
Insights On Provider Consolidation And Narrow Networks

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As is often the case, the latest volume of “Health Affairs,” an academic journal focused on health care economics and policy, includes several articles that are worth reading for anyone interested in competition issues in health care markets. Here, we summarize two of them and discuss their implications for antitrust regulation and enforcement.

The first, “Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene,” by Cory Capps, David Dranove, and Christopher Ody (hereafter, CDO), finds sizeable increases in physician practices across the U.S., largely as a result of numerous small transactions (rather than a few large transactions). The second, “Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth,” by Leemore Dafny, Igal Hendel, Victoria Marone, and Christopher Ody (hereafter, DHMO), finds that on average, narrow-network plans offered on Affordable Care Act exchanges were 16 percent less expensive than plans with broad networks.

Each of these studies yield results that could have important implications for anti-trust enforcement. Based on their findings, CDO propose some potential tools to address the challenges of piecemeal consolidation. These tools seem to be a natural extension of the Federal Trade Commission’s willingness to challenge transactions that are considerably smaller than the types of transactions it typically challenges in other markets. DHMO’s work highlights the potential for narrow-network plans to lower consumer costs. In that light, the U.S. Department of Justice’s scrutiny of practices that could foreclose

competition and limit the emergence or development of narrow-network products would be expected to continue.

Physician Practices Have Been Consolidating Through Small Acquisitions

In “Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene,” CDO documented the growth of physician practices using a proprietary data set of insurance claims data from 2007 to 2013 — covering approximately 12 percent of the U.S. population. They found that by 2013, smaller practices (those with 10 or fewer physicians at the start of the study period) were shrinking, while larger practices (those with 11 or more physicians at the start of the study period) were growing. Much of this growth came from small acquisitions. They found that approximately half of the growth of the various largest groups (100-plus physicians) came through acquisitions of groups of fewer than 10 physicians, and an additional third came from new hires¹.

As a result, by 2013, more than 60 percent of physician markets were “moderately concentrated” or “highly concentrated” under the Horizontal Merger Guidelines (HMG). Of the markets that were highly concentrated by 2013, most had become more concentrated over time. In most instances, the increase in concentration occurred without an acquisition that would be presumed anti-competitive under the HMG.

As the authors note, federal antitrust agencies are not well-equipped to address this trend toward increasingly concentrated physician group practice, for a number of reasons. First, the agencies are often unaware of the transactions, as most of these acquisitions are so small that they fall below the HSR filing guidelines. Second, even if the agencies do become aware of a transaction, often the incremental effect on concentration of any one acquisition is so small — and well below the thresholds set out in the HMG — that the agencies would face an uphill battle in seeking to enjoin the transaction. Third, the number of transactions is so great that the agencies lack the resources to investigate each one. The authors offer some partial solutions — lowering Hart-Scott-Rodino Antitrust Improvements Act (HSR) filing thresholds and adopting more modest bright-line concentration thresholds — though they acknowledge that these would not fully address the problems posed by piecemeal consolidation.

To date, the FTC has been willing to challenge mergers that fall below the HSR filing thresholds, if it concludes that the merger is presumptively anti-competitive per the HMG. Consider the proposed acquisition of the Saint Cloud Medical Group (SCMG) by CentraCare in 2016. SCMG is a 40-physician multispecialty practice group operating in four clinics in central Minnesota. The acquisition, which fell well below the HSR filing requirements, came to the attention of the Minnesota attorney general’s office, which then informed the FTC. Following an investigation, the FTC sued, challenging the acquisition, noting that “[t]he levels of concentration ... that would result from the Acquisition

create a strong presumption of anticompetitive harm” in the markets for adult primary care, pediatric primary care, and OB/GYN care.

The FTC ultimately settled with the parties, which had invoked a “failing firm” defense and which had offered nonstructural remedies in which the merging parties allowed physicians to leave the combined firm without being limited by noncompetes². The FTC’s current challenge of the merger of Sanford Health and Mid Dakota clinic is another example of its willingness to challenge transactions that fall below the HSR filing thresholds if it concludes that the merger is presumptively anti-competitive.

It’s too early to know whether the findings of CDO and similar findings (cited by CDO in their appendices) might embolden the FTC to challenge transactions even when they do not meet the HMG bright lines for presumption, perhaps along the lines suggested by the authors (i.e., using lower presumption thresholds). It is worth noting that at the end of the article, the authors write the following:

“[P]iecemeal consolidation and a large acquisition that have the same effect on HHI could have very different effects on scale efficiencies, quality, market power, and the manner in which bargaining over prices of services takes place. Understanding how different types of consolidation affect these outcomes of interest is an important topic for future research.”

Even if it were feasible to review every transaction, doing so at this point is likely not warranted — more research is necessary to determine how concentration that arises from piecemeal consolidation affects the marketplace.

Narrow-Network Plans and Premiums

In “Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth,” DHMO used data from the Robert Wood Johnson Foundation on all silver-tier health insurance plans offered on ACA exchanges in 2014 and 2015 for eight states: California, Colorado, Florida, Michigan, New Jersey, New York, Texas, and Washington. The research team then assembled hospital network information for each plan and used hospital discharge data to construct measures of hospital network breadth. The authors obtained measures of physician network breadth, for the same plans from another team of researchers at the University of Pennsylvania.[3]

The relationship between network breadth and premiums appears quite strong. In their preferred econometric specification, the authors found that: (1) an increase in hospital network breadth from “narrow” to “full” is associated with a premium increase of \$191 per year; (2) a corresponding increase in physician network breadth is associated with a premium increase of \$316 per year; and (3) an increase in both is associated with a premium increase of \$527 per year. Additionally, they found that narrow networks lowered premium subsidies by \$2.4 billion, though they cautioned that their findings should be taken with a grain of salt. The authors acknowledged that they lacked a quasi-experimental design, and that despite their best efforts to control for confounding factors, a

causal relationship between network breadth and premiums cannot be established by their findings.

These findings bring to mind recent DOJ scrutiny of anti-steering practices in health care markets. In the Carolina Healthcare Systems (CHS) case, the DOJ alleges that CHS — which has a 50 percent share of the Charlotte, North Carolina, market — prohibited some of its contracted insurers from placing other hospitals in a higher tier in their tiered plans, or featuring these competing hospitals in narrow-network plans⁴.

Narrow-network plans are one way for smaller insurers to compete with larger insurers. Particularly in traditional fee-for-service models, larger insurers tend to have greater bargaining leverage with hospitals than smaller insurers, and are able to negotiate lower fees. This enables larger insurers to market less expensive plans to employers. In a narrow-network arrangement, a hospital may be willing to accept lower rates from an insurer than it otherwise might, in exchange for the volume that results from being the featured hospital in the narrow network. In other words, the scale needed to negotiate low rates for a narrow network is smaller than it would be for a broad network. This enables the smaller insurer to level the playing field with competitors that boast greater scale, at least to a degree. Employers (and their employees) appear to be increasingly willing to accept the trade-off of having less choice for a lower cost, which fosters insurance market competition.

Some would argue that competition policy in health care should be focused on protecting competition between competing business models. A narrow-network product is one such example. The DOJ's efforts to challenge vertical restraints can be interpreted in light of this broader enforcement goal. Left unchallenged, CHS's conduct could put the development and emergence of narrow-network plans in the Charlotte, North Carolina, market at risk. While DHMO's findings are specific to on-exchange plans, it is likely that adoption of narrow-network plans by employers in the commercial insurance market would be similarly associated with lower costs to employers and/or lower premiums to their employees.

Conclusion

As already noted by the authors themselves, each study may engender further research. A natural next step for CDO — who convincingly demonstrated that provider markets are often concentrated, and often become concentrated in piecemeal fashion — would be to study the competitive effects of piecemeal consolidation. For DHMO, demonstrating a causal relationship between network breadth and prices (and the underlying mechanics of that causal relationship) and extending the results to non-ACA products may be the next step.

However, each has potential ramifications that regulators may take into consideration going forward. With respect to provider consolidation, challenges of even small transactions that are not presumptively anti-competitive under the HMGs may be in order, and with respect to vertical conduct that could derail the emergence of a competing business model, continued scrutiny of such conduct may be warranted.

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Endnotes

- 1 Cory Capps, David Dranove, and Christopher Ody, "Physician Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene," *Health Affairs*, September 2017 vol. 36 no. 9 1556-1563.
- 2 Danyll Foix, "FTC's Unusual Settlement For Minn. Physician-Practice Merger," *Law360*, Nov. 16, 2106; Complaint In the Matter of CentraCare Health.
- 3 Leemore S. Dafny, Igal Hendel, Victoria Marone, and Christopher Ody, "Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth," *Health Affairs*, September 2017 vol. 36 no. 9 1606-1614.
- 4 Complaint, United States of America and the State of North Carolina v. The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System.

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