Health Care Consolidation Continues Apace

The Impact on Providers and Patients Is Either Mixed or Unclear

Stephen Barlas

A potential reduction in pharmacy costs to insurance plan members is a key rationale underlying the most recent proposed mega-mergers in the health care industry. The Anthem/Cigna and Aetna/Humana combinations, now under scrutiny at the U.S. Department of Justice (DOJ), theoretically would benefit consumers by lowering drug costs, given the increase in covered lives the new companies would have as leverage when negotiating with pharmaceutical manufacturers. Those drug-cost savings might be boosted further by the secondary consolidation of pharmacy benefit managers (PBMs). Anthem uses Express Scripts, while Cigna uses Catamaran. Catamaran itself was merged with UnitedHealth's OptumRx PBM in 2015. Aetna uses the CVS Health PBM (which acquired Caremark PBM in 2007), while Humana has an in-house PBM.

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The deals are likely to have repercussions in other sectors, too, extending to drug wholesalers, retail drugstores, and hospitals. "The biggest potential impact for us is if we are locked out of additional payer networks due to the consolidation," says Kyle Skiermont, PharmD, Director of Specialty Pharmacy Operations for Fairview Pharmacy Services. "These groups often want to use their own specialty pharmacies, which make it difficult for health systems to care for their own patients."

The dizzying pace of mergers within the health care industry drew a reaction from presidential candidate Hillary Clinton, who said on October 21, "As we see more consolidation in health care, among both providers and insurers, I'm worried that the balance of power is moving too far away from consumers." But Robert Berenson, MD, an Institute Fellow of The Urban Institute, says he doesn't see health care consolidation becoming a front-rank political issue during the 2016 presidential campaign. While he views it as a very legitimate policy issue, he explains, "It is not as if there are clean solutions. It is murky, complicated stuff."

The Causes of Merger Mania

The phrase "fast and furious" has already been taken (by Vin Diesel as the title of his skein of action movies), but it could also be used to describe the pace of mergers in all sectors of the health care industry. Walgreens joined the merger mania at the end of October when it announced that Boots Alliance wants to absorb Rite Aid. The deal would unite two of the country's three biggest drugstore owners. Boots Alliance is composed of the Walgreens and Duane Reade retail pharmacies in the U.S. and Boots retail pharmacies in the United Kingdom and other foreign countries.

The health industry merger trend has probably been hastened in the past few years by the Patient Protection and Affordable Care Act (PPACA), which included a number of provisions aimed at encouraging "integrated care"—a concept in which success depends on the provision of a broad range of medical services by a single institution. "The national health care law reinforces the trend of providers, including doctors and hospitals, to merge into large regional health systems that dominate local markets," Christopher Pope wrote in a 2014 issue brief published by the Heritage Foundation. "The law also introduces new rules and restrictions that will reduce the degree of competition in the insurance market."

But the push toward integrated care doesn't explain consolidation among pharmaceutical manufacturers, which has more to do with filling in gaps in research and development pipelines. Only 11 of the original 43 members of the industry lobbying group Pharmaceutical Research and Manufacturers of America (PhRMA) exist today. The big deals of 2015 so far have been the acquisition by Valeant Pharmaceuticals International, Inc., of Salix Pharmaceuticals, Ltd.; the acquisition by Impax Laboratories, Inc., of CorePharma, LLC; and the purchase by Sun Pharmaceutical Industries Ltd. of Ranbaxy Laboratories Ltd. In the Impax/CorePharma and Sun/Ranbaxy cases, the Federal Trade Commission (FTC) ordered some divestiture of assets. These deals followed the Actavis PLC takeover of Allergan PLC in the fall of 2014. But whatever the rationale for drug company mergers, no one could argue that they have led to lower consumer prices for drugs, which have risen rapidly—in some cases geometrically—over the last few years.

Nor does the PPACA explain consolidation of PBMs, such as the 2015 acquisition by UnitedHealthcare, which operates the OptumRx PBM, of Catamaran. Express Scripts swallowed the Medco PBM in 2011, turning the Big Three in that industry into the Big Two. CVS ate CaremarkRx in 2007. The proposed Anthem/Cigna and Aetna/Humana mergers are partly about the presumed ability to obtain lower drug costs. The degree to which those costs will drop, much less whether the savings will be passed along to consumers, won't be established for some time.

Theoretically, to the extent consolidation promotes integration, the trend has positive potential, both in terms of saving money for consumers (not to mention the federal government, through Medicare, Medicaid, and Tricare) and promoting higher-quality care. But the evidence so far from accountable care organizations (ACOs)—the PPACA's major contribution to integrated care—is very mixed on both cost and quality metrics.

In a post on the *Health Affairs* blog on July 16, 2015, Thomas Greaney, Co-Director of the Center for Health Law Studies at the St. Louis University School of Law and a former FTC antitrust official, wrote that mergers within an industry can be self-perpetuating, without any particular benefit to consumers. "History also teaches that mergers often tend to beget mergers," he wrote. "Mergers are not always driven by efficiency considerations; sometimes a merger 'cascade' occurs simply because the other guy is doing it, hubris, or even 'empire-building.'"

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Finger-Pointing on Insurers' Mergers

The current political flashpoint is the two insurance-company mergers, Aetna's acquisition of Humana and Anthem's of Cigna. Advocates and detractors are in the midst of a heated "he said, she said" debate, hoping to influence the DOJ, which has taken the lead in investigating possible antitrust problems with both mergers. These prospective mega-mergers would result in larger companies competing in numerous markets, both in terms of the services provided and the geographic areas.

For example, the insurance companies provide administrative services to large, self-insured companies and offer health care services to individuals through the PPACA marketplaces, Medicare, and Medicaid. In both potential mergers, the new partners would have some overlap in products sold in particular geographic markets, but the overlap is not extensive. It appears likely that the DOJ will approve both mergers but require the two new giants to divest some business lines in some states.

Aetna's $37 billion acquisition of Humana is almost entirely about enlarging its Medicare Advantage business. Aetna has traditionally been a large commercial health-insurance company. By appending Cigna and its Medicare Advantage business, Aetna would balance itself out between private and public health plans. The resulting combined Medicare Advantage market for the new company would be only 8%, which is not likely to cause DOJ angst. Moreover, the Medicare Advantage population is half of the Medicare fee-for-service population: 18 million versus 37 million. Aetna CEO Mark Bertolini explains:

> We believe that the combination of Aetna and Humana will enhance competition at the local level by giving consumers a strong alternative to Blue Cross Blue Shield plans and other competitors. In this way, this combination is actually strongly procompetitive. Even after the acquisition, Aetna will continue to face significant competition from a large number of health plans and other new market entrants such as ACOs.

The Anthem/Cigna combo would also have a relatively small Medicare Advantage footprint—about 6%, according to a recent analysis by the Kaiser Family Foundation. Anthem does business in 20 states, primarily in New York, Ohio, and California. Cigna, meanwhile, does business in 15 states and the District of Columbia, primarily in Florida, Tennessee, Pennsylvania, and Texas. The companies thus have a highly complementary geographic footprint. As for the purchase of individual plans, where consumers obtain coverage directly for themselves (often through the exchange marketplaces or a broker), Anthem has a presence in 14 states and Cigna has a presence in 12 states. "The combined company would only share a limited number of rating regions within just five states, where there is now and will continue to be robust competition," states Joseph Swedish, President and CEO of Anthem, Inc. "Underscoring this is the fact that consumers can now choose from an average of 40 health plans in states participating in the insurance exchange marketplace—an increase of 25% in 2015."

Paul B. Ginsburg, PhD, Norman Topping Chair in Medicine and Public Policy at the University of Southern California, says the potentially problematic impacts of the Aetna/Humana merger appear mostly in the Medicare Advantage arena, where some local markets would become substantially more concentrated. These impacts can be addressed through divestitures, he believes.

However, the hospital and physician lobbies aren't buying that procompetitive claim. Rick Pollack, President of the American Hospital Association (AHA), says:

> The unprecedented level of consolidation these deals threaten could make health insurance more expensive and less accessible for consumers. This applies to health insurance purchased in the commercial market as well as Medicare Advantage (MA) plans. These deals also could further entrench the power of the Blues plans, which currently dominate the market in nearly every state.

The American Medical Association produced an analysis showing that there has been a near-total collapse of competition among health insurers, with seven out of 10 metropolitan areas rated as highly concentrated based on the DOJ and FTC Horizontal Merger Guidelines (2010) used to assess market competition. Moreover, 38% of metropolitan areas had a single health insurer with a commercial market share of 50% or more. Of course, just because one company holds 50% of any one market, that doesn't necessarily guarantee market dominance.

Hospitals on the Defensive

While the hospitals are playing offense against the proposed insurance-company mega-mergers, they are more accustomed to playing defense because of antitrust issues in their own industry. The FTC has been very active in opposing hospital mergers in local markets for years. Ginsburg says: "The effects of mergers in health care on prices and quality of care have received a great deal of attention from economists. Much of the research has focused on mergers among providers, especially hospitals, and clearly shows that hospital mergers have led to higher prices without measurable effects on quality." The United States has roughly 5,000 hospitals. Between 1998 and 2012, there were 1,113 mergers and acquisitions involving a total of 2,277 hospitals, according to the AHA's *Trendwatch Chartbook 2012: Trends Affecting Hospitals and Health Systems.*

Although no high-profile hospital merger is in the works at the moment, such mergers have clearly been multiplying faster in the wake of the PPACA's passage than they were before it. Health insurers have been sharply critical of hospital consolidations across the country, such as those in recent years between Trinity Health and Catholic Health East and between the Baylor Health Care System and Scott & White Healthcare. America's Health Insurance Plans, the industry's lobbying group, has said that when hospitals merge, it "comes with a price that consumers and employers simply cannot afford."

Not only are hospitals combining, they are taking over the ambulatory surgical centers that provide less-expensive medical services than the hospitals' outpatient wings. There are about 5,300 Medicare-certified ambulatory surgical centers across 50 states, according to the Ambulatory Surgery Center (ASC) Association. Medicare now pays ASCs about 56%, on average, of the hospital outpatient department payment rate for providing identical services. An analysis conducted by the association found that of 179 ASC closures since 2009, about one-third were a result of purchase by a hospital.

This disparity will worsen because reimbursements for out-

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patient surgery in general hospitals are automatically indexed to medical costs, while those in independent centers are adjusted by much-lower general inflation rates. That disadvantage for ASCs was compounded by the PPACA, which requires that payments to independent surgical facilities be further reduced in line with annual improvements in "medical productivity."

The PPACA has, in some minds, greased the skids for mergers in a number of ways. Pope's 2014 paper for the Heritage Foundation cited, for example, the medical loss ratio (MLR) requirement imposed on marketplace insurers. It dictates that they spend at least 85% of premium revenues for large groups (80% for small groups and individuals) on claims or "activities that improve health care quality." The need for sufficient scale to comply with MLRs is likely to impede start-up providers, Pope wrote, while the requirement to minimize administration costs as a percentage of revenues can be expected to induce mergers.

In addition, the PPACA created barriers to physician-owned hospitals. The act requires that such hospitals must obtain a federal certificate of need. A so-called "Stark exception" had allowed physicians to have an ownership or investment interest in a hospital where they referred patients, but Section 6001 of the PPACA eliminated that option for physicians who did not have such provisions in place as of December 31, 2010. A physician-owned hospital also cannot expand its treatment capacity unless certain restrictive exceptions can be met. According to Greaney: "The ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement."

A Dose of Pharmaceutical Mergers

Merger mania has characterized the pharmaceutical sector, too, with acquisitions by both brand-name and generics companies. A March 2015 Reuters story stated that 2015 pharmaceutical deals had "reached $59.3 billion, a 94% increase over that same period a year ago, and the highest value for this stage in any year since 2009."

The battle cry for drug-company mergers may have been sounded in 2014 by Actavis CEO Brent Saunders, who said his company's purchase of Allergen made Actavis a pioneer "in a new industry model: growth pharma." Then came 2015. Valeant beat out Endo for the absorption of Salix. Valeant had tried and failed the year before to acquire Allergan. Endo lost out on Salix, licked its wounds, and vowed to look for other deals. It announced in late September that it was spending $8 billion to buy Par Pharmaceutical Holdings, which would make it a top-five generics company in the U.S. based on sales.

Two of the early 2015 mergers brought FTC-imposed divestitures. Impax agreed to divest all of CorePharma's rights and assets to generic pilocarpine tablets and generic ursodiol tablets to settle FTC charges that Impax's proposed $700 million acquisition of CorePharma would likely be anticompetitive. Another 2015 consent decree forced Sun to divest Ranbaxy's interests in generic minocycline tablets after Sun bought Ranbaxy for $4 billion.

Consolidation of Pharmacy Benefit Managers

Valeant announced it was pulling back in its expansionist drive and focusing more on research and development (R&D). Health insurance companies such as Anthem and Aetna don't have any basic-science R&D to fall back on. They do plenty of marketing R&D, however, and those efforts have informed their two mergers—especially, it appears, in the area of the benefits of pharmacy synergy. It is not clear whether one current PBM will win out in each of the mergers, or whether Anthem/Cigna will ditch both PBMs and start its own, for example. In the case of Aetna and Humana, Humana already runs its own PBM, but would it have to be scaled up to accommodate the lives Aetna brings to the combined companies? Could it be scaled up?

Steve Miller, Chief Medical Officer at Express Scripts, said in an interview last January that his company covers about 85 million people, for whom Express Scripts simply administers pharmacy benefits. About 25 million of those members are on the national preferred formulary, mostly for commercial clients. That group's prescription drug choices are determined by Express Scripts. But Miller noted that noncommercial clients tend to follow the Express Scripts national formulary, too.

"Express Scripts has 85 million covered lives," notes Berenson. "Will another 10 million increase its clout? I have trouble accepting that argument."

Anthem's Swedish was somewhat opaque about potential pharmacy benefits during a conference call this summer with investment analysts. "Regarding the PBM, I'd like to highlight that we do believe there is significant value and opportunity for the combined company and our customers from a better pharmacy contract." But he seemed to indicate that there were some uncertainties around that "potential value" by adding, "That being said, we really want to take advantage of the time for our integration to look at the optionality that is available to our companies. And we think this requires a lot more research beyond that done through our due diligence."

An Anthem spokesman did not respond to a question about what Swedish meant by "optionality." Perhaps it was a reference to efficiencies in pharmacy operations that the new, larger company could achieve. However, David Balto, a Washington antitrust lawyer who formerly worked on health care issues at the FTC, says Anthem and Cigna, and Aetna and Humana, don't have to combine their PBMs in order to have smarter pharmacy operations. "Target doesn't have to combine with Walmart to become smarter," he says. "It just has to roll up its sleeves and get better. Maybe that means hiring better managers away from rival companies. It doesn't need a merger to do that."

It is probably reasonable to assume that, given the size of the two prospective mergers, the DOJ may be a bit more severe in its requirements for letting the Aetna/Humana and Anthem/Cigna deals go through. That assumes the department doesn't reject one or both deals. The DOJ showed its skepticism toward industry-changing mergers when it turned down Comcast's acquisition of Time Warner Cable. In that case, according to Balto, the two companies did not compete in the same markets geographically and product-wise. The DOJ's thumbs-down was the result of concerns that the new company would have a stranglehold as "gatekeeper" on "Internet-based services that rely on a broadband connection to reach consumers." Such a concern, if translated to the health care mergers up for review, could result in a rejection of the mergers because of their impact as gatekeepers on hospitals and physicians, not because of any consolidation in Medicare Advantage or PPACA marketplace offerings. ■