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On

"Examining Healthcare Markets: Fraud and Competition."

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Chairman Fitzgerald, Ranking Member Nadler, and distinguished members of the Subcommittee:

My name is Brian Miller, and I practice hospital medicine at the Johns Hopkins Hospital. As an academic health policy analyst, I serve as an Associate Professor of Medicine and Business (Courtesy) at the Johns Hopkins University School of Medicine and as a Visiting Fellow at the Hoover Institution. My research focuses on how we can build a more competitive and vibrant health sector to make healthcare more efficient, flexible, and personalized for patients. This perspective is based upon my prior regulatory experience at four federal regulatory agencies. Through my current role as a faculty member, I regularly engage with regulators, policymakers, and businesses in search of solutions to help create a better healthcare system for all. Today I am here in my personal capacity, and the views expressed are my own and do not necessarily reflect those of the Johns Hopkins University, the Johns Hopkins Health System, the Hoover Institution, the North Carolina State Health Plan or the Medicare Payment Advisory Commission.

Monopoly and its younger cousin, consolidation, remain a serious, pressing, persistent concern. Many healthcare markets are highly consolidated, resulting in a loss of price and non-price competition for consumers, employers, workers, and taxpayers. Competition counts. While price competition is critical to a functioning marketplace, the loss of non-price competition often explains many of the additional concerns that consumers and all of us patients experience: the lack of meaningful improvement in medical quality in many service areas, declining consumer experience/convenience, and persistent unsolved basic clinical operational challenges. Monopoly and regulation together protect incumbency and foreclose market-driven incremental improvement and revolutionary change through the removal of incentives to compete.

Through a variety of policy choices, government has at times placed its foot firmly on the accelerator in favor of consolidation. In other circumstances, the government has banned or severely restricted market entry, placing a heavy brake on competition and replacing it with statutory prohibition or regulation. Neither of these is an adequate substitute for competition.

In my testimony today, I will focus on three areas:
1. **Hospital consolidation scope and impacts**
2. **Drivers of hospital consolidation**
3. **State and federal law and regulatory policy changes to promote competition**

1. Hospital Consolidation Scope and Impacts

Scope of Hospital Consolidation

The scope of the problem is significant in scale. With over 2,000 mergers over the past 25 years,[1] the share of independent hospitals has declined from 90% in 1970 to 32% in 2019[2] all amidst the growth of mostly tax-exempt

health systems.[3] In 2024, in 47% of metropolitan areas, 1 or 2 health systems controlled the entire market for inpatient hospital care while in 83% of markets 1 or 2 health systems controlled more than 75% of the market. To make matters worse, 97% of metro areas were highly concentrated markets (as defined by the Department of Justice Antitrust Division) for inpatient care.[4] Locally, according to the Yale Health Care Affordability Lab, 71.2% of North Carolina hospitals are in highly concentrated or monopoly markets, with 25 hospitals operating as pure monopolies.[5]

Hospital-hospital consolidation is only the beginning. Physician consolidation into hospitals has resulted in increased prices, a loss of non-price competition, and no systematic measurable, durable gains in quality or patient experience. An estimated 82% of physicians are employed by hospitals or corporate entities and 63.9% are owned by the same.[6] For hospitals specifically, according to the Government Accountability Office (GAO) an estimated 47% of physicians were consolidated into hospital systems in 2024, up from 30% in 2012.[7] Other researchers have found that the most commonly integrated specialties (hematology-oncology, cardiology, and general surgery) are those associated with the delivery of lucrative hospital services.[8] The American Medical Association (AMA) physician benchmark survey validates many of these findings of shifting employment models, with physician employment in private practice declining from 60.2% in 2012 to 42.2% in 2024.[9]

Market ossification from consolidation is a problem worsened in rural markets. Researchers have found that rural hospital system affiliation results in decreased obstetric care, primary care, and on-site imaging all while increasing margins without any accompanying change in patient experience scores or hospital readmissions.[10] Further empirical work replicates the decrease in access to obstetric care,[11] a concerning finding. Some policy analysts have argued that rural health challenges result purely from financial distress. Empirical research demonstrates otherwise: while financial distress is a predictor of mergers, 77% of unprofitable rural hospitals over an eight-year period continued to operate. This study unintentionally highlights many challenges, including arguably relatively lax financial reporting standards for tax-exempt entities compared to their for-profit counterparts, and the misalignment of booked net income as opposed to cash flow margins from operating activities.

Price Harms of Hospital Consolidation

The loss of competition has both price and non-price impacts: we consider each in turn. Empirical research consistently demonstrates that hospital mergers – including in disparate geographies – result in higher prices and hence higher insurance premiums. Tax status is immaterial in terms of organizational behavior regarding prospective mergers: tax-exempt hospitals also exercise market power in the form of higher prices,[12,13] a finding no different than tax-paying, for-profit hospitals. Beyond in-market mergers, cross-market, in-state hospital mergers yield price increases of 7-9%,[14] and out-of-market acquisitions result in 17% price increases;[15] both types of transaction are becoming more common.[16] With hospital spending accounting for 40% of the growth in national health spending from 2022 to 2024,[17] scrutiny of hospital consolidation is imperative.

Hospital-physician mergers (frequently viewed as a vertical transaction) also result in higher prices. While not all vertical integration across the healthcare supply chain are uniformly harmful, hospital-physician mergers again have consistent evidence that they produce higher prices and hence higher premiums. Research has found that hospital acquisition of physician practices was associated with price increases of 14.1% post-acquisition, a number that grew when the hospital had a larger share of the inpatient market. Even the integration of primary care physicians increased spending by 4.9%.[18] Generally, hospital acquisition of physician practices increased prices, and spending was entirely driven by price increases with little change in utilization.[19] Finally, and arguably most critically, although insurance shields consumers from many of these costs directly, consolidation-driven price increases reach them through higher premiums: hospital acquisition of physician practices was associated with a 12% increase in Affordable Care Act (ACA) marketplace premiums[20] with another study further supporting the assertion that care delivery consolidation increases health insurance premiums.[21] A Medicare Payment Advisory Commission (MedPAC) literature review likewise found that hospital consolidation drives higher prices and that government policy such as the lack of site neutral payment drove hospital acquisition of physician practices.[22]

Non-Price Harms of Hospital Consolidation

In addition to and equal in importance to the harms of diminishing price competition, the loss of non-price competition harms consumers, purchasers, and workers in a variety of ways. Despite claims to the contrary, hospital mergers do not improve quality, with a study of 246 acquired hospitals compared to controls over a decade demonstrating no change in critical outcomes such as 30-day readmission rates or mortality – and even

demonstrating minor decrements in patient experience.[23] A subsequent review of 30 years of evidence found no clear pattern that hospital mergers improve quality,[24] a finding replicated by a second systematic review.[25]

Consumer and provider experience also represent significant non-price competition losses from hospital consolidation. Functionally, hospital-hospital and hospital-physician mergers exercise control over and limit or distort patient choice, with research demonstrating that hospital ownership of a physician increased the probability that the patient would select the owning hospital, and more likely a high-cost, low-quality hospital.[26] Furthermore, the loss of small providers may make accessing care more difficult for important, vulnerable, high-cost populations. Small practices may be easier for patients to navigate, especially those with multi-morbidity, and may offer greater care and access customization potentially serving patients with disabilities, special needs, or higher illness acuity.

Non-price competitive losses also encompass provider experience and the loss of choice and oversight over the clinical practice environment. Large health systems offer less flexibility, with a direct loss of clinical independence and externalization of the locus of control over clinical operations and even at times clinical decision-making. The tradeoffs are real, with externalization of the locus of control well-associated with burnout and loss of clinician compassion.[27] Burnout is also predictive of physician elective reduction in workload, further constraining supply.[28] In 2023, half of all physicians suffered from symptoms of burnout making this a meaningful concern.[29] Other workforce impacts are also worth noting, with the marketplace experiencing a move from physicians as small business owners to a largely employed workforce. An estimated 35.5% of physicians were owners in 2024 down from 53.2% in 2012, with 49.2% of private practices as having fewer than five physicians compared to 16.1% for hospitals – with one-third of hospital practices being larger than 50 physicians,[30] an assessment largely independently validated by the Physician Advocacy Institute.[31] The transition to a hospital-employed physician workforce results in a world akin to "Severance," with a new generation of employed physicians experiencing deep feelings of depersonalization, alienation, and disempowerment through dehumanization and excessive administrative control.

Non-price competition impacts are not limited to physicians. The hospital industry is a textbook example of employers using market power to reduce nurse wages. Recent work in the *American Economic Review* found that when hospital mergers increase local employer concentration, wages go down. For mergers in the top quartile of concentration increases, researchers estimated that wages for nursing and pharmacy workers were 6.8% lower four years after the merger than they otherwise would have been.[32] Other researchers replicated this, finding that increased hospital-system concentration in smaller metropolitan statistical areas is associated with slower real nursing wage growth with a 0.10 increase in market concentration associated with about a $0.70 reduction in real hourly nurse wage growth in smaller metropolitan areas.[33]

2. Policy drivers of hospital consolidation

Federal Policy Incentivizes Consolidation

Hospital consolidation results primarily from policy incentivizing consolidation and additional policy blocking market entry.

Federal policy unfortunately incentivizes and at times directly drives consolidation. On a first principles basis, payers should fund the right service for the right patient at the right time in the right setting by the right person. This also means that payers should not pay differential rates for the same service for non-clinical reasons – that is, if a colonoscopy has a defined cost and a patient chooses to undergo it in an ambulatory surgery center setting or a hospital outpatient department (HOPD), it should cost the same. The same argument applies to many other outpatient services, when comparing their completion in an HOPD versus a physician office. Unfortunately, the lack of site neutral payment in the Medicare program creates an opportunity for regulatory arbitrage to drive both increased payment and increased market power. [34] Because HOPDs are paid under a distinct payment system than freestanding clinics that results in higher rates for the same clinical service, hospitals have an economic rationale to acquire clinics and bill at the higher rate.

Congress recognized this and, in the Bipartisan Budget Act of 2015, mandated that new off-campus (>250 yards) HOPDs be paid at a lower rate. Grandfathered off-campus HOPDs and on-campus HOPDs remained unaffected. Fully closing this loophole by implementing site neutral payment would, per the Congressional Budget Office (CBO), generate $170 billion in savings.[35] The lack of site neutral payment also drives physician-hospital

consolidation, as noted by prior MedPAC Chair Chernew[36] and noted as far back as 2015 by the GAO.[37] Critically, research has demonstrated minimal impact on rural facilities if site neutral policy were implemented.[38]

In this setting, it is no surprise that a significant portion of hospital corporate strategy is to seek additional state and federal subsidies directly or undertake mergers to access or amplify regulatory-driven arbitrage opportunities. Consequently, clinical innovation and improvement are disincentivized. Incentives therefore need to be realigned to ensure that affordable products and services flow to the patients who need them, and that hospitals that need subsidies should access them directly.

State and Federal Policy Disfavors and Even Bans Competitor Entry

Certificate of Need (CON) laws at the state level disfavor entry. Briefly, a state health planning agency, the department of health, or another entity reviews and approves the creation of new health care facilities, facility expansion, or purchase of capital equipment. An estimated 35 states and the District of Columbia operate CON programs,[39] a marketplace spurred by the 1974 National Health Planning and Resources Development Act. This Act required states to adopt CON or federal health funding would be withheld, with policymakers positing that CON would ensure adequate care for rural and underserved areas and prevent overuse in other areas. In contrast, outcomes are the opposite, representing a failure of central planning, with the 1974 Act repealed as part of the 1986 Comprehensive Mental Health Services Act. Robust evidence has demonstrated the harms of CON, suggesting that they raise rather than restrain spending.[40,41] Quality impacts are also negative, with the presence of CON laws associated with greater Medicare spending, more ED visits, and hospital readmissions.[42] Access is also restricted, with evidence demonstrating that CON law restricts access to hospitals and ASCs including in rural areas,[43] in addition to decreasing access to imaging services such as MRI/CT/PET while simultaneously favoring hospital over nonhospital providers.[44] In this way, CON hurts rural states the most[45] and is thankfully widely recognized as anti-competitive, including by FTC Commissioners[46] and U.S. Department of Justice Antitrust Division frequently commenting on their anticompetitive nature and advocating for repeal.[47]

Stark Law, or physician self-referral law, was initially enacted in 1989 and expanded in subsequent years through statute and rulemaking. Stark Law prohibits self-referral for physician-owned enterprises to 12 designated services when billing Medicare or Medicaid.[48] There were valid concerns about physician self-referral in a fee-for-service setting, dating back to research from the 1980s regarding induced demand for imaging and lab services.[49] At the time as part of Stark Law, a specifically crafted “whole hospital exception” previously allowed self-referral to a hospital with physician ownership, with the conception that the physician owned an interest in an entity that provided a wide range of services, as opposed to an individual service. This exception was subsequently closed as part of the 2010 Patient Protection and Affordable Care Act (ACA) as a consequence of hospital industry lobbying.

Interestingly, no such self-referral ban in statute or rulemaking exists for tax-exempt and for-profit corporate entities, which frequently require self-referral as a condition of clinical practice and employment. Presupposing that one corporate form engages in self-referral for malignant reasons while other corporate forms with the same incentives engage in self-referral for only good reasons is a policy failure, substituting a need for regulation of all market participants with a statutory ban on a single market participant. Self-referral is a complex issue: self-referral for integrated care delivery sometimes has strong clinical value and in other settings it only has financial value. As a complex issue involving taxpayer-funded health benefits, oversight is critical. Yet, patients and practice patterns are unique and likely need some loco-regional flexibility. Recognizing this reality, utilization management practices are needed for all market participants. This would be best executed in the marketplace a dynamic tool that allows patients to have access to the benefits of integrated care delivery while ensuring against fraud, waste, and abuse.

Impacts of the Stark self-referral ban are real and include price and non-price competition impacts. Stark foreclosed the entire market for physician-owned and -operated integrated care delivery as Medicare and Medicaid often comprise half or more of patients for a care delivery organization. In contrast, tax-exempt health systems could employ an orthopedic surgeon and require internal system referral for imaging, physical therapy, and surgical services for a Medicare or Medicaid patient. Meanwhile, a physician-owned practice could not, as doing so would be statutorily illegal. In foreclosing the market for physician-owned and -operated care delivery, Stark Law decreased non-price competition in terms of medical quality, consumer experience and the clinician experience through the loss of service delivery innovation from front-line clinician owner-operators. This is the deterioration in quality that all of us, or those close to us, have experienced but that goes unmeasured. Critically, the loss of small business in care delivery sectors is an acute problem in rural areas where integrated care delivery is needed at

smaller scale, and larger corporations may not have an incentive to invest without significant subsidy. Policy has made owning and operating small business illegal in many care delivery markets.

Finally, the physician-owned hospital (POH) ban directly discourages entry. A provision pushed by the hospital trade association,[50] Section 6001 of the 2010 ACA[51] closed the "whole hospital exception" portion of Stark Law.[52] Around 200 POHs remain in existence but as clinical enterprises are prohibited from growing. Approximately half of the marketplace is community POHs (i.e. general acute care hospitals) and half are surgical specialty POHs, largely represented by cardiac and orthopedic POHs.[53] In the setting of the POH ban, patients lose price competition from community POHs and surgical specialty POHs, while physicians and nurses lose labor price and nonprice competition. Payers have fewer facilities to construct networks from, resulting in decreased bargaining power and higher prices for the insured. Quality impacts are real: a loss of service delivery innovation, and an absence of growth of focused factories.

A systematic review of 30 years of research demonstrated that patients experience higher quality of care in physician-owned hospitals even when accounting for patient differences:

- Orthopedic surgical specialty hospitals take a focused factory approach to procedures. For total knee and total hip arthroplasty, research demonstrated higher patient satisfaction from MD-RN communication, staff responsiveness along with lower length of stay (LOS) and expected v. observed LOS. These facilities also deploy nonsurgical therapy: POHs tried other interventions prior to surgery more frequently. (e.g. NSAIDs 93.0 vs 83.9%, PT 72.2 vs 67.1%). With respect to outcomes, there was a lower inpatient and 30-day mortality along with lower risk-adjusted readmission for joint replacements while there were lower complications: cardiac, sepsis, deep venous thrombosis, and renal complications for some spinal surgeries.
- Cardiac specialty hospitals take a focused factory approach to procedures exhibiting a lower LOS, lower inpatient and 30-day mortality rates such as in the setting of percutaneous coronary intervention. Highly morbid procedures such as abdominal aortic aneurysm repair had lower mortality as did coronary artery bypass graft surgery, carotid endarterectomy, and acute myocardial infarction treatment. Patients also exhibited a lower risk of severe complications such as post-op hemorrhage, post-op pulmonary embolus and death.

Access impacts from the POH ban on participation in Medicare were real. With the law's passage a statutory deadline of December 31, 2010 resulted in cessation of 45 hospital expansion projects and loss of access to focused factory, a model flourishing in other countries such as Narayana Health (focused factory for cardiac care)[54] and the Shouldice hospital (hernia repair).[55] Patients also lost access to owner-operated businesses run by the front-line clinicians who best understand clinical operations, and with them the service-delivery innovation those clinicians generate; the voice of the clinician became subsumed by administrators. Taxpayers also faced a revenue loss: POHs pay taxes, tax-exempt hospitals do not. Finally, the loss of price competition results in high costs in suburban and urban markets while the loss of non-price competition reduces quality, convenience/access. In contrast, in rural markets with loss of competition you may even lose market participation, an even more stark outcome that is not well-assessed.

3. State and federal law and regulatory policy changes to promote competition

Employer options

Policymakers have state and federal actions that can be taken to combat consolidation and promote competition. First, state health plans offer an opportunity to implement market-based solutions. The North Carolina State Health Plan (NC SHP), of which I serve as Vice Chairman of the Board of Trustees, is a 750,000-member, $4.8 billion self-insured health plan that recently undertook a fiscal turnaround[56] in partnership with employees and providers. The NC SHP worked with employees to set a target share of income for premiums, serving to create income-adjusted premiums and begin to create a budgetary framework for health expenditures. This forced the plan to make decisions about tradeoffs as a team – instead of seeking disproportionately greater subsidies from taxpayers and employees year over year. Instead of electing traditional choices of significant double-digit premium increases or cuts to benefits, this fiscal structure and discipline empowered the plan in partnership with members to creatively use the tools of network strategy and benefit design to drive provider competition.

In this setting, the plan elected to build a preferred provider network through volume-based purchasing with a minimum quality threshold to achieve significant price discounts. Preferred providers were aligned with favorable benefit design to drive volume (see **Figure 1**). Using a first principles approach, the member wins first on reduced

cost-sharing and then the plan wins on savings thus ensuring the members and the plan both benefit (albeit sequentially, not in parallel) from price competition.

	STANDARD PPO Plan				PLUS PPO Plan			
	Preferred	Access	Non-Preferred	Out-of-Network	Preferred	Access	Non-Preferred	Out-of-Network
Annual Deductible	$1,500 Ind $4,500 Fam	$3,000 Ind $9,000 Fam	$5,000 Ind $15,000 Fam	$15,000 Ind $45,000 Fam	$1,000 Ind $3,000 Fam	$1,500 Ind $4,500 Fam	$4,000 Ind $12,000 Fam	$12,000 Ind $36,000 Fam
Out-of-Pocket Maximum (combined medical & pharmacy)	$4,000 Ind $12,000 Fam	$6,500 Ind $16,300 Fam	$12,000 Ind $24,000 Fam	$36,000 Ind $72,000 Fam	$3,000 Ind $9,000 Fam	$5,000 Ind $15,000 Fam	$10,000 Ind $20,000 Fam	$30,000 Ind $60,000 Fam
	In-Network (deducitble & OOP max cross-accumulates)				*In-Network (deducitble & OOP max cross-accumulates)*			
MEDICAL BENEFITS								
Preventive	$0 Preventive Services				$0 Preventive Services			
Primary Care Provider (PCP)	$15 Preferred PCP listed on ID card $40 other PCP listed on ID card $50 other PCP			50% after deductible	$10 PCP Preferred PCP listed on ID card $30 other PCP listed on ID card $40 other PCP			40% after deductible
Walk-In Clinic	$40 other PCP on ID card $50 other PCP			50% after deductible	$30 other PCP on ID card $40 other PCP			40% after deductible
Specialist	$40	$65	30% after deductible	50% after deductible	$25	$50	20% after deductible	40% after deductible
Behavioral Health	$15			50% after deductible	$10			40% after deductible
Speech, Occupational, Chiropractic, Physical Therapy	$62			50% after deductible	$42			40% after deductible
High-Cost Imaging	$400	30% after deductible	$1,000, then 30% after ded	50% after deductible	$250	20% after deductible	$500, then 20% after ded	40% after deductible

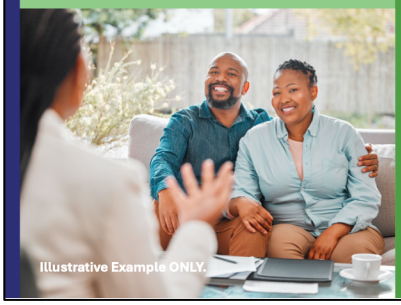
Figure 1: Abbreviated table of updated benefit design[57]

The preferred provider strategy also facilitates – for the first time in NC SHP history – for the member to undertake "time travel" in benefit design back to the richness of the 2011/2012 benefit design despite generally concentrated markets if one uses preferred providers (see **Figure 2**). This is an unheard-of occurrence in health insurance markets.

Member Scenario 3

Jack's Experience:

Coverage: Indv + Spouse
Income: Med-High
Both members have a chronic condition, anticipate hospitalizations.



STANDARD PPO Plan	#	2026	2027		
			Preferred	Access	Non-Preferred
Premiums Annual Total		$7,260	$7,623		
Annual Well Visit	2	$0	$0	$0	$0
Other Primary Care Visit	6	$30	$90	$60	$90
Specialist Visit	8	$376	$320	$160	$1,040
Urgent Care	2	$0	$200	$0	$200
Inpatient Stay (3 days/stay)	2	$10,944	$1,500	$11,040	$14,540
Pharmacy – Tier 1	28	$250	$700	$300	$700
Pharmacy - Tier 2	24	$600	$1,800	$640	$1,800
Pharmacy - Tier 4	4	$800	$800	$800	$800
Out-of-Pocket Cost		$13,000	$5,410	$13,000	$19,170
Total Member Cost		**$20,260**	**$13,033**	**$20,623**	**$26,793**

PLUS PPO Plan	#	2026	2027		
			Preferred	Access	Non-Preferred
Premiums Annual Total		$9,624	$10,105		
Annual Well Visit	2	$0	$0	$0	$0
Other Primary Care Visit	6	$60	$60	$60	$60
Specialist Visit	8	$630	$200	$400	$960
Urgent Care	2	$140	$140	$140	$140
Inpatient Stay (3 days/stay)	2	$7,200	$1,000	$7,200	$11,360
Pharmacy – Tier 1	28	$360	$420	$420	$420
Pharmacy - Tier 2	24	$1,210	$1,320	$1,320	$1,320
Pharmacy - Tier 4	4	$400	$400	$400	$400
Out-of-Pocket Cost		$10,000	$3,540	$9,940	$14,660
Total Member Cost		**$19,624**	**$13,645**	**$20,045**	**$24,765**

NOTE: Costs for the couple's care assume a specific ordering of services before they reach their out-of-pocket maximums in some scenarios.

Figure 2: Case example and side-by-side comparison of old/new benefit design[58]

With a 3-tiered benefit design, the Access tier serves as functionally an "any-willing-provider" in rural areas, whereas in concentrated urban markets through partnership with preferred health systems and robust independent physician networks, plan members can still benefit from price competition (see **Figure 3**). Geographically, deploying basic insurance design principles in partnership with employees allowed the plan to act as a prudent fiduciary and avoid persistent double-digit year over year rate increases.

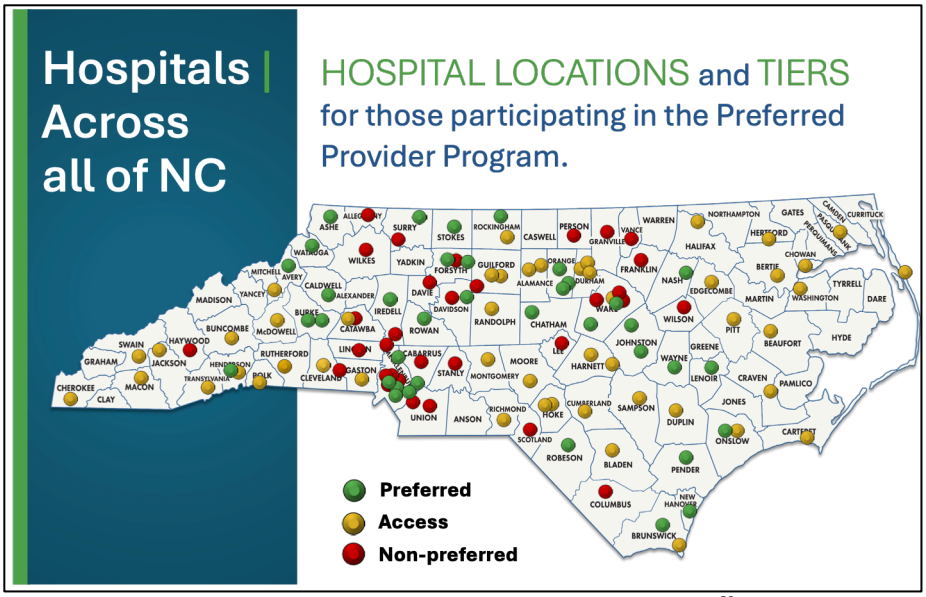


Figure 3: Geography of hospitals by network tier[59]

For elective surgeries, the NC SHP partnered with a vendor, Lantern, to construct a no-cost elective surgical benefit for spine, orthopedic, cardiac and other procedures. Recognizing that robust price competition to drive member and plan savings would result in a subset of provider options, the no-cost elective surgical benefit is optional, and members can still access care through the standard benefit design. Rather, the no-cost elective surgical benefit offers just that: no cost to the member. With a wide state and dispersed population, the plan also funds travel with the potential for mileage or even airfare and hotel to support member access to cost savings.[60] In this setting independent practices have an equal opportunity to compete as do large health systems, with OrthoCarolina, a Lantern partner, as an example.[61]

By deploying the principles of competition, steerage, and benefit design, self-insured employers in North Carolina and other states can design their health benefits along these principles to drive competition, as can other state employee health plans. Employers purchasing plan products can also demand – as customers – that health plans undertake a similar contracting strategy. Competition counts.

Options for State Policymakers

State policymakers have multiple options to combat consolidation. With 35 states and the District of Columbia operating CON programs of varying scope and scale,[62] state policymakers could undertake a full repeal. Recognizing that in many circumstances that is not a viable first step, policymakers could consider a phased repeal, with some combination of the following:[63,64]

1. Repeal service line by service line to help vulnerable populations (e.g. psychiatric facilities, Labor & Delivery units, substance use facilities).
2. Eliminate CONs for low-cost services (e.g. ambulatory surgery centers, home care).
3. Eliminate CONs for services that are not likely to be overprescribed (e.g. neonatal intensive care unit, dialysis, radiation treatment).
4. Exempt physician-owned enterprise from CON to promote competition.
5. Exempt private-equity-backed entities from CON to promote competition.
6. Exempt from CON geographic and service markets that meet the DOJ Antitrust Division's highly concentrated definition (HHI of 1,800).[65]
7. Sunset CON over time.

Recently, North Carolina has made progress in this direction, with CON long a target of meaningful reform.[66,67] With the current state of CON in NC still encompassing a wide range of facilities,[68] many opportunities remain. Phased repeal by service or facility type is a viable option, as with the recent repeal of CON for inpatient rehabilitation facilities.[69] Still, other venues such as constitutional challenges remain an option for either phased or ideally wholesale repeal, with ophthalmologist Jay Singleton M.D.[70] challenging the constitutionality of CON law, an effort supported by North Carolina Treasurer Brad Briner and the State Employees Association of North Carolina, the latter of which represents over 45,000 state employees.[71,72]

State policymakers could also prohibit anti-tiering and anti-steering provisions. Functionally, market dominant or monopoly health systems insert these provisions into managed care contracts, preventing plans from using financial incentives to direct patients to other systems or placing the health system in a lower tier compared to other providers (or alternatively requiring placement in the highest tier). The Department of Justice Antitrust Division successfully sued Atrium Health[73] over anti-competitive steering provisions and won, and recently sued OhioHealth[74] and New York Presbyterian (2026).[75] A White House Council of Economic Advisers report[76] estimates savings of 4-9% in impacted markets from preventing the use of anti-tiering and anti-steering provisions, with Texas' recently passed HB711[77] serving as an early success and example.

Finally, in the context of a rising policy effort to ban private equity investment in healthcare, state policymakers should do no harm. While private equity has risks and benefits, it is a potential positive force for competition. Banning one ownership model in favor of another replaces competition with a statutory prohibition, favoring one corporate form over another. In the case of physician-owned enterprise, Stark Law and the physician-owned hospital ban fundamentally destroyed independent practice, driving clinicians towards a large-corporation, fully employed model with many untoward side effects on patient care and workforce sustainability.

Options for Federal Policymakers

In addition to state action, federal policymakers have a litany of options to combat consolidation. First, federal policymakers can work to eliminate CON. Policymakers can deploy federal fiscal incentives and regulations to remove a barnacle-like entry barrier that persists in state law. Medicaid policy, a recent source of policy disagreement, offers an opportunity for bipartisan efforts. The Federal Medical Assistance Percentage or FMAP[78] is the share of Medicaid funds that the federal government pays. Policymakers could undertake a carrot and stick approach to FMAP adjusting FMAP upward by, for example, 1% for states that repeal CON within three years and downward by 2% for states that do not. There are multiple dials, including the size of the carrot, the size of the stick, and the timeline for a cutoff. Policymakers could undertake a similar exercise with Medicare Advantage benchmark policy, [79] adjusting benchmarks for the presence or absence of CON. Finally, policymakers could undertake the same exercise by reducing hospital payment (IPPS,[80] OPPS)[81] through a deflator when CON is present to account for increased market power and self-referral, and increase the rates when CON is absent.

Federal policymakers also have a wide range of potential solutions to implement site neutral policy either piecemeal or in whole and remove the consolidation accelerator in Medicare. Site neutral policy in hospital outpatient department markets has a wide range of supporters including experts at the American Enterprise Institute,[82] the America First Policy Institute,[83,84] the Brookings Institution,[85] the Committee for a Responsible Federal Budget,[86] the Heritage Foundation,[87] and the Paragon Health Institute.[88] MedPAC's proposed site-neutral service list includes 57 Ambulatory Payment Classifications (APCs).[89] Additionally, CMS[90] has specifically proposed site neutral drug administration while Congress has taken steps with the *Lower Costs, More Transparency Act* which passed the House in the prior session by a vote of 320 – 71[91] and has been reintroduced.[92] Finally, policymakers could work to implement an acuity adjuster that ties payment to patient acuity to ensure appropriate placement in a clinic, ASC, or hospital outpatient department. This would ensure that the right patient gets the care in the right setting at the right time. Other options include addressing grandfathered off-campus HOPDs and all on-campus HOPDs.

Repeal of the physician self-referral law (Stark Law) and of the POH ban would remove entry bans and work to reverse both hospital consolidation[93] and physician-hospital consolidation. The evidence for repeal is strong: the Section 6001 Medicare participation ban has foreclosed the nationwide hospital market to new POHs and expansion of existing POHs,[94] a systematic review of 30 years of research shows both price and non-price (medical quality) competition gains from POHs, and other work shows that general acute-care POHs have lower prices.[95] Repeal options are numerous and include repeal by:

1. Service market (e.g. specialty vs community or general acute care POHs)
2. Geography (rural, suburban, urban) noting that proposed H.R. 2191 narrowly does this for rural settings with a specific drive-time distance from other hospitals[96]
3. Site neutrality for all new on-campus and off-campus HOPDs for POHs
4. A 2% Medicare cut
5. Some combination

Policymakers should also consider adding a statutory exception to Stark Law in the setting of managed care, or a so-called “managed care exception." Both Medicare Advantage and Medicaid Managed Care Organizations are paid on a risk-adjusted, capitated basis and deploy network design and utilization management practices to manage costs. Stark could be preserved in the setting of Fee-for-Service Medicare and waived in the setting of managed Medicare and managed Medicaid, with utilization management oversight of referral patterns.[97] This would allow physician-owned businesses to serve the roughly 53% of Medicare and 72% of the Medicaid market and restore competition, removing a ban on market entry and replacing it with a dynamic market oversight model.

Additional federal policy options exist, including ERISA prudent fiduciary guidance to drive employers to transition from passive to active purchasers. Defining a prudent fiduciary and setting a target share of employee income for premium and additionally a target employee/employer financing split would force meaningful consideration of tradeoffs with networks, utilization management and costs in the employer-sponsored insurance market serving over 130 million Americans.

Finally, policymakers could work to support the already successful FTC competition advocacy program[98] by directing the agency to comment on competition impacts of Medicare and Medicaid regulations. Medicare rules occur on an annual cycle including IPPS/LTC Hospital, OPPS/PFS/ESRD,[99] MA Advance Notice and Rate Notice, MA-Part D rule, and others. In contrast, the Medicaid program has rules with competitive impacts including the Medicaid/CHIP managed care rules (most recently in 2020 and 2024) amongst others that are issued with less regularity. This would allow the FTC to have early input on the structure and functioning of public payer markets, driving competition.

Conclusions

Policy analysts of a variety of backgrounds, training and belief systems fundamentally agree that hospital markets are consolidated and that this results in significant price and non-price harms. A careful analysis reveals that government intervention through law and regulation has fundamentally distorted or eliminated market competition, through poor incentive structures or outright banning competition or specific categories of market participants. Instead of promoting more regulation and government control, a better answer is to recognize the need for dynamism, creativity, and innovation in the clinical setting and in policy and restore competition, as competition counts.

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