



What's The Big Deal?

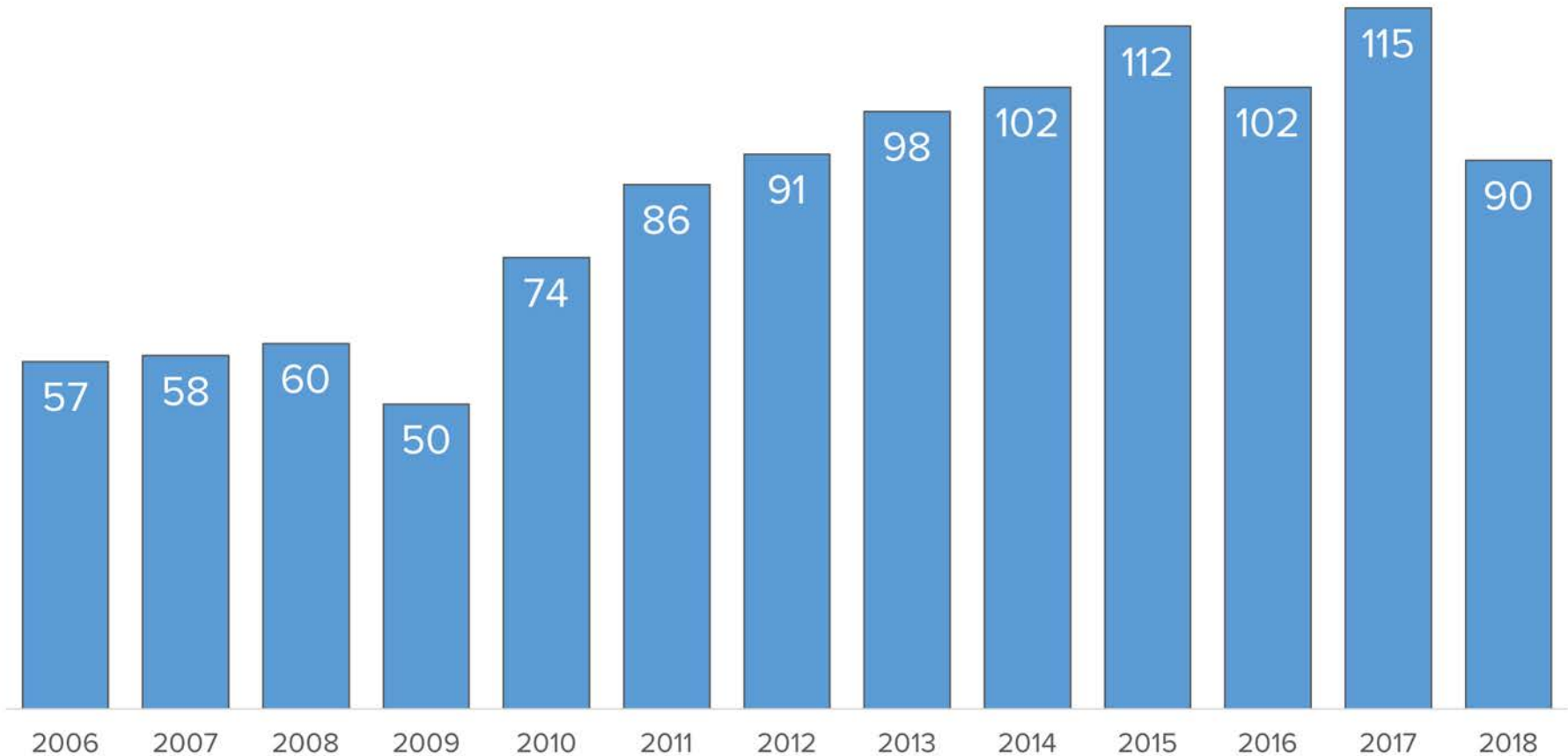
- ❑ **CONSOLIDATION TRENDS:** Horizontal consolidations between hospitals and hospital systems have been occurring at a rapid pace and are increasingly creating dominant regional and national systems.
- ❑ **CONSOLIDATION IMPACTS:** The vast majority of empirical evidence indicates that consolidation raises the prices hospitals receive from payers, often by very significant amounts and even when the consolidation did not increase market power in specific local markets.
- ❑ There is very little evidence that consolidation improves the quality of clinical care, and some evidence that quality is worse in less competitive markets or after a hospital acquisition.
- ❑ Some evidence points to lower post-merger production costs for some acquired hospitals, but not all consolidations lower costs and cost efficiencies may not be passed on to the consumer.
- ❑ **CONSOLIDATION OUTLOOK:** FTC antitrust enforcement has not significantly deterred consolidation. Consolidations will continue, and the broadening geographic scope of recent mergers makes it all the more difficult for the FTC to challenge these consolidations.
- ❑ Consolidations are hard to undo after the fact, and hospitals with market power will generally use that power to retain dominance.
- ❑ Policy responses to emerging and existing market power include measures to strengthen antitrust enforcement, improve competition and constrain pricing power of dominant systems.



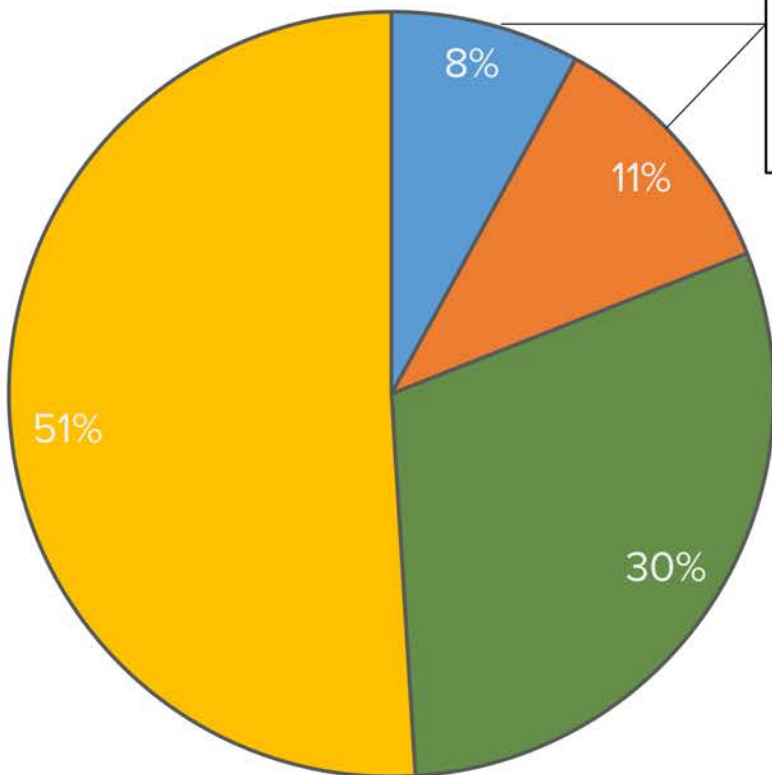
Consolidation Trends

Significant Consolidation Activity in Hospital Sector in Recent Years

Announced Hospital Consolidations



Many Mergers and Acquisitions Are Between Large, Strong Partners



In one fifth of the announced 2018 deals, the seller or smaller partner had **net annual revenues of more than \$500M**

Across all announced deals in 2018:

- ❑ the average revenue of the smaller partner was \$409 million, the highest figure in a decade of tracking
- ❑ only 20 percent of the deals involved a “financially distressed” partner

■ > \$1B ■ \$500M - \$1B ■ \$100M - \$500M ■ < \$100M

Annual Revenue of Seller or Smaller Partner in Transaction

Notable Recent Within-Market Consolidations

Ascension–Presence: largest non-profit system in US adds 10 hospitals to its existing network of 9 hospitals in the **Chicago** area

Fairview–HealthEast: 11-hospital system becomes largest in **Twin Cities** market

HCA adds 4 hospitals to the 10 they already own in the **Houston** market

Northwestern–Centegra: forms 10-hospital system in the **Chicago** area

Emory–DeKalb Memorial: forms 10-hospital system in the **Atlanta** area

Jefferson–Einstein Healthcare: will form 18-hospital system serving **Philadelphia** and nearby areas

Explosion of Large Regional Hospital Systems

Advocate–Aurora: 27 hospitals in WI and IL

Baptist Memorial–Mississippi Baptist: 22 hospitals in TN, AR and MS

Wellmont Health–Mountain States: 21 hospitals in TN and VA

UPMC–Pinnacle: dominant Pittsburgh system adds 8 hospitals in central PA to its existing network of 24 hospitals

Greenville–Palmetto: 13 hospitals across SC

Ardent Health–UT Health–East TX Medical Center: 10 hospitals in east TX

Adventist–Providence St. Joseph: 9 hospitals in northern CA

SSM Health–Congregation of Sisters of St. Agnes: 7 hospitals in WI and IL

HealthPartners–Hutchinson Health: Large-hospital system in Twin Cities extends reach into central MN

Beth Israel Deaconess–Lahey Health: 13 hospitals in MA

Partners–Care New England: dominant Boston system intends to add 3 hospitals in RI

Atrium–Navicent: 48 hospitals in Carolinas and GA

Piedmont–Columbus Regional: 10 hospitals in GA

Western CT–Health Quest: 7 hospitals in CT and NY

National Systems Expanding Footprints

Catholic Health Initiatives–Dignity Health: 142 hospitals in 21 states

Bon Secours Health–Mercy Health: 43 hospitals in 7 states

HCA–Mission Health: latest acquisition expands HCA's reach into NC and gives HCA 177 hospitals in 21 states

Steward Health System: rapidly expanded through acquisitions to reach 33 hospitals in 9 states

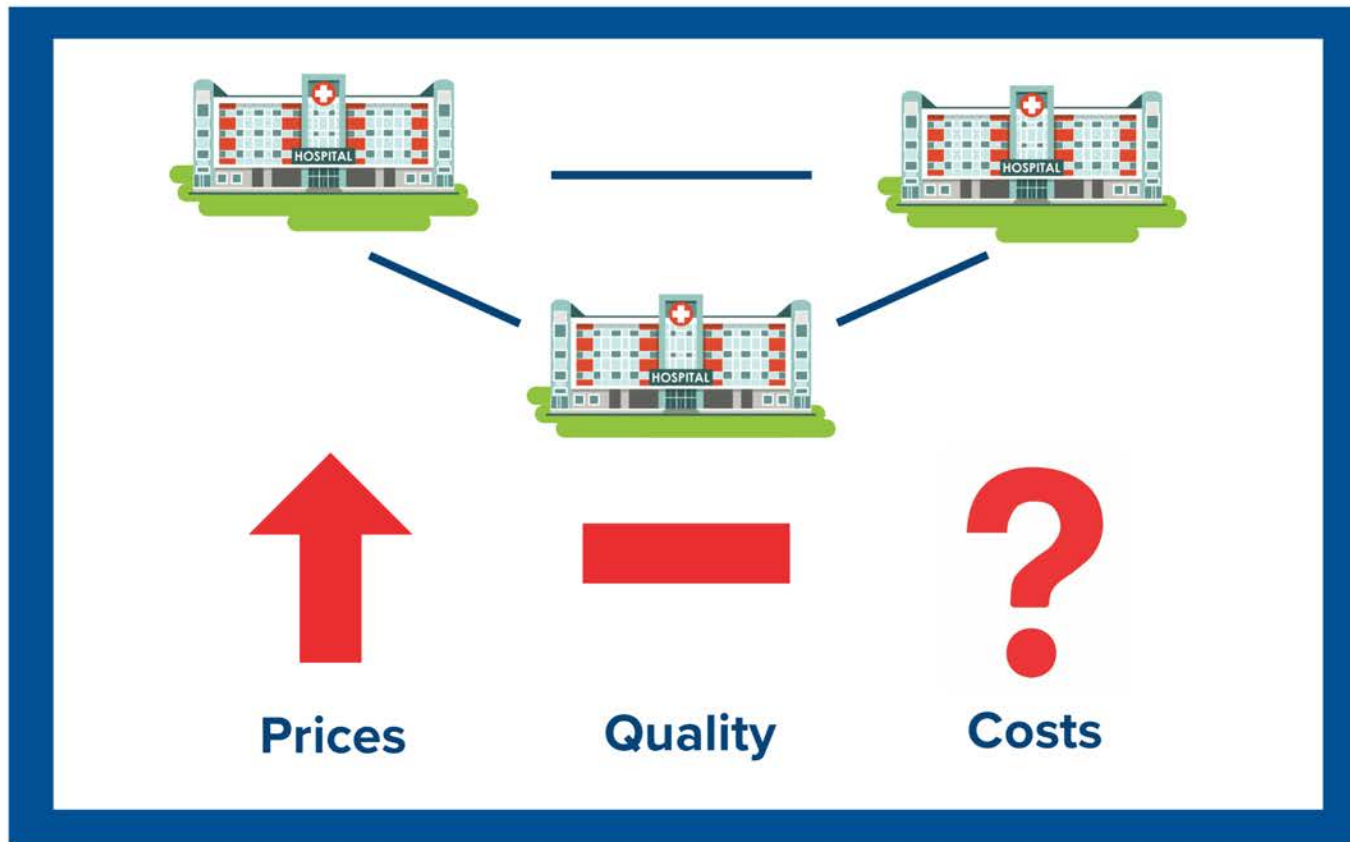
RCCH HealthCare Partners–LifePoint: 89 hospitals in 30 states, focusing on non-urban markets



Consolidation Impacts

How Do Hospital Consolidations Affect Consumers?

When hospitals consolidate, prices charged by hospitals go up – with mixed evidence on benefits from improved quality or better cost efficiency.



Within-Market Consolidation:

Rich Body of Research over Many Years^a

Price increases of **20-40%**
documented by many studies

... and increases of **55-65%**
reported in some instances

Generally find larger price
impacts when merging
hospitals are located closer to
one another

Also evidence that rival
hospitals raise prices after their
competitors merge

Cross-Market Consolidation:

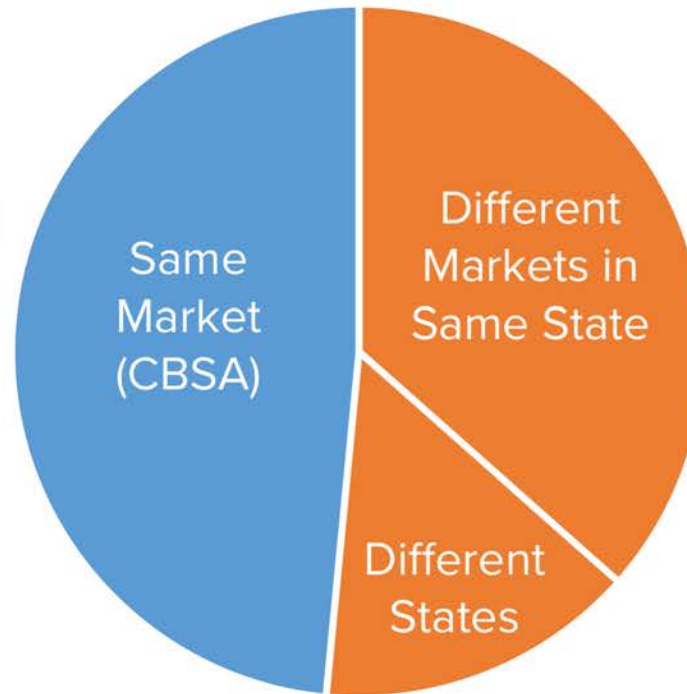
Findings from Emerging Research

Prices rise **7-9%** on average at
acquiring hospitals after merging
with a hospital in a different market
in the same state...

... but no significant price impacts
when acquired hospital is out of
state^b

Prices rise by **17%** when a
hospital is acquired by an out-of-
market hospital system; nearby
rivals raise their prices, too^c

Prices rise by **6-7%** when merger
leads to hospital systems competing
in multiple common markets^d



Hospital Mergers, 2000-2012^b

Quality^a

Evidence on quality is, at best, mixed:

- ❑ Few consistent or clinically or statistically significant quality benefits seen.
- ❑ While some studies find a few measures of quality improve modestly...
- ❑ Most studies find no significant impacts on the measures examined, and...
- ❑ Some studies indicate *higher* mortality and *worse* quality when there is less competition in the market.
- ❑ New evidence from a comprehensive study of hospital acquisitions found no evidence of quality improvements but worsening patient satisfaction after the ownership change.

Cost Efficiency

- ❑ Costs not lower for hospitals that are members of hospital systems.^b
- ❑ Some evidence that operating expenses grow more slowly after a hospital is acquired^{c-f} and of very modest savings in supply costs at acquired hospitals,^g but conflicting findings on whether this occurs mainly when the acquired hospital is located near the acquiring hospital^f or whether it happens only for out-of-market acquisitions.^c
- ❑ No evidence that costs decline for the acquiring hospital.
- ❑ Hospitals are more likely to realize cost efficiencies if merging partners fully integrate their operations and facilities.^{d, h, i} Not all consolidations achieve such integration.
- ❑ No guarantee that any realized cost savings will be passed on to consumers.



Consolidation Outlook

Ongoing consolidations will contribute to **emerging market power** and will be nearly impossible to unwind once they occur.



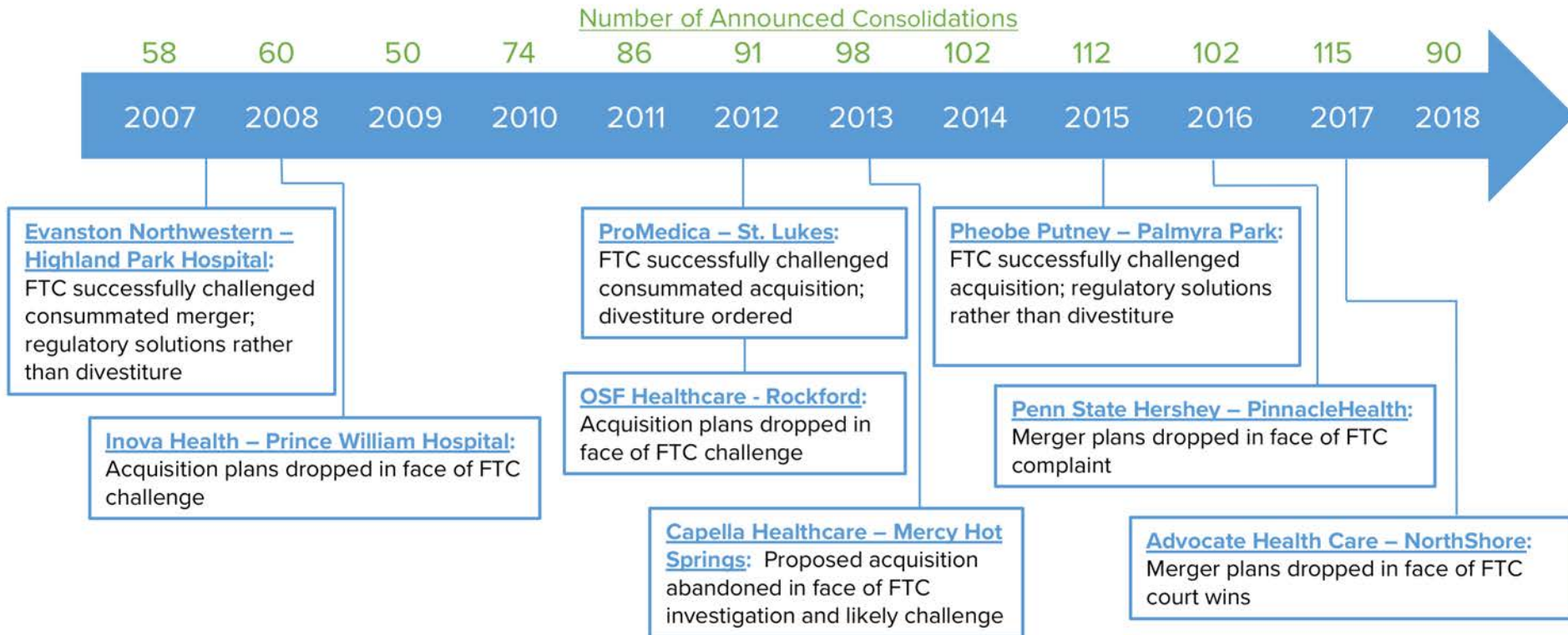
Stronger antitrust vigilance is needed to prevent consolidations that are likely to be anti-competitive.

Hospital systems that have already gained **existing market power** have incentives and opportunities to engage in behavior to retain market dominance.



In addition to policing anti-competitive behavior through antitrust enforcement, other approaches are needed to **improve competition and constrain pricing power of dominant systems**.

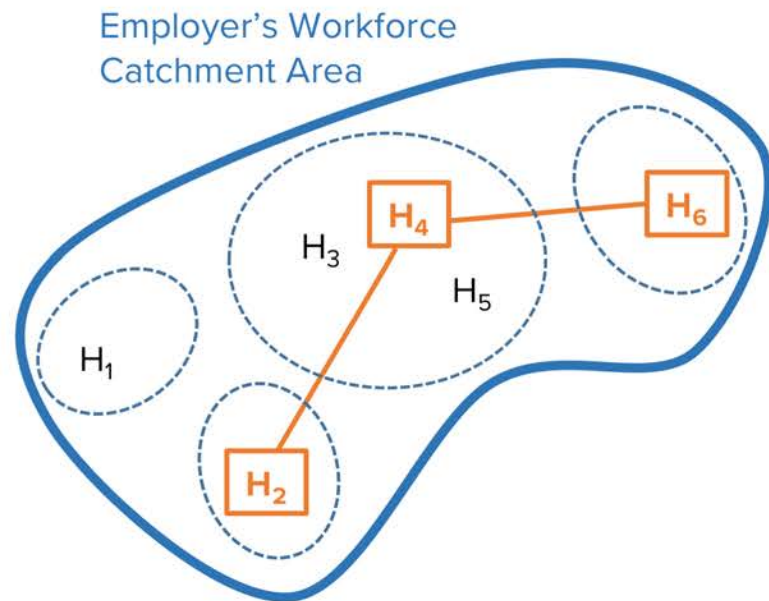
A decade of successful **within-market** hospital merger challenges by the FTC, but very few mergers have been challenged.



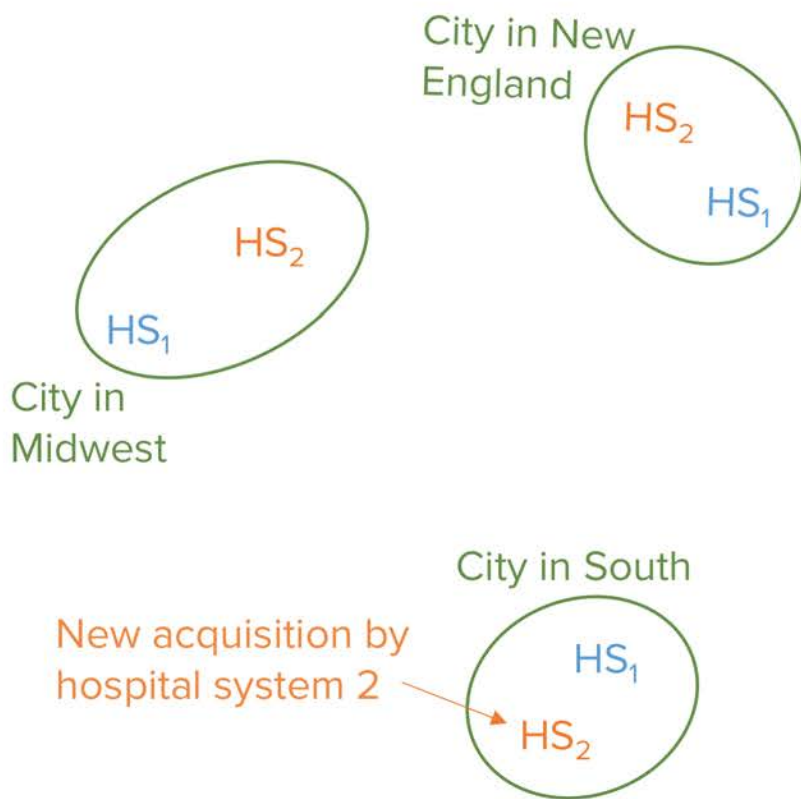
These emerging conceptual frameworks have not yet been used in a federal merger challenge, despite the rapid pace of cross-market and multimarket hospital mergers.

Cross-Market Regional Mergers^a

- ❑ Employers often draw workers from numerous distinct markets within a broader geographic region.
- ❑ To sell insurance to these employers, insurers must build a hospital network covering all markets where their employees live.
- ❑ A merger that gives a hospital system a presence in several of these distinct markets also gives that system more market power – **even if it does not increase hospital concentration within any of the smaller markets.**
- ❑ By negotiating on an “all or nothing” basis, the system can force insurers to include all system members in the network and to pay them higher prices.



These emerging conceptual frameworks have not yet been used in a federal merger challenge, despite the rapid pace of cross-market and multimarket hospital mergers.



Mergers Across Distant Markets^a

- ❑ As large hospital systems (HSs) expand their geographic reach nationally, they are increasingly competing against one another in multiple far-flung markets.
- ❑ The mutual forbearance hypothesis posits that such systems may avoid competing strenuously in any given common market so as to not set off vigorous competition with rival system members in other common markets.
- ❑ Consolidations that increase the extent of multimarket contact can lead to higher hospital prices – **even when the markets of the merging entities do not overlap at all and there is no increase in market power locally.**

- ❑ Several recent examples of states using **Certificates of Public Advantage (COPAs)** or other forms of state regulation to permit hospital consolidations that were attracting significant scrutiny from the FTC
- ❑ State accepts reduced competition in exchange for state regulatory oversight intended to mitigate downside risks of consolidation and achieve potential benefits to the public, such as maintaining access to providers and fostering population health
- ❑ Concerns about these arrangements include:
 - Limited evidence on whether state oversight can counter provider market power and deliver the anticipated public benefits
 - State politics and special interests can compromise strength of state oversight
 - Several COPAs put in place in the 1990s have been terminated by the enacting states, leaving the consolidated system in place without oversight

Strengthening Antitrust Enforcement

- ❑ Increase funding for FTC and DOJ antitrust work
- ❑ Extend FTC authority to challenge anticompetitive actions by non-profit health systems
- ❑ When evaluating mergers, give greater consideration to possible non-price detrimental impacts
- ❑ Use existing rule-making authority to clearly define unfair methods of competition
- ❑ Increase use of structural presumptions
- ❑ Discontinue states' use of certificates of public advantage
- ❑ Provide FTC technical assistance to state regulators

Enhancing Competition & Constraining Pricing Power

- ❑ Prohibit anti-competitive contracting methods
- ❑ At the state level, eliminate any willing provider and certificate-of-need laws
- ❑ Encourage consumer choice of high-value providers through benefit designs like reference pricing and other forms of value-based contracting
- ❑ Improve transparency regarding provider prices and quality
- ❑ Establish caps on provider payment levels
- ❑ Implement all-payer rate setting

Proposed Measures to Strengthen Anti-Trust Enforcement ^a

- ❑ **Increase funding for FTC and DOJ anti-trust work**, including support for research on new economic models reflecting broader geographies of mergers
- ❑ When evaluating mergers, **give greater consideration to possible non-price detrimental impacts**, e.g., stymied innovation, entry, choice
- ❑ Rather than relying on case-by-case adjudication in courts to establish anti-trust law, **use FTC's existing rule-making authority to clearly define unfair methods of competition**, reducing ambiguity about the legality of proposed mergers
- ❑ **Increase use of structural presumptions** identifying situations where mergers are presumed illegal based on their impact on market structure
- ❑ Extend FTC authority to **challenge anticompetitive actions by non-profit health systems**
- ❑ Provide FTC **technical assistance to state regulators** to improve their antitrust monitoring and enforcement
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^a The policy recommendations presented here are drawn from the reports and publications cited **WHERE?**

- ❑ **Prohibit anti-competitive contracting methods** (e.g., anti-steering and anti-tiering provisions, exclusive tying arrangements, all-or-nothing system contracting, gag clauses and non-disclosure agreements, most favored nation clauses, data blocking)

- ❑ **Eliminate** state laws preventing creation of value-based provider networks (**any willing provider laws**) **and** restricting market entry of new competing hospitals (**certificate-of-need laws**)
 - Consider tying Medicare reimbursement to repeal of these laws
 - H.R. 506 would create a new grant program for states to improve hospital infrastructure, with eligibility limited to states that do not have AWP or CON laws (among other criteria)

- ❑ **Encourage consumer choice** through benefit designs such as reference pricing

- ❑ **Improve transparency** regarding provider prices and quality (but with heightened attention to potential for price collusion)

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- ❑ **Establish caps on provider prices** (e.g., as a percent of Medicare rates), particularly in markets that are highly concentrated
 - H.R. 506 would apply Medicare rates to commercially insured and self-pay patients treated at Medicare-certified hospitals in certain types of concentrated markets

- ❑ **Ban or limit balance billing** by out-of-network providers

- ❑ Implement **all-payer rate setting**

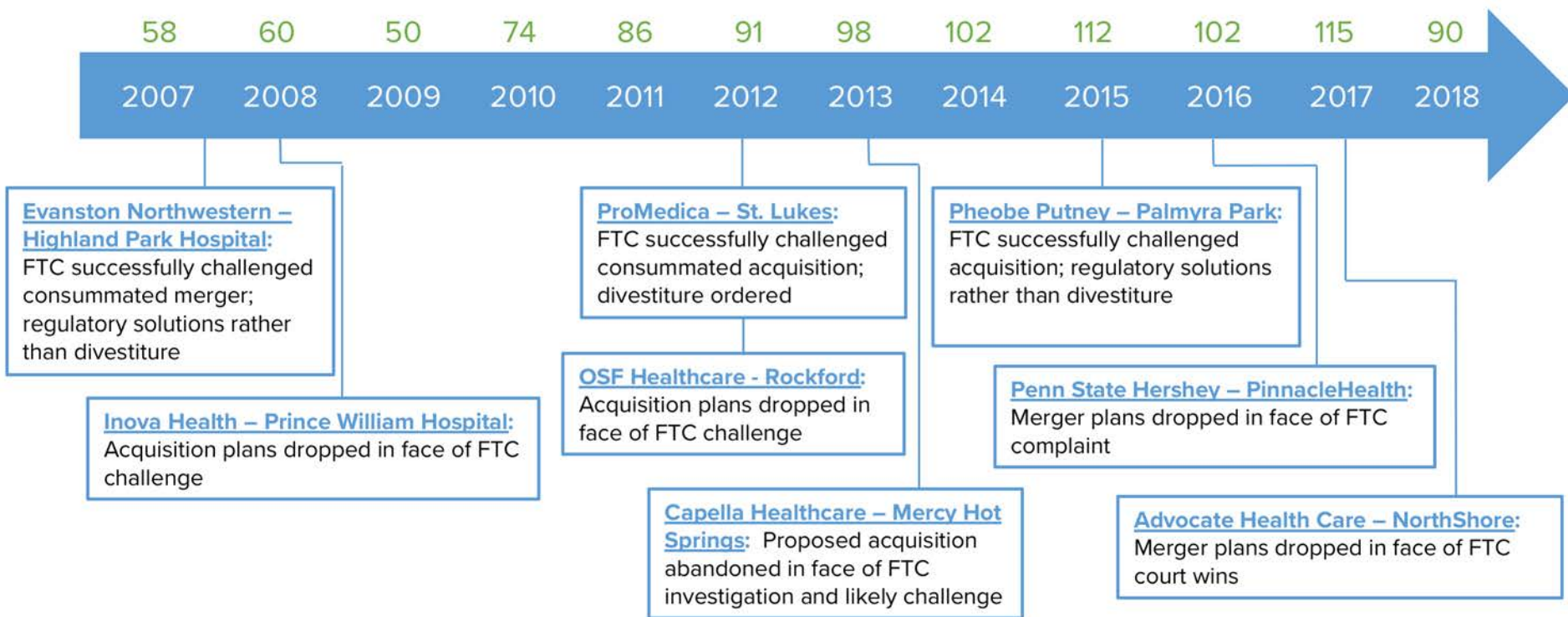
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- Emerging Market Power: Consolidations are nearly impossible to unwind once they occur
 - Existing Market Power: Providers with market power have incentives to engage in behavior to maintain their advantage
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A Decade of Successful Within-Market Hospital Merger Challenges by the FTC

But Very Few Mergers Are Challenged

Number of Announced Consolidations

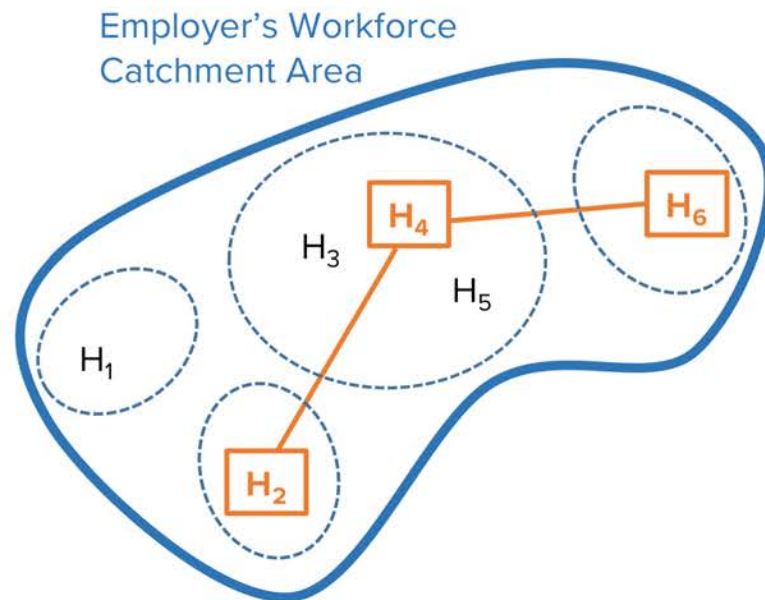


Successful merger challenges may deter some potential future mergers, but consolidations continue at a fast pace.

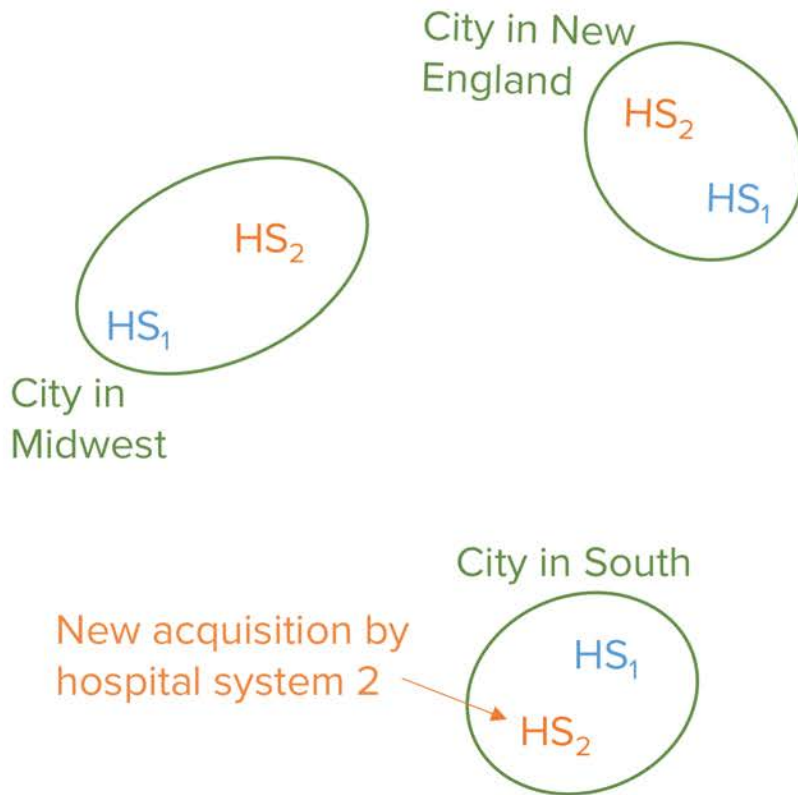
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