Consolidation and Competition in US Health Care

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Introduction

• The US relies on markets for the provision and financing (~1/2) of health care, but...
  – Those markets don’t work as well as they could/should.
  – Consolidation, concentration, and market power have a large part to do with that.
  – Matters for the ACA – depends on markets.

• Issues
  – Prices are high, and rising, there are quality problems, there’s too little organizational innovation.
  – Markets are highly concentrated.
  – More consolidation is happening.

• Organization of Talk.
  – What’s Happening?
  – Why Should We Care?
What’s Happening?

• Health spending
  – High and increasing.
    • Can’t be sustained without serious strain/harm.
      – Recent slowdown, but unclear if this is a structural change.
    • Hospital and physician services are ~9.2% of GDP.

• Prices
  – High, egregious billing practices.
  – Prices are a major driver of health spending increases.

• Quality
  – Concerns over quality.

• Innovation, Efficiency, Service
  – Health system characterized as sclerotic, unresponsive, uncreative.

• Consolidation
  – Lots of consolidation (hospitals, physicians, insurers).
Lots of Recent Publicity About Prices (or something)

- Steven Brill article in Time.
- CMS release of hospital charge data (and Medicare reimbursements).
  - Outpatient payments.
  - MD payments.
- NY Times article about prices.
What’s Driving the Growth in US Health Spending? It’s The Prices

Components of Health Spending Growth, Private ESI Insurance, 2010-2011

Massachusetts – It’s the Prices

Hospital Consolidation

• There has been a tremendous amount of consolidation in the hospital industry.
  – Mergers and Acquisitions.
    • Over 1,000 deals 1994-present.
    • Consolidation slowed in 2000s, but has picked up recently.

• Hospital Market Concentration.
  – Herfindahl-Hirschmann Index (HHI): sum of squared market shares.
  – Average MSA level HHI.
  – 2006 - 3,261; about like a market with 3 equally sized firms.
  – FTC/DOJ cutoff for highly concentrated market: HHI = 2,500.
  – In 2006, 75% of MSAs were highly concentrated.

• Why Did Hospitals Consolidate?
  – Response to rise of managed care.
  – Anticipation of ACA? Cost pressures?
  – Game of “musical chairs.”
Hospital Mergers

- Over 1,000 hospital mergers since mid-90s
- Most urban areas are now dominated by 1-3 large hospital systems


(1) In 2006, the privatization of HCA, Inc. affected 176 acute-care hospitals. The acquisition was the largest health care transaction ever announced.
Hospital Markets Have Become More Concentrated

• Most MSAs are highly concentrated.
• Most MSAs have become more concentrated.
Insurer Consolidation

• Insurer Consolidation.
  – Information not as good as for hospitals, but better than for physicians.

• Large Employer Market (Leemore Dafny).
  – 1998: HHI = 2,172; about like a market with 5 firms of equal size.
  – 2006: HHI = 2,956; somewhere between a market with 3 and 4 equally sized firms.
  – Average insurance market is highly concentrated after 2004.
  – Concentration starts increasing after 2002 (compared to mid to late 1990s for hospitals).

• Small Group Market (GAO).
  – Market share of largest carrier has been increasing over time (33% – 2002; 47% 2008).
  – 87% of states had five firms controlling 75% or more of the market
Physician Practice Consolidation

• Not nearly as much information about the physician market.
• Physician practices getting larger.
• Market concentration
  – Medicare (Kleiner, Lyons, and White).
    • Market share of 2 largest practices in market.
      – 33% primary care; 58% cardiology; 72% oncology.
    • HHI for market.
      – 761 primary care; 2,370 cardiology; 3,606 oncology.
  – Private, CA, 2001 (Schneider et al.).
    • County HHI for physician practices 4,430.
Physician-Hospital Consolidation

• A great deal of interest in physician-hospital consolidation.
  – Most forms of physician-hospital integration peaked in the mid-1990s (e.g., PHOs), and have declined steadily since then.

• The exception is the employment of physicians by hospitals, which has been growing steadily.
  – 32% increase in # of doctors employed by hospitals over last decade.
  – 20% of physicians now employed by hospitals.

• ACOs
  – 428 now; 164 in 2011.
  – More growth expected.
Why Should We Care?

• US uses a market system for providing care and for financing ~50% of it.
• Therefore we need markets to work as well as they possibly can.
• If not, we pay.
  – Higher prices.
  – Lower quality.
  – Poor service.
  – Inefficient, outmoded means of organizing and delivering care.
• Which also means:
  – Lower wages.
  – Lower benefits.
  – Fewer jobs.
  – More uninsured.
Empirical Evidence – Hospital Prices

• Hospital consolidation drives up prices.
  – Mergers lead to price increases of 3.5-53 percent.
  – Magnitude largely depends on availability of close substitutes
    • Summit-Alta Bates (Bay Area): 28-44% price increases due to merger.
    • French-Sierra Vista (San Luis Obispo): Price increases up to 53% due to merger.
  – Hospitals that have or acquire market power are able to charge higher prices on a permanent basis.
    • 100% pass-through to consumers.
Empirical Evidence – Hospital Quality

• Administered Prices (U.S. Medicare, England)
  – Competition increases quality (reduces mortality).
    • Substantial impacts – 1.46 percentage points lower mortality rate
      in least concentrated markets for Medicare heart attack patients.
    • Similar magnitudes in England.
    • English NHS reforms increased responsiveness of hospital choice
      to hospital quality.

• Market Determined Prices
  – Impacts on quality mixed, but mostly positive (U.S., England,
    the Netherlands).

• Effects on quality appear to be long lasting.
• Not much is known about non-mortality aspects of quality
  – Waiting times, MRSA rates unaffected (England)
Empirical Evidence – Hospitals, Not-for-Profit, Costs

• Not-for-Profit/Public Firms
  – One might think NFP or public hospitals would behave differently.
    • Little evidence that they do so (US).
    • Hospitals respond to competition (US, England, Netherlands).

• Costs
  – Efficiencies due to merger possible.
    • Little evidence that they are achieved (US, England).
    • If prices go up post-merger, what difference does it make?
Empirical Evidence – Physicians, Insurers

• Physicians
  – Not a lot of evidence - some that prices are higher in more concentrated markets.

• Insurers
  – Evidence that insurance premiums are higher in more concentrated markets (large employers).
  – Evidence of substantial market power in the Medigap market.
  – Evidence that competition has a large effect on premiums in Medicare+Choice.
  – Evidence that plan choice is “sticky.”
Policy Options

• Overall Goals
  – Efficiency, responsiveness, innovation.
    • Prices, quality, service.
  – Things can work better, but it’s not realistic to expect health care markets to work like markets for computers or groceries.

• Policy Options
  – “Invisible Hand”
    • Let the market do it.
  – “Heavy Hand”
    • Let government do it.
  – “Helping Hand”
    • Let government help the market do it.
Policy Options

• Market Approach - strengthen/open markets; encourage responsiveness, innovations.

• Framework
  – Set up rules of the road and enforce them.
  – Support an environment that supports competition.
  – Need.
    • Basic conditions.
    • Ongoing oversight.
Policy Options

• Regulatory Approaches – markets don’t/can’t work, e.g., so concentrated competition is infeasible.

• Price/Spending Controls
  – All-Payer Rate Regulation
  – Global Budgets
Policy Options

• The Helping Hand
  – Regular, ongoing monitoring and reporting of key measures, developments.
    • Requires data and analytics infrastructure.
  – Intervention
    • Triggered by monitoring.
    • Public Reporting.
    • “Moral Suasion.”
    • Reporting to enforcement agencies.
    • Direct intervention.