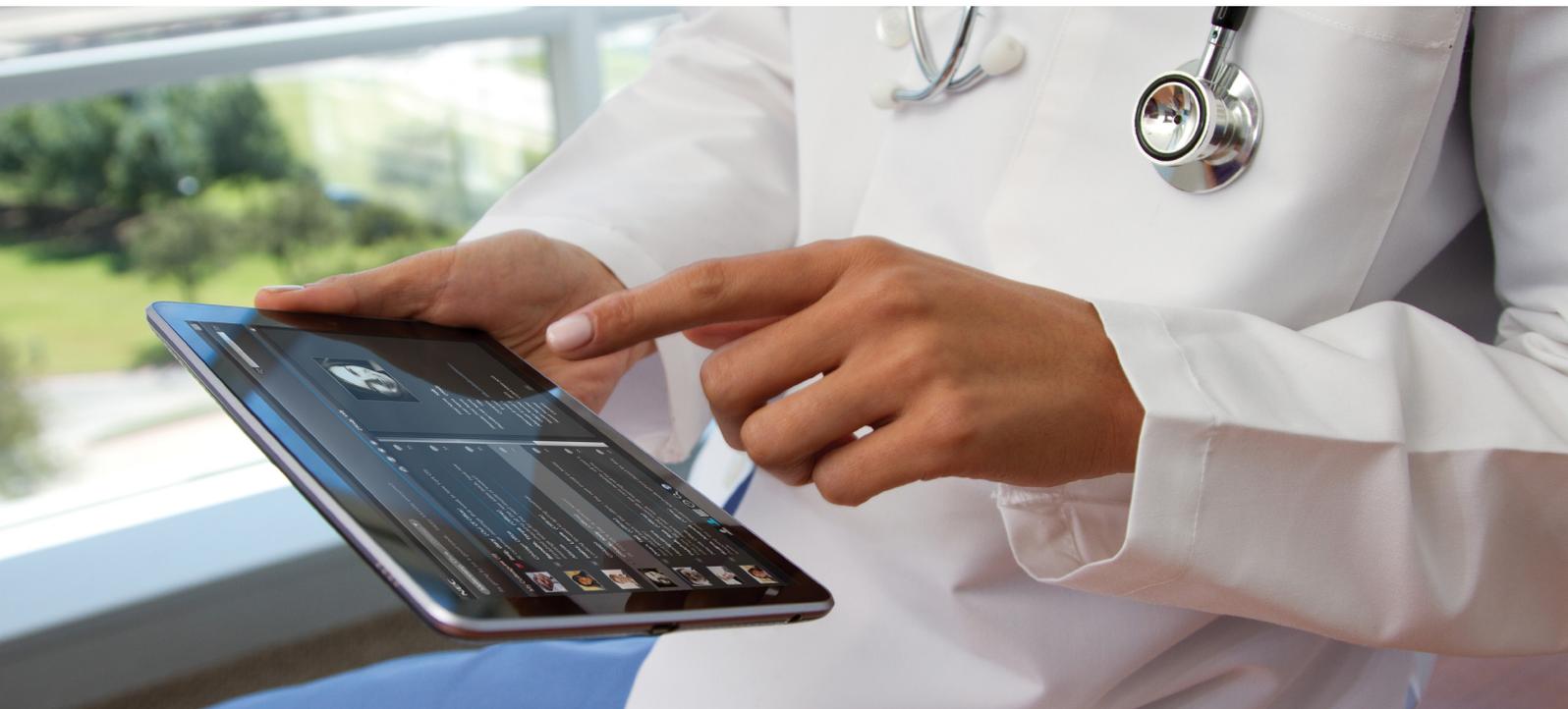


# MAKING HEALTH CARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE

ACTIONABLE POLICY PROPOSALS FOR THE EXECUTIVE BRANCH,  
CONGRESS, AND THE STATES

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# Executive Summary

The U.S. health care system does not work as well as it could, or should. Prices are high and vary in seemingly incoherent ways, yet quality of care is uneven, and the system lacks the innovation and dynamism that characterizes much of the rest of our economy. The dearth of competition in our health care markets is a key reason for this dysfunction.

There is a growing understanding that comprehensive efforts to control health care costs and improve the quality of care must address the functioning of the markets that undergird the health care system and the prices paid to providers. Ensuring that markets function efficiently is central to an effective health system that provides high quality, accessible, and affordable care. A large body of evidence shows that patients, employers, and private insurers pay more for health care in highly consolidated provider markets—for instance, where only one or two hospital systems exist. Higher health care costs lead to higher premiums, making insurance more expensive and less affordable. Even in public programs, such as Medicare, a lack of competition among providers is associated with lower quality care. The same is true of health insurance—it has been extensively documented that less competition leads to higher premiums.<sup>1</sup>

Each of us has been concerned about competition for quite some time. Earlier this fall, we convened a meeting supported by the Robert Wood Johnson Foundation, and co-sponsored by the American Enterprise Institute, the Brookings Institution, and Carnegie Mellon’s Heinz College, to formulate ideas for actionable policies that public and private stakeholders can implement to improve the functioning of health care markets. Approximately 40 academics, industry stakeholders, and federal and state government officials participated in the meeting, which produced focused, practical proposals. This white paper reflects the authors’ recommendations, taking the discussion at the meeting into account, without any attempt either to summarize the meeting or to associate the participants with these views.<sup>2</sup>

We propose a new “competition policy” for health care that involves multiple actors at the federal and the state level: the White House and state governors, federal and state executive agencies, and federal and state legislatures, as well as the federal and state antitrust enforcement agencies traditionally focused on competition. Inattention to the impact of policies on consolidation may have unwittingly put the U.S. on a path to less competition in health care markets; addressing it will require broader action and attention beyond antitrust enforcement as well. Pursuing this agenda will allow health care markets to function more efficiently, leading to higher quality, more accessible, and lower-cost care. We focus on policies to enable and support competition by health care organizations.

We propose specific, actionable policies to maintain and enhance the competitiveness of health care markets, promote entry by new competitors and remove barriers to entry, and prevent anticompetitive practices. We think these policies can have an immediate and meaningful impact. We note that these are non-partisan policies that can elicit support from across the political spectrum. The specific proposals are as follows.

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<sup>1</sup> Our focus is limited to providers of health care services (health systems, physician organizations) and health insurers. The competition and regulation issues relevant to pharmaceuticals are quite distinct and are outside of the scope of this paper.

<sup>2</sup> A list of the meeting participants is contained in the Appendix.

## 1. MAINTAIN AND ENHANCE THE COMPETITIVENESS OF HEALTH CARE MARKETS

- a) Reform Medicare policies that encourage consolidation, such as making payments site-neutral and reforming the 340b program.
- b) Simplify administrative and regulatory requirements.
  - i) The U.S. Department of Health and Human Services (HHS) should convene an advisory group of practicing clinicians and practice administrators to generate specific recommendations on ways that the federal government can simplify administrative requirements.
  - ii) Minimize the administrative burden associated with value-based payments by creating a roadmap for electronic quality reporting and creating a parsimonious set of outcome measures, standardized across payers and designed for an electronic environment.
  - iii) Enable the use of virtual groups by finalizing regulations governing their recognition and making these groups eligible for quality reporting and practice support.
  - iv) Regulators should restrict the practice of information and data blocking by hospitals and electronic health record (EHR) vendors.
- c) Support risk contracts for independent provider networks.
  - i) Revise the Medicare Shared Savings Program (MSSP) regulations to limit “Accountable Care Organization (ACO) squatting” (Accountable Care Organizations) by large hospital and health systems.
  - ii) HHS convene payers and providers to develop standardized gain-share contracts.
  - iii) Include affordable reinsurance or stop-loss protection.
  - iv) Improve capital access for small practice ACOs through programs like the federal loan-guarantee program or advances on shared savings.
  - v) The Centers for Medicare and Medicaid Services (CMS) should move ahead with its announced plans to provide quality and cost data at the practice level that can enable tiering and facilitate network formation.
- d) Provide transparency on quality and cost to providers and consumers.
  - i) Create and publicly disseminate a parsimonious set of quality measures.
  - ii) Create and publicly disseminate measures of cost, both total spending and the total amounts paid to providers for various procedures, potentially through all-payer claims databases or the creation of a national claims data repository that utilizes common (core) data elements and a common format.
  - iii) Insurers should disclose out of pocket costs for health services consumers are considering obtaining based on their benefits and network status of providers..
  - iv) States should also consider creating entities to engage in monitoring and public reporting on price quality, and other measures of health care performance.
  - v) CMS and commercial payers provide quality and cost data at the practice level that can enable tiering and facilitate network formation by risk-taking ACOs.

## 2) PROMOTE ENTRY BY NEW COMPETITORS AND REMOVE BARRIERS TO ENTRY

- a) States should eliminate certificate-of-need regulations.
- b) States should eliminate any willing provider laws. Neither the states nor the federal government should adopt new any willing provider laws or regulations.
- c) Require insurers to clearly and accurately identify all in-network providers to consumers, and consider requiring that all contracts with network providers be for a specified period.
- d) States should amend their criteria for scope of practice decisions so that the only justification for restricting scope of practice is the safety of the public.
- e) State licensing boards should seek to facilitate practices, such as telehealth, that may promote competition and innovation, and in crafting regulations should choose approaches that place the fewest possible restrictions on competition and innovation, while still satisfying legitimate and substantiated public health and safety goals.
- f) States should adopt provider licensure reciprocity across states.
- g) Medicare should adopt policies to promote entry into Medicare Advantage markets.

## 3) PREVENT ANTICOMPETITIVE PRACTICES

- a) Federal antitrust agencies and state attorneys general should continue scrutinizing horizontal mergers that pose risks of higher prices and lower quality.
- b) Federal and state antitrust enforcers should apply increased scrutiny of vertical mergers, particularly hospital acquisitions of physician practices.
- c) States should discontinue the use of certificates of public advantage to shield anticompetitive collaborations from antitrust scrutiny.
- d) Federal and state antitrust enforcers should actively monitor and pursue the use of anticompetitive practices by health care and health insurance firms, including (but not limited to) anti-tiering, anti-steering, and gag clauses, and most favored nations contracts.
- e) Congress should pass legislation to allow the Federal Trade Commission (FTC) to:
  - i) Enforce the antitrust laws in the health insurance industry;
  - ii) Study the health insurance industry; and
  - iii) Enforce all of the antitrust laws with respect to nonprofit health care firms.
- f) State legislatures should consider legislation to ban the use of anti-tiering, anti-steering, and most favored nation clauses in contracts between providers and insurers.
- g) State insurance commissioners should utilize their, often, broad powers to review insurers' contracts with providers.
  - i) If they detect problematic features in a contract, such as anti-tiering, anti-steering, gag, or most favored nation clauses, they should take action.
  - ii) If the commissioner has the power to reject problematic contract features, they should do so.
  - iii) If they do not have such powers, then they should draw problematic contracts to the attention of their attorney general's office.

# Introduction

The US health care system does not work as well as it could, or should. Prices are high and rising,<sup>3</sup> there are serious quality problems,<sup>4</sup> and many characterize the system as rigid and unresponsive, lacking dynamism and innovation.<sup>5</sup> A lack of competition is a major contributor to this dysfunction. In some cases, markets lack the basic conditions required to stimulate and support competition. In others, conditions have changed in ways that reduce competition. The latter has been particularly the case due to consolidation among both providers and insurers.

Consolidation has accelerated over the last few years, with more hospitals merging, health systems acquiring physician practices, and insurers merging or acquiring providers.<sup>6</sup> Many markets are now dominated by one or a small number of powerful health systems or health insurers (in some cases both), with more on the way. A firm that dominates a market and faces little competition doesn't have to lower prices or costs, push for better quality, or focus on innovation. As Nobel Laureate Sir John Hicks said over 80 years ago, "The best of all monopoly profits is a quiet life."<sup>7</sup>

The virtue of competition is that organizations are constantly pushed to do better—if they don't, another firm can and will take their place. Since consolidation is hard to reverse, recent trends highlight the importance of moving quickly both to block consolidation that is not in the public interest and to take steps that allow more competition in consolidated markets.

Concern about competition has been a priority for each of us for quite some time. Earlier this fall, we convened a meeting supported by the Robert Wood Johnson Foundation, and co-sponsored by the American Enterprise Institute, the Brookings Institution, and Carnegie Mellon's Heinz College to

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3 Cooper, Z., Craig, S.V., Gaynor, M., & Van Reenen, J. (2015) The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. National Bureau of Economic Research. Working Paper No. 21815. <http://www.healthcarepricingproject.org>; New York State Health Foundation. (2016). Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement. <http://nyshealthfoundation.org/resources-and-reports/resource/an-examination-of-new-york-hospital-reimbursement>; National Academy of Social Insurance. (April 2015). Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets. <https://www.nasi.org/research/2015/addressing-pricing-power-health-care-markets-principles-poli>; Laugesen, M.J., & Glied, S.A. (2011). Higher Fees Paid To US Physicians Drive Higher Spending For Physician Services Compared To Other Countries. *Health Affairs* 30(9), 1647-1656. <http://content.healthaffairs.org/content/30/9/1647.full.html>; Anderson, G.F., Reinhardt, U.E., Hussey, P.S., & Petrosyan, V. (2003). It's the Prices Stupid: Why the U.S. Is So Different from Other Countries. *Health Affairs* 22(3), 89-105. <http://content.healthaffairs.org/content/22/3/89.full.html>; and Aaron, H.J., & Ginsburg, P.B. (2009). Is Health Spending Excessive? If So, What Can We Do About It? *Health Affairs* 28(5), 1260-1275. <http://content.healthaffairs.org/content/28/5/1260.full.html>.

4 Committee on Quality of Health Care in America, Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. <http://nationalacademies.org/hmd/reports/2001/crossing-the-quality-chasm-a-new-health-system-for-the-21st-century.aspx>; and Kessler, D.P., & McClellan, M.B. (2000). Is Hospital Competition Socially Wasteful? *Quarterly Journal of Economics*. 115(2), 577–615.

5 Cutler, D. M. (2010). Where are the health care entrepreneurs? The failure of organizational innovation in health care. *Innovation Policy and the Economy* 11(1), 1-28. <http://www.journals.uchicago.edu/doi/10.1086/655816>; Herzlinger, R. (2016). Why Innovation in Health Care is So Hard. *Harvard Business Review*. <https://hbr.org/2006/05/why-innovation-in-health-care-is-so-hard>; and Chin, W.W., Hamermesh, R.G., Huckman, R.S., McNeil, B.J., & Newhouse, J.P. 5 Imperatives Addressing Health Care's Innovation Challenge, Forum on Healthcare Innovation. Harvard University. <http://www.hbs.edu/healthcare/Documents/Forum-on-Healthcare-Innovation-5-Imperatives.pdf>.

6 Ginsburg, P.B. (2016). Health Care Market Consolidations: Impacts on Costs, Quality and Access. Testimony before the California Legislature, Senate Committee on Health; Gaynor, M. (2011). Health Care Industry Consolidation. Statement before the Committee on Ways and Means Health Subcommittee, US House of Representatives, [https://waysandmeans.house.gov/UploadedFiles/Gaynor\\_Testimony\\_9-9-11\\_Final.pdf](https://waysandmeans.house.gov/UploadedFiles/Gaynor_Testimony_9-9-11_Final.pdf); Vaida, B, & Wess, A. (November 2015). Health Care Consolidation. Alliance for Health Reform. [http://www.allhealth.org/publications/Consolidation-Toolkit\\_169.pdf](http://www.allhealth.org/publications/Consolidation-Toolkit_169.pdf); Gaynor, M. (March 2015). New Health Care Symposium: Consolidation and Competition In US Health Care. *Health Affairs Blog*. <http://healthaffairs.org/blog/2016/03/01/new-health-care-symposium-consolidation-and-competition-in-us-health-care>; and Tsai T.C., Jha A.K.. (2014). Hospital Consolidation, Competition, and Quality. Is Bigger Necessarily Better? *JAMA*. 312(1), 29-30. doi:10.1001/jama.2014.4692.

7 Hicks, J.R. (1935). Annual survey of economic theory: The theory of monopoly. *Econometrica* 3 :1-20.

formulate ideas for actionable policies that public and private stakeholders can implement to improve the functioning of health care markets. Approximately 40 academics, industry stakeholders, and federal and state government officials participated in the meeting, which produced focused, practical proposals. This white paper reflects the authors' recommendations, taking the discussion at the meeting into account, without any attempt either to summarize the meeting or to associate the participants with these views.<sup>8</sup>

We propose a new “competition policy” for health care that involves the multiple actors at the federal and the state level: the White House and state governors, federal and state executive agencies, federal and state legislatures, and the federal and state antitrust enforcement agencies traditionally focused on competition.

Our proposals fall into three categories: maintaining the competitiveness of health care markets; preventing anticompetitive practices by dominant market players; and encouraging entry by new competitors. We think these policies can have an immediate and meaningful impact. We also note that these are non-partisan policies that elicit support from across the political spectrum. Ensuring that markets function efficiently is central to an effective health system that provides high quality, accessible, and affordable care. There is an opportunity for political leadership and bipartisan support for policies that will make markets work better.

In what follows, we first provide some background on health care costs and consolidation in health care markets. We then proceed to policy proposals. This analysis is generally limited to providers of health care services (health systems, physician organizations) and health insurers. The competition and regulation issues relevant to pharmaceuticals are quite distinct and are outside of the scope of this paper.

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<sup>8</sup> A list of the meeting participants is contained in the Appendix.

# Background

The U.S. health system is plagued by health care costs that are high and rising, high prices that vary in seemingly incoherent ways, problems with quality, and by being sluggish and unresponsive, especially compared to the rest of the economy. Here we provide a brief overview of these problems.

## HEALTH SPENDING

The United States spent \$3.2 trillion on health care in 2015, amounting to 17.8 percent of national income, and almost \$10,000 for every person in the United States.<sup>9</sup> While health care spending has grown more slowly in recent years than it has in the past, it has nevertheless continued growing—it's just a question of how fast. Further, while the recent “slowth” in health care spending is a welcome development, there is no guarantee it will continue in the future, particularly if policymakers fail to prioritize efforts to reduce health care costs. Indeed, the Center for Medicare and Medicaid Services Office of the Actuary recently projected 5.6 percent annual growth rates in health care spending from 2016-2025.<sup>10</sup> As a consequence, we believe that one should not conclude that the US has “bent the cost curve,” and that continued emphasis on controlling costs is both warranted and imperative.

High and growing health care costs lead directly to higher health insurance premiums, making health insurance more expensive and less affordable. They also constitute an increasing burden on the federal budget. First, increases in private spending are paid for by individuals, either directly if they have individual insurance policies, or indirectly via reduced total non-health care compensation if they have employer-sponsored health insurance.<sup>11</sup> The burden of private health care spending on U.S. households has been growing, so much so that it's taking up a larger and larger share of household spending and exceeding increases in pay for many workers. Figure 1 illustrates that middle class families' spending on health care has increased 25 percent since 2007, crowding out spending on other goods and services, including food, housing, and clothing. Health insurance fringe benefits for workers, chief among which is health care, increased as a share of workers' total compensation over this same period, growing from 12 to 14.5 percent, while wages stayed flat.<sup>12</sup>

Second, increases in public spending on health care (principally via Medicare and Medicaid) increase the tax burden on households or displace government spending on other programs.<sup>13</sup> The Congressional

9 Martin, A.B., Hartman, M., Washington, B., Catlin, A., & the National Health Expenditures Team. (2016). National Health Spending: Faster Growth in 2015 as Coverage Expands and Utilization Increases. *Health Affairs*, 36(1), 1-11. <http://content.healthaffairs.org/content/early/2016/11/22/hlthaff.2016.1330.abstract>.

10 Keehan, S.P., Stone, D.A., Poisal, J.A., Cuckler, G.A., Sisko, A.M., Smith, S.D., Madison, A.J., Wolfe, C.J., & Lizonitz, J.M. (2017). National Health Expenditure Projections, 2016–25: Price Increases, Aging Push Sector to 20 Percent Of Economy. *Health Affairs*, 36(3), 1-11. <http://content.healthaffairs.org/content/early/2017/02/14/hlthaff.2016.1627>.

11 Baicker, K., & Chandra, A. The Labor Market Effects of Rising Health Insurance Premiums. *Journal of Labor Economics*, 24(3), 609-634; Currie, J. & Madrian, B. (2000). Health, Health Insurance, and the Labor Market. In Ashenfelter, O., & Card, D. (Eds.), *Handbook of Labor Economics* (3309-3416). Amsterdam: Elsevier Science; and Anand, P. (2016). Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey. *Health Economics*. <http://onlinelibrary.wiley.com/doi/10.1002/hec.3452/full>.

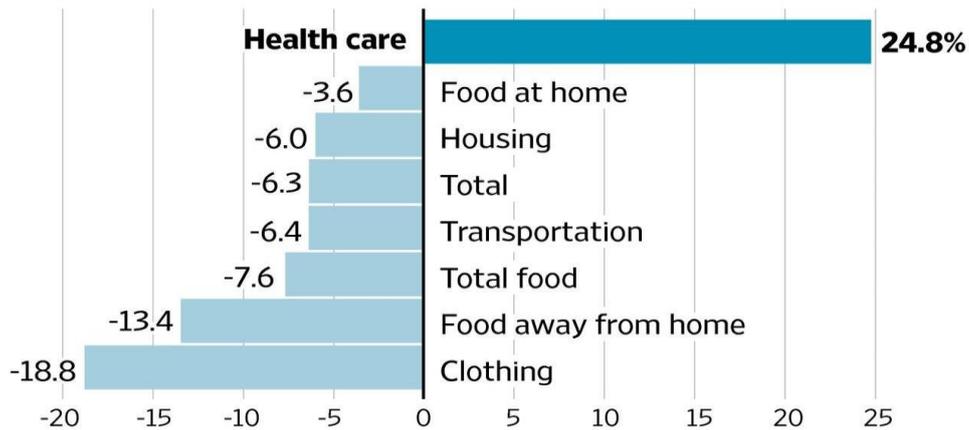
12 Table 1 in Monaco, K., & Pierce, B. (2015). Compensation inequality: evidence from the National Compensation Survey. US Bureau of Labor Statistics, *Monthly Labor Review*. <https://www.bls.gov/opub/mlr/2015/article/compensation-inequality-evidence-from-the-national-compensation-survey.htm>.

13 Kane, T. J., & Orszag, P.R. (2003). Higher Education Spending: The Role of Medicaid and the Business Cycle. Brookings Institution, Policy Brief #124, <https://www.brookings.edu/wp-content/uploads/2016/06/pb124.pdf>; Joffe, M. D. (2015). Long Term Trends in Medicaid Spending by the States. Mercatus Center, George Mason University, <https://www.mercatus.org/system/files/Joffe-State-Medicaid-Spending.pdf>; National Institute for Health Care Management. (2012). Government Spending for Health Entitlement Programs. <https://www.nihcm.org/awards/5-issue-brief/1301-government-spending-for-health-entitlement-programs-brief?showall=1>; and Craig, S.G., & Howard, L.L. (2014). Is Medicaid

Budget Office (CBO) projects health care to account for much of the increased government spending from 2017 to 2026, increasing federal deficits to 4.6 percent of GDP in 2026, and in turn increasing federal debt to 86 percent of GDP by 2026, the largest it has been since 1947.

**Figure 1. Percent Change in Middle-Income Households’ Spending on Basic Needs (2007-2014)**

Middle-class families’ spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.



Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department  
**THE WALL STREET JOURNAL.**

In short, rising health care spending is an increasing burden on the economy and the population, whether paid for by private or public dollars.

**PROVIDER PRICES**

Health care prices are one of the major factors driving increased health care spending.<sup>14</sup> Figure 2 shows the contribution of prices to the growth in private spending from 2014 to 2015. As can be seen, this is considerable. In particular, very little of the growth in spending is due to utilization, and spending for acute inpatient care and prescriptions would have fallen but for increased prices. While the information in this figure is for 2015, the same pattern exists for previous years.<sup>15</sup> Further, higher medical prices are projected to drive an increasing amount of health care spending growth over the next ten years.<sup>16</sup>

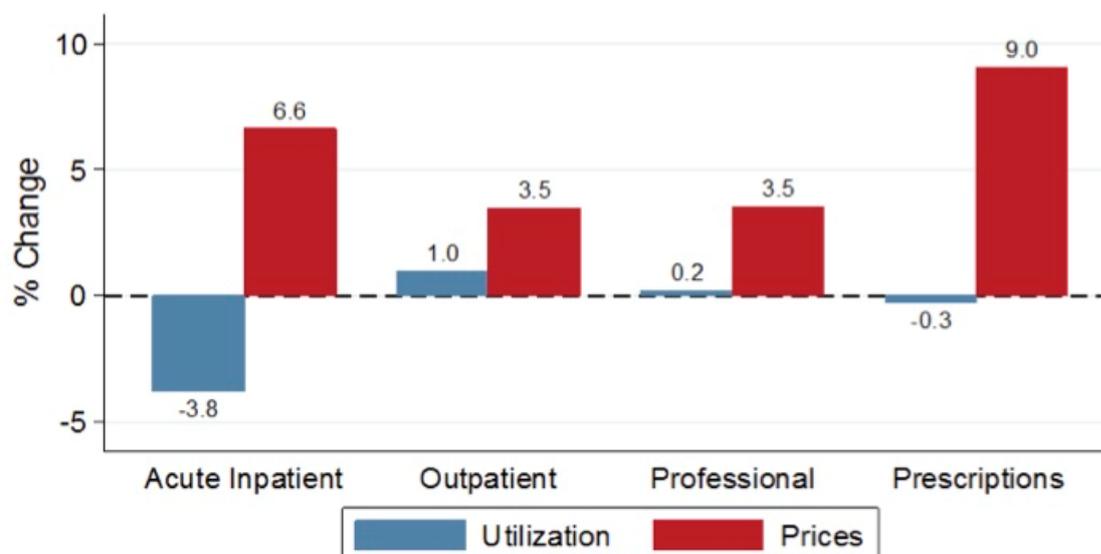
crowding out other state government expenditure? Internal financing and cross-program substitution. *Regional Science and Urban Economics*, 49, 164-178. <http://dx.doi.org/10.1016/j.regsciurbeco.2014.09.00>.

14 Martin et al. National Health Spending: Faster Growth in 2015 as Coverage Expands and Utilization Increases.; White, C., Reschovsky, J., & Bond, A. (2014). Inpatient Hospital Prices Drive Spending Variation for Episodes of Care for Privately Insured Patients. National Institute for Health Care Reform. Brief No. 14. <http://www.nihcr.org/Episode-Spending-Variation>.

15 Health Care Cost Institute. (2016). Health Care Cost and Utilization Reports, 2010-2015. <http://www.healthcostinstitute.org/report/>.

16 Keehan, S.P., et al. National Health Expenditure Projections, 2016–25: Price Increases, Aging Push Sector to 20 Percent Of Economy.

**Figure 2. Changes in Utilization and Prices of Health Care Service Categories, 2015**



Source: Figure 8 in 2015 Health Care Cost and Utilization Report, (2016), The Health Care Cost Institute, November.

In addition, prices vary tremendously geographically, both across and within geographic areas.<sup>17</sup> Figure 3 shows the extent of variation across the United States. As can be seen, this is considerable. To illustrate, the price of an MRI of the knee in the most expensive area in the country is 1,200 percent higher than in the least expensive area. Similar patterns are found for other common services.<sup>18</sup>

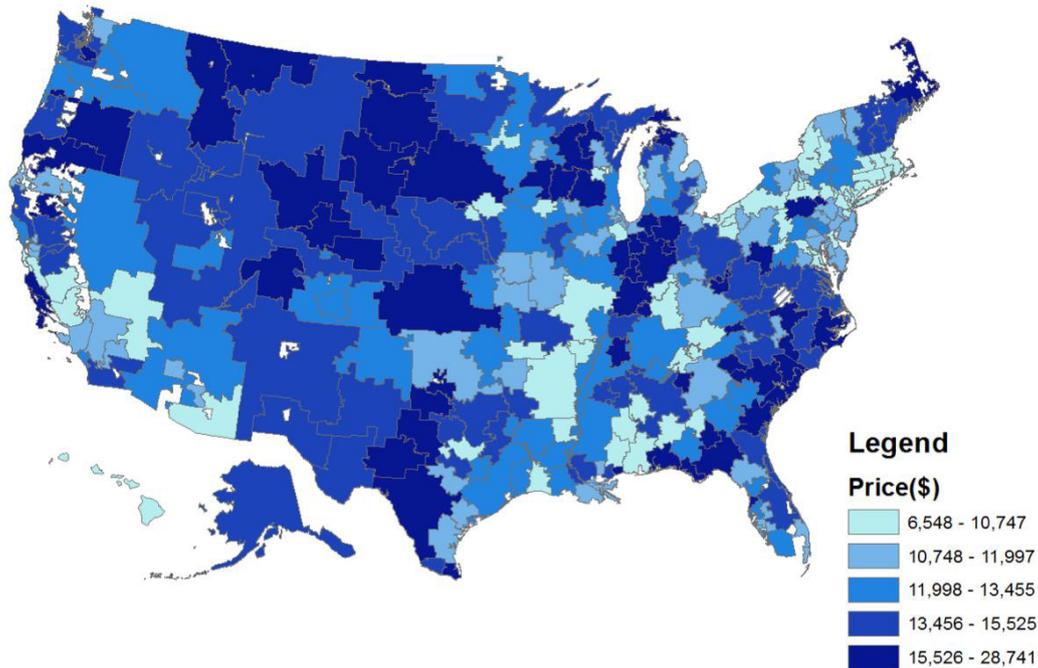
The evidence is that market power drives much of this variation in prices. Hospitals that face little in the way of effective competition are able to extract higher price concessions in their negotiations with insurers, and do.<sup>19</sup> Hospitals without local competitors are estimated to have prices nearly 16 percent higher on average than hospitals with four or more competitors, a difference of nearly \$2,000 per admission. Hospital consolidation in the 1990s is estimated to have raised prices by at least 5 percent, and likely by significantly more.

17 Cooper, Z. et al. Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured; and Ginsburg, P.B. (2010). Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. Center for Studying Health System Change. Research Brief No. 16. <http://www.hschange.org/CONTENT/1162/>.

18 Cooper et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured.

19 Vogt, W.B., & Town, R. (2006). How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? Robert Wood Johnson Foundation. Research Synthesis Report No. 9. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2006/rwjf12056/subassets/rwjf12056\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1); Ginsburg, P.B. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power.; Gaynor, M., & Town, R. (2012). The Impact of Hospital Consolidation – Update. Robert Wood Johnson Foundation. Policy Brief No. 9. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261); White et al. Inpatient Hospital Prices Drive Spending Variation for Episodes of Care for Privately Insured Patients. Cooper et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured; New York State Health Foundation, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement.

Figure 3. Price Variation Across the United States



Source: Cooper et al. (2015) "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" Working Paper No. 21815, National Bureau of Economic Research, Cambridge, MA

## INSURER PREMIUMS

Insurer premiums are driven in large part by medical expenses. Premiums cover the majority of health care expenses of enrollees, so factors that increase health care spending also increase health insurance premiums. However, the cost of private health insurance net of medical expenses also has grown rapidly in recent years (12.4 percent in 2014 and 7.6 percent in 2016), such that health insurance costs now comprises 6.6 percent of total health spending (2015), compared to 5.5 percent in 2009.<sup>20,21</sup> Further, there is substantial geographic variation in health insurance premiums. For example, premiums for an individual silver plan in the ACA marketplaces ranged from \$163 to \$1,119 per month,<sup>22</sup> while data from a recent study of premiums paid by large employers shows that 95 percent of the annual premiums for fully funded plans range from \$4,216.50 to \$11,448.42.<sup>23</sup>

Research evidence indicates that premiums are higher in more consolidated insurance markets, leading to concerns about competition among insurers and about increasing consolidation.<sup>24</sup> The merger between Aetna and Prudential in 1999 was found to have led to a 7 percent increase in premiums for large

20 Martin et al., National Health Spending: Faster Growth in 2015 as Coverage Expands and Utilization Increases.

21 While some of this increase may be due to increased enrollment in private insurance plans, the net cost of health insurance per enrollee also increased substantially, from \$726.94 in 2009 to \$1,064.88 in 2015.

22 Robert Wood Johnson Foundation. (2016). HIX Compare. <http://www.rwjf.org/en/library/collections/hix-compare.html>.

23 Authors' calculations from Table 1 in Dafny, L. Duggan, M., & Ramanarayanan, S. (2012). Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *American Economic Review*, 102(2), 1161-1185.

24 Dafny, L. (2015). Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience. The Commonwealth Fund. [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845\\_dafny\\_impact\\_hlt\\_ins\\_industry\\_consolidation\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf).

employers. Similarly, the Sierra United merger in 2008 was found to have led to an almost 14 percent increase in small group premiums.<sup>25</sup> Moreover, researchers have found that adding one more insurer to an ACA marketplace reduces premiums by 4.5 percent.<sup>26</sup>

## CONSOLIDATION

There has been a great deal of consolidation in hospital, physician, and insurance markets. There were 1,412 hospital mergers from 1998 to 2015, with 561 of them from 2010-2015.<sup>27</sup> While some of these mergers have no impact on competition, many include mergers between close competitors, especially given that hospital markets were already fairly concentrated at the beginning of this period. Hospital markets have become significantly more concentrated over time, with hospital markets on average changing from having the equivalent of five equal sized systems in the late 1980s to having the equivalent of only three equal sized systems by the mid-2000s.<sup>28</sup> As a result of this consolidation, nearly one half of hospital markets are highly concentrated,<sup>29</sup> and many areas of the country are dominated by one or two large hospital systems with no close competitors. This includes places like Boston (Partners), Cleveland (Cleveland Clinic and University Hospital), Pittsburgh (UPMC), and San Francisco (Sutter). Mergers that eliminate close competitors cause direct harm to competition. In addition, once a firm has obtained a dominant position it often engages in anticompetitive practices in order to maintain it.

Insurance markets are also often dominated by a small number of large insurers. The market share of the top 4 insurers nationally has increased steadily over time, growing from 74 percent in 2006 to 83 percent in 2014.<sup>30</sup> However, health insurance markets are for the most part local (due to access to local provider networks), so measures of local market concentration are likely more informative about the extent of potential competition in health insurance markets. Local health insurance markets are also dominated by a small number of firms. In the median state, the two largest insurers have 66 percent of the market, and in the median metropolitan statistical area (MSA), they have 70 percent.<sup>31</sup> In the vast majority of states and MSAs, the top two insurers have more than 50 percent of the market.<sup>32</sup> This structure is also true for Medicare Advantage health insurance markets. The top four firms controlled 61 percent of Medicare Advantage markets nationally in 2015, up from 48 percent in 2011.<sup>33</sup>

The structure of physician services markets has also been changing. Many physician practices are being acquired by hospitals. The percentage of physicians who are owners of their practice has fallen

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25 Guardado, J.R. Emmons, D.W. and Kane, C.K. (2013). The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra. *Health Management, Policy and Innovation*, 1(3), 16-35.

26 Dafny, L., Gruber, J., & Ody, C. (2015). More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. *American Journal of Health Economics*. 1(1), 53-81.

27 American Hospital Association. (Updated 2016). Chartbook, Chart 2.9: Announced Hospital Mergers and Acquisitions, 1998-2015. <http://www.aha.org/research/reports/tw/chartbook/ch2.shtml>.

28 Gaynor, M. Health Care Industry Consolidation. [Testimony].

29 Highly concentrated means that the sum of the squares of firms market shares (called the Herfindahl-Hirschman Index, or HHI) is 2,500 or higher, equivalent to a market with four equal sized firms. Cutler D.M., & Scott M.F. (2013). Hospitals, Market Share, and Consolidation. *JAMA*. 310(18), 1964-1970. <http://jamanetwork.com/journals/jama/article-abstract/1769891>.

30 Dafny, L. (2015). Health Insurance Industry Consolidation:

What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask? Testimony before the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights.

31 American Medical Association. (2014). Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2014 update. [https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product\\_id=prod2560005](https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2560005).

32 *Ibid.*

33 Dafny, L. Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask? [Testimony].

from 76.1 percent in 1983 to 50.8 percent in 2014.<sup>34</sup> The American Hospital Association reports a 56.7 percent increase in the number of physicians and dentists employed by hospitals from 1999 to 2014.<sup>35</sup> The American Medical Association reports that nearly 33 percent of physicians now work as hospital employees, up from 29 percent in 2012.<sup>36</sup> Approximately 40 percent of hospital admissions are reported to come from hospital-owned physician practices.<sup>37</sup> Further, the share of spending associated with hospital owned practices rose from 16.9 percent in 2007 to 26.5 percent in 2013.

Practice size has also been growing.<sup>38</sup> In 1983, 80 percent of physicians were in practices of 10 physicians or less. By 2014, that had declined to 61 percent. The percentage of physicians in solo practices fell from 40 percent in 1983 to under 20 percent in 2014. Hospital acquisition of physician practices has been shown to result in substantial increases in prices and spending,<sup>39</sup> and to affect where physicians in acquired practices admit their patients.<sup>40</sup> In addition, prices for physician services have been shown to be higher in more concentrated markets with fewer potential competitors.<sup>41</sup>

## QUALITY

There has been a great deal of concern expressed over quality in the U.S. health care system. This is both regarding the overall level of quality<sup>42</sup> and geographic variation in quality.<sup>43</sup> Research evidence shows that lack of competition can lead to compromised quality.<sup>44</sup> The evidence is not as clear-cut as it is for price, but there are strong studies showing that patient health outcomes are worse at hospitals that face less competition.<sup>45</sup> In particular, when prices are set by regulators, as in the Medicare program, less competition can lead to dramatically worse patient outcomes. An important paper shows that Medicare beneficiaries who experienced a heart attack had a 1.46 percentage point higher chance of dying within one year of treatment if they were treated by a hospital that faced few potential competitors, relative to

34 Kane, C. (2015). Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership. American Medical Association. Policy Research Perspectives. [https://www.m3globalresearch.com/img/resources/AMA\\_PRP\\_Physician\\_Practice\\_Arrangements.pdf](https://www.m3globalresearch.com/img/resources/AMA_PRP_Physician_Practice_Arrangements.pdf).

35 American Hospital Association. (2016). Table 5.2 from Chartbook: Trends Affecting Hospitals and Health Systems. <http://www.aha.org/research/reports/tw/chartbook/index.shtml>.

36 Kane, C. Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership.

37 Baker, L., Bundorf, M.K., & Kessler, D.P. (2015). The Effect of Hospital/Physician Integration on Hospital Choice. National Bureau of Economic Research. Working Paper 21497. <http://www.nber.org/papers/w21497>.

38 Muhlestein, D.B., & Smith, N.J. (2016). Physician Consolidation: Rapid Movement from Small To Large Group Practices, 2013–15. *Health Affairs*. 35(9), 1638-1642. <http://content.healthaffairs.org/content/35/9/1638>.

39 Baker, L.C., Bundorf, M.K., Kessler, D.P. (2014). Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending. *Health Affairs*. 33(5), 756-763. <http://content.healthaffairs.org/content/33/5/756.abstract>; Robinson, J.C., & Miller, K. (2014). Total Expenditures per Patient in Hospital-Owned and Physician Organizations in California. *JAMA*. 312(16), 1663-1669. <http://jamanetwork.com/journals/jama/fullarticle/1917439>.

40 Baker, L., Bundorf, M.K., & Kessler, D.P. The Effect of Hospital/Physician Integration on Hospital Choice.

41 Dunn, A., & Shapiro, A. (2014). Do Physicians Possess Market Power? *Journal of Law and Economics*. 57(1), 159-193. <http://www.journals.uchicago.edu/doi/abs/10.1086/674407>; Baker L.C., Bundorf, M.K., Royalty, A.B., Levin, Z. (2014). Physician Practice Competition and Prices Paid by Private Insurers for Office Visits. *JAMA*. 312(16), 1653-1662. <http://jamanetwork.com/journals/jama/fullarticle/1917436>; Austin, D.R., Baker, L.C. (2015). Less Physician Practice Competition is Associated with Higher Prices Paid for Common Procedures. *Health Affairs*. 34(10), 1753–60. <http://content.healthaffairs.org/content/34/10/1753.abstract>.

42 Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century.

43 Rosenberg B.L., Kellar J.A., Labno A., Matheson, D.H.M., Ringel M., VonAchen P., Lesser, R.I., Li, Y., Dimick, J.B., Gawande, A.A., Larsson, S.H., & Moses III, H. (2016). Quantifying Geographic Variation in Health Care Outcomes in the United States before and after Risk-Adjustment. *PLoS ONE* 11(12): e0166762. doi:10.1371/journal.pone.0166762.

44 Gaynor, M., Ho, K., & Town, R.J. (2015). The Industrial Organization of Health-Care Markets. *Journal of Economic Literature*. 53(2), 235-284. <http://dx.doi.org/10.1257/jel.53.2.235>; Vogt, W. B., & Town, R. How has hospital consolidation affected the price and quality of hospital care?; Gaynor, M., & Town, R. (2012). The impact of hospital consolidation—Update.

45 *Ibid*.

hospitals that faced many potential competitors.<sup>46</sup> A recent paper finds similar results for physicians.<sup>47</sup> Cardiologists who face less competition have patients with higher mortality rates. This gives further cause for concern about the negative impacts for the country of lack of competition in health care markets.

## **SPILOVERS ONTO PUBLIC PROGRAMS**

The Medicare program sets the prices it pays to hospitals and physicians, so it is not directly affected by lack of price competition in private markets. However, as indicated above, Medicare beneficiaries are still directly affected by lack of competition via impacts on quality.<sup>48</sup> In addition, the lack of competition indirectly affects Medicare in at least three ways.

First, higher private prices lead to pressure from providers on Medicare to increase its payment rates, which affects taxpayers and the overall economy.<sup>49</sup> Second, high private prices can lead to access problems for Medicare (and Medicaid) beneficiaries. Providers may prefer to see more profitable private patients instead of Medicare or Medicaid patients.<sup>50</sup> Failure to address private market problems can thus over time lead to pressures on Medicare and Medicaid.

Third, high private prices have substantial effects on federal and state budgets. The largest is from the tax exclusion of employer and most employee contributions for employment related health insurance, which led to a federal revenue loss of nearly \$342 billion in 2016.<sup>51</sup> Higher prices increase the cost of employer-sponsored health insurance, which increases the revenue loss from the tax exclusion for employer-sponsored health insurance. Finally, higher private prices increase the cost of premium tax credits in individual health insurance market reform.

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46 Kessler, D.P., & McClellan, M.B. Is Hospital Competition Socially Wasteful?

47 Eisenberg, M. (2014). The Impact of Competition on Quality in Physician Markets:

The Case of Cardiologists. Chapter from unpublished doctoral dissertation, Carnegie Mellon University.

48 Kessler, D.P., & McClellan, M.B. Is Hospital Competition Socially Wasteful?; and Eisenberg, M. The Impact of Competition on Quality in Physician Markets: The Case of Cardiologists.

49 MedPAC Staff. (November 2016). Meeting Highlight: Hospital Consolidation and Its Implications for Medicare. <http://www.medpac.gov/blog-/medpacblog/2016/11/15/meeting-highlight-hospital-consolidation-and-its-implications-for-medicare>.

50 *Ibid.*

51 Office of Tax Analysis. (2015). Tax Expenditures. US Department of the Treasury. <https://www.treasury.gov/resource-center/tax-policy/Documents/Tax-Expenditures-FY2017.pdf>.

# Proposals

Both the federal government and states have large impacts on health care markets and how well they function. In what follows, we describe a set of concrete, actionable policies to enable, enhance, and support competition. We begin with suggested reforms to the Medicare program to remove artificial incentives for physician practices to merge or be acquired, and thereby compromise competition. We then continue with policies that the federal government, but particularly the states, can take to promote entry by new competitors in health insurance and health care markets. Finally, we propose policies that the federal and state governments can pursue to prevent anticompetitive practices by existing firms attempting to protect their market position and diminish competition.

## 1. MAINTAINING AND ENHANCING THE COMPETITIVENESS OF HEALTH CARE MARKETS

The federal government has a large impact on the competitiveness of health care markets through Medicare policies regarding providers. These policies are generally adopted with a focus towards Medicare program goals without explicit consideration of market impacts. Nonetheless, Medicare is such a large and important payer that its actions can have profound impacts, not just on the intended areas, but also on markets generally. In addition, both federal and state governments can enhance the competitiveness of health care markets by providing transparency on quality and costs to both providers and consumers. We broadly recommend that federal and state governments assess the impacts on markets and competition when making policy decisions. Specifically, the federal government should seek to avoid policies that artificially encourage providers to consolidate, and federal and state governments should pursue policies that enable and enhance competition. In what follows, we describe specific policy recommendations to improve competition and the functioning of health care markets, focusing on payment policy and administrative and regulatory requirements.

Federal and state agencies should explicitly consider the impacts of rules, regulations, and policies on competition. Federal and state antitrust enforcement agencies can provide expertise and assistance as needed.

### **PAYMENT POLICIES**

#### **SITE-NEUTRAL PAYMENTS**

Medicare pays additional “facility fees” to hospitals for physician services provided in outpatient departments, even when the identical service can be performed in a freestanding physician’s office. These payments were originally intended to help cover the overhead costs for services that can only be provided in hospitals, especially those that involve standby costs, such as the emergency department and specialized services including high-end imaging and burn care.

As hospitals employ a large and increasing number of physicians, more and more of them are in specialties outside of the traditional hospital-based specialties.<sup>52</sup> This trend means that additional facility fees are now paid for a wide range of physician services that do not draw on specialized hospital overhead and are commonly provided outside of hospitals, sometimes in offices outside of the hospital campus.

Facility fees for services that can be provided outside of a hospital provide a strong incentive for hospitals to employ more physicians and for physicians to be acquired by hospitals, and thus encourage consolidation. Physician practices purchased by hospitals can get higher payment rates from payers and patients, both from the facility fees and from the greater leverage that hospitals have with private payers in negotiating payment rates for their employed physicians. Higher payment rates for physician services provide hospitals the wherewithal to pay physicians more than they can earn in private practice as well as to absorb the decline in physician productivity that often occurs when physicians move away from independent practice.<sup>53</sup>

Hospital employment of physicians reduces competition by combining practices and eliminating them as competitors, and through pressures on employed physicians to refer patients to that hospital and its affiliated specialists.<sup>54</sup> The Medicare Payment Advisory Commission (MedPAC) recommends eliminating this additional payment by Medicare for those services that are frequently performed in physician offices and which are not related to the emergency department.<sup>55</sup> Congress addressed the issue partially in 2015, eliminating these payments for physician services delivered away from the hospital campus for future hospital purchases of physician practices or facilities.<sup>56</sup> While this is a step in the right direction, this leaves existing payments in place and still allows physicians who newly begin practicing at on-campus hospital outpatient departments to receive higher facility fees.

***To fix the unintended distortions created by this payment policy, we recommend:***

- Medicare make payments for services typically performed in physicians' offices and not related to the emergency department site-neutral, i.e., the payment for a physician office-based service is the same whether the practice is independent or hospital owned; and
- State Medicaid programs and private insurers also adopt site-neutral payments if they are currently utilizing them.

We note that if Medicare changes its policy, it would likely increase the probability that Medicaid and private insurance also change their policies, thereby substantially magnifying the benefits of the policy change.

52 Traditional hospital-based specialties are emergency medicine, radiology, anesthesiology, and pathology. Many physicians in specialties such as family medicine, internal medicine, pediatrics, obstetrics/gynecology are now hospital employees.

53 Kocher, R., & Sahni, N. (2011). Hospitals' Race to Employ Physicians: Logic behind a Money-Losing Proposition. *New England Journal of Medicine*. 364, 1790-1793. <http://www.nejm.org/doi/full/10.1056/NEJMp1101959#t=article>.

54 Federal Trade Commission. (2015). St. Luke's Health System, Ltd, and Saltzer Medical Group, P.A. Retrieved November 6, 2016 from <https://www.ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa>.

55 Medicare Payment Advisory Commission. (2014). Chapter 6: Site-Neutral Payments for Select Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities. Report to the Congress: Medicare and the Health Care Delivery System. <http://www.medpac.gov/docs/default-source/reports/chapter-6-site-neutral-payments-for-select-conditions-treated-in-inpatient-rehabilitation-facilities.pdf?sfvrsn=0>.

56 H.R. 1314 – Bipartisan Budget Act of 2015. <https://www.congress.gov/bill/114th-congress/house-bill/1314/text>.

## THE SECTION 340B PROGRAM

Another payment policy that unintentionally fosters consolidation is the “Section 340b” program, which enables hospitals that treat substantial numbers of low-income patients to obtain pharmaceuticals at large discounts not available to independent physician practices.

The program was intended to help safety net hospitals providing substantial uncompensated care, but an increasing number of hospitals have qualified over time, and qualifying hospitals can receive the discounted price on all the medications they purchase, not just those dispensed to indigent patients.

The 340b program creates an artificial incentive for physicians who administer very expensive drugs, such as oncologists, to become employed by hospitals. 340b-eligible hospitals can earn substantial profits when drugs are administered to insured patients, especially in the outpatient department. This gives hospitals the ability to compensate specialists at higher rates than can be earned in independent practice.

### **We recommend that:**

- The Section 340b program be re-evaluated to examine whether it has become much broader than the intended purpose, and revised to reduce the anti-competitive results from increased hospital employment of physician specialists. Specifically, we recommend that the Health Resources and Service Administration (HRSA) investigate alternative implementation approaches.
  - Tying 340b discounts to eligible patients rather than to the site of service would achieve the objective of aiding hospitals treating indigent patients, but does not create an incentive for hospitals and physicians to consolidate.

## SIMPLIFY / REDUCE ADMINISTRATIVE AND REGULATORY REQUIREMENTS

### SIMPLIFYING ADMINISTRATIVE REQUIREMENTS

Mounting administrative burdens raise the fixed cost of practice, making it harder for smaller practices to compete. In turn, this creates an incentive for physicians to consolidate into larger groups, or be acquired by hospital systems, which have both been significant trends, as discussed in Section II, D. This consolidation tends to decrease the number of physician practices, thereby weakening competition. This is precisely the type of adverse impact that the Regulatory Flexibility Act,<sup>57</sup> enacted in 1980, seeks to mitigate. Its goal is to provide a level playing field for small entities; it is not intended to give an unfair advantage, but recognizes that the costs of complying with regulations may fall disproportionately on smaller entities versus larger organizations that can spread fixed compliance costs over a larger volume of production.<sup>58</sup> While federal agencies now routinely assess the impact of regulations on smaller businesses, their effects on consolidation and competition are generally not part of the overall assessment of the costs and benefits of such policies.

<sup>57</sup> Regulatory Flexibility Act, Pub. L. No. 96-354, 94 Stat. 1164 (codified at 5 U.S.C. § 601).

<sup>58</sup> Small Business Administration. (2012). A Guide for Government Agencies. How to Comply with the Regulatory Flexibility Act. [https://www.sba.gov/sites/default/files/rfaguide\\_0512\\_0.pdf](https://www.sba.gov/sites/default/files/rfaguide_0512_0.pdf).

Physicians vigorously complain that they are spending more time than ever with paperwork, EHR documentation, and bureaucratic “administrivia,” such as obtaining prior authorization.<sup>59</sup> The authors of one study concluded that for every hour a primary care physician spends in direct patient care, they spend two hours engaged in administrative functions.<sup>60</sup> These are believed to be major contributors to physician burnout and dissatisfaction,<sup>61,62</sup> and a major reason why physicians are pushed to give up independence in exchange for health system employment,<sup>63</sup> where an ever-larger army of clerical, administrative and billing staff, and consultants take on these onerous requirements for getting paid. Medicare, Medicaid, and private health plans will have to take more seriously the burden of these administrative requirements, which have been characterized as “individually reasonable, and collectively insane.”

Policy changes are needed to reduce unnecessary administrative burdens, both because those steps may produce direct savings but also because they will increase competition by making it more feasible for physician practices to remain smaller or independent. Potential actions include simplifying the administrative aspects of practice, creating pricing parity for independent primary care services, and providing assistance with meeting the increasing demands on quality data reporting.<sup>64</sup>

We recommend that HHS and private insurers work on reducing the administrative burden faced by physician practices. Technology can be used to a practice’s advantage in accomplishing this goal through greater automation and better use of the electronic health records, which have become a flashpoint of discontent. In addition, standardization across insurers will greatly reduce administrative burden.

**Specifically, we recommend:**

- HHS convene an advisory group of practicing clinicians and small practice administrators to generate specific recommendations on ways that the federal government can reduce the burden of administrative requirements. These could include:
  - CMS re-examining compensation levels and rules for time-based billing in Medicare. Physicians could be given the option to avoid onerous documentation requirements entirely and opt for more feasible time-based coding, which could be tracked and audited through interactions with the electronic health record.
  - Medicare requiring standardization of data collection and prior authorization forms across all Medicare Advantage (Part C) and Part D plans.
  - Clarifying that documentation into the medical record by any member of the practice team (and not just the physician) would be considered in determining and supporting the submitted billing codes.

59 O'Reilly, K.B. (2017). Survey quantifies time burdens of prior authorization. *AMA Wire*. <https://wire.ama-assn.org/practice-management/survey-quantifies-time-burdens-prior-authorization>

60 Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., Westbrook, J., Tutty, M., & Blick, G. (2016). Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Internal Medicine*. 165, 753-760. doi: 10.7326/M16-0961.

61 Rao, S. K., Kimball, A.B., Lehrhoff, S.R., Hidrue, M.K., Colton, D.G., Ferris, T.G., & Torchiana, D.F. (2017). The Impact of Administrative Burden on Academic Physicians: Results of a Hospital-Wide Physician Survey. *Academic Medicine*. 92(2), 237-243. [http://journals.lww.com/academicmedicine/Citation/2017/02000/The\\_Impact\\_of\\_Administrative\\_Burden\\_on\\_Academic.30.aspx](http://journals.lww.com/academicmedicine/Citation/2017/02000/The_Impact_of_Administrative_Burden_on_Academic.30.aspx).

62 Peckham, C. (2015). Physician Burnout: It Just Keeps Getting Worse. *Medscape Family Medicine*. [http://www.medscape.com/viewarticle/838437\\_3](http://www.medscape.com/viewarticle/838437_3)

63 Jackson Healthcare. (2015). Physicians Continue to Leave Private Practice for Employment. <http://www.jacksonhealthcare.com/physician-trends/other-articles/physicians-continue-to-leave-private-practice-for-employment/>.

64 American Academy of Family Physicians. (2017). AAFP’s Agenda for Regulatory and Administrative Reforms. <http://www.aafp.org/dam/AAFP/documents/advocacy/campaigns/ST-Reg-Admin-Reform-013117.pdf>.

- Accelerating use by health plans of electronic Prior Authorization standards as developed by the Committee on Operating Rules of the Coalition for Affordable Quality Healthcare (CAQH/CORE), a multi-stakeholder organization.
- CMS piloting decision-support as an alternative to prior authorization in the Medicare program (e.g., for repetitive non-emergency transports, home health services, durable medical equipment, and high-cost diagnostic imaging). Replicate examples of the use of decision support tools within clinical workflows to obviate the need for more onerous and time-consuming manual prior authorization processes.<sup>65</sup>
- The Office of the National Coordinator for Health Information Technology (ONC) leading a cross-agency team to standardize electronic data elements, vocabulary, format, and transport requirements for reporting from electronic health records to public agencies (e.g., request for medical documentation, public health case reporting, etc.), and embedding these standards into certification requirements for electronic health records. Standardizing forms (such as school/camp forms, employment, worker's compensation, etc.) and reporting requirements, and embedding them into electronic health records would substantially reduce administrative burden.
- The Centers for Disease Control and Prevention (CDC) using public health funding program requirements to standardize, rationalize, and harmonize communicable disease and other public health reporting requirements at the state level.

Of course, it is also important that private insurers adopt practices such as those we just described to reduce administrative burdens. It is often the case that practices adopted by CMS eventually flow to the private sector. However, we encourage private insurers and HHS to explicitly consider these issues and work together to find ways to achieve these goals.

### **ADMINISTRATIVE BURDEN ASSOCIATED WITH VALUE-BASED PAYMENTS**

The complexity of the Medicare Access and CHIP Reauthorization Act (MACRA) and the requirements under the mandatory quality payment program have raised concerns that the burden will push many physician practices to join hospitals and health systems. The final rule, published in the fall of 2016, includes two policies aimed at reducing these effects: lowering the bar of compliance requirements (including exempting large numbers of small practices) and helping independent practices meet these requirements (e.g., through shared resources).<sup>66</sup> Both of these policies will make succeeding as an independent physician under MACRA more feasible.

One of the most common features of value-based programs is the reliance on reported clinical quality measures. However, the burden of manual data collection and cumbersome reporting requirements for a

<sup>65</sup> Solberg, L.I., Vinz, C., & Trevis, J.E. (2012). A Technology Solution for the High-Tech Imaging Conundrum. *American Journal of Managed Care*. 18(8), 421-425. <http://www.ajmc.com/journals/issue/2012/2012-8-vol18-n8/a-technology-solution-for-the-high-tech-diagnostic-imaging-conundrum/#sthash.GkMqUvl6.dpuf>

<sup>66</sup> Centers for Medicare & Medicaid Services. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. [Rule]. <https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm>.

plethora of disparate measures is another factor pushing physicians to join larger institutions in order to benefit from teams dedicated to ensuring reporting compliance. At its most recent public meeting (March 2, 2017) MedPAC discussed going further in reducing administrative burdens for all practices, such as relying on claims data for quality measurement instead of additional reporting by medical practices.

As an alternative, Certified EHRs are now able to capture the clinical elements required to construct quality measures as part of the process of delivering care, and to report them at the patient level, or in the aggregate as calculated quality measures. However, the data collected are of variable quality and completeness, and the mapping of data elements to vocabulary and content standards are inconsistent; consequently, quality reporting still requires significant manual chart reviews. While CMS has led the way in accepting these electronic quality reports, the vast majority of health plans have not, and still require the time-consuming submission of additional information. These submissions are superfluous with current technology—changing this practice will substantially reduce administrative burden.

The future vision for quality measurement for improvement and accountability includes a parsimonious set of core measures, measures that are captured as part of the clinical workflow, and continuous feedback.<sup>67</sup>

***We recommend that:***

- CMS, ONC, and AHRQ create a roadmap for electronic quality reporting that will achieve the explicit goal of reliable electronic quality measurement that relies on information routinely generated and captured as a process of delivering care by 2020.
- Support the National Quality Forum (NQF) and leading measure development organizations to create a parsimonious set of outcome measures (including patient-reported measures) that are designed for an electronic environment from the ground up, rather than repurposed from legacy claims-based or chart-review measures.
- Until such measures are developed, the Core Quality Measure Collaborative, (led by the America's Health Insurance Plans (AHIP) and its member plans' chief medical officers, leaders from CMS and the National Quality Forum (NQF), as well as national physician organizations, employers and consumers) has identified seven sets of consensus core measure sets.<sup>68</sup>
  - Medicare, Medicaid, and federal agencies (DoD, VA, IHS) should require use of these core measures.
  - State Innovation Model awardees that seek to harmonize public and private payers at the state level should use these measures in value-based program designs.
  - Public and private employers (including FEHB) and insurance exchanges should require the use and reporting of the core measures by qualifying health plans.

67 Conway P.H., Mostashari F., & Clancy C. (2013). The Future of Quality Measurement for Improvement and Accountability. *JAMA*. 309(21), 2215-2216. doi:10.1001/jama.2013.4929.

68 Centers for Medicare & Medicaid Services. (Last Modified. 2016). Core Measures. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>.

## VIRTUAL GROUPS

The MACRA legislation explicitly provided for the establishment and recognition of voluntary “Virtual Groups” for practices with fewer than ten clinicians, with the goal of reducing the burden of quality reporting and compliance. Under MIPS (“Merit-based Incentive Payment System”),<sup>69</sup> clinicians will have the option to join “virtual groups” and combine their MIPS reporting across the four MIPS performance categories.

Models that facilitate integration without consolidation, like virtual groups, can give small practices a method of spreading large fixed costs over a larger patient panel. One of the key assumptions underlying health care for the past several years has been that only large, integrated delivery models would be able to implement the necessary supporting systems and successfully deliver on more advanced alternative payment models.

No one physician can afford the IT, regulatory, and management supports needed to thrive in modern health care with the increasing requirements of value-based payment models, but that does not necessarily imply that the only capable entities are integrated delivery networks.

Advances in information technology have made clinical integration without financial consolidation much more viable (e.g., cloud-based software, improved data interoperability, innovative networked business models). Independent practices can work in a coordinated way with centralized regulatory, information technology, and capital support. This allows for coordination without the financial consolidation that can jeopardize competition.

### ***We recommend that:***

- CMS finalize regulations governing recognition of virtual groups as soon as possible.
- CMS and other payers encourage practices to use virtual groups for quality reporting and practice support relating to value-based payments, and provide start-up funding and support (e.g., group purchasing of EHR interfaces) to these virtual groups.

## INFORMATION BLOCKING

Developments in information technology allow clinical integration to occur between different legal entities without the use of a single electronic health record. While progress has been made over the past decade on many of the technical challenges to such data sharing across networked providers, the business and competitive barriers to such data sharing remain formidable.

Many state health information exchanges have provided a platform for cross-organizational information exchange, but without state legislation, regulatory mandates, or strong financial incentives, participation by hospitals remains spotty and the financial viability of such organizations is uncertain. On the other hand, there are notable examples of states that have used a variety of policy and regulatory levers to

<sup>69</sup> Centers for Medicare & Medicaid Services. The Merit-Based Incentive Payment System (MIPS). [Presentation]. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf>.

encourage information exchange and interoperability.<sup>70</sup> For example, Florida's 1115 Managed Medical Assistance Waiver Demonstration Program requires hospitals receiving "Low Income Pool" funds to participate in the Florida Event Notification program.<sup>71</sup> Hospitals may see easy data portability as a competitive disadvantage that encourages "leakage" and loses patients to rivals. Health systems, then, have an incentive to facilitate data flows within their own organizations, but to impede them with rivals in order to retain patients. This of course decreases patient mobility and weakens competition. State-designated Health Information Exchange Organizations are a key resource to enable a level playing field for information exchange in the public interest.<sup>72</sup>

Similarly, Electronic Health Records vendors may also have financial disincentives to increase compatibility, creating barriers to export clinical data to a different system, or to use third party applications (e.g. for population health, or patient engagement), which reduce customer mobility and weakens competition in the EHR market as well as in the hospital market.

Anticompetitive interests can align between hospitals and their vendors: working together to oppose stronger regulation or enforcement of interoperability requirements, and to take advantage of Stark law waivers to provide community physicians with free or low-cost access to health system EHRs as a strategy for reinforcing consolidation and limiting the ability of affiliated physicians to break away.

These strategies are called "information blocking," and must be addressed vigorously if data and clinical integration across different practices with disparate EHRs is to serve as an alternative to consolidation under a single health system and/or a single EHR.

#### **We recommend that:**

- **ONC vigorously enforce surveillance of the EHR certification program, particularly as it relates to data portability and quality reporting.**
- **CMS use its various authorities (e.g., Hospital Health IT Incentive Program requirements) to ensure that hospitals are providing key information (e.g., notifications of admissions and discharges) to patients' primary care physicians outside of their own networks.**
- **States use legislative or regulatory levers to encourage data sharing by hospitals and discourage data blocking. The National Conference of State Legislatures should develop model state laws (e.g., fashioned after Maryland<sup>73</sup> or North Carolina<sup>74</sup>) and regulations (e.g., similar to Florida) that improve the use of state-designated Health Information Exchanges.**
- **Federal and state antitrust enforcement agencies consider whether such strategies constitute antitrust violations and if so, if one of these approaches, or some other, is in order.**

<sup>70</sup> Office of the National Coordinator for Health Information Technology. State Health IT Policy Levers Compendium. Retrieved March 8, 2017. from <https://dashboard.healthit.gov/dashboards/state-health-it-policy-levers-compendium.php>.

<sup>71</sup> Center for Medicaid & CHIP Services. (2015). Reimbursement and funding methodology for demonstration year 10 Florida's 1115 Managed Medical Assistance Waiver Low Income Pool. [Response Letter]. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-appvd-rmbrsmnt-fndng-mthdlyg-03012016.pdf>.

<sup>72</sup> HealthIT.gov. State Health Information Exchange Cooperative Agreement Program. Retrieved March 8, 2017 from <https://www.healthit.gov/policy-researchers-implementers/state-health-information-exchange>.

<sup>73</sup> Code of Maryland Regulations. Hospital Participation. 10.37.07.03. <http://www.dsd.state.md.us/comar/comarhtml/10/10.37.07.03.htm>.

<sup>74</sup> NC Statute G.S. 90-414.4(b). [http://www.ncleg.net/EnactedLegislation/Statutes/PDF/BySection/Chapter\\_90/GS\\_90-414.4.pdf](http://www.ncleg.net/EnactedLegislation/Statutes/PDF/BySection/Chapter_90/GS_90-414.4.pdf).

## **SUPPORTING RISK CONTRACTS FOR INDEPENDENT PROVIDER NETWORKS**

Recent evidence suggests that small, physician-owned practices have a lower average cost per patient,<sup>75</sup> fewer preventable hospital admissions,<sup>76</sup> and lower readmission rates than larger independent and hospital-owned practices.<sup>77</sup> However, the push to expand payment models that share risk with providers has the potential to drive independent practices into employment and affiliation with locally dominant health systems.<sup>78</sup> A recent study of ACOs found “...little acceleration in consolidation in addition to trends already under way, but there is evidence of potential defensive consolidation in response to new payment models.”<sup>79</sup>

Even independent physician organizations that are successful at delivering better care at lower cost can falter in new payment models if they can't obtain the necessary capital, manage governance between specialists and primary care providers, and negotiate contracts with payers.<sup>80</sup>

Moreover, when health systems enter accountable care arrangements, they can take advantage of Stark and anti-kickback waivers<sup>81</sup> and the claims data provided to capture referrals from independent practices without purchasing them outright. Such hospital-managed networks may form ACOs to receive the claims data, but then do not conduct many (if any) of the functions intended to reduce the total cost of patient care while improving quality that generate savings in the MSSP. Requiring a migration to two-sided risk for ACOs that include larger hospitals and health systems after a certain number of years, so that there is a cost (downside financial risk) to “ACO squatting,” would help to address this issue.

Ironically, such consolidation can defeat the intended purpose of the payment reforms if it endows providers with market dominance that allows them to refuse to accept new payment methods or negotiate payments from private payers so high that they undo the intended incentives. Simply put, payment reform cannot be considered independently of the need to maintain competition.

The evidence to date indicates that primary care-centric independent ACOs can compete favorably under new value-based models.<sup>82</sup> These ACOs likely do more to foster competition than ACOs led by hospitals or by multi-specialty groups. Those led by primary care groups have incentives to refer selectively to the

75 Robinson, J.C., Miller, K. (2014). Total Expenditures Per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. *JAMA*. 312(16), 1663-1669. doi: 10.1001/jama.2014.14072.

76 Casalino, L.P., Pesko, M.F., Ryan, A.M., Mendelsohn, J.L., Copeland, K.R., Ramsay, P.P., Sun, X., Rittenhouse, D.R., & Shortell, S.M. Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions. *Health Affairs*. 33(9), 1680-1688. doi: 10.1377/hlthaff.2014.0434.

77 McWilliams, J.M., Landon, B.E., & Chernew, M.E., (2013). Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated With a Commercial ACO Contract. *JAMA*. 310(8), 829-836. <http://jama.jamanetwork.com/article.aspx?articleid=1733718>.

78 Friedberg, M.W., Chen, P.G., White, C., Jung, O., Raaen, L., Hirshman, S., Hoch, E., Stevens, C., Ginsburg, P.B., Casalino, L.P., Tutty, M., Vargo, C., & Lipinski, L. (2015). Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica, CA: RAND Corporation. [http://www.rand.org/pubs/research\\_reports/RR869.html](http://www.rand.org/pubs/research_reports/RR869.html).

79 Neprash, H.T., Chernew, M.E., & McWilliams, J.M. (2017). Little Evidence Exists to Support the Expectation That Providers Would Consolidate to Enter New Payment Models. *Health Affairs*. 36(2), 346-354. doi:10.1377/hlthaff.2016.0840.

80 Abelson, R. (December 2016). Cornerstone: The Rise and Fall of a Health Care Experiment. *The New York Times*. [https://www.nytimes.com/2016/12/23/business/cornerstone-the-rise-and-fall-of-a-health-care-experiment.html?\\_r=0](https://www.nytimes.com/2016/12/23/business/cornerstone-the-rise-and-fall-of-a-health-care-experiment.html?_r=0).

81 Centers for Medicare & Medicaid Services. Medicare Program; Final Waivers in Connection with the Shared Savings Program. [Rule]. <https://www.federalregister.gov/documents/2015/10/29/2015-27599/medicare-program-final-waivers-in-connection-with-the-shared-savings-program>.

82 McWilliams, J.M., Hatfield, L.A., Chernew, M.E., Landon, B.E., & Schwartz, A.L. (2016). Early Performance of Accountable Care Organizations in Medicare. *New England Journal of Medicine*. 374, 2357-2366. doi: 10.1056/NEJMsa1600142.

highest-quality or most efficient specialists, hospitals, and post-acute facilities. These incentives foster increased competition among specialists and facilities, a phenomenon that is less incentivized in ACOs led by hospitals or jointly by a hospital system and a multispecialty group.

As a guiding principle, public and private payers should focus on alternative payment models that facilitate integration of delivery without consolidation. The following proposals will help make participation in risk-based contracts more feasible for independent physicians, which in turn can reduce the rate of consolidation. The goal of these proposals is to avoid risk-based payments acting as an unintentional and artificial spur to further consolidation or acquisition of physician practices by large hospital systems, further damaging competition.

***We recommend that:***

- CMS revise the Medicare Shared Savings Program regulations to limit one-sided risk for ACOs that include larger hospitals and health systems to one contract period. This will reduce the opportunity for “ACO squatting,” which reduces competition.
- HHS should convene payers and providers (including physician-led ACOs) through the Learning and Action Network to create a standard template for risk-sharing contracts. Standardized gain-share contracts modeled after the Medicare Shared Savings Program would reduce the cost and time required for contracting with smaller organizations.
- Smaller ACOs face greater difficulty in accessing capital markets and/or affordable reinsurance products. The MACRA legislation included provisions requiring an examination of the pooling of financial risk for physician practices, in particular for small practices. The federal government should seek ways to provide more affordable reinsurance for smaller ACOs taking risk (perhaps federally guaranteed) and/or stop-loss (that caps individual patient costs at a lower rate), which can minimize smaller organizations’ exposure to actuarial risk from outlier high-cost patients that would necessitate large financial reserves to manage.
- Capital access should be improved for small practice ACOs through programs like the federal loan guarantee program or advances on shared savings to physician groups.

***PROVIDE TRANSPARENCY ON QUALITY AND COST TO PROVIDERS AND CONSUMERS***

Information on quality and cost is necessary for healthy market function, but this information is often lacking in health care. Government also needs this information to remain informed and to formulate good policy. It should be understood, however, that competition in health care markets works somewhat differently than in markets for many other goods or services.

Competition in health care takes the form of what is often called “two-stage competition.” In the first stage, providers compete via price and quality to be included in a health plan’s network. Health plans select those providers that offer the best combination of quality and price for their enrollees. In the second stage, providers that have been selected for the plan’s network compete for enrollees. This second stage competition has been mostly been via quality, since enrollees are covered by insurance and out of pocket costs for them have varied little, if at all, across in-network providers.

In recent years, however, increasing numbers of individuals have been enrolling in high deductible health plans. Twenty-nine percent of individuals with employer-sponsored insurance were enrolled in high deductible health plans in 2016, up from 13 percent in 2010, with 51 percent of workers enrolled in a plan with an annual (single coverage) deductible of \$1,000 or more.<sup>83</sup> Enrollees in such plans can face meaningful differences in their out of pocket costs across providers. As a consequence, there is potential for information on provider quality and costs to make a difference in consumers' choices, and consequently to increase competition.

It is nonetheless important to note that while there is the potential for information to help health care markets work better, there are limits to the effects that such information can have, due to the nature of health care. As is well known, the majority of health spending is driven by a relatively small number of individuals with very high expenses.<sup>84</sup> These individuals have expenses that put them well beyond the cost-sharing features of even a high deductible insurance plan, hence differences in costs across providers should not matter to them. This means that the potential for information to lead to shopping by consumers on the basis of price is limited to situations where provider cost differences are reflected in consumers' out of pocket costs. It is also the case that some services are not "shoppable."<sup>85</sup> For some services consumers, do not have the time to choose providers. For others, the severity of the health condition is paramount, and information is complex, so physician recommendations play a primary role. There is not yet a large body of evidence on the effects of transparency policies that make information available to consumers, but the evidence is mixed. Some evidence shows that transparency leads to lower prices,<sup>86</sup> but there is also evidence that transparency has no impact.<sup>87</sup> There is also some question about how well people respond to cost-sharing incentives.<sup>88</sup> As a consequence, while there is the potential for policies providing information to the market to make a difference, it should be recognized that such policies can be a component of a comprehensive competition policy, but are not likely to move the market solely on their own.

Negotiations between insurers and providers will still play a critical role in driving competition and determining price and quality. While insurers clearly know their negotiated rates with providers, information on quality is more difficult to ascertain. The lack of standardized clinical measures across payers and the lack of a mechanism to aggregate quality performance across payers means that most measures

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83 Kaiser Family Foundation and Health Research and Educational Trust. (2016). Employer Health Benefits: 2016 Annual Survey. <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey>.

84 Cohen, S.B. (2014). The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions, 2012. Agency for Health Care Research and Quality. Statistical Brief #455. [https://meps.ahrq.gov/data\\_files/publications/st455/stat455.pdf](https://meps.ahrq.gov/data_files/publications/st455/stat455.pdf).

85 Recent work estimates that at most 42.5 percent of health care spending is on services that can be considered shoppable. See: Health Care Cost Institute (2016). Spending on Shoppable Services in Health Care. Issue Brief #11. [http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16\\_0.pdf](http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16_0.pdf); and Frost, A., Newman, D., and Quincy, L. (2016). Health Care Consumerism: Can the Tail Wag the Dog? *Health Affairs Blog*. <http://healthaffairs.org/blog/2016/03/02/health-care-consumerism-can-the-tail-wag-the-dog-2/>.

86 Whaley, C. (2016). Provider Responses to Online Price Transparency. [Unpublished]. [https://dl.dropboxusercontent.com/u/44201172/Provider\\_responses\\_transparency.pdf](https://dl.dropboxusercontent.com/u/44201172/Provider_responses_transparency.pdf); Brown, Z. (2017). An Empirical Model of Price Transparency and Markups in Health Care. [Unpublished]. [http://www.columbia.edu/~zyb2001/zbrown\\_jmp.pdf](http://www.columbia.edu/~zyb2001/zbrown_jmp.pdf); and Brown, Z. (2016). Equilibrium Effects of Health Care Price Information. [Unpublished]. [http://www.columbia.edu/~zyb2001/zbrown\\_eqm\\_price\\_transparency.pdf](http://www.columbia.edu/~zyb2001/zbrown_eqm_price_transparency.pdf)

87 Collado, M., & Ducas, A. (2016). Patients, Physicians, and Price Transparency: If You Build It, Will They Come? *Health Affairs Blog*, <http://healthaffairs.org/blog/2016/08/31/patients-physicians-and-price-transparency-if-you-build-it-will-they-come/>.

88 Brot-Goldberg, Z., Chandra, A., Handel, B.R., & Kolstad, J.T. (2015). What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. National Bureau of Economic Research. Working Paper No. 21632. <http://www.nber.org/papers/w21632>.

have very small numbers of patients for any given payer-provider relationship. As a consequence, quality measures currently play a smaller role in informing network formation or provider tiering for the purpose of benefit design.

In recent years, the rise of providers sharing risk with insurers has introduced a third mechanism whereby cost and quality information could enhance the competitiveness of markets. Even when lower value providers are included in payer networks (e.g., due to market power), risk-taking providers and accountable care organizations are motivated to direct patient care to downstream suppliers with higher quality and lower cost.<sup>89</sup> However, there is currently a dearth of publicly available and validated measures for specialist costs, which account not only for unit costs, but also for necessity, safety and quality of utilization across the entire episode of care. Also, unlike Medicare, most commercial insurers do not share full claims data with risk-taking providers, or excise information on incurred costs. Preferred high value networks that get more referrals from risk-taking providers can be an important counter-balance to increasing the dominance of large market players that command higher prices without higher quality. However, this requires increased transparency on provider cost and quality.

#### **We propose the following:**

- As indicated previously, a parsimonious common set of quality measures for providers should be created. CMS is in a position to lead such an effort, but private insurers and states should also be involved.
- Statistically valid information on provider performance in those quality measures should be provided publicly. This can be done by the federal government, state governments, and private payers.
- Measures of cost, both total spending and the total amounts paid to providers for various procedures, should be provided publicly. This can be done by states using all-payer claims databases. It could also be accomplished by an entity which has assembled comprehensive national data. That entity could be part of the federal government or a private nonprofit entity acting in the public interest.
- The data required to provide such measures should be made available. This can be through state all-payer claims databases, or a national database.
  - A number of states have or are pursuing all-payer claims databases.<sup>90</sup>
  - As mentioned above, a national claims data repository could be created. This has some advantages, in that it could in principle support any state (or other) efforts, which would then have common (core) data elements and a common format. A national data repository would also have the advantage of facilitating national, as opposed to state level, analyses.
- Consumers should have information provided to them about their out of pocket costs for health services they are considering obtaining.
  - These should have accurate information based on their benefits and the network status of providers.

89 McClellan, M., & Mostashari, F. [Eds.] Adopting Accountable Care: An Implementation Guide for Physician Practices. Washington, D.C.: The Brookings Institution. <https://www.brookings.edu/wp-content/uploads/2016/06/ACO-Toolkit-Full-Version-Text-1.pdf>.

90 Delbanco, S. and Bazzaz, S. (2014). State Policies on Provider Market Power. National Academy of Social Insurance and Catalyst for Payment Reform. [https://www.nasi.org/sites/default/files/research/State\\_Policies\\_Provider\\_Market\\_Power.pdf](https://www.nasi.org/sites/default/files/research/State_Policies_Provider_Market_Power.pdf).

- This needs to be done by insurers, since they possess information about consumers' benefits and spending, and network information and provider pricing.
- Many insurers are already doing this by making transparency tools available to their enrollees.
- States should consider requiring insurers to provide such information, and what information should be provided and in what form.
- As we discuss below (Section III.C.2), “gag” clauses in contracts between providers and insurers cannot be allowed. Such agreements would prevent the provision of information described here.
- Similarly, as described previously (III.A.2.d), “data blocking,” cannot be allowed. This would also prevent the free flow of information, damaging the market.
- States should also consider creating entities to monitor the performance of the health care sector, such as the Massachusetts Health Policy Commission.<sup>91</sup> Such entities engage in monitoring and public reporting on price quality, and other measures of health care performance, and thus make health care more transparent and providers more accountable.
- CMS should move ahead with announced plans to provide quality and cost data at the practice level that can enable tiering and facilitate network formation by risk-taking ACOs.
- Commercial payers that engage in risk-sharing with providers should also embrace data-sharing on cost and quality. Risk-taking providers must have access to line level claims and cost data as well as plan-provided tiering information.

## 2. PROMOTE ENTRY BY NEW COMPETITORS/REMOVE BARRIERS TO ENTRY

One of the most critical factors in making markets work is the feasibility of entry by more innovative or efficient new competitors. Firms that aren't pushed by the presence or risk of new competitors do not feel pressure to lower prices, work to increase their efficiency, or make new or better products. In what follows, we describe a number of policies that will facilitate entry of new health care providers or facilities. These include eliminating or refocusing policies that currently limit or discourage entry as well as policies designed to facilitate and encourage entry.

A number of state regulations unnecessarily limit the entry of providers (we have discussed issues pertaining to the impacts of federal regulations on providers in Section A). Some may have been intended to protect consumers, but they often protect incumbent providers. In addition, there are some simple changes the federal government can make that will facilitate increases in the number of competitors in Medicare Advantage markets. Our recommendations are as follows.

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<sup>91</sup> Massachusetts Executive Office of Administration and Finance. Health Policy Commission. Retrieved March 8, 2017 from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/>.

## CERTIFICATE OF NEED REGULATIONS

Thirty-five states and the District of Columbia have certificate of need (CON) regulations.<sup>92</sup> These regulations require review by a state appointed board of any entity that wishes to enter a market to provide care. This applies to de novo entry and to entry by an existing firm offering a new service or offering an existing service in a new location. CON laws end up protecting existing firms and erecting barriers to entry for new firms or existing firms entering new markets. Research has shown these regulations harm competition, leading to higher costs without improving quality, contrary to proponents' claims.<sup>93</sup>

### We recommend that:

- States that have CON regulations on the books eliminate them. In some cases, these laws can be allowed to sunset. In others, repeal will be required.
- If a CON law is not repealed, it should be amended to require the CON review board to explicitly assess impacts on competition and consumers as part of their review process, and to explicitly justify the reasons for denying a certificate of need if doing so would adversely affect competition.

## ANY WILLING PROVIDER LAWS

As of 2014, twenty-seven states had any willing provider (AWP) laws on the books.<sup>94</sup> These laws require health insurers to include any provider in their network who so desires and pay them at in-network rates. These laws may have been intended to protect consumer choice of provider, or possibly to protect providers against arbitrary exclusion by insurers. However, their main effect is to undermine competition.

In health care, competition takes the form of providers competing to be included in insurers' networks, by offering attractive prices and quality. This is where provider price competition takes place in health care markets. In-network providers then compete to attract patients from among an insurer's enrollees. That subsequent competition is mainly over convenience and quality.

Provider price competition, then, is induced by selective contracting. The quid pro quo is increased patient volume for provider in exchange for lower prices. Providers get increased patient volume because

92 Koopman, C. & Philpot, A. (2016). The State of Certificate-of-Need Laws in 2016. Mercatus Center, George Mason University. <https://www.mercatus.org/publications/state-certificate-need-laws-2016>; and Delbanco, S. and Bazzaz, S. State Policies on Provider Market Power.

93 Mitchell, M. & Koopman, C. (2016). 40 Years of Certificate-of-Need Laws Across America. Mercatus Center, George Mason University. <https://www.mercatus.org/publication/40-years-certificate-need-laws-across-america>; Stratmann, T., & David Wille, D. (2016). Certificate-of-Need Laws and Hospital Quality. Mercatus Center, George Mason University. <https://www.mercatus.org/publications/certificate-need-laws-and-hospital-quality>; Sloan, F. A. (1981). Regulation and the Rising Cost of Hospital Care. *Review of Economics and Statistics*. 63(4), 479–87; Sloan, F. A., & Steinwald, B. (1980). Effects of Regulation on Hospital Costs and Input Use. *Journal of Law and Economics* 23(1), 81–109; Joskow, P. L. (1980). The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital. *Bell Journal of Economics* 11(2), 421–47; Joskow, Paul L. (1981). Controlling Hospital Costs: The Role of Government Regulation. Health and Public Policy series, Book 2. Cambridge, MA: MIT Press; Lanning, J. A., Morrissey, M.A., & Ohsfeldt, R.L. (1991). Endogenous Hospital Regulation and Its Effects on Hospital and Nonhospital Expenditures. *Journal of Regulatory Economics* 3(2), 137–54; Rivers, P. A., Fottler, M.D., & Frimpong, J.A. (2010). The Effects of Certificate-of-Need Regulation on Hospital Costs. *Journal of Health Care Finance* 36(4), 1–16; and Ginsburg, P. B. (2010). Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. Center for Studying Health System Change. HSC Research Brief No. 16.

94 Delbanco, S. and Bazzaz, S. State Policies on Provider Market Power; Noble, A. (2014). Health Insurers and Access to Health Care Providers: Any Willing Providers. National Conference of State Legislatures. <http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>.

insurers do not include every provider in their network. If providers know that anyone can be in a network due to an AWP law, then they have significantly less incentive to compete on price.

Further, providers may also have little incentive to provide better quality or service, again because they must be included in any insurer's network. Research evidence shows that AWP laws increase health care costs.<sup>95</sup> If some consumers desire broader networks that include more providers and are willing to pay for them, then a well-functioning insurance market will provide consumers with that choice. Similarly, consumers who are not willing to pay for broader provider choice should be allowed to select plans that cost less and have narrower networks.

**We recommend that:**

- States with AWP laws eliminate them, either by allowing them to sunset, or by passing legislation to repeal them.
- Neither states nor the federal government adopt new AWP laws or regulations.

### **ACCURACY OF PROVIDER NETWORK DIRECTORIES**

Consumers need to be clearly informed about the nature of a plan's network and the identities of providers in the network. The frequent lack of accurate information on provider networks and directories depresses competition among providers (and insurers).

However, insurers' abilities to accurately identify in-network providers are limited by the fact that a non-trivial portion of network contracts with physicians are at-will, as opposed to for a fixed period (as is standard with hospitals).

**To remedy these issues, we recommend that:**

- States should require insurers to clearly and accurately identify all in-network providers to consumers, to the extent possible; and
- States should consider requiring that all contracts with network providers be for a specified period, so that insurers, and therefore consumers, are able to accurately identify if a physician is in their network.

### **SCOPE OF PRACTICE REFORMS**

All states have "scope of practice" laws that specify what services non-physician medical providers (e.g., nurse practitioners, certified registered nurse anesthetists, pharmacists, psychologists) are allowed to perform and the circumstances and extent to which they are allowed to practice independently. These

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<sup>95</sup> Vita, M.G. (2001). Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any-Willing-Provider' Regulations. *Journal of Health Economics*. 20(6), 955-966; Klick, J., & Wright, J. (2015). The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures. *American Law and Economics Review*. 17(1), 192-213; Durrance, C.P. (2009). The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures. *American Economic Journal*. 37(4), 409-423; Pinkovskiy, M. (2014). The Impact of the Political Response to the Managed Care Backlash on Health Care Spending: Evidence from State Regulations of Managed Care. Federal Reserve Bank of New York. Working Paper. [https://www.newyorkfed.org/medialibrary/media/research/economists/pinkovskiy/Impact\\_of\\_Political\\_Backlash\\_on\\_Health\\_Care\\_Costs.pdf](https://www.newyorkfed.org/medialibrary/media/research/economists/pinkovskiy/Impact_of_Political_Backlash_on_Health_Care_Costs.pdf); and Nichols, L.M. (2014). Déjà vu? The Debate Over Any Willing Provider Laws May Return, Sad To Say. Center for Health Policy Research and Ethics, George Mason University. Issue Brief #2. <http://chpre.org/wp-content/uploads/2015/05/CHPRE-Issue-Brief-2.pdf>.

restrictions are intended to protect consumers from harm from non-physician medical providers practicing beyond the scope of their training or capabilities. However, in practice these laws and the way they are implemented often prevent non-physician medical providers from practicing to the full extent of their capabilities. Allowing non-physician medical providers to practice to the full extent of their capabilities expands the supply of medical care services, particularly basic primary care services, increases access, and reduces cost.<sup>96</sup>

#### **We recommend that:**

- States review their scope of practice laws and how they are implemented.
- The criteria for decisions on scope of practice issues should be amended to indicate that the only justification for restricting scope of practice is the safety of the public. Restrictions, if any, should be narrowly targeted to address specific safety concerns, based on empirical evidence regarding the risk of harm.
- States should review how their boards are established and how they operate to make sure they are in compliance with these requirements. The Supreme Court has made clear that state boards established to make scope of practice decisions have to reflect clearly articulated state policy and that the policy must be actively supervised by the state.<sup>97</sup>

### **PROVIDER LICENSURE**

Similar issues arise with state licensing of professionals generally. States should make sure that their licensing laws and practices are written and executed to protect the public, not incumbents, and that licensing laws and practices do not squelch innovative entrants or practices. This applies, for example, to new practice developments like telehealth:

#### **We recommend that:**

- State licensing boards should seek to facilitate practices, such as telehealth, that may promote competition and innovation, and in crafting regulations should choose approaches that place the fewest possible restrictions on competition and innovation, while still satisfying legitimate and substantiated public health and safety goals.
- States (who have not done so already) adopt licensure reciprocity across states, in order to facilitate entry and the advance of innovative ways of organizing and delivering care.

### **ENTRY INTO MEDICARE ADVANTAGE MARKETS**

Health insurance markets depend on competition to function effectively. This applies to the Medicare Advantage program, in which private insurers supply health insurance to Medicare beneficiaries. Medicare

<sup>96</sup> Federal Trade Commission. (2014). Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses. <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf>;

Declercq, E.R., Paine, L.L., Simmes, D.R., & DeJoseph, J.F. (1998). State Regulation, Payment Policies, and Nurse-Midwife Services. *Health Affairs*, 17(2), 190-200. doi: 10.1377/hlthaff.17.2.190; and Robert Wood Johnson Foundation. (2012). Implementing the IOM Future of Nursing Report—Part III: How Nurses Are Solving Some of Primary Care's Most Pressing Challenges. <http://www.rwjf.org/content/dam/files/rwjf-web-files/Resources/2/cnf20120810.pdf>.

<sup>97</sup> Federal Trade Commission. (2015). North Carolina State Board of Dental Examiners. Retrieved November 6, 2016 from <https://www.ftc.gov/enforcement/cases-proceedings/north-carolina-state-board-dental-examiners>.

Advantage markets with a lower concentration of market share have lower premiums for beneficiaries.<sup>98</sup> Consequently, it is important for CMS to adopt policies that facilitate and promote entry by insurers.

The U.S. District Court decision against the Aetna-Humana merger provided strong evidence that industry participants believe that the current Medicare Advantage market does not favor new entrants.<sup>99</sup> The Justice Department's economic expert estimated that only 5.5 percent of any counties in question experienced any new entry between 2012 and 2016.<sup>100</sup> As enumerated by the President of the Humana division responsible for Medicare Advantage: "[t]he hardest part about getting into this business is knowing how to build networks, knowing how to file products, knowing how to manage CMS compliance, [and] knowing how to think about star ratings."<sup>101</sup>

The first few years of an MA plan are particularly difficult as new entrants do not yet have the scale to spread administrative costs, must invest heavily in marketing, are not able to capitalize on the premium advantages of 4-star or better plans, and cannot negotiate favorable terms with other suppliers. CMS could address each of these challenges to create a more favorable environment for new entry.

At present, CMS sets Medicare Advantage markets as counties. Not surprisingly, there are a number of counties with a small number of insurers offering Medicare Advantage plans.<sup>102</sup> Adding a small county to an adjacent large county can increase the number of plans in the former and thereby make these markets more competitive.<sup>103</sup>

#### **We recommend that:**

- CMS should selectively create multi-county areas for MA where there are opportunities to increase competition among plans by combining a county that has few competitors with adjacent ones with many competitors. CMS should consider whether a broader policy change to consolidate counties in metropolitan areas within a state's boundaries and into rural regions in a state would increase competition.

Medical loss ratio regulations require that health insurers spend a minimum percentage of their premium revenues on medical expenses. New health plans have high administrative expenses, therefore this requirement can be difficult for them to meet, and can act as a barrier to entry.<sup>104</sup>

98 Song, Z., Landrum, M.B., & Chernew, M.E. (2013). Competitive Bidding in Medicare Advantage: Effect of Benchmark Changes on Plan Bids. *Journal of Health Economics* 32(6), 1301-1312.

99 United States District Court for the District of Columbia. United States of America v. Aetna Inc. Case 1:16-cv-01494-JDB. <https://www.justice.gov/opa/press-release/file/930361/download>.

100 Aviv Nevo. U.S. and Plaintiff States v. Aetna Inc. and Humana Inc. [Presentation]. University of Pennsylvania. Reply Report. <https://www.justice.gov/atr/page/file/918706/download>.

101 United States District Court for the District of Columbia. United States of America v. Aetna Inc.

102 Twenty-four percent of Medicare beneficiaries are in counties with three or fewer insurers offering Medicare Advantage plans (one percent have no firms offering plans). Jacobson, G., Damico, A., Neuman, T., & Gold, M. (2016). Medicare Advantage Plans in 2017: Short-term Outlook is Stable. Kaiser Family Foundation. <http://kff.org/medicare/issue-brief/medicare-advantage-plans-in-2017-short-term-outlook-is-stable/>.

103 There is evidence from the ACA marketplaces that combining small counties with neighboring urban areas into a single region led to an increase in the number of insurers and lower premiums. Dickstein, M.J., Duggan, M., Orsini, J., & Tebaldi, P. (2015). The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the ACA. National Bureau of Economic Research. Working Paper No. 20907. <http://www.nber.org/papers/w20907>.

104 Gottlieb, S. (2016). How to Boost Competition in Obamacare. *Forbes*. <https://www.forbes.com/sites/scottgottlieb/2016/10/03/how-to-boost-competition-in-obamacare/#4b2ccfa0185b>.

### We recommend that:

- The medical loss ratio requirement be relaxed on a temporary basis for new health insurers in the Medicare Advantage market. This will better allow them to absorb the expenses associated with entering the market, thus facilitating entry and more competition.

## 3. PREVENT ANTICOMPETITIVE PRACTICES

Firms have the incentive to take actions to acquire or enhance their market power if they have the opportunity to do so. The following section focuses on the imperative to prevent further harmful provider consolidation, primarily among hospitals, and on restricting anticompetitive practices employed by dominant providers or insurers.

### **PREVENT ANTICOMPETITIVE CONSOLIDATION**

The most prevalent and familiar form of market power enhancing consolidation is the horizontal merger—i.e., mergers between firms in the same industry (e.g., hospital-hospital, insurer-insurer, etc.). As we indicated in Section II.D, there have been a tremendous number of mergers in health care, particularly (but not confined to) the hospital sector. The research evidence (and common sense) are very clear – when a merger is between close competitors the competition between those firms is eliminated by the merger, and the consequence is higher prices and lower quality.<sup>105,106</sup>

There have also been a large number of vertical mergers, particularly hospital acquisitions of physician practices.<sup>107</sup> The acquisition of physician practices by health systems has horizontal implications, since the acquired practices no longer compete with each other.<sup>108</sup> In addition, practices acquired by a system shift their referrals to that system, potentially impeding competition from other hospitals.<sup>109</sup>

Despite the competition issues posed by mergers, some states have recently issued, or are considering issuing, certificates of public advantage (COPAs) to merging hospitals (these could be issued to other health care firms as well, not only hospitals).<sup>110,111</sup> These COPAs shield the merging entities from antitrust scrutiny, with the promise of state oversight. However, there is not typically the infrastructure or experience

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105 Vogt, W.B., & Town, R. How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?; The Impact of Hospital Consolidation – Update.; Gaynor, M. Health Care Industry Consolidation; and Gaynor, M., Ho, K., & Town, R.J. The Industrial Organization of Health-Care Markets.

106 We note some recent evidence that mergers between hospitals in different markets (“cross-market mergers”) can have anticompetitive effects and lead to higher prices: See Lewis, M.S., & Pflum, K.E.. (2015). Diagnosing Hospital System Bargaining Power in Managed Care Networks. *American Economic Journal: Economic Policy*. 7(1), 243– 271; and Dafny, L., Ho, K. & Lee, R. (2016). The Price Effects of Cross-Market Hospital Mergers. National Bureau of Economic Research. Working Paper No. 22106. <http://www.nber.org/papers/w22106>.

107 Vertical mergers are between firms in different industries, such as hospital-physician, insurer-hospital, etc.

108 See, for example, the recent Federal Trade Commission case against the merger of St. Luke’s Health System and Saltzer Medical Group. Retrieved November 6, 2016 from <https://www.ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa>.

109 Baker L.C., Bundorf, M.K., Kessler D.P. The effect of hospital/physician integration on hospital choice.

110 Federal Trade Commission. (2016). Cabell Huntington Hospital/St. Mary’s Medical Center, In the Matter of. Retrieved November 6, 2016 from <https://www.ftc.gov/enforcement/cases-proceedings/141-0218/cabell-huntington-hospitalst-marys-medical-center-matter>.

111 Federal Trade Commission. (2016). Federal Trade Commission Staff Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System. [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-submission-tennessee-department-health-regarding-certificate-public-advantage-application/161122-wellmontcommenttenn.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-submission-tennessee-department-health-regarding-certificate-public-advantage-application/161122-wellmontcommenttenn.pdf).

for this kind of oversight in states that institute COPAs. The oversight in essence amounts to regulation, which requires a substantial amount of information and the ability to collect it, analyze it, and act on it. Since states do not already do this, COPA oversight amounts to instituting a regulatory apparatus for only two or three firms. It is unlikely states will provide the resources that will be adequate to the task. As a consequence, issuing a COPA risks allowing anticompetitive mergers without adequate oversight.

**We recommend that:**

- Federal antitrust agencies and state attorneys general must continue scrutinizing horizontal mergers that pose risks of higher prices and lower quality.
- Federal and state antitrust enforcers must also apply increased scrutiny of vertical mergers.
- States should discontinue the use of certificates of public advantage to shield anticompetitive collaborations from antitrust scrutiny.
- HHS and CMS should incorporate competitive impacts analysis when considering new rules, regulations, or policies. The FTC and the Department of Justice (DOJ) can provide assistance and collaboration as needed.

We recognize that vertical antitrust cases are more challenging. However, the trend in health care toward vertical consolidation, particularly hospital-physician acquisitions, is too important to be ignored. As explained previously (Section III.A), there are a number of policies that incentivize these acquisitions. Adopting the policies we recommend can act as a valuable preventive measure and potentially reduce the need for antitrust enforcement or allow enforcers to focus their attentions elsewhere.

### ***RESTRICT ANTICOMPETITIVE PRACTICES***

There has been a tremendous amount of consolidation in health care, so much so that many markets are now dominated by one or a small number of providers and insurers. However, even where this has occurred, federal and state officials can still play a crucial role in promoting competition.

Firms who have acquired a dominant position have a strong incentive to retain it and to use it. As a consequence, dominant firms may engage in practices designed to limit the ability of rivals to compete or to limit the potential for new firms to enter the market and compete away their dominant position. Given the extent to which many parts of the US now have dominant health care organizations, this is particularly important. Antitrust authorities and states, therefore, have an important role to play in limiting anticompetitive practices.

Certain recent antitrust cases illustrate the problem. The DOJ and the State of North Carolina recently sued the Carolinas Health System for contract provisions that prevent insurers from steering patients to other providers or from providing patients with information on price or quality in order to weaken competition and maintain their dominant position.<sup>112</sup> These are called “anti-steering” and “gag” clauses,

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<sup>112</sup> U.S. Department of Justice. U.S. and the State of North Carolina v. Carolinas Healthcare System. Retrieved November 4, 2016 from <https://www.justice.gov/atr/case/us-and-state-north-carolina-v-charlotte-mecklenburg-hospital-authority-dba-carolinas>.

respectively. A private case in California against Sutter Health System is over the same kind of behavior.<sup>113</sup> The DOJ sued Blue Cross Blue Shield of Michigan over the use of “most-favored-nation” clauses in provider contracts, which prevent providers from offering services to other payers at lower prices.<sup>114,115</sup>

Some states have passed legislation banning the use of anticompetitive clauses in contracts between health insurers and health care providers. Massachusetts banned “anti-tiering” clauses where dominant hospitals demand placement in the preferred tier in benefit designs, regardless of their quality or cost profile, as a condition of participation in a plan’s network.<sup>116</sup> And Michigan banned the use of “most-favored-nation” clauses in contracts by Blue Cross Blue Shield, which prevent providers from offering services to other payers at lower prices.

Hindering the ability to stem these abuses of market power, at present, the Federal Trade Commission is constrained from pursuing such cases due to legal limits on their authority over the insurance industry (McCarran-Ferguson Act, FTC Act, Section 6) and over any antitrust violations other than mergers by nonprofit firms (FTC Act, Section 4).<sup>117</sup> This means that the federal government is prevented from using the resources and expertise of one of its antitrust enforcement agencies to pursue this important problem.

#### **We recommend that:**

- Federal and state antitrust enforcers actively monitor and pursue the use of anticompetitive practices by health care and health insurance firms.
- The FTC should be empowered to:
  - Study the health insurance industry.
  - Enforce the antitrust laws in the health insurance industry.
  - Enforce all of the antitrust laws with respect nonprofit health care organizations.
- State legislatures consider legislation to ban the use of anti-tiering, anti-steering, gag, and most favored nation practices, similar to legislation enacted in Massachusetts and Michigan. We note that efforts to promote health care transparency cannot succeed in the presence of gag clauses, so transparency efforts must address this contracting restriction as well.
- State insurance commissioners should utilize their powers to review insurers’ contracts with providers as part of their review of insurer rates. To our knowledge, this power has not been exercised to prevent anticompetitive contracting and promote competition.
  - If they detect anticompetitive features in a contract, such as (but not restricted to) anti-tiering, anti-steering, gag, or most favored nations clauses, they should take action.

113 Kroh, E. 9th Circ. Revives Antitrust Suit Against Sutter Health. *Law360*. <https://www.law360.com/articles/818207/9th-circ-revives-antitrust-suit-against-sutter-health>

114 See <https://www.justice.gov/atr/case/us-and-state-michigan-v-blue-cross-blue-shield-michigan> for case materials.

115 The case was later dropped after the state of Michigan banned the use of such contracts by insurers: Orzeck, K. (2013). DOJ Ends Blue Cross Antitrust Suit After Favored Nations Ban. *Law360*. <http://www.law360.com/articles/427200/doj-ends-blue-cross-antitrust-suit-after-favored-nations-ban>.

116 Commonwealth of Massachusetts. (2010). S.2585. An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses. <http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288>; See Delbanco, S. and Bazzaz, S. State Policies on Provider Market Power for information on other states adopting similar policies.

117 The FTC has the ability to pursue mergers between nonprofits under the Clayton Act.

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- If the commissioner has the power to reject problematic contract features, they should do so.
  - If they do not have such powers, then they should draw anticompetitive contracts to the attention of the state attorney general's office, or to the federal antitrust enforcement agencies, as appropriate.
  - States where insurance commissioners do not have the power to reject anticompetitive contract provisions should consider providing commissioners with the power to do so.

# Appendix

## LIST OF SUMMIT ATTENDEES

**Robert Berenson**, Institute Fellow, Urban Institute

**Shawn Bishop**, Executive Vice President, Advancing Medicare and Controlling Health Care Costs, The Commonwealth Fund

**Stuart Butler**, Senior Fellow, Economic Studies, Brookings Institution

**James Capretta**, Resident Fellow and Milton Friedman Chair, American Enterprise Institute

**Sean Cavanaugh**, former Deputy Administrator & Director, Center for Medicare, Centers for Medicare and Medicaid Services

**Patrick Conway**, Acting Principal Deputy Administrator, Deputy Administrator for Innovation & Quality and Chief Medical Officer, Centers for Medicare and Medicaid Services

**David Cutler**, Otto Eckstein Professor of Applied Economics, Harvard University

**Leemore Dafny**, MBA Class of 1960 Professor of Business Administration, Harvard Business School

**Matthew Fiedler**, Fellow, Economic Studies, Brookings Institution

**Kathleen Foote**, Senior Assistant Attorney General, California Department of Justice

**Richard Frank**, Margaret T. Morris Professor of Health Economics, Harvard Medical School

**Martin Gaynor**, E.J. Barone Professor of Economics and Health Policy, Carnegie Mellon University

**Paul Ginsburg**, Leonard D. Schaeffer Chair in Health Policy Studies, Brookings Institution and Professor of Health Policy at the Sol Price School of Public Policy, Director of Public Policy at the USC Schaeffer Center for Health Policy and Economics, University of Southern California

**Scott Gottlieb**, Resident Fellow, American Enterprise Institute

**Katherine Hempstead**, Senior Advisor, Robert Wood Johnson Foundation

**Douglas Henley**, Executive Vice President and Chief Executive Officer, American Academy of Family Physicians

**Elinor Hoffmann**, Deputy Bureau Chief, Assistant Attorney General, Antitrust Bureau, Office of the NYS Attorney General

**Chris Jennings**, Founder and President, Jennings Policy Strategies, Inc.

**Allen Karp**, Senior Vice President of Healthcare Management, Horizon Blue Cross Blue Shield of New Jersey

**Tara Isa Koslov**, Acting Director, Office of Policy Planning, Federal Trade Commission

**David Lansky**, CEO, Pacific Business Group on Health

**Peter Lee**, Executive Director, Covered California

**Mark Miller**, Executive Director, Medicare Payment Advisory Commission (MedPAC)

**Teresa Miller**, Commissioner, Pennsylvania Insurance Department

**Farzad Mostashari**, CEO and Co-Founder, Aledade, Inc.

**Karen Murphy**, Secretary, Pennsylvania Department of Health

**Len Nichols**, Director, Center for Health Policy Research and Ethics, George Mason University

**Barak Richman**, Edgar P. and Elizabeth C. Bartlett Professor of Law, Duke University School of Law

**Craig Samitt**, Executive Vice President and Chief Clinical Officer, Anthem, Inc.

**David Schmidt**, Assistant Director, Applied Research and Outreach Division, Federal Trade Commission

**Grace Terrell**, Founder and Strategist, Cornerstone Health Enablement Strategic Solutions

**Karen Tseng**, Chief, Health Care Division, Office of Attorney General Maura Healey, Commonwealth of Massachusetts

**Stephanie Wilkinson**, Attorney Advisor, Office of Policy Planning, Federal Trade Commission

**Christen Linke Young**, Deputy Secretary for Policy & Operations, North Carolina Department of Health and Human Services

## AUTHOR BIOGRAPHIES



**Martin Gaynor**, E.J. Barone Professor of Economics and Public Policy, H. John Heinz III College, Carnegie Mellon University

**Martin Gaynor** is the E.J. Barone Professor of Economics and Public Policy at Carnegie Mellon University. He served as Director of the Bureau of Economics at the Federal Trade Commission in 2013-2014. He is one of the founders of the Health Care Cost Institute, an independent non-partisan nonprofit dedicated to advancing knowledge about US health care spending, and served as the first Chair of its governing board. He is also an elected member of the National Academy of Medicine and of the National Academy of Social Insurance, a board member of the Jewish Healthcare Foundation, a Research Associate at the National Bureau of Economic Research, and an International Research Fellow at the University of Bristol. He has been an invited visitor to the Toulouse School of Economics, the Department of Economics of the Hebrew University of Jerusalem, and the Center for the Study of Industrial Organization at Northwestern University. Prior to coming to Carnegie Mellon Dr. Gaynor held faculty appointments at Johns Hopkins and a number of other universities, and was a visitor at the Hungarian Academy of Sciences in Budapest in 1991. His research focuses on competition and antitrust policy in health care markets. He has written extensively on this topic, testified before Congress, worked with the state of Pennsylvania on its health innovation initiative, and advised the governments of the Netherlands, the United Kingdom, and South Africa on competition issues in health care. He has won a number of awards for his research, including the American Economic Journal: Economic Policy Best Paper Award, Victor R. Fuchs Research Award, the National Institute for Health Care Management Foundation Health Care Research Award, the Kenneth J. Arrow Award, the Jerry S. Cohen Award for Antitrust Scholarship (finalist), and a Robert Wood Johnson Foundation Investigator Award in Health Policy Research. Dr. Gaynor received his B.A. in economics from the University of California, San Diego in 1977 and his Ph.D. in economics from Northwestern University in 1983.

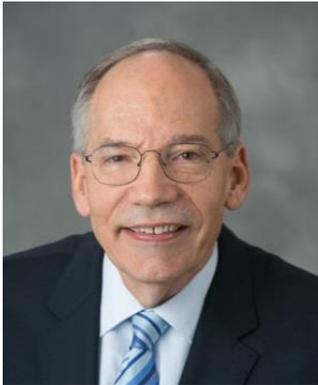


**Farzad Mostashari**, CEO and Co-Founder, Aledade, Inc.

**Dr. Farzad Mostashari** is the CEO of Aledade, a start-up he co-founded aimed at helping primary care doctors transform their practices and form accountable care organizations (ACOs). Prior to Aledade, he was a Visiting Fellow at the Brookings Institution in Washington DC, where he focused on payment reform and delivery system transformation. He served from 2011-2013 as the National Coordinator for Health Information Technology where he coordinated US efforts to build a health information technology infrastructure for health care reform and consumer empowerment. During his tenure at the Office of the National Coordinator, including his two years as Principal Deputy, he led the implementation of the Health IT for Economic and Clinical Health (HITECH) Act. He also collaborated with the Centers for Medicare and Medicaid Services on the design and implementation of the “Meaningful Use” Incentive Program, in addition to programs for health information exchange, health IT workforce, research, and privacy and security. Previously, Dr. Mostashari served at the New York City Department of Health and Mental Hygiene as Assistant Commissioner for the Primary Care Information Project, where he co-led agile development of population health management

functionality within a commercial EHR. Dr. Mostashari also led the NYC Center of Excellence in Public Health Informatics and an Agency for Healthcare Research and Quality-funded project focused on quality measurement at the point of care.

He conducted graduate training at the Harvard School of Public Health and Yale Medical School, served his internal medicine residency at Massachusetts General Hospital, and completed the CDC's Epidemic Intelligence Service program. He was a lead investigator in the outbreaks of West Nile Virus, and anthrax in New York City, and among the first developers of real-time nationwide electronic disease surveillance systems.



**Paul Ginsburg**, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution and Director of Public Policy, Schaeffer Center for Health Policy and Economics, and Professor of Health Policy, University of Southern California

**Paul Ginsburg** is the Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution. He is also Professor of Health Policy at the Sol Price School of Public Policy, University of Southern California and serves as Director of Public Policy at the USC Schaeffer Center for Health Policy and Economics. He is leading the Schaeffer Initiative on Innovation in Health Policy, which is a partnership between USC and Brookings. From 1995 through the end of 2013 he founded and served as President of the Center

for Studying Health System Change (HSC). Initiated with core support from the Robert Wood Johnson Foundation, HSC conducted research to inform policymakers and other audiences about changes in organization, financing and delivery of care and their effects on people. HSC was widely known for the objectivity and technical quality of its research and its success in communicating it to policy makers, industry and the media as well as to the research community. It enjoyed particular respect for its knowledge of developments in communities and health care markets.

Prior to his founding HSC, Ginsburg served as the founding Executive Director of the predecessor to the Medicare Payment Advisory Commission (MedPAC). Widely regarded as highly influential, the Commission developed the Medicare physician payment reform that was enacted by the Congress in 1989. In 2016, Ginsburg was appointed a MedPAC Commissioner. He was a Senior Economist at RAND and served as Deputy Assistant Director at the Congressional Budget Office (CBO). Before that, he served on the faculties of Duke and Michigan State Universities. He earned his doctorate in economics from Harvard University.

Ginsburg is a consultant on the changes in the financing and delivery of health care, particularly on the evolution of health care markets. As a Senior Adviser to the Bipartisan Policy Center, he has contributed to reports on reducing federal spending on health care (2010), on a strategy to contain health care costs (2013) and on approaches to provider payment reform in Medicare (2014-2015). He has been named to Modern Healthcare's "100 Most Influential Persons in Health Care" eight times. He received the first annual HSR Impact Award from AcademyHealth. He is a founding member of the National Academy of Social Insurance, a Public Trustee of the American Academy of Ophthalmology, served two elected terms on the Board of AcademyHealth, served on CBO's Panel of Health Advisors and serves on Health Affairs' editorial board. He served on the HHS National Advisory Council for Health Care Research and Quality.