

TESTIMONY OF LEEMORE S. DAFNY, Ph.D

**Bruce V. Rauner Professor of Business Administration
Harvard Business School
Harvard Kennedy School**

Before the

**U.S. House Committee on the Judiciary
Subcommittee on Antitrust, Commercial and Administrative Law**

On

**“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”**

April 29, 2021

- I. **High and Rising Provider Prices are Driving Higher Health Care Spending**
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I. **High and Rising Provider Prices are Driving Higher Health Care Spending**

The United States spends a larger share of its GDP (nearly 18 percent) on health care than any other country. The key driver is high prices, and the result is that we are not getting enough value for our spending.¹ These conclusions are supported by decades of research and hard data. 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.² 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. When discussing the effects of consolidation on this spending, we must consider the bifurcated insurance market. Health care providers are reimbursed differently by public insurance programs (like Medicare and Medicaid) and commercial insurance plans (offered or administered by for-profit and not-for-profit insurers). Recent analyses find that the growth in health care spending for the commercially-insured population is largely due to growth in the prices charged for commercially-insured patients, and the vast majority of that spending is on provider services.³

¹ [CMS, National Health Expenditure Accounts \(NHEA\)](#). Data reflect spending for 2019, the latest calendar year for which it is available. Total spending in 2019 was \$3.8 trillion or \$11,582 per capita.

² Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. *Health Aff (Millwood)*. 2019;38(1):87–95; Commonwealth Fund, “Mirror, Mirror: Comparing Health Systems Across Countries,” <https://www.commonwealthfund.org/series/mirror-mirror-comparing-health-systems-across-countries>; Gary Claxton et al., How Have Healthcare Prices Grown in the U.S. Over Time?, Peterson-Kaiser Health System Tracker (May 8, 2018), <https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-prices-grown-in-the-u-s-over-time/#item-start>; Miriam Laugesen and Sherry 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

³ Zack Cooper, Stuart Craig, Martin Gainer, and John Van Reenan, “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” *Quarterly Journal of Economics* 134, no. 1 (2019): 51–107. *Health Care*

Prices for commercially-insured patients are much higher than prices for publicly-insured patients,^{4,5} and the gap is widening. Commercial prices were around 10 percent higher than Medicare in the late 90s, but by 2012 were 76 percent higher.⁶ 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.⁷

In the commercial marketplace, there is also substantial variation in prices *for the exact same undifferentiated service* across markets, across providers within markets, and even within providers across insurance contracts.⁸ A striking depiction of this variation is presented in [Figure 2](#), which orders a sample of providers by their average commercial price for a lower-extremity MRI and contrasts the amounts with payments for the same test by Medicare, which sets prices and provides only limited scope for variation in those prices. At the low end, many providers charge less than \$1,000, still well above the Medicare price. At the high end, many providers charge over \$2,000, which is more than four times the Medicare price.

Some portion of this variation reflects variation in market-level resource costs (such as wages or rent), in production efficiency, and perhaps health care quality. A significant portion of this variation, however, reflects market power and market failures.⁹ The key question for this hearing is whether consolidation has strengthened market power and and/or enabled health care providers

Cost Institute, “2018 Health Care Cost and Utilization Report,” Presentation, Feb. 2020, <https://healthcostinstitute.org/annual-reports/2020-02-13-18-20-19>.

⁴ Zack Cooper et al., “Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-14,” *Health Affairs* 38, no. 2 (2019): 184–189.

⁵ Cooper et al. (2019), *supra* note 3. 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 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* 11, no. 2 (2019): 302–32.

⁶ Selden TM, Karaca Z, Keenan P, White C, Kronick R. The growing difference between public and private payment rates for inpatient hospital care. *Health Aff (Millwood)*. 2015;34(12):2147–50.

⁷ Chernew, Hicks, and Shaw. “Wide State-Level Variation In Commercial Health Care Prices Suggests Uneven Impact Of Price Regulation,” *Health Affairs* 39, No. 5 (2020): 791-99. The authors report professional services represent 20 percent of national health expenditures.

⁸ (Cooper et al. 2019).

⁹ For additional discussion, see Chernew, Dafny, and 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; see also, Cooper et al (2019) *supra* note 3, which shows that both within and across Health Referral Regions, provider market concentration explains the largest share of variation in commercial prices.

and insurers to exploit that power in health care markets. I summarize the academic research that concludes the resounding answer to the question is “yes.” While every merger is different and antitrust authorities must evaluate each on its own merits, too many harmful and anticompetitive mergers are occurring under the current review and enforcement regime. At the end of this testimony, I discuss legislative and regulatory interventions that could mitigate the harm from consolidation and deter future harmful consolidation.¹⁰

II. Health Care Markets a Decade After the ACA: Bigger, but Probably Not Better

Over the past decade, health care markets have increased substantially in size. Per-capita health care spending in 2019 stood at \$11,582, yielding a national total of \$3.8 trillion, as compared to \$8,383 in 2010, or a national total of \$2.6 trillion.¹¹ At the same time, many sub-sectors of health care have become substantially consolidated. 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.¹² 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 2018.¹³ Commercial health insurance markets have grown increasingly consolidated as well. By 2019, more than 74 percent of metropolitan areas were “highly concentrated” as defined in the FTC/DOJ *Horizontal Merger Guidelines*.¹⁴

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

¹⁰ My discussion focuses on consolidation that (1) occurs in an already-concentrated market (which are the majority of markets nationwide for many healthcare services) or consolidation that would create a concentrated market and (2) for which there are not clearly verifiable extenuating factors that would, with high likelihood, outweigh any anticompetitive effects. See the discussion in Leemore Dafny and Thomas Lee, “The Good Merger,” *NEJM* 372, no. 22 (2015): 2077–79, <https://www.nejm.org/doi/full/10.1056/NEJMp1502338>.

¹¹ CMS, “National Health Expenditure Accounts,” <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata>.

¹² Hospital merger count is based on data from the American Hospital Association and summarized by Gaynor in <https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/>.

¹³ 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* 39, no. 8 (2020): 1321–1325, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00017>.

¹⁴ American Medical Association, “Competition in Health Insurance: 2020 Update,” <https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf>.

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, e.g., consolidation arising from greater growth of large firms.

Some of the large-firm growth may well be due to anticompetitive conduct. For example, some dominant hospital systems’ contracts forbid insurers from using financial incentives to “steer” patients to other (typically smaller and less expensive) providers and/or may prohibit insurers from contracting with only a subset of the dominant system’s providers (e.g., selecting which of the system’s specialists to include in-network).¹⁵ 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.¹⁶

A. Evidence on the Effects of Health Care Mergers

A.1. Providers

Most research on provider mergers¹⁷ has focused on hospitals, which account for over 30 percent of U.S. health care spending.¹⁸ The extensive academic literature on the subject has been well-

¹⁵ See, e.g., Elizabeth 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/>.

¹⁶ 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). Although largely beyond the scope of my testimony today, 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, <https://www.justice.gov/opa/pr/justice-department-files-motion-dismiss-antitrust-lawsuit-against-blue-cross-blue-shield>. 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, <https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering>.

¹⁷ For additional discussion, see Claudia Williams, Robert Town, and William Vogt, “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?” The Synthesis Project Policy Brief No. 9, Feb. 2006; Martin Gaynor and Robert Town. “The Impact of Hospital Consolidation—Update.” The Synthesis Project Policy Brief No. 9 Revised, 2012; Martin Gaynor, “Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets,” Statement before the Committee on the Judiciary Subcommittee on Antitrust, Commercial, and Administrative Law, U.S. House of Representatives, March 7, 2019.

¹⁸ CMS, “The Nation’s Health Dollar, Calendar Year 2019,” <https://www.cms.gov/files/document/nations-health-dollar-where-it-came-where-it-went.pdf>.

summarized and reviewed elsewhere,¹⁹ so I describe only the key conclusions here. Several peer-reviewed, academic economic studies have shown that commercial prices tend to increase after hospital mergers, regardless of whether they involve for-profit or nonprofit hospitals. A number of studies also directly link high hospital market concentration with high prices and price growth.²⁰ In addition, 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 Simply put, due to consolidation we are paying more for our hospital care, but there is no evidence that we are getting more in return.

Research on physician mergers and consolidation is more limited, but the conclusions are the same. A study of commercial prices following a large merger of orthopedic physician groups found substantial price increases for the physician group, even though prices for other orthopedic physicians did not change.²² Studies also show that physician prices are higher in more concentrated physician markets.²³ More evidence is likely to emerge from the FTC's recently launched "6(b)" study of "the impact of physician consolidation during this period, including physician practice mergers and hospital acquisitions of physician practices."²⁴ Such studies are essential to informing both enforcement and regulation, and thus warrant adequate funding. I return to this subject in the recommendations I offer at the end of this statement.

Most research on the impact of mergers focuses on "within market" or horizontal transactions, but more recent research has evaluated the effects of "cross market" hospital mergers, or

¹⁹ See sources listed, *supra* note 17.

²⁰ E.g., Leemore Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *Journal of Law and Economics* 52 (2009): 523–50; Cory Capps and David Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs* 23, no. 2 (2004): 175–81 at 179; and 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* 134 (2019): 51–107.

²¹ E.g., Daniel Kessler and Mark 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 Zack Cooper, Stephen Gibbons, Simon Jones, and Alistair McGuire, "Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms." *The Economic Journal* 121, no. 554 (2011), 228–260., and Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, "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 Thomas Koch and Shawn Ulrick, "Price Effects of a Merger: Evidence From a Physicians' Market," *Economic Inquiry* 59, no. 2 (2021): 790–802, <https://onlinelibrary.wiley.com/doi/abs/10.1111/ecin.12954>.

²³ Abe Dunn and Adam Shapiro, "Do Physicians Possess Market Power?" *Journal of Law & Economics* 57, no.1 (2014):159-193, <https://www.jstor.org/stable/10.1086/674407>; Laurence Baker, Kate Bundorf, Anne Royalty, and Zachary Levin. "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *JAMA* 312, no. 16 (2014): 1653–62, <https://doi.org/10.1001/jama.2014.10921>

²⁴ FTC, "FTC to Study the Impact of Physician Group and Healthcare Facility Mergers," Jan. 14, 2021, <https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers>.

combinations occurring among hospitals in different, sometimes adjacent, geographic markets.²⁵ This research shows that acquisitions of hospitals, even by out-of-market hospital systems, often leads to substantial price increases both for acquired hospitals and for acquiring hospitals located in the same state.

Researchers have also documented that hospitals in more concentrated markets charge higher prices and are less likely to receive fixed, prospective payments—a payment methodology that creates incentives for providers to control costs. Specifically, hospitals are less likely to be paid based on patients’ diagnoses and conditions (as under the traditional Medicare 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).²⁶ This pattern shows that hospitals with market power are better-positioned to reject cost-containing payment innovations by insurers.

Research on vertical combinations of health care providers has focused on the effects of hospital acquisition of physician practices. Several studies find these combinations result in higher prices and higher spending; for example, one study based on detailed commercial claims data finds average price increases of 14 percent.²⁷ However, as with hospital care, evidence of improvements in patient outcomes is elusive. One recent study finds only negligible effects of vertical integration of hospitals and physicians on a set of health outcome measures.²⁸ Other research likewise finds either no relationship or a positive but small relationship between vertical integration of hospitals with physicians and measures of quality.²⁹ And, in the nursing-home sector, a recent study found that hospitals that own skilled nursing facilities were likelier to “self-

²⁵ Leemore Dafny, Kate Ho, and Robin S. 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>; Matthew S. Lewis and Keven E. 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>.

²⁶ Cooper et al. (2019), *supra* note 3.

²⁷ 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, <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591>; 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, <https://jamanetwork.com/journals/jama/fullarticle/1917439>.

²⁸ 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,.

²⁹ 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.

refer” profitable patients to those facilities, but those patients did not experience any significant changes in clinical outcomes.³⁰

The higher provider prices fueled by consolidation harm commercially insured plan members, both directly through higher out-of-pocket spending and higher premiums and indirectly through lower wages.³¹ If these higher prices were associated with better outcomes, the financial toll might be easier to justify, but the evidence does not support this conclusion. Because health care providers compete on non-price dimensions such as clinical outcomes and patient experience, consolidation that lessens competition also can be expected to worsen quality for both commercially insured and government-insured patients.

A.2. Insurers

Research on consolidation in the health insurance sector is less abundant than research on the provider sector, partly due to the very limited public data on commercial insurance premiums, plan characteristics, and enrollment. However, two peer-reviewed studies examine the impact of insurer mergers on premiums, one using data for large employers and a second using data for small groups.³² Both find evidence of premium increases in markets where the merging parties have the most pre-merger overlap. In addition, a study of the Health Insurance Marketplaces (i.e., ACA exchanges) finds that additional insurer participation, particularly when the insurer has substantial share in the individual market, yields lower premiums.³³

A number of other studies find that larger insurers are able to negotiate greater provider discounts.³⁴ However, no study has found evidence that these discounts result in lower insurance premiums. In the absence of competition, there is minimal pressure on insurers to pass savings on to downstream customers.

³⁰ David Cutler, Leemore Dafny, David Grabowski, Steven Lee, and Christopher Ody, “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, December 2020.

³¹ Daniel Arnold and Christopher Whaley, “Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages,” Working paper, RAND Corporation, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html; Katherine Baicker and Amitabh Chandra, “The Labor Market Effects of Rising Health Insurance Premiums,” *Journal of Labor Economics* 24, no. 3 (2006): 609–634, <https://www.jstor.org/stable/10.1086/505049>.

³² Leemore Dafny, Mark Duggan, Subramaniam Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review* 102, no. 2 (2012): 1151–1185, <https://www.aeaweb.org/articles?id=10.1257/aer.102.2.1161>; Jose Guardado, David Emmons, Carol Kane, “The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra,” *Health Management, Policy and Innovation* 1, no. 3 (2013): 16-35.

³³ Leemore S. Dafny, Jonathan Gruber, Christopher Ody, “More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces,” *American Journal of Health Economics* 1 no. 1 (2015): 53–81.

³⁴ Erin Trish and Bradley Herring, “How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?” *Journal of Health Economics* 42, no. 1 (2015): 104–114; Cooper et al. (2019), *supra* note 3. See also, Commonwealth Fund, “[Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience](#),” Nov. 20, 2015.

III. The Pandemic Should Not Delay Actions to Prevent Anticompetitive Consolidation

During the Covid pandemic, health care organizations have struggled with financial challenges created by decreases in revenue for services such as elective surgery, and higher costs related to personnel and measures required to keep patients and employees safe. The experience of “going it alone” has led some providers to conclude that their status quo is fraught, and they must explore consolidating into a larger organization. They point to success stories in which patients, personnel, medications, and equipment were moved among health care organizations to meet needs wherever they were greater. However, it is worth noting that such admirable cooperation occurred among distinct health care organizations, not just within them.

Any argument that the challenges associated with the pandemic should trump concerns about market consolidation is not compelling, as there has been no permanent change in the health care ecosystem that would imply a change in the dynamics associated with health care consolidation. If anything, the pandemic has exposed some of the harm linked to consolidation. Providers compensated on a fee-for-service basis have struggled financially, spurring a government bailout.³⁵ As noted above, researchers have shown that more dominant hospitals have successfully resisted the shift away from fee-for-service reimbursement and toward risk-sharing models; had more shifted in this direction prior to the pandemic, hospital systems would be on stronger financial footing today.

The pandemic has also exposed the limited degree of competition in the insurance sector. As medical expenses have declined, insurers’ earnings are soaring. In a competitive market, insurers would try to retain fully-insured customers by refunding premium payments for much of 2020 and reducing premiums for 2021. However, there is scant evidence of refunds beyond the minima required by statute.³⁶ When patients/employers have few rival insurers to turn to, any market imperative for insurers to share medical cost savings with customers is limited.

Going forward, there is growing concern that the pandemic is accelerating consolidation—e.g., by hastening the movement of physicians into employment with hospitals, insurers, and private equity-owned groups. Paired with greater exit by financially-strapped health care providers, this is a recipe for even higher prices.

The possibility of a different type of “long haul” effect of Covid—higher prices due to consolidation—is substantial enough that some stakeholders have called for a merger moratorium. In May 2020, a group representing large employers, whose members include

³⁵ Kaiser Family Foundation, “Distribution of CARES Act Funding Among Hospitals,” May 13, 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/distribution-of-cares-act-funding-among-hospitals/>.

³⁶ Kaiser Family Foundation, “Data Note: 2021 Medical Loss Ratio Rebates,” Apr. 12, 2021, <https://www.kff.org/private-insurance/issue-brief/data-note-2021-medical-loss-ratio-rebates/>.

Boeing, Salesforce, Tesla, and Walmart, asked Congress for a year-long ban on mergers and acquisitions among hospitals and physician groups that received government money to cope with the effects of the COVID-19 pandemic.³⁷

IV. Current State of Enforcement

A. Horizontal mergers

Antitrust enforcement vis-a-vis horizontal transactions among health care providers or payers is active,³⁸ although as I discuss later, it does not have sufficient resources to be as active as needed. In the past few years, the DOJ, together with State plaintiffs, successfully blocked two proposed mega-mergers of large health insurers.³⁹ In the past decade, the FTC and DOJ have successfully challenged over a dozen hospital mergers and a number of mergers among other health care providers, including matters settled with consent decrees requiring divestitures to preserve competition and matters the parties abandoned in the face of Agency opposition.

However, as Commissioner Rebecca Slaughter, the current acting FTC Chair has noted, these efforts have “faced resistance, with two of these recent victories only coming after district court setbacks.”⁴⁰ Blocking a horizontal merger, even when it appears to be an “open and shut” case to a layperson, requires extraordinary resources, including large investigation and litigation teams, as well as economic and other subject matter experts who must analyze the transaction, lay out the case for blocking the merger, and rebut arguments advanced by Defendants’ attorneys and experts.⁴¹ The higher the payoff from the merger for the merging parties—and the payoff in the case of an increase in market power can be substantial—the greater the incentive for Defendants

³⁷ Rebecca Spalding, “Large employers push back on U.S. healthcare mergers during coronavirus crisis,” *Reuters* May 22, 2020, <https://www.reuters.com/article/us-health-coronavirus-hospital-m-a/large-employers-push-back-on-u-s-healthcare-mergers-during-coronavirus-crisis-idUSKBN22Z015>.

³⁸ According to Dr. Nathan Wilson, Deputy Assistant Director of the FTC, around one-half of the FTC’s merger challenges between 2010-2018 involved healthcare providers. Nathan Wilson, “Editor’s Note: Some Clarity and More Questions in Healthcare Antitrust,” *Antitrust Law Journal* 82, no. 2 (2019): 435–440.

³⁹ Dafny, L., “Good Riddance to Big Insurance Mergers,” *New England Journal of Medicine*, 2017; 376:1804-1806.

⁴⁰ https://www.ftc.gov/system/files/documents/public_statements/1520570/slaughter_-_hospital_speech_5-14-19.pdf.

⁴¹ To pick a recent example, consider the proposed merger of two hospital systems in the Memphis area, which the FTC filed to block in November 2020. Based on the FTC’s complaint, the merger would have reduced the number of competing systems from four to three and created a system with over a 50% market share. In the face of litigation, the parties abandoned the deal—consistent with this being an open and shut case. (See FTC, “FTC Sues to Block Proposed Acquisition of Two Memphis-Area Hospitals,” Press release, Nov. 13, 2020, <https://www.ftc.gov/news-events/press-releases/2020/11/ftc-sues-block-proposed-acquisition-two-memphis-area-hospitals>.)

Although the FTC prevailed without a trial, it took nearly a year from the merger announcement to the abandonment. Over that period, the FTC would in all likelihood have already devoted thousands of staff hours to the investigation and lawsuit and expended substantial taxpayer resources on expert witnesses.

to invest extraordinary resources to fight a merger challenge. Even if there is only a middling (and in some cases, small) chance of getting a merger through, it may well be in the parties' interest to see if they can prevail, absorbing the Agencies' (i.e., DOJ and FTC's) scarce resources in that attempt and preventing them from devoting those resources to investigate other transactions or anticompetitive practices.

The substantial resources required to challenge transactions, paired with stagnating enforcement budgets, may explain why authorities have elected not to challenge some horizontal transactions they would likely have challenged in previous eras.⁴²

Because pre-merger reporting to the federal agencies is only required for transactions exceeding minimum dollar thresholds (currently \$92 million),⁴³ the Agencies have limited visibility into smaller acquisitions, as well as some larger combinations not involving asset exchanges. 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 parties is notoriously difficult, reducing the odds of a resolution that restores competition. A recent study found that an amendment to the HSR Act in 2000, which raised the effective asset threshold for reporting from \$10 million to \$50 million, resulted in a large increase in mergers of rivals in that range, relative to mergers among rivals in the always-exempt range (<\$10 million) or the never-exempt range (>\$50 million).⁴⁴ Importantly, the number of federal investigations into transactions in the newly-exempt range fell from around 150 per year to nearly zero. Clearly, reporting thresholds matter for competition, and in health care, where many transactions are small, many are escaping detection and investigation.⁴⁵

⁴² Using data on a wide range of industries, antitrust scholar John Kwoka documents that enforcers rarely raise concerns about changes in market structure that used to draw scrutiny—that is, mergers that yield 5 or more market participants. See Kwoka, J. “Reviving Merger Control: A Comprehensive Plan for Reforming Policy and Practice,” *American Antitrust Institute*, <https://www.antitrustinstitute.org/wp-content/uploads/2018/10/Kwoka-Reviving-Merger-Control-October-2018.pdf>.

⁴³ FTC, “HSR threshold adjustments and reportability for 2021,” Feb. 17, 2021, <https://www.ftc.gov/news-events/blogs/competition-matters/2021/02/hsr-threshold-adjustments-reportability-2021>.

⁴⁴ Thomas Wollmann, “Stealth Consolidation: Evidence from an Amendment to the Hart-Scott-Rodino Act.” *American Economic Review: Insights* 1, no. 1 (2019): 77–94.

⁴⁵ Capps et al. (2017), *supra* n. 27. The *de facto* safe harbor for the vast majority of small transactions is particularly concerning in light of empirical evidence showing that some incumbents acquire innovative targets (which are likelier to be small) for the purpose of pre-empting future competition.” So-called “killer acquisitions” may snuff out nascent competition and “mavericks” (firms that “play a disruptive role in the market to the benefit of consumers”) in a range of sectors throughout the U.S. economy. See Colleen Cunningham, Florian Ederer, and Song Ma, “Killer Acquisitions,” *Journal of Political Economy* 129, no. 3 (2021): 649–701. The authors use data on pharmaceutical mergers and find acquired drug products are less likely to be brought to market when they compete with the acquirer's existing products.

⁴⁵ US Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, issued Aug. 19, 2010, <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>.

B. Non-horizontal mergers

Both federal and state enforcement agencies have largely steered clear of challenging non-horizontal transactions in health care.⁴⁶ However, as I described earlier, there is substantial evidence that at least two common forms of non-horizontal integration among health care providers—hospital acquisitions of physician groups and cross-market mergers—can lead to significant increases in prices without commensurate benefits and, therefore, raise health care spending without any clear improvements for patients.

One reason enforcement agencies may not challenge these mergers is a belief – with a theoretical foundation but scarce empirical support – that vertical mergers are likely to be efficient. Another reason is a belief—held by some authorities and many in the private antitrust bar—that mergers that enable greater exploitation of *existing* market power (as opposed to *enhancing* market power) are not prohibited by the Clayton Act. While such combinations could be challenged as monopolistic conduct under Section 2 of the Sherman Act, my understanding is that sustaining the burden of proof for a Section 2 monopolization theory involves a very high hurdle in court for several reasons—including the fact that the federal antitrust agencies do not benefit from the presumptions that apply in merger cases where the merging parties have high combined market shares.

I will leave it to the witnesses with legal backgrounds to support or to challenge this understanding; however, as a non-attorney, it is clear to me from the evidence on consolidation and the state of enforcement that some combination of the laws, either as written or construed, and/or the ways in which they are being enforced today, are not protecting the public from the harmful effects of many transactions and business practices.

In the section below, I suggest reforms that can assist the Agencies in halting anticompetitive acquisitions and practices.

⁴⁶ The FTC is currently seeking, under a vertical theory of harm (that also involves issues of nascent competition), to block a proposed acquisition in the cancer detection space. FTC, “FTC Challenges Illumina’s Proposed Acquisition of Cancer Detection Test Maker Grail,” Mar. 30, 2021, <https://www.ftc.gov/news-events/press-releases/2021/03/ftc-challenges-illumina-proposed-acquisition-cancer-detection>.

V. Reforms to Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets

1. *Strengthen the federal enforcement agencies' ability to identify and review potentially problematic transactions and conduct in health care.*

- Require more health care transactions to be reported. Implement additional filing requirements, specifically lowering the asset value threshold and adding revenue thresholds to cover smaller facility and provider consolidation and transactions involving low- or no-asset transfers; and require filers to provide information that can facilitate the screening process, such as the distance and driving time between the closest establishments of the merging parties.⁴⁷
- Increase the budgets of enforcement agencies. The volume of transactions the Agencies must review has increased dramatically even as funding has declined in real terms.⁴⁸ The Agencies require these resources to develop expertise in a range of new and changing sectors, to litigate and establish new precedents that protect competition, and to advocate for pro-competitive policies. Investing in our enforcement agencies will help to prevent anticompetitive practices and consolidation and yield a return for years to come.
- Remove two unnecessary limitations on the authority of the FTC. The first precludes the FTC from investigating anticompetitive conduct by nonprofit organizations, and the second precludes the FTC from studying the business of insurance absent explicit Congressional authorization. These restrictions have no merit. The former results in an arbitrary and likely inefficient allocation or transfer of cases across the Agencies, and the latter impedes the FTC's efforts in a sector where the lines between provision of care and insurance are increasingly blurred.

2. *Request that the Agencies issue revised Health Care Statements (or "Health Care Guidelines").*

- Issued in 1996, the *Statements of Antitrust Enforcement Policy in Health Care* describe how the DOJ and FTC evaluate—or once evaluated—certain types of mergers, joint

⁴⁷ For more detailed and helpful suggestions on expanding and streamlining pre-merger reporting, see Bill Baer et al, "Restoring competition in the United States: A vision for antitrust enforcement for the next administration and Congress," Nov. 19, 2020, <https://equitablegrowth.org/research-paper/restoring-competition-in-the-united-states/>.

⁴⁸ Testimony of Bill Baer, "Hearing on 'Proposals to Strengthen the Antitrust Laws and Restore Competition Online,'" Oct. 1, 2020, <https://docs.house.gov/meetings/JU/JU05/20201001/111072/HHRG-116-JU05-Wstate-BaerW-20201001.pdf>.

ventures, and contracting practices among health care entities.⁴⁹ The health care landscape has changed considerably since 1996, and the guidelines should be updated and expanded to include discussions of recent types of transactions that have been shown to harm consumers, such as “cross-market” mergers of providers in adjacent geographic markets. The revised Statements, which should be renamed “Health Care Guidelines,” in keeping with Agency practice when issuing significant documents setting forth the Agencies’ approach to assessing mergers, should also describe concerns about the contracting clauses imposed by dominant health care systems, including but not limited to “all or nothing” provisions and anti-steering/tiering provisions, as well as range of pharmaceutical practices that weaken competition. The revised Guidelines would provide an opportunity for the DOJ and FTC to set forth their interpretation of antitrust statutes, provide valuable guidance to the health care industry, and potentially deter anticompetitive conduct and mergers that would otherwise be costly and time-consuming for the authorities to challenge even if they are highly likely to prevail.

3. *Amend and strengthen the antitrust statutes.*

- Per Clayton Act Section 7, the agencies must demonstrate a transaction “*substantially*” lessens competition or “tends to create a monopoly” in order to block a merger. Replacing “substantially” with “meaningfully” or “materially” could reduce the burden of merger challenges, and expand the scope of such challenges. For example, with such a change authorities may be able to address the problem of smaller acquisitions, such as serial acquisitions of physician practices by hospital systems, that may have not have substantial effects individually but, collectively, lead to the same outcomes as a large merger.⁵⁰
- Implement a legal framework—whether by amending the Clayton Act, amending Section 2 of the Sherman Act, or interpreting the agency's unfair methods of competition authority—to explicitly prohibit health care mergers that enable greater exploitation of existing market power and are likely to result in harm to consumers. Such a reform would discourage transactions that yield price increases without commensurate benefits to consumers, such as when a dominant hospital buys a suburban hospital and instantly raises its price, or when a new acquirer (such as a private equity firm) implements surprise billing to the detriment of patients.

⁴⁹ US DOJ and FTC, “Statements of Antitrust Enforcement Policy in Health Care,” Aug. 1996, <https://www.justice.gov/atr/page/file/1197731/download>.

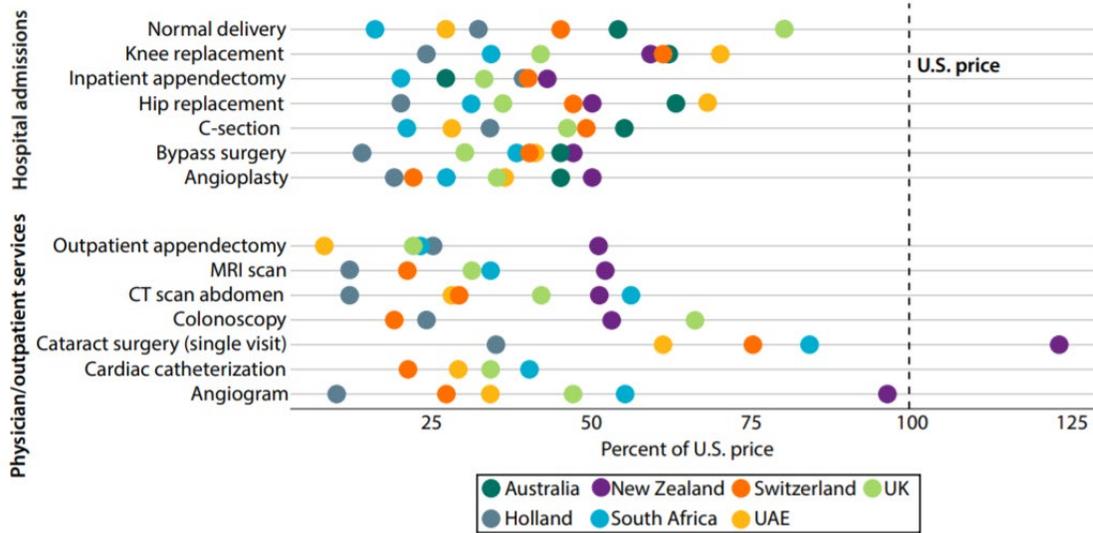
⁵⁰ Capps et al. (2017), *supra* n. 27.

- Ease the Agencies' legal burden for challenging certain combinations. This burden-shifting should be limited, but particularly for the largest transactions, and for those with especially high potential to prove anticompetitive, such a shift would help to deter anticompetitive mergers and conserve scarce Agency resources.
4. *Create a federal database to track health care ownership and spending, both private and public.*
- This database could form the basis for regularly scheduled reports by HHS or the enforcement agencies, and could inform public hearings on industry consolidation and its effects. It would also allow the antitrust agencies to more quickly and efficiently distinguish innocuous and potentially concerning provider transactions, which will be particularly useful if, as I recommend above, the reporting thresholds for such transactions are lowered. At a minimum, the data should be available to public agencies for use in analysis and investigations; ideally, it would be available to researchers for analysis as well, subject to all the necessary privacy and confidentiality protections.

VI. Conclusion

Although the current health care system is rapidly evolving, there is no reason to believe that consolidation in our health care sectors is likely to be less harmful going forward than it has been, on average, in the past. Indeed, as the share of the population that is publicly insured increases, and as commercial insurers increasingly administer health plans for the publicly insured, there is considerable risk that market power exercised vis a vis the privately insured population through higher prices will become apparent for the publicly insured as well. And consolidation-fueled price increases are not linked to improvements in patient outcomes or satisfaction. Congress should provide funding and pass needed legislation to support and promote competition in health care markets. It is precisely during this time of change in the health care system that the risks of consolidation are highest and the rewards of vigilance will be greatest.

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



Source: Adapted from Hargraves and Bloschichak (2019) using International Federation of Health Plans (IFHP) data.

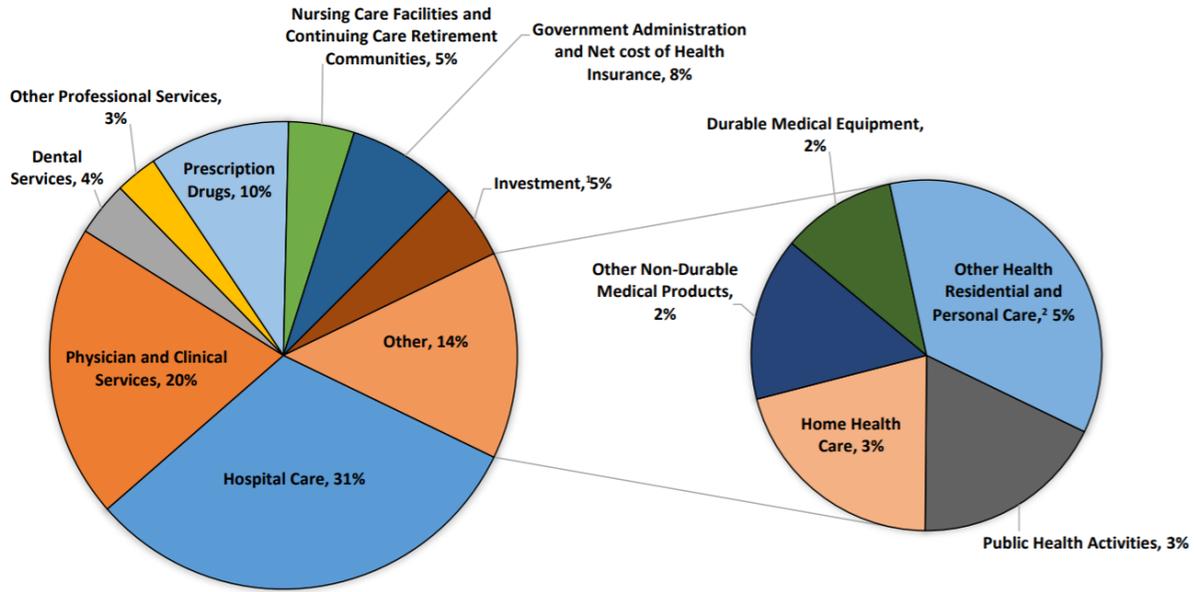
Notes: Data are from IFHP member companies in eight countries. International service price comparisons are complicated by potentially different service definitions, reimbursement arrangements, and health plan participation across countries.



Source: Chernew, Dafny, and 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.

Figure 2. U.S. Health Care Spending, By Category, 2019

**THE NATION'S HEALTH DOLLAR (\$3.8 TRILLION), CALENDAR YEAR 2019,
WHERE IT WENT**

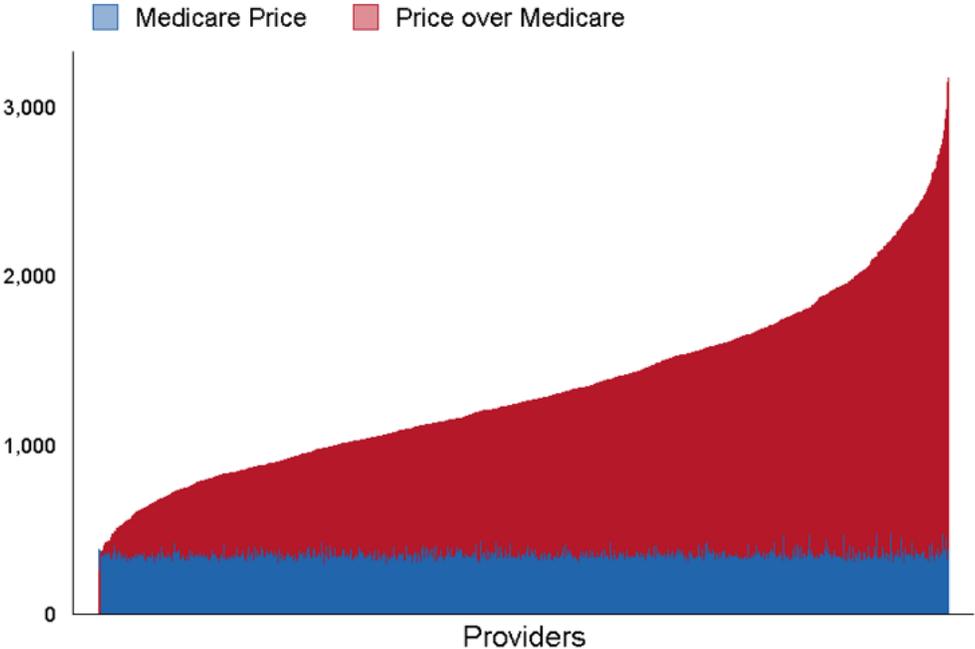


¹ Includes Noncommercial Research and Structures and Equipment.

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. Commercial and Medicare Price for a Knee MRI



Note: Each column is an individual hospital with at least 50 episodes included in the source data. Hospitals are ordered by their average commercial price. Data is for 2007-2011.
Source: Health Care Pricing Project, @Coopper, Gaynor, and Van Reenen, https://healthcarepricingproject.org/sites/default/files/papers/pricing_variation_slides.pptx