To Subscribe: https://fulfillment.healthaffairs.org

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution
Prologue: Ever since Adam Smith published *The Wealth of Nations*, economists have lauded the benefits of free, competitive markets. Even today the basic idea underlying much of Smith’s thought—that the good of society is promoted when individuals are free to pursue their own interests—holds enormous appeal. Astute though he was, Smith could not have anticipated the complexity and the powerful interests that compose the U.S. health care system. To be sure, market structure plays a key role in determining the specific nature of competition; this in turn determines specific effects on various stakeholders. Over the past twenty years growing concern over rising health spending has prompted several states to try promoting price competition in order to control costs. In this paper Jack Zwanziger and Glenn Melnick describe the dynamics of health care competition and review recent evidence on its effects on costs in California and Minnesota. The early returns are promising. Nonetheless, in an increasingly familiar refrain, the authors state that cost reductions might be coming at the expense of quality and access. Zwanziger and Melnick have been studying the effects and determinants of competition in California for more than a decade, and their findings grace the pages of a number of respected journals. Zwanziger is an associate professor at the University of Rochester in New York, where he heads the doctoral program in health services research. He has been a consultant to RAND since 1983. Melnick is an associate professor and head of the international program for health financing and policy at the University of California, Los Angeles, School of Public Health. He is also a RAND consultant. This paper was presented at the invitational conference, “The New Competition: Dynamics Shaping the Health care Market,” conducted by the Alpha Center and sponsored by The Robert Wood Johnson Foundation, 9 November 1995, in Washington, D.C.
Abstract: The health insurance sector has been transformed in the past fifteen years, with managed care replacing indemnity insurance as the norm. This transformation was intended to change the nature of competition in the health care system so that market forces could be used to control costs. Empirical studies have shown that this objective has been met, as areas with high managed care penetration have tended to have much lower rates of increase in their costs. Creating a more efficient health care system will require additional efforts to produce useful measures of quality and to maintain competitive markets.

Since the early 1980s in a transformation of unprecedented speed, fee-for-service health care reimbursement and indemnity insurance are being replaced by health insurance plans that feature provider risk sharing and active plan involvement in health care decisions (“managed care”). This paper first provides a theoretical framework describing competition in health care markets and how it can become more price-sensitive. We then examine the published studies that provide evidence that the growth of managed care plans has shifted the focus of competition from quality to price and that this shift has lowered health care costs. We conclude by outlining some implications of these new market dynamics.

Shape Of Competition

The competitive dynamics of health care are shaped by the parties to the transaction, namely the physician, the patient, and the payer. These parties not only have different preferences but also evaluate alternatives along entirely different dimensions. As a result, the nature of competition within a market depends on each party’s influence. Understanding the distinction between markets dominated by physicians and those dominated by insurers is critical to understanding the nature of competition and its effects.

Competition in physician-dominated markets. In environments in which insurers neither restrict beneficiaries’ choice of physician or hospital nor influence the care patients receive, physicians control the demand for most health services. Physicians decide when to admit patients and strongly influence the choice of hospital. After admission, physicians direct the deployment of hospital resources, ordering the tests, procedures, and other services that are part of the treatment regimen. Physician referral patterns determine a hospital’s market share in such markets. Therefore, hospitals compete for patients largely through efforts to attract physicians. Insurers play a passive role, providing fairly standard insurance products, processing claims, and adjusting premiums to maintain acceptable profit margins.

Physicians generally are insensitive to the costs of care at different hospitals, because fee-for-service insurance coverage insulates both them and their patients from these costs. Therefore, in physician-dominated markets, demand for a given hospital’s services is largely determined by its
location, quality, and amenities, compared with other nearby hospitals. Because quality and amenities come with high price tags, hospitals are able to raise prices to meet those costs because of physicians’ insensitivity to price. Thus, hospital competition in physician-dominated markets tends to increase hospital costs. The increased costs are borne by third-party payers, employers that pay premiums for their employees, taxpayers (in the case of public coverage), and patients themselves.

**Competition in insurer-dominated markets.** In areas where managed care plans have substantial market share, hospitals and insurers play a more complex game than in physician-dominated markets. Before attracting physicians, hospitals must first compete for inclusion in insurers’ provider networks. Hospitals that are able to control their costs are in a much better position to secure network contracts. Although possession of a contract does not guarantee an increased flow of patients, a contract channels patients by creating a “cost gap” whereby out-of-pocket costs are lower if patients use contract hospitals. As a result, hospitals without contracts are likely to have a smaller pool of patients. Price thus becomes an important factor in acquiring and retaining a patient base.

Insurers do not contract on the basis of price alone. They must trade off cost against access and quality. Aggressive negotiations risk achieving lower premiums at the cost of poor geographic coverage or poor-quality providers. Insurers’ most important customers are employers that purchase group plans for their employees. Employers prefer low-cost plans but also consider employees’ strong preferences for local hospitals with good reputations. (All studies of patient preference for hospitals have found travel distance for patients to be the dominant factor in explaining choice).3

Before entering into negotiations, both insurance plans and providers must gauge their relative bargaining power. Market structure is one major determinant. Another determinant, more idiosyncratic to the health care industry, is the degree of consumer allegiance to insurance plans versus providers, each of which ultimately must attract a subscriber base to survive. The extent to which consumers are willing to switch providers in order to join or remain with an insurance plan’s network becomes critical in assessing bargaining position.

In competitive market environments, providers must respond to the price-sensitivity of large purchasers of care, such as preferred provider organizations (PPOs), health maintenance organizations (HMOs), and self-insured employers that contract directly with providers. Insurance plans compete on the basis of both the cost to the payer and the quality of their provider network. Since payments to physicians and hospitals constitute the dominant component of their costs, purchasers that are better able to control these costs will have a major competitive advantage. Providers in
insurer-dominated markets must choose a marketing strategy-including the price that they will seek-to achieve their competitive objectives. As in most other industries, pricing strategies require balancing the need for revenue with the risk of losing market share if prices are too high.

### Research On The Effects Of Managed Care Growth

Research on the impact of managed care has been based on data from regions in which managed care has spread most rapidly, and centers on two subject areas. The first uses the competitive dynamics in the health insurance industry to explain the growth of managed care plans and their effects on insurance premiums. The other investigates how provider costs and revenues have been affected by changes in the competitive environment. In this section we describe the factors that led to the rapid growth of managed care plans in California and Minneapolis/St. Paul, Minnesota, and then describe the key results from studies on insurance and provider behavior in a price-competitive environment.

**California and Minnesota: leading the national transformation.** As noted previously, prior to the introduction of selective contracting and managed care, health care markets tended to be physician-dominated. Studies uniformly found that hospitals in more competitive areas tended to have higher costs. In an effort to control rapidly rising health care costs, California and Minnesota adopted explicit policies that encouraged the development of managed care. These areas have served as laboratories for research on the impact of managed care. Recent evidence suggests that the basic patterns that occurred in both areas now characterize national trends.

California was a high-cost area for health insurance when HMOs first appeared. By offering lower premiums, HMOs acquired 17 percent of California’s market by 1980. This percentage was far higher than that in other states at the time, but the vast majority of HMO beneficiaries belonged to a single HMO, Kaiser Permanente, which owned its own hospitals and contracted exclusively with a single medical group. Therefore, it had little direct effect on the competitiveness of the industry as whole. Although HMO membership grew steadily in the early 1980s) growth was so slow that indemnity plans were expected to stay dominant for the foreseeable future.

The situation changed markedly in 1982, when the California state legislature enacted a bill intended to inject price competition into the health care market by enabling insurers to restrict the choice of providers covered by insurance plans. These PPO plans achieved enormous gains in market share by undercutting the premiums offered by other insurers. PPOs financed lower premiums by leveraging discounts with network providers, selecting lower-cost providers (especially hospitals), and using utilization...
controls (particularly for inpatient care). Providers had to compete against one another to win a contract with a managed care plan or risk being locked out of a substantial (and growing) portion of the market.

Employers facilitated the success of PPOs by requiring employees who rejected PPO plans to pay for a portion of the additional cost of the premium. Thus, PPO beneficiaries retained the ability to use physicians and hospitals outside the network but faced higher copayment rates if they did so. This system gave incentives to providers to control their costs and to patients to include price in their decisions about services. With time, enrollment shifted to newly developed HMOs and hybrid plans that contracted with networks of hospitals and physicians.

As employers and beneficiaries switched to managed care plans, indemnity plans were left with mostly high-cost beneficiaries. Indemnity premiums soared, further enhancing the attractiveness of managed care plans. By 1990 managed care plans (HMOs and PPOs) covered more than 80 percent of California’s privately insured population. Growing enrollment and the merger of several managed care plans provided the plans with enough market power to extract large price concessions from providers in the early 1990s. In response, both physician groups and hospitals formed regional networks to create countervailing market power and to market regionally based integrated health services delivery systems. Employers began cooperating both in negotiating with insurers and providers and in generating more sophisticated analyses of health insurance plans and providers.

The transition to managed care occurred most rapidly in California, but change was under way in other places as well. In Minneapolis/St. Paul, the first HMOs were founded in the 1970s; over the next two decades managed care plans grew to dominate the insurance markets in the Twin Cities. As HMOs increased their market share, indemnity plans created “intermediate” products that incorporated some elements of managed care. Employers, beginning with the Minnesota state government, began to select managed care plans for their employees, and by the mid-1980s were requiring employees to bear the cost of choosing plans with higher premiums. The majority of consumers chose lower premiums and managed care over unrestricted access to providers. As a result, fee-for-service plans in the Twin Cities evolved into managed fee-for-service plans, and PPOs were formed.

A complex mixture of policy and market factors contributed to the rapid consolidation of health plans that occurred in the Twin Cities in the early 1990s) but the net effect was that each plan had more enrollees and, therefore, more market power. In response, employers and other purchasers of group plans joined forces in the Buyers’ Health Care Action Group (BHCAG) and the State of Minnesota Group Insurance Program (SIP). Although both groups have well below the 500,000 members recom-
mended in health care reform proposals, both plans have succeeded in keeping premiums fairly low while encouraging providers to develop care guidelines that can be used to monitor quality. Providers responded to the rapid concentration of market power on the demand side by strengthening their own market positions through mergers and reorganizations. Multi-hospital systems began to emerge in the 1980s) and by the 1990s hospitals and HMOs were merging and reorganizing themselves.

Despite its speed, health system transformation in California and the Twin Cities involved several distinct phases. First, insurers created plans that were HMO/indemnity hybrids. The new plans negotiated fee discounts and implemented utilization review, but these cost-containing measures were more limited than those used by HMOs, and provider networks were larger. Enrollment grew rapidly as consumers chose lower premiums and some loss in choice of physicians over traditional indemnity insurance.

In the second phase health plans used their market power to achieve more favorable arrangements with providers. Their leverage came from growing enrollment and efforts to gradually prune provider networks. Providers accepted more financial risk, larger fee discounts, and more intrusive utilization management review in return for remaining in networks. New risk-sharing arrangements included per diem, per discharge, or capitation arrangements for hospitals and withholds or capitation for physicians. Managed care plans also developed increasingly sophisticated methods of managing utilization and identifying cost-conscious providers. In addition, beneficiaries continued their migration to plans that offered even lower premiums despite restrictions on choice of providers.

Providers and payers each began to consolidate during the third phase as mergers increased in the hospital, physician, and insurance sectors. Vertical integration also occurred as plans and physician groups aligned with hospitals in a variety of combinations. Reimbursement structures became more complex. Negotiations between providers and managed care plans focused primarily on the sharing of risk through the division of revenue from capitated rates and the structuring of risk pools. Purchasers began to focus on broadening the measures to use in assessing plan performance.

The transformation is not yet over. In fact, we are far from the finish, and the process is so complex that we cannot easily predict the outcome. Yet there is empirical evidence that sheds light on the effects of the growth of managed care plans on health care costs. We focus the remainder of this paper on that evidence and its implications.

<table>
<thead>
<tr>
<th>Effects Of Managed Care Growth On Insurance Markets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Price-sensitivity to insurance premiums.</strong> A critical assumption of the</td>
</tr>
</tbody>
</table>
argument for using managed care plans to introduce price-based competition into health care markets is that beneficiaries are price-sensitive in their purchase of insurance. Empirical evidence has shown this to be true. Roger Feldman and Bryan Dowd studied changes in market share among plans offered to State of Minnesota employees and found a dramatic shift to low-cost plans over a period of five years (1998-1993) a sharp increase in the market share of the low-cost HMO, and a corresponding drop in the market share of indemnity and high-cost managed care plans.

A study of managed care plans in Minneapolis/St. Paul found that a one-percentage-point increase in the out-of-pocket premium differential was associated with an 8.6 percent decrease in market share based on enrollment. The majority of beneficiaries chose managed care and lower premiums over unrestricted access to providers. Price-sensitivity was especially high when beneficiaries chose among similar plans (defined on the basis of restrictions on choice of providers). Extending their work on premium price-sensitivity to a national sample of employers corroborated the Minnesota results and found that employees are sensitive to out-of-pocket premiums for the plans offered by their employers. In addition, they found that the favorable tax treatment of insurance premium payments reduces price-sensitivity.

These studies all support the theoretical assumption that employees will transfer from a plan with a high out-of-pocket premium to a lower-cost alternative. The dramatic growth over the past decade in managed care plans nationally suggests that price-sensitivity is a widespread phenomenon and that these plans have identified and taken advantage of this in attracting beneficiaries away from indemnity plans. Price competition in the insurance industry in turn forces plans to control their costs.

Insurance premiums and HMO market shares. The basic premise behind public policies to encourage the growth of managed care plans is that they act as cost-conscious purchasers of health care services and thereby reduce the rate of growth in total health care expenditures. For private employers, the best proxy for total health care expenditures is their insurance premiums. Therefore, one critical test of the performance of managed care plans is the relationship between insurance premiums and managed care penetration.

Two recent studies have dealt most directly with this issue. Using different national data sets and different approaches, both studies found that as HMO penetration increased in an area, insurance premiums tended to fall. Douglas Wholey and colleagues based their conclusions on data filed by HMOs with state regulators for 1988-1991. They found a generally negative relationship between HMO premiums and HMO market share. The second study is based on a survey of ninety-five insured groups over
1985-1992. It found that increased HMO penetration had a substantial effect on the average premium (an elasticity of -0.65). For example, an increase of HMO market share from 10 percent to 12.5 percent would tend to lower the rates of increase in insurance premiums from 7 percent annually to 5.9 percent (or from a 40 percent increase to a 33 percent increase after five years). Obviously, the increases in market share that have taken place in the past decade would have even larger long-range effects.

One issue that this research cannot address is whether these differences in premiums reflect lower costs (in particular, lower payments to providers), lower profit margins, or both. Insight into this issue can be provided by studies of the impact of managed care on provider costs.

Effects Of Managed Care Growth On Providers

Since provider revenue constitutes the vast bulk of total health care expenditures, any reduction in total expenditures will require lower provider revenue. Since providers are unlikely to reduce their incomes willingly, managed care plans that seek to lower costs must walk a fine line. They must reduce payments to providers while giving them incentives to continue to provide high-quality care to beneficiaries.

Managed care and total expenditures. One of the early studies (1988) evaluating the effect of managed care competition in California was part of a national study of hospital costs. It found that competition in California had been effective in lowering hospital costs and that the reductions were of the same magnitude as those stemming from hospital rate regulation in New York and New Jersey. We confirmed and broadened these conclusions in 1995 to three categories of expenditures: hospital services, physician services, and pharmaceuticals. In each of these categories California’s average annual rate of increase was far lower than the national average during 1980-1991 (Exhibit 1). Moreover, states with mandatory hospital rate setting generally experienced greater rates of increase than the national average. These results show that competitive pressure from managed care plans reduced cost growth for all major categories. By comparison, hospital rate regulatory programs over the period were far less successful in controlling the rate of cost increases. Two of the four regulatory states (New York and New Jersey), in fact, had rates of increase in hospital costs that were higher than the national average. More striking is the fact that whereas costs in California were uniformly lower than the national average, in every case the rates of increase in expenditures for physician services and pharmaceuticals were higher than the national average for the states with hospital rate regulation programs.

Zwanziger and colleagues compared rates of change of hospital revenues
Exhibit 1
Comparison Of Cumulative Growth In Real Total Per Capita Health Expenditures And In Selected Components Of Health Expenditures, United States And Selected States, 1980-1991

<table>
<thead>
<tr>
<th></th>
<th>Percent growth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>United States</td>
<td>63.0%</td>
</tr>
<tr>
<td>California</td>
<td>39.0</td>
</tr>
<tr>
<td>Maryland</td>
<td>59.0</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>70.2</td>
</tr>
<tr>
<td>New Jersey</td>
<td>86.4</td>
</tr>
<tr>
<td>New York</td>
<td>85.4</td>
</tr>
</tbody>
</table>


and expenses in California to national averages over the 1975-1982 and 1982-1990 periods. They showed that 1982 marked a trend reversal for a whole series of hospital characteristics. One key finding was that by 1990 Californians devoted a smaller proportion of their incomes to pay for hospital services than they did in 1982, whereas this proportion increased for the United States as a whole. Significantly, a similar trend reversal took place in 1982 for more disaggregate cost measures. Hospital expenditures per adjusted discharge rose at a rate higher than the national average over 1975-1982 and then increased at a far lower rate during 1982-1990 (Exhibit 2). Savings were generated both by lowering the average length-of-stay and reducing the intensity of services provided, despite an increase in the severity of the case-mix because of the shift from inpatient to outpatient care. Expenses per adjusted discharge and full-time-equivalent (FTE) employees per adjusted patient show a similar trend reversal (Exhibit 3)—evidence that hospitals have made fundamental changes in the way they provide care. Similar dramatic trend reversals appear in utilization measures, such as per capita admission rates, hospital days, and outpatient visits.

These studies illustrate far-reaching differences between the rate of cost increases in California and the rest of the nation in the 1980s. It is tempting to ascribe these differences to the explosive growth in managed care plans in California during this period, but it is premature to assume a causal link since other changes were taking place simultaneously (for example, growth in the uninsured population) that could explain these results. Studies at a more disaggregate level are required to strengthen the causal linkage.

Relationship between market competitiveness and hospital costs, revenues, and prices. Hospitals that are the sole providers of hospital care in their markets are not threatened by the growth of managed care plans. In the absence of an alternative provider, managed care plans have little
leverage with such hospitals to offer them concessions, such as discounted prices, in exchange for inclusion in the plan’s provider network. As a result, the growth of managed care plans should have little or no effect on hospitals’ behavior. On the other hand, hospitals in highly competitive markets should experience the full effects of the change in the competitive environ-

ment, and their behavior should change dramatically. Numerous studies have used designs based on such differential impacts to identify the effects of competition on hospital costs, revenues, and prices.

Several studies have shown that hospitals in more competitive areas have changed their relative costs and revenues with the advent of selective contracting and managed care. We found in 1988 that selective contracting had an immediate impact on hospital costs in California. Following the introduction of legislation to encourage the spread of managed care plans in 1982, the difference in total hospital expenses and revenues between hospitals in markets with high versus low competition began to decline steadily. The total reduction in the difference between the two was seven percentage points from 1982 to 1985. Through 1985 the impacts of selective contracting and the Medicare prospective payment system (PPS, introduced in 1983) were approximately the same. Again in 1988, using data from the same data sets but a fundamentally different analytical approach, we found a similar differential response; Hospitals in competitive markets had far slower cost growth after 1982.

James Robinson confirmed and built upon these results in 1991. In a study of 298 California hospitals between 1982 and 1988, he showed that costs per admission at hospitals in markets with relatively high HMO penetration grew at rates that were 9.4 percent lower than those in markets with low penetration. In 1988 he estimated that these hospitals saved a total of $104 billion because of HMO market penetration. This represents an average admission cost that was $483 less than we would expect without HMO penetration. The reduction in a given hospital’s costs was not tied to the proportion of its patients enrolled in HMOs. Costs were lowered because fee-for-service plans were forced to become more cost-conscious to compete with HMOs. The introduction of price competition exerted downward pressure on costs in all of the hospitals in the market.

Zwanziger and colleagues studied eight categories of services in 400 California hospitals between 1982 and 1988 and found cost reductions in every area except ambulatory care. Individual hospitals had contained their total costs by making small cuts in almost every service category, rather than significantly cutting back particular services. Hospitals greatly reduced both the cost and the volume of intermediate services, such as lab tests and acute care days. Large overall savings resulted. The authors performed a multivariate analysis and found that the degree of reduction in both unit costs and volume was significantly related to the competitiveness of the hospitals’ markets.

Most recently, Zwanziger and colleagues showed that changes in a price-competitive market were sustained. Using California hospital data from 1980-1990, they performed a multivariate regression analysis of hospital
expenses and revenues. In 1980-1982, a period preceding the explosive growth of managed care plans, hospitals in the most competitive markets tended to have higher costs and revenues than those in the least competitive markets. This result is consistent with the prevalence of quality and amenity-based competition during a period when physicians dominated health care markets. Immediately following the enactment of selective contracting legislation in 1982, expenses and revenues of California hospitals in the most competitive markets began to converge with those in the least competitive markets. Those in the most competitive markets increased their expenses by 17 percent less than did those in the least competitive markets. The difference in revenue growth between the least and most competitive markets was even more dramatic.

Melnick and colleagues illustrated some of the strategic considerations that affect the prices negotiated by hospitals and managed care plans.21 They analyzed the prices negotiated by the PPO formed by Blue Cross of California and the hospitals in its network. A multivariate regression analysis related these prices to a variety of hospital and market characteristics. They found that if payers could credibly threaten to move their beneficiaries to another provider, they were able to negotiate lower prices. To move their beneficiaries, payers must have other hospitals in the area, and those hospitals must have excess capacity. Similarly, hospitals that depended on a single plan for a large proportion of their patients gave payers larger discounts. Conversely, when the PPO relied on a single hospital to provide care to a large share of their beneficiaries in an area, it had to agree to a higher price. Plans that intend to avoid high prices must take this situation into consideration when pruning their networks. An “optimally configured” network that concentrates on the minimum number of hospitals in each area may not have the capacity it needs to maximize a plan’s bargaining power.

Conclusions And Implications

The central message here is that managed care plans have succeeded in their primary mission: to reduce the growth rate of health care costs. In other countries this task is a governmental function, a part of the budgetary process. In the United States the failure of governmental health care reform leaves the primary responsibility of increasing the efficiency of the health care system to the private sector. The studies summarized here strongly suggest that managed care plans have been successful in inducing price competition and forcing costs down. California’s experience shows that this pressure on costs has been sustained and that recent structural changes are, if anything, increasing this pressure. It is too early to celebrate, however.
First, some aspects of redesigning the health care system will be painful and unpopular. Hospital closures, restrictions on access to providers, and limitations on covered services will evoke much opposition. Therefore, governments, despite their reluctance, may be forced to get involved. Their responses, such as legislation requiring managed care plans to enroll “any willing provider,” can only undermine their ability to control costs.

Second, it is still unclear whether the health care system, as restructured to control costs, will be able to provide acceptable access and quality. One critical requirement for the continuation of high-quality care is that physicians be integrated into the functioning of managed care plans. Although one central theme of this paper has been how, by design, managed care has shifted power away from physicians, they must still direct patient care and become involved in developing the standards of care and evaluation systems that will oversee medical care in the future. Although physicians may no longer function as self-employed professionals, only they possess the knowledge necessary to make the system more efficient in its use of resources and more effective in producing desirable health outcomes. Incorporating physicians’ concerns and interests into the managed care environment is a primary challenge for the future.

Another challenge is to make true-value competition (whereby buyers trade off price and quality) a reality. With such competition, high-price plans would have to prove that they are selling a higher-quality product using a variety of quality measures. The specific measures used would play a critical role both in the success of individual plans and in ensuring high-quality care. To play this constructive role, these measures must reflect both the contribution that medical care can make to patients’ health and the aspects of health care delivery that are important to the public.

While the above are primarily challenges for the private sector, the government also faces two crucial tests in the restructured health care system. The first is to replace the hidden cross-subsidies that finance charity care and graduate medical education with public funding. In highly competitive markets neither private payers nor hospitals will be able to support these activities as they have in the past.

The second is that government must ensure competition in health care markets as they evolve, just as it enforces competition in other markets. For example, government must monitor advertising claims for accuracy and prevent anticompetitive mergers. This task will be especially difficult in the health care market because quality may be difficult to assess and because all sectors of the health care system face strong incentives to merge to increase efficiency, not just market power. Vertical mergers enable providers and plans to optimize supply jointly without having to worry about their bargaining power. Horizontal mergers provide plans and providers with both
greater market power and lower overhead rates. Case studies of hospital mergers suggest that there are small savings from consolidating administration, somewhat larger savings from “rationalizing” services (for example, providing all maternity services at one site and all cardiac services at the other), and the potential for substantial savings if acute care facilities are closed entirely. Offsetting cost increases also have been observed with the need for more administrative and clinical coordination and/or the temptation for merged hospital systems to use their resources to increase their range of services. Antitrust enforcement is left with the difficult task of deciding when vertical and horizontal mergers no longer benefit the public.

The cost containment success documented in this paper depends on effective competition at each level. If market competition fails and the system becomes increasingly inefficient, then a government takeover may become inevitable. There clearly are parties in both the health care system and the political process who would not find that outcome to be the least bit distasteful.

NOTES


8. Feldman and Dowd, “The Effectiveness of Managed Competition.”