

### *Nonprofit Health Care Market Concentration and the Public Interest*

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During the federal health care reform debates, concerns arose from several corners about health plans being too heavily concentrated in some markets. Various Democratic leaders even called for a public plan option and/or new nonprofit “co-op” plans to expand competition in such markets.

More recently, the U.S. Department of Justice (DOJ) has filed a suit against Blue Cross Blue Shield of Michigan alleging that the plan inappropriately used its market position through the negotiation of “Most Favored Nation” provisions in its contracts with many hospitals.

At the same time, concerns also have been raised about the consolidation of health care providers, especially hospitals, and the considerable market concentration that could occur with the creation of accountable care organizations (ACOs). What are the forces behind market concentration? Is such concentration good or bad with respect to the public interest? What role is government playing, and should it play, to protect the public interest in markets that currently are concentrated or have the potential to be concentrated?

These are among the issues explored in the following discussion, another in *Inquiry’s* ongoing Dialogue series, co-sponsored by the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on important nonprofit health care issues. The panelists for this discussion, held on April 18, 2011, were: **Howard Berman**, retired president and CEO of The Lifetime Healthcare Companies, Inc., of Rochester, N.Y., and publisher of *Inquiry*; **Arthur (Art) Lerner**, partner at Crowell & Mooring LLP in Washington, D.C.; **Patrick Madden**, retired president and

CEO of the Sacred Heart Health System in Pensacola, Fla., (now residing in Nashville, Tenn.); and **Lawrence (Larry) Van Horn**, associate professor of health care management and executive director, health affairs, at the Owen Graduate School of Management, Vanderbilt University, in Nashville. **Bruce McPherson**, president and CEO of the Alliance for Advancing Nonprofit Health Care in Washington, D.C., moderated the discussion.

**Bruce McPherson:** *Given that concerns over too much market concentration were primarily directed at health plans during health care reform deliberations, let’s start there. First, have mergers and acquisitions played a big role in health plan market concentration?*

**Arthur Lerner:** The American Medical Association has been releasing studies annually on health plan market concentration, but if you look at the places with the most concentration, mergers don’t appear to have had any impact. For instance, if there is a large Blues plan in a particular state or region, it likely grew that way over many decades.

**McPherson:** *Does health plan concentration create barriers to new entrants or otherwise reduce competition?*

**Howard Berman:** The capital costs involved in entering the health plan market are relatively small. For instance, large employers can self-insure whenever they want and go to whomever they want for administrative services and stop-loss coverage. They just

need cooperating provider networks. In contrast, the capital costs of building a hospital, for instance, are much higher and can create a significant barrier to entry.

Moreover, the larger the health plan's market share, the more vulnerable it is to competitors. Thirty percent of the differential in premium rates is arguably due to demographic factors. I could enter a market and offer low-cost products to the demographically favorable segment. Market loyalty tends to be very fluid on the health insurer side, even more so in today's weak economy. With a large market share, however, I can't do this. I become responsible for the market and can't "cherry pick" it.

**Lerner:** Despite what Howard said, the federal government and some states have been recently acting on the belief that there can be barriers to entry or expansion when large plans are able to get substantial price concessions from providers. At the same time, however, the health care reform law itself imposes regulatory burdens that make it somewhat more difficult for smaller plans to want to play.

**Berman:** Unfortunately, Art, the government's focus on provider price concessions fails to recognize the demographics I mentioned, which substantially affect health care utilization. If a competitor can control utilization better, because of good risks or better care management, price concessions don't matter much.

**Lerner:** I believe that the Justice Department will consider that type of argument. On your point about demographics selection, Howard, I have been seeing recently a number of situations where smaller plans are entering the Medicare Advantage market, which is different than the employer market, because you can offer a product and provider network that only has to satisfy a segment of the market.

**Berman:** I'm seeing the same thing with the Medicare Advantage market. Ads in this market tend to show younger, athletic elderly people and offer deals for membership in health clubs. They are targeting the healthier market segment, making a significant profit through marketing and risk avoidance—not effective care management.

**Lawrence Van Horn:** Segmenting the market to get the better risks doesn't come into play with self-insured employers. Health plans serving this market must be able to help these employers to promote the health of employees, manage their care, and/or provide a provider network with good rates.

**Berman:** Even here, Larry, a small plan can typically buy someone else's provider network.

**Patrick Madden:** Howard, in markets where I've run health systems, we couldn't get more insurance companies to enter. What's going on there?

**Berman:** The answer is that the profit potential isn't there for others to enter those markets, as opposed to other markets. It could be due to government regulation in those markets, as in the case of New York. It could be due to health risks of the population in those markets. It could be due to government pricing in those markets to participate in Medicare Advantage or Medicaid managed care programs. It could be due to the fact that other plans are unwilling or unable to manage care effectively. The fact that one or a few existing plans in a market might be dominant and have achieved certain price concessions isn't necessarily a key or deciding factor in such markets, or even a negative factor.

**Lerner:** You are right, Howard. Government will look at many factors, but like it or not, (government officials) are going to investigate more of these concentrated health plan markets than they have historically. In the proposed health plan mergers that they have investigated very heavily thus far, they have only challenged one, where the combined market share would have been something like 90%. Consequently, we haven't seen yet how far government might go in filing antitrust suits in concentrated health plan markets.

**Berman:** The point that gets lost in all of the allegations about too much health plan market concentration is that the greater the market shares of a health plan, the greater its market responsibility for ensuring an adequate delivery system. Without that, the plan will have nothing to sell.

If the large plan is nonprofit, especially a nonprofit Blue Cross Blue Shield plan or a

health plan that is owned by a nonprofit health system, this is your street corner to protect and serve. You aren't going anywhere else. If you don't serve that market well, others will step in. I've seen this kind of responsibility, for example, in New York, Alabama, and Minnesota. It's a different situation with a for-profit health plan that can pick up and move elsewhere.

**Madden:** Having worked in many concentrated health plan markets, including Florida, Alabama, Tennessee, and New York, it has been my experience that rates and costs were lower. The large plans in those states, which happened to be Blue Cross Blue Shield plans, held our feet to the fire. When you have many players, costs and rates tend to be higher.

**Lerner:** I agree with Howard's premise that there can be something different about a nonprofit health plan's level of responsibility, due to its mission and the composition of its board; however, the Federal Trade Commission (FTC) and the Department of Justice come at it from a law enforcement model which believes that competition among many, where practicable, will on balance result in the best mix of access, price, service, and quality. They're somewhat distrustful of the notion that any monopoly will be a beneficent monopolist acting for the greater good.

**Van Horn:** Right, Art. Health plan market concentration as Howard describes it, "with a benevolent centralist planner" operating on behalf of the population, is a far different model than how goods and services get allocated under a capitalist economy model.

**Lerner:** I think that the FTC and DOJ would agree, from an antitrust perspective, that there's nothing wrong necessarily with any company having a 30%, 40%, 50%, 60%, 80% or 90% market share if it has it because the ways in which it operates work for the community and engender a high level of its trust, support, and loyalty.

The question is whether the plan with a high market share, even a nonprofit plan, engages in activities that abuse its power and suppress the possibility of other competitors entering the market or expanding their market shares. The same question

applies to a large health care provider, such as a large hospital, a large health system, or a large physician office group. It's left to the antitrust agencies to figure out if it is engaging in exclusionary behaviors that lock in the status quo and don't give the market a chance to have other alternatives—if that's what the market wants.

**Van Horn:** In my view, many policymakers have been working off a fundamentally wrong assumption—that there are huge profits to be made in health insurance. I found last year that the profit margins of health plans ranked about 35<sup>th</sup> in the country, well behind chemicals, railroads, and so forth. I also found that the percentage increase in health insurance premiums tracked remarkably closely to the underlying rate of increase in health care costs.

Another misconception that has been used to indict the private health insurance market centers around comparisons of administrative costs as a percentage of total costs or premiums of the Medicare program with that of private health plans. The former's percentage is considerably lower, but it is not clear that it is optimum. Some jump to the conclusion that a single-payer system is the answer, but how effective has the Medicare program been administratively in reducing the rate of increase in its overall spending? Administrative costs in health plans serve a purpose, hopefully to put a break on cost growth. Comparing rates of growth in spending/costs per capita would be a far better and fairer analytic approach.

**McPherson:** *The DOJ has recently filed a lawsuit against Blue Cross Blue Shield of Michigan, alleging that it has abused its market position in negotiating "Most Favored Nation" (MFN) provisions in its contracts with many hospitals, wherein those hospitals cannot negotiate lower rates with other health plans. The DOJ has also publicly stated that it may file similar types of suits in other states. What's going on here?*

**Lerner:** MFN clauses are used in many situations, in a very positive way. Look at where the term comes from—international

relations. Such clauses have been used to facilitate international trade, not to obstruct it. There are many circumstances where such clauses can be presumptively quite proper, such as when you are signing a long-term contract and need to lock in the price terms in a way that protects you in case the market moves in unpredictable ways. I've seen them used in pipeline contracts and when there are substantial expenses involved in changing vendors and you want to keep your partners. Government will step in where it feels that the MFN may not be designed to protect the buyer's ability to compete but rather to obstruct the ability of a competitor. All such cases are fact-specific. In the Michigan case, the DOJ, joined by the state attorney general, alleges that the plan not only bargained to get prices as good as any other payer, but also, in some circumstances, used its size to negotiate prices 30% to 40% below those of other hospitals or payers. The Michigan Blues plan is of course defending itself vigorously, claiming that what it was doing had been approved by the state and that the facts of the case supported the legitimacy of its actions. I can't speak to the specific facts of the case. One of the many facts that the plan may be using is its "insurer-of-last-resort" status.

**Berman:** MFN clauses can be thought about in a different light. At least some Blues plans have argued historically that the provider should charge another plan the same price if that other plan exhibits the same coverage and business behaviors as they do. If the other insurer behaves differently, it should pay a different price and not get a free ride. Otherwise, you run the risk of losing those special behaviors.

I certainly don't know the facts of the Michigan case. But I would argue that if you would ask the question, "Is the state of Michigan and its health care system better off or worse off because of the high market share of the Blue Cross plan?"—which is already regulated by the state of Michigan through its insurance department—I think most people would say that the citizens of Michigan are better off.

**McPherson:** *Let's turn now to health care provider market concentration, especially nonprofit health care consolidation. Is it good, bad, or indifferent, and under what circumstances?*

**Madden:** I have been witnessing more and more concentration of hospitals, and physician groups as well, and most recently more and more hospitals and physicians coming together in various types of arrangements. Many young doctors coming out of training want to work for hospitals.

Clearly, there are opportunities for greater economies of scale and quality improvements with such consolidations. Another reason, but I don't think in most cases the primary reason for such consolidations, is to increase political and financial leverage in negotiations with private health plans and government programs. I see the provider consolidation trend continuing. But an unanswered question for me is: With health care costs rising in the midst of government budget deficits, where does this all lead—to more government regulation, to more privatization of health care financing, to a single-payer system?

**Van Horn:** An alternative hypothesis here is that market power begets market power. Take a market where you have a hospital or another provider that has amassed some market power and has been able to use that in contract negotiations. That provider then is able to expand its domain, through such means as purchasing primary care practices, thus extending that market power to alternative settings, thereby generating even greater returns. Competitors of that hospital or other provider are likely to follow suit if they have some market power.

Or take a market where the hospital or other provider has little or no market power. It is likely to consolidate with one or more competitors to achieve some market power.

The economic question is: Does a given provider consolidation generate efficiency gains that outweigh the market power effects? It's much easier for a larger organization to negotiate better prices than it is to engage in wholesale change of the production function to ring out efficiency gains.

**Lerner:** I've been an adviser over the years on many of these consolidation deals. I can't read people's minds, but my sense from their documents is that all of the factors Patrick and Larry have mentioned have come into play, with the strength of some varying over time. I think there was a period of time where a lot of nonprofit hospitals were merging not to achieve increased leverage with health plans, but to fend off a wave of expansion by for-profit hospital chains.

More recently, with uncertainties about the direction and implications of health care reform, I wonder if at least some consolidations are being driven not only by capital concerns, but also by a generalized fear of walking into the wilderness alone.

As Larry points out, the open question is whether the current wave of mergers occurring is more likely than those in the past to achieve true integration and coordination of care and cost reductions. I think in today's environment more attention will be paid to whether these mergers actually do that.

**Madden:** Picking up on one of Art's points, in my experience a critical factor in many of these consolidations is access to capital, the lifeblood of any organization. You have to have capital to maintain state-of-the-art medical technology, to improve your health information systems, and to renovate and/or to expand your facilities or services. That's the advantage of large health systems, and even within those systems the local operating units are competing for capital.

Increased efficiency has also become a very big driver. In my last system, we were looking in every nook and cranny for improvements in quality and efficiency. For instance, we began outsourcing services that I never would have dreamed of doing in the past, such as housekeeping and dietary. These are services that we had always held as basic to our mission.

**McPherson:** *We are also witnessing a significant number of for-profit acquisitions of nonprofit hospitals in some parts of the country, even safety-net hospitals in a few instances. How do you explain those*

*acquisitions, especially in this era of reform and government budget deficits, where the opportunities for substantial profits seem generally limited?*

**Van Horn:** The for-profit investors that are active in acquisitions right now have access to capital, which those they are acquiring do not. The empirical question, to which there is no answer at this point, is whether they will have a greater ability to generate revenues and reduce costs in order to achieve the levels of profits that will satisfy their investors. I think that over time they will change the mix of services provided.

**Madden:** At the risk of sounding cynical, size of a for-profit care system is a critical factor in its valuation in the stock market. So generally speaking, the more hospitals I acquire, the better the price of my stock and the greater my attractiveness for takeover by another investor.

**Berman:** I agree with both of you. On Larry's point, for-profit hospitals have a track record of investing capital to provide procedural services with high profit margins, whether they are truly needed or not.

**Van Horn:** There is also evidence that they make different staffing and other resource decisions independent of service mix. I think that their futures will be all about taking down costs.

**McPherson:** *So what is the federal government doing, or planning to do, about hospital or other provider consolidations and market concentration?*

**Lerner:** The FTC was on a losing streak in this arena for many years. It found a violation in a merger that had taken place in Illinois six years prior, but that case is still under appeal even though no divestiture was ordered. More recently, the FTC sought a preliminary injunction to block a merger between two hospitals in northern Virginia, but the two parties abandoned the merger a few days before the federal district court judge was to hear the case. It also challenged an acquisition by a hospital of two competing ambulatory surgery centers.

Since that time, the FTC has been investigating a number of other mergers, but has taken no action to date against any of them.

**Van Horn:** It is noteworthy that the FTC has recently changed its method of evaluating the competitive effects of mergers. The FTC moved from a “shipments” test, resulting in broad markets—which is why the FTC lost so many cases—to a “merger simulation” approach, leading to more narrow markets. It’s too soon to tell, however, how this will shake out in terms of the number of future challenges and their success rate.

**Lerner:** The one thing I’m quite certain about is that the FTC won’t have the resources or the inclination to look back at mergers that have already occurred.

**Berman:** What I’m concerned about, is that once you no longer have excess health care provider capacity in a particular community, you can’t really instill greater competition other than building another institution that would just increase costs. I think that capacity is already matched to need in second-tier markets, such as western New York, and in third-tier markets where there is a single hospital.

I don’t see competitive forces bringing more value when capacity is already matched to need. How do you control costs better in that situation? There is no mechanism to help ensure that community boards in those circumstances are acting, and will continue to act, responsibly.

**Van Horn:** I completely agree with your point, Howard, about capacity matching need; however, if I’m residing in Rochester, N.Y., my health plan or employer could incentivize to travel to Syracuse or Buffalo, at least for certain types of specialized services, if there is lower-cost care in those places.

**Lerner:** From an antitrust standpoint, the FTC and the DOJ have no tool to regulate a monopoly or something like a monopoly. Those situations are left to the state or some other arm of the government to decide whether the public would be better served by public utility or other regulatory mechanisms. Where antitrust regulation has a role is in the situation where, for

example, the market would support five competitors with equal economies of scale and they all wish to merge into two.

**Madden:** Howard has raised a fascinating question. I look at what has happened in the way of hospital consolidation and government regulation in New York City over the past 20 years, and I keep asking myself, “Are we inevitably heading toward less influence by health plans and even more government intervention, like public utility regulation or even a single-payer system? Do we get to the point where there is a shortage of capacity, as is the case in England, when it comes to secondary and tertiary care?”

**McPherson:** *On your last point, Patrick, look at what is happening in Rhode Island and Massachusetts, respectively, where increased powers have been granted or proposed for the state insurance commissioner to dictate terms in the contractual and payment arrangements between the health plans and the health care providers. One could view these moves as state provider rate regulation through the back door.*

*Related to your last point, Larry, new health insurance products are being offered, and apparently are being well received to date, in the individual and small group markets in Massachusetts. Hospitals are being tiered according to their costs, and lower premium contributions and/or less cost-sharing are offered to individuals and families using the hospitals in the lower-cost tiers. Art, what do you think about this market-oriented alternative to government intervention?*

**Lerner:** I have worked in merger situations where it has been alleged that a hospital, system, or other provider with market power, would not press health plans for higher rates. If it did, it would be cutting off its nose to spite its face, because the health plans would turn around and use such tiering techniques to steer business to other providers.

One of the counter arguments, however, is that if you’re powerful enough to get significantly higher rates, you may also be

powerful enough to put in a clause in contracts with health plans that would effectively prohibit or deter such tiering practices. I will be interested to see how these tiering products fare in markets with varying degrees of provider choice. I don't think they will work in markets with limited choice of provider.

**McPherson:** *Given all of our discussion today, what is the right role for government with respect to consolidations and concentrated markets?*

**Lerner:** I think the appropriate antitrust answer in health care, as in any other sector of the economy, is as follows. If the merger will create market power that wasn't there before, or if the conduct will create market power that wasn't there before if it's not a merger, then the burden of proof is on that party or parties, whether providers or health plans, to demonstrate why that consolidation or other conduct is critical to the achievement of market benefits that will outweigh the harm to competition.

Most of the time when the government brings a lawsuit, it is able to easily show a severe impact on competition, and any claim about efficiency is window dressing. Government has never had to deal with the more complex situations where efficiency and quality factors bear more consideration. It's just difficult for the FTC, DOJ, or the courts to do that balancing act where there are compelling arguments on both sides.

**Van Horn:** The basic issue is whether increased concentration leads to increased prices, or to better care coordination and

other efficiencies, thereby improving the social welfare. We currently don't have much transparency or insight into that. If the rate structure and negotiated terms between a payer and a provider were made public, we would have a lot more information to evaluate the results of concentration. Why are medical loss ratios of plans being regulated and made publicly available, while no light is being shone on the nature of the contracts and the prices paid to providers by health plans?

**Berman:** Transparency is a standard and attractive market argument, Larry. I would feel very comfortable with it if it really benefits the consumer. I'm very skeptical, however, on the benefits to a consumer in a single hospital community. Also, whenever anyone has a really serious health issue, isn't he or she going to want to go to the best place to deal with it?

Also, at least judging by past behaviors, I think there would be a great deal of opposition to such data disclosure by both health plans and providers claiming such data to be proprietary information.

**McPherson:** *In my view, and I'm sure the editor of Inquiry, Alan Monheit, will concur, this has been an important and excellent beginning of a rational discussion on consolidation and market concentration. To further that dialogue, I believe that all leaders at the operational level in nonprofit health care must do a much better job of communicating effectively with federal and state policymakers, regulators, and economists about the realities versus the theories of our marketplace in caring for people and improving the health of our communities.*