The Impact of Monopsony on the Practice of Medicine: Defining the Market

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We Need to Protect the Competitive Process

- This is best for patients
- It is best for physicians
- Best for other institutions as well
  - Employers
  - Even health insurers
- It is best for all of us
- Unfortunately, the process is threatened

Most Physicians Are Price Takers; Insurers are Price Makers

- Medicare – RBRVS
- Medicaid – fee schedules
- Commercial carriers
  - Impose fee schedules
  - Take it or leave it propositions

Overview of remarks

- Some key facts
- Monopsonies do not operate in the public interest
- The buying power index
  - Market share and market definition
  - Elasticities of supply and external demand
  - Physician switching costs
  - Physician payment discrimination

Competition, Power & Medicine

- What are the best interests of the patient?
- Access, availability & quality matter.
- "Price makers" dictate access, availability & quality in a way we may not like.
- Will there be declining supply just when demand peaks?

Some Facts and a Question

- Large, health insurers dominate
- Premiums rise and provider payment stagnates
- A natural response: "Actors Act"
  - Uninsured rolls expand
  - Employers develop buying coalitions
  - Hospitals react
  - Physician "exit"
- What is the enforcement role?

Large Insurers & Public Interest

- Price making is **not** welfare enhancing
  - Physician fee reductions don't necessarily mean that patients, consumers and employers benefit
- The benefits are not being passed on
- There is no evidence that economies of scale
- Market power may be misused in downstream markets

Monopsonies Create Problems

- A long run issue of reduced supply
- Long run quality effects are substantial
- And distribution matters
  - Who do we want to reward, insurance companies or our doctor?

Buying Power Index

- Dominant health insurer market shares
- Physicians' ability to switch
- Non-dominant insurers' ability to respond

Mathematically:

- $BPI = S/(e+?(1-S))$
- Health Insurer Share (S)
- Elasticity of supply – physician switching (e)
- Elasticity of fringe demand – other firms responses ($?$)

Market Share Requires Us To Define the Market

- Considered from the seller / physician's viewpoint
- Not the health insurer's downstream market – although "interacts"
- Patients' willingness to travel / to switch doctors is important

For Physicians, The Geographic Market is Generally Local

- Counties -- even neighborhoods
- Specialty matters
  - Specialists may have a broader geographic market
- A buyer may have regional power but lack it in a county or neighborhood & vice versa
- Hospital based physicians – markets may tie to hospital service areas

The Product Market

- Case by case analysis
- Ties to physician specialties

What Large Shares Mean

- Maximum ability to price discriminate
- Switching may be impossible

Physician Switching & Costs

- Physicians supply highly skilled labor
- Extremely perishable commodity
- Their ability to switch is limited
- Opportunity costs and lost volume seller issues need to be considered
- Switching costs are extremely high
- Switching costs can be non-linear

“Other” Health Insurer Buyers Ability to Expand is Often Limited

- Evaluate on a case by case basis
- “Other” buyers’ credibility may be low
- Input cost structures are important
  - Monopsonists demand and get lowest input costs
- Expansion requires capital –
  - Fringe buyers may not be able to get it

Generally

- Share matters - a lot!
- It is difficult for physicians to switch
- Other health insurers may not exist or may not be able to expand

Conclusion

- Structure matters
- Large dominant sophisticated health insurer buyers are price makers
- Many small fragmented physicians and physician groups
- Evidence that physicians are responding by departing the market