Rate Regulation Can Help Redirect Providers to Compete on Non-Price Dimensions of Care

This Blog provides supplementary comments on the recent Health Affairs article entitled "How Price Regulation Is Needed To Advance Market Competition" authored by Robert Berenson and Robert Murray.[1] The idea for the article was stimulated by conversations Bob Berenson and I have had in recent years regarding government administered pricing systems and market competition. Conventional U.S. health policy has asserted that these two approaches represent mutually exclusive strategies to address the issue of high and rapidly rising commercial health care prices. In our Health Affairs article, we attempt to refute this conventional wisdom by citing evidence that price regulation can induce providers to compete on the basis of non-price factors – such as patient choice, patient experience of care, and quality of care.

Given the market failures present in the current U.S. commercial health sector, several prominent health economists have called for the development of government regulated caps on high prices and restrictions on price growth. However, these recommendations tend to be apologetically and grudgingly advanced.[2],[3] Thus, we present our observations and arguments primarily as a way to reframe the debate regarding the need for price regulation, such that price regulation might be viewed as more palatable in what is currently an anti-government U.S. political mentality. We also argue that given the profound market distortions and market failures that are now prevalent in the U.S. healthcare system

and the inability of antitrust and so-called pro-competitive strategies to address unprecedented levels of provider concentration and commercial pricing power, it is time to shift the debate from whether to regulate commercial health care prices, to how best to do so.

The Need for Price Regulation

Well documented evidence shows that provider consolidation in health care has been the driving force behind high and rapidly rising commercial health care prices and contributes greatly to the high-cost structure and growing operating inefficiency of U.S. hospitals and health systems. MedPAC makes note of how provider consolidation has led to a vicious cycle where the increased ability of providers to extract higher prices from commercial insurers and self-funded plans is ultimately channeled in to so-called “empire building” strategies, where increased revenues are invested in physician practice acquisition, additional facilities, capital improvement projects, perquisites and bonuses for management and other strategies to dominate their local delivery systems.[4],[5] As surplus revenues are deployed in strategies that increase provider domination of the delivery system, while also increasing costs and lowering overall operating efficiency, management is then induced to pursue additional merger and acquisition activities to give them further negotiating leverage to raise prices and revenues even more.

In addition to continual increases in health care prices and revenues, we note other deleterious impacts of provider market concentration generally. These issues are discussed by health economist Marty Gaynor who notes that “Increased consolidation tends to preserve the status quo in health care by protecting

existing firms and making it more difficult for new firms to enter markets and succeed. This leads to excessive rigidity and resistance to change, as opposed to the innovation and dynamism that we see in other industries." He also observes that such rigidity has also generated serious concerns about the quality of care, noting that there is virtually no evidence that provider consolidation has improved care quality.[6] There is also evidence that consolidation reduces consumer choice through the purchase of physician practices and other providers and increased referral of low value care, such as unnecessary imaging services.[7],[8]

Additionally, health care monopolies, like other large conglomerates, ultimately protect their market dominance by turning their outsized economic power into political power. This political power is most obvious at the individual state level, where hospital and physician associations and powerful health systems augment their lobbying power to successfully shoot down any legislation which might constrain provider merger activity or implement government administered payment systems to forestall this unabated pricing power.[9] Thus, growing levels of provider, as well as insurer, concentration in the health care industry has been largely unconstrained by what some characterize as a minimalist, and largely ineffective antitrust policy over the past forty years.[10] Both the narrow scope antitrust activities and judicial decisions have been ineffective in preventing mergers which inevitably drive price, revenue and cost growth.

In short, multiple waves of provider consolidation has strangled off any possibility of viable market competition to lower prices and induce providers to improve their operations and competitiveness on other dimensions of care – such as quality and patient choice. Antitrust and procompetitive initiatives have failed to make headway to either improve the

competitiveness of the health care sector or forestall the cycle of higher concentration, higher prices and revenues, increased health system market failure and dysfunction and growing operating inefficiency. As Erin Fuse Brown wrote in a 2015 UC Hastings Law Review article, Resurrecting Health Care Rate Regulation, "The story of our unchecked health care spending in the United States is a story about high and undisciplined prices. Our health care pricing problem is driven at its core by a growing provider monopoly problem. The only policy capable of addressing the provider monopoly problem is rate regulation. The inescapable conclusion is that we must resurrect health care rate regulation and place it in the center of any policy approach to control our health care spending."[11]

Benefits and Success of Regulation

The performance record of the price and expenditure control abilities of rate regulatory methods are well documented both in the U.S. and internationally. In the U.S., literature on the Medicare payment system shows that prospective rate setting in this program has been extremely successful in controlling price and expenditure growth since the advent of these payment methods in the late 1970s and early 1980s. The Medicare payment system has also arguably improved market functioning by setting more rational prices – prices that reflect both absolute and relative resource use and cost. Markets work better and allocate resources more efficiently when prices reflect the cost of production. Literature on rate regulation shows that state-based mandatory pricing systems experienced great success in restraining price and expenditure growth during the 1970s, 1980s and into the 1990s.[12],[13],[14],[15]

However, it also appears that the presence of provider rate

regulation has promoted provider competition on non-price dimensions of care delivery. This evidence comes primarily from several prominent reports from the Organization of Economic Co-operation and Development (OECD) and the European Commission, which indicate that price regulatory systems in various developed countries, including the U.S. with its Medicare program, actually redirect provider activities toward competing on other dimensions of care, such as patient choice, patient experience of care and quality of care,[16],[17] because it forces providers to improve their operational efficiency and counteract other market failures that result from provider domination of the delivery system.

In our article, we also argue that increased standardization and improved affordability of care – achieved through rate regulation – can also encourage increased entry of insurers into the market which can enhance patient choice and increase competition over health insurance premiums. This was the experience in several states with all-payer rate-setting systems where the presence of more standardized and affordable provider pricing stimulated the entry of smaller insurers and managed care plans in the U.S. in the 1980s and 90s which in turn promoted insurer premium competition.[18]

Considering Opposition & Challenges

Despite this historical record of cost-control success of rate regulatory systems, many still oppose the use of these systems because of concerns that rate regulation will: 1) interfere with delivery system and payment innovation; 2) impede the ability of providers to parlay their ample revenues into investments in improved technology and quality of care; or 3) be prone to dysfunction of its own in the form of regulatory failure and

regulatory capture.[19]

In attempting to address these common criticisms, we note, from a review of the literature, that rate-setting systems that set prices too low, or below marginal cost, may indeed have the effect of curtailing investments in care quality. Nonetheless, evidence on this circumstance from past rate-setting regimes in the U.S. indicates that this circumstance was rare. In most rate-setting systems, while price and price growth were constrained, the systems did not force prices to be below margin costs and thus both access and quality of care did not suffer. Moreover, existing rate-setting systems in the U.S. and other OECD countries have increasingly incorporated pay-for-performance mechanisms in their systems which provide increased financial incentives for providers to improve care quality. We also observe that today, many nonprofit U.S. health systems, with market power to dictate prices, have amassed large surpluses in the form of cash and investments and have ample resources to invest in quality improvement if they find competitive reasons to do so.[20] Empirical studies, including the seminal reports of the Office of the Attorney General in Massachusetts, found that hospital prices do not vary based on quality, even in relatively competitive markets.[21]

With regard to rate regulation's effects on innovation, based on my experience running a major rate regulatory system, I believe that there is no reason that price regulation and the increased standardization that accompanies rate-setting systems would reduce the potential for payment or delivery system innovation. First, most payment innovation has actually been originated by government administered systems – not from the private sector. Second, rate setting can be structured to be compatible with productive and innovative changes in care delivery that focus on improved care coordination and cost reduction. A case study example of this was in Maryland, where the rate system was

structured to be compatible with the cost-reducing and efficiency improving motives of managed care delivery systems. The result was a proliferation of managed care plans where plans that actively worked to reduce hospital costs could work together with price regulation to accomplish mutually compatible goals.[22]

Finally, with regard to regulatory failure and regulatory capture, we examine two potentially debilitating phenomenon associated with regulatory systems,[1] both of which were evident in state-based all-payer rate setting in the 1970s and 1980s (McDonough). Based on an extensive literature search and my own experience with these issues, we found the following: 1) concerns regarding regulatory capture are frequently motivated by ideology and self-interest, and not backed up by strong empirical evidence; 2) capture is not a binary condition but rather can exist in varying degrees; 3) because the level of capture varies, it is likely that some regulatory systems and agencies have done a better job resisting it; and 4) there are structural features of regulation that can help insulate a regulatory agency from both capture and failure.[23],[24] Thus, we conclude that while the dangers of regulatory failure and capture are real, and most evident in highly complex and highly regulatory rate-setting systems, they are manageable.

Proposed Regulatory Approaches

Based on the review of these topics, we conclude that the development of administered pricing systems that are not overly complex; are fully transparent; and, ultimately, constitute a parsimonious regulatory intervention can best avoid the dangers of capture and failure. Accordingly, in the article we suggest two low-intensity rate regulatory approaches: 1) price caps on

out-of-network services and 2) flexible all-payer global budgets.

These two approaches are described in some detail in the article and in other publications.[25],[26] They are specifically designed to be limited in the degree of regulatory intervention applied and/or reliant on more formula-based rate-setting techniques which minimize the need for excessive regulatory complexity. Both approaches are compatible with concurrent pro-market strategies, greater price transparency, tiered and narrow-provider networks, relaxation of provider network adequacy provisions, expanded use of nonphysician health professionals, greater patient cost-sharing, wide adoption of telehealth, greater antitrust enforcement, and prohibition of anti-competitive contract provisions.

Conclusion

Conventional wisdom among U.S. economists and policy makers is that provider price regulation and market competition are mutually exclusive strategies to address high prices. In our article, we attempt to demonstrate that hospital price regulation potentially can support competition over important care delivery components other than prices, while at the same time creating incentives for providers to improve operating efficiency and addressing high and rising prices directly. Yet, we propose that “lighter touch” regulations using limits on permitted out-of-network prices and flexible budgets offer comparable control over prices with less administrative complexity and burden than offered by more commonly recommended direct limits on prices and price updates. Legislators and policy makers should redirect their energies from debating whether to regulate hospital prices to discussing how best to do

so.

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