

Provider Perspective

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Duke Clinical Research Institute

From Thought Leadership to Clinical Practice

Recent Press on Providers

PROGNOSIS: PROFITS

95 Comments

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As doctors flock to hospitals, bills spike for patients

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Health Insurers Raise Some Rates by Double Digits

By REED ABELSON

Published: January 5, 2013 | 1116 Comments

A Hospital War Reflects a Bind for Doctors in the U.S.

By JULIE CRESWELL and REED ABELSON

Published: November 30, 2012 | 552 Comments

For decades, doctors in picturesque Boise, Idaho, were part of a

FACEBOOK

Prices soar as hospitals dominate cancer market

Recommend 149 people recommend this. Be the first of your friends.

Ames Alexander, Karen Garloch & Joseph Neff

aaalexander@charlotteobserver.com, kgarloch@charlotteobserver.com and jneff@newsobserver.com

Nonprofit hospitals thrive on profits

Hospitals in the Charlotte region are among the most profitable in the U.S. They have billions in investments and real estate. Experts say they should do more to lower patients' rising costs.

Recommend 89 people recommend this. Be the first of your friends.

By Ames Alexander, Karen Garloch and Joseph Neff

aaalexander@charlotteobserver.com, kgarloch@charlotteobserver.com, jneff@newsobserver.com

Health costs are rising...where hospital mergers allow the larger systems to use their size to negotiate higher prices.

-Susan Voss, Iowa Insurance Commissioner

Novant-owned Presbyterian Matthews Hospital - 35% gross profit margin in 2010

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<http://www.charlotteobserver.com/2012/04/21/3189821/nonprofit-hospitals-thrive-on.html>

<http://www.charlotteobserver.com/2012/12/17/3728676/as-doctors-flock-to-hospitals.html>

<http://www.charlotteobserver.com/2012/09/24/3549634/prices-soar-as-hospitals-dominate.html>

<http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?pagewanted=all>

<http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?pagewanted=all>

Provider Prices in North Carolina

2007-2010 Change

	Change in Utilization ¹	Increase in Cost ²
Individual	-2.3%	14.4%
Group	-3.8%	39.5%

¹ Utilization based on inpatient admission per 1000 members

² Cost based on allowed cost per admission

Market Concentration

CHALLENGES FOR HOSPITALS

By James Robinson

Hospitals Respond To Medicare Payment Shortfalls By Both Shifting Costs And Cutting Them, Based On Market Concentration

DOI: 10.1377/hlthaff.2011.0220
HEALTH AFFAIRS 30,
NO. 7 (2011): 1265-1271
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The People-to-People Health
Foundation, Inc.

EXHIBIT 2

Contribution Margins For Medicare And Privately Insured Patients In Concentrated And Competitive Markets

Payer	Knee replacement	Hip replacement	Lumbar fusion	Cervical fusion	Angioplasty with stent	Pacemaker insertion	Defibrillator insertion
HOSPITALS IN CONCENTRATED MARKETS (\$)							
Medicare	-190	-303	-207	1,818	3,346	1,937	-231
Private ins.	13,731	15,938	28,185	13,020	19,554	16,452	25,694
HOSPITALS IN COMPETITIVE MARKETS (\$)							
Medicare	1,700	1,023	1,575	914	2,250	4,159	4,439
Private ins.	7,529	6,732	17,195	5,946	9,496	9,282	17,370

SOURCE Author's calculations on 2008 data obtained from hospitals as part of the value purchasing initiatives of the Integrated Healthcare Association and Aspen Health Metrics. **NOTES** For definitions of *concentrated* and *competitive* markets, see Note 25 in text. These margin estimates were adjusted for patient-specific differences in age, diagnoses, comorbidities, complications, and discharge destination, plus characteristics of the hospital where the patient was treated (procedure volume, staffed beds, teaching status, wage rate).

- Robinson (2011) compared prices for procedures in consolidated vs. competitive hospital markets
 - Procedures cost 44% more in consolidated markets
 - Nearly all profit: margins in consolidated markets 41% higher

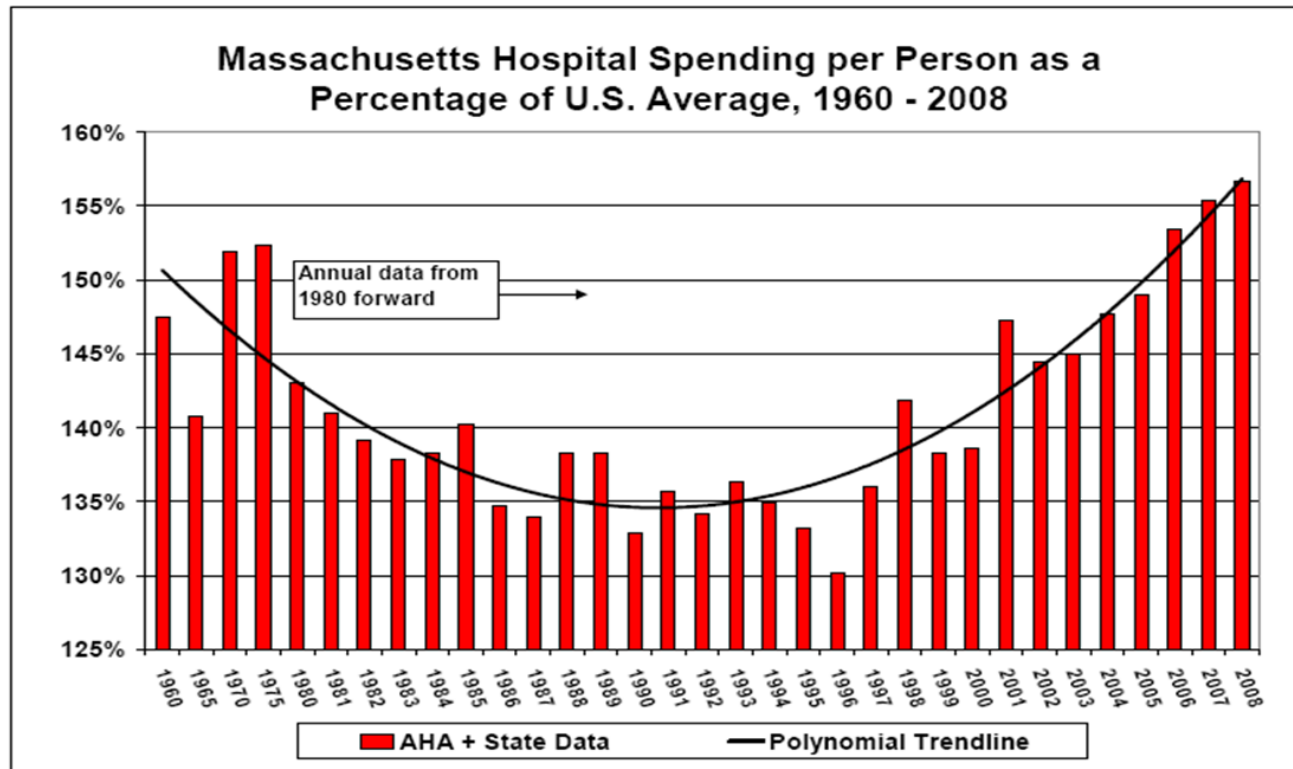
Market Concentration

- Dafny (2006) looked at price increases by *rivals* of merged hospitals in a specific market
 - Between 1989 and 1996, a rival's merger resulted in an average **40% increase in price by 1997** for neighboring hospitals within seven miles
 - Price increase is greater for hospitals that are closer together
 - Failing to instrument for rivals' mergers produces a statistically insignificant estimate of <2%
- Vita and Sacher (2001)
 - Analyzed a merger of two hospitals in Santa Cruz, CA
 - Prices at merged hospital rose 23%, 17% at rival
- Krishnan (2001)
 - Mergers among 22 OH and 15 CA hospitals
 - Compared mergers with HHI increases >2,000 to those <250
 - Prices rose 10% in >2,000 group vs. <250 group
- Capps and Dranove (2003)
 - Used transaction prices from a PPO to analyze 12 hospitals involved in consolidation from 1997-2001
 - Large price hikes vs. controls; 66% in one instance

Strategic Impact Over Time

**MASSACHUSETTS HOSPITAL SPENDING
REACHED 55.4 % PER PERSON
ABOVE THE U.S. AVERAGE IN 2007**

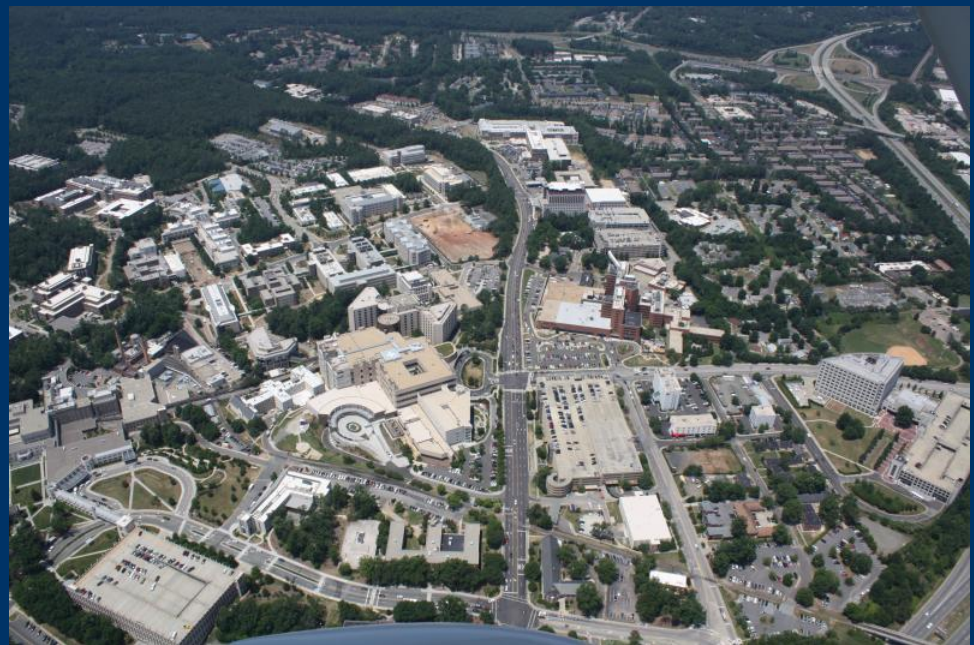
***Most of Excess Is Unjustified, and
State's Health Reform Law Is Negligible Factor***



Why Are Our Costs So High?

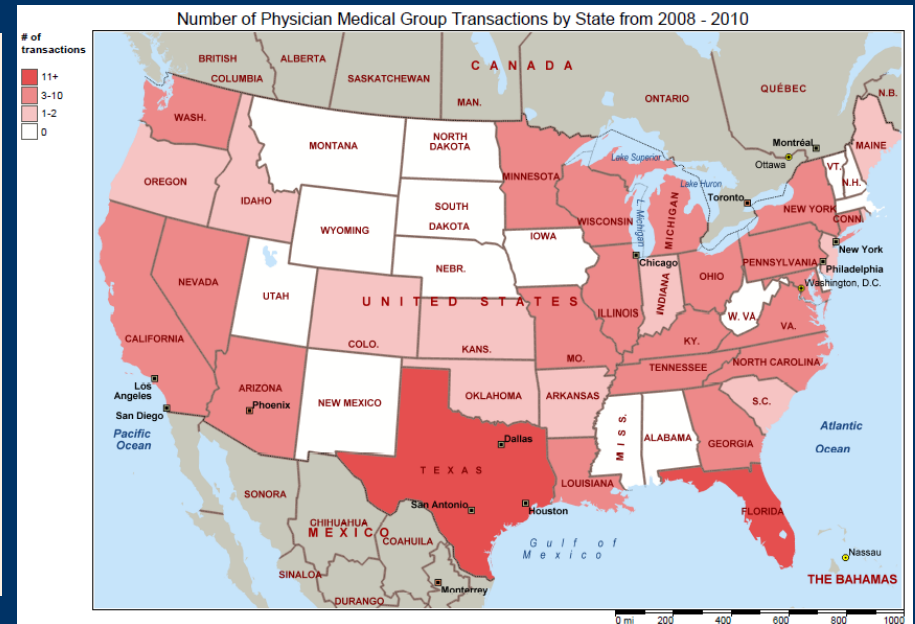
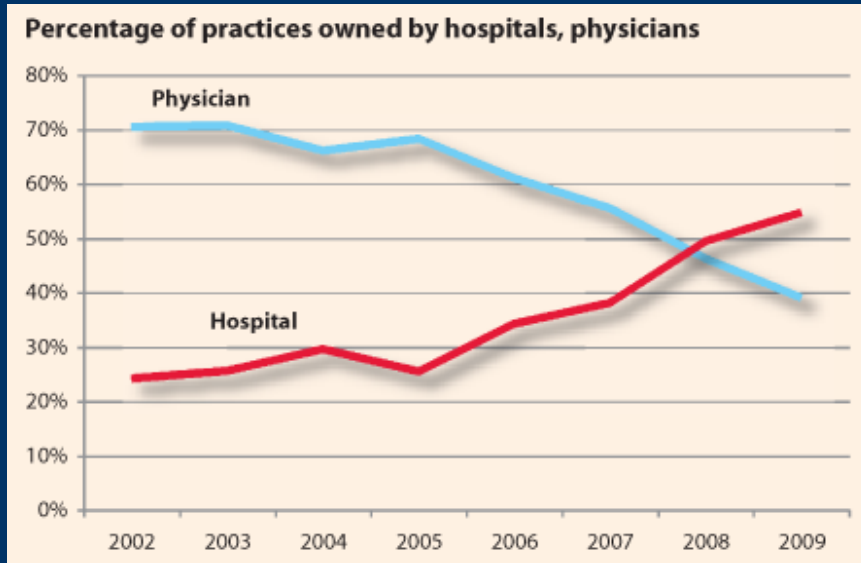
Complexity and infrastructure drive overhead costs

- Mission complexity
- Facility complexity
- Process complexity
- Management complexity
- Service line complexity
- Business process complexity (third-party payment)



Clayton M. Christensen, *The Innovator's Prescription: A Disruptive Solution for Health Care*, 2008

What's New: Physician Organization



Source: Medical Group Management Association

Note: Practices not owned by hospitals or physicians are owned by a variety of groups including the government, universities, and insurers.

Policy Approaches

Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.*

Physician Group Practice	Percentage of Quality Goals Attained				Shared Savings Payments (\$)			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45	0	0	0	0
Dartmouth–Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34	0	6,689,879	3,570,173	328,798
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34	0	129,268	0	0
Forsyth Medical Group, Winston-Salem, NC	100.00	100.00	96.23	96.23	0	0	0	0
Geisinger Clinic, Danville, PA	73.73	100.00	100.00	100.00	0	0	1,950,640	1,788,106
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00	4,565,327	5,781,573	13,816,922	16,154,242
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34	0	0	0	0
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00	0	0	0	0
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11	0	0	3,143,044	8,185,757
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23	2,758,370	1,239,294	2,798,006	5,222,852

* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

ACO's: Problems or Solutions

A Cautious Path Forward on Accountable Care Organizations

Barak D. Richman, JD, PhD

Kevin A. Schulman, MD

SPURRING THE CREATION OF ACCOUNTABLE CARE ORGANIZATIONS (ACOs) was a signature initiative in the Patient Protection and Affordable Care Act of 2010 (PPACA). To achieve potential efficiencies by having health care delivery coordinated by multiple health care entities (eg, hospitals, physician groups, clinics, health care systems), the act invites such entities to integrate in ACOs and instructs the Medicare program to share with an ACO any cost savings it can demonstrate.¹ Observers are expressing concern, however, that newly established ACOs are joining health care organizations that otherwise would compete with each other, thus creating networks with dangerous market power.² It appears that the main purpose of health care entities in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen negotiating power over purchasers in the private sector.

This may be the latest chapter in the steady accumulation of market power by hospitals, health care systems, and physician groups, a sequel to the waves of mergers in the 1990s when health care entities sought to counter market pressure from managed care organizations. The possibility

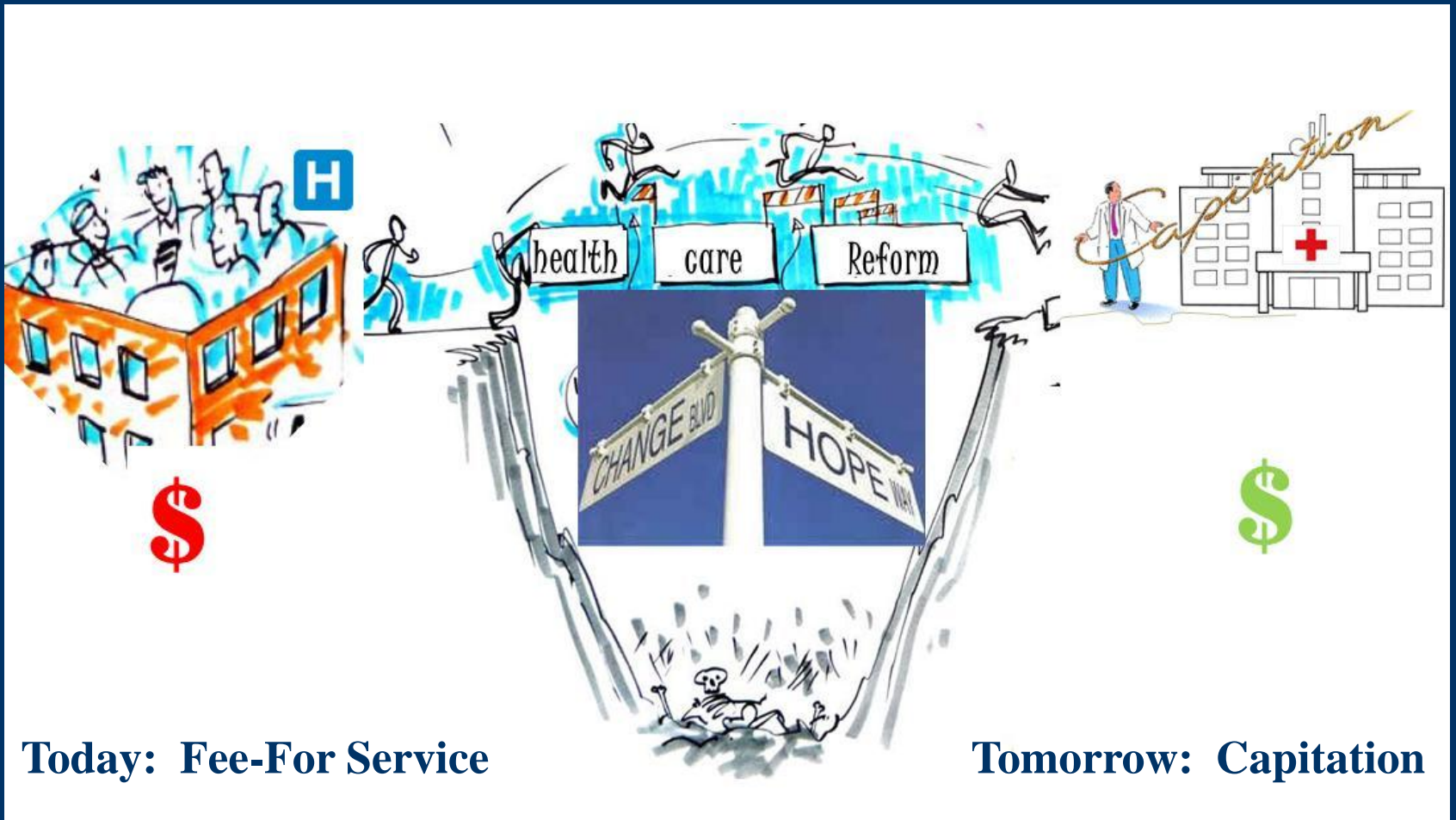
For legal, regulatory, and other reasons, health insurers in the United States cannot refuse to pay the high prices imposed by health care organizations, even when the price exceeds the likely value of the service to the patient. Instead, insurers are expected to cover any desired service deemed “medically necessary” by professional standards, whatever the cost. Health insurance, therefore, enables monopolists of health services to charge more than the textbook “monopoly price,” earn more than the typical “monopoly profit,” and capture more consumer dollars than monopolists in other industries.

Policy makers have been slow to recognize the dangers of market power in health care. In what has properly been called a failure of antitrust policy,^{4,5} policy makers did little to stem the accumulation of health care market power throughout the 1980s and 1990s. But the implications have been huge. For example, hospital mergers have led to estimated price increases of 40% in local markets.⁶ Dominant providers of insured services pose a severe challenge to health care affordability for individuals and for the nation as a whole.⁷

ACOs in Theory and Practice

Still a roughly defined policy concept, ACOs are in theory an attractive solution to problems stemming from the complexity and fragmentation of the health care delivery sys-

The Transformation Gap



Today: Fee-For Service

Tomorrow: Capitation

Transition Terror: How to Get From Here to There