



Balancing Act: Consolidation and Antitrust Issues in Health Care

Health care market consolidation has escalated in recent years, spurred by market forces that have been reinforced by Affordable Care Act (ACA) incentives toward integration. These influences have put greater emphasis on coordinated care for better patient outcomes, cost control, and improved quality, as well as a desire among hospitals for greater bargaining power with insurers.

Despite the positive results promised by consolidation, a reduction in the number of health care competitors may result in higher costs, higher prices, and fewer or poorer-quality services for patients. Under federal antitrust laws, regulatory agencies have long monitored consolidation in order to protect consumer interests against the effects of concentrated market power.

The inherent tension between the goals of integration and the assumptions that underlie a competitive marketplace makes antitrust compliance and enforcement a balancing act. This was recently on display in Idaho, where the federal government alleged that a hospital's acquisition of a physicians' group would substantially lessen local competition. In January 2014, a federal court agreed and ordered

divestiture of the affiliation. The case reveals some of the issues health care organizations face as they look toward greater integration, including the impact on cost and quality.

This issue brief is intended to help California health care stakeholders better understand the role of antitrust enforcement in ensuring affordable, quality health care. It summarizes highlights of a CHCF-funded research paper, "The Tension Between Antitrust Principles and Integrated Health Care: Implications for Consumers and Health Care Organizations," by Lisa Maiuro, PhD.

The research looks at hospital mergers, acquisitions, and joint ventures, as well as joint operating agreements and clinical affiliations with non-hospital providers. It also reviews the role of the ACA in fueling integration and the development of physician-hospital organizations (PHOs) and Accountable Care Organizations (ACOs).

What Is Driving Consolidation?

Over several decades, consolidation of hospitals into multi-hospital systems has increased their leverage in contract negotiations with insurers, which rely on these systems to ensure a strong and consistent provider network. In California, eight large systems comprise 40% of the state's hospitals and general acute care hospital beds.¹

They claim that their ability to command higher reimbursements allows them to invest in improving treatment outcomes. However, there is some evidence to the contrary — indicating that the absence of competitive pressures tends to produce organizational slack, weaker accountability for performance, and lower-quality care.

A corollary of the trend toward consolidation is the impetus for stand-alone hospitals to find partners in order to survive. A typical example in California was Doctors Medical Center in San Pablo, which saw the bulk of the area's patients. A patient payer mix that was heavily uninsured or underinsured was one of several reasons that this independent hospital had been financially struggling for nearly a decade and was seeking a partner. The hospital filed for bankruptcy in 2006. In 2014, the State of California allocated \$3 million in state funds to help prop up the hospital, and the City of Richmond promised to allocate millions in the future. Doctors Hospital is typical of many public and independent hospitals whose patients have few alternatives for care if the hospital closes.²

Passage of the ACA created additional financial incentives and mandates for increased coordination among providers, payers, and employers, intended to improve the quality of care and make the overall health care system more efficient. For example, the ACA includes mandates for new demonstration projects to test the effects of innovative, more integrated approaches to delivery of and payment for services. These innovations include:

Bundled Payment. Enabling a single payment for a “bundle” of services during an episode of care is intended to encourage better-coordinated and more efficient care and to eliminate ineffective and unnecessary treatment. Having services provided by a single, integrated operating entity helps control the costs associated with an episode of care and may enable providers to realize greater profits.

Accountable Care Organization (ACO). These are integrated networks of doctors and hospitals that share financial and medical responsibility for providing coordinated care to patients, with the intent of limiting unnecessary spending.

Patient-Centered Medical Home (PCMH). This is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. This care model promotes improved access and communication, care coordination, and quality.

Other ACA provisions have created financial incentives for integration. For example, independent medical practices must install costly electronic record-keeping, which makes remaining independent

less attractive. Another pressure on independent physician practices is a reimbursement mechanism that allows outpatient procedures to be better compensated when they are performed inside a hospital-owned practice versus an independent physician's office.

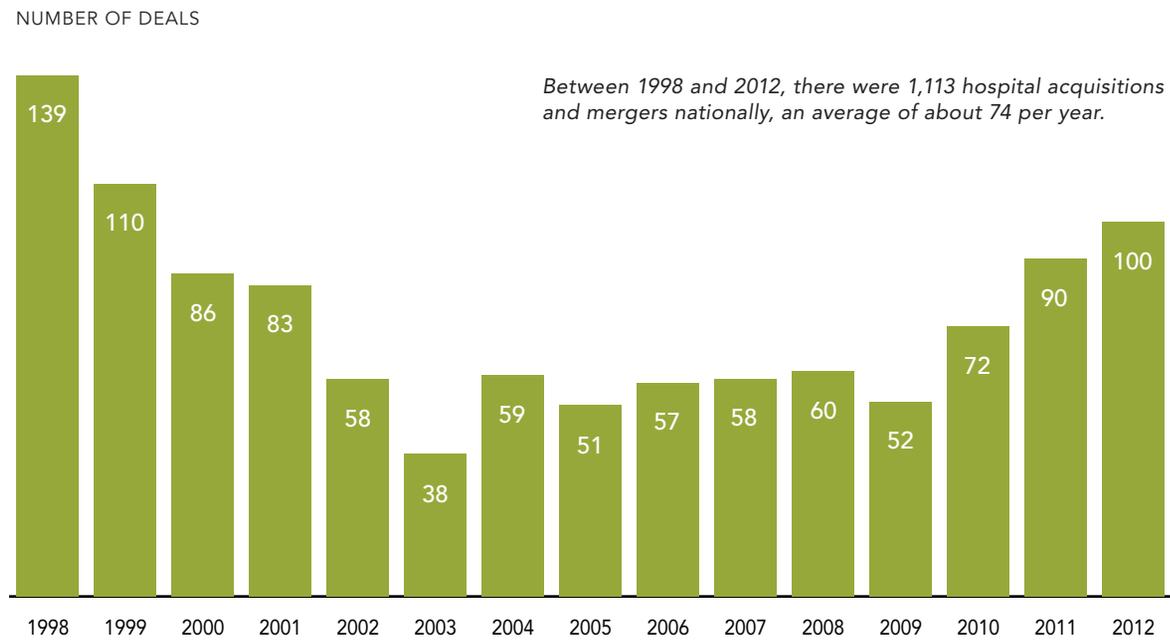
These and other recent health care reforms attempt to address barriers to efficiency that are exacerbated by silos in care delivery, lack of coordination of health information, and a general disaggregation in the health care market. However, increased consolidation has led to concerns that, in some markets, less competition between providers results in a significant reduction in or elimination of consumer choice as well as higher prices.

Recent History of Consolidation

Hospital mergers. National trends in hospital mergers from 1998 to 2012 are shown in Figure 1 (page 3). Most recent consolidations resulted in larger regional and national health care systems. The arrangements include not only consolidation among hospitals, but also consolidations among a range of health care providers and organizations including physicians, health plans, behavioral health organizations, and other entities.

Post-acute care organizations and services in particular are increasingly affiliated with hospitals: In 2011, 60% of hospitals offered home health services, 37% had skilled nursing facilities, 62% owned hospice services, and 15% provided assisted living options in various ownership structures or other affiliations.³

Figure 1. Hospital Mergers on the Rise Nationally



Source: American Hospital Association, "Trends Affecting Hospitals and Health Systems," *Trendwatch Chartbook 2012*, www.aha.org.

There is no comprehensive official list of hospital mergers and other health care consolidative transactions in California. However, much integration activity can be tracked through media reports and hospital transactions reviewed by the state Attorney General (CA-AG). The focus of those reviews, however, is often continued availability and access to health care services to the community more than the competitive effects of the transaction. Approval of a transaction by the CA-AG often includes conditions that must be met by the consolidating entities in

order to preserve services, particularly for vulnerable populations.

In California, the CA-AG Antitrust Division and Charitable Trusts are responsible for reviewing transactions that meet specific criteria. State law requires the Attorney General's review and consent for any sale or transfer of a health care facility owned or operated by a nonprofit corporation whose assets are held in public trust. This is generally conducted by Charitable Trusts.

Hospitals and physician groups. Hospitals have also been involved in transactions that align them with physician groups and other provider organizations, although California prohibits the direct employment of physicians by entities other than professional corporations. This restriction has historically limited the state's hospitals from this type of integration. However, hospitals and health systems increasingly turned to medical foundations and other mechanisms for formal alignment with physician groups that has allowed them to achieve many of the same benefits of direct employment.

Based on a 2013 Modern Healthcare survey, doctors directly employed by health care systems increased 39% to roughly 67,600 physicians from the previous year. This may have been a reflection of physician efforts to strengthen their position as local players and of hospitals to have a more integrated and coordinated care structure, thereby to more effectively manage readmissions and reduce inefficiencies.⁴

Providers and payers. Payers, too, have increasingly aligned with providers in management and administrative arrangements. In some instances, this has taken the form of Accountable Care Organizations (ACO) or other shared-risk models between payers and provider groups. In other cases, payers have acquired physician organizations or invested in their management companies.

ACOs. ACOs are based on integration of multiple providers to address population health issues, and operate in both public and private insurance spheres. As of May 2013, California ranked first in the nation in the number of commercial ACO contracting arrangements.⁵ Most are led by large physician

groups, but there is an increasing trend toward hospitals taking a more predominant role.⁶ As vehicles for promoting population-based care and value-based models, ACOs can compete regionally with Kaiser Permanente, which already implements the integrated care model. It remains to be seen, however, how these organizations and others can achieve an appropriate balance between market power and efficiencies, and how such clinical integration can be encouraged while avoiding excessive antitrust risk.

Recent Evolution of Antitrust Enforcement

In the mid-1980s and throughout the 1990s, mergers proliferated partly in response to the increasing presence of managed care, which pressured hospitals to reduce costs and excess capacity. Few of these transactions were successfully halted by the Federal Trade Commission (FTC) in court. However, in 2000, the FTC announced that it would review completed transactions and challenge those that had resulted in anticompetitive price increases. The review resulted in four published retrospectives and showed that the methodology relied on by courts failed to identify anticompetitive mergers.

Subsequently the FTC, relying on a different approach to present their case, successfully challenged Evanston Northwestern Healthcare's acquisition of Highland Park Hospital (2007), the first in a series of such successful challenges. Most recently the FTC has successfully challenged hospital mergers in Toledo, Ohio, and Rockford, Illinois. It also succeeded with its first fully litigated challenge

to a hospital acquisition of competing physician practices.

The FTC successes can be attributed in part to the new Horizontal Merger Guidelines ("2010 Guidelines") issued jointly by the FTC and the Department of Justice and the findings from the retrospective analyses. The new Guidelines offered a more nuanced application of market definition, market concentration, merger specificity, and efficiencies provisions. The econometric modeling focuses on whether a merger among providers that are close substitutes increases the merged provider's leverage with health plans because of inadequate alternatives.

Familiarity with the new merger guidelines is critical to providers who are concerned about possible intervention by regulatory agencies. Some of the key changes in the 2010 Guidelines from previous guidelines include greater receptiveness to a variety of methods to analyze evidence in determining whether a merger may substantially lessen competition. Some of the more important takeaways include:

- ▶ The "market definition" is not an end in itself or a necessary starting point for a merger analysis in contrast to the five-step analytic process described in the 1992 Guidelines that relies on first defining a relevant geographic and product market with respect to each of the products of the merging firms.
- ▶ The thresholds for measurement of market concentration have been updated. A measure known as the Herfindahl-Hirschman Index (HHI), used to quantify market concentration and the threshold at which the enforcement agencies see the potential for harm, has been

raised, although its weight relative to other evidence in a case may be lower.

- ▶ There is an increased emphasis on "coordinated effects." A red flag is raised if the enforcement agencies believe the merger will enhance the market's vulnerability to coordinated conduct.
- ▶ There is more attention paid to whether a merger increases the risk of either explicit collusion among competitors or "parallel conduct," which involves less overt or formal agreements on pricing or terms of sale.

The St. Luke's Case and Its Implications

The tension between consumer protection through the principles of antitrust and the promotion of more efficient health care through the integration of health care providers — and the newer ways courts may resolve these tensions — was spotlighted by the 2014 case of *Saint Alphonsus Medical Center-Nampa v. Saint Luke's Health System*. This case is particularly significant because it involved an FTC challenge to a hospital's acquisition of a physician practice group, a type of consolidation transaction that jumped 139% nationally in just one year (2010 to 2011) immediately following passage of the ACA.⁷

The St. Luke's case represents the first time a federal court has found a hospital's purchase of a physician practice to be unlawful, (although it should be noted that, technically, the case was tried as a horizontal merger involving physicians groups rather than as a merger between a hospital and physicians.) The case

sent a message that while the ACA promotes integration, it does not sanction merger activity that violates antitrust laws. It also sent the message that consummated transactions were not immune from review. The district court's decision was upheld in February 2015 by a federal appeals court, which affirmed that Idaho-based St. Luke's Health System violated state and federal antitrust laws when it acquired the medical group in 2012.

As California health care providers and insurers are scurrying to consolidate in order to remain viable, they must avoid integration that leads to significant consolidation of market power, creating an imbalance in power among providers and payers in the market. They must keep in mind that clinical and financial integration are not the same thing. Clinical integration among providers involves shared clinical data and shared patient relationships, mutual dependency on clinical outcomes, and aligned clinical incentives. Financial integration among providers involves shared financial data, shared financial risk and reward, mutual dependency on financial outcomes, and aligned financial incentives.

The St. Luke's case sent the message that full financial integration in the form of mergers or acquisitions is not always necessary to achieve the benefits of clinical integration, and those enforcement agencies and courts will be willing to step in even if the transaction has been consummated.

Questions to Ask

Before entering into formal agreements, all entities should first understand the 2010 Horizontal Merger Guidelines as well as the St. Luke's case. Some important questions and considerations:

- ▶ Can the parties demonstrate bona fide purposes for the integration, as opposed to simply a mechanism to enhance leverage with payers through joint negotiation? For example, in several advisory opinions the FTC has concluded that arrangements to improve quality and control costs through clinical integration, as opposed to primarily financial integration, are unlikely to violate the antitrust laws.⁸ Also, the FTC will consider whether agreements among participants regarding the terms on which they will deal with health care insurers are reasonably necessary to achieve the benefits of the collaboration. If so, then the collaboration is not likely to be considered per se illegal and instead will to be evaluated under a "rule of reason" standard, which considers whether the likely effect of the collaboration will be to help or harm competitors and consumers.⁹
- ▶ To what extent is common ownership, or quasi-employment of physicians, necessary for the coordinated entities to create scale and align financial and quality incentives, or would looser clinical affiliations be sufficient to achieve the same objectives of better care coordination?
- ▶ To what extent are efficiencies being claimed available only through the specific post-integration structure, or could the parties achieve the same results through a clinical arrangement rather than financial integration?
- ▶ To what extent will the combined entity raise rates for ancillary services (such as x-rays, charged at a higher hospital-billing rate), which will be passed on to patients? Price increases to consumers without significant compensating effects are likely to be viewed as anticompetitive behavior.¹⁰
- ▶ To what extent could the combined entity's anticompetitive bargaining advantage be used in ways (in addition to price increases) that could cause substantial injury to consumers? Examples of such harm to customers might be reduced output and diminished innovation resulting from decreased competitive constraints or incentives.
- ▶ Will the combined entity have a dominant market position which will enable it to negotiate higher reimbursement rates from health insurance plans, which will be passed on to the consumer?
- ▶ Will proclaimed savings and efficiencies from the merger be passed on to the consumer?
- ▶ Is the organization relying on the foundation model to align incentives between hospitals and physicians, without formally owning and operating the physician clinics? Indirect employment through a foundation will most likely not diminish regulatory agencies' concerns about the impact of physician-hospital organization; the agencies will likely treat this type of arrangement as if it were employment.

Two Coming Trends

California providers will likely see two trends that address the tensions between the incentives of the ACA and the antitrust issues raised by the St. Luke's case and the new Guidelines.

Creation of more integrated systems like Kaiser, better positioned to address "population health."

Hospital systems are acquiring health insurers or otherwise integrating insurance into their system. By combining the functions of health care services and health care insurance, these integrated systems can put competitors at a disadvantage. If this advantage ultimately decreases competition, it could allow the organization to raise premiums. Watchful of threats to competition and the effects on consumers and patients, antitrust regulators, like health care providers, are working to keep up with these transitioning market dynamics.

Greater attention on strategic alliances rather than mergers per se. Historically, mergers have been the preferred way to achieve size, scale, and bargaining power with health care payers. However, with hospital administrators citing a chilling effect from the FTC's scrutiny and high-profile rulings against the industry, traditional approaches to consolidation are now less appealing. Consequently, hospitals are seeking out affiliations, alliances, joint ventures, and other "non-merger mergers" that involve coming together to share knowledge, assets, or branding rather than ownership.¹¹ Despite this partnership structure, however, a critical question will remain as to the extent the parties involved will have increased bargaining leverage with other payers or providers.

More Reading

FTC industry guidance materials related to health care: Competition in the Health Care Marketplace, www.ftc.gov.

Horizontal Merger Guidelines, US Department of Justice and the Federal Trade Commission, August 19, 2010, www.ftc.gov.

Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals, by Joseph Farrell, Paul A. Pautler, and Michael G. Vita, www.ftc.gov.

The Impact of Hospital Consolidation — Update, by Martin Gaynor and Robert Town. Robert Wood Johnson Foundation, June 2012, www.cultureofdoubt.net.

About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

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Endnotes

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