

# Health Care Consolidation:

## Background, Consequences, and Policy Levers

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## EXECUTIVE SUMMARY

Rising health care costs affect every level of the economy, squeezing households, employers, and governments' budgets. A key driver of excess health spending in the United States is the consolidation of the health care market — which increases health care prices for the privately insured.

Health care consolidation among hospitals, health systems, and physicians has been increasing steadily for decades. Driven largely by the financial rewards of growth and market power, the national market for health services is now dominated by a handful of mega-health systems, with nearly every market considered highly concentrated. Despite the theoretical benefits of health care integration, evidence shows that increasing levels of health care consolidation harm patients, purchasers, employers, and their communities without yielding meaningful benefits.

This report discusses the harms of consolidation in health care and possible policy options to address them. Key findings include:

- Once begun, health care consolidation initiates a downward spiral: increased market concentration leads powerful systems to use their market power in anticompetitive ways to raise prices and weaken rivals. This, in turn, fuels more consolidation as smaller, independent providers may turn to the larger systems to survive.
- Health care consolidation raises provider prices, which increases health spending through higher insurance premiums and out-of-pocket costs. The result is decreasing consumer affordability and higher health care costs for employers and taxpayers.
- Health care consolidation does not meaningfully improve the quality of patient care and may diminish choice and access, especially in rural and underserved urban areas.
- Rising health care costs driven by consolidation have significant economic impacts both nationally and locally, depressing wages, inhibiting job creation, stifling economic development, and reducing tax revenues.

Competition in health care markets is necessary to improve affordability and access for Americans. Several policy options can promote competition and blunt the effects of market consolidation, including:



- **Improving price transparency.** Price transparency policies can counter the existing opacity of health care prices that prevent competitive pressure on high-priced providers. In addition to strengthening federal hospital price transparency and transparency in coverage rules, more data are needed to monitor consolidation activity and its effects on spending, quality, access, and practice patterns.



- **Strengthening antitrust oversight over health care consolidation.** To limit anticompetitive consolidation, policymakers could strengthen antitrust laws to allow greater oversight of health care transactions. These efforts include: (1) increasing funding for antitrust agency enforcement; (2) combining the value of “serial” transactions to trigger review of smaller mergers and acquisitions that currently do not receive antitrust scrutiny; (3) eliminating the exemption for non-profits from FTC jurisdiction; and (4) increasing scrutiny over non-horizontal (vertical and cross-market) transactions.



- **Banning anticompetitive health plan contract terms.** Dominant players can exploit their market power to demand anticompetitive terms in their service contracts, shielding themselves from competition to raise their prices. Policymakers can outlaw the use or threatened use of anticompetitive contract terms and render them void and unenforceable, including all-or-nothing contracting, anti-tiering and anti-steering clauses, gag clauses, and physician non-compete clauses.



- **Expanding site-neutral payment policies.** To blunt incentives for and cost increases from vertical consolidation, policymakers at the federal and state levels should (a) expand site-neutral payment policy within and beyond Medicare to commercial insurance markets; and (b) ban unwarranted facility fees for physician office visits and for off-campus outpatient services.

It is critical for policymakers, purchasers, and anyone who consumes health care to grasp the urgency and magnitude of the problem of health care consolidation, which threatens both health care affordability and our ability to invest in a higher-quality, more equitable health care system.

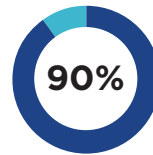
# HOSPITAL CONSOLIDATION AFFECTS US ALL



Evidence shows that **hospital consolidation raises hospital prices without resulting in gains in quality.** High prices are the primary driver of high health care costs for the 180M Americans with commercial insurance. (KFF)



In 2020, people with private health insurance were on average charged **224%** of what Medicare would have paid for the same services. (RAND)



**90% of hospital markets** are considered highly concentrated. (KFF)

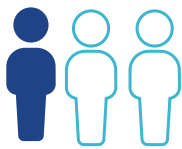
## PATIENTS + CONSUMERS

### HIGHER PREMIUMS

**\$22,463/yr**

In 2022, the **average premium for family coverage** was \$22,463 per year, an increase of 43% over the last decade. (KFF)

### HIGHER OUT-OF-POCKET COSTS WHEN CARE IS NEEDED.



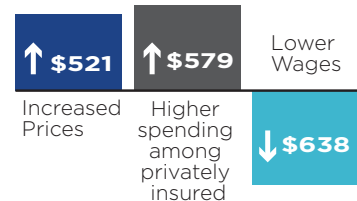
In 2022, nearly **one in three workers (32%) had a plan deductible of \$2,000 or more** (of workers with single coverage and a general deductible). (KFF)

### MEDICAL DEBT AND FINANCIAL STRAIN ARE KEY CONSEQUENCES OF HIGH PRICES.

**100M** Americans face medical **debt.** (KFF)

### LOWER WAGES (RAND)

Researchers have found that hospital mergers lead to:



### ACCESS



About four in 10 U.S. adults say they have **delayed or gone without medical care** in the last year due to cost. (KFF)



**Health care consolidation** also likely impedes patient choice and does not improve quality of care. Evidence suggests that powerful hospitals and health systems may reduce key, but unprofitable services, which increases travel distances and wait times, and reduces timely access to care for rural and low-income patients, particularly communities of color. (NIH)

## EMPLOYERS



Employers pay for health care premiums as a part of employee benefits. After wages, **employers spend more on health insurance than any other employee benefit** (about 8% of total compensation). (CAP)



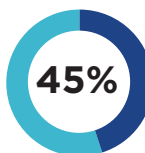
**High and rising health care costs** are one of the largest expenses for a business and depress businesses' profitability, ability to grow, hiring and compensation choices, and could even lead to business closures. (CAP)

## HEALTH CARE WORKERS

### CONSOLIDATION REDUCES WAGES FOR HEALTH CARE WORKERS AND LIMITS EMPLOYMENT CHOICES.



**Health care consolidation depresses wages** for the health care workforce, including nurse wages. (INET)



**45% of primary care physicians in 2018 were subject to noncompetes in hospital employment contracts**, which limit physician choice in employment and ability to change jobs over time. (JHR)

## INTRODUCTION

Rising health care costs affect every level of the economy, squeezing households, employers, and governments' budgets. A key driver of excess health spending in the U.S. is the consolidation of the health care market.

Despite the theoretical benefits of consolidation, the evidence shows that increasing levels of health care consolidation harm patients, purchasers, employers, and their communities without yielding meaningful benefits. Consolidation raises provider prices, which in turn increases health care spending through higher insurance premiums and out-of-pocket costs, ultimately restricting access to health care services. This increased health care spending does not come with gains in health care quality. Moreover, rising health care costs — driven by consolidation — have significant economic impacts, depressing wages, inhibiting job creation, stifling economic development, and reducing tax revenues. As health care entities grow, they consume an ever-larger share of the available resources of households, employers, businesses, and governments — resources that cannot be invested in other pursuits.

This white paper explains the drivers and trends of health care provider consolidation and examines its impact on the functioning of health care markets. The analysis then draws upon existing research to examine the consequences of consolidation on prices, consumer costs, employer spending, wage growth, health care quality, consumer choice, and access. The paper concludes by identifying policies to improve health care competition and address the impacts of consolidation, including increasing price transparency; strengthening antitrust merger oversight; restricting anticompetitive contracting practices; and expanding site-neutral payments and limiting facility fees.

## BACKGROUND

The main driver of health care consolidation appears to be the financial reward of growth — health systems with market power have the leverage to negotiate higher commercial prices from payers (MedPAC 2020). Other factors pushing health care provider consolidation include potential efficiency gains from economies of scale; the ability to manage financial risk and population health; pursuit of greater purchasing power for suppliers of drugs and devices; and the potential to pursue greater care coordination for patients. For physicians, motivations to consolidate with health systems include factors like the administrative burdens of practice management and health plan negotiations, the need for IT infrastructure, financial instability, and more flexibility in working hours. Health systems seek to acquire physician practices to take advantage of payment policy incentives, like the site of service differential and the desire to capture physicians' referrals. The result is a wave of health care consolidation that has been ongoing for three decades.



## SUTTER HEALTH

### A HEALTH CARE CONSOLIDATION CASE STUDY

**For years, California’s health care prices had been rising steeply. The problem was particularly bad in Northern California, where prices and premiums were significantly higher than in the southern part of the state:** Inpatient prices were 70 percent higher, outpatient prices were 17–55 percent greater, and premiums were 35 percent higher, on average (Petris Center 2018). Researchers found that these price increases were driven not by sicker patients or wage differences, but rather the growth of Sutter Health’s market power, which commanded prices that were \$4,000 more per patient admission on average than non-dominant hospitals (G. A. Melnick and Fonkych 2016). More than half of the 19 regions in the United States with the largest commercial price increases from 2012–2019 came from California, with eight located in northern California (Levinson et al. 2022).

As a Sacramento-based, nonprofit hospital system, Sutter expanded its footprint to the San Francisco Bay Area in 1996 when it acquired California Healthcare System. In the subsequent two decades, Sutter rapidly consolidated the Northern California market by amassing 24 hospitals, 36 surgery centers, and 12,000 physicians (Waters 2020). After years of failed attempts by state and federal regulators to block further Sutter mergers and other antitrust enforcement actions, in 2014, a group of employers and labor unions sued Sutter Health in state court, alleging it had anticompetitively used its market power to increase prices. Ultimately, this lawsuit was consolidated with a similar case filed by then-California Attorney General Xavier Becerra in 2018.<sup>1</sup> The plaintiffs alleged Sutter used “all-or-nothing” contracting to require health plans to accept all Sutter providers at the prices demanded or none at all; insisted upon anti-tiering or anti-steering clauses to prevent plans from using cost-sharing incentives to encourage patients to choose higher quality, lower cost providers; used high out-of-network prices; and imposed gag clauses that prevented anyone, including patients and employer plan-sponsors, from knowing the cost of services before they were charged (Gudiksen, Montague, and King 2021).

In 2019, the parties reached a settlement, which received approval by the state superior court in 2021 (Bird and Varanini 2022). In the settlement, Sutter agreed to pay \$575 million in damages, to cap its out-of-network prices, and to refrain from using anticompetitive contracting practices to ratchet up prices, including all-or-nothing negotiations, anti-tiering/steering clauses, and gag clauses. Despite these remedies to which Sutter agreed

<sup>1</sup> *UFCW & Employers Benefit Trust v. Sutter Health*, 241 Cal.App.4th 909, 194 Cal. Rptr. 3d 190, 2015 Trade Cas. (CCH) 79, 15 Cal. Daily Op. Serv. 11 (Cal. Ct. App. 2015).

in the settlement, the lack of a trial and court decision means the Sutter case sets no precedent that firmly establishes these contracting practices as anticompetitive under antitrust laws. In other words, under current law, big health systems like Sutter that have amassed significant market power are still able to carry out these anticompetitive contracting practices that increase health care costs and limit access to high value health care, suggesting that national legislation may be needed to curb these practices.

The story of Northern California is indicative of a larger trend across the country. As of 2018, nearly 95 percent of hospital markets and 77 percent of physician specialty markets nationally were highly concentrated (King et al. 2020). This market concentration has been driven primarily by the consolidation of providers into large health systems. Not only are hospitals merging within the same geographic area, but large systems are also absorbing outpatient clinics and physician practices through vertical consolidation and reaching across regions and state lines to build sprawling cross-market systems. Once they amass market power, dominant health systems use that market power to drive up prices through their massive negotiating leverage against payers without any significant improvements in quality of care (Beaulieu et al. 2020). Ultimately, purchasers and consumers pay the price through higher premiums, cost-sharing, dampened wage growth, and foregone care and necessities when health care becomes unaffordable. Consolidation in one sector of the health care system then drives consolidation across other sectors as other market participants attempt to maintain market power.

# HEALTH CARE PROVIDER CONSOLIDATION TRENDS OVER TIME

**Hospitals.** After years of mergers and acquisitions, most hospital markets are now dominated by a small number of large health systems that own multiple hospitals, outpatient clinics and surgery facilities, post-acute or rehabilitation facilities, and physician practices. Hospital markets across the country are highly concentrated and becoming more consolidated over time. Between 2010 and 2020, more than 1,000 hospital mergers and acquisitions were announced (Johnson and Frakt 2020). From 2010 to 2016, the mean HHI for hospital markets increased 5 percent to more than 5,500, which is considered “super concentrated” (Fulton 2017). As of 2016, 90 percent of hospital markets are highly concentrated. The trend continues, with a large majority of hospitals and hospital services being provided by a large health system, and a declining share by independent hospitals (Johnson and Frakt 2020). In the two decades between 2000 and 2020, the share of hospital beds owned by multi-hospital systems increased from 58 percent to 81 percent (Andreyeva et al. 2022).

Increasingly, the national market for health services is dominated by a handful of mega-health systems. As documented by David Dranove and Lawton Burns, the ten largest health systems in 2017 earned revenues comparable to a multi-national corporation: Sutter’s \$12 billion in revenues was comparable to Tesla’s, Cleveland Clinic’s \$8.4 billion was on par with the National Basketball Association, and UPMC’s \$16 billion compared with the revenues of Whole Foods that year (Dranove and Burns 2022). Many of these mega-systems are nonprofit academic medical centers. Within-market consolidation has increased to where nearly every major metropolitan area is now dominated by one or more mega-health care systems. For example, Jefferson-Einstein Healthcare owns 18 hospitals in the Philadelphia area, Emory-Dekalb Memorial operates 10 hospitals in the Atlanta area, and Fairview-Health East runs an 11-hospital system in the Twin Cities area (NIHCM 2020).

**Cross-Market Consolidation.** These mega-systems’ geographic footprints cross state lines and geographic regions and combine multiple product markets from acute-care hospital service, outpatient services, physician services, health plans, and administrative services and data analytics (Fulton et al. 2022). For instance, HCA owns 177 hospitals in 21 states, CommonSpirit Health (formed by the merger of Dignity Health and Catholic Health Initiatives) operates 142 hospitals in 21 states, and BCCH HealthCare Partners-LifePoint owns 89 hospitals in 30 states, focusing on non-urban areas (NIHCM 2020).

**Hospitals and Physicians.** Hospital-physician vertical consolidation has also been rising over the past decade. According to the American Medical Association, in 2020 more than 50 percent of U.S. physicians were employed by a hospital or health system, up 20 percent from 2012 (Kane 2021). The pace of vertical consolidation is substantial. From 2016 to 2018, the share of



physicians affiliated with health systems increased by 11 percentage points (40–51 percent), and the share of primary care physicians increased 38 percent (Furukawa et al. 2020). Most physician practice acquisitions are too small in dollar value to be reported under the Hart-Scott-Rodino Act threshold, so most vertical acquisitions go unreviewed by antitrust agencies (Capps, Dranove, and Ody 2017).



## DEFINING THE TERMS

**Below is a set of definitions for some of the key terms used in this report:**

**Consolidation** refers to the combining of previously separate or independent entities into one entity, whether through merger or acquisition. Consolidation can be horizontal, vertical, or cross-market (defined below).

**Concentration** refers to the level of competition in a particular market, typically measured by the Herfindahl-Hirschman Index (HHI). HHI is calculated as the sum of the squares of market shares of entities in a given market. According to the U.S. Department of Justice (DOJ) and Federal Trade Commission's (FTC) merger guidelines, markets with an HHI below 1,500 are unconcentrated, between 1,500–2,000 are moderately concentrated, over 2,500 are highly concentrated, and levels greater than 5,000 are super concentrated. (U.S. Department of Justice and Federal Trade Commission 2015; Fulton, Arnold, and Scheffler 2018)

**Horizontal consolidation** refers to combinations among entities offering the same type of service (e.g., acute care hospital services) in the same geographic region. This is consolidation among direct competitors.

**Vertical consolidation** refers to the combinations among entities that offer different types of products or services in the production process, i.e., among entities that do not directly compete with one another. In the context of health care markets, vertical consolidation typically refers to mergers and acquisitions of physician practices by hospitals or health systems. Vertical consolidation of this sort is often referred to as “vertical integration.”

**Cross-market consolidation** refers to mergers among entities in different geographic or product markets, and thus do not directly compete with each other (Dafny, Ho, and Lee 2019; J. S. King et al. 2022). Though discussion of cross-market consolidation could include vertical consolidation across different product markets (for example, between hospitals and physicians), the literature has focused on cross-market mergers that cross

geographic markets. A prominent recent example is the merger between Advocate Aurora Health based in Illinois and Atrium Health based in North Carolina (Liss 2022).

**Consolidation vs. Integration.** Traditionally, consolidation referred to horizontal consolidation, whereas vertical combinations are called “integration” (Schwartz et al. 2020). Theoretically, vertical integration can yield efficiencies and pro-competitive benefits, such as greater coordination of patient care and economies of scale. Yet the weight of empirical evidence suggests that vertical integration tends to increase prices and market power (Neprash et al. 2015). It is worth exploring whether policies could be designed to harness the potential benefits of integration while minimizing the harms to competition. Nevertheless, for the purposes of this paper, the terms consolidation and integration are used interchangeably.

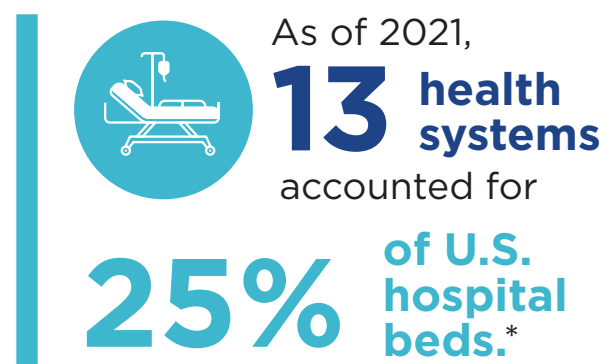
## COMPETITION CONTINUES TO DECLINE AS CONSOLIDATION PROCEEDS LARGELY UNCHECKED

Policymakers and regulators have primarily focused on horizontal hospital mergers, but the vast majority of hospital markets are already concentrated. In the 1990s, the FTC’s attempts to block hospital mergers largely failed, allowing hospital market consolidation to go unchecked for nearly a decade (King, et al. 2020). Despite a few high-profile wins more recently, there are simply too many health care acquisitions for antitrust enforcers to review them all. As a result, hospital market concentration has continued to increase for three decades.

Increasingly, health care consolidation consists of non-horizontal transactions, to which antitrust enforcement policies are largely blind. Vertical acquisitions of physician practices, outpatient clinics, and ambulatory surgery centers fly “under the radar” because they are too small in dollar value to be reported under the Hart-Scott-Rodino (HSR) Act, with a threshold of \$111.4 million in 2023 (Capps, Dranove, and Ody 2017). As discussed further below, payment policies, such as the site-of-service payment differential and the ability for hospitals to add-on facility fees for physician services after the hospital acquires them, further incentivize vertical integration (MedPAC 2020, Ch. 15, 477; Capps, Dranove, and Ody 2018).

Large health systems are also pursuing cross-market mergers, leading to mega-systems that exert market power across multiple regions or states. Between 2010 and 2019, the number of health systems that could potentially exert cross-market power across multiple urban commuting

zones increased 54 percent (Fulton et al. 2022). Antitrust enforcers have historically ignored cross-market mergers as posing no threat to competition because the merging entities did not compete in the same geographic markets. Emerging economic evidence shows that cross-market



mergers pose significant anticompetitive risks, yet antitrust enforcement tools have not been developed to address cross-market mergers (Fulton et al. 2022; King et al. 2022; King and Fuse Brown 2017).

In sum, health care consolidation of all forms continues unabated with adverse consequences for patients and purchasers for health care affordability and access.

## HEALTH CARE CONSOLIDATION CONCENTRATES MARKET POWER AND HARMS COMPETITION

Once begun, health care market consolidation initiates a downward spiral: Increased market concentration and reduced competition lead dominant systems to use their market power in anticompetitive ways to raise prices and weaken rivals. This, in turn, fuels more consolidation as smaller, independent providers might turn to the larger systems to survive.

Health care providers may seek to join larger systems for a multitude of reasons, including for potentially beneficial goals of economies of scale, improved efficiency, and the ability to serve and coordinate care for a larger patient population. Regardless of the justifications, consolidation increases market power, which health systems can leverage to limit further competition and raise prices (Cutler and Scott Morton 2013; Gaynor 2020). Some large systems engage in aggressive acquisition of competitors and affiliated doctors to cement their dominance. In 2012, Yale New Haven Health System acquired its sole competitor in New Haven, Connecticut, and then expanded its scope to the coast by acquiring two more hospitals and physician practices, leading to 25 percent price increases from 2012–2014 (Abelson 2018). In 2022, Yale New Haven Health System announced it would acquire three additional Connecticut hospitals for \$400 million, which if regulators approve, would further expand its reach and dominance in the region (Muoio 2022).

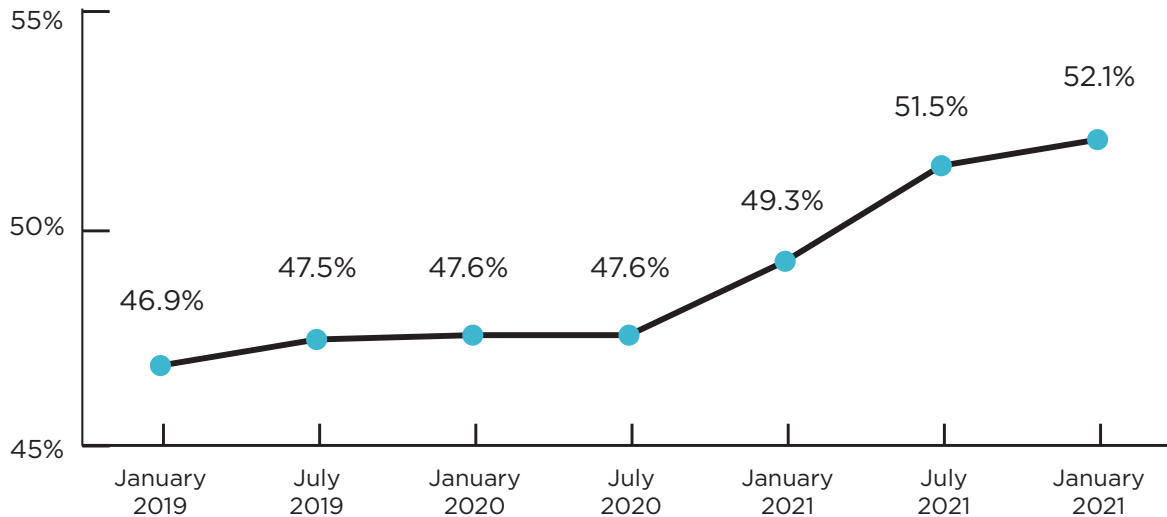
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\* Agency of Healthcare Research and Quality Compendium of U.S. Health Systems, 2021. <https://www.ahrq.gov/chsp/data-resources/compendium-2021.html>

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## MORE THAN HALF OF PHYSICIANS EMPLOYED BY HOSPITALS/HEALTH SYSTEMS AT THE END OF 2021

*Percent of U.S. Physicians Employed by Hospitals/Health System, 2019-21*



Physicians Advocacy Institute: COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment, 2019-2021. [https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI Avalere Physician Employment Trends Study 2019-21 Final.pdf](https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf)

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Dominant health systems then use their market power in anticompetitive ways to increase prices and bargaining leverage against payers. Large health systems use their size and possession of “must-have” providers to insist upon anticompetitive provisions in their contracts with health plans. For example, in 2018, Carolinas Health Care (which became Atrium Health) settled a lawsuit filed by the U.S. Department of Justice (DOJ) and the North Carolina Attorney General over its use of anti-tiering and gag clauses, which limit a plan’s ability to steer patients toward lower-priced providers or share information about more expensive providers, among other issues (Gudiksen, Montague, and King 2021).<sup>2</sup> Dominant systems also use their power to engage in abusive pricing practices, such as rapidly increasing prices and negotiating more services to be reimbursed as a percentage of charges, which shifts financial risk to payers, as charges are typically an excessive, artificially set “list” price determined by the hospital (Cooper et al. 2019). Vertical consolidation of hospitals and physicians allow the hospital to charge higher rates and facility fees for physician visits and outpatient services, by characterizing the services as “hospital-based” (Capps, Dranove, and Ody 2018). This “site of service differential” embedded in Medicare payment policy creates incentives for further vertical consolidation.

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<sup>2</sup> *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 3:16-cv-00311-RJC-DCK (W.D.N.C. Apr. 24, 2019).

Furthermore, it is market power, not their for-profit or nonprofit ownership status, that drives hospitals' pricing behavior (G. Melnick, Keeler, and Zwanziger 1999). In other words, nonprofit health systems are just as likely as for-profits to pursue aggressive consolidation and exploit their market power to raise prices, reduce unprofitable services and locations, and use anticompetitive practices.

The anticompetitive effects of non-competes in physician contracts are also exacerbated by consolidation. Typically, a non-compete clause limits the physician's ability to work within a given geographic area around any of the employer's practice locations (e.g., a 25-mile radius) for a given period (e.g., for two years) (Smith 2021). As the size of health systems and the number of acquired physician practices grow, so does the potential geographic reach of the non-compete agreements. For example, although a non-compete for a single practice location may only cover one metro region, a non-compete for a multi-site practice could expand over several regions, even across multiple states. Although the FTC has proposed a rule to bar non-competes, even if finalized, the rule would not apply to physicians employed by nonprofit health systems, over which the FTC lacks jurisdiction.<sup>3</sup>

Consolidation also fuels more consolidation as independent systems cannot often survive unless they join a larger system. Large health systems channel patients away from smaller independent hospitals and acquire and lock up physicians with generous compensation and non-compete clauses. For example, in the 2000s, UPMC, the dominant health system in the Pittsburgh area, engaged in a series of anticompetitive tactics to weaken its smaller rival, West Penn Allegheny Health System, including "raiding" key physicians from West Penn and paying them above market rates to keep them at UPMC, and securing an agreement from the largest health insurer to artificially depress West Penn's reimbursement rates.<sup>4</sup> Dominant systems can thus erode the financial conditions of independent community hospitals, especially those in rural areas, who might face the decision either to close their doors or consolidate with a larger system (Scott 2022b). Even if the facility remains open following acquisition, the community hospital faces pressure to close down essential services, such as labor and delivery, and send patients to the high-volume parent hospital, a trend heightened by Covid-19 (Scott 2022a).

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<sup>3</sup> Non-Compete Clause Rule, 88 Fed. Reg. 3482 (Jan. 19, 2023) (to be codified at 16 C.F.R. pt. 910).

<sup>4</sup> *West Penn Allegheny Health System, Inc. v. UPMC; Highmark, Inc.*, 627 F.3d 85 (3d Cir. 2010).

# THE CONSEQUENCES OF HEALTH CARE CONSOLIDATION

The empirical literature has documented the adverse effects of health care consolidation on health care prices (the negotiated prices paid, not just gross charges), consumer affordability, and health spending by purchasers (Liu et al. 2022; Fuse Brown 2023). Meanwhile, consolidation appears to have a negligible positive effect on the quality of patient care, while choice and access may be diminished. The adverse effects of health care consolidation ripple across the economy and are borne by individuals, households, employers, communities, and federal and state governments.

## Prices and Affordability

The preponderance of research evidence finds that a lack of competition increases health care prices, making health care less affordable for patients.

**Hospital Consolidation.** A large body of literature finds that horizontal hospital consolidation substantially increases commercial prices, with estimates ranging from 20–40 percent, though the price effects vary by the degree of concentration and market power (Dafny 2009; Haas-Wilson and Garmon 2011; Gaynor and Town 2012; MedPAC 2020; Schwartz et al. 2020; Liu et al. 2022). In addition, hospitals in monopoly markets have 12.5 percent higher prices, on average, than hospitals in markets facing more competition (Cooper et al. 2019). The price increases are felt acutely by the communities served by these hospitals. In Parkersburg, West Virginia, St. Joseph’s Hospital merged with Camden-Clark Memorial in 2011, which ultimately led to the closure of one facility and price increases of 54 percent (Abelson 2018). The price increases apply even when hospitals cross geographic areas, particularly if they share common insurers. Despite the reluctance of antitrust enforcers to review or block mergers of hospitals across different geographic areas, the economic literature suggests that such cross-market mergers can increase hospital prices by an estimated 6–16 percent (Lewis and Pflum 2017; Schmitt 2018; Dafny, Ho, and Lee 2019).

**Hospital-Physician Consolidation.** The weight of evidence suggests that vertical hospital-physician integration increases prices and total spending (Baker, Bundorf, and Kessler 2014; Liu et al. 2022). Such vertical integration can contribute to horizontal physician market concentration, which allows physician practices (together with the health system) to leverage greater market power to negotiate higher prices. Estimates of the price effects for vertical consolidation range from 14–33.5 percent, depending on the market concentration and specialty (Capps, Dranove, and Ody 2018; Carlin, Feldman, and Dowd 2017). Others have found that increased hospital-physician consolidation is associated with increased outpatient physician prices, including a 9 percent increase for specialist physicians and 5 percent increase for primary care (Scheffler, Arnold, and Whaley 2018).

KFF Health News has reported on consumers charged facility fees, including **Arielle Harrison**, whose 9-year-old saw a pediatric specialist at Yale New Haven Health System in 2021 via video and was charged a facility fee from the hospital in addition to the physician's bill for the telemedicine visit (Andrews 2021).

**Kyunghee Lee's** bill for steroid injections for arthritis in her right hand increased ten-fold, from \$30 to over \$350, when her physician's office was acquired by a hospital and charged as an outpatient department of the hospital. In addition to Lee's share, the total bill now included a \$1,262 facility fee even though the physician and services were identical (Weber 2021).

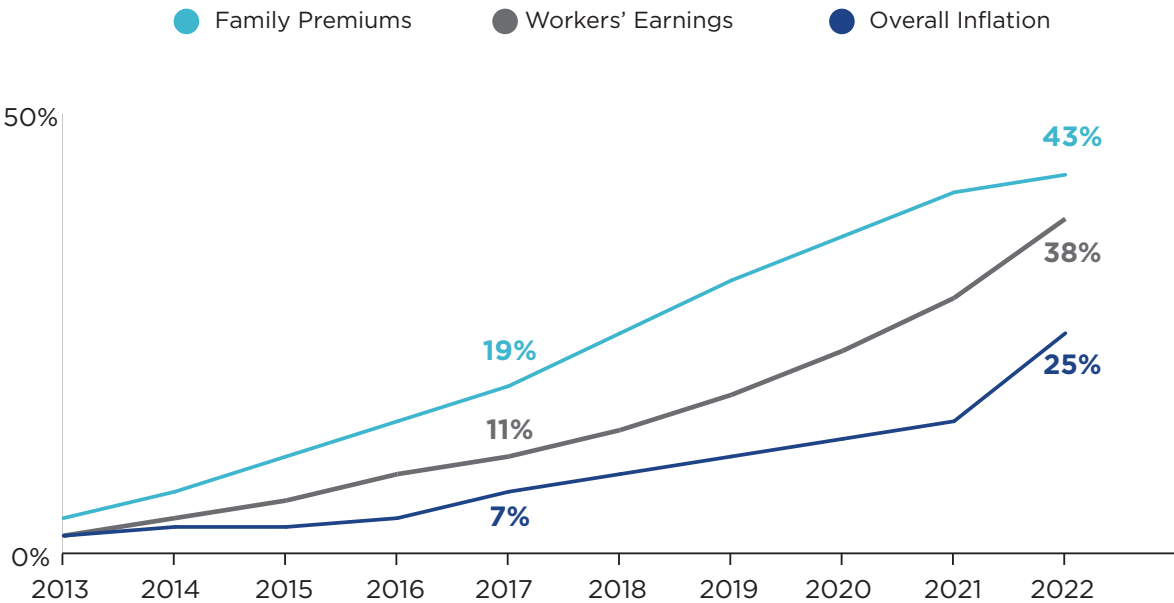
**David Hubbard** had a heart condition and required periodic echocardiograms. When he went to receive his routine echocardiogram at his cardiologist's office, he was shocked that the fee had jumped to \$1,605 from \$373 just six months earlier. Nothing about the service had changed, except that his cardiologist's practice was purchased by a local hospital system and was able to bill an added facility fee as an outpatient department of the hospital (Wilde Matthews 2012).

**Michael Kark's** five-year-old son was routinely seeing a psychologist for treatment of his food allergies. The Colorado dad had good insurance, and his copay was only \$20. But then came a \$500 "hospital facility fee" bill. He and his son hadn't visited the hospital, or needed complicated care, "There were no vital signs, there were no titanium screws, there was no surgery. This was literally just a lamp and a couch," Kark said. But, the hospital next door owned the office building and the psychologist's practice, allowing it to add the extraneous hospital facility fee. Ultimately, this expense ended his son's therapy because Kark couldn't afford it (Low 2022).

Vertical consolidation also increases health spending through the exploitation of the site-of-service payment differential (Whaley et al. 2021; Capps, Dranove, and Ody 2018; Neprash et al. 2015). The site-of-service differential describes how payers, including Medicare, reimburse higher rates for identical services when billed as an outpatient hospital department versus the physician fee schedule (MedPAC 2020, 478-80). Facility fees also contribute to the site-of-service differential because hospitals that acquire physician practices can exploit the ability to collect a facility fee in addition to the physician's professional fee, even for a simple doctor visit.

Vertical consolidation also increases spending by directing captive physician referrals to higher-cost hospital settings. Studies demonstrate that hospital-physician consolidation alters the referral patterns of acquired physicians, who are more likely than independent physicians to refer patients for MRIs or outpatient surgeries to higher-cost hospital outpatient settings (Chernew et al. 2018; Kessler n.d.; Koch, Wendling, and Wilson 2017; Young et al. 2021). One study found that following acquisition by a hospital, physicians shifted about 10 percent of their Medicare and commercially insured cases away from ambulatory surgery centers (ASCs) to more expensive hospital outpatient departments and were 18 percent less likely to use an ASC at all (Richards, Seward, and Whaley 2020). Other studies have found that hospital acquisition of physicians increased the odds of inappropriate MRIs by 20 percent (Young et al. 2021), increased the monthly number of more-expensive hospital-based diagnostic imaging and laboratory services and, decreased the number of non-hospital services (Whaley et al. 2021).

**OVER TIME, FAMILY PREMIUMS HAVE RISEN FASTER THAN WAGES AND INFLATION**



KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2011-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2011-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2011-2021.

**Impact on Premiums.** Given consolidation’s upward pressure on health care prices, evidence links hospital consolidation and hospital-physician consolidation with higher private insurance premiums. Areas with the highest levels of hospital market concentration had ACA Marketplace premiums that were 5 percent higher, on average, than the least concentrated (Boozary et





**A vaginal delivery** in the Boston metro area ranges from

**\$4,701 to \$15,973\***

al. 2019). Among highly concentrated hospital markets, increased vertical consolidation was associated with a 12 percent increase in premiums (Scheffler, Arnold, and Whaley 2018). These effects fall disproportionately on racial and ethnic minorities, who are more likely to be uninsured and to forego coverage in the face of premium increases (Town et al. 2007). Higher health care prices from consolidation lead to higher premiums for families and employers, which translates to foregone wages for those with employer-sponsored coverage and higher

out-of-pocket costs for patients regardless of insurance status. Researchers have found that hospital mergers are associated with a \$521 increase in prices, \$579 increase in spending among the privately insured, and a \$638 reduction in wages (Arnold and Whaley 2020).

**Impact on Out-of-Pocket Costs.** Health care consolidation increases consumers' health spending in the form of higher premiums, as well as out-of-pocket costs. In general, consumers' share of health spending has grown over time in the form of high deductibles, cost-sharing, and non-covered costs. Thus, as health care prices rise from consolidation, so does the out-of-pocket burden on households. Vertical consolidation further raises out-of-pocket costs through the specific mechanism of outpatient facility fees. One study found that between 2011 and 2017 cost-sharing for commercially insured patients' elective surgeries increased 200 percent for hospital-based settings compared to in-office settings (Billig et al. 2020). The study found that growth was largely driven by increases in facility fees and out-of-pocket cost-sharing, meaning that the burden of outpatient spending growth from vertical consolidation is largely borne by the patient. In interviews with consumer groups and regulators, researchers have found that the growing prevalence and magnitude of outpatient facility fees and high deductibles is decreasing affordability and increasing consumers' financial risk (Monahan, Davenport, and Swindle 2023). As affordability challenges grow, so does the prevalence of medical debt among the privately insured; in 2022, a KFF Health News investigation found that more than 100 million Americans have medical debt (Levey 2022).



**A blood test** in the El Paso metro area ranges from

**\$144 to \$952\***

**Price Variation.** Health care consolidation and the lack of price transparency lead to extensive price variations. Wide price variation within the same market signal a non-competitive, dysfunctional market (Bai and Anderson 2018; Levinson et al. 2022; Cooper et al. 2019).

\* Health Care Cost Institute: Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area, April 2019. <https://healthcostinstitute.org/all-hcci-reports/hmi-2019-service-prices>



**3X**

The median price of a **mammogram** in Bridgeport, Conn. is \$365, more than **the median price** of a mammogram in a similar market like Green Bay, Wisc. (\$109)\*

Certain standardized procedures, such as MRI, joint replacement, or colonoscopy, illustrate the extent of price variation because any differences in price are largely attributable to market power, not differences in labor costs, equipment and supplies, or patient acuity. In the New York/New Jersey area, the average price of a joint replacement in 2018 ranged from \$45,000 to over \$75,000, depending on which facility performed the service, while in San Diego, the prices ranged from \$20,000 to \$55,000 (Kurani et al. 2021). Prices not only vary by facility within a given region, but also by commercial payer within a given facility.

For instance, according to a *New York Times* report, the price for an MRI at Mass General varied from \$1,019 with a Cigna plan to \$3,809 with a Humana plan, while the price for a colonoscopy at University of Mississippi Medical Center ranged from \$782 without insurance to \$2,144 with an Aetna plan (Kliff, Katz, and Taylor 2021).

## Quality

In contrast to the breadth of evidence that health care consolidation increases prices and reduces affordability, there is little support for concluding that consolidation improves the quality of patient care, which is often touted as a justification for integration and consolidation. Evidence indicates the quality of care provided in noncompetitive markets is no better, and may be worse in some cases, than in competitive markets (Liu et al. 2022; Beaulieu et al. 2023). The studies also showed that consolidated hospitals showed less improvement over time in measures of patient experience (Beaulieu et al. 2020). The link between diminished competition and declining quality is best observed when rates are set by government payers, such as Medicare, because then providers compete on quality not cost (Frakt 2019). While vertical consolidation may financially integrate hospitals and physicians, it does not necessarily lead to clinical integration that facilitates better care and outcomes for patients or less spending (Fisher et al. 2020). Empirical studies show mixed effects of vertical consolidation on quality, with some studies showing no effect, while other studies show modest improvements on quality (Liu et al. 2022).

Anecdotally, large systems may prioritize investing in and providing high-margin specialty care to generate revenue, rather than investing in services, such as primary care and behavioral health services, that are foundational to improving patient outcomes.

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\* Health Care Cost Institute: Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area, April 2019. <https://healthcostinstitute.org/all-hcci-reports/hmi-2019-service-prices>

## Choice and Access

Beyond its impacts on affordability and quality, a lack of competition in health care markets limits access and choice for consumers and patients. As markets become less competitive, ownership of health care facilities and providers increasingly becomes limited to one or a small number of health systems, which may limit patients' ability to choose among providers, particularly among independent competitors that are not part of the same health system (Cutler and Scott Morton 2013). The growth of dominant health systems clearly limits the ability of purchasers and payers to substitute rival hospitals and physician networks when they are negotiating with providers, forcing them to agree to higher rates if they want access to must-have providers or facilities, which they are required to include under network adequacy rules.

Health care consolidation also impedes access to care, particularly in rural areas. Rural hospitals may seek to merge with larger health systems to remain financially viable, especially in states that have not expanded Medicaid (Bai et al. 2020; Jiang et al. 2022). Yet, even though consolidation may allow some rural hospitals to keep their doors open, evidence suggests that as larger systems acquire rural hospitals, they reduce key services, such as primary care, obstetrics, neonatal, non-emergency outpatient services, surgery, and diagnostic imaging in the rural hospital (O'Hanlon et al. 2019; Henke et al. 2021). These service line reductions increase travel distances and wait times and reduce timely access to care for rural and low-income patients, particularly in communities of color (Scott 2022b; Oates 2017). Moreover, consolidation contributes to unmet needs in rural areas, with merged hospitals less likely to increase their behavioral health compared with independent hospitals (Henke et al. 2021).

As health care markets become more consolidated, urban safety net hospitals and services in low-income urban areas also face cuts. Although health systems justify consolidation by noting that growth allows for greater financial stability across system facilities, there is nothing to stop consolidated health systems from closing less profitable safety net hospitals, even if they provide essential services.

Urban safety net hospitals have followed a pattern of disinvestment and closure, including Atlanta Medical Center, Hahnemann University Hospital in Philadelphia, Providence Hospital in Washington, D.C., and Westlake Hospital in Chicago. Often the unprofitable facilities or service lines serve lower income communities and thus may be considered a revenue drain for the larger system. While such closures improve the financial position of the health system, they dramatically reduce access to care within a patient's community, which poses equity concerns for people with low incomes, disabilities, or are non-English speaking, elderly, or without access to transportation.

## Impact on Local Communities

Health care consolidation affects local communities and their economies, particularly on wage growth and jobs. The health care industry is a major employer, if not the largest employer

in many localities. Research indicates that health care consolidation depresses wages for the health care workforce, including skilled workers, nurses, and pharmacists (Prager and Schmitt 2021; Allegretto and Graham-Squire 2023). Hospital closures and consolidation, particularly in rural areas, inhibit economic development as new businesses and employees will not locate in an area without adequate health services.

The higher prices from health care consolidation translate to higher health insurance premiums for coverage offered by employers and slower wage growth for workers, with the greatest burden for low-wage workers (Arnold and Whaley 2020). Over the past decade, health care inflation has generally outpaced wage growth, shifting more of the costs of health care to workers.

High health care spending and rising premiums also disproportionately burden local, small businesses and the self-employed, which are critical for local economies to grow and maintain economic vitality (Small Business Administration 2022). Unaffordable health insurance costs affect the ability of small businesses to recruit and attract employees or for individuals to start their own businesses. High and rising health care costs are one of the largest expenses for a business and depress businesses' profitability, ability to grow, hiring and compensation choices, and could even lead to business closures (Gupta et al. 2022; Hughes, Gee, and Rapfogel 2022).



## ATLANTA MEDICAL CENTER

### A HEALTH CARE CONSOLIDATION CASE STUDY

**In 2022, the Atlanta-area nonprofit health system Wellstar announced it was shutting down two of its eleven hospitals, both located in the urban core and serving lower income and predominantly Black communities (N. T. Ellis 2022).** Wellstar had acquired these hospitals as part of a five-hospital transaction from for-profit Tenet Healthcare Corporation just six years prior, in 2016. One of the shuttered hospitals, Atlanta Medical Center, operated one of two Level 1 Trauma centers in the region. Despite its critical role in the community, Wellstar abruptly announced the hospital closures, citing declining revenues and increased operating costs, despite the system's \$5.7 billion in assets and plans to expand in the Atlanta suburbs and merge with the state's teaching hospital in the wealthier city of Augusta. Critics, including the Mayor of Atlanta, filed complaints with the IRS and the HHS Office of Civil Rights alleging Wellstar's closure of its two downtown hospitals violated its obligations as a tax-exempt entity and civil rights laws (Amy 2023). As a nonprofit hospital, Wellstar is subject to a range of "community benefit" requirements in exchange for a tax break, including providing financial assistance to poor or indigent patients, limiting egregious billing practices, and providing other services based on community need. However, violations of community benefit have often been poorly enforced, even as evidence increasingly indicates that nonprofit hospitals are not fulfilling their community benefit obligations. (CAP 2022).

# INCREASING HEALTH CARE COMPETITION SHOULD BE A FOCUS FOR POLICYMAKERS

## Policy Options to Promote Competition in Health Care Markets

Competition in health care markets is necessary to improve the affordability and access for Americans. As such, there are several policy options that can promote competition and blunt the effects of market consolidation, including: (1) improving price transparency; (2) strengthening antitrust oversight over health care consolidation; (3) banning anticompetitive health plan contract terms; and (4) expanding site-neutral payment policies.

### Improving Price Transparency

Price transparency can enhance competition and market forces to allow consumers, employers, purchasers, and policymakers to select lower-priced, higher-value providers, and to enhance market oversight over consolidating transactions and anticompetitive conduct by dominant providers. In addition, data transparency is critical to researchers engaged in policy design and evaluation. Data allows health care purchasers to establish transparency tools to help consumers choose high-value providers and to drive a range of other health care policies to improve patient care and control costs.

Price transparency policies can counter the existing opacity of health care prices that prevent competitive pressure on high-priced providers. As noted above, the federal government implemented transparency in hospital pricing and coverage rules, requiring disclosure of standard prices and negotiated rates, but more enforcement is needed to increase compliance and, analysts need tools to translate the data into usable information.<sup>5</sup>

In addition to price transparency, more data are needed to monitor consolidation activity and its effects on spending, quality, access, and practice patterns. In a June 2023 hearing before the Senate Finance Committee, Karen Joynt Maddox, a researcher at the Washington University School of Medicine, recommended that Congress implement a comprehensive data system that allows CMS to track quality, access, costs, and consolidation across a range of health care providers (Joynt Maddox 2023). This system could build upon and fill key gaps in the current Medicare Cost Reports data to: (1) expand beyond hospitals and nursing homes to cover other providers, such as physicians; (2) gather data on spending, acquisitions, ownership structure, administrative costs, and staffing; and (3) update measures of quality, access, and equity.

All the policies described here are guided by data, whether strengthening merger oversight, detecting and enforcing laws against anticompetitive practices by dominant health care providers, or quantifying the amount of facility fees charged and enforcing policies for site-neutral payment.

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<sup>5</sup> 42 C.F.R. §§ 180.40 to .110 (Hospital Price Transparency Rules); 42 C.F.R. §§ 147.210 to .212 (Transparency in Coverage Rules).

## Strengthening Antitrust Oversight of Health Care Transactions

To limit anticompetitive consolidation, policymakers at the federal and state levels could strengthen antitrust laws to allow greater oversight of health care transactions, including:

- **Increasing funding for antitrust agency enforcement.** Antitrust enforcement agencies are significantly underfunded, which limits the ability to provide appropriate oversight over the growing volume of health care mergers. While health care merger activity has increased, federal antitrust enforcement resources have not kept pace (Kades 2018; Slaughter 2019). From 2010 to 2016, the number of reported mergers increased by 57 percent, while funding for federal enforcement agencies in real dollars fell by over 12 percent, and by some estimates, antitrust enforcement budgets would need to increase by over \$150 million annually to meet the need (Gaynor 2020). The result is that anticompetitive mergers and acquisitions go unchallenged. Although funding for antitrust enforcement has increased recently,<sup>6</sup> greater resources are needed to provide appropriate oversight of the ongoing wave of health care consolidation.
- **Combining the value of “serial” transactions to trigger review of smaller mergers and acquisitions that currently do not typically receive antitrust scrutiny.** Currently, transactions valued at less than \$111.4 million are exempt from reporting to antitrust agencies under the Hart-Scott-Rodino (HSR) Act. As a result, these deals go unreviewed and face no challenges by regulators (Wollmann 2019). Many health care deals fall below the threshold but have significant market impacts, including 30 percent of hospital mergers and the vast majority of physician acquisitions (Cooper 2023). Recently, the FTC proposed a rule to expand HSR reporting of information about prior transactions by either party to a transaction over the prior 10 years. While helpful, this rule (if finalized) would only apply to mergers above the HSR reporting threshold. Reforming the HSR reporting threshold to capture more of these transactions would provide more visibility to enforcement authorities and the public. This could be done by lowering the HSR reporting threshold for health care transactions or combining the value of serial transactions to trigger reporting.
- **Eliminating the exemption for non-profits from FTC jurisdiction.** Although the FTC has the authority to review all hospital mergers, under the current Federal Trade Commission Act, it lacks the authority to enforce the antitrust laws against the anticompetitive practices

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<sup>6</sup> Consolidated Appropriations Act of 2023, H.R. 2617, 117th Cong. (2021-2022). The spending bill for FY 2023 increased the budget for the DOJ antitrust division by \$25 million (to \$225 million) and grew the FTC’s funding by \$53.5 million (to \$430 million) over the prior year. In addition, the 2023 spending bill provides the antitrust agencies an additional \$1.4 billion over five years from increased filing fees for the largest mergers.

of non-profits, including non-profit hospitals.<sup>7</sup> Thus, Congress could eliminate the non-profit exemption from FTC jurisdiction, which would, according to FTC Commissioner, Kelly Slaughter, “allow the agency to go after anticompetitive conduct involving nearly half of the nation’s hospitals, including conduct uncovered in the course of FTC hospital merger investigations, which now must be policed by DOJ and state agencies alone.” (Slaughter 2019) In 2023, Representatives Pramila Jayapal (D-WA) and Victoria Spartz (R-IN) introduced bi-partisan bill H.R. 2890, titled the “Stop Anticompetitive Healthcare Act of 2023” that would eliminate the exemption for non-profit hospitals from FTC’s jurisdiction over unfair methods of competition.

- ***Studying and increasing scrutiny over non-horizontal (vertical and cross-market) transactions.*** Despite mounting evidence of their anticompetitive impacts, challenging non-horizontal mergers is more difficult than horizontal mergers because of the dearth of precedent and prior experience. The FTC should use its authority under the Merger Retrospective Program to study the effects of vertical and cross-market mergers and develop economic models and legal strategies to challenge these mergers moving forward (Slaughter 2019; Gaynor 2020; “Merger Retrospective Program” 2020).

## Banning Anticompetitive Contracting Terms

In health care markets that are already consolidated, dominant health care providers and other players exploit their market power to demand anticompetitive terms in their provider-insurer or service contracts, shielding themselves from competition to raise their prices. Federal and state policymakers can outlaw the use or threatened use of these contract terms and render them void and unenforceable. These anticompetitive contract terms include all-or-nothing contracting, anti-tiering and anti-steering clauses, gag clauses, and physician non-compete clauses (Gudixsen, Montague, and King 2021; Adler and Ippolito 2023).

- ***All-or-nothing contracting:*** An all-or-nothing provision requires the health plan to contract with all providers in that system or none of them. Health systems use all-or-nothing bargaining to leverage the status of their must-have providers or facilities to demand higher payment rates for the entire system. By bargaining on behalf of all its affiliates, a powerful health system can thus raise the prices for its less desirable providers by tying them to must-have providers.
- ***Anti-tiering or anti-steering clauses:*** Tiered networks and steering incentives are cost-saving strategies used by insurers to encourage patients to seek higher value care. When

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<sup>7</sup> FTCA §4, codified at 15 U.S.C. § 44 (applying the FTCA to corporations “organized to carry out business for its own profit or that of its members”); *Cnty. Blood Bank of Kansas City Area, Inc. v. F.T.C.*, 405 F.2d 1011, 1022 (8th Cir. 1969) (holding that “under § 4 [of the FTCA] the Commission lacks jurisdiction over nonprofit corporations without shares of capital, which are organized for and actually engaged in business for only charitable purposes, and do not derive any ‘profit’ for themselves or their members within the meaning of the word ‘profit’ as attributed to corporations having shares of capital”).

health systems use anti-tiering, they require a health plan to place that system's facilities or providers in the most preferred tier, even if they do not meet the cost or quality standards for the highest-value tier. In the case of anti-steering provisions, the health system may forbid the insurer from using cost-sharing incentives to steer patients to other providers, even if they offer better value. Dominant health systems use anti-tiering or anti-steering provisions to stop health plans from implementing these cost-control measures and thereby avoid competition.

- **Gag clauses:** Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party, such as employer plan-sponsors. Gag clauses are anticompetitive because they undermine price transparency tools for consumers, decrease plan sponsors' ability to push back on rising prices, and hide the magnitude of variation in provider rates and obscure the effects of an anti-steering clause. The Consolidated Appropriations Act of 2021 prohibits group health plans and health insurance issuers from entering into agreements with providers, third-party administrators (TPAs), pharmacy benefit managers (PBMs), or other service providers that restrict sharing provider-specific pricing, claims, or quality information with plan members, enrollees, the plan sponsor, or referring providers. Plans must attest compliance with the gag clause prohibition annually to the relevant federal agencies (Dept. of Labor, Dept. of Health & Human Svcs., Dept. of Treasury 2023). Although the gag clause prohibition went into effect for plan contracts starting in 2022, plan sponsors may still struggle to access pricing and claims data from TPAs. Administrative clarification on plan sponsors' rights to claims data as a plan asset would improve compliance (Corlette and Kona 2023; Strong et al. 2022).
- **Physician non-competes:** As physician employment grows, the use of non-compete clauses for physicians is pervasive. Acquirors of physician practices can use non-compete clauses in anticompetitive ways to protect the value of their investment — the physician's patient panel — but also restrict physicians' ability to practice elsewhere or leave employment if they object to the practice's operations. As such, physician non-competes can pose risks to patient care, entrench market consolidation, and increase prices.

Members of Congress have proposed bills to prohibit the use or enforcement of these anticompetitive terms in provider-insurer contracts, including the bipartisan Healthy Competition for Better Care Act introduced in 2023 by Senators Tammy Baldwin (D-WI) and Mike Braun (R-IN).<sup>8</sup> These provisions were also included in the 2019 Lower Health Care Costs Act,<sup>9</sup> which the CBO predicted (had it passed) would have reduced premiums and increased federal revenues \$1.1 billion over the budget window (Adler and Ippolito 2023). Some states have passed laws banning certain anticompetitive contracting practices: Massachusetts and Nevada have banned anti-tiering/steering and all-or-nothing contracting clauses; Minnesota has banned gag clauses;

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<sup>8</sup> Healthy Competition for Better Care Act, S. 3139, 117th Cong. (2023).

<sup>9</sup> Lower Health Care Costs Act, S. 1895, 116th Cong. (2019).



and California prohibits physician non-competes (Source on Healthcare Price and Competition n.d.). A legislative prohibition on anticompetitive contract terms can alter the bargaining dynamics to create a more level negotiating position between dominant health care systems and payers. In addition, antitrust enforcers at the federal and state levels could investigate and enforce antitrust laws against dominant health care entities that use these contracting practices to harm competition.

## **Expanding Site-Neutral Policies and Banning Unwarranted Facility Fees to Disincentivize Vertical Consolidation**

To blunt incentives for and cost-increases from vertical consolidation, policymakers at the federal and state levels should: (1) expand site-neutral payment policy within and beyond Medicare to commercial insurance markets; and (2) ban unwarranted facility fees for physician office visits and for off-campus outpatient services.

Current payment policy typically reimburses more for the same outpatient services provided in a hospital-owned setting than in physicians' offices. This pricing practice is called the site-of-service differential and is one of the main financial incentives driving hospital-physician consolidation. Medicare has taken some limited steps toward payment reform that would pay the same rate for the same service, regardless of where it is provided, referred to as "site-neutral payment." MedPAC and others have advocated for expansion of Medicare's site-neutral payment policy to all off-campus physician offices owned by hospitals and to eliminate the exception for grandfathered locations. One analysis estimates that adopting broader site-neutral payment policy would save Medicare \$231 billion over the next decade (P. Ellis 2023). Beyond Medicare, federal and state policymakers could consider expanding site-neutral payment policies to the commercial insurance market. One estimate predicts that adopting site-neutral payment for commercial insurance would save \$458 billion over the next decade (CRFB 2021).

A significant part of the site-of-service differential is driven by facility fees that hospital-owned providers can charge in addition to the physician's professional service fee. Vertical integration has increased the incidence of outpatient facility fees being added to physician office visit bills. As part of a broader site-neutral payment reform, policymakers could limit the ability of providers to charge unwarranted facility fees for physician office visits and certain outpatient services (Hensley-Quinn 2020). Policymakers could also take steps to improve transparency over the location where a service is provided through policies requiring every facility to have its own unique provider identifier number or requiring that physician offices owned by hospitals bill directly on office claims forms instead of hospital claims forms.

## **Policy Considerations**

Any policy solution to address health care consolidation should keep in mind differences across providers. The effects of a policy may vary depending on a provider's size and market

position. Some providers, such as rural or safety net facilities, will be affected differently than providers with larger margins, perhaps requiring policy exceptions or adjustments to reflect these differences.

These policy options to address health care consolidation range in their potential savings and can be scaled or combined to increase the level of savings. These savings can be harnessed to support parts of the health care system that promote quality, access, and equity, and be invested in community economic or business development, increased wages, or other worthy pursuits.

Finally, any policy approach to promote competition in health care markets should balance the benefits of clinical integration with guardrails to protect against price increases and other abuses that impact patient health and economic well-being.

## CONCLUSION

While none of these policy solutions alone will stem the problems associated with health care consolidation, it is critical for policymakers, purchasers, and anyone who consumes health care to grasp the urgency and magnitude of these problems. Health care consolidation poses a critical threat not just to health care affordability, but to our ability to afford to invest in a higher-quality, more equitable health care system.

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