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**CENTER ON HEALTH
INSURANCE REFORMS**

Assessing Responses to Increased Provider Consolidation in Three Markets: Detroit, Syracuse, and Northern Virginia

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Introduction and Approach

Rising health care prices have increased concerns about hospital and health system consolidation among policymakers, regulators, employers, and other purchasers of health coverage. Although merging hospitals and health systems claim they can achieve greater efficiencies through their consolidation, the economic literature almost universally finds that hospitals that merge have prices above those of surrounding hospitals.¹ More broadly, markets with increased levels of provider concentration, regardless of the reason, tend to see higher prices.² Indeed, increases in hospital prices have been a key factor driving the growth of commercial health insurance costs over the past decade.³

As prices have risen, employers have shifted an ever greater share of the costs to employees. Over the past ten years, the average worker contribution for family coverage has increased faster than the average employer contribution (65 percent vs. 51 percent). Indeed, employee contributions have risen almost 300 percent since 1999. High-deductible health plans are now 29 percent of the market (up from 9 percent).⁴ The increased negotiating clout of a concentrated provider sector also influences payers' ability to maximize value-improving practices, such as alternative payment models, quality improvement, and transparency efforts.

Insurers—under pressure from employer purchasers and policymakers to keep costs affordable while maintaining health care quality—are thus exploring a range of strategies to counter provider consolidation in their markets. The ability to implement and successfully deploy these strategies can vary significantly, depending on the market in which insurers are operating.

In a series of six market-level, qualitative case studies, we assess the impact of recent provider consolidations and overall provider concentration, the ability of market participants (and, where relevant, regulators) to respond to those consolidations, and effective strategies for constraining cost growth while maintaining clinical quality. Our case studies focus on the commercial insurance market, though we recognize that providers and insurers are often operating in multiple markets, including Medicare Advantage, Medicaid managed care, and the Affordable Care Act (ACA) marketplaces. We do not attempt to quantify the effect of provider consolidation in these markets, such as through provider rate or premium changes.

This interim report discusses findings from three markets studied to date. A final report will present cross-cutting findings from these and three additional markets chosen to reflect geographic diversity and a range of market dynamics.

Key Differences and Key Similarities Across Three Markets

Every health care market is unique, with provider-payer-purchaser ecosystems that are rarely replicated in other markets. For this study we sought a geographically diverse set of mid-sized health care markets that had experienced provider consolidation within the last 10 years. The three markets examined for this interim report: Detroit, Michigan; Syracuse, New York; and Northern Virginia (including Fairfax, Loudoun, and Prince William Counties and the independent cities of Arlington and Alexandria) have as many differences as similarities. However, all have experienced either hospital-hospital mergers within and outside the region, acquisitions of local independent hospitals by large national systems, and less formal clinical affiliations between hospitals.

Although all three study markets have experienced recent consolidation, the overall concentration varies. Northern Virginia has the most concentrated market, with Inova the dominant health system in the market. Syracuse and Detroit lack a single dominant health system. However, both have hospital systems with unique geographic or clinical service profiles that offer them a competitive advantage.

Additionally, all three markets are experiencing vertical integration, with local hospitals acquiring physician practices, urgent care centers, skilled nursing facilities, labs, and other ambulatory care providers. Hospitals use these acquisitions to channel patients to their inpatient facilities and to promote participation in and improve their

ability to manage accountable care organizations (ACOs) as well as other delivery system innovations, many of which were incentivized under the ACA.⁵ Hospital acquisitions or affiliations are also being used to expand the geographic reach of large providers into smaller communities throughout their region.

At the same time, all three markets have one or two dominant insurers – in all cases the local Blue Cross Blue Shield (BCBS) plan. However, Northern Virginia’s commercial market is divided geographically between two BCBS plans, and has somewhat more competition from other carriers than Detroit and Syracuse.

Two of the study markets—Detroit and Northern Virginia—have very large, regionally concentrated employers: the “Big 3” automakers in Detroit and the federal government in Virginia. Syracuse’s market is characterized more by small- and mid-sized businesses. However, in all three cases, employer-purchasers have to date taken a relatively passive role in their health plan benefit and network design, leaving negotiations over provider payments to their insurers (or third party administrators, in the case of self-funded employer plans). Additionally, in all three markets the health sector has been an area of employment growth, meaning that health systems are not just providers but major regional employer-purchasers of health care.

Cross-Cutting Findings: In Spite of Differences, Some Common Trends

Local complacency, but disruptive forces on the horizon

Health care markets can be strongly influenced by their unique local geography, economy, history, and culture. For example, in Northern Virginia, geography plays a critical role due in part to travel congestion, which creates an incentive for patients to use the closest hospitals. In Syracuse, negotiations over provider reimbursement have historically been eased by longstanding personal relationships among market actors. In Virginia, payers observed that the largest hospital system in the area has a history of “playing well in the sandbox.” In Detroit, the provider community effectively created BCBS of Michigan and maintains a strong governance role in the company, with several providers represented on its board of directors. These bonds may make providers with market clout less aggressive in demanding egregious price increases, but can also contribute to complacency and a reluctance among payers to pursue disruptive strategies to reduce costs.

However, respondents in all three markets noted emergent threats to the current provider-payer equilibrium. These include the acquisition of local independent hospitals by outside, national players; new executive leadership within some organizations that has shown a greater willingness to shake up established

norms; and pressure from the public sector—Medicare and state Medicaid agencies—to pursue non-traditional payment models and rein in costs. The effects of these changes are just beginning to be felt in these markets.

Increased provider consolidation contributes to higher prices, but there are constraints

Consistent with the economic literature documenting the price increases that follow a hospital merger, payers in our three study markets reported either price increases or greater pressure from providers for higher reimbursement in the wake of consolidations and increased concentration.⁶ In addition, perhaps counterintuitively, smaller hospitals have been able to piggyback on their competitors’ market clout, demanding higher prices from payers as a condition of preserving competition in the market.

Provider price gouging in these markets is not unfettered, however. Limiting factors in each market include (1) the existence of a large, dominant insurer with whom the providers need to maintain contracts to keep commercially insured patients; (2) the negative publicity that often accompanies a difficult payer-provider negotiation; and (3) the often “small town” nature of the local health care market, noted above.⁷

Payers' tools to combat higher prices are limited, and used with limited effectiveness

There are a limited number of tools in payers' toolbox to push back on the "must have" providers in the area, and the ones used appear to have limited effectiveness. One of the most obvious tools—exclusion of a high cost provider from the plan network, or a narrow or tiered network—is generally viewed as a nonstarter in the employer-sponsored market for coverage. Broad, unfettered access to a wide choice of providers is the norm in the employer market—narrow network plans are offered by just 7 percent of employers nationally.⁸

Consistent with this trend, employer-purchasers in the study markets demonstrated little willingness to push employees towards a narrower network product, even when doing so could reduce costs. Furthermore, payer strategies to reduce costs by excluding certain providers can have varied impacts, depending on how they are deployed. For example, an exclusive agreement with a dominant hospital system in one area could help to consolidate that system's market clout, while other payers may work to boost competition by contracting with smaller, less dominant providers.

Further, threats to terminate a high-priced hospital or health system are seen as akin to a "nuclear option," with big public and customer-relations risks. Payers in our study noted that employers rarely "have their back" in a negotiation that could result in the loss of a major provider from the plan network. However, narrow networks are seen as viable in the individual market, where buyers are more price sensitive.

Employers have been more willing to increase deductibles and enrollee cost-sharing as a cost containment strategy, but observers in all three markets assert that high deductible plans have been slower to take hold in their communities than in other parts of the country. Respondents noted that the introduction of high deductible plans has resulted in pushback not only from employees but also local providers, who expressed concerns about patients forgoing services or being unable to pay medical bills.

Some payers reported efforts to use a mix of provider payment and benefit design incentives to shift patients

to lower-cost care settings and out of the hospital. But the cost savings from such shifts may be lessened as hospital systems increasingly engage in vertical integration. When the hospital system owns the physician practice, ambulatory care facility, or other care setting, many demand higher prices or extra fees for care in these outpatient settings.

In Northern Virginia, one payer adopted what amounted to a "if you can't beat them, join them" strategy by entering into a joint venture with the largest hospital system. Respondents in the region reported mixed results from the agreement; it is not clear that the company has been able to generate the kind of price advantage that would enable it to gain market share with employers. Similarly, a major hospital in Detroit charges its own health plan subsidiary higher prices than the competing BCBS plan, negating any pricing advantage such integration might have provided.

Payers across the three study markets appear to be pinning most of their hopes for cost containment on alternative payment models that shift a greater degree of financial risk onto providers. But all concede that their ability to get a "must have" hospital system to agree to any contract that is not financially advantageous is difficult, and that their efforts in this area have not demonstrated significant results yet.

Public policy can play an important role—but beware of unintended consequences

Although there are a range of public policies that can help shape the negotiating dynamics within a health care market, our case study respondents identified three that had affected theirs. In some cases, these policies did not always have the results intended by policymakers. First, federal anti-trust enforcement plays an important role in limiting anti-competitive behavior, not only through formal legal actions but also because market actors report that they consider the potential for future such actions in their contracting and expansion decisions. For example, Inova's efforts at horizontal expansion in Northern Virginia have effectively been stalled, even though the most recent federal effort to oppose one of its acquisitions was a full decade ago.

State network access standards also could inhibit the development of narrow network plans and force insurers to contract with higher priced providers. For example, respondents in Syracuse, New York pointed to that state's network adequacy requirements as a likely impediment to the development of an exclusive arrangement with a local hospital system.

Lastly, respondents report that state certificate of need (CON) requirements, which mandate state review and

approval of any new hospital facilities, have inhibited the entry of competing health systems. However, provider respondents disagreed, arguing that a relaxation of CON could actually increase overall health care costs. In this view, the "gold rush" of new entrants would lead to an increase in utilization, negating any cost savings from increased price competition.

Conclusion

Respondents in all three markets suggested that their communities have been slower to adopt many of the health care trends highlighted in the national media, such as high deductible plans and alternative payment models such as ACOs. However, they may be more representative than they think.

All have experienced some degree of provider consolidation, both horizontal and vertical. All have one or two dominant payers. However, market dominance – whether on the payer or provider side – does not confer the unfettered ability to dictate terms in a contract negotiation. All are operating within both market and regulatory constraints. A payer strategy to exclude certain providers may have a differential impact depending on how a market's providers are arrayed. And dominant payers may have only a limited incentive to negotiate aggressively with providers, preferring market stability over modest savings.

In all cases, however, the tools within the commercial payers' toolboxes to constrain costs are limited, and of limited effectiveness. Public policy can play a role but may not always lead to the results policymakers expect.

Several developments signal potential future changes in our study markets. One possibility is that employers might take a more aggressive approach to negotiations.

A recent move in Detroit for an exclusive arrangement between General Motors and Henry Ford Health System provides such an example, although it is too early to know what impact it may have. Provider-insurer alliances could offer another means of changing the market dynamic or offering a counter-measure against a dominant provider or insurer. Although such measures in our study market have had limited impact to date, providers and insurers elsewhere have used these alliances to compete aggressively.¹⁰

Public payers, especially Medicare and Medicaid, are using their leverage to push for greater adoption of alternate payment models. Although we did not hear that these initiatives were having a substantial effect in our markets, this could change going forward. Finally, various trends could have a significant impact on evolving forces in our markets. For example, more use of telehealth could provide payers with ways to bypass contracting with some types of local providers. In addition, the tendency of millennials to forego traditional primary care in favor of urgent care centers or "minute clinics" could shake up traditional practice and referral patterns that can contribute to the hegemony of some hospital systems.

Case Study Analysis: The Detroit Health Care Market

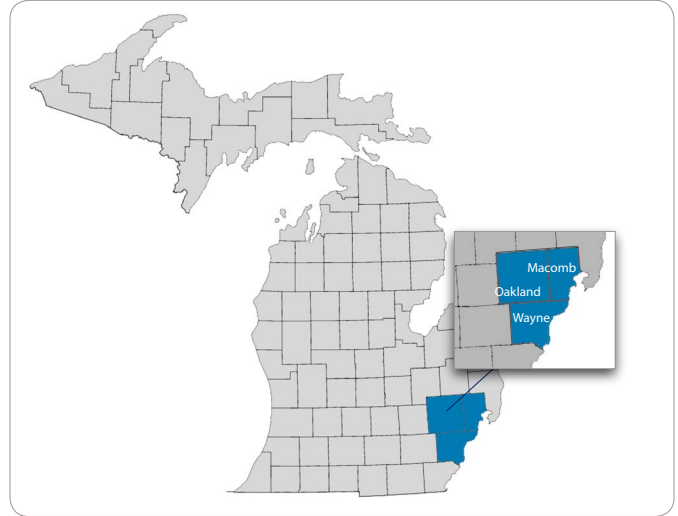
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Background, History, and Methodology

The Detroit metropolitan region, defined in this study to include Macomb, Oakland, and Wayne counties, is home to six hospital systems. These are: Ascension Health, Beaumont Health, Henry Ford Health System, McLaren Health Care Corporation, Tenet Healthcare, and Trinity Health. Three of the systems (Beaumont, Henry Ford, and McLaren) operate solely in the state of Michigan. The other three systems had origins as Michigan organizations but operate now as subsidiaries of larger, multi-state companies. Most of the systems have affiliates across the state, not just in the immediate Detroit area. There are an additional three independent or quasi-independent hospitals: Pontiac General, Oakland Regional, and Garden City. Of these, Garden City Hospital is owned by a national system, Prime Healthcare services. Although outside the immediate Detroit area, the University of Michigan Medical Center also draws patients from the city.

Detroit has historically been the heart of the American auto industry, which gave rise to the “big three” auto manufacturers (Ford, General Motors, and Chrysler (now Fiat Chrysler)). With the emergence of this industry in the early 20th century came a health sector to meet workers’ needs, including the construction of several non-profit and safety net hospitals, such as those now part of Trinity Health, Henry Ford Hospital, and the Detroit Medical Center. These providers, in turn, created the Blue Cross Blue Shield of Michigan (BCBS MI) insurance company in order to help their patients finance the services they provided.¹¹ At the same time, the rise of organized labor in the 1930s resulted in the establishment of the United Auto Workers (UAW) union, which secured contracts with automakers that, in addition to higher wages, included guaranteed medical coverage, often financed through BCBS MI.

To a large degree, BCBS MI remains the dominant insurer in the Detroit market, while the hospital sector has been more competitive. In 2010, the U.S. Department of Justice sued BCBS MI over “most favored nation” (MFN) clauses included in their provider contracts. These clauses prevented providers from charging competing insurers a



lower reimbursement rate than what they charged BCBS MI, enabling the company to offer lower-cost plans than competitors. The Department of Justice dropped its litigation after the Michigan legislature prohibited MFN clauses in insurer-provider contracts.¹²

In the last several years, the provider market has undergone changes that make it more consolidated. These include Tenet Healthcare Corporation’s 2013 acquisition of the nonprofit Vanguard Health Systems, which owned one of Detroit’s largest safety net hospitals, the Detroit Medical Center. This acquisition created the first, and thus far only, for-profit hospital in the Detroit region.

In 2014, the Detroit area experienced a merger among three hospital systems: Beaumont, Oakwood, and Botsford. The merger brought together a total of eight local hospitals, making the Beaumont Health System the largest hospital system in the state based on inpatient admissions and net patient revenue. In merger negotiations, the three systems cited population health, physician alignment, health IT integration, cost savings, and operational efficiencies as reasons for the merger.¹³

The succeeding years have witnessed additional integration among Detroit’s hospital sector. In 2015, Henry Ford acquired Allegiance Health, a hospital in Jackson County, about an hour away from Detroit, while Garden

City Hospital was acquired by Prime Health Care Services and Crittenton Hospital was acquired by Ascension Health, a national chain. More recently, Ascension Health and the Washington-based Providence St. Joseph Health systems have announced talks of a merger, which would make Ascension the largest U.S. owner of hospitals (although it would not add any hospitals in Michigan). Additionally, many of these hospital systems have invested heavily in vertical integration, through the purchase of physician group practices and other ancillary service providers.¹⁴

To assess the varying ways in which insurers respond to provider consolidation, we conducted an environmental scan, a literature review, and interviews with ten national experts and regulators. Additionally, we interviewed eight Detroit-area providers, insurers, large purchasers, and expert observers. All eighteen interviews occurred between November 3, 2017 and March 1, 2018.

Descriptive Analysis: Three Market Sectors

1. Hospitals, Health Systems, and Physicians

Despite the recent consolidation, the presence of six competing hospital systems means Detroit is not a concentrated provider market by most definitions. But as the area's independent hospitals have become part of larger systems, as some of the regional systems have aligned with larger national companies, and as some smaller systems have banded together to form larger systems (i.e., Beaumont Health), hospital providers have demonstrated a keen interest in increasing their geographic footprint, improving their access to capital, and leveraging their expanded market clout.

Respondents for this study have offered different descriptions of the competition that exists among Detroit's hospital systems. Some observers noted that there is not much head-to-head competition among hospitals, and that many hospitals aim to serve primarily the neighborhoods where they are located. Others suggest that people are willing to travel to use a particular hospital; as a result, hospitals compete directly. Another respondent observed that, unlike some other markets, there is no single "must have" hospital or health system in the area, although Detroit Medical Center and Henry Ford are the city's larger teaching hospitals. There is no public hospital in Detroit, and no

hospital seen as the sole safety net hospital. The safety net function is divided up among multiple hospitals, especially Detroit Medical Center and Henry Ford.

There are additional partnerships among hospital systems that represent loose affiliations, but not mergers. These have been the basis for some delivery system innovations such as clinically integrated provider networks. Several systems have been active in the acquisition of physician practices and other service providers. Although this trend may have been slower to materialize in Detroit than in many other markets, there is now a considerable degree of vertical integration. Many physicians and physician groups also contract with separate "physician organizations" to provide them with information technology, care coordination, and other services more efficiently than they could on their own; in some cases these organizations also negotiate reimbursement with payers on their members' behalf.

2. Insurers

Market concentration is far more evident among insurers, since the Detroit market is heavily dominated by one insurer, Blue Cross Blue Shield of Michigan and its HMO subsidiary, Blue Care Network. The exact market share depends on the way it is measured, but most estimates place it between 60 and 70 percent of the state's commercial market. There is more competition in the individual market, reflected in the participation of six other competitors on Michigan's Affordable Care Act marketplace and at least one other off-exchange participant. There is also more competition in the managed Medicaid and Medicare Advantage markets.

Local HMOs are characterized as relatively minor players in the Detroit market. One purchaser respondent suggested that "the HMOs end up being more expensive and are not better in quality."

The most prominent HMO is the Health Alliance Plan (HAP), affiliated with Henry Ford Health System. Although it has played an active role in the region for many years, it holds only a small share of the market. Early in its history the relationship with Henry Ford was much tighter, but today only a relatively small share of HAP members get care exclusively from Henry Ford providers.

3. Employer Purchasers

The largest employer purchasers in the Detroit market are the big three auto companies. A new element, borne out of the 2008-09 recession, is the UAW Retiree Medical Benefits Trust. It took responsibility for health benefits for 860,000 industry retirees (about half in state), thus making it a major health care purchaser. After the auto industry, hospitals and health systems are among the next largest employers in this market.

For the auto industry, health coverage was traditionally characterized by low cost sharing, low deductibles, and open provider networks. But the recession and near-collapse of the auto industry in 2008-09 (a “game changer” in the words of one provider respondent) was the catalyst for the adoption of insurance designs that are more common elsewhere in the country. Still, insurers have faced challenges making changes. Although nationally the average deductible in employer-based coverage exceeds \$1500 per year, one respondent noted that local providers pushed back against the recent introduction of a \$500 deductible plan, criticizing it for its overly high deductible.¹⁵ The auto industry and unions have also discouraged the entry of for-profit companies on either the provider or health plan side.

Findings

In some ways, the Detroit market lags the rest of the country with respect to a number of health industry trends. For example, though there have been several recent mergers and acquisitions among hospital systems, the provider market remains far more competitive than in many major metropolitan areas. Additionally, respondents noted that high deductible health plans and alternative payment models that shift risk to providers have been slow to take off in Detroit compared to other major health care markets. As one respondent put it, “Michigan markets have been slower to evolve than in . . . the rest of the nation.”

Respondents attribute Detroit’s relatively old-fashioned health care culture to a highly unionized workforce that has prioritized generous health coverage over wage growth and a lack of competition among insurers for commercial business. Also, the major hospital systems and payers in Detroit have, until recently, been locally owned and operated. Most have retained their non-profit

status, perhaps mitigating aggressive efforts on both sides to wring profits out of the system. Although change may be coming more slowly to Detroit than in other areas, health care stakeholders have lately been reassessing the old ways of doing things. The market has “started to rev up a bit,” in the words of one observer, with recent consolidations, acquisitions, and the emergence of new care delivery and payment models.

- **Blue Cross Blue Shield’s Longstanding Market Dominance Continues**

Respondents were united in their views that Michigan’s Blue Cross Blue Shield plan is the 800-pound gorilla of the Detroit market. One observer noted, “I believe it’s cultural in Michigan to have a Blue Cross card . . . it is an inherent expectation among the workforce, like a warm blanket.” Employers feel they must offer BCBS coverage to their workers and most workers choose it. For their part, providers have no choice but to be part of BCBS MI’s plan networks if they want paying patients.

Although state legislation barred BCBS MI from including MFN provisions in provider contracts, the company continues to use its market leverage to gain discounts from providers, regularly beating competing payers on price. As suggested by one observer, “Every time employers put something out to bid, BCBS MI undercuts everyone else.” For example, respondents noted that the Henry Ford Health System offers BCBS MI lower rates than it does its own health plan subsidiary. “They’re getting the best deal from providers,” observed one stakeholder. Similarly, a large multi-state purchaser based in Detroit noted that BCBS MI’s provider discounts are “much better than any state I’m in.”

The fact that stand-alone providers “have to take whatever [BCBS MI] offers” on reimbursement has spurred recent efforts among hospital leadership to pursue mergers or other acquisitions in southeastern Michigan, such as the recent merger creating the 8-hospital Beaumont Hospital System and Henry Ford’s acquisition of Allegiance Health. Although Detroit in 2018 continues to have a competitive provider market, there are few independent, stand-alone hospitals, and hospital systems are acquiring more and more physician groups each year in pursuit of vertical consolidation.

Competing insurers, meanwhile, are taking advantage of the emergence of hospital systems with greater capabilities and geographic reach to develop narrow network products that can better compete with BCBS MI on price. “The smaller plans are trying to break through the Blues’ monopoly [with a narrow network strategy],” one provider respondent told us, although it is not yet clear whether any of these products will gain significant market share.

- **In Spite of a Payer’s Dominance, Negotiations with Providers are Complicated**

BCBS MI’s ability to dictate price and contract terms is not unfettered. First, it is limited by expectations among major employer purchasers and many workers that they will continue to have access to large, open provider networks. “We have all the providers’ has historically been BCBS MI’s selling point,” one employer told us, adding: “Anything that’s about reducing benefits or choice is a very hard sell [with our employees].” Carving out a hospital system from their plans’ networks would require a renegotiation of union contracts, something this employer was loath to do.

Second, insurers may also worry about negative publicity if they drop a major provider from their network. Several respondents recalled a particularly nasty public relations campaign between BCBS MI and Beaumont Hospital during tough contract negotiations in 2011. “They were taking out full page ads on each other,” one purchaser recalled.

Third, for an insurer to expand its narrow network product offerings, it needs providers willing to be part of those narrow networks. But respondents report that hospital systems in Detroit have been reluctant to be the first in the market to acquiesce to significant reimbursement cuts in exchange for being part of a narrow network. “It’s a game of chicken of who’s going to go first,” observed one respondent. “I’m perfectly willing to negotiate price at the right level,” said one provider, “if the payer is willing to guarantee I can retain volume and control of the costs.” But, he continued, “if it’s going to be a free-for-all, there’s no trust in that.”

Fourth, BCBS MI itself was a creation of the provider community, formed in 1939 by hospital and physician associations to help finance the provision of health care

services.¹⁶ To this day the company—like Blues plans in some other states—maintains a close relationship with providers, and eight current members of its board of directors are either clinicians or representatives of provider organizations.¹⁷ Fifth, the hospital systems themselves are large customers for BCBS MI, with many of their clinicians and staff covered under their plans. These close relationships make it less likely the company will take steps to permanently alienate or exclude a major hospital system or group of providers.

- **Pressure Increases on Both Sides to Strike Tougher Bargains**

The Beaumont merger gave that system greater market power, but it is not yet clear how it will exercise it. As one expert noted, Beaumont is still “trying to figure out how to flex their muscle.” Detroit payers have observed a toughened stance among Detroit providers in recent years. For example, they note that hospital systems are increasingly telling insurers they must conduct their contract negotiations with a centralized “corporate” office that makes decisions for the entire system. “They tell us not to talk to the individual hospitals,” one insurer said.

Further, respondents noted that hospitals are under growing pressure from “sophisticated” payers in the state’s Medicaid market to keep prices low. This puts corresponding pressure on them to make up Medicaid-related shortfalls through their commercial business. At the same time, several hospitals and health systems have recently hired CEOs from other markets around the country; one observer suggested that these executives’ experience has contributed to a culture of tougher bargaining. Insurer and employer respondents told us that hospital providers are increasingly seeking to maintain or raise profit margins, and increasingly willing to issue termination threats to get what they want. A provider respondent confirmed: Detroit’s hospital systems are trying to use their increased negotiating leverage to get “fair” rates. “We’ve all tested the waters a little, and we may have done marginally better, but nothing earth-shattering,” he observed. Additionally, several respondents expressed concerns about the growth of facility fee charges for services performed in hospital-owned clinics and physician offices, although commercial contracts have limited the practice to some degree.

At the same time, major employers appear to be ratcheting up expectations that insurers deliver a lower-cost product, with one employer respondent pushing for narrow network designs. And while Michigan's large, self-funded employers have to date been willing to rely on insurers to handle price negotiations with providers, some are exploring other options. Recently, a major Detroit employer issued a Request for Proposals to directly contract with a provider system. Several local providers responded, a development that "shook the Blues to the core," said one hospital executive. Other large, self-funded employers are considering similar arrangements: "To this point, our carriers are the experts . . . but we remain open to the possibility we may have to directly negotiate [with providers]," said one purchaser. In response to the demand for lower-cost plans—and the threat that purchasers will go elsewhere if they can't deliver—payers, including BCBS MI, are developing higher deductible products as well as narrower network products, albeit at a pace slower than some employers might wish.

Payers are also working to implement payment reform initiatives, in which providers are given financial incentives to improve outcomes and quality, while delivering care more efficiently. "We are putting our eggs in the fee-for-value basket," said one insurer respondent, "but we have to change the mindset of the provider community [towards] shared value and affordability." Provider respondents confirm that they are under increased pressure to participate in value-based payment models, such as accountable care organizations and bundled payments for specific episodes of care. "It's all of the above" when it comes to alternative payment models, observed one executive.

Ultimately, purchasers and payers appear to be pinning their hopes for cost containment on convincing more providers to take on more health care risk. "The key is getting financial incentives aligned," one payer said. A hospital executive highlighted the increased pressure as well, noting that while early payment models included only upside risk for meeting efficiency and quality targets, recent ones have also included downside risk. It's a trend he sees accelerating in 2019 and beyond, in concert with the federal push for more downside risk.¹⁸

He further noted that much of the impetus for recent mergers and acquisitions in the provider sector has been to enable them to take on more risk, including downside risk.

Expectations for the Future

Respondents shared a wide range of views on how the Detroit market is likely to evolve. Further consolidation among providers is expected, while some predicted that a national insurer could enter the market and place some competitive pressure on BCBS MI. Another noted that local hospitals are over-invested in expensive "brick and mortar" (a problem not unique to Detroit), and will be challenged by new models of high-tech, consumer-directed care delivery and an increasing set of services provided outside the hospital setting.

Additionally, observers believe Detroit consumers can expect more products with narrow provider networks and higher deductibles. Others believe that payers—and their employer customers—will continue to ratchet up the pressure on providers to participate in more value-based and risk-sharing payment arrangements.

Epilogue

In August 2018, after the completion of our Detroit interviews, the Henry Ford Health System and General Motors completed a deal making Henry Ford the primary source of care for up to 24,000 General Motors salaried employees.¹⁹ Henry Ford has agreed on rates for this deal that are lower than what it offers other payers, and employees have strong incentives to use Henry Ford's providers (with some additional designated providers, such as the Detroit Children's Hospital). The deal includes annual spending goals, quality metrics, and shared-savings arrangements. Enrollment in the new arrangements will be effective January 1, 2019. This initiative will be an interesting test of one large employer's attempt to exert influence on provider pricing. It is less clear whether employers without the clout of General Motors will be able to piggyback on this type of initiative.

Case Study Analysis: The Syracuse Health Care Market

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Background, History, and Methodology

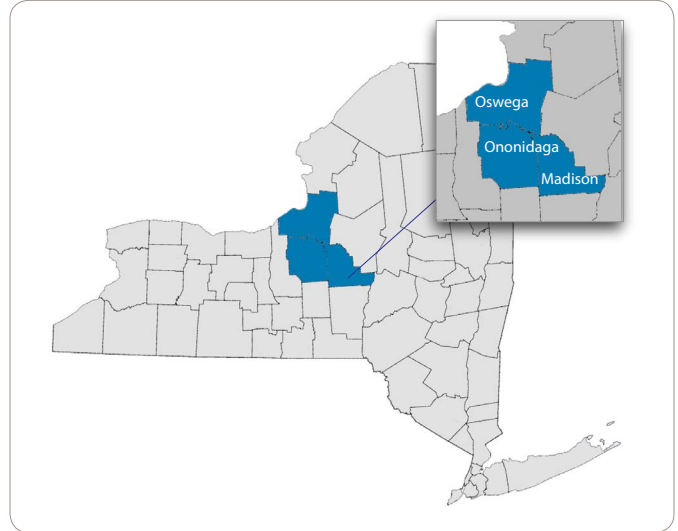
The Syracuse metropolitan region, defined in this study to include Onondaga, Oswego, and Madison counties, has three hospital systems. These are: SUNY Upstate University Hospital (SUNY Upstate), Crouse Hospital (Crouse), and St. Joseph's Health (St. Joe's). The three hospitals are physically very close to one another. SUNY Upstate and Crouse are adjacent—and physically connected by a bridge—with St. Joe's located less than a mile away.

These health systems compete in many practice areas. However, not all provide a full array of hospital services, and each health system has developed a somewhat distinct area of expertise. For instance, SUNY Upstate is known for its pediatric and neurology practices and houses the only local burn center. St. Joe's is highly regarded for cardiac surgery and orthopedics, while Crouse provides high-risk obstetrics and gynecological care.

Syracuse was previously a manufacturing hub with major outposts for companies like General Electric and General Motors. By the 1970s, the manufacturing industry had dwindled and the population of Syracuse declined. The city's reduced population led a state commission to call for hospital consolidation due to excess capacity.²⁰

Syracuse providers have had a long history of both successful and failed consolidation attempts.²¹ There were four major hospital systems in Syracuse as recently as 2011, when then-Upstate University Hospital, a teaching hospital that is part of the State University of New York system, merged with Community General Hospital, which was facing bankruptcy.²² This merger resulted in SUNY Upstate, which continues to be Syracuse's academic medical center.

In addition to this merger, the provider landscape in Syracuse has been altered by the entry of large out-of-market hospital systems. In 2015, St. Joe's was acquired by Trinity Health (Trinity), a large national system operating 94 hospitals in 22 states.²³ In 2017, Crouse—



the last independent hospital in Syracuse—entered into a partnership with Northwell Health (Northwell), the state's largest health care system with 22 hospitals but no presence in upstate New York.²⁴ Crouse entered into this partnership after a series of failed merger attempts.²⁵

Syracuse's insurance market is highly concentrated. Excellus BlueCross BlueShield (Excellus) has long been, and remains, the dominant insurer in the Syracuse market. Excellus has a significant market share across all lines but particularly in the employer market. MVP Health Care, a regional plan based in Schenectady, competes with Excellus but runs a distant second in terms of market share. Other major carriers, such as UnitedHealthcare and Aetna, sometimes compete for large employer accounts in Syracuse but have not commanded significant market share.

To assess the varying ways in which insurers respond to provider consolidation, we conducted an environmental scan, a literature review, and interviews with ten national experts and regulators. Additionally, we interviewed ten Syracuse-area providers, insurers, large employer purchasers, and expert observers. Syracuse-based interviews occurred between April 4, 2018 and June 5, 2018.

Descriptive Analysis: Three Market Sectors

1. Hospitals, Health Systems, and Physicians

As noted above, Syracuse's provider market has become increasingly concentrated over the last several years. Each of the three large hospital systems is owned by or aligned with a larger entity. SUNY Upstate is owned by the state, St. Joe's is owned by Trinity, and Crouse is in a new partnership with Northwell. Observers note that while Northwell's affiliation with Crouse is not a formal merger, it could be a "trial run" for Northwell as it considers expanding its footprint to the upstate region. While some respondents were uncertain about the future for Crouse and Northwell, others predict that Northwell will ultimately purchase Crouse.

More recently, the hospital systems have looked beyond Syracuse to pursue affiliation or partnership arrangements with smaller, more rural hospitals in contiguous counties.²⁶ To date, these partnerships have resulted in alignment, clinical affiliation, and, in some cases, referrals but not formal programs. One observer noted that there is not one "independent hospital that isn't either recently affiliated or about to affiliate." Respondents noted that these affiliations could allow for an expanded clinically integrated network across the broader geographic region and, with it, the potential to increase negotiating clout with insurers. Others thought it was primarily financially struggling rural hospitals that sought these affiliations in order to survive (rather than a competitive move by a health system). Regardless of the motivation, observers were unanimous in finding these affiliations to be, so far, limited in their effect. "Partnership without commitment seems to be the model," said one expert.

One partnership that respondents felt could have a bigger impact on market dynamics is a relatively new arrangement between St. Joe's and the University of Rochester Medical Center (URMC). This partnership with another academic medical center, albeit in Rochester, could pose a threat to SUNY Upstate. Respondents reported that St. Joe's has begun referring certain specialty cases, such as oncology cases, to URMC, which has a designated cancer center. St. Joe's has also brought in neurologists

from URMC to see patients (presumably to compete with SUNY Upstate's dominance in neurology). St. Joe's and URMC also announced a partnership with Auburn Community Hospital, which is about halfway between Syracuse and Rochester, in late 2017.²⁷ As one respondent put it, "there's potential for this arrangement to have an impact on the balance of power in Syracuse."

Syracuse is also experiencing considerable vertical integration as the three hospital systems accelerate their efforts to purchase physician practices, particularly primary care groups. Specialty care practices are less consolidated, although not completely. For example, St. Joe's has been rapidly "buying up specialists" following the acquisition by Trinity and reportedly acquired the last private cardiology practice in the area. Respondents believed these trends are being driven by 1) the desire for greater leverage in price negotiations with payers; and 2) the transition to risk-based payment arrangements that incentivize keeping patients within a hospital system.

In spite of considerable consolidation and distinct market niches, respondents report that those niches are eroding to some degree, and the three hospital systems do compete. Observers noted the high degree of advertising done by the three health systems, ranging from billboard advertising to St. Joe's recent purchase of naming rights for an amphitheater.²⁸ "They spend a ton of money advertising at each other," one observer commented. However, respondents agreed that the fact that each system has its own distinct clinical niche, even with increased competition over time, limits payers' ability to exclude any single system from its network without significant backlash from customers.

2. Insurers

Excellus is estimated to control up to 80 percent of the commercial employer market and an estimated 50 percent of the individual health insurance market. Excellus also competes in the Medicare Advantage program, although the Medicare market in Syracuse remains primarily fee-for-service. "Excellus has been the 800-pound gorilla for as long as I can remember," observed one expert.

Excellus is particularly dominant in the fully insured small- and mid-sized group market, while UnitedHealthcare and Aetna appear to compete primarily for large business accounts and to serve as TPAs for large, self-funded employers. In the individual market, consumers have a choice of Excellus, MVP Health, and Fidelis Care (a nonprofit insurer primarily in New York's Medicaid market that was recently acquired by for-profit Centene Corporation).

When asked why the Syracuse area is so heavily concentrated, one expert noted that the area “hasn't been an attractive market for other insurers to come into.” This is due in large part to the need for a network that is spread across a large geographic area, making the cost of entry significant. Others assert that new market entrants or smaller insurers are at a disadvantage in the bidding process for employer business. As one observer put it, local employers offer the incumbent insurer the “last look.” Thus, even if an insurer comes in with a competitive bid, the incumbent insurer—typically Excellus—is given an opportunity to re-bid with lower prices.

3. Employer Purchasers

Syracuse has experienced a decline of large, multi-national companies, and now has an economy dominated by the public sector, universities, and health care employers. The market is supported primarily by fully insured small- and mid-sized businesses. Respondents emphasized that the health care sector itself is a key economic lynchpin for the region, with many residents employed by one of the three health systems.

Respondents describe local employers as generally conservative in their approach to health plan purchasing, with little appetite for reducing employee choice of doctors or hospitals. While there were some efforts to shift towards managed care in the 1990s, employer plans today predominantly offer generous out-of-network benefits and broad choice through preferred provider organization (PPO) products.

Employer purchasers further noted little differentiation among insurers in network design, with many respondents noting that employers would simply not accept a plan that excluded any of Syracuse's three

hospital systems. This proved true in practice for at least one employer respondent that tried to create a limited network product but abandoned the idea after receiving negative feedback from employees. That employer now uses Excellus as a TPA in large part due to Excellus' ability to guarantee discounts with local providers and offer a national provider network through Blue Cross Blue Shield.

While respondents noted concerns about high health care costs, they emphasized that Syracuse is a low-cost area relative to other regions in New York and nationwide. Perhaps as a result, employers have not pushed back aggressively against annual rate increases. As one respondent put it, “we don't have employers showing up to meetings with pitchforks.” Nor have employers been catalysts for alternative, risk-based payment models designed to reduce cost growth. Instead, the primary employer strategy for managing costs to date seems to have been to increase employee cost-sharing, largely through higher deductibles. Some experts estimate that high-deductible health plans have grown to 30 percent of the commercial market. Additional examples of innovation in the employer market, reportedly prompted by Excellus, include telemedicine services, tobacco cessation programs, and real-time data analytics.

Findings

The Syracuse market lags the rest of the country with respect to a number of health industry trends. Although the provider market went through a recent wave of consolidation in 2011, observers believe additional consolidation is inevitable given the relatively small population and declining utilization. As one respondent put it, “Syracuse is just way behind in a lot of areas.”

Narrow or tiered provider networks, high-deductible health plans, and alternative payment models that shift risk to providers have been relatively slow to take off in Syracuse compared to other major health care markets. This appears to be driven by both employer preference for broad networks (resulting in sustained demand for PPO products) and the different clinical niches of each health system (resulting in all three systems being considered a “must have” in-network provider).

Syracuse is also a relatively small market and the health care community is tight-knit. This has resulted in significant overlap among key players, many of whom have worked together in the past, have long-standing personal relationships, serve on boards together, or even live next door to one another. As one respondent put it, “everyone knows each other in this region and we all go to the same meetings.” Given this culture, respondents raised concerns about the degree to which the entry of large non-local providers—such as Northwell and Trinity—will disrupt the current health care ecosystem.

- **Excellus Largely Perceived as Not Leveraging Its Market Dominance**

Respondents were united in their views that Excellus is, and is likely to remain, the dominant insurer in Syracuse. However, respondents also emphasized the importance of maintaining at least some competition in the insurance market, whether through MVP Health or encouraging the entry of more national insurers like UnitedHealthcare. For instance, respondents noted at least one instance where an insurer with smaller market share was approached by one of Syracuse’s provider systems. The provider system was concerned about the lack of competition in the insurer market, particularly the employer market, and “asked how they could help.” The smaller insurer was able to negotiate a more modest cost increase than expected.

There was less unanimity regarding whether Excellus effectively uses its market share to aggressively negotiate with providers. A number of respondents thought that Excellus could do much more, given its market position. As one noted, “Excellus does have market power because it has dominance, but I’ve never seen them successfully use their dominance relative to the providers.” Another observed that Excellus, which is based in Rochester, seems to have been much more aggressive in negotiating with providers there than in Syracuse. Still another suggested that Excellus’ dominance made it less aggressive, noting that Excellus might “play harder ball with the providers” if it faced more competition from other insurers.

Respondents did not report particularly contentious or public disputes between insurers—Excellus or otherwise—and providers over reimbursement rates, although this may change over time given the entry of Trinity and Northwell into the market. Instead, it appears that Excellus exerts its influence more through “soft power” and its long-standing relationships with key market players. Some respondents noted times when Excellus weighed in informally on provider developments by, for instance, discouraging all three provider systems from developing a heart center. As one respondent put it, “Excellus isn’t saying you do heart and you do hip, but you start to see [Excellus’ influence] from not having three heart centers.”

Some respondents thought that Excellus has taken steps to innovate. Excellus has prioritized longer term contracts with providers; invested in primary care, quality improvement, and population health; secured more heavily discounted provider rates for employers relative to other insurers; and developed an accountable care organization model called the Accountable Cost and Quality Arrangement (ACQA). As St. Joe’s and Crouse acquired or partnered with various primary care and family medicine physician groups, Excellus developed a virtual clinically integrated network and pays facilities based on historical physician performance, using quality metrics such as HEDIS®. This arrangement initially started with offering payment incentives to systems that meet specific budget goals and quality metrics, with plans to shift to providers assuming some downside financial risk, within limits.

With similar ACQA arrangements in areas such as Rochester and Utica, one potential long-term Excellus goal could be to weave together these high-performing networks into a tiered product. Excellus experimented with a tiered network offering in the individual market through a product called CNY Preferred. The lowest-cost tier includes St. Joe’s and Crouse, with other Excellus network providers and non-preferred providers on higher tiers. Both St. Joe’s and Crouse reportedly reduced their reimbursement level to below the full network product level to enable the product’s development.

Given employer hesitancy to move towards narrow or tiered network products, one respondent noted that Excellus is experimenting in the individual market because it is “the least threatening and lowest risk environment.” So far, enrollment in this product has been low, but respondents believed it is being used as a “proof of concept” for a tiered network offering that may be offered to employers in the future.

Because SUNY Upstate is not a primary care facility, it is limited in its ability to participate in the ACQA model noted above. However, Excellus is reportedly experimenting with risk-based arrangements in areas such as oncology to “give SUNY an opportunity to play in the population health space but to do it specific to specialty conditions.” According to respondents, SUNY Upstate is the most expensive provider system in Syracuse. However, payers may be willing to pay higher prices due to its unique specialty areas and the medical school. As an insurer respondent noted, “we believe SUNY has an important place in the market—to have a future workforce pipeline, you need a good medical school.”

- **In Spite of Its Dominance, Excellus Faces Some Limits on Its Ability to Negotiate**

Despite its dominant market position, Excellus’ ability to dictate price and contract terms is not unfettered, and the provider systems have leverage due to the nature of the Syracuse health care market. First, the three health systems’ distinct market niches limit opportunities for narrow network products. This differentiation of services and specialties across three different provider systems (including the physician groups they have acquired) has meant that Excellus needs all three providers in its networks. As one respondent observed, “if I were an insurer and I had to pick which hospital to exclude, I don’t know how I’d do it and still have employers be accepting of it. You’d have quite a backlash.”

All three systems are considered “must have” providers for reasons that include: 1) employer demand for broad networks, 2) state regulatory requirements, such as network adequacy standards, and 3) the complexity of developing a service line-only product (where a network would not include an entire facility but would,

for instance, use Crouse for neonatal services, SUNY Upstate for pediatric care, and St. Joe’s for cardiac care). On network adequacy, one respondent noted that “a St. Joe’s-only limited network HMO product won’t provide the volume of services needed to meet [New York’s] network adequacy standards.” Another noted that “it would be too risky to have a narrow network here because it would basically invite competition into the market.” Further, respondents thought that Excellus would face negative publicity if they dropped a major system from their network: an attempt to limit network access by Excellus “would get into newspapers that they’re trying to push people out of hospitals.”

Finally, employers have not been particularly active in advocating for lower-cost products and continue to demand broad, fully-inclusive provider networks. Although there is interest from employers in these models, respondents felt that employees would not accept coverage limitations. At least one employer respondent noted that their coverage had become more, not less, generous over time. That employer broadened its national network, eliminated its deductible, and moved from a coinsurance model to a copay model. Relative to other markets, there do not appear to be as many large businesses with market clout who are invested in pushing for change or more aggressive negotiations.

- **Recent Consolidation Has Not Had an Impact—Yet**

Most respondents expect some change as a result of the recent acquisitions and partnerships in the Syracuse market, but these effects have not yet been felt. As of now, respondents observed that the provider systems remain pretty competitive and have not engaged in price gouging.

This could, however, change. Excellus appears to have spent much time and attention on achieving an appropriate balance with Syracuse’s health care systems. As one respondent put it, “Excellus has played a major role here and has been good at maintaining balance and not advantaging hospitals.” Respondents noted that this balance could be—but has not yet been—upset by the recent entry of Trinity and Northwell into the Syracuse market.

To date, St. Joe's merger with Trinity and Crouse's affiliation with Northwell have primarily enabled shared services and back office support—and in St. Joe's case, the acquisition of their debt—rather than increased purchasing power. However, respondents widely expect this to change. Trinity and Northwell are believed to be using their acquisition and partnerships as a way to get a foot in the door to upstate New York, beginning with the Syracuse area. As one respondent put it, “Trinity's idea for St. Joe's is for it to be a hub in New York and then affiliate around it, and Northwell has the same expectation of Crouse.”

Respondents raised concerns that larger national or non-local providers like Trinity and Northwell may not share the same priorities as local leaders. One insurer noted that their current models “are based on a mutually trusting partnership agreement” whereas Trinity may prefer a relationship based more on “leverage of who can get a better deal as opposed to working in a partnership together.” Trinity is reportedly interested in increasing its market share through product innovation, such as a narrow network product designed around St. Joe's. Crouse is similarly approaching employers about a narrow network product focused on its clinically integrated network. Some respondents thought employers would not be interested in such products and thus take-up would be quite low. Others thought that such these products could yield significant savings, which would make such a product attractive to employers while also incentivizing high-quality care.

There is precedent for respondents' concerns. SUNY Upstate was reportedly aggressive after its 2011 merger with Community General in increasing prices and refusing, for instance, to phase in cost increases over time. As one insurer respondent noted, “my most expensive hospital took over my cheapest hospital so the pricing of my cheapest hospital is now the same as my most expensive hospital.” Trinity has reportedly been aggressive in other markets where they have acquired local hospitals, such as St. Peter's Hospital in Schenectady, where “Trinity tried to jack up the prices at St. Peter's and rates were much higher.”

If prices do rise, insurers are expected to push back but recognize some of their limitations. One insurer respondent expected the company to approach

negotiations the same way they always had: “we do our homework knowing what we've paid and what our budget is, and we try to find out what they're focusing on.” For example, noting falling inpatient utilization, insurers suggested a willingness to concede to higher inpatient rates in order to preserve reasonable outpatient rates.

Overall, respondents were mixed on whether Trinity or Northwell should be viewed as a bigger threat in upsetting the balance of power in Syracuse. Trinity has not yet begun aggressively negotiating alongside leaders at St. Joe's, but respondents expect this to happen eventually. As an insurer respondent put it, “we're preparing for St. Joe's to be much more aggressive since they have the backing of Trinity.” Others thought that Northwell's partnership with Crouse could be more significant—described as “the one to keep our eye on”—because of Northwell's history of “keeping things in network to the extent they can.”

Expectations for the Future

Respondents shared a wide range of views on how the Syracuse market is likely to evolve. Further consolidation among providers is expected. Northwell may formally acquire Crouse, and it is worth watching for additional formal partnerships or mergers between Syracuse-based providers and smaller, more rural hospitals in contiguous counties.

Additionally, representatives from Trinity are expected to become more active participants at the negotiating table with Syracuse insurers, including asking for higher reimbursement than St. Joe's has to date. Trinity's increased engagement could significantly change the dynamics among what have long been local conversations among local stakeholders.

Additionally, observers believe there is the potential to see more product experimentation that uses tiered provider networks and higher deductibles. Although Excellus has used this type of product design in its individual market offerings, it remains to be seen whether employers will be willing to purchase a product with a more limited network. If there is no market for this type of product, respondents believe that this will lead payers to continue to focus on population health, primary care models, and more value-based and risk-sharing payment arrangements.

Case Study Analysis: The Northern Virginia Health Care Market

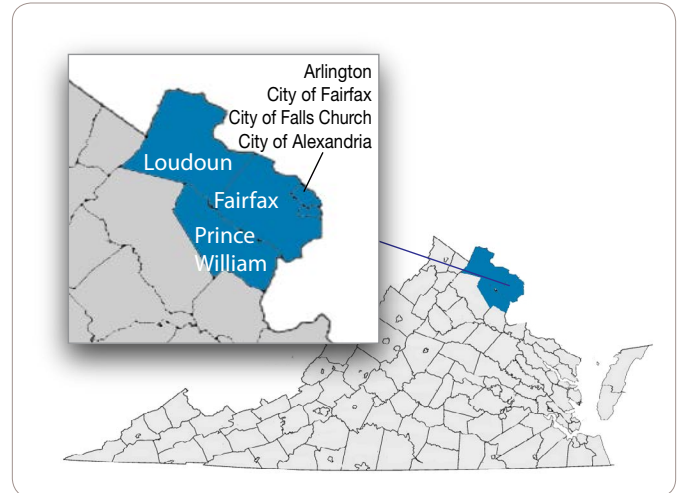
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Background, History, and Methodology

The Northern Virginia (NoVa) region is defined in this study to include the inner Washington suburbs of Arlington and Fairfax Counties; the independent cities of Fairfax, Alexandria, and Falls Church; and the outlying suburbs of Prince William and Loudoun Counties. The NoVa region, with a population of nearly 2.5 million, lies across the Potomac River from health care facilities in Maryland and the District of Columbia, but most respondents told us that relatively few consumers—maybe only 10 percent—cross the river for health care.

The core NoVa region has six health systems: Inova Health system (Inova); Kaiser Permanente (Kaiser); the for-profit HCA Virginia Medical System (HCA) owned by a large corporation headquartered in Tennessee;²⁹ the independent Virginia Hospital Center (VHC); Novant Health, a nonprofit health system headquartered in North Carolina; and Sentara, a nonprofit system based in Norfolk. Kaiser operates without its own hospital (although it operates several large ambulatory care centers in NoVa), and contracts with VHC for hospital services. VHC is in Arlington County; Inova's hospitals are in Fairfax City, Falls Church, Alexandria, and Loudoun County; and HCA has two hospitals, one about 20 minutes from central Arlington in Reston, and one in Loudoun County. The Novant and Sentara hospitals are in Prince William County.

Unlike hospitals in markets such as Syracuse, the hospitals in NoVa do not appear to compete against one another based on specific service lines such as cardiology, oncology, or OB/GYN. In addition, traffic patterns—and the notoriously congested roads—in the region mean that the hospitals can maintain relatively distinct geographic fiefdoms. For example, many people who live near VHC typically do not travel to other jurisdictions for care. Similarly, many opt to obtain services at Inova and HCA facilities primarily for reasons of proximity.



As a suburb of the nation's capital, Northern Virginia is an affluent area, home to numerous federal agencies and contractors, and headquarters of large companies like Verizon and Capital One. This affluence and high proportion of commercially insured residents has contributed to both high health care prices and the growth of medical systems.

Northern Virginia has a long history of health system consolidation and acquisition. What started as a region with several independent community hospitals in the 1960s and 1970s developed during the early 2000s into the dominant Inova Health System, which acquired over three decades the former Commonwealth Hospital, Fairfax County Hospital, Mount Vernon Hospital, Reston Hospital, Fair Oaks Hospital, Jefferson Memorial Hospital, Alexandria Hospital, and Loudoun Hospital Center.³⁰ In Inova's last and most recent attempt to acquire hospitals in Northern Virginia in 2008, the Federal Trade Commission (FTC) stepped in with an Administrative Complaint, which quickly ended the merger negotiations between Inova and the former Prince William Health System.^{31, 32}

Shortly after the Inova-Prince William Hospital merger came to a halt, Novant Health, which is now in a partnership with the University of Virginia Health System, moved into Northern Virginia by acquiring Prince William Hospital.³³ Novant Health also opened another hospital, Novant Health UVA Health System Haymarket Medical Center, in 2014.³⁴ Sentara acquired the former Potomac Hospital in Prince William County in 2012.³⁵

On the insurer side, there are carriers with significant market power, but not without competition. The Blues dominate NoVa, with CareFirst BlueCross BlueShield (CareFirst) and Anthem BlueCross BlueShield (Anthem) having the largest market share in the employer market. CareFirst and Anthem share the BlueCross BlueShield (BCBS) brand, but they split the NoVa market into two separate service areas, separated by a state highway. CareFirst serves the east side of the highway with the larger population in the close-in suburbs; Anthem serves the west, including Loudoun and Prince William Counties. Other insurers in the market include UnitedHealthcare, Aetna, Kaiser Permanente, and Cigna. However, all run a distant second in market share to the BCBS carriers in the region.

NoVa is home to two provider-payer partnerships: Kaiser Permanente and Innovation Health. Kaiser Permanente, which used to contract exclusively with Inova, ended their contract in 2013 and moved to VHC where they continue to contract today. In 2012, Inova entered into a joint venture with Aetna to create Innovation Health. Innovation Health contracts with all hospitals in the area, but it splits financial management of the company in half between Inova and Aetna.

To assess the varying ways in which insurers respond to provider consolidation, we conducted an environmental scan, a literature review, and interviews with ten national experts and regulators. Additionally, we interviewed thirteen NoVa-area providers, insurers, large employer purchasers, and expert observers. NoVa-based interviews occurred between June 29, 2018 and October 1, 2018.

Descriptive Analysis: Three Market Sectors

1. Hospitals and Physicians

Northern Virginia's hospital market has become increasingly consolidated over time, with respondents

describing the region's provider market as "super concentrated" and stating that "[the region] could not get much more concentrated." Currently, Inova dominates the region with five hospitals. Competition is limited to the region's only independent hospital, VHC, and the hospitals operated by HCA, Novant, and Sentara. In theory, the hospitals in the District of Columbia (D.C.) could be a source of competition for northern Virginia's hospitals, but in practice few patients receive care in D.C. "There's just not a significant amount of folks willing to cross the river (jokingly referred to as the 'Potomac Ocean') for a hospitalization," said one executive.

More recently, moves to acquire and merge hospitals within Northern Virginia have slowed. But respondents noted that more hospitals are opening or acquiring medical centers, ambulatory surgery centers, and urgent care centers across the region as a way to protect their market share. Another respondent noted that growth strategies now go beyond the purchasing of hospital beds: "It has to involve all of the other emerging and more dynamic aspects of health delivery, and that can be physicians and physician practices . . . [and] new nonhospital facilities."

Notably, the recent local acquisitions by out-of-region hospital systems like HCA, Sentara, and Novant have attracted notice, with one observer describing deep-pocketed health systems "elbowing their way into the region." However, other respondents suggested these outside hospital systems have yet to have any significant impact on the market and have mostly focused on the region's outlying communities. Another respondent described the outside health systems as "worthy competitors that [are] still relatively small and contained."

Although NoVa is seen to have fewer hospital-based physicians and more competition among physicians than among hospitals, the ambulatory sector also has seen consolidation. The Privia Medical Group, a private equity-backed company that entered the NoVa market in 2014, has been signing up numerous medical groups across the region (an estimated 725 northern Virginia physicians and advance practice practitioners are currently part of Privia).³⁶ The company is growing by offering group practices a mix of improved reimbursement and back-office support for alternative payment models and quality improvement.

Inova has been less aggressive in its efforts to acquire physician practices than may be typical of dominant health systems in other markets, but observers noted that their acquisition of physician practices has waxed and waned over time. By one estimate, Inova employs less than 10 percent of the region's physicians—although it affiliates with others through a clinical integration network. Privia also has been fiercely competing with Inova for the hearts and minds of area doctors.

While views were mixed on the extent of consolidation among local primary care practices, respondents generally agreed that specialty physicians have resisted acquisition and mergers. According to one provider respondent, these physicians value their independence and often stay in small groups. “We see onsie, twosie groups,” he said. “They don't want to be employed by health systems.” The area also has relatively few large multispecialty practices.

In addition, observers estimated that NoVa (and the broader Washington community) has a significant number of independent concierge practices, many of which don't participate in plan networks and require patients to pay a membership fee in exchange for improved service. Although concierge practices are numerous, respondents noted that their small patient panels prevent them from becoming a major factor influencing the market.

2. Insurers

Respondents had varied perspectives on the concentration of the payer market in NoVa. Some described it as more competitive and “a little more diffuse than on the provider side,” while one provider representative called it “super concentrated.” Observers agreed that CareFirst and Anthem hold the largest market share by far.

Cigna, UnitedHealthcare, Kaiser Permanente, and Aetna—which also jointly owns Innovation Health—divide up the remaining share of the large and small employer market. Cigna and Kaiser both compete with more success in the individual market, from which Anthem has mostly stayed away and where CareFirst charges relatively high premiums.

It does not appear that the Inova-Aetna joint venture Innovation Health has had a significant impact on the payer market. Six years after its launch, the company has a relatively small market share. Innovation was initially a player in the ACA's individual marketplace but did not participate in 2018; it continues to be active in the small group market. Observers noted that Kaiser too has struggled to establish a strong presence in the NoVa market, but they are opening new ambulatory care centers and seeking to grow their enrollment.

3. Employers

Although the federal government is the largest employer in the region, payers and other stakeholders report that it takes a hands-off approach to delivery system and payment reform efforts, leaving network design and reimbursement policies to the insurers that offer its health plans. Similarly, city government workforces in the region are heavily unionized, which can make it more challenging for employers to pursue cost containment efforts through the employee health plan. A major area university is part of the state university system and yields the lead in negotiating benefits to the state.

At the same time, while numerous large, multi-national companies have bases in the area, most lack enough covered lives to command the kind of market clout it would take to shift provider or insurer behavior. “We have major corporations here,” said one observer, “but [they don't cover] enough lives to dictate or influence the market in any way.” Another believes that the brokers and benefit consultants that largely drive purchasing decisions for local employers have been slow to embrace new models of care delivery or network design.

Employers interviewed for this study further observed that their employees are increasingly living in suburbs further away from D.C., largely due to increased housing costs in communities close to the city. As a result, in purchasing health benefits for their employees, employers must prioritize broad network access across the region.

Findings

Broadly speaking, respondents offered a sense that health sector stakeholders in the Northern Virginia market are complacent. Inova grew substantially and became the region's dominant health system by both opening new facilities and acquiring independent hospitals through the early 2000s. But the FTC complaint filed against its acquisition of Prince William Hospital led Inova to drop its proposed acquisition and appears to have moderated Inova's expansion. Virginia's strict enforcement of certificate of need (CON) requirements further serves as a deterrent to building new hospitals. Inova continues to grow through building and the acquisition of free-standing emergency departments, rehabilitation facilities, and physician practices. In the words of one observer, "The FTC came in and said no, you're tapped out." In slowing Inova's growth, it enabled the NoVA market to reach something of an equilibrium with one dominant player that, at least to date, has not exercised its clout enough to make anyone make dramatically different purchasing or network design decisions.

- ### Provider Concentration and the Exercise of Market Power

Inova remains the lynchpin of this market, the "must have" hospital system for all the payers except for Kaiser: "You can't build a network without Inova," said one payer. Multiple respondents characterized Inova's prices as "quite high" relative to other hospital systems in the region, suggesting the system uses its market clout to maintain generous reimbursement.

Although hospital prices are high relative to neighboring regions, several respondents noted that Inova has been relatively restrained in its price negotiations with payers. One insurer respondent speculated that Inova "does not want to jeopardize their position, so they have a tendency to . . . play in the sandbox" better than dominant provider systems in other markets. The idea, according to observers in the market, is that Inova is "cognizant of its market leverage" and seeks to be fair in its dealing with payers to avoid raising red flags with federal regulators.

Several years ago, when Inova's proposed acquisition of Prince William Hospital was being negotiated, the government presumption was that Inova has

the highest prices and the merger would push the Prince William hospital's price higher. But the reality, according to a local expert, "which . . . was stunning to everybody, [was that] the Prince William contracts were far superior to Inova's." One explanation was that Prince William had such a small market share that costs from this hospital amounted to a rounding error for payers. But Prince William also leveraged its position as an alternative to Inova by saying, in effect: "If you want us to rush into the hands of Inova, give us a really rotten rate deal so we can't survive . . . [But if] you think it's healthy to have independent health systems in this market, then give us [higher prices]."

Although the dominant payers in the region (CareFirst and Anthem) arguably have similar market clout to Inova, respondents suggested that the only real threat these payers can use in a contract negotiation is exclusion from the network—something akin to going to war with only a "nuclear option" in your armory. Respondents further noted that rules for the federal employees benefit plan require notification of the public when there is a threat of termination, resulting in public and customer relations troubles that both parties want to avoid.

Kaiser is the only major payer in the region to succeed in cutting ties with Inova, which respondents suggested was less about prices and more about their clinical partnership. Kaiser now has an exclusive arrangement with VHC (although it covers some patients at Inova facilities when VHC is unable to meet a specific clinical need). Respondents report that the Kaiser-VHC arrangement is operating well. However, one observer questioned whether VHC would continue to have sufficient inpatient hospital capacity if Kaiser succeeds in its efforts to expand membership in NoVa.

The region's other hospitals have their own forms of leverage. Sentara, Novant, and HCA each has a small presence in NoVa and their hospitals are in the outlying suburbs. But these systems use the fact that they have a higher share of the hospital market in other parts of Virginia to demand inclusion in payers' NoVa networks at high reimbursement rates. At the same time, VHC, the region's only independent hospital, has unique leverage due to its reputation for quality and location

in densely populated and well-to-do Arlington County. Traffic and other factors make VHC something of a must-have facility within the region. Inova, without a nearby facility to VHC, appears to focus on other parts of the region and thus does not take away enough business to hurt VHC's viability.

When Inova joined with Aetna to create Innovation Health, some thought this might be a step by Aetna to push back against a concentrated provider market—effectively a strategy of “if you can't beat then join them.” Five years later, Innovation might be called a success because it remains a player in the market, but one respondent argued, “I don't think it drove much of anything [with respect to competition]. [Other players] probably didn't like it very much . . . , but I wouldn't call it disruptive.” One limitation is that Innovation is not able to compete for business with employers that operate statewide because its plans are only offered in NoVa. Also, because Aetna maintained a separate presence in the market, both companies have had to engage in significant education of brokers and benefit consultants about their different products and services.

- **Impact on Cost Containment Efforts**

Neither employer purchasers nor payers in northern Virginia appear to be pursuing aggressive cost containment efforts. One of the most obvious cost containment strategies—reducing the size of the provider network—is largely written off as infeasible. Narrow networks are “a [human resources] nightmare . . . a last resort,” according to one large employer. Multiple stakeholders noted that the northern Virginia workforce is largely white collar and affluent, with employees who expect to be able to “go where they want to go,” without limits on their access to hospitals or specialists. The exception has been in the ACA marketplace where consumers have been more receptive to limited networks. But even there an effort by Cigna to offer a product for 2018 that excluded Inova encountered bad publicity; by April 2018, Cigna had added Inova as an in-network provider.

Payers in this market similarly observed that their employer customers are generally unwilling to face employee pushback over a narrow network in exchange for a few percentage points in cost savings.

To the extent the benefits of a narrow network are derived largely from selective discounts from providers (as opposed to re-engineering within a coordinated system), the price difference is just not big enough, several stakeholders observed. “I call it the ‘what if’ factor,” said one insurance executive. “What if I need to go see this doctor? What if I need to go to the hospital? Even if you have a product 5 to 6 percent cheaper in the market, it doesn't overcome the ‘what if’ factor.”

Payers and purchasers further acknowledged that Inova's reach across the region and market clout made excluding them from plan networks or pushing patients to use other facilities through tiering strategies impractical. Arlington's Virginia Hospital Center lacks capacity to take in a significant portion of Inova's patient population, and several informants emphasized northern Virginia's heavy traffic as a significant impediment to patients' ability to use more far-flung providers.

The payers we interviewed employ a range of alternative payment models to try to generate cost savings, although to date these are primarily physician-focused. Accountable Care Organization-type (ACO) models are popular among some employers, with one saying they view “ACOs as a ‘soft launch’ of a narrow network,” because employees “wouldn't know it was happening.” However, while the ACO models currently in place in northern Virginia provide financial incentives for primary care physicians to steer patients towards lower-cost specialists, facilities, and pharmaceuticals, payers have been slower to expose physicians to downside financial risk, preferring to gradually increase the practices' risk exposure over multiple years. “ACOs and [primary care medical homes] are still kind of in the pilot phase” in this market, said one observer.

Hospitals have largely not embraced ACOs, and their participation in payers' value-based payment models is mixed. As one hospital executive said, “we did a lot of things to look like an ACO without joining one.” Payers acknowledged that their ability to demand participation in these programs varies based on the hospital system's market clout. “It's different with hospitals,” one payer said. “They might say the right things

about value-based care . . . but they've got a bottom line they have to meet." A provider representative essentially confirmed this view, stating that the risk-sharing agreements they had seen to date "don't have favorable terms—there's no economic incentive" for us.

Several stakeholders told us that a primary strategy to lower costs is to encourage the delivery of services outside the hospital setting. One payer told us that shifting the site of care is "absolutely" one of their cost containment strategies, noting that doing so often had the added advantage of improving patient experience and outcomes. For example, a payer representative noted that encouraging surgeries in ambulatory settings and offering 24-hour clinical support has "probably cut our [emergency room] usage about two-thirds." At the same time, providers and payers alike admit that "old referral patterns" are hard to break, making it often difficult to steer patients to the lowest-cost specialists and facilities. "I don't think [payers] are prepared yet to use a stick, and I don't think the carrots are large enough to generate much change in referral patterns," said one executive. Additionally, hospitals in the region, recognizing the push to move care outside their walls, have been acquiring physician practices, ambulatory care centers, and other non-hospital facilities to re-capture that revenue.

While employers in the region have been reluctant to embrace narrow network products, they have been willing to shift employees into higher cost-sharing plans to lower overall costs. For example, the employer stakeholders interviewed for this study have recently introduced higher deductible plans or raised deductibles on existing plans. One employer observed that just having a deductible at all has been a significant "culture shift" for its employees, and that other, more aggressive cost-saving strategies will take time. Another employer respondent mentioned interest in exploring "reference-based pricing," in which the enrollee pays a higher price to use a higher-cost provider but recognized that it could take a few years to develop such a program and acculturate employees to it. "To figure out what someone might pay, and deal with [potential] balance billing, it would be a struggle," she said.

Is There Potential for More Competition in the Future?

Many respondents made note of the relatively recent presence of health systems competitors including HCA, Sentara, and Novant. Although their presence in Northern Virginia is modest today, these companies are well-financed regional or national systems. As a result, some suggested that an expanded role for these companies in the future might disrupt the equilibrium that exists in the market today.

Inova seems to be pushing back against this possibility. For example, Inova recently introduced a freestanding emergency department near a hospital competitor in Loudoun County. According to an observer, if a patient needed more care, "they would get a free ambulance ride over to Inova Loudoun hospital. They were really trying to seriously protect that market share they so enjoy."

Another factor that limits future expansion for some of the newer systems in the market is Virginia's CON requirement that requires the state to review and approve the entry of new hospital facilities. According to one observer, "growth is somewhat limited by the intervention of government, and so, what is there and what can be expanded is part of a planning process in VA."

Some payers believe that relaxing CON requirements could offer one pathway to containing the market's health costs. But providers contend that a push to deregulate would lead to "a gold rush of new entrants, and utilization will go up like crazy." In that view, higher utilization—especially through facilities like freestanding emergency departments—will mean higher costs.

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About Georgetown University - Center on Health Insurance Reforms

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