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Case Study Analysis: The Indianapolis Health Care Market

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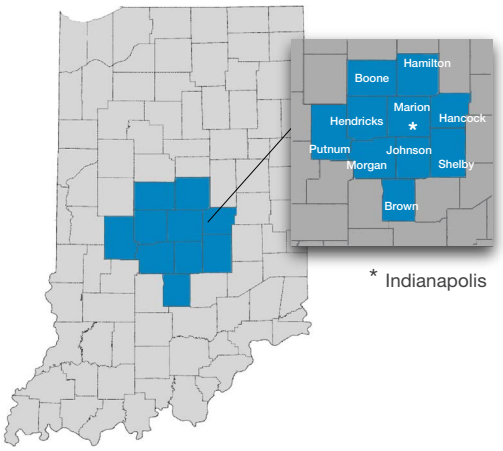
Rising health care prices have increased concerns about hospital and health system consolidation among policymakers, regulators, employers, and other purchasers of health coverage. Although merging hospitals and health systems claim they can achieve greater efficiencies through their consolidation, the economic literature almost universally finds that hospitals that merge have prices above those of surrounding hospitals.[1] And increases in hospital prices have been a key factor driving the growth of commercial health insurance costs over the past decade.[2]

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.[3] Further, the increased negotiating clout of a concentrated provider sector influences payers' ability to maximize value-improving practices, such as alternative payment models, quality improvement, and transparency efforts.

In a series of six market-level, qualitative case studies, we assess the impact of recent provider consolidations, 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 case study focuses on the Indianapolis, Indiana health care market. For findings from the other studied health care markets (Detroit, Syracuse, Northern Virginia, Asheville, and Colorado Springs), visit https://chir.georgetown.edu/projects-pubs/coverage-affordability/.



Background, History, and Methodology

This study defines the Indianapolis, Indiana region to include Marion County in the center of Indiana as well as nine surrounding suburban counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Morgan, Putnam and Shelby.

Indianapolis has four major health systems with flagship centers in downtown Indianapolis: Indianapolis University Health (IU Health), Ascension's St. Vincent Health (St. Vincent), Community Health Network (Community), and Franciscan Alliance's Franciscan Health (Franciscan). Indianapolis is also home to a safety net hospital, the Sidney and Lois Eskenazi Hospital, as well as a children's hospital.

The four major hospital systems in Indianapolis offer a full array of inpatient services and do not appear to have carved out clinical niches such as cardiology or orthopedics, as was documented in our Syracuse, New York, case study.[4] Historically, the hospital systems divided the city into four informal geographic quadrants. IU Health predominantly operated in the central and western part of the city, St. Vincent in the northern part, Community in the south, and Franciscan in the southeast. However, in recent years these health systems have expanded beyond the city limits, acquiring physician

groups, building facilities in the surrounding suburbs, and acquiring other independent hospitals around the state.

Until 1995, Indiana had a Certificate of Need (CON) law, which required state regulatory review of any new hospital construction. That law's repeal paved the way for extensive building of new facilities by health systems throughout the region, particularly in the affluent suburbs to the north of Indianapolis.[5] Between 2000 and 2011, the region experienced a 17 percent increase in staffed inpatient beds.[6]

Indianapolis physicians tend to be employed by the four major hospital systems, with few truly independent specialty practices remaining. In 2017, UnitedHealth Group acquired one of Indiana's last remaining independent physician practices, American Health Network, for $185 million. The group has become part of United's OptumCare division, which has over 20,000 physicians operating in 13 states.[7]

On the insurer side, the statewide Anthem BlueCross BlueShield (Anthem) plan has the greatest commercial market share, with UnitedHealth Group a distant second. IU Health Plans also offers commercial market plans. The Indianapolis insurance market has become steadily less competitive over time, witnessing departures by local and national insurers alike, including M Plan, MDwise, ADVANTAGE Health Solutions, Principal, and Humana.[8]

Anthem is not only the largest insurer in Indianapolis, but its headquarters in the city makes it one of the largest employers. Indianapolis is home to other large employers, most of which have self-funded health benefit plans, such as Eli Lilly and Company, CNO Financial Group, and Simon Property Group. Indiana employers jumped into the high deductible health plan (HDHP) trend earlier and more aggressively than employers in other markets; as a result, Indiana employees have higher deductibles than the national average.[9]

The high cost of health care in Indianapolis and Indiana more generally has been well documented. In 2016, the RAND Corporation was commissioned by the Employers' Forum of Indiana to study hospital prices in an ongoing transparency initiative.[10] The RAND study has called attention to the high commercial prices charged by Indiana's hospitals, with the major Indianapolis health systems charging three to five times Medicare rates.

Another recent study found that each of the four major nonprofit hospital systems in Indiana had overall profit margins of at least 10 percent with Franciscan showing the highest, a 20 percent margin.[11] This is much higher than in other markets such as Chicago and New York, where total profit margins are -0.8 percent and -1.2 percent, respectively.

Indiana's residents also tend to be less healthy than those in other states. Indeed, the percentage of residents in "fair" or "poor" health, once in line with the national average, has increased 2.5 percentage points to 20.6 percent since 2013 while the US average has remained relatively steady around 18 percent.[12] While health status is a factor in the state's high health care spending, evidence suggests that the primary driver of costs is provider prices.[13]

To assess the varying ways in which insurers have responded to provider consolidation and market power in Indianapolis, we conducted an environmental scan, a literature review, and interviews with ten national experts and regulators. Additionally, we interviewed thirteen Indianapolis-area providers, insurers, large employer purchasers, and expert observers. Indianapolis-based interviews occurred between November 15, 2018 and January 18, 2019.

Descriptive Analysis: Three Market Sectors

1. Hospitals, Health Systems, and Physicians

With its four major health systems, one might expect Indianapolis to have a competitive provider market. Yet respondents reported the opposite: that Indianapolis faces increasing vertical and horizontal consolidation. Historically, each of the four health systems—St. Vincent, IU Health, Franciscan, and Community—carved out geographic "mini-monopolies" within boundaries that were respected by the other health systems. This meant that the health systems often did not compete in a given region of the metro area.

This trend abated about 10 years ago as health systems went on a building boom and rapidly acquired physician practices and additional hospitals across the state. The new construction has included the proliferation of micro-hospitals, stand-alone emergency rooms (ERs), and new

specialty facilities (such as cardiac hospitals), in addition to full service hospitals. Some respondents acknowledged that such facilities in theory would be welcome innovations if they served as lower-cost options, but that many charge higher ER rates for outpatient services or the same prices as larger hospital facilities, meaning there are no cost savings.

Many, though not all, observers attributed the building boom in part to the repeal of Indiana's CON law in 1995. This allowed health systems to build new facilities essentially unfettered. Construction was prioritized in wealthier suburbs where there is already hospital capacity, such as Hamilton County, with little improved access in more rural or underserved areas. As one observer noted, "they built capacity where there [are] private insurance dollars." Another noted that micro-hospitals are being built "essentially across the street from a competitor" as part of a war over branding rather than cost or quality.

Indianapolis has also experienced considerable vertical integration: respondents estimate that about 80 percent of physicians, whether primary care physicians or specialists, are employed by the health systems. The remaining independent practices serve multiple health systems, primarily in urology, orthopedics, and gastroenterology.

Respondents point to "aggressive" competition between the health systems to acquire physician practices before a competing system could do so. They cited multiple reasons for vertical consolidation, many of which predated, but were exacerbated by, the Affordable Care Act's provisions encouraging delivery and payment system reforms. These reasons include the desire for a more integrated system, unchanging (or low, according to one provider) physician reimbursement rates, new burdens on independent physicians (such as electronic health records), and the proliferation of value-based reimbursement models that further advantaged integrated models of care delivery.

There has been statewide horizontal integration in Indiana as well. Through the acquisition of hospitals in other parts of the state, three of the four health systems have developed a statewide footprint that extends beyond the Indianapolis region. These statewide networks are often used as a point of leverage in negotiations with insurers to secure "all-or-nothing" contractual provisions that require inclusion of all the system's facilities in a network.

2. Insurers

Anthem, which has its headquarters in Indianapolis, is dominant in the commercial employer market, with UnitedHealthcare a distant second. The two compete primarily for large business accounts and to serve as TPAs for large, self-funded employers. Together, Anthem and UnitedHealthcare "probably account for 90 percent of our market," observed one expert.

Efforts by smaller players to enter the insurer market have generally been unsuccessful. ADVANTAGE Health Solutions, which was owned by St. Vincent and St. Francis, dissolved in 2016 after garnering about five percent of the commercial market. Respondents generally attributed this failure to inadequate pricing and inaccurate underwriting models. In 2011, IU Health launched a narrow network product that has not been very successful at penetrating the commercial market. Respondents noted that Anthem and UnitedHealthcare are strong competitors, and Anthem has been successful at minimizing the impact of, if not discouraging, other health systems from offering insurance products.

To date, Anthem's primary competitive strategy has been to secure discounts on provider prices. This was aided by the use of "most favored nation" clauses, which prevented providers charging competing insurers lower rates than Anthem. Although the legislature banned these clauses in 2007, Anthem continues to have a competitive edge in securing provider discounts. Some respondents criticized the discount-based approach to network contracting, asserting that it incentivizes Anthem to allow health care costs to increase so long as it is able to negotiate a large percentage discount. As one observer noted, "if your currency is discounts, you prefer higher prices."

3. Employer Purchasers

Indianapolis employers predominantly offer products with broad network access, and there is reportedly little appetite for reducing employee choice of doctors or hospitals. Respondents believe this commitment to broad networks is driven by concern about employee reactions to any limits and "a historical reluctance to limit choice."

The predominance of self-funded plans among Indianapolis employers means that employers carry the risk of rising health care costs. Unwilling to reduce network choice, employers have turned to other tools

to help hold down health spending. These tools include the widespread use of HDHPs, wellness and disease management programs, on-site primary care clinics, and telemedicine. These "demand-side" strategies reportedly have helped Indiana employers keep costs down while maintaining broad network access and promoting consumer engagement.

Despite these tools, respondents reported that many employers find the status quo to be unsustainable as costs continue to rise. As one observer put it, "you clearly want better solutions than transferring costs to your membership or employees." Another noted that "in the longer term, [HDHPs have] done nothing to bend the trend curve" in part because health care prices are so high.

Findings

Hospital Consolidation, Building Spree Have Driven Up Utilization and Prices

Observers of the Indianapolis health care market pointed to two main factors driving up costs: horizontal and vertical consolidation among the four main hospital systems and a recent building spree in the more affluent Indianapolis suburbs. The systems' acquisitions of other Indiana hospitals outside the metropolitan region were strategic, with one observer noting that "communities where there was a [hospital] monopoly" were targeted and then used to negotiate "tying contracts" with payers, meaning that payers wishing to contract with the "must have" hospital in one community were required to include all the hospitals in the system in their networks. There's no "value competition" in the Indianapolis market, said one employer representative, because the four hospital systems have achieved a "pretty broad" reach.

Hospitals' acquisition of physician groups has also driven up costs, but not entirely due to higher prices. Respondents report that although hospital systems tried to demand higher reimbursement for physician services, payers were largely able to keep their fee schedules the same. But hospitals' purchase of other service providers, such as labs and imaging centers, has led to price inflation. When a hospital acquires a sleep lab, for example, one stakeholder found "you're immediately [paying] the hospital's negotiated rate, which is typically higher than . . . when it was the independent provider."

Additionally, costs have increased because acquired physicians now refer patients within their health system rather than to the lowest-cost provider. Thus, instead of referring a patient to a lower-cost free-standing MRI facility, hospital-employed physicians refer the patient within the hospital system, even if the MRI costs 40 percent more.

The hospital systems have also used "facility fees," where payers are charged an extra fee for services delivered in a hospital-owned clinic, to generate more revenue. As one observer put it, hospitals saw "there was a lot of money to be made [having] physicians under the hospital's roof." Others noted that insurers initially fought these facility fees, but "didn't have anything to push back with," and eventually capitulated.

The hospitals' building boom in the Indianapolis suburbs has also, somewhat counterintuitively, pushed prices up. "Competition was supposed to keep prices down and that's not what's happening," said one large local employer. Others noted that the construction first led to an increase in utilization, thanks to an "overcapacity of beds" and hospitals' aggressive marketing efforts. The spike in utilization has leveled off in recent years but has led the hospitals to hike their unit prices "dramatically," according to one purchaser.

Experts further explained that existing hospitals that faced new competition often raised prices for the commercially insured to make up for the loss of inpatient revenue. With more competition, existing hospitals had fewer patients but the same overhead costs, leading hospitals to increase their prices in order to remain financially viable. "[The hospitals] compete on brand and buildings, not on quality and cost," critiqued a local physician.

Payers Have Lacked Incentives, Tools Push Back

Although Anthem, as the dominant payer in the market, should in theory be able to counter providers' demands for high reimbursement, they have not successfully done so. Several respondents attributed this to the demand among Indiana's employers for broad, open-access provider networks, leaving Anthem with little ability to drop a hospital system from its plans or even to establish a tiered network arrangement.

Instead, Anthem's business strategy has been to pursue the largest percentage discounts in the market, rather than attempt to lower providers' base prices. Hospitals, in turn, would agree to give Anthem a bigger discount, but increase their list prices. The fact that Anthem and other payers agreed to these price hikes some observers attributed to "middleman economics." In a market like Indianapolis, where a large portion of employers have self-funded plans, payers receive a percentage of overall medical spend to administer the plans, through "administrative services only" or ASO contracts. Higher list prices mean higher administrator fees, which can help boost payers' bottom lines. "I don't really think it's in [payers'] interests to hold down prices," said one observer, "they make more money when prices . . . steadily grow."

Additionally, payers, rather than taking advantage of increased hospital competition in the outlying suburbs by demanding price concessions, have instead agreed to price increases by those facilities. Hospitals have demanded—and received—hospital-level reimbursement for services delivered at new micro hospitals, labs, and other facilities.

Further, there were suggestions that payers have agreed to the higher price demands of hospitals facing a new local competitor in order to help them stay viable. "Do we allow the marketplace to play out and watch one of these two hospitals go out of business?" asked one payer. "In some communities . . . the hospital could be the main employer."

Unlike in other studied markets, Indianapolis' major payers do not appear to be actively pursuing payment models that would shift greater financial risk onto providers, such as accountable care organizations (ACOs) or bundled payments for a care episode. Some observers attribute this to the highly consolidated payer market, creating little incentive for the dominant payer, Anthem, to depart from its discount-based tactics and insufficient clout among the small payers to push providers to take on more risk.

Payers and purchasers alike also reported an unanticipated outcome related to the publication of RAND's study on Indiana's hospital prices. While the highest-priced hospitals largely disputed the report's methodology and findings, the lower-priced systems have used the data to seek reimbursement levels closer to their higher-priced peers.

Employers: Something Has to Change

Even before publication of the RAND study, employer-purchasers in Indiana had been conscious of the state's high provider prices. One employer with employees in multiple states noted that Indiana's prices have been significantly higher than in other markets. "Doctors and hospitals are paid at much higher rates than in neighboring states," said one employer, noting that it had been a concern "for a long time." Another observed that the company's headquarters would not authorize any new outposts in Indiana due to that state's high health care costs.

At the same time, a broad swath of stakeholders reported that the RAND study had really "woken people up" in an unprecedented way, with several large, self-funded employers willing to consider more radical cost containment strategies than they had in the past, including narrower provider networks. "The status quo isn't an option anymore," said one large employer. At the same time, it's not clear how broad an influence the RAND report has had. Some respondents suggested that many local employers, particularly smaller ones, were either unaware of the study or felt powerless to effect any changes.

Employer respondents did broadly agree that previously implemented strategies to lower utilization, such as HDHPs and employee wellness programs, are no longer sufficient to effectively constrain year-over-year cost growth. "They've shifted so much burden to their employees," said one observer, "that there is no more to shift."

Employers discussed a range of strategies that focus on bringing providers' prices down, including narrower or tiered networks, reference pricing, and the use of centers of excellence. "There's a lot of energy . . . to move in a bold . . . way [since the RAND report]," said a market observer. One large local employer also indicated interest in bypassing payers entirely and entering into a direct contract negotiation with a large local hospital system. However, other employers indicated they lacked the resources to engage in direct contracting. It is too "big a lift" said one employer; "It's just not going to happen," said another. Perhaps for that reason, providers report a lot of "noise" about direct contracting but "no action," at least so far.

Although more employers appear willing to contemplate a narrow network strategy, respondents noted that they would have to "ease into it" in order to blunt a negative reaction from employees. For example, one suggested they would offer both a broad and a narrow network plan, so that those employees wanting broader provider choice could still have it, albeit at a higher price.

Several employers in the region have implemented, or are planning to implement, softer strategies to guide enrollees to lower-cost care settings, such as on- or near-site health clinics. These clinics are paid a capitated rate to deliver primary care services, and some offer a referral service that connects patients to a care manager if needed, as well as to lower priced laboratory, imaging, and other services. However, employer respondents indicated that their efforts were too nascent to assess whether these clinics produce any savings.

Employer respondents agreed that they share some responsibility for the market's dysfunction. We "were not demanding the right information" or asking the right questions of the health plans, said one, "and the plans got lazy."

A Three-Way Game of Chicken

The Indianapolis market could be on the cusp of major change, but what that change is may depend on who has the greater advantage in what amounts to a three-way game of chicken. While employers ask the major payers to bring costs down by developing narrow network products, the payers, in turn, seek reassurance from employers that there will, at the end of the day, be a market for those products. "When I go to [negotiate with] these high-cost hospitals," said one payer, "I need the [employers] behind me." Another stakeholder pointed out that IU Health Plan has a narrow network design, but has seen little take up from employers.

Providers, for their part, want to know that if they make price concessions in order to be part of a narrow network, they'll be able to fill their beds with an increased volume of commercially insured patients. If insurers can't sell narrow network products to employers, those patients won't materialize, but the provider will be "on record" as accepting a lower price for their services.

At the same time, employers want to know that if they're going to face expected pushback from employees about newly restricted provider choice, they're getting meaningful price reductions in exchange. "At this point, it feels like a zero-sum" game to many of the market actors, said one stakeholder involved in the employer-payer-provider discussions.

Looking Forward

Some employer respondents expressed the belief that the only way to effect change will be for employers to band together and make collective network and pricing decisions – in other words to create a "multi-payer" purchasing model. "We are just not going to [successfully] fight them on our own," said one, while also acknowledging such an approach poses organizational and operational challenges. Another employer suggested the ultimate solution will be to "threaten [the hospitals'] non-profit status," given their high margins.

A provider respondent suggested that "tighter alignment" between hospital systems and payers would become more common, primarily due to changes in Medicaid and Medicare payments. However, this alignment would inevitably have spillover effects on commercial market networks and prices. One payer believes that new modes of care delivery, such as "hospital at home," telemedicine, and similar innovations, will help lower costs.

A few respondents noted that state policymakers could consider re-imposing CON requirements on providers, thus curtailing the building boom and potentially tamping down the price hikes and utilization driven by over-bedding. Indeed, at the time of this writing, a bill doing just that is pending in the Indiana legislature, but most were skeptical such an effort would gain traction, at least in the immediate future.

The Indianapolis commercial health care market is at a crossroads. Consolidation and construction within the provider sector have led to such significant price inflation that employer-purchasers are demanding change from the insurers who administer their plans and negotiate provider reimbursement. However, while each market actor is well aware of the changes needed to reduce health spending over the long term, they involve potentially painful trade-offs for providers, insurers, employers, and employees alike.

Endnotes

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