Mechanisms to Block the Growing Pricing Power of Hospitals and Health Systems

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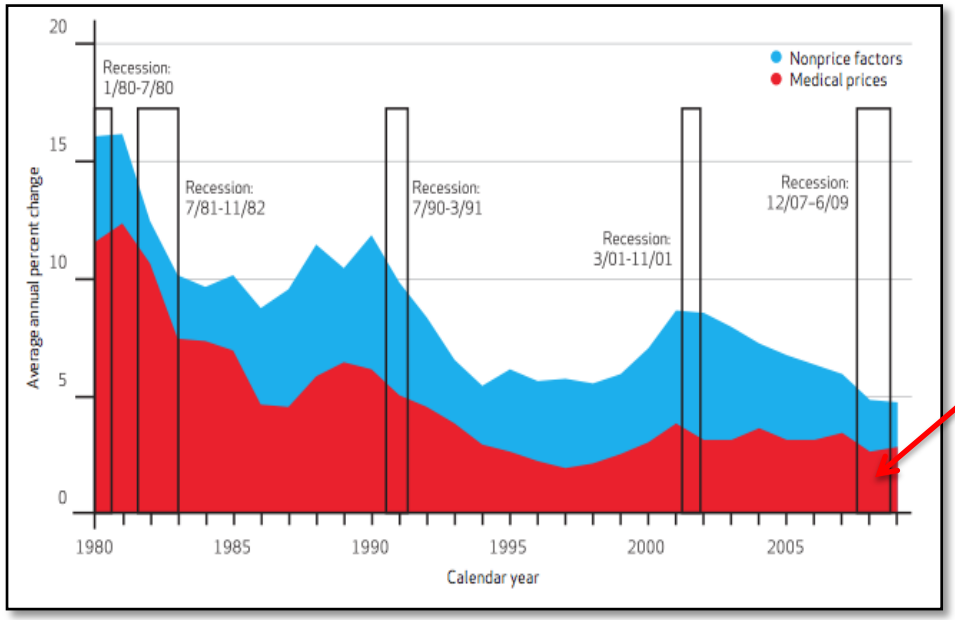
Presentation Overview

- "It's the Prices Stupid!"
- Two waves of Provider Consolidation
- How Providers Exercise Market Power to Increase Payments
- Limited Array of "Market-based" Tools to Address Provider Pricing Power
- Setting Prices Administratively – the Options
  - Selective Charge Limits
  - Hospital All-Payer Rate Setting
- Rate Setting Models to forestall Hospital/Health System Pricing Power and Promote Population-Based Health Care Delivery

Despite Slowing of Cost Growth – Prices are Primary Drivers



Factors Accounting for Growth in Personal Health Care Spending, 1980-2009

Their analysis showed that "prices accounted for more than 60% of the increase in overall spending in 2010"

Martin A, Lassman D, Whittle L, Catlin A. Recession contributes to slowest annual rate of increase in health spending in five decades. Health Aff (Milbank) 2011;30(1): 11-22.

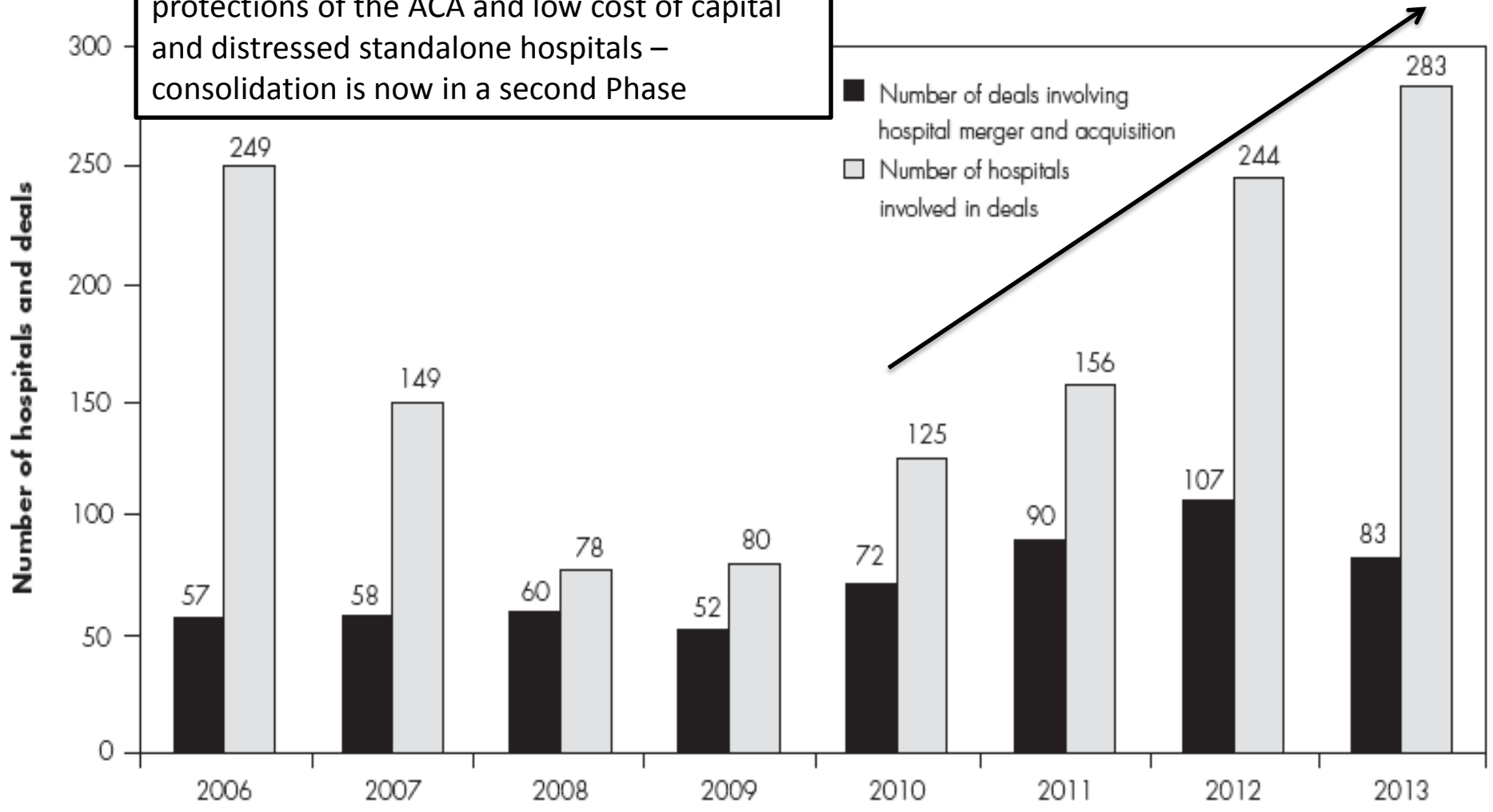
"The Health Care Cost Institute (HCCI) reports that payment rates to private insurers grew between **5 percent and 6 percent** per year from 2011 to 2013.

Hospitals in 2013 increased their prices sufficiently to generate **the highest overall profit margins in more than 20 years**, largely, according to MedPAC, because they had the market power to do so"

March 2015 MedPAC report to Congress

Second Phase Appears to be Occurring since 2009

Since 2009, perhaps in response to uncertainty related to Health Care Reform, safe-harbor protections of the ACA and low cost of capital and distressed standalone hospitals – consolidation is now in a second Phase



Source: MedPAC analysis of 2013 data from Irving Levin Associates Inc.

Other Factors and Tactics Help Drive up Prices

- Some economists say – to have continually increases prices – you must have continually increasing consolidation

- However, there **<u>are other factors/tactics</u>** that drive prices:
  - Must "Have Hospitals" and "Must Have" specialty services
  - So-called "Tying" of services & anti-competitive clauses in contracts
  - Multi-hospital systems over large regions (avoid anti-trust scrutiny) but able to negotiate broad price increases for all facilities
  - Relative geographic isolation – particularly in large spread-out geographic areas (Phoenix, AZ)
  - Acquisition of physician practices by hospitals – to increase negotiating leverage for both groups, forestall possible competition by physician-organizations and generate additional "facility fees"
  - Hospitals continually jack up Charge Levels – which increases their leverage with insurers and also drives of Payments in certain categories of care

Limited Array of Market-Based Tools

- Tiered and Narrow Network Development
  - Haven't taken off largely because Provider Cartels preclude Private Insurers from not featuring them in their Networks
  - Alternative is they are "non-par" and charge the insurer 400%+ of cost for patients they do happen to treat
- Encouraging payment reform that rewards quality and cost effectiveness
- Liberalizing the scope of practice restrictions to allow more efficient use of human resources
- Breaking down regulatory barriers to telemedicine and digital products that enable health management
- Refining anti-kickback rules and payment restrictions to enable innovative, integrated ventures that would change the delivery of care

Rate Regulatory Approaches

1. Legislate an **"Available and Limited Price"** in situations of greatest anti-competitive activity (Emergency Room care and egregious markups) – specific to the private sector
   - Law similar to the law that applies to MA plans now
   - If an MA plan cannot contract with a health system – defaults to Medicare FFS rates

2. **Traditional Prospective Mandatory** State-based All-Payer Hospital Rate Setting Systems
   - Option A: Prospective Hospital payments based on DRGs and more packaged Outpatient Services (EAPGs) with a system of "Volume Adjustments" to curtail tendency to ramp up hospital volumes
   - Option B: Rochester Style – system of Hospital Global Budgets on an All-Payer basis for States with Populations naturally mapped to individual hospitals (e.g., largely rural states with low population density)

3. System applicable to **Private Payers Benchmarked off of Medicare** Payment System (with a volume adjustment system)

#2A: Prospective Mandatory Systems

- Seven States Implemented Mandatory Hospital Rate Systems – Four received a "Waiver" from Medicare to create All-Payer Approaches
- Characteristics:
  - Administered by an Independent State Rate Setting Agency
  - Requires a Federal Waiver to Include Medicare and Medicaid
  - Usually based on a Payment Structure such as Per Case (DRGs), Per Episode (Admission & Readmission) or Per Outpatient Encounter (EAPGs)
  - Hospital Approved rates will vary from one hospital to another
  - Once Base Rates are set, they are updated by an approved "Trend Factor"
  - Should include various "adjustments" to rates for differences in case mix, levels of uncompensated care, teaching, labor market differences
  - Use of a "Volume Adjustment System" to curtail incentive to increase volume
  - Strong legal authority to enforce Rate Compliance

Prospective Mandatory Systems – Pros/Cons

- Pros:
  - Mandatory Systems: Good Track Record of Controlling Price/Cost Growth
  - Eliminates Anti-Trust concerns associated with hospital mergers
  - Also, improved the equity of payment (narrowed price differences across Payers)
  - Can finance social costs such as Uncompensated care & Teaching Costs
  - Some evidence of slowed Technology Diffusion – but Rate Systems can advance Quality through use of P4P mechanisms
  - Some systems structured to accommodate at-risk or other innovative payment structures such as Shared Savings Programs (SSPs)
- Cons:
  - Viewed as highly regulatory – few states receptive to Government Intervention
  - Systems can become very complex and difficult to understand/administer (Regulatory Failure)
  - Also subject to legal challenges
  - Rate Agencies subject to "Regulatory Capture" by the hospital industry

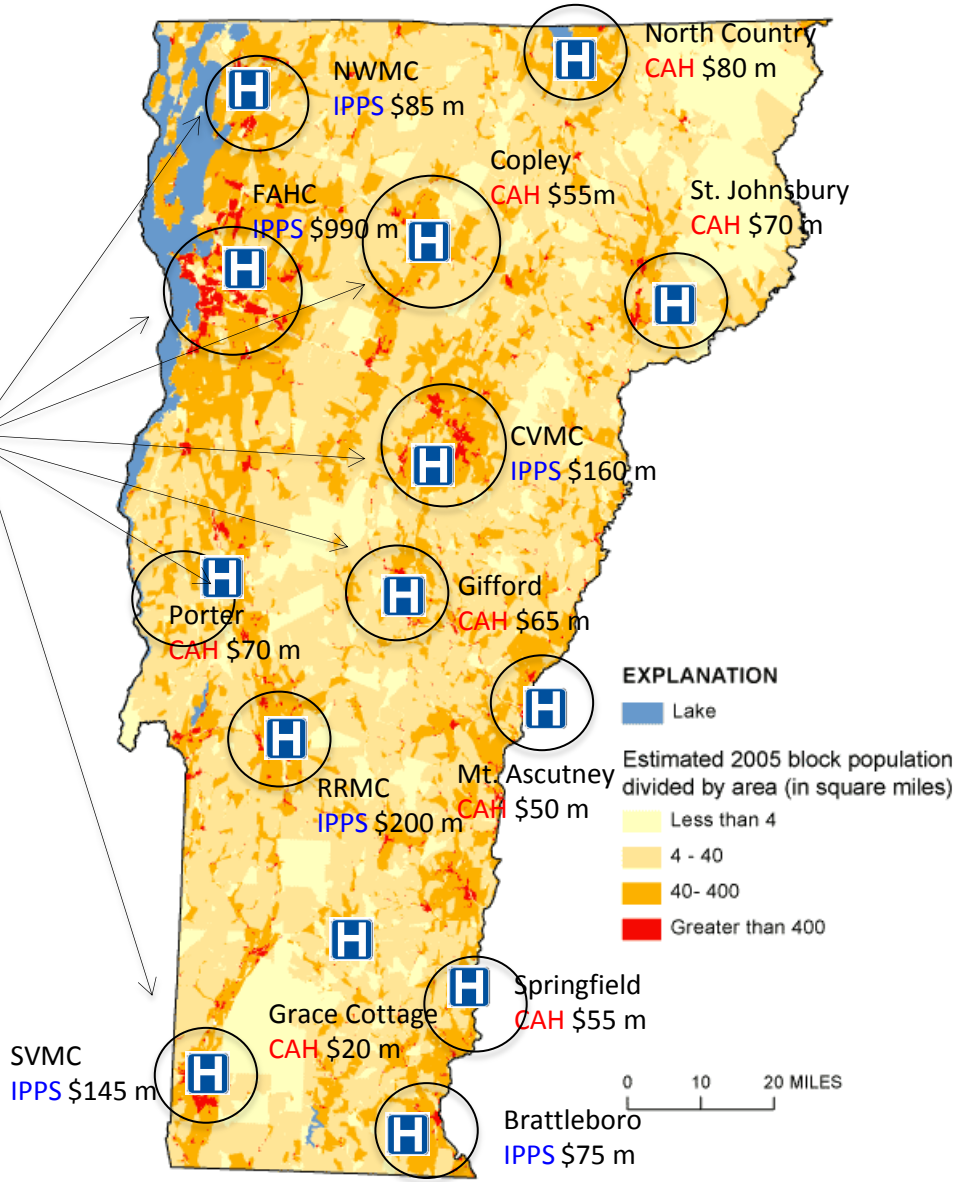
2B Prospective Mandatory Systems – Global Budgets

- Could be Modeled after very Successful Rochester and Finger Lakes Area "Hospital Experimental Payment Program" (HEPP)
- Best implemented in States or Regions where populations naturally mapped to individual hospital (or groups of hospital) service areas
- Characteristics of Global Hospital Budgets:
  - Rate Agency establishes fixed Global Budgets for hospitals & employed physicians that act as both a Limit and a Guarantee
    - (e.g., Hospital with a $200 million Global Budget is limited to this amount but also guaranteed this amount regardless of the number of services it provides to patients during the year)
  - Eliminates Fee-for-Service incentives and provides strong incentives for overall Cost Containment (on a per capita basis)
  - Budgets trended to future years at some affordable rate (i.e., Growth of GSP)
  - Can be structured to include employed physician revenues
  - Preserves existing Payment "Differentials" across payers but these can be narrowed over time
  - Potentially applicable to smaller hospitals (CAHs) with risk corridors

Rate Regulatory Global Budgeting System

Vermont's regional system of hospitals makes it well-suited for hospital Global Budgets

Populations are naturally mapped to individual Hospitals



Global Budget Systems – Pros/Cons

- Pros:
  - In Rochester and also in Maryland (2009-2013 and presently) strong cost control
  - Eliminates Anti-Trust concerns associated with hospital mergers
  - Can improve payment equity & finance social costs
  - Creates incentives for hospitals to be efficient in providing services and meeting community needs
  - Administratively much easier system to implement and more predictable payments and improved profitability
  - Very consistent with alternative payment systems such as ACOs and other SSPs – Global Budgets remove hospital resistance to the success of these programs
- Cons:
  - Difficult to implement in large urban areas with multiple hospitals (difficult to align populations to specific hospitals)
  - May result in reduction of care/services and lead to waiting lines – Definite need for Strong Quality-based P4P Programs to maintain or improve quality
  - May be at odds with specialists' incentives (although should support PCP-based care delivery and payment models)

#1 – Create an Available Price as a Back Stop to Excessive Charging Practices of Hospitals

- Hospitals' unlimited ability to raise charges undermines the negotiating leverage of private payers and contributes to higher payment levels
- For Example: in a typical negotiation a Health System faces two equivalent situations (in terms of revenue they can generate)
  - Negotiate a Contract with an Insurer at 250-300% of Medicare and stay a "featured" provider in the Payer's network – retaining a large volume of the insurer's beneficiaries
  - Go "non-par" and get a smaller proportion (say 20%) of the patients through their hospital ERs and charge 400%+ of Medicare
- In the end - Health Plans often don't push back against any of these tactics – and accept the 250%-300% payment levels
- Legislating a "Fall-Back" price level and making it legally available to Payers can help restore Payer/Hospital Negotiating balance

#1 - Focusing in Areas of Greatest Anti-competitive Behavior

- Evidence from MedPac shows that – this dynamic does not afflict MA Plans - **MA plans are able to negotiate payment levels from large Hospital Systems that are close to Medicare FFS levels**

- This is because MA Plans have a "**back-stop**" – if they can't get a provider to negotiate reasonable rates, the back-stop is the MA plan pays Medicare FFS rates

- This provides very strong evidence for the need for legislation to set a limit on out-of-network prices paid – particular for ED cases

- This approach is being studied in California where this problem is quite significant and continues to undermine the negotiating leverage of insurers

- State legislatures should pass a law **limiting these out-of-network "balance billing" strategies to 1.5 x Medicare** or less

That is the "Available Price" for any person or plan that might other wise face full charges

Thank

You!