The Rampant Trend of Hospital Consolidations and its Impact on Patients and Future Physicians

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Abstract

Hospital consolidations have become rampant since the implementation of the Affordable Care Act, with untold implications for patients and future physicians. These mergers have been increased in a changing healthcare environment that encourages better coordination of patient care and better access to advanced technologies while reducing administrative costs and moving towards fee-for-performance payment models. However, there has been a trend to consolidating market power with profits not necessarily being seen by the patient; studies have found an increase in healthcare spending with no change in healthcare utilization. Future physicians will find less negotiating power, lower reimbursement, and greater scrutiny with less authority. Proper regulatory forces are needed to curtail the negative behaviors hospital consolidations have been trending towards in the future.

Hospital consolidations have become rampant in response to the changing healthcare environment following the passing and implementation of the Affordable Care Act. While hospitals were merging before the passing of the ACA, many experts say that the ACA has accelerated the trend in recent years. Hospital mergers numbered 50-60 in the pre-recession years of 2005-2007, increased to 50-100 every year after, and reached over 100 for the first time in 2015 (Dafny, 2014; Associates 2011; Frakt, 2016). Since 2011, 16 hospitals have closed in New York State, 7 hospitals have been acquired by other NY hospital systems, and 45 hospitals have formed relationships in NY. Different forms of partnerships are forming throughout the country, such as mergers with community hospitals in the Harvard/Partners Health proposal, and greater Mergers and Acquisitions in the University of Pittsburgh Medical Center or Thomas Jefferson Hospital models. One example of the ACA's regulatory policies indirectly encouraging healthcare consolidation can be seen in the increased subsidies for services that only dominant hospitals are able to provide. Another example is the limiting of Medicare payment policies which force private physicians and other independent healthcare providers to

merge into integrated systems (Pope, 2014). Hospital consolidation has brought certain benefits in healthcare economics and delivery, but has left behind patients who are left with greater financial burdens and future physicians who are being pushed away from optimal medical decision-making.

In support of the mergers, providers argue that coordination of healthcare services lead to better coordination of patient care by better communication between Primary Care Providers and specialists, and better access to specialized facilities such as nursing homes, rehabilitation centers, and hospice care. For example, when a smaller hospital merges with a larger, better-equipped hospital system, patients at the smaller hospital acquire better access to advanced medical technologies and healthcare record systems that can cost up to millions of dollars which is unaffordable to smaller systems (Curfman, 2015). Large hospital systems also have greater ability to negotiate higher prices with insurance companies by serving a larger population leading to greater market power.

There are also cost-saving reasons why hospital consolidation is beneficial from a provider's perspective. The most commonly cited reason is that administrative costs can be reduced when resources are pooled over larger areas, the "economies-of-scale" phenomenon commonly seen in expanding businesses (Foster, 2014). Hospital consolidation also leads to increased capital and more efficient use of investment. Many hospital systems run on very small margins, therefore requiring greater resources on hand to invest in new technologies or infrastructure. Also, the movement away from fee-for-service to fee-for-performance models require larger data and greater pools to manage risk, which is only feasible with larger population and larger integrated systems (Pope, 2014).

However, hospital consolidations have not equally benefitted all areas. In many places, providers, "have begun to consolidate, increase their pricing power, and avoid passing savings on to consumers" (Brodwin, 2015). Several studies have been conducted to measure the effect of hospital consolidation on the cost to consumers (Gaynor & Town, 2012; Altman, 2013). Only in states such as California, with large populations and strong state regulatory measures, were cost reductions achieved and savings were passed onto consumers as a result of merging hospitals.

Larger hospital systems have the advantage of gaining a greater share of the consumer health market. This allows them to negotiate for higher pay for medical care and procedures from insurance companies at the risk that the insurance company loses out from a substantial population. However, many times these costs are not being borne by the insurance companies but rather being passed onto the consumers directly (Evans, 2015). In addition to the fact that insurance companies themselves have been seeing rampant consolidation, the price negotiating between providers and payers seem to be driving up health care costs and leaving the financial burden on patients.

Mergers typically discussed in the media are horizontal mergers, consisting of

deals between hospitals themselves. Another type of merger is known as vertical mergers, which occur between hospitals and physician groups and other healthcare professional services. Vertical mergers do fit the traditional idea of monopolizing healthcare features; however, a closer look reveals a great amount of costly inefficiencies. A 2015 JAMA-Internal Medicine study assessed changed is spending nationwide associated with physician-hospital integration (Neprash, 2015). They found amongst the areas with the top 25% increase in physician-hospital integration, there was a 3.1% ($2401, 95% CI $2400-$2414) increase in outpatient spending driven almost entirely by price increases with no change in healthcare utilization. They hypothesize this was mostly driven by a "facility fee" traditionally charged by hospitals for increased complexity of care in inpatient settings.

Physicians are more likely to refer to their hospital-affiliated emergency departments and facilities, where prices may not be as competitive as other services in the area. A study has shown that ambulatory services are greater for physicians linked to an integrated medical service creating higher costs for their patients (Richman, 2016). Likewise, hospitals can dictate policies demanding inpatient-level billing rates for outpatient services. Though other industries commonly use vertical integration in mergers, vertical integration for hospital systems already being consolidated would only reinforce monopolist problems. In the 1990s, the big wave of mergers between physicians and hospitals did not work out well because hospitals ended up paying way too excessively for these practices, and once physicians joined them, staff productivity and efficiency declined (Curfman, 2015; Xu, 2015).

Concern has been raised whether hospital consolidations are producing mergers large enough to violate antitrust laws. In the 1990s, the courts then ruled against the FTC, reasoning that "hospitals' mergers would provide better and more efficient care, that patients would travel to obtain cheaper care, and in any event, because the hospitals were nonprofit, they would not exercise market power to increase prices" (Curfman, 2015). Many of these predictions turned out to be untrue; several studies have shown that integrated hospital systems have shown no meaningful benefit in quality and delivery of care, but were associated with increased cost (Richman 2016, Carlin, Dowd, & Feldman, 2015; Evans, 2015).

Since the 2000s, the FTC began filing successful claims against large hospital mergers. Within the last year the FTC has combated mergers in West Virginia, Pennsylvania, and Chicago. However, these successes were only the most egregious cases involving horizontal mergers between hospital systems, and hardly addressed vertical mergers due to abiding to a different set of antitrust laws. Hospital systems that are merging together under the defense that there is a "great deal of upheaval because of profound changes" influencing healthcare are insulating themselves from uncertainty and becoming ever more resistant to urgently

needed reforms of the future (Curfman, 2015).

While more attention is being brought on the consequences of hospital consolidations, it does not seem that there will be a major reversal of such practices anytime soon. Future physicians can look forward to entering a job market with less negotiating power, lower reimbursement, and greater need for specialization of their services over primary care careers. As hospitals move from fee-for-service to value-based models, physicians will find themselves being trained to pick and choose diagnostic tests and treatments that are the most cost-efficient management for patients. Physicians will also find greater scrutiny of their medical practices as well as less authority. For example, recently a pharmaceutical shortage was found for many hospitals as companies were unable to keep up with the demand of many life-changing generic brands (Fink, 2016). Executives made the call of whether certain patients would receive medication over others, or whether all patients would receive less than recommended dosages. Physicians will frequently find themselves away from these kinds of decisions in the future.

Increased pressure for greater competition amongst healthcare providers can lead to several benefits. There are no quality measures and regulations that take into account lower costs to patients, and such innovations could lead to changes that greatly benefit patients. Network strategies that allocate insurance reimbursement between broader areas is another option for providers, though this puts a greater burden on out of network options (McClellan, 2016). Secondly, as one JAMA Viewpoint argues, Medicare should incentivize Accountable Care Organizations (ACOs) that pursue, "organizational structures that do not involve joint ownership of all assets" (Xu, 2015). Finally, transparency on services and claims data will allow research on the effect of consolidation on costs and quality.

While several natural factors have forced the rampant consolidation of hospitals in the recent decade, the unmitigated phenomenon is leading to more alarming consequences. Curtailing the explosion of mergers can lead to several benefits, however requires greater regulatory force achievable only by increased awareness. Such action is essential to avoid leaving behind patients and future physicians, the future shareholders of medicine.

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