

DR. CAROLINE POPLIN: But there are many middle quality physicians whose statistics you just don't know.

PAUL GINSBURG: I think we have a long way to go, but we're moving in order to have better information on provider quality available to all patients, but especially to those choosing a network.

DR. CAROLINE POPLIN: And now, somebody can answer – I mean, by that time you might be dead. But, somebody can answer my question about having – requiring for competition to have people redo their insurance every year and possibly redo their hospital, their provider, their network – the whole nine yards.

ERIC SCHNEIDER: I'll just say, I don't think that we know how – what the costs – the friction costs are related to that. I mean, obviously, what you're describing would be a lot of work in the Part D plan, just choosing pharmaceuticals each year. People are leaving a lot of money on the table each year—

DR. CAROLINE POPLIN: That's right.

ERIC SCHNEIDER: —because they don't want to make the change. Now, if we can reveal that to people, provide the decision support so they can make more effective choices each year and do it in a more – a less laborious way, then we might come a long way. But this is a problem, I agree, that we have to solve.

PAUL GINSBURG: We know when people – Medicare beneficiaries, when they choose Medicare Advantage plans, they don't switch plans every year because that market is pretty stable.

DR. CAROLINE POPLIN: Right.

PAUL GINSBURG: So, if you like the plan you're likely to be able to stay there. My hope is that the marketplace plans will, over time, become more stable. There are lots of reasons why they're so unstable today mostly because they were clueless as to who was going to sign up in the first place.

I think, you know, you can have a narrow network plan that is stable from year to year as to who's the network. Now, I think that there probably are things to do as far as networks so that perhaps you want to standardize network contracting between providers and plans so that it follows calendar years so you don't have as many cases of someone in the plan when you signed up drops out of the plan in the middle of the year.

THOMAS GREANEY: Let me just mention a place where that's particularly acute is in the Medicaid area where a large percentage of Medicaid beneficiaries turn into – when they get a job – into the exchanges and then when they lose the job back into Medicaid. And the states that are thinking carefully about it will have plans that offer both Medicaid managed care along with their exchange plans. But, coming from a state who has yet to expand Medicaid, I'm not sure that's going to happen sometime soon around the country.

ED HOWARD: Two quick things. One is that the Alliance had a series of briefings and publications on narrow networks last year and earlier this year and I would commend you to the Allhealth.org website if you want to explore further in that area.

Secondly, if you do have to leave, we're getting close to the end of our time, please take the time to fill out the blue evaluation form before you go and now let's get to the folks who have been at the microphones. Thank you for your patience.

STEPHANIE WILKINSON: Hi. My name is Stephanie Wilkinson. I'm with the Federal Trade Commission and I should just say at the outset the views I'm expressing are my own. It does not reflect the Commission or any individual commissioner. And first of all, I'd just like to thank the panel for some really interesting presentations today. Certainly helpful.

I'd like to just make a couple of comments and then ask for the panel reaction to a couple of questions. One, I think it's important to note that the FTC consistently advocates that the anti-trust laws are entirely consistent with the triple aimed goals of healthcare reform; that is, to reduce costs, improve quality, and improve patient experience and access to care and despite what some providers may claim, anti-trust laws do not stand in the way of pro-competitive collaboration or competitively benign consolidation that would benefit consumers. In fact, the FTC and DOJ challenge very few transactions among providers and only challenge those transactions that would substantially lessen competition and result in consumer harm. So, I'd like to just get the panel reaction to that position.

But then, more importantly, I'd like to get to, you know, what does the panel think about the recent resurgence among states to immunize healthcare providers from Antitrust scrutiny, and we've seen this take the form of certificate of public advantage laws and other Anti-trust exemptions for providers who wish to engage in mergers or other types of collaboration. I guess the question is, do you believe that state regulatory oversight is an adequate substitute for robust anti-trust enforcement for proposed mergers and collaborations? So, situations where the provider consolidation has not yet occurred.

THOMAS GREANEY: Well, probably no surprise. I do think it's a bad idea. The experience we've had with all sorts of interventions of this kind are cautionary tales. Many of you know a superior court judge in Massachusetts looked at a so-called conduct decree settling a merger case in which caps were placed on pricing and so forth, and she, quite correctly I think, decided this is not within the capabilities of the court to monitor and it's a very hard thing to regulate price ex-ante going forward. So these things are not good ideas, and I'll just mention one more along with what Paul was saying. There's a big movement now to engage in narrow network adequacy laws and those are extremely complicated. The National Association of Insurance Commissioners has a model law. Those are extremely difficult to craft and, to my mind, they make certificate of need regulation, which was a failure, look like child's play to regulate along those lines.

LAURENCE BAKER: So, I want to comment on the first part of your question, which is balancing the prices and the access issues and the quality, which I absolutely agree with. I think that's the whole – the nexus of the issues. We're trying to do integration or we think we can get some benefits from it because we kind of know we ought to be doing some integration to get some benefits from it. We want to watch out for the price pieces. I think it's just a very difficult thing. It's been hard for the courts to understand, it's been hard for regulators at states to understand, and so one of the questions is really getting these questions into a context where people who are pretty sophisticated about it can make the evaluations. And I think one of the challenges, you saw a little bit in Bruce's comments earlier, where I think we just have to be really careful when we think about applying a few examples of successes to the broad swath of integration stories so there are Intermountain out there, there are Kaisers out there that people like that do a nice job for various reasons. There are cases where getting more, say, high in cardiac services in the same hospital might provide some benefits, but then taking those examples and applying them with a very broad brush to say that every case of a larger organization is going to do a great job, every case of getting hospitals together is going to do a nice job of getting this kind of volume to happen is a very dangerous thing, and so we have to be careful about that, and that puts us in a difficult situation because what the research that we're doing, and other people are doing, says that it looks like a lot of the mergers and a lot of the integration that's been happening has not been doing that. Right? There are examples where it can, but it doesn't happen. And so we need to – it's a research thing but I also think it suggests that we need to get these questions in front of bodies with a lot of expertise to be able to evaluate and try to understand if we're going to regulate mergers at the state level, it's a little bit dangerous because it's hard to say, well, this one looks a little different. Every merging organization pulls out the well, this is going to be great for patients because look, we're going to buy an integrated computer system and stuff. And it



just looks like that hasn't always happened and so I think we want to be getting these things into a form where we can evaluate those.

BRUCE VLADECK: You know, I don't disagree with the sincerity of your argument to what the FTA is doing is consistent with the ACA but, in fact, the ACA has put a lot more of the burden on managing the healthcare system and controlling costs on states, or at least those states that have been willing to play along. As with Medicaid expansion, the share of the entire population that is covered by Medicaid or affected by Medicaid policy has increased very dramatically. And, as of course, the state run exchanges are key to the language, or to the logic of the ACA and it seems to me not entirely fair for the federal government to say you guys figure out how to control costs in the Medicaid program, although we won't let you do anything about benefits or eligibility, and you guys figure out how to make these exchanges work, although there's not enough dollars in the federal subsidies to provide good product to middle class people who are eligible for them. But you can't mess with our anti-trust jurisdiction as you try to change your health system to square these circles that the ACA has put in your lap. And that makes me a little uneasy or uncomfortable.

ED HOWARD: Yes. What I think will be the last question.

SUSAN XI: My name is Susan Xi, I'm a researcher at the Association of the American Medical Colleges. I'm a researcher, so I'm interested in the analysis, one that is, Professor Baker, you show that the office raises the price compared to the 10th percentile and 90 percentile and shows that the county that has the most consolidated market have a higher price. So my question is, do you factor in other factors, for example, if you draw a chart of outreach [Unintelligible] costs, whether they see highly correlated with the maps you have, and my second question is for all the panelists. Using this as a case, for example, one, either you or your family member needs to go to see a cardiologist for maybe heart surgery. Would the price factor in your decision? Do you ever even go to check the price when you go to see your doctor, one is maybe private practice, another affiliating, maybe in Cornell or Johns Hopkins. Do you ever even think about the price? Thank you.

LAURENCE BAKER: Ooh, I get to try both? So the answer to the correlation question is, of course, the longer one that if you all want to come to a research seminar sometime we can show you all the details. So the short answer is yes. We have lots of correlates in these models. We're trying to adjust for as many things about these markets as we can and we do that in a variety of different ways so I'll just assert and you can come talk to me or e-mail me if you really want the details, that I'm not that worried that these are being driven by something else in these markets, at least not something that we could observe. But, you know, we're researchers so we're always trying to learn. So I think, yes is the answer to your first question. We do that.

Do we look at the price? So, I'll just tell you, so we, Stanford University has got a high deductible health plan and we're part of it, and so we do look at prices when we can. And I think one of the big challenges in these markets is that it's hard to get the prices and it's

hard to understand what all the differences are when you're trying to make these decisions. So, you know, I know plenty of people who I think are trying to do this and might actually be swayed by prices. You pick a particular example and I think any time you pick – you know, we could pick ones where I would definitely move because of the price and we could pick ones where I might be more swayed by quality evidence or other things like that. But I think this is one of the questions—can we actually make this work in the real world or is this not ever going to work? I'm a little bit worried that it might only work up to a point getting people price information. There's only so many circumstances in which you can really shop. There's only so many circumstances in which a patient is ever going to be able to understand enough to really make a decision and be in a situation where they can do that. But, in some cases, it might be really valuable and there are certainly cases where it could work. So, I'm all for price transparency, although I'm not sure it's going to make a huge difference across the board. But, in some cases probably a lot.

PAUL GINSBURG: Actually, as far as consumers looking for prices, I mean, of course the first thing a consumer needs to focus on is whether a provider is in their network or not. But the last time I went onto the United Healthcare website, because that's the coverage I have, it was new, new looking. I'd used a tool 2 years ago to look at prices for MRIs, and now I find, when I just looked at physicians they not only have clear information whether the physician was in network, whether it was preferred, but also what the physician's price was for a common service and how that fit in with the locality that I lived in. So, you know, years ago we used to say, well, yes, it's really hard for consumers to get prices. It's getting easier. Now, I have to say that even though the tools are getting better and better, still I'm not sure about how their penetration as to how many people actually use them.

ERIC SCHNEIDER: Well, with that I think we'll bring this panel to a close. We've come to the time. I know there are many more questions we hoped we could get to but the time was limited. Thank you all for your interest in this. I want to say a special thanks to the staff, to Ed, and his staff at the Alliance, and to Rachel and the staff at Commonwealth Fund for bringing this together and please join me in thanking our panelists. I think they provided not a tasting menu but a banquet.

[Applause]

ERIC SCHNEIDER: And finally, there are two issue briefs on this topic that I hope you'll read and please get in touch with us if we can be helpful in any other way. Ed, thank you.