Yes, Cross-Market Hospital Mergers Can Really Drive Up Costs

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Leemore S. Dafny, Katherine Ho & Robin S. Lee, *The Price Effects of Cross-Market Hospital Mergers* (NBER Working Paper No. w22106, 2016).

The Price Effects of Cross-Market Hospital Mergers, by economists Leemore S. Dafny, Kate Ho, and Robin S. Lee is a must-read for anyone interested in healthcare price and competition. Now, don't get scared off by the fancy equations and economic terms like "concavity"—there is more than enough substance in plain English to make this paper accessible to an interested non-economist. The paper provides a missing link in current antitrust enforcement efforts by providing both theoretical and empirical evidence demonstrating that cross-market mergers can harm competition in ways that could violate both state and federal antitrust laws. Despite anecdotal claims to the contrary, antitrust enforcers have argued for years that cross-market mergers could not drive up the price of healthcare. Yet, we have continued to see significant consolidation in the healthcare system, both within and across geographic and product markets, along with the price increases that tend to accompany that consolidation.

Cross-market mergers have gone entirely without scrutiny from federal and state antitrust enforcers, who have argued that causes of action based on such mergers lack both a theoretical and empirical basis. However, a handful of scholars and international regulators—e.g. Vistnes & Sarafides and the European Commission—have begun to argue more forcefully that cross-market mergers can drive up costs even in markets that lack overlapping product and geographic markets, by creating what they call "portfolio power." But, until now, there has been a lack of empirical evidence to demonstrate that cross-market hospital consolidation could drive up costs.

Dafny, Ho & Lee offer both theoretical explanations of how cross-market mergers can harm competition, as well as the empirical data to back up their ideas. Their theoretical model is based on insight from Ho & Lee's 2015 paper, Insurer Competition in Healthcare Markets, which demonstrated that the merger of hospitals in different markets could influence insurer reimbursement rates, if those insurers had customers (employers) who employed workers in both markets. Employers would be looking to identify insurance plans whose networks provided the greatest value across all markets. As a result, an insurer's network would not be as attractive to the employer if it did not include both hospitals, even if they were not in the same geographic market. So the merger would make the utility loss of both hospitals greater than the sum of the losses of each hospital independently in the absence of the merger. As a result, the merger provides the merging hospitals more bargaining power despite their lack of shared product or geographic markets. This directly contradicts current thinking in antitrust enforcement.

What Dafny, Ho & Lee argue in this article is that this principle extends beyond just employers looking to insure employees in different geographic markets, and holds true for consumers in the same geographic market looking to purchase different products and for insurers looking to build a network across markets. Imagine that you are deciding between health plans for your family and you care most about a network that covers both your kids' pediatrician and your cardiologist. A plan that includes both is the most desirable, a plan that includes one or the other is slightly less, but a plan that includes neither is probably out of the question. Dafny et al. call this the "Common Consumer Effect." The main

idea is that a merger that includes both the pediatrician and the cardiologist would give the merged provider organization more utility, and therefore more bargaining power, than the sum of their independent utilities. Importantly, the common consumer effect results from a change in the parties' outside options, not from increased negotiating skill, which opens the door to antitrust enforcement.

The same theory also applies when there are no common customers, but instead common insurers—The Common Insurer Effect. Dafny et al. hypothesized that cross-market mergers can enable a hospital system to recoup revenues lost due to political or legislative constraints in one market (caps on increases) by acquiring a hospital in a non-constrained market, and then increasing rates in the non-constrained hospital and requiring all insurers to include both hospitals in their network.

To test their theories, Dafny, Ho & Lee examined two distinct samples of acute care hospital mergers over the period of 1996-2010, and examined the price trajectories after those mergers for three groups of hospitals: (i) hospitals acquiring a new system member in the same state, but not in the same narrow geographic market (adjacent treatment hospitals); (ii) hospitals acquiring a new system member out of state (non-adjacent treatment hospitals); and (iii) hospitals that are not members of target or acquiring systems.

Their research found that the prices for adjacent treatment hospitals increased 6 – 9% relative to controls, while non-adjacent treatment hospital price changes tended to be negative and statistically insignificant. Further, when they examined the degree of insurer overlap between the merging hospitals—it absorbed the entire price effect for adjacent hospitals, meaning that a common insurer is required for there to be a cross market price effect, which is consistent with their theoretical model. It also suggests that consolidation in the insurance market may enhance these effects. They also found a small effect showing that the distance to different hospitals also had an impact (within the common insurer) suggesting a common customer effect as well.

This research calls into significant question a common assumption in antitrust enforcement- that insurers' willingness to pay for a particular provider is linear. This assumption of linearity means that only mergers with overlapping product and geographic markets can result in anticompetitive price increases. Instead, the research suggests that both within-market and cross-market mergers between hospitals sharing a common consumer can result in higher willingness to pay by insurers and price increases. Further, merging hospitals with no common consumer or geographic market may be able increase prices via a common insurer effect through the use of double marginalization and use of an unconstrained market to alleviate price constraints in another market. Based on these findings, antitrust enforcers should more carefully scrutinize the potential impacts of cross-market mergers for harm to competition and actionable antitrust offenses.

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