U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

February 12, 2018

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Examining the Impact of Health Care Consolidation."

I. Introduction

The Subcommittee on Oversight and Investigations will hold a hearing on Wednesday, February 14, 2018, at 10:15 a.m. in 2322 Rayburn House Office Building. The hearing is entitled "Examining the Impact of Health Care Consolidation." The purpose of this hearing is to examine consolidation trends in the health care sector, the reasons behind those trends, and the effects they have on the cost and quality of care.

II. Witnesses

- Martin Gaynor, Ph.D., E.J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University;
- Leemore Dafny, Ph.D., Bruce V. Rauner Professor of Business Administration, Harvard Business School; and
- Kevin A, Schulman, M.D., Professor of Medicine, Gregory Mario and Jeremy Mario Professor, Duke University, Visiting Scholar, Harvard Business School.

III. Background

A. Health Care Expenditures

In 2016, U.S health care spending was estimated to be about $3.3 trillion, and the overall share of gross domestic product (GDP) related to health care spending was 17.9 percent (up from 17.7 percent in 2015).[1] According to the Centers for Medicare and Medicaid Services (CMS), 32 percent of the $3.3 trillion in expenditures was spent on hospital care, 20 percent was spent on physician and clinical services, 14 percent was spent on other (including, but not limited to home health care and durable medical equipment), 10 percent was spent on prescription drugs, 8 percent was spent on government administration and net cost of health insurance, 5 percent was spent on nursing care facilities and continuing care retirement communities, 5 percent was spent

[1] U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, *National Health Expenditures 2016 Highlights* (Dec. 2017), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf.

on investment, and 4 percent was spent on dental services.[2] The majority—75 percent—of the $3.3 trillion in expenditures was paid for by health insurance (34 percent by private health insurance, 20 percent by Medicare, 17 percent by Medicaid, and 4 percent by the U.S. Department of Veterans Affairs (VA), the U.S. Department of Defense (DOD), and the Children's Health Insurance Program (CHIP)).[3]

According to a Kaiser Family Foundation analysis of National Health Expenditure data released by CMS, total health expenditures have increased substantially over the past several decades.[4] Indeed, data released by CMS indicates that total health expenditures in the U.S. were about $721 billion in 1990, $1.4 trillion in 2000, $2.4 trillion in 2008, and $3.3 trillion in 2016.[5] Moreover, on a per capita basis, health spending has also grown—increasing from $8,412 in 2010 to $10,348 in 2016.[6] Although health care expenditures have continued to increase at a rapid pace, U.S. health care spending increased in 2016 at a slower rate than in previous years (in 2016, spending on health care increased by 4.3 percent compared to 5.1 percent in 2014 and 5.8 percent in 2015).[7]

Many different factors influence health care spending, including, but not limited to, population aging, prices, policy changes, and public and private initiatives.[8] In June 2017, the Medicare Payment Advisory Commission (MedPAC) reported that certain types of consolidation in the health care industry may contribute to higher commercial prices for health care and results in increased health care costs for Medicare and commercial insurers.[9] MedPAC noted that "[m]arkets with greater physician-practice consolidation have had greater increases in physician prices" and "[c]ommercial insurers also pay higher rates to hospitals with greater market power."[10] The Commission has expressed concerns that the market concentration effects of

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[2] U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, *The Nation's Health Dollar ($3.3 Trillion), Calendar Year 2016: Where it Came From, Where it Went* (Dec. 2017), *available at* https://www.cms.gov/Research-Statistics-Data-and -Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/PieChartSourcesExpenditures.pdf.
[3] *Id*.
[4] Rabah Kamal and Cynthia Cox, Peterson-Kaiser Health System Tracker, *How has U.S. spending on health care changed over time?* (Dec. 20, 2017), *available at* https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-total-health-expenditures-increased-substantially-past-several-decades_2017.
[5] *Id*.
[6] *Id*.
[7] Micah Hartman, et al., *National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions*, HEALTH AFFAIRS, Vol. 37, No. 1 (Dec. 6, 2017), *available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1299.
[8] Aaron C. Catlin and Cathy A. Cowan, *History of Health Spending in the United States, 1960-2013* (Nov. 19, 2015), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf; Sean P. Keehan, et al., *National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy*, HEALTH AFFAIRS (Mar. 2017), *available at* https://www.ssc.wisc.edu/~gwallace/Papers/Health%20Aff-2017-Keehan-hlthaff.2016.1627%20(1).pdf.
[9] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 10: Provider Consolidation: The Role of Medicare Policy* (June 2017).
[10] Medicare Payment Advisory Commission (MedPAC) Staff, *Why Have Medicare Costs Grown So Much Slower Than the Costs of Employer-Sponsored Insurance?* (Sept. 11, 2017), *available at* http://medpac.gov/-blog-/why-

provider consolidation may lead to increased Medicare spending if commercial prices are "imported" into the program.[11]

B. Health Care Consolidation

i. Overview

There has been consolidation in the health care industry for decades.[12] Consolidation can occur in a variety of different ways, including horizontal and vertical mergers of hospitals, physicians, health insurers, pharmaceutical companies, pharmaceutical benefit managers, pharmacies, and other stakeholders. While there can be efficiencies from consolidation, including reducing duplicative services and improving the quality of care, consolidation also can increase the market power of certain firms and result in increased prices or reduced quality of care.[13] Some experts have raised concerns about increased consolidation in certain parts of the health care industry and its impact on competition. For example, in May 2016, the former Chairwoman of the Federal Trade Commission (FTC), Edith Ramirez, expressed concerns about the "rapid rate of consolidation among healthcare providers."[14] Moreover, in October 2017, the Trump Administration issued an Executive Order to foster greater competition in the health care markets and directing the Administration to "continue to focus on promoting competition in healthcare markets and limiting excessive consolidation throughout the healthcare system."[15]

Many segments of the health care market are highly concentrated—one researcher found that, in 2016, 90 percent of Metropolitan Statistical Areas were highly concentrated for hospitals, 65 percent for specialist physicians, 39 percent for primary care physicians, and 57 percent for insurers.[16] According to Kaufman Hall, there were 115 transactions involving hospitals and health systems in 2017—a thirteen percent increase since 2016 and the highest amount in recent history.[17] Although the number of transactions in 2017 involving hospitals and health systems

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have-medicare-costs-grown-so-much-slower-than-the-cost-of-employer-sponsored-insurance/2017/09/11/why-have-medicare-costs-grown-so-much-slower-than-the-cost-of-employer-sponsored-insurance.

[11] *Id*.

[12] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 10: Provider Consolidation: The Role of Medicare Policy*, at 295 (June 2017).

[13] American Hospital Association, *Hospital Mergers: Foundation for a Modern, Efficient and High-Performing Health Care System of the Future* (Jan. 2017); Martin Gaynor, E.J. Barone Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University, *Statement before the Committee on Ways and Means Health Subcommittee, U.S. House of Representatives* (Sept. 9, 2011), *available at* https://waysandmeans.house.gov/UploadedFiles/Gaynor_Testimony_9-9-11_Final.pdf.

[14] Federal Trade Commission, *Keynote Address of FTC Chairwoman Edith Ramirez, Antitrust in Healthcare Conference* (May 12, 2016), *available at* https://www.ftc.gov/system/files/documents/public_statements/950143/160519antitrusthealthcarekeynote.pdf.

[15] Exec. Order 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017), *available at* https://www.gpo.gov/fdsys/pkg/FR-2017-10-17/pdf/2017-22677.pdf.

[16] Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFFAIRS, Vol. 36, No. 9 (Sept. 2017).

[17] Kaufman Hall, *2017 in Review: The Year M&A Shook the Healthcare Landscape* (2018), *available at* https://www.kaufmanhall.com/sites/default/files/2017-in-Review_The-Year-that-Shook-Healthcare.pdf.

was similar to the number of transactions in 2015, the aggregated revenue of the transacted organizations was almost double.

Deals Among Hospitals and Health Systems[18]

Year	Transacted Revenue ($ billions)	Number of Transactions
2017	$63,186	115
2016	$31,288	102
2015	$32,028	112
2014	$23,098	102
2013	$31,328	98

In addition to hospital and health system mergers, there has been consolidation in other parts of the health care industry as well. Physician groups, health insurers, pharmaceutical companies, pharmaceutical benefit managers (PBMs), pharmacy services, and other stakeholders have engaged in vertical and horizontal integration.[19] Following mergers within the PBM industry over the past decade, the largest three PBMs accounted for more than 70 percent of market revenues in 2016.[20] Over the past few years, there have been many mergers and acquisitions in the pharmaceutical industry too. According to an April 2017 report by IBIS World, the four largest brand name pharmaceutical manufacturers accounted for over 40 percent of total industry revenue.[21] Similarly, according to a March 2017 report by IBIS World, the top three generic pharmaceutical manufacturing companies in the United States accounted for 21.6 percent of industry revenue in 2017.[22]

To provide a brief overview of some of types of consolidation in the hospital, physician, and insurance markets, the next two sections of this memorandum discuss three examples of horizontal and vertical integration, including: (1) horizontal hospital integration; (2) vertical hospital-physician integration; and (3) horizontal insurer integration. This list is not provided as an exhaustive list of the different types of consolidation occurring in the health care industry.

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[18] *Id*.
[19] *See e.g*., Federal Trade Commission, Health Care Division, Bureau of Competition, *Overview of FTC Actions in Health Care Services and Product*s (Sept. 2017); Federal Trade Commission, Health Care Division, Bureau of Competition, *Overview of FTC Actions in Pharmaceutical Products and Distribution* (Sept. 2017).
[20] Evan Hoffman, *IBISWorld Industry Report OD4620: Pharmacy Benefit Management in the US*, IBISWORLD (Nov. 2016).
[21] Kelsey Oliver, *IBISWorld Industry Report 32541a: Brand Name Pharmaceutical Manufacturing in the US*, IBISWORLD (April 2017).
[22] Kelsey Oliver, *IBISWorld Industry Report 32541b: Generic Pharmaceutical Manufacturing in the US*, IBISWORLD (Mar. 2017); *See also* Marc-Andre Gagnon and Karen D. Volesky, *Merger mania: mergers and acquisitions in the generic drug sector from 1995 to 2016, Globalization and Health* (2017), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5567637/pdf/12992_2017_Article_285.pdf.

ii. Hospital and Hospital-Physician Consolidation

Hospitals and providers have been merging for decades.[23] According to Irving Levin Associates, Inc., there were 1,412 hospital deals involving 3,009 total hospitals from 1998 to 2015.[24] Although the number of announced hospital mergers and acquisitions stayed relatively consistent between 2002 and 2009 with fewer than 60 transactions a year, the number of announced hospital mergers per year began to increase following the Affordable Care Act.[25]

Announced Hospital Mergers and Acquisitions, 1998-2015[26]

Year	Number of Deals
1998	139
1999	110
2000	86
2001	83
2002	58
2003	38
2004	59
2005	51
2006	57
2007	58
2008	60
2009	52
2010	72
2011	93
2012	107
2013	88
2014	99
2015	102

Over the past ten years, hospitals have also acquired a significant number of physician practices. According to a 2015 report by the Government Accountability Office (GAO), the number of vertically consolidated hospitals increased from about 1,400 in 2007 to 1,700 in 2014, and the number of vertically consolidated physicians nearly doubled during that same period

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[23] Federal Trade Commission, *"Hospital Consolidation: The Good, The Bad, and The Ugly," Keynote Address by Maureen K. Ohlhausen, Commissioner, Federal Trade Commission* (Mar. 13, 2013), *available at* https://www.ftc.gov/system/files/documents/public_statements/115852/130313hospitalconsolidationspeech.pdf.
[24] American Hospital Association, *Trendwatch Chartbook 2016 Organizational Trends, Chart 2.9: Announced Hospital Mergers and Acquisitions, 1998-2015* (2016), *available at* https://www.aha.org/system/files/research/reports/tw/chartbook/2016/chart2-9.pdf.
[25] *Id.*; *See also* Matt Schmitt, *Do Hospital Mergers Reduce Costs?*, UCLA ANDERSON (Jan. 16, 2017), *available at* https://pdfs.semanticscholar.org/0005/6b7e6d5e18a0fa38e0747265e86b277ff368.pdf.
[26] American Hospital Association, *Trendwatch Chartbook 2016 Organizational Trends, Chart 2.9: Announced Hospital Mergers and Acquisitions, 1998-2015* (2016); *See also* Leemore Dafny, Ph.D., *Hospital Industry Consolidation – Still More to Come?*, NEW ENGLAND JOURNAL OF MEDICINE (Jan. 16, 2014).

from about 96,000 to 182,000.[27] Similarly, from 2007 to 2013, Medicare spending in hospital outpatient departments (HOPDs) increased, rising at an annual rate of 8.3 percent—substantially faster than the 5.8 percent growth rate in total Medicare Part B spending.[28] In November 2017, an analysis by Avalere Health showed that the number of physicians employed by hospitals increased by 49 percent between 2012 and 2015.[29]

Hospitals and providers have many arguments justifying consolidation, including improved coordination, enhanced efficiencies, reduced costs of capital, economies of scale, elimination of duplicative services, reduced regulatory burdens and practice management responsibilities for physicians, reduced regulatory costs, expanded scope of services available to patients, and improved quality of care.[30] At the same time, some research shows that consolidation of certain providers and hospitals may increase the cost of care and does not necessarily improve quality.

- In June 2017, MedPAC reported that hospital markets are highly consolidated. MedPAC wrote,

  > The literature generally finds that horizontal hospital consolidation leads to higher inpatient prices. Gaynor and colleagues summarize the findings: 'Mergers between rival hospitals are likely to raise the price of inpatient care and these effects are larger in concentrated markets. The estimated magnitudes are heterogenous and differ across market settings, hospitals, and insurers' (Gaynor et al. 2014).[31]

  On the impact of vertical physician-hospital consolidation on price, MedPAC stated that:

  > Vertical physician-hospital consolidation increases both commercial and Medicare prices paid for physician services. Commercial physician prices can increase because of the market power of the hospitals owning the practices. Medicare prices increase as the program pays a physician fee and a hospital facility fee for an office visit that would have been paid only a physician fee if the visit had been provided in a freestanding physician office.[32]

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[27] U.S. Gov't Accountability Office, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform*, GAO-16-189 (Dec. 2015).
[28] *Id*. at 1.
[29] Physician Advocacy Institute, *Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, Analysis by Avalere Health*, LLC (Nov. 2017), *available at* http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI_Medicare%20Cost%20Analysis%20--%20FINAL%2011_9_17.pdf.
[30] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 10: Provider Consolidation: The Role of Medicare Policy*, at 290 (June 2017); American Hospital Association, *Hospital Mergers: Foundation for a Modern, Efficient and High-Performing Health Care System of the Future* (Jan. 2017).
[31] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 10: Provider Consolidation: The Role of Medicare Policy*, at 299 (June 2017).
[32] *Id*.

With respect to provider consolidation, MedPAC indicated that,

> [T]he literature fails to find strong evidence that financial consolidation consistently leads to lower costs or higher quality (Burns et al. 2013, Gaynor and Town 2012b, Gaynor et al. 2017). While some integrated entities report strong cost or quality performance, in other cases, systems may financially integrate for the tangible financial benefits of market power and Medicare facility fees rather than a cultural commitment to affordable integrated care.[33]

- In 2018, research from the Kellogg School of Management at Northwestern University found that "from 2007 to 2013, almost 10 percent of physician practices in the [insurance-company data that they acquired for the study] were acquired by a hospital. Once acquired, prices for the services provided by those physicians rose an average of 14 percent."[34] The researchers also found that the "way the laws are currently written and enforced, the antitrust agency is unlikely *to even know* about the increases in provider concentration."[35]

- In 2016, Milliman examined the cost of cancer care and found that one "trend contributing to the increase in cancer care costs has been the shift in the site of chemotherapy infusion deliver from generally lower-cost physician office settings to generally higher-cost hospital outpatient settings."[36]

Federal and state policies can impact a hospital and a physician group's decision regarding whether to vertically integrate by providing financial, or other, incentives to consolidate.[37] For example, historically, the Medicare program's Hospital Outpatient Prospective Payment System (HOPPS) paid more for the same services provided at hospital outpatient departments than in other settings, such as a physician office or ambulatory surgery center.[38] Some experts argued that the payment differential accelerated consolidation of

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[33] *Id*. at 290.
[34] Cory Capps, David Dranove, and Christopher Ody, *When Healthcare Providers Consolidate, Medical Bills Rise*, Kellogg Insight (Feb. 1, 2018), *available at* https://insight.kellogg.northwestern.edu/article/when-healthcare-providers-consolidate-medical-bills-rise.
[35] *Id*.
[36] Kathryn Fitch, RN, Med, Pamela M. Pelizzari, MPH, and Bruce Pyenson, FSA, MAAA, *Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014*, Commissioned by the Community Oncology Alliance, MILLIMAN (Apr. 2016), *available at* http://www.siteneutral.org/wp-content/uploads/2016/06/1_COA-Study.-Cost-Drivers-of-Cancer-Care.pdf.
[37] *See*, *e.g.*, Martin Gaynor, H. John Heinz III College, Carnegie Mellon University, Farzad Mostashari, Aledade, Inc., Paul Ginsburg, The Brookings Institution, University of Southern California, *Making Health Care Markets Work: Competition Policy for Health Care, Actionable Policy Proposals for the Executive Branch, Congress, and the States* (April 2017), *available at* https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/.
[38] *See* Letter from Fred Upton, Chairman, H. Committee on Energy and Commerce, and Joseph R. Pitts, Chairman, Subcommittee on Health, H. Committee on Energy and Commerce, to Member of the Health Care Community, 114th Congress (Feb. 5, 2015).

providers, while other stakeholders questioned the concerns about consolidation.[39] In 2015, GAO examined Medicare payment policies and concluded that "regardless of what has driven hospitals and physicians to vertically consolidate, paying substantially more for the same services when performed in an HOPD rather than a physician office provides an incentive to shift services that were once performed in physician offices to HOPDs after consolidation has occurred."[40] In 2015, Congress enacted the Bipartisan Budget Act and moved toward partially equalizing rates between new off campus hospital outpatient departments and physician practices.[41] MedPAC continues to recommend that Congress establish site-neutral payments for all sites of care to protect the Medicare program from the cost of physician-hospital consolidation.[42]

Another federal policy that may create incentives for certain types of hospital-physician consolidation is the 340B Drug Pricing Program (340B program).[43] For example, a 2018 article published in the New England Journal of Medicine found that: "[t]he 340B Program has been associated with hospital-physician consolidation in hematology-oncology and with more hospital-based administration of parenteral drugs in hematology-oncology and ophthalmology."[44] Similarly, a 2017 report issued by the National Academies Press described how the 340B program may act to encourage consolidation of health care providers:

> For example, hospital-affiliated outpatient practices that qualify for 340B discounts can purchase drugs at reduced costs while still receiving full reimbursement for them in addition to their ability to charge facility fees. Conversely, community oncology practices that do not qualify for 340B discounts operate on lower per person-per treatment margins derived from the administration of the drugs they purchase, including the revenue generated off buy and bill reimbursements and the ability to charge facility fees (Polite et al., 2014). These disparities in revenue-generating incentives may act to encourage the consolidation of health care providers (baker et al., 2014; Cutler and Scott-Morgan, 2013). For example, there has been significant growth in 340B eligibility among outpatient clinics affiliated with 340B participating hospitals preceding and following [the Patient Protection and Affordable Care Act] implantation. As a result, GAO estimates that 340B

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[39] *Id*.
[40] U.S. Gov't Accountability Office, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform*, GAO-16-189 (Dec. 2015).
[41] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 10: Provider Consolidation: The Role of Medicare Policy*, at 305 (June 2017).
[42] *Id*. at 292 & 305.
[43] *See, e.g*., Martin Gaynor, H. John Heinz III College, Carnegie Mellon University, Farzad Mostashari, Aledade, Inc., Paul Ginsburg, The Brookings Institution, University of Southern California, *Making Health Care Markets Work: Competition Policy for Health Care, Actionable Policy Proposals for the Executive Branch, Congress, and the States*, at 12 (April 2017).
[44] Sunita Desai, Ph.D and J. Michael McWilliams, M.D., Ph.D, *Consequences of the 340B Drug Pricing Program*, THE NEW ENGLAND JOURNAL OF MEDICINE (Feb. 9, 2018).

discounts apply to 50 percent of cancer drugs sold and paid for by Medicare part B (GAO, 2015).[45]

iii. Insurer Consolidation

The landscape of competition in the health insurance industry has changed over the years and there has been a significant amount of consolidation in the market—the estimated national market share of the largest four insurers increased from 74 percent in 2006 to 83 percent in 2014.[46] Because health insurance generally operates within different regions, competition in the health insurance market is best examined by analyzing local market concentration.[47] According to a study released by the American Medical Association, in 2016, 43 percent of Metropolitan Statistical Areas had at least one insurer with at least a 50 percent share of the market.[48] Similarly, according to the Kaiser Family Foundation, enrollment in Medicare Advantage is highly concentrated in a limited number of companies in both national and local markets.[49] For example, in 2015, four insurers controlled 61 percent of the Medicare Advantage market nationally.[50] Likewise, in 2014, Avalere Health found that there was significant consolidation in the number of Medicare Part D standalone prescription drug plans (PDPs) and that offerings would decrease by approximately 14 percent in 2015 due to consolidation of offerings by the main plan sponsors—from 1,169 PDPs in 2014 to 1,001 PDPs in 2015.[51] In 2017, MedPAC reported that "[i]n 2017, plan sponsors are offering 746 PDPs, a 16 percent decrease from 2016, and 1,734 [Medicare Advantage Prescription Drug Plans (MA-

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[45] National Academies Press, *Making Medicines Affordable: A National Imperative*, Pre-publication Copy at 113 (Nov. 2017).

[46] Leemore Dafny, Ph.D, Professor of Strategy, Herman Smith Research Professor of Hospital and Health Services, Director of Health Enterprise Management, Kellogg School of Management, Northwestern University, Before the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights on *"Health Insurance Industry Consolidation: What Do We Know From the Past, Is it Relevant in Light of the ACA, and What Should We Ask?"* (Sept. 22, 2015), *available at* https://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[47] Martin Gaynor, H. John Heinz III College, Carnegie Mellon University, Farzad Mostashari, Aledade, Inc., Paul Ginsburg, The Brookings Institution, University of Southern California, *Making Health Care Markets Work: Competition Policy for Health Care, Actionable Policy Proposals for the Executive Branch, Congress, and the States*, at 12 (April 2017).

[48] Andis Robeznieks, *Health insurance markets are highly concentrated, new report reveals*, AMERICAN MEDICAL ASSOCIATION NEWS (Oct. 23, 2017), *available at* https://wire.ama-assn.org/ama-news/health-insurance-markets-are-highly-concentrated-new-report-reveals.

[49] Gretchen Jacobson, Anthony Damico, Tricia Neuman, *Medicare Advantage 2017 Spotlight: Enrollment Market Update* (Jun. 6, 2017), *available at* https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/.

[50] Leemore Dafny, Ph.D, Professor of Strategy, Herman Smith Research Professor of Hospital and Health Services, Director of Health Enterprise Management, Kellogg School of Management, Northwestern University, Before the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights on *"Health Insurance Industry Consolidation: What Do We Know From the Past, Is it Relevant in Light of the ACA, and What Should We Ask?"* (Sept. 22, 2015), *available at* https://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[51] Kelly Brantley, *Avalere Analysis Reveals Significant Consolidation Amoung PDPs*, AVALERE (Sept. 22, 2014), *available at* http://avalere.com/expertise/managed-care/insights/avalere-analysis-reveals-significant-consolidation-among-pdps/.

PDs)], a 3 percent increase from 2016. PDP reductions reflect mergers and acquisitions among plan sponsors as well as consolidation of plan offerings into fewer, more widely differentiated products."[52] MedPAC also reported, however, that beneficiaries continue to have broad choice among plans.[53]

C. Federal Trade Commission and Department of Justice

Antitrust authorities, including the FTC and the Department of Justice (DOJ), are best positioned to investigate and challenge horizontal mergers of providers that supply similar services in geographic proximity.[54] The FTC was initially unsuccessful in challenging provider mergers in the 1990s.[55] As a result, FTC utilized economists to review past hospital mergers after federal courts relied on broad geographic markets to thwart FTC and DOJ merger challenges.[56]

The FTC now focuses on "whether a merger is likely to affect the ability of an *insurer*—the company directly paying for the services—to avoid a price increase by excluding the hospitals in a given geographic area from its network of providers."[57] For example, since 2013, there have been multiple appellate court decisions "validating the [FTC's] approach to analyzing virtually every aspect of provider combinations, from market definition to competitive effects, failing firms, and efficiencies."[58]

Recently, the DOJ successfully blocked merger deals between Anthem Inc. and Cigna Corporation and between Aetna Inc. and Humana Inc.[59] According to DOJ's press release regarding the Anthem-Cigna merger, the merger would have "stifled competition, harming consumers by increasing health insurance prices and slowing innovation aimed at lower the costs of healthcare."[60] Similarly, according to DOJ's press release regarding the Aetna-Humana merger, the merger would have "stifled competition and led to higher prices and lower quality health insurance."[61] Because DOJ's actions blocking these mergers seems to have halted large-scale mergers of health insurers, some analysts have speculated that the new focus will likely be on vertical integration—"a merging of health care functions among providers, payers, care management, and finance."[62]

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[52] Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy, Chapter 14: Status report on the Medicare prescription drug program (Part D)* (Mar. 2017).
[53] *Id.*
[54] *See* Deborah L. Feinstein, Director, Bureau of Competition, FTC, *Remarks at AAI Healthcare Roundtable* (Feb. 22, 2017), *available at* https://www.ftc.gov/system/files/documents/public_statements/1120623/feinstein_aai_speech_2-22-17.pdf.
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] A.M. Best Company, *Best's Briefing, Market Segment Outlook: U.S. Health* (Jan. 2, 2018).
[60] U.S. Dep't of Justice, Office of Public Affairs, *U.S. District Court Blocks Anthem's Acquisition of Cigna* (Feb. 8, 2017), *available at* https://www.justice.gov/opa/pr/us-district-court-blocks-anthem-s-acquisition-cigna.
[61] U.S. Dep't of Justice, Office of Public Affairs, U*.S. District Court Blocks Aetna's Acquisition of Humana* (Jan. 23, 2017), *available at* https://www.justice.gov/opa/pr/us-district-court-blocks-aetna-s-acquisition-humana.
[62] A.M. Best Company, *Best's Briefing, Market Segment Outlook: U.S. Health* (Jan. 2, 2018).

IV. Issues

The following issues may be examined at the hearing:

- Why is consolidation occurring in the health care market?
- What sectors of the health care market has seen the most amount of consolidation?
- What is the impact of consolidation on patients and innovation?
- Are there any federal laws or policies that incentive consolidation in the health care market?

V. Staff Contacts

If you have any questions regarding the hearing, please contact Natalie Turner, Lamar Echols, or Jen Barblan of the Committee staff at (202) 225-2927.