Unchecked Provider Clout In California Foreshadows Challenges To Health Reform

ABSTRACT Faced with declining payment rates, California providers have implemented various strategies that have strengthened their leverage in negotiating prices with private health plans. When negotiating together, hospitals and physicians enhance their already significant bargaining clout. California’s experience is a cautionary tale for national health reform: It suggests that proposals to promote integrated care through models such as accountable care organizations (ACOs) could lead to higher rates for private payers. Because antitrust policy has proved ineffective in curbing most provider strategies that capitalize on providers’ market power to win higher payments, policy makers need to consider approaches including price caps and all-payer rate setting.

In current health reform discussions and proposed legislation, providers’ growing market power to negotiate higher payment rates from private insurers is the “elephant in the room” that is rarely mentioned. Here, in our study of the current negotiating environment in California, we explain that growing market power for providers caused a shift that gave providers a stronger bargaining position over health plans, leading in turn to higher insurance premiums.

Further, we explore why some of the proposed payment reforms and organizational delivery models—including so-called accountable care organizations (ACOs)—that have been championed at the national level have the potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power. Such provider dominance could offset some or all of the potential reforms to lower premiums through increased efficiency in delivery.

The trends in California suggest an urgent need for policy makers to address the issue of growing provider market strength. In our judgment, more active antitrust enforcement will not do the job. Rather, more direct regulatory approaches, including all-payer rate setting, need to be actively considered.

On average nationally, commercial insurers’ hospital and physician payment rates are nearly 30 percent and 20 percent higher, respectively, than Medicare rates. Evidence from two decades of hospital mergers and acquisitions nationally demonstrates that consolidating hospital markets drives up prices, with disagreement only over the magnitude of the increases. Some researchers have concluded that formation of hospital systems has primarily served to increase market power—not improve quality or efficiency of patient care—at least in the short run.

A recent study has shown that in California, after a downward trend in hospital prices for private-pay patients in the 1990s, a rapid upward trend began about 1999 that produced average annual increases of 10.6 percent over the period 1999–2005. The study’s authors concluded that the source of the near-doubling of California hospital prices remains “something of a mystery.”

Analysis of Medicare Cost Report data by the Medicare Payment Advisory Commission (Med-PAC), although national, shows that inpatient costs per admission increased only 5.5 percent...
per year during that period.\textsuperscript{6} Public reporting of hospital payment rates recently has drawn attention to large variations in hospital rates across the country, with specific University of California medical centers and Sutter Health hospitals, among others, establishing prices far above average.\textsuperscript{7}

Findings from our study of six major California markets are particularly instructive, both because of California’s bellwether status and because national health reform proposals encompass features of care as it has been financed, organized, and delivered in much of California.

In particular, accountable care organizations have organizations common in California as their prototypes: multispecialty group practices and independent practice associations (IPAs). These contract to receive a monthly per member (capitated) amount for all or a subset of services delivered to enrollees in health maintenance organization (HMO) plans.\textsuperscript{8} Accountable care organizations are groupings of providers given financial incentives to deliver efficient, high-quality care for a population of patients they serve. The House and Senate health reform bills propose introducing accountable care organizations within the Medicare program, with the presumption that the model will eventually spread to private payers.

As the dominant payer for the elderly and disabled, Medicare sets prices and is generally indifferent to providers’ negotiating clout. Private payers, which must negotiate with all hospitals and large physician practices, generally agree to pay much higher rates than Medicare pays to persuade providers to enter into a contract with them.

If accountable care organizations lead to more integrated provider groups that are able to exert market power in negotiations—both by encouraging providers to join organizations and by expanding the proportion of patients for whom provider groups can negotiate rates—private insurers could wind up paying more, even if care is delivered more efficiently.

Lessons from California, then, can inform current discussions about whether health delivery and payment reforms would reduce the rate of health care spending growth, not only in Medicare but overall. Our findings suggest the opposite: a definite shift in negotiating strength toward providers, resulting in higher payment rates and premiums. As one medical group executive said, “We are making out hand over fist.” In some cases, payment rates to hospitals and powerful physician groups approach and exceed 200 percent of what Medicare pays, with annual negotiated double-digit increases in recent years.

Here we examine the specific strategies that different types of provider organizations have developed to increase their leverage in negotiating payment rates.\textsuperscript{9} We point out those common in other parts of the country and those specific to California’s “delegated capitation” model of care.\textsuperscript{10} We next describe some of the moderating influences that somewhat limit provider payment demands. We conclude with a discussion of the relevance of these findings to the current national health reform debate.

\textbf{Study Data and Methods}

This study draws on site visits by the Center for Studying Health System Change to six California markets between October and December 2008. The goal was to examine regional differences in health care affordability, access, and quality. The six markets—Fresno, Los Angeles, Oakland/San Francisco, Riverside/San Bernardino, Sacramento, and San Diego—were chosen to reflect a range of economic, demographic, health care delivery, and financing conditions in California.

Two-member research teams conducted approximately 300 semistructured interviews in the six markets with representatives of hospitals, physician organizations, health plans, and large employers; benefit consultants; insurance brokers; policy makers; and other stakeholders. In each community we interviewed executive leadership from at least four of the larger hospitals/systems and physician organizations, as well as representatives of health plans and large employers; benefit consultants; and insurance brokers, to obtain insights and perspectives on the local health care system. Team members transcribed notes and reviewed them for quality and validation purposes. Staff coded interview responses using Atlas.ti, a qualitative data management and analysis software tool.

\textbf{Study Results}

\textbf{The Legacy of California Managed Care Contracting} In the most heavily populated California markets, physicians formed medical groups and IPAs in the 1980s and 1990s. These measures came largely in response to the presence—and competitive threat—of Kaiser Permanente, a prototypical and successful group-model HMO. In a parallel development, health insurers competing with Kaiser Health Plan developed HMO products that typically delegated responsibility for provider network development, physician credentialing, utilization management, and quality reporting to medical groups and IPAs. The insurers contracted with those groups on the basis of capitation (pay-
One commonly cited factor in the shift to broad provider networks was consumers’ desire for broad provider choice.

Because physician organizations and, in some cases, hospitals, were willing to take financial risk for providing a defined set of health benefits, HMO products were relatively attractive in California in the early 1990s. Responding to a string of annual premium increases approaching 20 percent, large purchasers of health insurance aggressively moved employees into HMOs and demanded lower premium increases.

Health plans, in turn, used their growing market power—backed by credible threats to move patients away from providers not participating in plan networks—to severely limit rate increases. Excess hospital and physician capacity in California at the time also contributed to the “collapse in payment rates for medical groups and their many subcontractors in the 1990s.”

In the late 1990s and early 2000s, providers responded to their compromised financial situation in a number of ways. Hospitals exited risk-based payment contracts, formed larger hospital systems through mergers and acquisitions, and attempted to form tighter physician alliances. Medical groups and IPAs consolidated, and the weaker ones went out of business.

**EVOlUTIONARY MARKET CHANGES** There were some differences in strategic emphasis across the six markets. For example, in Riverside/San Bernardino and Fresno, hospitals and physicians remain relatively dispersed geographically. Many physicians remain in small practices represented by IPAs in health plan contracting instead of forming multispecialty groups. Large horizontally integrated hospitals formed mostly in northern California, especially in Sacramento and Oakland, but were less pervasive in southern California.

Although the precise structure varies, hospitals and physicians have become increasingly sophisticated in developing organizational forms primarily to increase their negotiating clout with health plans.

**DEMAND FOR BROAD PROVIDER NETWORKS** One commonly cited factor in the shift to broad provider networks was consumers’ desire for broad provider choice, even in HMO products, following the managed care backlash of the mid-to-late 1990s. For example, a Fresno benefit manager’s analysis found that physician overlap in two prominent health plan networks was 97–98 percent. This reality weakens the position of health plans. If plans cannot exclude providers from their network because of customers’ demands for broad networks, they cannot credibly threaten network exclusion. That fact undermines their ability to resist providers’ demands for higher payment rates.

**CAPACITY CONSTRAINTS** A second commonly cited factor benefiting provider bargaining power was the dwindling hospital bed and physician workforce capacity that evolved in many parts of the state. A northern California policy analyst noted, “Ten years ago we were so overbedded, even Kaiser was thinking about closing down beds and contracting [for inpatient care], and then all of a sudden everyone was under capacity and no beds were available.”

Inpatient capacity did decline in relation to population. Inpatient acute care hospital beds in California declined from 2.2 beds per 1,000 population in 1999 to 1.9 beds per 1,000 in 2007—a 14 percent reduction in capacity. Certificate-of-need (a regulatory requirement intended to restrain and coordinate health care facility construction and services) had been abandoned in California many years ago, so that was unlikely to have been a factor in reducing acute care hospital beds. Low payment rates were probably a factor, since smaller operating surpluses would have reduced funds available for financing capital projects (including expanding acute care hospital bed capacity). Moreover, some of this reduced financing capacity has been devoted to replacing facilities that did not meet California’s stringent seismic standards.

Likewise, growing physician shortages have increased physician groups’ negotiating power with health plans. A Sacramento physician group executive observed, “Fifteen years ago, plans were dictating the terms. We’re in a much better position to negotiate [now] because of the shortage of physicians.”

**REGULATORY ENVIRONMENT** Health plan and provider representatives also point to a regulatory environment in the aftermath of the managed care backlash that appears to favor providers in negotiations. The state Department of Managed Health Care, which regulates all HMOs and some preferred provider organiza-
tions (PPOs), has been concerned about patients’ loss of access to providers after a contract termination. As a result, it requires plans to have a formal transition plan approved by the state that demonstrates how subscribers’ access to an acceptably broad network will be maintained. Until approval is received, in an uncertain and potentially prolonged process, health insurance plans must pay full charges to terminated providers.

**HORIZONTAL HOSPITAL INTEGRATION** Hospital mergers and acquisitions are not unique to California. However, pressure from managed care may have spurred earlier and more widespread merger activity there than elsewhere. The history and current hospital responses are well captured by a health plan executive with extensive California experience:

“In California—and northern California in particular—the hospital system underwent considerable attrition in the 1990s due to managed care constraints [low payment rates] that were placed on their delivery systems. Hospitals went out of business or consolidated. They took on risk and failed. The number of beds relative to the population [became] very low. The hospitals are at full capacity, and a number of them have consolidated into very powerful systems. They enjoy significant monopoly leverage [the ability to dictate terms] over all [health insurance] plans.”

Sutter Health and Catholic Healthcare West have been especially active in acquiring other California hospitals. Sacramento-based Sutter Health has two dozen northern California medical centers and hospitals, some with multiple locations. Catholic Healthcare West has thirty-three acute care hospitals throughout the state.

Negotiating as a system across a broad geographic area avoids antitrust scrutiny, which focuses on local market concentration. At the same time, this strategy permits hospital systems with strong bargaining positions in some markets to negotiate high rates elsewhere as well. Some respondents described particular hospital systems, such as Sutter, as adopting an “all or none” negotiating strategy, which means that a single contract defines the terms. The terms include all payment rates of all of the system’s hospitals, not just those hospitals that plans deem important to include in networks.

Hospitals in the University of California system now negotiate as a system rather than as individual entities. They realized only recently that the potential power of group negotiating trumped what some respondents described as bureaucratic inertia. In the words of one university hospital executive participating on the negotiating committee, “Contracting as a full [University of California] system is frightening to the payers.... These are contracts with big leverage.”

**‘MUST-HAVE’ HOSPITALS** It has become common in the parlance of health plan–provider relations to refer to “must-have” providers—especially hospitals—that must be included in a plan’s provider network to make the plan acceptable to customers. “Must-have” hospitals, by definition, have market leverage over health plans, because plans cannot plausibly threaten to exclude them. Importantly, “must-have” providers’ strong negotiating position is not necessarily derived from size but rather by factors not typically part of antitrust analysis. That is, they are “must-have” for reasons other than large market share.

A common basis for “must-have” status is reputation—lodged either in the hospital or physician group overall or with particular hospital service lines. For example, Los Angeles respondents agreed that Cedars-Sinai Medical Center is a “must-have.” Asked why Cedars did not engage in mergers and acquisitions to become a horizontally integrated system, as is common in northern California, a respondent from another area hospital suggested that Cedars can say, “Screw it; we have a strong marketing arm and the [movie] actors, let’s grow on campus and they will come to us.” As a result, according to another respondent, “Cedars has the highest rates in the world.... The hospitals down the street have no market power. They have to fight for every penny.”

Another source of “must-have” status comes from providing unique, specialized services, which the hospital then uses to demand and win higher rates for all services. In California, common specialized services include government-designated trauma center care, neonatal intensive care, transplants, and specialized cancer care. Major medical centers and even smaller community hospitals providing these services can often achieve “must-have” status for all of their services this way.

Provider consolidation has expanded the proportion of hospitals with “must-have” status. As larger hospital systems have formed, systems have been able to use the substantial reputation of the “flagship” hospital to obtain higher payment rates for all hospitals in the system, including those that would not have such status as independent hospitals. Consolidation is also important to some medical groups’ gaining “must-have” status, such as single-specialty groups with a very large share of the market in that specialty in a geographic sub-area.

**JOINT HOSPITAL AND PHYSICIAN-GROUP NEGOTIATION** California retains a “corporate practice of medicine” restriction that, with a few excep-
One clear goal of an alliance between hospitals and physicians is to improve negotiating clout for both.

As emphasized earlier, California health care delivery features multispecialty group practices and IPAs. Since physicians who are partners in medical groups share revenues, they can negotiate with insurers for both HMO and PPO enrollees. In contrast, an IPA is an intermediary organization that is permitted by the antitrust agencies to negotiate for member physicians because it assumes “substantial financial risk.” In California, IPAs generally represent physicians who otherwise compete only for capitated HMO contracts. For other contracts, physicians must negotiate on their own behalf, unless they obtain a ruling from the Federal Trade Commission (FTC) that they are “clinically integrated” by virtue of having organized processes to control costs and improve quality and by sizable investment to support these processes.

The large multispecialty group practices and IPAs that survived the shake-out of the 1990s can now exercise substantial market power. They do so by virtue of the lack of price competition for their services, facilitated by the market requirement for plans to have broad networks.

A health plan executive commented about the negotiating situation in the Bay Area by observing that two local IPAs—Brown and Toland, which recently received designation as “clinically integrated,” and Hill Physicians—both “have thousands of physicians so you can’t really be without them. They enjoy great leverage.” In reference to HMO products, another health plan respondent observed, “In this market, providers have leverage in every case. The exception is the relatively few—3,000–4,000—truly independent doctors who are vulnerable to ‘here’s your new rate, have a nice day’.”

In short, multispecialty groups and IPAs may have formed for other reasons, including greater ability to improve quality through clinical integration. However, now they wield their considerable market clout to negotiate favorable payment rates and other contractual terms with HMOs.

Payment variation across physicians in different practice circumstances is substantial. One group’s medical director estimated, “You can get 80 percent of Medicare [rates practicing independently]—or twice that in our groups. That is the real incentive. The word gets out about what doctors are paid at different levels. It’s a ‘grass is greener’ thing. In our market, it’s greener in bigger medical groups.”

Health plans recognize the growing negotiating strength that capitated groups have when contracting with health plans offering HMOs. This recognition has led some plans to attempt to shift insured lives from HMOs to PPOs. Plans appreciate that the greater strength physicians have in negotiating HMO contracts outweighs the theoretical advantages of HMOs, such as more integrated care and avoidance of the perverse incentives presented by fee-for-service PPO payments that promote increased service volume.

A health plan executive commented that HMOs are now the least profitable product of-
ffered by insurers. He said that plans face “aggressive capitation contracting by the group practices that know their value and are very smart. They demand fee increases on the order of double digits annually.” He pointed out that rate increases for PPO physicians not in medical groups have been single-digit—not low, but much below rate increases for medical groups. A medical-group physician commented facetiously that the last annual rate increases for his group had “deteriorated” from 20 percent to “only” 12 percent.

California is unique in having a broad base of large multispecialty groups and IPAs. As in other parts of the country, however, California physicians also are forming single-specialty groups to gain additional advantages when negotiating for PPO contracts. The formation of large single-specialty groups seemed a particularly desirable strategy in some relatively rural areas that don’t support larger multispecialty medical groups. These areas include parts of Sacramento, Fresno, and Riverside/San Bernardino Counties.

**Moderating Influences**

Although many providers have gained the upper hand with health plans, we also heard that certain factors prompt them not to fully exercise their market power. Some providers may balance their desire for high prices with the fragility of employer-sponsored insurance in their communities. As one hospital’s chief financial officer said, “Things will get so expensive that you’ll drive employers out of the county, or they’ll just stop offering health insurance. We always have to strike that fine balance.”

Insurers agree that some providers effectively leave money on the table in negotiations—physicians more than hospitals. According to health plan executives, medical groups in particular are concerned about the demise of capitation and the replacement of HMO products with PPOs, blunting their desire to drive as hard a bargain as they could.

A uniquely California factor moderating providers’ market power is the presence of Kaiser Permanente. Non-Kaiser hospitals and physicians consider Kaiser’s large market presence as constraining them from pushing for higher payment rates, which can lead to higher non-Kaiser insurance premiums and a loss of market share to Kaiser. Given this well-established competition, a number of provider respondents across the six markets expressed concern that employers might shift their employees to Kaiser. As a hospital CEO said, “When I came here, I said, ‘we can’t leverage managed care companies and jack up prices and stick on a percent of charges because that will drive patients to Kaiser.’ We have leverage, but we’re trying not to use it.”

Similarly, some providers specifically attempt to provide the same rates to all insurers out of concern that obtaining higher rates from smaller insurers would drive them from the market and further contribute to market dominance by a few plans.

**Discussion**

The shift in who holds the upper hand in negotiating payments—once held by health insurance plans but now resting with health care providers—has had a major impact on California premium trends. According to some survey respondents, the dynamic needs urgent policy attention. “I am shocked there isn’t an outcry over the fact that our costs are driven out of control,” a health plan executive complained. “We would like to establish some sort of boundary, beyond which these guys can’t go. We’d welcome some regulatory intervention to break up these monopolies, because they are just killing us.”

Even some provider respondents are cynical about providers’ motivation to join or form integrated practices. Coming from Fresno, an area without the kind of integration seen in other California markets, a medical-group physician offered, “The good thing about the systems not being highly integrated and coordinated [in Fresno] is that premiums are lower. Why are those hospitals and physicians [integrating]? It wasn’t for increased coordination of care, disease management, blah, blah, blah—that was not the primary reason. They wanted more money and market share.”

As the interviews document, provider market power is not a phenomenon associated just with integration strategies. A single “must-have” hospital can develop enough clout to obtain payment rates much higher than Medicare’s, acknowledging that many providers believe
Medicare payments to be inadequate. Indeed, across other markets studied by the Center for Studying Health System Change, providers are developing increased leverage through single-specialty group formation and merger-and-acquisition strategies that do not involve integration. Nevertheless, given the push in Congress and elsewhere to restructure health care delivery with accountable care organizations, it is instructive that whatever their merits in improving quality and efficiency, California-style integrated care systems currently produce higher prices that undermine cost containment.

Antitrust policy is generally viewed as a remedy for market power abuses. However, the FTC and U.S. Department of Justice (DOJ) mostly have been unsuccessful in challenging hospital mergers. The FTC/DOJ requirements that IPAs assume substantial financial risk or clinically integrate would meet such requirements to negotiate with health plans. Moreover, some strategies to increase provider leverage are perfectly legal from an antitrust perspective.

Unless market mechanisms can be found to discipline providers’ use of their growing market power, it seems inevitable that policy makers will need to turn to regulatory approaches, such as putting price caps on negotiated private-sector rates and adopting all-payer rate setting. Indeed, some purchasers who believe strongly in the long-term merits of increased integration of care delivery believe that price regulation may be a prerequisite for payment reforms that encourage integration.

The federal requirements also do not assure that cost reductions achieved through providers’ improved ability to improve quality and manage costs will be passed on to purchasers and consumers. Accountable care organizations could well expand the range of provider groups that would meet such requirements to negotiate with health plans. Moreover, some strategies to increase provider leverage are perfectly legal from an antitrust perspective.

NOTES

8 Multispecialty group practices are organizations of physicians of various specialties that share income from practice. IPAs are intermediaries that contract with health plans on a risk basis for the services of physicians in independent practices that have, in turn, contracted with the IPA.
9 Providers are able to gain leverage in contract negotiations over many “terms and conditions,” including prices.
10 California HMOs often contract with medical groups or IPAs so that the physician organizations assume risk for use of professional services and the responsibility for control of usage is delegated to them.
15 The University of California (UC) system includes five medical centers: UC San Diego, UCLA, UC San Francisco, UC Davis, and UC Irvine. The first four are in the markets in our study.