The Current Wave Of Hospital Consolidation: Cause And Effect

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I. Introduction and Background

Hospital consolidation is back. After the unprecedented peak of the late 1990s, M&A activity in the hospital sector is accelerating again.

There are important differences between now and then. The consolidation of the '90s was largely viewed as a response to pricing pressure from managed care penetration; the current trend is multi-causal. A perfect storm of events appears to have spawned an exceptionally vibrant market for local deal-making on the one hand and national private equity participation on the other.

II. Drivers

The robust forecast for an increased rate of M&A in this sector is based upon compelling drivers:

Private Equity

Until recently, private equity firms had some, but not large-scale, involvement in the hospital sector. It has been suggested that this somewhat tepid enthusiasm was due to concerns about regulatory oversight and reimbursement uncertainty. However, in light of numerous recent developments (e.g., the enactment of the Patient Protection and Affordable Care Act [ACA] and the build-up of investment capital), private equity firms have developed the expertise to evaluate and engage in transactions in this sector and are aggressively pursuing hospital acquisition strategies.

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Drivers Underlying Private-Equity-Funded Transactions

Healthcare expenditures are expected to exceed 20 percent of GDP (more than $3.3 trillion) by the year 2018. The healthcare provider sector is a relatively stable sector poised for steady growth as the U.S. population ages. Accordingly, investing in hospitals is perceived as a relatively stable investment strategy. It has also been suggested that the private equity markets are now poised for investment in this sector after holding back in the aftermath of the 2008 financial crisis.

Acute-care hospitals need to invest in infrastructure and must have access to capital. However, according to the American Hospital Association, approximately 30 percent of hospitals had negative operating margins in 2009. Eleven percent have profit margins of less than 2 percent. Accordingly, many hospitals have difficulty obtaining necessary capital for investments in infrastructure.

Clinical integration will require investment. For some hospitals, clinical integration is, arguably, their only path to survival. As Accountable Care Organizations (ACOs) become established, so will the need for costly upgrades to information systems that are needed to integrate clinical care rendered by networks of physicians, hospitals, outpatient facilities, home health providers, etc. Many acute-care hospitals are therefore considering different models of participation from outside investors.

Struggling Nonprofit Hospitals

An accumulation of circumstances places many nonprofit hospitals in difficult financial predicaments, and indeed, there will be hospital closures by those institutions that either have no suitors or fail to effectively respond to overtures. Put more succinctly, “hospitals can close, or they can merge with other hospitals.” Indeed, approximately 15 percent of acute-care hospitals have closed in the past 25 years.

Substantial reductions in Medicare revenue imposed by the ACA are an additional factor. Note, for example, the following cost-savings items incorporated into the ACA: reduction in readmissions, reduction in hospital-acquired conditions, and modifications to the market basket adjustments. According to CMS, the 10-year savings from these three initiatives will exceed $210 billion, signaling a substantial reduction in Medicare revenue that would have historically flowed to acute care hospitals, at least in part.

The build-up in infrastructure is not limited to software and hardware systems. It includes vertical infrastructure with other providers in their communities such as primary and specialty care physicians through employment arrangements. These arrangements must be attractive to key physicians in the community in order to maintain the hospital’s competitive edge.

The relatively high unemployment rate is also a factor. Individuals who have lost health insurance coverage forego using health care services, thus adding additional downward pressure on the utilization of acute-hospital services.

Patient Protection and Affordable Care Act

The ACA imposes a squeeze on hospitals by, on one hand, imposing revenue reductions and, on the other, promoting clinical integration. As noted above, acute-care hospitals that intend to form ACOs will have additional expenses arising from ACO development and operations. According to the American Hospital Association, these costs can range from $5.3-12 million for startup and $6.3-14 million for ongoing operations.

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Health Plan Consolidation

It has also been suggested that the consolidation of health insurance plans triggers hospital consolidation. A 2007 study by the American Medical Association found, for example, that in the HMO product market, 99 percent of Metropolitan Statistical Areas (MSAs) are “highly concentrated” under the Herfindahl-Hirschmann Index. The same study found that 100 percent of MSAs are “highly concentrated” regarding the PPO product market. Accordingly, the threat of downward pressure on hospital rates resulting from insurer consolidation may indeed trigger hospitals to respond in kind.

III. Implications Of Consolidation

A. Cost Implications

A widely reported study on the effect of hospital consolidation sponsored by the Robert Wood Johnson Foundation summarized its findings as follows:

The great weight of the literature shows that hospital consolidation leads to price increases, although a few studies reach the opposite conclusion. Studies that examine consolidation among hospitals that are geographically close to one another consistently find that consolidation leads to price increases of 40 percent or more.

It has also been suggested that merged hospitals, even in different geographic areas, can lead to increased prices when a “must have” hospital drives up prices for its “more ordinary” hospital elsewhere. These findings have significant implications regarding antitrust enforcement. (See discussion of antitrust issues below in Section IV.)

B. Quality Implications

The impact that hospital consolidation has on quality of care is less clear. The above-mentioned Robert Wood Johnson report summed up the literature as follows:

On balance, the evidence suggests that increasing hospital consolidation lowers quality. This finding has several caveats, however. It is not robust across the research and there are significant holes in our knowledge. This conclusion is sensitive to both the type of procedure and geography.

A more recent study published by the Congressional Budget Office supports the tentative conclusion expressed in the Robert Wood Johnson report:

Unlike previous studies, this analysis finds that hospital mergers are associated with increased treatment intensity and higher inpatient mortality rates among heart disease patients.

This is not to say that the quality of care provided at the consolidated hospitals declined. Rather, as the author points out, consolidation leading to farther travel time could explain these findings.

C. Services Mix Implications

Hospital consolidation involves non-profit and for-profit hospitals. To the extent the outcome of the consolidation leads to an increased presence of for-profit hospitals, or to the extent nonprofit hospitals act more like for-profit hospitals, distinctive attributes of for-profit hospitals may emerge as more consolidation occurs.

Recent studies of the differences between for-profit and non-profit hospitals are illuminating. It has been found, for example, that an increase in for-profit ownership is correlated with a decline in services for AIDS patients, psychiatric emergency services and trauma. On the other hand, for-profit hospitals are more likely than nonprofit hospitals to offer angioplasty, cardiac catheterization, open heart surgery, pediatric intensive care and alcohol and drug inpatient services. It has also been suggested that for-profit hospitals are more likely to close or restructure than nonprofits.

IV. Heightened Concern About Antitrust Enforcement

Recent statements from the chairman of the House Ways and Means Health Subcommittee and from the commissioner of the FTC strongly suggest there will be increased governmental scrutiny of consolidated hospital arrangements and ACOs.

In his opening statement to recent hearings on the consolidation of the healthcare industry, House Ways and Means Health Subcommittee Chairman Wally Herger offered the following observation:

I recognize that, at least in theory, consolidation can lead to greater efficiencies and improved outcomes. Unfortunately, research has shown that higher prices are more often the result.

And he continues:

In many ways, the Democrats’ health law has made a challenging situation worse as all signs point to the law leading to even greater consolidation as providers try to blunt the impact of the law’s one-half trillion dollars in Medicare cuts and massive new regulations. ... Providers teaming up in preparation for the ACO program are likely to be able to command higher private insurance rates whether or not their ACO is successful.

Notably, President Obama’s FTC commissioner appears to agree with the Republican congressman from California. Characterizing clinical integration as "the biggest loophole in the antitrust laws I had seen," Commissioner Rosch expressed his suspicion of ACOs as follows:

Whatever one thinks about the health-care reform legislation from 2010, it’s hard not to be skeptical about the prospects of the Medicare Shared Savings Program. CMS’s own pilot program was far from a success, and there is a significant risk that, like Medicare and Medicaid generally, any purported cost savings from the program will be offset by higher costs to payors in the commercial markets. Against the very meager prospects for cost savings, there is a very real risk that some ACOs will be formed with an eye toward creating or exercising market power. The net result of the Shared Savings Program may therefore be higher costs and lower quality health care – precisely the opposite of its goal. (emphasis in original)

At relatively high levels in Washington, therefore, the antitrust implications of consolidation in the healthcare industry is certainly being watched.

Adding to this concern is a relatively new strategy implemented by the FTC that employs the use of post-merger data. After a string of losses in the 1990s, the FTC finally succeeded in its 2004 challenge of a hospital merger by using multivariate regression analysis of data obtained several years following the merger.

An amicus brief in a related proceeding filed by multiple economics professors characterized the FTC’s efforts as follows:

In [Evanston Northwestern Health], the FTC combined rigorous new analysis of market power with strong empirical evidence to overcome past objections. In a seeming landmark decision, an administrative court judge accepted the FTC’s conclusion that concentration was excessive and ordered the hospitals to be split up.

It has been suggested that the Evanston Northwestern Healthcare decision, perhaps in light of the FTC’s successful econometric analysis of post-merger data, will lead to more antitrust challenges.

V. Conclusion

Hospital M&A activities now underway will have far-reaching effects and require a heightened sensitivity to recent FTC activities and to strategies for the development of clinical integration.

From a health policy perspective, cost, quality and access to care are likely to be affected by further hospital consolidation, and diagnosis and insurance status will exert even more influence on an individual’s access to healthcare services.