

Hospital Services Market

A Brief History of American Hospitals

(1 of 2)

- Three factors transformed hospitals into the modern medical institutions they are now:
 - The germ theory of disease
 - Advances in medical technology
 - Increased urbanization
- With these changes came a change in patients' expectations; they want a cure
- Previously, hospitals were financed through taxation and philanthropy; patient fees of minor importance; by 1900, patient fees 1/3 of hospital income

A Brief History of American Hospitals

(2 of 2)

- 1960s & 70s – expansion of hospitals & clinics, advanced medical procedures; expensive
- 1980s – health care exceeds 10% of GDP; Medicare sets new reimbursement plan based on principal diagnosis, not services; financing becomes prospective, not retrospective
- 1990s – managed care dominant; hospitals as cost centers; horizontal integration
- 2000s – Medicare drug benefit; State Children's Health Insurance Plan; to boost income, doctors invest in their own facilities; 2010, ACA passes

The U.S. Institutional Setting

- Physician-Owned Facilities
 - In 2000, physicians had ownership interest in over 3,028 ASCs, 1,784 diagnostic testing facilities, and 56 specialty hospitals
 - By 2003, the number of ASCs had increased 23 percent to 3,735 and the number of diagnostic testing facilities had increased 35 percent to 2,403
 - Today, there are over 5,000 ASCs performing over 23 million surgeries annually
 - There are currently 238 physician-owned specialty hospitals in the U.S., down from 265 before the ACA (which prohibits the establishment of new physician-owned facilities).
 - Mostly located in urban areas, are organized as for-profit entities, lack emergency departments, and generally do not accept Medicaid patients or uninsured

The Theory of Cost Shifting

(1 of 2)

- **Cost Shifting** - when hospitals shift the cost of care for the uninsured and underinsured to private pay patients
- Legally, a hospital is obligated to accept patients that do not cover the fully allocated cost of their care.
- The government payment mechanism has an impact on the amount private patients pay for hospital services
- When Medicare lowers the rates paid to hospitals for treating the elderly, there is downward pressure on prices paid by everyone else

The Theory of Cost Shifting (2 of 2)

- The Practice of Cost Shifting
 - Public programs pay only 90% of hospital costs vs. 140% for private insurance (does not prove cost shifting, it is called Price Discrimination).
 - **Figure 10.1** suggests a negative correlation between the payment-to-cost ratios paid by privately insured patients and Medicare and Medicaid patients
 - Price differentials are primarily the result of differences in bargaining power between providers and payers

Structure of the Hospital Market

- Hospital markets do not fit the competitive model
 - Local markets have a limited number of hospitals
 - Services are not standardized across hospitals
 - Relatively uninformed consumers
 - Third-party insurance pays for most of the care, leaving patients insensitive to price differences
- Competition is based on quality of care and other amenities, not price
- In the 1980s, competition resulted in a medical arms race that improved the quality of care but drove up costs
- In the 1990, competition improved quality and decreased costs

Cost-Containment Strategies in the U.S

- Policies do not encourage market solutions
- Policy makers are more likely to propose government solutions that include price controls
- Solutions have focused on controlling federal outlays for Medicare and Medicaid

Pricing Hospital Services (1 of 2)

- In 1950, hospitals were paid on a per diem basis (average cost of a hospital day plus a small increment)
- In 1965, Medicare and Medicaid adopted cost-plus pricing
- By 1983, the government abandoned the cost-plus pricing model in favor of a fixed payment per case
- Private insurance payment is based on negotiated prices on discounts from billed charges
- In 1997, Medicare margins drop from a high of 11.9 percent into negative territory by 2003, falling as low as -7.3 percent by 2008

Pricing Hospital Services (2 of 2)

- Margins improved slightly to -5.8 percent by 2014 and were positive in only 30 percent of all hospitals
- In 2014, all-payer margins were +7.3 percent
- The growth of managed care and its bargaining power moved hospital pricing from charged-based rates to negotiated rates
- Hospitals use a file system called a *chargemaster* to keep track of the prices they charge for procedures
- Hospitals pricing for the same service varies across the country (Table 10.3)

TABLE 10.3 CHARGES AND DISCOUNTS FOR DIAGNOSTIC BILATERAL MAMMOGRAM

Hospital (Location)	Official charge	Medicare	Medicaid	HMOs, Health plans	Policy on uninsured
UCLA Medical Center (Los Angeles)	\$460	\$127	\$90	Up to \$242	Gives discounts based on individual's ability to pay
Oregon Health & Science University (Portland)	\$240	\$65	\$59	Average \$128	Works with uninsured patients to help them find financial aid; offers sliding scales, payment plans
Jamaica Hospital (Queens, N.Y.)	\$351	\$50	\$96	\$40 to \$78	Has sliding fee scales for uninsured
Johns Hopkins Hospital & Health System (Baltimore)	\$261	\$156	\$173	\$186	State regulation of charges reduces disparity between bills to insured and uninsured
Grinnell Regional Medical Center (Grinnell, Iowa)	\$285	\$73	\$79	\$119 to \$190	Works with uninsured to set a payment schedule

Source: Lucette Lagnado, "A Young Woman, an Appendectomy, and a \$19,000 Debt," *Wall Street Journal*, March 17, 2003, A1.

The Role of Not-for-Profit Organization in the Hospital Industry

- At start of 20th century, most hospitals were organized as not-for-profit institutions
- Some state legislatures even made for-profit hospitals illegal
- By 2000, over $\frac{3}{4}$ of all community hospitals were not-for-profit or government owned
- But for-profit hospitals have increased steadily from 12.5% in 1980 to 21.3% in 2013.
- For-profit hospitals now have a 16.9% share of hospital beds, at the expense of government-owned hospitals

The Not-for-Profit Organizational Form

- Substantial differences between for-profit and not-for-profit hospitals
- Main difference is that a not-for-profit does not have the right to transfer assets
 - Does not have shareholders
 - Capital comes from donations
 - No dividends to be paid; use of surplus funds restricted
 - Cannot provide *ex post* incentives to managers
 - If liquidation, no individual owner receives the proceeds

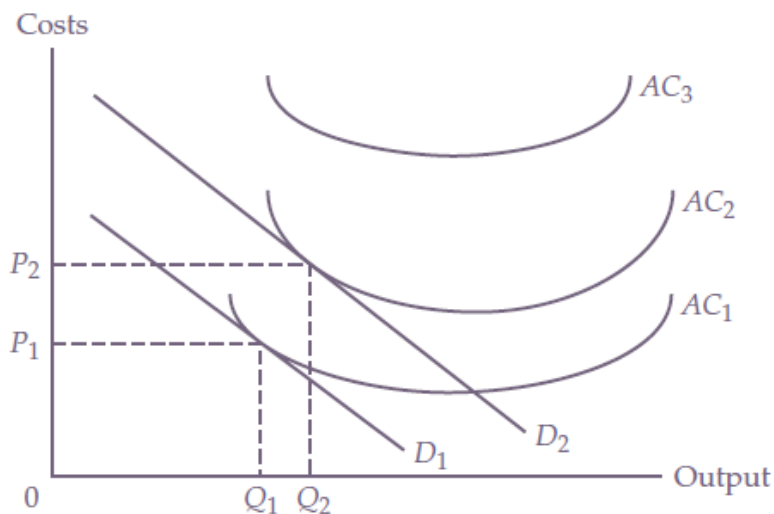
Nature of Competition in the Not-for-Profit Sector

- Why are most hospitals non-profit?
 - Because of asymmetric information? Patients prefer to deal with providers who do not suffer from the profit motive
 - Because profit-maximizing hospitals will not undertake any activity in which the marginal revenue is less than the marginal cost? And research, education, public health measures would suffer
 - Because this form most benefits physicians? Physicians purchase services, for their patients; hospitals compete for physicians, not patients

Alternative Models of Hospital Behavior

- Utility-Maximizing Models
 - Decision makers maximize utility subject to a break-even constraint
- Physician-Control Models
 - Staff physicians may have a financial stake in maintaining efficient operation
 - Private physicians with admitting privileges may be more concerned with their own productivity than with hospital efficiency

The Impact of Quality Improvements on Average Cost and Demand



The Trend Toward Multihospital Systems

- The theory of consolidation
 - Horizontal integration allows businesses to take advantage of economies of scale, reduce administrative costs and improve customer access to information
- Empirical evidence on consolidation
 - Under the cost-plus reimbursement standard, hospitals had little incentive to lower costs
 - Shift to prospective payment made cost reduction paramount

Long Run Average Cost Curve

