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ESSAYS ON TRENDS, INNOVATIVE IDEAS AND CUTTING-EDGE RESEARCH IN HEALTH CARE

The Future of Health Care Costs:

Hospital-Insurer Balance of Power

Austin Frakt, PhD, Health Economist, Department of Veterans Affairs and Assistant Professor, Boston University

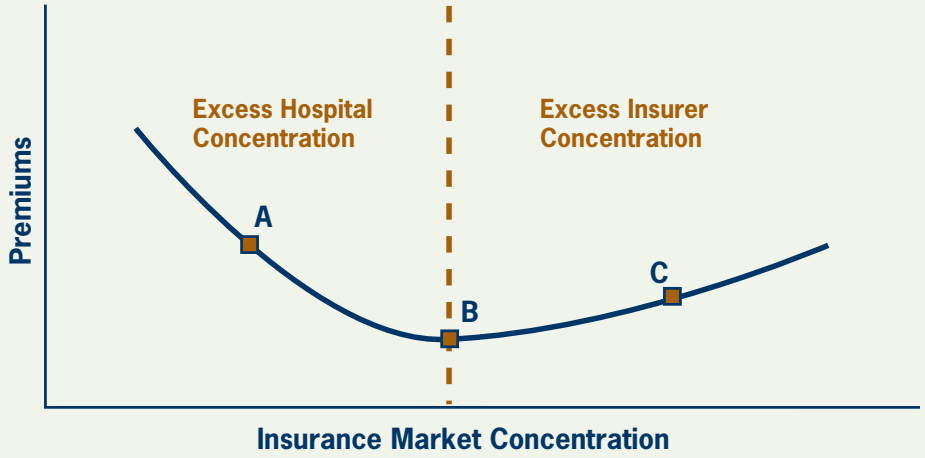
Cory Capps and Rexford Santerre provided valuable insights for this essay.

Even with the passage of the Patient Protection and Affordable Care Act (ACA), the U.S. health care system is and will remain predominantly private and market-based. With the exception of the military, Indian, and veteran health systems, private-sector institutions provide most health care services. Likewise, while public insurance plays a central role for the elderly and low-income populations, most insured are covered by private plans.

Market forces, then, heavily influence the characteristics and costs of the U.S. health system. In particular, market structure defined by the degree of consolidation in the hospital and insurance industries is a key determinant of the price paid for hospital services, affecting both the revenue earned by hospitals and the costs to indemnity insurers, self-funded employer plans and policyholders. Government policy plays a role in private markets, too, setting market constraints and addressing efficiency, quality and price issues within public programs in ways that may have spillover effects for the private market. With the passage of the ACA, government policy and market dynamics are expected to interact and change, with possible consequences for providers, insurers and consumers.

In this essay, I draw on the large and growing body of research on the history and consequences of hospital and insurer market concentration to support hypotheses about how provisions of the ACA may differentially affect hospitals, insurers and consumers in the public and private health care market sectors. I also offer suggestions for areas where antitrust policy and health economics research need more attention in order to prepare for the changes ahead.

Figure 1. The Effect of Insurer Market Concentration on Health Insurance Premiums For a Fixed Level of Hospital Market Concentration



Hospital and Insurer Consolidation and Premiums

Over the last two decades, both the hospital and health insurance markets have become significantly more concentrated as a result of horizontal mergers and acquisitions,[1,2] likely imparting growing market power to firms remaining in the market. At the same time, health insurance premiums have also risen at a rapid rate, outpacing general inflation in every year since 1997. With about 33 cents of every private premium dollar being paid out to hospitals in 2008,[3] the prices negotiated between insurers and hospitals are an important determinant of overall premiums. In any given market these prices will reflect the relative market concentration of hospitals versus insurers, as well as the negotiating clout held by "must have" or "star" hospitals.

Understanding how hospital versus insurance concentration affects hospital prices and premiums is difficult due to the complex nature of price competition in the market for hospital services. A simplified picture of this complex relationship is illustrated in Figure 1, which shows how health insurance premiums in a market would be expected to vary depending on the "balance of power" between insurers and hospitals. This curve assumes a fixed level of concentration among hospitals so that the relative balance of power varies as insurer concentration changes along the horizontal axis. When insurance market concentration is low relative to that of hospitals (point "A"), the dominant hospitals can exercise market power and command relatively high prices from insurers, which are passed on to consumers in the form of higher premiums. As insurer concentration and relative power vis-à-vis hospitals increase (moving from point "A" toward point "B"), dominant insurers gain monopoly-busting power and can use the threat of network exclusion to negotiate lower prices and, thereby, offer relatively lower premiums. If, however, insurer market concentration

far exceeds that of hospitals (point "C"), insurers can mark up the lower prices they obtain from hospitals and retain the difference as profit with little fear of losing enrollees to other insurers.

The rough shape of the curve illustrated in Figure 1 can be reproduced with formal economics models and features of it have been empirically verified by numerous studies. Most prior work has focused on hospital consolidation and concluded that greater hospital market concentration raises hospital prices, sometimes by very significant amounts.[4,5,6] Insurer consolidation can also lead to higher premiums, but available evidence points to a very modest impact. One recent study showed, for example, that the significant increase in insurer concentration that took place between 1998 and 2006 explained only 2 percent of the total increase in premiums over that period.[7] Other studies have found that insurer market power can counteract hospital monopoly power, reducing prices while increasing access.[8,9]

Since the relative concentration of hospitals and insurers varies by market and over time, different markets and eras are associated with different points on the curve illustrated in Figure 1. It is possible for hospital and insurer market concentration to be in optimal balance in one market in one year and out of balance in another place or time. Consequently, public policy that systematically shifts the relative market power of hospitals and insurers may have an ameliorative effect in one market and a detrimental impact in another.

Looking Ahead

The ACA includes many provisions that will alter the nature of health care markets. Chief among these changes is the encouragement for providers to form more integrated delivery systems capable of organizing care for a defined population and accepting new forms of payment that promote efficient provision of high quality care. Medicare and Medicaid will begin testing these new "accountable care organizations" (or ACOs) in 2012. The extent of provider integration and the locus of control that will develop in these new models are as yet unknown and bound to vary across pilot test sites. A growing number of observers, however, are voicing concerns about the potential for increased hospital market power, especially if hospitals control the flow of money and access to other providers in the ACO or if several hospitals in a market join forces.

Historically, public programs have been largely immune from the effects of provider market power since they use administered prices rather than negotiating rates. The ACO model could, thus, reduce public health care spending relative to trend even in the face of provider consolidation. As Figure 1 illustrates, however, market power is clearly relevant to private-sector costs and premiums. Though scholars debate the extent to which hospitals can and do shift costs from public to private payers,[10,11] a period of high hospital market power relative to insurers and declining public payments presents the perfect conditions for this to occur. It was precisely these conditions that gave rise to the high private hospital margins – and high premium increases – of the late 1980s.[12] The possibility of seeing public-sector savings but negative consequences for the private sector will make it important to take a broad view when evaluating the success of ACOs.

Considerations for Antitrust Enforcement and Future Research

As of this writing it is unclear how antitrust enforcers will view ACOs but early indications are that enforcement efforts are unlikely to hamper provider integration significantly.[13] The ACA also gave the Secretary new latitude to grant waivers and create safe harbors protecting ACOs from anti-kickback, self-referral and civil monetary penalty laws. If ACO formation proceeds with few checks, the scenario described above is more likely to play out, resulting in lower public-sector costs but higher private-sector premiums. Subjecting provider integration initiatives to stronger antitrust scrutiny and enforcement of fraud and abuse laws would help to moderate these effects.

Another issue related to antitrust enforcement pertains to courts' inability to untangle the complex relationships among employers, insurers and consumers in order to allocate damages from illegal use of hospital market power. In April 2010 the U.S. District Court for the Northern District of Illinois denied class certification in an antitrust action against the January 2000 Evanston Northwestern Healthcare Corporation's acquisition of Highland Park Hospital, ruling that the plaintiffs did not prove "common impact." Specifically, the court found that the effect of hospital price increases stemming from the merger may differ for direct purchasers (insurers, self-insured employers) and indirect purchasers (insured employers and policyholders). In the future, methodologies must be developed to allocate damages among diverse stakeholders or regulations must otherwise be reformed to facilitate redress. The ability for direct and indirect purchasers of health care to form classes deemed legitimate in the eyes of courts would be a disincentive for providers to exercise potentially illegal market power.

Finally, additional research is needed to develop a more complete characterization of the curve illustrated in Figure 1, not just nationally, but market-by-market, as well as over time and in response to changes in public policy. Comparing independent measures of hospital and insurer market concentration to thresholds provides an incomplete characterization of the potential for harm (or benefit) to consumers or upstream providers. Rather, it is the relative balance of market power between hospitals and insurers that matters. Our current knowledge of when and how to achieve the optimal balance is, unfortunately, not sufficient to guide regulators and policymakers as they attempt to navigate the changing landscape of the nation's health care system.

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