



## Health Care Industry Consolidation: A Driving Force of the U.S. Health Care Affordability and Quality Crisis

### Introduction

The cost of health care in the U.S. has been rising at an unsustainable rate for far too long. Nearly half of all Americans have had to forgo medical care due to cost,<sup>1</sup> and a third of them have indicated that the cost of medical care interferes with their ability to secure basic needs like food and housing.<sup>2</sup> On a per capita basis, health care spending in the U.S. has increased more than fourfold over the last four decades, from \$2,582 per person in 1970 to \$11,582 per person in 2019 in inflation-adjusted terms.<sup>3</sup> Moreover, this excessive growth in costs is primarily driven by paying higher prices than anywhere else in the world for health care, including prescription drugs, hospital stays, MRIs and CT scans, births, and time in the intensive care unit (ICU).

This high pricing generally does not buy Americans higher quality. Indeed, it is quite the opposite. Financial barriers reduce access to care and hurt our economy. People living in America see the doctor at a small fraction of the rate of people in Western Europe and Japan,<sup>4</sup> and they have more limited access to most medications. This combination of high costs and limited access to care contributes to poor population health outcomes. Although the nation spent an estimated \$3.9 trillion on health care in 2019 alone,<sup>5</sup> Americans suffer from the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized countries.<sup>6</sup> Despite these startling disparities, the U.S. is spending vastly more than other nations — nearly 20% of its total national gross domestic product.<sup>7</sup>

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Simply stated, America's families, workers and employers are paying exorbitant health care prices without getting better care or improving their overall health. **The current system is undermining and disincentivizing affordable, high-quality health care, with nearly three-quarters of Americans in agreement that the U.S. health care system does not provide good value to the people it serves.**<sup>8</sup>

It is time for our nation's health care system to deliver on its obligation to provide high-quality, affordable and cost-effective care to the people of this country. Consumer organizations, employers, workers, and primary care clinicians stand united in calling for action to rein in growing trends of consolidation and pricing abuses. To be accountable for the health of all people in our nation, systems and resources must be reoriented. Congress and the Biden administration must take bold policy action in 2022 and beyond to address the U.S. health care affordability and quality crisis.

### **America's health care affordability crisis**

Over the last several decades, families, working people and employers have borne the brunt of rising health care costs due to health care payment and delivery policies that prioritize the business interests of the health care sector at the expense of consumers and patients. Recent polling of voters across the political spectrum shows that nearly 90% of people surveyed want to see policymakers take action to lower health care costs.<sup>9</sup> Further, 87% of large employers across the country say that the cost of providing health benefits over the next 5 to 10 years will become unsustainable if health care costs are not lowered.<sup>10</sup> These increasing costs create ripple effects that impact the ability of working people to earn a living wage. Over the last 40 years, America's workers have experienced stagnant wages largely due to rising health care costs.<sup>11</sup> In other words, today's real wages — or wages after accounting for inflation — are the same as roughly four decades ago.<sup>12</sup>

One of the major drivers of unaffordable health care in the United States is the underlying price of health care services, also known as unit prices.<sup>13</sup> These higher unit prices result in nearly \$240 billion in waste annually to the health care system.<sup>14</sup> In particular, hospital prices have recently attracted increased scrutiny given that hospital care represents the largest share of national health care spending (33%) with an estimated \$1.2 trillion in spending each year.<sup>15</sup> Moreover, the very high prices Americans pay for hospital care raise questions because of the pervasive role of hospital consolidation in eliminating real competition for value and driving up hospital prices.

## Key trends in health care industry consolidation

Over the last 20 to 30 years, there has been dramatic consolidation in the health care sector, which has resulted in noncompetitive health care markets across the country.<sup>16</sup> **In fact, there are few truly competitive health care markets left, with 95% of metropolitan statistical areas (MSAs) having highly concentrated hospital markets, nearly 80% of MSAs having highly concentrated specialist physician markets and 57% of MSAs having highly concentrated insurer markets.**<sup>17,18</sup> Substantial economic research indicates that industry consolidation across and within U.S. health care markets has led to anti-competitive practices by both health plans and providers as well as skyrocketing health care prices.<sup>19,20,21,22</sup> It is important to look at the role each sector of the health care industry plays in this increasingly consolidated system in order to best determine how to address this crisis.

## Meet the players

### Hospitals and health systems

Hospitals are at the center of the U.S. health care system, which is particularly evident as hospital workers continue to serve on the front lines of the COVID-19 pandemic, striving each day to provide the best patient care and save lives. Yet the business practices of the hospital industry are often in conflict with the interests of the people hospitals serve and are largely responsible for driving the U.S. health care affordability crisis.

In the aftermath of the Clinton administration's failed health reform efforts of the early 1990s and the shift to managed care in the late 1990s, hospitals and providers increasingly turned to consolidation as a way to manage financial risk and increase leverage in contract negotiations with managed care organizations.<sup>23</sup> According to the American Hospital Association, there were 1,577 hospital mergers from 1998 to 2017.<sup>24</sup> An estimated 40% of those mergers took place from 2010 to 2015.<sup>25</sup> Another 90 hospital mergers have taken place since 2018.<sup>26</sup>

Mergers occurring between hospitals located in close proximity (that is, hospitals in the same health care market) and mergers between hospitals that are located farther from each other (that is, hospitals across markets) are both problematic and lead to higher prices.<sup>27</sup> The growth in hospital consolidation has resulted in health care markets in many parts of the country that are dominated by one or two large hospital systems with no true competitors. This dynamic can be seen in cities and regions like Boston, Massachusetts, dominated by Partners HealthCare; Cleveland, Ohio, dominated by Cleveland Clinic and University Hospital; Pittsburgh, Pennsylvania, dominated by University of Pittsburgh Medical Center and Highmark Health; southern Arizona, dominated by Banner Health; and San Francisco, California, dominated by Sutter Health.<sup>28</sup> Once a health system has gained sufficient market power to claim a dominant position, it has a financial incentive to protect and increase its market power to unilaterally raise prices by engaging in anti-competitive practices, prohibiting the flow of data to consumers and providers, and restricting provider networks.<sup>29</sup>

## Big Consequences for Real People

### Tamara Hamilton, Colorado

Tamara Hamilton lives in Mancos, Colorado, a small rural town of around a thousand people. Across Colorado, there has been a steady pattern of hospital mergers that have swallowed up smaller, independent hospitals and created larger hospital systems. Smaller, rural hospitals simply cannot compete and often have to reduce hours, cut services or shutter their doors altogether. Meanwhile, [larger hospitals are expanding their health networks to cover increasingly large areas of the state](#), leaving patients like Tamara with few options for nearby health care and higher prices. Making matters worse, in Tamara's corner of Colorado, insurance premiums are higher than anywhere else in the state. Every doctor in the county is on the same network, so there is no competition. Medical appointments are hugely backlogged in her area and often must be booked four months out. Tamara has even told a receptionist trying to book her not to bother because, as she said, "That far from now, I'll either be better, or I'll be dead."

This is not an exaggerated risk. When her 1-year-old grandson, Tucker, fell ill with COVID-19 and had low oxygen levels, Tamara and her daughter worried it would be too risky to take the seven-hour trip to Denver that was required to get him on oxygen, so they decided to manage his care at home. Thankfully, her grandson recovered, but it could have been a very different story.

### Physicians

There has been increasingly significant consolidation among physician practices with a substantial rise in the number of hospital acquisitions of physician practices over the last decade.<sup>30</sup> The number of hospital-acquired physician practices grew from 35,700 in 2012 to more than 80,000 in 2018.<sup>31</sup> Over this same time period, the percentage of physicians employed by a hospital or health system nearly doubled, from 25% to 44%.<sup>32</sup> Recent research found that over 55% of physicians are now employed in hospital-owned practices.<sup>33</sup> This trend was accelerated by the COVID-19 pandemic, which exacerbated the financial vulnerabilities of independent and smaller physician practices and threatened the near collapse of entire sectors of the health care system — particularly primary care. Nearly 23,000 physicians left independent practice to work for a hospital or other corporate entity after the onset of the COVID-19 pandemic, while hospitals and other corporate entities acquired nearly 21,000 additional physician practices from 2019 to 2020, representing a 25% increase in corporate-owned practices.<sup>34</sup> The increase in hospital and health system acquisitions of physician practices is the latest trend in consolidation leading to anti-competitive practices that result in unaffordable, low-quality care for consumers.

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### **Insurers**

Insurance markets are not nearly as highly concentrated as providers, but there is evidence of markets with little competition between insurers. Between 2006 and 2014, the four-firm concentration ratio — the extent of market control held by the four largest firms, Aetna, Blue Cross Blue Shield, United and Anthem — for the sale of private insurance increased from 74% to 83%.<sup>35</sup> These high concentration ratios mean the insurance market is consolidated and does not have real competition, which results in monopolistic health care prices that lead to unaffordable health care and poorer quality. Many health plans — like Kaiser Permanente, Intermountain Healthcare and Geisinger Health System — have substantial presence in local markets rather than large national footprints. Insurer mergers occurring in local insurance markets can also result in loss of competition among insurers to reduce costs and improve quality, and allow payers to focus more on increasing revenue by increasing the total health care spend (for example, in an environment where profit is capped as a percentage of spend through medical loss ratio (MLR) requirements). Ultimately, this loss of competition results in poorer-quality care and health, and costs for the employer sponsors of coverage and consumers continue to increase.<sup>36</sup>

### **The impact of increased health care industry consolidation on health care prices and care quality**

For decades, lawmakers, academics, policymakers and advocates worked to uncover the root causes of high and variable health care prices among hospitals and across cities. A 2010 landmark report by then-Attorney General of Massachusetts Martha Coakley showed a positive correlation between high and variable prices in Massachusetts and market power and leverage over negotiations among insurers, hospitals and physician groups.<sup>37</sup> A similar 2016 report by the New York State Health Foundation found a positive correlation between increased market share and high prices.<sup>38</sup> These studies also show that, in many instances, higher prices were not correlated — either positively or negatively — to the quality of care that the institutions provided.<sup>39,40</sup> **In other words, these studies found that paying more for health care does *not* result in better care, and there is, in fact, no relationship at all between the prices consumers pay for health care and the quality of the care they receive.** Alarming, the dynamics of the Massachusetts

and New York health care markets described in those reports are seen in health care markets across the nation.<sup>41</sup>

### **Impact of hospital and health system consolidation on consumers**

Hospitals and health plans negotiate prices for commercially insured patients. The outcome of those negotiations depends heavily on the competitive market conditions for both parties. Through horizontal integration — the consolidation of hospital markets — and vertical integration — the merging of hospitals, physicians and other provider systems — hospitals and providers consolidate market power, increasing their leverage in price negotiations with insurers.

Unchecked industry consolidation, particularly among providers, has led to a growing divide between commercial prices — prices paid by private plans and employers — and Medicare prices.<sup>42</sup> Unlike commercial prices, which are subject to the market power of insurers and providers to negotiate prices, Medicare prices are established administratively and are often considered the benchmark price for health care goods and services across the U.S. health care system. In fact, Medicare's efforts to set prices (flawed as they might be) through analysis of the resources and intensity of care needed to provide services may be viewed as the only real effort to establish a rational price for care.<sup>43</sup> In fact, in most instances, commercial payers, Medicaid and other payers simply pay a percentage of the prices set by Medicare (for example, 100%, 150%, etc. of the Medicare price).<sup>44,45</sup>

From 1996 to 2017, commercial prices for inpatient services essentially doubled relative to what Medicare paid, increasing from 110% to 204% of what Medicare paid for inpatient services.<sup>46,47</sup> In 2017, commercial prices for outpatient services were even higher at 293% of what Medicare paid.<sup>48</sup> In some states, employers and private plans pay *nearly 350%* of what Medicare pays for hospital inpatient and outpatient services.<sup>49</sup> The growing divide between commercial prices and Medicare prices results in higher premiums, lower take-home pay and higher cost-sharing requirements for the more than 176 million Americans who obtain health insurance either through their employer or purchase it directly from a health plan.<sup>50</sup>

The variation in health care prices across geographic locations also indicates the irrationality of those prices. Researchers' findings from over a decade ago show extreme variation in health care price between comparable cities, where the average payment rate across hospital inpatient services in 2010 ranged from 147% of what Medicare pays in Miami to 210% in San Francisco.<sup>51</sup> In some cases, hospitals were able to negotiate nearly 500% of what Medicare pays for inpatient care and 700% for outpatient services.<sup>52</sup>

Two individuals living in two different cities, even those in close proximity and with similar cost of living, can be paying significantly different prices for health care, with no connection to input costs or care quality. For example, the average price for a knee replacement for a patient in Tucson,

Arizona, is \$21,976, while the same procedure would cost about \$38,000 more in Sacramento, California.<sup>53</sup> Patients in New Mexico pay about 25% above the national average of health care prices, while those in Arizona pay 15% below the national average.<sup>54</sup>

Prices also can vary significantly within U.S. health care markets. A recent exposé by *The New York Times* found that prices for health care services *within a single hospital system* varied significantly across payers. **For example, the price of an MRI at Mass General Hospital in Boston, Massachusetts, ranged from \$830 to \$4,200 depending on the insurance carrier.**<sup>55</sup>

Increased consolidation has not resulted in reduced costs through economies of scale, improved care coordination or quality oversight as industry proponents have argued. Instead, the evidence overwhelmingly confirms that consolidation has produced exploitative markets that drive high prices and costs, without improving the quality of care:<sup>56</sup>

- » One study of 15 integrated health care delivery systems found *no evidence* that hospitals in these consolidated systems provided better clinical quality or safety than their competitors.<sup>57</sup>
- » Another study found that the risk-adjusted one-year mortality for heart attacks in Medicare patients was 4.4% *higher* in highly concentrated hospital markets than in less concentrated markets.<sup>58</sup>
- » Yet another study found that Medicare patients treated for hypertension had *worse* health outcomes and higher health care expenditures in concentrated cardiology markets compared with markets that were not concentrated.<sup>59</sup>

## Big Consequences for Real People

### Kyunghee Lee, Ohio

In early 2021, [Kaiser Health News](#) reported the story of Kyunghee Lee, who has run a family dry-cleaning business near Cleveland, Ohio, for many years. Kyunghee has arthritis in two of her fingers, so, about once a year, she goes to see a rheumatologist who gives her a steroid injection in the affected joints. For the past few years, the cost for these injections was about \$30. One day when she went to receive her injections, she noticed her doctor's office had moved up a floor, but everything else was the same, until the bill arrived. Kyunghee received a bill for \$1,394, including a \$1,262 facility fee listed as "operating room services." The balance included a clinic charge and a pharmacy charge. Kyunghee's portion of the bill was \$354.68 — more than 10 times what she usually paid. Kyunghee's doctor's office had moved to a "hospital setting," and the hospital had added a facility fee of more than \$1,200. This is one of the results of consolidation: The hospital that bought the doctor's office added this fee, not her doctor.

## A call to action for Congress and the Biden administration

Clearly, the high and rising health care costs and low-quality care resulting from health care industry consolidation are unsustainable for our nation and must be addressed.

But where do we go from here? Efforts to “un-merge” consolidated health systems are very unlikely to be successful and may be totally impractical.<sup>60</sup> It is unrealistic to expect that government entities can unwind every anti-competitive merger in the system and undo health system consolidation. We cannot simply “unscramble the eggs.”<sup>61</sup>

Further complicating matters, as health care spending increases both nominally and as a percentage of U.S. gross domestic product, the political power of the health care sector grows. Put simply, consolidation concentrates political power. Ultimately, both economic growth and concentration through consolidation result in an outsized ability of the sector to influence policy decisions that can run counter to the interests of consumers, working people and employers.<sup>62</sup> The result is further entrenched policies that perpetuate the broken economic incentives in our health care system, reducing consumer purchasing power in the health care market and shifting the burden of rising health care costs to families and employers across the country.<sup>63</sup>

Yet federal policymakers and regulators have the power to enact a wide variety of policies to counterbalance these industry pressures and uproot the underlying distortions in the health care system that drive higher costs and lower-quality care. These types of policies often are wildly popular among the American people across the political spectrum.<sup>64</sup> In fact, over the last two years, federal policymakers have already begun to take important steps to address the anti-competitive practices that drive unaffordable health care:

- » On July 9, 2021, President Joe Biden issued an [executive order](#) to promote competition in the American economy,<sup>65</sup> elevating key issues including hospital consolidation and hospital price transparency.
- » The U.S. Department of Health and Human Services (HHS) is currently implementing two key regulations focused on requiring hospitals and health plans to disclose health care pricing information, including negotiated rates: the hospital price transparency<sup>66</sup> and the transparency in coverage regulations.<sup>67</sup> The underlying price of health care has historically been deemed proprietary information in plan and provider contracts and has not been available to the public, but as of January 1, 2021, each hospital operating in the United States is required to provide clear, accessible pricing information online about the items and services they provide — a critical step forward.
- » In November 2021, HHS released the [final calendar year 2022 Hospital Outpatient Prospective Payment System \(OPPS\) rule](#), which increased the penalty for noncompliance with the hospital transparency price rule.

- » The 117th U.S. Congress has held key committee hearings assessing hospital consolidation and its impact on affordability and quality of care, including a [hearing held by the Senate Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights in May 2021](#).
- » In June 2019, the Senate Committee on Health, Education, Labor and Pensions (HELP) passed the [Lower Health Care Costs Act of 2019](#) with a rare strong bipartisan vote of 20-3. It was a piece of landmark legislation that included numerous provisions aimed at reining in health care prices and anti-competitive behavior. While the full bill never received a vote on the Senate floor, two of its key provisions were enacted into law as part of the COVID-19 economic relief bill in December 2020: protecting consumers from surprise medical bills and a prohibition on “gag clauses” used in contracts between health plans and providers that prevent sharing of critical information about the cost and quality of health care.

Each of these actions, taken in combination with a federal ban on surprise medical billing and recent federal intervention on pharmaceutical company pricing of prescription drugs, indicates that federal policymakers are increasingly interested in working to prevent abuses that drive high and rising health care costs. But these are first steps. Additional policy changes are needed to make meaningful progress to lower health care costs for our nation’s families, working people and employers.

### **Policy solutions to address the negative effects of health care industry consolidation**

Real change is possible if federal policymakers commit to putting the needs of everyday people over the interests of wealthy and powerful health industry players. Moreover, the health care budget crisis for the federal government, states, employers and families creates tremendous political currency and interest.<sup>68</sup>

Oftentimes the health care industry prefers to point at any issue other than excessive unit prices as a mechanism to lower health care costs. This includes addressing social determinants of health or reducing unnecessary and inappropriate use of health care services. These are laudable goals, but they are also an effort to change the subject. **Health care prices are simply too high.** From 2013 to 2017, the utilization of commercial insurance decreased by 0.2%, but average health care prices *increased* by more than 17% overall (4% to 5% per year) — far outpacing inflation in the larger economy.<sup>69</sup> Ultimately, policymakers have to reckon with this gross disparity by taking on the fundamental distortions in our health system that allow these pricing abuses to continue.

Families USA urges Congress and the Biden administration to enact the following key policy reforms that rein in industry consolidation, restore market competition and lower health care costs in order to make health care truly affordable for consumers, working people and employers.

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## Legislative policy recommendations

- » **Prohibit anti-competitive terms in provider and insurer contracts that limit access to higher-quality, lower-cost care.** In highly consolidated markets, large providers have the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit patient access to alternative sources of higher-quality, lower-cost care such as:
  - › “Anti-tiering” and “anti-steering” clauses in contracts between providers and health plans that restrict the plan from directing or incentivizing patients to use other providers and facilities with higher quality and lower prices.
  - › “All-or-nothing” clauses in contracts between providers and health plans that require health insurance plans to contract with all providers in a particular system or none of them.

Banning anti-competitive contracting has strong bipartisan support as passed by the Senate HELP Committee in 2019 in Section 302 of S.1895 and was recently introduced as [S.3139, the Healthy Competition for Better Care Act](#). The Congressional Budget Office estimated that enacting this provision would reduce the total employment-based health care costs by 0.05%, amounting to savings of more than \$500 million per year.<sup>70</sup>

- » **Equalize Medicare payments for a specific set of health care services across care settings, often referred to as site-neutral payments.** The growing trend of payment differentials based on the site of service where care is provided has created a financial incentive for hospitals to acquire physician practices and is a significant driver of high and rising health care costs. To push back on this trend, Congress should expand site-neutral payments to cover all off-campus provider-based departments, as well as on-campus provider-based departments, freestanding and nonfreestanding emergency departments and off-campus provider-based entities. Specifically, Congress should:
  - › Eliminate the “grandfathering” of higher outpatient payment rates to existing off-campus provider-based departments for all services, not just clinic visits. According to the Congressional Budget Office, implementing this policy will save an estimated \$13.9 billion from 2019 to 2028.<sup>71</sup>

- › Extend site-neutral payments for clinic visits to all on-campus provider-based departments. The Medicare Payment Advisory Commission’s (MedPAC) 2017 report estimated that implementing site-neutral payments for clinic visits at on-campus and off-campus provider-based departments would save Medicare \$2 billion per year.<sup>72</sup>
- › Extend site-neutral payments across a broader set of clinical services delivered in on-campus provider departments, starting with the 24 Ambulatory Payment Classifications identified in MedPAC’s 2013 report, which found no additional benefits to performing those services in a hospital setting.<sup>73</sup>
- » **Establish a national all-payer claims database (APCD) to lower Americans’ health care costs.** It is practically impossible to understand how much a health care service will cost, how the cost of that service compares with similar services and whether providers offering that service are providing high-quality care. This is because this information is not available in an effective, interoperable way. The lack of real-time national health care data — including utilization and payment — has been a major hindrance to the U.S. pandemic response. Without this data the ability to effectively address the specific challenges faced by people of color and others disproportionately impacted by the pandemic has been further impeded. Moreover, the lack of comprehensive national health care claims data poses a significant barrier to the successful integration of high-value care into the broader health care system. Without such data, providers cannot possibly provide the most well-informed and best possible care for patients, and purchasers and consumers will not be able to understand which providers and treatments are high value and which are a waste of money. Congress should:
  - › Require both public and private payers to report health care utilization and claims data to the national APCD according to federally established standards across multiple categories. Data should be stratified by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and disability status. Establishing a national APCD has strong bipartisan support and was passed by the Senate HELP Committee in 2019 (Section 303 of S.1895)

### Administrative policy recommendations

- » **Use administrative levers to crack down on anti-competitive behaviors.** In addition to congressional efforts described above, the U.S. Department of Health and Human Services should prohibit the use of anti-competitive contracting terms in provider and insurer contracts that limit access to higher-quality, lower-cost care as a condition of Medicare participation for hospitals.
- » **Build upon efforts to expand site-neutral payments.** In addition to congressional efforts described above, the administration can work to improve site-neutral payment policy through the next annual Outpatient Prospective Payment System proposed rule and require

Medicare to pay the same rate to all on- and off-campus hospital outpatient departments, ambulatory surgery centers, emergency departments, and off-campus physician offices. This recommendation should include exceptions for underserved urban and rural areas to prevent any unintended adverse impact on underserved communities.

- » **Make important improvements to the hospital price transparency rule.** Consumers and employers ultimately pay for health care through insurance premiums, deductibles and copays. The fact that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been delivered must change. The hospital price transparency rule, including the modifications in the calendar year 2022 OPSS rule, is a big step forward. The administration can further strengthen it by:
  - › Requiring hospitals to report pricing information on a nationally uniform set of services. A reasonable requirement would be the publication of 100 total services to include a broad representative sample of services (that is, imaging, evaluation and management, core surgical specialties) from the following categories:
    - Fifty highest dollar volume (price times volume) inpatient services.
    - Fifty highest dollar volume (price times volume) outpatient services.
  - › Increasing the civil monetary fine for noncompliant hospitals from \$10 per bed per day to \$300 per bed per day.
- » **Leverage Medicare demonstration authority to allow states to set and administer all payer price regulation and global budgets for all hospitals as a mechanism to control the rising costs of hospital services.** Maryland has had hospital rate regulation operated under the Health Services Cost Review Commission, an independent state agency, since 1974, and the system includes Medicare hospitalizations under a long-standing Medicare waiver. Beginning in 2014, the system shifted to hospital global budgets that move hospitals away from fee-for-service payment and toward incentives to invest in population health, operating under a CMS Innovation Center (CMMI) demonstration.<sup>i</sup> Pennsylvania has also adopted a related model for rural hospitals under CMMI authority. There is enormous power to reduce overall system costs using both aspects of this model: all-payer rate regulation and global budgets. Maryland now pays the lowest prices for hospital care of any state despite a highly concentrated hospital market dominated by huge academic medical centers.<sup>74</sup>

<sup>i</sup> Global budget payments offer providers a fixed reimbursement amount for a specific patient population over a fixed period of time. This enables providers to have flexibility to deliver tailored care to patients while being held accountable for the total cost of care for the population being served.

*The fact that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been delivered must change.*



» **Ensure that federal antitrust laws are fully applied to health system consolidation.**

The Federal Trade Commission (FTC) and the U.S. Department of Justice have authority to push back on new mergers through existing antitrust laws and to undo particularly egregious monopolies through legal action. The agencies should prioritize development of a specific strategy, market by market, to appropriately crack down on horizontal integration among hospitals, health systems and pharmaceutical companies; vertical integration between physician practices and hospitals as well as among health plans, pharmacy benefit managers and specialty pharmacies; and cross-sector mergers and acquisitions between health plans and pharmaceutical managers. Furthermore, the FTC should develop a set of recommendations for a more sophisticated judicial capacity to understand health care consolidation and other anti-competitive health sector behaviors (for example, analogous to the federal patent bar).

» **Establish stricter review and enforcement of physician practice consolidation, including physician practice mergers and hospital acquisitions of physician practices, upon completion of the FTC's study under the Merger Retrospective Program.**

The FTC study seeks to analyze patient-level commercial claims data for inpatient, outpatient and physician services in 15 U.S. states to understand the impact of physician practice mergers and hospital acquisitions of physician practices — vertical integration — on health care prices. The FTC should use the results of this study to make recommendations to Congress to enable the commission to prevent physician practice consolidation and increase health care market competition.

### **The future of the U.S. health care system**

Individually, none of the policy changes recommended in this brief can reverse the damage that health care industry consolidation has done to our health system. But, collectively, they constitute a road map for long-term and meaningful change that can put our health system on a much healthier track for the future. Taken together, these policy recommendations can reorient and

redesign many of the broken economic incentives in the health care system that have prioritized the business interests of some health care industry executives at the expense of the health and economic security of our nation's families.

Congress and the Biden administration have a critical opportunity — and responsibility — to build on recent momentum toward system change by restoring fair competition in U.S. health care markets and lowering health care costs for America's families, workers and employers. The longer we wait, the more entrenched perverse payment incentives and industry manipulations will become, and the harder it will be to change the system. **Our leaders must take bold and immediate action to reorient our health care resources and systems to be held accountable for the health of all people in the nation, not just for providing units of disconnected health care.** Only then can we realize our national goals of living longer, healthier lives, free from disparities and unburdened from economic constraints on health and health care.

## Endnotes

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