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Integrated Delivery Networks: In Search of Benefits and Market Effects

by Jeff Goldsmith, Lawton R. Burns, Aditi Sen and Trevor Goldsmith, February 2015

Any examination of the role that hospitals play in health care cost growth is complicated by the fact that in many large markets, hospitals may be part of integrated delivery networks (IDNs), either vertically integrated

health services networks that include physicians, post-acute services and/or health plans or fully integrated provider systems inside a health plan. Looking at the benefits to society, the authors found that there is evidence that IDNs have raised physician costs, hospital prices and per capita medical care spending; looking at the benefits to the providers, the evidence also showed that greater investments in IDN development are associated with lower operating margins and return on capital. As part of this report, the authors conducted a new analysis of 15 of the largest IDNs in the country. While data on hospital performance at the IDN level are scant, the authors found no relationship between the degree of hospital market concentration and IDN operating profits,

between the size of the IDN's bed complement or its net collected revenues and operating profits, no difference in clinical quality or safety scores between the IDN's flagship hospital and its major in-market competitor, higher costs of care in the IDN's flagship hospital versus its in-market competitor, and higher costs of care when more of the flagship hospital's revenues were at risk.

The authors conclude that the public interest would be served if IDNs provided more detailed routine operating disclosures, particularly the amount of hospital operating profit as a percentage of the IDN's total earnings and the IDN's physician and hospital compensation policies. How IDNs allocate overhead and ancillary services income between the three main lines of business should also be disclosed. It should also be possible to determine from an IDN disclosure if capitated risk is transmitted from the IDN's health plan or risk-accepting organization to its hospitals and physicians. Analysis of societal benefits would also be materially aided by a comprehensive, national all-payer claims database.

State Policies on Provider Market Power

by Suzanne Delbanco and Shaudi Bazzaz, July 2014

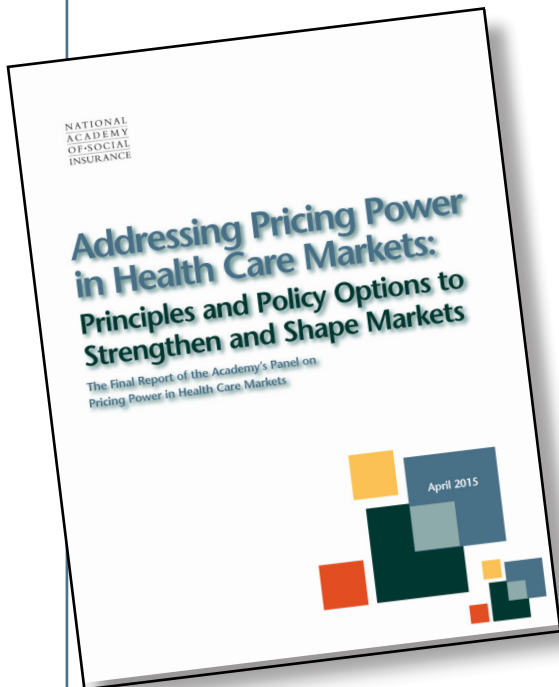
Health care economists broadly agree that the market power of certain health care providers is a major driver of price increases, and is associated with significant payment variation across and within markets. This report catalogues the laws and regulations that state governments are using to enhance the competitiveness of health care markets and reduce the ability of providers to use market power in such a way that creates negative consequences for those who use and pay for care. The authors researched regulatory approaches, specifically recent state efforts pertaining to: antitrust; price and quality transparency; competition in health plan contracting; price regulation; the development of Accountable Care Organizations (ACOs); expanding the authority of state Departments of Insurance; and facilitating the entry of new providers into the marketplace.

Specifically, this paper catalogues existing state statutes and regulations that address the contracting practices of health plans and providers likely to reduce competition and lead to higher prices. In doing so, this paper provides insight into the current scope of state authority to regulate and monitor health care prices. In addition, because states may pursue policies that would not be captured in a review of laws and regulations, this paper also explores efforts beyond the legislative realm by states taking an active role to address these issues.



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Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets

The Final Report of the Academy's Panel on Pricing Power in Health Care Markets

Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets is the final report of a panel of national experts—ranging from hospital leaders, insurance and antitrust experts, economists and others—who came together to examine the role and impact of market power

in the U.S. health care system.

To balance the differences in views of study panel members and to assist policymakers beginning to look at the issue, the panel agreed upon four key principles to guide the development of policy options to address market power. Collectively, they reflect a preference for market competition solutions, but targeted regulation in areas lacking competition may also be needed. They include:

- Market competition is the best way to motivate providers to increase efficiency and improve the quality of care; where market competition is ineffective, public policy can enhance market competition or, if that is not likely to be successful, regulate prices directly.
- Greater transparency of the prices of health care services and the quality of care provided is needed to help consumers make better choices about their care.
- While payment and delivery system reforms may improve quality, they may also contribute to excessive provider consolidation within markets; before making exceptions for specific delivery and payment reforms in legislation, the costs and benefits of the new models should be fully evaluated.
- Variation in the price of services should reflect real differences in costs, organizational mission and consumer preferences, and not the leverage that insurers and providers have when negotiating, which may be unrelated to performance.

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