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**THE STATE OF COMPETITION IN THE HEALTH CARE MARKETPLACE**  
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S IMPACT ON COMPETITION

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*The views expressed in this testimony are those of the author and do not necessarily represent those of AEI.*

## Introduction

The healthcare sector is undergoing a secular consolidation as payers and providers assume a historic level of mergers and acquisitions. These trends were underway prior to implementing the Affordable Care Act. But there's little question that ACA hastened them.

While we've seen other waves of consolidation sweep the health services sector, (most recently in the late 1990s); the current series of mergers and acquisitions is different. It's wider, and more sustained. It's unfolding on an industry that was already heavily consolidated. As a result, the impact on patients is more profound and enduring.

I want to focus on the consolidation underway in the market for physician services. By some estimates, care delivered by doctors accounts for 20% of national health spending in the United States<sup>1</sup> and 3.6% of GDP (representing more than \$515 billion in 2010,<sup>2</sup> a figure that's equivalent to a third of the economic activity of the entire Canadian economy<sup>3</sup>).

The consolidation of physicians at the local level has served to reduce competition. In the end, most healthcare delivery is local. Once an institution has monopolized most of the providers in its market, it renders market-based reforms hard to achieve, and reduces the ability of competition to be used as a tool for improving quality and holding down costs.

To give a full measure of the scope of consolidation that's underway, I'll briefly recount some of the recent trends in the hospital and managed care sectors as well. I'll discuss how these developments also factor into the trends underway when it comes to physicians.

It's important to remember that the scope of consolidation that we're seeing in healthcare is not a response to market factors. Rather, it's a deliberate function of recent policy choices.

Even if some of these mergers and acquisitions were inevitable, and some of these trends were underway prior to passage of the ACA, that law envisioned that providers would consolidate. The ACA was predicated on the kinds of changes unfolding in the way healthcare is delivered. They are a necessary precursor to many of the ACA's constructs.

The same policy prerogatives driving consolidation in the market for physician services are also stoking mergers and acquisitions in the hospital and health plan sectors. In the hospital sector, 100 merger deals were completed in the sector in 2014 -- up 14% from the previous year, according to Wall Street research firm Irving Levin Associates. For 2015, there is likely

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<sup>1</sup> Micah Hartman, Anne Martin, Patricia McDonnell, Aaron Catlin, and the National Health Expenditure Accounts Team. National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998 <http://content.healthaffairs.org/content/28/1/246.abstract>

<sup>2</sup> Martin, et al., 2012

<sup>3</sup> OECD, 2011

to be even more deals closed. These trends are up sharply from 50 to 60 deals that were announced annually in the pre-ACA years of 2005–2007.<sup>4</sup>

The consulting firm Booz & Co. predicts that 1,000 of the nation's roughly 5,000 hospitals could seek out mergers in the next five to seven years.<sup>5</sup> What's particularly notable about the recent transactions is that the deals are both "horizontal" and "vertical." In other words, the hospitals aren't just buying other hospitals. In many cases, they're purchasing physician practices, rehabilitation facilities, nursing homes and other ancillary healthcare providers.<sup>6</sup>

In the managed care sector, there are similar trends underway, with some large merger deals announced in just the last few months. But the impact of this consolidation is being experienced differently across the different segments of the insurance industry. What's happening in the commercial space is not the same as what's unfolding in Medicare.

In the commercial market for private coverage, there's been a contraction in the number of carriers offering health plans. The problems aren't the mergers per se, but policies that make it difficult for new health plans to enter the market and replace those that are eliminated.

For example, startup health plans often must channel more of their revenue into their initial operating expenses to help pay for the costs associated with launching a new health plan. But controls placed on the operating margins of health plans, limiting how much money they can spend on administration, has made it more difficult for new health plans to get started.

As a consequence, there has been very little investor capital entering this space, and little new de novo plan formation. Under the entire Obama presidency, there has been no net new plan formation. Only about 50 new health carriers have entered the commercial market since 2008, according to a November analysis from Goldman Sachs. Half of these are the struggling not-for-profit co-op plans that the ACA subsidizes. At the same time, around 40 health plans have also left the market over this same stretch of time. Many of these plans merged with competitors, but at least 13 were shut down or liquidated.<sup>7</sup>

Working with research staff at the American Enterprise Institute, I developed data that shows even fewer new health plans entering the market since 2008. We defined new entrants as health carriers or provider organizations that sold health insurance plans sometime between 2008 and 2015 and had never before offered coverage in the market. We found only 38 new entrants. Of these plans, 23 were co-ops, 6 were provider-sponsored plans being offered by hospitals or health systems, and only 7 were new commercial carriers.

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<sup>4</sup> A wave of hospital mergers. The New York Times. August 12, 2013

([http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?\\_r=0](http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0))

<sup>5</sup> Julie Creswell and Reed Abelson. New Laws and Rising Costs Create a Surge of Supersizing Hospitals. The New York Times, August 12, 2013. [http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?pagewanted=2&\\_r=0](http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?pagewanted=2&_r=0)

<sup>6</sup> Hospital Consolidation: Can It Work This Time? May 11, 2015, Wharton School of Business.

<http://knowledge.wharton.upenn.edu/article/hospital-consolidation-can-it-work-this-time/>

<sup>7</sup> Scott Gottlieb. How the Affordable Care Act Is Reducing Competition. The Wall Street Journal, July 5, 2015. <http://www.wsj.com/articles/how-the-affordable-care-act-is-reducing-competition-1436136236>

The market for commercial plans, however, stands in contrast to what's unfolding in the Medicare Advantage market. There, despite consolidation that has concentrated more plans in the hands of a smaller number of very large carriers, there is still new plan formation and new capital being invested behind the creation of brand new health insurance carriers.

In large part, this more vibrant economic activity is being driven by secular trends that are growing the market for Medicare Advantage plans. As a consequence, according to a new analysis released by the consulting firm Avalere Health, at least 28 new parent organizations entered the MA market from 2012 to 2014 and currently offer coverage. Together, these new entrants offer 104 plan options to more than 13.6 million beneficiaries in 24 states.<sup>8</sup> Medicare beneficiaries in 2015 can choose from an average of 18 MA plan options.

This activity is notable in part because the MA plans have been a focus of the recent acquisitions. Observers worry that the consolidation of large health plans will lead to too much concentration of the Medicare business, and fewer choices for beneficiaries.

There's no indication that the Medicare Advantage market is suffering the same stagnation as the commercial plan space. On a relative basis, investors have perceived Medicare plans as a more attractive market in recent years. Secular trends that are growing the MA market are a big factor, as is the relative value of Medicare business when compared to traditional commercial plans, where there is increasing unpredictability and shrinking profitability.

Medicare enrollment is projected to grow organically to 66 million by 2021 from 54 million today, owing to an aging population.<sup>9</sup> The Medicare Advantage program has been attracting a growing proportion of these new-to-Medicare beneficiaries. Moreover, I believe that the recently enacted "doc fix" is going to continue to drive more beneficiaries into MA plans.

The complexity that the new law creates for providers that see Medicare beneficiaries as part of the program's fee-for-service schedule is going to grow significantly as a result of the provisions in the new law. I predict that more providers are going to opt to see most or all of their Medicare patients under the auspices of one or a few Medicare Advantage plans. While consolidation is shrinking options in an already contracting commercial market, the contours of the Medicare market are different. There is still new investor capital coming into the MA space, new Medicare plans being formed, and a net expansion in the number of offerings.

## **Physician Ownership as Government Policy**

For all the mergers that are underway in the hospital and plan sectors, the activity still dwarfs the scope of a historic consolidation of physician practices. In most cases, doctor practices

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<sup>8</sup> Avalere analysis of 2015 Medicare Advantage Landscape File and June 2015 Medicare Advantage Enrollment File. New MA entrants are parent organizations who did not contract with Medicare in 2011 but who did contract in 2012, 2013, 2014, or 2015 and who remain under contract in 2015. Analysis does not count PACE, Cost, or Duals-Demo plans as Medicare Advantage plans.

<sup>9</sup> 2015 Medicare Trustees Report

are being acquired by hospitals to form regional health systems, where a single hospital will control a significant number of the physicians in the outlying community.

This trend toward ownership of physician practices is not new. But like the consolidation underway in the hospital and plan space, this time, things may be much different.

The relationships that doctor practices are forging with their acquiring entities are far stickier than past arrangements. Moreover, for doctors, the opportunity to unwind these business engagements, and go back to their old configurations, are much more narrow. There is far more reason to believe that the new, consolidated doctor arrangements will persist.

In the past two decades, there have been at least two other waves of consolidation, where doctors were merged into health systems and hospitals. During each of these periods, physicians typically entered into employed relationships with the acquiring entities.

The first wave came with the advent of the for-profit physician practice management companies (PPMs) in the late 1990s. The model was premised on a view that PPMs could exploit cost savings through economies of scale and centralization, expanded access to capital, and bargaining clout with managed care companies. Most of the PPMs foundered, in part because they couldn't deliver on the promised efficiencies, and in part because they had promised high up-front payments to acquire the doctor practices and then couldn't recoup these investments. Most of the venture backed PPMs were liquidated. Doctors who had joined them dislodged their practices and went back to running their own medical offices.

The second major era of physician consolidation also unfolded in the 1990s, when hospitals made their first major foray into acquiring medical practices. These acquisitions were driven by the adoption of managed care in the 1990s. Hospitals and health systems became concerned that they would be excluded from contracting as HMOs started to shift risk onto providers through capitated arrangements. The providers, bearing financial risk, would adopt measures to avoid costly referrals to the hospital, or steer their patients only to low cost institutions. Or so the theory went. In a defensive bid to preserve market share, the hospitals started to acquire the doctors so that they could control their referral patterns.

These same concerns were part of the initial economic thesis behind the creation of the practice management companies. The belief was that the PPMs could also consolidate physicians, implement management tools that would enable the PPM to get more control over the doctor's clinical practice, and then contract directly with the HMOs to service the risk-bearing contracts. At the same time that hospitals were buying up doctor practices in many communities, they were also facing active competition from the investor-owned PPMs such as Phycor and MedPartners that were also purchasing large physician groups.

But the push toward capitation and narrow network HMOs receded, largely a consequence of a consumer and political backlash to the restrictive practices that shifted financial risk for medical care onto providers. This countermovement eventually led to the introduction of the Patients Bill of Rights in Congress.<sup>10</sup> Economics also played a role. In many cases,

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<sup>10</sup> Despite apparent bipartisan support, the 105th Congress failed successively to pass legislation protecting the rights of patients enrolled in managed care. See Clinton Signs Act Streamlining FDA Approval Of New Drugs,

owning doctors proved to be a money-losing proposition. Hospitals found that they were sustaining operating losses on these practices in excess of \$80,000 per physician.

The hospitals responded by rapidly divesting the practices once the trend toward managed care and capitation subsided. It was not profitable to own doctors, and it was no longer a strategic necessity. A handful of large, integrated delivery systems managed to survive. These include Intermountain Health and Geisinger Health System – two delivery systems that developed their modern footprint during this wave of physician consolidation. It should come as no coincidence that the systems that managed to survive, and prosper, by owning doctors under these integrated arrangements also had certain unique marketplace features.<sup>11</sup>

It's been noted that both of these efforts – one well-funded and predicated on expected profit opportunities, and the other formulated by insiders and created for supposed strategic advantages – have largely failed. Combined with the limited organic growth of group practices, this suggests that the economics of physician practice may be more complicated than perceived. The presumed economies of scale and scope of larger physician practices are illusory. That is, the small physician practice may in fact be economically robust.<sup>12</sup> Such considerations don't seem to have given any pause to pursuing these same concepts again.

### **The Third Wave of Physician Consolidation**

We are now experiencing the third wave of physician consolidation. This time, it's not business factors alone that are driving these mergers. This time, the consolidation is a consequence of deliberate policies designed to instigate these marketplace changes.

The ACA envisions doctors practicing in large, integrated health systems, often with a hospital at its hub. The newly consolidated entities need to be big enough to take capitated risk and invest in the kinds of technologies that, it's believed, will lead to better coordination of medical care. The ACA's mix of policies seeks to hasten these outcomes.

This isn't just an economic prerogative. It's the triumph of a political philosophy. In the early 2000s, Republicans made a concerted push toward “consumer directed healthcare.” The notion was that, by empowering consumers to engage more actively in their medical care, and by exposing them to some of the incremental costs of their healthcare decisions, consumers would help control health spending and lead to more optimal medical decisions.

These concepts formed the basis for policies contained in the Medicare Modernization Act, including the expansion of Health Savings Accounts, the private delivery of Medicare benefits, and efforts to improve the information that consumers had to make decisions.

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Endorses Patient 'Bill Of Rights,' Buffalo News, Nov. 21, 1997, at A16; Marilyn Chase, Work in Progress, New 'Bill of Rights' Makes a Modest Start at Protecting Patients, Pittsburgh Post Gazette, Dec. 2, 1992, at E4.

<sup>11</sup> For example, many enjoyed geographic isolation that limited their local competition.

<sup>12</sup> Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11

Liberals largely rejected these concepts. Their opposition turned on a number of concerns. First, there was a belief that many consumers aren't able to make optimal medical decisions owing to the complexity of medical care and the information asymmetries that persist in the doctor-patient relationship. Liberals also worried that consumers would forgo necessary care if they had to foot some of the bill, or wouldn't be able to afford the resulting cost sharing.

Finally, opponents of the consumer-driven policies believed that people shouldn't be forced to contemplate economic considerations when they were confronted with illness. There were other concerns, but these were the principal considerations to the opposition. To these ends, the ACA represented a wholesale rejection to many of the provisions of the Medicare Modernization Act and the Republican-led effort to implement consumer-driven healthcare.

But under a system dominated by third party payment for medical care – where consumers are not directly involved in paying for services -- there are only several ways to instill some restraint on the demand for services, if that discipline doesn't reside with the consumer.

These considerations can reside with the government, through constructs that aim to control price and access through national coverage decisions. To some degree, the ACA relies on these approaches, for example by giving the Centers for Medicare and Medicaid Services broad authority to tweak “mispriced” codes and become more actively engaged in using payment as a tool to control demand. The Independent Payment Advisory Board is also a personification of these ideas. But creating more explicit policy tools for rationing care is fraught with political risk. The rationing decisions become obvious.

So the ACA takes the final path. It puts these decisions on doctors, through arrangements that transfer risk for the cost of medical care directly onto physicians. It's a throwback to the 1990s practice of capitation, with new acronyms ascribed to the measures. Yet putting doctors on the hook for making these rationing decisions is the least transparent place for these considerations to reside. Patients may never know the options they weren't offered.

## **A Throwback to 1990s Capitation**

These concepts pre-date the 1990s. Congress passed the Health Maintenance Act of 1973 in response to growing healthcare costs, as a way to provide government support to these ideas.<sup>13</sup> But they didn't gain wide adoption until the 1990s, in response to escalating healthcare costs that sent businesses search for a way to manage demand for healthcare.

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<sup>13</sup> Under the Federal HMO Act, the federal government approved loans and grants to entrepreneurs interested in creating HMOs that met federal requirements. In order to receive financial assistance from the government, an HMO had to abide by certain requirements set forth in the Act. The rules and regulations provided a structure that the HMOs had to follow to assure quality health care. The Act also required HMOs to assume all responsibility for health care services on a prospective basis. However, the 1973 Act also permitted physicians contracted by the HMOs to assume financial risk for the rendering of health care services.

The HMOs made doctors responsible for the financial cost of caring for defined populations of patients.<sup>14</sup> Doctors got a fixed sum of money for taking responsibility for a panel of patients. If caring for that panel ended up costing more than the contracts allowed, doctors absorbed the loss. If the physicians spent less money than they were allotted, they kept the excess revenue as profit, and as a financial inducement to closely manage the cost of care.

Consumers rejected these capitated models, largely out of concern that these arrangements confronted doctors with a financial conflict.<sup>15 16 17</sup> Physicians earned more money when they made decisions – subtle or overt -- to withhold medical care.<sup>18</sup> These concerns were heightened by “gag” clauses that the HMOs maintained in their contracts with doctors. The provisions sought to prevent doctors from discussing these tradeoffs with patients.<sup>19 20</sup>

The ACA should be viewed as nothing short of a wholesale re-embrace of these capitated arrangements and the concept of shifting financial risk onto providers. To enable this risk taking, the ACA adopts a series of measures designed to change the organization and delivery of medical care in order to make the practice arrangements more economically amenable to taking on capitated risk. The physician consolidation (mostly around hospitals) is a key part of this new political economy. In response to the concerns, progressives argue that the shortcomings of these arrangements – in particular, the conflict that the doctor faces between providing care and maximizing profit -- can be reduced through proper regulation.

The economic behind these arrangements raise some more fundamental questions. For one thing, these constructs were, in part, a response to criticism of the fee-for-service approach to payment, which is widely presumed to give doctors a financial incentive to prescribe more

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<sup>14</sup> See Alycia Regan, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, J.L. & Soc. Probs. 635, 637 (1997) (describing the growth of managed care). Since 1993, MCOs have dramatically grown in number and expanded into new markets. In 1995, approximately 19% of Americans were enrolled in health maintenance organizations (HMOs). It is estimated that 73% of Americans who receive health insurance through their employers are enrolled in MCOs. “[T]his increasing reliance on managed care may be traced to a growing belief among employers and legislators that health care costs were spiraling out of control and that the traditional medical system could not adequately contain those costs.”

<sup>15</sup> Diana Bearden & Bryan Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 *Baylor Law Review*. 285, 294-95 (1995)

<sup>16</sup> Ralph O. Bischoff & David B. Nash, *Managed Care: Past, Present, and Future*, 80 *Medical Clinics of North America*. 225 (1996)

<sup>17</sup> Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?*, 83 *Georgetown Law Journal*. 1821, 1825 (1995)

<sup>18</sup> David Orentlicher, *Paying Physicians More to do Less*, 30 *University of Richmond Law Review*. 155, 155-64 (1996); see also James Freiburg, *The ABC's Of MCOs: An Overview of Managed Care Organizations*, 81 *ILL. B.J.* 584 (1993) (arguing that the term “managed care” is misleading because it is not really care at all, rather it is a comprehensive term describing a system of health care cost containment)

<sup>19</sup> Diane Swanson, Comment, *Physician Gag Clauses - The Hypocrisy of the Hippocratic Oath*, 21 *S. ILL. U. L.J.* 313, 315-16 (1997) (discussing gag clauses and their impact on health care). The author notes that MCOs use a drastic mechanism known as a gag clause to preclude physicians from criticizing managed care plans. See *id.* at 314-16. “Gag clauses are provisions in physician contracts which prevent them, explicitly or implicitly, from giving patients information about treatment options that may not be covered by their health plan.” *AMA Takes Stand Against Health Plan ‘Gag’ Rules*, *West’s Legal News*, July 12, 1996, available in 1996 WL 382081. In essence, a gag clause constrains free and unfettered discussion between a doctor and patient.

<sup>20</sup> Julia Martin and Lisa Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physicians Contracts*, 22 *American Journal of Law and Medicine*. 433, 434 (1996).



care. As the analysis commonly goes, under FFS arrangements, doctors are paid more when they do more things, and not necessarily when they improve outcomes.

But in reaction to these concerns, have we merely traded one flawed set of financial incentives for another? After all, if the financial incentives work in one direction, they have to work in the opposite direction. If doctors will prescribe unnecessary care when they're paid to do more, as critics of FFS medicine maintain, won't these same inducements work in reverse? Won't doctors prescribe less care when they are paid more to do less?

This raises another key question, this one clinical. Are patients better off, on the whole, when they're prescribed a little more care than they need, or a little less? The body of clinical literature doesn't fully resolve this question. Where studies try and tackle this question, many of the analyses seem to adopt methodologies that are colored by policy assumptions of the authors. The answer probably varies widely based on the clinical circumstance.

Another consideration is the propriety of these constructs. If nothing else, the capitated arrangements are the least transparent form of rationing. This seems to be part of their political appeal. When doctors make decisions to withhold some aspect of medical care out of a consideration of its cost, the patient may never know the option that they weren't granted. This remains the central concern over these arrangements.

But political opposition to these constructs has receded since they were first adopted, and then abandoned, in the 1990s. These ideas now form a central part of the ACA's premise, and a key rationale for the law's efforts to re-structure the organization and delivery of care.

To enable these constructs, the belief was that the organization of physicians had to change. Doctors had to be organized in larger units that were capable of taking on the capitated risk.

The advent of the Accountable Care Organizations was always perceived by the ACA's architects as an interim step toward these outcomes. In these goals, the ACA has been largely successful. Different surveys peg the numbers differently, but all point to greater consolidation of physicians into salaried roles, usually with a hospital or hospital-based health system at the center. One survey of some 20,000 U.S. doctors found that 35% described themselves as independent, down from 49% in 2012 and 62% in 2008. In another large survey, from 2007 to 2013, nearly 10% of physicians sampled were acquired by a hospital, increasing the share of physicians that are hospital owned by more than 50%.<sup>21</sup>

In 2010, full- and part-time hospital employment of physicians represented more than 15% of all practicing physicians.<sup>22</sup> A detailed analysis done that year of the membership of the Medical Group Management Association found hospitals employed roughly 28% of the

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<sup>21</sup> Cory Capps, David Dranove, Christopher Ody. Institute for Policy Research Northwestern University, Working Paper Series WP-15-02. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending, February 2015. <http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf>

<sup>22</sup> Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation [http://www.physiciansfoundation.org/uploads/default/Future\\_of\\_Medical\\_Practices\\_Goldsmith\\_Final.pdf](http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices_Goldsmith_Final.pdf)

212,000 physicians practicing in MGMA member groups — about 60,000 physicians.<sup>23</sup> Another 27.3% of MGMA group physicians (almost 58,000) practice in various other non-physician-owned groups such as HMOs and medical school faculty practice plans.

These trends have continued since then, with more doctors continue to take on employed relationships, selling their medical practices – mostly to hospitals. To recap some other published surveys: Since passage of the ACA, neurologists report an 8% increase in academic practice settings, a 2% decrease in private practice settings, and a 5% decrease in solo practice settings. Surveys of family physicians showed that 60% are now employees of hospitals or larger groups.<sup>24</sup> In another survey, from 2004 to 2011, hospital ownership of primary care physician practices increased from 24% of practices to 49%.<sup>25</sup>

Another survey conducted by the American Hospital Association (AHA) reported that about 15% of all physicians were full or part time hospital employees as of 2010. Of this number, 12.2% were reported to be full-time employees.<sup>26</sup>

Not all of the consolidation is through outright purchases of medical practices. Some of the consolidation is through contracting. Tax and regulatory considerations sometimes make it more advantageous, in certain circumstances, for a practice to sell its physician infrastructure to a hospital and then contract its services, for example. To these ends, research by the Deloitte Center for Health Solutions found that 60% of primary care practices are now exclusively aligned with a single hospital, though not necessarily employed by it.

The shift is more pronounced in medical specialties where there's a larger financial arbitrage between Medicare's generally lower-paying outpatient reimbursement and its higher-paying inpatient billing schemes.<sup>27</sup> Researchers at the Center for Studying Health System Change examined nearly 600,000 private insurance claims and found that average hospital outpatient department prices for common imaging, colonoscopy, and laboratory services are double the price for identical services provided in community settings. For example, the average price of a colonoscopy in a hospital was \$1,383 compared with \$625 in an outpatient setting.<sup>28</sup> In many of these cases, by acquiring medical practices, hospitals are able to capture more revenue. Medicare will reimburse more for services when they're performed in hospital ambulatory clinics rather than in a doctor's private office.

Cardiology is the most prominent example where hospitals are playing this arbitrage, in part owing to coding adjustments ushered in by the ACA that made it far more profitable to perform procedures like stress tests and echocardiograms in the hospital outpatient setting, rather than a private office. As a result of these reimbursement changes, between 2007 and

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<sup>23</sup> Fabrizio, 2012

<sup>24</sup> Elaine C. Jones, and David A. Evans. Defending the solo and small practice neurologist. *Neurol Clin Pract* April 2015 vol. 5 no. 2 158-163 <http://cp.neurology.org/content/5/2/158.short>

<sup>25</sup> [http://scholar.harvard.edu/files/cutler/files/jsc130008\\_hospitals\\_market\\_share\\_and\\_consolidation.pdf](http://scholar.harvard.edu/files/cutler/files/jsc130008_hospitals_market_share_and_consolidation.pdf)

<sup>26</sup> Elliott, 2012

<sup>27</sup> Medpac Report to Congress, June 2013. Medicare payment differences across ambulatory settings. [http://www.medpac.gov/documents/reports/jun13\\_ch02.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0)

<sup>28</sup> National Institute for Health Care Reform (NIHCR), authors Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services. Washington, DC: NIHCR; June 2014. (NIHCR Research Brief No. 16).

2012, the number of cardiologists working for hospitals more than tripled, according to a survey from the American College of Cardiology.<sup>29</sup> Over the same period, the percentage of cardiologists working in private practice fell to 36% from 59%. At the time of the survey, an additional 31% of practices were either in the midst of merger talks or considering it.

Oncology provides another example where this arbitrage exists, especially when it comes to the higher rates paid to the infusion of chemotherapy in the hospital outpatient department. This has caused a massive shift of oncology providers into hospitals.

Between 2005 and 2011 the amount of chemotherapy infused in doctors' offices fell to 67%, from 87%, according to an analysis of Medicare billing data done for community oncology groups. The share of Medicare payments for chemotherapy administered in hospitals (as opposed to outpatient oncology practices) increased to 41% in 2011, from 16.2% in 2005. The ACA's expansion of the 340B program is also driving these trends.<sup>30</sup>

This has a particularly profound effect on rural markets, where patients can find harder to receive care at a site near their homes.

It also affects costs. Because the overhead for a hospital is higher than for a doctor's office, a patient treated in a hospital clinic incurs \$6,500 more in costs than the same person treated in a private medical office, according to data from the Community Oncology Alliance. Patients who get chemotherapy at a hospital also face an additional \$650 in co-pays and other out-of-pocket expenses. The price for infusing the drugs alone rises by 55%, according to an analysis of Medicare data. These inflated prices for cancer treatment inevitably drive up the cost of health insurance.<sup>31</sup>

## **How the ACA Drives Physician Consolidation**

As noted, the ACA is driving this consolidation as a key part of its economic principle. The ACA is crafted on a premise that excess healthcare spending is a consequence of inefficient delivery and unnecessary utilization. The FFS physician payment system, it's argued, is a key driver of excessive utilization. So is the fragmented structure of the delivery system.

To ameliorate these shortcomings, the ACA changed payment rules, and advanced other constructs, as part of an effort to consolidate providers into integrated delivery systems, usually with a hospital as the central hub. These constructs were viewed as a gateway to the payment reforms advanced by the ACA. There was hardly a single speech that President Obama gave on the topic of healthcare reform where he didn't use one of the purported models for these designs – institutions such as Mayo Clinic, Geisinger Health, or

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<sup>29</sup> <http://www.nccacc.org/news/2012USCVPracticeCensusNorthCarolina.pdf>

<sup>30</sup> Scott Gottlieb. How ObamaCare Hurts Patients. The 340B program was meant to help about 90 hospitals buy drugs to treat the poor. Now 1,675 hospitals qualify. The Wall Street Journal, July 30, 2013  
<http://www.wsj.com/articles/SB10001424127887324110404578630522319113676>

<sup>31</sup> Scott Gottlieb. How ObamaCare Hurts Patients. The 340B program was meant to help about 90 hospitals buy drugs to treat the poor. Now 1,675 hospitals qualify. The Wall Street Journal, July 30, 2013  
<http://www.wsj.com/articles/SB10001424127887324110404578630522319113676>

Intermountain Health – as the standard for his reforms. The ACA seeks to replicate these institutions nationwide, even though their successes had more to do with local traditions and superior management. That’s hard to engineer through legislation.<sup>32</sup> Nonetheless, to try and duplicate these constructs, the ACA adopted specific provisions to drive such consolidation.

These ACA-led provisions can be broken into four broad categories:

1. The Bias Toward ACOs: Payment rules were deliberately biased against independent doctors and toward models where physicians were in employed relationships as part of health systems. In particular, the ACA envisions the creation of Accountable Care Organizations (ACOs) -- integrated health systems that are, in many respects, a throwback to the 1990s concept of Physician Sponsored Organizations (PSOs).

Many supporters of these concepts in the ACA argue that the ACOs were not the inevitable goal, but merely an interim construct. The ACOs were, in this analysis, devised as a way to condition providers to take on risk, and a way to develop the incentives that would create the kinds of organization to make it possible for providers to take this capitation.

These constructs are tied to new payment rules that try to link pay to performance. Doctors will see their income decline unless they’re practicing as part of these new arrangements. Small practices will be disadvantaged in these programs because they lack sufficient patient caseloads to demonstrate statistically reliable measures that these new schemes demand.<sup>33</sup>

Smaller, independent practices also lack the footprint to form the arrangements that will make them eligible for these new payment schemes.

For one thing, provider practices that want to participate in the “reformed” physician payment plan must control their own IT infrastructure to comply, as opposed to collaborating freely across space rented in the cloud. This practical need can require IT infrastructure that costs millions of dollars. It can make participation in these programs prohibitively expensive for anyone but a hospital that already has its own server hub.<sup>34</sup>

Also, waivers of certain anti-kickback provisions (that prevent doctors from forming needed business partnerships) only apply when providers qualify as an ACO.<sup>35</sup> <sup>36</sup> But ACO qualification is largely dependent on requirements that create the same need for physical infrastructure and bureaucratic overhead that’s hard to replicate outside the hospital setting.<sup>37</sup>

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<sup>32</sup> Scott Gottlieb. The Doctor Won’t See You Now. He’s Clocked Out. The Wall Street Journal, March 14, 2013 <http://www.wsj.com/articles/SB10001424127887323628804578346614033833092>

<sup>33</sup> Nyweide et al., 2009

<sup>34</sup> Scott Gottlieb. ObamaCare’s Threat to Private Practice. The Wall Street Journal, December 7, 2014. <http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367>

<sup>35</sup> Robert G. Homchick and Sarah Fallows. ACOs: Fraud & Abuse Waivers and Analysis. Davis Wright Tremaine, LLP.

[https://www.healthlawyers.org/Events/Programs/Materials/Documents/HCT13/h\\_homchick.pdf](https://www.healthlawyers.org/Events/Programs/Materials/Documents/HCT13/h_homchick.pdf)

<sup>36</sup> Lisa Schencker. HHS extends Stark, anti-kickback waiver for ACOs. Modern Healthcare, October 17, 2014. <http://www.modernhealthcare.com/article/20141017/NEWS/310179934>

<sup>37</sup> Scott Gottlieb. ObamaCare’s Threat to Private Practice. The Wall Street Journal, December 7, 2014. <http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367>

2. Paying More for Hospital Care: Payment was skewed toward the inpatient delivery of care, by reducing payment for outpatient procedures while increasing (or holding steady) the reimbursement when the same procedures are done in the outpatient hospital setting.<sup>38</sup>

This is especially true for certain cardiology procedures. The differentials have been a big factor behind the rapid consolidation of cardiologists. These “site of service” pay differentials enable hospitals to charge more for physician services provided in a hospital outpatient setting than when the same services are provided in a private practice. The pay disparities are significant factor driving the hospital-based ownership of doctors.<sup>39</sup>

A March 2013 report by the Medicare Payment Advisory Commission found that an office visit with a physician in a hospital outpatient department is reimbursed at a rate 80% higher than the same procedure performed in a physician’s office. As a result, the report cites a steady shift of services from physicians’ offices to outpatient departments from at least 2009, “consistent with the financial incentives in the current payment system.” MedPAC “expressed concern that higher payment rates in OPDs [outpatient departments] may induce hospitals to acquire physician practices and deem these practices part of the OPD.”<sup>40</sup>

The figures suggest that on only two services—evaluation and management visits and echocardiograms—Medicare paid hospitals \$1.3 billion more in 2010 than they would have paid if the services had been performed in a physician’s office rather than an outpatient department, MedPAC reports. In 2011, that number rose to \$1.5 billion.<sup>41</sup>

3. Rising Costs, Wilting Revenue: At the same time, doctors saw their profitability reduced. Government rules increased their practice costs while reducing their revenue under Medicare. At the very best, doctors have seen their Medicare reimbursement levels held largely flat, even while the rise in their medical practice costs continues to outpace inflation.

According to one survey of 5,064 physicians conducted in 2014 by CareCloud and QuantiaMD, 39% of all physicians foresee their profitability eroding, not increasing, up from 36% in 2013. Issues weighing on their finances are led by declining reimbursement (60%), rising costs (50%), requirements from the ACA (49%), and the transition to ICD-10.<sup>42</sup>

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<sup>38</sup> Anna Wilde Mathews. Same Doctor Visit, Double the Cost, Insurers Say Rates Can Surge After Hospitals Buy Private Physician Practices; Medicare Spending Rises, Too. The Wall Street Journal, August 27, 2012. <http://www.wsj.com/articles/SB10000872396390443713704577601113671007448>

<sup>39</sup> Hospitals Bristle as MedPAC Warns of Controversial Billing Initiative. At issue is how much large provider systems can charge for services after they’ve acquired physician practices. Managed Care Magazine, July 2013. <http://www.managedcaremag.com/archives/2013/7/hospitals-bristle-medpac-warns-controversial-billing-initiative>

<sup>40</sup> Medpac Report to Congress, June 2013. Medicare payment differences across ambulatory settings. [http://www.medpac.gov/documents/reports/jun13\\_ch02.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0)

<sup>41</sup> Scott Baltic. Monopolizing medicine: Why hospital consolidation may increase healthcare costs. Medical Economics, February 24, 2014. <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full>

<sup>42</sup> The Second Annual Practice Profitability, Carecloud and QuantiaMD. 2014 Edition. <http://on.carecloud.com/rs/carecloud/images/PPI-Report.pdf>

4. Combatting Narrow Networks: Finally, the growing propensity of exchange-based plans to contract with narrow networks of doctors, as a way to reduce costs and utilization, has put physicians at risk of being excluded from managed care contracts. These narrow networks were a significant part of the economic thesis supporting the ACA.

The law's architects envisioned health plans using restrictive networks as the primary tool for cost control. Other traditional ways that plans try and control costs – among them, by changing their benefit design, increasing their cost sharing, and underwriting risk -- were largely banned by the ACA. As a result, the principal tool plans were left with was their ability to control utilization. And the primary way to control utilization is to get more leverage over providers. The health plans achieved these ends either by owning the doctors outright, or by contracting with a more selected number of providers.<sup>43 44 45</sup>

In most cases, the doctors prefer to sell their practices to hospitals. So the insurers are left with narrow networks as their principal tool for managing costs. As a defensive response to these narrow networks, and to make sure they don't get excluded from managed care contracts, the doctors themselves are merging or forming businesses alliances. This is how consolidation begets still more consolidation in the sector.<sup>46</sup>

### **Consolidation Reduces Clinical Productivity**

As the Physicians Foundation notes,<sup>47</sup> compelling economies of scale are not apparent in physician practice. This has been borne out by studies that examined the question. A recent economic analysis by Douglas Hough of Johns Hopkins and David Gans of MGMA, for example, found scale economies in physician practice to be elusive. The survey examined 1,647 medical practices. Using 2008 data on the cost of medical care, physician productivity (as measured by gross physician revenues per full time equivalent physician) actually declined as medical groups grew in size from one to eight. It rose only modestly in groups of more than eight. For primary care specialties like family practice, the negative returns to scale continued until the group size reached 25. Keep in mind that the average family practice group size is six doctors. After that level, modest incremental revenue growth was seen.<sup>48</sup>

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<sup>43</sup> <http://www.nytimes.com/2014/03/06/opinion/in-health-care-choice-is-overrated.html?ref=topics>

<sup>44</sup> Bruce Japsen. Patients' choices may narrow as insurers adjust standards for doctors, hospitals - Quality measurements raise concerns about conflict between best care, cost controls. The Chicago Tribune, September 04, 2010. [http://articles.chicagotribune.com/2010-09-04/business/ct-biz-0825-network-choices-20100904\\_1\\_doctors-and-hospitals-care-hmo-illinois](http://articles.chicagotribune.com/2010-09-04/business/ct-biz-0825-network-choices-20100904_1_doctors-and-hospitals-care-hmo-illinois)

<sup>45</sup> Kocher, Robert, Ezekiel J. Emanuel, and Nancy-Ann M. DeParle, (2010). "The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges," *Annals of Internal Medicine*, vol. 153, (8), Oct. 19, pp. 536-39.

<sup>46</sup> Martin Gaynor. Statement before the Committee on Ways and Means, Health Subcommittee. Health Care Industry Consolidation. September 9, 2011.

[http://waysandmeans.house.gov/UploadedFiles/Gaynor\\_Testimony\\_9-9-11\\_Final.pdf](http://waysandmeans.house.gov/UploadedFiles/Gaynor_Testimony_9-9-11_Final.pdf)

<sup>47</sup> Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation [http://www.physiciansfoundation.org/uploads/default/Future\\_of\\_Medical\\_Practices\\_Goldsmith\\_Final.pdf](http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices_Goldsmith_Final.pdf)

<sup>48</sup> Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11

What's going on?

Part of the issue seems to turn on practice productivity. There's evidence that as doctors transition into becoming salaried employees of hospitals and health systems, their individual productivity (in terms of metrics such as volume and intensity of care delivered) generally declines outright, or is unfavorably impacted by these arrangements in other, more subtle ways.<sup>49 50 51 52 53</sup> Analyzing the source of the hospitals' physician practice losses, MGMA found that practice expenses for hospital-operated physician groups were actually 8% lower than those of non-hospital MGMA member groups. However, physician productivity in hospital employment was far lower. Net collected revenues for hospital-owned practices were more than \$100,000 per FTE physician lower than revenues for physician-owned practices and an impressive 35% lower than better performing practices. This result is, in large part, of markedly lower physician productivity.<sup>54</sup>

It's important to note that studies that have examined this question contain many limitations. This is because of the inherent difficulty in studying the impacts of different payment systems as well as the lack of good metrics for assessing physician productivity.

Many of the studies also rely on measuring Relative Value Units, which probably don't capture the full measure of a doctor's productivity. The RVUs are a formula that Medicare already uses to set doctor-payment rates. RVUs are supposed to measure how much time and physical effort a doctor requires to perform different clinical endeavors.

Medicare assigns each clinical procedure a different RVU and then multiplies this figure by a fixed amount of money to arrive at how much it will pay a doctor for a given task. A routine office visit has an RVU of about 1.68, while removing earwax has one of 1.26. Setting a finger fracture rates a 3.48. But this system misses the intangible factors that help gauge the quality and efficiency of the care being delivered. It can focus physicians on the wrong goals for promoting health, such as how well they code charts to capture higher-value "units."<sup>55</sup>

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<sup>49</sup> Lawton Robert Burns and Ralph W. Muller. Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration. *Milbank Quarterly* 2008;86:375-434

<sup>50</sup> Christopher D. Ittnera, David F. Larckerb, Mina Pizzinic. Performance-based compensation in member-owned firms: An examination of medical group practices, May 2007

<sup>51</sup> Wolinsky F, Marder W. Spending time with patients, the impact of organizational structure on medical practice. *Medical Care* 1982; 20(10):1051-9

<sup>52</sup> I S Kristiansen, K Holtedahl. Effect of the remuneration system on the general practitioner's choice between surgery consultations and home visits. *Journal of Epidemiology and Community Health* 1993;47:481-484

<sup>53</sup> Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behavior of primary care physicians: a systematic review. *Journal of Health Service Research Policy* 2001 Jan;6(1):44-55

<sup>54</sup> Advisory Board, 1999

<sup>55</sup> Scott Gottlieb. The Doctor Won't See You Now. He's Clocked Out. *The Wall Street Journal*, March 14, 2013 <http://www.wsj.com/articles/SB10001424127887323628804578346614033833092>

As a result of the shortcomings of assessing productivity by measuring RVUs, the studies may actually understate the loss of productivity that results from the physician acquisitions.<sup>56</sup>

The data does show some offsetting economic impacts to these drops in productivity. For example, physicians' use of services such as diagnostic tests demonstrate a corresponding decline when doctors move into salaried arrangements. The totality of the data suggests, however, that the reduction in costs generated by the salaried schemes (typically as a result of the delivery of fewer diagnostic tests) may be partially, if not completely offset by the lower intensity of work (productivity) that physicians achieve under these arrangements.<sup>57</sup>

While it's generally hard to isolate the impact of payment structure on productivity, a number of other studies have attempted to assess these impacts. I summarized some of this literature in prior testimony I delivered before the Ways & Means Committee in May 2012.<sup>58</sup>

In one study, researchers used a resident continuity clinic to compare prospectively, the impact of salary versus fee-for-service reimbursement on physician practice behavior. This model allowed randomization of physicians into salary and fee-for-service groups, therefore enabling the separation of the effects of reimbursement from patient behavior.<sup>59</sup>

The authors found that physicians reimbursed by FFS scheduled more visits per patient than salaried physicians (3.69 visits versus 2.83 visits,  $P < .01$ ) and saw their patients more often (2.70 visits versus 2.21 visits,  $P < .05$ ) during the 9-month study. FFS physicians also provided better continuity of care than salaried doctors by attending a larger percentage of all visits made by their patients (86.6% of visits versus 78.3% of visits,  $P < .05$ ), and by encouraging fewer ER visits per enrolled patient (0.12 visits versus 0.22 visits,  $P < .01$ ).<sup>60</sup>

Another review article surveyed the available literature examining how salaried arrangements impact physician productivity. It drew similar conclusions. The article found that salary payment reduces activity compared with fee for service. Capitation appeared to have a similar but more subdued effect. The authors concluded that "if cost containment is a key policy aim of government then salaried payment systems are more likely to achieve this compared with FFS and possibly more effective than capitation systems. However, cost containment by itself may be inefficient if it results in the provision of sub-optimal care."<sup>61</sup>

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<sup>56</sup> Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. *Cochrane Database Systematic Reviews* 2000;(3)

<sup>57</sup> T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. *QJM* 1999;92:47-55

<sup>58</sup> [http://www.aci.org/wp-content/uploads/2012/05/-scott-gottlieb-testimony\\_094622558298.pdf](http://www.aci.org/wp-content/uploads/2012/05/-scott-gottlieb-testimony_094622558298.pdf)

<sup>59</sup> Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. *Pediatrics* 1987;80:344-350

<sup>60</sup> Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. *Pediatrics* 1987;80:344-350

<sup>61</sup> T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. *QJM* 1999;92:47-55



There's also evidence that smaller practices may actually demonstrate higher productivity than large integrated practices, contrary to conventional wisdom (and certainly contrary to the economic assumptions that underpin the provisions in the ACA).

In one study, the mean multispecialty practice generated more than three times the total gross charges as the mean single-specialty practice, but with almost five times the number of FTE physicians. As a result, the mean multispecialty practice produced 29% less charges per FTE physician (\$367,000 versus \$515,000). Controlling for practice size, the mean multispecialty practice employed more ancillary, clinical, and office staff and fewer midlevel providers than did the mean single-specialty practice.<sup>62</sup> The per-physician productivity gains from physician ownership are estimated to be \$94,000 for all practices, \$26,000 for multispecialty physician practices, and \$64,000 for single-specialty practices.<sup>63</sup>

This data raises a fundamental choice: If the goal is reduce spending by driving down utilization then the salaried arrangements might provide a more direct means of imposing top-down controls. If the goal is to reduce costs by increasing productivity then the salaried arrangements might thwart these types of outcomes.

Taking a broader assessment of our fiscal challenges when it comes to healthcare, the only way that we are going to solve some of our long-term economic challenges facing entitlement programs like Medicare is to get more healthcare for every dollar of GDP that we spent on it. Under these circumstances, the last thing we ought to be doing is adopting structures that are going to reduce productivity.

## **Raising the Cost of Healthcare**

Studies show the physician consolidation also raises the cost of healthcare to consumers, in part owing to the lost productivity, in part owing to the lost competition that accrues as institutions monopolize their local providers. There's direct evidence that hospital-owned physician practices, in particular, incur higher costs of care than physician owned practices.<sup>64</sup>

One recent study examined total medical spending for about 4.5 million HMO patients in California from 2009 to 2012. The figures reflected the total cost of care, including

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<sup>62</sup> Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24

<sup>63</sup> Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24

<sup>64</sup> Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014 Oct 22-29;312(16):1663-9.  
<http://www.ncbi.nlm.nih.gov/pubmed/25335148>

hospitalizations, prescription drugs and physician visits. The data were obtained from the Integrated Healthcare Association, which includes insurers and medical providers.<sup>65</sup>

According to this 2012 study of 158 organizations, physician-owned medical provider organizations had mean expenditures of \$3,066 per patient (95% CI, \$2,892 to \$3,240), while hospital-owned physician organizations had mean expenditures of \$4,312 per patient (95% CI, \$3,768 to \$4,857), and physician organizations owned by multihospital systems had mean expenditures of \$4,776 (95% CI, \$4,349 to \$5,202) per patient. After adjusting for patient severity and other factors over the period, local hospital-owned physician organizations incurred expenditures per patient 10.3% (95% CI, 1.7% to 19.7%) higher than did physician-owned organizations (adjusted difference, \$435 [95% CI, \$105 to \$766],  $P = .02$ ).<sup>66</sup>

Organizations owned by multihospital systems incurred expenditures 19.8% higher than physician-owned organizations (95% CI, 13.9% to 26.0%; adjusted difference, \$704 [95% CI, \$512 to \$895],  $P < .001$ ). The largest physician organizations incurred expenditures per patient 9.2% higher than the smallest organizations (95% CI, 3.8% to 15.0%,  $P = .001$ ).

Most of the available studies look at the effects of hospital acquisition of doctors because hospitals have been the largest acquirer of physicians.

A May 2014 Health Affairs study found that when hospitals buy physician practices, the result is higher hospital prices and increased spending. The authors used hospital claims for the non-elderly, privately insured in the period 2001-2007, to construct county-level indices of prices, volumes, and spending and adjusted them for enrollees' age and sex. They measured hospital-physician integration using information from the American Hospital Association on the types of relationships hospitals have with physicians.

The study found that an increase in the market share of hospitals with the tightest vertically integrated relationship with physician practices (mostly through ownership) was associated with higher hospital prices and spending. "We found that an increase in contractual integration reduced the frequency of hospital admissions, but this effect was relatively small," the authors write. "Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured."<sup>67</sup>

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<sup>65</sup> Chad Terhune. Study: Medical costs up to 20% higher with hospital-owned physician groups. Los Angeles Times, October 21, 2014. <http://www.latimes.com/business/healthcare/la-fi-hospital-physician-costs-20141021-story.html>

<sup>66</sup> Of the 158 healthcare organizations that the researchers surveyed, 118 (75%) were physician-owned and provided care for 3,065,551 patients, while 19 (12%) were owned by local hospitals and provided care for 728,608 patients, and 21 (13%) were owned by multihospital systems and provided care for 693,254 patients.

<sup>67</sup> Baker LC, Bundorf MK, Kessler DP. Vertical integration: hospital ownership of physician practices is associated with higher prices and spending. *Health Affairs (Millwood)*. 2014;33:756–763.

## The Consolidation creates its own Instability

In part for these reasons, physician ownership is a mixed financial bag for hospitals. Once the arbitrage found in the Medicare rates is inevitably sanded away, many of these new arrangements will become a financial drag on hospitals, and may well strain their solvency.

According to the MGMA, in 2013 the average hospital-employed physician generated more than \$206,000 in losses (the difference between total practice revenue and costs of operating the practice). These burgeoning losses have occurred at the same time that hospitals' top lines have stopped growing. The economic facts suggest that any major deterioration of hospital operating profits will put these strategies, and hospital finances at significant risk.<sup>68</sup>

Losses from physician employment were a common theme in recent Moody's reports on the financial health of not-for-profit hospitals.<sup>69</sup> "For hospitals to break even, newly hired PCPs must generate at least 30% more visits, and new specialists 25% more referrals, than they do at the outset... Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities,"<sup>70</sup> Moody's wrote.

It's quite possible that the hospitals rolling up practices have neither the economic resources nor management capacity to absorb a much larger portion of the practicing physicians.<sup>71</sup> These realities, however, don't seem to be slowing the pace of the ensuing consolidation.

This is not a path to higher productivity. It's not a construct that's going to lead to lower costs, or more efficiency. It's not going to improve patient choice. Worse still, the consolidation is not an inevitable consequence of market forces or the demands of patients. Nor is it a failure of government to properly regulate these markets.

It's a direct consequence of a deliberate policy decision to create financial incentives for the formation of these new structures, based on what increasingly appears to be a flawed premise about how physician services should be organized, and medical care delivered.

In large measure, the policy ideas that gave rise to the consolidation are themselves an accommodation to the shortcomings of centrally managed, federally administered healthcare.

Well-managed private health plans are able to more closely evaluate medical care and contract with higher-performing providers. They are able to scrutinize reimbursement and establish rules that try and tie reimbursement to value. But under Medicare's FFS payment

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<sup>68</sup> Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation

[http://www.physiciansfoundation.org/uploads/default/Future\\_of\\_Medical\\_Practices\\_\\_Goldsmith\\_Final.pdf](http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith_Final.pdf)

<sup>69</sup> Beth Kutscher. Making physicians pay off: Hospitals struggle to balance current costs with future benefits of employing docs. Modern Healthcare, February 22, 2014.

<sup>70</sup> Kocher R, Sahni NR. Hospitals' race to employ physicians--the logic behind a money-losing proposition. New England Journal of Medicine 2011;364:1790-1793.

<sup>71</sup> Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation

[http://www.physiciansfoundation.org/uploads/default/Future\\_of\\_Medical\\_Practices\\_\\_Goldsmith\\_Final.pdf](http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith_Final.pdf)

system, the government is too removed from the provision of care to exercise this level of supervision. So compromises must be made. The consolidation of providers into systems that can take wholesale risk for large populations of patients is one such compromise.

It's a concession made to remote, government administration of healthcare.

### **The Need to Reform the 'Reforms'**

Once independent doctors become the exception rather than the rule, the continued advance of the ACA's agenda will become inevitable. Local competition between providers, who vie to contract with health plans, is largely eliminated by these consolidated systems.

Since all health care is local, the lack of competition will soon make it much harder to implement a market-based alternative to the ACA. The resulting medical monopolies will make more regulation the most obvious solution to the inevitable cost and quality problems.

To change these outcomes, I believe that Congress needs to reform the "reforms" embedded in the ACA and advanced in the recent "doc fix." This starts with removing the pervasive biases in the ACA that favor hospital ownership of medical practices. Payment reforms that create incentives for the coordinated delivery of medical care (like ACOs and payment "bundles") all turn on arrangements where a single institution owns the doctors. They're biased against less centralized engagements where independent doctors enter into contractual relationships among themselves. As the Physicians Foundation recently noted, the ACA "virtually ignored the task of renovating and strengthening medical practice."<sup>72</sup>

To preserve competition and market incentives that grow productivity, Congress must give independent, private-practice doctors an equal footing. The technology to enable providers to enter into more virtual collaboration is greatly improved since the original concepts around practice management failed in the 1990s.

One legislative concept worth expanding on would let a new class of "independent risk managers" act as third parties to help individual doctors analyze and share the risk of caring for these patient pools. This would make it possible for independent medical offices to band together and bid against hospitals for a pool of patients. Private companies specializing in analyzing and pricing medical risk could serve as brokers and help the doctors know what they're getting into. But for the most part, I believe the ACA deliberately crowds out this sort of market innovation in favor of hospitals and their existing networks.<sup>73</sup>

Individual, provider-owned medical practices also deserve equal footing when it comes to reimbursement. Right now, Medicare is paying much more for many procedures when

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<sup>72</sup> Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation

[http://www.physiciansfoundation.org/uploads/default/Future\\_of\\_Medical\\_Practices\\_\\_Goldsmith\\_\\_Final.pdf](http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf)

<sup>73</sup> Scott Gottlieb. ObamaCare's Threat to Private Practice. The Wall Street Journal, December 7, 2014.

<http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367>

performed in a hospital outpatient clinic rather than an independently owned medical office. As I noted recently in the Wall Street Journal, things as common as heart scans (\$749 versus \$503), colonoscopies (\$876 versus \$402) and even a 15-minute doctor visit (\$124 versus \$70) all pay more when done by a hospital-based doctor than a privately owned medical office.

Many in Washington know that hospitals are buying doctor practices to take advantage of this difference. They have only recently expressed concerns about these differentials, and the effects. But it may be too late. The consolidation that these pay differences stoked will be hard to unwind. Right now, there is a prevailing view that favors hospital ownership of doctors and see these pay differentials as a small cost to drive that migration.

At a time when the urge is to merge doctors into hospitals and turn physicians into salaried roles, there's a private-market, counter-effort to create new models that have physicians practicing in smaller units. Many aspects of medical practice are not responsive to scale. And where scale does help -- many of the characteristics of healthcare that benefit from integration can be achieved without consolidation, by better use of new technology.

As the Physicians Foundation noted in a recent report on the topic, new practice models — from the solo “micropractice” to the patient-centered medical home to direct-pay practice — hold promise both for diversifying physicians’ service offerings and for improving physician productivity.<sup>74</sup> Moreover, digital technologies that enable real-time claims management and payment, automate dictation and coding, and improve physicians’ communication with each other and with patients could lower overhead costs and enable more efficient practice. Medical practice innovation holds the key to private practice being a viable alternative to salaried employment for the next generation of physicians.<sup>75</sup> This would create more competition, innovation, and ultimately choice and access for patients.

A legislative proposal to improve healthcare quality and manage its costs would support local competition between providers and choice for patients. Reform of the ‘reforms’ would seek to improve productivity, and preserve the entrepreneurship, autonomy and local provider competition that have long been the hallmark of American medical progress.

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<sup>74</sup> The average hospital group size is almost 90

<sup>75</sup> Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation  
[http://www.physiciansfoundation.org/uploads/default/Future\\_of\\_Medical\\_Practices\\_Goldsmith\\_Final.pdf](http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices_Goldsmith_Final.pdf)