



Federal and State Policy Options for Mitigating the Negative Impacts of Provider Consolidation and Provider Market Power

The unfortunate news is that the continuing trend of consolidation and market power among health care providers drives up prices and has minimal to no impact on quality. This does not mean there are no ways to mitigate its impact. There are a variety of federal and state policy approaches that could soften the impact of provider consolidation. None of the strategies discussed here are within the power of purchasers alone. However, by supporting certain efforts of federal and state government there is opportunity to shift market dynamics and lessen the impact of consolidation-driven price inflation.

1. THE FEDERAL GOVERNMENT

We have all heard the expression that health care is local and market dynamics certainly vary tremendously. This means that, compared to the federal government, there may be more that purchasers, payers and state governments can do to lessen the negative consequences of provider consolidation and market power. However, there are some specific roles the federal government can play. While not an exhaustive list, a few important strategies to advocate for include:

- **Antitrust activity – monitoring and pursuing injurious mergers:** The Federal Trade Commission (FTC) and Department of Justice should continue to pursue vigorous antitrust enforcement activities, although this poses challenges. Most markets are highly concentrated and there has been a surge of mergers since the passage of the Affordable Care Act. Such mergers are continuing and unraveling them can be politically unpopular and disruptive. Nevertheless, additional “wins” by the FTC or DOJ can help forestall future anti-competitive mergers and act as a partial brake on egregious contracting and pricing behavior of consolidated systems.
- **Improving the Accuracy of the Medicare Physician Fee Schedule:** The current Medicare fee schedule for physicians distorts payment levels, causing some medical services to be highly profitable and others to be less so. It clearly rewards specialty procedures at the expense of primary care services, resulting in too many patient procedures and too little primary care interaction, prevention and care management. This drives higher than necessary volume and adds to the overall cost of health care for both public and private payers. There are various proposals to recalibrate the fee schedule, particularly from MedPAC, which seek to rationalize the relative payment weights to provide more efficient allocation of payments and resources. A revised physician fee schedule for Medicare is also important for other payers because most Medicaid departments and private payers benchmark their fee schedules off of the Medicare system. Thus, changes in Medicare’s payment levels for physicians have the potential to influence payments for Medicaid plans and private insurers as well. Similarly, a realigned physician fee schedule would support alternative payment methods that do not incentivize increased volumes of services and instead focus on providing effective and efficient episodes of care to broader populations of patients.
- **All-Payer Rate Regulation:** Given the political infeasibility of developing a single payer system and the inability of federal and state anti-trust action to curtail the abuse of market power by providers, a potentially promising means of constraining prices and costs may be the development of a mandatory system of coordinated prices. An all-payer system could countervail the market leverage of dominant provider groups by establishing fees for all services and payers directly. Putting all payers on a level playing field with regard to pricing will also mean that private payers will have no reason to oppose cost containment efforts of public payers.



2. STATE GOVERNMENTS

States can also create laws that can mitigate the negative impacts of provider consolidation and market power in ways that are sensitive to local market dynamics. These include policies like:

Laws enhancing price transparency

- **All Payer Claims Databases (APCDs):** State laws may mandate the creation of an APCD and also require that pricing information be made available to consumers via a searchable public website that includes information about hospitals and physicians for a wide variety of inpatient and outpatient services and procedures. State laws can go further by requiring price information to be based on actual paid amounts as opposed to the providers' charges; this is important because provider charges are a far less reliable indicator of price compared to what a consumer will actually pay. States can also mandate that the website contain price information on both hospitals and physicians and provide price information for a variety of inpatient and outpatient services. APCDs can give employers and health plans better access to information about payment and quality variation, which can support value-based insurance design, payment reforms, and a stronger negotiating position with providers.

Laws addressing prices directly

- **Global budgets:** Maryland, Pennsylvania, and Vermont have used global budgets¹ to put a cap on hospital spending. Like bundled payment, these full- or partial-risk, population-based reimbursement arrangements for hospitals and their employed physicians, do not directly enhance competition among providers. But these experiments hold promise for improving quality and containing costs. If a state wishes to include Medicare payments in the global budget, they must seek waivers from the Center for Medicare and Medicaid Services.
- **Out of Network Billing:** States have taken different approaches to address involuntary out-of-network charges, which occur when patients receive care from outside their carrier's network because they slacked any options for in-network care. More than half of the states have passed or expanded laws to protect patients from surprise and balance billing.² Of those, nine states offer near comprehensive protections that limit patient responsibilities to their insurance cost-sharing amounts; others limit protections for patients to certain types of providers or care. When states put out of network billing protections in place, health plans typically have to pay the remainder of provider charges. To protect health plans from exposure to exorbitant, non-negotiated charges, some states have enacted legislation to limit the health plan's obligation to a payment amount that is a percent of what Medicare would pay.³
- **Surprise billing:** Other instances of out-of-network service use may be inadvertent, such as when an enrollee encounters an out-of-network provider (e.g. an anesthesiologist) in the course of treatment at an in-network hospital or surgical center, or when their in-network provider refers them to an out-of-network provider for services such as laboratory testing or radiology. These situations often lead to what are often called "surprise medical bills," because patients may not have been aware that they were exposing themselves to the potentially large cost sharing and balance bills for out-of-network services.⁴ States are implementing or considering a variety of billing and contractual laws and regulations to protect patients from surprise bills.⁵ In California, for example, a law limits the cost-sharing

¹ https://www.shvs.org/wp-content/uploads/2018/05/SHVS_-_Global-Hospital-Budgets_FINAL.pdf

² https://www.commonwealthfund.org/sites/default/files/2019-01/To_the_Point_BalanceBilling.pdf

³ <https://www.rand.org/pubs/periodicals/health-quarterly/issues/v6/n4/07.html>

⁴ <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/>

⁵ <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer>



of patients who visit in-network facilities to the usual in-network amount when they receive care at that facility from an out of network provider.

- **Prices for Emergency Services:** Under federal law, health plans cannot charge patients higher cost sharing for emergency services they receive from out-of-network providers, and are required to count any payments toward deductibles and the plan's out-of-pocket limit.⁶ However, these provisions, cannot stop out-of-network providers from billing out of network emergency patients the balance of what they want to be paid.

Acute emergency care is inherently monopolistic since patients in emergency situations have limited ability to decide where to seek care. Providers often charge out of network patients much more than what they accept from Medicare or private insurers with established contracts. Most state legislatures are reluctant at present, but establishing a maximum payment obligation as a percentage of Medicare payment levels could reduce cost shifting, re-establish negotiating balance between hospitals and payers, and reduce costs. It could also help patients without insurance who obtain emergency services.

- **Prohibiting physician hospital-based billing:** States can pass laws that prohibit health systems from billing using inpatient or outpatient facility fees for procedures that could be done in a physician's office. As one approach to protect consumers, the State of Connecticut passed a law prohibiting health plans from charging a separate co-payment for a facility fee.⁷
- **Rate setting:** Under an all-payer rate-setting system, a public body has the legal authority to establish the prices paid by both government and private health plans to hospitals and other providers for medical services. An all-payer system requires a common unit of payment and, in its purest form, mandates the payment level for a given service at a given provider across all patients. All-payer systems can countervail the market leverage enjoyed by dominant provider groups by establishing the fees for all services and payers and helping to reduce administrative costs, improve system transparency, enhance payer and patient equity, ensure provider financial viability, and be a platform for innovative payment reform. Most states are reluctant to pursue strategies perceived as highly regulatory and interventionist and, therefore, many see all-payer rate regulation as a strategy of last resort. The State of Maryland has a unique all-payer hospital rate setting system. It is important to note, however, that the U.S. is the only industrialized nation that does not actively reinforce the purchasing side of the health care marketplace through such intervention.⁸

Laws Prohibiting Anti-Competitive Practices

- **Laws prohibiting “most favored nation” contract clauses:** Most favored nations (“MFN”) clauses in hospital contracts mean that the hospital promises to a particular health plan that it won't offer better prices to any competing health plans.⁹ MFN clauses have the effect of setting a price “floor;” providers lose any incentive to offer discounts, and “Since no buyer receives a discount, prices are higher across the board.” In 2013, Michigan's Insurance Commissioner banned the implementation and enforcement of MFN clauses in all insurance carrier contracts.

⁶ <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/>

⁷ <https://sourceonhealthcare.org/legislation/conn-gen-stat-%c2%a7-38a-477bb-cost-sharing-re-facility-fees-health-insurance-in-general/>

⁸ <https://innovation.cms.gov/initiatives/maryland-all-payer-model>

⁹ <https://sourceonhealthcare.org/issue-brief-most-favored-nation-clauses/>



- **Laws overturning any willing provider & scope of practice laws:** States with Any Willing Provider Laws (AWPs) require managed care organizations to include “any qualified provider who is willing to accept the terms and conditions of a managed care plan.”¹⁰ These laws hamper health plans’ ability to create narrow or tiered networks, which are designed to lower prices and costs by excluding high-cost providers and health systems. Scope of Practice Laws “specify what services non-physician medical providers are allowed to perform and the circumstances and extent to which they are allowed to practice independently.”¹¹ All states have Scope of Practice laws, but when implemented broadly, these regulations stem the supply of alternative medical providers (e.g. nurse practitioners, physician assistants, midwives, etc.) into the market place. Policy think tanks like The Brookings Institute recommend that states review their Scope of Practice laws and their implementation, limiting restrictions to focus solely on public safety.^{12,13}
- **Laws prohibiting hospitals from “tying” services:** One monopolistic practice that large health systems pursue is to bundle services into “all or nothing” packages. For example, a hospital that provides the only transplant service a given area may mandate that all health plans who keep them in-network for transplants must also keep them in-network for maternity, orthopedics, and other services where the hospital may not be cost or quality competitive.
- **Laws banning anti-tiering, anti-steering and gag clauses in provider contracts:** Some states have passed laws that prohibit contract provisions between health care providers and health plans that prevent health plans from steering patients to high-value providers, or obscuring information that would enable patients to act as informed consumers. For example, Massachusetts passed a law that bans providers from using anti-tiering and anti-steering clauses in their contracts with health plans.

Conclusion

Absent a major legislative overhaul from the federal or state government(s), reversing the trend of provider consolidation and mitigating its effects is likely to remain a primary cause of health care price inflation. There are solutions that the federal and state governments can pursue to stem the impact of consolidation. However, there are organized forces fighting against policy solutions, such as provider advocacy groups, and even private health insurance companies. If purchasers want these laws to pass, they will need to actively lobby and advocate for them.

¹⁰ <http://www.ncsl.org/issues-research/health/state-roles-in-health-reform-provisions-related-to.aspx>

¹¹ <https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/>

¹² <https://www.brookings.edu/>

¹³ <https://www.brookings.edu/research/improving-efficiency-in-the-health-care-system-removing-anticompetitive-barriers-for-advanced-practice-registered-nurses-and-physician-assistants/>