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Working Paper 29809  
<http://www.nber.org/papers/w29809>

NATIONAL BUREAU OF ECONOMIC RESEARCH

1050 Massachusetts Avenue

Cambridge, MA 02138

February 2022, Revised January 2023

This project received financial support from the National Institute on Aging P01-AG019783. The authors acknowledge the assistance of the Health Care Cost Institute (HCCI) and its data contributors, Aetna, Humana, and UnitedHealthcare, in providing the claims data analyzed in this study. We benefited enormously from the excellent research assistance provided by Elodie Chervin, Krista Duncan, and Lev Klarnet. We also received helpful feedback on earlier drafts from Ivan Badinski, Steven Berry, Melinda Buntin, Stuart Craig, Leemore Dafny, Martin Gaynor, Craig Garthwaite, Peter Hull, Jonathan Skinner, and Amanda Starc. All mistakes are our own. The views expressed herein are those of the authors and do not necessarily reflect the views of the National Bureau of Economic Research.

At least one co-author has disclosed additional relationships of potential relevance for this research. Further information is available online at <http://www.nber.org/papers/w29809>

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## Do Higher-Priced Hospitals Deliver Higher-Quality Care?

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JEL No. I10,I11,I13,I18

### **ABSTRACT**

Hospitals in the US compete on price and quality. There are fears that because of general idiosyncrasies in the market for health care services, competition between hospitals will not generate efficient prices. These concerns have led to widespread calls for price regulation in the \$1.3 trillion hospital sector. A clear prediction from the growing literature on hospital insurer bargaining is that more appealing hospitals should be able to negotiate higher prices. Following this prediction, we introduce a simple test of the extent to which the market for hospital care in the US is functioning: analyzing whether high priced hospitals have higher quality, controlling for patient selection. We find that being admitted to a hospital with two standard deviations higher prices raises spending on patients by 53% and lowers their mortality by 1 percentage point (37%). However, the relationship between higher prices and lower mortality is only present at hospitals in less concentrated markets. Receiving care from expensive hospitals in concentrated markets increases spending but has no detectable effect on mortality.

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## I. Introduction

The \$1.3 trillion US hospital industry, which accounts for 6.1% of US gross domestic product (GDP) and 31% of domestic health spending, is an international outlier (Centers for Medicare and Medicaid Services, 2020). Outside of the US, hospitals in virtually every other developed nation are paid via some form of government-regulated reimbursement (Tikkanen et al., n.d.). The use of regulated reimbursements in the hospital sector, rather than market-determined prices, stems from a long-standing view among policy-makers and economists, dating back to Arrow (1963), that idiosyncrasies in markets for health care services—challenges consumers face observing and responding to prices and quality, information asymmetries, large returns to scale, and the frictions associated with firms’ entry and exit—impede competition between hospitals from generating efficient prices.<sup>1</sup> In the US, while public insurers pay hospitals regulated reimbursements, private insurers, which cover approximately 60% of the population, negotiate market-determined prices with hospitals.

There are growing concerns about the functioning of the market for hospital care in the US and, in particular, about the pricing of US hospital services (Skinner, 2011; Cutler, 2011; Pany, Chernew and Dafny, 2021). According to the Bureau of Labor Statistics (BLS), from 2000 to 2020, prices for hospital services increased faster than prices in *any* other US industry. There is also extensive variation in hospital prices across regions, within regions, and even within hospitals. For example, Cooper et al. (2019) found that hospital prices for routine services, like joint replacements and magnetic resonance imaging (MRI) scans, varied by a factor of more than five within major US cities.

Concerns about dysfunctional hospital pricing in the US are motivated, in part, by the rise in hospital market concentration that has occurred during the last two decades. Between 2000 and 2020, there were over 1,500 hospital mergers among the nation’s approximately 5,000 hospitals (American Hospital Association, 2018). At present, the majority of US hospital markets have an Herfindahl-Hirschman Index (HHI) of greater than 5,000 and are considered “highly concentrated” according to the joint Department of Justice and Federal Trade Commission horizontal merger guidelines (Fulton, 2017; Department of Justice and the Federal Trade

<sup>1</sup>There are similar, long-standing debates over regulating prices in other industries, such as the market for electricity (e.g., Cicala, 2022).

Commission, 1997). In short, the growing concerns are that high hospital prices may reflect providers' market power, or may simply be a function of idiosyncrasies in the market for health care services rather than a reflection of providers' clinical outcomes or their strategic investments in quality (Pany, Chernew and Dafny, 2021; Garthwaite, Ody and Starc, 2020). These concerns have led to widespread, bipartisan calls from academics, policy-makers, and elected officials to regulate hospital prices.<sup>2</sup>

The goal of this paper is to introduce a simple test of the extent to which the market for hospital services for care delivered to the privately insured in the US—one of the largest sectors of the US economy—is functioning. There is a growing body of work that has modeled the negotiations from hospitals and insurers (see Gaynor, Ho and Town (2015) and Handel and Ho (2021) for summaries). Insurers compete with one another over the quality and breadth of their network of providers, among other things (Dafny, 2010; Ho, 2009; Ho and Lee, 2019). Losing an appealing hospital from an insurer's network has been shown empirically to lead to a drop in the insurer's market share (Shepard, 2022). As a result, a simple prediction of these models of hospital insurer bargaining is that more appealing hospitals will be able to negotiate higher prices. We test this prediction empirically.

We analyze whether receiving care from higher-priced hospitals in an emergency results in higher quality, and whether the correlation between price and quality we observe differs in concentrated versus unconcentrated hospital markets. We focus on patient mortality as our quality score both because it often dominates welfare considerations and because it is correlated with other measures of hospital outcomes, such as adherence to clinical guidelines (Doyle et al., 2015). In this setting, we view emergency mortality, following Chandra et al. (2016), Gaynor, Moreno-Serra and Propper (2013), and Cooper et al. (2011), as the “canary in the coal mine” and a signal of overall hospital quality.

To date, there has been scant research assessing whether hospital prices are correlated with quality. This, in part, is due to the challenge of addressing selection bias—sicker patients may differentially be admitted to higher-priced hospitals. We aim to overcome selection bias by using an instrumental variable (IV) approach, first introduced by Doyle et al. (2015) and subsequently used by Chan,

<sup>2</sup>See, for example, Pany, Chernew and Dafny (2021); Kocher and Berwick (2019); and two bills in the US House of Representatives, H.R. 506 and H.R. 1332.

Card and Taylor (2022), which exploits the fact that ambulance companies are effectively randomly assigned to emergency calls within neighborhoods and have clear preferences regarding the hospitals to which they transport patients. Taken together, these features of the pre-hospital care system induce plausibly exogenous variation in hospital destinations among emergency patients. Our empirical strategy is therefore to compare the outcomes of privately insured patients from the same ZIP codes that are taken, in an emergency, to high- and low-priced hospitals as a function of the ambulance company sent to transport them. Prior work that has compared hospitals in this way has all compared hospital spending measured through administratively set prices in public programs (e.g., in Medicare and the VA), where variation in spending stems from differences in the quantity of care provided. We are the first to use this strategy to assess the relationship between hospitals' prices and quality. Our identification strategy does not test the causal effect of exogenously raising or lowering hospital prices. Rather, it allows us to test for a correlation between prices and quality after adjusting for patient selection.

What makes a hospital appealing should differ between concentrated and unconcentrated hospital markets. Past literature has shown that patients are elastic to quality and that small increases in travel distance can meaningfully reduce the probability a hospital gets chosen (Gowrisankaran, Nevo and Town, 2015; Brekke et al., 2014). In general, there are more hospitals per capita in unconcentrated hospital markets where there is greater population density. We posit that in these markets, hospitals will compete on prices and quality and, if the theory is correct, higher-quality hospitals should be able to negotiate higher prices. Conversely, in concentrated markets, where alternative hospitals are less available, it is likely distance concerns will dominate patient choice. This has the potential to obviate the correlation between hospitals' prices and quality.

Our analysis relies on data from the Health Care Cost Institute (HCCI) that includes providers' negotiated prices. The HCCI database is composed of insurance claims for individuals with employer-sponsored health insurance from Aetna, Humana, and UnitedHealthcare. The data capture claims for approximately 27.6% of individuals in the US with employer-sponsored insurance (Health Care Cost Institute, 2015). For each hospital, we construct an inpatient price index that adjusts for the mix of patients a hospital treats and the mix of services a hospital delivers. As a result, our analysis tests whether patients taken to hospitals

with higher prices for all inpatient services have lower in-hospital mortality for emergency admissions.

Our analysis reveals that receiving inpatient care at high-priced hospitals lowers mortality for nondeferrable conditions and raises health spending during the initial hospitalization and over the subsequent year. This is in contrast to the imprecise, negative correlation between prices and quality we observe when we do not instrument for hospital choice. Indeed, we find consistent evidence that selection effects bias a simple analysis that regresses providers' quality on their prices.

In particular, using our IV strategy, we observe that being admitted to high-priced hospitals (defined as facilities with two standard deviations or \$9,396 higher prices—roughly the equivalent of moving from 20<sup>th</sup> percentile of the national distribution of hospital prices to the 80<sup>th</sup> percentile) lowers in-hospital mortality for emergency cases by 1.02 percentage points off of a mean mortality rate of 2.75%. This 37% reduction in mortality that stems from receiving care from high-priced versus low-priced hospitals is substantial, and has a similar magnitude as the gains from major clinical improvements in care over the last 25 years, such as lowering the door-to-needle times for patients with heart attacks (McNamara et al., 2007). At the same time, being admitted to high-priced hospitals raises spending during emergency admissions by 53.49% and total spending at 365 days post admission by 41.72%. Notably, we do not find any relationship between hospitals' charges — their posted prices that are not set via bargaining — and patient outcomes. This serves as a placebo test and further highlights how the price quality-relationship we observe is likely a function of the bargaining process described in (Ho, 2009).

Notably, the relationship between hospital prices and survival we observe is driven by a price-quality relationship that is only present in hospitals located in less concentrated hospital markets (i.e., markets with an HHI of less than approximately 4,000).<sup>3</sup> In both more and less concentrated markets, patients who are admitted to higher-priced hospitals have roughly 53% higher spending during their index admissions. In less concentrated markets, they are also 1.29 percentage points (47%) less likely to die. Our point estimates suggest that in

<sup>3</sup>We chose this threshold because it is approximately the mean HHI in our sample and because there are two bills in the US House of Representatives, H.R. 506 and H.R. 1332, each introduced in the 116<sup>th</sup> Congress, which seek to set hospital prices based on the Medicare fee schedule in markets with an HHI over 4,000.

less concentrated markets, high-priced hospitals save an additional life at a cost of approximately \$1 million—spending per life saved that is likely cost effective.

Conversely, in more concentrated markets, we do not find evidence of lower mortality among patients admitted to higher-priced hospitals. Being admitted to high-priced hospitals in concentrated markets results in substantially higher spending, with no evidence of decreases in in-hospital mortality. Differentially high prices in these markets likely reflect hospitals' higher markups (e.g., rents) from market power, rather than demand for or investment in quality.

We then compare the ways that high-priced hospitals in unconcentrated markets differ from other hospitals in our sample. High-priced hospitals in markets with an HHI of less than 4,000 do not deliver higher-intensity care to patients admitted during an emergency, do not appear more likely to engage in surgical interventions on their emergency admissions, and do not appear to have higher cost structures (e.g., more technology or more nurses per bed). Instead, high-priced hospitals in unconcentrated markets have a substantially larger share of physicians who graduated from Top 25 US medical schools. Thus, the higher quality of high-priced hospitals in unconcentrated markets appears to be a function of the better human capital of their employees.

Ultimately, this paper makes contributions to both the academic and policy literature. First, this paper adds to the literature assessing the functioning of competition in health care provider markets. Like Chandra et al. (2016), this paper demonstrates that markets can function in the hospital sector. However, unlike prior work, this paper explores the functioning of markets where hospitals compete on price and quality (the dominant form of hospital competition in the US). Theory and the empirical evidence show clearly that in markets where hospitals' prices are regulated and hospitals can only differentiate themselves on non-price aspects of care (e.g., quality), competition between hospitals leads to higher quality as long as the regulated reimbursements are greater than hospitals' marginal costs (Gaynor, Ho and Town, 2015; Kessler and McClellan, 2000; Cooper et al., 2011; Gaynor, Moreno-Serra and Propper, 2013; Bloom et al., 2015). However, the theory and the empirical evidence regarding how competition will impact quality and prices in markets where prices and quality are market-determined is ambiguous, and depends on the relative elasticities of patients to price and quality (Gaynor, Ho and Town, 2015; Propper, Burgess and Green, 2004). We show that competition can function in these markets, assuming that they are uncon-

centrated, and that the prices generated via competition are likely cost effective. Our findings confirm predictions from (Ho, 2009) that more appealing hospitals should be able to negotiate higher prices.

Second, we add to the literature assessing the drivers of price variation in hospital markets. A growing literature has documented substantial variation in US hospital prices, even within narrow geographic markets (Cooper et al., 2019; Pany, Chernew and Dafny, 2021; White and Whaley, 2021). There also is clear evidence that hospitals with more market power have higher prices (Cooper et al., 2019; White, Reschovsky and Bond, 2014). The scale of the price variation in the hospital sector has led to calls to regulate hospitals' prices (e.g., Pany, Chernew and Dafny, 2021). Likewise, past work that did not address patient selection observed a negative correlation between hospital prices and hospital quality (e.g., Beauvais et al., 2020). However, as Cooper et al. (2019) demonstrate, even after controlling for hospital characteristics, local area characteristics, and provider and insurer market concentration, there is still a substantial amount of unexplained variation in hospital prices within markets. Consistent with findings on pricing in non-health sector differentiated product markets, this paper illustrates that provider quality is also likely driving variation in hospital prices.

Third, on the policy front, our findings suggest policy-makers should use caution in regulating hospital prices in less concentrated markets. At a minimum, our findings suggest that regulating hospital prices, particularly in markets where competition is geographically feasible, is complex and likely involves nuanced trade-offs between price and quality. In the past, it has been argued that the presence of extensive variation in hospital prices is suggestive that price regulation could lead to substantial cost savings without adversely affecting quality (Liu et al., 2021). Our findings suggest that indiscriminate price regulation might lower spending and could potentially also lower quality. While we cannot rule out a positive or negative relationship between price and quality in concentrated markets, our results suggest that should policymakers be interested in pursuing price regulation, concentrated provider markets where competition is geographically infeasible are likely the places to begin.

Going forward, this paper is structured as follows. In Section II, we give an overview the market for hospital care in the US, summarize the literature on hospital/insurer bargaining, and describe why we believe hospital prices and quality should be correlated. In Section III, we describe our empirical framework and

the identification strategy we use. In Section IV, we describe the data used in this analysis, detail how we construct key variables, and present our summary statistics. We present our results in Section V and conclude in Section VI.

## **II. Background and Predictions**

The majority of individuals in the US under age 65 get their health insurance from a private insurer either via their employer (e.g., employer-sponsored coverage) or through the individual market (Kaiser Family Foundation, 2019). Insurers negotiate network participation agreements with health providers and compete against one another for customers based on these networks, premiums, customer responsiveness, and other tools and offerings, like wellness programs, health support tools, and decision-support aids (Handel and Ho, 2021). Health care providers (e.g., hospitals) compete on price and quality and engage in a price/quantity trade-off when determining whether to participate in an insurer’s network (Cooper, Scott Morton and Shekita, 2020). In exchange for a negotiated price with an insurer, an insurer designates the provider as in-network and applies lower cost-sharing rates for that provider, thus increasing the volume of patients that provider is able to attract.

There are thousands of hospitals and hundreds of insurers in the US. The US relies on competition between insurers to determine insurance premiums and on competition between hospitals to determine hospitals’ prices (Cooper et al., 2019; Dafny, 2010). At present, health insurance in the US is hugely expensive — the median plan for a family of four was \$22,221 in 2021 — and is one of the most expensive individual purchases families make annually (Claxton et al., 2021). The high cost of health insurance largely reflects the high costs of medical care. Ultimately, hospital services account for the largest single category of health care spending — 31% of health spending (Centers for Medicare and Medicaid Services, 2020). Hospital care prices are high — the average baby delivery, one of the highest volume services for the privately insured, is approximately \$14,000, which is markedly higher than prices for baby deliveries in other countries — and prices have gone up markedly over the last two decades (Cooper et al., 2019; Oi, 2015).

There is a growing literature that models negotiations between hospitals and insurers. These negotiations have been characterized by a multi-stage model summarized, for example, by Gaynor, Ho and Town (2015) and Handel and Ho (2021). In the first stage of this model, hospitals make strategic investments, like

investing in capital and hiring staff, that determine their quality. In the second stage, after quality has been determined, hospitals negotiate with insurers over reimbursements and network participation. In the third stage, insurers set their premiums, conditional on their own characteristics, the characteristics of their competitors, and their payments to providers, in order to maximize their objective functions (e.g., profits). In the fourth stage, individuals, conscious of their own health status and possible future health care needs, choose an insurance plan. In the final stage, after enrolling in insurance, some consumers become injured or sick and require medical care. These consumers then choose a hospital to receive medical care from the insurer's network or choose to go out of network.

There is a broad literature on each stage of this model (see Gaynor, Ho and Town (2015) and Handel and Ho (2021) for detailed reviews of this literature). For example, building on the wider literature on how firms endogenously select quality, Garthwaite, Ody and Starc (2020) illustrate that hospitals in markets with more privately insured patients make more investments in quality, which they posit raises their costs and, in turn, their prices. We take hospitals' quality as given and focus on the second and third stages of this multi-stage model: the equilibrium price hospitals negotiate with insurers and the extent to which that price is correlated with clinical quality.

Networks of providers are vital for insurers. At a minimum, insurers need to include a broad mix of service providers within their networks in order to be able to offer comprehensive packages of care to enrollees. As Ho (2006) notes, when selecting an insurance plan, individuals place substantial weight on the attractiveness of an insurer's network. For example, losing a star hospital from a network can cost insurers market share (Shepard, 2022). The empirical evidence suggests that from a consumer's perspective, demand for hospital care is driven by hospitals' location and quality.<sup>4</sup> Standard choice models (e.g., Capps, Dranove and Satterthwaite (2003) and Gowrisankaran, Nevo and Town (2015)) show that demand for hospitals decreases sharply as distance increases. For example, Gowrisankaran, Nevo and Town (2015) observes that a five-minute increase in travel time to a hospital reduces demand by between 17% and 41%. Likewise, evidence illustrates that patients have a preference for higher-quality providers. Past work has shown a strong, positive relationship between hospital demand and

<sup>4</sup>Once the decision to receive hospital care has been made, as Brot-Goldberg et al. (2017) demonstrate, differences in cost sharing have little influence on which hospital patients choose.

quality, where quality is measured using mortality (e.g., Beckert, Christensen and Collyer (2012), Moscone, Tosetti and Vittadini (2012), Gaynor, Propper and Seiler (2016), McConnell et al. (2016)), readmission rates (McConnell et al. (2016), Moscone, Tosetti and Vittadini (2012), Varkevisser, van der Geest and Schut (2012)), composite quality scores (e.g., Bundorf et al. (2009)), and hospital reputation (e.g., U.S. News and World Report ratings, as shown by Pope (2009)). Here, for example, year-on-year changes in U.S. News and World Report ratings can shift as much as 5% of hospitals' planned patient volume annually.

The importance of networks to the consumers of insurance leads to predictions from, for example, Ho (2009) that more appealing hospitals can negotiate higher prices. This is the core prediction we test empirically in this paper. We focus on analyzing the functioning of hospital markets in the US, by testing whether more appealing hospitals negotiate higher higher prices. Given the responsiveness of patient demand to quality, we posit that there should be a positive correlation between hospital prices and quality after controlling for selection. To the extent that prices are uncorrelated with quality, it would be a sign that, despite patients' demand for quality, high-quality providers are not rewarded with higher reimbursements. This prediction is related to predictions from Chandra et al. (2016) that another signpost of a functioning markets in the hospital sector is the extent to which higher-quality hospitals will achieve greater market share.

We posit that the correlation between price and quality should differ in concentrated and unconcentrated markets. In concentrated markets, the correlation between price and clinical quality should be weaker than it is in unconcentrated markets. In unconcentrated markets (consider the market for hospital care in a dense city, where the relative distance between hospitals is small), because differences in differential travel distance between hospitals are less important and patients demand quality, high quality hospitals should be able to negotiate higher prices. In this setting, these higher prices likely reflect patients' demand for high-quality hospitals and possibly the higher costs associated with producing higher quality care (Garthwaite, Ody and Starc, 2020). Conversely, take the extreme case of a highly concentrated market where there is only one hospital that is generally accessible by patients (e.g., the differential distance to the second closest hospital is high). In this market, quality will not vary, and a hospital is appealing not because of the quality of care it offers, but rather simply because it is much more accessible than its nearest neighbor. Consistent with this prediction,

Cooper et al. (2019) have documented that in the cross-section, monopoly hospitals are able to negotiate 12% higher prices than hospitals in quadropoly markets. In these markets, high prices do not reflect the higher costs of producing higher-quality care or patient demand for star hospitals; rather, high prices likely reflect the rents hospitals accrue in the absence of having competitors.

### III. Empirical Framework

#### A. Ambulance Referral Patterns

The location where patients receive hospital care is seemingly nonrandom and likely correlated with patient characteristics. For example, it is highly plausible that patients with complex medical needs differentially attend higher-quality hospitals that may also have higher prices. These high prices could reflect hospitals' higher costs. As a result, the empirical challenge in this paper is overcoming the endogenous sorting of patients to hospitals that would bias cross-sectional estimates of the relationship between hospital prices and hospital quality. Indeed, past work that has regressed hospital quality against hospital prices *without* addressing selection has found a negative correlation between quality scores and prices (Beaulieu et al., 2020).

Our empirical strategy to address this bias leverages the plausibly exogenous drivers of patients' hospital assignment that are determined by ambulance company preferences and the manner in which ambulance companies are assigned to emergency calls. Because local areas are generally served by multiple ambulance companies, the assignment of an ambulance company to a patient is ostensibly random. In some communities, ambulance calls are broadcast to multiple companies, and the nearest ambulance is assigned to transport the patient (Chiang, David and Housman, 2006; Ragone, 2012). In communities with a single ambulance provider, ambulance companies from other regions can be assigned to pick up slack during periods of high demand (Doyle et al., 2015). Likewise, in most cities, private ambulance companies work in partnership with local fire departments, which also provide emergency medical services and transportation (Johnson, 2001).

Ambulance companies have strong preferences for particular hospitals. Their preferences are shaped, in part, by long-term relationships that paramedics develop with local emergency departments (Doyle et al., 2015). Ambulance com-

panies’ preferences are also influenced by the ownership structures of ambulance firms (Skura, 2001). In many cases, ambulance companies are operated by non-profit hospitals, are stationed within those facilities, and tend to transport patients to these facilities in emergencies.

To operationalize the quasi-random variation driven by pre-hospital factors — the random assignment of ambulance companies to patient calls and the fact that ambulance companies have strong preferences regarding where they transport their patients — we construct a set of instrumental variables based on the average inpatient price at hospitals where each ambulance company takes other patients (i.e., not the patient they are currently transporting). This leave-out-the-mean approach is similar to jackknife IV estimators (Stock, Wright and Yogo, 2002).

In practice, for patient  $i$  assigned to ambulance company  $a_i$ , we calculate the average hospital price among patients in our sample for each ambulance company.

$$(1) \quad Z_{a_i} = \frac{1}{N_{a_i} - 1} \sum_{j \neq i}^{N_{a_i} - 1} P_{h_j}$$

This measure,  $Z_{a_i}$ , is the ambulance company fixed effect in a model predicting  $P_h$  that leaves out patient  $i$ .  $P_h$  is an inpatient price index constructed following Cooper et al. (2019). The price index, which we describe in more detail in Section IV.C, measures a hospital’s average price conditional on its patients’ characteristics and its mix of services delivered.

### B. Estimation

We want to analyze whether a patient-episode  $i$ , originating from five-digit ZIP code  $z$  and place of origin (e.g., home)  $o$ , treated in year  $t$  at hospital  $h$  with two standard deviations higher prices  $P_h$ , achieves a better outcome  $Outcome_{i,t}$ :

$$(2) \quad Outcome_{i,t} = \pi_0 + \pi_1 P_{h_i} + \pi_2 X_{i,t} + \pi_3 A_i + \pi_4 D_i + \theta_{z_i} + \phi_{o_i} + \lambda_{t_i} + \epsilon_i$$

where  $X_{i,t}$  is a vector of patient controls including age (measured in 10-year bands), sex, and a Charlson comorbidity score measured over the preceding six months. One concern is that ambulances that take patients to higher-priced hos-

pitals could deliver more care en route. To control for this possibility, we also include a vector,  $A_i$ , of ambulance characteristics, including the payment the insurer made to the company as a summary measure of treatment intensity, indicators for distance traveled, and an indicator for whether the transport was coded as an emergency (e.g., “lights and sirens”). However, as we show in Table 6, our results are robust to excluding these ambulance characteristics as controls. We also include a set of principal diagnosis fixed effects  $D_i$ . We include ZIP  $\theta_{z_i}$  and place-of-origin fixed effects  $\phi_{o_i}$  to compare patients from the same neighborhood and originating from the same type of location — e.g., their place of residence — where we expect the assignment to be effectively random. While our main outcome (in-hospital mortality) is binary, we prefer to rely on OLS and 2SLS because of the over 6,000 ZIP, origin, and year fixed-effects included in our estimator.

Because patient selection will likely confound Equation (2), we estimate it using a two-stage least squares regression in which we instrument for hospital price using our ambulance instrument  $Z_a$ , with standard errors clustered around patients’ health service area.<sup>5</sup> Our first stage takes the form:

$$(3) \quad P_{h_i} = \alpha_0 + \alpha_1 Z_{a_i} + \alpha_2 X_{i,t} + \alpha_3 A_i + \alpha_4 D_i + \theta_{z_i} + \phi_{o_i} + \lambda_{t_i} + v_i$$

where the the price index for the hospital chosen for patient  $i$  is regressed on the instrument and the same set of controls as in the outcome equation. Estimating Equation (3) allows us to compare the outcomes of individuals in the same ZIP code who are picked up by ambulances with different “preferences” about where they transport their patients.

Ultimately, our ambulance instrument provides plausibly exogenous variation in the location where patients are treated. As a result, we are measuring the causal effect of being taken to a high-priced hospital, not the effect of raising or lowering prices on quality at a given hospital. We focus on whether being admitted to high-priced hospitals impacts in-hospital mortality. There is an expansive literature on using in-hospital mortality as a quality measure (see Doyle et al. (2015); Department of Health and Human Services (2007) for reviews). Past work has illustrated a high correlation between in-hospital mortality and 30-day

<sup>5</sup>As we illustrate in Table 6, our results are robust to clustering around patients’ home ZIP codes or their hospital referral regions (HRRs).

mortality across a range of medical conditions (Rosenthal et al., 2000; Borzecki et al., 2010).<sup>6</sup>

We also analyze whether patients have better outcomes when treated at high-priced hospitals located in concentrated versus unconcentrated markets. There are widespread concerns about using an HHI as an independent variable and, for example, regressing firm prices against a HHI (Berry, Gaynor and Scott Morton, n.d.). In this analysis, rather than using a HHI as a dependent variable, following Cooper et al. (2011) and Gaynor, Moreno-Serra and Propper (2013), we use a measure of hospital HHI to divide our sample into concentrated and unconcentrated regions so that we can compare the price-quality relationship in both types of areas. As we discuss in Section IV.D, for each hospital registered with the American Hospital Association, including hospitals not in our analytic sample, we construct a time-invariant, hospital-specific HHI using a market around each hospital defined by a 30-minute travel time (Raval and Rosenbaum, 2018). We then include our baseline instrument and our instrument interacted with an indicator for being in a concentrated market. We also include a specification in which we separately interact our instrument with indicators for being in a concentrated market and being in an unconcentrated market. We also show our results are robust to alternative measures of HHI (e.g., one where the hospital market is defined by a fixed 15-mile radius drawn around each hospital or time-varying HHIs).

### *C. Assumptions and Threats to Identification*

Our empirical strategy is to use the ambulance instrumental-variable strategy to generate as-good-as-random assignment of patients to hospitals. This strategy is similar in spirit to the “judge IV” literature (e.g., Kling, 2006; Doyle, 2007; Dobbie and Song, 2015; Dobbie, Goldin and Yang, 2018). Our identification strategy, like the “judge” literature, relies on a standard set of assumptions (independence, monotonicity, and exclusion) (DiNardo and Lee, 2011; Frandsen, Lefgren and Leslie, 2019).

Ultimately, the core identification challenge we are seeking to overcome — independence — is that potentially sicker patients differentially attend higher-priced hospitals, which would bias the uninstrumented cross-sectional relationship between hospital prices and quality. We demonstrate via balancing tests that our

<sup>6</sup>We cannot link HCCI data to Medicare claims, so we cannot simultaneously analyze outcomes for Medicare beneficiaries.

IV strategy does result in balanced observable characteristics of patients at high-priced and low-priced hospitals. As a summary that illustrates the appeal of our research design, we construct a measure of predicted mortality based on patient observables. We then use our predicted mortality measure as the dependent variable in OLS and IV estimates of the relationship between hospital prices and quality. If ambulance company assignment is effectively random, then this measure of patient illness severity should not be correlated with the instrumented hospital price.

We also work to address monotonicity concerns. With judge designs, strict monotonicity is unlikely to hold (Frandsen, Lefgren and Leslie, 2019). We rely instead on weaker forms of monotonicity, such as probabilistic monotonicity (DiNardo and Lee, 2011) or average monotonicity (Frandsen, Lefgren and Leslie, 2019). Under probabilistic monotonicity, individuals have a probability of treatment (in our case a probability of choosing a high-priced hospital), and the identifying assumption is that this probability is increasing with the instrument. Under this interpretation, the IV estimates a local average treatment effect where the weights are proportional to the effect of the instrument on the probability of treatment receipt. The probability of treatment can vary with the characteristics of patients and their potential outcomes because the probability determines the weighting rather than the underlying treatment effects. Under average monotonicity, the covariance between a patient's ambulance-specific treatment status and the ambulance's overall propensity is positive. These monotonicity conditions result in tests that are commonly conducted, including whether the instrument applies similarly across distinct patient cohorts. That is, we examine whether the coefficient on our first stage is similarly scaled and powered when we run it independently on cohorts of male patients, female patients, younger patients, older patients, sicker patients, and healthier patients.

In terms of the exclusion restriction, we return to our research question: whether high-priced hospitals differ in terms of quality compared to low-priced hospitals. We stress that we are not testing whether raising prices would raise quality. Rather, we are testing whether price and quality are positively or negatively related, which is an important consideration when crafting regulatory policy and one that informs the debate on the functioning of healthcare markets. We explore the potential mechanisms by which high-priced hospitals deliver higher-quality care by investigating the differences between high-priced and low-priced hospi-

tals in concentrated and unconcentrated markets across a range of observable characteristics.

#### IV. Data, Sample Construction, and Summary Statistics

##### A. Data and Sample Construction

We use HCCI data from 2008 to 2014. The data capture insurance claims for individuals aged 0 through 64 who have employer-sponsored insurance provided by Aetna, Humana, or UnitedHealthcare. The data capture spending by all health care providers (including ambulances), but exclude spending on pharmacy-dispensed drugs.

We rely on a sample of patients admitted to the hospital via ambulance with a “nondeferrable” condition for which treatment cannot be delayed. Admissions that are discretionary tend to occur less frequently on weekends, but nondeferrable admissions do not. Dobkin (2003), Card, Dobkin and Maestas (2009), and Doyle, Graves and Gruber (2017) identify nondeferrable conditions as those with diagnoses on a weekend that are proportional to rates of admissions during the week. We use diagnoses they identify as nondeferrable and also include conditions designated as nondeferrable based on expert panels (Mulcahy et al., 2013). Appendix Table 1 shows the conditions we use in our analysis. Nondeferrable admissions represent 34.45% of all HCCI inpatient admissions and 23.19% of total hospital revenue from HCCI payors (see Appendix Table 2). On average, patients with a nondeferrable condition transported by ambulance from a given ZIP code attend 5.92 different hospitals.

We lose approximately 2% of these ambulance rides because they went to a hospital for which we do not have a price index, either because the treatment location is not a general acute care hospital or because it did not perform 50 inpatient cases involving HCCI beneficiaries annually. We drop a further 1.77% of rides that are associated with admissions in Maryland hospitals, where prices are regulated. We also restrict our sample to ambulance companies for which we still have at least 10 rides and patients from ZIP codes in which we see more than 10 observations across our sample period, which excludes 4.98% and 10.33% of remaining observations, respectively. Finally, we require patients to be treated within 50 miles of their home ZIP codes, which excludes 9.04% of cases.

*B. Data on Hospital Characteristics*

We bring together a range of data on hospitals’ characteristics (hospitals’ count of technologies, bed count, for-profit status, payor mix, and count of nurses per bed) from the American Hospital Association (AHA) Annual Survey. The AHA data also contain information on whether a hospital is a member of the Council of Teaching Hospitals and Health Systems (COTH) (i.e., the hospital is a “major” teaching hospital) or is not a COTH affiliate but has a residency program (i.e., it is a “minor” teaching hospital). We merge in data on hospitals’ publicly reported quality from the Centers for Medicare and Medicaid Services (CMS) Hospital Compare database. Finally, using a 2017 extract from the CMS Physician Compare tool, we measure the characteristics of physicians who treat patients at each hospital (e.g., their sex, their average number of years since graduation from medical school, and the share of physicians practicing at a hospital who graduated from a Top 25 medical school) based on U.S. News and World Report rankings.

*C. Measuring Hospital Prices*

We construct a measure of hospitals’ time-invariant inpatient prices following the approach used in Cooper et al. (2019). Hospitals differ in the mix of patients they treat (e.g., the demographics and severity of illness of their patients) and the mix of services they offer (e.g., high-acuity versus low-acuity care and high-tech versus low-tech care). Our price measure is a hedonic price index that captures a hospital-level price conditional on the mix of patients a hospital treats and the mix of services a hospital delivers.

The inpatient price index captures the combined amount paid by patients and insurers (e.g., the allowed amounts) for inpatient episode  $e$  in diagnosis related group (DRG)  $d$  delivered in hospital  $h$  between 2008 and 2014. We limit the data to general medical/surgical hospitals with at least 50 cases in this period. Following Gaynor and Vogt (2003) and Gowrisankaran, Nevo and Town (2015), we regress hospital payments ( $p_{e,h,d}$ ) on hospital fixed effects ( $\alpha_h$ ), a vector of patient characteristics ( $\mathbf{X}_{e,h,d}$ ) comprised of indicators for patient age (measured in ten-year age bands), a dummy for the patient’s sex, and a vector of DRG fixed effects ( $\gamma_d$ ). The regression to produce our inpatient prices has the form:

$$(4) \quad p_{e,h,d} = \alpha_h + \mathbf{X}_{e,h,d}\beta + \gamma_d + v_{e,h,d}$$

where  $v_{e,h,d}$  is the stochastic error term. We recover the vector of hospital fixed effects  $\hat{\alpha}_h$  and calculate a hospital price index for each hospital at the sample means of the patient characteristics ( $\bar{\mathbf{X}}$ ) and the DRG indicators,  $\bar{d}$  (i.e., a sample mean basket of DRGs):

$$(5) \quad \hat{p}_h = \hat{\alpha}_h + \bar{\mathbf{X}}\hat{\beta} + \bar{d}\hat{\gamma}_{\bar{d}}$$

This yields the hospital’s price, adjusted for its mix of treatments and mix of patients (note that the fixed effect  $\hat{\alpha}_h$  is the key output:  $\bar{\mathbf{X}}\hat{\beta} + \bar{d}\hat{\gamma}_{\bar{d}}$  is just a constant across all hospitals to match the mean in the data).

The inpatient price sample is derived from hospital claims for all inpatient care provided to individuals age 18 through 64 who have insurance coverage from an HCCI payer and who receive care at hospitals registered with the AHA and classified as general and surgical facilities. For each DRG, cases above the 99<sup>th</sup> percentile of length-of-stay or those in which the price is below the 1<sup>st</sup> percentile or above the 99<sup>th</sup> percentile are excluded to get rid of outliers (e.g., the \$30 or \$1 million knee replacement).

#### D. HHI Calculation

We use an HHI to designate hospital markets as concentrated and unconcentrated, so that we can compare the price-quality relationship in the two types of markets. Our goal is to rely on the variation in concentration that is a function of geography and historical precedent, rather than short-run changes in provider quality. To do so, we build an HHI where we define the size of the market using a 30-minute travel time around each hospital (e.g., a market definition that is not based on actual patient flows). We choose a 30-minute travel time because it is two times the average time patients generally travel for hospital care (Lam, Broderick and Toor, 2018). We also show robustness, in Appendix Table 8, to measuring markets defined using fixed radii (e.g., a circular market around each hospital defined using a 15-mile radius).

For each hospital  $h$  in each year  $t$ , we calculate a HHI based on the number of beds in hospital  $h$  and in all  $H_{h,t}$  hospitals in the relevant market, as measured via the AHA annual survey. We rely on a fixed count of hospital beds because these are less sensitive to year-on-year changes in provider quality and, as Park Hung, Gaynor and Richards-Shubik (2017) note, past policies, including the Hill-Burton

Act, have heavily influenced present day hospital location and bed volume. We construct the bed-based HHI measure ( $HHI_{h,t}$ ) in the following way:

$$HHI_{h,t} = \sum_{h=1}^H \left( \frac{\text{Number of beds in hospital } h \text{ in year } t}{\text{Total number of beds in all } H_{h,t} \text{ hospitals in the market in year } t} \right)^2$$

$$HHI_{h,t} \leq 1$$

We do not view other hospital sites within the same health system as competitors, although our results are robust to doing so. We average the hospital-year level HHI across all years from 2008 to 2014 to create a time-invariant HHI, so that our HHI measure does not change during our sample period because of mergers or changes in quality. Likewise, as we illustrate in Appendix B, our results are robust to using a time-varying HHI that allows the HHI to vary annually.

Because HHI is defined at the hospital level, an ambulance may take patients from the same neighborhood (which we control for using ZIP code fixed effects) to hospitals that vary in the level of competition they face. The intuition here is as follows. Imagine a patient picked up at their home, which is located equidistant from two hospitals (Hospital A to the east and Hospital B to the west). The only hospital nearby Hospital A is Hospital B. Conversely, Hospital B is both a competitor to Hospital A and a competitor to Hospital C and Hospital D, which are both farther east of Hospital B. In this way, individuals who live near one another may be treated at hospitals that face varying levels of competition.

#### *E. Predicted Mortality*

We create a measure of patients' predicted in-hospital, inpatient mortality based on observables measured from the HCCI data. We predict that a patient will die during their inpatient stay using controls for the patient's sex, their age, interactions between sex and age, Charlson Index of Comorbidity Score, and International Classification of Disease (ICD) 9 codes. The  $R^2$  on the OLS regressions used to predict inpatient mortality is 0.08.

*F. Summary Statistics*

Our analytic sample is composed of 191,045 admissions among 162,263 patients that occurred at 1,857 hospitals between 2008 and 2014.<sup>7</sup> We present patient-level descriptive statistics in Appendix Table 3. As we illustrate in Panel A of Table 1, the mean hospital price is \$14,865 and varies substantially (the standard deviation is \$4,698, and the interquartile range is \$11,713 to \$17,045). Among our sample, the mean hospital HHI is 4,388 and the HHIs at the 25<sup>th</sup> and 75<sup>th</sup> percentile are 2,366 and 5,464, respectively. As we illustrate in Appendix Table 4, because of our sample restrictions, our analytic sample of hospitals differs from the universe of hospitals registered with the American Hospital Association. Hospitals in our analytic sample tend to be located in less concentrated markets, less rural areas, and larger areas.

Panel B of Table 1 shows means and standard deviations for key patient characteristics and aspects of patients' ambulance transport to the hospital. The modal patient in our sample was between 55 and 64 years of age and was transported to a hospital by ambulance from their home. The third column reports the difference in the mean of the covariate when the instrument constructed in Equation (1) is above or below its median value as computed from a regression that controls for ZIP code and year fixed effects, divided by the pooled standard deviation. Relative to widely used standardized difference thresholds for assessing sample balance (e.g., a 0.25-standard deviation difference from Rubin (2001)), these standardized differences are small across the wide range of control variables and show a pattern consistent with effectively random assignment of ambulance companies to patients.<sup>8</sup>

Likewise, in Table 2, we show a balance table that illustrates how patient characteristics and patient diagnoses vary across the quartiles of our ambulance price instrument. Patients appear balanced on sex, age, diagnoses, and comorbidity scores. Likewise, across the top 15 diagnoses in our data, there is no significant difference in incidence across quartiles of the instrument. We do not find significant differences in patient characteristics or patient diagnoses across the first and fourth quartiles of our instrument. The only characteristic that differs between

<sup>7</sup>17,702 patients in our sample have multiple nondeferrable admissions. Our results are qualitatively unchanged when we exclude patients' subsequent admissions.

<sup>8</sup>We also find no strong relationship between our instrument and whether patients get admitted across all patients the companies transport.

the first and fourth quartile of the IV is the share of patients with an “injury of the neck and nose” (0.167 in the first quartile; 0.171 in the fourth quartile,  $p < 0.1$ ). In Appendix Table 1, we show balance across all 29 diagnoses. These balance tests lend support to the credence of our as-good-as-random identification strategy.

## V. Results

### A. Hospital Prices, Mortality, and Health Spending

Table 3 presents results from our 2SLS analyzing whether patients have lower mortality when they are admitted and receive care at higher-priced hospitals. In Panel A, we show the first stage of our 2SLS, in which the dependent variable is hospitals’ time-invariant inpatient price. Our point estimate in Panel A reveals that a one-unit increase in our instrument leads to a \$0.67 increase in hospital prices. Because hospital prices vary substantially within geographic areas and ambulance companies generally have a single preferred hospital, our instrument has considerable predictive power, with a standard error of 0.02 and a first-stage F-statistic of 877.<sup>9</sup> As we illustrate in Appendix Table 5, we get a strong first stage when we run our IV strategy separately on distinct patient cohorts (e.g., on younger patients separately from older patients).

In Panel B of Table 3, we show the OLS estimates of Equation (3) and show the relationship between being admitted to a high-priced hospital, spending on the index emergency admission, inpatient mortality, and predicted mortality. Unsurprisingly, we find, via our OLS, that admission to hospitals with two standard deviations higher prices (a price increase of \$9,396) raises health spending during emergency episodes by 54.27% (\$15,322). However, in our OLS specification, we also find that receiving care from hospitals with two standard deviations higher prices is associated with an imprecise increase in in-hospital mortality of 0.18 percentage points off of a mean mortality rate of 2.75% (7%). Despite the inclusion

<sup>9</sup>The 95% confidence interval on our first stage coefficient ranges from 0.6260 to 0.7126. This standard error does not take into account that the instrument is a generated regressor. Bootstrapping our standard error to incorporate this estimation produces a standard error of 0.0205 and a similar 95% confidence interval of 0.6452 to 0.7257. When we shift our sample to patients we observe for 365 days, our first-stage point estimate is similar (0.6811), with a standard error of 0.0227. In practice, our instrument applies to patients with some hospital choice. This is the case for the vast majority of ZIP codes in our sample in which patients generally attend two or more hospitals, even in rural areas. We have a large F-statistic (i.e., over 100) on our first stage when we limit our sample to patients in counties with HHIs over and under 4,000 and counties above and below the national median of population density.

of our controls, this OLS estimate may be biased by patient selection. Indeed, when we use our predicted mortality measure and regress it against hospital prices (and do not include our patient controls), we see that hospitals with two standard deviations higher prices receive patients with 0.26 percentage points higher predicted mortality.<sup>10</sup>

In Panel C of Table 3, we show the second stage of our 2SLS estimation. Instrumenting this relationship has little impact on the coefficient on spending. Our instrumented results in Column (1) of Panel C illustrate that receiving care from hospitals with two standard deviations higher hospital prices raises health spending during emergency admissions by 53.49% (\$15,101). However, moving to an IV framework reverses the sign on the effect of being admitted to a high-priced hospital on mortality. In Column (2) of Panel C, we find that admission to hospitals with two standard deviations higher prices—roughly equivalent to moving from the 20<sup>th</sup> percentile of the national distribution of hospital prices to the 80<sup>th</sup> percentile—lowers in-hospital mortality by 1.02 percentage points off of a mean mortality rate of 2.75% (37%). As we illustrate in Appendix Table 7, we do not observe a precisely estimated relationship, in our IV framework, between hospital prices and patient readmissions within 30, 60, or 90-days of the initial admission.

Likewise, as we illustrate in Appendix Table 7, going to a hospital with higher charges (rather than market-determined prices) does not lead to lower mortality. Hospitals' charges are not competitively determined. Instead, they are set unilaterally by hospitals and seldom feature in negotiations with insurers (Reinhardt, 2006; Cooper et al., 2019). As a result, the fact that we do not see a relationship between prices, measured via hospital charges, and mortality serves as a placebo test and illustrates that the price-quality relationship we observe is likely a function of the bargaining process described by Ho (2009).

Further, juxtapose results in Columns (2) and (3) in Panel C of Table 3. Results in Column (3) show almost no relationship between attending a higher-priced hospital and predicted mortality after we instrument for price. These results illustrate how our instrument addresses the patient selection that undermines the OLS regressions between hospital prices and quality presented in Columns (2) and (3) of Panel B in Table 3.

<sup>10</sup>Indeed, as we illustrate in Appendix Figure 1, hospital prices are positively correlated with our time invariant HHI, the number of technologies at each hospital, the size of hospitals (measured using FTE employees), and hospital activity.

In Figure 1, we present our results graphically. In Panel A, we present a bin-scatter plot showing the relationship between our residualized predicted mortality measure on the Y-axis and our residualized price IV on the X-axis. It shows virtually no relationship between our IV for price and predicted mortality. By contrast, in Panel B, we present residualized actual inpatient mortality on the Y-axis and our residualized price IV on the X-axis. The bin scatter in Panel B clearly illustrates the negative relationship between our residualized price IV and residualized inpatient mortality measure.

Results in Table 4 illustrate how attending a higher-priced hospital impacts inpatient hospital spending, outpatient hospital spending, physician spending, and post-acute spending during the index episode of care and in the 365 days following the initial ambulance trip (excluding spending on care delivered during the initial admission). Results from our 2SLS estimates of Equation 2 indicate that attending a hospital with two standard deviations higher prices raises total spending over the subsequent 365 days after the initial ambulance ride by 42%. This increase is almost entirely driven by the 63% increase in inpatient spending during the index episode. While we observe a 17% increase in inpatient spending and a 12% increase in physician spending after discharge and within the 365 days after the initial ambulance ride, as well as a 10% increase in post-acute spending during that admission and the 365 days following, none of those changes are statistically significant. Likewise, we do not observe any evidence of statistically significant offsetting savings as a result of the higher inpatient spending during the index admission (e.g., we do not observe that the increase in inpatient spending during the initial admission is offset by lower outpatient spending post discharge).

Our results in Table 5 illustrate that the reductions in mortality following care at a high-priced hospital do not appear to be driven by marked differences in the intensity of care provided during an inpatient stay. In Table 5, we analyze whether patients taken to hospitals with two standard deviation higher prices receive more care (measured via the average DRG weight of cases—a measure of care intensity), are in the hospital for longer periods of time (measured via length of stay), or are more likely to receive a medical procedure during their admission.<sup>11</sup> While our OLS estimates in Panel A indicate that patients at high-priced hospitals appear to

<sup>11</sup>We measure whether a procedure was performed based on whether the patient was coded for a DRG involving a procedure or not. We identify DRGs with procedures from the Agency for Healthcare Research and Quality’s Patient Safety Indicators Appendices.

receive more intensive care, have longer lengths of stay, and a higher probability of a procedure — results consistent with a bias generated by patient selection — when we instrument for prices in Panel B, our 2SLS results demonstrate that these point estimates shrink substantially and become statistically insignificant.

In Appendix Table 5, we show results when we construct our instrument separately for patient cohorts (e.g., for male patients, female patients, patients under age 55, patients older than 54, patients with a Charlson score of zero, and patients with a Charlson score greater than zero) and then run our analysis cohort by cohort. Our first-stage estimates are large when we focus on each cohort independently. Our second stage results in Panel B illustrates that the biggest differences in mortality between high- and low-priced hospitals occurs for patients over age 54 and those in worse health, as categorized by a non-zero Charlson severity score.

As we illustrate in Table 6, these results are robust to a number of alternative specifications, some of which we present here. All results in Table 6 present 2SLS estimates of Equation 2 in which the dependent variable is inpatient mortality. In Column (2), we run our main estimates and illustrate that our results are qualitatively similar when we exclude our ambulance controls from our analysis. In Columns (3) and (4), we show our results are robust to using ZIP-level and HRR-level clusters, respectively, rather than using the HSA-level clusters we use in our main analysis. When we use these alternative clusters, our main estimates remain similarly precise. In Columns (5) and (6), rather than including ZIP code fixed effects, we alternatively use HSA and HRR fixed effects. This does not meaningfully shift our point estimates. In Column (7), because there may be concerns that patients' diagnoses are endogenously coded by hospitals (e.g., high-intensity hospitals might code more aggressively), we also estimate our main regression absent controls for patients' diagnoses. As we illustrate, this change does not qualitatively shift our findings. In Column (8), we loosen our count restrictions requiring ambulance and ZIP codes to have at least 10 cases across the sample period. Finally, in Column (9), rather than including ZIP and origin fixed effects separately, we include ZIP x origin fixed effects.

Another issue with leave-out instruments is the potential to have weak instruments, as the underlying variation comes from assignment to many ambulance companies. We find that the results are not affected when we implement alternative estimators, such as residualizing the instrument of the ZIP fixed effects before calculating the leave-out mean of those residuals (Kolesár, 2013). Further,

our results are similar when we reduce the noise in the instrument by restricting the sample to ambulance companies with more observations (Appendix Table 6).

*B. Hospital Prices, Mortality, and Spending by Hospital Market Concentration*

In Figure 2, we show the distribution of prices for hospitals from our sample with an HHI below or above 4,000. In addition to the sizeable variation in hospital prices across our sample — a coefficient of variation of 0.32 — notably, there are high- and low-priced hospitals on either side of this HHI cutoff. The mean inpatient price in hospitals with an HHI below 4,000 is \$14,724, and for hospitals with an HHI above 4,000 is \$15,027.

In Table 1, we show how the relationship between receiving care from high-priced hospitals, mortality, predicted mortality, and spending varies as a function of hospitals’ market concentration. Labeling a market as “concentrated” is empirically challenging, since the HHI calculated for a given market will depend on how that market is defined (Baker, 2001). While the DOJ and FTC define a market as highly concentrated if it has an HHI of 2,500 or greater, recent proposals to regulate hospital prices define concentrated markets as those with an HHI of 4,000 or greater. We begin with a cutoff for concentrated markets of 4,000. This is close to both our sample mean and the cutoff in policy proposals such as H.R. 506. We also illustrate how our results vary when we alter the cutoff used to define concentrated markets. We chose to use HHIs constructed with hospital beds to capture market shares (not actual patient flows) to define market concentration, and not willingness to pay measures, because the latter would likely be more reflective of market power due to quality and confound our analysis.

Column (1) in Table 1 shows our baseline results across the universe of hospitals in our sample. In Column (2), we include our baseline instrument and an interaction between our baseline instrument and an indicator for whether a hospital is in a market with an HHI of greater than or equal to 4,000. Panel A presents OLS estimates; Panel B presents our 2SLS estimates. Results in Table 1 reveal the relationship between admission to a higher-priced hospital and our outcome in hospital markets with an HHI of less than 4,000, along with the marginal change in the relationship between price and mortality when patients are admitted to a hospital with an HHI greater than or equal to 4,000.

When doing so, we find a small and insignificant coefficient on the interaction in the spending regression in Column (2). However, we do find a highly significant

interaction in the mortality regression that is similar in size to our uninteracted coefficient and has the opposite sign. Results in Column (4) suggest that admissions to hospitals with two standard deviations higher prices that are located in markets with HHIs of less than 4,000 lead to a 1.29 percentage point reduction in mortality. Conversely, receiving care from hospitals with two standard deviations higher prices in markets with HHIs greater than or equal to 4,000 does not have a detectable impact on mortality when adding the two coefficients. Our results also imply that there is a statistically significant difference in the relationship between price and mortality in markets with HHIs above and below 4,000 ( $p < 0.05$ ).

In Columns (5) and (6), we show estimates when the dependent variable is predicted mortality. Notably, in our OLS, higher-priced hospitals have patients with higher predicted mortality. However, when we instrument for hospital prices, results in Column (6) illustrate no relationship between predicted mortality and price in either concentrated or unconcentrated hospital markets.

Our point estimates on the effect of receiving care from higher-priced hospitals on mortality and spending in Column (4) in Panel B of Table 1 suggest that in markets with an HHI of less than 4,000, each life saved comes via an additional \$1.19 million in health spending.<sup>12</sup> This is well below the Environmental Protection Agency’s (EPA’s) widely accepted estimate of the value of a statistical life of \$8.7 million (Environmental Protection Agency, 2020).<sup>13</sup> Given the high 10-year survival rates for patients under age 65 admitted to the hospital with pneumonia or heart attack (two of the most common nondeferrable conditions), this suggests that higher-priced hospitals are likely saving lives cost effectively (Eurich et al., 2015; Herlitz et al., 2001).

Hospitals with high-priced care for pneumonia and heart attacks also have high prices for services where quality does not vary (e.g., MRI scans and colonoscopies) (Cooper et al., 2019). The nondeferrable care we analyze accounts for 23.19% of hospitals’ revenue from HCCI beneficiaries. If we assumed that the quality gains from being admitted to higher-priced hospitals *only* accrued to patients with nondeferrable conditions, our estimates would suggest that high-priced hospitals in unconcentrated markets generate an additional life at a cost of approximately \$4 million. Even at this level, high prices in these markets are still likely cost-

<sup>12</sup>We obtain this by multiplying our spending coefficient in Column (2) by the mean sample spending and then dividing by the mortality point estimate in Column (4) for unconcentrated markets.

<sup>13</sup>We use the EPA’s estimate of \$7.4 million in 2006, which we convert into 2014 dollars using the All Urban Consumers Consumer Price Index (Federal Reserve Bank of St. Louis, 2021).

effective.

These results are robust to alternative definitions of hospital markets and alternative HHI cutoffs. For example, while in our main results we define HHIs using travel times, as we illustrate in Appendix Table 8, this result is robust to using an HHI measured within a circular market defined by a 15-mile radius around each hospital. Using this alternative specification, we find that in markets with an HHI of less than 4,000, admission to a hospital with two standard deviations higher prices lowers mortality by 1.31 percentage points ( $p < 0.01$ ), whereas there is no significant relationship between price and mortality in concentrated markets (with a point estimate that is statistically different from the uninteracted coefficient).

In Table 8, we show the relationship between admission to a high-priced hospital and mortality in concentrated and unconcentrated markets defined using alternative HHI cutoffs. In each specification, we include two interaction terms: (1) an interaction between our hospital price instrument and an indicator for whether a hospital is below an HHI cutoff; and (2) an interaction between our hospital price instrument and an indicator for whether a hospital is greater than or equal to an HHI cutoff. This specification reveals the relationship between admission to a higher-priced hospital in markets above and below the HHI cutoff, and allows us to also test whether the point estimates are different from one another. We focus on markets above and below an HHI of 3,000 (1,000 points below our main cutoff and the 37<sup>th</sup> percentile in the distribution of hospital HHIs in our sample), markets above and below a cutoff of 3,773 (the median market in our sample), and markets above and below a cutoff of 5,000 (1,000 points above our main cutoff and the 63<sup>rd</sup> percentile in our sample).

As these results illustrate, in markets below HHI cutoffs of 3,000, 3,773, 4,000, and 5,000, receiving care from high-priced hospitals leads to lower mortality ( $p < 0.05$ ). Conversely, in markets with an HHI greater than or equal to the cutoffs, we do not observe a significant relationship between receiving care from a high-priced hospital and mortality. At the 3,000, 3,773, and 4,000 thresholds, we can reject the null that the point estimates between price and quality are the same in concentrated and unconcentrated markets ( $p < 0.05$ ).

In our main estimates, we rely on a time-invariant measure of hospital prices and a time invariant measure of hospital HHIs. In Appendix A, we repeat all our analyses using time-varying hospital prices. In Appendix B, we repeat all

our analyses using time-varying hospital HHIs. In Appendix C, we repeat all our analysis using both time varying HHIs and prices.

*C. What Are High-Priced Hospitals in Less Concentrated Markets Doing Differently?*

High-priced hospitals in markets with an HHI less than 4,000 spend 54% more during an emergency admission and have 1.29 percentage points lower mortality. What are these hospitals doing differently, and how do they themselves differ from either low-priced hospitals in less concentrated markets or high-priced hospitals in more concentrated markets?

In Table 9, we run 2SLS estimates and extend the analysis in Table 5 to see whether there are differences in the mean DRG weight (a measure of the intensity of care provided), length of stay, and share of cases in which a procedure was performed at high-priced hospitals in more and less concentrated markets. In Panel A of Table 9, we show results via OLS estimates, which suggest that higher-priced hospitals in less concentrated markets provide care with higher DRG weights, longer lengths of stay, and more procedures. However, after instrumenting for hospital prices, our 2SLS results show that hospitals in less concentrated markets with higher prices do not provide more intense care (measured via the mean DRG weight of the care they provided), have a length of stay that is only 0.3571 days longer (7%)( $p < 0.10$ ), and have no meaningful difference in the rate at which procedures are performed.

In Table 10, we compare the characteristics of high- (above median) and low- (below median) priced hospitals in markets with an HHI of less than 4,000 and greater than or equal to 4,000. There is a range of dimensions in which high-priced hospitals differ from low-priced hospitals. For example, high-priced hospitals tend to have more technologies (e.g., MRI scanners); are bigger; are more likely to be affiliated with a medical school; provide care that, on average, has a higher DRG weight; and have higher lengths of stay. However, these differences between high- and low-priced hospitals are similarly scaled in more and less concentrated markets. Likewise, process and outcomes quality scores measured by CMS do not appear to differ meaningfully across high-priced and low-priced hospitals.

However, high-priced hospitals in unconcentrated markets do appear to differ from other hospitals in their human capital. First, high-priced hospitals in less concentrated markets are much more likely to be Council of Teaching Hospital members (a designator of being a major academic medical center). Second, high-

priced hospitals in less concentrated markets have a substantially higher share of physicians working at their facilities who graduated from a Top 25 medical school in the US. Collectively, these results suggest that a core characteristic driving lower mortality at high-priced hospitals in less concentrated markets is likely to be the quality of physicians offering care (e.g., more doctors from Top 25 medical schools).<sup>14</sup>

## VI. Discussion

The majority of the US receives insurance coverage from private insurers. Unlike what occurs in most other developed countries, in the US, hospital prices for the privately insured are market-determined and set via negotiations between hospitals and insurers. These price negotiations are largely unregulated and, as a result, the nation relies on competition to generate efficient prices.

However, there are broad concerns about the functioning of markets in the health sector in general and in the hospital industry in particular Skinner (2011); Cutler (2011); Pany, Chernew and Dafny (2021). A substantial literature has highlighted a range of informational issues, market frictions, and patterns of consumer behavior that may undercut the functioning of competition in health care and hospital markets (Arrow, 1963; Cutler, 2011; Skinner, 2011; Brot-Goldberg et al., 2017; Chernew et al., 2021). Likewise, the US hospital sector has experienced significant consolidation over the last two decades (Fulton, 2017). This has prompted concerns about whether hospital markets can even support competition, and whether hospital prices should be regulated (Pany, Chernew and Dafny, 2021). These concerns have been bolstered by evidence of the substantial variation present in hospital prices within and across hospital markets in the US and the striking growth in hospital prices that have occurred in the 2000s (Cooper et al., 2019; U.S. Bureau of Labor Statistics, n.d.).

What drives hospital prices to vary so much in the US? On the one hand, price variation could reflect differences in providers' market power or idiosyncrasies in hospital markets. Indeed, a large body of work finds that hospitals in more concentrated markets have higher prices and that mergers can allow hospitals to raise their prices (Cooper et al., 2019; White, Reschovsky and Bond, 2014; Gowrisankaran, Nevo and Town, 2015; Gaynor and Vogt, 2003; Haas-Wilson and

<sup>14</sup>We also see that privately insured patients make up a higher share of admissions at high-priced hospitals in unconcentrated markets.

Garmon, 2011; Dafny, Ho and Lee, 2019; Lewis and Pflum, 2017). To the extent that high hospital prices are simply a function of market power generated by mergers or idiosyncrasies in the functioning of markets in the health sector, it would seem prudent to explore the scope for regulating hospital prices. However, in differentiated product markets, price variation could also reflect differences in producers' quality. Indeed, Ho (2009) predicts that when hospital markets are functioning, more appealing hospitals will be able to negotiate higher prices.

In this paper, we test whether patients who receive care at higher-priced hospitals get better outcomes. We do so to better understand the functioning of hospital markets. Analyzing whether hospital prices are correlated with quality in a way that is informative for evaluating the functioning of hospital markets requires overcoming selection bias: sicker patients are differentially likely attend better hospitals that may have higher prices. We address issues of selection by using an instrument that exploits the fact that, in an emergency, there is quasi-random assignment of the ambulance companies sent out, and that ambulance companies have strong preferences regarding where they transport patients. This generates plausibly random assignment of patients to hospitals. We use this instrument to generate an experiment that tests whether patients from the same five-digit ZIP code have lower in-hospital mortality during an emergency admission for nondeferrable care if they are taken to and treated at hospitals with higher prices.

We find that receiving care from hospitals with two standard deviations higher inpatient prices leads to a 37% reduction in in-hospital mortality. However, the relationship between hospital prices and in-hospital mortality is only present for hospitals located in relatively unconcentrated markets. In markets with an HHI of less than 4,000, receiving care from hospitals with two standard deviations higher inpatient prices leads to a 1.29 percentage point decrease in mortality, a 54% increase in spending on the emergency episode, and a 59% increase in one-year total health spending. This implies that hospitals in these markets spend an additional \$1 million on nondeferrable emergency cases for each life saved—spending that is likely cost effective. Conversely, receiving care from hospitals with two standard deviations higher prices in markets with an HHI of greater than or equal to 4,000 leads to substantially higher spending, but we do not detect that it leads to lower mortality.

We show that high-priced hospitals in unconcentrated markets do not perform

more procedures or delivery higher-intensity care. Likewise, these facilities do not appear to rely on more nurses per bed or a greater use of technology. Instead, the most striking difference is that these high-priced hospitals in unconcentrated markets appear to have a markedly higher share of physicians who received their training from Top 25 medical schools.

Ultimately, our analysis suggests that in unconcentrated markets, allowing hospitals to compete and prices to be market-determined is not necessarily wasteful. That is, markets can function in the hospital sector, assuming those markets are not highly concentrated. This is consistent with evidence from Chandra et al. (2016) that high-quality hospitals grow more over time, predictions from Ho (2009) that more appealing hospitals should be able to negotiate higher prices, and with findings from Garthwaite, Ody and Starc (2020) that, in some markets, high hospital prices may reflect investments by firms to increase quality, and not patients' lack of outside options. Conversely, while competition in unconcentrated markets appears to generate prices that are correlated with quality, we do not observe a correlation between hospital prices and quality in concentrated markets. Notably, approximately 50% of the US population accesses care in hospital markets that are highly concentrated. In many of these markets, competition is not geographically feasible. Going forward, policy-makers must consider what to do in these markets. This should include considering regulating hospitals' prices, and strategies to limit the rents that firms collect without adversely affecting quality.

## REFERENCES

- American Hospital Association.** 2018. “Trendwatch Chartbook 2018: Trends Affecting Hospitals and Health Systems.” American Hospital Association.
- Arrow, Kenneth J.** 1963. “Uncertainty and the Welfare Economics of Medical Care.” *The American Economic Review*, 53(5): 941–973.
- Baker, Laurence C.** 2001. “Measuring Competition in Health Care Markets.” *Health Services Research*, 36(1 Pt 2): 223–253.
- Beaulieu, Nancy D, Leemore S Dafny, Bruce E Landon, Jesse B Dalton, Ifedayo Kuye, and J Michael McWilliams.** 2020. “Changes in Quality of Care after Hospital Mergers and Acquisitions.” *New England Journal of Medicine*, 382(1): 51–59.
- Beauvais, Brad, Glen Gilson, Steve Schwab, Brittany Jaccoud, Taylor Pearce, and Thomas Holmes.** 2020. “Overpriced? Are Hospital Prices Associated with the Quality of Care?” *Healthcare*, 8(2): 135.
- Beckert, W., M. Christensen, and K. Collyer.** 2012. “Choice of NHS-funded hospital services in England.” *The Economic Journal*, 122(560): 400–417.
- Berry, Steven, Martin Gaynor, and Fiona Scott Morton.** n.d.. “Do Increasing Markups Matter? Lessons from Empirical Industrial Organization.” *Journal of Economic Perspectives*, 33.
- Bloom, Nicholas, Carol Propper, Stephan Seiler, and John Van Reenen.** 2015. “The Impact of Competition on Management Quality: Evidence From Public Hospitals.” *The Review of Economic Studies*, 457–489.
- Borzecki, Ann M., Cindy L. Christiansen, Priscilla Chew, Susan Loveland, and Amy K. Rosen.** 2010. “Comparison of In-Hospital Versus 30-Day Mortality Assessments for Selected Medical Conditions.” *Medical Care*, 48(12): 1117–1121.
- Brekke, Kurt, Hugh Gravelle, Luigi Siciliani, and Odd Rune Straume.** 2014. “Patient Choice, Mobility and Competition Among Health Care Providers.” In . Vol. 12 of *Developments in Health Economics and Public Policy*, ed. R. Levaggi and M. Montefiori, 1–24. Springer.
- Brot-Goldberg, Zarek C., Amitabh Chandra, Benjamin R. Handel, and Jonathan T. Kolstad.** 2017. “What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics.” *The Quarterly Journal of Economics*, 132(3): 1261–1318.
- Bundorf, M., N. Chun, G. Goda, and Kessler D.** 2009. “Do markets respond to quality information? The case of fertility clinics.” *Journal of Health Economics*, 28(3): 718—727.

- Capps, Cory, David Dranove, and Mark Satterthwaite.** 2003. “Competition and Market Power in Option Demand Markets.” *The RAND Journal of Economics*, 34(4): 737–763.
- Card, David, Carlos Dobkin, and Nicole Maestas.** 2009. “Does Medicare Save Lives?” *The Quarterly Journal of Economics*, 124(2): 597–636.
- Centers for Medicare and Medicaid Services.** 2020. “National Health Expenditures 2020 Highlights.”
- Chan, David, David Card, and Lowell Taylor.** 2022. “Is There a VA Advantage? Evidence From Dually Eligible Veterans.” *NBER Working Paper*.
- Chandra, Amitabh, Amy Finkelstein, Adam Sacarny, and Chad Syverson.** 2016. “Health Care Exceptionalism? Performance and Allocation in the U.S. Health Care Sector.” *American Economic Review*, 106(8): 2110–44.
- Chernew, Michael, Zack Cooper, Eugene Larsen Hallock, and Fiona Scott Morton.** 2021. “Physician Agency, Consumerism, and the Consumption of Lower-Limb MRI Scans.” *Journal of Health Economics*, 76.
- Chiang, Arthur J, Guy David, and Michael Gene Housman.** 2006. “The Determinants of Urban Emergency Medical Services Privatization.” *Critical Planning*, 13.
- Cicala, Steve.** 2022. “Imperfect Markets versus Imperfect Regulation in US Electricity Generation.” *American Economic Review*, 112(2): 409–441.
- Claxon, Gary, Matthew Rae, Gregory Young, Nisha Kurani, Heidi Witmore, Jason Kerns, Jackie Cifuentes, Greg Shmavonian, and Anthony Damico.** 2021. “2021 Employer Health Benefits Survey.” Kaiser Family Foundation.
- Cooper, Zack, Fiona Scott Morton, and Nathan Shekita.** 2020. “Surprise! Out-of-Network Billing for Emergency Care in the United States.” *Journal of Political Economy*, 128(9): 3626–3677.
- Cooper, Zack, Stephen Gibbons, Simon Jones, and Alistair McGuire.** 2011. “Does Hospital Competition Save Lives? Evidence From the English NHS Patient Choice Reforms.” *The Economic Journal*, 121(554): F228–F260.
- Cooper, Zack, Stuart Craig, Martin Gaynor, and John Van Reenen.** 2019. “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured.” *The Quarterly Journal of Economics*, 134(1): 51–107.
- Cutler, David M.** 2011. “Where Are the Health Care Entrepreneurs? The Failure of Organizational Innovation in Health Care.” *Innovation Policy and the Economy*, 11(1): 1–28.

- Dafny, Leemore.** 2010. “Are Health Insurance Markets Competitive?” *American Economic Review*, 100: 1399–1431.
- Dafny, Leemore, Kate Ho, and Robin Lee.** 2019. “The Price Effects of Cross-Market Mergers: Theory and Evidence From the Hospital Industry.” *The RAND Journal of Economics*, 50(2): 289–325.
- Department of Health and Human Services.** 2007. “Guide to Inpatient Quality Indicators: Quality of Care in Hospitals—Volume, Mortality, and Utilization.” Agency for HealthCare Research and Quality.
- Department of Justice and the Federal Trade Commission.** 1997. *Horizontal Merger Guidelines*. U.S. Department of Justice and the Federal Trade Commission.
- DiNardo, John, and David S. Lee.** 2011. “Chapter 5 - Program Evaluation and Research Designs.” In . Vol. 4 of *Handbook of Labor Economics*, , ed. Orley Ashenfelter and David Card, 463–536. Elsevier.
- Dobbie, Will, and Jae Song.** 2015. “Debt Relief and Debtor Outcomes: Measuring the Effects of Consumer Bankruptcy Protection.” *American Economic Review*, 105(3): 1272–1311.
- Dobbie, Will, Jacob Goldin, and Crystal S Yang.** 2018. “The Effects of Pretrial Detention on Conviction, Future Crime, and Employment: Evidence from Randomly Assigned Judges.” *American Economic Review*, 108(2): 201–240.
- Dobkin, Carlos.** 2003. “Hospital Staffing and Inpatient Mortality.” *Unpublished Working Paper*.
- Doyle, Joseph J.** 2007. “Child Protection and Child Outcomes: Measuring the Effects of Foster Care.” *American Economic Review*, 97(5): 1583–1610.
- Doyle, Joseph J, John A Graves, and Jonathan Gruber.** 2017. “Uncovering Waste in U.S. HealthCare: Evidence From Ambulance Referral Patterns.” *Journal of Health Economics*, 54: 25–39.
- Doyle, Joseph J, John A Graves, Jonathan Gruber, and Samuel A Kleiner.** 2015. “Measuring Returns to Hospital Care: Evidence From Ambulance Referral Patterns.” *Journal of Political Economy*, 123(1): 170–214.
- Environmental Protection Agency.** 2020. “Mortality Risk Valuation.”
- Eurich, Dean, Thomas Marrie, Jasjeet Minhas-Sandhu, and Sumit Majumjar.** 2015. “Ten-Year Mortality After Community-Acquired Pneumonia: A Prospective Cohort.” *American Journal of Respiratory and Critical Care Medicine*, 192(5): 597–604.

- Federal Reserve Bank of St. Louis.** 2021. “Consumer Price Index for All Urban Consumers: All Items in U.S. City Average.”
- Frandsen, Brigham R, Lars John Lefgren, and Emily C Leslie.** 2019. “Judging Judge Fixed Effects.” *NBER Working Paper*.
- Fulton, Brett D.** 2017. “Health Care Market Concentration Trends in the United States: Evidence and Policy Responses.” *Health Affairs*, 36(9): 1530–1538.
- Garthwaite, Craig, Christopher Ody, and Amanda Starc.** 2020. “Endogenous Quality Investments in the U.S. Hospital Market.” National Bureau of Economic Research.
- Gaynor, Martin, and William B Vogt.** 2003. “Competition Among Hospitals.” *The RAND Journal of Economics*, 34(4): 764–785.
- Gaynor, Martin, Kate Ho, and Robert J Town.** 2015. “The Industrial Organization of Health Care Markets.” *Journal of Economic Literature*, 53(2): 235–84.
- Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper.** 2013. “Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service.” *American Economic Journal: Economic Policy*, 5(4): 134–66.
- Gaynor, M., C. Propper, and S Seiler.** 2016. “Free to Choose? Reform, Choice, and Consideration Sets in the English National Health Service.” *The American Economic Review*, 106(11): 3521–3557.
- Gowrisankaran, Gautam, Aviv Nevo, and Robert Town.** 2015. “Mergers When Prices Are Negotiated: Evidence From the Hospital Industry.” *American Economic Review*, 105(1): 172–203.
- Haas-Wilson, Deborah, and Christopher Garmon.** 2011. “Hospital Mergers and Competitive Effects: Two Retrospective Analyses.” *International Journal of the Economics of Business*, 18(1): 17–32.
- Handel, Benjamin, and Kate Ho.** 2021. “Industrial Organization of Health Care Markets.” National Bureau of Economic Research.
- Health Care Cost Institute.** 2015. “2014 Health Care Cost and Utilization Report.”
- Herlitz, Johan, Björn Karlson, Johnny Lindqvist, and Margareta Sjölin.** 2001. “Important Factors for the 10-Year Mortality Rate in Patients with Acute Chest Pain or Other Symptoms Consistent with Acute Myocardial Infarction with Particular Emphasis on the Influence of Age.” *American Heart Journal*, 142(4): 624–632.

- Ho, Kate, and Robin S. Lee.** 2019. “Equilibrium Provider Networks: Bargaining and Exclusion in Health Care Markets.” *American Economic Review*, 109(2): 473–522.
- Ho, Katherine.** 2006. “The Welfare Effects of Restricted Hospital Choice in the US Medical Care Market.” *Journal of Applied Econometrics*, 21(7): 1039–1079.
- Ho, Katherine.** 2009. “Insurer-Provider Networks in the Medical Care Market.” *American Economic Review*, 99(1): 393–430.
- Johnson, Robin.** 2001. *The Future of Local Emergency Medical Service Ambulance Wars 1 Or Public-Private Truce?* Reason Public Policy Institute.
- Kaiser Family Foundation.** 2019. “Health Insurance Coverage of the Total Population - State Health Facts.” Kaiser Family Foundation.
- Kessler, Daniel P, and Mark B McClellan.** 2000. “Is Hospital Competition Socially Wasteful?” *The Quarterly Journal of Economics*, 115(2): 577–615.
- Kling, Jeffrey R.** 2006. “Incarceration Length, Employment, and Earnings.” *American Economic Review*, 96(3): 863–876.
- Kocher, R, and Donald M Berwick.** 2019. “While Considering Medicare For All: Policies For Making Health Care In The United States Better.” *Health Affairs Blog*. June, 6.
- Kolesár, Michal.** 2013. “Estimation in an Instrumental Variables Model with Treatment Effect Heterogeneity.” *Unpublished Manuscript*.
- Lam, Onyi, Brian Broderick, and Skye Toor.** 2018. “How Far Americans Live from the Closest Hospital Differs by Community Type.” Pew Research Center.
- Lewis, Matthew S., and Kevin E. Pflum.** 2017. “Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions.” *The RAND Journal of Economics*, 48(3): 579–610.
- Liu, Jodi L., Zachary M. Levinson, Nabeel Qureshi, and Christopher M. Whaley.** 2021. “Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans.” The RAND Corporation.
- McConnell, K., R. Lindrooth, D. Wholey, T. Maddox, and N. Bloom.** 2016. “Modern management practices and hospital admissions.” *Health Economics*, 25(4): 470–485.
- McNamara, Robert, Jeph Herrin, Yongfei Wang, Jephtha Curtis, Elizabeth Bradley, David Magid, Saif Rathore, Brahmajee Nallamothu, Eric Peterson, Martha Blaney, Paul Frederick, and Harlan Krumholz.** 2007. “Impact of Delay in Door-to-Needle Time on Mortality in

- Patients With ST-Segment Elevation Myocardial Infarction.” *The American Journal of Cardiology*, 100(8): 1227–1232.
- Moscone, F., E. Tosetti, and G. Vittadini.** 2012. “Social interaction in patients’ hospital choice: evidence from Italy.” *Journal of the Royal Statistical Society*, 175(2): 453–472.
- Mulcahy, Andrew, Katherine Harris, Kenneth Finegold, Arthur Kellermann, Laurel Edelman, and Benjamin D Sommers.** 2013. “Insurance Coverage of Emergency Care for Young Adults Under Health Reform.” *New England Journal of Medicine*, 368(22): 2105–2112.
- Oi, Mariko.** 2015. “How Much Do Women Around the World Pay to Give Birth?” *BBC News*.
- Pany, Maximilian J, Michael E Chernew, and Leemore S Dafny.** 2021. “Regulating Hospital Prices Based On Market Concentration Is Likely to Leave High-Price Hospitals Unaffected: Study Examines Regulating Provider Prices Based on Market Concentration.” *Health Affairs*, 40(9): 1386–1394.
- Park Hung, Andrea, Martin Gaynor, and Seth Richards-Shubik.** 2017. “Subsidies and Structure: The Lasting Impact of the Hill-Burton Program on the Hospital Industry.” *Review of Economics and Statistics*, 99: 926–943.
- Pope, D.** 2009. “Reacting to Rankings: Evidence From “America’s Best Hospitals.” *Journal of Health Economics*, 28(6): 1154–1165.
- Propper, Carol, Simon Burgess, and Katherine Green.** 2004. “Does Competition Between Hospitals Improve the Quality of Care?: Hospital Death Rates and the NHS Internal Market.” *Journal of Public Economics*, 88(7-8): 1247–1272.
- Ragone, Michael.** 2012. “Evolution or Revolution: EMS Industry Faces Difficult Changes.” *JEMS: a Journal of Emergency Medical Services*, 37(2): 34–39.
- Raval, Devesh, and Ted Rosenbaum.** 2018. “Why Is Distance Important for Hospital Choice? Separating Home Bias from Transport Costs.” *Federal Trade Commission Working Paper*.
- Reinhardt, Uwe E.** 2006. “The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy.” *Health Affairs*, 25(1): 57–69.
- Rosenthal, Gary E., David W. Baker, Donald G Norris, Lynne E. Way, Dwain L. Harper, and Richard J. Snow.** 2000. “Relationships Between In-Hospital and 30-Day Standardized Hospital Mortality: Implications for Profiling Hospitals.” *Health Services Research*, 34(7): 1449–1468.

- Rubin, Donald B.** 2001. “Using Propensity Scores to Help Design Observational Studies: Application to the Tobacco Litigation.” *Health Services and Outcomes Research Methodology*, 2(3): 169–188.
- Shepard, Mark.** 2022. “Hospital Network Competition and Adverse Selection: Evidence from the Massachusetts Health Insurance Exchange.” *American Economic Review*, 112(2): 578–615.
- Skinner, Jonathan.** 2011. “Chapter Two - Causes and Consequences of Regional Variations in Health Care.” *Handbook of Health Economics*, 2: 45–93.
- Skura, Barry.** 2001. “Where Do 911 System Ambulances Take Their Patients? Differences Between Voluntary Hospital Ambulances and Fire Department Ambulances.”
- Stock, James H, Jonathan H Wright, and Motohiro Yogo.** 2002. “A Survey of Weak Instruments and Weak Identification in Generalized Method of Moments.” *Journal of Business & Economic Statistics*, 20(4): 518–529.
- Tikkanen, Roosa, Robin Osborn, Elias Mossialos, Ana Djordjevic, and George Wharton.** n.d.. *International Profiles of Health Care Systems*.
- U.S. Bureau of Labor Statistics.** n.d.. “Consumer Price Index.”
- Varkevisser, Marco, Stéphanie A. van der Geest, and Frederik T. Schut.** 2012. “Do Patients Choose Hospitals with High Quality Ratings? Empirical Evidence from the Market for Angioplasty in the Netherlands.” *Journal of Health Economics*, 31: 371–378.
- White, Chapin, and Christopher M Whaley.** 2021. “Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings From an Employer-Led Transparency Initiative.” *Rand Health Quarterly*, 9(2).
- White, Chapin, James D. Reschovsky, and Amelia M. Bond.** 2014. “Understanding Differences Between High- And Low-Price Hospitals: Implications for Efforts to Rein In Costs.” *Health Affairs*, 33(2).

Table 1: Hospital- and Ride-Level Characteristics

Panel A: Hospital Level								
	Mean	SD	p5	p25	p50	p75	p95	N
Price Index	14,865	4,698	8,765	11,713	14,335	17,045	23,520	1,857
Hospital HHI	4,388	2,614	1,225	2,366	3,773	5,464	10,000	1,857
Panel B: Patient-Ride Level								
	Mean	Standard Deviation	Standard Difference in Means 1(instrument > median)					
Ambulance Instrument	14,924	987	0.468					
Ambulance Payment	826	561	0.033					
Advanced Life Support	0.755	0.330	-0.008					
Ride From Home	0.629	0.412	-0.009					
Emergency Transport	0.950	0.189	-0.011					
Male	0.511	0.437	-0.002					
0–17 Years Old	0.046	0.182	0.000					
18–24 Years Old	0.051	0.194	0.003					
25–34 Years Old	0.073	0.228	0.003					
35–44 Years Old	0.131	0.296	0.003					
45–54 Years Old	0.269	0.389	-0.001					
55–64 Years Old	0.430	0.429	-0.004					
Charlson Comorbidity Score	1.115	1.553	0.006					

*Note:* The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. In Panel B, values are adjusted for year and zip code fixed effects. Our comorbidity score is measured via a Charlson Index constructed using six months of prior health claims.

Table 2: Balance Test of Patient Characteristics and Diagnoses Across Quartiles of the IV

	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	1st vs. 4th Difference	Below vs. Above Median
Ambulance Instrument	14,567	14,820	14,981	15,328	760.442***	461.393***
Male	0.51	0.51	0.51	0.51	0.001	-0.001
0–17 Years Old	0.05	0.05	0.05	0.05	-0.001	0.000
18–24 Years Old	0.05	0.05	0.05	0.05	0.002	0.001
25–34 Years Old	0.07	0.07	0.07	0.07	0.002	0.001
35–44 Years Old	0.13	0.13	0.13	0.13	0.002	0.001
45–54 Years Old	0.27	0.27	0.27	0.27	-0.001	-0.000
55–64 Years Old	0.43	0.43	0.43	0.43	-0.002	-0.002
Charlson Comorbidity Score	1.11	1.12	1.13	1.11	-0.001	0.009
General Symptoms	0.60	0.60	0.60	0.60	0.000	-0.000
Other Lung Diseases	0.25	0.25	0.25	0.25	0.001	0.001
Injury Neck, Nose	0.17	0.16	0.16	0.17	0.004*	0.001
Pneumonia, Unspecified Organism	0.11	0.11	0.11	0.10	-0.002	-0.001
Acute Myocardial Infarction	0.08	0.09	0.08	0.08	-0.000	-0.001
Other Urinary Tract Infection	0.08	0.08	0.08	0.08	0.000	0.000
Septicemia	0.07	0.07	0.07	0.07	-0.000	0.000
Cerebral Artery Occlusion	0.07	0.07	0.07	0.07	-0.001	-0.001
Diseases of Esophagus	0.05	0.06	0.06	0.05	-0.000	-0.000
Transient Cerebral Ischemias	0.05	0.05	0.05	0.05	0.000	0.000
Disorder of Muscle Ligament and Fascia	0.04	0.04	0.04	0.04	-0.000	-0.001
Precerebral Occlusion	0.04	0.04	0.04	0.04	-0.001	-0.000
Psychotropic Agent Poisoning	0.03	0.03	0.03	0.03	-0.000	-0.000
Intestinal Obstruction	0.03	0.03	0.03	0.03	-0.001	0.000
Ankle Fracture	0.03	0.03	0.03	0.03	0.000	0.000
Observations	48,052	47,548	47,739	47,706		

*Note:* Values are adjusted for zip code fixed effects. Our comorbidity score is measured via a Charlson Index constructed using six months of prior health claims. The diagnoses listed represent 87 percent of non-discretionary diagnoses in our sample. For full list see Appendix Table 1. The data are at the patient-ride level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Table 3: First- and Second- Stage Regressions Estimating the Relationship Between Hospital Prices, Episode Spending, and Mortality

Panel A: First Stage			
	Inpatient Price Index (1)		
Ambulance Average Hospital Price Index	0.6683*** (0.0226)		
First-Stage F Stat	877		
Outcome mean	14,865		
Observations	191,045		
Panel B: OLS			
	Log Admission Spending (1)	In-Hospital Mortality (2)	Predicted Mortality (3)
Inpatient Price Index	0.5427*** (0.0145)	0.0018 (0.0011)	0.0026*** (0.0005)
Outcome Mean	28,232	0.0275	0.0275
Observations	191,045	191,045	191,045
Panel C: Second Stage of 2SLS			
	Log Admission Spending (1)	In-Hospital Mortality (2)	Predicted Mortality (3)
Inpatient Price Index	0.5349*** (0.0360)	-0.0102*** (0.0037)	0.0005 (0.0013)
Outcome Mean	28,232	0.0275	0.0275
Observations	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The outcome mean in Panel A is reported at the hospital level. We use logged spending as a dependent variable, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Table 4: Estimating the Relationship Between Hospital Prices and Spending on Outpatient Care, Physician Services, and Post-Acute Care

	Log Spending Log Inpatient Spending		Log Outpatient Spending		Log Physician Spending		Log Post-Acute Spending	
	365 Days	Admission	365 Days Without Admission	Admission	365 Days Without Admission	Admission	Without Admission	365 Days
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Price index	0.4172*** (0.0409)	0.6268*** (0.0369)	0.1706 (0.1518)	0.0385 (0.1230)	-0.0335 (0.1996)	0.0496 (0.0565)	0.1219 (0.0862)	0.1008 (0.0902)
Outcome mean	62,883	23,871	18,937	419	2,195	3,941	8,310	3,521
Observations	143,578	191,045	143,578	191,045	143,578	191,045	143,578	191,045

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient’s comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. We use logged spending as a dependent variable but report the outcome mean in levels. “365-Days Without Admission” spending refers to spending that occurs from the day after the discharge date to 365 days after the ambulance ride. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

Table 5: Estimating the Relationship Between Hospital Prices, DRG Weights, Length of Stay, and Indicator for Whether a Procedure Was Performed

Panel A: OLS			
	Mean of DRG Weights (1)	Length of Stay (2)	Procedure Preformed (3)
Inpatient Price Index	0.1147*** (0.0180)	0.6166*** (0.0698)	0.0321*** (0.0034)
Outcome Mean	1.6340	5.0825	0.2442
Observations	191,045	191,045	191,045
Panel B: Second Stage of 2SLS			
	Mean of DRG Weights (1)	Length of Stay (2)	Procedure Preformed (3)
Inpatient Price Index	0.0435 (0.0531)	0.2802 (0.1767)	0.0100 (0.0100)
Outcome Mean	1.6340	5.0825	0.2442
Observations	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims between 2008 and 2014. Procedure is an indicator equal to one if the patient has a surgical DRG. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics, and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Table 6: Robustness of Mortality Analyses to Alternative Samples, Clusters, Fixed Effects, and Controls

	Baseline Specification	No Ambulance Controls	ZIP Code Level Clusters	HRR Level Clusters	HSA Fixed Effects	HRR Fixed Effects	No Diagnoses Controls	No Count Restrictions	ZIP x Origin Fixed Effects
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Inpatient									
Price Index	-0.0102*** (0.0037)	-0.0068* (0.0037)	-0.0102*** (0.0039)	-0.0102*** (0.0032)	-0.0092*** (0.0030)	-0.0039** (0.0020)	-0.0100*** (0.0038)	-0.0071* (0.0040)	-0.0087** (0.0040)
Outcome Mean	0.0275	0.0275	0.0275	0.0275	0.0275	0.0275	0.0275	0.0277	0.0272
Observations	191,045	191,045	191,045	191,031	191,044	191,031	191,045	217,476	189,330

*Note:* In Column 2, we exclude ambulance controls from the main specification. These controls include payment to the ambulance company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. In Columns 3 and 4 we cluster standard errors at the zip code level and hospital referral region (HRR) level, respectively, opposed to hospital service area (HSA) level in the main analysis. In Columns 5 and 6, HSA fixed effects and HRR fixed effects are used, respectively, opposed to zip code fixed effects included in the main analysis. Column 7 excludes diagnoses controls which are 29 non-discretionary diagnoses codes. Column 8 no longer includes our count restrictions requiring ambulance and ZIP codes to have at least 10 cases across the sample period. Column 9 includes interactions of ZIP code and origin fixed effects. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01. All columns report the effect of a two standard deviation increase in price.

Table 7: Estimating the Relationship Between Hospital Prices and Mortality in Concentrated and Unconcentrated Markets

Panel A: OLS						
	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5427*** (0.0145)	0.5359*** (0.0163)	0.0018 (0.0011)	0.0007 (0.0013)	0.0026*** (0.0005)	0.0026*** (0.0006)
Inpatient Price Index * HHI Above 4,000		0.0386 (0.0314)		0.0053** (0.0026)		-0.0001 (0.0012)
Outcome Mean	28,232	28,232	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045	191,045	191,045
Panel B: Second Stage of 2SLS						
	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5349*** (0.0360)	0.5415*** (0.0394)	-0.0102*** (0.0037)	-0.0129*** (0.0041)	0.0005 (0.0013)	0.0010 (0.0013)
Inpatient Price Index * HHI Above 4,000		0.0034 (0.0537)		0.0115** (0.0052)		-0.0011 (0.0021)
Outcome Mean	28,232	28,232	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes. We use logged spending as dependent variable in Columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Table 8: Estimating the Relationship Between Hospital Prices and Mortality at Various HHI Cutoffs

HHI Cutoff	In-Hospital Mortality			
	3,000	3,773	4,000	5,000
	(1)	(2)	(3)	(4)
Inpatient Price Index * HHI Below Cut-off	-0.0138*** (0.0043)	-0.0127*** (0.0041)	-0.0129*** (0.0041)	-0.0118*** (0.0042)
Inpatient Price Index * HHI Above Cut-off	-0.0040 (0.0043)	-0.0028 (0.0049)	-0.0014 (0.0049)	-0.0043 (0.0050)
Test of equality between interacted coef.:				
F-Stat	4.0855	4.0675	4.9292	1.7927
P-Value	0.0435	0.0439	0.0266	0.1808
Outcome Mean	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045

*Note:* Columns (1)–(4) report results for different HHI cutoffs, with Column (2) representing the median HHI in our sample. All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient’s comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Table 9: Estimating the Relationship Between Hospital Prices and Care Delivered in Concentrated and Unconcentrated Markets

Panel A: OLS						
	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.1147*** (0.0180)	0.1176*** (0.0208)	0.6166*** (0.0698)	0.6193*** (0.0820)	0.0321*** (0.0034)	0.0311*** (0.0038)
Inpatient Price Index * HHI Above 4,000		-0.0087 (0.0411)		0.0100 (0.1301)		0.0062 (0.0074)
Outcome Mean	1.6340	1.6340	5.0825	5.0825	0.2442	0.2442
Observations	191,045	191,045	191,045	191,045	191,045	191,045
Panel B: Second Stage of 2SLS						
	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.0435 (0.0531)	0.0476 (0.0600)	0.2802 (0.1767)	0.3571* (0.2006)	0.0100 (0.0100)	0.0115 (0.0110)
Inpatient Price Index * HHI Above 4,000		0.0288 (0.0879)		-0.1217 (0.2397)		0.0040 (0.0165)
Outcome Mean	1.6340	1.6340	5.0825	5.0825	0.2442	0.2442
Observations	191,045	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes.. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

Table 10: Hospital Characteristics by Market Concentration and Price Levels

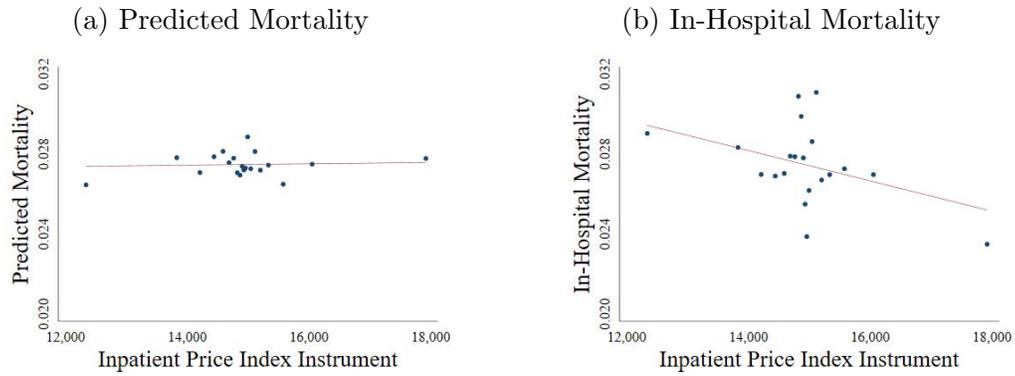
Price	HHI < 4,000		HHI ≥ 4,000		Difference in Means		
	Low	High	Low	High	(2) vs. (1)	(4) vs. (3)	(4) vs. (2)
	(1)	(2)	(3)	(4)			
<u>Hospital Characteristics</u>							
Number of Technologies	60	66	53	61	5.953***	7.558***	-5.418***
Number of Beds	293	340	199	262	47.271***	62.368***	-78.234***
<u>Graduate Medical Education</u>							
Accredited Program	0.44	0.47	0.19	0.26	0.028	0.068***	-0.211***
Medical School Affiliation	0.49	0.52	0.27	0.33	0.021	0.061**	-0.187***
Council of Teaching Hospital Member	0.13	0.22	0.04	0.06	0.097***	0.025*	-0.162***
Government	0.10	0.10	0.12	0.10	0.002	-0.023	-0.008
Non-Profit	0.72	0.67	0.68	0.72	-0.052*	0.037	0.051*
Medicare Share of Patient	44.65	41.29	48.05	47.15	-3.353***	-0.898	5.858***
Medicaid Share of Patient	19.37	20.45	18.19	18.10	1.080	-0.093	-2.352***
FTE Registered Nurses Per Bed	1.63	1.86	1.48	1.76	0.232***	0.284***	-0.099**
FTE Licensed Practical Nurses Per Bed	0.08	0.07	0.14	0.12	-0.009*	-0.013	0.048***
Payroll Per Bed	334,001	413,921	292,660	377,237	79,920***	84,576***	-36,685***
<u>Physician Measures</u>							
Years Since Graduation in 2014	21.15	20.33	20.95	20.67	-0.824***	-0.281**	0.337***
<u>Share of Graduates From a Top 25 U.S. Medical School</u>							
Share of Male Physicians	0.18	0.23	0.15	0.17	0.048***	0.021***	-0.059***
Share of Male Physicians	0.74	0.73	0.78	0.77	-0.013***	-0.015***	0.036***
Observations	514	477	404	462			

Table 10: Hospital Characteristics by Concentration and Price Levels (Continued)

Price	HHI < 4,000		HHI ≥ 4,000		Difference in Means		
	Low	High	Low	High	(2) vs. (1)	(4) vs. (3)	(4) vs. (2)
	(1)	(2)	(3)	(4)			
<u>Quality Measures</u>							
30-Day Acute Myocardial Infarction Survival Rate	0.84	0.85	0.84	0.84	0.002*	0.001	-0.003***
30-Day Heart Failure (HF) Survival Rate	0.89	0.89	0.89	0.88	-0.000	-0.001	-0.008***
30-Day Pneumonia Survival Rate	0.89	0.89	0.88	0.88	-0.000	-0.000	-0.006***
% Acute Myocardial Infarction Patient Given Aspirin at Discharge	97.14	97.94	95.21	97.56	0.800**	2.349***	-0.375
% HF Patient Given Discharge Instr.	86.82	89.57	87.18	88.40	2.748***	1.221*	-1.174**
% HF Patient Tested for Left Ventricular Systolic (LSF) Function	97.94	98.60	96.91	98.41	0.658***	1.503***	-0.193
% HF Patient Given ACE Inhibitor/ARB for LSF Dysfunction	94.15	95.56	92.88	94.89	1.412***	2.013***	-0.672**
% Pneumonia Patient Given Most Appropriate Initial Antibiotics	92.64	93.49	91.98	93.72	0.855***	1.742***	0.228
% Patient Given Antibiotic 1hr Pre-Surgery	95.33	95.60	94.57	96.08	0.271	1.509***	0.481
<u>Sample Derived Hospital Characteristics</u>							
Average DRG Weight for Patient in Sample	1.54	1.62	1.40	1.52	0.077***	0.114***	-0.102***
Average Length of Stay for Patient in Sample	4.80	5.03	4.43	4.85	0.232**	0.424***	-0.181
Observations	514	477	404	462			

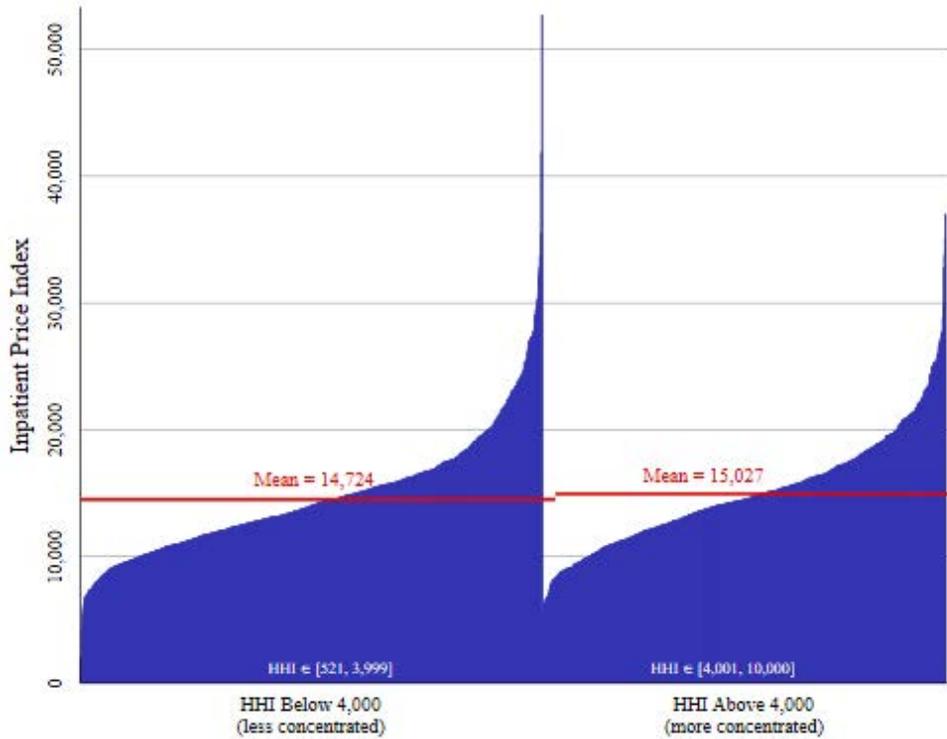
*Note:* The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. The observations are unique at the hospital level. “Low” (respectively, “High”) price corresponds to hospitals with a price index below (above) the median price index amongst all hospitals in the AHA data. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes. The physicians measures are from 2017. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Figure 1 : Residualized Mortality vs the Residualized Price Index



*Note:* Panel A is created by regressing predicted mortality and the inpatient price instrument on point of origin and ambulance characteristics. Panel B is created by regressing in-hospital mortality and the inpatient price instrument on point of origin, diagnoses, patients' comorbidity scores, demographics, and ambulance characteristics. 5-digit zip code and year fixed effects are included in the regressions for both panels. Each dot in the bin scatter plot represents approximately 93 hospitals.

Figure 2 : Distribution of the Hospital Inpatient Price Index In Markets with an HHI Above and Below 4,000



*Note:* The HHI measure is calculated at the hospital level and based on bed counts for hospitals accessible in under 30 minutes. We compute a time-invariant measure by averaging the hospital-year level measures between 2008 and 2014.

*DO HIGHER-PRICED HOSPITALS DELIVER HIGHER-QUALITY CARE?*

## **ONLINE APPENDIX**

Appendix Table 1: Balance Test - Full List of Non-Discretionary Diagnoses

	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	1st vs. 4th Difference	Below vs. Above Median
General Symptoms	0.60	0.60	0.60	0.60	0.000	-0.000
Other Lung Diseases	0.25	0.25	0.25	0.25	0.001	0.001
Injury Neck, Nose	0.17	0.16	0.16	0.17	0.004*	0.001
Pneumonia, Unspecified Organism	0.11	0.11	0.11	0.10	-0.002	-0.001
Acute Myocardial Infarction	0.08	0.09	0.08	0.08	-0.000	-0.001
Other Urinary Tract Infection	0.08	0.08	0.08	0.08	0.000	0.000
Septicemia	0.07	0.07	0.07	0.07	-0.000	0.000
Cerebral Artery Occlusion	0.07	0.07	0.07	0.07	-0.001	-0.001
Diseases of Esophagus	0.05	0.06	0.06	0.05	-0.000	-0.000
Transient Cerebral Ischemias	0.05	0.05	0.05	0.05	0.000	0.000
Disorder of Muscle Ligament and Fascia	0.04	0.04	0.04	0.04	-0.000	-0.001
Pre-cerebral Occlusion	0.04	0.04	0.04	0.04	-0.001	-0.000
Psychotropic Agent Poisoning	0.03	0.03	0.03	0.03	-0.000	-0.000
Intestinal Obstruction	0.03	0.03	0.03	0.03	-0.001	0.000
Ankle Fracture	0.03	0.03	0.03	0.03	0.000	0.000
Other Noninfective Gastroenteritis	0.03	0.03	0.03	0.03	0.000	-0.000
Tibia and Fibia Fracture	0.03	0.03	0.03	0.03	0.000	0.000
Analgesic, Antipyretics Poisoning	0.02	0.02	0.02	0.02	-0.001	-0.000
Solid, Liquid Pneumonitis	0.02	0.02	0.02	0.02	-0.000	-0.001
Fractured Rib, Sternum, Trachea	0.02	0.02	0.02	0.02	0.001	0.001
Intracerebral Hemorrhage	0.02	0.02	0.02	0.02	-0.000	0.000
Fracture Neck of Femur	0.02	0.02	0.02	0.02	-0.001	-0.000
Pneumonia, Other Bacterial	0.02	0.02	0.02	0.02	0.000	0.000
Malignant Neoplasm of Trachea, Lung	0.02	0.02	0.02	0.02	-0.000	-0.000
Secondary Malignant Neoplasm	0.02	0.02	0.02	0.02	-0.000	0.000
Pelvic Fracture	0.01	0.01	0.01	0.01	-0.000	0.000
Gastric Ulcer	0.01	0.01	0.01	0.01	-0.000	-0.000
Duodenal Ulcer	0.01	0.01	0.01	0.01	0.000	0.000
Vascular Insufficiency of Intestine	0.01	0.01	0.01	0.01	0.000	0.000
Observations	48,052	47,548	47,739	47,706		

Note: Values are adjusted for zip code fixed effects. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

DO HIGHER-PRICED HOSPITALS DELIVER HIGHER-QUALITY CARE?

Appendix Table 2: Inpatient Admission Characteristics

	Total Number of Inpatient Admissions	Percentage of Non-Discretionary Diagnoses in All Inpatient Admissions (%)	Percentage of Ambulance Transport in All Inpatient Admissions (%)	Percentage of Ambulance Transport in Admissions with a Non-Discretionary Diagnosis (%)	Non-Discretionary Admission Spending As a Share of Total Hospital Revenue (%)
Inpatient admissions	13,490,137	34.45	2.86	6.44	23.19

*Note:* Non-discretionary admission spending and total hospital revenue are obtained from inpatient and outpatient claims.

Appendix Table 3: Summary Statistics

	Mean	SD	p5	p25	p50	p75	p95	N
In-Hospital								
Mortality	0.028	0.163	0	0	0	0	0	191,045
30-Day Spending	32,584	46,461	3,490	9,614	18,131	36,465	110,148	181,891
180-Day Spending	53,411	90,486	4,723	12,232	24,689	56,322	196,565	160,045
365-Day Spending	62,883	109,203	5,346	13,727	28,182	65,362	235,309	143,592
Charlson Score	1.115	1.803	0	0	0	2	6	191,045
Male	0.511	0.500	0	0	1	1	1	191,045
0-17 Years Old	0.046	0.210	0	0	0	0	0	191,045
18-24 Years Old	0.051	0.220	0	0	0	0	1	191,045
25-34 Years Old	0.073	0.260	0	0	0	0	1	191,045
35-44 Years Old	0.131	0.338	0	0	0	0	1	191,045
45-54 Years Old	0.269	0.443	0	0	0	1	1	191,045
55-64 Years Old	0.430	0.495	0	0	0	1	1	191,045

*Note:* Spending is expressed in 2014 USD. The Charlson score is calculated using a 180-day claim history. The HHI measure is based on bed counts in hospitals accessible in under 30 minutes. The data are at the patient-ride level.

Appendix Table 4: Hospital characteristics

	All AHA Hospitals		Hospitals in Analytical Sample		Difference in Means
	Mean	SD	Mean	SD	
Total HCCI Spending	10,036,286	21,508,803	20,853,884	28,197,822	10,817,598***
Time-Invariant HHI	6200	3100	4400	2600	-1800***
Bed Count	166	181	276	205	111***
For-Profit Hospital	0.16	0.35	0.20	0.39	0.04***
Rural Hospital	0.24	0.41	0.07	0.24	-0.17***
Medicaid Share of Patients	0.17	0.09	0.19	0.09	0.02***
Medicare Share of Patients	0.50	0.12	0.45	0.09	-0.05***
Observations	4,463		1,857		

*Note:* This is based on the AHA Annual Surveys and HCCI Claims Data, 2008—2014. HCCI spending is obtained from inpatient and outpatient claims.

Appendix Table 5: Mortality Results for Subgroups, Instrument Calculated by Subgroup

Panel A: First Stage							
	Baseline Specification (1)	Male Patients (2)	Female Patients (3)	Patients Age 55-64 (4)	Patients Age 0-54 (5)	Charlson Score of Zero (6)	Non-Zero Charlson Score (7)
Inpatient	0.6683*** (0.0226)	0.6701*** (0.0238)	0.6381*** (0.0349)	0.5699*** (0.0371)	0.7007*** (0.0250)	0.7023*** (0.0270)	0.6047*** (0.0391)
F-Statistic	877	795	335	236	774	676	240
Outcome Mean	14,865	14,850	14,890	14,842	14,850	14,838	14,729
Observations	191,045	83,215	77,991	64,652	96,408	105,215	56,504
Panel B: Second Stage of 2SLS							
	Baseline Specification (1)	Male Patients (2)	Female Patients (3)	Patients Age 55-64 (4)	Patients Age 0-54 (5)	Charlson Score of Zero (6)	Non-Zero Charlson Score (7)
Inpatient	-0.0102*** (0.0037)	-0.0036 (0.0059)	-0.0162** (0.0068)	-0.0205* (0.0107)	-0.0061 (0.0045)	-0.0073* (0.0039)	-0.0175 (0.0115)
Outcome Mean	0.0275	0.0300	0.0238	0.0355	0.0206	0.0158	0.0428
Observations	191,045	83,215	77,991	64,652	96,408	105,215	56,504

*Note:* In Column 1, we report the results of our baseline regression, with the usual controls. In the remaining columns, we restrict our sample to various subgroups and then calculate the instrument for the subgroup before performing the regressions. In Columns 2 and 3, we restrict the sample to male patients and female patients, respectively. In these regressions, we exclude our gender control. In Columns 4 and 5, we restrict our sample based on patient age. In our main sample, the median age falls within the 45-54 age band and approximately 43 percent of our sample falls within the 55-64 age band. In these regressions, we exclude age controls. In Columns 6 and 7, we restrict our sample to patients with a Charlson Score of zero and patients with a non-zero Charlson Score, respectively. In these regressions, we do not control for Charlson Score. The observations in, for example, Columns 2 and 3 do not sum to the baseline number of observations due to the 10 ambulance rides and 10 patients from a zip code count restriction being made after we restrict the sample by subgroup and calculate the instrument. Further observations are dropped due to singletons in the regressions. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix Table 6: Robustness of Mortality Analyses to Larger Ambulance Rides Sample Restrictions

	At Least 10 Rides (1)	At Least 20 Rides (2)	At Least 30 Rides (3)
Inpatient Price Index	-0.0102*** (0.0037)	-0.0093** (0.0039)	-0.0097** (0.0042)
Outcome Mean	0.0275	0.0272	0.0274
Observations	191,045	182,404	174,287

*Note:* In Column (1) we include the ambulance restriction in our main sample; ambulance companies are required to have at least 10 rides across the sample period. In each subsequent column this count restriction is increased. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

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Appendix Table 7: Estimating the Relationship Between Hospital Prices and Readmissions

Panel A: First Stage					
	Inpatient Price Index				
	(1)				
Ambulance Average Hospital Price Index	0.6683*** (0.0226)				
First-Stage F Stat	877				
Outcome mean	14,865				
Observations	191,045				
Panel B: OLS					
	30 Days	60 Days	90 Days	180 Days	365 Days
	(1)	(2)	(3)	(4)	(5)
Inpatient Price Index	-0.0026 (0.0039)	0.0014 (0.0040)	0.0038 (0.0040)	0.0064* (0.0037)	0.0070* (0.0039)
Outcome Mean	0.2359	0.2865	0.3158	0.3663	0.4124
Observations	191,045	191,045	191,045	191,045	191,045
Panel C: Second Stage of 2SLS					
	30 Days	60 Days	90 Days	180 Days	365 Days
	(1)	(2)	(3)	(4)	(5)
Inpatient Price Index	0.0015 (0.0114)	0.0075 (0.0116)	0.0058 (0.0118)	0.0066 (0.0123)	0.0088 (0.0124)
Outcome Mean	0.2359	0.2865	0.3158	0.3663	0.4124
Observations	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. . \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

Appendix Table 8: Effect of Price on Mortality in Concentrated and Unconcentrated Markets [15-Mile HHI]

	Log Admission Spending		In-hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5349*** (0.0360)	0.5272*** (0.0388)	-0.0102*** (0.0037)	-0.0131*** (0.0041)	0.0005 (0.0013)	0.0005 (0.0013)
Inpatient Price Index * HHI Above 4,000		0.0587 (0.0463)		0.0111** (0.0046)		0.0007 (0.0017)
Outcome Mean	28,232	28,232	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics, and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals within 15 miles. We use logged spending as dependent variable in columns 1 and 2, but report the outcome mean in levels. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

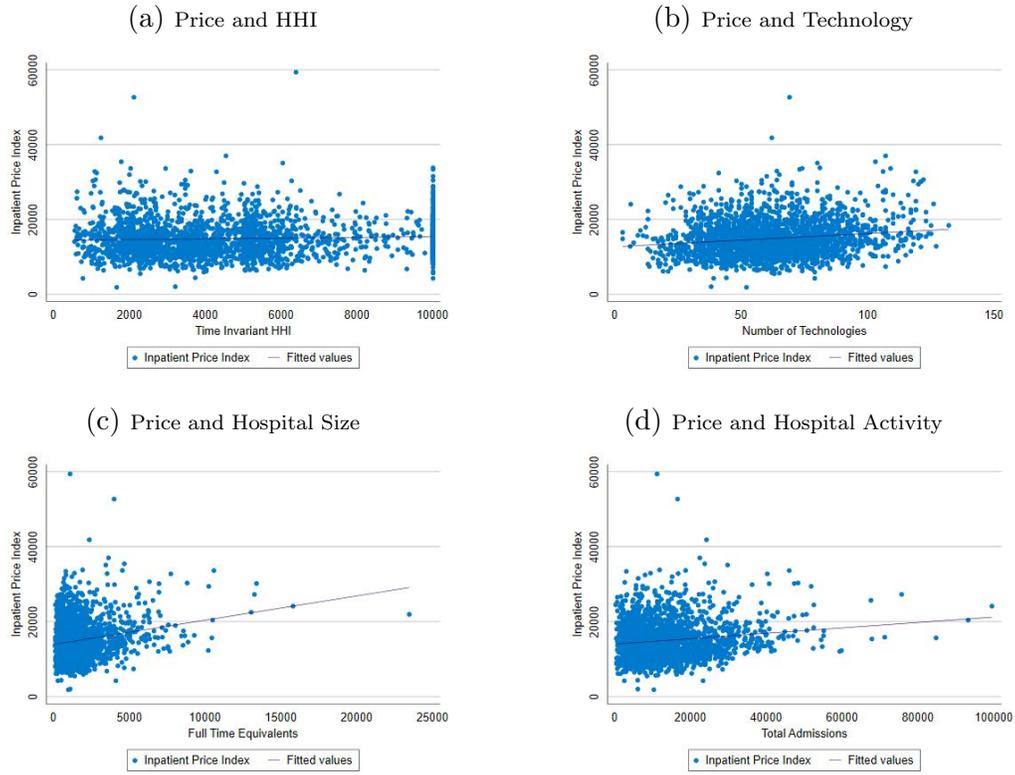
Appendix Table 9: First- and Second- Stage Regressions Estimating the Relationship Between Hospital Prices, Episode Spending, and Mortality using Charges to Construct Price Index

Panel A: First Stage			
	Inpatient Price Index (1)		
Ambulance Average Hospital Price Index	0.6864*** (0.0173)		
First-Stage F Stat	1,566		
Outcome mean	28,620		
Observations	190,949		
Panel B: OLS			
	Log Admission Spending (1)	In-Hospital Mortality (2)	Predicted Mortality (3)
Inpatient Price Index (Charges)	0.2538*** (0.0245)	0.0030** (0.0012)	0.0012** (0.0006)
Outcome Mean	28,239	0.0275	0.0275
Observations	190,949	190,949	190,949
Panel C: Second Stage of 2SLS			
	Log Admission Spending (1)	In-Hospital Mortality (2)	Predicted Mortality (3)
Inpatient Price Index (Charges)	0.0925* (0.0486)	-0.0018 (0.0047)	0.0003 (0.0013)
Outcome Mean	28,239	0.0275	0.0275
Observations	190,949	190,949	190,949

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient charges (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The outcome mean in Panel A is reported at the hospital level. We use logged spending as a dependent variable, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

DO HIGHER-PRICED HOSPITALS DELIVER HIGHER-QUALITY CARE?

Appendix Figure 1 : Relationship Between Hospital Prices and Hospital Characteristics



*Note:* This figure shows the relationship between hospital prices and our time invariant HHI, the number of technologies at each hospital, the size of hospitals (measured using FTE employees), and hospital activity (measured using total admissions). The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes.

*DO HIGHER-PRICED HOSPITALS DELIVER HIGHER-QUALITY CARE?*

## **APPENDIX A**

Appendix A Table 1: Hospital- and Ride-Level Characteristics (Time Varying Price Index)

Panel A: Hospital Level								
	Mean	SD	p5	p25	p50	p75	p95	N
Price Index	14,332	4,620	8,346	11,180	13,719	16,477	23,138	1,819
Hospital HHI	4,351	2,599	1,212	2,348	3,733	5,439	10,000	1,819
Panel B: Patient-Ride Level								
	Mean	Standard Deviation	Standard Difference in Means 1(instrument > median)					
Ambulance Instrument	14,304	1,053	0.518					
Ambulance Payment	826	560	0.038					
Advanced Life Support	0.755	0.330	0.026					
Ride From Home	0.629	0.412	-0.019					
Emergency Transport	0.950	0.189	-0.014					
Male	0.511	0.438	0.005					
0–17 Years Old	0.046	0.182	-0.004					
18–24 Years Old	0.051	0.194	0.003					
25–34 Years Old	0.073	0.228	0.002					
35–44 Years Old	0.131	0.296	0.004					
45–54 Years Old	0.269	0.389	-0.003					
55–64 Years Old	0.430	0.429	-0.001					
Charlson Comorbidity Score	1.115	1.554	0.004					

*Note:* The price index is based on all inpatient claims between 2008 and 2014. In Panel B, values are adjusted for year and zip code fixed effects. Our comorbidity score is measured via a Charlson Index constructed using six months of prior health claims.

Appendix A Table 2: Balance Test of Patient Characteristics and Diagnoses Across Quartiles of the IV (Time Varying Price Index)

	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	1st vs. 4th Difference	Below vs. Above Median
Ambulance Instrument	13,931	14,130	14,364	14,789	857.926***	545.692***
Male	0.51	0.51	0.51	0.51	0.001	0.002
0–17 Years Old	0.05	0.05	0.05	0.05	-0.000	-0.001
18–24 Years Old	0.05	0.05	0.05	0.05	0.001	0.001
25–34 Years Old	0.07	0.07	0.07	0.07	0.002	0.001
35–44 Years Old	0.13	0.13	0.13	0.13	0.002	0.001
45–54 Years Old	0.27	0.27	0.27	0.27	-0.000	-0.001
55–64 Years Old	0.43	0.43	0.43	0.43	-0.004	-0.000
Charlson Comorbidity Score	1.11	1.12	1.13	1.10	-0.005	0.006
General Symptoms	0.60	0.60	0.60	0.60	-0.001	-0.001
Other Lung Diseases	0.25	0.25	0.25	0.25	0.001	0.003*
Injury Neck, Nose	0.17	0.16	0.16	0.17	0.005**	0.002
Pneumonia, Unspecified Organism	0.11	0.11	0.11	0.10	-0.002	-0.001
Acute Myocardial Infarction	0.08	0.08	0.09	0.09	0.000	0.001
Other Urinary Tract Infection	0.08	0.08	0.08	0.08	-0.000	-0.000
Septicemia	0.07	0.07	0.07	0.07	-0.000	0.000
Cerebral Artery Occlusion	0.07	0.07	0.07	0.07	-0.001	-0.001
Diseases of Esophagus	0.05	0.05	0.06	0.06	0.000	0.001
Transient Cerebral Ischemias	0.05	0.05	0.05	0.05	-0.000	0.001
Disorder of Muscle Ligament and Fascia	0.04	0.04	0.04	0.04	-0.000	-0.000
Precerebral Occlusion	0.04	0.04	0.04	0.04	-0.001	-0.000
Psychotropic Agent Poisoning	0.03	0.03	0.03	0.03	-0.000	0.000
Intestinal Obstruction	0.03	0.03	0.03	0.03	-0.000	-0.000
Ankle Fracture	.03	.029	.029	.03	0.000	0.000
Observations	47,427	47,430	47,421	47,424		

Note: Values are adjusted for zip code fixed effects. Our comorbidity score is measured via a Charlson Index constructed using six months of prior health claims. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 3: First- and Second- Stage Regressions Estimating the Relationship Between Hospital Prices, Episode Spending, and Mortality (Time Varying Price Index)

Panel A: First Stage			
	Inpatient Price Index (1)		
Ambulance Average Hospital Price Index	0.5561*** (0.0239)		
First-Stage F Stat	542		
Outcome mean	14,374		
Observations	189,702		
Panel B: OLS			
	Log Admission Spending (1)	In-Hospital Mortality (2)	Predicted Mortality (3)
Inpatient Price Index	0.5691*** (0.0140)	0.0010 (0.0012)	0.0019*** (0.0005)
Outcome Mean	28,190	0.0275	0.0275
Observations	189,702	189,702	189,702
Panel C: Second Stage of 2SLS			
	Log Admission Spending (1)	In-Hospital Mortality (2)	Predicted Mortality (3)
Inpatient Price Index	0.5696*** (0.0419)	-0.0166*** (0.0050)	-0.0010 (0.0015)
Outcome Mean	28,190	0.0275	0.0275
Observations	189,702	189,702	189,702

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The outcome mean in Panel A is reported at the hospital level. We use logged spending as a dependent variable, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 4: Estimating the Relationship Between Hospital Prices and Spending on Outpatient Care, Physician Services, and Post-Acute Care (Time Varying Price Index)

	Log Spending Log Inpatient Spending		Log Outpatient Spending		Log Physician Spending		Log Post-Acute Spending	
	365 Days	Admission	365 Days Without Admission	Admission	365 Days Without Admission	Admission	Without Admission	365 Days
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Price index	0.4383*** (0.0490)	0.6597*** (0.0429)	0.0496 (0.1774)	0.1784 (0.1453)	0.5129* (0.2619)	0.0503 (0.0664)	0.1508 (0.1051)	0.0365 (0.1123)
Outcome mean	62,783	23,827	18,902	418	2,193	3,945	8,311	3,521
Observations	142,660	189,702	142,660	189,702	142,660	189,702	142,660	189,702

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. We use logged spending as a dependent variable but report the outcome mean in levels. "365-Days Without Admission" spending refers to spending that occurs from the day after the discharge date to 365 days after the ambulance ride. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

Appendix A Table 5: Estimating the Relationship Between Hospital Prices, DRG Weights, Length of Stay, and Indicator for Whether a Procedure Was Performed (Time Varying Price Index)

Panel A: OLS			
	Mean of DRG Weights (1)	Length of Stay (2)	Procedure Preformed (3)
Inpatient Price Index	0.0918*** (0.0180)	0.5891*** (0.0680)	0.0277*** (0.0032)
Outcome Mean	1.6352	5.0851	0.2444
Observations	189,702	189,702	189,702
Panel B: Second Stage of 2SLS			
	Mean of DRG Weights (1)	Length of Stay (2)	Procedure Preformed (3)
Inpatient Price Index	0.0065 (0.0645)	0.2912 (0.2146)	0.0053 (0.0117)
Outcome Mean	1.6352	5.0851	0.2444
Observations	189,702	189,702	189,702

*Note:* All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims between 2008 and 2014. Procedure is an indicator equal to one if the patient has a surgical DRG. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics, and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 6: Robustness of Mortality Analyses to Alternative Samples, Clusters, Fixed Effects, and Controls (Time Varying Price Index)

	Baseline Specification	No Ambulance Controls	ZIP Code Level Clusters	HRR Level Clusters	HSA Fixed Effects	HRR Fixed Effects	No Diagnoses Controls	No Count Restrictions	ZIP x Origin Fixed Effects
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Inpatient									
Price Index	-0.0166*** (0.0050)	-0.0124** (0.0051)	-0.0166*** (0.0050)	-0.0166*** (0.0040)	-0.0130*** (0.0039)	-0.0057** (0.0025)	-0.0169*** (0.0052)	-0.0137*** (0.0053)	-0.0133*** (0.0043)
Outcome Mean	0.0275	0.0275	0.0275	0.0275	0.0275	0.0275	0.0275	0.0277	0.0272
Observations	189,702	189,702	189,702	189,688	189,701	189,688	189,702	215,771	188,014

*Note:* In Column 2, we exclude ambulance controls from the main specification. These controls include payment to the ambulance company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. In Columns 3 and 4 we cluster standard errors at the zip code level and hospital referral region (HRR) level, respectively, opposed to hospital service area (HSA) level in the main analysis. In Columns 5 and 6, HSA fixed effects and HRR fixed effects are used, respectively, opposed to zip code fixed effects included in the main analysis. Column 7 excludes diagnoses controls which are 29 non-discretionary diagnoses codes. Column 8 no longer includes our count restrictions requiring ambulance and ZIP codes to have at least 10 cases across the sample period. Column 9 includes interactions of ZIP code and origin fixed effects. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01. All columns report the effect of a two standard deviation increase in price.

Appendix A Table 7: Estimating the Relationship Between Hospital Prices and Mortality in Concentrated and Unconcentrated Markets (Time Varying Price Index)

Panel A: OLS						
	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5691*** (0.0140)	0.5607*** (0.0148)	0.0010 (0.0012)	0.0000 (0.0013)	0.0019*** (0.0005)	0.0018*** (0.0005)
Inpatient Price Index * HHI Above 4,000		0.0449 (0.0287)		0.0050** (0.0025)		0.0003 (0.0008)
Observations	189,702	189,702	189,702	189,702	189,702	189,702
Outcome Mean	28,190	28,190	0.0275	0.0275	0.0275	0.0275
Panel B: Second Stage of 2SLS						
	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5696*** (0.0419)	0.5774*** (0.0453)	-0.0166*** (0.0050)	-0.0191*** (0.0056)	-0.0010 (0.0015)	-0.0008 (0.0016)
Inpatient Price Index * HHI Above 4,000		-0.0054 (0.0580)		0.0108* (0.0059)		0.0000 (0.0022)
Observations	189,702	189,702	189,702	189,702	189,702	189,702
Outcome Mean	28,190	28,190	0.0275	0.0275	0.0275	0.0275

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes. We use logged spending as dependent variable in Columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 8: Effect of Price on Mortality: Different Interaction Cutoffs (Time Varying Price Index)

HHI Cutoff	In-Hospital Mortality			
	3,000	3,733	4,000	5,000
	(1)	(2)	(3)	(4)
Inpatient Price Index * HHI Below Cut-off	-0.0195*** (0.0058)	-0.0187*** (0.0055)	-0.0191*** (0.0056)	-0.0178*** (0.0056)
Inpatient Price Index * HHI Above Cut-off	-0.0109** (0.0054)	-0.0103* (0.0060)	-0.0084 (0.0060)	-0.0118** (0.0060)
Test of equality between interacted coef.:				
F-Stat	2.4421	2.2393	3.2917	0.8766
P-Value	0.1184	0.1348	0.0699	0.3493
Outcome Mean	0.0275	0.0275	0.0275	0.0275
Observations	189,702	189,702	189,702	189,702

*Note:* Columns (1)–(4) report results for different HHI cutoffs, with column (2) representing the median HHI in our sample. All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2007 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient’s comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 9: Estimating the Relationship Between Hospital Prices and Care Delivered in Concentrated and Unconcentrated Markets (Time Varying Price Index)

Panel A: OLS						
	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.0918*** (0.0180)	0.0813*** (0.0184)	0.5891*** (0.0680)	0.5652*** (0.0757)	0.0277*** (0.0032)	0.0246*** (0.0033)
Inpatient Price Index * HHI Above 4,000		0.0572 (0.0382)		0.1390 (0.1187)		0.0166*** (0.0063)
Outcome Mean	1.6352	1.6352	5.0851	5.0851	0.2444	0.2444
Observations	189,702	189,702	189,702	189,702	189,702	189,702
Panel B: Second Stage						
	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.0065 (0.0645)	0.0040 (0.0707)	0.2912 (0.2146)	0.3481 (0.2386)	0.0053 (0.0117)	0.0062 (0.0126)
Inpatient Price Index * HHI Above 4,000		0.0512 (0.0938)		-0.0617 (0.2604)		0.0051 (0.0176)
Outcome Mean	1.6352	1.6352	5.0851	5.0851	0.2444	0.2444
Observations	189,702	189,702	189,702	189,702	189,702	189,702

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes.. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

Appendix A Table 10: Hospital Characteristics by Market Concentration and Price Levels (Time Varying Price Index)

Price	HHI < 4,000		HHI ≥ 4,000		Difference in Means		
	Low	High	Low	High	(2) vs. (1)	(4) vs. (3)	(4) vs. (2)
	(1)	(2)	(3)	(4)			
<u>Hospital Characteristics</u>							
Number of Technologies	60	66	53	61	6.172***	8.614***	-4.845**
Number of Beds	293	343	197	271	50.128***	74.569***	-72.028***
<u>Graduate Medical Education</u>							
Accredited Program	0.44	0.47	0.18	0.28	0.032	0.093***	-0.197***
Medical School Affiliation	0.50	0.52	0.27	0.34	0.017	0.065**	-0.178***
Council of Teaching Hospital Member	0.12	0.23	0.03	0.07	0.111***	0.040***	-0.159***
Government	0.10	0.10	0.12	0.10	0.005	-0.020	-0.007
Non-Profit	0.72	0.67	0.67	0.73	-0.056*	0.062**	0.063**
Medicare Share of Patient	44.66	41.06	48.01	46.88	-3.599***	-1.137*	5.818***
Medicaid Share of Patient	19.58	20.36	18.22	18.17	0.781	-0.052	-2.183***
FTE Registered Nurses Per Bed	1.62	1.87	1.48	1.77	0.247***	0.285***	-0.099**
FTE Licensed Practical Nurses Per Bed	0.08	0.07	0.13	0.12	-0.011**	-0.012	0.049***
Payroll Per Bed	332,359	414,683	293,584	376,301	82,324***	82,717***	-38,382***
<u>Physician Measures</u>							
Years Since Graduation in 2014	21.09	20.37	20.90	20.68	-0.723***	-0.221*	0.308**
<u>Share of Graduates From a Top 25 U.S.</u>							
Medical School	0.18	0.23	0.15	0.17	0.052***	0.025***	-0.059***
Share of Male Physicians	0.74	0.73	0.78	0.77	-0.011**	-0.013***	0.036***
Observations	509	472	387	451			

Appendix A Table 10: Hospital Characteristics by Concentration and Price Levels (Time Varying Price Index) (Continued)

Price	HHI < 4,000		HHI ≥ 4,000		Difference in Means		
	Low	High	Low	High	(2) vs. (1)	(4) vs. (3)	(4) vs. (2)
	(1)	(2)	(3)	(4)			
<u>Quality Measures</u>							
30-Day Acute Myocardial Infarction Survival Rate	0.84	0.85	0.84	0.84	0.002**	0.002**	-0.003***
30-Day Heart Failure Survival Rate	0.89	0.89	0.89	0.88	-0.000	-0.001	-0.007***
30-Day Pneumonia Survival Rate	0.89	0.89	0.88	0.88	-0.000	-0.000	-0.005***
% AMI Patient Given Aspirin at Discharge	97.09	97.88	95.50	97.45	0.784**	1.951***	-0.422
% HF Patient Given Discharge Instr.	86.57	89.65	87.27	88.37	3.075***	1.099	-1.277**
% HF Patient Tested for Left Ventricular Systolic (LSF) Function	97.97	98.59	96.97	98.41	0.621***	1.439***	-0.176
% HF Patient Given ACE Inhibitor/ARB for LSF Dysfunction	94.02	95.54	93.03	94.85	1.512***	1.819***	-0.685**
% PN Patient Given Most Appropriate Initial Antibiotics	92.60	93.44	91.98	93.64	0.845***	1.659***	0.195
% Patient Given Antibiotic 1hr Pre-Surgery	95.31	95.58	94.74	96.03	0.262	1.296***	0.459
<u>Sample Derived Hospital Characteristics</u>							
Average DRG Weight for	1.54	1.61	1.42	1.52	0.062**	0.105***	-0.084**
Average Length of Stay for Patient in Sample	4.81	5.00	4.49	4.90	0.199*	0.410**	-0.108
Observations	509	472	387	451			

Note: The price index is based on all inpatient claims between 2008 and 2014. The observations are unique at the hospital level. “Low” (respectively, “High”) price corresponds to hospitals with a price index below (above) the median price index amongst all hospitals in the AHA data. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes. The physicians measures are from 2017. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

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Appendix A Table 11: Balance Test - Full List of Non-Discretionary Diagnoses (Time Varying Price Index)

	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	1st vs. 4th Difference	Below vs. Above Median
General Symptoms	0.60	0.60	0.60	0.60	-0.001	-0.001
Other Lung Diseases	0.25	0.25	0.25	0.25	0.001	0.003*
Injury Neck, Nose	0.17	0.16	0.16	0.17	0.005**	0.002
Penumonia, Unspecified Organism	0.11	0.11	0.11	0.10	-0.002	-0.001
Acute Myocardial Infarction	0.08	0.08	0.09	0.09	0.000	0.001
Other Urinary Tract Infection	0.08	0.08	0.08	0.08	-0.000	-0.000
Septicemia	0.07	0.07	0.07	0.07	-0.000	0.000
Cerebral Artery Occlusion	0.07	0.07	0.07	0.07	-0.001	-0.001
Diseases of Esophagus	0.05	0.05	0.06	0.06	0.000	0.001
Transient Cerebral Ischemias	0.05	0.05	0.05	0.05	-0.000	0.001
Disorder of Muscle Ligament and Fascia	0.04	0.04	0.04	0.04	-0.000	-0.000
Precerebral Occlusion	0.04	0.04	0.04	0.04	-0.001	-0.000
Psychotropic Agent Poisoning	0.03	0.03	0.03	0.03	-0.000	0.000
Intestinal Obstruction	0.03	0.03	0.03	0.03	-0.000	-0.000
Ankle Fracture	0.03	0.03	0.03	0.03	0.000	0.000
Other Noninfective Gostroenteritis	0.03	0.03	0.03	0.03	-0.000	-0.001
Tibia and Fibia Fracture	0.03	0.03	0.03	0.03	0.000	-0.000
Analgesic, Antipyretics Poisoning	0.02	0.02	0.02	0.02	-0.000	-0.000
Solid, Liquid Pneumotitis	0.02	0.02	0.02	0.02	-0.000	-0.000
Fractured Rib, Sternum, Trachea	0.02	0.02	0.02	0.02	0.001	0.001
Intracerebral Hemorrhage	0.02	0.02	0.02	0.02	0.000	0.001
Fracture Neck of Femur	0.02	0.02	0.02	0.02	-0.001	-0.001
Pneumonia, Other Bacterial	0.02	0.02	0.02	0.02	0.000	-0.000
Malignant Neoplasm of Trachea, Lung	0.02	0.02	0.02	0.02	-0.000	-0.000
Secondary Malignant Neoplasm	0.02	0.02	0.02	0.02	-0.000	0.000
Pelvic Fracture	0.01	0.01	0.01	0.01	0.000	0.001*
Gastric Ulcer	0.01	0.01	0.01	0.01	-0.000	-0.000
Duodendal Ulcer	0.01	0.01	0.01	0.01	0.000	0.000
Vascular Insufficiency of Intestine	0.01	0.01	0.01	0.01	0.000	0.000
Observations	47,427	47,430	47,421	47,424		

Note: Values are adjusted for zip code fixed effects. \* p <0.1; \*\* p <0.05; \*\*\* p <0.01.

Appendix A Table 12: Summary Statistics (Time Varying Price Index)

	Mean	SD	p5	p25	p50	p75	p95	N
In-Hospital								
Mortality	0.028	0.164	0	0	0	0	0	189,702
30-Day Spending	32,527	46,308	3,495	9,616	18,123	36,417	109,951	180,613
180-Day Spending	53,337	90,374	4,728	12,232	24,680	56,245	196,097	158,959
365-Day Spending	62,785	109,063	5,350	13,726	28,169	65,293	234,714	142,674
Charlson Score	1.115	1.803	0	0	0	2	6	189,702
Male	0.511	0.500	0	0	1	1	1	189,702
0-17 Years Old	0.046	0.210	0	0	0	0	0	189,702
18-24 Years Old	0.051	0.220	0	0	0	0	1	189,702
25-34 Years Old	0.073	0.260	0	0	0	0	1	189,702
35-44 Years Old	0.131	0.338	0	0	0	0	1	189,702
45-54 Years Old	0.269	0.444	0	0	0	1	1	189,702
55-64 Years Old	0.430	0.495	0	0	0	1	1	189,702

*Note:* The data are at the patient-ride level. Spending is expressed in 2014 USD. The Charlson score is calculated using a 180-day claim history.

Appendix A Table 13: Hospital Characteristics(Time Varying Price Index)

	All AHA Hospitals		Hospitals in Analytical Sample		Difference in Means
	Mean	SD	Mean	SD	
Total HCCI Spending	10,036,286	21,508,803	21,202,860	28,378,178	11,166,574***
Time-Invariant HHI	6200	3100	4300	2600	-1800***
Bed Count	166	181	279	205	114***
For-Profit Hospital	0.16	0.35	0.20	0.39	0.04***
Rural Hospital	0.24	0.41	0.07	0.24	-0.17***
Medicaid Share of Patients	0.17	0.09	0.19	0.09	0.02***
Medicare Share of Patients	0.50	0.12	0.45	0.09	-0.05***
Observations	4,463		1,819		

*Note:* This is based on the AHA Annual Surveys and HCCI Claims Data, 2008—2014. HCCI spending is obtained from inpatient and outpatient claims.

Appendix A Table 14: Mortality Results for Subgroups, Instrument Calculated by Subgroup (Time Varying Price Index)

Panel A: First Stage							
	Baseline Specification (1)	Male Patients (2)	Female Patients (3)	Patients Age 55-64 (4)	Patients Age 0-54 (5)	Charlson Score of Zero (6)	Non-Zero Charlson Score (7)
Inpatient Price Index	0.5561*** (0.0239)	0.5413*** (0.0240)	0.5368*** (0.0397)	0.4612*** (0.0354)	0.5786*** (0.0277)	0.5836*** (0.0289)	0.4736*** (0.0386)
F-Statistic	542	510	183	170	430	409	151
Outcome Mean	14,374	14,347	14,286	14,212	14,329	14,347	14,166
Observations	189,702	82,636	77,432	64,203	95,761	104,438	56,146
Panel B: Second Stage of 2SLS							
	Baseline Specification (1)	Male Patients (2)	Female Patients (3)	Patients Age 55-64 (4)	Patients Age 0-54 (5)	Charlson Score of Zero (6)	Non-Zero Charlson Score (7)
Inpatient Price Index	-0.0166*** (0.0050)	-0.0058 (0.0084)	-0.0228*** (0.0078)	-0.0266* (0.0152)	-0.0148** (0.0062)	-0.0127** (0.0051)	-0.0201 (0.0155)
Outcome Mean	0.0275	0.0300	0.0238	0.0354	0.0206	0.0158	0.0429
Observations	189,702	82,636	77,432	64,203	95,761	104,438	56,146

*Note:* In Column 1, we report the results of our baseline regression, with the usual controls. In the remaining columns, we restrict our sample to various subgroups and then calculate the instrument for the subgroup before performing the regressions. In Columns 2 and 3, we restrict the sample to male patients and female patients, respectively. In these regressions, we exclude our gender control. In Columns 4 and 5, we restrict our sample based on patient age. In our main sample, the median age falls within the 45-54 age band and approximately 43 percent of our sample falls within the 55-64 age band. In these regressions, we exclude age controls. In Columns 6 and 7, we restrict our sample to patients with a Charlson Score of zero and patients with a non-zero Charlson Score, respectively. In these regressions, we do not control for Charlson Score. The observations in, for example, Columns 2 and 3 do not sum to the baseline number of observations due to the 10 ambulance rides and 10 patients from a zip code count restriction being made after we restrict the sample by subgroup and calculate the instrument. Further observations are dropped due to singletons in the regressions. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 15: Robustness of Mortality Analyses to Larger Ambulance Rides Sample Restrictions (Time Varying Price Index)

	At Least 10 Rides (1)	At Least 20 Rides (2)	At Least 30 Rides (3)
Inpatient Price Index	-0.0166*** (0.0050)	-0.0153*** (0.0053)	-0.0155*** (0.0055)
Outcome Mean Observations	0.0275 189,702	0.0273 181,191	0.0274 173,229

*Note:* In Column (1) we include the ambulance restriction in our main sample; ambulance companies are required to have at least 10 rides across the sample period. In each subsequent column this count restriction is increased. \*  $p < 0.1$ ; \*\*  $p < 0.05$ ; \*\*\*  $p < 0.01$ .

Appendix A Table 16: Estimating the Relationship Between Hospital Prices and Readmissions (Time Varying Price Index)

Panel A: First Stage					
	Inpatient Price Index				
	(1)				
Ambulance Average Hospital Price Index	0.5561*** (0.0239)				
First-Stage F Stat	542				
Outcome mean	14,374				
Observations	189,702				
Panel B: OLS					
	30 Days	60 Days	90 Days	180 Days	365 Days
	(1)	(2)	(3)	(4)	(5)
Inpatient Price Index	0.0013 (0.0040)	0.0054 (0.0041)	0.0067 (0.0041)	0.0095** (0.0037)	0.0096** (0.0039)
Outcome Mean	0.2359	0.2865	0.3158	0.3663	0.4125
Observations	189,702	189,702	189,702	189,702	189,702
Panel C: Second Stage of 2SLS					
	30 Days	60 Days	90 Days	180 Days	365 Days
	(1)	(2)	(3)	(4)	(5)
Inpatient Price Index	-0.0010 (0.0142)	0.0053 (0.0148)	0.0038 (0.0152)	0.0055 (0.0152)	0.0045 (0.0153)
Outcome Mean	0.2359	0.2865	0.3158	0.3663	0.4125
Observations	189,702	189,702	189,702	189,702	189,702

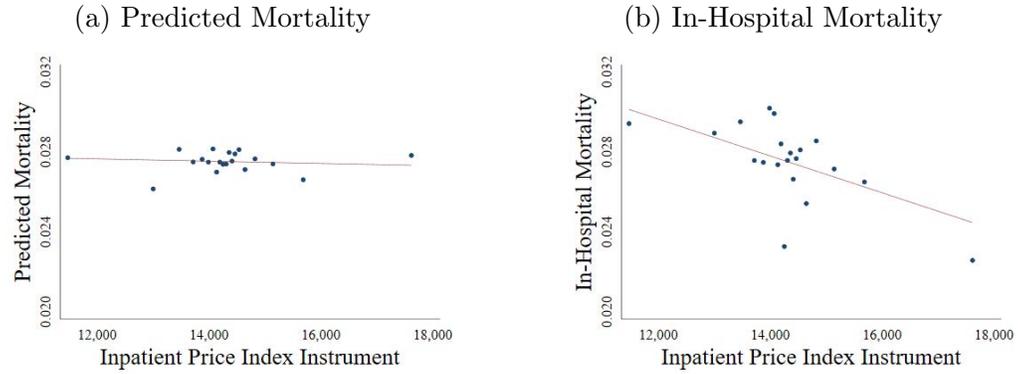
*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. . \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Table 17: Effect of Price on Mortality in Concentrated and Unconcentrated Markets [15-Mile HHI] (Time Varying Price Index)

	Log Admission Spending		In-hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5696*** (0.0419)	0.5622*** (0.0451)	-0.0166*** (0.0050)	-0.0193*** (0.0055)	-0.0010 (0.0015)	-0.0012 (0.0016)
Inpatient Price Index * HHI Above 4,000		0.0533 (0.0515)		0.0102* (0.0053)		0.0014 (0.0018)
Outcome Mean	28,190	28,190	0.0275	0.0275	0.0275	0.0275
Observations	189,702	189,702	189,702	189,702	189,702	189,702

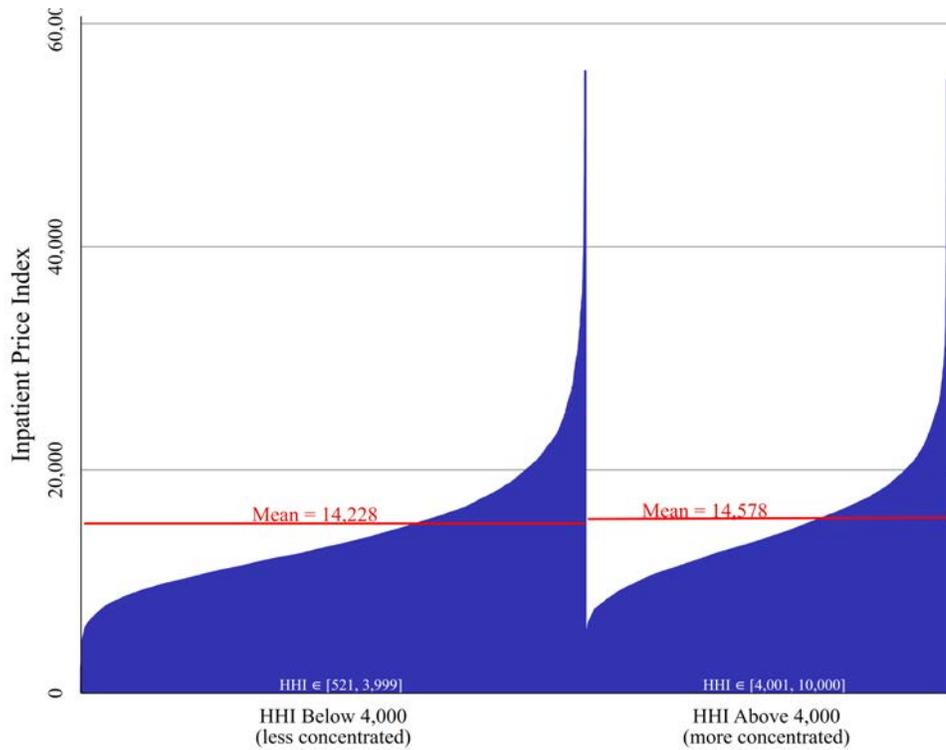
*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics, and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals within 15 miles. We use logged spending as dependent variable in columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix A Figure 1 : Residualized Mortality vs the Residualized Price Index (Time Varying)



*Note:* Panel A is created by regressing predicted mortality and the inpatient price instrument on point of origin and ambulance characteristics. Panel B is created by regressing in-hospital mortality and the inpatient price instrument on point of origin, diagnoses, patients' comorbidity scores, demographics, and ambulance characteristics. 5-digit zip code and year fixed effects are included in the regressions for both panels.

Appendix A Figure 2 : Distribution of the Hospital Inpatient Price Index (Time Varying) In Markets with an HHI Above and Below 4,000



*Note:* The HHI measure is calculated at the hospital level and based on bed counts for hospitals accessible in under 30 minutes. We compute a time-invariant measure by averaging the hospital-year level measures between 2008 and 2014.

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## **APPENDIX B**

Appendix B Table 1: Estimating the Relationship Between Hospital Prices and Mortality in Concentrated and Unconcentrated Markets (Time Varying HHI)

	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5427*** (0.0145)	0.5388*** (0.0164)	0.0018 (0.0011)	0.0007 (0.0013)	0.0026*** (0.0005)	0.0026*** (0.0006)
Inpatient Price Index * HHI Above 4,000		0.0202 (0.0290)		0.0053** (0.0027)		0.0001 (0.0011)
Outcome Mean	28,232	28,232	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045	191,045	191,045
Panel B: Second Stage of 2SLS						
	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5349*** (0.0360)	0.5475*** (0.0395)	-0.0102*** (0.0037)	-0.0130*** (0.0042)	0.0005 (0.0013)	0.0008 (0.0013)
Inpatient Price Index * HHI Above 4,000		-0.0188 (0.0469)		0.0112** (0.0050)		-0.0004 (0.0020)
Outcome Mean	28,232	28,232	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital level, and based on bed counts for hospitals accessible in under 30 minutes. We use logged spending as dependent variable in Columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix B Table 2: Estimating the Relationship Between Hospital Prices and Care Delivered in Concentrated and Unconcentrated Markets (Time Varying HHI)

	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.1147*** (0.0180)	0.1199*** (0.0207)	0.6166*** (0.0698)	0.6502*** (0.0821)	0.0321*** (0.0034)	0.0316*** (0.0038)
Inpatient Price Index * HHI Above 4,000		-0.0246 (0.0371)		-0.1633 (0.1219)		0.0025 (0.0067)
Outcome Mean	1.6340	1.6340	5.0825	5.0825	0.2442	0.2442
Observations	191,045	191,045	191,045	191,045	191,045	191,045
Panel B: Second Stage of 2SLS						
	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.0435 (0.0531)	0.0606 (0.0601)	0.2802 (0.1767)	0.4034** (0.2004)	0.0100 (0.0100)	0.0128 (0.0108)
Inpatient Price Index * HHI Above 4,000		-0.0188 (0.0734)		-0.2869 (0.2199)		-0.0003 (0.0136)
Outcome Mean	1.6340	1.6340	5.0825	5.0825	0.2442	0.2442
Observations	191,045	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses. clustered at the HSA level. The HHI measure is calculated at the hospital-year level, and based on bed counts for hospitals accessible in under 30 minutes. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix B Table 3: Estimating the Relationship Between Hospital Prices and Mortality at Various HHI Cutoffs (Time Varying HHI)

HHI Cutoff	In-Hospital Mortality			
	3,000	3,773	4,000	5,000
	(1)	(2)	(3)	(4)
Inpatient Price Index * HHI Above 4,000	-0.0138*** (0.0044)	-0.0137*** (0.0042)	-0.0130*** (0.0042)	-0.0115*** (0.0041)
Inpatient Price Index * HHI Above 4,000	-0.0041 (0.0041)	-0.0010 (0.0046)	-0.0018 (0.0046)	-0.0055 (0.0047)
Test of equality between interacted coef.:				
F-Stat	4.3036	6.2652	5.0354	1.4146
P-Value	0.0382	0.0124	0.0250	0.2345
Outcome Mean	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045

*Note:* Columns (1)–(4) report results for different HHI cutoffs, with Column (2) representing the median HHI in our sample. All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient’s comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix B Table 4: Effect of Price on Mortality in Concentrated and Unconcentrated Markets [15-Mile HHI] (Time Varying HHI)

	Log Admission Spending		In-hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5349*** (0.0360)	0.5269*** (0.0384)	-0.0102*** (0.0037)	-0.0128*** (0.0040)	0.0005 (0.0013)	0.0005 (0.0013)
Inpatient Price Index * HHI Above 4,000		0.0565 (0.0435)		0.0101** (0.0044)		0.0006 (0.0016)
Outcome Mean	28,232	28,232	0.0275	0.0275	0.0275	0.0275
Observations	191,045	191,045	191,045	191,045	191,045	191,045

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics, and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital-year level, and based on bed counts for hospitals within 15 miles. We use logged spending as dependent variable in columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

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## **APPENDIX C**

Appendix C Table 1: Estimating the Relationship Between Hospital Prices and Mortality in Concentrated and Unconcentrated Markets (Time Varying HHI and Price Index)

	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5691*** (0.0140)	0.5631*** (0.0148)	0.0010 (0.0012)	-0.0001 (0.0013)	0.0019*** (0.0005)	0.0018*** (0.0005)
Inpatient Price Index * HHI Above 4,000		0.0304 (0.0253)		0.0055** (0.0025)		0.0003 (0.0008)
Outcome Mean	28,190	28,190	0.0275	0.0275	0.0275	0.0275
Observations	189,702	189,702	189,702	189,702	189,702	189,702
Panel B: Second Stage of 2SLS						
	Log Admission Spending		In-Hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.5696*** (0.0419)	0.5878*** (0.0452)	-0.0166*** (0.0050)	-0.0200*** (0.0057)	-0.0010 (0.0015)	-0.0010 (0.0016)
Inpatient Price Index * HHI Above 4,000		-0.0428 (0.0487)		0.0130** (0.0055)		0.0008 (0.0021)
Outcome Mean	28,190	28,190	0.0275	0.0275	0.0275	0.0275
Observations	189,702	189,702	189,702	189,702	189,702	189,702

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims (adjusted for inflation) between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital - year level, and based on bed counts for hospitals accessible in under 30 minutes. We use logged spending as dependent variable in Columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix C Table 2: Estimating the Relationship Between Hospital Prices and Care Delivered in Concentrated and Unconcentrated Markets (Time Varying HHI and Price Index)

	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.0918*** (0.0180)	0.0833*** (0.0186)	0.5891*** (0.0680)	0.5841*** (0.0772)	0.0277*** (0.0032)	0.0253*** (0.0033)
Inpatient Price Index * HHI Above 4,000		0.0437 (0.0353)		0.0373 (0.1123)		0.0123** (0.0059)
Outcome Mean	1.6352	1.6352	5.0851	5.0851	0.2444	0.2444
Observations	189,702	189,702	189,702	189,702	189,702	189,702
Panel B: Second Stage of 2SLS						
	Mean of DRG Weights		Length of Stay		Procedure Performed	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index	0.0065 (0.0645)	0.0190 (0.0714)	0.2912 (0.2146)	0.4036* (0.2406)	0.0053 (0.0117)	0.0071 (0.0126)
Inpatient Price Index * HHI Above 4,000		-0.0064 (0.0739)		-0.2654 (0.2320)		0.0023 (0.0143)
Observations	189,702	189,702	189,702	189,702	189,702	189,702
Outcome Mean	1.6352	1.6352	5.0851	5.0851	0.2444	0.2444

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital - year level, and based on bed counts for hospitals accessible in under 30 minutes. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix C Table 3: Estimating the Relationship Between Hospital Prices and Mortality at Various HHI Cutoffs (Time Varying HHI and Price Index)

HHI Cutoff	In-Hospital Mortality			
	3,000	3,733	4,000	5,000
	(1)	(2)	(3)	(4)
Inpatient Price Index * HHI Below Cut-off	-0.0196*** (0.0058)	-0.0202*** (0.0057)	-0.0200*** (0.0057)	-0.0182*** (0.0056)
Inpatient Price Index * HHI Above Cut-off	-0.0107** (0.0053)	-0.0073 (0.0056)	-0.0070 (0.0055)	-0.0114** (0.0054)
Test of equality between interacted coef.:				
F-Stat	2.8140	5.1075	5.4912	1.4988
P-Value	0.0937	0.0240	0.0193	0.2211
Outcome Mean	0.0275	0.0275	0.0275	0.0275
Observations	189,702	189,702	189,702	189,702

*Note:* Columns (1)–(4) report results for different HHI cutoffs, with Column (2) representing the median HHI in our sample. All models include 5-digit zip code and year fixed effects and measure the effect of a two standard deviation increase in price. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.

Appendix C Table 4: Effect of Price on Mortality in Concentrated and Unconcentrated Markets [15-Mile HHI] (Time Varying HHI and Price Index)

	Log Admission Spending		In-hospital Mortality		Predicted Mortality	
	(1)	(2)	(3)	(4)	(5)	(6)
Inpatient Price Index * HHI Above Cut-off	0.5696*** (0.0419)	0.5653*** (0.0450)	-0.0166*** (0.0050)	-0.0192*** (0.0055)	-0.0010 (0.0015)	-0.0013 (0.0016)
Inpatient Price Index * HHI Above Cut-off		0.0394 (0.0484)		0.0098* (0.0052)		0.0016 (0.0018)
Outcome Mean	28,190	28,190	0.0275	0.0275	0.0275	0.0275
Observations	189,702	189,702	189,702	189,702	189,702	189,702

*Note:* All models include 5-digit zip code and year fixed effects. The price index is based on all inpatient claims between 2008 and 2014. We control for point of origin (home, nursing home, or scene of accident), diagnoses, demographics, and ambulance characteristics. Diagnostic controls include a list of 29 non-discretionary diagnoses codes. Demographic controls include indicators for age category and gender. Ambulance controls include payment to the company, whether the transport utilized advanced life support, and whether the transport was coded as emergency transport. We also control for the patient's comorbidity score, which is measured via a Charlson Index constructed using six months of prior health claims. The regressions with Predicted Mortality do not control for patient characteristics, including: age, gender, diagnosis, and comorbidity score. The observations are unique at the patient-ride level. Standard errors are in parentheses, clustered at the HSA level. The HHI measure is calculated at the hospital - year level, and based on bed counts for hospitals within 15 miles. We use logged spending as dependent variable in columns 1 and 2, but report the outcome mean in levels. \* p < 0.1; \*\* p < 0.05; \*\*\* p < 0.01.