Informational Hearing

Health Care Industry Consolidation and its Impact on California's Health Care Prices

Tuesday, November 17, 2020 ♦ 10:00 a.m. – 12:30 p.m.
State Capitol ♦ Room 4202

BACKGROUND

INTRODUCTION

This hearing will provide an overview of health care consolidation in California across various sectors and the impact on delivery, access, quality, and health care prices. This hearing will include discussion on the current regulatory landscape and explore potential options for addressing the adverse impact of consolidation to consumers and to the health care market as a whole.

HEALTH CARE SPENDING

The most recent data available for California indicate that health care spending in the state totaled $292 billion in 2014. According to the January 2020 California Health Care Foundation (CHCF) report entitled, "Getting to Affordability: Spending Trends and Waste in California's Health Care System," per capita spending has grown steadily over time for all sources of coverage, employer-sponsored insurance, Medi-Cal, Medicare, and private health insurance. Private health insurance coverage faced the highest growth rates at 4% per year. Most of the spending comes from inpatient hospital stays and office-based medical provider services ($60 billion each) followed by prescription drugs ($45.6 billion).

HEALTH CARE INDUSTRY CONSOLIDATION

A critical factor in the fast growth of prices in California compared with the rest of the country is market concentration. This market concentration, including hospital and physician consolidation, has been proliferating in the state along with price acceleration according to a 2019 CHCF report entitled, "Sky's the Limit: Health Care Prices and Market Consolidation in California (Sky's the Limit report)." As market concentration rises, so do prices. The Sky's the Limit report points out that while there are potential benefits to hospital-physician consolidation (also known as vertical consolidation, further discussed below**),** including reduced transaction costs and technological interdependencies that improve coordination of care, such integration can also result in higher

prices, particularly when the hospital or physician organization has significant share in its market. The combined effect of higher hospital and physician prices results in higher health insurance premiums, making healthcare even more unaffordable.

A common type of health care industry consolidation is horizontal consolidation (or concentration) which refers to the merger of the same type of entities, such as two hospitals. One way to measure hospital concentration and its impact on competition is the Herfindahl-Hirschmann Index (HHI), which is used by the Federal Trade Commission (FTC) and the Department of Justice (DoJ). HHI measures market concentration on a range from zero to 10,000. Markets with HHIs between 1,500 and 2,500 points are considered to be moderately concentrated and those with HHIs in excess of 2,500 points are considered to be highly concentrated. Mergers that would increase the HHI in a market by over 200 points and leave the market with an HHI over 2,500 are assigned the highest level of concern and scrutiny according to DoJ/FTC guidelines because of their impact on competition and prices.

A typical argument in favor of hospital consolidation is that efficiency improvements will result from economies of scale and eliminate redundant services and that improvements in quality of care are possible through enhanced care coordination and sustained capital investment to expand clinical services. Stroke intervention and post-stroke care are examples of how hospital consolidation can improve outcomes and potentially reduce costs.

Another type of consolidation is "vertical consolidation." According to a 2019 CHCF blog, vertical consolidation (sometimes also called vertical integration) occurs when entities at different levels of the health care supply chain combine, such as when hospitals acquire physician practices or health plans acquire pharmacy benefit managers. Academic and political interest in vertical consolidation has increased as the rate of independent practices being acquired by hospitals has accelerated. Analysis by the Physicians Advocacy Institute and Avalere Health found that in California the total share of physician practices owned by hospitals increased from 14% in 2012 to 31% in 2018. A 2018 study published in *Health Affairs* found that between 2010 and 2016, the percentage of California physicians in practices owned by a hospital increased from 25% to over 40%. The estimated impact of the increase in vertical consolidation from 2013 to 2016 in highly concentrated hospital markets was found to be associated with a 12% increase in healthcare premiums. For physician outpatient services, the increase in vertical consolidation was also associated with a 9% increase in specialist prices and a 5% increase in primary care prices.

In California, a 2018 report by the University of California at Berkeley Petris Center (Petris Center report) on consolidation in California's health care market found that of the 54 California counties with a hospital, 44 were highly concentrated (HHI above 2,500) and six were moderately concentrated (HHI between 1,500 and 2,500). The mean HHI across the 54 counties analyzed was a staggering 5,613 in 2016. The Sky's the Limit report found that prices for both inpatient and outpatient services rise when market concentration increases. An example on the inpatient side is the association between cesarean delivery price and horizontal concentration of

hospitals. For cesarean births without complications, a 10% rise in hospital HHI is associated with a 1.3% increase in price. An increase in hospital HHI from 1,500 to 2,500 would be associated with an increase in price of $1,152 ($16,386 to $17,538). Outpatient services prices also respond to market consolidation. For example, there is a relationship between head scan prices and horizontal and vertical concentration of radiologists. A 10% increase in radiologist HHI is associated with a 1.4% increase in price. An increase in radiologist HHI from 1,500 to 2,500 would be associated with an increase in price of $44 ($566 to $610).

Consolidation is also growing in the health care insurance industry. In 2015, there were at least four health insurance company mergers considered with implications nationally and in California: Blue Shield of California's acquisition of Care 1st, Aetna's acquisition of Humana, Anthem's acquisition of Cigna, and Centene's acquisition of Health Net. These mergers would have reduced the top five plans to three. While the Blue Shield-Care 1st and Centene-Health Net mergers were permitted, the DoJ blocked both the Anthem-Cigna and the Aetna-Humana mergers as anticompetitive. Anthem's acquisition of Cigna would have made it the largest health insurance company in the U.S. putting United Health into second place. An August 2015 analysis by Cattaneo and Stroud on the impacts of these proposed mergers in California indicated that there would have been minor changes in enrollment numbers resulting in three plans representing 55% of the market, but there would also have been fewer competitors in many counties. With the Anthem-Cigna merger, competitiveness would have been reduced in 31 counties and Aetna-Humana would have reduced competitiveness in eight counties. While the study concluded that major concentration had already occurred prior to the proposed mergers and/or acquisition, the proposed transactions would have further exacerbated the concentrations. There would have been a reduction of competing plans in the majority of California counties, which would likely have resulted in increased contracting pressure on delegated medical groups.

Finally, less pronounced in scope and impact, is prescription drug market consolidation. According to a 2019 Drug Channels article, for 2018, about three-quarters of all equivalent prescription claims were processed by three pharmacy benefit management (PBM) companies: CVS Health (including Caremark and Aetna), Express Scripts, and the OptumRx business of UnitedHealth. The top six PBMs handle more than 95% of total U.S. equivalent prescription claims. This concentration helps plan sponsors and payers, who can maximize their negotiating leverage by combining their prescription volumes within a small number of PBMs. Five of the largest PBMs are combined into companies that offer health insurance and operate specialty pharmacies. This vertical integration is motivated partly by the ongoing growth in specialty drugs. These drugs treat a small minority of patients, but they account for a high and growing share of payers' drug spending. Specialty drug spending, however, is split between the pharmacy benefit and the medical benefit. Patients who take expensive specialty drugs tend to have high medical expenses.

A 2019 University of Arizona study, entitled "Mergers, Product Prices, and Innovation: Evidence from the Pharmaceutical Industry," examined the impact of mergers on product prices

(including prescription drug prices) and innovation using novel data from the pharmaceutical industry. The study cited that the price of Celgene's top selling drug Revlimid rose 3.5% on the day its planned deal with Bristol-Myers Squibb was announced. The study found that product prices increase approximately 5% more within acquiring versus matched non-acquiring firms. These price increases are more pronounced for horizontal mergers and for acquisitions of large and publicly traded targets.

PRICING

As indicated above, lack of competition impacts the overall costs of healthcare, and this lack of competition is exacerbated by multi-hospital systems, which are often involved in many types of mergers and consolidations. A 2016 study published in the *Journal of Health Care Organization, Provision and Financing* examined hospital prices in California over time with a focus on hospitals in the largest multi-hospital systems. The data showed that hospital prices in California grew substantially (+76% per hospital admission) across all hospitals and all services between 2004 and 2013, and that prices at hospitals that are members of the largest, multi-hospital systems grew substantially more (113%) than prices paid to all other California hospitals (70%). The study noted that the substantial price differential was not driven by other factors such as case mix, payor mix, and changes in local wage costs and local market competition or other hospital characteristics.

A 2018 study published in the *Journal of Health Economics* titled, "The effect of hospital acquisitions of physician practices on prices and spending," noted that during the past decade, U.S. hospitals have acquired a large number of physician practices. For example, from 2007 to 2013, hospitals acquired nearly 10% of the physician practices in the study. According to the study, the prices for the services provided by acquired physicians increased by an average of 14.1% post-acquisition. Nearly half of this increase is attributable to the exploitation of payment rules where price increases are larger when the acquiring hospital has a larger share of the inpatient market. The study found that consolidation/acquisition of primary care physician practices increase enrollee spending by 4.9%.

EFFECTS OF CONSOLIDATION ON CONSUMERS

In a Commonwealth Fund-supported study in *Health Affairs*, researchers explored the effect of market consolidation across California between 2010 and 2016 on outpatient visit prices and premiums for individual coverage on the Covered California marketplace. The study concluded that consolidation among health care providers and health plans has the potential to improve the coordination and quality of patient care. However, when markets become highly concentrated, served by a single or a few large health care organizations, competition is curtailed and health care prices and insurance premiums tend to rise.

Recently, the Sky's the Limit report points out that California pays more for common health care services that the rest of the country. Due in large part to market consolidation, there is also wide

price disparity in health care prices and premiums across the state. For example, vaginal delivery is 24% higher in Northern California than Southern California ($13,855 vs. $11,202); the average price of colonoscopy in Northern California is $1,007 while it is $887 in Southern California. The Petris Center report also notes that inpatient procedures were 70% higher in Northern California ($223,278) than Southern California ($131,586). For outpatient procedures, Northern California prices were 17-55% higher than Southern California prices in 2014, depending on physician specialty. Additionally, premiums also vary widely across Covered California's 19 rating regions, with Northern California notably higher than Southern California. However, premiums, hospital, and physician prices are not the only sectors where price disparities exists. Pharmacy costs range from an average of $650 per member per year in several locations, such as Alameda County, Central Valley North, Kern County, and much of the southeastern part of the state to $1,100 per member per year in San Francisco.

Significant price increases in California markets with high hospital-physician employment and hospital consolidation point to the need for careful scrutiny of health care mergers and acquisitions, and further research is needed to determine if price increases are tied to improvements in patient care. For instance, if care is more expensive because it is more comprehensive, then overall utilization and spending should decrease. Experts also point out that regulatory laws and actions may be needed to prevent some health care organizations from attaining unfair market advantages that shut out rivals and raise prices.

CURRENT REGULATORY LANDSCAPE

Three major federal anti-trust laws, the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Act, govern state and federal review of the effects of competition on health care entity conduct and consolidations. Under the Hart-Scott-Rodino Act (which amends the Clayton Act), the FTC and DoJ review most of the proposed transactions that affect commerce in the U.S. and are over a certain size, and either agency can take legal action to block deals that it believes would "substantially lessen competition." California also has its own anti-trust law, the Cartwright Act.

California law also requires the Attorney General's (AG's) review and consent for any sale or transfer of a health care facility owned or operated by a nonprofit corporation whose assets are held in public trust. This requirement covers nonprofit health care facilities that are licensed to provide 24-hour care, such as hospitals and skilled nursing facilities. The review process includes public meetings and, when necessary, preparation of expert reports. The AG's decision often requires the continuation of existing levels of charity care, continued operation of emergency rooms and other essential services, and other actions necessary to avoid adverse effects on healthcare in the local community. Specifically, the law provides the AG with the discretion to consent to, give conditional extent to, or not consent to any agreement or transaction involving a nonprofit health facility based on the consideration of any factors that the AG deems relevant, including but not limited to:

1) Whether the agreement or transaction is at fair market value;
2) Whether the proposed use of the proceeds from the transaction is consistent with the charitable trust on which the assets are held by the health facility or by the affiliated nonprofit health system;
3) Whether the transaction would create significant effects on the availability or accessibility of health care services to the affected community; or,
4) Whether the transaction is in the public interest.

The law also prohibits the AG from consenting to a health facility transaction in which the seller restricts the type or level of medical services that may be provided at the health facility that is the subject of the transaction. The AG is authorized to contract with experts when deciding whether to give consent to a transaction or to monitor ongoing compliance with the terms and conditions of any transaction and requires the nonprofit corporation to reimburse the AG for all reasonable and necessary costs to conduct the review or monitoring ongoing compliance.

Additionally, legislation was introduced in 2018 to strengthen California's oversight of consolidation in the health insurance industry as these mergers can mean fewer choices and competition. AB 595 (Wood), Chapter 292, Statutes of 2018, requires health plans seeking to merge to file notice and secure prior approval from the Department of Managed Health Care (DMHC). In reviewing the proposed merger, DMHC would consider competition in health care service plan products and obtain an independent analysis of the impact of the transaction on subscribers and enrollees, the stability of the health care delivery system, or hold a public meeting when the proposed transaction is considered a major transaction or agreement.

RECENT FEDERAL RULES

Recognizing the need to increase price transparency to empower patients and increase competition among all hospitals, group health plans and health insurance issuers in the individual and group markets, the federal Centers for Medicaid and Medicare (CMS) recently promulgated new rules requiring greater price transparency in the health care industry. Beginning January 1, 2021, hospitals will be required to display a list of at least 300 "shoppable services" (or as many as the hospital provides if less than 300) that a health care consumer can schedule in advance. The list must contain plain language descriptions of the services, group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.

Starting on January 1, 2023, health plans will also be required to offer an online shopping tool that will allow consumers to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services. Finally, starting on January 1, 2024, these shopping tools will be required to show the costs for the remaining procedures, drugs, durable medical equipment, and any other item or service they may need.

OTHER EFFORTS TO ADDRESS HEALTH CARE INDUSTRY CONSOLIDATION

To contain health care costs, many states have established cost containment commissions to establish cost growth targets for health care. One of these states is Massachusetts. In 2012, the Massachusetts Health Policy Commission (HPC) was established to make health care more affordable for its residents. HPC has a broad array of responsibilities, including monitoring health care spending growth by establishing a health care cost benchmark and providing data-driven policy recommendations regarding health care delivery and payment system reform. A key function of the HPC is to issue cost and market impact review (CMIR) of planned health care mergers and a recommendation is submitted to the Massachusetts AG on these proposed mergers and acquisitions. The CMIR report includes an impact analysis of a proposed consolidation on cost and market, quality and care delivery, and access to health care. This year, AB 2817 (Wood) was introduced, which would have established a cost containment commission in California, called the Office of Health Care Affordability, and would have, among many functions, established a cost growth target and monitored trends in the health care market, including consolidation and market power on competition, prices, patient access, and quality. However, due to the COVID-19 pandemic, AB 2817 did not move forward.

CONCLUSION

The growth in health care spending and affordability challenges are not unique to California; many states are exploring multiple ways to control spending. Central to cost containment efforts is defining the appropriate role of the state in the review of proposed health care mergers and acquisitions in order to control health care prices. California needs to look for innovative solutions to address the continuous growth in health care spending and policy makers cannot ignore the growing impact of market consolidation, not only in health care pricing, but most importantly on health care quality, delivery, and access.