The New Goliaths

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Godzilla versus King Kong:
Hospitals increasingly have the edge on insurance companies.
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By Margot Sanger-Katz

In 1999, Evanston Northwestern Healthcare, a two-hospital group just north of Chicago, sought to merge with one of its smaller rivals, Highland Park Hospital. Executives promised board members of both companies that the deal would help all three hospitals succeed in the marketplace by enabling them to demand higher prices from insurance companies. It would “increase our leverage, limited as it may be, with the managed-care players and help our negotiating posture,” Evanston President Mark Neaman told the boards, according to meeting minutes. The directors approved the merger.

The plan worked, and the new company asked insurers to pay more. At the end of the first year alone, Neaman issued a memorandum trumpeting $24 million in increased revenue, about a 3 percent lift overall. Evanston was just getting started: Within four years, it had raised the price of care by as much as 48 percent, according to a government analysis. “None of this could have been achieved by either Evanston or Highland Park alone,” he wrote in a post-merger memorandum. “The ‘fighting unit’ of our three hospitals and over 1,600 physicians was instrumental in achieving those ends.”

The change was so extreme that it attracted the attention of the Federal Trade Commission, which ruled in 2008 that the merger was anticompetitive; it ordered the hospitals to negotiate their insurance contracts separately in the future. But the Evanston executives had vindicated their prediction that bigger companies could negotiate higher fees—a tactic that hospitals now use often. To pay those costs, insurers pass them along to consumers by marking up premiums.

Trouble is, this isn’t some ancillary problem
in the industry. The 2010 health care reform law is likely to make it much, much worse. And consumers will have to foot the bill.

The aim of the Patient Protection and Affordable Care Act was to cover more Americans, but it was also designed to arrest ever-escalating costs by changing the system. Authors hoped to improve the quality of care and reduce unnecessary treatment (both of which would save money) by imposing new rules on providers and building a less profitable, more competitive insurance industry. It incentivized the use of electronic records (shown to reduce errors), punished hospitals that perform poorly, and launched experiments in which caregivers who work in teams to keep patients healthier could share in the savings.

The results would “bend the cost curve” and slow the rate of growth. “We agree on reforms that will finally reduce the costs of health care,” President Obama said in December 2009 as Congress was working on the bill. “Families will save on their premiums; businesses that will see their costs rise if we do nothing will save money now and in the future. This plan will strengthen Medicare and extend the life of that program. And because it gets rid of the waste and inefficiencies in our health care system, this will be the largest deficit-reduction plan in over a decade.”

But ultimately, the law could do the opposite. The new rules inadvertently encourage hospitals to buy smaller rivals for whom the requirements are too expensive. They push doctors to abandon their practices and join large health care centers. According to one analysis, the number of hospital mergers and acquisitions has increased by more than 50 percent since the law’s passage.

It will take some time for the economic effects to shake out, but decades of data show that hospital consolidations almost always lead to higher prices for patients. The last big wave of consolidations, in the 1990s, caused market prices nationwide to climb by at least 5 percent—and as much as 40 percent in some markets. To pay the rising hospital bills, insurers passed the costs along to consumers by raising premiums.

The result could create a nation of Evanstons. Which is to say, a law designed to lower costs will likely raise them instead.

UNINTENDED CONSEQUENCES
For Congress, the obvious way to reimagine health care was to start with Medicare, since it represents about 20 percent of the country’s health care spending and 15 percent of the federal budget. It has huge clout and a history of shaping the market: The medical industry has adopted Medicare’s billing codes, and most insurance plans are structured around the same fee-for-service payments that it uses. Legislators and the president thought that changes to Medicare wouldn’t just lower government costs; supposedly they would lower costs in the private-insurance system, too. To do that, the law instructs hospitals that accept Medicare to track measures of quality—how often in the first month after being released, for instance, are patients readmitted?—and then pays less to those that underperform. It requires health care providers to adopt electronic medical record systems. It slows the annual increase in what Medicare pays for treatments. And it established a $10 billion center to test payment models that reward providers who keep their patients healthy rather than simply furnish care.

These new payment models encourage consolidation. The main vehicle is the accountable care organization: a group of providers who coordinate care and share in the savings if their patients spend less with them than they would have in the old system. The model is based on existing health systems—such as the Mayo Clinic in Minnesota—that employ physicians, rely on data, and deliver high-quality care for less than the nationwide average.

ACOs appear to work best when large health care organizations put all of their providers—doctors, clinics, hospitals—under one roof. To this end, hospitals that want to participate have a new incentive to buy up their referral networks. And they’re doing so rapidly. Physician acquisition is accelerating nationwide, according to data from the Medical Group Management Association; the American Hospital Association; Irving Levin

A new ecosystem:
Hospitals are gobbling up competitors lower on the food chain.
Associates (a publisher that tracks mergers and acquisitions in the industry); and the Advisory Board (a consulting firm that works with health systems). In 2006, 32 practices sold themselves, according to Levin Associates. In 2010, it was 63. Last year, it was 100, with a bigger proportion of sales to hospitals, not large physician groups.

When these companies start buying up doctors’ practices, they can set off a chain reaction in which competitors feel pressure to purchase the remaining independent players. Dr. Michael Mirro, a cardiologist in Fort Wayne, Ind., went through a typical case. Doctors in his market, he says, all started selling to local hospitals around the same time. Their motive, in part, was a change in Medicare payment rates, but he says they also felt peer pressure. “When you start talking to cardiology groups about integration with your local hospital, it’s kind of like you meet up with some of your old sorority sisters and say, ‘I got married. You should consider it,’” Mirro says. Current regulations also protect ACOs from tough antitrust scrutiny that many hospitals worried would interfere with their plans.

Meanwhile, the law’s raft of new requirements has made life hard for smaller players. Even physicians who don’t join accountable care organizations are banding together in large practice groups or selling to hospitals, says Dr. Susan Turney, MGMA’s president. In 2011, the organization saw a 35 percent uptick of member practices owned by hospitals from 2010. Turney expects to see an even bigger change this year. “I think that they’re doing what they have to do to survive,” she says.

Smaller hospitals also struggle with the new mandates. These providers often have poor patients who suffer chronic ailments and rely more on the skimpier paychecks of Medicare and Medicaid. Independent hospitals tend to have narrower profit margins, meaning they can’t simply fork over the cash—up to $50 million for a midsize facility—to digitize their records. (Even those with access to credit can’t borrow for the conversion, because electronic systems depreciate quickly as new versions make them obsolete.) Research by Ashish Jha, an associate professor at Harvard’s School of Public Health, has shown that many of the hospitals likely to be penalized are the ones that are already struggling financially.

So, to avoid shouldering those costs alone, hospitals are snapping each other up to create economies of scale. “It’s sort of like musical chairs, and everyone is afraid the music is going to stop any moment, so they’re looking for a partner,” said Craig Garner, the former CEO of Coast Plaza Hospital in Norwalk, Calif. Last year, Coast Plaza was acquired by Avanti Hospitals, a group that owned three other community hospitals in the state. The looming cost of implementing electronic medical records was a major cause, Garner says.

The Affordable Care Act is not the only reason more hospitals are merging and expanding now than before. Many physicians had already begun abandoning the traditional model—the independent practice—in favor of having a salary and a 9-to-5 job. Doctors talk about it as a generational issue: Younger MDs want predictable hours and access to all the technology they used during their residencies, rejecting the old-fashioned model of physician-managers and overnight calls. Some communities have been essentially run by one or two major providers since the 1990s, when the market responded to the growth of managed care and the specter of health reform under the Clinton administration.

But consolidation has only intensified since the 2010 law passed, according to Levin Associates. Sandy Steever, the editor of its Health Care M&A Information Source, counts 86 deals involving 145 hospitals in 2011, compared with just 73 in 2010 and 52 in 2009. In Connecticut last year, for instance, Yale-New Haven Hospital acquired the Hospital of St. Raphael, its only private competition in town.

Moody’s, which rates hospital bonds, predicts more. The median revenue of hospitals it rates is $502 million, but the median revenue of ones with the highest Aa rating is $1.6 billion. “Health systems, even at more than $1 billion of revenue, are wondering if they’re big enough,” says Daniel Zismer, a former health system executive who now studies health policy and management at the University of Minnesota. Which means there’s plenty of consolidation yet to come. Zismer points to a recent survey of health system chief financial officers, who have seen a significant acceleration in merger talks since the law passed.

COMPETITION MATTERS

Most hospitals and doctors make ends meet by overcharging private insurers. It’s called cost-shifting, and its higher charges are built into the system. Because the federal Medicare and state Medicaid programs pay low, fixed reimbursements, most hospitals run a deficit on these patients and make up the difference by raising prices on everyone else. The rates in a given market are set in negotiations between hospitals and insurance companies, whose strength (in numbers) affects the terms. In a market with few private insurers, payers have the upper hand; they can dictate what they’ll shell out for services.

But when several insurers and only a few hospital groups are involved, the reverse happens: Hospitals can essentially name their price, and insurers can’t afford to walk away. That effect can be particularly pronounced when a large group also has a well-liked brand. A 2008 Boston Globe investigation of local hospital prices found that the mammoth Partners Group, which owns Massachusetts General Hospital, got paid 15 to 60 percent more than its competitors—up to three times more for some procedures. The Globe dubbed the phenomenon “the Partners effect.” A similar dynamic occurs on the physician side: Small practices lacking market clout get handed a price sheet from insurers that looks a lot like Medicare rates, and they can take it or leave it. Larger practices—and those owned by must-have hospital groups—can command higher prices.

The American Hospital Association disputes that there’s a connection between market share and negotiating leverage (which would make consolidation look ominous), but repeated studies show the phenomenon is real. Robert Town, a health care economist at the University of Pennsylvania’s Wharton School, studied the wave of hospital mergers in the 1990s and found associated price hikes of up to 40 percent, even though most hospitals became more efficient after they centralized their administrations. The next wave will likely “result in higher prices and lower quality,” predicted a 2006 report that Town cowrote for the Robert Wood Johnson Foundation.

Market advantages are reason enough to merge, but the health reform law piles on incentives: Looming Medicare cuts mean that cost-shifting will become increasingly important for providers. A recent study in the policy journal Health Affairs found that cost shifts were bigger in markets with highly consolidated health care than in more-competitive markets.

Cost-shifting boosts the price of care, and international data show how these high prices
drive health care economics. A 2011 report by the Organization for Economic Co-operation and Development, which collects data from 34 developed nations, described the United States as an extraordinary outlier on this point. Per capita health care spending here is nearly $8,000, more than double the OECD average. The country with the next-highest average, Switzerland, spends $3,000 less per resident. Measures of health care spending as a percentage of gross domestic product were similarly divergent, suggesting that the difference is about more than just America’s comparative wealth.

The OECD report found that the volume of health care services didn’t vary much by country. That vitiated the focus of policymakers who blame “utilization”—unnecessary scans on a doctor’s order, avoidable hospital readmissions, and duplicate tests or drugs. Instead, the problem appears to be the price we pay compared to our peers abroad. American patients pay 163 percent more to hospitals, 238 percent more for doctors’ visits, and 152 percent more for drugs than the OECD average. Unlike in other countries, the United States has no across-the-market system to control price growth. “It’s a structural defect in the U.S. system,” says Mark Pearson, the head of the organization’s social-policy division.

Local analyses finger concentrated markets as the root of this problem. The California hospital market, which experienced rapid increases in private-insurance premiums between 1999 and 2005, is a good example. A Health Affairs study found that a period of significant consolidation handed hospitals much more leverage to negotiate with insurers; they were charging 10 percent more every year. (“We are making out hand over fist,” one medical-group executive told the authors.) Another review by Martha Coakley, the Massachusetts attorney general, blamed the same culprit for rising hospital prices after that state’s 2006 health care overhaul.

Of course, when insurance companies pay more, so do consumers. Insurers naturally turn a profit (though the reform law limits how much they can pocket); but, even now, the vast majority of cash they collect in premiums goes to medical providers. Those premiums are based on insurers’ best guess of what it will cost to care for certain patients. So, as the price of care rises, so will the premiums. That means employers—and, to a growing degree, employees—will ultimately foot the bill when hospitals and doctors negotiate higher pay rates. Soon, taxpayers will have to pay more, too. Although federal dollars are currently focused on Medicare and Medicaid spending, where prices are basically fixed, the health care law creates a system of tax credits to help middle-income Americans afford premiums. The subsidy is designed so that people have to pay only a set portion of their income for insurance. So for the first time, hospitals that cost-shift will be passing those obligations back to the federal government instead of just to the commercial market.

The American Hospital Association insists that its members are not the problem. It published a white paper in 2010 disputing the Health Affairs and Massachusetts studies. It contended the real problem was that hospitals’ underlying costs were increasing, not that growing market share gave them more power. Insurers, the association argued, are still the dominant negotiators because hospitals know that they are obliged to treat patients regardless of whether the two sides agree on a contract. “Most mergers and acquisitions won’t have any anticompetitive consequences,” says Mindy Hatton, the association’s general counsel.

But one person’s cost could be seen as another person’s waste. Hospitals that demand high prices are often the ones that spend generously: higher salaries for nurses, the newest fancy medical scanning machine, and elaborate renovations. “The truth is that when hospitals feel less pricing pressure, they probably feel less pressure to become efficient,” says Jha, the Harvard professor. “They can spruce up their lobbies, and have better food, and do a lot of things that patients really like.”

WHAT TO DO

Health care optimists—and there are many—see consolidation as a sign that providers are getting ready for the big changes to come. Len
Nichols, a health care economist at George Mason University who tours the country speaking to hospital groups, says that hospital executives know they can’t keep raising prices forever. To that end, a growing number of private payers are trying new payment models.

Nichols says that outside pressures, as employers begin to push back against annual insurance increases, will couple with Medicare cuts to make hospitals more efficient. The answer could be accountable care organizations, bundled payments (in which hospitals get a flat rate for all care associated with a particular procedure or hospitalization instead of a fee for each individual service), or any number of other experiments now under way. It could be simple belt-tightening, as hospitals streamline their electronic systems, stop handing out raises, and offer less-generous benefit packages to employees.

In the meantime, the Federal Trade Commission is battling mergers that seem truly anticompetitive. After losing a string of cases, it had its first big win in the Evanston case once a series of FTC econometric studies demonstrated how much certain mergers could move markets. The judge’s analysis has emboldened the agency to challenge more mergers as anticompetitive. It currently has two cases open, including one in which the FTC issued a preliminary ruling against a proposed merger between hospitals in Toledo, Ohio.

But a more pessimistic view holds that hospitals like the idea of ACOs because they want to make money, not because they want to improve the quality of care. Alan Sager, a professor at the Boston University School of Public Health, points out that expensive, inefficient teaching hospitals have displaced leaner community hospitals in many American cities. Hospitals could be favoring the accountable-care model because the federal government will forgive the anticompetitive mergers of groups that use them. “To what degree are hospitals embracing ACOs because they see it as a workable solution to cost and quality problems, and to what degree are they embracing it because they promise to assuage their survival anxieties?” he asked.

Even if hospitals buy in, none of the changes will be instant. Most of the payment pilots are still years away from widespread adoption. And the meaningful use of information technology is still the exception, not the rule: Only 40 percent of hospitals are using electronic medical records to enter physician or electronic systems, stop handing out raises, and offer less-generous benefit packages to employees.

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