"Why Health Care Is Unaffordable: Anticompetitive and Consolidated Markets"

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I. Introduction

Thank you, Mr. Chairman and members of the committee. It is an honor to testify before you on a topic that is extraordinarily important to our nation's long-term fiscal health.

Latest statistics reveal that the United States spends about 19% of its Gross Domestic Product on healthcare services. This is almost twice the average for OECD nations and far more than #2, which spends less than 13%. Viewed another way, the United States in purchase-adjusted dollars spends more than two-and-a-half times the OECD average per capita on health care and more than one-and-a-half times the second largest spender. Yet in spite of our leadership in healthcare spending, we are safely in the bottom half of OECD nations on most measures of health care outcomes.

We are spending too much and getting too little in return. All discussions about healthcare policy should begin with the recognition that curbing healthcare spending needs to be among our highest national priorities. The cost of private health insurance is bankrupting companies and families alike, and the cost of public healthcare programs are putting unmanageable burdens on the federal and state budgets.

I want to emphasize three main points before delving into specifics.

First, **our healthcare prices are too high**. Many studies suggest that the cost of healthcare is unsustainable not because we consume too much healthcare, but because we pay too much for the healthcare that we do consume. In other words, as one study put it famously, "It's the Prices, Stupid."[1]

Second, **the biggest problem is hospital prices**. We spend 31% of our healthcare dollars on hospital care. This is much more than we spend on physicians and physician clinics (20%) and pharmaceuticals (less than 10%). There is enormous evidence that the prices we pay for physician services and prescription drugs are also inflated and much higher than a rational market should allow, but the primary driver of excessive healthcare costs is spending on hospital care.

And third, **hospital prices are too high because of monopoly power**. One of the most severe contributors to the rise of healthcare prices has been the alarming rise in market power by healthcare providers. The past several decades have witnessed extraordinary consolidation in local hospital markets, and recent consolidation trends have seen hospitals acquire local physician practices. Both of these consolidation trends have been extremely costly to American patients and citizens, and the continued consolidation of healthcare providers requires an urgent rethinking of both American health policy and American antitrust policy.

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[1] Gerard F. Anderson et al., It's the Prices, Stupid: Why the United States Is So Different from Other Countries, HEALTH AFFS., May-June 2003, at 89.

Consolidation in the American health sector has brought with it many painful lessons, and one of them is that competition policy in the health sector has been at least one decade behind market trends. In other words, it is not enough to identify past errors and pledge not to repeat them. We need a competition policy that both recognizes the unfortunate reality that consolidation is a current reality and that is sufficiently forward-looking to anticipate current trends before they wreak more damage onto American healthcare markets.

II. Hospital Consolidation and the Gradual Emergence of 1990s Antitrust Policy

Consolidation by healthcare providers began with an aggressive wave of hospital mergers in the 1990s. By 1995, hospital merger and acquisition activity was nine times its level at the start of the decade, and by 2003, almost 90 percent of Americans living in the nation's larger metropolitan statistical areas (MSAs) faced highly concentrated provider markets.[2] This wave of hospital consolidation, predictably, was alone responsible for price increases for inpatient services of "at least five percent and likely significantly more," and similarly responsible for price increases of 40 percent where merging hospitals are closely located.[3] A second merger wave from 2006 to 2009 significantly increased the hospital concentration in thirty additional MSAs,[4] and for the past two decades, the vast majority of Americans have been subject to monopoly power in their local hospital markets.

It is hard to overstate how harmful this consolidation wave was to American patients and consumers, and an abundance of research examining hospital acquisitions over that period reveals some basic truths: When nearby hospitals merge, prices go up;[5] cities with fewer competing hospitals exhibit higher prices;[6] and even hospitals acquired

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[2] William B. Vogt and Robert Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? (Robert Wood Johnson Foundation, Research Synthesis Report 9, February 2006), www.rwjf.org/files/research/no9researchreport.pdf; Claudia H. Williams, William B. Vogt, and Robert Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? (Robert Wood Johnson Foundation, Policy Brief 9, February 2006), www.rwjf.org/files/research/no9policybrief.pdf

[3] Gloria J. Bazzoli et al., "Hospital Reorganization and Restructuring Achieved through Merger," Health Care Management Review 27, no. 1 (2002):7–20; Martin Gaynor, "Competition and Quality in Health Care Markets," Foundations & Trends in Microeconomics 2, no. 6 (2006): 441–508.

[4] Cory Capps and David Dranove, Market Concentration of Hospitals (Bates White Economic Consulting Analysis, June 2011).

[5] Reed Abelson, "When Hospitals Merger to Save Money, Patients Often Pay More," *New York Times* (Nov. 14, 2018)

[6] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured, *The Quarterly Journal of Economics*, Volume 134, Issue 1, (Feb. 2019) 51–107.

by distant health systems increase prices more than unacquired, stand-alone hospitals.[7] In fact, most of America's unsustainable health care costs are driven by hospital care, and most of that price inflation over the past decades has been due to hospital mergers.[8]

Although the Federal Trade Commission and other antitrust enforcers were aware of these developments, effective antitrust policy to counter this consolidation meaningfully began only in the late 2000s. Antitrust policymakers failed to halt the rapid consolidation of hospital markets in part because many judges[9] and health policy leaders[10] used to believe, falsely, that hospital consolidation led to efficiencies and better care delivery. It took years of painstaking academic research to arrive at this updated understanding of the market. Although hospital systems have continued to consolidate, policymakers are now armed with better analytical techniques and a wealth of evidence that they started employing can be used to stop the most egregiously anticompetitive mergers. Enforcement actions finally started credibly stopping mergers in the 2010s,[11] but these improved antitrust enforcement tools came after many local hospital markets were already consolidated.

Current antitrust enforcement actions in the healthcare sector continue this focus on preventing mergers between hospitals and hospital systems.[12] To be sure, halting these mergers saved consumers and patients from the typically severe costs of hospital market power, including extortive prices and declines in quality. But provider consolidation now takes a variety of different forms. These new consolidation trends, which are at least as costly as those in the 1990s, require a different policy strategy to counter. If policymakers continue relying on an antitrust policy that was forged from the experiences of a couple decades ago, it cannot address the market's current challenges.

III. Current Competition Challenges in Provider Markets

We encounter three distinct consolidation challenges, none of which can be halted with current policies or antitrust enforcement strategies.

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[7] Matthew S. Lewis, Kevin E. Pflum, Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions, Rand Journal of Economics, vol.48, no.3 (Fall 2017): 579-610.

[8] Health Affairs Research Brief: The Role Of Prices In Excess US Health Spending (June 9, 2022)

[9] Barak D. Richman, Antitrust and Nonprofit Hospitals: A Return to Basics, Univ. of Pennsylvania Law Review, vol.156 (Feb. 2007).

[10] Adam Gaffney, What the Healthcare Debate Still Gets Wrong, Boston Review (Oct. 17, 2019).

[11] See, e.g., FTC v. ProMedica Health, 749 F.3d 559 (6th Cir. 2014)

[12] Federal Trade Commission, Congressional Budget Justification FY2024, at 33 https://www.ftc.gov/system/files/ftc_gov/pdf/p859900fy24cbj.pdf

Confronting Established Monopolies and Exclusionary Conduct. First, we must confront the reality that most local hospital markets are already highly concentrated, so greater focus should address anticompetitive conduct by these current hospital monopolies.

The most pressing competitive danger these current monopolies pose is the entrenchment of their dominance and their foreclosure of more efficient entrants. They are doing this through a variety of well-tested techniques. One is using their dominance to impose "all-or-nothing" contracts, which require insurers to pay for all of a hospital system's services or drop out of the market altogether. This strategy prevents insurers from contracting with select providers — creating so-called "narrow networks" — that can direct patients to higher-value providers and stimulate competition between rival facilities. Hospital monopolists bundle their services together, which forces patients to pay for a system's costly services if they want to rely on their critical services; for example, in order to have access to the only trauma center in town, patients must also commit to the hospital system's oncologists and cardiologists, practices that would be vulnerable to competition from other providers and telemedicine companies. And hospital monopolists work to squeeze out small, nimble providers that might offer lower-cost alternatives to the multi-specialty giants; and if they fail to drive them out, they purchase them.

Another tactic is through collaborating with dominant insurers. Conventional wisdom suggests that dominant insurers and dominant hospital systems would be at loggerheads over the price of medical services. In fact, these large entities often collude with each other to keep out other competitors. By promising each other that they won't give smaller entities more favorable terms — these arrangements are commonly called most-favored-nation, or "MFN" contracts — giant payers and giant providers secure each other's dominance. (This collusion-among-giants was discovered and challenged in Massachusetts and Michigan, but quiet cooperation between dominant payers and providers is widespread.)

The main lesson is that challenging hospital mergers do little to step the harm from already dominant systems, many of which are engaging in anticompetitive conduct that foreclose competition and enshrine their market power. A regular staple of healthcare policy must be to monitor these consolidated markets and ensure that their citizens can still benefit from the dynamism of competition.

Hospital Acquisitions of Independent Physicians. Second, we need to confront a new and equally harmful consolidation trend. Over the past decade – and especially once the Covid pandemic took hold – hospitals have been acquiring physician practices at a rapid rate. Nearly three-quarters of America's physicians are now employed by hospitals or corporate entities, compared to less than one third less than two decades ago.

Current antitrust policy considers hospital acquisitions of physician practices as "vertical" mergers that are largely innocuous because they do not increase the

concentration in either hospital or physician markets. But mounting evidence has shown that these acquisitions lead to higher costs, probably because many of these transactions are better described as mergers of substitutes rather than compliments. In other words, many outpatient clinics offer similar services as those offered in hospitals, so when hospitals acquire physician practices, they eliminate competition. Worse, outpatient care is less costly than similar services offered inside hospitals, and medical advances continually expand what can be done in outpatient settings. The loss of the independent physician practice means the loss of the often better and almost always less expensive alternative.

The dynamic consequences of these acquisitions — the harm to innovation — are probably even more costly. Controlling physicians means controlling referrals, and hospitals rely on referrals for their most lucrative services. Reciprocally, the biggest threat to hospital dominance is if physicians direct their patients elsewhere, and the current market now offers real alternatives to traditional hospital care: specialty providers, regional providers with telemedicine follow-ups, hospital-at-home care and even physician practices that expand into secondary care. Moreover, many of these new practice models are built atop digital analytics, virtual technologies and innovative financing that have the potential to produce new care models that might upend hospital monopolies altogether.

Perhaps what is most frightening to hospitals is that many of these innovations are designed to promote population health such that people are kept out of the hospital, i.e., they are intended to drastically reduce our need for hospitals altogether. So, when hospitals acquire the source of these potential innovations, they don't merely enshrine their monopoly position, they also engineer a future in which we continue our dependence on them.

"Cross-Market" Mergers. A third consolidation challenge emerging with greater frequency is the so-called "cross-market" hospital merger. These mergers are better described as "hospital megamergers" and include the union of Advocate-Aurora with Atrium hospital systems, which combined 67 hospitals and 1,000 sites of care, and Essentia Health with Marshfield Health, which joined 25 hospitals under one system.

Antitrust authorities describe these mergers as "cross-market" or "out-of-market" because they involve providers that do not compete within a single geographic hospital services market. As such, their treatment under current merger law is uncertain. Nonetheless, research indicates that out-of-market systems acquiring independent hospitals lead to price increases, with larger price effects when the merging hospitals are within close proximity of each other (while remaining in separate markets) and when the merging hospitals contract with common insurers.[13] Additional evidence suggests that

[13] Leemore S. Dafny, Kate Ho & Robin S. Lee, The Price Effects of Cross-Market Hospital Mergers (Nat'l Bureau of Econ. Research, Working Paper No. 22106, 2016), http://www.nber.org/papers/w22106

these mergers endow hospital systems with pricing power over regional insurers and large employers.[14]

Antitrust enforcement, when acting only with familiar models and with reliable predictions, is to be commended for its care and precision. But the experience of antitrust policy in hospital markets reveals not care but instead excessive caution. To be sure, the Federal Trade Commission can only pursue policies that are supported by our federal judiciary, and our federal judges have an unfortunate history of failing to block even the most egregious hospital mergers. Still, antitrust enforcement is, at least in part, designed to prevent market harm before it takes place. A competition policy that lags decades behind consolidation trends is doomed to fail.

IV. Suggestions for a Revived Competition Agenda in the Health Sector

New consolidation trends require new policy strategies. Continued vigilance in policing hospital mergers remains essential, but the enforcement techniques refined in the and 2000s and 2010s are inadequate to protect American patients and consumers from continued monopolistic harm.

I echo those who have asked Congress for continued and enhanced support of the antitrust agencies, which historically have simply not had the resources necessary to stem the steady waves hospital acquisitions. But in addition to the frequent and important requests for an invigorated and adequately resourced (traditional) antitrust policy, I offer three suggestions – tailored especially for this Committee – that could meaningfully bolster competition policy in the American health sector.

(1) Engaging CMS in Competition Policy.

Historically, the Centers for Medicare and Medicaid Services have focused their attention almost exclusively on policies that involve the financing of healthcare. Perhaps it is because Medicare enjoys pricing power that CMS paid little attention to the consolidation of healthcare providers, but this was an error. Even if hospital monopoly power does not directly impose higher prices onto the Medicare program, it does have two adverse consequences on the Medicare program.

First, a reduction in competition translates into a reduction in the quality of care, and Medicare beneficiaries have surely suffered because they lived in markets with little competition between hospitals. And second, because hospital monopolies enjoy enormous pricing power over private commercial insurers, they experience less pressure to economize on the costs of care. Accordingly, hospitals that enjoy monopoly power in

[14] Tim Greaney, Barak Richman, Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities, American Antitrust Institute Whitepaper (June 2018)

commercial markets exhibit higher costs and, indirectly, cause Medicare payments to increase for the same healthcare.

For these reasons, CMS' policy responsibilities and objectives are deeply shaped by the industrial concentration of US hospital markets, and it therefore should be armed and encouraged to advance pro-competition policies. Additionally, because it gathers enormous amounts of patient outcomes data, it is uniquely well-positioned to assess the costs of monopoly and to identify the benefits of competition.

CMS could contribute to healthcare competition policy in a number of ways. First, most simply, it could invest in an office of provider competition policy – this could either sit alongside or within CMMI, CMS' innovation center. Such an office could use CMS's wealth of data to issue reports, identify markets where competition is limited or is painfully needed, and offer suggested avenues for encouraging entry. And because payment is so central to the entry and survival of provider strategies, a competition policy that is integrated with payment policy would offer important complementarities.

CMS could also play a more central role in administering merger policy. Just as certain industry mergers must gain the approval of the Department of Transportation and the Federal Communications Commission, in addition to clearing the antitrust laws, CMS could either offer assessments or issue authorizations of proposed mergers. The hospital sector certainly would be more efficient and offer more value if hospitals had been required to pass through a more scrutinizing approval process.

(2) Confronting State Immunities from Federal Antitrust Enforcement

In the past month, the North Carolina Senate unanimously approved a bill that would give antitrust immunity to one of the state's major health systems. Just as there is consensus among health policy experts that hospital competition is desirable – that it brings value, improves quality, and reduces prices – there is consensus that antitrust immunity is undesirable, because it does the opposite.

Why would the state senate offer such a sweeping and harmful antitrust immunity? Sadly, this is a reflection of the political economy of healthcare, in which hospitals are often the largest employers and most powerful economic entities in the regions in which they are located. For these reasons, they often enjoy outsized political influence, at the expense of dispersed patients and consumers.

Over the past decade, just as the Federal Trade Commission increased its scrutiny of provider consolidation, hospitals have increasingly turned to their state legislatures to sanction them to pursue transactions that the antitrust laws would prohibit. So-called "certificates of public advantage" (COPA), which give permission to specific mergers under stated conditions, are one exercise of this state action immunity. Others, like the bill passed in North Carolina, are more sweeping.

Those who decry monopolies and seek competitive markets know that the state, particularly when it acts as a grantor of specific political favors, can be the most harmful impediment to meaningful competition policy. Congress should be aware that many states are using the "state action doctrine" to evade federal antitrust enforcement, and Congress should know that it has the power to preempt states' efforts to invoke the doctrine.

(3) Bolstering ERISA Fiduciary Duties

Because much of healthcare is purchased through intermediaries, such as insurers and employers, consumers and patients alike rely heavily on both the wisdom of and legal obligations imposed upon those intermediaries. Like all intermediaries, however, these healthcare purchasers are imperfect agents. For this reason, Congress passed the Employee Retirement Income Security Act (ERISA), which imposes a fiduciary duty on employers when they manage employee benefit dollars.

ERISA enforcement has historically focused exclusively on protecting employee pensions and retirement plans, but it equally applies to employee health benefits as well. That means that employers that administer an ERISA plan have a fiduciary obligation to be faithful stewards of their employees' healthcare dollars. Too frequently, employer-sponsored health plans do not invest in shopping for high value healthcare and instead pay the inflated prices that establish hospitals offer. This not only wastes employee dollars, it also allows lethargy to spread throughout the market.

ERISA offers legal levers to compel employer-sponsored plans to be more active, demanding, and creative shoppers for healthcare. Some employers have taken seriously their roles as careful fiduciaries for their employees' healthcare, and several have forged valuable programs that should become the norm for most American employers: teaming with centers of excellence programs, collaborating with local primary care providers, contracting in bulk for high-volume tertiary care, and similarly creative healthcare purchasing. America can learn from these innovations, and ERISA could compel many employers to do so.

V. Conclusion

There is an urgent need to recognize the unusually serious consequences, for both consumers and the general welfare, of leaving America's healthcare consumers exposed to monopolized healthcare markets. If consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it, they surely would demand more value from their healthcare purchases.

Aggressive antitrust enforcement can prevent further economic harm and perhaps can undo costly damage from providers that in error were permitted to become monopolists. To be sure, such a policy includes aggressive hospital merger review, but it requires

much more, and greater attention – and an antitrust policy updating – is necessary to address new waves and types of provider consolidation.

Creative market and regulatory initiatives will be needed to unleash the competitive forces that consumers need. Where there is danger, there is opportunity, and competition-oriented policies can and should yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for resources that appear to become increasingly limited. This might involve including agencies (such as CMS) and legal authorities (such as ERISA) that have not been part of the traditional competition policy toolbox.

We ultimately need to understand how the American healthcare market works and the particular dysfunctions it nurtures. One dysfunction is that hospital monopolies are easily formed and rarely punished. A second is that lobbying state legislatures for protections against provider competition generates lucrative rewards. A third is that intermediary purchasers have shown little eagerness either to contest provider market power or to pursue meaningful innovations to how they purchase care for their subscribers. If Americans are to enjoy the fruits of a competitive healthcare marketplace, policymakers need to address all three of these market failures.