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TESTIMONY

Hospital and Physician Consolidation and Its Impact on the Federal Budget

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Chairman Arrington, Ranking Member Boyle, and Members of the Committee, I appreciate the opportunity to appear before you today. In consultation with Budget Committee staff, I have focused this testimony on consolidation among health care providers and its impact on the federal budget.

How Does Providers' Consolidation Affect the Federal Budget?

The markets for hospitals' and physicians' services have become increasingly consolidated in recent decades. The share of hospitals affiliated with a health system increased from 53 percent in 2005 to 68 percent in 2022, and the share of physicians employed by a hospital or health system increased from 29 percent in 2012 to 41 percent in 2022.[1]

The federal government subsidizes health care for enrollees in private health insurance and for enrollees in public health care programs, and consolidation increases costs in both cases. Consolidation can affect the federal budget by increasing prices in private health insurance, by increasing the intensity of services provided through public programs, or by shifting those services to more costly settings.

Consolidation gives providers more bargaining power, allowing them to negotiate higher prices with private insurers. Those higher prices increase private insurers' spending on claims, which in turn increases premiums. In employment-based health insurance, an increase in premiums shifts a portion of employees' compensation from taxable wages to tax-favored health insurance, the Congressional Budget Office estimates. That shift increases the federal deficit. In nongroup insurance, higher premiums increase premium tax credits for plans purchased through the health insurance marketplaces. CBO projects that federal subsidies for private health insurance will total $6.4 trillion through 2033, so even small changes in prices for private insurance could impact the federal budget.[2]

In the fee-for-service programs in Medicare and Medicaid, the federal and state governments set providers' prices through laws and regulations, and managed care plans in those programs tend to follow those prices. In that context, consolidation among providers generally does not increase the prices paid. However, empirical studies suggest that consolidation can increase spending in Medicare and Medicaid by encouraging providers to deliver more services, to provide more intensive services, or to supply care in more costly settings.[3] If hospitals acquire physician practices, certain services provided by those physicians may be billed at hospital outpatient rates. Those rates include facility fees and are generally higher than the rates paid to independent physician practices. Physicians whose practices are acquired by hospitals may send their patients to receive care in hospitals rather than in less costly settings, or they might recommend more costly treatments. Those changes affect the federal budget by directly increasing Medicare and Medicaid spending.

What Are Some Federal Policy Approaches to Slow Providers' Consolidation?

CBO expects that providers' consolidation will continue to increase over the next decade. In 2022, the agency identified several policies that could reduce that consolidation, including policies that would promote competition among providers—for example, by further equalizing Medicare's payments across sites of service or expanding federal agencies' antitrust capacity.[4] In CBO's assessment, adopting a broad set of such policies would avert up to a quarter of the expected growth in consolidation.[5] CBO previously estimated that the reduction in federal subsidies for employment-based insurance and

1. Zachary Levinson and others, "Ten Things to Know About Consolidation in Health Care Provider Markets," *KFF* (April 19, 2024), https://tinyurl.com/4cjjb7vd.

2. Congressional Budget Office, *Federal Subsidies for Health Insurance: 2023 to 2033* (September 2023), www.cbo.gov/publication/59273.

3. Michael R. Richards, Jonathan A. Seward, and Christopher M. Whaley, "Treatment Consolidation After Vertical Integration: Evidence From Outpatient Procedure Markets," *Journal of Health Economics*, vol. 81 (January 2022), 102569, https://doi.org/10.1016/j.jhealeco.2021.102569; Jeah Jung, Roger Feldman, and Yamini Kalidindi, "The Impact of Integration on Outpatient Chemotherapy Use and Spending in Medicare," *Health Economics,* vol. 28, no. 4 (April 2019), pp. 517–528, https://onlinelibrary.wiley.com/doi/10.1002/hec.3860; and Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "The Effect of Hospital/Physician Integration on Hospital Choice," *Journal of Health Economics*, vol. 50 (December 2016), pp. 1–8, https://doi.org/10.1016/j.jhealeco.2016.08.006.

4. Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (September 2022), www.cbo.gov/publication/58222.

5. Michael Cohen, Daria Pelech, and Karen Stockley, "Potential Federal Policies to Reduce or Limit Commercial Plan Payments to Hospitals and Physicians," *NEJM Catalyst Innovations in Care Delivery*, vol. 4, no. 10 (October 2023), https://doi.org/10.1056/CAT.22.0432.

for nongroup insurance would shrink the federal deficit in 2032 by 0.2 percent to 0.6 percent. The corresponding effects on Medicare and Medicaid spending would depend on the details of the policy specifications, and CBO has not estimated those effects.

The effects of the policies CBO identified would be limited for two main reasons. First, markets for health care services are already highly consolidated, and undoing that consolidation would be difficult—particularly within the 10-year budget window, since the effects of some policies would take significant time to materialize. Second, some of the factors that drive consolidation are not amenable to change by legislation. For instance, providers might still seek to expand service lines or to achieve economies of scale. And even if the government removed some of the incentives to consolidate that currently exist in federal programs, providers would still benefit from consolidation because they would gain bargaining leverage with private insurers.

CBO focuses principally on the effects of providers' consolidation on the federal budget. Policies that promote competition may have other effects that are outside of the agency's purview, such as fostering greater patient choice or provider independence.

Chapin White prepared this testimony with contributions from Jared Maeda, Daria Pelech, and Joyce Shin and with guidance from Berna Demiralp. In keeping with CBO's mandate to provide objective, impartial analysis, this testimony makes no recommendations. Jeffrey Kling reviewed the testimony, Christine Browne edited it, and Jorge Salazar prepared it for publication. The testimony is available at www.cbo.gov/publication/60279.