Health Affairs Blog

New Health Care Symposium: Consolidation And Competition In US Health Care

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Editor's note: *This post is part of a* Health Affairs *Blog symposium stemming from "The New Health Care Industry: Integration, Consolidation, Competition in the Wake of the Affordable Care Act," a conference held recently at Yale Law School's Solomon Center for Health Law and Policy. Links to all posts in the symposium will be added to Abbe Gluck's introductory post as they appear, and you can access a full list of symposium pieces here or by clicking on the "Yale Health Care Industry Symposium" tag at the bottom of any symposium post.*

Virtually all health care in the United States is delivered through markets, with a few small exceptions for specific groups, such as the Veterans Administration. This means that the health care system will work only as well as the markets upon which it relies. However, there is growing concern that those markets do not work as well as they should: prices are high and rising, there are quality problems, and there is too little organizational innovation.

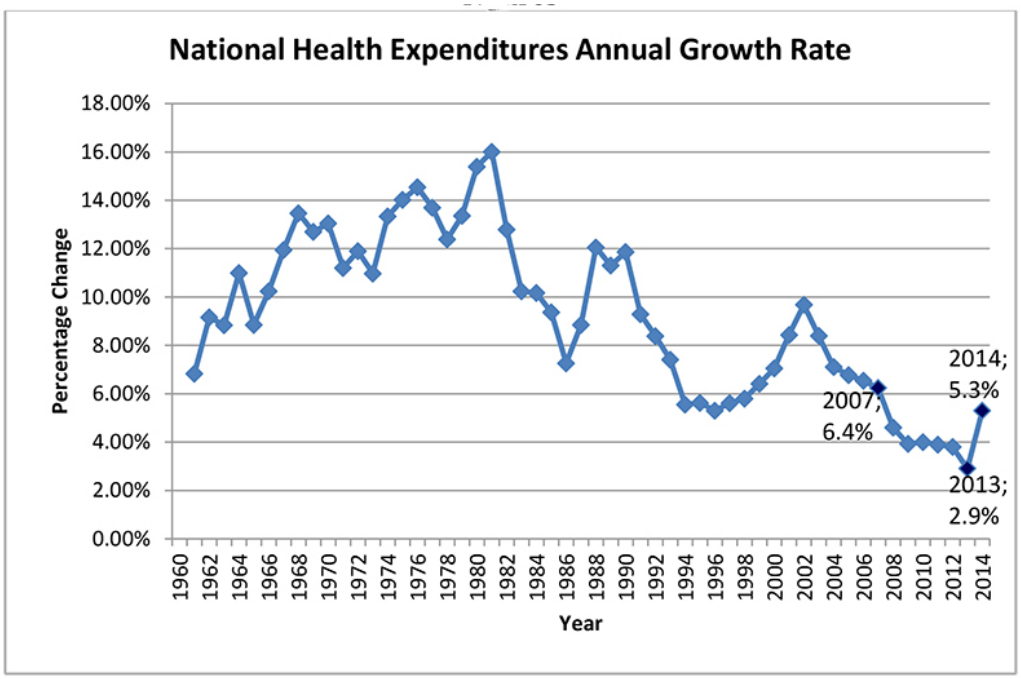
In my opinion, consolidation, concentration, and market power have a great deal to do with these problems. Many health care markets in the country are already highly concentrated, and more consolidation is happening. This isn't good for patients and their families, either for their pocketbooks or for the quality of care they receive. Moreover, what happens in health care markets matters for the success of the Affordable Care Act (ACA) specifically, and for all health reform generally. Markets are the chassis upon which the health care system runs — and if the chassis is broken, the car won't run, no matter how elegant or well designed the reforms designed to act upon it.

In what follows I describe what's happening in health care markets, with regard to health spending, prices, and consolidation. In particular, I focus on the potential benefits and potential harms of consolidation and what research evidence we have on both. I then turn to briefly discuss directions for policy, given the problems with markets I have described.

What's Happening?

The US has experienced high and growing health spending for decades, until very recently. Figure 1 illustrates the annual growth rates of national health expenditures from 1961-2014. As can be seen, growth in health spending has fluctuated substantially over the years, but has always been positive; health spending has grown every year since 1960, it's just a question of how fast.

Figure 1: Health Care Cost Growth 1961-2014

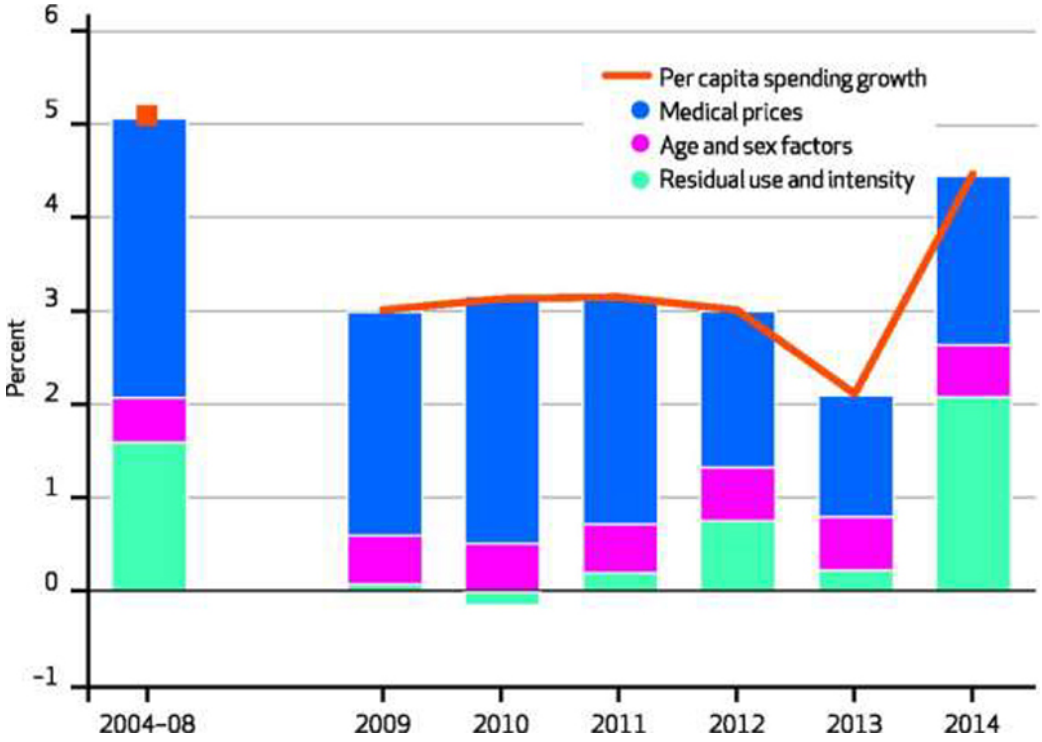


Source: Historical National Health Expenditure Data, National Health Expenditure Accounts, Centers for Medicare and Medicaid Services, US Department of Health and Human Services,

As many have noted, there has been substantial slowing of the rate of growth in recent years (one can see a marked downward trend since 2002), although the rate of growth increased again in 2014. It's nearly impossible to forecast the future (at least with accuracy), but it seems likely that health care spending will grow at a high enough rate that it will remain an important policy issue for the US.

Given that, it's critical to understand what's driving the growth in health spending. The first cut is to decompose spending into its constituent components. Spending is price times quantity, which is simple enough. In addition, health care prices or quantities could also increase due to intensity of service. The Centers for Medicare and Medicaid Services (CMS) national expenditure accounts team decomposes per capita growth in health spending into prices, age, and sex factors, and residual use and intensity. As can be seen from Figure 2, growth in prices is a major factor driving increases in total national health spending. The influence of price growth is remarkable, since this includes Medicare and Medicaid, which have government-set prices that are not subject to substantial growth.

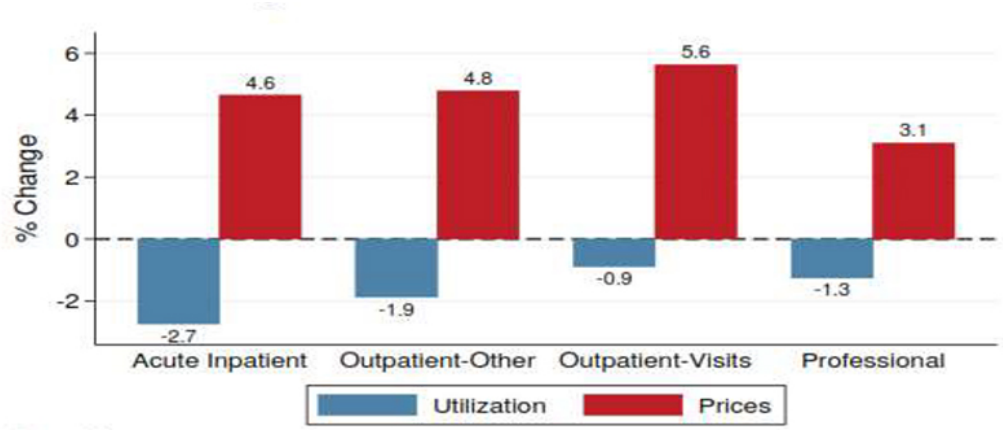
Figure 2: Factors Accounting For Growth In Per Capita National Health Expenditures, 2004-2014



Source: Anne B. Martin et al. (2016) "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," Health Affairs, 35(1):150-160.

The impact of prices on spending growth is even more pronounced when focusing only on private health spending. Figure 3 illustrates the sources of growth in health spending for those with employer-sponsored health insurance in 2014. The red bars are the growth due to prices and the blue bars capture growth in spending due to utilization. Clearly prices are the drivers of spending growth, as utilization decreased across all the categories of services documented there.

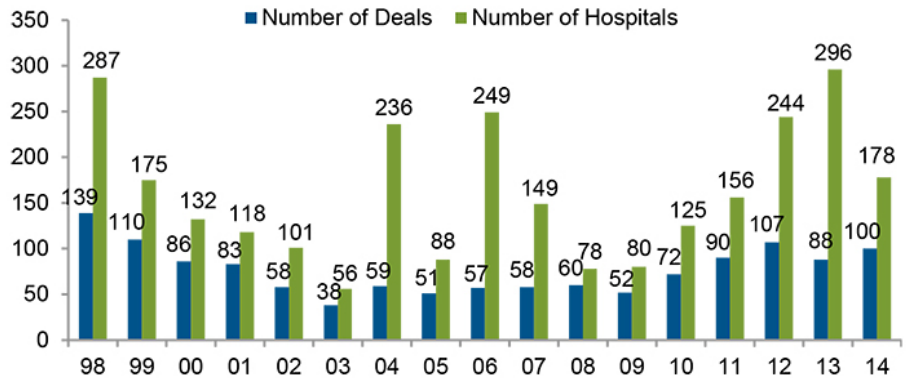
Figure 3: Changes In Utilization And Prices Of Medical Service Categories, 2014



Source: 2014 Health Care Cost and Utilization Report, Figure 8, Health Care Cost

There has been a tremendous amount of consolidation in health care over the past 20-plus years, in particular among hospitals. Figure 4 illustrates this. There have been over 1,200 hospital mergers since 1994, involving a substantial portion of US hospitals. There was a large hospital merger wave in the mid- to late-90s, followed by some slowing. Hospitals have recently started merging again at a dizzying rate; there were 457 mergers from 2010-2014.

Figure 4: Hospital Mergers And Acquisitions, 1998-2014



Source: American Hospital Association, Trendwatch Chartbook 2015, Chart 2.9

There has been so much consolidation that most urban areas in the US are now dominated by one to three large hospital systems — examples include Boston (Partners), the Bay Area (Sutter), Pittsburgh (UPMC), and Cleveland (Cleveland Clinic, University Hospital) (Note 1). It is also now more likely that further consolidation will combine close competitors, given how many mergers have already occurred.

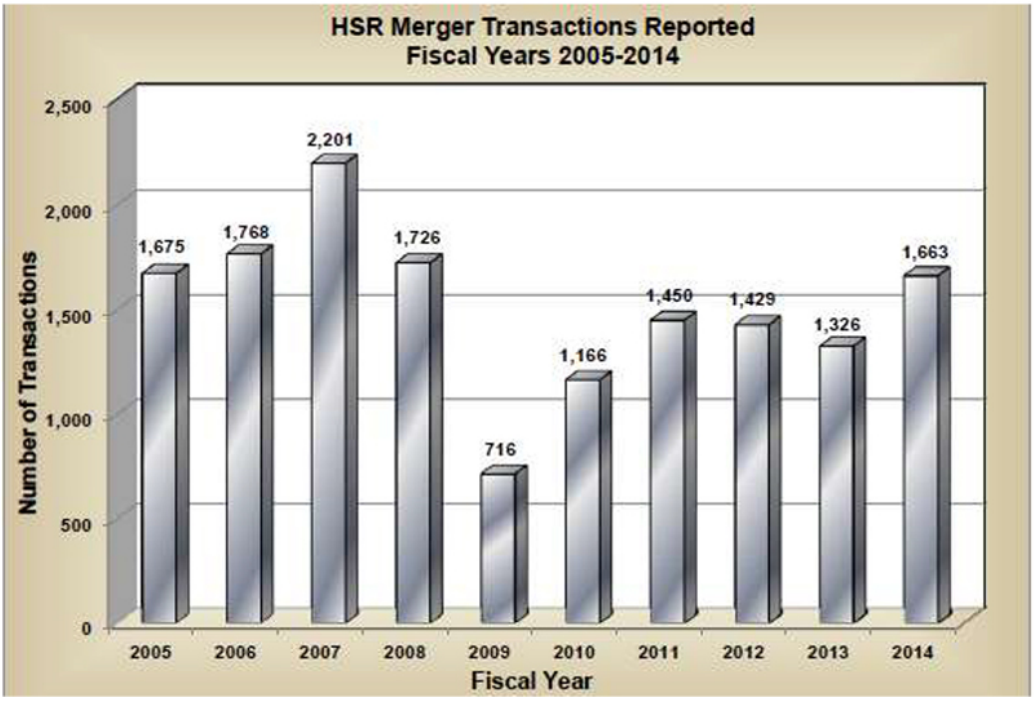
There has been a more recent trend towards acquisitions of physician practices by hospitals. While there are no comprehensive numbers on this phenomenon, it's reported that there has been a 32 percent increase in the number of doctors employed by hospitals over the last decade (Health Forum LLC. AHA hospital statistics 2012 edition. Chicago (IL): Health Forum LLB; 2011.), and that 32.8 percent of physicians are now employed by hospitals. (Account creation required.) The overall picture is of a highly concentrated provider sector that is rapidly becoming even more consolidated.

There are a number of explanations given for this rapid and extensive consolidation by health care providers. One has to do with the desire for enhanced bargaining power in negotiations with insurers. This seems to have been one of the drivers of the 1990s hospital merger wave: hospital consolidation followed the rise of managed care. It is also commonly thought to be a motive for hospital mergers between competitors today.

Another explanation has to do with the movement away from fee-for-service payments and towards new payment methods that shift risk to providers. Providers commonly state a perceived need to spread the risk associated with these new payment methods by getting bigger. (I note that bigger isn't always better. Small and nimble is sometimes a better way to ride out, and even prosper in, turbulent times.)

Another commonly stated reason for consolidation has to do with the changes wrought by the ACA and change in the health care sector generally. Providers may be attempting to shelter themselves from uncertain times by getting larger. It should also be noted that there has been a surge in mergers across all sectors of the economy, due in part to some post-recession "catching up" and the availability of ready cash. Figure 5 illustrates this. This suggests that some of what we observe with health care consolidation may be due to economy-wide, as opposed to health care-specific, factors.

Figure 5: Economy Wide Mergers, 2005-2014 (Hart-Scott-Rodino Reportable Mergers)



Source: Hart-Scott-Rodino Annual Report, Fiscal Year 2014, Federal Trade Commission and Department of Justice.

There are also a set of explanations for consolidation related to “The Triple Aim” of improving quality, reducing costs, and supporting population health. The claim is that consolidation will allow providers to improve quality for patients by better coordinating care or by having the scale to invest in information technology systems or other processes. Consolidation is also said to decrease costs by reducing or eliminating duplication and allowing firms to achieve economies of scale. Last, providers claim that they need to consolidate in order to have the scale and scope to address population health.

Potential Benefits Of Consolidation — And Evidence

While there is a logic to these claims regarding the potential benefits of consolidation, the evidence does not support them. Hospital mergers do not generally lead to reduced costs or improved quality. Merely changing ownership via consolidation does not imply integration. Not surprisingly, real integration is what’s required to realize any potential benefits from consolidation, and integration is hard.

Further, the vaunted reputation of integrated delivery systems does not hold up to inspection. While integrated delivery systems may seem in principle to be a superior form of organization, it turns out that most integrated delivery systems are neither cheaper nor better than independent providers.

Potential Harms Of Consolidation — And Evidence

The concern about consolidation is that mergers between close competitors will substantially damage or eliminate competition in markets where this occurs. Providers compete to be included in payers’ networks based on price and quality. If two (or more) providers are close competitors, a merger between them will eliminate that competition. Competition in the market will be harmed unless there are sufficient remaining alternative providers that are close substitutes for the merged entity.

This concern is particularly pronounced now that US health care markets are so concentrated. If mergers have already reduced the number of close competitors in a market, the next merger is quite likely to seriously harm competition.

There is very strong evidence that mergers between hospitals that are close competitors lead to substantial increases in price. There is an extensive scientific literature examining hospital competition, and it consistently shows that competition leads to significantly lower prices (and vice versa). Studies of hospital mergers show that mergers between close competitors can lead to price increases anywhere from 20 to up to 60 percent. It's important to recognize that while these price increases are paid directly by insurers, they are ultimately passed on to consumers in the form of higher premiums or reduced total compensation for workers with employer sponsored health insurance.

There is now also substantial research evidence on the impact of consolidation on the quality of care. There is strong evidence that reduced competition harms quality when prices are administered (as for the Medicare program or in the English National Health Service). The effects of competition on quality when prices are market determined (as they are for the privately insured) is less clear, although in my opinion the best studies to date find that competition is associated with better quality. Clearly more work is needed here.

Why Should We Care?

We've reviewed what's happening with regard to health care spending, prices, and consolidation. Why should we care about all this? We should care because health care spending growth is high and unsustainable. Unless it changes we are mortgaging our future and our children's futures.

Much of higher private health care spending is paid for by workers. Higher health care costs are passed on by employers to their workers. The average American family hasn't had an increase in their real income net of health care costs in a long time. In addition, these costs are a disproportionate burden on the least fortunate among us — higher prices are a greater burden for low-income individuals. Higher private prices make less remunerative public programs (such as Medicaid) less attractive to providers, likely harming access.

Rigidities in health care markets lead to higher prices, lower quality, and likely impede innovation. Lower quality of care can have profound consequences for patients. Firms with dominant market positions don't necessarily have strong incentives to innovate. This may be one reason that the health care sector has been so slow to develop and adopt new and better ways of organizing and delivering care, including taking full advantage of advances in information and medical technology.

Another potentially serious consequence of provider market power is that dominant providers may have the ability to resist attempts by insurers to introduce payment reforms, or simply to subvert the incentives in those new payment methods. A dominant provider can bargain with an insurer not only over payment levels, but over payment methods. Dominant providers can simply refuse to accept new payment methods if status quo methods (such as fee for service) are more beneficial for them. There are anecdotal reports of this happening. More broadly, how providers are paid can't create competition, and some methods (e.g., reference pricing) will work poorly or not at all if there's insufficient competition.

Even if a provider accepts a new payment method, it can undo the incentives in that payment method if it negotiates a high enough rate. The methods in payment reform rely on rates being close enough to providers' costs to offer an incentive to reduce costs or improve quality. If a dominant provider negotiates a high enough rate they will face little pressure and therefore have little or no incentive to respond.

What Should We Do? Time To Focus On Supply Side Policies

Policies toward health care markets can be roughly divided into "demand side" and "supply side" policies. Demand side policies are those that act on consumers with regard to their use of health care. These include coverage expansions, cost sharing, and information. At this point, I don't see further major new policies with regard to coverage expansion following the ACA. There is a lot of

discussion about consumer cost sharing (e.g. high deductible health plans) and information (e.g., transparency).

Health insurance policies should have some consumer cost sharing (tailored to what the individual can afford). This lowers premiums and provides incentives to reduce utilization. Transparency aims to provide consumers with information about prices and quality, and in particular what their out-of-pocket expenses will be for a service at particular providers.

These are all fine things to do (within reason). However, it's not realistic to expect these policies to drive change in health care markets by themselves. One key reason has to do with the nature of health care expenses. It's well known that a small proportion of individuals account for the vast majority of spending. Those individuals have expenses that are (and should be) well beyond the cost-sharing features of any reasonable health insurance plan. What that means is that they have no incentive to choose care or providers based on costs, no matter how good the information is that they have.

As a consequence, the majority of health care costs are not going to be responsive to cost sharing or transparency initiatives. This doesn't mean we shouldn't bother with such initiatives—they can still be beneficial—but we shouldn't expect these kinds of policies to drive health care markets. In addition, some recent evidence suggests that consumers don't respond rationally to cost-sharing incentives, casting doubt on the ability of such methods to reduce costs or curtail inappropriate utilization.

Last, as stated previously, many markets are dominated by large powerful providers. In situations like this consumers have little choice, so providing them with incentives or information will accomplish little (if anything at all).

As a consequence, in my opinion it is time to focus on supply side policies. There are two broad supply side categories: payment reform/incentives and competition policy. By payment reform I mean changing the methods by which providers are paid to encourage higher-quality care at lower cost. By competition policy I mean the constellation of things that affect the functioning of health care markets.

Competition policy includes federal and state antitrust enforcement. It also includes federal and state policies that set the "rules of the road" for markets and profoundly affect who is in those markets and how (and if) they compete: examples include any willing provider regulations; certificates of need; network adequacy regulations and oversight; transparency requirements; market monitoring, and scope of practice regulations. These are affected by both state and federal actors. We need policies that will encourage and support beneficial forms of integration while preserving and promoting competition.

As I alluded to earlier, payment and competition policies are complements. Providers who face little or no competition can subvert payment policy, rendering it ineffective. Conversely, payment policy can augment competition, contracting on things markets may not deliver on their own.

The US is facing a great challenge to our health care system. If left unchecked, consolidation could undermine attempts to control costs, improve care and increase the responsiveness and innovativeness of our health care system. We need new and vigorous supply side policies to encourage beneficial organizational change and competition. If we fail, we may have an even more expensive, less responsive health care system that will be exceedingly hard to change.

Author's note: *This paper is based on a presentation I gave at the Solomon Center Inaugural Conference "The New Health Care Industry: Integration, Consolidation, Competition in the Wake of the Affordable Care Act," at Yale University, November 12, 2015. I am grateful to the organizers Abbe Gluck and Fiona Scott Morton, to Michael Ulrich and Chris Fleming for help with this paper, and to the other conference participants for valuable interactions and comments. All opinions and errors, however, are mine alone.*

Note 1

There has also been substantial consolidation in health insurance. Leemore Dafny documents this in her post in this symposium.

ASSOCIATED TOPICS: COSTS AND SPENDING, HOSPITALS, INSURANCE AND COVERAGE, ORGANIZATION AND DELIVERY, PAYMENT POLICY, POPULATION HEALTH, QUALITY
TAGS: CONSOLIDATION, INSURER CONSOLIDATION, MARKET CONSOLIDATION, YALE HEALTH CARE INDUSTRY SYMPOSIUM