Current Perspective

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Beer and Health Care

The Affordable Care Act (ACA) intentionally promoted horizontal and vertical integration in health care. Hospitals aggregate into bigger and bigger systems. Physician groups coalesce into a smaller number of larger ones. Nancy-Ann DeParle, former Director of the White House Office of Health Reform, famously wrote in the *Annals of Internal Medicine,* "The economic forces put in motion by the [ACA] are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups."[1] In 2015 there were 112 hospital mergers—up substantially from the prior year. The consolidation of providers was felt to be a highly desirable process in the search for higher-quality, less-costly care.

In 2009, as the ACA was being considered, 2 core questions were raised. The first, "Where is the evidence that consolidation leads to better care?" confronted consolidation's fundamental rationale. The other question (which was largely ignored) concerned itself with the basic principles of market consolidation. As the number of independent providers of services drops, doesn't their market power increase and won't prices rise? Put another way, "Who fell asleep during Economics 101?"

As proof that the laws of supply and demand and monopolistic behavior still apply, economists are attributing a substantial percentage of the recent rises in health insurance cost in some markets to exactly this consolidation process. And this concern partly explains the government's recent push to block the proposed Aetna acquisition of Humana and the Anthem acquisition of Cigna (combined price tag about $90 billion). If these corporate mergers were to occur, the American commercial insurance market would be down to 3 major players—with only 1 or 2 in some regional markets.

The Department of Justice lawsuits filed opposing the insurance mergers have engendered reactions that fall along ideological lines. A *New York Times* editorial on July 25 predicted that the mergers would lead to restricted choices and higher premiums and would give physicians and hospitals less bargaining power in contract negotiations.

They offered a comparison to the beer industry, pointing out that only when Anheuser-Busch InBev (the world's largest beer company) divested itself of SABMiller's stake (second largest beer company) in MillerCoors (one-quarter of the American market) would the government allow their merger to proceed. They implied that a similar process in health care might make for an acceptable outcome.

A *Wall Street Journal* editorial on the same date came to a different conclusion, while first making the point (expressed here above) that "huge health systems, salaried physicians, and mega-insurers" were the policy goal in the first place. It then noted that the same logic that leads the government to challenge the private insurers' mergers should lead it to "break up ObamaCare" and (failing that) mega-insurers may be needed to compete with ObamaCare.

Regardless of our personal politics, consolidation is a fact of life in the health care system. However, a very large percentage of physicians (particularly specialists) practice in small groups and would prefer not to surrender their professional control and autonomy simply to acquire contracting authority in an integrated marketplace. For many, retaining autonomy and market power can be best achieved by relief from antitrust laws. This would afford small independent practices a better chance of thriving. In addition, it better confers upon patients—not the insurer or health care system—the ability to choose their own physicians. After all, we are doing something a tad more complex than making beer.

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And, by the way, as for that first question about consolidation and its impact on cost and quality: Multiple recent studies provide evidence that small, physician-owned practices yield lower cost and higher quality care than hospital-owned practices.

1 Kocher R et al. *Ann Intern Med.* 2010;153(8):536-539.