



**The Role of Hospital
Monopolies in America's
Health Care Crisis**



Open Markets Institute

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Executive Summary

The astronomically high cost of health care in the United States results primarily from Americans being forced to pay inflated prices for the medical services they receive, not from them receiving more or better care. An often-overlooked factor behind these high prices is the increasing corporate concentration of ownership, particularly among hospitals. After a wave of hospital mergers over the last few decades, most hospital markets in the United States are highly concentrated, often dominated by a single corporate entity that has absorbed most local doctors' practices as well. The Federal Trade Commission's ability to prevent or roll back harmful mergers is hamstrung by several loopholes including inadequate reporting thresholds and the inability to prosecute anti-competitive practices by multimillion-dollar hospital chains and conglomerates because they are classified as nonprofits. Hospital consolidation should be a standard part of health policy discussion, particularly if proposals to move to a single-payer system gain steam. If implemented without addressing consolidation, a single-payer system could force the government into subsidizing private monopolies without garnering meaningful savings for families.

Introduction

Rising health care costs continue to erode the American standard of living. For a typical American family of four, the annual cost of health care now surpasses \$28,000.¹ Using these numbers and extrapolating to a family of four, a typical family can expect to pay more than \$11,000, or about 40% of the total, in premium and out-of-pocket charges. On average, the remaining \$17,000 is covered by the employer, with the cost accruing to the family indirectly, as employers reduce worker compensation to cover ever-rising health care costs. Since 2008, deductibles have increased eight times as fast as wages.² Over the last five years, the direct costs borne by families (namely, premium and out-of-pocket charges) have increased ten times faster than inflation.³

Overutilization is often blamed for rising U.S. health care costs, and it is a large factor. But citizens in other countries like Germany see doctors more, spend more days in the hospital and undergo procedures at roughly similar rates while spending far less as a percentage of GDP for health care.⁴ The U.S. actually deploys fewer health resources per capita than other OECD countries: fewer doctors and nurses, fewer medical school graduates, and fewer hospital beds.⁵

Thus, inflated prices, rather than overutilization, are the primary reason why Americans have to spend so much more on health care than their counterparts in other advanced nations. In OECD countries, the median cost of a hospital stay in 2014 was \$10,500; in the U.S., that same stay was over \$21,000.⁶ And for all that Americans pay, U.S. health metrics lag behind those of peer nations. Our life expectancy, which has been declining for several years, ranks below that of Chile, Slovenia, and much of the European Union.⁷

The Challenges Caused by Concentration in Hospital Markets

The U.S. pays more for less. What explains this disparity? One large and often overlooked factor is the increasing monopolization of the health industry. This includes increasing corporate concentration among pharmaceuticals, medical devices, and health insurance.⁸ But of even more consequence is the increasing monopolization found among hospitals, which account for the lion's share of U.S. health care spending.

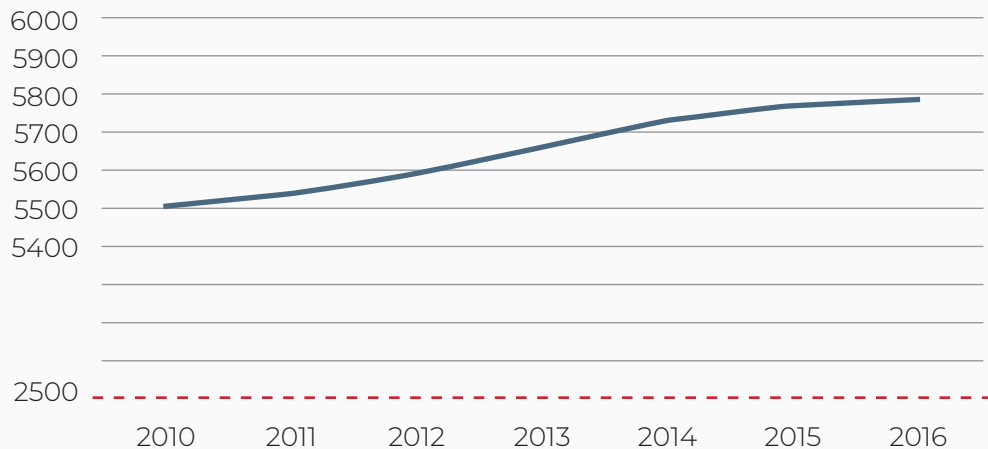
Hospital markets in 90% of Metropolitan Statistical Areas are officially highly concentrated, according to the standard metric used by the Federal Trade Commission, the Herfindahl-Hirschman Index (HHI).⁹

HERFINDAHL-HIRSCHMAN INDEX (HHI)

HHI is used to measure degrees of concentration, and it is calculated using the percent market share of each corporation in the target market and industry. The percent market shares are squared and then summed. HHI runs on a scale of 0-10,000, with a score of <1,500 indicating a competitive marketplace, a score of 1500-2,500 indicating moderate concentration, and a score above 2,500 indicating high concentration.

FIGURE 1.

HOSPITAL MONOPOLIES ARE PREVALENT AND RISING



Note that red dashed line marks the point at which the DOJ and FTC consider a market to be highly concentrated

Source: Fulton, Brent D., "Health Care Market Concentration Trends In The United States: Evidence and Policy Responses," *Health Affairs*, 36, no. 9 (2017): 1530-1538.

THE NONPROFIT LOOPHOLE

Nonprofit hospitals, a majority of the hospitals in the U.S., often bring in hefty sums despite their tax-exempt status.¹⁰ In fact, seven of the ten most profitable hospitals in the U.S. were technically designated as nonprofits in 2013.¹¹ From 2016-2017, the top ten highest-revenue nonprofit hospitals in the U.S. had a combined revenue of over \$137 billion.¹² The highest-paid executive among those ten hospitals made \$21.6 million, and another seven executives in that group made above \$4 million each.¹³ All told, the net assets among the top 10 totaled over \$125 billion.¹⁴

In return for tax-exempt status, nonprofit hospitals are expected to provide social welfare. From the 1950s till 1969, a hospital's tax-exempt status was based on the "financial ability standard," or its promise to provide care to patients who were unable to pay. In 1969, the IRS changed the standard, and now nonprofit hospitals must only provide an undefined "community benefit" to retain tax exemption.¹⁵ Present-day, nonprofit hospitals provide about the same amount of uncompensated care as for-profits.¹⁶

The FTC's ability to regulate is weakened by several hospital-specific quirks.¹⁷ First, many smaller mergers and acquisitions are under the reporting threshold to the FTC, so the FTC may not learn of them in detail or in time.¹⁸ Second, the FTC can review all mergers, but it is not permitted to prosecute anticompetitive practices by nonprofit organizations, which comprise nearly half of hospitals in the U.S. In other words, the FTC can review the merger of a nonprofit hospital, but it cannot review antitrust violations committed by that hospital following the merger.

PRICE GROWTH

When hospitals buy out their competitors, the effect is almost always higher prices. According to a literature survey by the Robert Wood Johnson Foundation, "[t]he magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent."¹⁹ The correlation between an increase in consolidation and higher prices was also recently found in research by the Health Care Cost Institute.²⁰ Moreover, a recent study by Yale economist Zack Cooper and others has found that if you stay in a hospital that faces no competition, your bill will be 12% higher on average than if you stay in a hospital facing four or more competitors.²¹

Hospital officials often use buying power and efficiency gains as justification for hospital acquisition. Recent research, however, suggests that merger target hospitals save only 1.5% annually following an acquisition, with mixed savings for acquiring hospitals.²² And if hospital mergers are indeed creating efficiency gains, it is difficult to find instances in which the savings are being shared with customers. When mergers occur, even among hospitals operating in different regions, studies have found that the result is higher prices of between 7 percent and 17 percent.²³

REDUCED ACCESS

Hospital consolidation can also lead to reduced access and quality of care. In many American cities and towns, independent community hospitals that serve vital health care needs and provide dignified work in small communities are faced with the decision to join chains or close. By 2017, approximately two-thirds of hospitals in the U.S. had been subsumed by a chain.²⁴ As the industry becomes dominated by corporate entities, many communities are losing their independent, local hospitals. While hospitals close for a variety of reasons, a brief review of the 21 reported hospital closures in 2018 reveals that over half were closed by their parent corporation, typically for not feeding enough revenue back into the parent company.²⁵

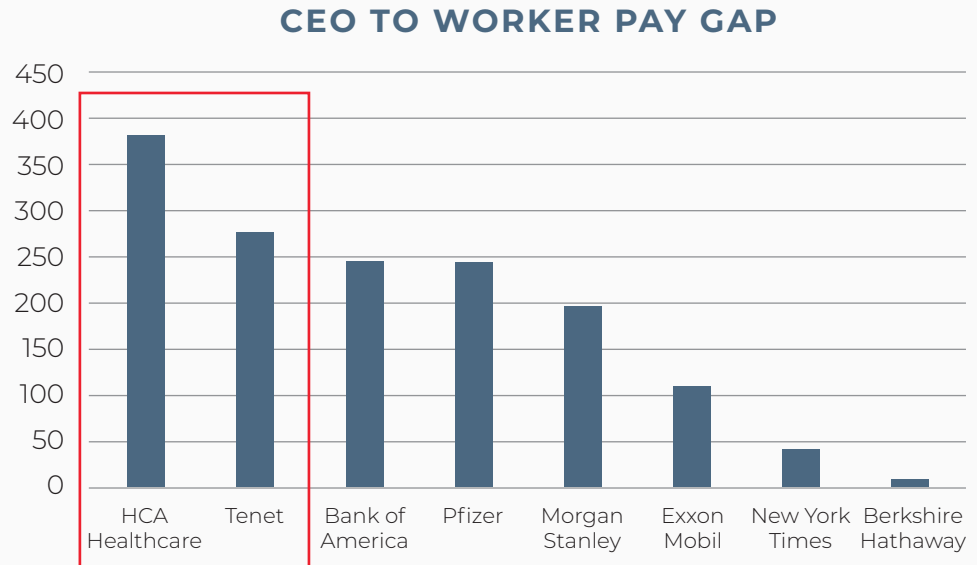
As happened in Immokalee, Florida, large hospital systems may worsen the problem by obstructing grassroots efforts to open local hospitals in areas of great need.²⁶ Because of consolidation, many Americans have to travel much farther to reach the nearest hospital, which can have dire health care consequences for people with medical emergencies or chronic conditions.²⁷

RISING HOSPITAL WORKER AND EXECUTIVE WAGE GAP

As hospitals merge into larger and larger entities, compensation for hospital CEOs and executives is soaring. From 2005 to 2015, the average major nonprofit medical center CEO compensation rose by 93 percent, while the average health care worker wages rose 8 percent.²⁸ The wage gap between executives and physicians is

also increasing. AFL-CIO data reveals that some of the largest health systems in America, HCA Healthcare and Tenet, have a larger CEO to worker pay gap – 383:1 and 277:1, respectively - than many other major corporations, including Bank of America (247:1), Morgan Stanley (198:1), and Exxon Mobil (110:1).²⁹

FIGURE 2.

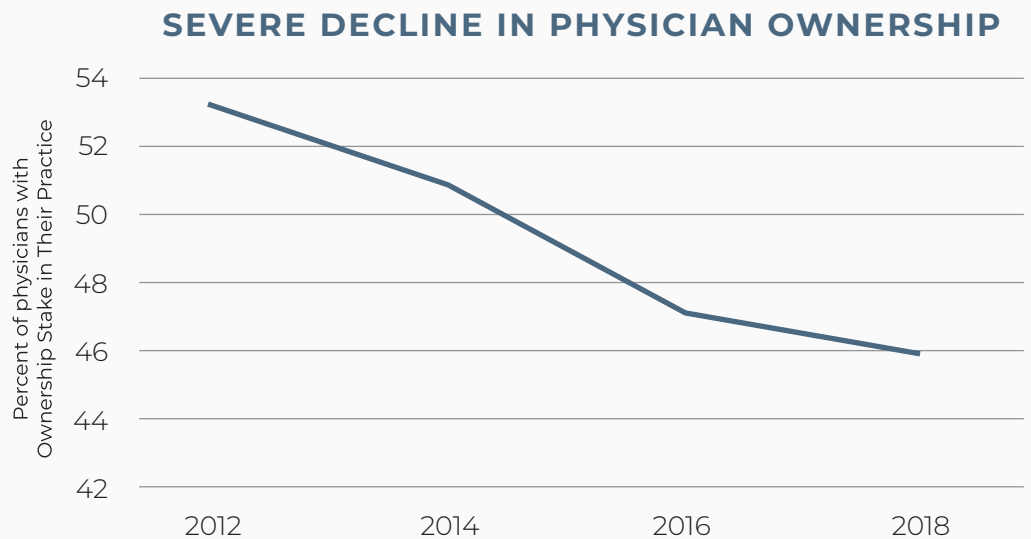


Source: "Company Pay Ratios," AFL-CIO, Accessed August 7, 2019, <https://aflcio.org/paywatch/company-pay-ratios>.

VERTICALLY INTEGRATING HEALTH CARE DELIVERY PLATFORMS.

Today, hospital chains are expanding not just by buying other hospitals, but also by buying out doctors' practices. In 2016, for the first time ever, a majority of physicians did not own the place where they practiced, a decrease of roughly 30 percent compared to 1983.³⁰ This trend drives up prices with little gain in quality.³¹

FIGURE 3.



Source: Carol K. Kane, "Policy Research Perspectives," American Medical Association, 2019, <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>.

Researchers from Northwestern University found that acquired physicians charge an average of 14% more for the same services after they have been acquired, with increases going up even more when the physicians are acquired by a hospital that is a monopolist.³² The researchers blamed nearly half of the observed increase on an “exploitation of the payment rules,” or gaming the complicated insurance system. When a hospital acquires a physician practice, the hospital-and-doctor organization effectively becomes part of a regional, vertically integrated monopoly that dictates the prices that patients and insurers must pay.

Hospital monopolies weaken local health care markets. In the San Francisco Bay area, the Sutter hospital conglomerate amassed such market power – up to 100 percent of the market for inpatient hospital services in Berkeley and Davis – that it forced health care plans to sign contracts in which they promised to steer patients to Sutter hospitals and not to lower-cost hospitals.³³ Similarly, kickback agreements between hospitals and physicians are illegal, but a hospital can try to get around the regulation by buying up surrounding physician practices.³⁴

MONOPOLIZATION IN INSURERS

Insurers have responded to the increase in hospital consolidation by engaging in a merger frenzy of their own. By 2017, the American Medical Association and others found that insurers are highly concentrated in 57 percent to 73 percent of Metropolitan Statistical Areas.³⁵ Hospital chains have reciprocated, in a perpetual consolidation cycle, seeking to maintain their power by forming or buying their own insurers.³⁶ This creates a vicious cycle of payers and providers merging against the public interest.

Solutions

ALLOW THE FTC TO MORE EFFECTIVELY REGULATE HOSPITAL CONSOLIDATION.

Permit the FTC to regulate hospitals more effectively by requiring hospitals, regardless of nonprofit status, to report mergers and acquisitions if the hospital receives Medicare and Medicaid funds. Currently, many of these mergers and acquisitions go unreported, as they are under the minimum reporting threshold.

REQUIRE STATE OR FEDERAL NOTIFICATION OF PHYSICIAN ACQUISITION.

Hospitals can acquire physicians and physician practices without triggering antitrust authorities’ notice. A requirement that these organizations notify the appropriate authorities when making acquisitions would slow the process of vertical consolidation.

UPDATE ANTI-KICKBACK LEGISLATION.

Over the last several decades, Congress has passed anti-kickback laws and other measures designed to prevent doctors from making money from referrals to specialists. Yet in an era of lax antitrust enforcement, health care providers in any community can get around these prohibitions against kickbacks simply by combining into a single enterprise. Updated anti-kickback legislation could explicitly prohibit hospitals from rewarding physicians, including the hospital’s employed or contracted physicians, for patient referrals or increased patient revenue.

SET HOSPITAL PRICES IN HIGHLY CONSOLIDATED AREAS.

Hospitals in highly consolidated markets tend to charge more. As a condition for operating in a heavily concentrated market, HHS should require hospitals to accept Medicare reimbursement rates from privately insured patients, keeping prices capped. This provision need not apply to hospitals under a certain percentage of the market share in the area, to allow smaller hospitals a better chance to compete.

END PRICE DISCRIMINATION.

In the absence of effective antitrust enforcement, the states and the federal government also could legislate price caps, requiring all hospitals to accept Medicare rates for commercially insured patients.³⁷

Conclusion

Hospital consolidation can lead in some instances to economies of scale and better-integrated care.³⁸ Yet in the absence of coherent policies for preserving and managing competition in health care markets, the real-world results of corporate concentration in this sector have been hospital closures, increased prices, and loss of choice for health care consumers.

Going forward, the local monopolies that now dominate health care delivery present a deep threat to meaningful health care reform. Given their impact on jobs and health in local communities, hospital monopolies hold heavy sway over legislators. While some have held up a “single-payer” or “Medicare for all” payer system as a cure for many of our country’s health care failures, hospital monopolies still hold all the bargaining power under this approach, akin to sole-source Pentagon contractors, both in their market power and their deep political power to shape health care reform to their goals.³⁹

A recent case study in Washington State proved this point: when the state passed a public option for the insurance marketplace, hospital lobbyists forced legislators to increase the amount the state will pay hospitals, effectively cutting cost savings that the bill may have garnered.⁴⁰ On a national level, such lobbying is even more of a threat.

Meaningful reform of the American health care system requires shrewd use of competition policy to tame monopolies and restructure health care markets.

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