

REPORT 08 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Impact of Integration and Consolidation on Patients and Physicians
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Interim meeting, the Council presented CMS Report 3, which was an informational report that provided background on the issue of health system consolidation. The next report in the Council's ongoing series on this topic is presented here and examines the impact of horizontal and vertical integration on health care prices and spending, patient access to care, quality of care, and physician wages and labor. This report also includes an overview of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a role in preventing anticompetitive behavior and outcomes.

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician practice vertical integration on physicians, patients, and local markets. An important distinction to make is that private equity investment in a hospital or a physician practice is not the same as vertical or horizontal integration, but instead is an issue of a change in ownership. While this is also a prevalent issue in health care, it is not the focus of this report.

Both horizontally and vertically integrated health care entities may engage in a range of anticompetitive behaviors, including raising prices, excluding rivals, raising their costs, bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts.

This report examines the shared jurisdiction between the FTC and the DOJ in the merger and acquisition process. Typically, the FTC reviews mergers between providers (hospitals, physician groups, etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive control over criminal enforcement.

When examining a potential health care merger or acquisition, the FTC focuses on four areas: price effects, clinical quality effects, patient access, and provider wages. While evidence of impacts on health care prices and spending is stronger and more consistent, data on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time.

The Council recommends that the American Medical Association (AMA) continue to monitor the impact of hospital-physician practice integration and hospital-hospital consolidation on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor, as well as the impact of non-compete clauses on physicians. The Council also recommends that the AMA broadly support efforts to collect relevant information on mergers and acquisitions in their state and/or region and work with state attorneys general (AG) to ensure proper review of these transactions before they occur. Finally, the Council recommends that the AMA support and encourage physicians to share their own experiences with mergers and acquisitions with the FTC through their online submission process.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 08-A-23

Subject: Impact of Integration and Consolidation on Patients and Physicians

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

At the 2022 Interim meeting, the Council presented CMS Report 3 which was informational and provided background on the broad issue of health system consolidation. Consistent with Policy D-215.984, which requested regular updates, this report examines the impact of horizontal and vertical integration on health care prices and spending, patient access to care, quality of care, and physician wages and labor. This report also includes an overview of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a role in preventing anticompetitive behavior and outcomes.

BACKGROUND

It is important to distinguish the difference between horizontal integration and vertical integration. A horizontal transaction often refers to a merger, purchase, or acquisition of an entity. Horizontal integration (or consolidation) reflects arrangements between entities that “operate in a similar position along the production process,”¹ meaning that they offer the same services and compete with one another. One hospital acquiring or merging with another hospital would be considered horizontal consolidation. Vertical integration reflects arrangements between entities that “operate at different points along the production process,”² meaning that they do not directly compete with one another. An example of this could be a hospital acquiring a physician practice. For the purposes of this report, hospital-hospital mergers will be referred to as horizontal consolidation, while hospital-physician practice transactions will be referred to as vertical integration, although the latter may also have horizontal aspects if the hospital already owned other physician practices before the transaction. We note that mergers and acquisitions are complex economic issues and recognize that there are many different types of transactions – and nuances within each of those transactions – but the Council has chosen to focus on these two types of transactions for this report.³

HOSPITAL-PHYSICIAN INTEGRATION AND HOSPITAL-HOSPITAL CONSOLIDATION

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician vertical integration on physicians, patients, and local markets. At the onset, an important distinction to make is that private equity investment in a hospital or a physician practice is not the same as vertical or horizontal integration, but instead is an issue of a change in ownership. Recently there has also been an uptick in the number of physicians employed by corporate-owned or publicly traded practices (i.e., CVS, Amazon). While these are also prevalent issues in health care, they are not the focus of this report, and we would encourage members to reference CMS Report 2-I-22, Corporate Practice of Medicine, for more information on this topic.

In the United States, 90 percent of Metropolitan Statistical Areas (MSAs) are considered concentrated for hospital services, and 65 percent of MSAs are considered concentrated for

outpatient specialty care. Research suggests that the impact of hospital-hospital horizontal consolidation includes higher prices for services, higher insurance premiums and consumer cost sharing, lack of quality gains and decrements in the patient experience. Hospital markets are not the only component of care delivery that is concentrated, with an estimated 39 percent of MSAs considered concentrated for primary care physicians and 65 percent for specialty care. Rising prices and reduced choice for patients are often the outcome following hospital-hospital consolidation and/or hospital-physician integration.⁴

Vertically integrated health care entities may engage in a range of potentially anticompetitive behaviors, including raising prices, excluding rivals (or raising their costs), bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts (such as restrictive covenants on employed physicians).⁵

Although billions of dollars in COVID-19 federal relief funds have been dispersed across the health care industry, a majority of the funding has gone to large hospital systems. This has left many independent physician practices to suffer reductions in patient visits and revenues, making them vulnerable to hospital-physician practice vertical integration.⁶ The risks such transactions pose to patients include higher prices, increased spending, and reduced choice. The economic impact of the COVID-19 pandemic on independent physician practices has accelerated pressure for vertical integration between hospitals and physician practices. Remaining independent physician practices are under financial strain due to the economic impact of the pandemic, and even those who previously resisted acquisition face new pressure to sell to large hospital systems or private equity investors for financial stability and survival.⁷

Data from the AMA's 2022 Physician Practice Benchmark Survey indicates that physicians in practices wholly owned by physicians have decreased from 60 percent to 47 percent from 2012 to 2022. Conversely, physicians in practices wholly or jointly owned by hospitals have increased from 23 percent to 31 percent over the same time period. In 2022, ten percent of physicians were directly employed by or contracting with a hospital (up from six percent in 2012). While there are many factors driving these changes, it is important to note the trends in physician practice ownership over the last decade.

Impact on Health Care Prices and Costs

Evidence suggests that hospital-physician integration leads to higher health care prices – including higher hospital prices, percent higher physician prices, and 10-20 percent higher total expenditures per patient.⁸ Prices have been shown to increase in hospitals following such integration. The harms of hospital-hospital consolidation also include higher prices for patients.⁹

There are several ways hospital-physician integration can increase health care prices. These include the addition of facility fees that hospitals can charge for outpatient services provided by acquired physicians, increased market power when negotiating with payers, and direct referrals of captive physician practices to a greater extent than independent physicians not related to the hospital system, which could increase referrals to higher-cost providers and services.¹⁰

Generally, prices will ascend to the level a market will pay. If a certain entity has market power, prices can rise to offset rising expenses and declining patient volume.¹¹ According to a paper prepared for Congress by economists Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg addressing horizontal consolidation of hospitals, hospitals without local competitors are estimated to have prices nearly 16 percent higher on average than hospitals with four or more competitors, which is a difference of nearly \$2,000 per admission.¹² A large body of economic literature

summarized by Gaynor in 2021 found substantial increases in hospital prices as a result of hospital-hospital consolidation. Increases are widely seen, but vary significantly, from three percent to 65 percent. A 2019 study by Cooper et al., found an average price increase of six percent as a result of hospital mergers, and Arnold and Whaley (2020) found an average price increase of 3.9 percent.^{13,14,15,16}

Impact on Patient Access to Care

Current data on the impact hospital-physician integration has on patient access to care is limited, making this issue one to continue to monitor. Nonetheless, the Council is concerned that vertical integration may lead to a more difficult environment for the remaining physician-owned practices in terms of competition and referral steering. To the extent that consolidation may narrow networks or make areas harder for new practices to enter, this may have the effect of reducing patient choice. Thus far, there have only been two peer reviewed studies that examined the effect of vertical integration of hospitals and physician practices on access to care.¹⁷

Increased vertical integration in health care could also potentially reduce consumer choice by creating larger, exclusive networks and driving patients and health plans to pay higher prices. Data does not yet indicate that these higher costs and reductions in choice among independent providers are offset by higher quality or efficiency from improved care coordination. As vertical integration continues to occur, states are increasingly searching for ways to curb the rising costs and loss of choices.¹⁸

Data on the impact of hospital-hospital consolidation are also limited. There have been two recent studies that examine the effect of consolidation on rural hospitals specifically, but there is no conclusive data on other markets. Henke et al., (2021) found that merged rural hospitals were more likely than independent hospitals to eliminate maternal, neonatal, and surgical care services. There was also a decrease in the number of mental health and substance use disorder-related stays. However, there is an important caveat to consider: without a merger a rural hospital may be forced to close and even limited services would be eliminated from a community entirely.^{19,20} Similarly, O'Hanlon et al. (2019), found that rural hospitals that became affiliated with integrated health systems experienced a significant reduction in diagnostic imaging technologies, obstetric and primary service availability, and outpatient nonemergency visits.^{21,22} While these results could be an early indication of a trend following hospital-hospital consolidation, more evidence is needed before conclusions can be drawn. For more information on Rural Health Care, please see CMS Report 9-A-23.

Impact on Quality of Care

Empirical studies examining the effect of vertical integration of hospitals and physician practices on quality of care showed mixed effects.²³ Findings from two studies suggest no effects on quality of care while two other studies using data from the American Hospital Association (AHA) found mixed effects. The findings of the studies using AHA data suggest that organizations that are fully clinically integrated had small positive effects on some measures of quality while arrangements that were not fully clinically integrated had no effect on the quality of care.²⁴

Studies on hospital-hospital consolidation on quality of care are also inconclusive. Some have found no change in the quality of care while others have shown a decrease in the quality of care. A 2020 study by Beaulieu et al., examined 246 hospital mergers between 2007 and 2016 and found that relative to similar hospitals that did not experience a merger, hospitals acquired in a merger saw no significant differential change in 30-day readmission rate and 30-day mortality rate in the

Medicare population. Interestingly, patient experience measures declined. However, it is important to note that the association between mergers and declines in patient experience does not necessarily imply causality; other factors may be in play. Therefore, one should be cautious in the interpretation of those findings. Additionally, it is important to note that data on the impact of integration and consolidation on quality is meaningless without clearly defined quality metrics.^{25,26}

Impact on Physicians

The AMA has long supported physician-led care teams and physician supervision of non-physicians. When either hospital-physician integration or hospital-hospital consolidation occurs, motives may shift to focus on profit and physicians may be replaced with non-physician practitioners in an effort to achieve cost savings. However, emerging data suggests that a provider mix (i.e., the number of physicians vs. non-physician practitioners) shift occurs in the years following a merger or acquisition, with physicians being replaced by non-physicians to lower costs and increase profits. Emerging data suggest shifting more patients to non-physician practitioners could ultimately increase cost and simultaneously decrease quality of care.

Available data from recent studies on the impact of vertical integration on health care wages and labor supply are limited, insufficient, and ultimately, inconclusive. In terms of compensation, a 2021 study by Whaley, Arnold, et.al., found that ownership of a physician's practice by a hospital or health system was associated with lower income among physicians overall.^{27,28} As with the data on patient access to care, further evidence is needed to conclusively determine the impact of hospital-physician integration on health care wages and labor market changes.²⁹ There are even fewer studies available on the effect of hospital-hospital consolidation on physician wages. There is some evidence that nurses' and pharmacists' wages decrease following a hospital merger, but there is no significant data on the impact on physician wages.³⁰

On January 5, 2023, the FTC proposed a rule to ban future noncompete clauses and invalidate existing agreements. In the proposed rule, the FTC stated that noncompete clauses depress worker wages and limit competition. Typically, a noncompete clause would bar a physician from practicing medicine for a certain period of time within a defined geographic area or specific mile radius. FTC regulators argue that noncompete clauses stifle competition and cause price increases for patients in markets that are highly concentrated, as many health care markets are in the United States. Critics question whether this proposed rule is within the purview of the FTC. One of those critics is the AHA, which stated in its comments that "the proposed regulation errs by seeking to create a one-size-fits-all rule for all employees across all industries, especially because Congress has not granted the FTC the authority to act in such a sweeping manner. Even if the FTC had the legal authority to issue this proposed rule, now is not the time to upend the health care labor markets with a rule like this."³¹ The public comment period for this proposed rule was open until April 19, 2023.³² At the time of writing, AMA comments were still being prepared. The Council will continue to monitor the issue and its impact on physicians.

OVERSIGHT AND ENFORCEMENT

There is shared jurisdiction between the FTC and the DOJ when reviewing mergers and acquisitions. Typically, the FTC reviews mergers between providers (hospitals, physician groups, etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive control over criminal enforcement.

The FTC, DOJ, and private parties suffering antitrust injury use the Clayton Act, the Sherman Act, and in the case of the FTC, the FTC Act to enforce antitrust laws. The Sherman Act of 1890 is the

1 US antitrust law which prescribes the rule of free competition among those engaged in commerce.
2 Importantly, the Sherman Act does not prohibit every restraint of trade, only those that are
3 unreasonable. Certain acts are considered so harmful to competition that they are almost always
4 illegal under the Sherman Act. These include plain arrangements among competing individuals or
5 businesses to fix prices, divide markets or rig bids. The Clayton Act of 1914 addresses specific
6 practices that are not directly addressed by the Sherman Act, including mergers. Specifically,
7 Section 7 of the Clayton Act prohibits mergers and acquisitions where the effect “may be
8 substantially to lessen competition or tend to create a monopoly.” The Clayton Act was amended in
9 1976 by the Hart-Scott-Rodino Act, which purposely exempts small transactions (valued at less
10 than \$111.4 million as of February 27, 2023) from pre-merger notification to not increase the
11 regulatory burden on small enterprises in addition to avoiding generating unnecessary transactions
12 for FTC staff to review. This threshold is adjusted annually and results in many health system,
13 hospital and/or physician mergers proceeding without FTC and/or DOJ review.

14
15 Another hurdle contributing to increases in consolidation in recent years is FTC constraints on its
16 ability to enforce antitrust laws in the not-for-profit health care sector. Vertical integration is
17 particularly challenging for the FTC to monitor because it is often the result of hospitals acquiring
18 many smaller practices and each of those transactions may fall under the \$111.4 million threshold
19 of having to notify the FTC. Additionally, the FTC has raised concerns about its inability to
20 enforce antitrust rules on most non-profit organizations, including most non-profit hospitals. The
21 FTC can only enforce Section 5 of the FTC Act against persons, partnerships, or corporations.
22 “Corporations” are defined as those entities organized to carry on business for-profit. Accordingly,
23 the FTC Act does not give the FTC the ability to enforce Section 5 against most non-profit entities,
24 which constitute the vast majority of hospitals.

25
26 The Council met with representatives from the FTC to discuss the process of reviewing mergers
27 and acquisitions. When examining a potential merger or acquisition, FTC staff focus on four areas:
28 price effects, clinical quality effects, patient access, and provider wages. When a proposed merger
29 filing comes in, FTC staff have 30 days to decide whether or not to issue a challenge. If a challenge
30 is issued, the deal is prohibited from closing until further investigations are completed. During
31 these investigations, the merging entities may negotiate further to receive the approval of the FTC,
32 or the case could go to court. Alternatively, the two merging entities may decide to abandon the
33 deal altogether.

34
35 The representatives from FTC stressed the importance of physicians as the best advocates for
36 patients, especially regarding mergers between health care facilities. FTC staff time is limited,
37 especially given the quick timeline in which the FTC must decide whether or not to challenge a
38 merger, so input from impacted communities is helpful in flagging potential concerns. Information
39 shared by physicians is used by the FTC when evaluating potential mergers and acquisitions and is
40 immensely helpful in providing a voice for physicians and patients who would be impacted most.
41 The FTC encourages physicians to share their experience via email to the following address which
42 is monitored regularly by staff: antitrust@ftc.gov. Physicians are encouraged to work with their
43 state medical associations and/or state attorneys general (AG) to report mergers or acquisitions that
44 fall below the FTC threshold for review. Alternatively, physicians (or any member of the public)
45 are welcome to report potential antitrust violations to the FTC here:
46 <https://www.ftc.gov/enforcement/report-antitrust-violation>.

47
48 In 2020, the FTC and DOJ published, and the FTC subsequently withdrew, revised Vertical Merger
49 Guidelines. After withdrawing the guidelines because they cited “unsound economic theories” the
50 FTC stated that it will continue working with the DOJ Antitrust Division to update merger
51 guidance to better reflect market realities. Updated Vertical Merger Guidelines are expected in

2023. Physicians are strongly encouraged to review these guidelines when they are available and provide comments during the public comment period.

States also have a critical role in oversight because vertical integration transactions often fly under the radar of federal antitrust agencies because they tend to be too small in size to be reported under the Hart-Scott-Rodino Act, which has a threshold of \$111.4 million in 2023. States can be proactive in the merger process by data gathering using all-payer claims databases, pre-transaction review and approval, oversight of vertically integrated entities, and controlling outpatient costs (i.e., restrictions on facility fees to counteract private-equity based acquisitions).³³ States can study the price, utilization, or referral effects of vertical transactions; detect targets for enforcement; provide oversight of vertically integrated entities; plan and assess the need for new and additional services; quantify the amount of facility fees charged; enforce compliance with surprise out-of-network billing rules; or implement global budgets. Many states already require hospitals to notify state officials of proposed mergers or acquisitions; however, states could expand the requirement to transactions involving physicians. One example of this is in Washington state, which passed a law in 2019 to require notification to the state AG of health care transactions, including those involving “provider organizations,” below the Hart-Scott-Rodino threshold. Connecticut requires 30-day notice] to the AG and the head of the Office of Health Strategy of any proposed transaction involving a physician practice of eight or more physicians. In Massachusetts, all provider organizations must provide the AG, the Health Policy Commission, and the Center for Health Information Analysis with a 60-day notice of any mergers, acquisitions, or affiliations. Unlike the FTC, state AGs can regulate transactions involving nonprofit entities.³⁴

AMA POLICY

The AMA has long-standing policy emphasizing the importance of competition in health care markets and striving to protect physician autonomy and well-being before, during, and after health care mergers and acquisitions (H-215.960, H-215.969).

Policy D-215.984 states that the AMA will study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing health care consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation; and regularly review and report back on these issues to keep the House of Delegates apprised on the relevant changes that may impact the practice of medicine. Furthermore, Policy D-383.980 affirms that the AMA will study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and develop an action plan for legislative and regulatory advocacy to achieve a more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

DISCUSSION

In general, empirical evidence is emerging on the impact of vertical integration on patients, physicians, and health care. While evidence of impacts on health care prices and spending is stronger and more consistent, evidence on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time. However, research continues to be conducted, such as on the effects of hospital-physician integration on quality as well as on the potential mechanisms underlying its effects on prices and spending, especially as this and other acquisitions of physician practices become more common. The Council will continue to stay informed of new data and research and will address future policy recommendations as needed.

As data continue to be collected and vertical integration involving physicians continues to occur regularly, physicians should work with their state medical associations who in turn should work with their state attorneys general and state legislators to address these transactions. Potential state policy solutions include notification of health care transactions to public officials and pre-transaction review by states for those mergers and acquisitions that fall under the FTC/DOJ review threshold. Flagging these transactions will allow time to review the impacts each would have on the patients and physicians within a community and broader market concentration effects in the impacted areas.

When meeting with representatives from the FTC, it was repeatedly stressed that the most important thing physicians can do regarding concerning mergers and acquisitions is to share individual perspectives on how consolidation has impacted their practice, their patients, and their community. When published, physicians should review the FTC's update to the Vertical Merger Guidelines and provide feedback during the public comment period.

The Council believes that changes in provider mix and wages following a merger or acquisition is an issue that should be monitored closely but that peer-reviewed data on the topic is not yet robust enough for policy recommendations at this time. Similarly, the Council believes that mergers or acquisitions may impact access and quality of care and will continue to monitor this data as it becomes available.

The recommendations presented in this report are more actionable and supersede the recommendations in Policy D-215.984, Health System Consolidation. Thus, we recommend that policy be rescinded with the adoption of the following recommendations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor. (New HOD Policy)
2. That our AMA continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians. (New HOD Policy)
3. That our AMA broadly support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission(FTC)/Department of Justice review threshold. (New HOD Policy)
4. That our AMA encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior. (New HOD Policy)

- 1 5. That our AMA encourage physicians to share their experiences with mergers and
2 acquisitions, such as those between hospitals and/or those between hospitals and physician
3 practices, with the FTC via their online submission form. (New HOD Policy)
4
5 6. That our AMA rescind policy D-215.984. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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