Executive Summary

of

Assessment of Cost Trends and Price Differences for U.S. Hospitals[1]

"In a market with differentiated products [such as a hospital market], different price levels are neither necessary, nor sufficient, to demonstrate the exercise of market power."

– Federal Trade Commission Working Paper No. 294[2]

This paper is the second in a series examining issues that have a bearing on the development of new and innovative healthcare delivery arrangements, such as Accountable Care Organizations ("ACOs"), medical homes and other arrangements that require greater clinical and/or financial integration among caregivers (hospitals and physicians).

The first paper, "A Critique of Recent Publications on Provider Market Power" (Critique), examined claims made in two publications widely cited as support for limiting caregivers' flexibility to develop or expand innovative delivery arrangements with exaggerated claims of provider market power. These publications focused on differences in prices among hospitals in two states, linking higher hospital prices to insurers directly to market power. Both ignored or rejected other explanations for price differences, such as differences in the prevalence of disease or illness and numerous other tangible factors. The Critique concluded after rigorous analysis that neither publication lends any credible support for such claims.

This second paper, "Assessment of Cost Trends and Price Differences for U.S. Hospitals" (Cost Trends), provides an in-depth examination of the costs hospitals incur in providing patient care and why those costs may differ among various types of hospitals, as well as the relationship of costs to prices. The key findings demonstrate that hospital prices are directly related to the costs of providing services to patients and their communities, including wages, capital investment, and the level and specialization of services. Thus, Cost Trends should dispel un- or poorly-supported claims that differences in hospital prices are attributable automatically to market power. Perhaps more importantly, the research demonstrates a link between improving care coordination, cost reduction and, lower prices.

A brief summary follows.

HOSPITAL COSTS – NATIONAL TRENDS

From 2000 through 2009, hospital revenues closely tracked cost increases, meaning that hospital margins did not increase appreciably. Both revenues and expenses per adjusted admission increased by roughly 5% per year.

Frequently Used Terms

Adjusted admissions:	includes inpatient admissions and outpatient visits, with a conversion for the latter to make it comparable to inpatient admissions.
Cost:	hospital expenses.
Level and type of care:	refers to the overall medical complexity and severity of illness of the patients treated, as well as the mix of services delivered by a provider.
Margin:	the difference between hospital revenues and hospital costs as a percentage of hospital costs; it is used synonymously with "profit" margin.
Price:	hospital revenue per inpatient discharge or per adjusted admission.
Revenue/Reimbursement:	payments or revenues from insurers, Medicare and other payors for hospital services, net of contractual allowances and discounts.
Spending:	the sum of all payments made by all payers for hospital services, it is used synonymously with 'expenditure' throughout.

Viewed in the larger context of national healthcare expenditures, hospital care accounted for a steady proportion of national healthcare expenditures over the last decade of slightly more than 30% and is expected to maintain that level over the next decade. Not surprisingly, labor costs accounted for more than half of hospitals' total expenses. Labor costs grew by between 5 to 8% a year from 2002 to 2008.

An increasingly significant issue for hospitals is the growth in the patients covered by the federal Medicare program or a state Medicaid program; these patients now constitute more than 60% of all admissions. Neither program pays the full cost of care. Medicare paid 99.1% of costs in 2000, but by 2009 paid only 90.1%; Medicaid paid 94.5% in 2000, but by 2009 paid only 89.0%. Likewise, uncompensated care – free or reduced cost care for patients who need financial assistance or shortfalls from patients unable to pay for care – amounts to 6% of total hospital expenses. Some of these costs of providing under- or uncompensated care are reflected in the hospital costs absorbed by other payors.

PRICE DIFFERENCES – AN ANALYSIS

Extensive analyses of hospital costs derived from five years of data from thousands of hospitals across the country and extensive data on costs, level and type of care, and community-specific information demonstrate that hospital revenues and costs track each other closely, and that there are numerous, identifiable sources of costs that explain prices and price differences. These analyses confirm that unsupported claims of market power cannot be used to explain price differences among hospitals.

The key findings are as follows:

- Hospital prices are directly related to an array of costs associated with labor and capital costs, and the level and type of care received by the patients treated by the hospital.
- Up to 72% of the differences across hospitals in non-Medicare prices can be explained by factors that include case mix, regional costs, hospital investments in capital and other improvements, type of hospital, and other tangible factors. These factors also explain up to 83% of differences across hospitals in all-payor prices (which include Medicare), further validating the importance of cost and services as the sources of price differences.
- A variety of factors likely account for the remaining differences, chief among which are the costs associated with providing higher quality care. These factors also include costs imposed by different state regulations, different cost-containment strategies employed by hospitals, and errors or inconsistencies in the data. There is no reason to believe that the remaining differences are due to market power. This conclusion is entirely consistent with a Working Paper by the Federal Trade Commission's Bureau of Economics concluding that in hospital markets different price levels are neither necessary nor sufficient to demonstrate the exercise of market power.[3]

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[1] This report benefited substantially from the assistance of Jeffrey Raileanu and Matthew Schmitt of Compass Lexecon. This report made use of healthcare literature, data from the Centers for Medicare & Medicaid Services ("CMS"), and AHA data. The views and opinions presented are solely those of the authors and do not necessarily reflect the views of organizations with which the authors are or have been affiliated. The co-authors have worked on a number of healthcare matters for a variety of healthcare entities, including providers, health plans, government, and associations. A summary of the healthcare experience is available at www.compasslexecon.com.

[2] Haas-Wilson, Deborah, and Christopher Garmon, "Two Hospital Mergers on Chicago's North Shore: A Retrospective Study," Bureau of Economics, Federal Trade Commission, *Working Paper*, No. 294 (2009), p. 9.

[3] *Id.*