

# Surviving merger mania

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Medical Economics Volume 95 Issue 23  
November 28, 2018

When doctors talk about the biggest challenges facing the profession, they generally focus on topics such as burnout, the shortcomings of EHRs, and the transition to value-based care.

Often overlooked, however, is the rapid consolidation taking place throughout the healthcare industry, a trend with profound implications for the availability and affordability of medical care.

Whether it's hospitals buying up independent medical practices, hospital systems swallowing one another, or insurance companies merging with pharmacy chains, the prevailing attitude now is that bigger is better.

Among providers, that sentiment results in part from the uncertainty created by shifting payment models and competition from new entrants in the industry, says Anthony LoSasso, PhD, professor in health policy and administration at the University of Illinois-Chicago and executive director of the American Society of Health Economists.

"The feeling is that size will protect them [hospitals and doctors] in the face of new initiatives, be they market-driven or government-instituted policies," LoSasso says. "Essentially, they're trying to buy a seat at the table."

## Quickening pace

While consolidation hasn't received as much attention as, say, the price of prescription drugs, it's far from a new phenomenon.

A 2014 study for the National Bureau of Economic Research, for example, noted that more than 1,000 hospital mergers had taken place since 1994. In 2015 Congressional testimony Leemore S. Dafny, PhD, now a professor of business administration at the Harvard Business School, showed that in 2006 the four largest commercial insurers already controlled 74 percent of the healthcare insurance market. (By 2014 it was 83 percent.)

That said, the pace of consolidation has increased dramatically in the last few years. Consider that in 2018 alone:

- Texas-based hospital systems Baylor Scott & White Health and Memorial Hermann Health announced plans to merge, creating a 68-hospital system with annual revenue of more than \$14 billion.

- Philadelphia-based Jefferson University said it would acquire Einstein Healthcare Network, creating an 18-hospital system in and around Philadelphia.
- Cincinnati-based Mercy Health completed an \$8 billion merger with Maryland-based Bon Secours Health System to form the nation's fifth-largest Catholic health system, with 43 hospitals and more than 2,100 physicians.
- Summa Health, headquartered in Akron, Ohio, revealed it was seeking to merge or partner with another healthcare system
- Drugstore chain CVS received government approval to buy Aetna, the country's third-largest health insurance company, for \$69 billion.
- Health insurance giant Cigna and pharmacy benefit manager Express Scripts received the government's OK for their \$52-billion merger.

All this activity follows a year that saw 967 merger and acquisition deals among healthcare payers and providers, according to the PwC Health Research Institute.

### **Drivers of consolidation**

Experts cite a variety of motivations for the accelerating pace of mergers and acquisitions among healthcare providers, most of which involve the drive to grow revenue and profits.

That leads hospital systems, for example, to acquire primary care practices to increase the size of their patient base, ensure that patients are referred to specialists within their system, and take advantage of lucrative facility fees—the charges tacked on to services and procedures performed at a medical practice when it becomes part of a hospital system.

“The idea is, ‘let’s capture as much of the patient dollar and as much of the patient services as we can, and let’s keep it under one organizational umbrella,’” explains Timothy Hoff, PhD, professor of healthcare systems and healthcare policy in the D’Amore-McKim School of Business at Northeastern University in Boston.

The movement toward value-based reimbursements is another catalyst for hospitals to buy independent primary care practices, Hoff says, in that it causes hospitals to broaden their focus beyond inpatient care and expensive surgical procedures.

“Essentially they [hospitals] are looking to reinvent themselves, and that involves placing more emphasis on services like primary care and population health,” Hoff says. That process, in turn, spurs hospital systems to acquire primary care practices and even establish new primary care “access points,” such as urgent care centers.

The result, Hoff says, is that even under value-based payment models, “consolidation will keep moving along because there are rewards for getting ahold of a patient population and providing them with a range of services, from prevention to primary care to acute care. And big hospital systems think that with more primary care access points they can be one-stop shops for all those kinds or services.”

Bringing more patients under a single corporate umbrella also gives hospital systems more leverage when negotiating with insurance companies, notes J.B. Silvers, PhD, professor of healthcare finance at Case Western Reserve University's Weatherhead School of Management in Cleveland.

A payer can refuse to include an individual hospital in its network unless the hospital agrees to substantially discount its fees. "You had a pushback sentiment that said, 'the reason you're able to get away with that is I'm sitting out here by myself. But if I become part of a larger entity, then it shifts market power from the payer back to the provider,'" Silvers explains.

The providers' growth, in turn, motivates payers to get bigger so as to recapture some of their negotiating leverage, and to join forces with pharmacies and pharmacy benefit managers to try and bring prescription drug costs—a large and rapidly-growing expense—under control. Meanwhile, independent practices—faced with the expense of EHRs and the staffing and data requirements of value-based care—often find they have little choice but to become part of a hospital system or merge with other practices.

A study commissioned by the Physicians Advocacy Institute released earlier this year found that hospitals acquired 5,000 independent practices between July of 2015 and 2016, and that 42 percent of the nation's doctors were hospital-employed by July 2016. In 2012 it was 25 percent.

### **The impact on patients**

What's good for the bottom line of healthcare providers, however, may not always be good for their patients.

"Consolidation [among hospital systems] is always pitched as a positive thing, that it will lead to lower costs and more investment in the things that bring higher quality care," says Hoff. "But when you look at the research, the opposite of those things can often occur. In highly consolidated markets, patient choice of providers and services is often reduced, and quality can improve but in some cases has been shown either to stay the same or even go down."

Hoff notes that another effect of consolidation among hospitals is to limit patient choice. He cites the Boston region, which is dominated by the Beth Israel Deaconess and Partners HealthCare systems. "If you don't want to go to one of these systems to get care, the options become very limited," he says.

And while growth sometimes enables hospital systems to reduce their operating costs through economies of scale, those reductions don't always result in lower prices for insurance companies or patients, Hoff says.

The same dynamic occurs among insurance companies, according to Eric Schneider, MD, FACP, senior vice president for policy and research at The Commonwealth Fund, a healthcare policy research foundation.

Although their growth often enables them to negotiate price discounts with providers, “there’s very little evidence that they are passing those savings along to consumers in the form of lower premiums or copays,” he says.

Along with higher costs, an additional—and often overlooked—impact of consolidation among providers is the transportation problems it causes patients, says Caitlin Donovan, a spokeswoman for the Patient Advocacy Foundation.

“If your doctor’s office closes you have to find a new site of care, and especially for people in rural areas or the elderly, it can be a really big problem, especially if there’s no public transportation,” Donovan says.

### **The impact on doctors**

But if consolidation, broadly speaking, is not benefiting patients, its impact on doctors appears to be more mixed, and often determined by individual circumstances.

For Howard Mandel, MD, an independent ob/gyn physician practicing in Los Angeles, it has meant a nearly two-thirds decline in annual income since the mid-1990s. That’s largely because most of the independent primary care doctors who used to be his main source of referrals have joined Cedars Sinai Medical Center, a regional hospital system, and refer their patients to Cedars Sinai-affiliated specialists.

Mandel notes that although the Stark Law forbids hospital systems from requiring their doctors to refer patients to others in the system, they can offer other incentives, such as tying financial bonuses to how much revenue the doctor generates for the system, including through referrals to specialists.

Sometimes the penalties for not being part of a hospital system can take subtler forms, such as getting less desirable surgery times or having surgery privileges linked to the number of procedures the doctor performs.

“If you work for a hospital system, that’s really easy because they’re constantly feeding you patients,” Mandel says. “I’m someone who wants to only operate when necessary, so what do I do now? Either I change my practice style and start doing surgeries more liberally, or I lose my privileges for doing certain types of surgeries.”

In contrast, Fred Nichols, DO, is expecting a substantial bump in income as a result of consolidation. He is affiliating his Hamburg, New Jersey-based ob/gyn practice with Atlantic Health Partners (AHP), a network of specialty practices operated by Atlantic Health System, which owns six hospitals in the northwest corner of the state.

Nichols will continue to run the practice, but bill at the higher reimbursement rates AHP has been able to negotiate with payers because of its size. Had he been part of AHP for 2018, he would have been reimbursed an additional \$265,000. “Obviously I can’t ignore that type of difference,” he says.

In addition, AHP will take over the practice's billings and collections and provide IT support, for which Nichols will pay an amount equal to 12 percent of his collections, compared to the 16 percent he now pays for those services.

A further benefit comes from implementing Atlantic Health System's EHR. "If I send a referral to one of their affiliated physicians, I can look up their consult, look up the results, really get that seamlessness of information they [EHR manufacturers] talk about. I see that as a plus," he says.

As to whether being part of AHP will limit the choice of nearby doctors to whom he can refer patients, Nichols says, "In theory that's true, but in practice Atlantic Health's penetration in this area is around 90 percent, so most of the doctors I'm referring to are already part of the system." Moreover, the nearest hospital not part of Atlantic is 40 miles away. "That distance is prohibitive for most people around here," he says.

### **The limits of consolidation**

Are there limits to how far consolidation in healthcare can go?

One possibility is the federal government stepping in to block mergers or acquisitions on anti-trust grounds.

"I think the main countervailing trend is just regulatory oversight," says Christopher Whaley, PhD, an associate policy researcher at the RAND Corporation. "We see the Federal Trade Commission taking a bit more active role in thinking about hospital and physician mergers and the Department of Justice has been pretty active in looking at insurance mergers."

Regarding the latter, Whaley cites the Justice Department's role in blocking the proposed mergers between insurance giants Aetna and Humana and Cigna and Anthem.

Over the long term, however, a more powerful constraint—among hospital systems, at least—may be the unwieldiness and diminished efficiency that often results from getting too large.

"Just because you're big doesn't mean you'll figure out how to do things in a way that will keep you successful," says Hoff. "Over time, it gets really difficult to manage a multi-layered organization. And in some ways it's even worse with a hospital system because they are highly siloed organizations and you can only integrate so much across the different care delivery streams."

In addition, Hoff says, large consolidated hospital systems could face pushback from patients who don't want care from what they perceive as a faceless, bureaucratic institution.

Instead, he says, "I think we're going to see some pullback to a model that's not as big, where patients get more of a personal touch and are able to interact more humanely with their providers."

## **Why one hospital system is seeking a partner**

In early 2018 Summa Health, based in Akron, Ohio, announced it would begin looking for another health system for a partnership or merger. With four hospitals, 10 health centers, and about 7,000 employees spread over two counties, Summa has faced mounting financial challenges in recent years, culminating in a \$28 million operating loss in 2017 and an announced plan to eliminate 300 jobs.

In its announcement, Summa acknowledged that changes in the healthcare industry “have put pressure on hospitals and healthcare systems to expand access to care while minimizing costs,” and that Summa would need a partner to achieve those objectives.

Summa’s experience is a useful lens through which to view the financial and economic forces behind hospital consolidation. Summa President and CEO Cliff Deveny, MD, explains that a major catalyst for its decision to seek out a merger or affiliation partner is the reimbursement cuts it is facing from government payers: a half percent from Medicare, and five percent from Medicaid.

The latter program, he adds, covers 22 percent of the system’s patient population. Reimbursements from commercial payers and private employers are expected to be no better than flat.

“Meanwhile, we know we have expenses that will continue to go up, whether it’s pharmaceuticals or medical supplies or making sure our people get appropriate salary increases,” he says. Summa has responded by cutting expenses over the last five years or so, while adding or expanding some clinical services.

As a result of these efforts, Deveny says, the system expects to end 2018 in the black. “Now we’re at a point of strength and we want to see if there’s an opportunity to kind of super-charge our success and bring certain services and more access points and all kinds of other things we need to invest in,” he says.

At the same time, Summa faces growing competition for patients and revenue. In 2015 the Cleveland Clinic, one of the nation’s largest healthcare systems, purchased nearby Akron General Hospital. More recently Portage Medical Center, another Akron-area hospital, was acquired by University Hospitals Health System, which is based in the same neighboring county as the Cleveland Clinic.

“We had essentially been the tertiary health system for Portage, but since University took it over, we’ve seen a 70 percent reduction in transfers from them. Now they’re all being sent to Cleveland,” Deveny says.

Meanwhile commercial payers, faced with resistance to spiraling health insurance premiums, are growing increasingly hard-nosed in their contract negotiations with providers, including Summa.

So another benefit of merging or partnering, Deveny says, is enhanced ability to attain what he terms “appropriate reimbursement” from insurance companies and self-insured employers.

Responding to concerns that Summa’s decision could lead to facilities being closed and/or patients having fewer choices among providers, Deveny predicts that, if anything, the opposite will occur.

“In fact, what we want to do is expand and grow. We feel like there’s a significant amount of demand for our services, especially in the ambulatory area,” he says, citing services such as such as women’s healthcare, behavioral health and treating opioid addiction.

“Those things aren’t sexy, or as profitable as some other services, but we want to make sure we continue focusing on services that are important to our charter as a community hospital,” he says.

Asked what lessons Summa’s experience might hold for other health systems, Deveny says, “You’ve got to embrace change, and know that you’ve got to continue to find avenues to grow.”