AMERICAN
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America's Health Care Consolidation Crisis: A Ledger of Harms and Framework for Advancing Economic Liberty for All

October 2024

REPORT

INTRODUCTION

For decades, policymakers on both sides of the aisle have tried to expand access to health care with the assumption they could pursue that goal through strategies that were indifferent to or actively promoted market consolidation. These strategies, it was thought, would promote efficiency and improve outcomes without affecting costs.

News coverage of health care mergers during the 1990s frequently touted the resulting economies of scale.[1] The Clinton administration's Federal Trade Commission (FTC) and Department of Justice (DOJ) revised their joint merger guidelines in 1997, "recogni[zing] that cost savings and other efficiencies from a merger can enhance the merged firm's ability and incentive to compete."[2] More than a decade later, under the Obama administration, the Affordable Care Act (ACA) of 2010 promoted "integration across the continuum of care." [3] The law continues to provide cover for proponents of consolidation, who "argue that mergers are a necessity for survival after the passage of the ACA and its new regulatory burdens."[4]

These views, as it turned out, were woefully naive. The health care system — from payers, like insurance companies and pharmacy benefit managers (PBMs), to providers, like hospitals, physicians, and pharmacies — has indeed become extremely consolidated. More than three in four metropolitan areas had highly or very highly concentrated hospital markets in 2021. Just 44% of physicians owned their own practice in 2022, compared with 76% in the 1980s.[5] And prescription-drug middlemen are also extremely concentrated; the three largest PBMs, group purchasing organizations (GPOs), and wholesalers control between 79% and 95% of their respective markets.[6] At the same time, commercial insurers

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1 Leslie Eaton, "Aetna to Buy U.S. Healthcare In Big Move to Managed Care," *The New York Times*, April 2, 1996, https://www.nytimes.com/1996/04/02/business/aetna-to-buy-us-healthcare-in-big-move-to-managed-care.html.

2 "FTC/DOJ Announce Revised Guidelines on Efficiencies in Mergers," Federal Trade Commission, April 8, 1997, https://www.ftc.gov/news-events/news/press-releases/1997/04/ftcdoj-announce-revised-guidelines-efficiencies-mergers; Debra Valentine, "Health Care Mergers: Will We Get Efficiencies Claims Right?," Federal Trade Commission, Nov. 14, 1997, https://www.ftc.gov/news-events/news/speeches/health-care-mergers-will-we-get-efficiencies-claims-right.

3 Robert Kocher, Ezekiel Emmanuel, and Nancy-Anne DeParle, "The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges," *Annals of Internal Medicine*, Oct. 19, 2010, https://www.acpjournals.org/doi/10.7326/0003-4819-153-8-201010190-00274.

4 Ibid.; Matthew Gibson, "Exceptional Efficiencies: A Valuable Defense for Healthcare Mergers," *Columbia Law Review*, November 2022, https://columbialawreview.org/content/exceptional-efficiencies-a-valuable-defense-for-healthcare-mergers/.

5 "Hospital Concentration Index," Health Care Cost Institute, June 2023, https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index; Carol Kane, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022," American Medical Association, May 16, 2024, https://www.ama-assn.org/system/files/2022-prp-telehealth.pdf.

6 Sara Sirota, "The Dirty Secret of Drug Shortages," American Economic Liberties Project, October 2023, https://economicliberties.us/wp-content/uploads/2023/10/20230720-AELP-DrugShortages_Brief_v7.pdf; Adam Fein, "The Top Pharmacy Benefit Managers of 2023: Market Share and Trends for the Biggest Companies – And What's Ahead," Drug Channels Institute, April 9, 2024, https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html.

are integrating vertically, snapping up providers, PBMs, data analytics firms, and other health care businesses. UnitedHealth Group — the nation's fourth-largest corporation, its largest insurance company, and its largest physician employer — is a prime example.[7]

But consolidation has failed to deliver its purported clinical and administrative benefits. The United States spends nearly twice as much on health care as other countries, with far worse outcomes and vast disparities. Our caretaking workforce is both overworked and underpaid, and the system's profits increasingly flow to health care rent seekers and middlemen.

Health care is not alone in facing a crisis of consolidation; virtually every industry in America is in the throes of a broader concentration crisis.[8] This is because policymakers have favored consolidation as an industrial policy since the late 1970s.[9]

However, unlike other industries, health care receives most of its funding — 48% in 2023, more than any other source — from the federal and state governments.[10] So, the government is responsible for shaping health care market structure. And it has the power to fix it.

The American Economic Liberties Project (AELP) has compiled a ledger of harms to chronicle the research showing both the extent of health care's concentration crisis and how it hurts patients, providers, and other market participants. We also offer several policy suggestions for restoring healthy competition.

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7 Complaint ¶ 312, Arkansas ex rel. Rutledge v. Eli Lilly & Co., No. 60cv-22-2976, May 11, 2022, https://content.govdelivery.com/attachments/ARAG/2022/05/11/file_attachments/2156162/2022-05-11-%20Insulin%20Complaint%20FINAL%20DRAFT.pdf; Bob Herman, "UnitedHealth is on a buying spree of outpatient surgery centers," *Stat*, March 11, 2024, https://www.statnews.com/2024/03/11/unitedhealth-outpatient-surgery-centers-medicare-advantage-ncp-fresenius/.

8 "Confronting America's Concentration Crisis: A Ledger of Harms and Framework for Advancing Economic Liberty for All," American Economic Liberties Project, July 2020, https://www.economicliberties.us/wp-content/uploads/2020/08/Ledger-of-Harms-R41.pdf.

9 Lina Khan, "Amazon's Antitrust Paradox," *Yale Law Journal*, January 2017, https://www.yalelawjournal.org/note/amazons-antitrust-paradox.

10 Jacqueline Fiore et al., "National Health Expenditure Projections, 2023-32: Payer Trends Diverse As Pandemic-Related Policies Fade," *Health Affairs*, June 12, 2024, https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469.

CONSOLIDATION RAISES PRICES FOR CONSUMERS AND OTHER STAKEHOLDERS

Health care executives claim consolidation will save money. Instead, patients, employees, employers, insurers, and taxpayers end up paying more for lower-quality care.

- Health care consolidation leads to higher prices, which drive up annual premiums while driving down wages for workers with employer-sponsored insurance.[11]
- Price increases associated with hospital mergers range from an estimated 3% to 65%, depending on the proximity of the two merging hospitals, the size of the transaction, and negotiations between the merged entity and various health plans.[12]
- Primary care visits in the most highly concentrated markets cost between 23% and 29% more than the national average.[13]
- Private equity acquisition is closely linked with higher costs for patients and payers, with increases ranging from 4% in primary care and dermatology to 16% in oncology.[14]
- Vertical integration between hospitals and providers incentivizes the resulting conglomerates to steer patients to their hospital outpatient departments, which can — and almost always do — charge junk facility fees that drive up prices relative to ambulatory surgical centers (ASCs) or independent physician offices.[15] One study

11 Richard Scheffler et al., "Consolidation Trends In California's Health Care System: Impact On ACA Premiums And Outpatient Visit Prices," *Health Affairs*, September 2018, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0472; Maria Polyakova et al., "ACA Marketplace Premiums and Competition Among Hospitals and Physician Practices," *The American Journal of Managed Care*, Feb. 15, 2018, https://www.ajmc.com/view/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices; Erin Trish et al., "How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums," *Journal of Health Economics*, July 2015, https://www.sciencedirect.com/science/article/abs/pii/S0167629615000375?via%3Dihub; Daniel Arnold and Christopher Whaley, "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages," RAND Corporation, July 28, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

12 Jodi Liu et al., "Environmental Scan on Consolidation Trends and Impacts in Health Care," RAND Corporation, Sept. 30, 2022, https://www.rand.org/pubs/research_reports/RRA1820-1.html; Zachary Levinson et al., "Ten Things to Know About Consolidation in Health Care Provider Markets," *KFF Health News*, April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.

13 Laurence Baker et al., "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *JAMA*, Oct. 22, 2014, https://jamanetwork.com/journals/jama/article-abstract/1917436.

14 Alexander Borsa et al., "Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systemic review," *BMJ*, July 19, 2023, https://www.bmj.com/content/382/bmj-2023-075244; Richard Scheffler et al., "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets," American Antitrust Institute, Nicholas C. Petric Center on Health Care Markets and Consumer Welfare, University of California, Berkeley, and Washington Center for Equitable Growth, July 10, 2023, https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

15 Cheryl Damberg, "Health Care Consolidation: The Changing Landscape of the U.S. Health Care System," RAND Corporation, May 17, 2023, https://www.rand.org/content/dam/rand/pubs/testimonies/CTA2700/CTA2770-1/RAND_CTA2770-1.pdf.

found hospital facility fees were roughly 55% more than those at ASCs in the same county and under the same health plan.[16] Another found facility fees at Florida hospitals ranged from $2,013 to $15,759.[17]

- Brand-name drug monopolies and PBMs drive up pharmacy list prices. Between January 2022 and January 2023, the list prices of more than 4,200 drugs increased; the average change was 15.2%, or $590, far outpacing inflation.[18]

CONSOLIDATION JEOPARDIZES AMERICANS' HEALTH AND SAFETY

These higher prices don't translate to improved quality or access; instead, the opposite is often true.

- Hospital consolidation is associated with higher readmission rates, reduced access to care, and worse patient outcomes.[19] Rural hospitals acquired by consolidators experience significant reductions in service, including on-site imaging, obstetric and primary care, and outpatient nonemergency care.[20]
- Between 1998 and 2021, hospital mergers reduced the number of hospitals nationwide by roughly 25%.[21] In Pennsylvania, roughly one in three hospital mergers, acquisitions, or ownership changes resulted in a full or partial hospital closure.[22]
- Large medical practices spend more on care and report higher readmission rates, especially for high-need patients, than the smallest practices.[23]

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16 Yang Wang et al., "Facility Fees for Colonoscopy Procedures at Hospitals and Ambulatory Surgery Centers," *JAMA Health Forum*, Dec. 15, 2023, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812610.

17 Tony Zitek et al., "Florida emergency department facility fees vary significantly based on hospital ownership," *Academic Emergency Medicine*, Feb. 15, 2023, https://onlinelibrary.wiley.com/doi/abs/10.1111/acem.14696.

18 "Changes in the List Prices of Prescription Drugs, 2017-2023," Assistant Secretary for Planning and Evaluation Office of Health Policy, Oct. 6, 2023, https://aspe.hhs.gov/sites/default/files/documents/0cdd88059165eef3bed1fc587a0fd68a/aspe-drug-price-tracking-brief.pdf.

19 "Costs & Quality After Independent Hospitals Are Acquired by Health Systems," Elevance Health Public Policy Institute, August 2023, https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/63/EH_Hospital%20Merger_R6_7-21-2023_FINAL.pdf; Nancy Beaulieu et al., "Changes in Quality of Care after Hospital Mergers and Acquisitions," *NEJM*, Jan. 1, 2020, https://www.nejm.org/doi/10.1056/NEJMsa1901383.

20 Claire O'Hanlon et al., "Access, Quality, And Financial Performance Of Rural Hospitals Following Health System Affiliation," *Health Affairs*, December 2019, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00918.

21 Hoag Levins, "Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality," Leonard Davis Institute of Health Economics at the University of Pennsylvania, Jan. 19, 2023, https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/.

22 "Patient Perspectives on Hospital Closures, Consolidation, and 'Healthcare Deserts,'" Pennsylvania Health Access Network, May 14, 2024, https://www.pahouse.com/files/Documents/Testimony/2024-05-14_085643__Testimony-%20Health%20Care%20Deserts.pdf.

23 Lawrence Casalino et al., "Medical Group Characteristics and the Cost and Quality of Care for Medicare Beneficiaries," *Health Services Research*, July 5, 2018, https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13010.

- Consolidation of cardiology practices is significantly associated with worse patient outcomes, including increases in mortality, emergency department visits, and hospital readmissions.[24]
- Hospitals acquired by private equity firms see their assets — such as equipment, buildings, and technology, all of which are necessary for patient care — stripped. One study of such hospitals measured a 24% reduction in assets in the two years following acquisition compared with controls.[25]
- Patients at nursing homes acquired by private equity firms appear healthier, "which could reflect an effort to pursue more financially attractive patients."[26] Nonetheless, private equity ownership is associated with an 11% increase in mortality, likely due to staffing reductions and compliance failures.[27]
- Higher drug cost-sharing is associated with increased mortality due to medication nonadherence. A $100 drop in a Medicare patient's monthly drug benefit budget is linked to a nearly 14% increase in mortality.[28]
- Drug shortages — a byproduct of avaricious middlemen — are associated with worse patient outcomes, including increased out-of-pocket costs, drug error rates, adverse events, mortality, and complaints.[29]
- PBMs' profiteering also played a role in the opioid crisis. The Department of Justice announced in June 2024 that OptumRx, UnitedHealth Group's PBM subsidiary, agreed to pay $20 million to resolve allegations that it had improperly filled opioid prescriptions in violation of federal law.[30]

CONSOLIDATION REINFORCES HEALTH INEQUITIES

In addition to reducing access to quality care, health care consolidation exacerbates

24 Thomas Koch et al., "Physician Market Concentration and Patient Welfare: An Examination of Medicare Beneficiaries," Federal Trade Commission, January 2017, https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=IIOC2017&paper_id=138.

25 Elizabeth Schrier et al., "Hospital Assets Before and After Private Equity Acquisition," *JAMA*, July 30, 2024.

26 Atul Gupta et al., "Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes," National Bureau of Economic Research, February 2021 (updated August 2023), https://www.nber.org/system/files/working_papers/w28474/w28474.pdf.

27 Ibid. at 26.

28 Amitabh Chandra et al., "The Health Costs of Cost-Sharing," National Bureau of Economic Research, updated February 2024, https://www.nber.org/system/files/working_papers/w28439/w28439.pdf.

29 Ibid. at 6. Jonathan Minh Phuong et al., "The impacts of medication shortages on patient outcomes: A scoping review," PLOS One, May 3, 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#:~:text=Findings,complaints%20during%20times%20of%20shortage.

30 "OptumRx Agrees to Pay $20M to Resolve Allegations that It Filled Certain Opioid Prescriptions in Violation of the Controlled Substances Act," U.S. Department of Justice Office of Public Affairs, June 26, 2024, https://www.justice.gov/opa/pr/optumrx-agrees-pay-20m-resolve-allegations-it-filled-certain-opioid-prescriptions-violation.

inequities among patients.

- The first wave of hospital consolidation, in the 1990s and early 2000s, led to higher prices, which translated to higher premiums and lower coverage rates among racial and ethnic minority groups as well as in lower-income households.[31]
- Similarly, brand-name drug monopolies and related patent abuses exacerbate racial, ethnic, and income-based disparities in health outcomes.[32]
- More than one in three U.S. counties are designated as maternity care deserts.[33] Hospital and provider consolidation drives care deserts.[34] Such deserts are associated with higher costs and worse outcomes, especially for people of color.[35]
- Mergers involving nonprofit hospitals are linked with decreased community benefit services, such as free or low-cost clinical care. These are services nonprofit hospitals are required to offer as a condition of receiving and maintaining their tax-exempt status.[36]

CONSOLIDATION STRIPS HEALTH CARE WORKERS OF WAGES AND OPPORTUNITIES

Health care consolidation benefits conglomerates, executives, and shareholders at the expense of the industry's workforce, which results in lower wages; strips autonomy from doctors, nurses, and other health care professionals; increases job insecurity; and accelerates burnout.

- Following a merger, hospital employers have more leverage in negotiations with their employees, forcing employees to sign restrictive noncompete agreements

31 Robert Town et al., "Hospital Consolidation And Racial/Income Disparities In Health Insurance Coverage," *Health Affairs*, July/August 2007, https://faculty.wharton.upenn.edu/wp-content/uploads/2014/09/19_Racial-Income_Disparities.pdf.

32 Sarah McGraw, "The Double-Edged Sword of Medical Patents: How Monopolies on Healthcare Products Disparately Impact Certain American Populations," *The University of Cincinnati Intellectual Property and Computer Law Journal*, 2021, https://scholarship.law.uc.edu/cgi/viewcontent.cgi?article=1029&context=ipclj.

33 "Nowhere to Go: Maternity Care Deserts Across the U.S.," March of Dimes, April 22, 2022, https://www.marchofdimes.org/maternity-care-deserts-report.

34 Deena Chisolm et al., "Improving health equity through health care systems research," *Health Services Research*, Nov. 28, 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10684038/.

35 Tara Oakman et al., "How States Can Advance Equity When Addressing Health Care Consolidation," The Century Foundation, March 6, 2024, https://tcf.org/content/report/how-states-can-advance-equity-when-addressing-health-care-consolidation/.

36 "Hospital Community Benefits," National Center for Healthy Housing, accessed July 22, 2024, https://nchh.org/tools-and-data/financing-and-funding/healthcare-financing/hospital-community-benefits/#:~:text=Nonprofit%20hospital%20organizations%20are%20required,from%20paying%20federal%20income%20taxes.

that limit their mobility and income.[37] An estimated 37% to 45% of physicians were bound by such agreements in 2023.[38]

- Hospital mergers hurt wage growth and lead to “reductions in employment.”[39] Four years after mergers, wages for nurses and pharmacy workers were 6.8% lower than what they would have been sans merger; for nonskilled medical workers, they were 4% lower.[40]
- Consolidation leaves physicians and other providers feeling powerless, contributing to burnout, attrition, and suicide.[41] Physician burnout negatively affects the quality and safety of patient care, drives health care spending, and deters medical students from pursuing patient-facing roles.[42]
- Brand-name drug monopolies and middlemen, which are often vertically integrated with insurance companies, put downward price pressure on generic drug manufacturers, resulting in offshoring and closings. The July 2021 Mylan plant closure in Morgantown, West Virginia, resulted in the loss of an estimated 4,642 jobs in Monongalia County, or 6% of its overall employment, and nearly $63 million in local and state tax revenue.[43]

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37 Ibid. at 35.

38 Andis Robeznieks, “AMA backs effort to ban many physician noncompete provisions,” American Medical Association, June 13, 2023, https://www.ama-assn.org/medical-residents/transition-resident-attending/ama-backs-effort-ban-many-physician-noncompete.

39 Ibid. at 19.

40 Elena Prager and Matt Schmitt, “Employer Consolidation and Wages: Evidence from Hospitals,” *American Economic Review*, February 2021, https://www.aeaweb.org/articles?id=10.1257/aer.20190690.

41 Noam Schieber, “Why Doctors and Pharmacists Are in Revolt,” *The New York Times*, updated Dec. 5, 2023, https://www.nytimes.com/2023/12/03/business/economy/doctors-pharmacists-labor-unions.html; Eyal Press, “The Moral Crisis of America’s Doctors,” *The New York Times*, June 15, 2023, https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html; Ryan O’Connell et al., “Why Do Physicians Depart Their Practice? A Qualitative Study of Attrition in a Multispecialty Ambulatory Practice Network,” *The Journal of the American Board of Family Medicine*, October 2023, https://www.jabfm.org/content/early/2023/10/18/jabfm.2023.230052R2.

42 Philip Shin et al., “Time Out: The Impact of Physician Burnout on Patient Care Quality and Safety in Perioperative Medicine,” *The Permanente Journal*, June 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10266854/; “Clinician of the Future 2023: Education Edition,” Elsevier Health, October 2023, https://assets.ctfassets.net/zlnfaxb2lcqx/3CKQYVWKqoF75jKTMmbWkY/e67283ff092a738ca149cb9844530421/CLINICIAN-OF-THE-FUTURE_REPORT-2023.pdf.

43 ”The economic impact of the Viatris pharmaceutical plant closing in Morgantown, West Virginia,” Democracy Collaborative, July 2021, https://www.documentcloud.org/documents/21015587-viatris-pharmaceutical-plant-closing-analysis.

CONSOLIDATION THREATENS THE SUPPLY OF CRITICAL GOODS

Consolidation among drug and device manufacturers, their clients, and the middlemen who liaise among them weakens the medical supply chain.

- There was a record number of active drug shortages — 323 — during the first quarter of 2024, including for ADHD medications and generic sterile injectables used in chemotherapy.[44]
- Drug shortages further fuel health care costs. Each year, hospitals spend an estimated $600 million managing shortages, including by diverting personnel who could otherwise provide direct patient care.[45]
- Americans' prescription drug supply is increasingly manufactured overseas, beyond Food and Drug Administration (FDA) oversight, raising questions about quality and affordability.[46]

CONSOLIDATION UNDERMINES SMALL BUSINESSES AND COMMUNITY WELL-BEING

More consolidation means independent businesses — such as medical practices, pharmacies, and device manufacturers — increasingly must choose between acquisition or closure.

- At least 2,275 pharmacies — 1,139 larger chains and 1,136 independents and small to mid-sized chains — have closed in 2024 following years of decline due to consolidation among and between PBMs and insurers.[47] Nearly 800 ZIP codes that had at least one pharmacy in 2015 now have none, meaning patients — especially those in rural and low-income areas —are increasingly stranded in pharmacy deserts.[48]

44 Erin Fox, "National Drug Shortages: Active Shortages by Quarter – 10 Year Trend," American Society of Health-System Pharmacists and the University of Utah Drug Information Service, April 2024, https://www.ashp.org/drug-shortages/shortage-resources/drug-shortages-statistics.

45 "Policy Considerations to Prevent Drug Shortages and Mitigate Supply Chain Vulnerabilities in the United States," U.S. Department of Health and Human Services Office of the Secretary, April 2, 2024, https://aspe.hhs.gov/reports/preventing-shortages-supply-chain-vulnerabilities.

46 Neriman Beste Kaygisiz et al., "The Geography of Prescription Pharmaceuticals Supplies to the U.S.: Levels, Trends and Implications," National Bureau of Economic Research, December 2019, https://www.nber.org/system/files/working_papers/w26524/w26524.pdf.

47 Benjamin Jolley, "2275 pharmacies have closed so far in 2024," Ramblings of a pharmacist, Sept. 16, 2024, https://benjaminjolley.substack.com/p/df63c75f-2215-4dbf-95c9-f94c7e38cfe3?postPreview=paid&updated=2024-09-12T16%3A44%3A06.874Z&audience=everyone&free_preview=false&freemail=true.

48 Reed Abelson and Rebecca Robbins, "The Powerful Companies Driving Local Drugstores Out of Business," The New York Times, Oct. 19, 2024, https://www.nytimes.com/2024/10/19/business/drugstores-closing-pbm-pharmacy.html.

- More than 44,000 medical practices were acquired — by hospitals, insurers, pharmacy chains, and private equity firms — between 2019 and 2024. Today, nearly 60% of practices are owned by corporations, and more than three-fourths of U.S. physicians are employed by corporate entities.[49]
- More recently, the February 2024 cyberattack on Change Healthcare — a UnitedHealth Group subsidiary that processes at least half of all health insurance claims — paralyzed broad swaths of the health care system and sent community medical practices into liquidity crises. UnitedHealth Group's 2022 acquisition of Change Healthcare created a single point of failure for the entire health care system, vulnerable to hackers. Nonetheless, UnitedHealth Group capitalized on the crisis by reportedly buying up desperate community medical practices unable to access cash amid the outage.[50]

CONSOLIDATION DEPRESSES BUSINESS DYNAMISM AND UNDERMINES INNOVATION

As in other industries, consolidation in health care perverts market economics.

- Between 2016 and 2020, the 14 largest drug companies spent $577 billion on stock buybacks and dividends — $56 billion more than they spent on research and development, despite claims that higher list prices were necessary to ensure innovation. During the same period, research dollars often went toward bolstering monopolies and preventing competition from generic manufacturers.[51]
- Even during the COVID-19 pandemic, GPOs continued to prevent new drug and device manufacturers from successfully entering the market. This exacerbated shortages of personal protective equipment, lifesaving drugs, and medically necessary devices, including the retractable syringes necessary to draw all six doses in each COVID-19 vaccine vial.[52]

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49 Rebecca Pifer, "More than three-fourths of doctors are employed by corporations, report finds," *Healthcare Dive*, April 12, 2024, https://www.healthcaredive.com/news/doctor-corporate-ownership-growing-hospital-insurer-pai-avalere/712988/.

50 "Economic Liberties Urges HHS & ONC to Bolster Electronic Claims Standard Following Change Crisis," American Economic Liberties Project, March 12, 2024, https://www.economicliberties.us/press-release/economic-liberties-urges-hhs-onc-to-bolster-electronic-claims-standard-following-change-crisis/.

51 "Drug Pricing Investigation," U.S. House of Representatives Committee on Oversight and Reform, December 2021, https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf.

52 Eric Cortellessa, "Why We're Wasting 20 Percent of the Covid Vaccine," *Washington Monthly*, March 17, 2021, https://washingtonmonthly.com/2021/03/17/why-were-wasting-20-percent-of-the-covid-vaccine/.

CONSOLIDATION WEAKENS OUR DEMOCRACY

Dominant corporations use their monopoly power to shape public discourse, influence government policy, undermine democratic institutions, and avoid accountability.

- Health care is the leading industry in terms of lobbying spending at both the federal and state levels.[53] Industry spending on lobbying increased by more than 70% between 2000 and 2020. In common with the sector they represent, these lobbyists are highly concentrated, with the top 10% of firms accounting for the bulk of spending.[54]
- The hospital and nursing home industries have successfully pushed back against efforts to increase minimum staffing levels. In Minnesota, the state legislature, bowing to pressure from Mayo Clinic and the Minnesota Hospital Association, removed nurse staffing ratio requirements from a bill in 2023.[55]
- Corporate influence extends to academic research; medical education; clinical guideline and drug formulary development; and medical drug and device manufacturing.[56] Such influence allows corporate actors to supplant health care professionals, risking public trust and patient safety. For example, court documents filed in 2019 by the attorney general of Massachusetts allege that doctors who met with Purdue Pharma drug reps were 10 times more likely to have prescribed opioids to patients who later died of an overdose than their peers who prescribed opioids without having met the company's drug reps.[57]

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53 Dan Auble et al., "Layers of Lobbying: An examination of 2021 state and federal lobbying from K Street to Main Street," OpenSecrets, June 22, 2022, https://www.opensecrets.org/news/reports/layers-of-lobbying/state-and-federal-lobbying.

54 William Schpero et al., "Lobbying Expenditures in the US Health Care Sector, 2000-2020," *JAMA Health Forum*, Oct. 28, 2022, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2797734.

55 David Muoio, "Minnesota lawmakers cut nurse staffing ratios from union-backed bill due to Mayo Clinic, industry pushback," *Fierce Healthcare*, May 23, 2023, https://www.fiercehealthcare.com/providers/minnesota-lawmakers-cut-nurse-staffing-ratios-union-backed-bill-due-mayo-clinic-industry.

56 James Trayer et al., "Industry influence in healthcare harms patients: myth or maxim?," *Breathe*, June 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9584590/.

57 Jonathan Marks, "Lessons from Corporate Influence in the Opioid Epidemic: Toward a Norm of Separation," June 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7357445/#CR47.

A FRAMEWORK FOR ADVANCING ECONOMIC LIBERTY FOR ALL

There's no silver bullet to undoing corporate consolidation in health care. But a robust, pro-competition industrial policy agenda for health care that spans federal agencies, Congress, and state governments can cure what ails us.

FEDERAL AGENCIES

AELP supports an industrial policy for health care that restores power to providers and patients, structures markets to foster fair competition, and builds resilient infrastructure that meets care needs and is insulated from corporate extraction. The Biden administration must take a range of actions to further this agenda; each day of delay compounds the harms of health care consolidation.

- **Vigorous antitrust enforcement:** The FTC, DOJ, and U.S. Department of Health and Human Services (HHS) should build on their recent efforts to prevent illegal mergers and challenge monopolies in the health care sector. This includes bringing cases against drug manufacturers for discriminatory pricing under the 1936 Robinson-Patman Act, which has been largely unenforced by the government for decades.[58]
- **Reform Medicare Advantage:** Alongside Congress, federal health agencies should stop over-subsidizing Medicare Advantage, including by reducing risk-adjustment payments, which incentivize upcoding, and requiring participating plans to use third-party entities for claim and prior authorization adjudication.[59] Similarly, Congress should address private payer abuses in Medicaid managed care.

58 "Fact Sheet: Robinson-Patman Act enforcement will lower – not raise – prices for consumers and create a level playing field for businesses of all sizes," American Economic Liberties Project, June 20, 2024, https://www.economicliberties.us/our-work/robinson-patman-factsheet/.

59 Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care," American Economic Liberties Project, April 2024, https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf.

- **Build physician supply:** Medicare, as the largest payer for health care services and the direct funder of graduate medical education, should be much more active in both increasing and rationally allocating physician supply.
- **Invest in primary care:** Medicare should also increase payments to primary care physicians, who receive short shrift compared with specialists, and wrest charge of physician rate-setting from the specialist-dominated American Medical Association, a lobbying group.
- **Implement public, standardized pricing:** Building on the Biden administration's assault on junk fees, which includes tackling hospital facility fees and junk insurance, HHS should adopt models that standardize payment across providers and payers. Otherwise, the status quo of price discrimination will continue to incentivize provider consolidation and drive spending.
- **Treat insurers and facilities more like public utilities:** Agencies should update the conditions of participation in Medicare and Medicaid to prohibit participating private payers from owning providers and strengthen nondiscrimination laws and rate regulation.
- **Promote physician ownership:** The federal government can promote physician ownership via the tax code.
- **Stem patent abuse:** The U.S. Patent and Trademark Office and the FDA should do more to curb drug manufacturers' sham patent listings, such as banning drug manufacturers from listing device-only patents in the Orange Book.

CONGRESS

While existing laws can be enforced to address health care consolidation, new federal legislation is sorely needed.

- **Enact a Glass-Steagall Act for health care:** Borrowing from New Deal banking reform, Congress should bar insurance companies and PBMs from owning providers and pharmacies.
- **Ban price discrimination:** Congress should pass legislation that standardizes health care prices according to geographic region and caps price growth, which would undo the incentive to consolidate. Alternatively, as stopgap measures, Congress could pursue site-neutral Medicare payment, which would equalize prices for the same service regardless of where it is provided, or U.S. Rep. Jim

Banks' (R-IN) 2019 bill, which would deter mergers by requiring hospitals in highly concentrated markets to accept Medicare rates from commercial insurers.[60]

- **Invest in traditional Medicare:** With the savings that come from Medicare Advantage reform, Congress should expand benefits, lower cost sharing, and increase payments to primary care physicians.
- **Update medical loss ratio (MLR) requirements:** Congress should increase the MLR threshold from 85% and strengthen price transparency requirements to protect against MLR gaming.
- **Eliminate problematic exemptions:** Congress should repeal the safe harbor in the anti-kickback statute, which allows health care middlemen like GPOs and PBMs to exploit kickbacks and rebates that otherwise would constitute a felony offense. Similarly, lawmakers should reverse the nonprofit exemption from the 1914 FTC Act, which exempts nonprofit hospitals from certain antitrust regulations.
- **Prohibit anti-competitive contracts:** Congress should rein in health care monopolies' use of unfair terms, including most-favored nation clauses, product tying, and price discrimination. To start, Congress should pass the Pharmacists Fight Back Act by U.S. Reps. Jake Auchincloss (D-MA) and Diana Harshbarger (R-KY), which would safeguard independent pharmacies from PBMs' use of such contracts, during the lame-duck session.
- **Require transparency in ownership:** Congress should update transparency laws to bring vertical consolidation and corporate ownership into the sunlight.
- **Support countervailing worker power:** Building on the FTC's rule banning noncompete agreements, Congress should support health care union activity, including among physicians.

STATE GOVERNMENTS

States should also play an important role in confronting health care's consolidation crisis.

- **Repurpose bans on the corporate practice of medicine:** States, with the support of the federal government, can update and repurpose dormant bans on the corporate practice of medicine to address various forms of corporate ownership and investment.

60 Zachary Levinson et al., "Five Things to Know About Medicare Site-Neutral Payment Reforms," KFF, June 14, 2024, https://www.kff.org/medicare/issue-brief/five-things-to-know-about-medicare-site-neutral-payment-reforms/; Bob Herman, "House member targets hospital consolidation," *Axios*, Jan. 11, 2019, https://www.axios.com/2019/01/11/rep-jim-banks-hospital-consolidation-bill.

- **Require stricter review of proposed mergers:** Legislatures should mandate that hospitals and providers seeking to merge in their state inform the attorney general. They should also grant the attorney general clear authority to block mergers that harm care quality.
- **Repeal certificate of public advantage and certificate of need laws:** Many states have these laws, which exempt hospital mergers from antitrust laws in exchange for increased state oversight. Repeal would enable antitrust regulators to review proposed mergers and take remedial action.
- **Promote physician and public ownership:** Like the federal government, states can promote physician ownership through the tax code; they can also acquire struggling practices and hospitals and invest in additional capacity as needed.

CONCLUSION

The American economy — and especially the health care sector — is rife with consolidated corporate power that threatens the health and well-being of consumers, clinicians, and competition.

"John D. Rockefeller would be happy to be alive today," David Balto, a former FTC attorney who represents clients suing PBMs, told KFF Health News in May 2023. "He could own a PBM and monopolize economic power in ways he never imagined."[61]

Enforcing existing laws and passing new ones can eradicate this disease. Reducing corporate concentration is essential and should occur in tandem with other critical policy priorities: attacking the deep structural barriers to capital and economic opportunity faced by historically marginalized groups; strengthening labor bargaining power; and shifting responsibilities for providing essential necessities, including health care, from private monopolies to equitable public systems. Realizing this agenda will help level the playing field between patients and payers, providers and middlemen, and labor and capital. It will also pave paths to health- and wealth-building for people who have for too long been left out.

61 Arthur Allen, "PBMs, the Brokers Who Control Drug Prices, Finally Get Washington's Attention," *KFF Health News*, May 11, 2023, https://kffhealthnews.org/news/article/pharmacy-benefit-managers-prescription-drug-prices-congress-legislation/.

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