Concentration & Competition in Health Care

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Competition Policy and Health Reform

- Reform controversies implicate competition
  - Need for regulation to deal with market imperfections
  - Role of the insurance exchange
  - Public plan option
- Competition issues
  - Concentration
  - Provider behavior
  - Payor competition
Provider Markets: Worst of Both Worlds

- Provider markets exhibit BOTH excessive concentration AND fragmentation
- Hospitals: Very significant horizontal merger activity and system-building over last 15-20 years
  - *Result*: 90% of population are in highly concentrated hospital markets in *large* MSAs.
  - *Cost implications*: Inpatient price increases from 5-40% (depending on proximity of hospitals) \textit{RWJ Synthesis Project}
  - *Quality studies*: Mixed, some show concentration reduces quality, others no effect
Provider Concentration cont’d

- Hospitals: concentration enables collusion
  - Horizontal cartels to inhibit entry
    - Collusion vis a vis specialty hospitals
    - Collusions to divide markets using CON
- Physicians
  - Increasing concentration in single specialty practices
  - Decrease in multi-specialty practices
    - Hence, large percentage of primary care physicians solo or in very small groups
  - Physician Cartels (over 70 FTC DOJ case, advisories, etc)
  - Recent uptick in hospitals employing physicians
    - Which ended badly in the 90’s
Outcomes: Leverage, high prices and little care coordination

- Leverage
  - Empirical studies (see MedPAC Public Hearings Oct 09)
    - GAO study of FEHBP PPOs, after controlling for cost and service differences
      - Physician prices varied by 100%
      - Hospital prices varied by 259%
      - Less competition (measured by hospital concentration and amount of HMO capitation) was associated with higher prices.
      - Volume and other factors only partially offset price correlations
  - Center for Studying Health Systems Change
    - Recent California reports illustrate provider leverage
Insurance Market Concentration

- AMA data
  - 400+ Mergers
  - 94% of “markets” are highly concentrated
  - One or two firm dominance common
- High concentration in individual and small group sectors (where reform legislation will expand mkt)
- HMO/PPO dynamic
  - Spillovers of change in practice styles
- McCarran repeal: Less than meets the eye
  - www.healthreformwatch.com
Implications for Competition

- Private insurance: Hospitals, physician groups with leverage resist price or utilization concessions
- Medicare Advantage bidding:
  - 30 of top 100 markets one firm has >50% market share
  - 70% Highly concentrated
- Traditional (FFS) Medicare
  - Costs rise as price does in concentrated markets
    - MedPAC: Hospitals with less pressure in private markets tend to have higher costs (more MAR, administrative slack, high salaries)
  - Increasing pressures for Congress to raise payments
    - Political attention on “cross subsidies”
- The uninsured
  - Provider prices 2x (specialty physicians) to 3x (hospitals) higher
  - Mark Hall *Price Gouging by Doctors and Hospitals* [ww.healthreformwatch.com](http://ww.healthreformwatch.com)
Why haven’t market forces “fixed” organizational problems?

- Imperfect market conditions
- Erroneous court decisions
- Legal impediments
- Weak political support for competition
- Consumer-driven snake oil
- Behavioral economics

Antitrust Law: No Silver Bullet for Concentration

- Antitrust rarely, if ever, “deconcentrates” monopolized markets
- The law’s prime remedy is prophylactic
  - Blocking mergers (BUT: lost 7 cases in a row in 90’s)
  - Forbidding outright collusion (price fixing, market division agreements) among firms
- Dominant firm conduct challenged only if
  - Exclusionary (or predatory)
  - Lacking business justifications
- Examples: Response to specialty hospital
  - Unilateral hospital actions v. collusive hospital actions
Concentration: Implications for Health Reform

- Reform Bills peg hopes for cost control on markets
- Obstacles to cost/volume control
  - Concentrated buyer and seller markets
  - “Must have” hospitals and specialty groups
  - Entry barriers (professional, brand names, etc)
- Bilateral Monopoly
  - Uncertain outcomes
  - Live and let live experience in Massachusetts
- Role of the Public Plan
  - Maverick competitor? Benchmarking? Innovator?
Regulatory Adjustments

- Tim Jost: Medicare Amendments “a laundry list of every idea for improving delivery, enhancing quality, or controlling costs...Its like they read thru the table of contents of every Health Affairs for the past five years.”
- The problem: How will the delivery system vessels develop into which Medicare pours bundled $$ etc???
- The Insurance Exchange
  - The Commish has power to “negotiate” with bidders under the House bill
Regulatory Adjustments to Improve the Delivery System

- Medicare Payment: driver of delivery system change?
  - Medical homes, ACOs
  - Bundled payments,
  - SGR reform to

- Other Regulation
  - Standardization
  - Information
  - Subsidies to infrastructure
  - Insurance Exchange

Commish: Negotiator? Regulator?
Parting Thoughts

- It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of businessmen in general. (Kenneth Arrow).
- [For physicians], nonfinancial incentives such as patient outcomes, autonomy, regret, and peer approval, may have as strong or stronger an impact on physician behavior than financial incentives (Robert Town)
- It’s the delivery system, stupid (Bill Sage).
Summing Up.....