Market Consolidation and Alignment

Author Commentary

CHAPTER ABSTRACT: Consolidation in the healthcare industry is driven by a number of factors. Classically, the major driver has been access to capital; but more recently, physician alignment and employment also has been a major issue. The implementation of the Affordable Care Act has further encouraged competition, while declining reimbursements have forced consolidation in order to take advantage of economies of scale and to increase leverage with private payers in a given market. This chapter explores the factors driving consolidation, examines specific cases, and outlines the pitfalls academic health centers must avoid in order to remain competitive in a rapidly-changing healthcare industry.

While the movement toward consolidation in healthcare has been based in large part on the goal of reducing costs, it seemingly has resulted in increased prices, at least in certain markets. Almost all the literature I reviewed shows that when a system achieves a significant market share via horizontal integration, it can command significantly higher prices. This has now been repeated in multiple markets where hospital systems have become larger by, in many cases, acquiring community hospitals or merging with other systems.

The Affordable Care Act, in pushing for the formation of Accountable Care Organizations where alignment between physicians and hospitals is critical, has stimulated many hospitals and health systems to acquire physician practices, which results in vertical integration. The leverage that results once a significant volume of physician practices has been acquired also, in many cases, has resulted in higher prices. Higher prices also may result in certain communities where the reputation of a hospital or system is such that higher prices can be demanded because payers can't afford not to have them in the system based on demand from their beneficiaries.

Consolidation in the healthcare industry is destined to continue. I think that, in most major cities, we will see a couple of dominant systems, if that has not already occurred. In part, this is to defuse some of the leverage that resides with the payers. In our own market in Philadelphia, with really only two payers dominating the market and almost complete fragmentation on the provider side, there is considerable discussion about consolidation. I think payers will try to offset some of that in any way that they can—often by playing one system against another. Circumstances will vary from city to city, depending on the level of concentration on the provider side vis-à-vis that level on the payer side. The formation of limited networks may also offset some price increases as systems may compete to be included, and the deciding factor ultimately may be price.

Another phenomenon we will see is some of the larger urban systems looking to expand in suburban areas, recognizing that the site of care and the cost of care are important, especially as we look toward some of the risk models that we are all getting into with payers. It is becoming increasingly important to provide care in the most appropriate and cost-effective settings for systems to continue to survive.

I believe we are going to see more and more physicians aligning themselves with hospitals or health systems, either with an employed arrangement or some other relationship. Anyone in a leadership position needs to be looking at how best to align physicians, whether they are employed or independent, with the goals and vision of the organization. In the long run, this type of alignment may be more easily achieved in an employment model.

Academic health center leaders need to be deeply cognizant of the market in which they exist. They need to be looking at how they interact with payers, and whether they are set up to provide care in the most cost-effective setting for the problem being treated. In a risk-sharing model, keeping people out of the emergency room and out of the inpatient setting—essentially prospectively managing wellness—is going to be the way that we can work most efficiently and best utilize the healthcare dollar.

The situation right now is very dynamic. Things are changing almost on a day-to-day basis. The full implications of the implementation of the ACA are not yet known. A number of states have not accepted Medicaid expansion. In those that have, people who may have been previously uninsured are availing themselves of insurance, and when they do, they tend to use it; so I think access is going to continue to be an issue. Accordingly, we need to position ourselves to address the demands that will be placed upon us as more people are insured. That means we have to be looking at the most efficient ways to practice medicine. Clearly, that is going to involve not just physicians but other healthcare providers—nurse practitioners, dietitians, pharmacists, physical therapists—in population management strategies. Every major system, and every hospital for that matter, needs to be looking at ways to align with their physicians and to be prepared to work with them to achieve high-quality, cost-effective care in risk-sharing arrangements with payers.

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