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REPORT

KEEPING SCORE

HOW NEW YORK CAN ENCOURAGE VALUE-BASED HEALTH CARE COMPETITION

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Executive Summary

America's health care system is undergoing systemic changes. While the defining health care reform of this generation is undoubtedly the Affordable Care Act (ACA), passed by Congress, there also exists an important role for state health care regulators and legislators. The goals of reforms such as the ACA—better health, better care, and lower costs—cannot be accomplished without engagement from states. This is especially true when it comes to competition within local hospital markets.

In standard economic theory, competitive markets are thought to produce the optimal allocation of resources through their use of pricing signals. But U.S. hospitals have long argued that competition is antithetical to their successful operation, given the unique characteristics of hospital markets, which include natural barriers to entry and hospitals' safety-net and medical-teaching roles. These characteristics, the argument went, make it difficult to apply competitive norms to hospitals; indeed, they might even frustrate hospitals' efforts to adapt to the ACA by taking on the greater financial risks and capital investments associated with bundled or outcomes-based payment reforms (an increasing priority with private payers, as well as public payers like Medicare and Medicaid).

Post-ACA, we have seen a sharp increase in hospital mergers. Traditional antitrust analysis suggests that the market power gained as a result of these consolidations could frustrate the ACA's intent to improve health care outcomes and lower costs. Meanwhile, defenders of consolidation project that the potential gains in clinical integration and economies of scale will outweigh any potential losses from anticompetitive behavior. This paper examines these core questions of competition in hospital markets as they relate to New York State, particularly in light of the state's ongoing Medicaid-reform efforts: it explores the implications of hospital consolidation in the Empire State for public payers, commercial payers, and patients—in terms of outcomes and costs.

We find that hospital mergers typically result in higher prices, with little improvement in quality; these results are most pronounced in markets that have already experienced a significant degree of hospital consolidation. We find that proponents of greater hospital size tend to ignore the fact that many of the documented benefits derived from hospital mergers are tied to managerial quality, not to size. And we argue that antitrust litigation—because it is infrequently used and does not address existing factors that limit competition in hospital markets—should be only one of several tools deployed by regulators.

INDEED, NEW YORK'S LEGISLATORS AND REGULATORS SHOULD FOCUS ON THE UNDERLYING FORCES THAT HAVE LED TO ANEMIC COMPETITION IN HOSPITAL MARKETS AND SHOULD SEEK TO FOSTER SUCH COMPETITION THROUGH A VARIETY OF SUPPLY- AND DEMAND-SIDE REFORMS:

- 1.** Encourage greater pricing and quality transparency for hospitals, beginning with the full implementation of the state's all-payer-claims database (APCD) in a transparent, consumer-friendly, highly accessible format; for a licensing fee, the APCD should also be opened to commercial researchers to support APCD operations and analysis.
- 2.** Require all health care providers to provide binding cost estimates to patients before provision of service; failure to comply should result in the suspension of providers' tax-exempt status.
- 3.** Prohibit anticompetitive contracts between providers and health care plans that either restrict transparency or prohibit steering patients to high-value providers.
- 4.** Transition state and municipal employees into value-based health plans that leverage cost and quality calculators based on the APCD and other trusted, third-party sources; benefit designs should encourage the use of safe, low-cost, high-quality providers, and reference-pricing strategies should be used for "shoppable" services.
- 5.** Repeal barriers to entry in health care markets—including certificate-of-need (CON) laws, the prohibition on the corporate practice of medicine, and the certificate of public advantage (which immunizes certain providers from antitrust challenges)—to remove unnecessary restrictions on the supply of firms offering health care services.
- 6.** Establish a New York State Health Cost Commission, modeled after the Massachusetts Health Policy Commission, that is mandated to produce annual reports on health care cost and consolidation trends in New York State, including barriers to entry faced by new firms and business models.



KEEPING SCORE

HOW NEW YORK CAN ENCOURAGE VALUE-BASED HEALTH CARE COMPETITION

I. Introduction

The ACA contains several provisions designed to increase health care competition and reduce cost growth in order to offset new spending associated with its Medicaid and private insurance-coverage expansion. Two of these provisions, in particular—reductions in the growth rate of Medicare reimbursement for hospital-based services and incentives for providers to form Accountable Care Organizations—are designed to encourage greater efficiency and care coordination among providers.

However, providers have responded to these changes by consolidating, both with other hospital systems and by acquiring freestanding physician groups. Market power gained as a result of these consolidations could frustrate the ACA's intent to improve health care outcomes and lower costs. Yet defenders of consolidation argue that consolidation will benefit patients and payers by allowing hospitals and other providers to better bear the capital costs and financial risks associated with new contract designs that shift reimbursement toward a quality- and outcomes-based health care system.

For New York State, the interplay between the forces of consolidation, reimbursement reform, and antitrust concerns is likely to be especially complex in the context of Medicaid reform, led by the state's Delivery System Reform Incentive Payment (DSRIP) program.

Medicaid reform is a critical state priority. The program has been hobbled for decades by high costs, inefficient use of resources, and mediocre outcomes for patients, as noted in the final report of the Medicaid Redesign Team convened by Governor Cuomo in 2011:

New York’s Medicaid program, the nation’s largest, spends nearly \$53 billion to serve 5 million people, which is twice the national average when compared on a per recipient basis. At best, New York is in the middle of the pack when it comes to health care quality.... [W]hile national rankings tend to show New York in the middle of the pack when it comes to overall health care quality, those overall statistics mask major problems in areas such as avoidable hospital use, where New York ranks 50th in the country. Major disparities exist in health status among racial, ethnic, and socioeconomic groups in New York State. These quality issues are not limited to Medicaid but are reflected in the entirety of the health care system.¹

New York’s policymakers must carefully balance two competing concerns. The first is that Medicaid reform allows the state to drive greater efficiencies throughout the program, delivering better outcomes for beneficiaries at the same, or less, cost for taxpayers. Second, the state will have to be careful not to entrench the market power of large health care systems, already among the state’s leading employers; and it will have to allow smaller (and, perhaps, more innovative) providers to enter the market and compete under new, value-based payment arrangements.

These goals are not incompatible; but they require a careful analysis of the state’s current competitive landscape and a willingness to implement reforms to encourage greater competition—not only across the Medicaid program but across every health care market segment. Progress in antitrust analysis over the last two decades has generated a wealth of empirical evidence on the impact of provider consolidation on health care pricing and quality. Policymakers should use this evidence to identify and address barriers to competition across New York’s health care system.

In this paper, we begin with a brief historical overview of the national landscape of hospital competition and consolidation, with a focus on the empirical evidence on the effect of hospital consolidation on prices, total spending, and quality. While we observe that there may be theoretical benefits to consolidation, empirical research generally finds significant harms to consumers from reduced hospital competition.

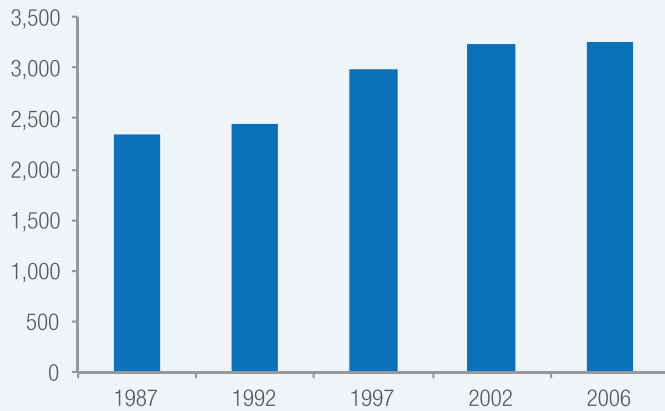
Though we are sympathetic with the concerns voiced by federal antitrust regulators, antitrust litigation is a very narrowly crafted tool. Successful antitrust litigation is rare, expensive, and time-consuming. Even more limited are conduct-focused antitrust remedies—typically agreed upon by merging entities and state or federal regulators. Such remedies may also be resource-intensive to monitor. Successful antitrust lawsuits may deter the most egregious examples of anticompetitive behavior. But antitrust remedies were not able to check the wave of hospital consolidation that occurred well before the ACA and that continues today.

New York’s broad structural impediments to competition must, instead, be addressed through a wide set of reforms. While policymakers should address the concerns raised by federal antitrust regulators, it is even more critical for policymakers to reframe the state’s role in the day-to-day regulation and licensing of health care facilities and providers to encourage new entrants and to create robust competition. In particular, we believe that the state and New York City, as the largest purchasers of health care, should place much more emphasis on becoming active, value-based purchasers. The state and city should require that the hospital sector participate in transparency initiatives related to the total cost of care for a given diagnosis, quality (not just process outcomes), and safety for the more than 1.3 million active and retired state and city employees,² as well as the state’s 6.5 million Medicaid beneficiaries.³ Similar initiatives in New Hampshire, Maine, and California have already shown promising results.

By adopting best practices now increasingly utilized by large,⁴ self-insured public and private employers, New York’s policymakers can drive competition across multiple markets—Medicaid, dual-eligible, self-insured, and commercial insurance—as well as promote a more rapid transition from volume- to value-based reimbursement contracts. Medicaid reform and statewide initiatives to enhance competition and attract new entrants, in other words, are not an either/or proposition. Later in the paper, we present examples from other large states of successful supply- and demand-side strategies for improving hospital competition that have been enacted by the private sector and by public entities like CalPERS.

FIGURE 1.

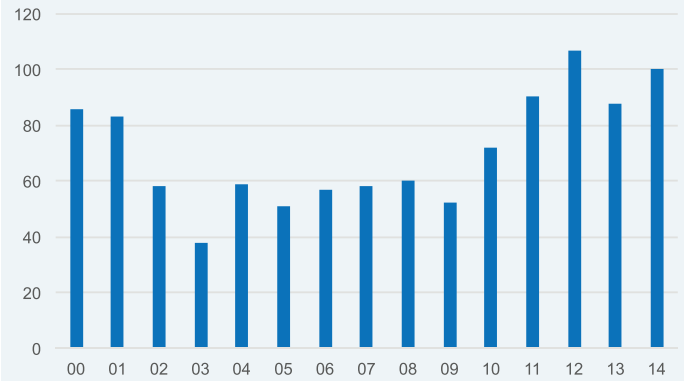
Pre-ACA Mean HHI by MSA, 1987–2006



Source: http://waysandmeans.house.gov/UploadedFiles/Gaynor_Testimony_9-9-11_Final.pdf

FIGURE 2.

Number of Hospital Acquisitions by Year, 2000–14



Source: American Hospital Association TrendWatch Chartbook

II. Historical Trends

Provider consolidation in America's health care sector is generally cyclical, driven by macroeconomic and public-policy changes that lead smaller, independent entities to affiliate with larger systems that have greater bargaining power with insurers.

Figure 1 shows that hospital-market concentration, as measured by the Herfindahl-Hirschman Index (HHI), increased by nearly 40 percent in the decades before the ACA was adopted. During 1997–2006, the number of independent hospitals declined by about 17 percent, while the largest hospital chains (those with multiple facility licenses in a metropolitan statistical area, or MSA) increased in number by 29 percent.⁵

At least some of the consolidation of the 1990s might be attributed to a reaction to the rise of health maintenance organizations (HMOs), insurers with narrow provider networks with little, or zero, out-of-network coverage. HMOs attempted to limit health care cost growth by restricting consumer access to specialists and other costly providers. Hospitals' response to narrow networks and HMOs' bargaining power was to merge with other hospitals and physician groups to counteract the market power of insurers and to lobby for greater network access. Indeed, the merger wave of the early-to-mid-1990s appears to have coincided with the largest market penetration of HMOs. Hospital mergers peaked in 1996 and then plateaued until the passage of the ACA.

Hospital consolidation has accelerated in the wake of the ACA. During 2009–14, the number of announced M&A deals jumped, from 52 to 100 (**Figure 2**).⁷ According to the American Hospital Association, more than 70 M&As have been announced in each of the past five years, compared with 59 in 2004 and 51 in 2005.⁸ Another notable trend involves hospitals acquiring physician groups. Physicians are increasingly gravitating toward hospital- or health-system employment: 30 percent of physician practices are now employed by hospitals, compared with just 16 percent in 2007.⁹ This trend may be driven by the higher reimbursements received for hospitals' outpatient departments—which are also paid facility fees—compared with those for physicians' offices, which do not receive such fees. The added costs associated with the transition to electronic medical records, as required by the ACA, may also be a factor.

Defining HHI

Market shares of individual firms are useful; but averages or medians of market shares blur the effects of new firms entering, or leaving, the market. To understand the effects of consolidation, a common measure of market concentration was needed. The Herfindahl-Hirschman Index (HHI) is used by economists, as well as the Federal Trade Commission (FTC), to determine the level of concentration in a market. A market's HHI is calculated by summing the squared market shares of competitors in a market. For instance, in a market with four firms, with market shares of 50 percent, 25 percent, 15 percent, and 15 percent, the HHI equals 3,575 ($50^2 + 25^2 + 15^2 + 15^2$). The FTC considers markets with an HHI of less than 1,500 to be not concentrated, an HHI of 1,500–2,500 to be concentrated, and an HHI of more than 2,500 to be highly concentrated. (In a pure monopolized market, the HHI would be 10,000.)

However, this simple formula—which can be applied to various measures of market share, including inpatient admissions and revenues—significantly understates the difficulty in determining appropriate hospital markets over which to measure competition. Indeed, much of the disagreement during an FTC merger challenge focuses on determining the relevant market for hospital services. Typically used geographic measures may over- or underestimate the geographic reach of hospital markets. For instance, one analysis employing a “structural” approach to measuring hospital markets implies that traditional geographic measures, such as MSAs, may understate hospital consolidation by a factor of more than three.¹⁰

III. Hospital Consolidation: Theory and Practice

Consolidating firms cite the potential benefits of economies of scale: greater care coordination and/or improved access to capital markets, for investments in new technologies and facilities to improve patient outcomes. Investments in health IT, such as electronic medical records and data analytics, can cost millions to implement, staff, and maintain; such costs are more easily recouped over larger patient populations. Smaller hospitals, with narrower margins, may be unwilling to make these investments without the support of larger hospitals. Smaller hospitals could also benefit from access to the greater bargaining power that comes with the larger group-purchasing organizations used by hospital systems to help lower acquisition costs for new technologies.

Hospitals have also argued that consolidating firms take advantage of staffing synergies by consolidating, or closing, duplicative facilities; and that consolidating firms take advantage of a natural division of labor in areas where they may each have greater competency. Likewise, hospitals may be able to drive greater cost-efficiency and better manage population health when they can improve the quality of care delivered in the community and focus hospital facilities on the highest-needs patients—while reducing inappropriate use of emergency rooms and readmissions.

Economists have generally been skeptical of such claims: well-functioning markets, they note, usually depend on competition between many small and medium-size firms, resulting in lower prices and/or higher-quality products for consumers. In the absence of competition, firms exercise their market power to extract “monopoly rents,” demanding

higher prices and providing fewer, and possibly lower-quality, services than would be sustainable in the face of competition. Before we review the empirical evidence on consolidation, consider the two main types of consolidation or integration that can occur.

Horizontal integration occurs where firms in the same line of business merge (a hospital purchases another hospital, for example); vertical integration occurs when firms that are “upstream” or “downstream” in the same supply chain merge (a hospital purchases an outpatient radiology center). Health care reformers, including New York's DSRIIP program, theorize that consolidated hospital systems will become “vertically integrated delivery systems” that offer greater benefits: better clinical integration, lower costs, and improved population health. These integrated delivery networks (IDNs) will then compete on the basis of cost and quality.

Empirical evidence, however, largely confirms the fears that consolidated firms use their market power to increase prices without delivering greater offsetting benefits to consumers: whether pre- or post-ACA, the evidence suggests that decreasing competition among hospitals results in lower-quality services and higher prices for consumers and payers. A 2012 literature review by health economists Martin Gaynor and Robert Town found that:¹¹

- ◆ Across geographic markets, hospital consolidation results in higher prices; in concentrated markets, price increases can surpass 20 percent.
- ◆ In administered-pricing systems like Medicare, competition improves quality of care. In market-determined systems, the evidence is more mixed but tilts toward improved quality.
- ◆ Vertical consolidation between physicians and hospitals has not resulted in improved quality or reduced costs—much of the motivation for these mergers was to enhance bargaining power, not boost clinical integration.

Horizontal mergers are generally viewed with the greatest skepticism by regulators and economists. One such example was the North Shore Health System’s merger with Long Island Jewish Medical Center in 1997. Today, North Shore University Hospital in Nassau County accounts for 28 percent of inpatient discharges there; similarly, Long Island Jewish Medical Center, located in Queens County,¹² controls some 27 percent of discharges in that county.¹³ Across the “East Long Island” hospital referral region, the North Shore–LIJ health system accounts for over 30 percent of patient days.¹⁴

Though North Shore–LIJ clearly dominates this market—a fact that suggests that any operational efficiencies should, by now, be apparent—outcomes have been decidedly mixed. For example, at four of North Shore–LIJ’s facilities, mortality for heart attacks (acute myocardial infarctions, or AMI) has generally not been statistically different from state levels; North Shore–LIJ’s heart-failure (HF) mortality rates appear to have improved since 2009, but they remain no better than the state average (**Figure 3**).¹⁵

North Shore–LIJ’s AMI and HF Mortality Rates (at Select Facilities) vs. New York State Average, 2009–13*

FIGURE 3.

Year	Hospital	AMI Mortality Rate	HF Mortality Rate
2009	North Shore Forest Hills	NS	Above
	North Shore Plainview	NS	Above
	North Shore University Hospital	NS	Above
	Long Island Jewish Medical Center	NS	Above
2010	North Shore Forest Hills	NS	Above
	North Shore Plainview	NS	NS
	North Shore University Hospital	NS	Above
	Long Island Jewish Medical Center	NS	NS
2011	North Shore Forest Hills	NS	NS
	North Shore Plainview	NS	Above
	North Shore University Hospital	NS	Above
	Long Island Jewish Medical Center	Below	NS
2012	North Shore Forest Hills	Above	NS
	North Shore Plainview	NS	Above
	North Shore University Hospital	NS	NS
	Long Island Jewish Medical Center	Below	NS
2013	North Shore Forest Hills	NS	NS
	North Shore Plainview	NS	Above
	North Shore University Hospital	NS	NS
	Long Island Jewish Medical Center	NS	NS

*NS = not significantly different. Rates are risk-adjusted in the Statewide Planning and Research Cooperative System (SPARCS) data set. Source: SPARCS Inpatient Quality Indicators

It is true that comparing a hospital system with state-level outcomes may not be methodologically sound because the state-level population may not be similar enough to serve as a control. But even studies with adequate control groups struggle to find any quality benefits from horizontal mergers.

Indeed, empirical evidence from well-designed studies suggests that hospital competition improves quality in patient outcomes under administrative as well as market-pricing systems. Two studies cited in the aforementioned Gaynor and Town literature review (which included New York) found lower mortality across a variety of conditions for patients in less concentrated hospital markets.¹⁶ In particular, higher HMO penetration—which translates to lower hospital bargaining power—was associated with lower mortality from gastrointestinal hemorrhage and congestive heart failure.

When it comes to prices, studies that evaluated specific mergers—“event studies”—come to especially alarming results. A 2011 analysis of the Evanston-Highland Park merger in Illinois,¹⁷ for instance, found that price increases there, across payers, were 10 percent–50 percent (or more) higher than those at non-merging hospitals.¹⁸ This particular example might be seen as a partial success story: the FTC required the two hospitals to negotiate separately with managed-care organizations, limiting the anticompetitive effects of the merger. Another FTC analysis—of its failed case against the Sutter-Summit merger in California—found that while Summit’s price increases were statistically similar to a control group across three insurers before the merger, post-merger price increases were 23 percent–50

percent greater than those of the control group.¹⁹

Vertical mergers raise different concerns; though, as with horizontal mergers, the FTC still considers the potential effect of vertical mergers on competition. Determining the latter can be more complicated, particularly when the merger occurs across different industries and services are bundled together. This can allow hospitals to exercise market power across several different lines of business. Renown Health’s acquisition of two cardiology groups in the Reno, Nevada, area, for instance, had horizontal as well as vertical elements. The effects of the expansion therefore involved more than a simple increase in HHI. As a provider of acute hospital services, Renown Health entered into a better bargaining position with payers overall. More important, the complaint to the FTC alleged that Renown Health would not only become the employer of 97 percent of cardiologists in the area but also that the non-compete agreements that the doctors would be forced to sign would reduce potential competition in the market for cardiology services.

Further research examining ownership changes at three clinic systems in Minneapolis found that when integrated delivery networks acquire new clinics, referrals to their own hospitals tend to increase.²⁰ A recent National Bureau of Economic Research working paper similarly finds that financial interests and bargaining power are the likely drivers of physician-hospital mergers: after such mergers, patients are more likely to be steered to the acquiring hospital and patients are more likely to choose high-cost, low-quality hospitals (**Figure 4**).²¹

Profits Are Higher in Consolidated Markets

FIGURE 4.

Type of Market	Angioplasty	CRM Device Insertion	Knee Replacement	Hip Replacement	Lumbar Fusion	Cervical Fusion
Consolidated	\$32,411	\$47,477	\$26,713	\$29,140	\$51,998	\$23,755
Margin	62%	50%	55%	56%	54%	49%
Competitive	\$21,626	\$30,399	\$18,337	\$19,534	\$39,568	\$18,370
Margin	49%	36%	35%	36%	36%	39%

Source: https://ajmc.s3.amazonaws.com/_media/_pdf/86aee848e56115f8d8d43711599ce6ef.pdf

There is also little evidence that IDNs offer the theoretical benefits claimed by merger proponents. A review of 15 IDNs and of the literature on physician-hospital integration found “little evidence that integrating hospital and physician care has helped to promote quality or reduce costs.”²² The review notes that flagship hospitals tend to be more expensive than their competitors, which suggests that larger health care systems have difficulty exploiting greater economies of scale.

These examples illustrate why economists generally have significant concerns about mergers, which are often impossible to undo, once consummated. As Gaynor observed: “[When the

government gets involved] post facto ... [mergers] are hard to undo.”²³ As such, antitrust litigation has its place. And an FTC with powerful analytic capabilities and strong leadership is needed. But relying solely on litigation is a high-risk strategy: the FTC’s string of losses in antitrust litigation in the mid-to-late 1990s began after the introduction of a new, flawed approach to examining hospital mergers (**Figure 5**).²⁴ Strategic behavior by the FTC—picking the cases it is most likely to win, while not challenging most mergers—means that the underlying market structure is unlikely to be changed, or even significantly slowed, by antitrust litigation.

Mergers Challenged Since 1989*

FIGURE 5.

Year of Action	Merging Parties	Vertical or Horizontal	Location	Merger Blocked?
1989	Rockford Memorial Corporation— SwedishAmerican Corporation	Horizontal	Rockford, IL	Yes
1994	Ukiah Adventist Hospital— Adventist Health System/West	Horizontal	Ukiah, CA	No
1995	Freeman Hospital—Oak Hill Hospital	Horizontal	Joplin, MO	No
1995	Mercy Health Services— Finley Tri-States Health Group	Horizontal	Dubuque, IA	Merger Abandoned
1996	Butterworth Health Corporation— Blodgett Memorial Medical Center	Horizontal	Grand Rapids, MI	No
1997	Long Island Jewish Medical Center— North Shore Health System	Horizontal	New Hyde Park, NY	No
1998	Tenet Healthcare Corporation— Poplar Bluff Physicians Group	Horizontal	Poplar Bluff, MO	No
2000	Sutter Health System—Summit Hospital	Horizontal	Oakland, CA	No
2005	Evanston Northwestern Healthcare Corporation—Highland Park Hospital	Horizontal	Evanston, IL	No/Remedies
2008	Inova Health System Foundation— Prince William Health Systems	Horizontal	Manassas, VA	Merger Abandoned
2011	ProMedica Health System— St. Luke's Hospital	Horizontal	Lucas County, OH	Yes
2011	Universal Health Services— Psychiatric Solutions	Vertical	Multistate	No/Remedies
2012	OSF Healthcare System— Rockford Health System	Horizontal	Rockford, IL	Merger Abandoned
2012	Renown Health—Sierra Nevada Cardiology Associates— Reno Heart Physicians	Vertical	Reno, NV	No/Remedies
2014	Community Health Systems— Health Management Associates	Horizontal	Multistate	No/Remedies
2015	Phoebe Putney Health System— Palmyra Park Hospital	Horizontal	Albany, GA	No/Remedies

*Year of action is when the merger was blocked, permitted, or abandoned; in the Phoebe Putney case, for instance, we use 2015 as the last year of action because the consent order was issued in 2015, even though the Supreme Court decided the case in 2013.
Source: Capps 2010, FTC Annual Reports 2009–14, Gaynor 2012²⁵

Are There Unique Factors Affecting Post-ACA Mergers?

In theory, the recent attempt to move toward outcomes-based contracting could help offset the potential market power afforded by consolidation. As Kenneth Davis, president of New York's Mount Sinai hospital, argued in the *Wall Street Journal*: “[H]ospital mergers now offer the potential for higher quality and more efficiency.”²⁶ This line of reasoning is based on the recognition that natural barriers to entry may make competition less desirable in an industry with high fixed costs and low marginal costs and that consolidation allows better coordination of care than in a more fragmented delivery system. While past mergers may not have demonstrated these benefits, new payment contracts, such as bundled payments and accountable care organizations (ACOs) that offer performance bonuses—or, conversely, withhold payments for not meeting metrics—may hold providers more accountable for their performance than was the case in the past.

It is also true that integrated networks that deliver better care at lower cost should provide enough of a benefit to payers and consumers to capture greater market share *without* these types of contracts in place. If barriers to entry and competition frustrate the success of otherwise high-performing IDNs (or other new entrants), reformers should reconsider the ability of contracting practices alone to drive cost and quality improvements in the absence of effective competition.

IV. Kaiser Permanente

Kaiser Permanente—a California-based IDN routinely praised for its commitment to cost containment and patient outcomes—has many of the characteristics identified by merger proponents. Indeed, policymakers and providers routinely point to Kaiser as a paradigm for the type of clinical-care improvements that are possible from vertical mergers. Kaiser owns and operates its hospitals (but not the physician practices) and has a separate entity that sells insurance as an HMO product. Kaiser’s high-quality, if not always low-cost, delivery system has become a byword for efficiency among health-service researchers. But even Kaiser has found it difficult to replicate this success outside the Golden State.

In 1985, Kaiser, already successful in California and Oregon, entered the North Carolina market.²⁷ Though the structure of its organization in North Carolina was similar to its operations elsewhere, Kaiser did not own any hospitals in North Carolina. Instead, it contracted for inpatient services. Kaiser’s first target was state employees: by 1993, it had the highest enrollment of any alternative to the employees’ indemnity option. Kaiser’s enrollment in the private sector was strong, too: by 1997, total enrollment hit 134,000 (though, by then, the organization was in decline in North Carolina, with total net losses of nearly \$126 million during 1996–99). Over the next few years, however, enrollment slowly declined. In 1999, Kaiser shuttered its North Carolina operations.²⁸ Why did Kaiser’s operations fail in the Old North State?

Kaiser appears to have had a “first-mover advantage” in markets where it was a pioneer, where regulations likely evolved around Kaiser’s preexisting structure, and at a time (1950s–1970s) when there were few real managed-care competitors. In North Carolina, however, regulations were built around separate insurers and hospitals, discouraging strong financial incentives for care coordination. Kaiser could not send patients outside the Raleigh area for specialist care, even when doing so would have led to lower prices; other kinds of patient steerage were prohibited, too. Kaiser’s failure in North Carolina also appears to have been driven by competition from other health plans. As more HMOs entered the market in the 1990s, Kaiser’s rate of growth in enrollment slowed, even among public workers—a fact that supports the first-mover advantage hypothesis. Kaiser’s dominance in California may thus be, in part, the result of high natural barriers to entry, which have limited competition from other plans. North Carolina’s stringent benefit-design requirements (tied to the indemnity-plan option) under the public-employee health plan limited Kaiser’s ability to tier benefits and offer more competitive premiums. Even when Kaiser’s cost to the state was lower than the traditional indemnity plan (true in the first year), enrollees could not reap financial savings by choosing a less

expensive plan.²⁹ This made it difficult for Kaiser’s lower-cost business model to compete with less efficient plan designs.

Though state policymakers believed that Kaiser and other HMOs cherry-picked healthier patients, the opposite was likely true: premiums for Kaiser’s offerings were typically higher than the indemnity plan. Nonetheless, North Carolina imposed a \$10/month surcharge for HMO enrollees up to age 40.³⁰ This risk adjustment did not include other conventional measures of risk, such as gender and illness severity. Instead, the surcharge was used to set up a surplus fund for the indemnity plan. This meant that—all else being equal—the indemnity plan could charge below cost while the HMOs had to price above cost (charge higher premiums). The implicit subsidy of the indemnity plan, combined with the lack of consumer incentive to enroll in lower-priced plans, resulted in enrollees leaving Kaiser for the indemnity plan during the early-to-mid-1990s.

Cultural and organizational factors also played a role in Kaiser’s failure in North Carolina. The company faced significant opposition from the state’s medical community, which was reluctant to embrace the prepaid group practice (PGP) model.³¹ Kaiser also likely underestimated the risk pool it needed to enroll: the Research Triangle market, where Kaiser focused its recruitment efforts, did not have the population density to provide the economies of scale required to manage regulatory burdens and offset marketing and entry costs.

Kaiser initially assumed that financial viability would be achieved with enrollment of about 40,000 people; but the real number was likely closer to 100,000 people—in the Research Triangle alone. Management challenges included unrealistic assumptions about the value of Kaiser’s brand in driving enrollment and the ability to maintain a 15 percent–20 percent price discount relative to competitors. It is also true that, in North Carolina, Kaiser did not own its hospitals and initially had to contract out with specialists, which limited Kaiser’s control over provider cost and utilization patterns.³²

A critical factor in Kaiser’s success in other markets, including the Federal Employees Health Benefit Program, has been benefit designs that allow enrollees to capture savings accrued to lower premiums, thereby driving a value-oriented market:

[A]n important factor has been strong backing from influential local organizations (e.g., unions) and institutions (medical center affiliation). Local sponsors such as unions have provided an enrollee base and lent important political support. On the West Coast and in Colorado, Kaiser had strong backing from the AFL-CIO, which liked its emphasis on comprehensive benefits and preventive medicine and demanded that employers offer Kaiser as an alternative to traditional insurance.³³

More recently, Kaiser's model failed in Ohio: two years after acquiring Kaiser's Ohio business, insurer HealthSpan is shuttering it after failing to earn profits in the individual and small-group markets.³⁴ The substantial real-world evidence highlighting the negative effects of hospital consolidation thus contradicts many of the theoretical arguments offered by proponents of consolidation. Why might this be?

As noted, Kaiser's success in California—and failure in North Carolina and Ohio—cannot be attributed to a single factor: the company's physician-led culture, interdependence between provider and insurance units (Kaiser is an HMO), and local market forces all exerted influence. For instance, whereas Kaiser relied on cooperation with local medical groups to drive efficiencies in California, much of America's current wave of provider consolidation is led by hospitals, not physicians.

More broadly, evidence on the success of ACOs, a type of IDN, is mixed: of 333 Medicare ACOs, 152 (45 percent) had spending greater than the benchmarks; 89 (26 percent) spent below benchmarks but not enough to qualify for

shared savings; and only 86 ACOs (25 percent) saved enough to share savings with Medicare.³⁵ The total amount saved thus represents about one-tenth of a percentage point of Medicare spending over two years and was driven by higher benchmarks, not lower utilization.³⁶ The ACO experiment has seen better outcomes at physician-led ACOs, which reinforces the assertion that hospital-led organizations should not be the focus of DSRIP.

All this suggests that bottom-up management may be necessary to establish compliance with the evidence-based protocols and stringent peer-review norms that can enable success in capitated, or outcomes-based, contracting environments. On the other hand, top-down hospital management of multiple, formerly independent, groups of physicians and specialists may, along with larger built-in capital costs, limit the ability of new, vertically integrated organizations to control costs and reduce unnecessary utilization. This would explain why cost efficiencies have been difficult to achieve and replicate in IDNs to date.

Measuring Quality

Without reliable measures for health outcomes, shifting reimbursement contracts to reward value, not volume, will be difficult, if not impossible. Fortunately, there are many measures already available that, while not ideal, provide a platform for policymakers, insurers, and providers to improve. The 83 Healthcare Effectiveness and Data Information Set (HEDIS) measures are used by 90 percent of U.S. insurance plans “to measure performance on important measures of care and service.”³⁷ The Agency for Healthcare Research and Quality operates a primary-care practice-based research network (PBRN) that brings physicians together “to answer community-based health questions and translate research findings into practice.”³⁸ The Patient Centered Outcomes Research Institute, the Health Care Transformation Network, and other multi-stakeholder groups can also develop valuable information on clinical best practices for high-needs populations and develop the evidence needed to establish baseline quality-improvement metrics.

It is also true that the evidence-based, as well as best-practice, patterns will evolve over time in response to new technologies. As such, organizational and physician learning will be a key component of continuous improvement. Clinicians will need to use all available tools to make the best decisions, not simply follow rote protocols: when compared on a risk-adjusted basis, the AMI mortality rate, for instance, can indicate a hospital's performance in relation to its peers; but other measures, such as documenting whether physicians gave discharge instructions to asthma patients, may simply be “an exercise in futile box-checking.”³⁹ Further, clinicians will need to be aware of the comparative cost and effectiveness of the tools at their disposal.

Creating a dynamic health care learning system should be the ultimate goal of New York's policymakers. In the process, better-targeted outcome measures will be needed to drive patient-centered decision making across the state. Data platforms—including all-payer-claims databases and other transparency tools that allow researchers to differentiate the most useful outcomes and quality measures with increasing detail—are useful and should be adopted with care.

V. The Limits of Antitrust

If the ACA is to lower costs and improve quality and patient satisfaction, New York’s policymakers must encourage robust competition in the state’s health care markets. Targeted deregulation would allow a greater variety of business models to compete. Expanded geographic markets would widen the scope of competition. And government acting as a value-based purchaser would drive more efficient practice patterns—with positive spillover effects in the commercial and self-insured markets. Without these reforms, consolidation in hospital markets will continue apace as a de facto attempt to blunt the pro-competition aims of federal and state reformers. Policymakers must therefore focus on the core problems that have prevented effective competition from developing throughout America’s health care sector.⁴⁰

Poor Transparency on Pricing and Quality

It can be difficult for even large purchasers of health care services (self-insured employers, say) to understand the true quality and costs of the services provided by hospitals. Until recently, hospitals—and even insurers—have been reluctant to make cost, quality, and safety data broadly available to enable more sophisticated analysis on a risk- and quality-adjusted basis.⁴¹ In the absence of these metrics, patients and employees have often assumed that high-cost automatically equals high quality and that larger networks and famous hospitals are always better.

Despite recent reform efforts, New York still received an F grade on Catalyst for Payment Reform’s 2015 review of state transparency laws.⁴² Nine of ten plans in New York’s commercial sector have cost calculators, but only 40 percent of physician- or hospital-selection tools have integrated cost calculators; and only 60 percent of plans report costs to members that take benefit design—including copays, deductibles, or coinsurance—into account.⁴³

High Natural and Regulatory Barriers to Entry

Many states, including New York, have CON laws; many states prohibit the corporate practice of medicine; and many states have licensing requirements that make it difficult for new providers and business models, such as telemedicine, to enter the market. Building hospitals is very expensive and time-consuming; but in New York, only nonprofit entities are allowed to run hospitals.

Ill-advised regulations and laws also limit the ability of integrated networks, such as Kaiser, to compete: North Carolina’s definition of service areas prevented the steering of patients to lower-cost providers; and the state’s insurance-benefit design gave little incentive for employees to consider the lower-cost insurer’s option. (In New York, state

employees are at least offered several insurance options—though it is not clear if any are value-driven.) Given that they are often among the largest employers in their cities and counties, hospital systems’ ability to use their political clout to suppress competition is hardly surprising.

Fragmented Reimbursement Systems

Different payment rates among Medicaid, Medicare, and private employers make it difficult to identify a real market price for delivering a given bundle of services to a given patient population. Providers often argue that these price discrepancies reflect necessary cross-subsidies that sustain the provision of charity/uncompensated care, safety-net providers in rural areas, and physician training. But without the market discipline that price competition imposes, providers have little incentive to improve efficiency and contain cost growth by eliminating unnecessary services and facilities. Because Medicaid funding is split between the state and federal government, states also have less incentive to reduce unnecessary or wasteful Medicaid spending—cutting one dollar of state spending requires cutting three dollars of total Medicaid spending.

While the harm inflicted by consolidation is well documented, fighting consolidation via antitrust litigation will not, as discussed, alleviate the core challenges facing America’s health care market. Some regulation is necessary to maintain quality; but much anticompetitive regulation should be discarded, and other useful tools to increase transparency should be embraced.

Previous Health Care Reform Efforts

America’s two most recent attempts at nationwide health care reform offer important lessons for today’s reformers. Although the Clinton health care plan founded in 1992, it was followed by nearly a decade of lower-than-average health care cost growth: HMOs held health care spending at about 13 percent of GDP from 1992 to 2000.⁴⁴

Yet HMOs eventually faced a backlash from a coalition of providers and consumers. “Any-willing-provider” laws were passed in many states (though not in New York), eroding the ability of HMOs to tightly manage provider networks. In the absence of meaningful data on cost and quality, consumers voted with their feet for preferred-provider organizations (PPOs), where they had the option of accessing out-of-network providers at slightly higher cost.⁴⁵ In the early 2000s, PPOs became the dominant form of private health insurance;⁴⁶ by 2005, health care’s share of U.S. GDP had risen by 2 percentage points.⁴⁷ And by the late 2000s, health care cost growth had reemerged as a pressing political and economic concern.

The key lesson from the earlier failure of HMOs (which are seeing a resurgence on the ACA's exchanges and among some employer plans, in the form of tiered networks)⁴⁸ is that patient-consumers must buy in to new health-utilization strategies that aim to offer better outcomes at lower costs. Without meaningful transparency on cost and quality, patients assume that efforts to control costs are a tool for increasing insurer profits rather than ensuring better quality.

Today, the ACA is driving another round of hospital consolidation, as hospitals seek greater negotiating power against insurers looking to impose network restrictions on providers. The ACA itself contains a number of reforms designed to reduce hospital utilization by emphasizing more community-based and medical home-based care for patients with chronic illnesses. The ACA also provides stronger incentives for providers to engage in more robust competition on price and quality. Hospitals, in turn, are responding to decreased demand for hospital beds by pursuing consolidation. Writes David Cutler of Harvard University and Fiona Scott Morton of Yale University:

A large reduction in use of inpatient care combined with the incentives in the Affordable Care Act is leading to significant consolidation in the hospital industry. What was once a set of independent hospitals having arms-length relationships with physicians and clinicians who provide ambulatory care is becoming a small number of locally integrated health systems, generally built around large, prestigious academic medical centers.... The typical region in the United States has 3 to 5 consolidated health systems, spanning a wide range of care settings, and a smaller fringe of health care centers outside those systems. Consolidated health systems have advantages and drawbacks. The advantages, in theory, include the ability to coordinate care across different practitioners and sites of care. Offsetting this is the potential for higher prices resulting from greater market power.⁴⁹

Must policymakers accept greater consolidation as the price of greater clinical value? We think not: competition is the key to cutting this Gordian knot of integration and cost. A 2015 National Bureau of Economic Research working paper noted that high-quality hospitals tend to have higher market shares but that the correlation is strongest when patients have a choice of hospitals—thereby implying that high-quality hospitals attract patients, directly and through physician admissions:

[O]ur findings of a positive correlation between quality and market share are systematically and substantially stronger among patients who have more scope

for choice: that is, within a condition the correlation between hospital quality and allocation is stronger for admissions that are transfers from other hospitals than admissions that come via the emergency room. We interpret these results as consistent with a role for consumer demand—either by patients or their surrogates—to affect the allocation of patients to hospitals. [emphasis added]⁵⁰

For these reasons, policymakers need to reconsider the assumption that bigger size enables better quality. The number of procedures in which high volumes produce better clinical outcomes is relatively limited;⁵¹ and most hospital systems have already reached the threshold of diminishing marginal returns from consolidation. Improved patient outcomes also reflect care-management processes, such as checklists and team coordination, that have little to do with scale. Effective management can deliver excellent care at smaller institutions, just as poor management can deliver suboptimal outcomes at larger institutions. Above all, more effective management is encouraged by greater hospital competition in a relatively transparent marketplace.

In addition to encouraging hospital competition, technology can sharply lower the costs of care-improvement initiatives. In the area of transparency, in particular, New York is poised to reap important gains. The advent of a statewide health information exchange, the State Health Information Network (SHIN-NY), should allow providers and hospitals to share information related to care, identify care patterns and outcomes, and create virtual platforms for care integration across unaffiliated providers. These efforts can lower the costs and overhead associated with clinical integration.

Ironically—as the debate over the lack of interoperable electronic medical records (EMRs) shows—larger firms may be reluctant to share information with other providers and insurers because it allows patient-consumers to shop elsewhere for better care or lower prices. Indeed, proprietary EMRs represent “new islands of data in which information is seen as a tool to retain patients within their system, not as a tool to improve care.”⁵² Rather than regulate who can deliver care, New York policymakers should focus on encouraging better outcomes and more value-based competition.

Antitrust Concerns in a Rapidly Evolving Market

The traditional tools available to policymakers focus on preventing anticompetitive mergers, disentangling specific lines of services, and limiting price increases (for a period of time or through administrative price-setting). The problem with these à la carte strategies is that they treat the symptoms rather than tackle the underlying problem (insufficient competition); they affect only a handful of the most problematic

mergers; and they ignore the market power that consolidated firms continue to exercise over time, across multiple markets and bundles of care.

Undoing mergers poses more than regulatory and political challenges. One reason that the FTC chose not to force divestiture of the Evanston-Highland Park merger, for instance, was the potentially significant cost of decoupling the joint system, post-merger. While we have a long way to go—patients cannot be expected to navigate today’s system alone, given current limitations on making quality and cost information widely available and easily understandable—policymakers can work to empower patients and their intermediaries by making more information available that allows larger purchasers, insurers, and other intermediaries to create novel consumer-support tools. Such tools would allow patient-consumers to be more comfortable with novel benefit designs (tiered networks, reference pricing, narrow networks) and allow them to choose among competing networks of providers on an apples-to-apples basis (i.e., risk- and quality-adjusted).

In short, while antitrust is, and must remain, a vital tool in New York’s arsenal (the state should work closely with the FTC and the DOJ to analyze and share data on prospective mergers), a complementary strategy can be found in addressing core deficiencies in state markets that handicap competition. These include:

- ◆ Lowering barriers to entry for new competitors and business models.
- ◆ Encouraging greater competition among providers and across geographic regions through value-based purchasing arrangements (medical tourism, for example).
- ◆ Creating labor contracts that leverage gain-sharing between taxpayers and employees through the use of safe and more cost-effective providers.
- ◆ Improving transparency surrounding price, quality, and safety metrics on multiple public and private platforms (including exchanges, APCDs, State-wide Planning and Research Cooperative System [SPARCS], and SHIN-NY).

By effectively merging supply- and demand-side reforms, policymakers can address the root causes of the lack of competition in health care markets without micromanaging provider experimentation—and potential consolidation—among providers.

VI. State-Based Health Care Competition

Responsibility for the day-to-day regulation of health care markets falls largely on state and local legislators and agencies. New York policymakers have historically focused on regulating insurance-benefit designs, as well as insurers’ and providers’ rates, rather than on encouraging pro-competition policies that could boost value for consumers and patients. This focus should change—though this is not a call for wholesale deregulation, it is a recognition that competition can help deliver better value while allowing regulators to focus on their core role of consumer protection (policing fraud, abuse, deceptive marketing, and other forms of anti-competitive behavior).

This pro-consumer regulatory role can be enhanced by making more detailed information available on provider price and quality. Rather than rely on CON laws to police a medical arms race focused on hospital beds, regulators should encourage new competitors who can deliver better services at lower cost, thereby allowing hospitals to focus on the “last mile” of critical care—the treatment of highly complex patients with multiple comorbidities who require intensive management, including occasional hospital care.

Hospitals can leverage their experience and large population databases to directly contract with employers and other payers in managing (and preventing) high-cost cases. Ultimately, this should lead to the development of fewer all-things-to-all-people hospitals and the growth of regional centers of excellence that focus on core areas of competence. As in other industries, the coin of the realm in this area will hinge on effective, timely data analytics. With a renewed focus on competition, policymakers should carefully consider how payment reforms—as New York State is attempting with its DSRIP program—have the potential to create incentives, positive and negative, that can affect competition in multiple sectors of the health care market.

DSRIP

As part of a nationwide effort to inject more value into Medicaid programs, the Centers for Medicare & Medicaid Services (CMS) launched the DSRIP program. DSRIP allows states to redirect supplemental Medicaid funding—used to reimburse hospitals for covering the uninsured and for patients who do not pay their bills—to regional health care systems to invest in care coordination with other providers, to develop primary-care medical homes, to contract with non-health care providers, to reduce spending on Medicaid “super-utilizers” (i.e., the frequently sick), and to adopt alternative, value-based payment contracts.

To date, six states have been awarded multiyear DSRIP funding (two others have DSRIP-like programs).⁵³ At \$12.8 billion, including \$6.4 billion in federal funds, New York's DSRIP program is the largest in the country, with more than 64,000 providers divided into 25 ACO-like "performing-provider systems" (PPSs). DSRIP programs aim to advance better health, better care, and lower costs by developing medical infrastructure and paying for quality reporting and performance.⁵⁴

Henceforth, state departments of health will be held responsible for ensuring that participating providers meet the performance goals agreed to by CMS under each state's expanded 1115 waiver.⁵⁵ If the performance goals are not met, future waiver payments by the federal government are reduced. Unlike some of the initial DSRIP programs, New York's approach is more prescriptive, requiring participants to choose from a list of projects. Participants are then evaluated on the same metrics as other providers in the state. Many of the projects available target high-risk and high-cost populations. Goals include reducing premature birth, reducing HIV transmission and morbidity, and preventing and managing diabetes and cardiovascular disease.⁵⁶

Much of New York's DSRIP initial funding supports system-transformation activities, such as integration. But by the fifth year, 55 percent of such funding will be used for pay-for-performance and 40 percent will go to pay-for-reporting.⁵⁷ As part of its DSRIP waiver, New York has committed to reduce preventable hospital admissions by 25 percent and to shift 90 percent of Medicaid managed-care payments into value-based methodologies based on additional DSRIP measures.

Despite these laudable goals, the program has been controversial. One of the biggest controversies has been the state's issuance of certificates of public advantage (COPA) that immunize DSRIP participants from federal antitrust action under the state-action doctrine.⁵⁸ In April 2015, FTC regulators notified New York of its concern that performance-provider systems may share sensitive financial information that would allow them to gain market power over commercial payers. The letter stated:

FTC staff is concerned that combining the DSRIP program with the COPA regulations will encourage health care providers to share competitively sensitive information and engage in joint negotiations with payers in ways that will not yield efficiencies or benefit consumers. Furthermore, although the DSRIP program applies only to Medicaid patients, the potential anticompetitive effects of information sharing and joint payment negotiations under a COPA may extend

to commercial and Medicare patients as well. For example, it is possible that participating PPS providers would need to share information about all of their patient populations—including commercial, Medicare, and Medicaid patients—in order to properly implement the value-based payment models contemplated under the DSRIP program.⁵⁹

We share the FTC's concerns and believe that New York should consult with the FTC on how these arrangements may affect commercial-rate negotiations. Rather than grant COPA exemptions, the state could empower a state health care cost and competition commission to work with federal agencies to carefully monitor how PPS arrangements may affect negotiations in commercial or self-insured markets. New York should reserve the potential for antitrust action to deter potentially anticompetitive behavior.

More generally, as noted in a 2014 National Academy of Social Insurance report,⁶⁰ states are taking an increasing role in regulating providers' market power in an effort to check health care cost growth. Many of these initiatives are relatively new; but others have shown promising early results and should be considered by New York policymakers and regulators.

California: Banning Anticompetitive Contracts

In 2012, California enacted state law SB1196, which prohibits its "gag clauses" in provider contracts:

No health insurance contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health insurer and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a policyholder or insured of the insurer or beneficiaries of any self-insured health coverage arrangement administered by the insurer.⁶¹

Two other anticompetitive contracting practices that policymakers should consider banning are anti-tiering clauses, which prohibit plans from excluding other hospitals or providers in a given health system, and "most-favored-nation" clauses (banned in 18 states), which require providers to charge a dominant health plan the lowest rate that it negotiates with other commercial payers. These reforms would encourage greater competition and pricing transparency, as well as entry by more efficient providers and insurers who would compete on price, thereby slowing future cost growth.

Massachusetts, Maine, Washington: Leveraging State Purchasing Power

Massachusetts. Short of banning anti-tiering provisions,

another option would require plans covering public employees to offer tiered health plans and to pass premium savings directly to employees. Massachusetts requires insurers that cover state employees to offer tiered hospital coverage. Insurers are only allowed to include one academic medical center, rather than an entire hospital system, in a lower-cost plan. Savings are passed on to state employees. The Massachusetts Health Policy Commission publishes annual cost-trend reports that help regulators, such as the state attorney general, and legislators better understand local cost trends and consolidation's effect on them. When hospital transactions are expected to significantly affect the market, the commission issues a "cost-and-market impact review" to evaluate potential effects. New York should create a similar commission.⁶²

Maine. In 2006, Maine's employee health plan began evaluating provider performance, stratifying providers into different tiers based on various factors, including the Leapfrog Group's Hospital Safety Survey and CMS clinical-outcome data. Patient cost-sharing is lower at "preferred" hospitals: for instance, daily copays of \$100 for inpatient admissions are waived at preferred hospitals. Three years after implementation, the number of preferred hospitals more than doubled.⁶³ In the latest Leapfrog Hospital Safety Survey, Maine has the highest share of hospitals with an A grade (New York receives an F).⁶⁴ Maine's State Employee Health Commission—in a promising example of the potential for collaboration between private- and public-sector employers—uses data from the Maine Health Management Coalition, a nonprofit employer group, to help manage the tiering system that the former established.⁶⁵ New York should build a similar coalition to help guide best practices across private and public markets.

Washington. The Washington State Health Care Authority oversees Medicaid and health benefits for 2.1 million state employees. Since the start of 2016, employees have been offered two high-value networks as an alternative to the standard employee health plan (in addition to offerings by Kaiser and Group Health).⁶⁶ Employees are offered lower premiums and deductibles as an incentive to enroll in high-value networks.⁶⁷ To the extent that these networks use evidence-based standards (rather than simply cost-minimizing standards), Washington is encouraging value-based care and more risk-sharing with providers. High-value networks will likely become narrower, too, placing further competitive pressure on providers.

New Hampshire: Making the Most of an All-Payer-Claims Database

In 2003, New Hampshire became one of the first states to implement an all-payer-claims database. By 2007, the state had developed NH Health Cost, a health care-pricing website

that provides provider- and insurer-specific prices for various procedures. A 2014 California Health Care Foundation report found that the website influenced hospital pricing in the state—though not because it directly affected consumer behavior.⁶⁸ Instead, by documenting large gaps in provider pricing for the same services—between different hospitals and between hospital-based outpatient departments and freestanding clinics—the price differentials displayed on the website became "part of ... the fabric of [public] communication about health care in the state."⁶⁹ Price differentials had long been common knowledge among insurers in New Hampshire. Yet the existence of an independent, trusted third-party source on hospital pricing significantly changed the negotiating dynamic between hospitals and plans and encouraged plans to develop new benefit designs that incentivized patients to utilize lower-cost provider options.

This dynamic played out to dramatic effect in the 2010–11 confrontation between Anthem and Exeter Hospital—a "must-have" hospital in New Hampshire that was also the state's most expensive. Pointing to the NH Health Cost website, Anthem stopped covering Exeter Hospital after the pair's 2011 contract expired. In response, Exeter Hospital offered pricing concessions, pledging to adhere to 3 percent rate increases. After Anthem declined this offer, Exeter eventually agreed to cut prices.⁷⁰

NH Health Cost has also helped encourage "a shift toward insurance products with benefit designs that give consumers financial incentives to be price-conscious when they choose providers."⁷¹ (As noted, price-conscious options include high-deductible health plans [HDHPs], narrow networks, and tiered plans.) HDHP growth in New Hampshire was particularly rapid, rising from just 1.5 percent of commercial plans in 2006 (pre-NH Health Cost) to 18 percent in 2011.⁷² In the small-group market, HDHP penetration was even higher (30 percent). Tiered plans proliferated, too, with different fees for hospital-affiliated outpatient facilities and freestanding labs and clinics, such as Quest and LabCorp. Anthem also deployed a "site-of-service" benefit across its plans, creating tiered copayments for lower-cost facilities.

In 2014, New Hampshire's government, the state's largest employer, added the site-of-service design to its entire workforce. At the same time, price-shopping tools proliferated. Most interesting, hospitals responded to increased competition and lower volumes for previously high-cost procedures by lowering prices and shifting delivery of services to lower-cost settings. Some hospitals even began offering their own price-transparency tools, including discounts to uninsured patients.⁷³

Updating APCDs regularly and providing comprehensive analytics are expensive. Yet such costs are likely to be small, compared with the tremendous savings that APCDs encourage. (States could hire outside experts to warehouse and analyze APCD data.) Following in Colorado’s path, New York’s APCD could offer consulting services for clients, such as private employers, to help offset the costs of maintaining its APCD. For a licensing fee, the latter could even allow external commercial users—hospitals, plans, entrepreneurs, and researchers—to access de-identified data.

VII. Rising Hospital Consolidation in the Empire State

With the third-largest economy in the U.S.—and 15th-largest in the world⁷⁴—it is little surprise that the Empire State has a large, thriving hospital sector. New York has 197 hospitals, with average gross patient revenue of more than \$800 million.⁷⁵ These hospitals provide employment for the state’s large health care workforce—equal to about 9 percent of the total state labor force⁷⁶—and they play a major role in training some 10 percent of America’s physicians (the highest share of any state).⁷⁷ All this, of course, does not mean that New York’s current hospital status quo is ideal—far from it. New York’s hospital markets are ripe for pro-competition reforms.

Measuring Hospital Markets

Because hospital markets tend to be local (though not necessarily within county or zip-code boundaries), statewide measures of hospital competition are not very useful. For this reason, measuring hospital markets according to hospital referral regions (HRRs), hospital service areas (HSAs), or MSAs is more instructive. When calculating HHI using HRRs, this paper excludes hospitals in non-New York HRRs; it uses the Dartmouth Atlas’s City-to-HRR crosswalk to identify appropriate geographic boundaries; and it observes market share at the system, not the facility, level. When using SPARCS data, we define hospital markets by county boundaries.

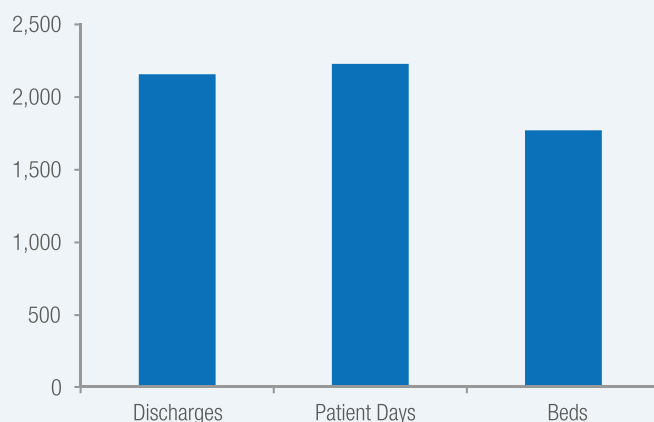
Hospital Consolidation in New York

We find varying levels of consolidation, depending on what data are used. The most recent American Hospital Directory (AHD) data⁷⁸ indicate that, across HRRs, New York’s hospital sector is moderately to severely concentrated (**Figure 6**). This statewide average masks significant variation. For instance, using patient days as the measure of consolidation—and using the FTC’s 2010 merger guidelines⁷⁹—we find that the Bronx is extremely concentrated, with an HHI of more than 4,000; at 1,700, Manhattan is moderately concentrated. We also find that five of ten HRRs in the state are significantly concentrated; three are moderately concentrated; and two are not concentrated.

For perspective on hospital consolidation in New York over time, we use the SPARCS data set public-use files for 2009–13. (SPARCS data cover the entire population of hospital stays in the state; but because the data are not easily comparable on an HRR basis, we focus on county-level breakdowns of total discharges.)⁸⁰ During 2009–13, the average HHI shows

FIGURE 6.

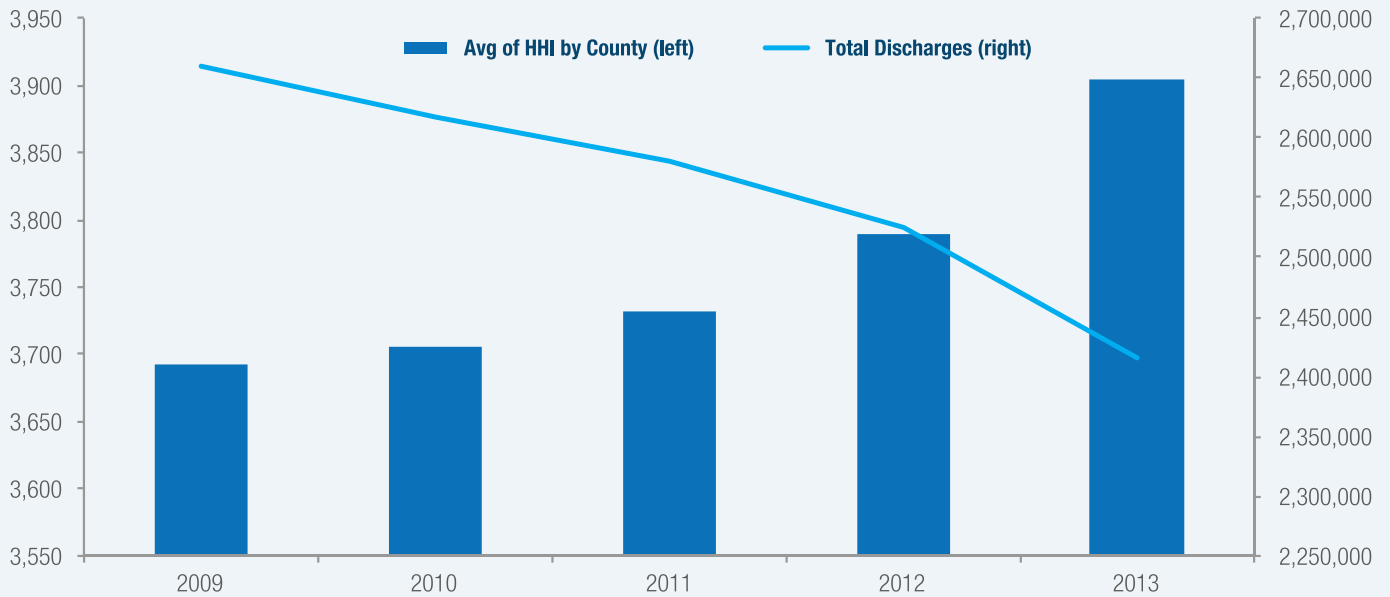
Mean HHI Across HRRs, New York State



Source: Authors' analysis of American Hospital Directory data

FIGURE 7.

Average HHI by County and Total Inpatient Discharges, New York State, 2009–13



Source: Authors' analysis of SPARCS data; HHI is weighted by the number of operating certificates in the county.

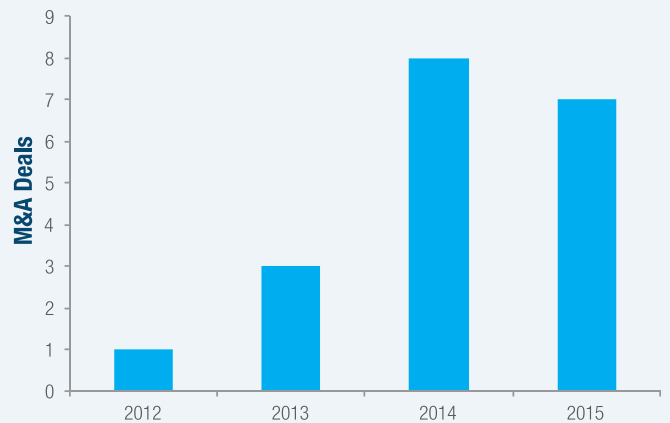
a moderate relative increase of nearly 6 percent (Figure 7). Partly because we use a narrow geographic market—counties, not HRRs—New York’s hospital market appears much more consolidated than traditional geographic measures would indicate. New York’s inpatient market also mirrors national trends in declining inpatient discharges. This decline is likely putting financial pressure on hospitals to find new revenue sources, thereby incentivizing consolidation.

New York’s actual level of hospital consolidation is likely somewhere between what the AHD data and the SPARCS data reveal. Because we do not completely measure SPARCS data at the system level, a narrower geographic measure biases market concentration upward. Instead, we use an “operating certificate number” to identify hospitals—though this does not appear to uniquely identify ownership across counties. Though county-level measures of hospital markets may be too narrow, a narrow bias is not a serious cause for concern because hospital markets are often measured too broadly.⁸¹

Regardless of the absolute measure of consolidation, our findings suggest that consolidation is growing in New York’s hospital sector. The state’s recent wave of hospital mergers and acquisitions (M&As) further supports this conclusion (Figure 8 and Figure 9). During 2012–15, New York ranked sixth nationwide for hospital M&A deals;⁸² in 2014, M&A ac-

FIGURE 8.

Hospital M&A Deals in New York State, 2012–15*



*An M&A deal is counted when the target is located in New York State. We focus only on hospital-based mergers and exclude Sagard Capital’s 2012 acquisition of IntegraMed Fertility.

Source: Authors' analysis of American Hospital Directory data

tivity hit a record high, with nine deals announced. On the eve of broad-based DSRIP reforms that may give providers even more bargaining power, New York’s trend toward greater hospital consolidation is concerning.

Hospital M&A Deals in New York State, 2012–15*

FIGURE 9.

Year	Acquirer	Target
2012	Universal Health Services	Ascend Health Corp
2013	Montefiore Health System	Sound Shore Health System
2013	New York–Presbyterian	New York Downtown Hospital
2013	University of Rochester Medical Center	Lakeside Health System
2014	Bon Secours Charity Health System	Westchester Medical Center
2014	Catholic Health	Orleans Community Health / Medina Memorial
2014	New York–Presbyterian	Hudson Valley Hospital Center
2014	New York–Presbyterian	Lawrence Hospital
2014	North Shore–LIJ Health System	Northern Westchester Hospital
2014	North Shore–LIJ Health System	Phelps Memorial Hospital Center
2014	NYU Langone Medical Center	Lutheran Medical Center
2014	University of Rochester Medicine	Noyes Health
2015	Catholic Health System of Buffalo	Mount St. Mary's Hospital and Health Center
2015	North Shore–LIJ Health System	Maimonides Medical Center
2015	North Shore–LIJ Health System	Peconic Bay Medical Center
2015	Rochester Regional Health System	Clifton Springs Hospital
2015	Stony Brook University Hospital	Eastern Long Island Hospital
2015	Trinity Health	St. Joseph's Hospital Health Center
2015	University of Vermont Health Network	Alice Hyde Medical Center

*An M&A deal is counted when the target is located in New York State. We focus only on hospital-based mergers and exclude Sagard Capital's 2012 acquisition of IntegraMed Fertility.
Source: Authors' analysis of Modern Healthcare's M&A Database

DSRIP: Further Risks

New York's DSRIP program is one of several DSRIP programs encouraged by the HHS. It is also likely the most ambitious, explicitly requiring some degree of association across hospitals and encompassing the largest number of providers. The PPSs that have been selected under the program involve coordination between several large hospital systems. The program, as discussed, aims to improve outcomes and reduce unnecessary hospital utilization. Unfortunately, it may create numerous problems, too.

For example, the Advocate Community Providers PPS—identified as potentially problematic by the FTC⁸³—involves multiple hospitals and hospital systems in the New York City area. The Advocate PPS has applied for a certificate-of-public advantage, which offers immunity from federal antitrust supervision for collaborative activities. (The stated rationale behind the request is vague and alludes to the need for cooperation to achieve DSRIP goals.)⁸⁴ The Advocate PPS has also applied for waivers from New York State referral and revenue-sharing (anti-kickback) regulations.⁸⁵ Acceptance of these applications may encourage joint negotiations with insurers, leading to higher prices with no improvement in quality.

If we were to treat the aforementioned collaboration as a merger, what might be its effect on standard competition? When Manhattan is treated as a hospital market, the effects on competition become very pronounced. According to 2013 data, Manhattan's HHI is 1,411.⁸⁶ The three Manhattan-based facilities (this includes other facilities accounted for by the operating certificate) in the PPS—Mount Sinai Hospital, St. Luke's Roosevelt, and Lenox Hill—account for 32 percent of inpatient discharges in Manhattan. A hypothetical merger would create the largest hospital system (at the operating certificate level) in Manhattan. (New York Presbyterian would follow, at 27 percent.) The effect on HHI would thus be enormous, rising by more than 600 points, to 2,084. (According to the FTC's horizontal merger guidelines, a merger that raises HHI by 100 points or more in a moderately or heavily concentrated area would likely warrant scrutiny.)⁸⁷

This example does not consider the effect of simultaneous PPS consolidations, either. Some hospitals and health systems, such as Calvary Hospital, are participating in multiple PPSs. In theory, if the PPSs engage in joint price negotiations for their members and members are part of more than one PPS, this would enhance the PPSs' bargaining power. In its aforementioned application, the Advocate PPS acknowledges its desire for an integrated delivery system, as well as the possibility that it may be viewed as a "cooperator" of participating hospitals:

[Advocate] will form an IDS with an organizational structure comprised of committed leadership, clear governance and communication channels. ACP's leadership, in consultation with advisory and functional committees, will be largely responsible for decision making that will ensure that the PPS meets project metrics and the overall goals of the DSRIP program.⁸⁸

Simply stated, the greater the extent of a PPS's control over participants, the greater the potential for joint negotiation. This is especially worrisome in the context of COPA antitrust immunity. It is also true that PPSs may be different from traditional horizontal or vertical mergers. For instance, the creation of PPSs under DSRIP is explicitly tied to outcomes and projects—this implies that the primary motivation behind PPSs is not simply to enhance bargaining power but rather to compete in a new regulatory system that imposes financial risks on hospitals. The DSRIP requirement that 90 percent of managed-care-organization payments be tied to value should impose additional discipline on PPSs, too.

PPSs may not endure, either. DSRIP is a five-year program: if it fails to reduce unnecessary hospital utilization and fails to offset lost revenues to participating systems, PPSs will be closed and, with them, any new market power. The opposite is also possible: hospitals and health systems may maintain PPSs—or, at least, affiliations created under PPSs—solely to keep up their new bargaining power. In the latter scenario, it will be even more difficult for regulators to monitor such large, further entrenched providers. For these reasons, New York's policymakers should limit the potentially negative effects of DSRIP consolidation without short-circuiting its potential benefits.

VIII. Policy Recommendations

As noted, effective antitrust enforcement is difficult and time-consuming. Leemore Dafny of Northwestern University finds that the "relevant market" may be more difficult to define than previously believed,⁸⁹ which suggests that the

FTC and the DOJ may need to rethink their market definitions. (Dafny notes that hospitals that acquire firms in an adjacent market gain market power when insurers consider them close substitutes; hospital consolidations in nonadjacent markets do not appear to gain such pricing power.) Nevertheless, New York's policymakers can incentivize far more effective, ongoing hospital-based competition—to complement DSRIP and other state health care reform goals—by implementing the following reforms across commercial, self-insured, and Medicaid markets.

Unleash the Supply Side

Various supply-side restrictions severely limit the ability of new entrants to compete in New York's hospital markets. CON laws raise barriers to entry. Bans on the corporate practice of medicine and for-profit hospitals discourage promising new business models. Repealing these types of restrictions should be a priority. (To assuage the concerns of risk-averse policymakers, these restrictions could be suspended on the condition that new entrants participate in cost- and quality-transparency initiatives, including the state's APCD.)

In particular, policymakers should follow the lead of 15 other states and reform or eliminate New York State's CON law. In the 1970s, New York was the first state to pass a CON law: at the time, proponents argued that if, say, too many new hospitals opened, this would unleash "unnecessary" demand for more medical services; and that, to ensure continued (subsidized) service to low-income and uninsured patients, existing hospitals needed "healthy" profit margins. In practice, CON laws were promoted by powerful incumbents to limit competition. The result has been regulatory capture and artificially high prices for patients. Further, a 2015 Mercatus Center study found no evidence that CON laws boost the supply of care for the poor.⁹⁰

Empower Antitrust

Empowering New York's antitrust regime would help reduce the number of anticompetitive mergers. Follow Massachusetts's successful example, and form a New York State health cost commission, with authority to review "systemically significant" mergers before they can proceed. This would not only enhance the state's ability to challenge mergers; it would also provide state and federal antitrust regulators with useful longitudinal information on statewide hospital competition.

Stimulate the Demand Side

Reform how contracts are designed, and encourage the development of a highly accessible APCD. Though contracts between hospitals and insurers are not available for public inspection, hospitals with market power often incorporate so-called anti-steerage clauses into such contracts. Anti-steerage clauses prohibit insurers from using benefit

designs, such as tiered copays, networks, and deductibles, to prod patients away from such hospitals. Some hospital systems, such as Sutter Health in California, include explicit requirements to steer patients to their facilities—and penalize (by charging higher fees) insurance plans that do not do so.⁹¹

Anti-steering clauses preclude insurance plans from deploying tiered networks, favorable copays, and other tools that penalize inefficient providers. Regulators might ban such clauses altogether; or, as in Massachusetts, they might require plans that insure public employees to offer a tiered-network option, with the resulting savings passed on directly in the form of copay or premium reductions.⁹² Similarly, any contract clause that prevents disclosure of provider prices should be prohibited.

As New Hampshire's experience suggests, pricing transparency's strongest effect on consumer behavior may be indirect: offering a neutral benchmark that other players in the public debate—the media, consumer organizations, and academics—can reference when plans and hospitals negotiate in the public eye. Pricing transparency can also allow plans to experiment with novel benefit designs that employers and consumers may otherwise be reluctant to adopt.

New York should harness its position as a major employer to become a value-based purchaser, too: overly generous insurance can encourage hospitals' market power.⁹³ Making public employees' insurance less generous may be politically difficult; but reforms to encourage greater competition—tiered networks, “hold-harmless” HSAs, and price-comparison tools—may be politically attractive when paired with salary increases tied to slower health care cost growth. Value-based purchasing arrangements should include reduced cost-sharing for using more cost-effective services and products. Reference pricing for discrete, “shoppable” services might also be beneficial. Maine's approach to identifying “preferred” hospitals—including participating in initiatives like Leapfrog's Hospital Safety Survey and displaying metrics prominently for employees—should similarly encourage a “race to the top.”

For Medicaid patients, New York should require managed-care plans to develop capitated contracts. While Medicaid managed-care plans are currently paid on a capitated basis, much of Medicaid spending remains fee-for-service. Moving closer to a system with risk-adjusted capitated payments would impose greater financial risk on hospitals, limiting their ability to use market power to raise prices. With DSRIP funding, capitation—and perhaps even global budgeting—should become more politically palatable as hospitals become better prepared to assume additional risk.

Foster Transparency

Various other reforms with both supply- and demand-side elements are worth pursuing. Requiring hospitals to provide a binding cost-of-care estimate before a patient is admitted would encourage hospitals to reduce unnecessary costs, particularly in an era of high-deductible health plans. New York could copy the U.K.'s mandate that physicians who refer patients to hospitals provide a list of alternative hospitals for patients to consider. To streamline such decision making, New York could make data from its SHIN-NY database easily accessible on a website for patients and physicians—in the U.K., a similar initiative was associated with a decrease in AMI mortality.⁹⁴

Though only a small part of New York's health insurance market, the state's health insurance exchange can serve as a testing ground for new transparency and decision-making tools. Cost-of-care calculators, for instance, could be made available on the exchange and could be customized to insurers' networks; California's exchange, which requires plans to submit claims data, may be worth imitating. Supplemented with quality and safety metrics, New York's health insurance exchange could become a prototype to help patient-consumers identify high-quality, affordable provider networks—and to encourage insurers to construct such networks.

Tax-Exempt Status

Because most hospitals are nonprofits, they reap enormous benefits from their ability to escape property taxes. And because property taxes are the domain of states and localities, New York has a powerful bargaining chip: tax status should be made contingent on charitable-care provision (as in Illinois) or even tied to price changes (hospitals could be required, say, to keep price increases to no more than inflation-plus-1 percent to maintain their tax-exempt status).

IX. Conclusion

In New York and elsewhere, hospitals and insurers have engaged in a consolidation arms race. Some policymakers have responded to this development by suggesting that a duopoly is advisable in health care markets, with a few large hospital systems negotiating with a few large insurers. A more accurate analysis recognizes that without effective competition across the entire health care system, providers and plans will remain high-cost, inefficient, and unable to provide the best mix of technologies and services to consumers and taxpayers at an affordable price.

This paper makes clear that provider consolidation is a threat to the public good. At the same time, providers should not be demonized: they are merely behaving rationally by

responding to current incentives, which discourage competition or misdirect it. If policymakers adopt the aforementioned pro-competition reforms, the losers will be providers that exploit today's conditions of market opacity to charge excessively high prices and deliver poor quality. Under these new and improved conditions, hospitals that currently create good value for patients will be rewarded with more business, as will nimble new entrants.

New York policymakers should not accept the argument that higher-quality services and clinical integration require hospitals to integrate financially. As various high-performing hospitals have shown, clinical integration is largely the result of engaged, informed hospital management that is patient-focused and innovation-intensive. Hospitals have adopted innovations developed by other firms, such as freestanding imaging and surgery facilities and stand-alone urgent-care clinics. But they have not developed such innovations themselves, and, generally, they initially opposed them. Indeed, as New Hampshire's experience shows, without the pressure imposed by greater transparency, pro-competition progress is unlikely to happen.

This paper demonstrates that hospital consolidation rarely delivers the promised benefits. Instead, New York's hospital sector needs meaningful supply- and demand-side reforms, from structural adjustments to value-based insurance, tiered networks, and reference pricing. The reward: hospitals across the Empire State that better serve everyone, no matter their insurance.

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Abstract

In standard economic theory, competitive markets are thought to produce the optimal allocation of resources through their use of pricing signals; but U.S. hospitals have long argued that competition is antithetical to their successful operation, given the unique characteristics of hospital markets, which include natural barriers to entry and hospitals' safety-net and medical-teaching roles. This paper examines these core questions of competition in hospital markets as they relate to New York State, particularly in light of the state's ongoing Medicaid-reform efforts: it explores the implications of hospital consolidation in the Empire State for public payers, commercial payers, and patients—in terms of outcomes and costs.

Key Findings

1. Hospital mergers typically result in higher prices, with little improvement in quality; these results are most pronounced in markets that have already experienced a significant degree of hospital consolidation.
2. Proponents of greater hospital size tend to ignore the fact that many of the documented benefits derived from hospital mergers are tied to managerial quality, not to size.
3. Antitrust litigation—because it is infrequently used and does not address existing factors that limit competition in hospital markets—should be only one of several tools deployed by regulators.