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Assessing Responses to Increased Provider Consolidation

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Case Study Analysis: The Detroit Health Care Market

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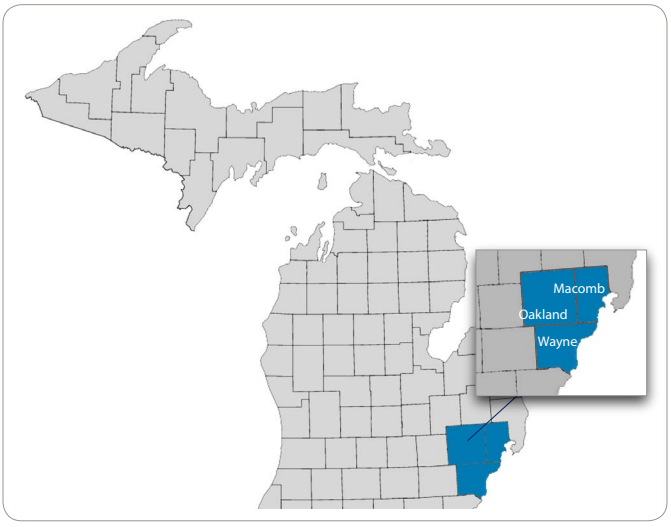
Rising health care prices have increased concerns about hospital and health system consolidation among policymakers, regulators, employers, and other purchasers of health coverage. Although merging hospitals and health systems claim they can achieve greater efficiencies through their consolidation, the economic literature almost universally finds that hospitals that merge have prices above those of surrounding hospitals.[1] And increases in hospital prices have been a key factor driving the growth of commercial health insurance costs over the past decade.[2]

As prices have risen, employers have shifted an ever greater share of the costs to employees. Over the past ten years, the average worker contribution for family coverage has increased faster than the average employer contribution (65 percent vs. 51 percent). Indeed, employee contributions have risen almost 300 percent since 1999.[3] Further, the increased negotiating clout of a concentrated provider sector influences payers' ability to maximize value-improving practices, such as alternative payment models, quality improvement, and transparency efforts.

In a series of six market-level, qualitative case studies, we assess the impact of recent provider consolidations, the ability of market participants (and, where relevant, regulators) to respond to those consolidations, and effective strategies for constraining cost growth while maintaining clinical quality. Our case studies focus on the commercial insurance market, though we recognize that providers and insurers are often operating in multiple markets, including Medicare Advantage, Medicaid managed care, and the Affordable Care Act (ACA) marketplaces. We do not attempt to quantify the effect of provider consolidation in these markets, such as through provider rate or premium changes.

This case study focuses on the Detroit, Michigan, health care market. For the interim report discussing findings across three health care markets (Detroit, Syracuse and Northern Virginia), visit https://georgetown.box.com/s/cbd5cipawi7dsr9n0jqzz05gvwdnmex8.



Background, History, and Methodology

The Detroit metropolitan region, defined in this study to include Macomb, Oakland, and Wayne counties, is home to six hospital systems. These are: Ascension Health, Beaumont Health, Henry Ford Health System, McLaren Health Care Corporation, Tenet Healthcare, and Trinity Health. Three of the systems (Beaumont, Henry Ford, and McLaren) operate solely in the state of Michigan. The other three systems had origins as Michigan organizations but operate now as subsidiaries of larger, multi-state companies. Most of the systems have affiliates across the state, not just in the immediate Detroit area. There are an additional three independent or quasi-independent hospitals: Pontiac General, Oakland Regional, and Garden City. Of these, Garden City Hospital is owned by a national system, Prime Healthcare services. Although outside the immediate Detroit area, the University of Michigan Medical Center also draws patients from the city.

Detroit has historically been the heart of the American auto industry, which gave rise to the "big three" auto manufacturers (Ford, General Motors, and Chrysler (now Fiat Chrysler)). With the emergence of this industry in the early 20th century came a health sector to meet workers' needs, including the construction of several non-profit and safety net hospitals, such as those now part of Trinity

Health, Henry Ford Hospital, and the Detroit Medical Center. These providers, in turn, created the Blue Cross Blue Shield of Michigan (BCBS MI) insurance company in order to help their patients finance the services they provided.[4] At the same time, the rise of organized labor in the 1930s resulted in the establishment of the United Auto Workers (UAW) union, which secured contracts with automakers that, in addition to higher wages, included guaranteed medical coverage, often financed through BCBS MI.

To a large degree, BCBS MI remains the dominant insurer in the Detroit market, while the hospital sector has been more competitive. In 2010, the U.S. Department of Justice sued BCBS MI over "most favored nation" (MFN) clauses included in their provider contracts. These clauses prevented providers from charging competing insurers a lower reimbursement rate than what they charged BCBS MI, enabling the company to offer lower-cost plans than competitors. The Department of Justice dropped its litigation after the Michigan legislature prohibited MFN clauses in insurer-provider contracts.[5]

In the last several years, the provider market has undergone changes that make it more consolidated. These include Tenet Healthcare Corporation's 2013 acquisition of the nonprofit Vanguard Health Systems, which owned one of Detroit's largest safety net hospitals, the Detroit Medical Center. This acquisition created the first, and thus far only, for-profit hospital in the Detroit region.

In 2014, the Detroit area experienced a merger among three hospital systems: Beaumont, Oakwood, and Botsford. The merger brought together a total of eight local hospitals, making the Beaumont Health System the largest hospital system in the state based on inpatient admissions and net patient revenue. In merger negotiations, the three systems cited population health, physician alignment, health IT integration, cost savings, and operational efficiencies as reasons for the merger.[6]

The succeeding years have witnessed additional integration among Detroit's hospital sector. In 2015, Henry Ford acquired Allegiance Health, a hospital in Jackson County, about an hour away from Detroit, while Garden City Hospital was acquired by Prime Health Care Services and Crittenton Hospital was acquired by Ascension Health, a national chain. More recently, Ascension Health and the Washington-based Providence St. Joseph Health systems have announced talks of a merger, which would make Ascension the largest U.S. owner of hospitals (although it would not add any hospitals in Michigan). Additionally, many of these hospital systems have invested heavily in vertical integration, through the purchase of physician group practices and other ancillary service providers.[7]

To assess the varying ways in which insurers respond to provider consolidation, we conducted an environmental scan, a literature review, and interviews with ten national experts and regulators. Additionally, we interviewed eight Detroit-area providers, insurers, large purchasers, and expert observers. All eighteen interviews occurred between November 3, 2017 and March 1, 2018.

Descriptive Analysis: Three Market Sectors

1. Hospitals, Health Systems, and Physicians

Despite the recent consolidation, the presence of six competing hospital systems means Detroit is not a concentrated provider market by most definitions. But as the area's independent hospitals have become part of larger systems, as some of the regional systems have aligned with larger national companies, and as some smaller systems have banded together to form larger systems (i.e., Beaumont Health), hospital providers have demonstrated a keen interest in increasing their geographic footprint, improving their access to capital, and leveraging their expanded market clout.

Respondents for this study have offered different descriptions of the competition that exists among Detroit's hospital systems. Some observers noted that there is not much head-to-head competition among hospitals, and that many hospitals aim to serve primarily the neighborhoods where they are located. Others suggest that people are willing to travel to use a particular hospital; as a result, hospitals compete directly. Another respondent observed that, unlike some other markets, there is no single "must have" hospital or health system in the area, although Detroit Medical Center and Henry Ford are the city's larger teaching

hospitals. There is no public hospital in Detroit, and no hospital seen as the sole safety net hospital. The safety net function is divided up among multiple hospitals, especially Detroit Medical Center and Henry Ford.

There are additional partnerships among hospital systems that represent loose affiliations, but not mergers. These have been the basis for some delivery system innovations such as clinically integrated provider networks. Several systems have been active in the acquisition of physician practices and other service providers. Although this trend may have been slower to materialize in Detroit than in many other markets, there is now a considerable degree of vertical integration. Many physicians and physician groups also contract with separate "physician organizations" to provide them with information technology, care coordination, and other services more efficiently than they could on their own; in some cases these organizations also negotiate reimbursement with payers on their members' behalf.

2. Insurers

Market concentration is far more evident among insurers, since the Detroit market is heavily dominated by one insurer, Blue Cross Blue Shield of Michigan and its HMO subsidiary, Blue Care Network. The exact market share depends on the way it is measured, but most estimates place it between 60 and 70 percent of the state's commercial market. There is more competition in the individual market, reflected in the participation of six other competitors on Michigan's Affordable Care Act marketplace and at least one other off-exchange participant. There is also more competition in the managed Medicaid and Medicare Advantage markets.

Local HMOs are characterized as relatively minor players in the Detroit market. One purchaser respondent suggested that "the HMOs end up being more expensive and are not better in quality."

The most prominent HMO is the Health Alliance Plan (HAP), affiliated with Henry Ford Health System. Although it has played an active role in the region for many years, it holds only a small share of the market. Early in its history the relationship with Henry Ford was much tighter, but today only a relatively small share of HAP members get care exclusively from Henry Ford providers.

3. Employer Purchasers

The largest employer purchasers in the Detroit market are the big three auto companies. A new element, borne out of the 2008-09 recession, is the UAW Retiree Medical Benefits Trust. It took responsibility for health benefits for 860,000 industry retirees (about half in state), thus making it a major health care purchaser. After the auto industry, hospitals and health systems are among the next largest employers in this market.

For the auto industry, health coverage was traditionally characterized by low cost sharing, low deductibles, and open provider networks. But the recession and near-collapse of the auto industry in 2008-09 (a "game changer" in the words of one provider respondent) was the catalyst for the adoption of insurance designs that are more common elsewhere in the country. Still, insurers have faced challenges making changes. Although nationally the average deductible in employer-based coverage exceeds $1500 per year, one respondent noted that local providers pushed back against the recent introduction of a $500 deductible plan, criticizing it for its overly high deductible.[8] The auto industry and unions have also discouraged the entry of for-profit companies on either the provider or health plan side.

Findings

In some ways, the Detroit market lags the rest of the country with respect to a number of health industry trends. For example, though there have been several recent mergers and acquisitions among hospital systems, the provider market remains far more competitive than in many major metropolitan areas. Additionally, respondents noted that high deductible health plans and alternative payment models that shift risk to providers have been slow to take off in Detroit compared to other major health care markets. As one respondent put it, "Michigan markets have been slower to evolve than in . . . the rest of the nation."

Respondents attribute Detroit's relatively old-fashioned health care culture to a highly unionized workforce that

has prioritized generous health coverage over wage growth and a lack of competition among insurers for commercial business. Also, the major hospital systems and payers in Detroit have, until recently, been locally owned and operated. Most have retained their non-profit status, perhaps mitigating aggressive efforts on both sides to wring profits out of the system. Although change may be coming more slowly to Detroit than in other areas, health care stakeholders have lately been reassessing the old ways of doing things. The market has "started to rev up a bit," in the words of one observer, with recent consolidations, acquisitions, and the emergence of new care delivery and payment models.

- **Blue Cross Blue Shield's Longstanding Market Dominance Continues**

  Respondents were united in their views that Michigan's Blue Cross Blue Shield plan is the 800-pound gorilla of the Detroit market. One observer noted, "I believe it's cultural in Michigan to have a Blue Cross card . . . it is an inherent expectation among the workforce, like a warm blanket." Employers feel they must offer BCBS coverage to their workers and most workers choose it. For their part, providers have no choice but to be part of BCBS MI's plan networks if they want paying patients.

  Although state legislation barred BCBS MI from including MFN provisions in provider contracts, the company continues to use its market leverage to gain discounts from providers, regularly beating competing payers on price. As suggested by one observer, "Every time employers put something out to bid, BCBS MI undercuts everyone else." For example, respondents noted that the Henry Ford Health System offers BCBS MI lower rates than it does its own health plan subsidiary. "They're getting the best deal from providers," observed one stakeholder. Similarly, a large multi-state purchaser based in Detroit noted that BCBS MI's provider discounts are "much better than any state I'm in."

  The fact that stand-alone providers "have to take whatever [BCBS MI] offers" on reimbursement has spurred recent efforts among hospital leadership to pursue mergers or other acquisitions in southeastern Michigan, such as the recent merger creating the 8-hospital Beaumont Hospital System and Henry Ford's acquisition of Allegiance Health. Although Detroit in 2018 continues to have a competitive provider market, there are few independent, stand-alone hospitals, and hospital systems are acquiring more and more physician groups each year in pursuit of vertical consolidation.

  Competing insurers, meanwhile, are taking advantage of the emergence of hospital systems with greater capabilities and geographic reach to develop narrow network products that can better compete with BCBS MI on price. "The smaller plans are trying to break through the Blues' monopoly [with a narrow network strategy]," one provider respondent told us, although it is not yet clear whether any of these products will gain significant market share.

- **In Spite of a Payer's Dominance, Negotiations with Providers are Complicated**

  BCBS MI's ability to dictate price and contract terms is not unfettered. First, it is limited by expectations among major employer purchasers and many workers that they will continue to have access to large, open provider networks. "'We have all the providers' has historically been BCBS MI's selling point," one employer told us, adding: "Anything that's about reducing benefits or choice is a very hard sell [with our employees]." Carving out a hospital system from their plans' networks would require a renegotiation of union contracts, something this employer was loath to do.

  Second, insurers may also worry about negative publicity if they drop a major provider from their network. Several respondents recalled a particularly nasty public relations campaign between BCBS MI and Beaumont Hospital during tough contract negotiations in 2011. "They were taking out full page ads on each other," one purchaser recalled.

  Third, for an insurer to expand its narrow network product offerings, it needs providers willing to be part of those narrow networks. But respondents report that hospital systems in Detroit have been reluctant to be the first in the market to acquiesce to significant reimbursement cuts in exchange for being part of a narrow network. "It's a game of chicken of who's

going to go first," observed one respondent. "I'm perfectly willing to negotiate price at the right level," said one provider, "if the payer is willing to guarantee I can retain volume and control of the costs." But, he continued, "if it's going to be a free-for-all, there's no trust in that."

Fourth, BCBS MI itself was a creation of the provider community, formed in 1939 by hospital and physician associations to help finance the provision of health care services.[9] To this day the company—like Blues plans in some other states—maintains a close relationship with providers, and eight current members of its board of directors are either clinicians or representatives of provider organizations.[10] Fifth, the hospital systems themselves are large customers for BCBS MI, with many of their clinicians and staff covered under their plans. These close relationships make it less likely the company will take steps to permanently alienate or exclude a major hospital system or group of providers.

- ### Pressure Increases on Both Sides to Strike Tougher Bargains

The Beaumont merger gave that system greater market power, but it is not yet clear how it will exercise it. As one expert noted, Beaumont is still "trying to figure out how to flex their muscle." Detroit payers have observed a toughened stance among Detroit providers in recent years. For example, they note that hospital systems are increasingly telling insurers they must conduct their contract negotiations with a centralized "corporate" office that makes decisions for the entire system. "They tell us not to talk to the individual hospitals," one insurer said.

Further, respondents noted that hospitals are under growing pressure from "sophisticated" payers in the state's Medicaid market to keep prices low. This puts corresponding pressure on them to make up Medicaid-related shortfalls through their commercial business. At the same time, several hospitals and health systems have recently hired CEOs from other markets around the country; one observer suggested that these executives' experience has contributed to a culture of tougher bargaining. Insurer and employer respondents told us that hospital providers are increasingly seeking to maintain or raise profit margins, and increasingly willing to issue termination threats to get what they want. A provider respondent confirmed: Detroit's hospital systems are trying to use their increased negotiating leverage to get "fair" rates. "We've all tested the waters a little, and we may have done marginally better, but nothing earth-shattering," he observed. Additionally, several respondents expressed concerns about the growth of facility fee charges for services performed in hospital-owned clinics and physician offices, although commercial contracts have limited the practice to some degree.

At the same time, major employers appear to be ratcheting up expectations that insurers deliver a lower-cost product, with one employer respondent pushing for narrow network designs. And while Michigan's large, self-funded employers have to date been willing to rely on insurers to handle price negotiations with providers, some are exploring other options. Recently, a major Detroit employer issued a Request for Proposals to directly contract with a provider system. Several local providers responded, a development that "shook the Blues to the core," said one hospital executive. Other large, self-funded employers are considering similar arrangements: "To this point, our carriers are the experts . . . but we remain open to the possibility we may have to directly negotiate [with providers]," said one purchaser. In response to the demand for lower-cost plans—and the threat that purchasers will go elsewhere if they can't deliver—payers, including BCBS MI, are developing higher deductible products as well as narrower network products, albeit at a pace slower than some employers might wish.

Payers are also working to implement payment reform initiatives, in which providers are given financial incentives to improve outcomes and quality, while delivering care more efficiently. "We are putting our eggs in the fee-for-value basket," said one insurer respondent, "but we have to change the mindset of the provider community [towards] shared value and affordability." Provider respondents confirm that they are under increased pressure to participate in value-based payment models, such as accountable care organizations and bundled payments for specific

episodes of care. "It's all of the above" when it comes to alternative payment models, observed one executive.

Ultimately, purchasers and payers appear to be pinning their hopes for cost containment on convincing more providers to take on more health care risk. "The key is getting financial incentives aligned," one payer said. A hospital executive highlighted the increased pressure as well, noting that while early payment models included only upside risk for meeting efficiency and quality targets, recent ones have also included downside risk. It's a trend he sees accelerating in 2019 and beyond, in concert with the federal push for more downside risk.[11] He further noted that much of the impetus for recent mergers and acquisitions in the provider sector has been to enable them to take on more risk, including downside risk.

Expectations for the Future

Respondents shared a wide range of views on how the Detroit market is likely to evolve. Further consolidation among providers is expected, while some predicted that a national insurer could enter the market and place some competitive pressure on BCBS MI. Another noted that local hospitals are over-invested in expensive "brick and mortar" (a problem not unique to Detroit), and will be challenged by new models of high-tech, consumer-directed care delivery and an increasing set of services provided outside the hospital setting.

Additionally, observers believe Detroit consumers can expect more products with narrow provider networks and higher deductibles. Others believe that payers—and their employer customers—will continue to ratchet up the pressure on providers to participate in more value-based and risk-sharing payment arrangements.

Epilogue

In August 2018, after the completion of our Detroit interviews, the Henry Ford Health System and General Motors completed a deal making Henry Ford the primary source of care for up to 24,000 General Motors salaried employees.[12] Henry Ford has agreed on rates for this deal that are lower than what it offers other payers, and employees have strong incentives to use Henry Ford's providers (with some additional designated providers, such as the Detroit Children's Hospital). The deal includes annual spending goals, quality metrics, and shared-savings arrangements. Enrollment in the new arrangements will be effective January 1, 2019. This initiative will be an interesting test of one large employer's attempt to exert influence on provider pricing. It is less clear whether employers without the clout of General Motors would be able to piggyback on this type of initiative.

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