Physician-Hospital Consolidation: The Good, the Bad, and the Solution

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What are the **virtues** of consolidation?

Closer alignment between **physicians** and **hospitals** offers great potential **advantages**

- Better scheduling and use of inpatient capacity
- Better collaboration on quality and safety
- Better discharge planning; shorter LOS
- Better supply chain purchasing
- Less duplication of ambulatory services
- Shift from bed-focus to population-focus
Alignment is most obviously accomplished by organizational merger and physician employment.
What are the **vices** of consolidation?

Physician-hospital consolidation…

- sometimes falls short of the promise of efficiency
- can create higher prices than competitive markets
- creates large integrated delivery systems which can be complex, slow-moving, defensive, and costly
- may stifle innovation which often occurs in smaller, newer organizations
What do the data say?
Total Cost of Care per Patient in Physician Organizations in California

Average Total Cost of Care per Patient

<table>
<thead>
<tr>
<th>Year</th>
<th>PO owned by Member Physicians</th>
<th>PO owned by local hospital</th>
<th>PO owned by multi-hospital system</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$1,000</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>2010</td>
<td>$1,000</td>
<td>$3,000</td>
<td>$4,000</td>
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<tr>
<td>2011</td>
<td>$1,000</td>
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</tr>
<tr>
<td>2012</td>
<td>$1,000</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

What are possible solutions?

- High deductible health plans?
- Narrow networks?
- Reference pricing?
- Vivity? ACO?
Growth of High Deductible Health Plans in the Employment-based Insurance Market

Percentage of Covered Workers Enrolled in a Plan with a Deductible of $1,000 or More for Single Coverage
# High Deductible Health Plans in California’s Health Insurance Exchange

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Subsidy Eligible</th>
<th>Unsubsidized</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>24%</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>Silver</td>
<td>66%</td>
<td>30%</td>
<td>62%</td>
</tr>
<tr>
<td>Gold</td>
<td>5%</td>
<td>13%</td>
<td>6%</td>
</tr>
<tr>
<td>Platinum</td>
<td>4%</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total Enrollment</strong></td>
<td><strong>1,222,320</strong></td>
<td><strong>173,609</strong></td>
<td><strong>1,395,929</strong></td>
</tr>
</tbody>
</table>

Source: Covered California enrollment, 10/1/13 – 3/31/14. Data includes individuals who finished applications and selected plans through April 15, 2014.
National Prevalence of Narrow Networks

**EXHIBIT 1**

70 percent of hospital networks on exchanges are narrow or ultra-narrow

*Distribution of networks by network breadth*¹
2014 individual exchange – Percent of analyzed silver networks (n = 120)²

- **Ultra-narrow**: 38
- **Narrow**: 32
- **Broad**: 30

1. Broad networks: less than 30% of largest 20 hospitals by number of beds are not participating. Narrow networks: 30-69% of largest 20 hospitals are not participating. Ultra-narrow networks: at least 70% of largest 20 hospitals are not participating.
2. Networks offered in silver in Atlanta, Bridgeport, Dallas, Nashville, Houston, Salt Lake City, Miami, Tampa, Louisville, Indianapolis, St. Louis, Los Angeles, San Jose, Pittsburgh, Denver, Philadelphia, Seattle, Chicago, Washington D.C., and Portland, ME.


Data as of 11.15.2013 McKinsey & Company
An explanation: **Reference Based Benefits (RBB)**

- Sponsor establishes a *maximum contribution*—*reference price*—it will make towards paying for a particular service or product

  ![Diagram illustrating Reference Based Benefits (RBB)]

  - **Reference Price**: This limit is set at minimum or median of the price range charged by comparable providers.
  - **Provider (A) Price**: Patient must pay full difference between this limit and the actual price charged by the provider.
  - **Provider (B) Price**: Patient "chooses" cost sharing by choosing provider.

- Patient has good coverage for low-priced options but **full responsibility for choice of high-priced options**
- RBB has been applied to inpatient procedures, ambulatory procedures, imaging, lab tests, drugs
### Prices in Hospital Outpatient Departments (HOPD) and Freestanding Ambulatory Surgery Centers (ASC) Prior to Implementation of Reference-based Benefits

<table>
<thead>
<tr>
<th>Reference Price</th>
<th>ASC Price</th>
<th>HOPD Price</th>
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</tbody>
</table>
Percentage of Patients Selecting Ambulatory Surgery Centers (ASC) over Hospital Outpatient Departments (HOPD) Before and After Implementation of Reference-based Benefits

- **Anthem**
- **CalPERS**

![Graph showing the percentage of patients selecting ASC over HOPD](image-url)
Total Payment per Procedure Before and After Implementation of Reference-based Benefits

- **CalPERS**
  - 2009: $2,500
  - 2010: $3,000
  - 2011: $3,500
  - 2012: $3,000
  - 2013: $2,500

- **Anthem**
  - 2009: $3,000
  - 2010: $3,000
  - 2011: $3,000
  - 2012: $2,500
  - 2013: $2,500

Reference Price Implementation
Can plans and providers **collaborate** for efficiency and price moderation?

### Vivity Model
- Center the network around major hospital systems, but agree on price and cost targets to achieve market-driven premiums
- Anthem Blue Cross and UCLA Medical Center

### ACO Model
- Put medical groups and IPAs at the center of broad PPO networks
- Anthem PPO and Brown & Toland Physicians