Overcoming the Pricing Power of Hospitals

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AMID A PERIOD OF UNPRECEDENTED CHANGE AND IMprovement in the US health system, the changes leading to larger local hospitals and health systems, including academic medical centers, are cause for concern. For decades, the dominant business strategy of local hospitals and health systems has been to gain local and regional market share and use that local market power to increase prices charged to private payers.

This model has been successful because large businesses must select health plans that satisfy the physician and hospital preferences for hundreds if not thousands of employees. Consequently, employers opt for broad and inclusive networks. This reduces their bargaining power, forcing employers to become price takers and tolerate 8% to 10% year-on-year increases in hospital prices.[1]

Moreover, health plans seem to have become immune to these price increases for 2 reasons: first, any single hospital, no matter how egregious its price increases, has only a small effect on total premiums. Second, price increases are common to all insurers, and do not constitute a competitive disadvantage. However, in a market where all hospitals aggressively increase prices, the net effect is large.

Hospital Spending and Consolidation

Hospital spending remains the largest category of health care costs, consuming nearly one-third of national health expenditures.[2] More than $880 billion will be spent on hospitals in 2012,[2] which is more than Social Security spending ($769 billion) or defense spending ($671 billion). Even more importantly, hospital price increases are now the largest contributor to increases in insurance premiums. According to an estimate for 2013, hospital prices will increase 8.2%—more than any other sector of health care spending.[1]

If the hospital market were functioning well, price increases would not continuously outpace inflation and would not be immune to a recession in which prices in the rest of the economy remained flat or decreased. Moreover, hospitals are increasing prices as demand declines—exactly the opposite of pricing behavior in competitive businesses.

Hospital consolidation is a long-term trend that predates enactment of the Affordable Care Act. It has multiple contributing factors, including the decline in hospital stays because an increasing number of procedures are performed at outpatient facilities. For instance, today, except for bone marrow transplantation, routine chemotherapy is almost never administered in the hospital—a substantial change from the mid-1990s. This decline in inpatient hospital use means there are too many hospital beds and low occupancy rates in many communities.

Health care reform has stimulated additional consolidation as well as having hospitals purchasing physician practices. Hospitals now employ a majority of physicians.[3] Hospitals justify this consolidation as necessary to support integrated care, investments in health information technology, and new payment models like accountable care organizations. In 2011, there were 86 hospital mergers and acquisitions, which was the most in the last decade.[4]

Hospital consolidations have not created high-quality and low-cost integrated delivery systems. Prices for hospital services are 13% to 25% higher in consolidated hospital markets.[5]

Challenges in Countering Hospital Pricing Power

State and federal policy makers, regulators, and health plans have struggled to design policies to counteract hospital market power. Hospitals, particularly academic medical centers, have substantial political clout. In many communities, hospitals are the largest employers and create high-paying jobs. For instance, hospitals in San Francisco, California, and Boston, Massachusetts, are among the largest local employers and sources of new jobs. Because price increases in part lead to higher wages for hospital workers, which translate into local economic growth, efforts to reduce hospital market power are politically complicated.

Patients and physicians frequently exacerbate the problems posed by hospital consolidation. Patients typically seek care at a hospital near their home. Neither the referring physicians nor patients typically know the prices charged by various hospitals or differences in the outcomes and patient experience that may justify price differences. With the exception of a small number of procedures (eg, organ transplantation), health plans have been ineffective at guiding patients to centers of excellence or hospitals offering better value. Despite high cost-sharing benefit designs and the increasing acceptance of consumer-directed health plans, individual members have rarely demanded price data and are subjected to out-of-pocket bills that amount to hundreds of dollars. In some cases, these bills are higher based solely on which local hospital patients choose.

3 Steps to Reduce Hospital Market Power

Incentivize Physicians to Be Sensitive to Hospital Prices. Changing reimbursement from fee-for-service to payment mechanisms that make physicians sensitive to the value of the hospital services can serve as an impediment to high prices. Shared-savings programs, bundled payments, reference-based

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pricing payment models, and global payments reward physicians for delivering high-value care. In designing these programs, it is important to ensure that physicians are responsible in some way for the total costs of care and therefore sensitive to the prices charged by hospitals. Well-designed programs produce lower hospital resource use, fewer bed days, and fewer emergency department visits.[6] Moreover, independent physician groups are more likely to direct their patients to lower cost hospitals. As the most profitable commercially insured patient volume flows away from high-cost hospitals that are not able to deliver better outcomes, the hospitals will have strong incentives to lower prices or substantially increase their value.

Support Pricing Transparency. Patients and physicians currently do not understand the out-of-pocket ramifications of hospital choices and the existence of lower cost nearby options. Some health plans are designed so that patients bear up to 40% of most medical costs up to out-of-pocket maximums and deductibles of several thousand dollars. Consequently patients have a strong incentive to know they will receive similar or better quality care at lower costs. Because hospital price and quality have little correlation, every major market in the United States is ripe for patients empowered by knowing out-of-pocket cost differences to leverage this arbitrage opportunity.

There are significant barriers to pricing transparency. Some of them are so-called gag clauses in contracts. Others are myriad prices offered for the same service. Lawmakers should simply prohibit pricing gag clauses in contracts. In addition, lawmakers should require clinicians to provide patients with a good faith estimate of total cost and their share of the costs at the time of scheduling the test or treatment.

Redefine Local Markets. For many purposes, such as antitrust enforcement and insurance offerings, local markets are defined as hospital referral regions. However, except for a few specialized services performed at major academic referral centers, most hospital care is local. Patients seldom access clinicians spread far across hospital referral regions. In major metropolitan markets, patients receive virtually all of their care within a small radius of their residence. Hence, patients effectively choose between only 1 or 2 hospitals. As a result, hospitals have pricing power far in excess of their market share in the hospital referral region.

To recognize the local nature of current health care delivery, regulators should consider local market effects of mergers and acquisitions when evaluating consolidation for antitrust violations. Traditional measures like market share within a medical service area or changes in the Herfindahl index do not capture these local effects. Health plans should create insurance products that more generously reward patients with lower deductibles and co-payments for seeking out and traveling to hospitals with lower prices and higher quality for specific services. This will require more transparency on hospital quality and pricing to patients.

These 3 recommendations operate synergistically and could create more competitive markets in which relative value for price drives competition and ultimately, differences in price. With the exception of antitrust enforcement and prohibition on gag clauses, these can be pursued today by private payers. Technology is also making each of these easier.

If these actions do not succeed in reducing hospital price growth, 2 potent additional policies could work in combination with these: prohibit hospitals from negotiating physician rates for their employed groups to reduce their market power; and adopt an all-payer rate system like that used in Maryland. Over the last few decades, Maryland has succeeded in reducing the rate of hospital price increases.[7]

Create Competitive Hospital Markets

Creating competitive hospital markets benefits patients and is essential to reduce the rate of health care cost growth. Moving from an era of market power enabling hospitals to be price setters to a market in which patient demand drives hospital prices and quality improvement has the potential to transform the US health delivery system. When this occurs, hospitals may offer differentiated services at a variety of price points, such as more personalized services for patients with chronic illness; offer guarantees and warranties for care; and build systems that deliver outcomes as opposed to activity, are focused on service and quality, and reduce if not eliminate waiting times.

The first step on the transformation pathway is to adopt policies that create the right incentives. The 3 proposed changes of incentivizing physicians, supporting pricing transparency, and reforming local markets (with the exception of prohibiting gag rules) can largely be done without new legislation.

Large employers can take the lead through their purchasing of care, engagement of their workers and health plans through changes in their reimbursement approaches, benefits designs, and supporting transparency. Doing so will save patients and payers money and help them receive better care in a market competing on value.

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