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Assessing Responses to Increased Provider Consolidation

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Case Study Analysis: The Northern Virginia Health Care Market

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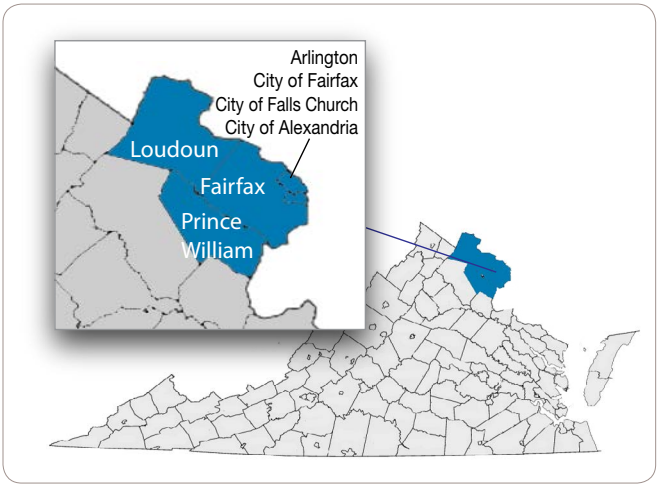
Rising health care prices have increased concerns about hospital and health system consolidation among policymakers, regulators, employers, and other purchasers of health coverage. Although merging hospitals and health systems claim they can achieve greater efficiencies through their consolidation, the 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 Northern Virginia health care market (Arlington, Fairfax, Prince William, and Loudoun counties and the independent cities of Fairfax, Alexandria, and Falls Church). 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 Northern Virginia (NoVa) region is defined in this study to include the inner Washington suburbs of Arlington and Fairfax Counties; the independent cities of Fairfax, Alexandria, and Falls Church; and the outlying suburbs of Prince William and Loudoun Counties. The NoVa region, with a population of nearly 2.5 million, lies across the Potomac River from health care facilities in Maryland and the District of Columbia, but most respondents told us that relatively few consumers—maybe only 10 percent—cross the river for health care.

The core NoVa region has six health systems: Inova Health system (Inova); Kaiser Permanente (Kaiser); the for-profit HCA Virginia Medical System (HCA) owned by a large corporation headquartered in Tennessee;[4] the independent Virginia Hospital Center (VHC); Novant Health, a nonprofit health system headquartered in North Carolina; and Sentara, a nonprofit system based in Norfolk. Kaiser operates without its own hospital (although it operates several large ambulatory care centers in NoVa), and contracts with VHC for hospital services. VHC is in Arlington County; Inova's hospitals are in Fairfax City, Falls Church, Alexandria, and Loudoun County; and HCA has two hospitals, one about 20 minutes from central Arlington in Reston, and one in Loudoun County. The Novant and Sentara hospitals are in Prince William County.

Unlike hospitals in markets such as Syracuse, the hospitals in NoVa do not appear to compete against one another based on specific service lines such as cardiology, oncology, or OB/GYN. In addition, traffic patterns—and the notoriously congested roads—in the region mean that the hospitals can maintain relatively distinct geographic fiefdoms. For example, many people who live near VHC typically do not travel to other jurisdictions for care. Similarly, many opt to obtain services at Inova and HCA facilities primarily for reasons of proximity.

As a suburb of the nation's capital, Northern Virginia is an affluent area, home to numerous federal agencies and contractors, and headquarters of large companies like Verizon and Capital One. This affluence and high proportion of commercially insured residents has contributed to both high health care prices and the growth of medical systems.

Northern Virginia has a long history of health system consolidation and acquisition. What started as a region with several independent community hospitals in the 1960s and 1970s developed during the early 2000s into the dominant Inova Health System, which acquired over three decades the former Commonwealth Hospital, Fairfax County Hospital, Mount Vernon Hospital, Reston Hospital, Fair Oaks Hospital, Jefferson Memorial Hospital, Alexandria Hospital, and Loudoun Hospital Center.[5] In Inova's last and most recent attempt to acquire hospitals in Northern Virginia in 2008, the Federal Trade Commission (FTC) stepped in with an Administrative Complaint, which quickly ended the merger negotiations between Inova and the former Prince William Health System.[6, 7]

Shortly after the Inova-Prince William Hospital merger came to a halt, Novant Health, which is now in a partnership with the University of Virginia Health System, moved into Northern Virginia by acquiring Prince William Hospital.[8] Novant Health also opened another hospital, Novant Health UVA Health System Haymarket Medical Center, in 2014.[9] Sentara acquired the former Potomac Hospital in Prince William County in 2012.[10]

On the insurer side, there are carriers with significant market power, but not without competition. The Blues dominate NoVa, with CareFirst BlueCross BlueShield (CareFirst) and Anthem BlueCross BlueShield (Anthem) having the largest market share in the employer market. CareFirst and Anthem share the BlueCross BlueShield (BCBS) brand, but they split the NoVa market into two separate service areas, separated by a state highway. CareFirst serves the east side of the highway with the larger population in the close-in suburbs; Anthem serves the west, including Loudoun and Prince William Counties. Other insurers in the market include UnitedHealthcare, Aetna, Kaiser Permanente, and Cigna. However, all run a distant second in market share to the BCBS carriers in the region.

NoVa is home to two provider-payer partnerships: Kaiser Permanente and Innovation Health. Kaiser Permanente, which used to contract exclusively with Inova, ended their contract in 2013 and moved to VHC where they continue to contract today. In 2012, Inova entered into a joint venture with Aetna to create Innovation Health. Innovation Health contracts with all hospitals in the area, but it splits financial management of the company in half between Inova and Aetna.

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 thirteen NoVa-area providers, insurers, large employer purchasers, and expert observers. NoVa-based interviews occurred between June 29, 2018 and October 1, 2018.

Descriptive Analysis: Three Market Sectors

1. Hospitals and Physicians

Northern Virginia's hospital market has become increasingly consolidated over time, with respondents describing the region's provider market as "super concentrated" and stating that "[the region] could not get much more concentrated." Currently, Inova dominates the region with five hospitals. Competition is limited to the region's only independent hospital, VHC, and the hospitals operated by HCA, Novant, and Sentara. In theory, the hospitals in the District of Columbia (D.C.) could be a source of competition for northern Virginia's hospitals, but in practice few patients receive care in D.C. "There's just not a significant amount of folks willing to cross the river (jokingly referred to as the 'Potomac Ocean') for a hospitalization," said one executive.

More recently, moves to acquire and merge hospitals within Northern Virginia have slowed. But respondents noted that more hospitals are opening or acquiring medical centers, ambulatory surgery centers, and urgent care centers across the region as a way to protect their market share. Another respondent noted that growth strategies now go beyond the purchasing of hospital beds: "It has to involve all of the other emerging and more dynamic aspects of health delivery, and that can be physicians and physician practices . . . [and] new non-hospital facilities."

Notably, the recent local acquisitions by out-of-region hospital systems like HCA, Sentara, and Novant have attracted notice, with one observer describing deep-pocketed health systems "elbowing their way into the region." However, other respondents suggested these outside hospital systems have yet to have any significant impact on the market and have mostly focused on the region's outlying communities. Another respondent described the outside health systems as "worthy competitors that [are] still relatively small and contained."

Although NoVa is seen to have fewer hospital-based physicians and more competition among physicians than among hospitals, the ambulatory sector also has seen consolidation. The Privia Medical Group, a private equity-backed company that entered the NoVa market in 2014, has been signing up numerous medical groups across the region (an estimated 725 northern Virginia physicians and advance practice practitioners are currently part of Privia).[11] The company is growing by offering group practices a mix of improved reimbursement and back-office support for alternative payment models and quality improvement.

Inova has been less aggressive in its efforts to acquire physician practices than may be typical of dominant health systems in other markets, but observers noted that their acquisition of physician practices has waxed and waned over time. By one estimate, Inova employs less than 10 percent of the region's physicians—although it affiliates with others through a clinical integration network. Privia also has been fiercely competing with Inova for the hearts and minds of area doctors.

While views were mixed on the extent of consolidation among local primary care practices, respondents generally agreed that specialty physicians have resisted acquisition and mergers. According to one provider respondent, these physicians value their independence and often stay in small groups. "We see onsie, twosie groups," he said. "They don't want to be employed by health systems." The area also has relatively few large multi-specialty practices.

In addition, observers estimated that NoVa (and the broader Washington community) has a significant number of independent concierge practices, many of which don't participate in plan networks and require patients to pay a membership fee in exchange for improved service. Although concierge practices are numerous, respondents noted that their small patient panels prevent them from becoming a major factor influencing the market.

2. Insurers

Respondents had varied perspectives on the concentration of the payer market in NoVa. Some described it as more competitive and "a little more diffuse than on the provider side," while one provider representative called it "super concentrated." Observers agreed that CareFirst and Anthem hold the largest market share by far.

Cigna, UnitedHealthcare, Kaiser Permanente, and Aetna—which also jointly owns Innovation Health—divide up the remaining share of the large and small employer market. Cigna and Kaiser both compete with more success in the individual market, from which Anthem has mostly stayed away and where CareFirst charges relatively high premiums.

It does not appear that the Inova-Aetna joint venture Innovation Health has had a significant impact on the payer market. Six years after its launch, the company has a relatively small market share. Innovation was initially a player in the ACA's individual marketplace but did not participate in 2018; it continues to be active in the small group market. Observers noted that Kaiser too has struggled to establish a strong presence in the NoVa market, but they are opening new ambulatory care centers and seeking to grow their enrollment.

3. Employers

Although the federal government is the largest employer in the region, payers and other stakeholders report that it takes a hands-off approach to delivery system and payment reform efforts, leaving network design and reimbursement policies to the insurers that offer its health plans. Similarly, city government workforces in the region are heavily unionized, which can make it more challenging for employers to pursue cost containment efforts through the employee health plan. A major area university is part of the state university system and yields the lead in negotiating benefits to the state.

At the same time, while numerous large, multi-national companies have bases in the area, most lack enough covered lives to command the kind of market clout it would take to shift provider or insurer behavior. "We have major corporations here," said one observer, "but [they don't cover] enough lives to dictate or influence the market in any way." Another believes that the brokers and benefit consultants that largely drive purchasing decisions for local employers have been slow to embrace new models of care delivery or network design.

Employers interviewed for this study further observed that their employees are increasingly living in suburbs further away from D.C., largely due to increased housing costs in communities close to the city. As a result, in purchasing health benefits for their employees, employers must prioritize broad network access across the region.

Findings

Broadly speaking, respondents offered a sense that health sector stakeholders in the Northern Virginia market are complacent. Inova grew substantially and became the region's dominant health system by both opening new facilities and acquiring independent hospitals through the early 2000s. But the FTC complaint filed against its acquisition of Prince William Hospital led Inova to drop its proposed acquisition and appears to have moderated Inova's expansion. Virginia's strict enforcement of certificate of need (CON) requirements further serves as a deterrent to building new hospitals. Inova continues to grow through building and the acquisition of free-standing emergency departments, rehabilitation facilities, and physician practices. In the words of one observer, "The FTC came in and said no, you're tapped out." In slowing Inova's growth, it enabled the NoVA market to reach something of an equilibrium with one dominant player that, at least to date, has not exercised its clout enough to make anyone make dramatically different purchasing or network design decisions.

- ### Provider Concentration and the Exercise of Market Power

  Inova remains the lynchpin of this market, the "must have" hospital system for all the payers except for Kaiser: "You can't build a network without Inova," said one payer. Multiple respondents characterized Inova's prices as "quite high" relative to other hospital systems in the region, suggesting the system uses its market clout to maintain generous reimbursement.

  Although hospital prices are high relative to neighboring regions, several respondents noted that Inova has been relatively restrained in its price negotiations with payers. One insurer respondent speculated that Inova "does not want to jeopardize their position, so they have a tendency to . . . play in the sandbox" better than dominant provider systems in other markets. The idea, according to observers in the market, is that Inova is "cognizant of its market leverage" and seeks to be fair in its dealing with payers to avoid raising red flags with federal regulators.

  Several years ago, when Inova's proposed acquisition of Prince William Hospital was being negotiated, the government presumption was that Inova has the highest prices and the merger would push the Prince William hospital's price higher. But the reality, according to a local expert, "which…was stunning to everybody, [was that] the Prince William contracts were far superior to Inova's." One explanation was that Prince William had such a small market share that costs from this hospital amounted to a rounding error for payers. But Prince William also leveraged its position as an alternative to Inova by saying, in effect: "If you want us to rush into the hands of Inova, give us a really rotten rate deal so we can't survive . . . . [But if] you think it's healthy to have independent health systems in this market, then give us [higher prices]."

Although the dominant payers in the region (CareFirst and Anthem) arguably have similar market clout to Inova, respondents suggested that the only real threat these payers can use in a contract negotiation is exclusion from the network—something akin to going to war with only a "nuclear option" in your armory. Respondents further noted that rules for the federal employees' benefit plan require notification of the public when there is a threat of termination, resulting in public and customer relations troubles that both parties want to avoid.

Kaiser is the only major payer in the region to succeed in cutting ties with Inova, which respondents suggested was less about prices and more about their clinical partnership. Kaiser now has an exclusive arrangement with VHC (although it covers some patients at Inova facilities when VHC is unable to meet a specific clinical need). Respondents report that the Kaiser-VHC arrangement is operating well. However, one observer questioned whether VHC would continue to have sufficient inpatient hospital capacity if Kaiser succeeds in its efforts to expand membership in NoVa.

The region's other hospitals have their own forms of leverage. Sentara, Novant, and HCA each has a small presence in NoVa and their hospitals are in the outlying suburbs. But these systems use the fact that they have a higher share of the hospital market in other parts of Virginia to demand inclusion in payers' NoVa networks at high reimbursement rates. At the same time, VHC, the region's only independent hospital, has unique leverage due to its reputation for quality and location in densely populated and well-to-do Arlington County. Traffic and other factors make VHC something of a must-have facility within the region. Inova, without a nearby facility to VHC, appears to focus on other parts of the region and thus does not take away enough business to hurt VHC's viability.

When Inova joined with Aetna to create Innovation Health, some thought this might be a step by Aetna to push back against a concentrated provider market —effectively a strategy of "if you can't beat then join them." Five years later, Innovation might be called a success because it remains a player in the market, but one respondent argued, "I don't think it drove much of anything [with respect to competition]. [Other players] probably didn't like it very much . . . , but I wouldn't call it disruptive." One limitation is that Innovation is not able to compete for business with employers that operate statewide because its plans are only offered in NoVa. Also, because Aetna maintained a separate presence in the market, both companies have had to engage in significant education of brokers and benefit consultants about their different products and services.

- **Impact on Cost Containment Efforts**

  Neither employer purchasers nor payers in northern Virginia appear to be pursuing aggressive cost containment efforts. One of the most obvious cost containment strategies—reducing the size of the provider network—is largely written off as infeasible. Narrow networks are "a [human resources] nightmare . . . a last resort," according to one large employer. Multiple stakeholders noted that the northern Virginia workforce is largely white collar and affluent, with employees who expect to be able to "go where they want to go," without limits on their access to hospitals or specialists. The exception has been in the ACA marketplace where consumers have been more receptive to limited networks. But even there an effort by Cigna to offer a product for 2018 that excluded Inova encountered bad publicity; by April 2018, Cigna had added Inova as an in-network provider.

  Payers in this market similarly observed that their employer customers are generally unwilling to face employee pushback over a narrow network in exchange for a few percentage points in cost savings. To the extent the benefits of a narrow network are derived largely from selective discounts from providers (as opposed to re-engineering within a coordinated system), the price difference is just not big enough, several stakeholders observed. "I call it the 'what if' factor," said one insurance executive. "What if I need to go see this doctor? What if I need to go to the hospital? Even if you have a product 5 to 6 percent cheaper in the market, it doesn't overcome the 'what if' factor."

  Payers and purchasers further acknowledged that Inova's reach across the region and market clout made excluding them from plan networks or pushing patients to use other facilities through tiering strategies

impractical. Arlington's Virginia Hospital Center lacks capacity to take in a significant portion of Inova's patient population, and several informants emphasized northern Virginia's heavy traffic as a significant impediment to patients' ability to use more far-flung providers.

The payers we interviewed employ a range of alternative payment models to try to generate cost savings, although to date these are primarily physician-focused. Accountable Care Organization-type (ACO) models are popular among some employers, with one saying they view "ACOs as a 'soft launch' of a narrow network," because employees "wouldn't know it was happening." However, while the ACO models currently in place in northern Virginia provide financial incentives for primary care physicians to steer patients towards lower-cost specialists, facilities, and pharmaceuticals, payers have been slower to expose physicians to downside financial risk, preferring to gradually increase the practices' risk exposure over multiple years. "ACOs and [primary care medical homes] are still kind of in the pilot phase" in this market, said one observer.

Hospitals have largely not embraced ACOs, and their participation in payers' value-based payment models is mixed. As one hospital executive said, "we did a lot of things to look like an ACO without joining one." Payers acknowledged that their ability to demand participation in these programs varies based on the hospital system's market clout. "It's different with hospitals," one payer said. "They might say the right things about value-based care . . . but they've got a bottom line they have to meet." A provider representative essentially confirmed this view, stating that the risk-sharing agreements they had seen to date "don't have favorable terms—there's no economic incentive" for us.

Several stakeholders told us that a primary strategy to lower costs is to encourage the delivery of services outside the hospital setting. One payer told us that shifting the site of care is "absolutely" one of their cost containment strategies, noting that doing so often had the added advantage of improving patient experience and outcomes. For example, a payer representative noted that encouraging surgeries in ambulatory settings and offering 24-hour clinical support has "probably cut our [emergency room] usage about two-thirds." At the same time, providers and payers alike admit that "old referral patterns" are hard to break, making it often difficult to steer patients to the lowest-cost specialists and facilities. "I don't think [payers] are prepared yet to use a stick, and I don't think the carrots are large enough to generate much change in referral patterns," said one executive. Additionally, hospitals in the region, recognizing the push to move care outside their walls, have been acquiring physician practices, ambulatory care centers, and other non-hospital facilities to re-capture that revenue.

While employers in the region have been reluctant to embrace narrow network products, they have been willing to shift employees into higher cost-sharing plans to lower overall costs. For example, the employer stakeholders interviewed for this study have recently introduced higher deductible plans or raised deductibles on existing plans. One employer observed that just having a deductible at all has been a significant "culture shift" for its employees, and that other, more aggressive cost-saving strategies will take time. Another employer respondent mentioned interest in exploring "reference-based pricing," in which the enrollee pays a higher price to use a higher-cost provider but recognized that it could take a few years to develop such a program and acculturate employees to it. "To figure out what someone might pay, and deal with [potential] balance billing, it would be a struggle," she said.

Is There Potential for More Competition in the Future?

Many respondents made note of the relatively recent presence of health systems competitors including HCA, Sentara, and Novant. Although their presence in Northern Virginia is modest today, these companies are well-financed regional or national systems. As a result, some suggested that an expanded role for these companies in the future might disrupt the equilibrium that exists in the market today.

Inova seems to be pushing back against this possibility. For example, Inova recently introduced a freestanding emergency department near a hospital competitor in Loudoun County. According to an observer, if a patient

needed more care, "they would get a free ambulance ride over to Inova Loudoun hospital. They were really trying to seriously protect that market share they so enjoy."

Another factor that limits future expansion for some of the newer systems in the market is Virginia's CON requirement that requires the state to review and approve the entry of new hospital facilities. According to one observer, "growth is somewhat limited by the intervention of government, and so, what is there and what can be expanded is part of a planning process in Virginia."

Some payers believe that relaxing CON requirements could offer one pathway to containing the market's health costs. But providers contend that a push to deregulate would lead to "a gold rush of new entrants, and utilization will go up like crazy." In that view, higher utilization—especially through facilities like freestanding emergency departments—will mean higher costs.

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