How competitive is the insurance industry?

- The US is unique in its reliance on the private insurance sector to finance healthcare for its residents

- The assumption is that competition among insurers will lead to more efficient outcomes – lower prices, more flexible benefits, better technology, quickly adaptation to changing times, etc.

- A 2004 report by the FTC and DOJ finds most "experts" believe the market is highly competitive (with vocal exceptions of groups representing physicians).

- Outsourcing of public insurance to the private sector (in both Medicare and Medicaid)

- Lax antitrust enforcement. Over the past 20 years there has been extensive insurer consolidation (with only three challenges by the DOJ and only in select markets).

- Empirically it is tough to measure the degree of market power. One would want a measure of the degree of market power among private insurers – or "how much control over the price of their product do insurers have?" Given the complicated nature of insurance contracts and the multi-market nature of firms and insurers (and the fact that insurance companies probably don't want people to know!) makes this tough to do.

- A study by Leemore Dafny, a health economist at Northwestern University attempts to measure the extent of market power enjoyed by private insurers.

- She obtains a database of fully insured health plans offered by a sample of large, multi-site employers between 1998 and 2005.

- She finds that firms with positive profit shocks subsequently face larger premium increases (even for the same health plan).

- This increase is greatest in markets with the fewest insurance carriers – the effect is particularly large when there are 6 or fewer carriers).

- If markets were competitive then insurers vying for each contract would bid down the premium until it had no relation to the employer's willingness to pay.

- That is, a multi-site firm with high profits in a given year will subsequently face significantly higher health insurance premiums – but only at sites served by a concentrated insurance market.

- Firms are much less likely to switch carriers in "good times", since this exposes them to more profit extraction.

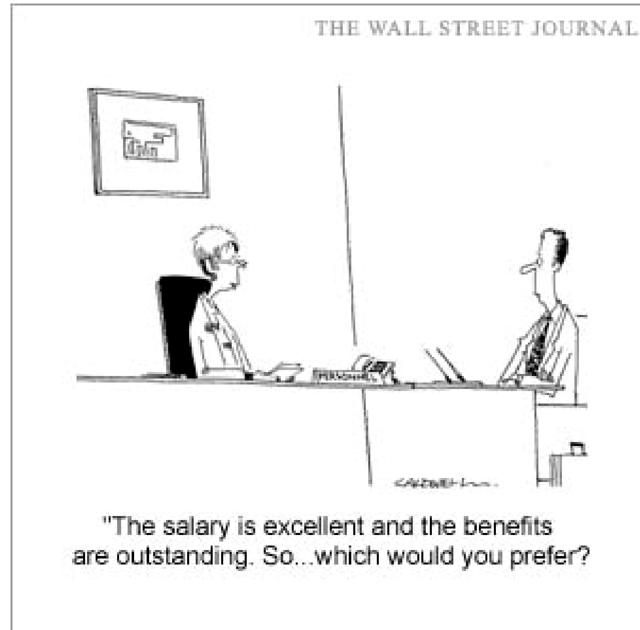
- Appears that the strong bargaining position of insurers in concentrated markets enables them to capture more of the extra surplus generated by profit shocks.

- "a 10-percentage-point increase in the after-tax return on assets (about a one standard deviation change) is followed by a 1.2 percent increase in health insurance premiums. Given that operating margins for insurers are generally less than 5 percent, this is a rather large effect.

- In 1998 only 7 percent of covered employees were in markets with 6 or fewer carriers, by 2005 this was 23 percent – and continues to grow.

- Likewise Katherine Ho finds looks at the "upstream bargaining" between insurers and hospitals. She finds that insurers tend to successfully extract the rents of hospitals in their networks

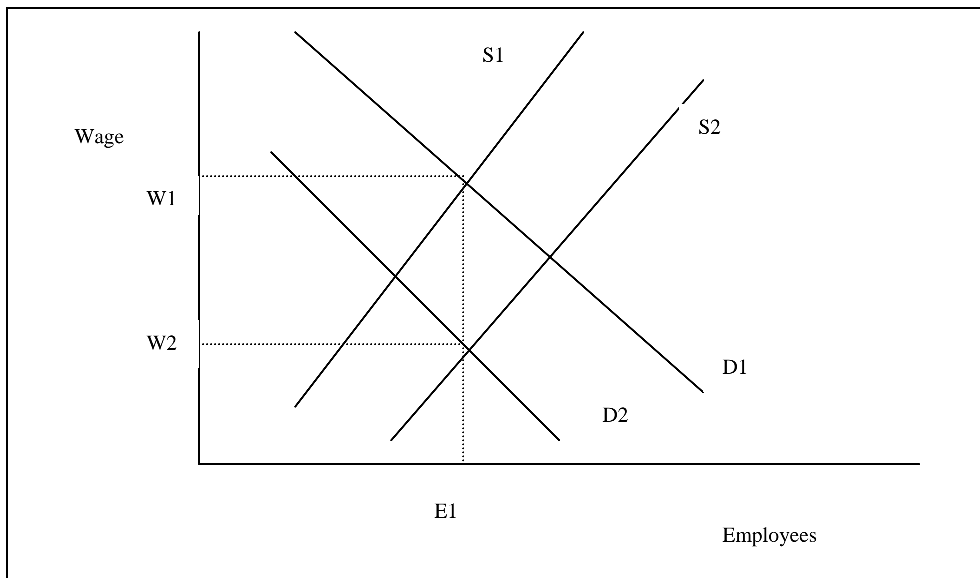
Who Pays for Insurance?



"The salary is excellent and the benefits are outstanding. So...which would you prefer?

For many employees the firm provides them with insurance coverage. But who bears the burden of this benefit is a different question.

To see this consider the supply and demand for labor:



- The worker's wage is lowered by an amount exactly equal to the amount of insurance. Thus the worker "pays" for the insurance by accepting a proportionate lower wage.

- Family Coverage – Most firms that offer insurance for family members of their employers typically require the worker to pay directly for the additional cost of that coverage. Single workers and workers with families receive the same salary, if the worker with family wants the family coverage the premium is taken directly out of the worker's wage. Ignoring the differences in tax liability that this creates, both are equally well off.

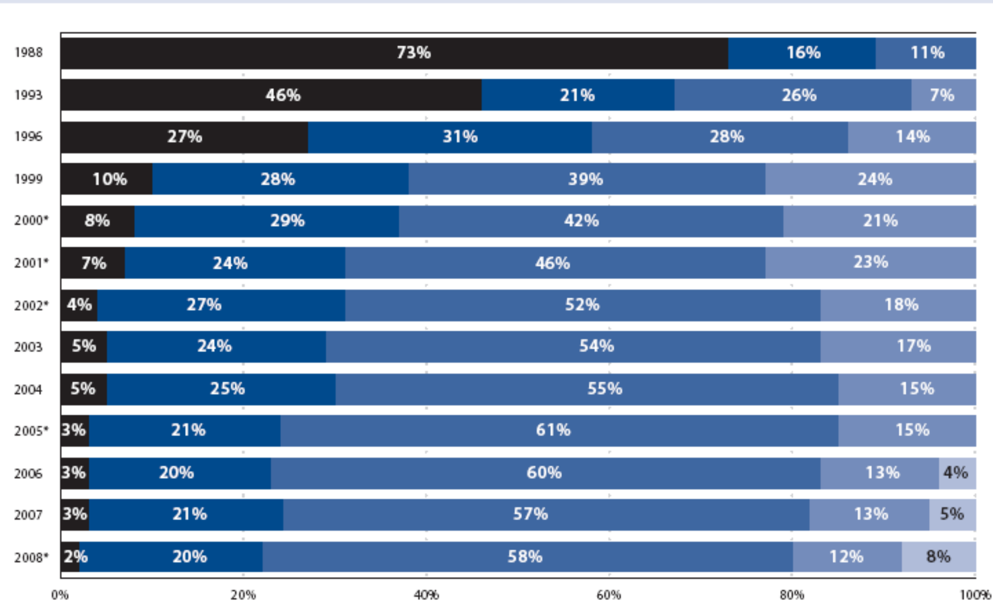
- For firms that do pay for family coverage note that there will be a cross-subsidization. Note that this will tend to result in these types of firms attracting only workers with families, which may be a good thing! This is an example of how a firm can use benefits to attract a certain type of worker that would be illegal to do with wages .

- Note that the above analysis is static (there is no change over time). What happens as health care costs increase? This is where it gets sticky!

Structure of Insurance Markets

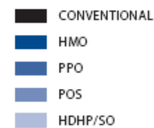
EXHIBIT 5.1

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2008



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.



* Distribution is statistically different from the previous year shown ($p<.05$). No statistical tests were conducted for years prior to 1999. No statistical tests are conducted between 2005 and 2006 due to the addition of HDHP/SO as a new plan type in 2006.

Note: Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

Managed care:

- HMO = Health Maintenance Organization. These plans generally provide comprehensive care and the marginal costs are generally very low (no copays or deductibles), but they require that all care be delivered through the plan's network and that the primary care physician (or gatekeeper authorize most services provided. The Staff Model HMO employs the physicians directly. Plans that set up networks by contracting with physicians in solo or small group practices are called independent practice associations (IPAs).

- PP0= Preferred Provider Organization. These are similar to HMOs, but they give the patient the option of going out of network. Usually the marginal costs are very low if care is received in-network, but there is a large penalty for going out of network (large deductible and copays)

- POS = Point of Service Plans. Like PPOs, POS plans offer two tiers of insurance benefits with higher cost for out of network providers than with in-network providers. But like HMOs, POS plans assign each member a gatekeeper physician who must authorize care in order for the care to be covered.

- HDHP/SO are high deductible health plans with a savings option.

- As managed care became a dominant form of health insurance throughout the 1990s there is pretty convincing evidence that this resulted in a one time reduction in health care expenditures. This is consistent with managed care helping to alleviate the moral hazard problem

- But note that this did nothing to affect the *growth rate* in health care expenditures.

- Managed care is a market based (supply-side) attempt to alleviate the moral hazard/physician induced demand problem.

- Under its various forms, the common theme is that the insurance company pays the providers some fixed fee to treat the patients under the insurance company's contract.

- The consumer generally has a small co-payment for care, but the marginal cost to the consumer is still close to zero. The incentive to restrict care is given to the provider.

- From the view of the hospital and physician, moral hazard is "good for business", and so reducing it hurt business. Physician incomes were reduced throughout the 1990s, and they were some of the most outspoken opponents of managed care.

- Consumers tend to dislike managed care because given the way the system is structured they are not allowed to consume all the care they would like.

- Thus, the structure of the insurance contract creates friction between consumers, physicians, the hospital, and the insurance company.

- A successful managed care contract must provide providers enough compensation to cover their costs of treatment plus enough to make them willing to sign on, but the premium charged to consumers must be low enough to attract consumers into the contract (typically through employers). This balance has been difficult to achieve.

Managed care in public insurance
Medicare+Choice vs. Medicare Advantage.

On the other hand, Managed care's presence in Medicaid has been fairly stable. More than half of Medicaid enrollees are in a managed care type of arrangement. Some have argued that Medicaid is managed care's final bastion. Why would this be?

Many of the arguments against managed care – lower quality, restricted access, incentives to under-provide imply that managed care insurance is inferior to other types of coverage. Do these apply to Medicaid? If so, why has MC managed to maintain such a strong presence?

Note the incentives are different. Medicaid is a welfare program we are providing care for those who otherwise could not afford it (or for reasons of adverse selection, the market would not operate efficiently).

Consumer-Driven Health Care

The shopping problem in health care

- We have some stock of health and are "producing" that good through the use of inputs (environment, lifestyle, etc. and health care).
- In many situations, we really don't understand how health care inputs affect our health.
- "experience goods". Over time you can figure out what you like and don't like by learning from "mistakes".

1. Traditional fee-for-service insurance allowed the physician to be the shopper for the patient
2. managed care – the insurer in many ways became the shopper for the patient.
3. consumer-driven health care. The consumer is the shopper?

- Consumer driven health plans are a demand-side attempt at lowering spending.
- The logic here is to increase the *marginal* cost of care by increasing co-payments and deductibles while lowering monthly premiums. Then giving the consumer a "savings" account that he/she spends as needed for his/her health care needs. This type of plan then forces the consumer to compare the marginal cost of care to the marginal benefits.

Note that the moral hazard issue all assumes that the demand for health care is price-elastic. That is, that consumers are sensitive to changes in the price

- So the effectiveness in consumer driven plans in lowering health care costs, to a certain degree, depends on how elastic the demand for health care is. These are pretty tough to estimate, but estimates are as follows:

Hospital Admissions:	-.14
Hospital LOS	-.06 to -.29
Physician Office Visits	-.08 to -.35
Total Spending	-.22 to -.79
Preventative Care	-0.43

So these numbers would imply that the moral hazard effect from insurance is not all that large in general (though for certain markets the demand is likely to be much more price sensitive (second opinions, the marginal test, etc. and so consumer driven plans are likely to result in savings here).

Note that the demand elasticities above are for the market in general, firm specific elasticities are much larger.

Physician Services –3 to –5.7
Hospital services (patient days or admissions) -.74 to -.8
These are numbers as they apply to a particular hospital or office.

The medical home

The idea is motivated out of the growing role of and the current system's failure to manage chronic conditions.

Figure. 2[4] Unhealthy Lifestyles and Aging Demographics Drive Costs Up

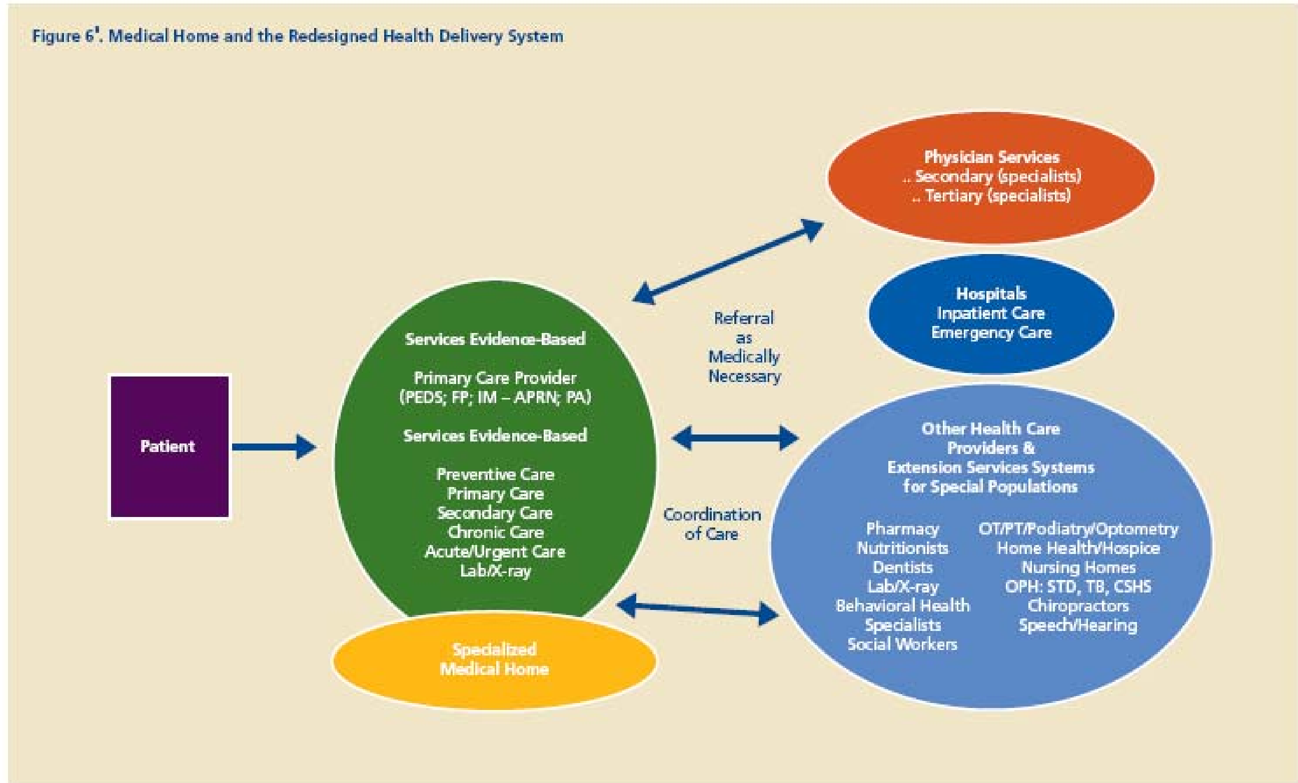
EXHIBIT 3
Decomposition of Changes in Nominal Health Care Spending, Fifteen Most Costly Medical Conditions, 1987-2000

Condition	Total change in spending (millions of dollars)	Percent changes in spending attributes to		
		Increased cost per treated case	Rise in treated prevalence	Increased population
Heart disease	26,228.5	68.6	1.1	30.3
Pulmonary conditions	24,792.0	37.5	41.9	20.6
Mental disorders	24.503.3	21.1	59.2	19.7
Cancer	17.734.3	41.9	27.4	30.7
Hypertension	15,385.8	59.8	18.9	21.3
Trauma	14.596.6	169.1	-108.5	39.5
Cerebrovascular disease	11.078.9	20.8	60.3	18.9
Arthtritis	10,282.8	44.3	31.6	24.1
Diabetes	9,626.8	23.6	49.8	26.6
Back problems	9,486.4	21.7	52.6	25.8
Skin disorders	7,286.5	54.8	22.0	23.2
Pneumonia	7,203.8	9.38	-18.4	24.6
Infectious disease	6,191.6	95.2	-17.5	22.3
Endocrine	5,029.1	28.0	43.4	28.6
Kidney	3,231.4	8.8	55.8	35.4

Source: 1967 National Medical Expenditure Survey (NMES) and 2000 Medical Expenditures Panel Survey, Household Components (MEPS-HC)

Note: All changes were statistically significant at the .05 level except for changes in spending, kidney disease (at the .10 level): rise in treated prevalence, heart disease (not significant): and increased cost per treated case, endocrine and kidney disease (not significant). Medical conditions ranked by change in spending between 1987 and 2000.

The Medical Home is s term used to describe a health care model in which individuals use primary care practices as the basis for accessible, continuous, comprehensive and integrated care. The goal is to provide a patient with a broad spectrum of care, both preventative and curative, over a long period of time, and coordinate all of the care the patient receives.



The role of “disruptive innovation”