The pace, driving force, and impact of hospital consolidations after ACA

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Keywords: ACA, Public Health, Hospital consolidation

Abstract: The trend of continuing health system consolidation after ACA drives attention of both researchers and policy markers. There are few driving forces such as increasing scales to reduces cost, enhance bargaining power, and the uncertain market or policy environment. However, there is no conclusion about the best responds. Hospital merger as well as acquisition would lead larger sizes, while is neither a necessary nor sufficient condition for the health system to reduce waste and improve overall quality.

1. Introduction

After 2010, the year that Obama signed the Affordable Care Act (ACA), pharmaceutical companies and hospitals participated in an orgy of mergers, especially the hospitals are consolidating into major systems and connecting with care organizations. In general, consolidation refers to two or more companies combine and can be vertical or horizontal, either occurs between companies in different lines or joins two similar companies. The process swept throughout the U.S. health care system at an increasing rate as the planner convinced that consolidation would lead to decreased health care spending by cutting off duplication and thus incentivizing better utilization. Compared with most other consolidation driven by natural market forces, the hospital mergers are driven by government policies instead of consumer-focused reasons. In this case, whether the hospital consolidation would benefit the patients is controversial. It's of great importance to scrutinize future mergers and acquisitions as they have profound influences on the excessively concentrated health marketplace. In the light of the Triple Aim goals of the ACA - enhancing access to care, reducing cost, and strengthening quality- I will evaluate the key reasons as well as the effect behind these consolidations, and how well they move hospitals toward the goals.

Hospital consolidation, if it occurs properly in a competitive area, can be overall positive. Like many other markets, the health care market benefits from competition. A study found there is a continuation of the increasing number of acquisitions, and the author claimed that the total hospital combinations increased 3 percent in 2013, to 98 deals. Moreover, the number of hospitals involved in deals in 2013 hit a 5-year high with a 22 percent decline in the number of transactions[1]. With approximately 77 percent of Americans live in highly concentrated hospital markets, both profit and nonprofit hospitals showed the trends to have highly localized competition[1]. In other words, increasing consolidation leads to the elimination of competition in a concentrated market, however, it would be easier for providers to pass higher prices to the patients. To solve this problem, a further active health care merger enforcement agenda is needed to provided by the U.S. antitrust agencies. Some evidence showed specific transactions had anti-competitive consequences but that is not represented as a general trend; concentration in geographic dimension is also needed to be consistent with antitrust standards for a concise analysis.

1.1 Driving Forces

For every consolidation, it possesses unique reasons or missions. With the architect thought of forming a streamlined system and improving the quality of medical service with lower prices, Obama signed the most radical restructuring and lead to widespread consolidation. One of the prior objectives of the ACA is to bend the curve of the oversized health care spending, while the hospital

  DOI: 10.25236/icemeet.2020.006

comprises about one-third of the budget[2]. Focusing on the single biggest line item in the national medical bill, the ACA exacerbated further policies and regulations to encourage the hospital consolidations. As a result, hospitals overall would have more market power with achieving economies of scale, which implies the decline in average costs as volume increased. It may also imply that the hospital's exact motives for consolidation may not line up with society's best needs. The price of health care is highly related to the providers' market power. For the hospitals, the most important motivation is to increase negotiating power in insurer-provider contracting. After consolidation, the hospitals have a larger scale and fewer competitors; they rushed to gain more leverage power over price negotiations, especially in the private market which covers roughly 55 percent of all insured people[3]. In this case, the hospitals as a provider are dominant to set prices according to what they demand instead of putting the quality or underlying medical cost as their first concerns.

The last key factor behind consolidation is that the ACA unleashed an uncertain environment in the health care system. The uncertainty continues after 10 years of the ACA's passage, strengthening the consolidations even more; there was a reconfiguration in the existing health market, shifting from the original dominant fee-for-service reimbursement models to the "experimental" bundled payment[4]. Under these conditions, the health care system could, to some extent, improve rewards and penalty for quality, create a fair capitation-friendly payment method, and include a new group of patients. Nevertheless, the new environment still needs private payers to develop innovative models with a balance of cost and quality to adapt, aiming for intensive and consistent medical care for the new populations. What's more, there is another political uncertainty as the Trump Administration questioned many following actions caused by the massive investments, however, the administration didn't provide clear alternatives. In other words, these uncertain conditions made the consolidation movement for a larger scale more compelling.

1.2 Integration and Consolidation

Advocating hospital consolidation does not imply a definite, greater integration of care. It is noticeable that consolidation does not simply equal to integration, which is the real objective of the government behind ACA. Consolidation simply refers to bringing the previously entities together, while integration implies furthermore, including reducing duplication and comprehensively managing the new entity. In this case, clinical integration requires data collecting as well as sharing, effective system performing, and streamlined care transitions. There is still much room for hospitals to have further development on health information exchanges to serve better. In the past, large clinics were less motivated to join as they already had a large proportion of market share and competent patient information. In this case, the hospital merger would form a novel system for data share and improve care.

2. Pace of Hospital consolidation

The ACA had promptly increased hospital consolidation since 2010, and the pace quickened during these 10 years. Some of the market concentration indices, such as the Herfindahl-Hirschman Index (HHI), are developed to measure firm concentration ratio. More explicitly, the HHI is the sum of the squared per firm in the market. A recent study done by Fulton measured hospital concentration from 2010 to 2016, showing an annual 48-points increase of the average mean HHI[1]. There is an overall increasing trend since 2010. There are profound reasons behind the data of consolidation pace. Regardless better or worse, the ACA had unleashed those driving forces and became a foothold for the management of the novel business environments. Monitoring the pace of hospital consolidation is of great importance as the scale is closely relative to essentiality, a key determinant to weigh the success of the business. Essentiality refers to a characteristic composed of many factors such as brand, market position, service, mission, cost structure[4]. Consolidation is not a guarantor of essentiality, but it can help by merging into larger organizations with spreader geographic areas which relate to the factors above. Thus, the pace of consolidation reflects how the hospitals rule the market by obtaining essentiality, and further exert leverage with payers.

How competitive is the health care services before and how much of the impact on competition is likely to have are the core questions to merger reviews from the antitrust perspective? As mentioned in the above paragraphs, the U.S. antitrust authorities use the HHI as an indicator for market concentration; greater than 2,500 is considered highly concentrated, between 1,500 and 2,500 is considered moderately concentrated, and below 1,500 is considered unconcentrated[5]. The HHI is a useful indicator, yet it does not provide a direct answer to how the proposed merger would impact the prices in the market. Rather, together with other factors, such as pre-merger market shares, the HHI draws attention to the competition risks raised by high concentration among suppliers. Based on the data provided by the Centers for Medicare & Medicaid Services(CMS), the average HHI is 2000 was 2,054, increasing to 2,676 by 2017. There is a clear shift from moderately concentrated to highly concentrated. Thus, a more competitive health market had born. Competition can have a positive effect on improving quality if both the government and private payers can commit to reform payment. In competitive markets, hospitals theoretically tend to have better management by reducing substantial costs[6]. However, the presence of better management is hard to translate to better care partially because of the fee-for-service environment, focusing mostly on volume. As a potentially better option, a pay-for-performance can create a balanced market with good health care quality.

3. Impact of Hospital consolidation

Whether there is an association between hospitals' market concentration and costs is the next step to explore the consolidation impacts. There is a study of 90,995 patients nationwide from 2003 to 2011 to analysis the cost of complex surgeries and how it relates to market concentration. They found the cost of pancreatic resections was 5.5% higher in unconcentrated hospital areas than in the moderately concentrated market and 8.3% lower in highly concentrated markets. For hepatic resections, the highly concentrated markets had 8.4% lower cost and 10.5% lower charge than those in unconcentrated markets[7]. In a nutshell, highly concentrated hospital markets imply the best value proposition, that is, better quality and lower cost for complex surgery such as hepatopancreatic surgery[8]. However, difficult surgical interventions just represent a small proportion of hospital services; there is a need to take a closer look at the general cost changes after consolidation.

It is not definite that merging and specializing clinical hospitals can improve overall outcomes by increasing scales and volumes. More explicitly, the consolidation has not led to either improved quality or eliminated price because it is for the primary purpose of enhancing bargaining rather instead of true integration. On one side, it does not improve quality. Undeniably there were some cases that high- volume hospitals have better outcomes base on their delivery of health care, especially the technically difficult surgical interventions, such as esophagectomy and pancreatectomy[6]. However, for most other cases, bigger is not always better. As the majority of hospitals had certain scales above the threshold, it is unlikely to have significant improvement by increasing volume. The volume may be the proxy of other factors such as regional differences and manage complications. Relying on increasing scales could be confusing cause and effect. In this case, the market share could be a better indicator to examine the high quality. Whereas, the promotion in consolidation does not mean a direct increase in market share at the same time. There were some argument about larger hospital systems means more investment in improving system and quality. Nonetheless, quality does not mainly depend on expensive and unnecessary technologies; rather, the hospitals ought to focus on prior parts or remove quality improvement interventions, including a commitment to data collection, monitoring, and evaluation[6]. Tsai and Jha's assertion also supports this point: there is little evidence to prove consolidation can improve quality become quality improvement comes not from size but leadership[9]. In many cases, small institutions can provide inexpensive but high-quality improvements.

On the other side, it fails to eliminate the price to benefit patients. After the scholars did a thorough research study, they found in general, hospital consolidation leads to a higher price, more explicitly, exceeding 20% in very concentrated markets[9]. Some arguments claim the health-care

system delivery becomes more efficient, more people are covered, and hospital mergers further promotes these positive trends. Nonetheless, the Massachusetts Health Policy Commission found that the proposed acquisition of hospitals would increase spending as a result[9]. As a result, patients wind up paying more, rarely benefit from the lower insurance premiums of out-of-pocket expenses after hospital mergers. The reasons behind the increasing price could be relatively complex. One common explanation given in the above paragraph is one of the driving forces-enhancing leverage power over price negotiations after consolidation. The dominant hospitals could greatly affect the market prices, considering reducing their costs and maintaining financial stability. And the merged dominant hospitals usually have a well-known brand, for instance, Yale New Haven Health after merger defends a higher rate to charge private insurers as the headquartered in the United States; patients may pay more for the brand instead of health care services[10]. These conditions finally left health insurers no alternative option but to accept higher fees. Another perspective could also help to explain. In 2017, Deloitte's Center for Health Solutions, together with Healthcare Financial Management Association(HFMA), analyze how hospital mergers and acquisitions impact the service as well as transaction outcomes. They found that hospital margins had overall improvement during the analysis period, and the clinics "experienced a post-transaction decline in operating margins, revenue, and expenses that typically lasted two years"[7]. The investment, mostly used by hospitals to update the clinical information system, is the core factor to influence hospitals' financial performance during the post-transaction period. As required to achieve a better quality of care, hospitals would choose to improve their health information technology as well as equipment, and physician recruitment. These investment offsets cost reduction achieved by consolidations. By increasing the health services, those hospitals are indeed shifting the risks from themselves to the insurers.

4. Conclusion

The ACA undeniably spurs the process and pace of hospital consolidation, with a few driving forces such as increasing scales to reduces cost, enhance bargaining power, and the uncertain market or policy environment. As a result, the competitiveness, as well as the market concentration in original areas increase, while the insurers are not benefiting from a lower price or better quality. These influences have put greater emphasis on coordinated care for better patient outcomes, and what already happened is hard to undo. After all, there are still many remaining questions: It is unclear to define what exactly the "high quality" health care is. Whether it is necessary to pursue "high quality" with increasing costs while no one could afford? To what extent does the government need to balance the quality and cost? If consolidation or mergers are not the best strategies, will the alliance be a better option? The hospitals are at the special position to balance market neutral and the government's objectives; adding value and avoiding antitrust challenges are hard to achieve at the same time, a better management strategy is needed to prioritize care quality and reduce cost for the insurers.

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