Healthcare Provider Consolidation: Facts and Myths

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2015 Massachusetts Cost Trends Hearing

October 6, 2015

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Competition is a bedrock of the U.S. vision for healthcare

- U.S. relies heavily on private markets to deliver, manage, and insure healthcare
  - The Affordable Care Act extended and expanded this approach
- For markets to achieve efficient outcomes, we need robust competition in all key healthcare sectors
- In general, robust competition requires many "small" buyers and sellers

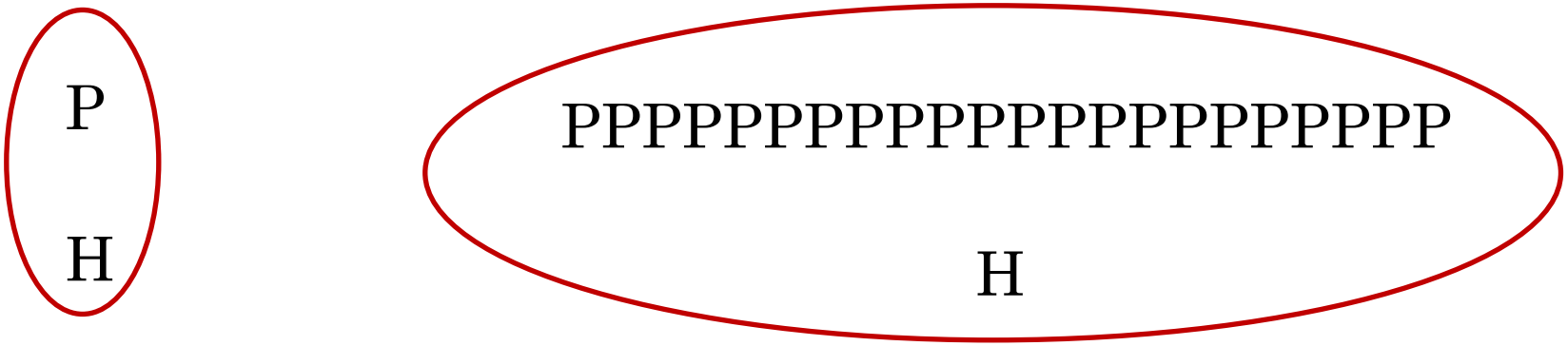
  → We've been seeing a lot of consolidation
- Goal today: what are the facts about consolidation and myths about antitrust enforcement?

Definitions

- Vertical chain of production is source of integration labels
  - **Horizontal**: combinations in the same product and geographic market and part of the value chain
  - **Vertical**: combinations up or down the value chain
  - **Lateral**: everything else

Non-horizontal

Hospital acquisition of physicians has vertical and horizontal components



The Facts

“Get your facts first, then you can distort them as you please.”

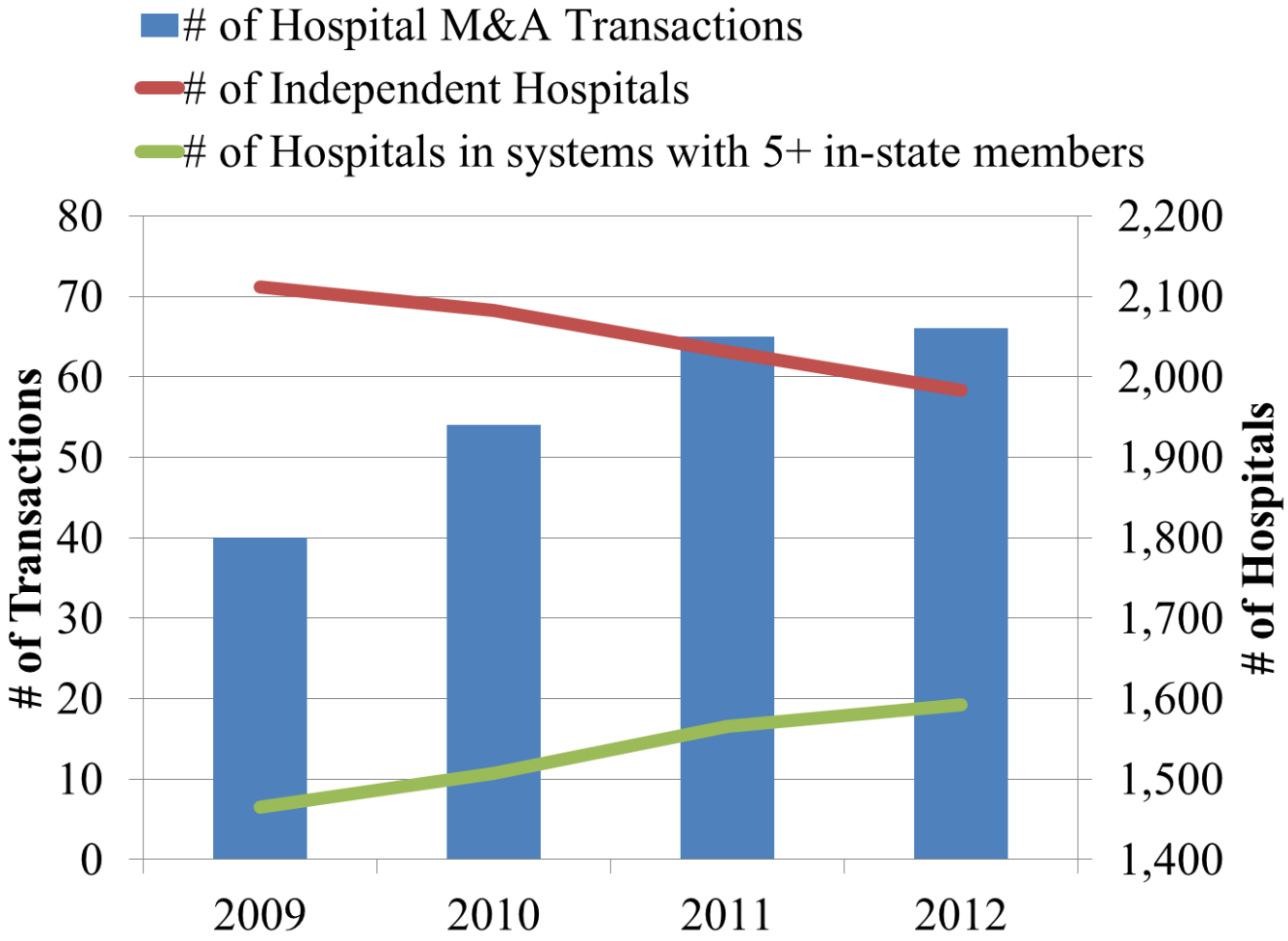
--Mark Twain

Horizontal consolidation is occurring among physicians and among hospitals

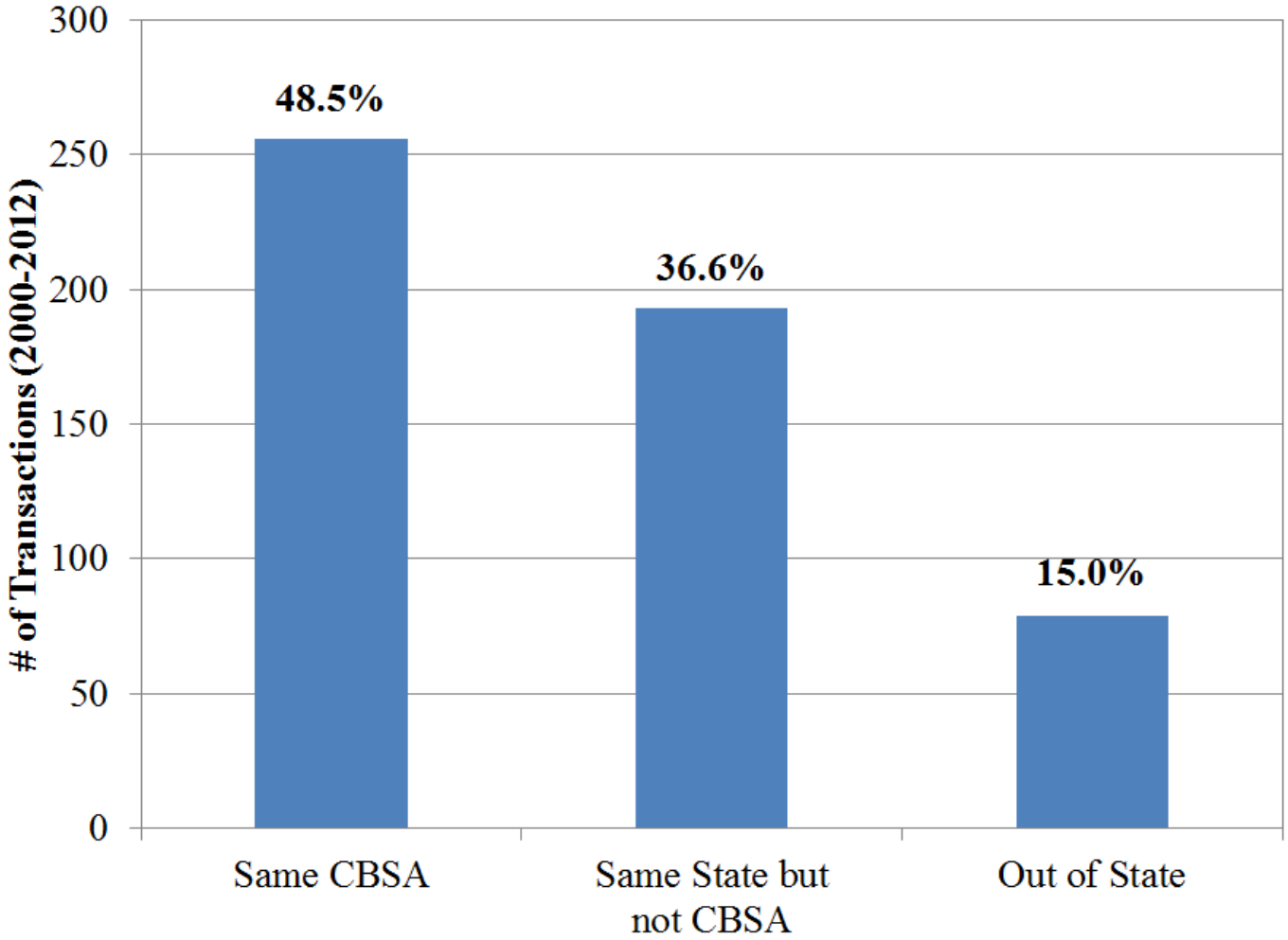
- Physician practices
  - Increase in mean practice size outside hospitals
  - Significant increase in hospital employment of MDs: 29% now employed by hospitals or hospital-owned practices (up from 16% in 2007)
- General acute care hospitals
  - Most MSAs are highly concentrated, and have become more so
  - 357 hospital transactions since 2010

Sources: American Medical Association, Gaynor (2015)

Hospital mergers are proceeding apace



Many hospital mergers do not have any traditional horizontal overlap



Notes: Based on 528 general acute care hospital mergers reported by Irving Levin over 2000-2012

Vertical integration trends

- Hospital-physician acquisitions and joint ventures
- Other cross-provider partnerships
  - DaVita and Healthcare Partners
- Provider-healthplan joint ventures
  - JVs: Anthem and Cedars-Sinai, UCLA, others in LA
- Provider-healthplan combinations
  - Highmark and West Penn Allegheny Health
  - Optum (United subsidiary) and Monarch HealthCare

So what? Bigger could be better

- Little evidence this is true for horizontal combinations
  - Mergers of competing hospitals lead to higher prices and (likely) lower quality (Gaynor and Town 2012)
  - Recent studies suggest consolidation may also raise price in outpatient settings
    - Physician services (e.g., Baker et al. 2013)
    - Dialysis (Cutler, Dafny and Ody working paper)

So what? Bigger could be better, *continued*

- Discouraging early evidence for integration of physicians with hospitals
  - Price and total spending increases in areas with increases in physician-hospital financial integration (Bundorf et al 2014)
  - Referral patterns shift toward acquiring hospital, and patients more likely to select high-cost, low-quality hospitals (Baker et al 2015)
  - Total risk-adjusted Medicare spending is higher for patients served by large hospital-based groups. No evidence of higher quality (McWilliams et al 2013)

So what? Bigger could be better, *continued*

- Recent evidence suggests cross-market mergers lead to higher hospital prices
  - Anecdotal
    - Community Tracking Study: *"Numerous participants in contract negotiations between health plans and hospitals noted that provider leverage depends on how big the hospital or hospital system is and how much of an insurer's patient volume it generates."*
  - Systematic
    - Hospitals joining systems with a member in same broad metro area raise price 4-7 percent (Cuellar and Gertler 2005)
    - Acquisition of indep hospitals by systems leads to higher prices even when other members are outside broad metro area (Lewis & Pflum 2014, 2015)
- But it is proceeding anyway

Why are cross-market mergers attracting little attention from antitrust enforcers?

- Clayton Act Sec 7 prohibits acquisitions where the effect "may be substantially to lessen competition, or to tend to create a monopoly"
- What to do about
  - Mergers that result in higher price due to greater ability to bear risk or improved bargaining skill
  - Mergers that result in higher spending due to changes in service mix
  - Mergers that enable exploitation of pre-existing market power
  - Mergers that bundle services in different patient and/or geographic markets

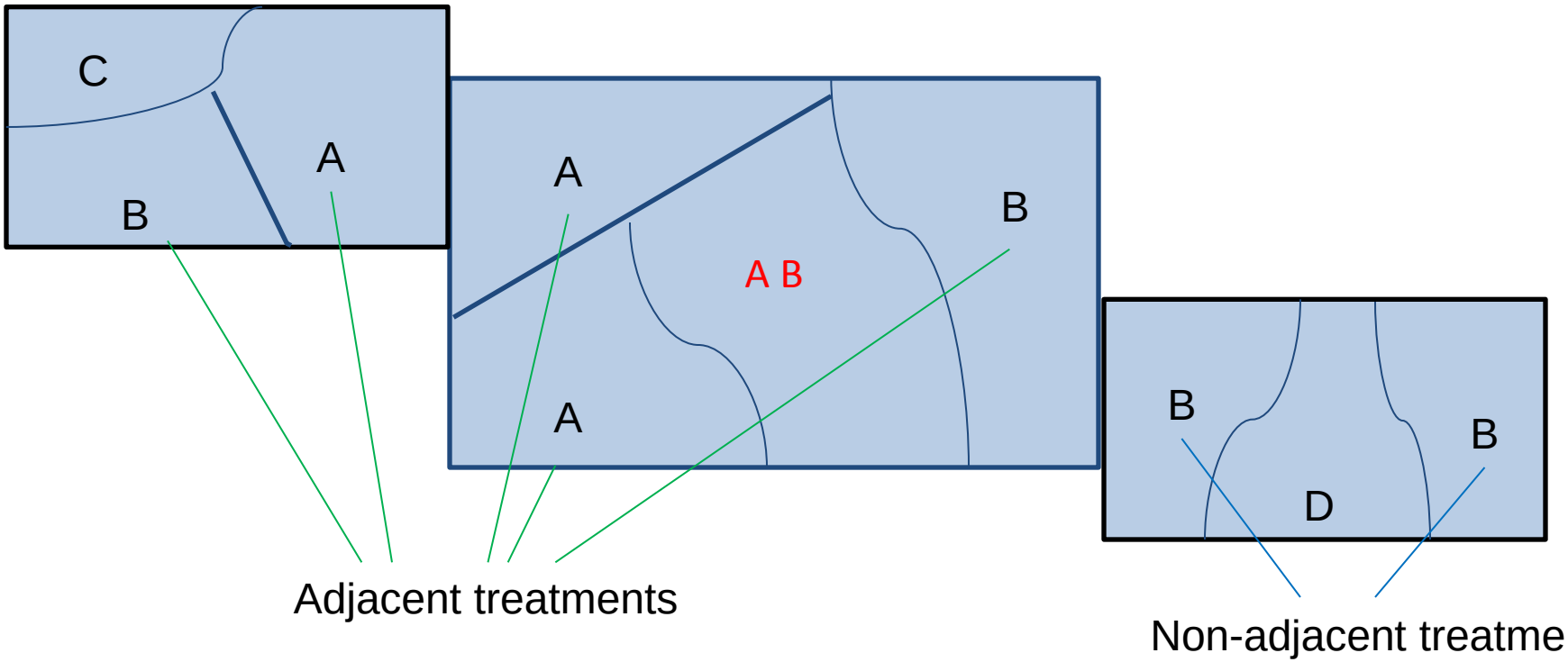
New research suggests enforcers might focus on a different market

- Focus to date: competition among hospitals for the same service
  - Under standard model only a merger of hospitals that compete for the same patients affects joint bargaining position and therefore the negotiated price with insurers
- Reality: customers purchase option to use a *bundle* of provider services from insurers
  - If same customer values both providers, the providers are substitutes vis a vis inclusion in the bundle
    - E.g. families who value both adult and pediatric hospitals
    - E.g. employer with employees in both relevant geo markets
- This **common customer effect** should be stronger for mergers in close proximity

Graphical depiction of new research design

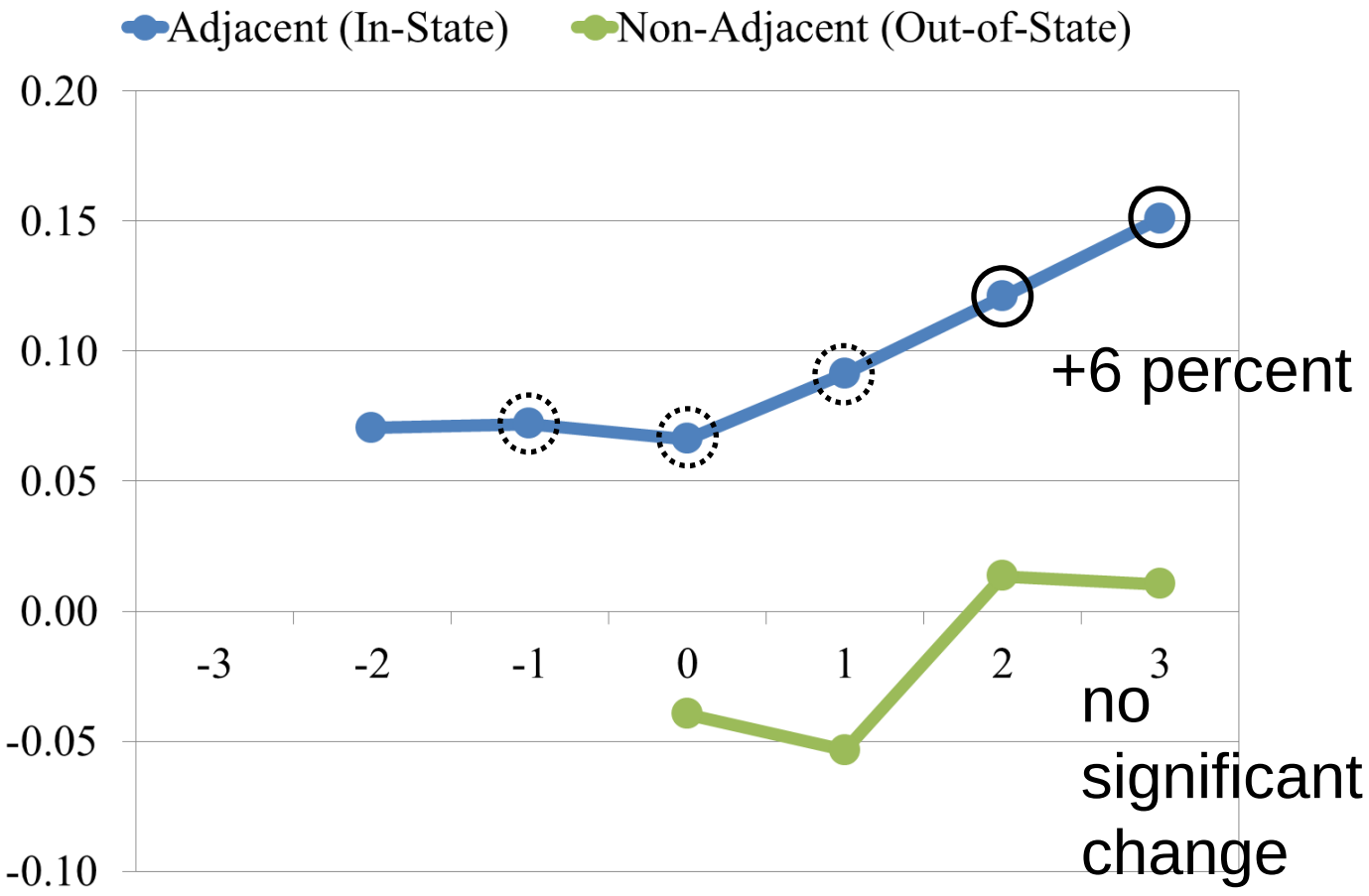
Consider two different types of "treatment hospitals"

Merger of System A and System B



Notes: Each rectangle is a state; wavy lines signify within-state geo markets

Results: FTC Sample



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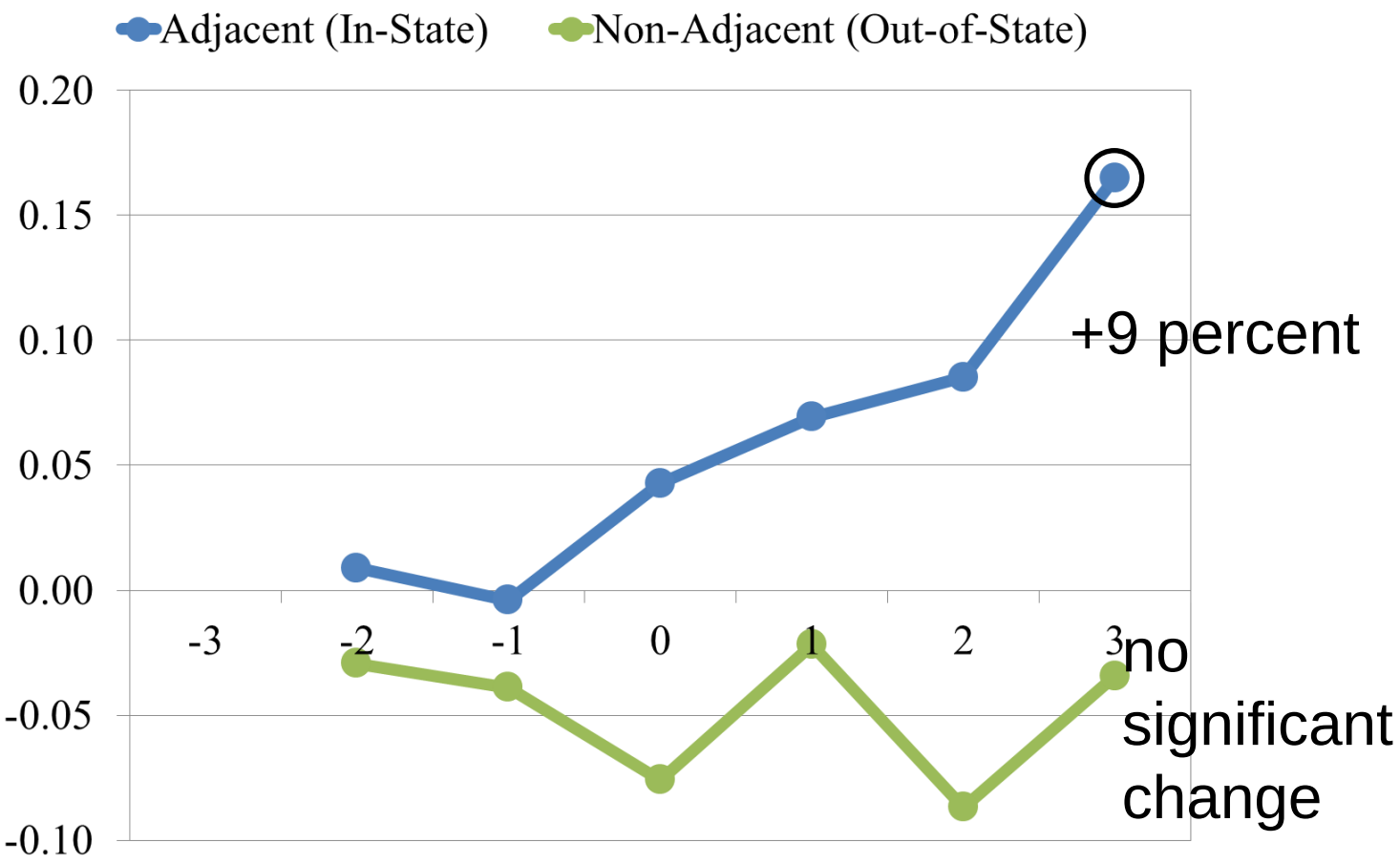
Results: Broad Sample



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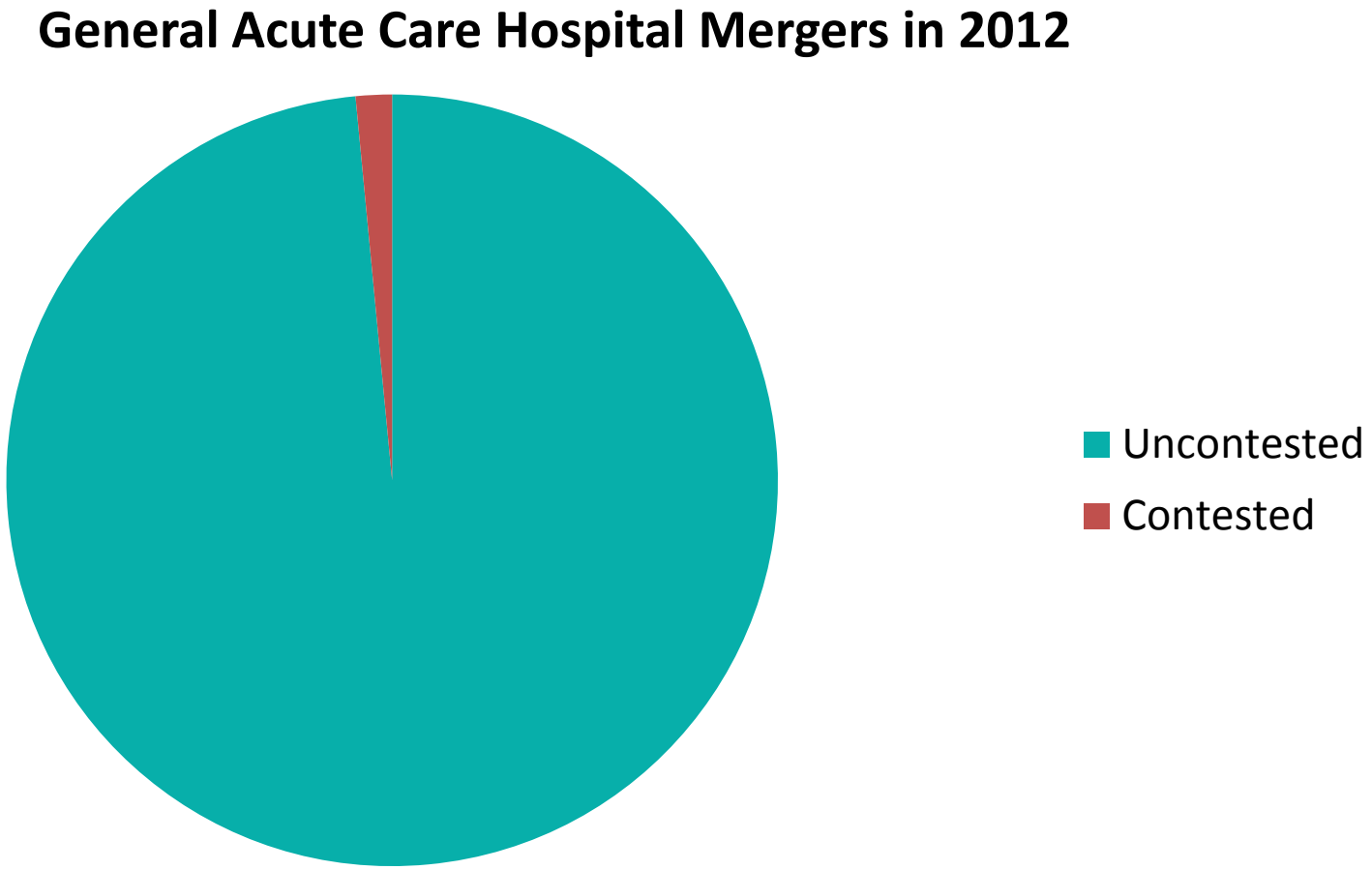
Cross-market mergers as potential target for antitrust enforcers

- New research suggests hospitals in different, nearby, markets can constrain one another's pricing because contracting with insurers occurs at broader geographic units than local hospital markets
- Enforcers may need to broaden criteria for deal investigations
  - But there must also be a limiting principle
  - And some of the estimated effect may be due to factors other than a "lessening of competition"

Myth #1: Antitrust enforcers block a lot of mergers



Myth #2: Antitrust enforcers will be able to ensure competitive markets

- Take a look around
- Antitrust agencies enforce the laws, and they are narrow
  - E.g. merger that facilitates exercise of pre-existing market power may not be construed as violation of Clayton Act
- They need evidence that something bad will happen, not evidence that something good is likely to happen
- They are saddled with legal precedents, including antiquated market definitions
- They avoid gray areas, and are deathly afraid of losing

→ We need industry leadership, and HPC-like entities to help

Myth #3: The ACA encourages provider consolidation

- Clinical integration $\not\rightarrow$ financial integration
- "We reject the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the three-part aim [of the Shared Savings Program]."

  -Centers for Medicare and Medicaid Services, Final Rule,11/2011
- E.g., In recent merger case prosecuted by FTC, St. Luke's VP of Payer Relations, formerly of Advocate Health, testified that independent physicians could be financially incentivized to meet specific quality metrics
  - "Consolidation is not integration. Clinical integration requires meaningful data sharing, systems for effective handoffs, and streamlined care transitions. These processes can be achieved through other mechanisms," Tsai and Jha, *JAMA* 2014

- The ACA does not exempt organizations or collaborations from the antitrust laws

Myth #3: The ACA encourages provider consolidation, *continued*

- “In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment. But **the Clayton Act is in full force**, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment.”

  - St. Luke’s decision, Judge Winmill, 1/2014

- "I would prefer to reverse that order of events and instead consider any future proposed Partners' expansion only after Partners demonstrates an ability to contribute to health care cost containment in Massachusetts."

  – MA Attorney General Maura Healey, 1/2015

If traditional antitrust enforcement isn't enough, what can be done?

- Sunlight is the best disinfectant. Information can inspire alternatives to consolidation and/or mobilize opposition

- Regulation is an option
  - E.g., ban "facility based billing" for physicians recently/newly acquired by hospitals
  - Incentivize consumer choice of healthplans, e.g. via private or public exchanges

- Broader reading of antitrust laws may be possible