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# “Health Care Consolidation and Competition after PPACA”

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*The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.*

## Introduction

Chairman Goodlatte, Ranking Member Watt, and Members of the Subcommittee, I appreciate the opportunity to testify here today.

By next year, about two-thirds of American physicians will be working as salaried employees of large groups and hospitals. This movement has been underway for years. Over the last decade, the number of independent physicians was falling by about 2% a year. But these trends are now accelerating. Many observers point to provisions in the recently enacted Patient Protection and Affordability Act (PPACA) as a primary driver. Starting in 2013, the number of independent physicians will start declining by 5% a year according to a recent report by Accenture Health.<sup>i</sup>

The largest proportion of these newly salaried physicians are being directly employed by hospitals or hospital owned medical practices.<sup>ii</sup> Hospital physician employment rose 32% from 2000 to roughly 212,000 physicians in 2010. That means that hospitals directly employ about a quarter of all U.S. physicians.<sup>iii iv</sup>

These realities are reflected in multiple surveys. Another report found 70% of national hospital and health systems plan to hire more physicians in the next three years. Meanwhile, two-thirds of hospitals reported that they are seeing more requests from independent physician groups seeking direct employment or collaboration with hospitals.<sup>v</sup> This is confirmed by a recent review of the open job searches held by one of the country's largest physician-recruiting firms. It shows that nearly 50% are for jobs in hospitals, up from about 25% five years ago.<sup>vi</sup>

According to the Medical Group Management Association, almost two-thirds of the doctors who signed employment contracts in 2009 entered into arrangements with hospitals. This includes half of all doctors' leaving residency training.<sup>vii</sup> Surveys of physicians demonstrate that an increasing number of newly minted doctors prefer the salaried arrangements to the traditional private practice models. Recent survey data also shows that physicians believe the current employed trend will continue and be a preferred option for them.<sup>viii</sup>

It's not only hospitals that are acquiring doctors. Health plans are also dipping their toes in the water, looking to purchase healthcare delivery organizations to gain more control over practices, utilization rates, and in turn costs. Toward the end of 2011, United Health Group purchased Monarch, the largest physician group in Orange County California with 2300 members. As another example, Pennsylvania-based insurer Highmark is teaming up with West Penn Allegheny Health System to compete with UPMC, the large, well-known medical center in Pittsburgh.<sup>ix</sup>

Investment bankers who work on mergers and acquisitions in the healthcare services industry privately concede that there is a lot of activity among health plans looking to acquire physician networks. So far, the large health plans have not been

able to buy as many assets as the hospitals. For their part, the doctors seem to prefer to sell their practices to hospitals rather than the health plans.

These trends aren't a consequence of natural market forces. It's the outgrowth of a deliberate industrial policy set in motion by changes in the way healthcare is being organized and reimbursed. These new arrangements have been hastened by PPACA. The law relies on layers of provisions designed to shift financial risk onto providers in a bid to move away from the fee-for-service reimbursement model that's blamed for excessive, and some argue inappropriate use of healthcare services.<sup>x</sup> PPACA contains deliberate constructs to industrialize healthcare by moving physicians into capitated arrangements and larger groups where reimbursement, utilization, and quality measures can be more tightly controlled. These arrangements have many champions, but also carry significant uncertainty.

As I will discuss at the close of my testimony, the only sure way that we're going to bend the cost curve is by coming up with fundamentally new ways to deliver healthcare services that improve efficiencies and enable us to get more medical care for each dollar we spend. These ideas are going to come forward the same way better ideas have always arisen – from start-ups backed by entrepreneurs, supported by investment capital, coming together in search of profits. Yet PPACA contains provisions that I fear tilt against these kinds of innovations. The legislation relies instead on arrangements that could serve to entrench existing players.

Principal among these new arrangements is the creation of Accountable Care Organizations (ACOs). This concept envisions that providers will consolidate into networks that will, in turn, take charge for the medical care of defined populations of patients. An ACO will be able to share in some of the savings that they achieve by reducing utilization and improving outcomes for the patients assigned to it. Along with other forms of capitated payment arrangements (such as bundled payments and medical homes) the combined effect of the legislation's payment reforms is to shift financial risk to providers. In the face of these changes, doctors are choosing to sell their medical practices rather than take on added uncertainty.

Many industry experts are asking whether the current trend to employ physicians is sustainable or just a revisiting of what occurred in the 1990s, when hospitals were employing physicians in response to managed care, growing competition, and pressure to aggregate market share. The 1990s mergers were mostly defensive gestures aimed at thwarting competition from expanding, for-profit hospital chains.

This time things may be different, and in many ways the same.

This time, there may be no turning back from these arrangements. Doctors who enter into these new salaried appointments may find themselves hard pressed to unwind these relationships, even should the terms change and these affiliations no longer appear financially attractive or personally rewarding.

The current consolidation is being hailed in some quarters as a needed industrialization of the practice of medicine -- a way to make the delivery of medical care more efficient and scalable. There is a premise that once doctors become employed by larger groups and health systems, it will be easier to put in place measures to manage doctors' use of medical services in ways that can improve efficiencies and lower costs. There's also a perhaps excessive faith that larger, consolidated networks of providers will have the incentive, capital, and wherewithal to pursue management and technology improvements that lead to better coordination of care. There is plenty of reason to be skeptical of these assumptions.

### **Impact of Consolidation on Clinical Productivity**

First, there's evidence that as doctors transition into becoming salaried employees of hospitals and health systems, their individual productivity (in terms of metrics such as volume and intensity of care delivered) generally declines outright, or is unfavorably impacted by these arrangements in other, more subtle ways.<sup>xi xii xiii xiv xv</sup>

It's important to note that studies that have examined this question contain many limitations. This is because of the inherent difficulty in studying the impacts of different payment systems.<sup>xvi</sup> It's hard to look at controlled experiments that address questions of how doctors respond to different payment systems.

It's also true that data shows some offsetting economic impacts to these drops in productivity. For example, physicians' use of services such as diagnostic tests and procedures also shows corresponding decline when doctors move into salaried arrangements. The totality of the data suggests, however, that the reduction in costs generated by the salaried schemes (typically as a result of the delivery of fewer tests and treatments) may be partially, if not completely offset by the lower intensity of work (productivity) that physicians achieve under these arrangements.<sup>xvii</sup>

While it's generally hard to isolate the impact of payment structure on productivity, a number of studies have attempted to assess these impacts. In one study researchers used a resident continuity clinic to compare prospectively the impact of salary versus fee-for-service reimbursement on physician practice behavior. This model allowed randomization of physicians into salary and fee-for-service groups and separation of the effects of reimbursement from patient behavior.<sup>xviii</sup>

The authors found that physicians reimbursed by fee-for-services (FFS) scheduled more visits per patient than salaried physicians (3.69 visits versus 2.83 visits,  $P < .01$ ) and saw their patients more often (2.70 visits versus 2.21 visits,  $P < .05$ ) during the 9-month study. Fee-for-service physicians also provided better continuity of care than salaried physicians by attending a larger percentage of all visits made by their patients (86.6% of visits versus 78.3% of visits,  $P < .05$ ), and by encouraging fewer emergency visits per enrolled patient (0.12 visits versus 0.22 visits,  $P < .01$ ).<sup>xix</sup>

Another review article surveyed the available literature examining how salaried arrangements impact physician productivity. It drew similar conclusions. The article found that salary payment reduces activity compared with fee for service. Capitation appeared to have a similar but more subdued effect. The authors concluded that “if cost containment is a key policy aim of government then salaried payment systems are more likely to achieve this compared with FFS and possibly more effective than capitation systems. However, cost containment by itself may be inefficient if it results in the provision of sub-optimal care.”<sup>xx</sup>

This data raises a fundamental choice: If the goal is reduce spending by driving down utilization then the salaried arrangements might provide a more direct means of imposing top-down controls. If the goal is to reduce costs by increasing productivity then the salaried arrangements might thwart these types of outcomes.

### **Consolidation can drive up Healthcare Costs**

Concerns have also been raised about the potential for consolidation to drive up costs. If constructs such as ACOs end up fostering more market concentration among providers, they have they could merely shift costs to payors. “Must-have”<sup>xxi</sup> hospitals and physician groups can exert considerable market power to demand higher rates from insurers. There is plenty of empiric evidence demonstrating that these arrangements can add to costs. Studies of pricing have shown that some providers, particularly hospitals, can gain significant market power to negotiate higher-than-competitive prices as they gain this sort of local market share.<sup>xxii</sup>

While a full discussion of these economic issues is beyond the scope of my testimony today, we need to carefully consider the potential impact from the arrangements that are being encouraged under PPACA. It has been observed that exclusive relationships, particularly those involving highly sought after or high-quality specialist physicians and hospitals, could give a consolidated network such as an ACO undue leverage.<sup>xxiii</sup> Exclusivity may also promote increased internal referrals within the network, which could magnify the effects of increased market power.<sup>xxiv</sup> In the past, antitrust policy has generally proved ineffective in curbing provider strategies that capitalize on gains in market power to win higher payments.<sup>xxv</sup> For these reasons, we should be especially mindful of the potential risks of encouraging a rapid evolution toward these consolidated relationships.

While observers are pointing to other entities that might form ACOs (large multispecialty medical groups, venture capital backed services companies) the bottom line remains that hospitals are likely to dominate the formation of these new arrangements. There are two principal reasons. First, the largest avoidable costs are related to hospitalizations. Second, in many communities, the hospital is the only organized delivery system able to access capital and execute on the model.<sup>xxvi</sup>

The hospitals also have an ulterior motive. It’s still unclear if ACOs will be profitable, successful enterprises. But for a hospital to succeed with the model, it need not

succeed in lowering costs. If the process of forming an ACO lets a hospital consolidate local providers, the hospital will win even if the ACO fails to succeed.

Physicians, for their part, are being driven to these arrangements by changes in the landscape that sees their practice costs rising, their reimbursement falling, while the financial risk they need to bear under PPACA increases through more capitated arrangements. Seeing costs rise amidst shrinking revenue, doctors are finding the prospect of trading in their businesses for a salaried position at a hospital attractive.

The concern that ACOs and other consolidated networks could serve to increase healthcare costs have already been raised among a diverse group of observers, including employers,<sup>xxvii</sup> the Federal Trade Commission (FTC)<sup>xxviii</sup>, as well as policymakers. For example, it has been suggested that the schemes may exacerbate cost shifting to commercially insured patients by ACOs looking to qualify for the Medicare cost-reduction bonuses.<sup>xxix</sup> This cost shifting may be enabled by the ACOs' new market power. One study showed that this is what happened in California as independent practice associations flourished there.<sup>xxx</sup>

For their part, some hospitals and other dominant providers in local markets have long sought to concentrate their power. They have been checked in these efforts by legal uncertainty and anti-trust concerns. We need to be careful that the urge toward creation of ACOs and other entities capable of bearing risk not be used to provide a guise to enable consolidation that is fundamentally unattractive. The widespread political appeal of ACOs should not be allowed to influence how the FTC and Justice Department interpret their responsibilities in these areas.<sup>xxxi</sup>

Otherwise, we could end up with the worst of both outcomes: consolidated providers that reduce efficiencies and raise costs, without any offsetting benefits from the (still largely untested) ACO model.<sup>xxxii</sup> In part, the nod toward hospitals to be the consolidators and the entities that stand up ACOs should heighten these concerns. Hospitals are an industry with some unique attributes, but it's been said that nothing about the specifics of the health care industry suggests that the unregulated use of market power in this industry is socially beneficial.<sup>xxxiii</sup>

### **PPACA Leaves Considerable Uncertainty among Providers**

Finally, the consolidation is leaving a great deal of uncertainty among providers about what is permissible and appropriate and, as a business matter, what physicians should be doing. This is distorting the kinds of business decisions that get made. Many of the mergers are being driven merely out of a desire to gain market share rather than pursue efficiencies because providers don't trust that the business arrangements will be legally or financially sustainable in the long run.

In part, this uncertainty is heightened by the fact that when it comes to concepts like ACOs, that much of these basic ideas have been tried before, without success.

Among the sweeping changes of the Balanced Budget Act (BBA) of 1997 was a provision enabling providers to contract directly with Medicare through the formation of a provider-sponsored organization (PSO). This provision was part of a package that created a new Medicare Part C, giving beneficiaries the choice to elect to receive benefits through the traditional fee-for-service Medicare or through enrollment in a “Medicare Choice” plan that took financial risk, and was eligible to offer health insurance or health benefits coverage.

A PSO was widely defined as a managed care contracting and delivery organization that accepted full risk for beneficiary lives. The PSO received a fixed monthly payment to provide care for Medicare beneficiaries. PSOs could be developed as for-profit or not-for-profit entities of which at least 51% must be owned and governed by health care providers (physicians, hospitals or allied health professionals).<sup>xxxiv</sup> As a practical matter, these PSOs were structured similarly to how the ACOs are being conceptualized. The two concepts also aimed at achieving some of the same goals in terms of giving providers an incentive to better coordinate care, and to introduce other efficiencies and controls to reduce the use of services deemed wasteful.<sup>xxxv</sup>

Yet the Provider Sponsored Organizations failed badly. The reasons that these entities couldn’t succeed seem to mirror some potential shortcomings in the ACO model. This history only heightens the uncertainty in the provider community around not only whether the consolidated entities now being created will be legally permissible, but also whether they are sustainable and whether the government will continue to partner with these new organizations once the current fashion fades.

Most of the PSOs had inadequate resources to finance their risk and weak management. They lacked the capacity to introduce cost-saving innovations in how they coordinated and delivered care, and manage the use of services. A few of these ventures survived, evolved, and went on to have success, most failed badly.<sup>xxxvi</sup> Some of the successful ventures include the Geisinger Health System in Pennsylvania and Intermountain Health Care in Utah. But most of these PSO ventures failed.

The very changes to the Medicare reimbursement schedule that’s driving doctors toward consolidation, only serve to underscore how uncertain the entire landscape is and, at times, how variable, if not predictable, Medicare can be when it comes to entering into business relationships with providers and provider-led entities.

As the Part B reimbursement schedule is dramatically reduced for many procedures such as cardiology and radiology, doctors and hospitals see an advantage to moving these services under the Part A billing scheme, which has remained comparatively intact. The magnitude of the cuts to certain Part B procedures is adding to provider concerns that they cannot rely on their Medicare-based revenue models.

The resulting effort to link up with hospitals, and move from the Part B to Part A billing scheme, is a temporary arbitrage, to be sure. It’s another reason why the

consolidation that looks attractive now to the hospitals may be unwieldy and unsustainable once the Medicare payment schedule catches up with these new realities. It's another reason why the consolidation that is taking place in the provider community may fall far short of its hoped for effects of improving efficiencies, driving greater coordination of care, and ultimately lowering costs. And it's another reason why there is so much uncertainty about the long-term structures.

For their part, the hospitals are experiencing economic losses as they acquire medical practices – another reason providers are engaging in these relationships on shaky ground. The losses stem in part because reimbursement levels don't leave much room for operating profits. It is also a function of the fact that the hospitals have been focused on acquiring specialty practices like cardiology and surgical specialties, which require the payment of larger, longer-term employment contracts. The losses that hospitals experience in acquiring practices are likely to exceed the potential gain sharing that they stand to earn under PPACA for operating under new shared savings arrangements created by PPACA.<sup>xxxvii</sup> This, of course, begs the question as to whether hospitals will merely shift the costs onto payors once they gain sufficient local market concentration. There is ample evidence, from past experience, to demonstrate this can be precisely what happens.<sup>xxxviii xxxix xl</sup>

Finally, providers also need to face the prospect that whatever relationships they enter into now may be hard to unwind should the legal or reimbursement environment change with respect to concepts like ACOs and the consolidation taking place today around hospitals. In the late 1990s, when physicians sold their practices to practice management companies (such as Medpartners and PhyCor) many of these companies eventually failed. Once these outfits folded, doctors were able to unwind the relationships that they had with these firms and go back to the individual practices. Today's current round of consolidation may not end as well.

Hospitals will realize that these relationships are not financially sustainable owing to declining hospital reimbursement, an inevitable equalization between the Part A and Part B payment schemes, and the high cost of owning and managing physicians. Physicians will have a hard time going back to their old arrangements. In many cases, they simply won't have the capital to regain their prior medical practices.

A 2011 survey by the American Medical Group Association, looking at the operating margins of large, often multi-specialty medical groups, would suggest that running a large group of physicians (whether they are employed by an independent multi-specialty group or a hospital) isn't profitable in today's payment environment. This financial analysis only serves to underscore these points, and the reason to be uncertain about the new arrangements that are taking shape in today's market.

The cost of practicing medicine continues to rise while reimbursement rates remain largely flat, or decline slightly over time. As a result, the survey of operating margins of large medical groups shows that most groups are operating at a loss. The

northeast has some of the worst performing groups. According to the survey, groups in this region are operating at an average loss of around \$10,000 per physician.<sup>xli</sup>

There is a possibility that, through pursuit of policy constructs that aim to consolidate providers into larger networks, we end up with the worst of both worlds: A Medicare policy failure that drives private-sector costs higher.<sup>xlii</sup>

### **Does Consolidation leave a Role for Entrepreneurship?**

In the end, PPACA's most significant challenge to organizational change in how providers are structured and services delivered is the legislation's relationship to innovation and entrepreneurship in this space. In my opinion, the modest rewards offered to accountable care organizations, through gain sharing, may not be enough to incentivize these groups to make meaningful investments in costly new systems and infrastructure that lead to genuine improvements in the coordination of care.

As a result, the entities taking advantage of the opportunity set may be those who have other motives. They will be the existing market participants who stand to gain through the ability to consolidate providers and gain local market power.

Historically, innovations in the delivery of healthcare -- from the advent of the first HMO to creation of long term care hospitals and home infusion (to name just several) -- arose as the result of start-up outfits, often backed by venture capital, and headed by entrepreneurs who were in search of above market returns on invested capital. Under the existing rules, this often meant that new arrangements sought to earn profits by moving patients from higher cost settings of care to lower cost settings and capturing some of the money they saved the system in that process.<sup>xliii</sup>

But PPACA contains deliberate provisions aimed at regulating returns on invested capital; discouraging different forms of entrepreneurship. These provisions are, in many cases, the expression of a political philosophy that guides a number of provisions in PPACA. That philosophy views profits earned on the provision of care as money that should have been channeled instead into direct patient care.

The result is that entrepreneurs are not pursuing new health services ventures. Capital flowing to these endeavors has fallen sharply. The lack of incentive for entrepreneurs further entrenches existing players, meaning that tools that could help better coordinate care (for example, healthcare information technology) is only adopted through outright subsidies to existing providers, rather than through the creation of new approaches to replace an existing way of delivering care.

I work with investors who support entrepreneurs creating some of these new ideas. I have also served as a consultant to, and board member, of firms working on entrepreneurial healthcare services start-ups. I worry that PPACA advances a number of provisions that tilt too much against these entrepreneurs. The combined effect of these policies will serve to potentially freeze out disruptive new models.

There are other legacy practices that create impediments to innovation, entrepreneurship, and genuine change in the delivery of healthcare services. For example, existing laws restrict innovative ways to provide primary care (PPACA merely restricts how we pay for it). We could develop entities that make better use of skilled nurses and other non-physicians providers to reach into homes, workplaces and communities to provide early care more efficiently and cheaply.

This would cause “prevention” to rise rather than having PPACA make “prevention” free without addressing the fact that people often don’t see doctors because it’s inconvenient. Such efforts would require changes in laws that empower certain providers over others and create barriers to more flexible approaches to delivering care. In the past, physicians have been resistant to extending more responsibility to non-physician providers. I expect this resistance to diminish as the incentives change under new payment schemes. Under capitated schemes, there’s more incentive to move patients from costly hospitals and offices and (where appropriate) into lower costs settings and providers. Under these arrangements, doctors may be keener to share increasing responsibilities with other providers.

## **Conclusion**

In a well functioning market that creates proper incentives for innovation in delivery of healthcare, consumers would have a closer relationship to the insurance product that they carry and their purchase of routine healthcare. In a well functioning market, the insurance product would be portable across employers and states, and would enable multi-year contracts, guaranteed-renewable products, and other elements similar to the way consumers buy life insurance today.

Such a market would provide cash vouchers to individuals priced out of the system because of their economic or medical circumstances. Under the current scheme, where health insurance products are tightly regulated, where government agencies and not consumers choose what is covered, and where profits are punished, it leaves little room for entrepreneurship in how healthcare services are delivered.

Yet the only way we’re going to bend the healthcare cost curve is by introducing genuine innovations in how we provide medical care – new approaches that lower costs while providing more healthcare for each dollar that we spend. These innovations won’t arise as a result of the critical mass created through carefully orchestrated mergers. These ideas won’t be incubated inside CMS.

Nor are these concepts likely to arise from new twists on old concepts like capitation and PSOs. Instead, genuine innovation in the delivery of healthcare is going to come about the way it always has – from entrepreneurs who raise capital in search of profitable new ways to re-engineer old systems, appealing to consumers by bringing them a better service at a more affordable price. PPACA tries to engineer

its own new constructs, while pursuing provisions that could crowd out entrepreneurs from developing their own ideas. We could end up with neither.

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- <sup>i</sup> Clinical Transformation: Dramatic Changes as Physician Employment Grows, Accenture Health, 2011
- <sup>ii</sup> Anne Mutti and Jeff Stensland. Provider consolidation and prices. Presentation before the Medicare Payment Advisory Committee. October 9, 2009
- <sup>iii</sup> 2012 Edition of the American Hospital Association Statistics
- <sup>iv</sup> Haydn Bush. Hospital Statistics Chart Rise in Physician Employment. Hospital and Health Networks Daily, January 06, 2012
- <sup>v</sup> Karen M. Cheung. 70% hospitals, health systems plan more physician employment. Fierce Healthcare, October 12, 2011
- <sup>vi</sup> Scott Gottlieb. No, You Can't Keep Your Health Plan. The Wall Street Journal, May 18, 2010
- <sup>vii</sup> Medical Group Management Association. Physician Placement Starting Salary Survey: 2010 Report Based on 2009 Data. June 4, 2010
- <sup>viii</sup> Survey by McKesson Practice Consulting and Modern Medicine, 2011
- <sup>ix</sup> Rita Numerof. Massive Healthcare Consolidation in the PPACA Era, April 13, 2012
- <sup>x</sup> Atul Gawande. The Cost Conundrum, What a Texas town can teach us about health care. The New Yorker, June 1, 2009
- <sup>xi</sup> Lawton Robert Burns and Ralph W. Muller. Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration. Milbank Quarterly 2008;86:375-434
- <sup>xii</sup> Christopher D. Ittnera, David F. Larckerb, Mina Pizzinic. Performance-based compensation in member-owned firms: An examination of medical group practices, May 2007
- <sup>xiii</sup> Wolinsky F, Marder W. Spending time with patients, the impact of organisational structure on medical practice. Medical Care 1982; 20(10):1051-9
- <sup>xiv</sup> I S Kristiansen, K Holtedahl. Effect of the remuneration system on the general practitioner's choice between surgery consultations and home visits. Journal of Epidemiology and Community Health 1993;47:481-484 doi:10.1136/jech.47.6.481  
[http://jech.bmj.com/content/47/6/481.abstract?ijkey=286b3bd9c25afb8bb73203854199b0c2b49d86e0&keytype2=tf\\_ipsecsha](http://jech.bmj.com/content/47/6/481.abstract?ijkey=286b3bd9c25afb8bb73203854199b0c2b49d86e0&keytype2=tf_ipsecsha)
- <sup>xv</sup> Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behavior of primary care physicians: a systematic review. Journal of Health Service Research Policy 2001 Jan;6(1):44-55
- <sup>xvi</sup> Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. Cochrane Database Systematic Reviews 2000;(3):CD002215.
- <sup>xvii</sup> T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. QJM 1999;92:47-55
- <sup>xviii</sup> Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. Pediatrics 1987;80:344-350
- <sup>xix</sup> Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. Pediatrics 1987;80:344-350
- <sup>xx</sup> T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. QJM 1999;92:47-55
- <sup>xxi</sup> These must have groups are generally providers that health plans need to include in networks to be attractive to employers and consumers in a local market.
- <sup>xxii</sup> Ginsburg PB. Wide variation in hospital and physician payment rates evidence of provider market power. Res Briefs 2010 Nov;(16):1-11

- 
- xxiii Berenson RA, Ginsburg PB, Christianson JB, Yee T. The growing power of some providers to win steep payment increases from insurers suggests policy remedies may be needed. *Health Affairs* 2012 May;31(5):973-81
- xxiv Richard M. Scheffler, Stephen M. Shortell, Gail R. Wilensky. Accountable Care Organizations and Antitrust Restructuring the Health Care Market. *Journal of the American Medical Association* 2012;307(14):1493-1494. doi:10.1001/jama.2012.451.  
<http://eresources.library.mssm.edu:11635/article.aspx?doi=10.1001/jama.2012.451>
- xxv Berenson RA, Ginsburg PB, Kemper N. Unchecked provider clout in California foreshadows challenges to health reform. *Health Affairs* 2010 Apr;29(4):699-705
- xxvi Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. *Health Affairs*, January 2011 vol. 30 no. 1 32-40
- xxvii Employers express anti-trust and cost-shifting concerns on ACOs. *America's Health Insurance Plans Coverage*. June 3, 2011. <http://www.ahipcoverage.com/2011/06/03/employers-express-anti-trust-and-cost-shifting-concerns-on-acos>. Accessed October 2012
- xxviii Federal Trade Commission, Department of Justice. Statement of antitrust enforcement policy regarding accountable care organizations participating in the Medicare shared savings program. *Federal Register* 2011;76(209):67026-67032
- xxix Remarks of J. Thomas Rosch. Accountable Care Organizations: What Exactly Are We Getting? Commissioner, Federal Trade Commission, before the ABA Section of Antitrust Law Fall Forum, Washington, DC. November 17, 2011.  
<http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf>
- xxx Robert A Breneson, Paul B. Ginsbur, Nicole Kemper. Unchecked provider clout in California foreshadows challenges to health reform. *Health Affairs* 2010;29:699
- xxxi Federal Trade Commission, Department of Justice, Antitrust Division. Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. *Federal Register* Vol. 76, No. 75. Tuesday, April 19, 2011
- xxxii Remarks of J. Thomas Rosch. Accountable Care Organizations: What Exactly Are We Getting? Commissioner, Federal Trade Commission, before the ABA Section of Antitrust Law Fall Forum, Washington, DC. November 17, 2011.  
<http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf>
- xxxiii Gaynor M. Why don't courts treat hospitals like tanks for liquefied gases? Some reflections on health care antitrust enforcement. *Journal of Health, Politics, Policy and the Law* 2006 Jun;31(3):497-510
- xxxiv Stephen C. Gleason, Jacque J. Sokolov, and Christine Henshaw. Provider Sponsored Organizations: A Golden Opportunity in Medicare Managed Care Physicians and other providers will soon have a chance to bypass the middleman and compete in managed Medicare. *Family Practice Management* 1998 Mar;5(3):34-45
- xxxv Judith R. Peres. PSOs offering new partnership potential; provider service organizations: a possible gateway to 21st-century long-term care - Forecast '98. February 1998
- xxxvi Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. *Health Affairs*, January 2011 vol. 30 no. 1 32-40
- xxxvii Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. *Health Affairs*, January 2011 vol. 30 no. 1 32-40
- xxxviii Vogt WB, Town R. How has hospital consolidation affected the price and quality of hospital services. Princeton (NJ): Robert Wood Johnson Foundation; 2006. Research Synthesis Report No. 9
- xxxix Berenson RA, Ginsburg PB, Kemper N. Unchecked provider clout in California foreshadows challenges to health reform. *Health Affairs*. 2010;29(4):699-705
- xl Anne Mutti and Jeff Stensland. Provider consolidation and prices. Presentation before the Medicare Payment Advisory Committee. October 9, 2009
- xli American Medical Group Association. 2011 Medical Group Compensation and Financial Survey Finds Continued Financial Losses in Most Regions, Average Increase in Physician Compensation at 2.4%. August 16, 2011

- 
- <sup>xlii</sup> Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. *Health Affairs*, January 2011 vol. 30 no. 1 32-40
- <sup>xliii</sup> Chris van Gorder and Eric Topol. Embracing the Future. *Modern healthcare*, May 14, 2012. 24