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“Improving Care, Lowering Costs: Achieving Health Care Efficiency”

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- I. High and rising provider prices are driving higher health care spending**
- II. Consolidation within and across health care subsectors is a key driver of higher prices and total costs of care**
- III. Federal antitrust enforcement requires more resources and legislative support to have greater impact**
- IV. Recommendations**

I. High and rising provider prices are driving higher health care spending

The U.S. spends 18.3 percent of its GDP on health care, a larger share than any other country. U.S. provider prices are extremely high by international standards (see [Figure 1](#)), and studies show that these high *prices*, not the quantity of services consumed nor the underlying health of our population, are the primary driver of higher spending in the U.S. International comparisons of health care quality also show the U.S. lags other leading OECD nations on most dimensions.¹ We are not receiving the highest possible value for our dollars – far from it.

[Figure 2](#) depicts where we spend our health care dollars. My focus today is health care providers, such as hospitals, physicians, and clinics, who jointly account for just over half of health care spending. Whereas public insurance programs set the prices they pay to health care providers, commercial insurance plans negotiate rates with providers who are then included “in network”; covered services performed by in-network providers are accessible to enrollees at much lower out-of-pocket cost than services provided by out-of-network providers. The growth in health care spending for the commercially insured population is largely due to growth in these negotiated rates, also called “commercial prices.”²

Commercial prices are much higher than prices for publicly-insured patients,^{3,4} and the gap is widening. Commercial prices were around 10 percent higher than Medicare in the late 90s, but

¹ Anderson, GF et al. “It’s still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt,” *Health Affairs* 2019 38(1):87–95; Commonwealth Fund, “Mirror, Mirror: Comparing Health Systems Across Countries,”; G. Claxton et al., “How Have Healthcare Prices Grown in the U.S. Over Time?,” Peterson-Kaiser Health System Tracker (May 8, 2018); M. Laugesen and S. Glied, “Higher fees paid to US physicians drive higher spending for physician services compared to other countries,” *Health Affairs* 30, no. 9 (2011): 1647–56.

² Zack Cooper, Stuart Craig, Martin Gaynor, and John Van Reenen, “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” *Quarterly Journal of Economics* 2019 134(1): 51–107. Health Care Cost Institute, “2018 Health Care Cost and Utilization Report,” [Presentation](#), Feb. 2020.

³ Zack Cooper et al., “Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-14,” *Health Affairs* 2019 38(2): 184–189.

⁴ Cooper et al. (2019), *supra* note 2. Private insurers administer benefits for a large portion of Medicare and Medicaid-insured beneficiaries, and for these enrollees, insurers and providers must agree to the terms, including price, under which a provider is included in-network. However, for Medicare Advantage plans, CMS requires providers that participate in Traditional Medicare to accept its fee-for-service price schedule for any out-of-network care, reducing the ability of most providers to negotiate for Medicare Advantage rates that are much higher. See

by 2012 were 76 percent higher and are even higher today.⁵ A recent (2020) study found that *average* commercial prices for inpatient and outpatient services were *double* Medicare reimbursement rates, while prices for professional services – e.g., physician services rendered with hospital-based care – were 60 percent larger.⁶

While public insurance programs do not pay these commercial prices, there are significant federal budgetary implications of high commercial prices. Most directly, high commercial prices mean high employer-sponsored premiums, raising the cost of the tax exclusion for employer-sponsored coverage. High commercial prices also impact the premiums, and therefore the federal subsidy dollars, for enrollees purchasing subsidized plans through the Health Insurance Marketplaces. There are important indirect effects as well. The organizational structure and market concentration within the health care industry, which serves enrollees of all insurance programs, is heavily influenced by commercial prices and vice versa. These factors affect the quality and quantity of care provided to publicly-insured enrollees, as well as the site where that care is delivered – which directly affects the price the federal government pays.

Providers defend their negotiation of higher commercial rates by saying they must cover the costs of government-insured and uninsured patients, for whom care is reimbursed at rates below their actual costs. This dynamic ignores the fact that costs are themselves affected by reimbursement: economic research finds that hospital expenses fall when prices fall.⁷ In other countries, this type of gap does not exist or is smaller, and cross-subsidization reduces pressures on providers to pursue efficiencies. If it is possible to negotiate higher commercial rates, that is an easier path than redesigning care to reduce costs and overall spending. It is also essential for payers, both public and private, to support providers in this work – for example through reimbursement arrangements that allow funding for case management that prevents costly care.

Laurence Baker, Kate Bundorf, Aileen Devlin, and Daniel Kessler, “Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays,” *Health Affairs* 35, no. 8 (2016): 1444–51; Vilsa Curto et al., “Health Care Spending and Utilization in Public and Private Medicare,” *American Economic Journal: Applied Economics* 2019 11(2): 302–32.

⁵ Selden TM, Karaca Z, Keenan P, White C, Kronick R. “The growing difference between public and private payment rates for inpatient hospital care,” *Health Affairs* 2021 Dec; 34(12): 2147–50.

⁶ Michael Chernew, Andrew Hicks, and Shivani Shah. “Wide State-Level Variation In Commercial Health Care Prices Suggests Uneven Impact Of Price Regulation,” *Health Affairs* 2020 39(5): 791-799.

⁷ White C, Wu VY. “How do hospitals cope with sustained slow growth in Medicare prices?” *Health Serv Res.* 2014;49(1):11–31. Stensland J, Gaumer ZR, Miller ME. “Private-payer profits can induce negative Medicare margins,” *Health Affairs* 2010 29(5):1045–51.

II. Consolidation within and across health care subsectors is a key driver of higher prices and total costs of care

Increases in commercial prices have coincided with massive consolidation within and across health care provider sectors. There were nearly 1,600 hospital and hospital system mergers over the 20 years from 1997 to 2017, involving thousands of hospitals. This merger and acquisition activity has increased the absolute size and geographic footprint of hospital and health care delivery systems – and with it, their market power and political heft.⁸ Merger and acquisition activity in physician markets has also increased, and the share of physicians employed in practices wholly or partly owned by hospitals has increased from below 20% in the mid-2000s, to 30% in 2012 and 50% in 2018.^{9,10}

Given that consolidation has coincided with substantial growth in commercial prices and spending, the question of whether consolidation has *caused* these increases has attracted significant attention from researchers as well as various stakeholders. To date, the most conclusive research derives from analyses of “structural changes” in markets—i.e., mergers and acquisitions, divestitures, and exits. I summarize the results of these studies below. However, it is important to recognize that a good deal of consolidation to date is non-structural, that is, it results from the swift growth of large firms.

Some of the large-firm growth may well be due to anticompetitive conduct (in addition to mergers and acquisitions). For example, some dominant hospital systems’ contracts forbid insurers from using financial incentives to “steer” patients to other (typically smaller and less expensive) providers¹¹ and/or may prohibit insurers from contracting with only a subset of the

⁸ Hospital merger count is based on data from the American Hospital Association and summarized by M. Gaynor in <https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/>.

⁹ Carol Kane, “Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees,” White paper, American Medical Association, 2019, <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>; Carol Kane and David Emmons, “New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment,” White paper, American Medical Association, 2013, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf; Michael Furukawa et al., “Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18,” *Health Affairs* 2020 39(8): 1321–1325.

¹⁰ Commercial health insurance markets have grown increasingly consolidated as well. By 2021, 75 percent of metropolitan areas were “highly concentrated” as defined in the FTC/DOJ *Horizontal Merger Guidelines*. American Medical Association, “[Competition in Health Insurance: 2022 Update](#).” Although I limit my attention in this testimony to provider consolidation, I note that there is evidence on the effects of insurer consolidation as well. In particular, studies find more competition among insurers leads to lower premiums for employer-sponsored coverage as well as plans offered on the Health Insurance Exchange. For additional details see L. Dafny, “How Health Care Consolidation Is Contributing to Higher Prices and Spending, and Reforms That Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets,” Testimony to the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021.

¹¹ Hospital systems that know they are indispensable in their markets sometimes agree to participate in insurance products in which there are no out-of-pocket differences among providers, but refuse to participate in products in

dominant system’s providers (e.g., blocking an insurer from including just some of the system’s specialists in-network).¹² Such “all or nothing” contracting can enable a system to allocate services efficiently across different facilities, but it can also be a means for a system with market power to potentially expand its reach by “tying” access to its providers in more competitive markets to access to its most highly-valued providers.¹³

Below, I provide a brief summary of the empirical evidence on the effects of provider consolidation.¹⁴ I emphasize studies published in peer-reviewed, academic journals.

A. Expansion of hospital systems within and across geographic areas increases prices

Hospitals account for over 30 percent of U.S. health care spending and 5.7 percent of GDP.¹⁵ The landscape of the U.S. hospital industry has changed significantly in the past half-century, with the share of hospitals operating independently declining from 90 percent in 1970 to 33 percent in 2019. This consolidation has occurred both within and across geographic markets. By 2019, nearly one-third of hospitals belonged to systems with 20 or more other hospitals.¹⁶

Researchers have studied the effects of hospital mergers for several decades now, and there is substantial, robust evidence showing that hospital mergers, on average, lead to higher commercial prices.¹⁷ This research, which has focused on mergers among hospitals serving patients in the same geographic area, finds that combinations of close rivals yield the largest price effects.¹⁸ Joining forces with a competitor enables the merged system to negotiate a higher price with insurers, who can no longer turn to the competitor if they fail to agree on price with

which there are “tiers” with different co-payments, based upon the prices of the providers. These conditions can render tiered products unviable in that market.

¹² See, e.g., E. Mitchell, “Seizing on the Sutter Health Settlement to Create Competitive Health Care Markets Nationwide,” <https://www.milbank.org/2020/01/seizing-on-the-sutter-health-settlement-to-create-competitive-health-care-markets-nationwide/>.

¹³ That is, under an all-or-none contract, the dominant system requires insurers, as a condition of contracting with its most highly-valued hospitals and medical groups, to also contract with the system’s less highly-valued providers (even if the price and quality of those providers are such that the insurer would otherwise choose not to contract with them).

¹⁴ For more comprehensive summaries, see RAND: Liu et al., 2022.

¹⁵ Figures from Centers for Medicare and Medicaid Services, [National Health Expenditures](#), for CY 2021.

¹⁶ Fulton et al., “The Rise of Cross-Market Hospital Systems and Their Market Power in the US,” *Health Affairs* Nov 2022 41(11): 1652-1660.

¹⁷ For additional discussion and study citations, see M. Gaynor, “Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets,” Testimony before the Committee on the Judiciary, Subcommittee on Antitrust, Commercial, and Administrative Law, U.S. House of Representatives, March 7, 2019 and Z. Cooper, “Consolidation and Corporate Ownership in Health Care”, Testimony before the Senate Committee on Finance, June 8, 2023.

¹⁸ For a recent example, see Brand et al, “In the Shadow of Antitrust Enforcement: Price Effects of Hospital Mergers from 2009-2016,” *Journal of Law and Economics*, forthcoming.

one of the hospitals. Studies also find that in markets that are more consolidated, price levels are higher and price growth is steeper.¹⁹

While most research on the impact of hospital consolidation focuses on “within market” or horizontal mergers, recent studies have evaluated the effects of so-called “cross market” hospital mergers, or combinations occurring among hospitals in different, sometimes adjacent, geographic markets.²⁰ This research shows that acquisitions of hospitals, even by hospital systems without a local presence, often leads to substantial price increases both for acquired hospitals and for acquiring hospitals located in the same state.

Importantly, numerous studies fail to find systematic evidence of benefits to consumers from mergers in terms of clinical outcomes or patient experience, and many studies link more hospital competition to higher quality.²¹ While some research finds evidence of modest cost savings from hospital consolidation – specifically mergers of hospitals in different geographic areas - the substantial body of evidence that prices increase on average after hospital mergers implies that such savings are typically not sufficiently large or not “passed through” via lower prices.²² To sum it up: due to consolidation we are paying more for our hospital care, and there is no evidence that we are getting more in return.

Researchers have also found evidence that hospitals in more concentrated markets are less likely to receive fixed, prospective payments – a payment methodology that creates incentives for providers to control costs – and more likely to receive payments linked to billed charges.²³ This pattern shows that hospitals with market power are better-positioned to reject cost-containing payment innovations by insurers.

¹⁹ For a summary, see M. Gaynor and R. Town, “The Impact of Hospital Consolidation - Update.” Policy Brief No. 9, The Synthesis Project, Robert Wood Johnson Foundation, Princeton, NJ, June 2012.

²⁰ L. Dafny, K. Ho, and R. Lee, “The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry,” *RAND Journal of Economics* 50, no. 2 (2019): 286–325, <https://doi.org/10.1111/1756-2171.12270>; M. Lewis and K. Pflum, “Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions,” *RAND Journal of Economics* 48, no. 3 (2017): 579–610, <https://doi.org/10.1111/1756-2171.12186>; Matt Schmitt, “Do Hospital Mergers Reduce Costs?,” *Journal of Health Economics* 52 (2017): 74–94, <https://doi.org/10.1016/j.jhealeco.2017.01.007>.

²¹ E.g., D. Kessler and M. McClellan, “Is Hospital Competition Socially Wasteful,” *Quarterly Journal of Economics* 115, no. 2 (2000): 577–615; Studies of quality competition in the U.K. include Z. Cooper et al., “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms,” *The Economic Journal* 121, no. 554 (2011), 228–260., and M. Gaynor et al., “Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service,” *American Economic Journal: Economic Policy* 5, no. 4 (2013): 134–66. Cooper et al. studied the introduction of greater competition among hospitals into the English National Health System and find that heart attack mortality decreased the most in areas with the greatest increases in competition. Gaynor et al. study the same English NHS reforms but examine a broader set of quality and efficiency measures and find that hospital competition improves quality without lowering costs.

²² Schmitt, Matt, “Do Hospital Mergers Reduce Costs?” *Journal of Health Economics*, 2017, Vol. 52, pp. 74-94.

²³ Specifically, hospitals are less likely to be paid based on patients’ diagnoses and conditions (as under Medicare’s Prospective Payment System), and more likely to be paid based on their list charges, giving hospitals an incentive to render more care and to increase list charges. Cooper et al. (2019), *supra* note 3.

Researchers have also examined the effects of consolidation on health care workers. These studies find that wage growth for health care workers declines in the wake of hospital and insurer mergers that result in large increases in market concentration.²⁴ The economics underlying these findings is straightforward: just as market power enables suppliers to charge more for their output (i.e., health care services or insurance plans), it also enables them to pay less to employees, particularly those with industry-specific skills.²⁵ The wage growth slowdowns attributable to hospital mergers are attenuated in markets with stronger labor unions. Health care worker unions have garnered national attention in recent months, owing to the strike by 75,000 employees of Kaiser Permanente and the announcement on October 13 by physicians at a major Midwest system, Allina, that they had voted to unionize. Steps toward unionization have also been taken by physicians-in-training throughout the country.

To the extent that hospital consolidation leads to lower wages and poorer terms of employment, it will exacerbate burnout among health workers, an issue of growing concern for our nation.²⁶

B. Consolidation of physicians also leads to higher prices and spending

Physician markets have also experienced extensive consolidation in recent years. [Figure 3](#) depicts the number of publicly announced physician mergers and acquisitions between 2012 and 2022. Perhaps the most significant phenomenon affecting physician markets in the past decade has been the acquisition of physician practices by hospitals. The American Medical Association, the professional association of physicians, reports the share of physicians working directly in hospitals or in practices with partial or full hospital/health system ownership increased from 29 percent in 2012 to 41 percent in 2022. Other sources place the current share at over 50 percent.²⁷ Another significant trend is the growth of physician employment by corporations such as insurers (notably Optum, a subsidiary of United Healthcare, the nation’s largest health insurer), private-equity firms, and companies like CVS Health, Walgreens, WalMart, and Amazon.

Research on physician mergers and consolidation mirrors the findings from the hospital consolidation literature, although the body of research is smaller. Physician prices are higher in

²⁴ E. Prager and M. Schmitt, “Employer Consolidation and Wages: Evidence from Hospitals,” *American Economic Review*, 2021, Vol. 111(2), pp. 397-427. L. Dafny et al, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review*, 2012, Vol. 102(2), pp. 1161-1185.

²⁵ Prager and Schmitt find the effects of mergers on wage growth are stronger among those with industry-specific skills, such as nursing and pharmacy workers. Consistent with economic theory, they find no effect of mergers on wage growth among unspecialized workers whose roles are not unique to the hospital setting, such as cafeteria workers. They are unable to examine physician incomes using their data sources.

²⁶ See, for example, “Addressing Health Worker Burnout: The U.S. Surgeon General’s Advisory on Building a Thriving Health Workforce,” Department of Health and Human Services, 2022.

²⁷ A [study](#) commissioned by the Physicians Advocacy Institute and performed by Avalere Health reports 52.1 percent of physicians were employed by a hospital or health system in January 2022.

more concentrated physician markets.²⁸ There is evidence that physician prices increase following mergers in the same specialty and geographic area, and when generalists are integrated with specialists in the same organization.²⁹ In addition, many studies find higher prices and spending following hospital acquisition of physician practices. For example, one study based on detailed commercial claims data finds average price increases of 14 percent.³⁰ Importantly, these affiliations are associated not only with price increases but also with a shift of patients toward higher-priced hospitals and higher-priced services – yielding an increase in spending even if prices were held constant.³¹ A study published just last month found that when primary care physicians are part of large health care systems, patients have more specialist visits and higher total spending; more care is also provided within the integrated system, yet the authors found no change in readmission rates.³²

Evidence of improvements in patient outcomes with physician consolidation is elusive. One recent study finds only negligible effects of vertical integration of hospitals and physicians on a set of health outcome measures.³³ Other research likewise finds either no relationship or a positive but small relationship between vertical integration of hospitals with physicians and measures of quality.³⁴ One recent working paper finds the recent increase in integration of gastroenterologists with hospitals has led to significant changes in care processes – including

²⁸ A. Dunn and A. Shapiro, “[Do Physicians Possess Market Power?](#)” *Journal of Law & Economics* 57, no.1 (2014):159-193; L. Baker et al. “[Physician Practice Competition and Prices Paid by Private Insurers for Office Visits.](#)” *JAMA* 312, no. 16 (2014): 1653–62.

²⁹ T. Koch and S. Ulrick, “Price Effects of a Merger: Evidence From a Physicians' Market,” *Economic Inquiry* 59, no. 2 (2021): 790–802. L. Baker et al., “Does Multispecialty Practice Enhance Physician Market Power?” *American Journal of Health Economics*, Summer 2020.

³⁰ Cory Capps, David Dranove, and Christopher Ody, “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending,” *Journal of Health Economics* 59 (2018): 139–152. The authors estimate hospital acquisitions of physician practices increase prices by 14% on average, with about half the increase attributable to higher unit prices and half to payment rules that reimburse services performed at or billed through a hospital at a higher rate. See also, Caroline Carlin, Roger Feldman, and Bryan Dowd, “The Impact of Hospital Acquisition of Physician Practices on Referral Patterns,” *Health Economics* 25 (2016): 439–454; Hannah T. Neprash *et al.*, “Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices,” *JAMA Intern Med.* 175, no. 12 (2015): 1932–1939; James Robinson and Kelly Miller, “[Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California.](#)” *JAMA* 312, no. 16 (2014): 1663–1669.

³¹ L. Baker, M. Kate Bundorf, Daniel P. Kessler, “The effect of hospital/physician integration on hospital choice,” *Journal of Health Economics*, Volume 50, 2016, Pages 1-8.

³² A. Sinaiko et al, “Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems. *JAMA Health Forum.* 2023;4(9).

³³ Thomas Koch, Brett Wendling, and Nathan E. Wilson, “[The Effects of Physician and Hospital Integration on Medicare Beneficiaries' Health Outcomes.](#)” *Review of Economics and Statistics*, March 2020.

³⁴ Marah Short and Vivian Ho, “[Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality.](#)” *Medical Care Research and Review* 77, no. 6 (2020): 538–48.; Rachel Machta, et al., “A Systematic Review of Vertical Integration and Quality of Care, Efficiency, and Patient-Centered Outcomes,” *Health Care Management Review* 44, no. 2 (2019): 159–173.

greater use of anesthesia with deep sedation – and a substantial increase in post-procedure complications and spending.³⁵

A number of studies have shown that Medicare’s preferential reimbursement for services delivered in hospital-owned sites is a key driver of physician-hospital integration.³⁶ One study attributes a sizeable share of the overall increase in hospital employment of physicians between 2009 and 2013 to a change in Medicare reimbursements in 2010 that led to a further relative increase in payments for services performed in hospital-owned sites, observing that “organizational structure responds to profit incentives.”³⁷

As private-equity firms acquire more physician practices, research on the prevalence and repercussions of these transactions is growing. Private-equity firms typically acquire multiple practices over time, and often amass significant market share within certain specialties and geographic areas. Once they acquire practices, they tend to increase volume and spending by insurers. For example, one recent study of 578 dermatology, gastroenterology, and ophthalmology physician practices that had been acquired by private equity companies found an 11 percent increase in price per claim, as well as a 38 percent increase in visits by new patients, as compared to 2,874 similar independent practices.³⁸ Another study found statistically significant commercial price increases following private-equity acquisitions in 8 of 10 specialties studied.³⁹ A study of the effect of private-equity acquisition of ophthalmology practices on Medicare enrollees finds an increase of 22 percent in the use of higher-cost treatments.⁴⁰

Recently, the FTC sued U.S. Anesthesia Partners, the dominant provider of anesthesia services in Texas, and private-equity firm Welsh, Carson, Anderson & Stowe, alleging that they executed a “multi-year anticompetitive scheme to consolidate anesthesiology practices in Texas” that

³⁵ Saghafian et al, “The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices,” *National Bureau of Economic Research Working Paper Series* No. 30928, 2023.

³⁶ For example, in 2019 the payment rates for a midlevel (Level 4) office visit for an established patient were \$110.28 if provided in an independent physician office and \$195.86 if provided in a hospital-affiliated site of care. *MedPAC Report to Congress*, March 2020 Ch. 15. Relevant studies include Dranove D, Ody C. Employed for higher pay? how Medicare payment rules affect hospital employment of physicians. *Am Econ J Econ Policy*. 2019;11(4):249-271; Post B, Norton EC, Hollenbeck B, Buchmueller T, Ryan AM. Hospital-physician integration and Medicare’s site based outpatient payments. *Health Serv Res*. 2021;56(1):7-15; Song Z, Wallace J, Neprash HT, McKellar MR, Chernew ME, McWilliams JM. Medicare Fee Cuts and Cardiologist-Hospital Integration. *JAMA Intern Med*. 2015 Jul;175(7):1229-31; and Saghafian et al., 2023, *supra* note 35.

³⁷ Dranove and Ody, 2019, *ibid*. Note that hospital-affiliated physicians do not need to treat patients in a hospital outpatient department in order to bill a “facility fee.”

³⁸ Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. “Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization,” *JAMA Health Forum*. 2022;3(9): e222886.

³⁹ Private-equity investments are common in other healthcare sectors as well, including hospitals and nursing homes. For an overview see “The Growth of Private Equity in US Health Care: Impact and Outlook,” *NIHCM Expert Voices* Brief, May 2023.

⁴⁰ Y. Singh et al, “Increases in Medicare Spending and Utilization following Private Equity Acquisition of Retina Practices,” *Ophthalmology* 2023.

resulted in growing monopoly power and prices “double the median rate of other anesthesia providers in Texas.”⁴¹ This marks the first lawsuit of its kind by federal enforcers, signaling their concern about serial acquisitions or “rollups” that engender market power as well as the strategies adopted by some private-equity backed provider organizations.

C. Consolidation in other provider sectors is also linked to higher prices and lower quality

In the interest of brevity, my testimony focuses on the two largest and best-studied provider sectors: hospitals and physicians. However, there are studies of provider consolidation in other subsectors, and many studies of which I am aware echo the results obtained in the hospital and physician consolidation. These include studies of kidney dialysis centers and nursing homes.⁴²

As I highlight below, studies such as those described in the sections above are increasingly difficult to perform, as researchers have limited and expensive access to data – particularly commercial claims data. These studies are critical for understanding the drivers of price and spending growth for commercial and public insurers alike, and for illuminating important changes or stasis in modes of health care delivery and outcomes.

III. Federal antitrust enforcement requires more resources and legislative support to have greater impact

Americans rely on the federal antitrust enforcement agencies to enforce our competition laws, which prohibit both anticompetitive conduct and mergers. This is not the setting for a comprehensive discussion of U.S. antitrust enforcement, however it is important to acknowledge that (1) substantial anticompetitive consolidation has occurred notwithstanding the existence of federal agencies tasked with preventing it; (2) there have been recent efforts to reinvigorate enforcement, including the release of draft Merger Guidelines by the DOJ and FTC (“the Agencies”) which highlight the Agencies’ plans to investigate and challenge the types of transactions that are driving consolidation of health care providers.

⁴¹ “FTC Challenges Private Equity Firm’s Scheme to Suppress Competition in Anesthesiology Practices Across Texas,” news release, September 21, 2023.

⁴² “How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry,” with Ben Heebsh, Ryan McDevitt, and James Roberts, *Quarterly Journal of Economics*, February 2020. A. Gupta et al. Does private equity investment in healthcare benefit patients? Evidence from nursing homes. No. w28474. National Bureau of Economic Research, 2021; T. Wollman, “How to get away with merger: stealth consolidation and its real effects on US healthcare,” *National Bureau of Economic Research* working paper, February 2022.

There are many reasons for the rise of consolidation in health care provider sectors in spite of antitrust enforcement, including

- Limited visibility and timeframe to investigate smaller proposed mergers and acquisitions because federal pre-merger reporting is required only for transactions that exceed high dollar and party size thresholds, and many provider merger fall beneath these thresholds. Even if the agencies become aware of so-called “non-reportable” transactions, the parties may legally merge before an Agency has reviewed the transaction. Unwinding consummated transactions is notoriously difficult, reducing the odds of a resolution that restores competition.
- Judicial and Agency interpretations of the Clayton Act, which prohibits mergers and acquisitions when “the effect may be substantially to lessen competition, or tend to create a monopoly,” as well as the high legal burden the government faces for challenging anticompetitive transactions and conduct.⁴³
- Stagnating budgets for the Agencies despite a growing and consolidating economy, more and larger transactions, and an increase in resources required to investigate or challenge them.

In light of stagnating budgets, the Agencies have devoted an increasing share of their resources to preventing further structural consolidation, leaving ever limited resources to investigate and challenge anticompetitive *conduct*.⁴⁴ Some current examples in health care include “all or none” and “anti-steering” clauses in contracts demanded by dominant provider organizations, efforts by such organizations to impede patients’ access to unaffiliated, lower-cost providers of some services, and referral of profitable patients to within-system providers and unprofitable patients elsewhere.⁴⁵

⁴³ For additional discussion of potential changes to the antitrust statutes which would facilitate vigorous enforcement, see L. Dafny, “How Health Care Consolidation Is Contributing to Higher Prices and Spending, and Reforms That Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets,” Testimony to the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021.

⁴⁴ The antitrust agencies can and have investigated conduct by dominant actors in the health care system that may lessen competition. For example, DOJ successfully challenged a health insurer’s use of most favored nation (MFN) and “MFN+” provisions that contractually required hospitals to not negotiate lower prices—and sometime specified higher prices—to the dominant insurer’s rivals. DOJ, “[Justice Department Files Motion to Dismiss Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts](#),” Press release, Mar. 25, 2013. In another action, the DOJ successfully ended a dominant hospital system’s use of “anti-tiering” provisions that prevented insurers from using narrow and tiered networks to steer patients to the system’s rivals. DOJ, “[Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions](#),” Press release, Nov. 15, 2018.

⁴⁵ See, for example, Cutler et al, “Vertical Integration of Healthcare Providers Increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing Facilities,” *NBER Working Paper 28305*, updated 2023.

Even if antitrust enforcement is reinvigorated and proves successful, it will be insufficient to address the harmful consequences of consolidation that has already taken place, or to address the lack of competition inherent in some markets that are too small to support multiple competing providers. For these reasons, I am among the set of health care economists calling for some form of price regulation, specifically caps on the highest commercial prices.⁴⁶ There are a number of ways to implement such caps, which could be applied to bind prospectively, could apply to either or both in-network and out-of-network providers, and could be based on commercial or Medicare rates.⁴⁷ Price caps can also be complemented with restrictions on the rate of price growth permitted for providers of varying price levels, and flexible oversight to address evasion.

It will be most feasible for states to experiment with such caps or limits on price growth, and some are already taking steps toward doing so.⁴⁸ However, any such efforts will be significantly hampered without access to data about the prices actually being paid for commercial services as well as the quantity and nature of services being delivered. This is infeasible without action by federal legislators to facilitate the creation of an All Payer Claims Database, as I discuss next.

IV. Recommendations

1. Establish and fund an All Payer Claims Database (APCD).

A national APCD will enable regulators and researchers to track and analyze the effects of consolidation. This database would contain health care claims submitted by self-insured group health plans, federal insurance programs, and fully insured individual and group health plans. *States cannot achieve this goal without federal intervention* owing to the fact that self-insured plans are regulated under the federal ERISA statute, and a 2016 Supreme Court decision barred states from requiring self-insured plans to supply insurance claims to a state APCD.⁴⁹ While some states that had already built APCDs before the decision continued to

⁴⁶ For details, see Michael Chernew, Leemore Dafny, and Maximillian Pany, “A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market,” *Policy Proposal 2020-08*, The Hamilton Project, Brookings Institute, March 2020.

⁴⁷ For a review of alternative proposals to address prices, including price regulation, see “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services,” Congressional Budget Office Report, September 29, 2022.

⁴⁸ For a survey of healthcare antitrust enforcement and regulation by states, see C. Capps, T. Shvydko, and Z. Zabinski, “Healthcare Antitrust Enforcement and Regulation by the States,” Stigler Center, *The Economics of US Healthcare: Competition, Innovation, Regulation, and Organizations*, Ch. 7.

⁴⁹ The case is *Gobeille v. Liberty Mut. Ins. Co.* The No Surprises Act enacted in December 2020 required the formation of a State All Payer Claims Databases Advisory Committee, “charged with advising the Secretary of Labor regarding the standardized reporting format for the voluntary reporting by group health plans to State All Payer Claims Databases.” The Committee offered recommendations regarding standardizing data format and submissions, data privacy and security issues, and “voluntary data submission processes.” The Act also authorized grants to support State APCDs, but funds for these grants have not been appropriated to date.

operate them, and others are underway, without data from self-insured plans it is impossible for states to obtain a comprehensive assessment of utilization, spending, and prices. In addition, developing and maintaining APCDs on a state-by-state basis is expensive and duplicative, requiring each state to establish data standards and an infrastructure.⁵⁰ Finally, access to APCDs by researchers and regulators has been limited to date; legislation to develop and govern a national APCD could facilitate such access and speed the ability of researchers, regulators, and policymakers to use the data to develop actionable insights. The APCD would also be of great value to states in implementing surprise billing reforms.

2. **Increase funding for federal antitrust enforcement agencies.**

Notwithstanding substantial economic growth and an increase both in reported transactions and in the degree of consolidation across a range of industries – heightening the need for merger reviews as well as non-merger or “conduct” investigations – funding for the antitrust enforcement activities of the FTC and the DOJ has stagnated over the past several decades. For example, while GDP increased in real terms by over 55 percent between 2000 and 2022, the budget allocation to the Antitrust Division increased just 2.6 percent.⁵¹

Approximately *half* of enforcement actions by the FTC are in the health care sector. The FTC also requires funding to complete “6(b)” studies, which provide valuable insight into industries and practices; two such studies in the health care space are currently underway, including a study to assess the impact of physician consolidation.⁵² The DOJ also devotes significant resources to healthcare matters, including two successful challenges of proposed health insurer mergers in 2017. The draft Merger Guidelines released jointly by the Agencies in July 2023 signal that the Agencies’ intent to increasingly investigate and challenge conduct as well as transactions that are common in the health care industry. In addition to ensuring that Agency funding reflects the bipartisan aims of the Merger Modernization Act, additional appropriations are sorely needed to support increased enforcement and to modernize the information technology essential to performing data- and document-intensive investigations.

⁵⁰ As of 2021, 18 states had legislation mandating the creation and use of APCDs or were establishing an APCD, and others were in various stages of development, per the [Agency for Healthcare Research and Quality](#). However, grants to support state APCDs, legislated under the No Surprises Act, have not been appropriated.

⁵¹ Growth in real GDP calculated using seasonally adjusted data for calendar years 2000 and 2022, [reported](#) by the St. Louis Federal Reserve Bank in chained 2017 dollars. Growth in real appropriations to the Antitrust Division of DOJ is calculated using [annual appropriation amounts reported by DOJ](#), for fiscal years 2000 and 2022, deflated by the Consumer Price Index obtained from <https://www.usinflationcalculator.com/>.

⁵² [“FTC to Study the Impact of Physician Group and Healthcare Facility Mergers,”](#) FTC news release, Jan. 14, 2021.

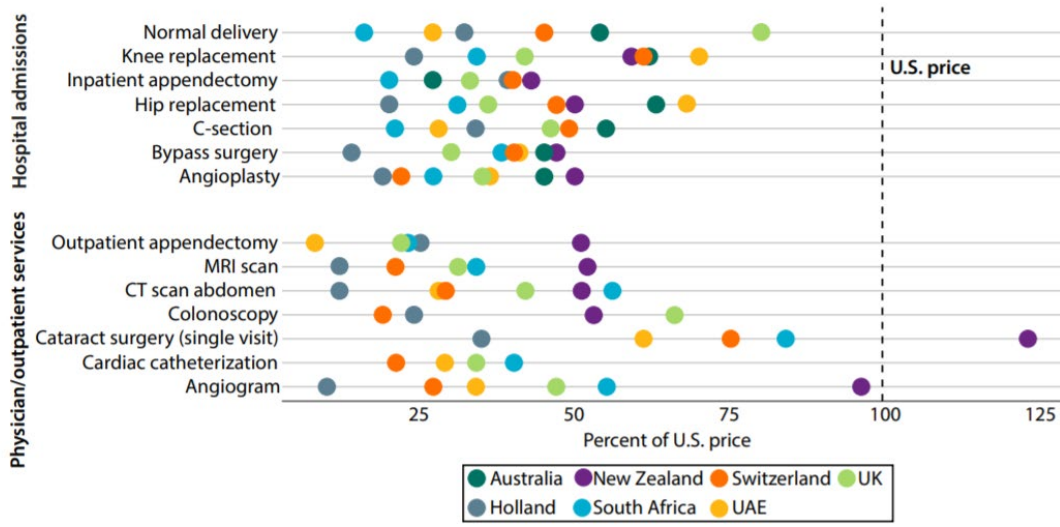
3. Support “site-neutral” payment reform for Medicare

Higher Medicare reimbursement for hospital-affiliated services has led to an increase in hospital-physician integration, which in turn drives greater utilization of hospital-affiliated services, higher commercial prices, and higher total spending by all payers. Given that Medicare’s payment structure is often mimicked by private insurers, inaction by the federal government is exacerbating a situation that drives higher spending and greater expansion by hospitals.

The Medicare Payment Advisory Commission (MedPAC) has studied this issue extensively and made a set of recommendations on aligning payment rates across ambulatory settings.⁵³ Taking steps toward site neutral payments can reduce the incentive to consolidate and to continue providing care in expensive settings.

⁵³ June 2023 Report to the Congress: Medicare and the Health Care Delivery System.

Figure 1. International Medical Prices for Selected Services as a Percentage of U.S. Price



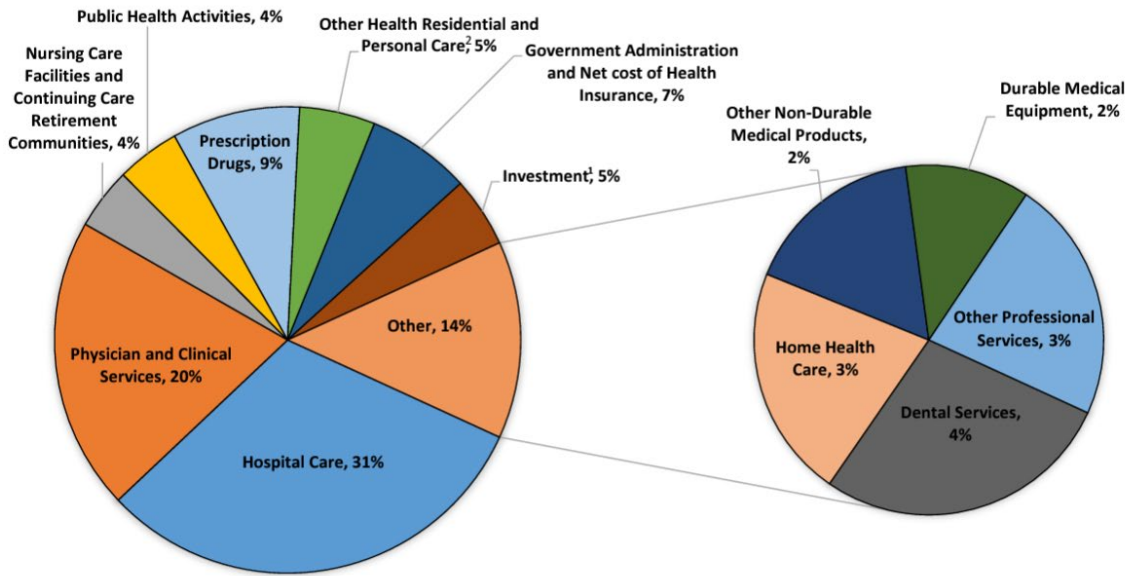
Source: Adapted from Hargraves and Bloshchikak (2019) using International Federation of Health Plans (IFHP) data.
 Notes: Data are from IFHP member companies in eight countries. International service price comparisons are complicated by potentially different service definitions, reimbursement arrangements, and health plan participation across countries.



Source: Chernew, ME, Dafny, LS, Pany, MH. “A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market,” *Policy Proposal 2020-08*, The Hamilton Project, Brookings Institute, March 2020. The chart compares the median prices paid by a sample of private health insurance companies for specific health care services in nine countries.

Figure 2. U.S. Health Care Spending, By Category, 2021

**THE NATION'S HEALTH DOLLAR (\$4.3 TRILLION), CALENDAR YEAR 2021:
WHERE IT WENT**

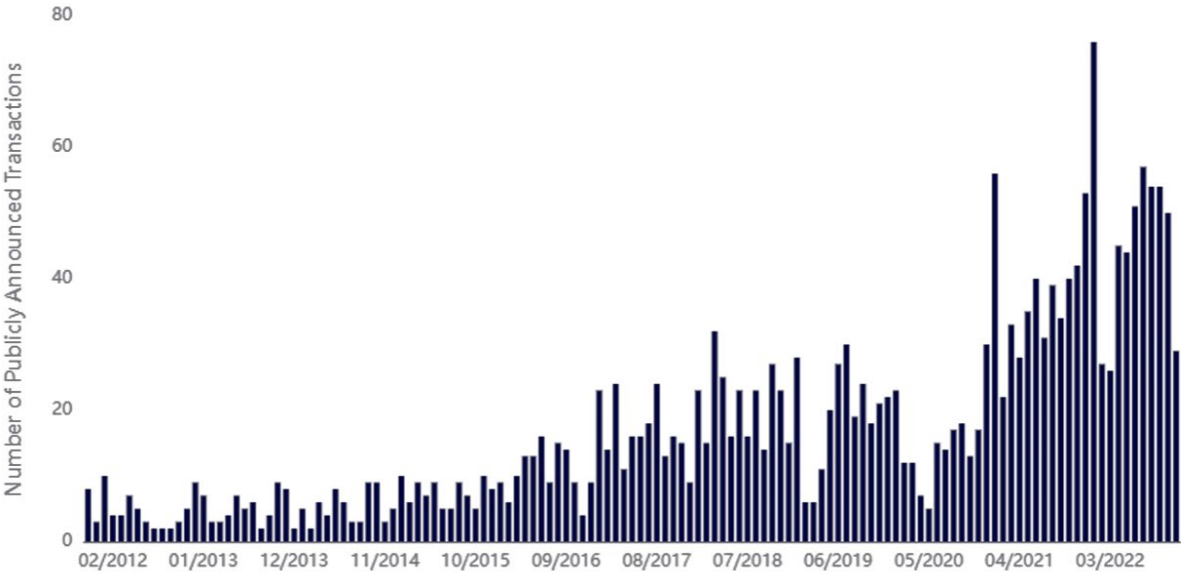


¹ Includes Noncommercial Research and Structures and Equipment.

² Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid. Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Figure 3. Physician Group Mergers and Acquisitions by Month, 2012-2022



Source: *Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis - Report One*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 2023, Figure 3-3 p. 18. Original Data Source, LevinPro HC, Levin Associations, December 2022.