Provider Perspective

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From Thought Leadership to Clinical Practice
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

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.

http://www.charlotteobserver.com/2012/04/21/3189821/nonprofit-hospitals-thrive-on.html
# Provider Prices in North Carolina

## 2007-2010 Change

<table>
<thead>
<tr>
<th></th>
<th>Change in Utilization&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Increase in Cost&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>-2.3%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Group</td>
<td>-3.8%</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

<sup>1</sup> Utilization based on inpatient admission per 1000 members

<sup>2</sup> Cost based on allowed cost per admission

Source: BCBSNC 2007-2010 claims data
Market Concentration

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

Exhibit 2

<table>
<thead>
<tr>
<th>Payer</th>
<th>Knee replacement</th>
<th>Hip replacement</th>
<th>Lumbar fusion</th>
<th>Cervical fusion</th>
<th>Angioplasty with stent</th>
<th>Pacemaker</th>
<th>Defibrillator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals in concentrated markets</strong> (in $)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>-190</td>
<td>-303</td>
<td>-207</td>
<td>1,188</td>
<td>3,346</td>
<td>1,937</td>
<td>-231</td>
</tr>
<tr>
<td>Private Ins.</td>
<td>13,731</td>
<td>15,938</td>
<td>23,165</td>
<td>13,020</td>
<td>19,554</td>
<td>16,452</td>
<td>25,694</td>
</tr>
<tr>
<td><strong>Hospitals in competitive markets</strong> (in $)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>1,760</td>
<td>1,029</td>
<td>1,575</td>
<td>914</td>
<td>2,290</td>
<td>4,159</td>
<td>4,459</td>
</tr>
<tr>
<td>Private Ins.</td>
<td>7529</td>
<td>6,732</td>
<td>17,195</td>
<td>5946</td>
<td>9,496</td>
<td>9,282</td>
<td>17,370</td>
</tr>
</tbody>
</table>

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

Source: Avik S. A. Roy; MAHP Annual Conference, 11-19-2011
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.
## Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.*

<table>
<thead>
<tr>
<th>Physician Group Practice</th>
<th>Percentage of Quality Goals Attained</th>
<th>Shared Savings Payments ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
</tr>
<tr>
<td>Billings Clinic, Billings, MT</td>
<td>90.91</td>
<td>97.78</td>
</tr>
<tr>
<td>Dartmouth–Hitchcock Clinic, Lebanon, NH</td>
<td>95.45</td>
<td>97.78</td>
</tr>
<tr>
<td>Everett Clinic, Everett, WA</td>
<td>86.36</td>
<td>95.56</td>
</tr>
<tr>
<td>Forsyth Medical Group, Winston-Salem, NC</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Geisinger Clinic, Danville, PA</td>
<td>72.73</td>
<td>100.00</td>
</tr>
<tr>
<td>Marshfield Clinic, Marshfield, WI</td>
<td>81.82</td>
<td>100.00</td>
</tr>
<tr>
<td>Middlesex Health System, Middletown, CT</td>
<td>86.36</td>
<td>95.38</td>
</tr>
<tr>
<td>Park Nicollet Clinic, St. Louis Park, MN</td>
<td>95.45</td>
<td>97.78</td>
</tr>
<tr>
<td>St. John's Clinic, Springfield, MO</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>University of Michigan Faculty Group Practice, Ann Arbor</td>
<td>95.45</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* 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.
A Cautious Path Forward on Accountable Care Organizations

Barak D. Richman, JD, PhD
Kevin A. Schulman, MD

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purring 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