

# Hospital consolidation matters

How antitrust enforcement in the United States can improve competition in the U.S. healthcare system to promote more equitable economic growth

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# Washington Center *for* Equitable Growth

*Evidence for a stronger economy*

The Washington Center for Equitable Growth is a non-profit research and grantmaking organization dedicated to advancing evidence-backed ideas and policies that promote strong, stable, and broad-based economic growth. Our fundamental questions have been whether and how economic inequality—in all its forms—affects economic growth and stability, and what policymakers can do about it.

We work to build a strong bridge between academics and policymakers to ensure that research on equitable growth and inequality is relevant, accessible, and informative to the policymaking process. And we have the support and counsel of a steering committee that comprises leading scholars and former government officials. Members have included Melody Barnes, Alan Blinder, Raj Chetty, Janet Currie, Jason Furman, John Podesta, Emmanuel Saez, and Robert Solow.

Since our founding in 2013, we have funded the work of more than 150 scholars and built a broader network through our working papers series, events, and convenings. By supporting research and bringing these scholars together to exchange ideas, we have learned a great deal and advanced a broad range of evidence-based policy approaches to addressing economic inequality and delivering broad-based economic growth to communities and families.

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# Overview

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The U.S. policy landscape is replete with reports from organizations across the political spectrum decrying the lack of competition in hospital markets around the nation and the resulting high prices, mixed quality, and potential drag on labor markets. The COVID-19 pandemic simultaneously accelerated the trend of hospital consolidation and revealed, in the starkest terms, the consequences of this consolidation: reduced capacity to care for critically ill patients and healthcare workers pushed to (and beyond) their breaking point.

Yet despite ample evidence of a worsening problem with significant financial and health consequences for patients and local economies, as well as a plethora of thoughtful, actionable, available policy solutions, the federal government has taken modest steps toward action in this area. Antitrust agencies have taken the threat of hospital consolidation seriously, and the Federal Trade Commission has made significant shifts to address some of the largest threats to competitive hospital markets. Yet even if the agency ups its game, federal antitrust enforcement alone cannot turn the tide. Other federal agencies and states can and must do more if a market-oriented approach to hospital care is to deliver on its promises.

Determined not to add to the pile of previous reports from respected institutions, academics, and commentators lamenting the breakdown of competition in hospital markets, the Washington Center for Equitable Growth in this report aims instead for a call to action. We aim to provide a clear-eyed assessment of whether competition in hospital markets is hopeless—and how we can begin to chart a path to better, more affordable healthcare provided by fairly compensated and equitably managed providers.

A prescient report from a quarter-century ago noted: “The United States has embraced a market-oriented approach to health policy. The success of this approach critically depends on promoting and protecting competition in healthcare markets[.]” Yet consolidation of hospital markets has continued—and, indeed, accelerated—all while academic research finds that consolidation raises prices without offsetting quality or access to care improvements. If the government and private firms cannot deliver competition in healthcare markets, then perhaps it is time to reconsider whether a market-oriented approach is the right one.

Why? Because hospital competition matters for U.S. workers, their families, and our nation's overall fiscal and economic strength. A lack of hospital competition leads to higher prices.<sup>2</sup> Mergers of hospitals within 5 miles of each other lead to an average price increase of 6 percent.<sup>3</sup> Monopoly hospitals' prices are, on average, 12 percent higher than hospitals with three or more nearby competitors.<sup>4</sup> After hospital mergers in already-concentrated markets, "[p]rice increases on the order of 20 or 30 percent are common, with some increases as high as 65 percent,"<sup>5</sup> according to Martin S. Gaynor, the E.J. Barone Professor of Economics and Public Policy at the H. John Heinz III School of Public Policy and Management at Carnegie Mellon University.

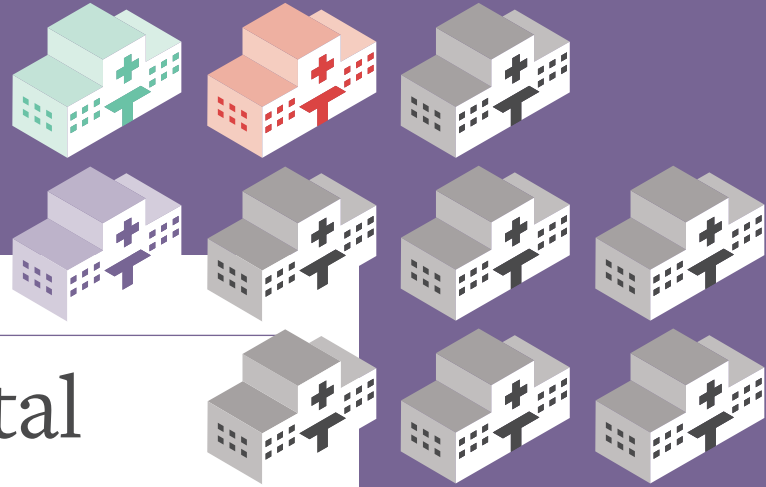
Additionally, Gaynor finds, "Several studies have found that patient health outcomes are substantially worse at hospitals in more concentrated markets, where those hospitals face less potential competition."<sup>6</sup> Other studies find weak or no improvements in the quality of care from hospital mergers.<sup>7</sup> On balance, the impact of mergers on quality is mixed, at best.

These factors indicate falling competition in the U.S. hospital sector and the baleful consequences. On the flip side, there is extensive evidence that, where it exists, hospital competition leads to lower prices and often also to better quality.<sup>8</sup> Theoretically, there can be benefits from increased consolidation of hospitals in the form of convenience, interoperability, and other synergies. The empirical evidence, however, demonstrates that increased costs outweigh these benefits.<sup>9</sup> Ultimately, hospitals' increasing spending, with little if anything to show in the way of higher quality, indicates a broken market.

Moreover, these price increases create significant hardships for patients. Unlike some products, consumers cannot simply choose to forgo hospital services, even if they are unaffordable. Hence, there is a growing pile of medical debt and a ceaseless flow of medical bankruptcies in the United States. The high cost of healthcare and the United States' lack of social support services would be a problem even if hospital markets were competitive. However, the consolidation of hospital markets and the lack of effective competition for hospital services make the situation immeasurably worse.

In the following pages, this report will revisit a recent and detailed report on the rising consolidation of hospitals in the United States and the harms (and occasional benefits) of this trend for healthcare providers and patients, as well as the nation's overall fiscal and economic outlook. The report then examines the current evidence for what federal and state policymakers can glean to address these issues, before delving into more detail on the competition issues with which these policymakers must grapple to deal with hospital consolidation. The report then closes with a comprehensive set of suggested policy actions.

These policy recommendations include suggested legislative and administrative solutions to increase the transparency of hospitals' pricing and quality-of-care metrics, as well as proposals to improve antitrust reviews of mergers. There also are suggested ways for decisions by the judiciary to be better informed with better data-driven evidence of the competitive harms caused by hospital consolidation. All these practical solutions to better antitrust enforcement of hospital mergers rest on suggested ways in which policymakers at the federal and state levels can work with the national antitrust laws and regulations as they stand today—recognizing that, for a variety of reasons, antitrust remedies alone cannot resolve the growing problem of the increasing consolidation of hospitals in our nation.



# The state of hospital consolidation and its impacts

The scale of the hospital sector in the United States is enormous.<sup>10</sup> It accounts for \$1.3 trillion of healthcare spending, and continuing to grow more rapidly than other healthcare sectors, including physician and clinical services and prescription drugs.<sup>11</sup> Additionally, the hospital sector has experienced a wave of mergers and acquisitions that began about 30 years ago and has accelerated steadily since 2010.<sup>12</sup> In a report released by Equitable Growth in 2023, we dive into the impacts of this hospital consolidation on local economies, providers, and patients.<sup>13</sup>

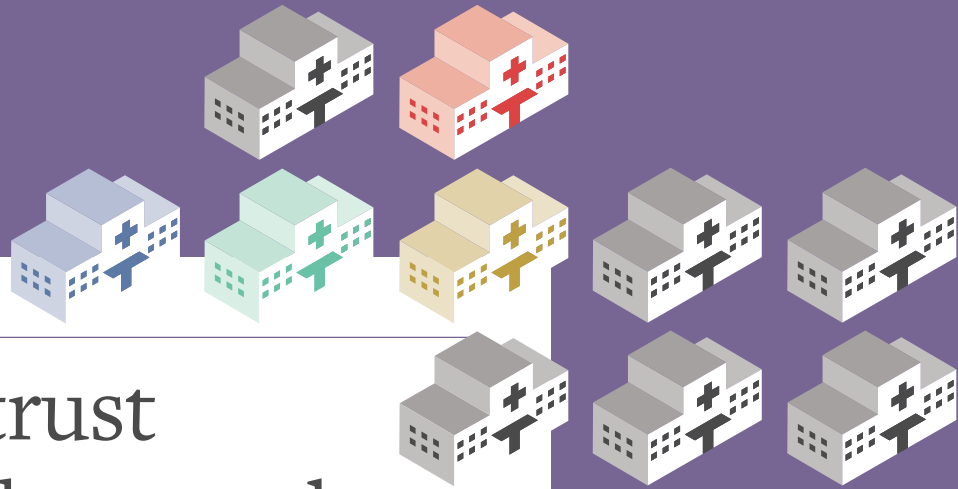
In 2016, 90 percent of U.S. metropolitan statistical areas had highly concentrated hospital markets.<sup>14</sup> Looking closer at what this concentration means for patients, as of 2017, 19 percent of markets—representing 11.2 million patients—were served by only one hospital system.<sup>15</sup> These concentrated markets are susceptible to, or have already been impacted by, these shifts in market dynamics and subsequent changes in bargaining leverage exercised by consolidated hospitals and health systems on prices and local labor markets. Numerous studies have already found that consolidation is associated with high healthcare prices. This is important because healthcare costs in the commercial sector drive healthcare spending growth.<sup>16</sup>

Consolidation and mergers that reduce competition result in price increases and the trickle-down effects of those increases on wages and on government, employer, and household budgets. But our 2023 report finds that consolidation and mergers affect more than just prices. A growing body of evidence also shows clinician wage stagnation,<sup>17</sup> health insurance premium increases,<sup>18</sup> and closures of hospitals and lines of service.<sup>19</sup> Despite promises by hospital executives that quality will increase post-mergers, the research evidence on that is decidedly mixed.<sup>20</sup>

Ultimately, the 2023 report concludes that hospitals' increasing spending without measurable improvements in quality indicates a broken market. When hospitals no longer need to compete on that basis, their incentives to provide higher-quality care or invest in innovations and technologies can be affected. This can manifest as decreased financial investment in low-profit-generating initiatives, such as quality improvement or social determinants of health interventions.<sup>21</sup>

By prioritizing the preservation of competition, the transparency of merger and acquisition activities, and equitable access to care, policymakers and researchers can help create a healthcare system that benefits all stakeholders and improves health outcomes for all patients. When markets maintain a healthy level of competition, the U.S. economy can become more equitable and improve the lives of all Americans.





# Current antitrust literature and research on hospital consolidation

As evidenced by the current state of hospital consolidation and competition and the ongoing policy discussions, there is a consensus that there is room for improvement in the implementation and/or framework of current antitrust enforcement in the U.S. healthcare sector. Recent legal developments—such as the case against Sutter Health in Northern California and the review of the affiliation between Cedars-Sinai Memorial Health System and Huntington Memorial Hospital in Southern California—demonstrate the importance of investigating the unchallenged consolidation of healthcare providers into multi-market health systems and the local market leverage these transactions allow systems to utilize in setting prices and contracting terms.<sup>22</sup>

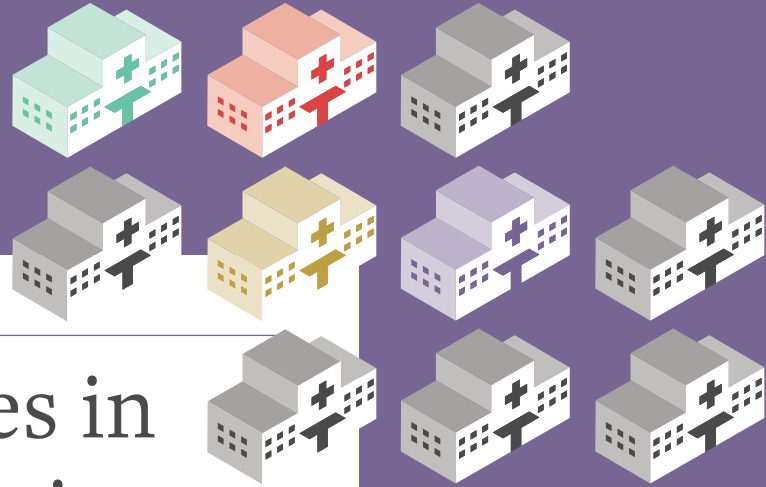
Yet the preferred tactics and areas of focus for regulators and policymakers remain up for debate among researchers. Many leading academic and legal minds in the field argue for more creative and proactive solutions in local markets already characterized as highly concentrated instead of more traditional and reactive approaches. Given the wave of consolidation and concentration that has already taken place with little opposition over the past few decades, the Federal Trade Commission (the federal agency that usually oversees hospital antitrust cases) is now forced to play catch up and risks remaining a step behind. Some academics go so far as to imply that there may be no markets left without fixes to healthcare markets soon.<sup>23</sup>

Many researchers argue that current policies unintentionally encourage consolidation and inhibit entry into hospital markets. These researchers point to outdated or flawed approaches, including Certificates of Public Advantage, or COPAs

(which states can issue to hospitals to avoid federal antitrust review), contracting practices and barriers to entry, and regulatory challenges that inadvertently discourage competitive markets. Other academics, however, contend that further antitrust enforcement would harm the free market or that pursuing antitrust law and enforcement is not the right avenue to address the challenges in healthcare markets.

These critiques still maintain that when thoughtfully done, antitrust policies and enforcement at the state and federal levels can be effectively deployed to begin to address healthcare concentration and competition. But among those more critical or skeptical of antitrust as a solution, critiques are focused on the feasibility of antitrust as a tool and the preservation of free-market dynamics. These critics argue specifically about the following:

- **The benefits of scale and integration:** Critics of aggressive antitrust enforcement argue that hospital consolidation can lead to benefits such as economies of scale, improved care coordination, and investments in technology and infrastructure.<sup>24</sup> They argue that by increasing the intensity of oversight or enforcement, hospitals could be disincentivized to invest or seek out these growth and quality-improvement activities. As explained above, however, these benefits often fail to materialize, are overstated, and are outweighed by the costs of lost competition. Significant experimentation is also taking place, including related to big data and AI, which might lead to new benefits from scale or integration.
- **Legal challenges:** Some opponents argue that antitrust litigation can be lengthy, costly, and uncertain, and they question the ability of antitrust agencies to effectively address complex healthcare market dynamics. This is of particular note when looking at federal and state capacity to bring forth more cases or even to increase oversight to identify or review questionable market activity.<sup>25</sup>
- **Market-specific analysis:** Opponents of aggressive antitrust enforcement in healthcare sometimes argue that such enforcement is unnecessary or inappropriate in certain markets. In particular, they say that acquisitions of healthcare providers in many rural or underserved areas, where hospital consolidation can be driven by economic necessity because smaller hospitals struggle to maintain operations, can be beneficial.<sup>26</sup> More broadly, there is a concern that without some limiting principle, mergers will be over-deterred.
- **Regulatory alternatives:** Some argue that alternative regulatory mechanisms, such as certificate-of-need programs or price controls, might be more effective and practical in ensuring access to affordable healthcare and quality services.



# Competition issues in hospital consolidation

Insurance significantly complicates competition in healthcare markets, including hospital markets. Models articulating the unique two-stage competition dynamic in hospital markets were the key to unlocking the market definition door that once kept antitrust effectively out of hospital mergers.<sup>27</sup> In the first stage, hospitals compete in local markets to attract patients. In the second stage, hospitals compete for inclusion in insurance networks. The popularity of a hospital with patients is an essential input into the hospital's negotiation for inclusion in insurance networks. Likewise, the hospital's inclusion in insurance networks is an important input into the hospital's ability to attract patients in local markets. The two-stage nature of hospital competition and other unique aspects of hospital markets result in some notable characteristics at each level of hospital competition.

Anticompetitive behavior in hospital markets also takes on unique forms because of dynamics particular to hospital competition. The so-called capture of referral networks, for example, provides both an incentive for systems to make acquisitions and a means by which systems erect barriers to entry by others.<sup>28</sup> Hospitals that already have monopoly power know that strategic, temporary investments to stave off new entrants can be worthwhile to protect that monopoly position.<sup>29</sup>

One way that powerful hospitals exercise their market power is by rejecting forms of payment they do not like, such as reference pricing and tiered networks, and so hospital consolidation also poses a serious challenge for payment reform.<sup>30</sup> Patient referrals are also impacted by consolidation. Studies find physicians in a practice owned by a health system are much more likely to refer patients to specialists and hospitals in that health system.<sup>31</sup>

Finally, hospital control of medical data provides a unique way in which hospitals can exercise and enhance their market power. “There are extensive reports of health systems engaging in “data blocking”—impeding the flow of patient information to providers outside the system,” according to Carnegie Mellon’s Gaynor, making it more difficult for patients to switch providers.<sup>32</sup>

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## Competition for networks

At the first stage of the two-stage competition model, hospitals compete to be included in fully insured and self-insured insurance networks. Inclusion in the insurance networks used by patients in its local market is a critical driver of patient flow to a hospital. At the same time, for insurance products to appeal to employers who select insurance plans to offer their employees, the insurance product’s network of providers must be sufficiently robust and comprehensive to satisfy their employees’ needs.

In this first stage of competition for inclusion in insurance networks, negotiations between the insurers and the hospitals determine prices.<sup>33</sup> To construct viable networks, insurers must have provider coverage for the vast majority of the geographic area and for core services. While networks with isolated coverage holes can remain viable, too many gaps in coverage make a network insufficient. Seeking to take advantage of this dynamic, hospital systems use their critical mass of providers to gain bargaining leverage by only bargaining on an “all-or-nothing” basis.

The need for insurers to have broad coverage networks allows hospital systems to insist on including hospitals in insurance networks, even in markets where the system’s hospitals do not provide good value. Systems do this by conditioning inclusion in the network of their so-called must-have hospitals on the inclusion of all their hospitals, even the less valuable ones.

As insurers developed tools, such as tiered networks and steering patients to more affordable providers through co-pays and other mechanisms, systems have increasingly insisted on contract terms prohibiting these mechanisms. These restrictive practices have significantly dragged down price and quality competition in the second stage of hospital competition.<sup>34</sup>

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## Competition for patients

Competition at the second stage of the two-stage model, where hospitals compete to attract patients, is notably different from competition in most markets. Researchers have established, for example, that hospitals engage in limited competition for patients based on price.<sup>35</sup> Because most patients are insured and the costs to them do not vary much with the price charged by the hospital, hospitals competing for these insured patients do not advertise prices or otherwise use prices to differentiate themselves on the patient side.

In addition, demand for hospital services is relatively resistant to price changes.<sup>36</sup> People are reluctant to forego hospital services, even in the face of price increases and the risk of medical debt or, in some cases, bankrupting themselves.<sup>37</sup>

Finally, the difficulty of measuring hospital quality and the limited opportunities for patients to observe hospital quality directly means that patients rely primarily on referrals and proximity when choosing hospitals.<sup>38</sup> This is why capturing referral networks is often a profitable, largely anticompetitive strategy for hospitals.

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## Competition for workers

Hospitals are not just providers of services but also are significant employers. The nation's 6,129 hospitals employ more than 7 million workers, ranging from clinicians to technicians to food industry workers.<sup>39</sup> They are also the primary employer for some types of clinicians, such as registered nurses, for whom general medicine and surgical hospitals employ more than half of those practicing.<sup>40</sup>

For some workers, such as doctors and nurses with specialized hospital skills, hospitals compete primarily with other hospitals; for others, such as custodians and receptionists, hospitals compete with a broader array of employers to attract and retain workers. For those workers with skills specialized for a hospital setting, hospital consolidation can significantly impact the competitiveness of the market for their labor. Mergers with significant increases in concentration have been shown to reduce wages for these specialized workers, with little effect on the less specialized workers.<sup>41</sup>

The increased use of noncompete agreements has exacerbated hospital consolidation's impacts on specialized workers' labor markets. Broadly, they have been a problem across all industries, with almost 1 in 5 U.S. workers—30 million people—subject to a noncompete agreement.<sup>42</sup> These agreements have long been used in the healthcare industry and have long been problematic. The Federal Trade Commission and the U.S. Congress both turned their attention to these issues in 2023, with a proposed rule change to ban noncompetes and legislation to limit their use, respectively.<sup>43</sup>

Hospital consolidation has increased the problems inherent with noncompete agreements, contributing to ongoing consolidation. A noncompete imposed by a standalone hospital in a competitive hospital market would prohibit a doctor or nurse who signed it from working at a competing hospital in that same market. The price employees would demand to sign the noncompete would be driven by the competition for their services between the various hospitals in their market. Regardless of the noncompete, employees would retain the option to leave the local area and go to work for another hospital.

As hospital markets have become more concentrated and hospitals are increasingly part of larger systems, these dynamics interact with noncompete agreements in problematic ways. In more concentrated hospital markets, there is less competition for the labor of doctors and nurses in the first place, which reduces their ability to demand compensation in exchange for initially agreeing to the noncompete and also limits their options for hospital employment on different terms. In a monopoly situation—where the entry of one or more hospitals would be most acutely needed to revive competition—all of the local doctors and nurses may be bound by noncompete agreements, making it impossible for a potential competitor to secure the necessary workforce to enter the market.<sup>44</sup>

Moreover, where hospital systems impose noncompete agreements, these restrictive terms of employment often apply systemwide. A doctor bound by a noncompete with a freestanding hospital would be free to go to another market to practice at a different hospital, but a doctor bound by a systemwide noncompete agreement is often barred from practicing in any market where the system has a facility—which is increasingly a problem as systems expand geographically. This consolidation dynamic greatly amplifies the scope of the noncompete problem and serves as a drag not only on mobility and wages, but also on competitive market entry and market dynamism.

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## Contracting practices

With the rise of hospital systems, we have become concerned about the anticompetitive effects of certain contract terms deployed by systems in their contracts with insurers. These terms include anti-steering and so-called most favored nation, or MFN, clauses that can be used to limit price competition between providers and insurers, gag rules that prevent disclosure of prices to patients or for use in price comparison tools, and the use of “all-or-nothing” contracts, or the bundling of healthcare services in the contract terms.<sup>45</sup> Each of these practices impacts competition by influencing where or with whom care is provided or at what rates and which services are covered, regardless of price.

For instance, all-or-nothing contracts hamstring insurers into network inclusion by requiring them to pay for all of a hospital system’s services or face holes in their network. This strategy prevents insurers from contracting with select providers who can direct patients to higher-value practitioners and stimulate competition. All-or-nothing contracts ultimately drive up costs and limit market entry of potential competitors.<sup>46</sup> At the same time, gag rules limit the ability of price-sensitive patients to find the lowest-priced providers. This makes it even harder for efficient entrants to make headway in the market.

A self-reinforcing combination of anti-tiering, anti-steering, gag rules, and all-or-nothing contract provisions was at issue in the case against Sutter Health, which employed this strategy through its pricing structures and other contract terms to intensify the effects of the all-or-nothing clauses.<sup>47</sup> If a health plan wanted to exclude a newly acquired Sutter provider, Sutter would raise rates for their contracted providers and charge excessive out-of-network rates. Such terms made it economically favorable for the health plan to include a newly acquired Sutter service provider and accept the all-or-nothing terms rather than pay the higher prices.<sup>48</sup> Similar claims against Atrium Health were the basis of a U.S. Department of Justice case that was settled in 2018.<sup>49</sup>

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## Cross-market effects

Reminiscent of the prior shift in thinking about hospital competition that led to the application of the two-stage competition model, scholars and policymakers are currently grappling with new thinking about so-called cross-market mergers and their potential to impact competition.<sup>50</sup> Historically, mergers between hospitals not operating in the same geographic or product markets have been considered

unproblematic. Recently, however, evidence has emerged that even mergers between hospitals that do not directly compete with one another for patients often lead to price increases.<sup>51</sup>

Although the evidence of this price effect is strong, much less is understood about its cause and whether it is related to a reduction in competition.<sup>52</sup> In their recent book, researchers David Dranove, the Walter McNerney Distinguished Professor of Health Industry Management at Northwestern University's Kellogg Graduate School of Management, and Lawton R. Burns, the James Joo-Jin Kim Professor at the Wharton School at the University of Pennsylvania, analogized the phenomena to quantum mechanics and referred to documented cross-market pricing effects as “spooky pricing at a distance.”<sup>53</sup>

This is not to say there are no theories about the source of this pricing effect; indeed, there are multiple potential explanations, and they are largely complementary. These explanations include changes to the bargaining dynamic with customers who use or value both merging parties, altered bargaining dynamics with a common insurer, and impacts of costs from combining services.<sup>54</sup> Which effect is driving pricing in any given situation is a factual question, the answer to which will also determine whether the pricing effect results from a reduction in competition or some other mechanism. Moreover, identifying the dominant mechanism or multiple mechanisms driving the price effect in any given case will be critical to determining the appropriate remedy.

Looking across these mergers, researchers have determined that the price effect is often present where market linkages create a so-called concavity effect.<sup>55</sup> Such an effect occurs where the value to a patient or a network from having access to both services provides greater value than the sum of the value of the individual services—in other words, when the whole is greater than the sum of its parts.<sup>56</sup> This can happen on the patient side, where a patient or a family needs multiple services or services at multiple locations, or on the network side, where an insurer or an employer needs to cover multiple services or localities to assemble a viable network.

In addition, researchers have established that the price effect cannot be explained away solely by the increased bargaining power that a large, sophisticated system introduces when it acquires a new hospital. Leemore Dafny, the Burce V. Rauner Professor of Business Administration at Harvard Business School and member of the faculty of Harvard's John F. Kennedy School of Government, and her team have shown that such mergers result in increased prices not just at the acquired hospital (which might be a result of increased bargaining skill) but also at other hospitals in the acquiring hospital system (where no change in bargaining power has occurred).<sup>57</sup>



Bargaining power in this context is the aptitude to bargain (better negotiating tactics, using your position better, or having better information) or a market change that allows for a strong bargaining position or more bargaining leverage, such as the removal of noncompete agreements or higher number of insurers in local hospital markets.<sup>58</sup> So, cross-market effects are an important piece of the hospital competition dynamic, but more work is needed to tease out the competition-related cross-market effects from those unrelated to competitive dynamics.

As the discussion above illustrates, hospital consolidation leads to significant competition concerns that empirical results have borne out. That being said, it is worth asking whether hospital consolidation also positively impacts competition.

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## Potential positive impacts on competition from hospital consolidation

Despite the well-documented evidence of competition issues arising from hospital consolidation, it continues unabated. There were 1,519 hospital mergers announced, though not all completed, in the past 20 years, with 680 announced since 2010.<sup>59</sup> Several explanations have been offered for why this consolidation does not threaten competition. The two most prominent are countervailing power and integrative efficiencies. While countervailing power is surely important, particularly with regard to price increases and insurer impacts, this report will focus on integrative efficiencies, to which we turn next.

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## Limited economic gains from consolidation/integration

One explanation is that consolidation leads to integrative efficiencies. Some antitrust scholars argue this consolidation is necessary to shift to value-based care.<sup>60</sup> Others argue that large systems can provide a broader range of services in an integrated network, even under a fee-for-service model. The difficulty with the latter explanation is that, as Carnegie Mellon's Gaynor put it, "Consolidation is not integration."<sup>61</sup>

The consolidation of businesses does not necessarily mean or precede the integration of service provision within or across these newly acquired care sites. So, as hospitals consolidate into systems and markets become more concentrated, those systems are not necessarily fulfilling their promise to provide integrated care in a way that benefits patients. Clinical integration is often touted as a merger benefit for hospitals, but it is rarely achieved in the way that systems such as Kaiser, for example, have accomplished.

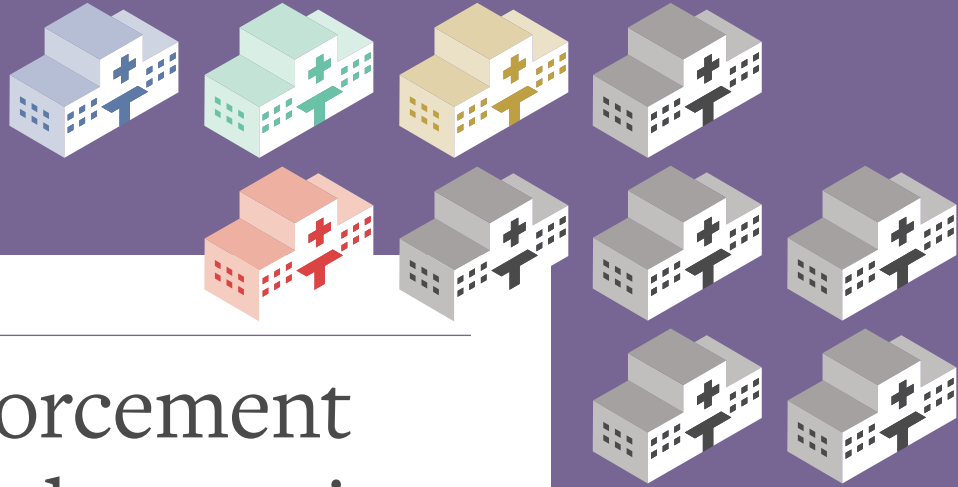
To the extent those systems have integrated via, for example, electronic medical records, that integration would seemingly have been possible without a complete merger. In antitrust terms, these integration efficiencies are not merger-specific and, therefore, are not relevant to whether a merger threatens competition. In any event, to justify a merger, antitrust law requires any merger efficiencies to outweigh anticompetitive effects,<sup>62</sup> and even where some efficiencies are present, there is little evidence that efficiency gains from most hospital mergers clear this high bar.

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## Regulatory challenges

An often-overlooked competition challenge in hospital markets is the potential harm to competition arising from state regulations and policies. These state policies encompass such things as licensure and scope-of-practice limitations, which restrict who may practice in a state and the types of care licensed providers can undertake; certificate of need, or CON, determinations, which limit entry into hospital markets absent a state determination of the need for a new provider; and how state medical boards operate in their state, which often involves exclusionary practices designed to protect existing providers at the expense of new entrants and competition.<sup>63</sup>

When licensing and scope of practice are limited, the pool of clinicians able to provide services is reduced. CON laws can impact competition by creating barriers to entry and expansion.<sup>64</sup> When medical boards are run by those benefiting from decreases in market competition, their role, or how they are subject to state oversight, should interest state competition regulators.



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# Antitrust enforcement against hospitals over time

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Federal antitrust enforcement against hospital consolidation has waxed and waned over the past 40 years.<sup>65</sup> When the federal antitrust authorities first began to focus on hospital consolidation in earnest, they used standard product and geographic market definition tools for other goods and services. Because these models failed to account for the unique characteristics of hospital markets, attempts to use them in hospital merger cases led to a string of losses by the government, which allowed consolidation to proceed largely unchecked. This string of losses was the impetus for retrospective analyses and the development of new theories and models to better account for the realities of hospital competition. The result was a series of wins and the widespread adoption of the two-stage competition model.<sup>66</sup>

Over the entire period, however, federal antitrust enforcement across all industries has primarily focused on horizontal mergers.<sup>67</sup> In the hospital context, these are mergers between hospitals that directly compete with one another in the same markets for patients or network inclusion. Federal guidance on vertical and cross-market hospital mergers was limited, and enforcement against such mergers was virtually nonexistent. Vertical consolidation involving hospitals—such as hospitals acquiring physician groups or hospitals offering their own insurance products (so-called provider-sponsored plans)—has, like vertical mergers generally, received light scrutiny.<sup>68</sup>

Additionally, federal enforcers have not acted to block or limit cross-market mergers or develop robust cross-market competition theories.<sup>69</sup> This partially reflects the theoretical and empirical uncertainty about the dynamics and impacts of vertical and cross-market mergers, in contrast with the relatively straightforward account of the harms to competition from horizontal mergers.

The nonprofit status of many hospitals has also limited federal enforcement.<sup>70</sup> The Federal Trade Commission’s enforcement authority against nonprofit healthcare providers is somewhat limited, despite research that shows “nonprofit hospitals exploit market power just as much as for-profits.”<sup>71</sup> Beyond legal limitations on enforcement authority, nonprofit hospitals have enjoyed a patina of public interest due to their nonprofit status. This reputational halo may have been driven by marketing and lobbying efforts by the hospitals themselves and is not supported by the legal requirements for nonprofit status.<sup>72</sup>

These efforts by nonprofit hospitals to burnish their image have been somewhat successful, as some courts have expressed skepticism that nonprofit hospitals will face the same incentives to exercise market power as for-profit entities. However, studies show that nonprofit hospitals devote the same or fewer resources to charity care than their for-profit counterparts, undermining any rationale for special treatment under competition law.<sup>73</sup>

State Certificate of Public Advantage, or COPA, laws present another barrier to federal enforcement against hospital mergers. When hospitals or systems want to consolidate but are worried about violating federal antitrust law, they can apply to their states for a Certificate of Public Advantage. With COPAs, states can immunize hospital mergers from federal antitrust law, provided the hospital agrees to state oversight of their prices, quality, and other metrics.

Nearly half of U.S. states have or used to have COPA laws.<sup>74</sup> The existing research shows that the benefits of COPAs have not come to fruition, with most COPAs that have been approved resulting in a single hospital monopoly.<sup>75</sup>

The Federal Trade Commission advocates against using COPAs, which it perceives as a means to shield an otherwise-illegal hospital merger.<sup>76</sup> The agency also points to the instability and longevity of the policies, stating that COPAs can be overturned by future state legislators, leaving the merged entity intact and its exercise of market power unconstrained.<sup>77</sup>

Acknowledging the cross-section of agencies and authorities required to address these issues, in 2021, the Biden administration issued a bold executive order proclaiming a “whole of government” approach to competition, suggesting that agencies other than the Federal Trade Commission would develop and implement meaningful policies to support hospital competition.<sup>78</sup> Unfortunately, other agencies have not heeded the call to exercise the power they already possess to implement competition-friendly hospital policies.

Instead, the Centers for Medicare and Medicaid Services and the U.S. Department of Health and Human Services have continued to propagate payment and governance policies that reward consolidation and have failed to embrace reforms that have long been vocally advocated for, let alone develop and embrace innovative ideas to infuse competition in hospital markets. This includes, among many other ideas, bolstering price transparency and its operability, the move to site-neutral payments in Medicare, and reforming the 340b program incentives for physicians who administer costly drugs to become employed by 340b-eligible hospitals.<sup>79</sup>

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## State track records

While states are deeply interested in hospital transactions and have varied tools to monitor and police hospital mergers and acquisitions, they often lack the information and resources they need to track transactions effectively. Additionally, many of the tools available to them only cover some hospitals or some transactions or certain types of considerations.<sup>80</sup> In particular, the lack of pre-transaction notice requirements and the short time given to state authorities to act pose barriers to state oversight and intervention.

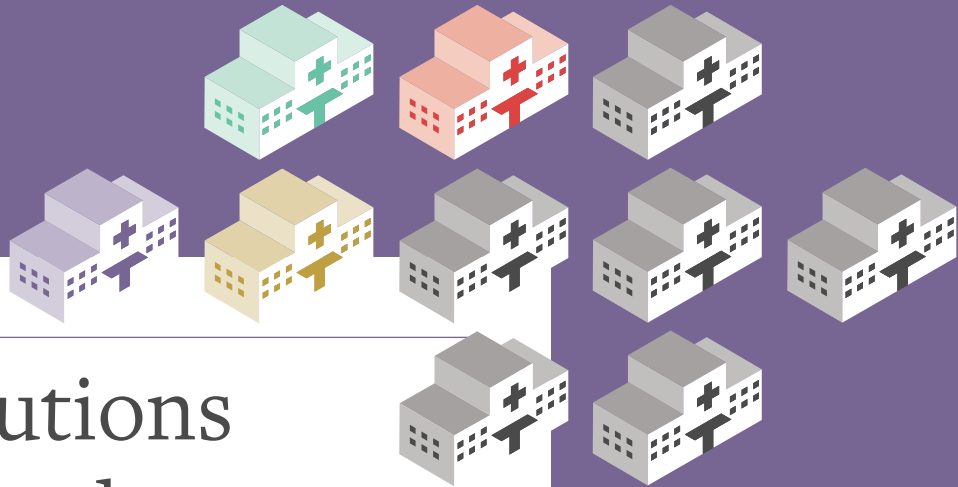
As of 2018, only five states—Colorado, Hawaii, Massachusetts, Illinois, and Washington state—require advance notice to the state and a mandatory waiting period before a hospital undertakes a merger or acquisition, regardless of the hospital's nonprofit or for-profit status.<sup>81</sup> An additional 11 states hold the ability to block or impose conditions on mergers or acquisitions of nonprofit hospitals without court approval.<sup>82</sup> In three of those states—Massachusetts, California, and Oregon—the legislature has created independent state agencies to oversee healthcare markets and review transactions.<sup>83</sup> The effectiveness of these authorities and reviews has yet to be thoroughly studied, although recent work from Alexandra D. Montague at the University of California College of the Law, San Francisco (formerly of UC Hastings) and others provides an insightful and thorough overview of some of the major issues and research to date.<sup>84</sup>

In addition to regulatory authority, state authorities can bring lawsuits to block and unwind hospital mergers under federal and state laws. Such suits are rare, partly because of the lack of advance notice to states, but there have been some success stories. Notably, the Rhode Island Attorney General's office successfully blocked a hospital merger that would have given the resulting hospital a near monopoly within the state.<sup>85</sup>

State *parens patriae* litigation—based on the common law power of the state to challenge harmful behavior on behalf of its citizens—has also resulted in consent decrees imposing conditions on mergers that are allowed to move forward.<sup>86</sup> While these decrees have worked to mitigate price increases in the immediate aftermath of mergers, they are typically time-limited and do nothing to check price increases after expiration.<sup>87</sup>

States also have sued powerful hospitals engaged in anticompetitive conduct, with some recent successes.<sup>88</sup> In the case of Sutter Health, California’s attorney general filed suit, alongside a private class action suit against Sutter, claiming it leveraged its market power to violate California’s Cartwright Act and Unfair Competition Law. In 2019, Sutter settled for \$575 million and a minimum of 10 years of specific injunctive relief. The injunctive relief, in this case, includes limitations on out-of-network charges, permits insurers and self-funded payers access to Sutter’s pricing, quality, and cost information, calls for a halt to its activities denying patients access to lower-cost plans, and puts a stop to its use of all-or-nothing contracts.<sup>89</sup>

Private enforcement actions also have sought to combat and seek recompense from hospitals for anticompetitive conduct, including the above-mentioned Sutter Health class action suit. Still, there have been few, if any, successful private lawsuits to block or unwind hospital acquisitions.<sup>90</sup>



# Antitrust solutions moving forward

The competition problems surrounding hospital consolidation across the United States are deep, widespread, and well-known. The challenge at this point is not to determine whether hospital consolidation presents a problem for competition but instead to figure out what to do about it. Antitrust enforcement is part of the solution but is clearly insufficient on its own to cure what ails these markets. More is needed—more antitrust enforcement and more holistic thinking about generating and protecting competition in these markets.

As an initial matter, any policy solution must center around building political will and alignment. Many of the technical fixes that enjoy broad support—such as site-neutral payments, which would reduce the incentives for hospitals to acquire outpatient facilities—have been on the table for years but remain elusive due, in part, to the influence of special interests and other legislative and regulatory priorities. What is needed to move from the realm of ideas to the realm of policy action is the will on behalf of federal legislators, the executive branch, and the agencies to make it happen.

But, as the Biden administration has experienced, the political will of one branch or political party is likely insufficient, and a broader base or an alignment of political incentives is also needed. Careful drafting and attention to detail are required to ensure smooth and effective implementation of site-neutral payments. Yet there is no excuse for inaction. Concerted attention to implementing these solutions could quickly achieve meaningful improvements in the functioning of hospital markets.

Building political will begins with making the case that the scale and scope of the problem demand attention, combined with concerted campaigns to educate the public and policymakers about the available solutions. The United States, in 2021, spent \$4.3 trillion on healthcare, making up 18.3 percent of U.S. Gross Domestic Product. Hospital-related expenses accounted for \$1.3 trillion, or 31 percent of that \$4.3 trillion of domestic health spending and roughly 6 percent of U.S. GDP.<sup>91</sup> While the lack of competition in hospital and healthcare markets is a drag on GDP, it is also hurting the pocketbooks and the health of patients, impacting jobs and wages for those who work in healthcare and even those who do not, and undermining businesses, local economies, and state budgets.

Building political will also requires convincing people and policymakers that policy solutions exist and that achieving competition in hospital markets is possible. It may not be perfect competition, but meaningful competition that can drive prices lower, foster higher quality of care, boost innovation, and create more robust labor markets.

What follows is a summary of the most promising policy solutions to improve competition in hospital markets, broken out by the branch of government that is positioned to put these solutions into place. Some would require new legislation, but many can be implemented now by agencies and enforcers that are already empowered to make these changes.

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## Legislative solutions

While grand legislative healthcare solutions, such as the federal Affordable Care Act of 2010, may only be possible during rare moments when the political stars align, we believe a range of targeted but effective pieces of legislation at the federal and state levels are politically viable now. These laws have the potential to meaningfully, if incrementally, improve the competitiveness of hospital markets in the United States.

## Transparency

Transparency is a necessary condition for well-functioning markets. Patients and insurers cannot be expected to make choices that select for high quality and low costs if they have no way to tell which hospitals provide quality services or know how much those services cost.



The obvious necessity of transparency in hospital prices and quality is presumably why initiatives promoting it have received widespread support from both sides of the political aisle. This is an unequivocally good thing, but we should not fool ourselves into thinking that transparency alone will infuse hospital markets with effective competition. This is so for two immediate reasons:

- **Empirical evidence suggests price transparency efforts have not worked as anticipated.** As Northwestern University’s Dranove and UPenn’s Burns bluntly put it in their recent book: “The problem is that no one has figured out how to consistently translate price transparency into lower health spending.”<sup>92</sup> For instance, doctors and hospitals are not as interchangeable as widgets, and there is information asymmetry between providers and patients, such that patients may feel reluctant to go against their provider’s referral to a cheaper doctor.
- **Hospital quality is tough to measure.** There are a multitude of accepted metrics for hospital quality, and even those that are most often used are widely acknowledged to be, at best, crude proxies. Moreover, because there are so many that can be combined in a seemingly infinite number of ways, there is little consensus on which quality metrics are relevant. As a result, pricing and price comparisons are largely ineffective because it is hard to discern whether higher pricing indicates a higher quality of service.

Then, there’s the more complicated problem: More information is useless without effective choice. Transparency improves competition by reducing information costs, leading to better-informed choices. Yet technical transparency that is not provided in a useful format does not reduce information costs. And information without the ability to make different choices based on that information is of little use.

This has been seen with the implementation of the Centers for Medicare and Medicaid Service’s hospital price transparency regulation, effective January 1, 2021, which requires every hospital operating in the United States to make public its standard charges for the items and services it provides. Hospitals must do so via a consumer-friendly display of at least 300 shoppable services and through a comprehensive, machine-readable file (helpful to researchers).<sup>93</sup>

Yet standardization of formats and the readability of the pricing information has been slow to implement, and, in many cases, while “available” on hospital websites, the information can be difficult to locate. The Centers for Medicare and Medicaid Services has been focused on compliance by hospitals as a measure of success, as well as taking stakeholder feedback on access and standardization; however, evidence of awareness of these tools and the level of use by patients and purchasers has remained less clear.<sup>94</sup>

As discussed above, insurance means that most patients are largely indifferent to prices in hospital markets, and results from state-level transparency efforts bear this out, showing mixed impacts on prices from All-Payer Claims Databases, for example.<sup>95</sup> Pricing reforms, such as reference pricing, might encourage more patients to pay attention to price differences, but hospital systems have discouraged their adoption.

## Increased merger review

Antitrust agencies need to review more hospital mergers and have the authority to scrutinize mergers regardless of the size of the hospitals involved or the owner's nonprofit status. The new merger guidelines make significant strides in this direction, but some changes require legislation and rulemaking. The following measures would enhance hospital merger review:

- **Provide advance notice to state attorneys general about hospital mergers in their respective states.** While a few states have laws requiring such reporting, no law currently mandates or even allows federal antitrust agencies to share with states the information reported to them about planned mergers.<sup>96</sup> State-specific reporting requirements create additional burdens for merging parties and add unnecessary complexity to the merger process, whereas rules to enable sharing of the information already being reported under federal Hart Scott Rodino rules would accomplish much of the objective with minimal additional effort. As discussed further below, modifications to Hart Scott Rodino reporting are also recommended to better enable hospital merger review, as current rules fail to capture some competitively significant mergers, even at the federal level.
- **Relax legal protections from antitrust enforcement for nonprofit hospitals.**<sup>97</sup> In particular, the U.S. Congress should amend the Federal Trade Commission Act to include all hospitals, including 501(c)(3) nonprofit organizations, removing limits on the agency's authority to enforce the antitrust laws against nonprofit hospitals. Currently, the agency can challenge nonprofit mergers but not anticompetitive nonmajor behavior of nonprofits because they lack the necessary authority.<sup>98</sup> In 2023, this solution was included in The Stop Anticompetitive Healthcare Act (H.R. 2890), which U.S. Reps. Pramila Jayapal (D-WA) and Victoria Spartz (R-IN) introduced. Yet after introduction, the bill was referred to the U.S. House Committee on the Judiciary and never emerged from the committee.<sup>99</sup> Experience and studies show that anticompetitive conduct is no less of a problem with nonprofit hospitals than with for-profit hospitals, so antitrust agencies should have equal enforcement authority for both.

■ **Crack down on nonprofit/community benefit requirements for institutions that enjoy tax advantages through their nonprofit status.**

There is ample evidence that nonprofit hospitals act like for-profit hospitals.<sup>100</sup> Based on the assumptions and requirements around community-benefit laws, these hospitals receive nonprofit status and attendant tax advantages in exchange for the provision of benefits in the communities in which they operate.<sup>101</sup> In practice, however, these community benefits are poorly defined, insufficient to compensate for the tax advantage conferred on the hospitals, and inadequately enforced. Stakeholders and agencies have actively advocated for changes, including the Government Accountability Office, the nonpartisan investigative arm of the U.S. Congress, and the Center for American Progress.<sup>102</sup>

■ **Unwind local Certificate of Need laws and other state-level impediments to more robust competition.**<sup>103</sup> Multiple state-level regulations inhibit competition in hospital markets and should be overridden by federal action or state reconsideration. Certificate of Need laws and Certificate of Public Advantage laws directly prohibit the entry of new hospitals into markets, protect existing hospitals from federal antitrust scrutiny, and hamper competition. COPAs are particularly problematic when they are used to clear mergers posing competition problems and subsequently repealed, as often happens, leading to price increases.<sup>104</sup> COPAs have also been paired with arguments for preserving quality and equity of access to gain merger approval, especially in the case of nonprofit hospitals. However, these efforts have been mostly ineffective in achieving equity and access goals and providing effective competition alternatives to merger control.<sup>105</sup> Similarly, restraints on the scope of providers' practice and limitations on transferring licenses across states inhibit the free flow of providers and make it harder for hospitals to enter new markets and respond to market conditions.

■ **Simplify reporting of sub-Hart-Scott-Rodino mergers of healthcare providers.**<sup>106</sup> Many healthcare provider mergers are too small to require reporting under current federal rules governed by the disclosure provisions of the federal Hart Scott Rodino Act. These so-called sub-HSR mergers often nonetheless have significant competition impacts for local healthcare markets. Requiring full Hart Scott Rodino reporting of these mergers is impractical and inefficient. However, a streamlined and simplified reporting system for sub-HSR healthcare mergers could allow antitrust authorities to quickly assess which smaller mergers merit additional scrutiny. This reporting could take place at the federal level to limit the administrative burden on hospitals and ensure nationwide consistency, and then be shared with states, per the recommendation above.

- **Ban anticompetitive contracting terms.** State legislators, federal legislators, or both could simultaneously mitigate the exercise of market power by extant multi-market systems and reduce the incentives for further consolidation of hospitals into systems by banning certain anticompetitive contract terms. Several state legislatures have done this already, but there is significant room for further action in many states and at the federal level.<sup>107</sup> The National Academy for State Health Policy has developed a tool for state legislatures hoping to address this issue.<sup>108</sup>

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## Judicial solutions

In the realm of competition policy, the judicial branch plays an outsized role. While courts are, to some extent, beyond the reach of policymaking, policymakers and enforcers can influence courts by providing tools and evidence to drive improved decision-making. Through careful case selection and concerted litigation strategies, precedents can be developed within courts to better address hospital consolidation. These strategies include:

- **Continuing efforts to use the courts to prevent additional consolidation.** Central to this effort is promoting consistent standards for evaluating hospital mergers that take account of the best, current economic understanding of these markets. While many hospital markets are already highly concentrated, there is still value in preventing them from further consolidation. And where hospital markets are not highly concentrated, it is all the more important to prevent them from becoming so because it is much harder to deconcentrate a market than to prevent the concentration in the first instance. On top of the policies recommended in the rest of this report, it bears emphasizing that these changes are in addition to continuing the critical work already being done to use existing court processes to preserve competition that still exists.
- **Expanding the frontiers of hospital consolidation litigation to focus not just on horizontal mergers, but also on cross-market mergers of hospitals and vertical acquisitions of providers, suppliers, and insurers.** In doing so, enforcers must consider how to address the uncertainty surrounding the mechanisms by which these mergers lead to higher prices and shape their legal arguments to address them. Some commentators argue that the uncertainty favors shifting the burden to hospitals to prove their mergers are procompetitive. This would represent a significant and unprecedented shift in merger policy. Others suggest

that the uncertainty surrounding cross-market mergers weighs in favor of continuing to litigate these cases under the rule of reason until we have a better understanding of their dynamics, even if the consequence is that most of these mergers are allowed to proceed.<sup>109</sup> By pressing more of these cases, litigants can help models in the context of specific cases and build precedent outlining when and how they can be stopped on antitrust grounds.

- **Encouraging courts to more carefully scrutinize and demand hard evidence to support claims of post-merger quality increases in hospital deals.** Several studies have looked retrospectively at hospital mergers and their claims of increased quality, and found them largely unfounded.<sup>110</sup> To the extent that courts and agencies are currently crediting loose claims of future efficiencies by merging hospitals, enforcers and research must push back hard on these claims and work with courts and agencies to demand credible, detailed proof of future efficiencies—and hold merging parties accountable when claimed efficiencies fail to materialize.<sup>111</sup>

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## Administrative solutions

Given the difficulties in passing legislation in the current political environment and the slow and unpredictable nature of litigation, perhaps the most promising realm for progress in this area is to use existing administrative powers to promote hospital competition.

The Biden administration's executive order and its whole-of-government approach to competition suggest support for marshaling existing powers to act. Still, little meaningful action on hospital competition has followed since it was made in 2021. Nevertheless, the opportunity remains. Federal agencies could take the following measures:

- **Promote transparency about healthcare costs and quality.**<sup>112</sup> Despite the previously discussed limitations of transparency as a tool for driving competition in hospital markets, there is broad consensus that it is a necessary feature of healthy competition and enjoys bipartisan support.<sup>113</sup> To be effective, such transparency should include standardizing quality reporting to reduce administrative burdens from duplicative standards and enable better comparisons across hospitals.<sup>114</sup> Toward that end, the U.S. Department of Health and Human Services should set up a national healthcare data warehouse to make existing and future data readily available for study.<sup>115</sup> State-level all-payer claims databases could provide a template for such an effort. While some

have raised concerns that price disclosure risks collusion, we believe those risks are limited where the data is public but also anonymized, and discussion of future prices is avoided.<sup>116</sup> That said, similar proposals have previously failed, and the first step toward moving these ideas forward is to develop an understanding of the factors that doomed earlier efforts.

- **Agencies should not encourage hospital consolidation, particularly the Centers for Medicare and Medicaid Services.** As Carnegie Mellon’s Gaynor observes, the agencies must “[e]nd policies that incentivize consolidation.”<sup>117</sup> While hospital consolidation has many drivers, some of which are outside of the federal government’s control, that is no excuse to delay eliminating those government policies that provide incentives for hospital consolidation to the detriment of competition. First and foremost among these policies is the disparate rates for procedures depending on their site of delivery. The lack of site-neutral payment policies from the Centers for Medicare and Medicaid Services has long been recognized as a major driver of consolidation and price increases. CMS and other agencies should take immediate action to implement site-neutral payment models, including changes to Medicare’s facility fees and reform of the 340b drug pricing system.<sup>118</sup>
- **Lower regulatory barriers.** Healthcare generally, and hospitals specifically, are understandably heavily regulated products. Many of these regulations are sound and provide needed reassurance of quality and prevent opportunism. Others, however, are more restrictive than necessary and inadvertently hamper competition. Identifying and eliminating those regulations is an easy way to promote competition in these markets. For instance, by easing restrictions on licensing and scope of practice and the delivery of telemedicine, the geographic scope of various hospital markets—or at least markets for some hospital services—could be greatly expanded, bringing more competitors into these markets without new entry.<sup>119</sup> In some cases, effectively reducing these barriers will require overriding state-level regulatory regimes that are more limiting, often in protectionist ways, supported by lobbying from the physicians benefitting from these restrictions.<sup>120</sup> This is another area where there is strong bipartisan support.<sup>121</sup>
- **Consider putting conditions on Medicare and Medicaid payments barring restrictive contracting practices.** Recent cases have drawn attention to increasingly widespread anticompetitive contracting practices between hospitals and insurers. Specifically, at the insistence of hospitals, payer contracts often include co-called anti-tiering, anti-steering, or all-or-nothing clauses, or some combination thereof. These clauses are specifically

designed to thwart the tools that insurers would otherwise use to force hospitals to compete for inclusion in networks and to provide competitive incentives to their insured customers to seek care at in-network hospitals providing good value. The hospitals deploying these clauses all accept Medicaid and Medicare payments, so the U.S. Department of Health and Human Services should consider conditioning the receipt of these funds on agreement by the hospitals not to use such contract clauses or practices. The risk in such an approach is that it will open the door to conditioning these payments on policy choices generally, in a process subject to politicization.

■ **Consider whether to cap the prices of providers with market power.**<sup>122</sup>

The U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services have enormous power to affect change through rate-setting. One way this power could mitigate the impact of increasing hospital market power is to inversely correlate Medicare and Medicaid reimbursement rates with market concentration. This approach avoids direct price regulation and is targeted at price increases driven by heightened concentration rather than other sources, such as added cost. The caps could be set using comparable, competitive markets to calibrate the caps to the relevant metric. Massachusetts has had some success with a similar approach, implemented in 2012.<sup>123</sup> That said, such an approach would be legislatively, administratively, and legally complex, which might render it infeasible. While some healthcare scholars also advocate for direct price regulation in this space,<sup>124</sup> it is challenging to execute well, and experience to date has not shown this approach to be effective.

- **Break up existing hospital systems.** A final suggestion by some commentators is that the federal government should break up existing hospital systems to restore competition. This is a controversial solution, to be sure, but one that should be available to agencies as a last resort to deal with explicit and repeated abuses of market power by a merged entity.

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## More studies needed

In addition to immediate action to implement ready solutions to established competition problems in hospital markets, more study is needed to develop the theory and evidence surrounding hospital consolidation further. In particular, researchers should focus on the following areas:

- **Impacts of hospital-provider acquisitions.** One hospital's acquisition of another can be recognized as a relatively straightforward horizontal merger once market definition is adequately understood. The competitive impacts and dynamics of hospitals' acquisitions of providers, however, are less clear. Providers are not only, in some cases, horizontal competitors with hospitals but also are important referral sources for the hospitals. Accordingly, these mergers have both horizontal and vertical dimensions, with complex impacts.<sup>125</sup> For the purposes of antitrust enforcement, targeted research on the dynamics of referral capture and identifying the markers of vertical mergers where anticompetitive impacts are likely to outweigh efficiencies would be beneficial.
  
- **Cross-market hospital acquisitions and developing a theory of impacts.** There are several compelling theories about why cross-market hospital mergers lead to price increases, but what is desperately needed is hard economic data to study and develop those theories effectively. To date, researchers seeking to work in this area have encountered considerable pushback in accessing and publishing data that tests or confirms these theories. A concerted effort is needed to push for more data-driven study in this area to better understand the complexity arising from the interaction between the multitude of ways these mergers impact prices and identify the characteristics of mergers likely to harm competition.
  
- **Data blocking.**<sup>126</sup> One understudied potential competition issue in hospital consolidation (and provider consolidation more generally) is data blocking, or using the control of patient data to impair competition by raising rivals' costs. While there are legitimate reasons for institutions to hold patient data close—namely, patient privacy laws—there is evidence that hospitals selectively invoke privacy concerns to deprive competitors of data while freely sharing that same data with friendly third parties and affiliates. This suggests that privacy is not the motivating concern for data sharing criteria, but that some hospitals use patient data as a chit to curry favor and exclude rivals.
  
- **Systematic impacts of anticompetitive insurance contracting practices and noncompete agreements.** Outside of the context of particular cases and bad actors, more study is needed on the systemic effects of common practices impacting hospital competition generally, such as anticompetitive contracting practices and noncompete agreements. The primary concern is that these practices have diffuse impacts on competition that do not lend themselves to resolution through case-by-case litigation, but nonetheless are impactful.





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# The limits of antitrust

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Antitrust enforcement is a critical part of hospital market competition. Existing levels of enforcement should be at least maintained and ideally increased and expanded. All the same, antitrust can only do so much and has certain limitations that must be acknowledged in making effective policy in this space.

First, U.S. antitrust laws are not well-suited to deal with extant market power.<sup>127</sup> Unlike some other nations, our country lacks an abuse-of-monopoly-power rule that directly prohibits the exercise of market power to raise prices and lower quality. This is not simply a legislative oversight that can be easily corrected, either. Instead, it reflects a deep philosophical commitment within U.S. antitrust law not to criminalize the lawful attainment of market power, provided it is not used to prevent competition.

As a practical matter, this limits the ability of U.S. antitrust enforcers to curtail market power after it has been accumulated, absent evidence that the powerful party is tying up distribution channels or otherwise seeking to exclude or raise costs for rivals. Rules against expanding and maintaining monopolies by illegal means are one arrow in the antitrust regulators' quiver, as are post-merger break-ups of deals subsequently found to decrease competition. But the former is a limited tool, and the latter is considered a rare and extreme remedy. This means that if we believe hospital markets are already too concentrated, which they are, then tools beyond antitrust are needed to restore competition and/or mitigate the harmful effects of this concentration.

Second, a separate but related limitation on the ability of antitrust enforcers to stem price increases from concentration is that, in some cases, price increases do not reflect an overcharge but rather the repricing of "underpriced" services. Due to a sense of duty or poor management, many hospitals do not seek to maximize

the market value of their services and thus underprice those services, compared to what the market would otherwise bear. When those hospitals are acquired by managers unconstrained by a sense of duty or more skilled at maximizing prices, they may experience an increase in prices that cannot reasonably be said to arise from a reduction in competition. The competitive landscape facing these acquired hospitals is unchanged; all that has changed is management's response to it. To prevent this type of price inflation due to mergers, we need a tool beyond the scope of antitrust.

Third, there may be some markets, particularly rural ones, where there is insufficient demand to sustain hospital competition, and no amount of antitrust enforcement will change those circumstances. Instead of focusing on competition between hospital facilities in such markets, regulators should zero in on services critically needed by rural patients, such as obstetrics and outpatient primary care, and seek to preserve access to these services through regulation or by placing enforceable conditions on mergers.<sup>128</sup> Evidence suggests that following mergers, the availability of such services decreases in rural areas.<sup>129</sup> Other evidence suggests a similar reduction in mental health services.<sup>130</sup>

Fourth, until we better understand the dynamics that lead to price increases from cross-market mergers, antitrust remedies are not a ready solution. As discussed above, there are several primary theories for how cross-market mergers cause price increases, and only one of them sounds like it fits in the realm of antitrust.

Fifth, the central challenge for antitrust is to identify and stop anticompetitive mergers and conduct without overly deterring efficient conduct, including experimentation with business models that may lead to helpful discoveries. Getting this balance precisely right is exceedingly tricky and requires a certain amount of flexibility in applicable standards and conservatism in translating new research into actionable antitrust policy. As a result, antitrust law and policy evolve relatively slowly.

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# Conclusion

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As noted at the outset of this report, the fundamental question is whether the government and private firms can ensure effective competition in healthcare markets. None of the policy solutions discussed herein should be expected to deliver effective competition to every aspect of healthcare delivery. Most healthcare markets can be made more competitive than they are now through thoughtful and directed policy choices. It may be time to reconsider whether a market-based approach remains the appropriate means for hospital governance, particularly in rural markets.

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