UNDERSTANDING THE HEALTH CARE COST CONUNDRUM
The Facts

- Health care in the US is 18% of GDP
- One of every three new jobs is in health care, 2007-2017
- US spends two times what other wealthy countries spend, but has worse outcomes
What’s Driving Spending?

~30% of health care spending is wasteful

Price and intensity have been the primary drivers of health care spending.
Health care consolidation trends

- 1,629 hospital mergers from 1993-2017
- 90% of hospital markets are highly concentrated

% of markets that are highly concentrated:

- 65% of specialty physician markets
- 57% of insurer markets
- 39% of primary care markets

Hospital Consolidation → Higher Prices

Hospital consolidation leads to significantly higher prices in concentrated markets.

Estimated price increases ranged from 20-40%


<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Result</th>
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<tbody>
<tr>
<td>Dafny (2009)</td>
<td>Merging hospitals had 40% higher prices than non-merging hospitals</td>
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<tr>
<td>Haas-Wilson, Garmon (2011)</td>
<td>Post-merger, Evanston NW hospital had 20% higher prices than controls</td>
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<td>Tenn (2011)</td>
<td>Summit/Sutter prices increased 28% - 44% compared to controls</td>
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Consolidation and Quality

• Patient outcomes are worse in more concentrated markets, where hospitals or physicians face less competition (Gaynor et al. 2013, Koch et al. 2018)
• Hospital ownership of physician practices led to higher readmission rates and no better quality measures (McWilliams et al. 2013, Neprash et al. 2015)

Against the mounting evidence that consolidation raises prices, there is a noted lack of evidence that consolidation improves quality or reliably generates cost savings through reduced utilization or improved efficiency.
Inpatient hospital stay charges have increased faster for private insurance than for Medicare or Medicaid.

Average inflation-adjusted, standardized payment rates per inpatient hospital stay, by primary payer, 1997-2015

Private insurance
Medicare
Medicaid

Note: The average payment rates were computed as if each primary payer paid for all non-maternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient’s age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays.

The Cost Shifting Challenge

- Underpayment by Medicare and Medicaid
  - Cost shift to other payers
  - Community benefit
- Would equalizing public and private payment rates reduce cost shift?
  - One recent study* found hospitals receiving an unexpected 10% increase in Medicare payment rates...
    - Added new technology
    - Increased nursing staff
    - Increased payroll by 1/3

Drug spending has grown rapidly in recent years, but most health dollars are spent on hospitals and physicians.
The share of household budgets devoted to health expenses has been increasing, 2002-2012.

Average portion of household budget devoted to health (nonelderly families), 2002-2012

- Out-of-pocket costs: 2.1%
- Insurance premiums: 3.1%
- Total health expenses: 5.2%

Source: Kaiser Family Foundation analysis of Consumer Expenditure Survey
Spending on deductibles/coinsurance have far outpaced wages, while copayments have fallen.