Making Healthcare Affordable

Presentation to
California Assembly Committee on Health

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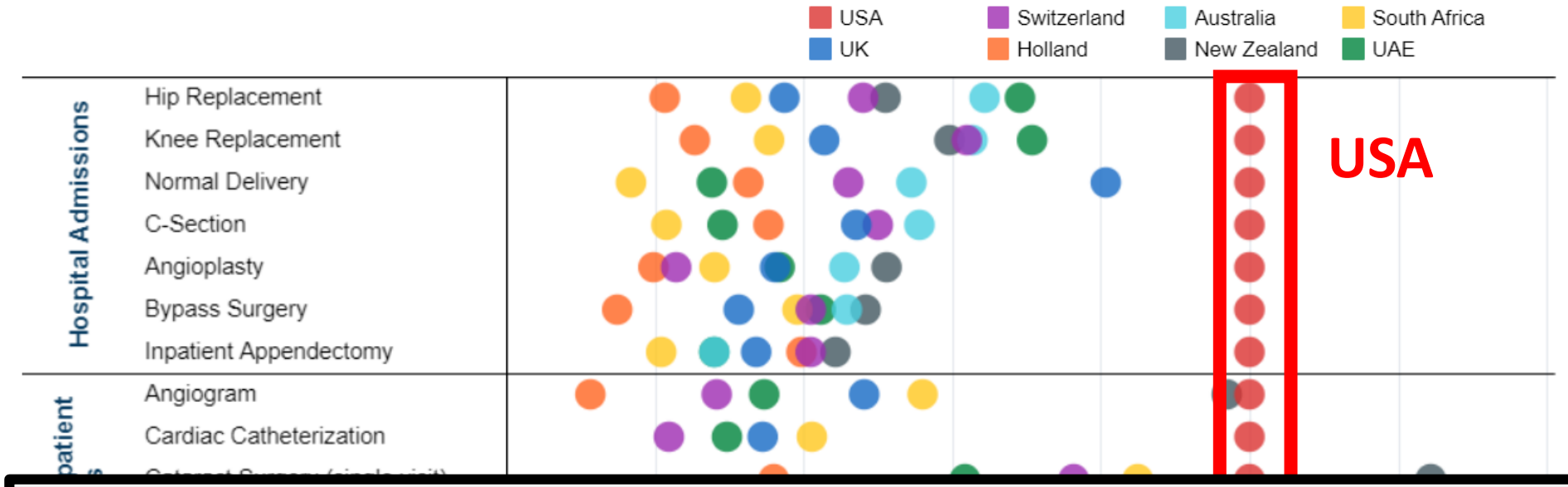
Figure 1: Medical Prices in 2017 as a Percent of US Prices

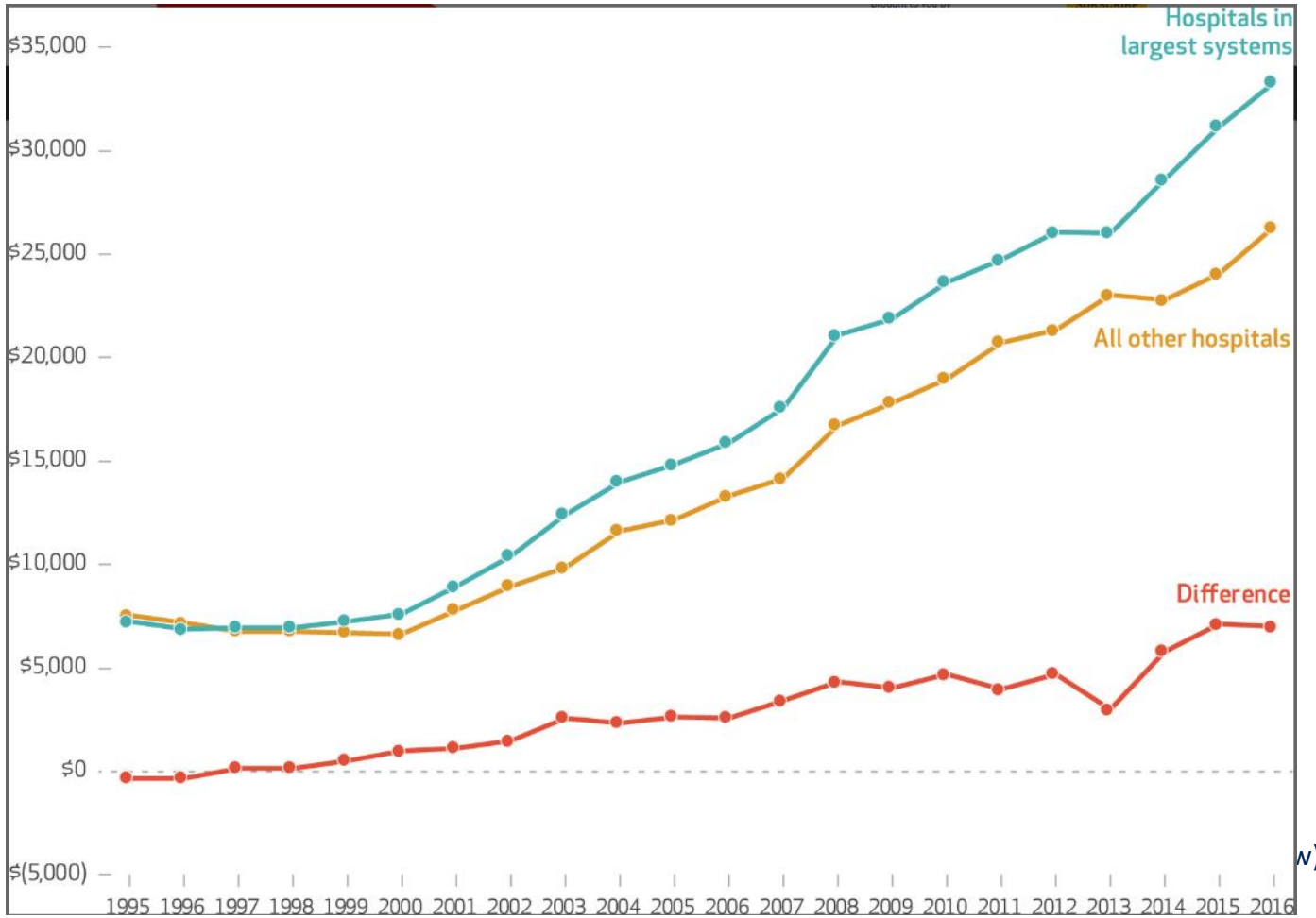


"Prices are the **primary** reason why US spends more on health care than any other country"

- Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, *It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt*, Health Affairs 38:1 (2019)

Source: John Hargraves and Aaron Bloschichak, International comparisons of health care prices from the 2017 iFHP survey, Health Care Cost Institute's #HealthyBytes Blog (Dec. 17, 2019), https://healthcostinstitute.org/blog/entry/international-comparisons-of-health-care-prices-2017-ifhp-survey

In CA, As Concentration Increases, So Do Prices



Source: Glenn A. Melnick, Katya Fonkych, and Jack Zwanziger, The California Competitive Model: How Has It Fared, And What's Next?, 37 Health Affairs **1**417 (Sept. 2018)

Health Care in Northern California Costs More than in Southern California by 33%

Table H-1

Cost Index Area Summary

Cost Index Area	*North / South Area*	*Facilities*	*(Allowed Based) Buyer Cost Index*
Alameda-Contra Costa-Solano	North	21	1.246
Central	North	35	0.897
North	North	11	1.038
Sacramento	North	13	1.322
San Francisco-San Mateo-Marin	North	13	1.184
Sonoma-Napa	North	8	1.193
South Bay	North	13	1.345
Central Coast	South	17	0.793
Los Angeles-NE	South	25	1.058
Los Angeles-NW	South	13	0.770
Los Angeles-SE	South	15	0.813
Los Angeles-SW	South	15	0.788
Orange	South	26	0.889
Riverside-San Bernardino	South	28	0.822
San Diego	South	23	0.917
Total		276	1.000
	North	114	1.178
	South	162	0.885

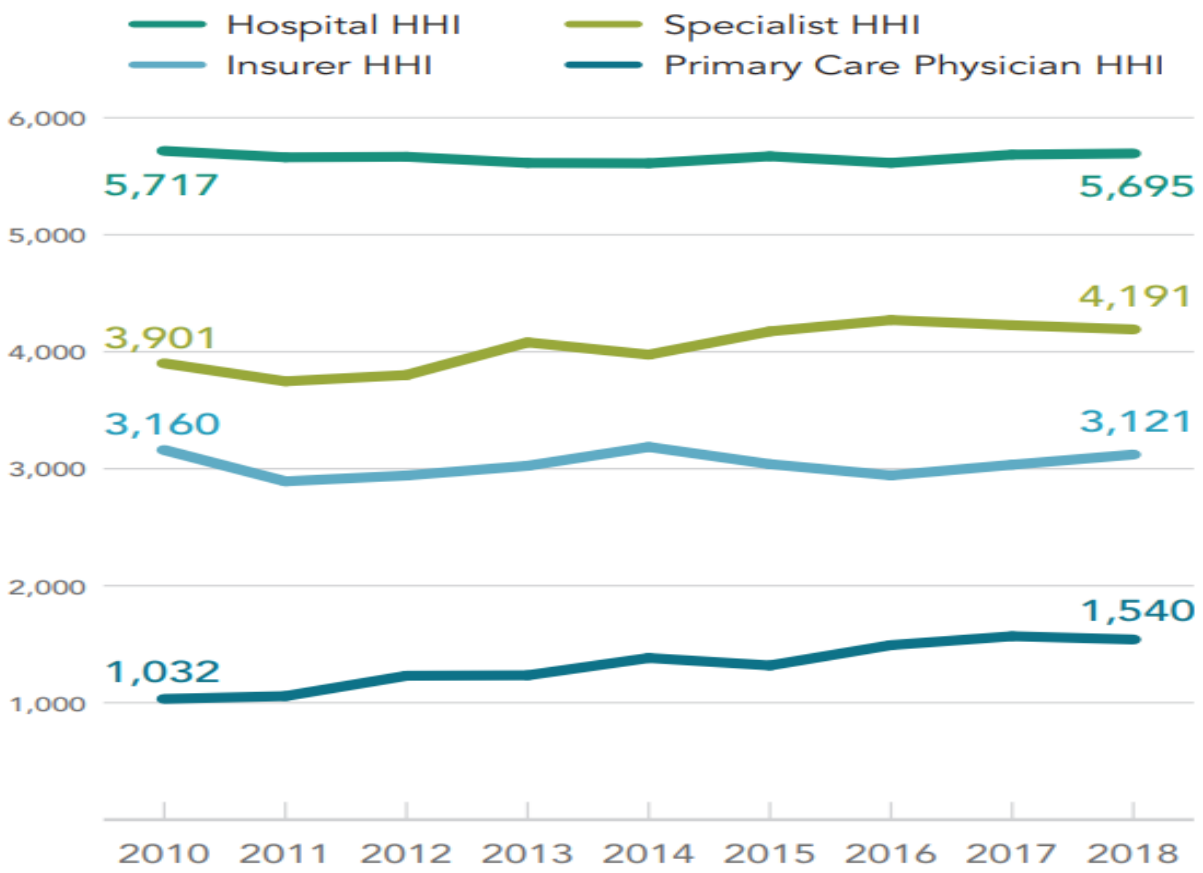
33% difference

Source: Will Fox & John Pickering, Cost Efficiency at Hospital Facilities In California: A Report Based On Publicly Available Data, Milliman (Oct. 2017)

California Horizontal Concentration

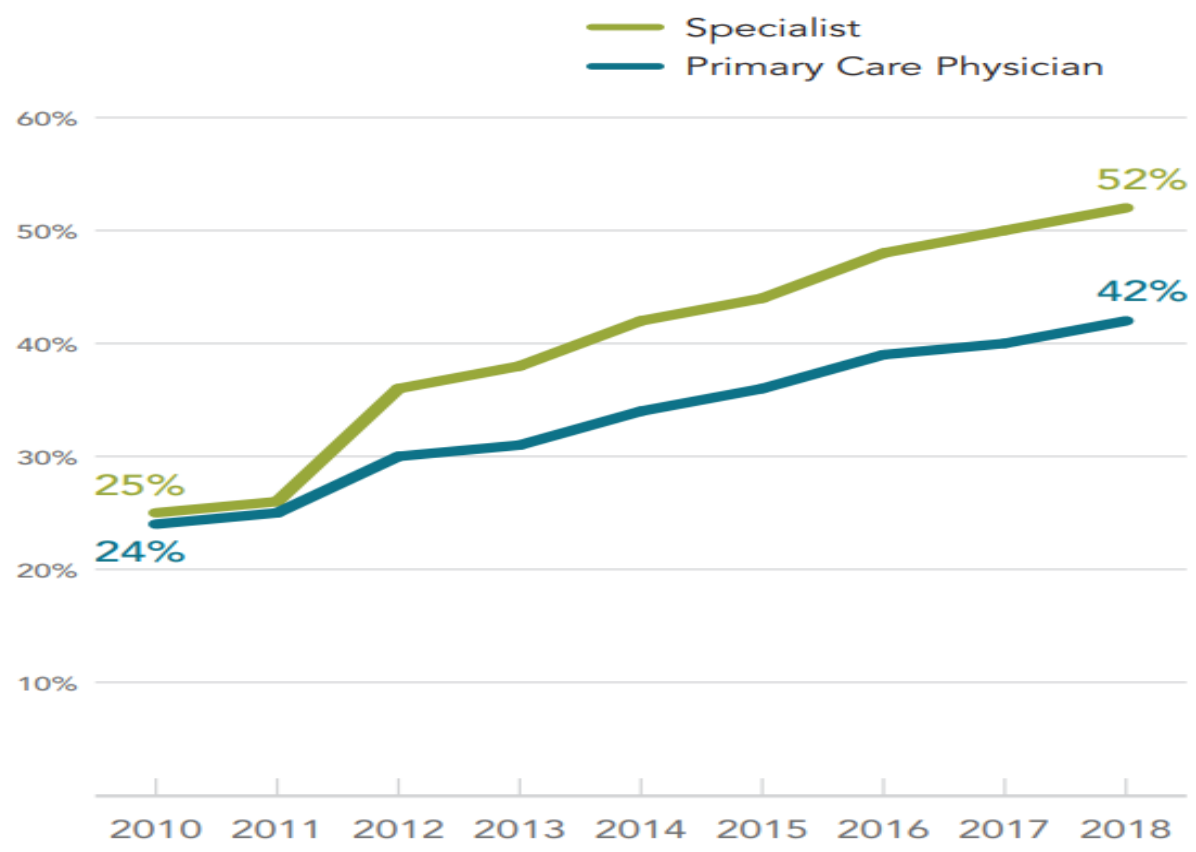
HHI>2500 = Consolidated Market

Figure 19. California Health Care Horizontal Concentration Trends, by County Level HHI, 2010–2018



California Vertical Concentration

Figure 20. Percentage of Physicians in Practices Owned by a Hospital/Health System in California
by Type of Physician, 2010–2018



Increased Concentration in CA Leads to Higher Provider Prices Leading to Higher Premiums

Inpatient hospital prices (CA)

HHI increase from 1,500 to 2,500 associated with an increase in price of $1,152 ($16,386 to $17,538).*

Physician outpatient services (CA)

Increased vertical integration (hospital/physician) 9 percent increase in specialist prices and a 5 percent increase in primary care prices.**

ACA premiums (CA)

Vertical integration in highly concentrated hospital markets associated with a 12% percent increase in ACA premiums.**

Multi-Specialty Physician Practices (national data)

Specialists integrating with generalists in concentrated markets associated with higher prices for both***

* Scheffler et al. 2019, The Sky's the Limit, CHCF Report ** Scheffler et al. 2018, Health Affairs***Baker,

The Culprits on Consolidation: How did we get here?

- Under-enforcement of Antitrust Merger Law
- Erroneous decisions by the Courts
  - Courts approval of mergers shown mistaken
- Regulatory Gaps and Incentives to Merge
  - Payment rules rewarding physician acquisitions (site of service regs)
- Misinterpreting Reform: "*The ACA Made Me Do It*"
- "Gold Rush" Mentality Prompting Consolidation

Antitrust Law & Dominant Providers: Paper Tiger?

- Mergers: 7 Years of Neglect
  - Erroneous court decisions
  - Lax enforcement at Federal level
  - Creeping consolidation
- Conduct
  - Antitrust law does NOT challenge existing monopolies
  - ONLY if improperly obtained/maintained
- Obstacles
  - Cost of Litigation
  - Overly-demanding legal standards
  - Inadequate Information for enforcers

Myth-Busting About Consolidation

- **Sumo Wrestler Fallacy**
  - Are consumers better off with large health systems & insurers?
  - Econ. history: wrestlers often shake hands
- **Markets are self-correcting**
  - Barriers to entry, other factors debunk Chicago School assumption
- **Quality Improves with Size**
  - Contrary economic studies
  - Limited evidence of volume/quality

More Myth Busting: Consolidation ≠ Integration

"[C]onsolidation was primarily for the purpose of enhanced bargaining power with payers, and hence did not lead to true integration."

- Martin Gaynor and Robert Town, The Impact of Hospital Consolidation – Update, Robert Wood Johnson Foundation (June 2012)

"[C]onsolidation isn't necessary to achieve the benefits of clinical integration."

- Martin Gaynor, Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee, U.S. House of Representatives (Feb. 14, 2018)

Conduct: Anticompetitive Contracts of Dominant Providers & Payers

- Most Favored Nations Clauses
- Anti-steering and Anti-tiering clauses
- Price Gag Clauses
- All or Nothing Contracting
- Exclusive Dealing

- Analysis: UC Hastings, The Source on HC Price and Competition, Gudiksen et al., Preventing Anticompetitive Contracting Practices in Healthcare

Coping with Concentration:
1. Improving State Antitrust Merger Enforcement

- Prior Notice of All Mergers and Other forms of Consolidation
  - For profit as well as nonprofit entities
  - Hedge fund acquisitions
- Prior Approval by Attorney General
- Input from Dept of Health or Independent Agency
- Enhanced/clarified Presumption of Illegality
- Broader Scope of Substantive Review
- Consent Decree Transparency & Post Merger Monitoring
- Analysis: UC Hastings, *Preventing Anticompetitive Consolidation*, The Source on Healthcare Price and Competition

Coping with Concentration: 2. Addressing Anticompetitive Contracts

- Legislative Prohibitions on Anticompetitive Contracting
  - E.g., 19 states ban MFNs
  - SB 977
- Antitrust Litigation
  - *UFCW & Employers Benefit Trust* and *People of the State of California ex rel Xavier Becerra v. Sutter Health; Sidebe v. Sutter; U.S. v. Atrium; US v. Mich. BCBS*
- State Insurance Department Review of Provider Contracts (Rhode Island)
- Rate Caps on Dominant Providers
- Certificate of Public Advantage Regulation
- All Payer Rate Regulation/Single Payer Reform

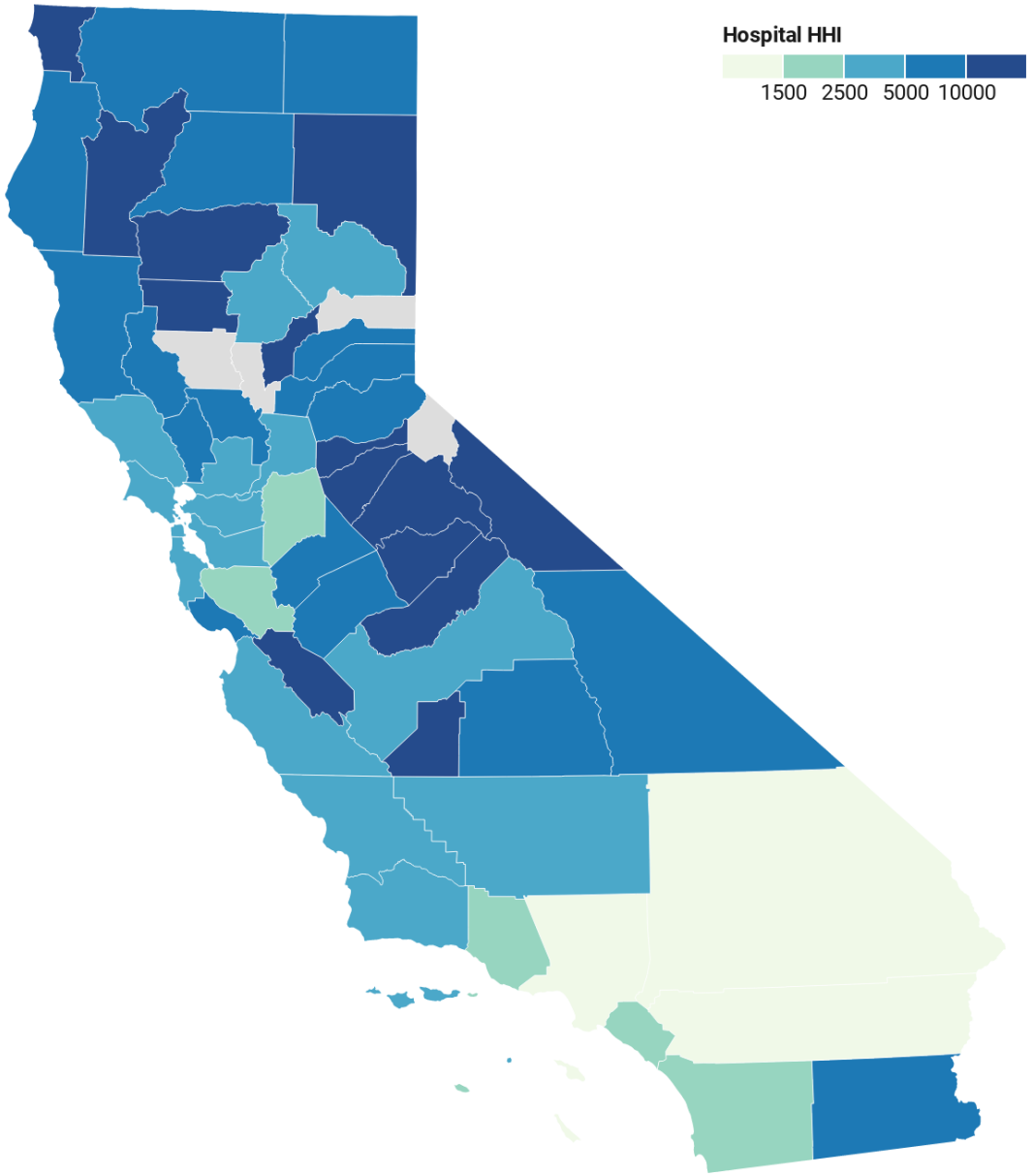
Insurance Regulation in Rhode Island

- Rhode Island Affordability Law
- Empowers State Department of Health Insurance
  - Approve or disapprove health plan rates based on:
    - Affordability criteria
    - High payments to dominant providers
    - Requires INCREASED funding for primary care
- Model can be adapted to permit Insurance Commissioner to
  - Reject plans with anticompetitive contract clauses
  - Set maximum reimbursements (e.g. 150% Medicare)
  - Require value-based payment methods.

Takeaways

- High provider concentration results in high provider prices
- High provider prices result in high insurance premiums, copays and deductibles
- Which in turn increases UNINSURANCE and UNDERINSURANCE
- Improved Antitrust Oversight: Necessary, but Not Sufficient
- Legislative Options:
  - Prohibit anticompetitive contracts (anti-tiering; gag clauses; MFNs)
  - Provider rate caps or price setting
  - Insurance Dept. Review of Rates and Contracts
  - Enhanced Attorney General Authority

Hospital HHI by CA County, 2018



Source: Petris Center (UC Berkeley School of Public Health) analysis of hospital market concentration data from the American Hospital Association's Annual Survey Database
Notes: HHI = Herfindahl-Hirschman Index. Hospital HHI only includes general, community hospitals.

Hospital HHI by NCHS Urban/Rural County Classification, 2018

NCHS County Classification (# of counties included)	Average Hospital HHI	Counties Included
Large central metro (8)	1,900	Los Angeles, San Diego, Orange, Riverside, Santa Clara, Alameda, Sacramento, San Francisco
Large fringe metro (8)	4,641	San Bernardino, Contra Costa, San Mateo, Placer, Marin, Yolo, El Dorado, San Benito
Medium metro (13)	4,367	Fresno, Kern, Ventura, San Joaquin, Stanislaus, Sonoma, Tulare, Santa Barbara, Monterey, Solano, San Luis Obispo, Santa Cruz, Merced
Small metro (7)	7,046	Butte, Shasta, Imperial, Madera, Kings, Napa, Yuba
Micropolitan (8)	8,157	Humboldt, Nevada, Mendocino, Lake, Tehama, Tuolumne, Lassen, Del Norte
Non-core (10)	8,386	Calaveras, Siskiyou, Amador, Glenn, Plumas, Inyo, Mariposa, Mono, Trinity, Modoc

Source: Petris Center (UC Berkeley School of Public Health) analysis of hospital market concentration data from the American Hospital Association's Annual Survey Database and the National Center of Health Statistics' (NCHS) Urban-Rural Classification Scheme for Counties (https://www.cdc.gov/nchs/data_access/urban_rural.htm).
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Thank You!

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