Consolidation within Health Care

Background Paper Prepared for the 2018-2019 APhA Policy Committee (not yet copyedited)

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2018-2019 Policy Committee to recommend policy to the APhA House of Delegates related to vertical integration in healthcare and its impact on access to pharmacist-provided patient care. The Board's guidance on this topic included -but was not limited to- vertical integration's impact (positive and negative) on (1) system, provider, and patient incentives, (2) the competitive process, (3) restriction on product supply, (4) patients' right to choose providers, and (5) patient access to care.

Background

In 2015, David Szotsak (Assistant General Counsel at Blue Cross and Blue Shield) described the U.S. health care system as "hopelessly fragmented" [1]. In the DePaul Journal of Health Care Law [1] he wrote:

Health care providers offer services to patients in distinct venues – hospitals, out-patient surgery centers, physicians' offices, drugstores, and may other places. In a wholly separate industry, health insurance companies finance this care. This dysfunctional system arose over many decades, due to the combination of historical accident and government policy. Not surprisingly, nobody knows what anything really costs – or should cost, at least, based on market value – and financial incentives encourage all kinds of counterproductive behavior … Imposing change across so many separate entities and industries, each with its own economic interests and motivations, is increasingly difficult, and progress remains sclerotic. The necessary and inevitable solution is for a major player in the health care industry to undertake dramatic, all-encompassing vertical integration.

According to a report published by the Healthcare Financial Management Association [2], healthcare organizations are facing pressure to "reduce the cost of care, improve the coordination of care delivery, and assume financial risk for the health outcomes of patient populations." In addition, health care service providers need to monitor and measure quality and costs in ways that are being imposed upon them by payers and government agencies. All of this adds to the costs of transacting in the new systems of health care. To meet these pressures organizations are "seeking partners who can help them add new capabilities, achieve economies of scale, enrich data on clinical outcomes, or widen access to services" [2].

Such organizational behaviors are not new. In 1997, during the era of managed care expansion, Robert Pitofsky, then chair of the Federal Trade Commission (FTC) suggested that "as pressures to control healthcare costs and assure quality continue, there is an increasing recognition of the efficiencies that can come about through cooperation and collaboration" [2,3]. More recent examples of vertical

integration include pharmacy partnerships and mergers with insurance companies, wholesalers, and pharmacy benefit managers. Another example is vertical integration between pharmaceutical manufacturers and integrated delivery networks for distribution of specialty pharmaceuticals.

As background, two organizational behavior frameworks are instructive: (1) Transaction Cost Economics and (2) Collaboration Theory. Transaction Cost Economics reveals how vertical integration can control certain costs. Collaboration Theory reveals how vertical integration can improve some processes of patient care. Each will be described next.

Transaction Cost Economics

In channels of distribution for goods and services, firms will internalize activities that they are able to perform at lower cost and will rely on other firms for activities in which other channel members have an efficiency or effectiveness advantage [4]. The "transaction cost economics" framework proposes that members of the channel of distribution for a service are assumed to (1) be opportunistic (having a tendency to take competitive advantage of other parties) if given the chance, (2) have imperfect or asymmetric information, and (3) have bounded rationality (i.e. rationality that is limited by available information, cognitive limitations, and finite amount of time for decision making) [4]. These market forces work to bring about an "efficient sort" for transactions and channel governance structures so that exchange relationships can be understood in terms of "transaction cost economizing" [5].

When it comes to organizations within a channel of distribution, the decision to "make" (i.e. provide the service or function themselves) or "buy" (i.e. outsource the service or function to another channel partner) depends upon the (1) specificity of the service or function, (2) level of uncertainty about the future of the relationship between channel members, (3) complexity of the interaction, and (4) frequency of trade. For these four factors, higher levels of each are associated with a more integrated channel of distribution.

We propose that healthcare provision is becoming more integrated, orchestrated, and harmonized through vertical integration in order to minimize the costs of transacting for firms engaged in such strategies. We believe that there will be success and failure for organizations as channel members "compete for market power, efficiencies, and chances to be opportunistic in order to be profitable in both the short and long term" [6]. We suggest that healthcare provision is in a highly competitive period in which both healthcare providers and payers need to minimize costs of transacting.

Collaboration Theory

Collaboration Theory [7-11] provides guidance for "how joint decision-making among autonomous, key stakeholders of an inter-organizational domain can be used to resolve planning problems of the domain and/or manage issues related to the planning and development of the domain" [11]. Working together enables the participating organizations to create and capture mutual advantages that translate into positive return on investment and more efficient management. Collaboration Theory consists of five features:

1. Collaborative performance system
2. Information sharing
3. Decision synchronization
4. Incentive alignment
5. Integrated processes

The practical application of collaboration theory has been realized in the past by product supply chains [7] and by the travel sector [11] through which multiple organizations worked together to fill gaps, achieve efficiencies, and create extra value that could be shared amongst organizations. In the current health care environment, similar approaches could be successful in the health care domain.

Collaborative Performance System

A collaborative performance system devises and implements performance metrics that guide the collaborating organizations to improve overall performance [7]. This process resolves the related issues of (1) who should be involved in determining the mutual objective and (2) what performance objectives should be specified with respect to the mutual objective. This process is assumed to enhance each participating organization's profit, return-on-investment, and cash flow. For example, current and future quality care indicators could be used to assess the performance of a collaborative system, which could affect the costs of care and payments to the providers involved. Since many health care performance metrics are associated with medication use, collaboration between pharmacists and other health care team members is essential.

Information Sharing

Information sharing denotes access to private data in all partners' systems enabling the monitoring of the progress of service provision as customers pass through each process in the overall system [7]. This includes data acquisition, processing, representation, storage, dissemination, status metrics, cost data, and performance data. Such access to information enables the participating organizations to elicit the bigger picture of the situation that takes into account important factors for making effective decisions. For example, health information exchanges can be created to serve as a vital platform for providing coordinated care and for collecting information essential to continuous quality improvement initiatives to enhance outcomes of care.

Decision Synchronization

Decision synchronization can be defined as the extent to which the participating organizations are able to orchestrate critical decisions for optimizing overall performance. This includes re-allocating decision rights in order to synchronize planning and execution that seeks to match capacity for service provision with demand for services [7]. The way to judge effective decision synchronization is based on its effects on (1) response towards fulfilling customer demands (logistical benefits) and (2) profitability and efficiency for participating organizations (commercial benefits). For example, often community pharmacists identify information that is important to the success of medication therapy after the medication has been prescribed. Closer synchronization of drug selection and regimen overview is likely to improve medication management and outcome. One way this could be accomplished is to have the pharmacist select the most appropriate medication to fit the patient's health and financial situation within a collaborative practice agreement.

Incentive Alignment

Incentive alignment refers to the process of sharing costs, risks, and benefits among the participating organizations. This motivates entities to act in a manner consistent with their mutual strategic objectives, including making decisions that are optimal for the overall domain and revealing truthful private information [7]. It covers estimating costs, risks and benefits as well as formulating incentive schemes such as pay-for-performance and pay-for-effort [7]. The assumption is that the actions of individual organizations are based on the expectation the act will result in mutual benefit and will result in benefit to the individual organizations. For example, a collaborative system including hospitals, clinics,

and community pharmacies could have payments linked to the quality and costs of care they jointly provide for a panel of patients.

Integrated Processes
Integrated processes refer to the extent to which participating organizations design efficient processes that deliver services to customers in a timely manner at lower costs [7]. Explicit description of these processes allows organizations to synchronize the entire sequence of integrated work activities required to deliver services that fulfill customer needs. Flexibility is needed in order to respond to the variety of customer requirements at minimum costs with respect to supply capacity. To create flexibility, participating organizations can redesign the distribution system, service offerings, production processes, and management systems to be cost effective and flexible to match supply with different conditions of customer demand. An example of this would be closer coordination across provider types when patients are hospitalized and then discharged. Sharing complete information and designing full integration during transitions of care would enhance care decisions, benefiting providers and patients.

Based on the background just presented, it is not surprising that vertical integration is taking place in the U.S. health care system. Reducing the costs of transacting and improving coordination of care delivery will help organizations assume financial risk for the health outcomes of patient populations.

Benefits of Vertical Integration in Healthcare

As explained by Transaction Cost Economics [4-6] and Collaboration Theory [7-11], there are potential benefits that can be gained from vertical integration in healthcare. These include:

1. Streamlining care delivery to reduce costs [2, 12]
2. Providing a seamless care experience [2, 12]
3. Integrating/coordinating clinical operations [2, 12]
4. Potentially increasing medical quality [2, 12]
5. Spurring innovation [2, 12]
6. Altering financial incentives to overuse care [13]

Some argue that these goals are consistent with recent health care reforms that have created powerful incentives for health care organizations to form vertically integrated systems to shift away from fee-for-service to new payment models based on value [13].

Detriments of Vertical Integration in Healthcare

There has been relatively little vertical integration antitrust enforcement in the United States [14] because vertical arrangements are viewed as procompetitive inasmuch as such integration is necessary to innovate, lower costs, or managed clinical and financial risk [12]. However, concerns can arise if a "network's power in one market in which it operates enables it to limit competition in another market" [12,15,16]. **That is, does the vertical integration create market power for the network to limit competition in the sales of any other services?**

There is evidence that vertical integration carries potential downside risks to competition and consumer welfare through (1) exercise of market power, (2) unnecessary increases in referrals and reimbursement rates, and (3) reductions in consumer choice [13]. Increases in market power may lead to tying/bundling of services that restrict competition and access to care [13]. It may also lead to "foreclosure" which

occurs when actual and potential competitors are disadvantaged through boycotts, restriction of supply, restrictive contracts, refusals to deal, raising barriers to entry, elimination of a potential entrant, facilitation of collusion, evasion of rate regulation as a result of post-merger opacity of transfer prices, or other strategies that inhibit rivals from competing [2,12,13,15,17,18]. Another anticompetitive effect of vertical integration is that merged entities may increase health spending from greater utilization and patient volume by increasing referrals and reimbursement rates within the bounds of health self-referral laws [13]. Finally, reductions in consumer choice may arise because patients are forced into decisions that are at odds with their interests but would instead maximize the integrated network's profits [13].

Contemporary Examples from 2018

Thomas Greaney and colleagues [19,20] prepared an assessment of the 2018 proposed mergers of CVS/Aetna and Express Scripts/Cigna as examples of vertical mergers that combine payment and the provision of healthcare items and services. Their assessment showed these integrations could signal a major change in how pharmaceuticals are purchased and used, and these mergers might enable insurers to restructure health benefits altogether. The detriments of such mergers relate to the risk of "foreclosure" in which the merged entities would cut off rival's access and, thus impair competition in the pharmacy and PBM markets. There is also the risk that such a high level of market concentration would lead to higher prices [19,20].

The benefits of such mergers could mean that pharmaceutical benefits would no longer be considered in isolation from medical and hospital benefits [19,20]. When pharmaceutical benefits are separate, they are viewed as costs. However, if integrated they would be viewed as products that could offset substantial costs elsewhere. Such a shift could mean that decisions related to formulary tiers and maximization of drug rebates would now be based on holistic assessments of the costs and benefits from their use in patient care (rather than on profits from rebates).

Policy recommendations from their analysis included:

1. The need for vigorous antitrust enforcement to assure that the "pro-competitive benefits of financial and clinical integration are not thwarted by excessive concentration, collusion, or abuse of dominant positions" [19].
2. Unbundling of Monopolized Services [20]
3. Challenging Anticompetitive Terms in Insurer-Provider Contracts [20]
4. Promotion of Provider and Insurer Entry [20]
5. Advocacy in Scope of Practice Laws [20]
6. Price and Quality Transparency [20]
7. Pro-Competitive Policies at CMS [20]

The American Medical Association also conducted an analysis and prepared a position paper for the CVS/Aetna merger. Their assessment was that such mergers "substantially lessen competition in many health care markets, to the detriment of patients" [21].

Policy Issues for Pharmacy

Does vertical integration in healthcare impact access to pharmacist-provided patient care? The answer to that question is 'yes', but the impact can be a double-edged sword with not only the potential to create collaborative care opportunities for pharmacists but also the potential to lead to unfair market power that restricts access to providers and restrains patient choice [13].

Based on the findings presented in this paper, we recommend the following topics for consideration by the 2018-2019 APhA Policy Committee:

1. The need for vigorous antitrust enforcement to assure that the "pro-competitive benefits of financial and clinical integration are not thwarted by excessive concentration, collusion, or abuse of dominant positions."

2. Unbundling of Monopolized Services that would Restrict Pharmacist-Provided Patient Care Provision (ACCESS)

3. Challenging Anticompetitive Terms in Insurer-Provider Contracts

4. Promotion of Provider and Insurer Entry

5. Advocacy in Scope of Practice Laws for Pharmacist-Provided Patient Care in Integrated Systems

6. Price and Quality Transparency (TRANSPARENCY)

7. Pro-Competitive Policies at CMS

8. Advocacy for Patients' Right-to-Choose Providers for Pharmacist-Provided Patient Care (CHOICE)

As a starting point, we recommend three topics for discussion by the policy committee: (1) Access to Care (#2 above), (2) Transparency in price and quality monitoring (#6 above), and (3) Choice for patients (# 8 above). As these discussions take place, it would be important to keep in mind some of the unique characteristics of the health care system:

- The payer of care is not present when care is provided.
- Patients are not sure how to assess "quality" of the care provided.
- Incentives in the healthcare system are not aligned among payers, providers, and patients.

These unique aspects of healthcare make policy discussions difficult. For further reading that is specific to vertical integration in the pharmacy and pharmaceutical domains, we refer you to references 19-21 in this report.

Related APhA Policy

2004, 1990 **Freedom to Choose**
1. APhA supports the patient's freedom to choose a provider of health care services and a provider's right to be offered participation in governmental or other third-party programs under equal terms and conditions.
2. APhA opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient's freedom to choose a provider or health care services.
3. APhA supports that patients who must rely upon governmentally-financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.
(Am Pharm NS30(6):45 June 1990) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010) (Reviewed 2015)(Reviewed 2018)

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