Markets and Competition in Health Care

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Health Care Pricing Project

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The average premiums for health insurance for a family of four in 2015 was $17,545

Source: Kaiser Family Foundation, 2016

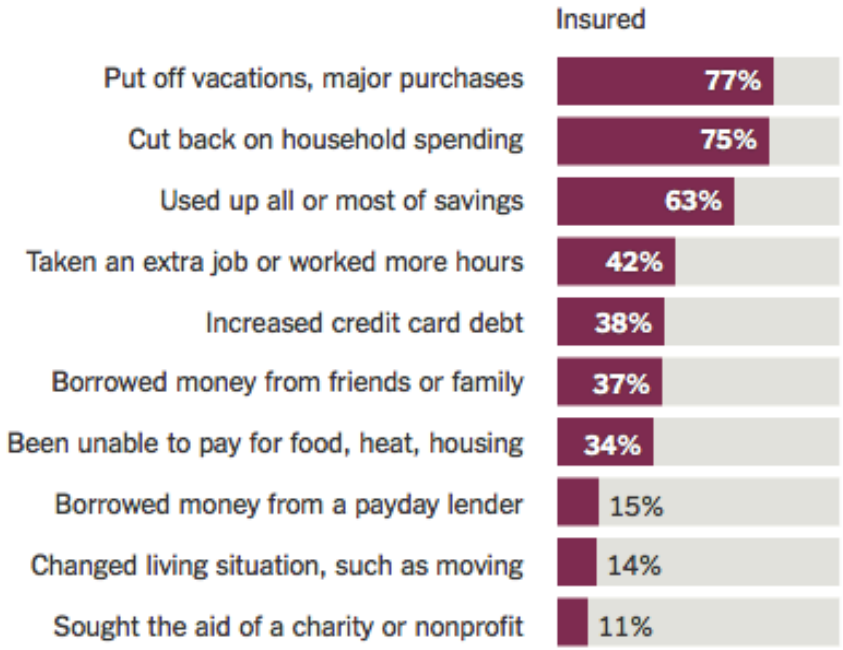
PUBLIC HEALTH

Even Insured Can Face Crushing Medical Debt, Study Finds

Margot Sanger-Katz @sangerkatz JAN. 5, 2016

Medical Problems Lead to Financial Sacrifices

People who reported problems paying medical bills in the last year told pollsters they'd done the following:



Source: The New York Times and Kaiser Family Foundation survey

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> cold showers, can't fix plumbing. other needed repairs have been patched as best as possible but not fixed.
> – man, 62, South

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> Letting people move in with us to help pay bills.
> – woman, 25, South

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> CANT TAKE THE KIDS ANYWHERE WISH I COULD DO MORE FOR MY KIDS!!!!!!!
> – man, 41, Midwest

The Context

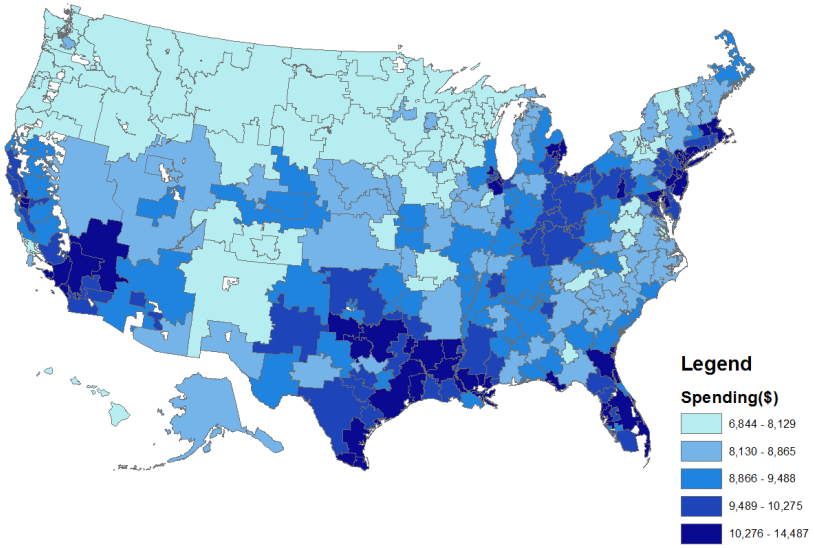
- We spend 17.5% of GDP on health care
- The price of health care services are high, they vary, and there are countless examples of egregious billing
- Quality isn't what it should be
- We don't see innovation at the pace we require

Functioning Markets Underpin our Health System

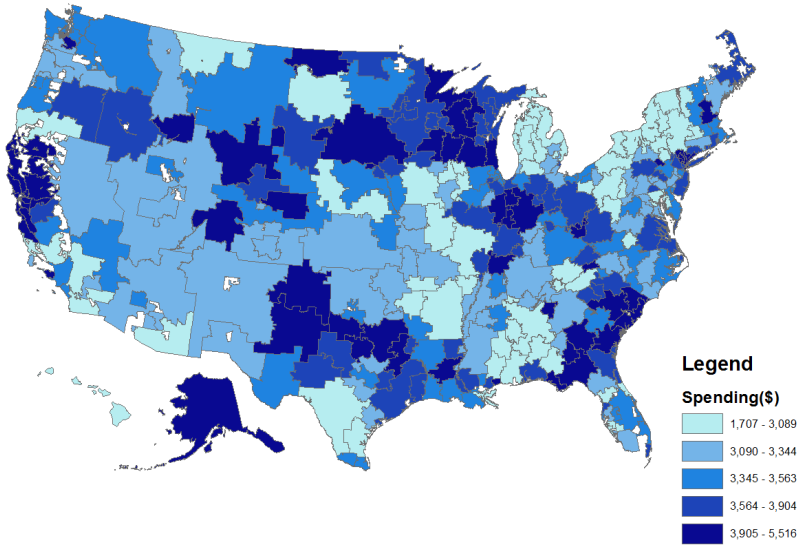
- The US relies on markets for the provision of about half of US Health Care
- The health of the health system is determined by how well those markets are functioning
- Right now, those markets are not functioning well and we're seeing the consequences
  - Hospital and insurance markets are highly concentrated
  - They are becoming more concentrated over time

Medicare and ESI Overall Spending Per Beneficiary

Total Medicare Spending Per Beneficiary, 2011



Total Private Spending Per Beneficiary, 2011



Correlation of Public and Private Total Spending Per Beneficiary: 0.140

Note: Data on Medicare is for 2011 and from the Dartmouth Atlas. Spending for Medicare beneficiaries includes Part A & B and is risk adjusted by age, race, and sex. Spending on private enrollees is adjusted by age and sex and includes all inpatient, outpatient, and physician claims

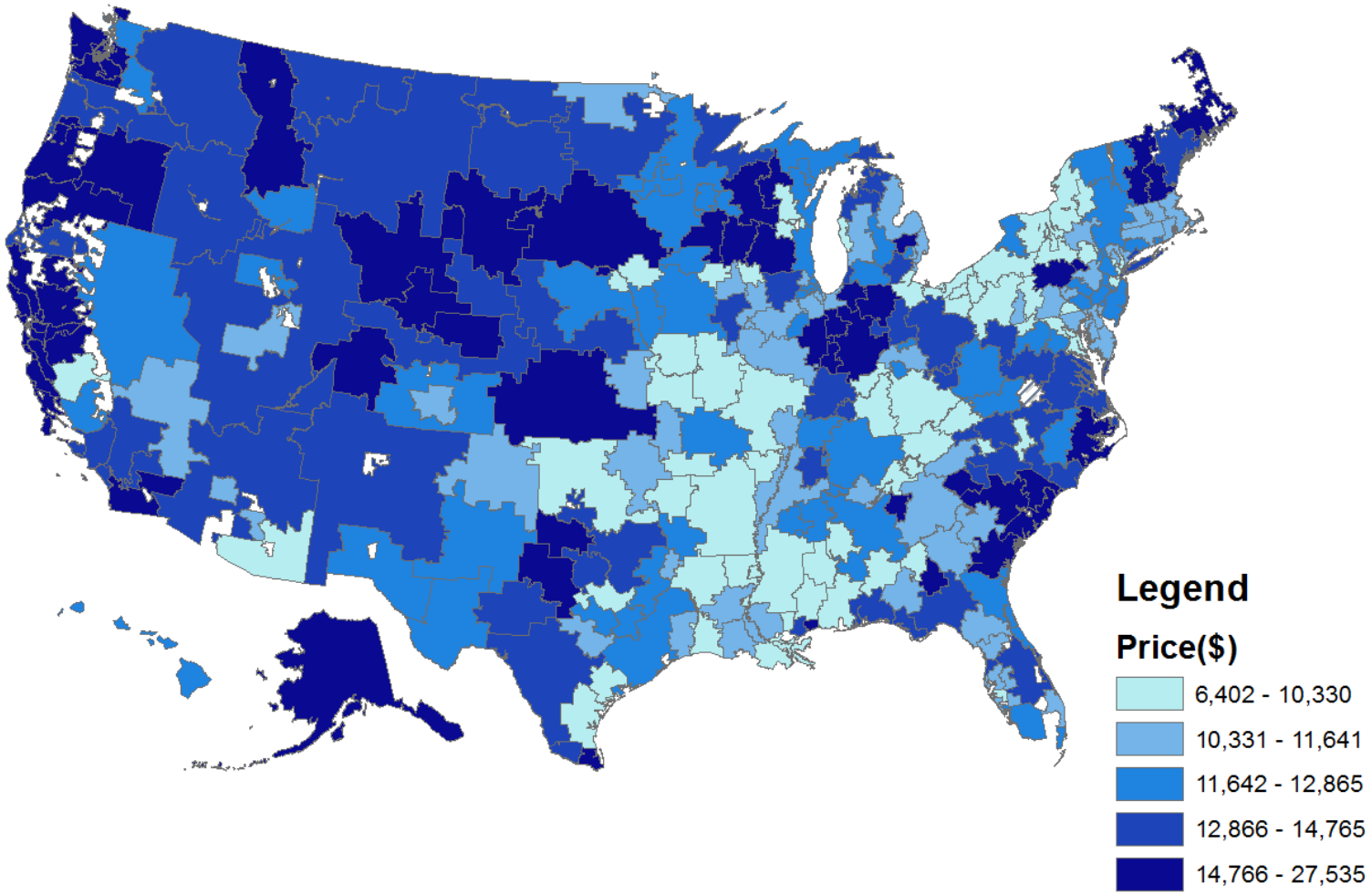
Decomposition Results

	Medicare Spending Drivers			Private Spending Drivers		
	Share Price	Share Quantity	Share Covar.	Share Price	Share Quantity	Share Covar.
Variation in Spending per Beneficiary	9.37%	76.65%	13.95%	45.89%	36.19%	17.92%

Note: This is based on a formal decomposition where: $var(ln(p_d q_d)) = var(ln(p_d)) + (var(ln(q_d)) + 2cov(ln(p_d), ln(q_d))$. This is carried out by DRG. To capture the share of variance in spending attributable to variation in price across HRRs, we divide the $var(ln(p_d))$ term by the variation in total spending. To capture the share in spending attributable to the variation in quantity of care across HRRs, we divide the $var(ln(q_d))$ term by the variation in total spending. We come up with the price/quantity contribution by averagin for decomposition results for each DRG by spending per DRG.

Inpatient Prices

Risk-Adjusted Inpatient Hospital Price, 2008-2011



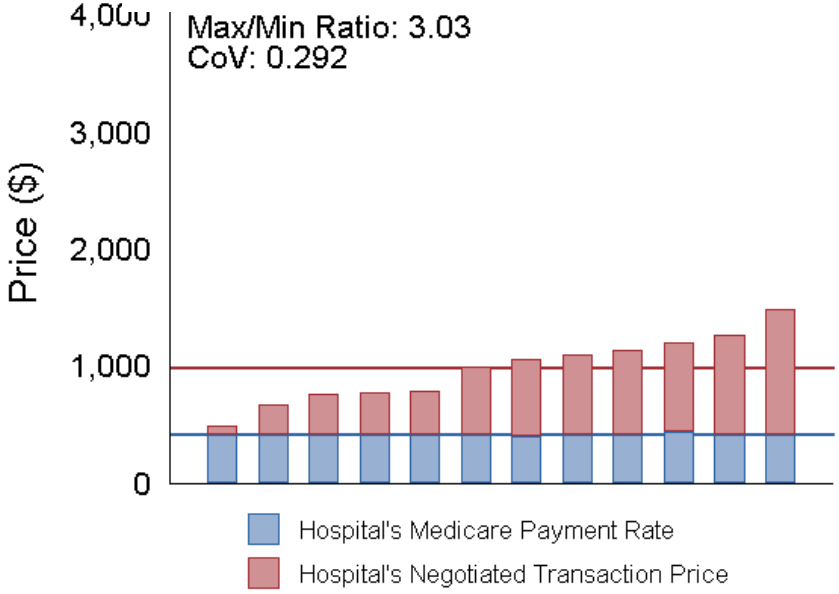
High Private Health Spending in New Haven and Bridgeport

	Private-Payer Average Inpatient Hospital Price
Bridgeport, CT HRR	103rd highest prices (of 306)
Hartford, CT HRR	206th highest prices (of 306)
New Haven, CT HRR	175th highest prices (of 306)

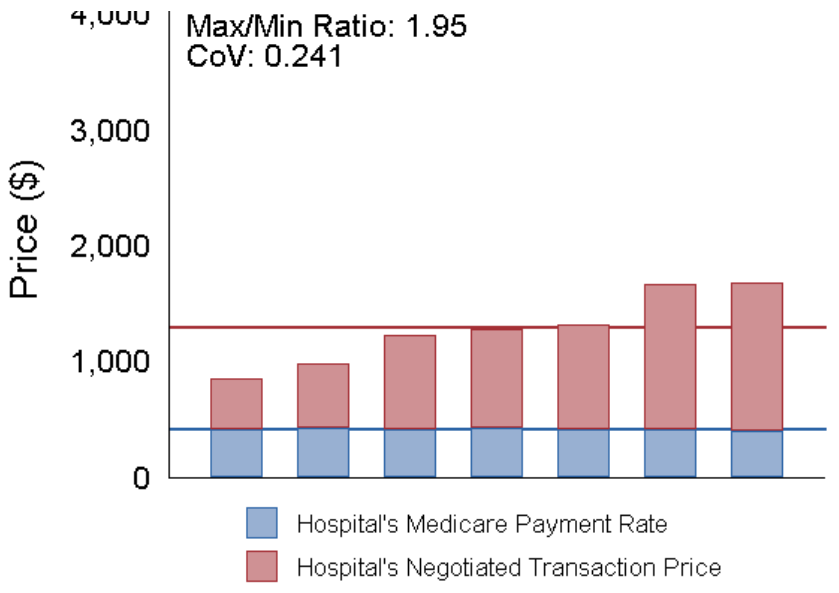
Notes: Data on Medicare spending was downloaded from the Dartmouth Atlas http://www.dartmouthatlas.org/. An HRR with a rank of 1 has the lowest spending per beneficiary of all HRRs. An HRR with a rank of 306 has the highest spending per beneficiary of all HRRs. Overall spending does not include pharmaceutical spending. Private data from Cooper et al. 2015.

Knee Replacement Prices in New Haven and Hartford

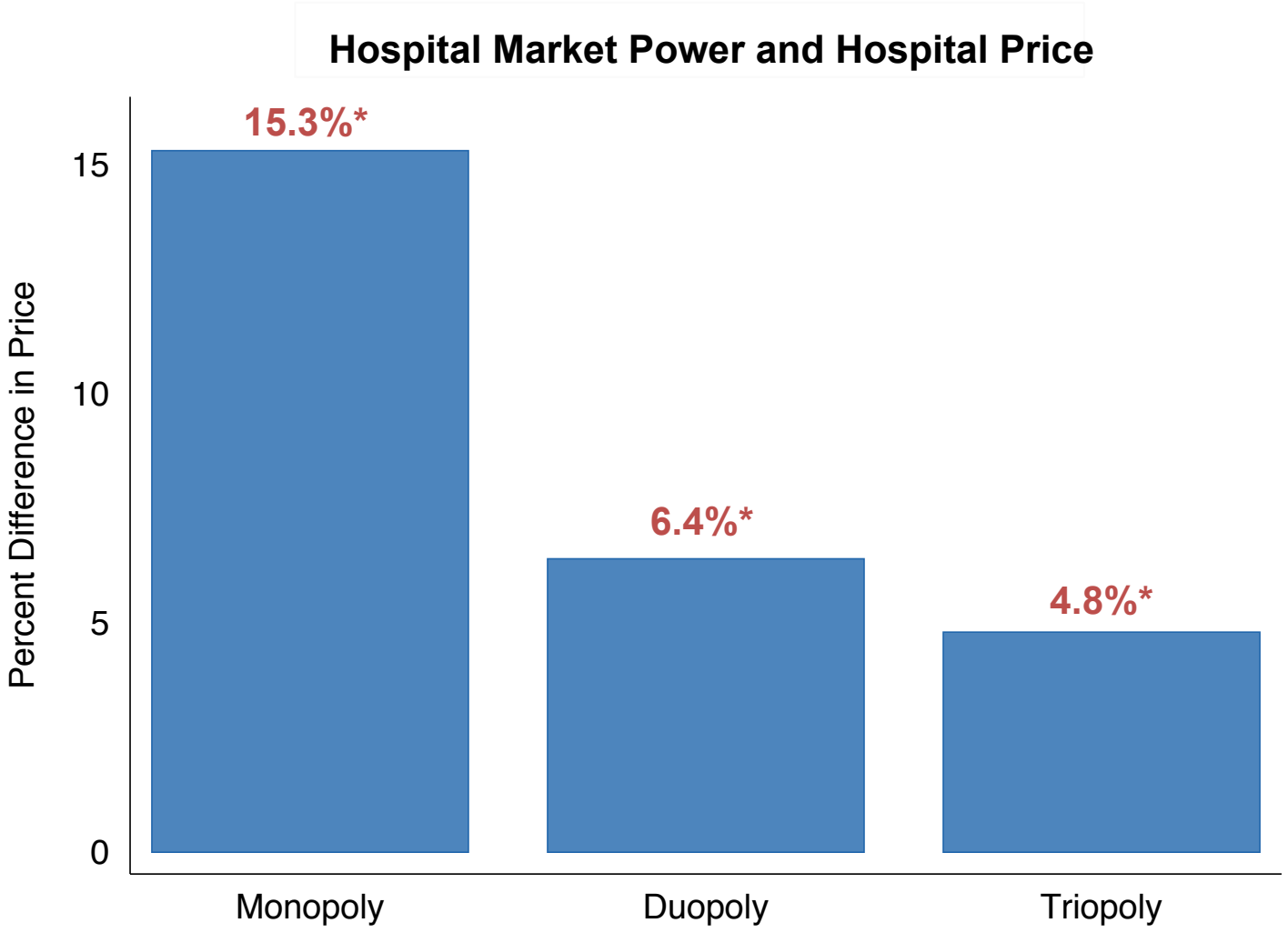
Lower Limb MRIs, Hartford Ct
2008 - 2011



Lower Limb MRIs, New Haven Ct
2008 - 2011

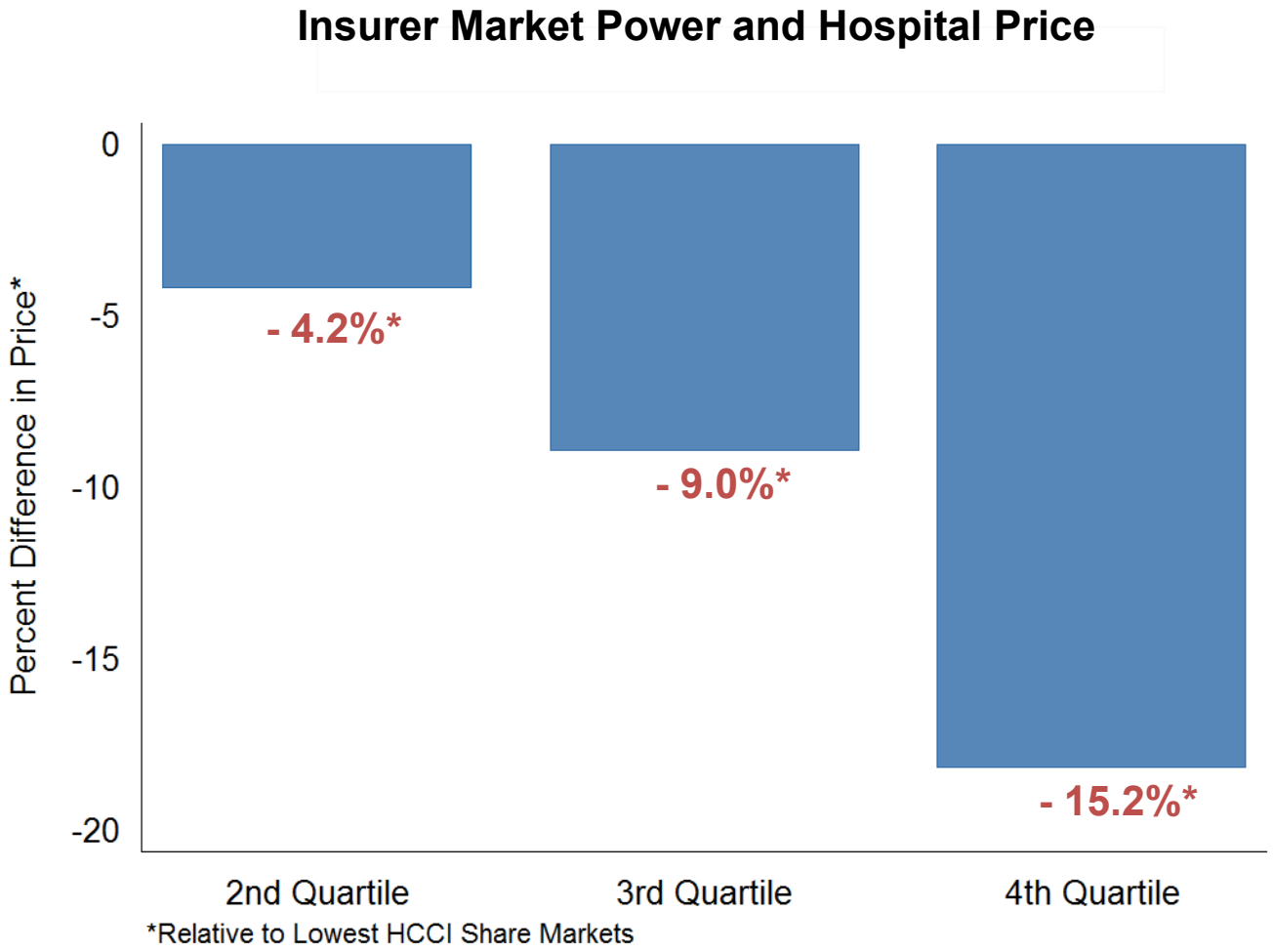


Hospital Market Power Raises Hospital Prices



Note: An asterisk indicates significance at the 5% level. This figure is based on OLS estimates for 8,176 hospital-year observations with standard errors clustered at the HRR-level in parentheses. The controls include insurance market structure, HCCI insurer share by county, hospitals use of technology, U.S. News & World Report Ranking, hospital beds, indicators for teaching hospitals, government-owned hospitals, and not for profit hospitals, the Medicare base payment rate, the share of hospitals' patients that are funded by Medicare, and the share funded by Medicaid. The regressions also include HRR fixed effects and year fixed effects.

Greater Insurance Market Power Lowers Hospital Prices



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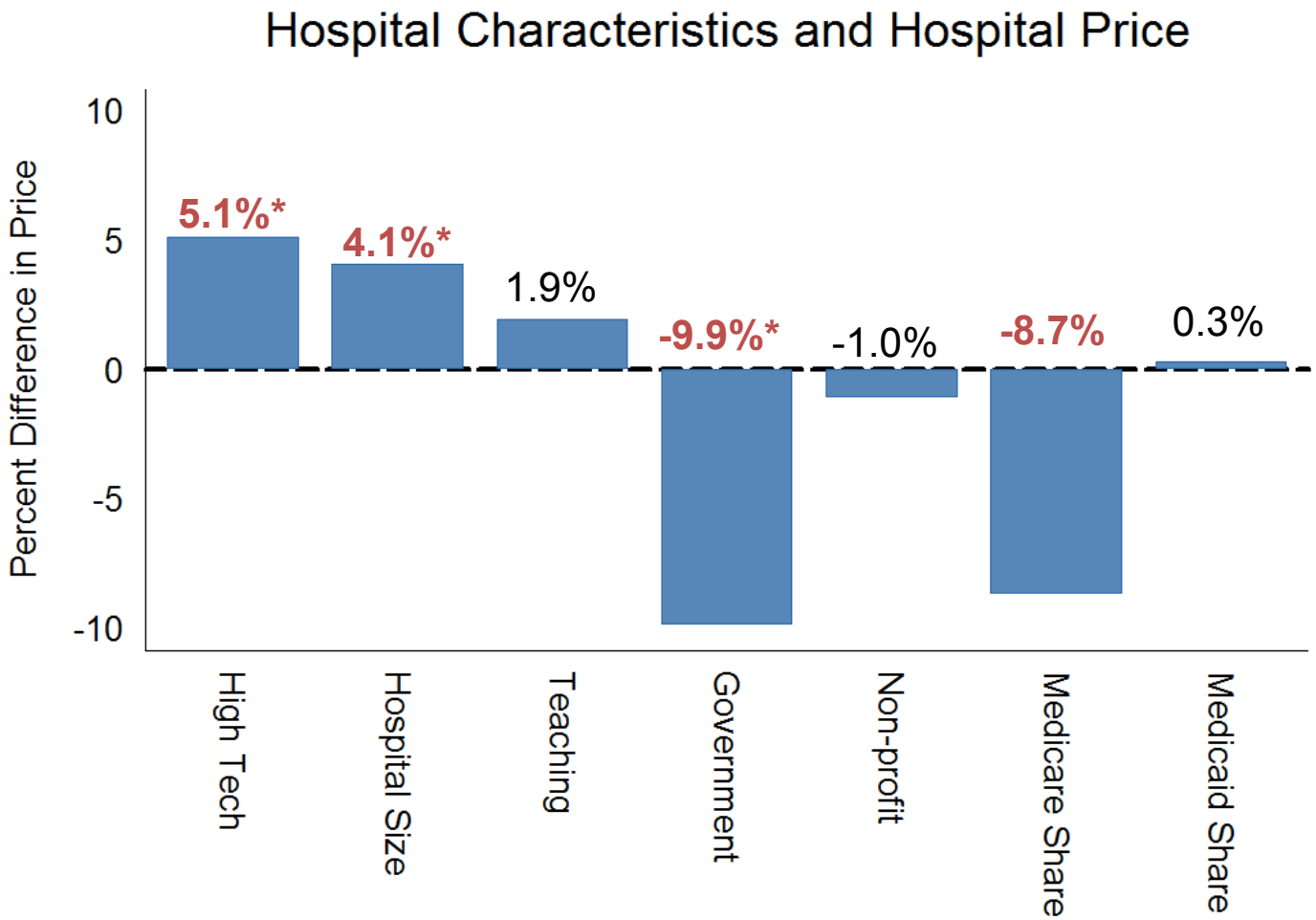
Bigger, High Tech Hospitals Have Higher Prices



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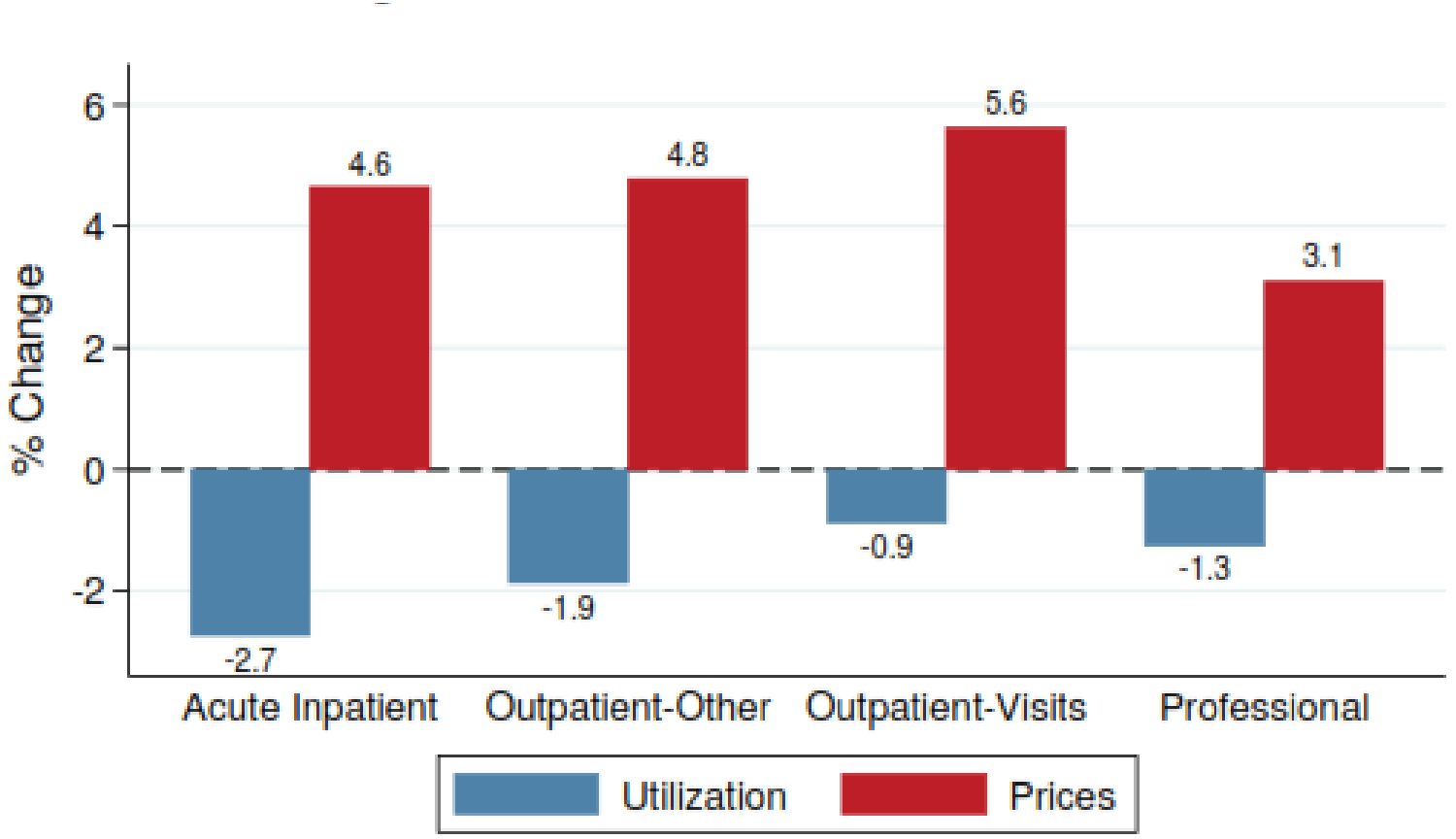
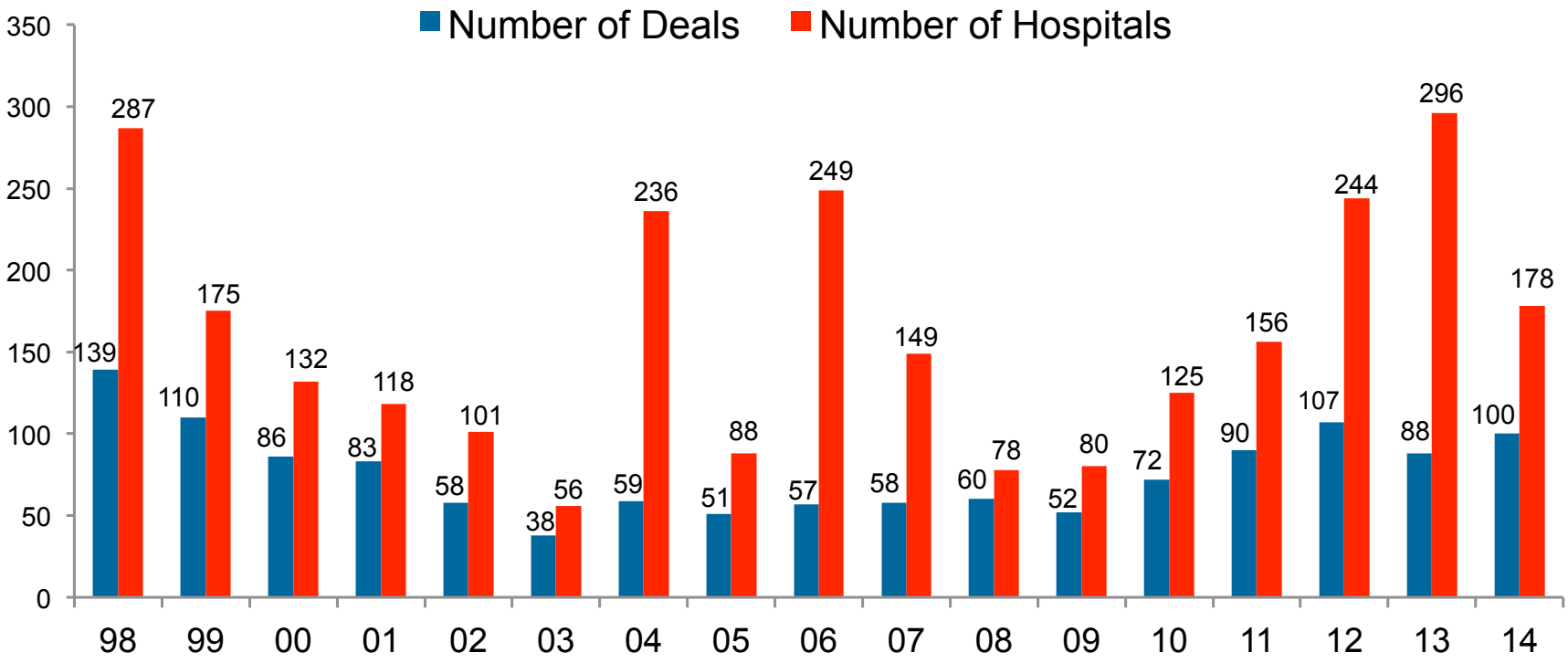
Why Is Health Spending Going Up?



Source: Health Care Cost Institute

Hospital M&A from ‘98 – ‘14



- Most areas in the US are dominated by 1 – 3 large hospital systems (Yale, Partners, Sutter)

Source: American Hospital Association

Other Providers Are Also Consolidating

Physician practices

- Significant increase in hospital employment of MDs: 29% now employed by hospitals or hospital-owned practices (up from 16% in 2007);
- Increase in mean practice size outside of hospitals

Dialysis Clinics

- Share of two two chains is 66% (up from 33% in 2000)

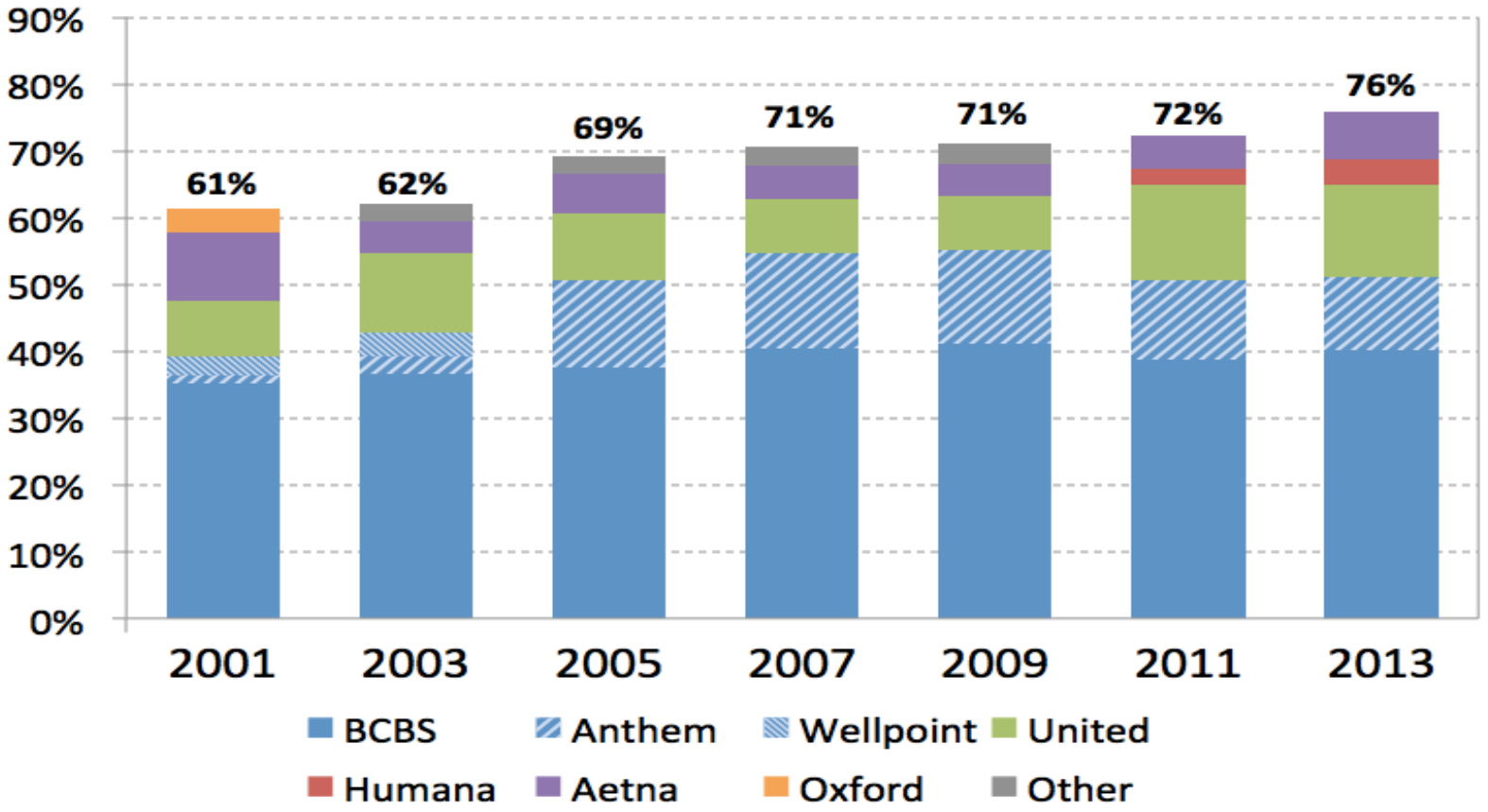
Long-term Care Pharmacies

- Share of top two chains is now up to 57%

Sources: Dafny, 2014, American Medical Association, Cutler et al., 2014, FTC

Also Significant Insurance Market Consolidation

Market Share of Top 4 Insurers, Fully-insured Commercial



Source: Martin Gaynor using data from NAIC & CCIIO. Excludes California.

Benefits of Consolidation

Benefits

- More coordinated care, less duplication, better outcomes
- Returns to scale
- A focus on health improvement and population health

The Evidence

- No evidence that consolidation leads to benefits
  - No evidence of cost decreases
  - Little or no evidence of improved quality
  - Charity care does not go up
  - Not-for-profits don’t have lower prices

Evidence on Price Changes Following Hospital Mergers

Haas-Wilson and Garmon (2011) analysis of Evanston-Northwestern Merger

- Four out of five insurers experienced rate increases of 20.1%, 26.5%, 35.1%, and 64%

Tenn (2011) analysis of Sutter and Summit Hospital systems in San Francisco

- Price increases of 55.6% and 65.3% for two insurers, no effect for a third, and price decreases of 30% for a fourth

Vita and Sacher analysis of Dominican Santa Cruz and AMI Community Hospitals in Santa Cruz, CA

- Price increase of 23% at Dominican and 17% an nearby non-merging hospital

Dafny (2009)

- Hospitals increase price by 40% following mergers of nearby rivals

Nevo, Gowrisankaran, and Town (2014) analysis of Inova Health System Price William in VA

- Price increase of 30.5%

Source: Gaynor 2016

Hospital Competition and Clinical Quality

Consolidation can lead to substantially lower quality – administered prices

- 1.46 percentage points higher death rate from heart attack in most concentrated markets for Medicare patients (Kessler and McClellan, 2000)
- Higher mortality rates in more concentrated markets for English NHS patients (Cooper et al., 2011; Gaynor et al., 2014; Bloom et al., 2015)

Consolidation can lead to lower quality – market determined prices (but some studies go the other way)

- Hospital merger (Evanston) had no effect on some quality indicators, harmed others (Romano and Balan, 2011)
- Hospital mergers in NY state had no impacts on many quality indicators, led to increases in mortality for AMI, heart failure patients (Capps, 2005)

Source: Gaynor 2016

Evidence from Physician Practice Consolidation

Physician practice mergers

- Can lead to large price increases (Dunn and Shapiro, 2014, Baker et al., 2014a)
- Can lead to higher price growth (Baker et al., 2014a)

Hospital acquisitions of physician practices

- Greater referrals to integrated hospitals (Capps 2014)
- Higher prices (Baker et al., 2014b, Capps et al., 2015)
- More likely to go to high cost, low quality hospital (Baker et al. 2015)

Source: Gaynor 2016

Insurance Competition

Increased market concentration leads to substantial premium increases

- Aetna Prudential merger in large group market (Dafny et al. 2012)
  - Increase in concentration led to 7% increase in premiums 1998-2006
  - ~$34 billion per year; $200 per insured person
- Small group market (Guardado et al. 2013)
  - Merger of United and Sierra in Nevada
  - 13.7% increase in premiums due to the merger
- Individual exchange market (Dafny et al. 2014)
  - Premiums decrease of 5.4% had another firm entered the exchanges
  - Exchange premiums would have been 11.1% lower if all insurers in a state had participated
- Medicare Advantage bids (Song et al. 2012)
  - Each additional insurer in a market lowered bids by $1.28

Source: Gaynor 2016

Joint FTC DOJ Statement on CON Laws

CON laws, when first enacted, had the laudable goals of reducing health care costs and improving access to care. However, after considerable experience, it is now apparent that CON laws can prevent the efficient functioning of health care markets in several ways that may undermine those goals.

First, CON laws create barriers to entry and expansion, limit consumer choice, and stifle innovation.

Second, incumbent firms seeking to thwart or delay entry or expansion by new or existing competitors may use CON laws to achieve that end.

Third, as illustrated by the FTC's recent experience in the *Phoebe Putney* case, CON laws can deny consumers the benefit of an effective remedy following the consummation of an anticompetitive merger.

Finally, the evidence to date does not suggest that CON laws have generally succeeded in controlling costs or improving quality. For these reasons, explained more fully below, the Agencies historically have suggested that states consider repeal or retrenchment of their CON laws, and, in this case, respectfully suggest that South Carolina repeal its CON laws.

Joint FTC/DOJ Statement on CON Laws

My Reticence about CON Laws

- They constrain the supply of health care and shield incumbent providers from competition from new entry
  - Raise cost and uncertainty of entry of new providers
- De Novo entry may be where the innovation is most likely to happen
- CON laws are subject to political capture
- Can be used as a shield against Federal action (e.g. West Virginia and Albany Georgia

Source: FTC/DOJ joint statement on CON laws

Solutions: Focus on the Supply Side

- Need price transparency and a national private health insurance claims database
- Better payment policy – my vote would be cap on FFS payment levels and shift firms towards some form of capitated payments
- Probably price regulation in concentrated markets
- Aggressive anti-trust policy and state policy that encourages entry and allows exit of providers