Statement before the House Budget Committee on "Breaking up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation"

Examining the Budgetary Effects of Health Care Consolidation

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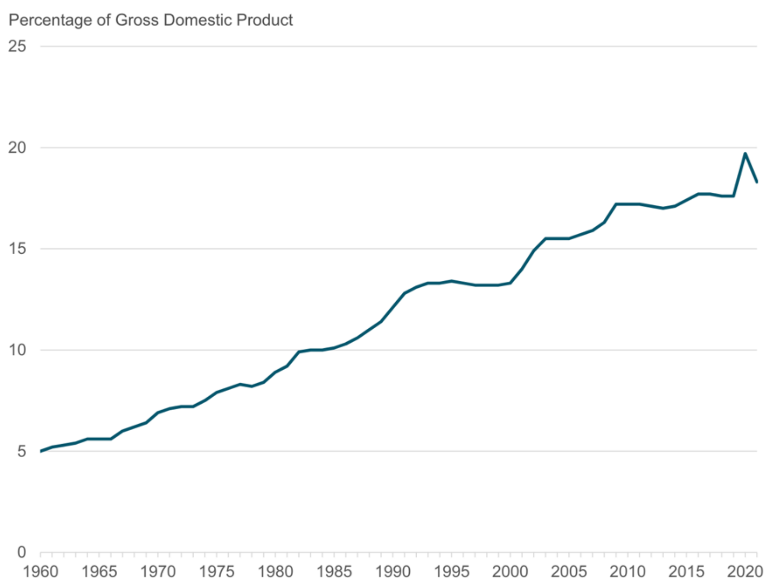
Introduction

Health costs play a central role in the federal budget and the United States' long run fiscal imbalance. Total federal spending on Medicare, Medicaid, and individual market subsidies alone amount to $1.67 trillion per year, which is slightly larger than the entire discretionary budget.[1] A decade ago, these programs were 23 percent less than the discretionary budget. In addition, income tax exemptions for employment-based insurance reduce federal revenues by over $300 billion per year.[2] As commercial health costs rise, the implicit cost of this tax exemption does as well.

Over the last 60 years, health costs have risen from rough 5 percent of gross domestic product (GDP), to nearly 20 percent. Remarkably, the last decade has seen relatively modest cost growth by historical standards (with an exception due to the covid pandemic). Should health costs grow at more typical historical rates, they would put more acute pressure on the federal budget. Notably, the Congressional Budget Office anticipates that health costs will grow at a faster rate in the coming decade, particularly due to Medicare spending, which is expected to rise from 3.3 to 4.1 percent of GDP.[3]

[1] Merkel, T., & Gonshorowski, D. (2024). Government's Mandatory Health Care Spending Now Exceeds Entire Discretionary Budget. Paragon Health Institute. https://paragoninstitute.org/paragon-pic/government-health-spending-exceeds-discretionary-budget/
[2] CBO. (2022). Federal Subsidies for Health Insurance Coverage for People Under 65: 2022 to 2032. https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf
[3] CBO. (2023, February 8). The Budget and Economic Outlook: 2023 to 2033. https://www.cbo.gov/publication/58946



Note: Figure taken from Topoleski, J. (2023). "Long-Term Projections of Health Care Spending and the Implications for the Federal Budget." *Congressional Budget Office.* https://www.cbo.gov/system/files/2023-05/58610-OECD.pdf

How consolidation affects federal spending

Consolidation within health care markets is an important contributor to federal health spending. A large amount of empirical research has shown that this consolidation has increased prices paid by commercial insurers.[4] This is true of horizontal consolidation between similar firms (e.g., two hospitals merging) and vertical integration between different types (e.g., a hospital acquiring physicians' practices). Research has found little evidence of commensurate improvements to quality. While empirical studies have focused more on health care providers, horizontal and vertical consolidation in other markets, like Pharmacy Benefit Managers or health insurers, can raise similar concerns.

[4] For reviews of the literature, see Gaynor, Martin. "What to Do about Health-Care Markets? Policies to Make Health- Care Markets Work." *Hamilton Project Policy Proposal* (2020) https://www.hamiltonproject.org/publication/policy-proposal/what-to-do-about-health-care-markets-policies-to-make-health-care-markets-work/; Levinson et al. "Ten Things to Know About Consolidation in Health Care Provider Markets." KFF. April 19, 2024. https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

Importantly, research has also shown that increasing health costs, which raises the cost of employers offering health insurance, leads to lower wages for workers.[5] This effectively means a larger share of total compensation is delivered through a tax-exempt vehicle and is a key reason consolidation lowers federal tax revenues. As noted above, this exemption currently costs over $300 billion per year and is expected to rise to over $600 billion by 2032.[6]

Consolidation can also directly increase spending in public programs. Notably, Medicare typically pays more for the same service if it is delivered in a hospital outpatient department than a physician's office (and to a lesser degree, an ambulatory surgery center). Thus, if hospitals acquire physicians' offices and turn them into HOPDs, Medicare spending increases directly (in addition to beneficiary out-of-pocket spending). By incentivizing consolidation, this also illustrates an example of how public programs can increase commercial health care spending.

Opportunities to reduce consolidation and health costs

In this section, I briefly highlight a few policies that would lessen consolidation and its subsequent effects on costs. While not exhaustive, these policies include a number that have been the subject of recent Congressional proposals.

Reduce incentives to further consolidate

As a starting point, Congress can amend policies that contain incentives for further consolidation within health care markets. One notable example is Medicare's current lack of site neutral payments. As I have previously written:[7]

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[5] E.g., Gruber, J. (1994). The incidence of mandated maternity benefits. *The American economic review*, 622-641 https://www.jstor.org/stable/2118071. Arnold, D., & Whaley, C. (2020). Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. *RAND Corporation*. https://www.rand.org/pubs/working_papers/WRA621-2.html

[6] CBO. (2022). Federal Subsidies for Health Insurance Coverage for People Under 65: 2022 to 2032. https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf

[7] Ippolito, B. Lowering Health Care Costs Through Transparency and Competition. House Committee on Energy and Commerce Subcommittee on Health. January 31, 2024. https://energycommerce.house.gov/events/health-subcommittee-hearing-health-care-spending-in-the-united-states-unsustainable-for-patients-employers-and-taxpayers

In typical markets, prices are effectively determined by the most efficient producer of a product. For example, suppose a new firm can make an equally good cup of coffee as Starbucks for half the price. Customers would rapidly shift to their new competitor unless Starbucks was able to reduce their prices to competitive levels.

The same phenomenon should exist in health care markets. If lower-cost providers are able to offer a service of similar quality for lower price, purchasers ought to shift towards those settings. Current Medicare policy interrupts this dynamic by often paying hospitals (and to a lesser degree, Ambulatory Surgery Centers) more than it would pay a doctor's office for services that can be safely performed in either setting.

This policy increases costs to Medicare and, in turn, taxpayers. It also raises beneficiary out-of-pocket spending who face coinsurance based on the service's price. In addition, this policy provides hospitals with a clear incentive[8] to acquire physician's offices, which can reduce competition between providers and increase costs outside of Medicare.[9]

In cases where a service can be safely delivered in a physician's office, there is a strong argument for Medicare paying the Physician Fee Schedule rate regardless of where a service is delivered. This would reduce costs to Medicare and beneficiaries while lessening consolidation incentives. One can argue for such a policy to apply to at least two groups of services. The first is any service delivered at off-campus hospital outpatient departments (HOPDs). Those services are unlikely to use hospital-based resources given that they are

[8] See Brady Post et al., "Hospital physician Integration and Medicare's Site based Outpatient Payments," *Health Services Research* 56, no. 1 (February 2021): 7–15. https://doi.org/10.1111/1475-6773.13613

[9] E.g., Marah Noel Short and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review* 77, no. 6 (December 2020): 538–48. https://doi.org/10.1177/1077558719828938; Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–52. https://doi.org/10.1016/j.jhealeco.2018.04.001; Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs* 33, no. 5 (May 2014): 756–63. https://doi.org/10.1377/hlthaff.2013.1279

delivered away from the facility. The second is any service for which clinical evidence suggests it can be safely administered outside of a hospital (e.g., if that service rarely results in use of hospital-based follow-on care).[10]

A policy that paid a site neutral rate for all services delivered at off-campus HOPDs and certain services at on-campus HOPDs would lower Medicare spending by around $150 billion over a decade.[11] A much more limited version that applied only to drug administration at off-campus HOPDs was recently included in the Lower Cost, More Transparency Act.

One potential tradeoff associated with this (and many policies that could reduce revenues to certain providers) is that it could reduce access if it leads some financially vulnerable hospitals to close. Should policymaker view this as a credible concern, that is still not a compelling justification for maintaining the status quo for all hospitals. Congress could pass legislation that comprehensively addresses problematic incentives while explicitly subsidizing hospitals in financially tenuous positions through other more direct means.

There are other policies that may similarly encourage consolidation. For example, many argue that the 340B discount drug program may encourage hospitals to acquire certain physician practices and dispense more expensive drugs.[12]

Consider attenuating providers' ability to leverage consolidated market power

[10] MedPAC, "Medicare and the Health Care Delivery System," *Report to the Congress*, June 15, 2022. https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/
[11] Committee for a Responsible Federal Budget. 2021. Equalizing Medicare Payments Regardless of Site-of-Care. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care
[12] Adler, L., & Ippolito, B. (2023). Procompetitive health care reform options for a divided Congress. *Brookings*. https://www.brookings.edu/articles/procompetitive-health-care-reform-options-for-a-divided-congress/

Congress can also consider policies that might moderate the ability of consolidated entities to leverage their existing market power for higher prices. For example, previous legislative proposals have included restrictions on the use of clauses that may be considered anticompetitive. These include:[13]

- **Anti-tiering clauses**—Requirements that the dominant provider is not on a worse insurance "tier" than any other provider. This impedes health plans' ability to incentivize enrollees to pick a different, lower-cost provider.
- **Anti-steering clauses**—Clauses that disallow the insurer from "steering" (or incentivizing) enrollees to see other providers.
- **All or nothing contracts**—Provisions that the insurer must include every provider affiliated with the dominant system in their network or none (e.g., a dominant hospital could require all affiliated outpatient facilities or physician groups to be included in network if the insurer wants to include the hospital). This could allow the dominant provider in one part of the market to extend its power to other parts of the market.
- **Most favored nations clauses**—Requirements that providers guarantee a dominant insurance plan the most favorable pricing among insurers. This protects the position of the most dominant insurer in a market.

These provisions are less problematic in competitive markets, where firms have the choice of avoiding contracting with firms that demand them. In cases where markets are already relatively consolidated, however, they are likely to be more impactful (this is particularly true in cases where they interact with network adequacy requirements). Congress could restrict the ability of firms to use such contracts, which may limit the ability of dominant firms to leverage their market power. That said, these policies will likely have a

[13] Description of contract provisions taken from Adler, L., & Ippolito, B. (2023). Procompetitive health care reform options for a divided Congress. *Brookings*. https://www.brookings.edu/articles/procompetitive-health-care-reform-options-for-a-divided-congress/

modest effect because dominant firms still retain significant market power that they can use in second-best ways. The CBO has suggested that this type of policy would slightly reduce health costs.[14]

Federal antitrust options

Federal antitrust agencies—the Federal Trade Commission and the Department of Justice—provide oversight of mergers and acquisitions, along with other potentially anticompetitive behavior. Congress could give the agencies greater transparency into proposed transactions or an increased ability to contest them.

For example, Congress could pass legislation that lowered the threshold for reporting certain transactions to the agencies. Currently, those limits require disclosure for transactions over $119.5 million (updated annually), which excludes most transactions.[15] Congress could also require disclosure if the cumulated value of acquisitions by a parent company exceeds a threshold (either existing or new), even if the marginal transaction would not trigger disclosure. This could help increase awareness of cases where parent companies acquire very large market shares through a series of small transactions. While the subject of more debate, some have argued in favor of amending the Clayton Act to lower the bar agencies must meet in their challenges. For example, Section 7 of the Clayton Act requires that regulators demonstrate a transaction "substantially" lessens competition, which could be altered to "meaningfully" or "materially" lessens competition.[16] Supporters of such a change would likely argue that a large share of non-contested mergers (or those that went through despite a challenge) have nonetheless raised health costs. Still, it would be important to consider tradeoffs associated with any such change.

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[14] CBO. (2019). Cost Estimate for S.1895, Lower Health Care Costs Act. https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

[15] Fulton, B. D., King, J. S., Arnold, D. R., Montague, A. D., Chang, S. M., Greaney, T. L., & Scheffler, R. M. (2021). States' Merger Review Authority Is Associated With States Challenging Hospital Mergers, But Prices Continue To Increase. *Health Affairs*, *40*(12), 1836–1845. https://doi.org/10.1377/hlthaff.2021.00781; Capps, C., Dranove, D., & Ody, C. (2017). Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene. *Health Affairs*, *36*(9), 1556–1563. https://doi.org/10.1377/hlthaff.2017.0054

[16] Testimony of Leemore S. Dafny, Ph.D.: Hearing before the U.S. House Committee on the Judiciary, "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" (2021). https://docs.house.gov/meetings/JU/JU05/20210429/112518/HHRG-117-JU05-Wstate-DafnyL-20210429.pdf