

# Hospital Industry Consolidation — Still More to Come?

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The Affordable Care Act (ACA) has unleashed a merger frenzy, with hospitals scrambling to shore up their market positions, improve operational efficiency, and create organizations capable of managing population health. The figures are impressive: 105 deals were reported in 2012 alone, up from 50 to 60 annually in the pre-ACA, pre-recession years of 2005–2007.<sup>1</sup> This activity could have lasting repercussions for consumers; the last hospital-merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit.<sup>2</sup> Since the primary driver of growth in private spending in recent years has been price increases for health care services, a compelling argument can be made for putting the brakes on consolidation.<sup>3</sup> But, unless new public and private initiatives are developed to discourage consolidation and to support enforcement of antitrust law, most of these deals will proceed unchallenged.

At the moment, the agencies responsible for enforcing antitrust law are well positioned to investigate and, if the evidence warrants, to challenge one particular type of consolidation: so-called horizontal mergers of providers that supply similar services in geographic proximity. In the past year alone, two hospital systems were forced to abandon their plans to acquire nearby rivals, and a third system is appealing an order to divest a recently acquired hospital. Enforcers have also objected to hospitals' accumulating market power in physician services by acquiring com-

peting practices in the same specialty and geographic area. For example, this fall, the Federal Trade Commission (FTC) challenged the purchase of Saltzer Medical Group in Nampa, Idaho, by St. Luke's, the state's leading hospital system. Together with Idaho's attorney general, the FTC has alleged that combining St. Luke's 12% market share in adult primary care services with Saltzer's 66% would reduce competition in the adult primary care services market and increase St. Luke's bargaining leverage, which would ultimately lead to increased health care costs.

Notwithstanding these important victories and ongoing efforts, even seemingly straightforward challenges of horizontal mergers can prove problematic. In February, for example, the FTC scored a victory in the Supreme Court, winning the right to challenge a merger that combined the only two general acute care hospitals in the six-county area surrounding Albany, Georgia, despite the merging parties' attempt to invoke "state action doctrine" to exempt them from federal antitrust oversight. The case was remanded to the lower court for a trial on the merits. However, the lower-court judge had earlier denied the FTC's request for a preliminary injunction to prevent the hospitals from merging until the case could be tried, and the hospitals combined operations in 2011 and ceded a state license that enabled them to operate two independent facilities. The FTC settled the case in August without having its day in court. If the agency

had prevailed at a trial and obtained a court order to force the merged hospitals to divest a campus, the prospective acquirer would still need to obtain a license from Georgia's Certificate of Need Commission in order to operate it. In a press release announcing the settlement, the FTC acknowledged that such an outcome was unlikely.

Even when mergers have not yet been consummated or the prospects for dissolving a union are rosier, enforcers must devote substantial time and resources to evaluating these individual transactions and — if appropriate — to satisfying the legal standards for challenging them. Economics experts must comb through reams of claims data, using complex statistical methods to assess the extent to which the merging hospitals compete and, where possible, to predict the magnitude of likely price increases. On the other side of the scale, enforcers must weigh the potential benefits that would accrue from the merger (and that cannot otherwise be realized), which may arise from cost reductions, improvements in quality or access to care, or all of the above. Quantifying these benefits is particularly difficult because of the dearth of relevant empirical research and the lack of consensus on what should be measured and what value should be assigned to it.

The complexity of this undertaking highlights a fundamental enforcement reality. If it's this hard for regulators to demonstrate why a patently worrisome acquisition should be blocked, it

is even less likely that they will investigate or attempt to halt mergers for which potential effects are unclear.

Many of the deals taking place today involve health care providers that cover separate geographic or service areas. As others have observed, such deals do not generally raise concerns under conventional antitrust analysis.<sup>4</sup> Although new evidence links multimarket hospital systems to higher prices, more research is needed to confirm this result.<sup>5</sup> In addition, to block mergers, the government must prove that postmerger price increases result from diminished competition between merging parties. Other factors, such as tougher bargaining stances by larger systems, may also play a role. Several economists (including me) are working on models and methods for determining when such combinations could generate “actionable antitrust offenses” even in circumstances in which final consumers do not view the providers as close substitutes for one another. Even if such work were to demonstrate cause for concern, however, it can take years to make scholarship courtroom-ready, and not all legal professionals embrace complex economic models. For these reasons, the government today faces formidable challenges in investigating nonhorizontal combinations, which are a big part of the latest merger wave.

Consolidation will surely continue before we can determine whether it is benign. This reality

would be of limited consequence if it were easy to undo combinations that prove harmful. However, as the Georgia case (and others, such as *FTC v. Evanston Northwestern Healthcare*) illustrate, unwinding deals is exceedingly difficult in practice; in antitrust vernacular, these efforts are labeled “unscrambling the eggs.” Therefore, it would behoove health care analysts and policymakers who are concerned about consolidation to give enforcers more tools for doing their jobs and to develop other avenues for slowing the march toward conglomeration. Such efforts would provide much-needed time for assessing which organizational structures will yield the best return for our health care dollars and under what circumstances.

A full discussion of possible initiatives is beyond the scope of this article, but three ideas are worth mentioning. First, angel investors and venture capitalists could help create innovative health care provider organizations that deliver clinically integrated, evidence-based care at the lowest possible cost without reducing competition. New funders would consider different organizational ideas and bring strategic and operational skills to their ventures, and they might be better positioned than local health care systems or physician groups to accept the associated risks. Second, Medicare could experiment with reimbursement schemes that provide incentives to newly forming accountable care organizations to

pursue organizational structures that do not involve joint ownership of all assets. Joint ventures and contractual relationships would be easier to unwind than mergers, if that proved necessary.

Last, but certainly not least, we could urge private and public insurers to make detailed claims data readily available to public agencies and private researchers, as some insurers have begun to do through the Health Care Cost Institute. These data would enable researchers and enforcers to assess how the latest types of consolidations affect both costs and quality. We will need sunshine to illuminate the path forward.

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