Health Market Consolidation

Joshua Sager, Health Policy Intern
Michael Miller, Strategic Policy Director

ONE FEDERAL STREET
Boston, MA 02110
617.338.6035
Fax: 617.451.5838
www.communitycatalyst.org

Table of Contents

Introduction

One of the major issues facing the U.S. healthcare system today is the trend toward increased market consolidation for both payers and providers. Mergers and acquisitions have created large payer and provider entities that command disproportionate amounts of market power. The establishment of these large payer and provider entities has caused many to worry about the potential for monopolies and cartels to form, distorting the market, reducing competition and increasing profits at the expense of other stakeholders, including consumers.

Health care markets are essentially massive tug-of-war contests. A key strategy used by payers to increase their profitability is to compel providers to accept lower compensation or reduce expenses in other ways. They can also seek to increase revenue through setting higher premiums for consumers, but competitive markets or regulation may limit this option. Similarly, providers seek to increase their accumulated financial resources (or profits) by attracting more patients and increasing the amount of compensation that they receive from payers for caring for these patients. Finally, consumers want to have access to a broad selection of high-quality, affordable health care providers. Unfortunately, these goals can be mutually exclusive, creating tension between payers, providers and consumers.

Neither consolidation among payers or providers is good or bad in all cases. Large providers have the means to invest in clinical care improvements and may also have the ability and incentive to invest in community health that may be absent in a more fragmented delivery system. Large payers can be more administratively efficient and have greater ability to push back on provider demands for rate increases. However, research has found harmful effects from both payer and provider consolidation, and regulators and advocates should evaluate any proposed consolidation in terms of the cost and quality impacts on consumers and the public at large—this consolidation varies across states based on market and regulatory factors and does not have a uniform effect across payers and populations.

Market consolidation may allow both payers and providers to pursue their goals at the expense of other participants in the marketplace, and both parties have an incentive to grow and seek a dominant market position. Payers who gain a disproportionate amount of market power in a specific market have the ability to exclude from their networks, providers that demand high compensation, and thus can force providers to give them lower rates (which can either be taken as profits or passed back to consumers in lower premiums or out of pocket costs). Providers who gain a disproportionate amount of market power can set higher prices because plans that do not include them in their networks will not be attractive to consumers and employers.

In a worst case scenario, both payers and providers are consolidated, making it possible, absent effective regulation, for providers to demand high compensation from payers, while allowing payers to transfer these costs onto consumers and employers through high premiums without significant dangers of losing business (they simply don’t have many competitors). This represents an offloading of costs down onto the consumer, who typically have the least market power. In addition, consolidated entities may wield significant political power, making it difficult to offset excessive market power by setting limits on market conduct.

Understanding payer and provider consolidation is particularly important today, as both provider and insurer markets continue to consolidate, with some analysts pointing to the current push for more integrated care systems as a contributing cause.[1]

For instance, insurance giants Anthem and Aetna have recently proposed to purchase Cigna and Humana respectively, drawing scrutiny from Congress and opposition from physicians and hospitals.[2] As states expand Medicaid under the ACA, they have also shifted more members to managed care plans, which may expand the market power of existing MCOs. On the provider side, the ACA focuses on promoting "integrated delivery systems," frequently organized by large health providers that have the capacity to perform a variety of functions (e.g., Accountable Care Organizations, Patient Centered Medical Homes, etc.).

Measuring Market Consolidation

The most common metric that academics and regulators use to quantify market consolidation (both in payers and providers) is the Herfindahl-Hirschman Index (HHI). This metric is calculated by determining the percentage of the market each provider has, then squaring each percentage (as a whole number value; ex. 20% = 20) and adding them together to get a total score.

For example: A market composed of five entities, each of which controls an identical amount of the market share (20%) would have a HHI of $20^2+20^2+20^2+20^2+20^2=2000$.

Most analysts consider markets with an HHI of <1,500 to be unconcentrated, markets with an HHI between 1,500 and 2,500 to be moderately concentrated, and markets with an HHI >2,500 to be highly concentrated. The absolute maximum HHI score, where only one buyer or seller is in the market (a perfect monopoly), is 10,000.

Federal and state regulatory agencies utilize the HHI when investigating market consolidation and determining whether or not to approve mergers between payers or providers. The Department of Justice (DOJ) and Federal Trade Commission (FTC) have established criteria[3] for evaluating HHI changes due to mergers that they use as a guideline for analyzing the market effects. According to the federal criteria, mergers which increase the HHI by less than 100, or occur in unconsolidated markets, are unlikely to have a significant effect on competition. However, mergers which result in the HHI increasing by over 100 in markets that are already moderately or highly concentrated raise concerns and are often investigated. Finally, increases in the HHI of more than 200 in markets that already have an HHI of over 2,500 (highly consolidated) are "presumed to be likely to enhance market power," thus are almost always investigated for monopolistic impacts.

Provider Consolidation

Healthcare providers include a variety of entities, ranging in size from large care organizations (ex. ACOs), to mid-sized independent hospitals and small individual practices. They may be for-profit, not-for-profit or public. Consolidation occurs when these entities merge and grow as larger entities buy smaller ones and incorporate them into their existing network.

Current Status and Trends

Current health care markets in the United States are fairly consolidated, and are trending towards even greater consolidation. A 2013 Cutler and Morton study[4] dealing specifically with hospital consolidation quantified this trend using HHI assessments from the FTC.

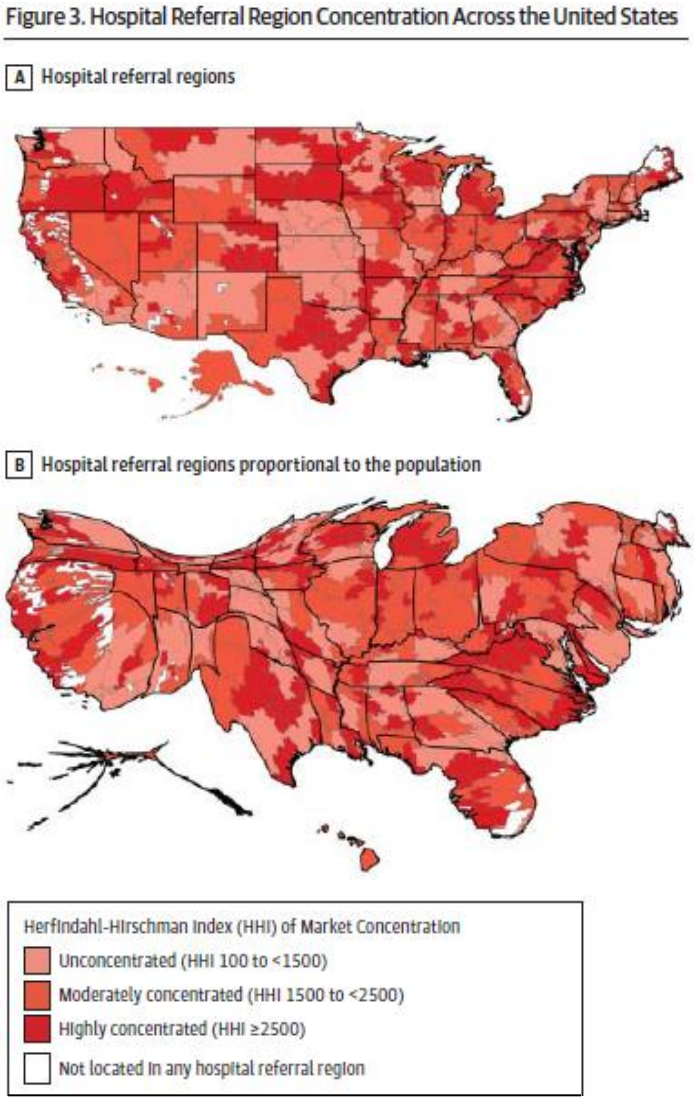


Figure 1: Cutler and Morton, JAMA, 2013

There are 306 hospital referral regions in the U.S.,[5] and according to Cutler and Morton, 150 (49%) of these regions are classified as "highly concentrated" due to their HHI score. Of the remaining regions, 98 (32%) are considered "moderately concentrated," while only 58 (19%) are considered "unconcentrated." On average, the top five providers within each region accounted for 88% of total care volume, while the top three providers accounted for approximately 77% of total care.

These maps were produced to illustrate the geographic distribution of hospital market consolidation. The top map displays the actual hospital referral regions and color-codes them based upon their level of consolidation, while the bottom map has been adjusted to reflect the populations being served in each region.

This trend toward consolidation has not been uniform, and the fastest rates of consolidation occurred in the 1990s. The consolidation during the late 20th century was primarily driven by hospitals attempting to push back against payer consolidation and the rise of large HMOs.

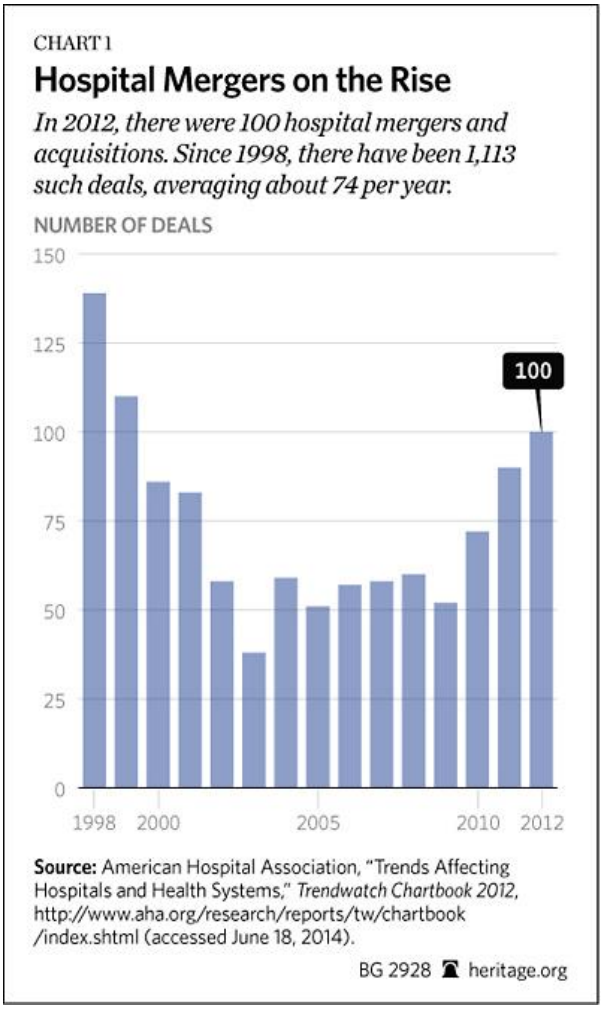
While this trend toward consolidation slowed at the turn of the century, the number of mergers and hospital acquisitions in the United States has increased significantly over the last decade, approaching the rates that were seen in the late 1990s. As these mergers are a cumulative process and far outstrip the number of new providers entering the market, it is easy to see why health care markets are becoming increasingly consolidated.

Some health market experts have pointed to the passage of the Affordable Care Act (ACA) in 2010 as a major driver of this recent increase in consolidation.[6] Specifically, they identify the ACA's promotion of accountable care organizations (ACOs) and integrated care as a major driver of consolidation.[7] ACOs are large integrated provider organizations which are intended to reduce

overall costs by increasing coordination and efficiency. While ACOs may be a promising avenue to improve the health care system, there are concerns[8] that they could be used as an excuse to consolidate markets further and increase profits by failing to transfer cost savings to patients.

Risks Associated with Provider Consolidation

There is a significant body of research concerning the benefits and consequences of market consolidation within health care providers.



Supporters of market consolidation argue that larger and more integrated providers have distinct advantages in care quality, efficiency and the capacity to innovate. Additionally, some argue that large providers are more capable of implementing innovations that may benefit consumers or cut costs in the long run, such as adopting new medical technologies or information systems.[9] They point to research which indicates that better care coordination and higher volume can correlate with better outcomes, more institutional stability and lower costs.[10]

Many of the health care reforms which are currently being implemented on the state and federal levels focus on promoting integrated provider organizations (e.g., PCMHs and ACOs). These reforms would necessitate some consolidation of providers, although they would also implement reformed payment systems, such as global budgeting and bundled payments for episodes of care that could mitigate increases in provider costs at least for public payers. As most of these are relatively new, there is limited information on how effective they will be in the long run at improving quality and efficiency.

Opponents of market consolidation argue that consolidated provider markets give providers too much market power and create monopolistic conditions that allow them to dramatically increase prices. In a consolidated provider market, there is less incentive for providers to compete for "customers" and they become price-setters who can demand above-market rates from payers.[11] Because payers have fewer choices, they lose market power relative to providers and have less leverage during negotiations.[12]

In addition to pointing to increasing prices, opponents of consolidation dispute whether volume is necessarily correlated with quality[13] and argue that consolidated markets could allow large providers to choke smaller, quality providers out of the marketplace.[14] If a market becomes consolidated enough that payers have little choice as to who they contract with, then the existing providers may have little incentive to improve quality, yet still be able to insulate themselves from new competitors.

According to a 2012 meta-analysis by the Robert Wood Johnson Foundation (RWJF),[15] the balance of the peer-reviewed studies concludes that increased provider consolidation and decreased competition led to significantly higher prices, yet didn't produce consistent increases in care quality—consolidation in some cases actually led to lower quality, as it decreased competition and insulated providers from market consequences if their care quality began to decline. In totality, this analysis found that competition between providers drives increased quality and efficiency.

The conclusions of the RWJF meta-analysis are backed up by empirical studies which have tracked care prices before and after mergers. For example, a 2011 study in the International Journal of the Economics of Business by Haas-Wilson and Garmon,[16] tracked prices and care quality during a merger of the Evanston Northwestern Healthcare Corporation, the Glenview Community Hospital and the Highland Park Hospital. They concluded that, post-merger, the consolidated provider had no appreciable increases in care quality, yet had overall cost growth 11 to 17 percent faster than control hospitals.

In 2015, the National Academy of Social Insurance (NASI) published a study on the issue of health market consolidation.[17] They found that market consolidation within providers can lead to dramatic price increases, yet found no evidence that it improves quality.

Potential Reforms

Many health reform advocates have proposed reforms aimed at reducing future market consolidation among providers and mitigating the consequences of existing consolidation. For the most part, these reforms utilize either market intervention (i.e., creating new market entrants) or regulation (i.e., restricting private providers/payers contracts).

In their 2015 report, NASI compiled a comprehensive list of 11 potential reforms that could be used to reduce provider market consolidation or mitigate its negative impacts[18]. The following table is a condensed summary of these reforms (the full summary can be found on pp. 29-48 of the NASI report. Note that all of these options have pros and cons which are not discussed here):

Regulatory Reforms	Market-Based Reforms
States can reform their regulatory regimes in order to combat monopolistic providers. • Reduce barriers to entering the provider market (e.g., certificate of need, scope of practice, etc.) • Strengthen network adequacy requirements (e.g. set maximum wait times for patients to access providers) • Regulate provider contracts by banning anti-competitive provisions, requiring rate review, and restricting out of network provider charges • Cap acceptable payment rates at a percentage above the Medicare price or implementing all-payer rate setting • The state could increase anti-trust restrictions (e.g. preventing mergers)	• States tend to have large public health insurance pools (e.g., state workers) that command large amounts of buying power. They can use this power to compel providers to lower rates and increase quality by setting minimum standards for participation. • Improve market transparency by establishing public oversight boards or mandating the creation of portals that publically list prices and safety metrics for providers.

In the case of non-profit hospitals, state and federal community benefit requirements should be used to mitigate the ability of consolidated provider systems to accumulate inappropriate financial reserves at the expense of their charitable missions, to provide care to the uninsured and to support improvements in community health.[19]

In addition to the reforms mentioned in the NASI report, some reformers have pointed to a shift away from fee-for-service and towards fee-for-value as a potential way to mitigate the damage from provider consolidation. By shifting to capitation or episode-based-payment schemes, it is possible (in theory) to control overall costs while rewarding provider revenues for increased efficiency—if the savings from efficiency overtake the revenue reductions from decreased compensation, there is a net-positive impact on both consumers and providers.

The political feasibility and potential effectiveness of each of these reforms varies greatly across states. For example, rural states may simply not have the population to support enough providers in the market to create real competition. This limits the effectiveness of reforms like reducing barrier-to-entry regulations, as there simply isn't enough demand to support a new provider, even if it is easier for new providers to enter the market.

While the NASI report stops short of advocating for the dissolution of existing large, consolidated providers, another more dramatic solution to consolidation would be to use federal anti-trust law power to break up institutions that have grown so large that they threaten the overall market. Anti-trust enforcement actions against existing consolidated facilities are difficult to achieve—it is significantly harder to break up an institution than to prevent a pending merger—and have uncertain outcomes, and thus have rarely been attempted. However, state Attorneys' General and courts have successfully challenged proposed mergers based upon the projected impact on prices in the market and their impact on consumers, as in a court ruling banning Partners Health Care's proposed acquisition of a suburban hospital in Massachusetts.[20]

Payer Consolidation

There are a wide variety of payers for health care in the United States—these range in size from massive public payers (e.g., Medicare) to individual buyers of health care. Generally speaking, these payers follow the rules of the market and have market power proportional to their share of each local healthcare market. This means that large commercial payers can capture local markets, crowd out other commercial private competition and establish contractual arrangements with providers that give them preferential status over other payers. Public payers can use their purchasing and regulatory power to set or negotiate rates for physicians, hospitals, pharmacies, drug manufacturers and other providers.

Current Status and Trends

Since the late 20th century, the U.S. health insurance markets have been highly consolidated, with a relatively small number of payers controlling vast portions of the market. By a wide margin, the largest single payer in the market is the United States government (through the Center for Medicare and Medicaid Services). Approximately 16 percent of the total U.S. population is covered under Medicare[21] and approximately 17 percent is covered under Medicaid.[22] The influence of Medicare is significantly larger than the volume of recipients would suggest, as Medicare recipients tend to use significant numbers of services (since they are over 65 or are disabled) and thus account for

disproportionate percentages of hospital costs/revenue. This large pool of enrollees gives CMS market power which completely eclipses that of any private payer.

According to NAIC data (as of June 2014), the seven largest private health insurance companies in the U.S. are: United Health (12.29% of total market share), Kaiser (7.87%), Wellpoint (6.92%), Aetna (5.68%), Humana (5.05%), Health Care Services Corporation (3.06%) and Cigna Health Group (2.7%).[23] While not as large as CMS, these private payers are still extremely large and able to virtually dominate local markets.

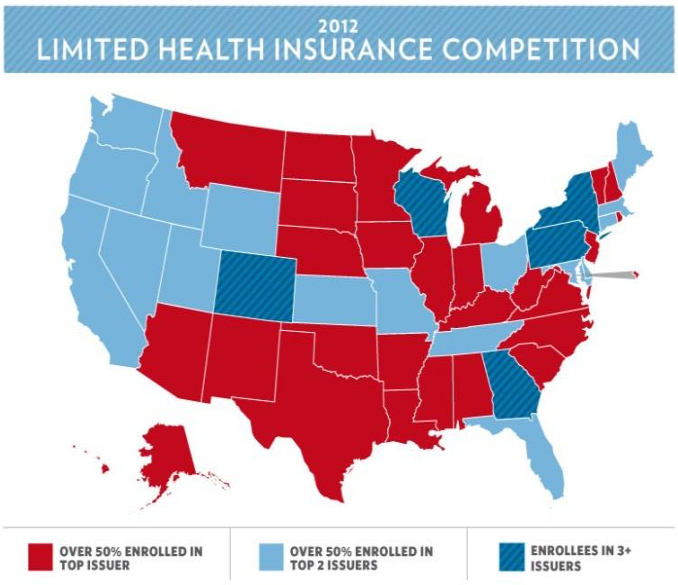


Figure 2: Produced by the Obama Administration, 2012

For example, according to the Kaiser Family Foundation,[24] Blue Cross Blue Shield controls 93% of the commercial health insurance market in Rhode Island, 91 percent of the market in Alabama and 89 percent of the market in Vermont. This gives them virtual monopoly power over the health insurance "markets" in each of these states.

According to a 2014 study by the American Medical Association,[25] 72 percent of metropolitan health insurance markets were "highly concentrated" under FTC/DOJ metrics (HHI). Additionally, in 41% of these markets, one payer controlled more than half of the total market share.

On the state-level, a vast majority of health insurance markets are highly consolidated. For example, the least competitive markets for individual insurance are located in Rhode Island (HHI = 8,680), Alabama (HHI = 8,250) and Vermont (HHI = 8,040). Only nine states have moderately consolidated individual markets (OR, CO, WY, PA, MO, NY, GA, KA and MA), while only one has an unconsolidated market (WI).[26] This consolidation is even more extreme in large group insurance markets, with the most extreme example being North Dakota, where 97% of the group market is controlled by the top insurer (HHI = 9,394).[27]

While it is virtually impossible for certain markets to get more consolidated (e.g., North Dakota), there is a general trend towards more consolidation. This trend is nowhere near as fast as it was during the late 20th century, but the high levels of consolidation already within the market mean that any mergers could involve significant increases in insurer size. For example, Aetna is currently in the process of buying Humana for $37 billion,[28] and unless regulators step in to block the deal, it could be finalized within months—as Aetna controls 5.68% of the national commercial market share and Humana controls 5.05%, the resulting entity could control as much as 10.73% of the total commercial market in the United States. While this may not initially sound significant, these payers are concentrated in specific state markets, thus their market power is actually very high relative to overall market share (e.g., Aetna controls 84 percent of the Alaskan insurance market while Humana controls 66 percent of the Kentucky market).[29]

Risks Associated with Payer Consolidation

Consolidation in the health insurance markets has several effects, which may be good or bad depending on your point of view. First, it allows payers to exert market pressure on providers and compel them to accept lower prices. Second, it insulates existing payers from competition and makes it hard for new entries into the market to compete on equal footing with existing insurers (they have less ability to extract price concessions from providers and thus are at a competitive disadvantage). Third, it tends to lead to increased premiums for consumers and employers,[30] as consolidated markets have less competition to drive down prices (as consumers "shop around" for the best deal).

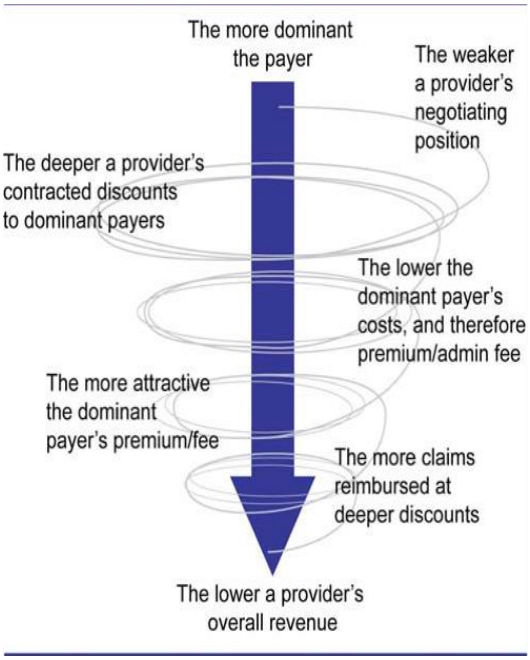


Figure 3: Graphic by PCS Avility

Monopolistic payers control a significant amount of the market share in their local insurance market and can restrict their network of "in-network" providers to punish providers that demand higher prices. If a provider refuses to give them preferential treatment over smaller payers, they have the ability to exclude that provider from their network or place them in a higher cost-sharing tier and thereby reduce the number of patients who will seek care at that provider. As this reduction has the potential to significantly damage profits for a hospital, it acts as a potent tool for payers to compel providers to make deals. Studies have identified several consequences from the increased bargaining power created by payer consolidation.

There is evidence that payer consolidation tends to cause providers' profits and physician pay to decrease[31]—these are a direct result of a decreased compensation for care. Conversely, nurses' pay and employment tend to rise slightly, as providers begin using them as a lower-cost alternative to doctors in some care areas.

The research also indicates that payer consolidation tends to decrease hospital prices, particularly in markets where hospitals are not consolidated, but there is disagreement as to the effects on consumer premiums. Some researchers have argued that payers simply use the negotiated savings to decrease premiums, thus consider more payer consolidation a good thing.[32] On the other hand, some researchers argue that payer consolidation has little effect on premiums or even increases them slightly, as monopolistic payers don't have to worry about competing with other payers for business (they pocket the saving from negotiations and increase premiums anyway).[33] In effect, consolidated payers may be able to compel lower prices from providers, but barring regulation, they may choose to simply retain these savings as increased revenue rather than passing them on to consumers as premium decreases.

History tends to indicate that consolidation among payers can incentivize providers to consolidate in order to expand their market power and defend against coercive bargaining agreements.[34] This pattern started in the late 20th century with the expansion of Health Management Organizations and has continued in recent decades. Given these trends, it is fair to assume that this dynamic will

continue into the future if it is not mitigated by public policy or limited by the sheer fact that no more consolidation is possible in certain markets.

Potential Reforms

Several of the same reforms that could be used to mitigate provider monopolies can be applied to mitigating payer monopolies.

First and foremost, regulations can be applied to prevent mergers and acquisitions that would significantly increase consolidation (as quantified with the HHI). These regulations would prevent consolidation from getting worse than it already is, but would do little to reduce current levels of concentration.

Second, regulators can pass restrictions on payer premiums and conduct that directly mitigate their ability to utilize market power in a way that harms consumers. For example, the Affordable Care Act has several such provisions (though additional authority is likely needed). Section 1001 of the ACA[35] limits the acceptable medical loss ratio for private payers by mandating that payers spend at least 80% of premiums on paying for patient care rather than administrative expenses. This may attenuate the incentive for payers to raise premiums (though it also reduces the incentive to squeeze down on provider prices and could result in implicit collusion between payers and providers). The ACA also requires that health plans participating in Marketplaces must meet network adequacy standards. These criteria ensure that consumers have access to needed care without "unreasonable delays.[36] Additionally, Section 1003 of the ACA[37] mandates the creation of a process by which state and federal regulators can perform annual reviews of premium increases in order to prevent consumers from being unfairly charged higher prices.

A few states have gone further than the federal government, with Rhode Island making perhaps the most aggressive use of the rate review process.[38] In Rhode Island, insurance companies are required to submit all rate increases 60 days prior to implementation to the Office of the Health Insurance Commissioner. If the rate increases are considered to be against the public good or without reasonable justification, they may be blocked at the discretion of the Commissioner. All applications are public and posted online.[39]

Third, the government can support the entry of new payers into the market. The co-ops in the ACA are an attempt to do this, but their challenges to date illustrates the difficulties involved in creating viable new payers.[40]

Currently, there appears to be little organized effort to break the payer consolidation in the United States by implementing these reforms. This is likely due to the fact that we already have a highly consolidated market and the lack of conclusive evidence tying payer monopolies to serious harm to consumers. Additionally, some argue that payer consolidation just helps balance provider consolidation, and that increased payer consolidation may be positive because it will mitigate the harms caused by provider consolidation.[41] Under this argument, it may be dangerous to address payer consolidation without simultaneously dealing with provider consolidation, as reducing the market power of consolidated payers would shift the balance of power further toward consolidated providers.[42]

Bilateral Monopolies in Payer/Provider Markets

In markets where both providers and payers are consolidated (e.g., if a market has only one major provider and one major commercial payer), a bilateral monopoly is created.[43] This means that while both the provider and the payer have significant market power and can easily block new competitors, they have largely equal power relative to each other.

Because providers are consolidated, payers cannot threaten to exclude a provider who refuses to give them preferential rates, and because payers are consolidated, providers cannot simply demand high compensation rates without having to worry about pushback.

Bilateral monopolies create the risk that providers and payers will agree on terms that offload costs onto consumers. Payers give providers their inflated compensation and simply increase premiums on consumers in order to protect their profits. Because consumers have few—if any—other options in that marketplace, they are forced to accept the higher premiums or go without care. Employers are likewise forced to accept higher premiums for covering their employees.

This situation realizes the worst consequences of both types of monopoly simultaneously, and would require significant government intervention to address (likely through breaking up monopolies, setting rates, or even establishing a public payer to compete with the commercial payers).

Conclusion

Health market consolidation is an extremely important issue that must be recognized and addressed by advocates and policymakers. While more research is needed to accurately quantify the risks of such consolidation, the currently available evidence indicates that both types of consolidation produce real risks to consumers. Particularly lacking is any sort of dynamic analysis that weighs the effects of consolidation in one sector in the context of consolidations occurring in the other.

As both payers and providers seek dominant market position, there is a powerful incentive toward consolidation that has not been effectively addressed by regulatory oversight. As detailed in this brief, the preponderance of the evidence indicates that this race for market consolidation—both in private payer and provider markets—has a real effect on consumer prices and overall health care costs. Monopolistic practices by the largest entities in health care markets threaten to inflate prices and insulate them against market-driven demands for better quality. Furthermore, given the high degree of consolidation that already exists, merely freezing (or more likely slowing) further consolidations may not adequately protect consumer interests. Government has an imperative to intercede in the market and ensure that the public interest is not damaged by market consolidation.

While there are regulatory avenues that can be used to prevent further consolidation in markets (e.g., anti-trust provisions in both state and federal law), some markets are already so consolidated that these remedies are of limited effectiveness. In addition, in some parts of the country, (e.g., rural areas) the population may not be adequate to support numerous competing payers and providers. Finally, the recent focus on promoting "integrated care" in health care reform efforts has, if anything, added more fuel to the consolidation fire, as integrating care tends to involve more horizontal integration of care providers.

As a result, it is necessary, not only to skeptically review further provider and insurer mergers, but also to create additional regulatory tools beyond those already put in place by the ACA, to safeguard the public interest in affordable, quality health care.

Sources

[1] Health Plan Concentration and Consolidation. (2011, October 1). Retrieved January 13, 2016, from http://www.hcfo.org/publications/health-plan-concentration-and-consolidation#health_plan
[2] Herman, B. (2015, September 8). Healthcare consolidation hearings likely to include #ACA blame game. Retrieved January 13, 2016, from http://www.modernhealthcare.com/article/20150908/NEWS/150909907
[3] US DOJ. Horizontal Merger Guidelines. Issued August 2010. From http://www.justice.gov/atr/public/guidelines/hmg-2010.html#5c
[4] Cutler, D., & Morton, F. (2013). Hospitals, Market Share, and Consolidation. JAMA, 310(18), 1964-1964. Retrieved January 13, 2016, from http://scholar.harvard.edu/files/cutler/files/jsc130008_hospitals_market_share_and_consolidation.pdf
[5] The Dartmouth Atlas of Health: Data By Region. (n.d.). Retrieved January 13, 2016, from http://www.dartmouthatlas.org/data/region/
[6] Health Plan Concentration and Consolidation. (2011, October 1). Retrieved January 13, 2016, from http://www.hcfo.org/publications/health-plan-concentration-and-consolidation#health_plan
[7] Summer, Laura. (2011). Integration, Concentration, and Competition in the Provider Marketplace. Academy Health. From http://www.academyhealth.org/files/publications/AH_R_Integration%20FINAL2.pdf
[8] Adamopolous, H. (2013, November 7). Accountable Care Organizations and Market Share: Could Care Coordination Drive Monopolization? Retrieved January 13, 2016, from http://www.beckershospitalreview.com/accountable-care-organizations/accountable-care-organizations-and-market-share-could-care-coordination-drive-monopolization.html
[9] Appleby, J. (2010, September 26). As They Consolidate, Hospitals Get Pricier. Retrieved January 13, 2016, from http://khn.org/news/hospital-mergers-costs/
[10] Guerin-Calvert, M. (2014). Hospital Realignment: Mergers Offer Significant Patient and Community Benefits. FTI Consulting. Retrieved April 4, 2016, from http://www.fticonsulting.com/~/media/Files/us-files/insights/reports/hospital-realignment-mergers-offer-significant-patient-and-community-benefits.pdf
[11] Ibid. Cutler, D., & Morton, F. (2013)
[12] Ibid. Cutler, D., & Morton, F. (2013)
[13] Gaynor, M., & Town, R. (2012, June 1). RWJF Synthesis Report: The impact of hospital consolidation. Retrieved January 13, 2016, from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261
[14] National Academy of Social Insurance Staff [NASI]. (2015, April). Addressing Pricing Power in Health Care Markets: Principles and Policy Options Strengthen and Shape Markets. Retrieved January 13, 2016, from https://www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf
[15] Ibid. Gaynor, M., & Town, R. (2012)
[16] Haas-Wilson, D., & Garmon, C. (2011). Hospital Mergers and Competitive Effects: Two Retrospective Analyses. International Journal of the Economics of Business, 18(1), 17-32. Retrieved January 13, 2016, from http://www.smith.edu/economics/documents/Haas-WilsonGarmon.pdf
[17] ibid. NASI (2015)
[18] Ibid. NASI (2015)
[19] MA DHCFP Staff. (2010). Study of the Reserves, Endowments, and Surpluses of Hospitals in Massachusetts. Retrieved January 13, 2016, from https://www.harvardpilgrim.org/pls/portal/docs/page/members/about/mass-rates/hospital_reserves_report.pdf
[20] Schencker, L. (2015, February 18). Partners HealthCare drops plans to acquire South Shore. Retrieved January 13, 2016, from http://www.modernhealthcare.com/article/20150218/NEWS/150219905/partners-healthcare-drops-plans-to-acquire-south-shore
[21] Medicare Beneficiaries as a Percent of Total Population. (2012). Retrieved January 13, 2016, from http://kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/
[22] Medicaid Enrollment: An Overview of the CMS April 2014 Update. (2014, June 10). Retrieved January 13, 2016, from http://kff.org/medicaid/fact-sheet/medicaid-enrollment-an-overview-of-the-cms-april-2014-update/
[23] National Association of Insurance Commissioners Staff. (2015). 2014 State Market Share Reports. Retrieved January 13, 2016, from, http://www.naic.org/documents/prod_serv_statistical_msr_hb.pdf
[24] Market Share and Enrollment of Largest Three Insurers- Individual Market, 2013. (2013). Retrieved January 13, 2016, from http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/
[25] AMA Study Finds WellPoint to be the Largest Health Insurer in Many Local Markets. (2014, October 9). Retrieved January 13, 2016, from http://www.ama-assn.org/ama/pub/news/news/2014/2014-10-09-wellpoint-competition-health-insurance-market.page
[26] Individual Insurance Market Competition. (2013). Retrieved January 13, 2016, from http://kff.org/other/state-indicator/individual-insurance-market-competition/
[27] Large Group Insurance Market Competition. (2013). Retrieved January 13, 2016, from http://kff.org/other/state-indicator/large-group-insurance-market-competition/
[28] Hammond, E., Campbell, M., & Tracer, Z. (2015, June 25). Aetna Closing In on Deal to Acquire Humana. Retrieved January 13, 2016, from http://www.bloomberg.com/news/articles/2015-06-25/aetna-said-to-be-closing-in-on-acquisition-of-humana
[29] Market Share and Enrollment of Largest Three Insurers- Large Group Market, 2013. (2013). Retrieved January 13, 2016, from http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/
[30] Dafny, L., Gruber, J., & Ody, C. (2014). More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. NBER working paper 20140. Retrieved January 13, 2016, from http://www.nber.org/papers/w20140
[31] Dafny, L., Duggan, M., & Ramanarayanan, S. (2009). Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry. NBER working paper 15434. Retrieved January 13, 2016, from http://www.nber.org/papers/w15434.pdf
[32] Melnick, G., Shen, Y., & Wu, V. (2011). The Increased Concentration Of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices. Health Affairs, 30(9), 1728-1733. Retrieved January 13, 2016, from http://content.healthaffairs.org/content/30/9/1728.full.html
[33] Ibid. Dafny, L., Duggan, M., & Ramanarayanan, S. (2009)
[34] Ibid. NASI (2015)

[35] Kirchhoff, S. (2014, August) Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress. Congressional Research Service. Retrieved January 13, 2016, from https://www.fas.org/sgp/crs/misc/R42735.pdf
[36] Ngugen, Q. (2015). Network Adequacy: What Advocates Need to Know. Retrieved January 13, 2016, from http://www.communitycatalyst.org/resources/publications/document/Network-Adequacy_what-advocates-need-to-know_FINAL-01-28-14.pdf
[37] 45 CFR Part 154. (2011). Retrieved from http://www.cms.gov/CCIIO/Resources/Files/Downloads/rate_increase_final_rule.pdf
[38] Rhode Island General Laws, Title 27, Chapter 18, Section 8. Retrieved from http://webserver.rilin.state.ri.us/Statutes/TITLE27/27-18/27-18-8.HTM
[39] Health Plan Review. (2016). Retrieved April 12, 2016, from http://www.ohic.ri.gov/ohic-formandratereview.php
[40] Corlette, S., Miskell, S., Lerche, J. and Giovannelli J.. (2015). Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition. The Commonwealth Fund. Retrieved April 13, 2016, from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf
[41] Kaplan, J., Lawyer, P., Adigozel, A., Duffy, M., & Gorlin, D. (2015, July 1). The Promise of Payer Consolidation for U.S. Health Care. Retrieved January 13, 2016, from https://www.bcgperspectives.com/content/articles/health-care-payers-providers-post-merger-integration-promise-payer-consolidation-us-health-care/
[42] Ibid. NASI (2015)
[43] Ibid. NASI (2015)