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the continued move to greater integration and consolidation

The $69 billion proposed acquisition of Aetna by CVS Health has created a lot of speculation about the effects that a major pharmacy benefit manager with a large retail presence like CVS could have if it can gain access to the large insurance base represented by Aetna.

This type of speculation only increased when a short time later UnitedHealth Group announced the acquisition of DaVita Medical Group's 300 clinics, urgent care centers, and outpatient surgery centers for just under $5 billion following its other acquisitions, such as MedExpress, which provides access to urgent care centers.

The most noteworthy aspect of these acquisitions is that they represent moves toward an increasing vertical integration of health care that excludes hospitals. In part, these acquisitions reflect the increased potential that new technological advances offer for providing more complex care in less costly settings outside the traditional inpatient or outpatient hospital settings. Although this type of integration might support a strategy aimed at lowering the cost of healthcare delivery in the future, one obvious question remains: Which sector is most likely to capture the potential gains of lowered costs—the purchasers of care (i.e., the employers and insurers), the consumers of care, or both but not necessarily in equal amounts?

Regulators are likely to pose these types of questions when acquisitions come before them for approval, although the answers could be more elusive than answers to questions about mergers and consolidations occurring within a single sector (e.g., only hospitals or only insurers), which are frequently controversial in their own right.

Intensifying Pressure on Hospitals

The moves toward vertical integration minus the hospital also suggest that hospitals may find themselves struggling to maintain their share of the healthcare dollar. This is a major concern for many hospitals because these acquisitions are coming at a time when the hospital sector is already experiencing lower patient volumes, increasing costs, and rising bad debt. Hospitals have been responding in a variety of ways, the most direct having been to to search for ways to lower their own costs while increasing their share of the healthcare delivery system.

The pressure to lower costs has been an ongoing issue because Medicare typically assumes an increase in hospital productivity when setting payment rates under the DRG payment system. These pressures have led hospitals to search out lower-cost ways to deliver care, such as using healthcare resources more efficiently or treating patients in lower-acuity settings.

These pressures also have led hospitals to seek ways to increase their share of the healthcare delivered in the United States. Hospitals had been aggressively acquiring physician practices, with almost 40 percent of physicians now employed by hospitals—although the acquisitions appear to have slowed recently. Being employed by a hospital has become attractive to many physicians because it relieves them of the financial risks of

practicing in a changing delivery system environment. Employing physicians has been attractive to hospitals because the physicians ensure the hospitals have a constant flow of patients.

Cost of Hospitals' Actions

Unfortunately for public programs as they are currently structured, hospital-employed physicians also increase the cost for some public programs. Medicare, for example, pays hospitals at a higher rate for some procedures when they are provided on an inpatient basis than when the same services are provided in an ambulatory setting. This issue has been considered "ripe for reform," where the nation would move to a payment system under which Medicare would pay the same rate for the same procedure, irrespective of where it is performed, just as a relative value today is the same in Medicare payment irrespective of the type of physician that provides the service. As it increasingly becomes more feasible to deliver a broad range of medical services in a variety of settings, this issue may yet be revisited.

Meanwhile, hospitals continue to pursue their own mergers and acquisitions. For example, Illinois' Advocate Health Care and Wisconsin's Aurora Health Care plan to merge. Together they would create the nation's 10th largest not-for-profit system, with 27 hospitals and more than 3,300 physicians.

And the two largest not-for-profit Catholic hospital chains—St. Louis-based Ascension Health, with 141 hospitals, and Renton, Wash.-based Providence St. Joseph Health, which runs 50 hospitals—have discussed merging. Together they would exceed in size HCA, the largest for-profit hospital system, which has 177 hospitals.

Two other hospitals systems also have announced plans to merge: Englewood, Colo.-based Catholic Health Initiatives and San Francisco-based Dignity Health. Together they would form a system of 139 hospitals valued at $28 billion.

Hospitals justify their mergers using an argument similar to that used by other groups: Mergers provide opportunities for hospitals to achieve scale, which will allow them to get better pricing for drug and device purchasing and to provide the information systems that are so crucial to documenting improved quality in care delivery.

The Key Question: Who Benefits?

There is some evidence that achieving larger scale does allow hospitals to obtain cost savings. A recent study in the *Journal of Health Economics* estimated cost savings on average of 4 to 7 percent following a hospital acquisition.[a] Again, the question raised regarding hospital mergers is similar to the ones that are being raised for the vertical acquisitions that exclude hospitals: Who will benefit from the lowered costs produced?

The answer to this question regarding hospitals is mixed, although it appears it may differ according to whether the mergers involve hospitals within a state or in different states. Mergers and acquisitions within a state, such as California, appear to be associated with price increases. The effect on prices when hospitals in different states merge is less clear, but it does not appear to be significant—if it occurs at all.

Because most of the largest mergers being discussed that involve hospital systems or systems that exclude hospitals represent multistate rather than single-state transactions, it may be that, in the very least, the transactions will not result in higher pricing to any significant degree. How the potential for savings will be distributed among the providers of care, the purchasers of care, and the consumer is another matter—one well worth consideration by regulators. ■

a. Schmidt, M., "Do Hospital Mergers Reduce Costs?" *Journal of Health Economics,* Feb. 7, 2017.

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