Competition in Health Care Markets: What Antitrust Enforcers Do (and Don't Do)

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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 what is the role of antitrust enforcers?

The Facts

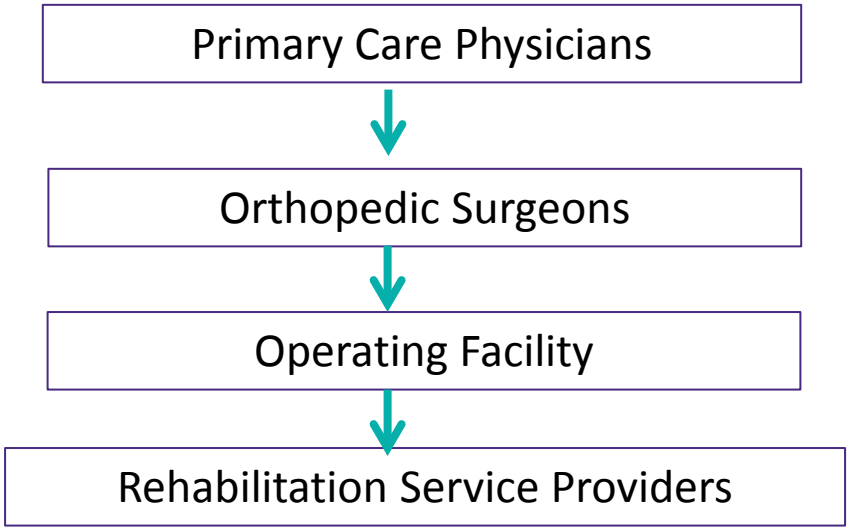
“Get your facts first, then you can distort them as you please.”

--**Mark Twain**

Definitions

- Vertical chain of production is source of integration labels

Vertical Chain of Production for Orthopedic Surgery

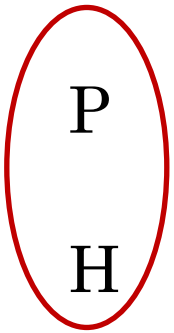


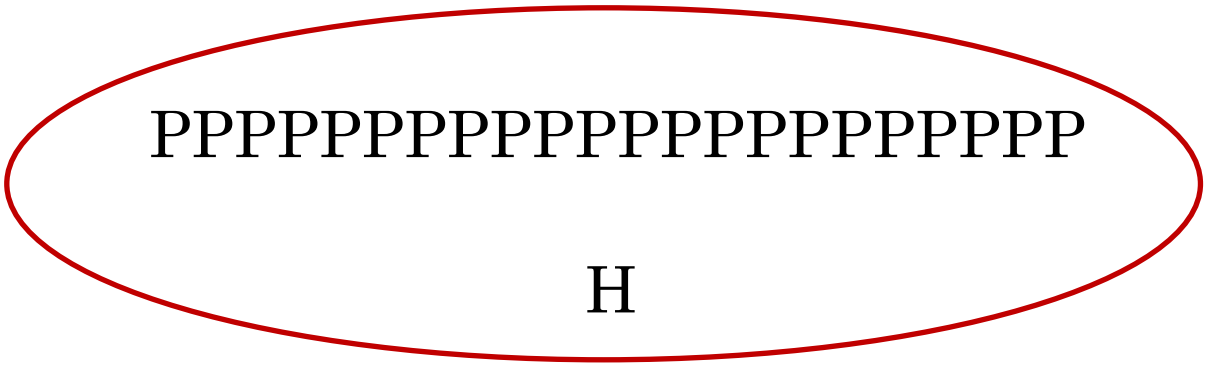
Definitions, *continued*

- **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





Motives for Horizontal Integration

Example: shift from solo to group physician practice

- Reducing cost/improving quality
  - Economies of scale in production (including specialization)
  - Economies of scale in purchasing
- Raising price
  - Product variety or improvements facilitated by scale can enable higher prices (value-creating)
  - Swallowing the competition can strengthen bargaining power (value-transferring)

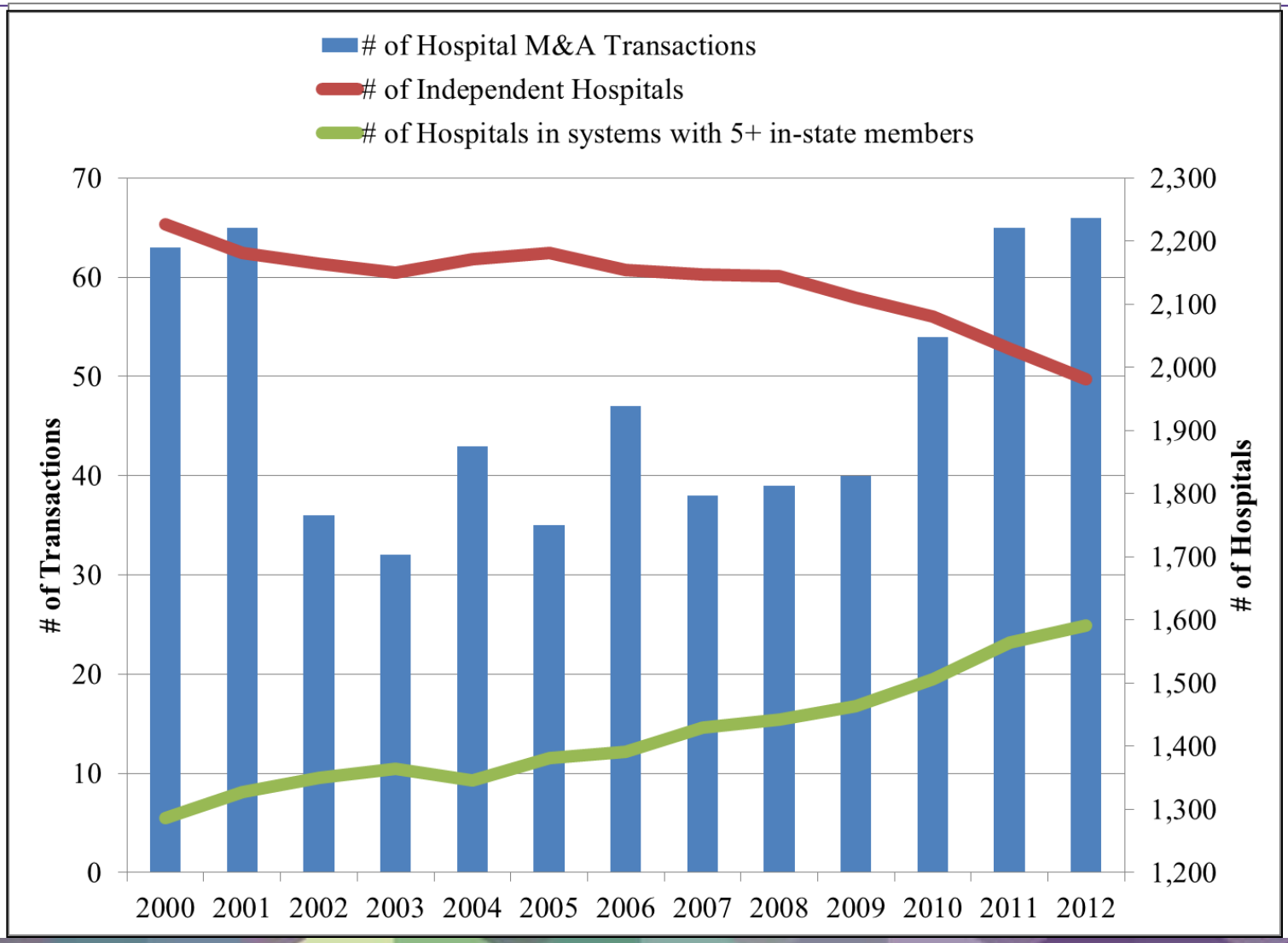
Motives for Vertical Integration

Example: pharma R&D and marketing/sales functions

- The obvious: product improvements and cost reductions from aligned incentives, improved communication; prevent leakage of proprietary info
- The less-obvious: encourages optimal level of specific investments by all parties
- Requires some thought: internalize price or quality externalities
- *Healthcare-specific: sometimes vertical integration can enable higher markups due to reimbursement loopholes*

Motives for Vertical Integration

Hospital mergers are on the rise again



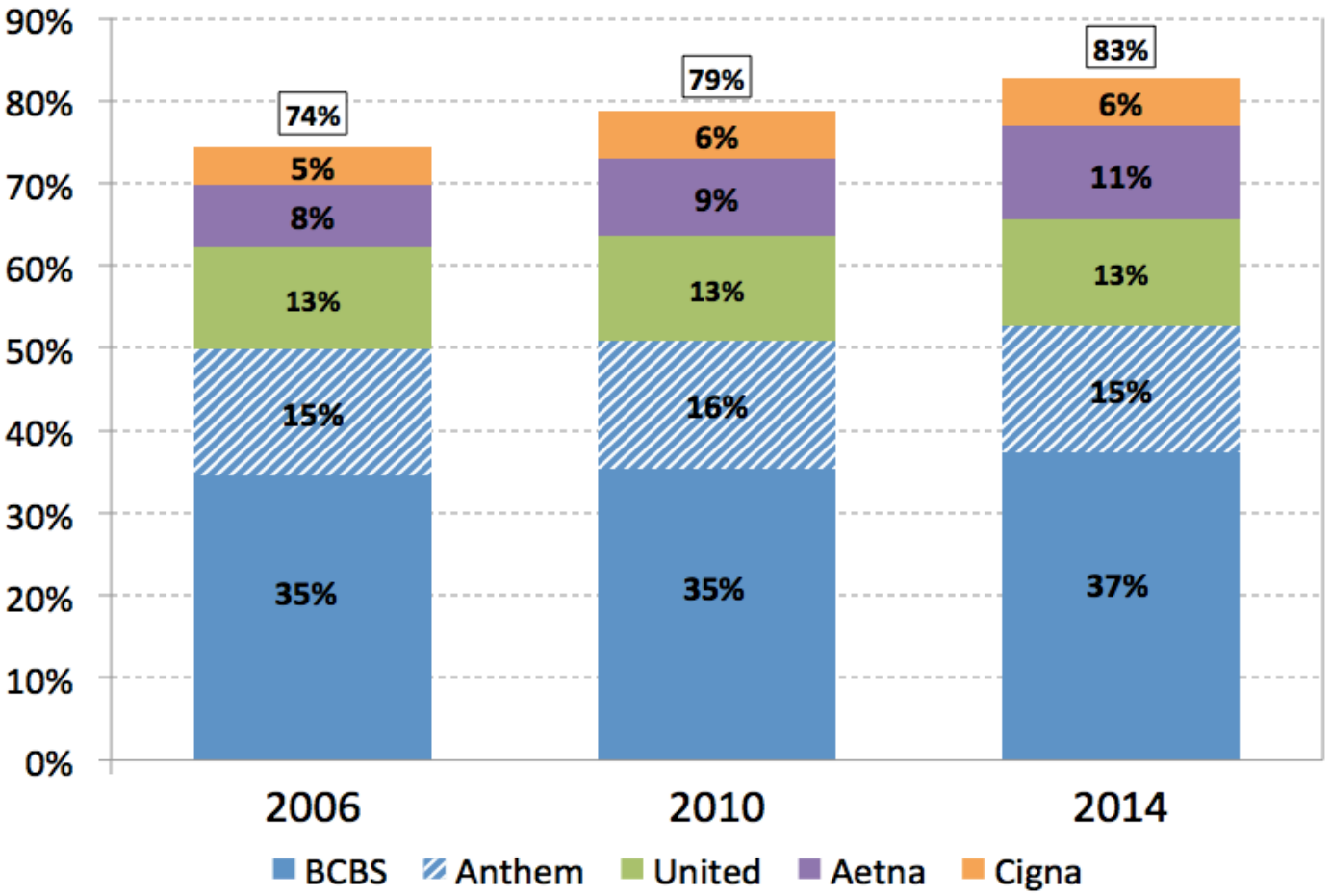
Local insurance markets have become more concentrated, too

- Commercial insurance: median HHI within MSAs for increased from 1,716 in 2001 to 2,973 in 2012
  - More than half of metro areas have an insurer with 50+ percent commercial market share
- Medicare Advantage within-county HHI has increased since 2009
- Insurance exchanges may shake things up
  - Impact of new entrants still TBD

Sources: Author's calculations, American Medical Association

Insurance industry is also consolidating nationally

Top 4 insurers



Source: NAIC, CCIIO, and company annual reports. BCBS figures may include non-comprehensive medical insurance

Vertical integration trends

- Hospital-physician acquisitions and ownership interests
- 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's 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 2014)
  - Insurance mergers lead to higher premiums even though providers may be paid less (Dafny, Duggan and Ramanarayanan 2012; Trish and Herring 2014)

So what? Bigger could be better, *continued*

- Discouraging early evidence for non-horizontal integration
  - Independent hospitals acquired by systems outside their market raise price 14-18% (Lewis and Pflum 2014)
  - Hospitals gaining a system member in the same state (but not same geo market) raise price 6-9 percent (Dafny, Ho and Lee 2015)
  - Price and total spending increases in areas with increases in physician-hospital financial integration (Bundorf et al 2014).

Antitrust Enforcement in Healthcare: Facts *and* Myths

Why Should I Care About This?

- A number of horizontal healthcare mergers have drawn antitrust scrutiny in recent years
  - Valuable to know when a combination could raise a competition concern
- Anticompetitive conduct reduces social welfare
- Knowledge is power
  - Lawsuits are expensive and distracting, and could result in fines (and in extreme cases, criminal convictions)
  - If you know what's anticompetitive you can complain about it or call out rivals
  - You may be asked or required to submit information in your capacity as a customer or vendor
  - You could benefit as a bystander

Antitrust Basics

- Agencies: Antitrust Division of Dept of Justice ("DOJ"); Federal Trade Commission ("FTC"); state attorneys general
- Main Statutes:
  - **Section 1** of the Sherman Act: no agreements in restraint of trade
  - **Section 2** of the Sherman Act: no predatory or exclusionary conduct to obtain or maintain a monopoly
  - **Section 7** of the Clayton Act: no acquisitions "[where] the effect of such acquisition may be substantially to lessen competition"
- Merger-related investigations: some reviews are mandatory, others optional
- Outcomes: no complaint filed; complaint filed and settlement agreed upon; complaint filed and litigation ensues

Brief Overview of Enforcement Related to Horizontal Integration in Healthcare

- Insurance mergers (DOJ), steady level of activity
  - Most are approved, with occasional divestiture requirements (e.g. United-Sierra, Aetna-Prudential)
- Physician affiliations and mergers – both agencies
  - Frequent, successful challenges to coordinated negotiation, and to large single-specialty combinations
- Hospital mergers (FTC and DOJ), very active 80s-90s
  - Early challenges successful, then 6 consecutive FTC/DOJ losses in 1994-2000 and a moratorium
  - Efforts resurrected after “Hospital Merger Retrospectives Project” and FTC has scored several recent victories
    - E.g., ProMedica-St. Luke’s in Ohio, OSF-Rockford in Illinois, Inova-Prince William in Virginia
- Judges and even the public have a say, too!

Partners HealthCare Acquisitions in Boston area Squashed by Judge

- Background
  - Partners Healthcare
    - 10 hospitals, ~6,000 physicians, ~60,000 employees
    - ~$11 billion annual revenue
  - South Shore Hospital
    - 378 beds
  - Hallmark Health System
    - 234 beds and 134 beds
- Massachusetts Health Policy Commission executed its first “Cost and Market Impact Report”
  - Agency created in 2012, with a mission “to advance a more transparent, accountable, and innovative health care system through independent policy leadership and programs.”

COMMONWEALTH OF MASSACHUSETTS

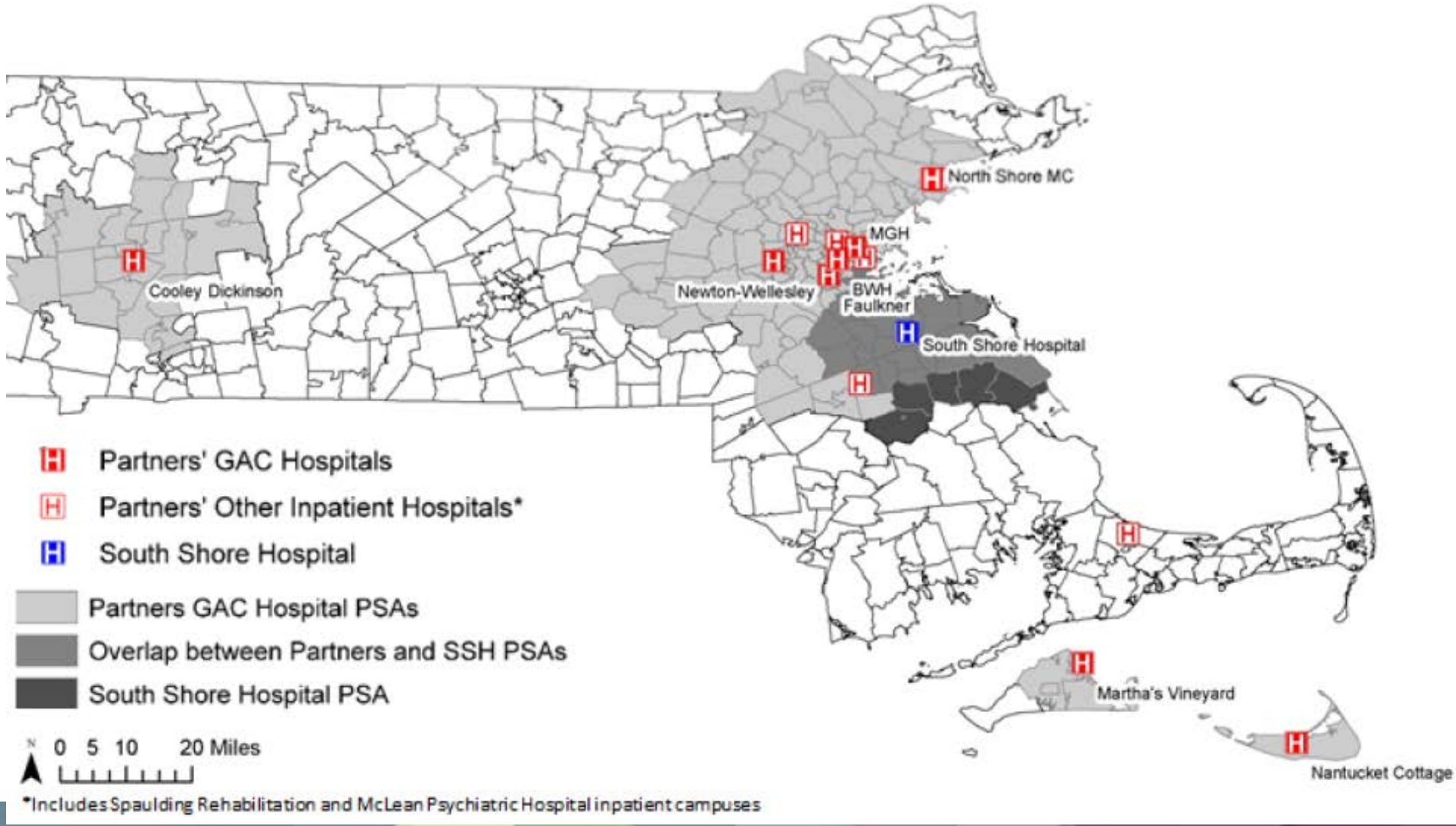
HEALTH POLICY COMMISSION

REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2)

FINAL REPORT

FEBRUARY 19, 2014

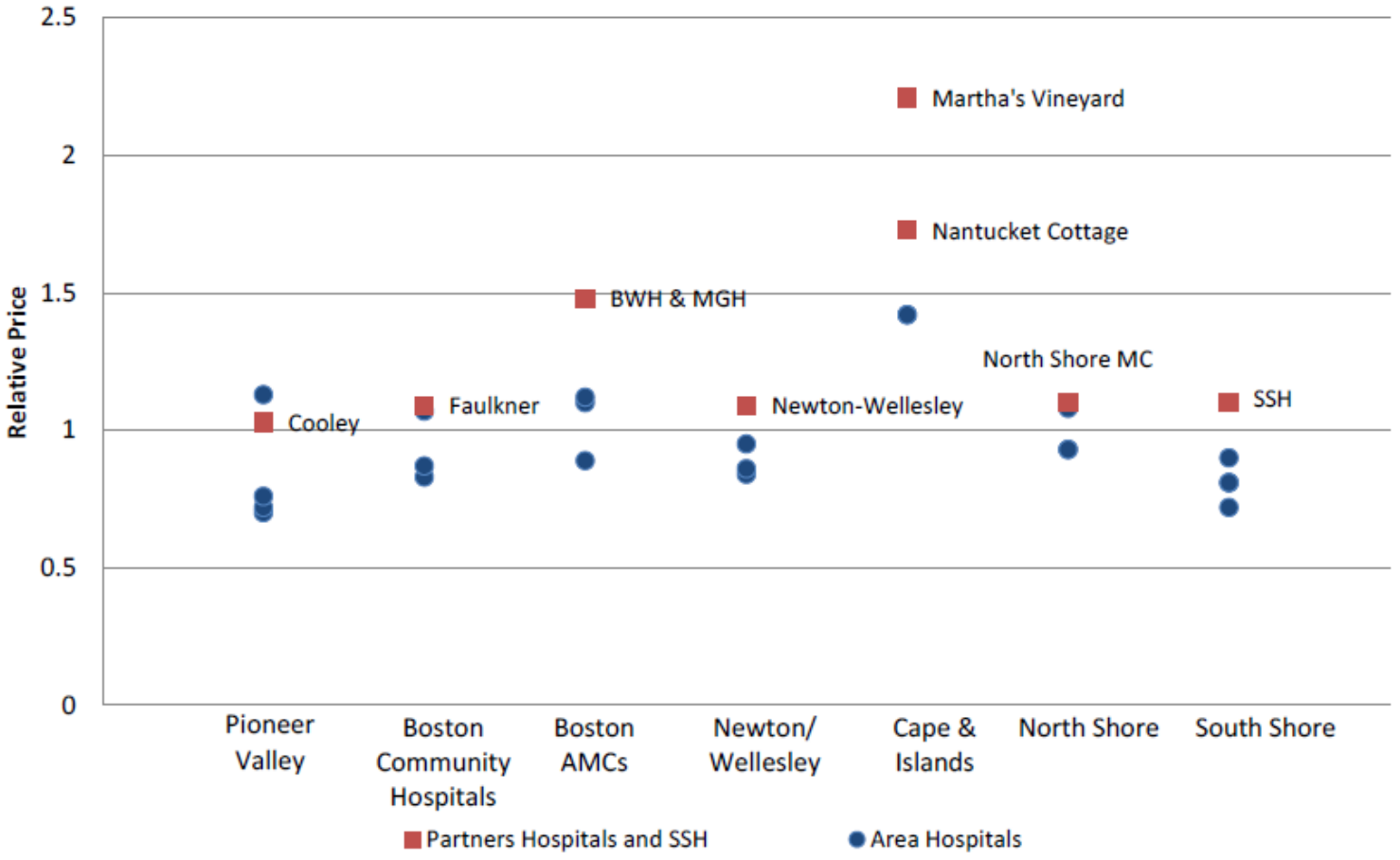
Primary Service Areas (PSAs) of Partners' Hospitals and South Shore Hospital



Market Shares in South Shore Hospital's Primary Service Area

Hospital System	Number of Commercial Discharges	Share of Commercial Discharges	Share of Non-Tertiary Commercial Discharges	Share of Tertiary Commercial Discharges
South Shore Hospital	**7,927**	**26%**	**26%**	**16%**
Partners	**7,586**	**24%**	**24%**	**35%**
Beth Israel Deaconess	4,155	13%	13%	15%
Steward	3,988	13%	13%	9%
Signature Healthcare	2,091	7%	7%	3%
Other	5,225	17%	16%	23%

Prices for South Shore and Partners are Higher than Other Area Hospitals (BCBS 2012)



Area hospitals: Pioneer Valley (Baystate MC, Holyoke, Mercy MC, Noble); **Boston Community** (Carney, Norwood, St. Elizabeth's MC); **Boston AMCs** (BIDMC, BMC, Tufts MC); **Newton/Wellesley** (BID-Needham, Metrowest MC, Mt. Auburn); **Cape & Islands** (Cape Cod, Falmouth); **North Shore** (Addison-Gilbert, Beverly, Lahey, Lawrence Memorial, Melrose-Wakefield); **South Shore** (BID-Milton, Good Samaritan MC, Quincy, Signature Brockton)

Source: CHIA *2012 Relative Prices, APM, and TME by Payer Databook*, *supra* note 40.

Attorney General and Partners Agreed on a Complicated Settlement

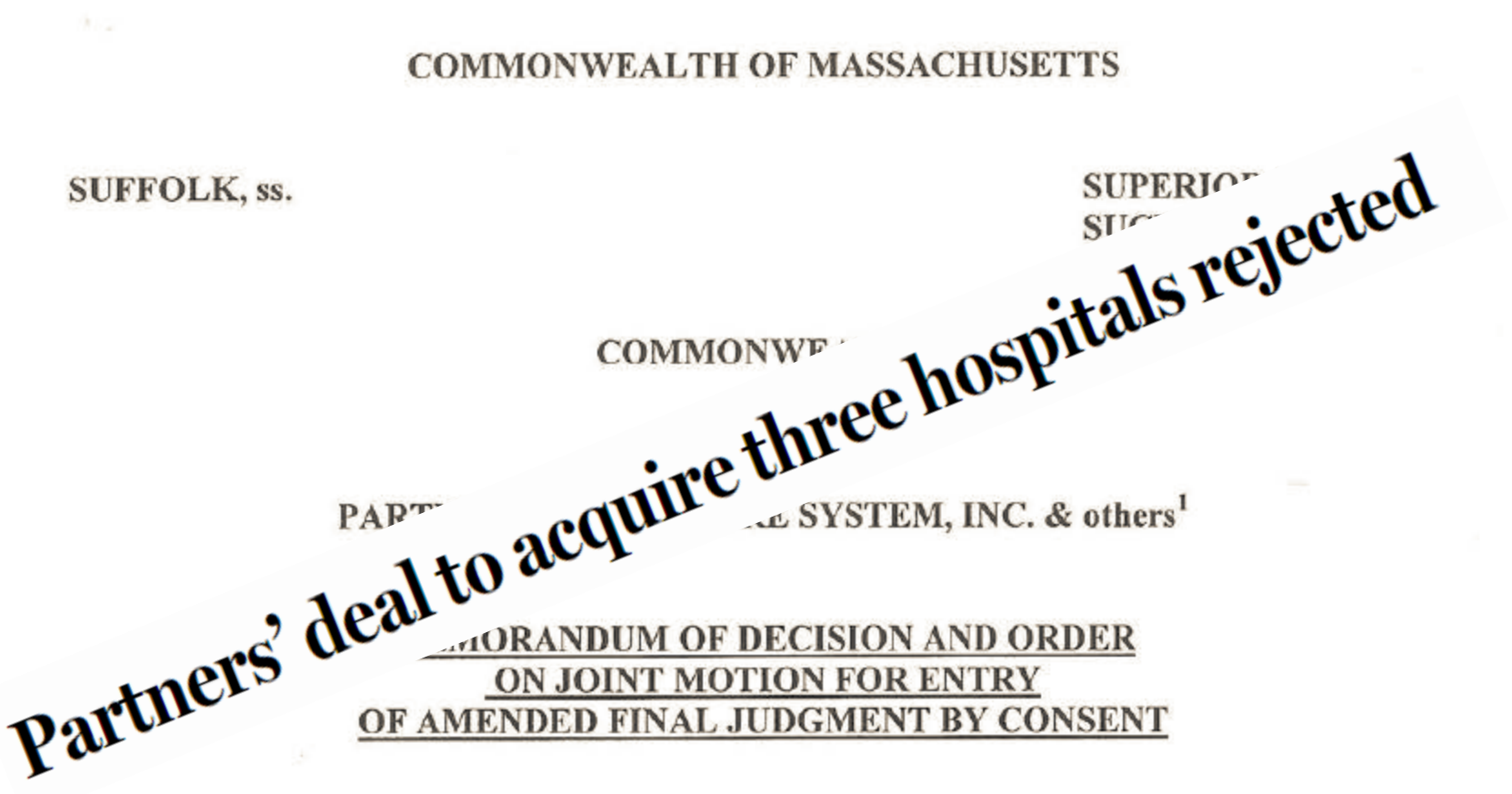
- Component contracting (7-10 years)
  - Components are: SSH, Hallmark, Community Hospitals and Physicians, Academic Medical Centers
- Price growth cannot exceed inflation (6.5 years)
- Total medical expenditure growth cap (6.5 years) for certain patients
- Physician and hospital growth restrictions (5-7 years)
- Independent monitor (10 years)

Judge asked for public comments

Experts call on judge to block Partners' hospital takeovers

"We do not believe that the proposed restrictions on Partners' conduct included in the [settlement] will offset the consumer harm that is likely to arise from the acquisitions of South Shore and Hallmark hospitals and their physician affiliates," they wrote in a petition to Judge Janet L. Sanders.

"This is a regulatory solution that's unprecedented in its scope," Dafny said of Coakley's pact with Partners. "It's an attempt by the attorney general to remedy 20 years of behavior stemming from the merger that created Partners. This is a central planner's approach to the health care system. And in our opinion, it's not the way to go."


COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

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PART SYSTEM, INC. & others[1]

MORANDUM OF DECISION AND ORDER
ON JOINT MOTION FOR ENTRY
OF AMENDED FINAL JUDGMENT BY CONSENT

Partners' deal to acquire three hospitals rejected

"…this Court has serious concerns as to the enforceability of the Proposed Consent Judgment"

"….the CMIRs provide an important factual context for the Proposed Consent Judgment"

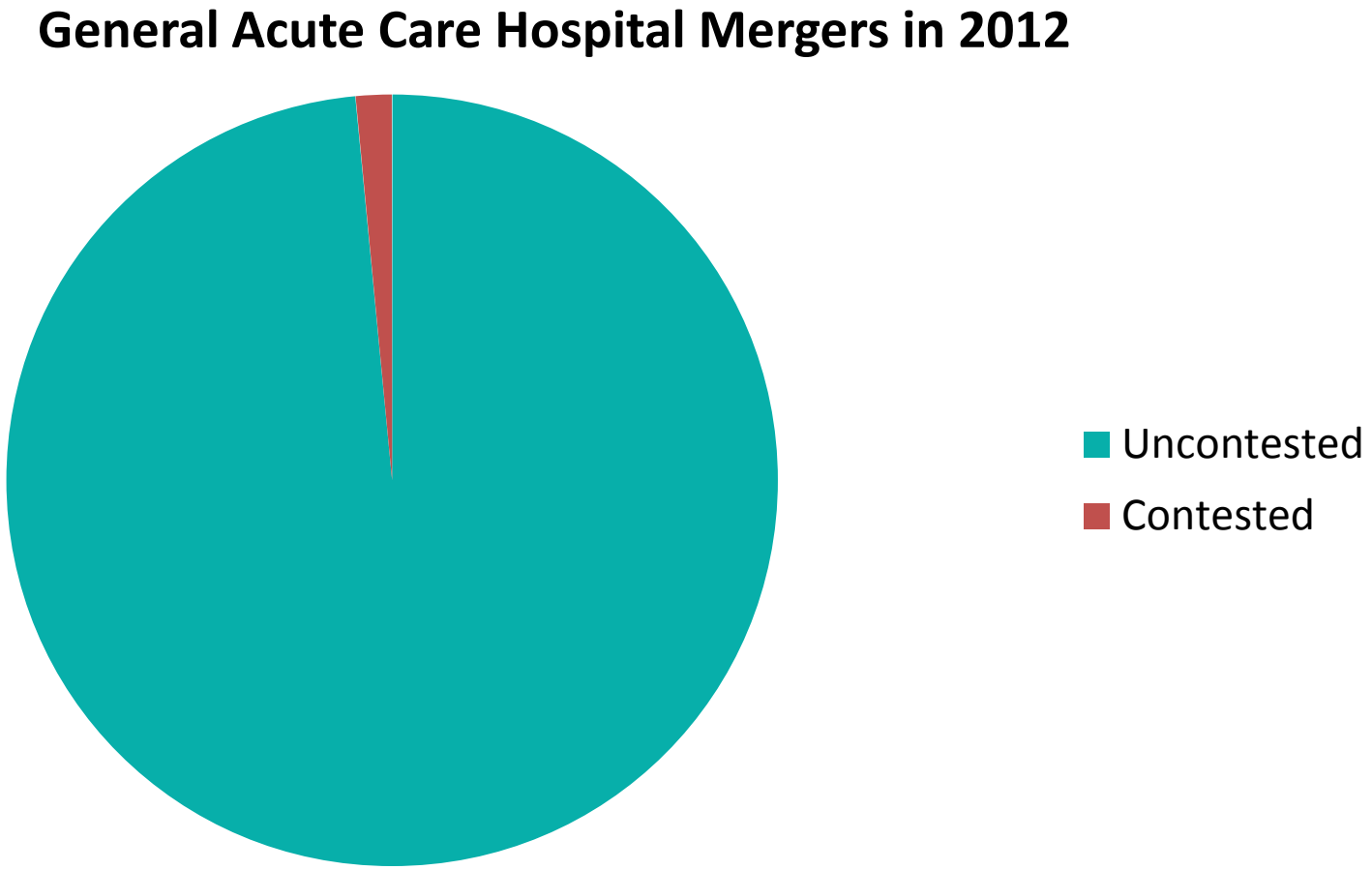
"…more than twenty professors from some of the leading universities across the country outlined their reasons for their opposition to the Proposed Consent Judgment"

Myths

- Antitrust enforcement myths (3)

- Affordable Care Act myth

Myth #1: Antitrust enforcers block a lot of mergers



Myth #2: Antitrust enforcers don't consider efficiencies arising from mergers

- Cognizable efficiencies are:
  - *Merger-specific*
  - *Verifiable*: "Efficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means."

"Population health management means services must be coordinated … This requires hospital systems to provide a full suite of services for their patient populations, warranting expansion through acquisitions of other hospitals, as well as physician medical practices and outpatient clinics."

-Mt. Sinai CEO, *Wall Street Journal* 9/15/2014

"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, such as participating in health information exchanges." – Tsai and Jha, *JAMA* 7/2/2014

Myth #2: Antitrust enforcers don't consider efficiencies arising from mergers, *continued*

- Anticompetitive effects < Efficiencies is not enough
  - There is also the matter of "pass through" of efficiencies
  - Where anticompetitive effects are large, authorities impose stricter inequality

- If you are efficient but lack rivals, will there be a sufficient incentive to pass on the savings?

Myth #3: 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 afraid of losing

Myth #4: 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., recent court testimony by former Advocate executive that independent physicians could be financially incentivized to meet specific quality metrics
- The ACA does not exempt organizations or collaborations from the antitrust laws

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