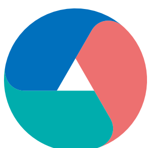
Ensuring Access, Affordability, and Quality in the Age of Healthcare Consolidation: Lessons Learned and Insights for the Future



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We are pleased to present *Ensuring Access, Affordability, and Quality in the Age of Healthcare Consolidation: Lessons Learned and Insights for the Future*. This report looks at the increasing marketplace dominance of large health systems and explores options for safeguarding competition and protecting patient care.

KFF

FEBRUARY 2025

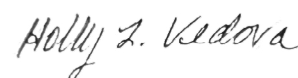
The report builds on a convening held in Washington, DC in May 2024 that brought together 17 health policy experts to consider the status of consolidation among healthcare providers, the challenges it poses to healthcare, and the legal, regulatory, and policy frameworks that can influence its impact. We had the privilege of serving as cochairs of that stellar, nonpartisan Working Group. The meeting was organized by the Health, Medicine, and Society program of the Aspen Institute, with the participation of KFF (formerly known as the Kaiser Family Foundation).

Together, we identified a package of strategies that could reduce the ability of providers to dominate the healthcare landscape in ways that pose a broad threat to patient care. The Working Group's vigorous discussions were informed by two background papers, which are included as part of this report: "Policy Options to Address Consolidation in Healthcare Provider Markets," prepared by Benedic Ippolito of the American Enterprise Institute, and "Ten Things to Know about Consolidation in Health Care Provider Markets," prepared by KFF's Zachary Levinson, Jamie Godwin, Scott Hulver, and Tricia Neuman.

Our most sincere thanks go to the Working Group members who offered their exceptional expertise and insights and gave so generously of their time, and to Arnold Ventures, whose support made this project possible. Alan Weil, editor-in-chief of Health Affairs, kept us focused with his remarkable abilities as convening facilitator, and HMS communications consultant Karyn Feiden masterfully synthesized the discussions and research into this report.

We believe the ideas presented here, and especially the proposals for action, can point the way towards a more competitive healthcare system that honors the right of the American people to have equitable access to quality services at a price they can afford. This report is dedicated to that shared goal.

Kathleen Foote
Cochair



Holly Vedova
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American healthcare has become increasingly consolidated over the past few decades. Health systems* are acquiring hospitals, health systems and hospitals are both acquiring physician practices, and physician practices are pairing up. Some of these mergers and acquisitions occur within the same geographic area, but they are also taking place across different regions of the country. At the same time, private equity firms and corporations that have not traditionally provided healthcare services, such as Amazon, are entering the marketplace and aggressively purchasing clinical practices.[1]

The potential for these developments to tamp down competition has fostered considerable debate. Two key questions frame the discussions: What is the impact of consolidation on cost, quality, equity, and access to services? And do existing legal frameworks and regulatory structures at the federal and state levels offer adequate safeguards against monopolistic practices? A careful analysis is essential to find the answers and inform proposals for policy change.

To explore the ramifications of consolidation among healthcare providers, the Health, Medicine & Society (HMS) Program of the Aspen Institute, with the participation of KFF (formerly known as the Kaiser Family Foundation), convened a Working Group in May 2024. Funding for the convening—*Ensuring Access, Affordability, and Quality in the Age of Healthcare Consolidation: Lessons Learned and Insights for the Future*—was provided by Arnold Ventures. The meeting was cochaired by Kathleen Foote, who recently retired as antitrust chief of the California Office of the Attorney General, and Holly Vedova, who recently retired as director of the Bureau of Competition at the Federal Trade Commission (FTC).

"What is the impact of consolidation on cost, quality, equity, and access to services? Are existing safeguards against monopolistic practices adequate?"

Fifteen other participants with a broad range of health policy expertise in the public, private, nonprofit, and academic sectors joined the Working Group (see Appendix 1). Their charge was to consider the forces that are driving provider consolidation; the nature of existing regulations and their gaps; the consequences for market competition, price, and access to care; and the opportunities to curb further consolidation.

Two background papers were circulated to the Working Group before the convening to ensure a baseline of knowledge as discussions began:

* While definitions of health systems vary, they are often described as having at least one hospital plus other types of providers (e.g., one or more physician groups) or as including multiple hospitals (see Agency for Healthcare Research and Quality, *Defining health systems*, at https://www.ahrq.gov/chsp/defining-health-systems/index.html and American Hospital Association, Fast facts: U.S. health systems, at https://www.aha.org/system/files/media/file/2022/06/Fast-Facts-US-Health-Systems-2022-with-FY20-Data.pdf).

"Policy Options to Address Consolidation in Healthcare Provider Markets," prepared by Benedic Ippolito of the American Enterprise Institute, reviews potential federal and state strategies for increasing competition. These strategies include increasing transparency around consolidation, strengthening antitrust enforcement authority, tamping down on anticompetitive contract provisions, introducing premerger approval requirements, and repealing Certificate of Public Advantage (COPA) laws.[2]

"Ten Things to Know About Consolidation in Health Care Provider Markets," prepared by Zachary Levinson and colleagues at KFF, highlights consolidation trends, key findings from existing research, potential harms and benefits, and policy options that could promote more competition.[3]

"A widely accepted premise is that there are benefits to vigorous competition and the degree of patient choice that competition offers."

This report builds on those background papers and captures the vigorous conversations at the Working Group convening, supplementing them with additional research and further input from the participants. However, it is important to acknowledge it is by no means a comprehensive look at every factor fueling consolidation in healthcare markets nor all the potential remedies available for anticompetitive practices. Political shifts, the changing dynamics of regulatory authority, and structural changes to the healthcare system could all alter the landscape in ways that the Working Group could not predict and did not fully consider. Nor did it examine the increasing consolidation within the insurance industry, which has resulted in highly concentrated insurance markets in 95 percent of the nation's metropolitan statistical areas and is a likely driver of further provider consolidation.[4,5]

In focusing instead on the challenges that mergers and acquisitions among providers pose to the American healthcare system, a shared goal emerged: identifying ways to leverage the healthcare system so that it is competitive enough to provide quality, affordable, and accessible care.

The State of Healthcare Consolidation Today

A widely accepted premise is that there are benefits to vigorous competition and the degree of patient choice that competition offers. "There is reasonably strong agreement across ideological bounds of the value of competitive marketplaces and the challenges that consolidation pose to having competitive marketplaces,"** observed one Working Group participant. "If you're a market kind of person, you want the markets to work and if you're a regulator, you want to use that regulatory lever as

** Quotes throughout the document are synthesized from Working Group comments at the convening.

little as possible. And so to the extent that you can rely on markets, that's a good thing."

Increasing consolidation clearly threatens the possibility of competitive healthcare markets. KFF's issue brief describes three broad forms of mergers, all of which are becoming more common: horizontal mergers of two entities providing similar services (e.g., a health system acquiring a hospital); vertical mergers of different providers along the supply chain (e.g., a health system acquiring a physician practice); and cross-market mergers, in which providers combine across geographic market boundaries. A recent example of a consequential cross-market deal was the merger of Advocate Aurora Health and Atrium Health in 2022, which created a health system that operates 67 hospitals and more than 1,000 other clinical sites in six states.[6]

"A large body of evidence indicates that consolidation has led to increases in the price of healthcare services as providers gain bargaining power."

In 2005, slightly more than half of all hospitals were affiliated with a health system (53 percent); by 2022, that figure had jumped to more than two-thirds (68 percent). Likewise, in 2012, fewer than one-third (29 percent) of physicians either worked for hospitals or were in practices at least partially owned by a hospital or health system, according to survey data; by 2022, that figure had increased to 41 percent.[7]

In an evolving landscape, there are also mergers that involve both vertical and horizontal consolidation, joint ventures, and various affiliation agreements that do not involve ownership changes but nonetheless increase market domination. As well, there are transactions that one Working Group participant described as "involving everything in healthcare—payer, provider, pharmaceutical benefit manager, pharmacy chain, data pipelines, and everything in the middle."

A large body of evidence indicates that consolidation has led to increases in the price of healthcare services as providers gain bargaining power. While this evidence is especially strong in analyses of hospital mergers, similar trends are suggested by research into mergers of hospitals and physicians and of physician practices.[8]

Studies have likewise generally reported that consolidation is associated with a rise in overall spending as patient choice diminishes. This could reflect some combination of price increases, greater use and intensity of healthcare services, and a shift in care toward more expensive settings, such as a hospital outpatient department rather than a physician's office. For example, one study indicates that total spending on chemotherapy tends to increase after oncologists are integrated into a hospital system.[9]

While private payers are most affected by healthcare consolidation, the cost consequences are also felt in the federal budget. In testimony before the US House of Representative's Committee on the Budget, Chapin White, director of health analysis for the Congressional Budget Office, noted that the resulting price increases may affect tax revenue if employers shift labor costs from taxable wages to tax-free insurance benefits. Higher prices can also drive up the federal subsidies provided through the Affordable Care Act's health insurance marketplace.[10]

Research on the impact of consolidation on quality of care is mixed. The majority of studies have found either no quality difference or a negative impact after horizontal hospital consolidation. Studies of vertical hospital or physician consolidation variously show negative, positive, or mixed effects or none that are statistically significant.[11,12] In total, the research is limited, and the findings vary with the measures used. The lead time before the effects of consolidation become apparent, the potentially different effects across patient populations, and the differences in the nature of mergers also contribute to uncertain results.

Another question about consolidation is how it relates to hospital closures or the availability of certain service lines. One Working Group participant called out evidence that consolidation can be a precursor to closure and said that is happening more quickly than in the past. "Even before the ink is dry in the transaction, the hospital is being parceled up and readied to shut down," he said. Conversely, a merger can sometimes be the only option for a financially fragile hospital to survive. For example, one study found health system affiliation was associated with a reduced risk of closure among rural hospitals with weak finances.[13] Overall, the evidence here, too, is mixed.

Health inequities loom as another troubling risk of consolidation. "What's happening in this market is that it has a different effect on different populations," indicated one participant. In healthcare, he said, it is "creating a social disparity unlike what we've seen in any other industry." The research on access to care is limited, and the findings are again mixed, but The Century Foundation, a progressive think tank, has called out longer travel times for those who can least afford them; the need to leave trusted communities to find care; decreased local employment opportunities; and the prospect of "care deserts," including for maternal health and pediatric services, which are especially crucial for vulnerable populations.[14]

"Health inequities loom as another troubling risk of consolidation."

Despite the many concerns, Working Group participants agreed that consolidation might offer benefits under certain limited circumstances. The potential advantages are particularly likely to enter conversations about financially vulnerable rural hospitals. In sparsely populated areas—where

competition is limited, new entrants into the marketplace are unlikely, and the prospect of closure is a looming threat—merging with a larger health system could be an appropriate option to preserve hospital access and perhaps create a springboard for expanding services.[15,16] However, these pluses must be weighed against the risk that such acquisitions could lead to higher prices and reduced services.

The potential also exists for vertical integration to improve the coordination of clinical care, such as by easing provider-to-provider communication and ensuring readier clinician access to medical records. Furthermore, consolidation in any form could offer opportunities for economies of scale, reduced administrative burdens, lessened waste and service duplication, and other efficiencies.[17]

Absent in these conversations are clear criteria for identifying potentially beneficial mergers, acquisitions, or affiliation agreements. The lack of adequate data or definitive standards for measuring the trade-offs inherent in consolidation make ambiguity and disagreement inevitable. Though it is difficult to draw, a road map would be useful to differentiate between transactions likely to raise costs, scale back services, or produce other negative outcomes and those with a reasonable prospect of yielding new healthcare investments or other benefits.

"The lack of adequate data or definitive standards for measuring the trade-offs inherent in consolidation make ambiguity and disagreement inevitable."

Federal and State Authorities to Promote Competition

A multitiered regulatory structure provides some leverage over healthcare consolidation. At the federal level, the FTC and the Department of Justice (DOJ) are empowered to enforce federal antitrust laws, challenge mergers and acquisitions perceived as threats to competition, and curtail the anticompetitive conduct of existing entities.[18] In general, the FTC specializes in provider markets, while DOJ primarily oversees health insurance markets. The FTC can challenge mergers involving either nonprofit or for-profit entities but lacks the authority to challenge other anticompetitive practices among nonprofits. While it can refer those to the DOJ, the department's history of enforcement action against nonprofit health systems is limited. Additional capacity is lodged within the offices of state attorneys general, who are guided by both federal and state statutes and often work in partnership with federal regulators.[19]

But the current structure was not built for overseeing or regulating the scale and stakes of the consolidation that is occurring in healthcare today. Indeed, one Working Group participant suggested that the legal framework had changed only modestly since Standard Oil was broken up more than a century ago.

One example of the limits is that federal law currently requires that the FTC be notified before certain mergers or acquisitions valued at more than $119.5 million take place (the figure is adjusted annually).[20] But a series of small acquisitions, each of which falls below this threshold, is commonplace in healthcare, allowing many of the cumulative effects to go forward without scrutiny. "The rollups and sequential mergers [in which investors combine multiple small entities into a single larger one] can have the same effect as two large entities merging," one participant explained. "And whether that's done through private equity acquisitions or more traditional acquisitions, it's very significant. The impacts really need to be looked at."

The rapid growth in cross-market mergers promises to have a particularly powerful impact on prices and access to care.[21,22] From 2010 through 2019, more than half of completed mergers or acquisitions involved hospitals or health systems in different markets.[23] "Cross markets are the burning issue," asserted one participant. "That is what is going to change the direction of healthcare consolidation." While government antitrust agencies have intervened in few, if any, of these transactions, the FTC sees them as an important area of interest.[24]

"The rapid growth in cross-market mergers promises to have a particularly powerful impact on prices and access to care."

The Working Group agreed that identifying and potentially curtailing anticompetitive practices in healthcare is a shared responsibility likely to call for a combination of legislation, regulation, and litigation that engages federal agencies, state agencies, and private plaintiffs. Given the cost and complexity of legal action, the FTC and the DOJ are highly selective in the cases they pursue, generally choosing those most likely to have not only a substantial impact on the litigants involved but also a deterrent effect on other big health systems. In practice, said one participant, that means "carefully picking the right cases to get at the root causes of the problems and then pushing the law in the right direction."

While bigger agency budgets would likely improve the capacity to enforce or strengthen oversight, additional funds alone will not be a panacea. Limited authority, adverse court decisions, a rapidly shifting marketplace, and the risk of unintended consequences can all complicate health system antitrust efforts. The challenges of hiring and placing qualified personnel, establishing an evidence base that is persuasive to judges, and juggling demands to address mergers and acquisitions in other fields are further constraints.

Nonetheless, regulatory responses to marketplace shifts in recent years suggest there may be new enforcement opportunities. For example, the FTC has indicated an interest in using Section 5 of the Federal Trade

Commission Act more aggressively.[25] Section 5 explicitly prohibits unfair methods of competition and can be used "for unusual cases that don't fall into the monopolization standard to get at something that's unfair and is going to lead to competitive harm," explained one Working Group member. "That's something unique that the FTC brings to the table."

In 2021, the FTC rescinded a statement it had issued in 2015, explaining that it "contravenes the text, structure, and history of Section 5 and largely writes the FTC's standalone authority out of existence."[26] The earlier statement, wrote the FTC, essentially abrogated "the Commission's congressionally mandated duty to use its expertise to identify and combat unfair methods of competition even if they do not violate a separate antitrust statue."

Another tool of interest is the 2023 Merger Guidelines, which were released jointly by the FTC and the DOJ following a two-year public engagement process.[27] According to KFF, "the guidelines expand the definition of highly concentrated markets, rely on a lower threshold for identifying large changes in market concentration, consider the combined effect of a series of acquisitions (e.g., of a health system acquiring several small physician practices over time), add an explicit discussion of the agencies' views on how workers may be negatively impacted when their employers merge, and touch on cross-market mergers."[28]

"The FTC seems eager to identify new legal frameworks for challenging a wider variety of healthcare mergers that risk further concentrating the marketplace, but such actions will involve a challenging journey through the courts."

Just how those guidelines, which are nonbinding, will be applied to antitrust actions remains to be seen. But Working Group participants suggested that they demonstrate the FTC's eagerness to identify new legal frameworks for challenging a wider variety of healthcare mergers that risk further concentrating the marketplace. Such actions will require in-depth investigation and involve a challenging journey through the courts, so the new guidelines will take some time to demonstrate impact.

In a further signal that it intends to pursue more aggressive enforcement, the FTC issued a Request for Information (RFI) in February 2024, acknowledging concern about healthcare provider transactions that "may generate profits for those firms at the expense of patients' health, workers' safety, and affordable healthcare for patients and taxpayers." The RFI called for public input about how these transactions could affect "patients, communities, payers, employers, providers, and other healthcare workers and businesses."[29] That request, said one Working Group member, is a strong indication that the FTC is eager to take action "with the right case, with the right facts, with a good story."

State-level engagement varies considerably, but the knowledge of local market conditions that rests with state officials can make them important partners to federal actors. State laws can limit anticompetitive contract clauses and define the authority that attorneys general have to oversee mergers and file lawsuits. They can also require mergers falling below the federal $119.5 million threshold to be reported to state authorities. Conversely, there are structures that allow states to shield mergers from federal antitrust laws or limit competition in other ways (see below for a discussion of COPA and Certificate of Need [CON] laws).

Opportunities for Action

In broad strokes, the Working Group agreed on the need to address the harms of consolidation. Although market power is not the only reason for high healthcare prices, it is a significant enough influence to warrant a nimble, multilevel policy response. “The question is not just how do we use the tools we already have, but how do we reshape them to meet the moment of where the market is actually going?” asked one member.

“Although market power is not the only reason for high healthcare prices, it is a significant enough influence to warrant a nimble, multilevel policy response.”

The power of well-resourced health systems, which are often major employers in a community and wield significant local and national political influence, looms as a barrier. The extent to which advocates have the capacity and willingness to push forward actions opposed by hospitals is uncertain. “How much do we want to alienate or poke the tiger of the hospital lobby?” one Working Group participant asked. But, he warned, “That might be the first thing we have to do. It might be a necessary condition to anything else we do.”

That could mean, for example, supporting punitive action or substantial financial penalties where clear antitrust violations are established. “We’re never going to have enough enforcement resources for everything,” acknowledged a participant. “How can we start sending signals to actors in this field that it’s in their interest to be on the right side of this?”

In addition to the appropriate mix of federal and state policy and regulation, important roles exist for private legal action and for the academics and advocates who can inform the conversation. “We need as much engagement as possible among the law enforcers, economists, academics, and policymakers to try to understand how today’s more complex healthcare markets function,” urged a Working Group participant. “We need to figure out what the mechanisms are, tell a convincing story, and translate that into enforcement.”

Shared goals could also unite unlikely partners interested in bringing new providers into the marketplace. A potential alliance between insurers and patients, for example, is often overlooked. "There is a lot more alignment with the payers and consumers than what is visible publicly," one participant pointed out.

The shape of the response will depend in good measure on local conditions. In markets that are not yet heavily consolidated, the goal would be to reduce the likelihood that consolidation will take hold. Strategies here could include measures to encourage the entry of competitors, where feasible; enforce existing regulations more forcefully and expand their reach; and make consolidation less financially desirable from the provider perspective.

Where options to foster competition are few, such as in rural areas and for highly specialized services, the emphasis could shift to constraining the market power of dominant providers, regulating prices, or regulating spending. Here, authorities could prohibit anticompetitive contract provisions and encourage service delivery innovations. It may also be possible to take affirmative action to retain or restore competition by unraveling previous mergers, although that could prove very challenging.

The Working Group recognized that no single solution would be sufficient to curb healthcare consolidation. The multiple intersecting and overlapping strategies they explored at both the federal and state levels are presented below and organized as follows:

- Emphasizing transparency, value, stakeholder education, and analytic capacity.
- Strengthening federal and state regulations and enforcing them more vigorously.
- Reducing financial incentives for health systems to consolidate.
- Barring anticompetitive provisions in contracts between health systems and payers.
- Unwinding consolidation where it is already embedded.
- Considering innovative care delivery models in sparsely populated areas.
- Filling data and research gaps on quality, access to care, and the labor market.

"No single solution would be sufficient to curb healthcare consolidation but multiple intersecting and overlapping strategies exist at both the federal and state levels."

Emphasizing transparency, value, stakeholder education, and analytic capacity could alter the healthcare consolidation landscape.

A number of cross-cutting strategies could help foster competition in diverse healthcare markets.

- **Requiring more price, cost, and ownership transparency:** The capacity to take preventive action or pursue antitrust cases to reduce consolidation is closely linked to the availability of information. In the current environment, informed policymaking is stymied by the lack of clear and comprehensive information about provider prices, cost inputs, and ownership.[30] (The absence of contract transparency, discussed below, is a related barrier.) Explicit reporting mandates could alter provider and patient behavior and influence public policy.

  Some states do require providers to feed data into all-payer claims databases, which provide key information about pricing, but self-insured employers are not obligated to report, and no federal database would allow data to be aggregated and analyzed. Federal regulations do require hospitals and payers to report prices for healthcare services, though using these data can be difficult.[31] "There is no transparency in everything in the supply chain that goes into the commercial price, from the provider all the way up to data about the purchase and ultimately to the consumer," said one Working Group participant.

  Likewise, no single database documents who owns what. The complexity of affiliation agreements further clouds any attempt to figure out the locus of control. "To establish a case, you have to know who the owner of a physician practice is, and right now we can't tell," said one participant.

- **Elevating value:** A number of proposals could clear certain barriers to competition by allowing more high-value care—defined as services that result in measurable health improvements at lower cost[32]—to enter the marketplace and expand. For example, federal and state policies could direct more financial resources and administrative support to primary care physicians and their practices, which are a particular target of acquisitions. As well, some states are attempting to increase the clinician supply by broadening the scope of allowable practice for nurse practitioners, physician assistants, and other nonphysicians. Innovative structures that deliver healthcare in new ways—for example, through telehealth and in-home hospital models—can also draw players into the market.

"Informed policymaking is stymied by the lack of clear and comprehensive information about provider prices, cost inputs, and ownership."

- **Educating stakeholders:** Tamping down the power of dominant health systems requires a mix of sound public policy, enforced by regulation; effective litigation, confirmed by court decisions; and informed marketplace decisions.

  These approaches require federal and state elected officials to understand the justification for passing laws that promote competition, regulators and litigators to be cognizant of provider conduct that leads to monopoly behavior, judges to recognize the validity of claims made in antitrust cases, and purchasers and patients to be able to consider the relative value of healthcare as they make decisions. Educating each of these stakeholders requires advocates, user-friendly policy reports and recommendations, and narrative changes that highlight the perils of consolidation. "What has helped to turn the tide in terms of the political narrative at the national level has been amplifying the abuses and the harmful effects on affordability and access to quality care," commented one Working Group participant.

- **Boosting capacity for analysis, discovery, and action:** Although the FTC and DOJ have had some success at challenging hospital mergers, the time and resources involved limit the scope of their activity. To curb further consolidation and address the conduct of already-consolidated health systems requires new resources, statutory changes, and successful sentinel litigation that serves as a warning to dominant providers.

  A platform for addressing market domination is also needed at the state level, where the existing tools available in the attorneys general office or elsewhere are sometimes insufficient. A 2024 Health, Medicine & Society Program/KFF report, "State Efforts to Control Healthcare Costs: Lessons Learned and Insights for the Future," outlines a number of measures that could facilitate state action to lower healthcare costs. Among others, the report called for a supportive infrastructure to give each state "a platform to facilitate the effective use of data, accommodate appropriate oversight, allocate the necessary resources, and ensure that the expertise needed to bring stakeholders together and drive action is available."[33] Such a platform could also serve as the springboard for measures that promote competition.

"Tamping down the power of dominant health systems requires a mix of sound public policy, enforced by regulation; effective litigation, confirmed by court decisions; and informed marketplace decisions."

Strengthening federal and state laws and regulations and enforcing them more rigorously could slow consolidation.

The Working Group considered the regulatory changes at both the federal and state levels that could limit consolidation. Some of these involve changes to the legal framework that are relevant to any antitrust action, while others are health specific.

- **Expanding premerger reporting or review:** At the federal level, new policies could prevent at least some mergers from falling under the regulatory radar screen. In addition to lowering the transaction threshold for premerger reporting, mandatory reporting could kick in when the total value of a new healthcare entity reaches a certain size. That would capture the multiple smaller transactions that together lead to greater consolidation. Policymakers could also collect more information from providers about ownership and market shares, as the FTC's Bureau of Economics has begun to do.[34] Access to such data could improve the oversight capacity of antitrust agencies and has the potential to inform further action.

  States have separate authority to establish premerger reporting, such as by requiring disclosure at lower thresholds than the federal mandate. They can also establish their own review requirements, including mandating prior government approval for certain mergers, or all of them, and expanding the authority of attorneys general to challenge transactions. A number of states are already experimenting with broader reporting mandates.[35]

  Some are also considering legislation designed to curb abuses among businesses that have a dominant market share within the state.[36] Proposals define dominance in various ways—for example, by percentage of market share or volume of services—but generally have the stated aim of fostering a more competitive economy. New standards could subject more health systems to further regulatory requirements.

- **Lowering burden-of-proof requirements in antitrust laws:** Current federal regulations require evidence that a merger would "substantially" lessen competition before a challenge can go forward. The Working Group expressed interest in a proposal to alter the language so that mergers that "meaningfully" lessen competition come under greater scrutiny. "That seems like a fairly profound change," said one member. "It would be quite helpful to have a better understanding of the potential pitfalls, trade-offs, and counterarguments."

- **Challenging anticompetitive practices among nonprofit hospitals:** Beyond mergers, the FTC currently has limited authority to challenge anticompetitive practices of nonprofits, as noted previously. Legislation to amend the FTC Act to extend its authority—the Stop Anticompetitive Healthcare Act of 2023—has been introduced in Congress.[37]

- **Restricting COPA laws:** Certificate of Public Advantage laws are statutes currently in place in 19 states[38] that essentially shield mergers

"States have separate authority to establish premerger reporting. They can mandate prior government approval for certain mergers, or all of them, and expand the authority of attorneys general to challenge transactions."

from federal antitrust laws and replace them with state regulation. The theory is that under certain circumstances it is less harmful to allow a hospital merger than to deny one with the potential to improve healthcare quality, efficiency, or access. Financial distress, clinician shortages, and competitive impact are all factors that states may consider in approving a COPA. In exchange, state regulators can impose any number of new requirements to address potential harms, such as capping rates in some form, requiring public reports of quality metrics, requiring additional community services or more outreach to underserved populations, providing more charity care, or increasing research funding.[39]

The FTC has been explicit in its objection to COPAs. "Experience and research demonstrate that COPA oversight is an inadequate substitute for competition among hospitals and a burden on the states that must conduct it. … Research demonstrates that COPAs have resulted in significant price increases and contributed to declines in quality of care."[40]

"The Federal Trade Commission and this Working Group have been forceful in their concerns about Certificates of Public Advantage."

Like the FTC, the Working Group was forceful in its concern about COPAs, suggesting that in the face of the immense political power hospitals often wield, states face substantial barriers to regulating prices, ensuring quality of care, and promoting innovation at merged hospitals. The effect of COPAs depends crucially on their design, enforcement, and duration, and even COPAs that are initially successful may fail over time as enforcement wanes or lapses. "COPAs rarely work as promised," asserted one participant. Indicating that the signal against COPAs is "flashing red," members generally agreed that states without COPA laws should not enact them. They also expressed considerable support for repealing existing laws that would permit future harmful mergers while ensuring continuing state oversight of systems that had already merged under a COPA.

- **Reconsidering Certificate of Need laws:** Thirty-five states and Washington, DC, currently have some type of CON law (three others use similar processes).[41] These laws vary considerably, but all require state approval before a health provider is permitted to undertake major capital expenditures or a new provider enters the market. Initially intended to reduce the costs and inefficiencies that can result from oversupply, critics argue that they have instead shielded existing providers from competition and contributed to higher costs.[42]

  A number of states have repealed their CON laws, and Working Group participants agreed that they can be a barrier to competition that works to the advantage of dominant providers. But they also discussed the possibility of using the existing infrastructure and expertise of the

CON mechanism to serve new purposes, possibly for planning or as a way to oversee proposed transactions, the availability of healthcare services, or access to care.

In that context, an effective CON approach could work as both carrot and stick. In North Carolina, for example, the attorney general opposed a CON request from a dominant provider to increase beds, instead issuing the certificate to a different provider in order to foster competition.[43] In another scenario, a state could consider past behavior in deploying its approval authority. One participant proposed this message: "You have to comply with the conditions that were placed on your transaction. And, oh, you didn't comply the last time? Then sorry, you're not going to be able to get the new CON to purchase the next round of physicians or to acquire the community hospital because you closed a key facility or a key service line when you promised you wouldn't."

Payment and pricing reforms and other policy changes could make healthcare market consolidation less financially rewarding to providers.

If a key motivation for consolidation is to enhance revenue, measures could be put in place so it becomes less lucrative for health systems to pursue mergers. "Getting the payment incentives right means you don't have to tackle this tactic by tactic, transaction by transaction," advised one Working Group participant. "You can get ahead of consolidation in a much more scalable way."

"If a key motivation for consolidation is to enhance revenue, measures could be put in place so it becomes less lucrative for health systems to pursue mergers."

- **Requiring site-neutral payments:** Under the current reimbursement structure, Medicare often pays more for identical procedures provided in hospital outpatient settings than in an unaffiliated physician's office, creating a clear incentive for physician practices to merge with hospitals.[44] Changing this two-tiered system so that reimbursement is the same regardless of the service site—a move that sounds straightforward enough for one participant to call it "low-hanging fruit"—has garnered a degree of bipartisan support.

  In a limited number of circumstances, Medicare has already imposed site-neutral payments, and there have been repeated attempts in Congress to legislate further mandates.[45] These policies would reduce costs for both the Medicare program and for beneficiaries and could have spillover effects on commercial prices and spending (e.g., by reducing consolidation incentives). However, opponents of site-neutral

reforms argue that lower hospital revenues could reduce access to care and that higher payments are needed to support emergency care and certain other services.

- **Regulating prices and spending in the private market:** Working Group participants agreed that high commercial prices had to be part of any dialogue about market domination. Because the ability to negotiate prices is one reason that providers seek to merge, price and spending regulations—including capping prices at a percentage of Medicare reimbursement rates, limiting out-of-network charges, establishing global budgets, creating spending growth targets, or implementing state-level health coverage public options (in the absence of a federal option)—could all reduce incentives for consolidation. The true impact deserves closer study, however, because regulating price and spending could, in theory, create an incentive for further consolidation as providers seek the efficiencies and scale that allow them to maintain profits.

  More broadly, price and spending constraints could improve affordability for patients and employers. However, major policy changes in this arena are vehemently opposed by the hospital industry, which claims that they can diminish access to care and harm quality.[46] Beyond acknowledging their potentially critical role, the details of these strategies were not explored at the convening.

- **Reforming the 340B program:** The federal 340B program requires pharmaceutical manufacturers participating in Medicaid to offer significant purchase discounts to eligible nonprofit and government providers. The intent is to stretch federal resources while supporting entities that provide care to low-income and other underserved populations.[47] The American Hospital Association is a vigorous defender of the program, claiming that it benefits both vulnerable populations and the capacity of hospitals to expand health services.[48]

  Research suggests, however, that 340B hospitals prescribe more costly drugs and employ more physicians in specialties that use more expensive therapies[49] but do not actually treat more underserved populations.[50] One Working Group participant said, "340B creates huge incentives for becoming part of a qualified entity so you can get access to low-price drugs. It creates huge incentives for consolidation that have nothing to do with efficiency or equity."

  Several reform proposals has been put forth to ensure that the program works as originally intended. One would shift program rules so that it no

"Research suggests that 340B hospitals prescribe more costly drugs and employ more physicians in specialties that use more expensive therapies but do not actually treat more underserved populations."

longer provides blanket discounts to certain health providers but rather is available only for drugs provided to low-income patients.[51] Another proposes an enforceable standard that would ensure discounts are given only to outpatient facilities and pharmacies that serve vulnerable populations or are located in medically underserved areas.[52]

- **Strengthening bans on the corporate practice of medicine:** Legislation in more than 30 states bars corporations, as nonlicensed providers, from controlling, employing, or owning physician practices. However, the contractual affiliations that many corporate entities have increasingly put in place, typically through management services organizations, arguably undermine this restriction. In effect, they can force physicians to cede control of billing and coding practices, personnel decisions, and payer contracts while imposing constraints on their freedom to speak out. Often positioned as a way to eliminate administrative burdens while protecting physician autonomy over clinical decision making, they instead can turn physicians "into cogs in a corporate wheel," claimed one participant.

  The intent of a strengthened ban would not be to clamp down on contracting out back-office support but rather to prevent corporate owners from taking full charge of coding, billing, and personnel decisions or imposing noncompete and nondisclosure clauses. "It restores the principal-agent relationship where the practice will still be in charge," said one participant. However, the effects of bans are not well studied, and another participant warned that they could, in principle, make it harder to develop a new physician practice. In any case, the scope of new provisions is unlikely to affect most vertical mergers, because many states exclude hospitals from restrictions against owning and controlling physician practices.

Prohibiting anticompetitive contracting provisions could reduce the ability of health systems in consolidated markets to exert their market power.

Consolidation can allow health systems to tamp down on competition and protect their dominant position by dictating contract terms with payers that enhance their control over the composition of provider networks, limit referral options, restrict patient choice, and reduce transparency. Yet those contract provisions are often labeled as proprietary, even to purchasers, making it almost impossible to identify and assess their anticompetitive impact or to respond with informed policy. While pushing for fully

"Contract provisions are often labeled as proprietary, even to purchasers, making it almost impossible to identify and assess their anticompetitive impact or to respond with informed policy."

transparent contracts will engender significant pushback, advancing the position that purchasers with a fiduciary duty to health plan enrollees should know the contract terms seems easier. “It makes no sense that you can be legally responsible for doing the best thing for your employees and not actually have an ability to see what you’re binding them to,” said one participant.

One of the best-known attempts to challenge a package of anticompetitive contract clauses was a series of lawsuits filed against Sutter Health, a large nonprofit health system in California created through a number of mergers that took place over several decades. One Working Group participant said that Sutter had “the most sophisticated system of contracting terms anyplace in the country.” Navigating uncharted waters through a lengthy investigation, a consolidated state case culminated in a 2019 settlement requiring Sutter to halt some dozen different contracting practices and pay $575 million in damages.[53]

Whether such cases ultimately have a broader deterrent effect is uncertain, especially since health systems have so many opportunities to pursue workarounds. Indeed, one participant paraphrased a hospital executive who had just learned about a successful legal challenge to another hospital’s anticompetitive clause. The executive purportedly said, “We had better close our deal with the insurer we are negotiating with before they hear about this. We have this exact same provision, so let’s speed things up.”

Arguably, an alternative to after-the-fact litigation would be federal or state legislation that prohibits anticompetitive conduct. But here, too, powerful health systems may find ways to sidestep contractual restrictions, essentially insisting on the same provisions without actually putting them in writing. The result, suggested one participant, is that “at the end of the day, when we’re sitting at the negotiating table, they are still taking that [anticompetitive] stance, so it’s not actually changing the relative power.”

“Powerful health systems may find ways to sidestep contractual restrictions, essentially insisting on the same provisions without actually putting them in writing.”

Nonetheless, policymakers could consider prohibiting any combination of the following provisions (in some states, this has already occurred):[54,55]

- **All-or-nothing clauses** require an insurer to contract with every provider in a given health system if it is going to contract with any of them. This makes it impossible for insurers to create more limited networks or to exclude higher-cost, lower-value providers. Any ban on such clauses could include carveouts for smaller physician practices where market power is not a concern to lessen their administrative burdens and help them remain competitive.

- **Antitiering and antisteering clauses** prevent insurers from using mechanisms that encourage patients to seek higher-value care. Antitiering clauses bar insurers from sorting providers into preferred and nonpreferred slots, while antisteering clauses bar insurers from offering incentives, such as lower cost sharing, to influence the provider choices patients make.
- **Exclusive contracting clauses** prevent insurers from including competing providers as in-network providers. Similar clauses can limit a physician's ability or willingness to make referrals outside their own health system.
- **Noncompete clauses** prevent clinicians from taking jobs with other health systems or hospitals within a certain geographical distance or within a certain period of time.
- **Gag clauses** prohibit parties to a contract from disclosing its terms. That can undermine negotiations between health systems and insurers because the insurer does not know if a competitor is getting more favorable terms. Gag clauses can also be imposed on physicians once their practices have been incorporated into a larger system or used to prevent certain claims data from being shared.
- **Most-favored-nation clauses** require a provider to give an insurer the lowest price it negotiates with any competitor. Unlike the other provisions described here, this is primarily a benefit to insurers, not health systems, but it also affects pricing by discouraging competing providers from negotiating lower rates with one insurer that it would then have to match with others.

"Working Group participants did not dismiss the possibility that some kind of assertive action to break up consolidated entities could be warranted. They wanted the possibility of mandatory divestiture to remain an option."

Options for unraveling consolidated healthcare markets merit consideration.

Given the degree of healthcare consolidation that has already taken place, Working Group participants did not dismiss the possibility that some kind of assertive action to break up consolidated entities could be warranted. While reversing "facts on the ground" introduces an additional layer of complexity to any policy response, the Working Group wanted the possibility of mandatory divestiture to remain an option, especially for physician practices. "It shouldn't be off the table by any means," commented one participant. "We've bought the argument that provider hospitals have made—'once we've integrated our electronic health records, you can't pull us apart'—but that's just not true for other provider types."

Some policy advocates believe that it is, in fact, reasonable to target fully consolidated health systems. One analyst suggested giving health systems two choices: "remain consolidated but without monopoly pricing power" or "voluntarily divest some holdings to restore competition in a hospital market."[56] Members also suggested that an affirmative attempt to reverse mergers could be a potent deterrent to future ones.

In sparsely populated areas unable to support competition, innovative approaches to delivering care could broaden access.

In some regions, especially rural areas, the population may be too small to support high-quality care at multiple hospitals, so competition may not be a realistic goal. At the same time, the possible closure of a sole rural hospital raises concerns, given research that demonstrates negative health impacts, especially for patients with time-sensitive health conditions when there are no alternative providers nearby.[57,58,59]

A regulatory approach may thus be needed both to address the harmful consequences of complete market dominance and to ensure ready access to at least some hospital services. Here, policymakers could think less about maintaining access to hospital care and more about maintaining appropriate access to healthcare. "When we think about the hospital as something that's irreplaceable, not only are we locking ourselves into a bad delivery system, but we are also precluding the possibility of valuable innovation," said one Working Group participant. Alternative delivery systems in rural markets could involve more care provided by nurse practitioners, the use of telehealth, and limited-service hospitals with hub-and-spoke linkages to centers of excellence.

"In sparsely populated areas, policymakers could think less about maintaining access to hospital care and more about maintaining appropriate access to healthcare."

More research is needed to understand the cumulative effects of consolidation on quality, access to care, and the labor market; the effects on price are well established.

Marketplace changes spurred by a combination of horizontal and vertical mergers are likely to have a more potent effect than either of them alone. A deeper understanding of what happens when a single health system becomes the dominant—or, in some cases, only—player in a community, region, or state can inform both regulation and litigation. So, too, could a fuller understanding of cross-market mergers and their impact, an urgent need made more challenging because datasets across states are inconsistent and difficult to compare.

While the research is clear on the impact of consolidation on pricing, more knowledge is needed to fully understand its effect on quality and access. The consequences for the labor force, where workforce shortages and

increased demand on providers are already stressing the system, is another realm that demands attention. Some research suggests that consolidation leads to lower wages and reduce staffing, but to the extent that it prevents hospital closures—an area of study with inconsistent results—it could also preserve jobs.[60]

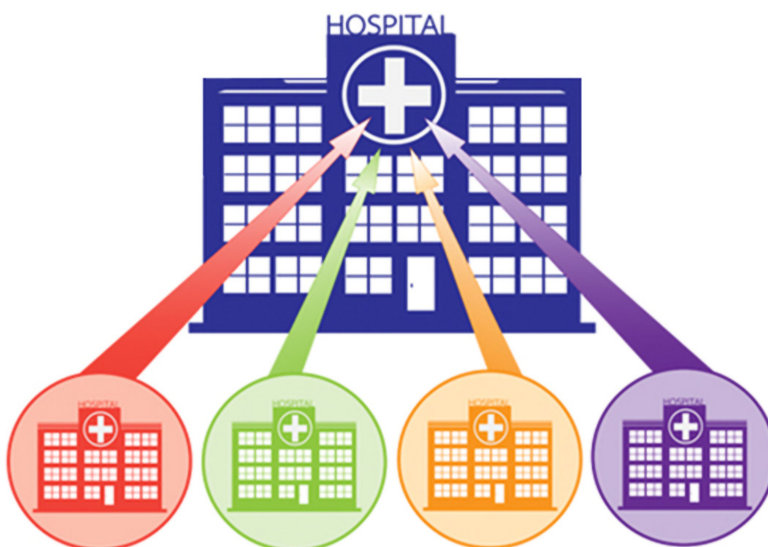
Weak reporting mandates, data gaps, and a lack of transparency have limited the capacity to conduct much of that research. "We need a lot more research and investment of resources to document the effects in order to have a shot at change," urged one Working Group participant.

"There are hints that public sentiment and political will are shifting as research documents the rising healthcare prices that accompany consolidation, without clear improvements in quality."

Conclusion

In an optimal policy environment, the structures to promote competition would already have been put in place before so many communities became dominated by so few health systems. Addressing consolidation today is something of a catch-up game, and any policy reforms are certain to face resistance and court challenges prior to implementation. "Change is going to be super slow," acknowledged one participant.

The narrative among many health providers has been that, like it or not, they have to become part of a consolidated entity to survive. But the evidence to support this claim is limited, and there are hints that public sentiment and political will are shifting as research documents the rising healthcare prices that accompany consolidation, without clear improvements in quality. A constituency may be emerging that is prepared to challenge assumptions about healthcare systems, promote policies designed to foster a more competitive healthcare marketplace, and better serve the public interest.



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Background Papers

- **Policy Options to Address Consolidation in Healthcare Provider Markets**
  Benedic Ippolito, PhD, MS

- **Ten Things to Know About Consolidation in Health Care Provider Markets**
  Zachary Levinson, PhD, MA, MPP, Jamie Godwin, PhD, Scott Hulver, PhD, and Tricia Neuman, DSc, MS

Policy Options to Address Consolidation in Healthcare Provider Markets

Benedic Ippolito, PhD, MS

Introduction

Well-functioning healthcare markets rely on competition among firms to lower costs and encourage high quality. However, many healthcare markets have high and rising levels of consolidation that can weaken these competitive dynamics. This paper briefly summarizes the state of consolidation in hospital and physician markets and outlines state and federal policy options that could increase competition in these markets. While similar competitive issues are relevant for other healthcare markets, including insurance and drug markets, they are beyond the scope of this paper.

The last few decades have seen significant consolidation within hospital and physician markets (Fulton, 2017; Gaynor, 2020; Levinson et al., 2024). This includes both horizontal consolidation between potential competitors (e.g., two hospitals merging) and vertical integration between different types of providers (e.g., a hospital acquiring a physician practice). The effects of consolidation are theoretically ambiguous. On one hand, it can allow for efficiencies that come from a larger scale, reduce the need for duplication of certain services, or improve coordination across different entities. On the other, it can reduce competitive pressures among firms, leading to higher prices and depressed quality.

The effect of consolidation within provider markets has been the subject of considerable research. In general, the accumulated evidence suggests that provider consolidation over the last few decades has increased prices with limited evidence of improvements to quality or access. A large body of research shows that hospital mergers within the same market tend to increase costs to varying degrees and may reduce the quality of care (e.g., see Gaynor, 2020; Liu et al., 2022, for reviews). A smaller body of research suggests this may also be true of mergers and acquisitions involving hospitals in different markets within the same state (Dafny et al., 2019; Lewis & Pflum, 2017). Research suggests that consolidation within physician markets also leads to higher prices (e.g., Austin & Baker, 2015; Baker, Bundorf, Royalty, and Levin, 2014; Dunn & Shapiro, 2014; Koch & Ulrick, 2021). Likewise, a growing body of evidence finds that vertical integration between hospitals and physicians within the same market tends to increase costs (Baker, Bundorf, & Kessler, 2014; Capps et al., 2018; Godwin et al., 2021; Post et al., 2017; Saghafian et al., 2023), while research has not yet found clear evidence of quality improvements (Koch et al., 2021).

Economic theory predicts that higher payments to healthcare providers will ultimately be passed on to consumers. Higher prices may be directly reflected in higher cost sharing for individuals receiving care. However, most individuals are heavily insured, meaning that their out-of-pocket payments account for a small share of total costs. As a result, individuals pay these costs through higher insurance premiums and other less-direct ways. Empirical research is consistent with these predictions. Increased healthcare costs have been shown to lower wages, reduce employment, and trigger changes in benefit design, such as greater cost sharing (Arnold & Whaley, 2020; Baicker & Chandra, 2006; Gruber, 1994; Sommers, 2005; Vistnes & Selden, 2011).

Together, the evidence from recent decades suggests that consolidated healthcare markets have tended to raise costs. Efforts to increase competition, or dissuade further consolidation, have the potential to benefit consumers who ultimately bear the burden of higher healthcare costs.

The remainder of this paper outlines federal and state options to dissuade further consolidation and encourage competition in hospital and physician markets. In doing so, it is worth noting the potential limits of procompetitive policies on markets. Notably, some healthcare markets are unlikely to sustain meaningful levels of competition even under an ideal policy environment. For example, less densely populated rural areas may not support more than one acute care hospital. Moreover, it may be difficult to generate competition within markets that are already heavily consolidated, at least in the near term. While there remain many opportunities to improve competition, these constraints are relevant as policymakers weigh their policy options.

Federal Policy Options to Increase Competition

The federal government has several mechanisms through which it can affect competition in healthcare provider markets. Notably, the two federal antitrust agencies—the Federal Trade Commission (FTC) and Department of Justice (DOJ)—oversee mergers and acquisitions along with anticompetitive business practices. Congress can implement laws that would increase their awareness of potentially anticompetitive behavior and enhance their ability to impede it. Congress could also amend features of public programs, such as Medicare, that may incentivize consolidation. Finally, they can expand transparency efforts that may have procompetitive effects.

Increasing the Transparency of Mergers and Acquisitions

Existing law requires that antitrust authorities are notified of certain mergers or acquisitions with a value over $119.5 million (Federal Trade Commission [FTC], 2024) (adjusted annually). In practice, this excludes most transactions. Research shows that the average hospital merger between 2016 and 2020 and the vast majority of transactions involving physicians has fallen below this threshold (Capps et al., 2017; Fulton et al., 2021). Such mergers and acquisitions are much less likely to be challenged (Wollmann, 2019).

While larger mergers often raise the most pronounced competitive concerns, these smaller mergers can meaningfully increase consolidation. Notably, firms can acquire large cumulative market shares through a series of small or modestly sized transactions (Fuse Brown et al., 2021). Even modestly sized transactions may raise competitive concerns, particularly in markets with high existing levels of consolidation.

Policymakers could increase the transparency of these transactions in a number of ways. First, Congress could pass legislation that lowers the threshold for reporting proposed transactions to federal antitrust agencies, allowing them to identify modestly sized mergers that raise antitrust concerns. Legislation could also require premerger notification if the accumulated value of transactions by a single parent company in a given market exceeds reporting thresholds, regardless of whether the marginal acquisition alone would exceed that threshold (Adler & Ippolito, 2023).

Relatedly, lawmakers could pass legislation that increases transparency of ownership structures and market shares. Doing so could make it easier for antitrust agencies to quickly assess the competitiveness of a healthcare market and distinguish innocuous transactions from more concerning ones. This could be particularly helpful in cases in which antitrust agencies are tasked with assessing more transactions, as many relevant policies envision. One antitrust scholar has suggested establishing a database that contains ownership and spending information for healthcare entities (Dafny, 2021). Similar information could be generated by adding information on the volume of services to the Transparency in Coverage Rule, which currently requires insurers to release pricing data. There has been some recent legislative interest in increasing ownership transparency, but legislators have particularly focused on cases in which providers are controlled by private equity funds (e.g., Healthcare Ownership Transparency Act, 2022).

Many of these policies come with similar tradeoffs. Devoting more resources to antitrust enforcement in healthcare may reduce the agencies' enforcement ability in other areas. Some observers have argued that agency budgets have not increased appropriately over time, suggesting this may be a notable concern (Gaynor, 2020). Congress could increase agency budgets; however, this has been the subject of some recent debate. The Merger Filing Fee Modernization Act of 2022 increased fees on merging parties, which functionally increased funding of antitrust agencies. On the other hand, recent proposals from the House and Senate Appropriations Committees would limit how much this could increase DOJ funding (Consolidated Appropriations Act, 2024).

These policies also often impose additional burdens on firms. Greater premerger notification, for example, increases costs on firms that previously did not need to notify regulators about transactions, including those that raise no competitive concerns. The size of these costs would depend on the specific policy. Requiring reporting of ownership structures or additional information also comes with administrative costs that should be weighed against potential benefits.

Policies Affecting Antitrust Enforcement Standards

Congress could also make it easier for federal antitrust agencies to challenge transactions they view as problematic.

First, while the FTC has broad authority to review proposed mergers, it is currently prohibited from investigating other anticompetitive conduct by nonprofit firms. This is a particularly notable omission in hospital markets in which nearly half of all hospitals are nonprofits (American Hospital Association, n.d.-b). Congress could expand the FTC's enforcement authority to include nonprofits. The Stop Anticompetitive Healthcare Act (2023) would amend the Federal Trade Commission Act in such a manner.

More generally, policymakers could explicitly lower the required burden of proof for the agencies when challenging transactions. One antitrust scholar has suggested amending Section 7 of the Clayton Antitrust Act of 1914, which requires that agencies demonstrate that a transaction "substantially" lessens competition or "tends to create a monopoly" (Dafny, 2021). Replacing "substantially" with "meaningfully" or "materially" could lower the burden of proof on agencies in these cases.

Proposals to alter the Clayton Antitrust Act in this manner would likely trigger substantial debate about the appropriate burden of proof on antitrust agencies. Supporters of such a change are likely to

argue that current law imposes an unduly high bar and results in many anticompetitive transactions moving forward (either because the agencies lose their legal challenge or because they are dissuaded from challenging an action).

Little evidence exists on how such a change would alter markets. The FTC conducted retrospective analyses of a few mergers that were consummated after the agency or state attorney general unsuccessfully attempted to block them. The agency found evidence of price increases in two cases (Haas-Wilson & Garmon, 2009; Tenn, 2011), no effect on prices in one (Haas-Wilson & Garmon, 2009), and mixed results in one (Thompson, 2011). Supporters of this policy are likely to note that a large share of consummated hospital mergers results in increased prices (Cooper et al., 2019).

Opponents are likely to emphasize the potential costs from overly active enforcement. Targeting too many transactions could both impede otherwise innocuous market activity and impose significant costs on those that are challenged. Potential opposition is likely to be stronger if these changes applied to all markets regulated by the agencies, including those in which consolidation may be a less pronounced concern than in healthcare.

Prohibiting Potentially Anticompetitive Contracting Practices

Providers with significant market power can require that insurers agree to contracting provisions that could limit competition. These include antitiering clauses, which require that the provider is not placed on a lower tier of coverage than any other. Similarly, antisteering provisions disallow the insurer from using financial incentives to encourage patients to see another provider. Finally, all-or-nothing contracts require that an insurer include either all providers affiliated with a dominant health system or none of them.

By limiting insurers' ability to incentivize enrollees, antitiering and antisteering clauses could make it more challenging for a lower-cost or higher-quality competitor to attract patients away from a dominant provider. All-or-nothing provisions could further allow a provider with a dominant position in one market segment (e.g., acute care hospitals) to extend that market power to others. These types of clauses may make it difficult for existing competitors to gain market share and dissuade potential competitors from entering a market in which they may be disadvantaged.

The effects of these contracting provisions are likely to be most noticeable in markets that have less competition. If a hospital in a competitive market demanded one of these provisions, insurers could omit that provider from their networks in favor of a competitor. In markets with few providers, however, insurers may not have a credible option to do so. These clauses may also be more powerful where network adequacy laws effectively require the inclusion of certain providers. That said, limited direct evidence exists on how these contracting practices affect healthcare costs.

Restricting these types of contracting practices may have a small effect on healthcare costs because dominant providers would still have significant market power. As the Congressional Budget Office (CBO, 2022) noted, it also may be difficult to enforce such a ban if providers and insurers implicitly agreed to similar terms without formalizing them in contracts.

Providers, particularly those with significant market share, are likely to oppose policies that would impede the use of these contracting tools. They argue that prohibiting antitiering or antisteering

provisions would reduce access by encouraging insurers to make it difficult for enrollees to seek care at their preferred provider (American Hospital Association, n.d.-a). Moreover, they argue that insurers have significant market power, suggesting this type of policy might increase their bargaining position too much. Finally, they are likely to argue that these contracting tools are not unusually anticompetitive but instead reflect negotiations in which a provider agrees to a lower rate in exchange for a larger volume of an insurer's patients.

Congress has considered multiple proposals that would restrict the use of these clauses. Examples include provisions in the Lower Health Care Costs Act (2019) and the Bipartisan Primary Care and Health Workforce Act (2023), which the CBO (2019, 2024) projected would lower costs. The Addressing Anti-Competitive Health Care Contract Clauses Act, introduced in 2023, would require the US Government Accountability Office to study the effects of these clauses and assess the ability of antitrust agencies to take action in these cases.

Site-Neutral Payments

Medicare typically pays more for a service if it is delivered in a hospital outpatient department (HOPD) rather than in a physician's office or, to a lesser degree, an ambulatory surgery center. This payment differential is meant to reflect higher operating costs for hospitals. For example, hospitals maintain capabilities to treat a larger range of emergencies than a physician's office. However, current policy also provides an incentive for physicians' offices to consolidate with hospitals and take advantage of the ability to charge higher rates (see Medicare Payment Advisory Commission [MedPAC], 2023, for a discussion of this issue).

Many observers argue that this payment difference is not justified for services that rarely use those hospital-specific capabilities. Medicare could instead pay the lower physician fee schedule price regardless of where services were delivered. This site-neutral rate would lower Medicare spending and reduce the incentive for hospitals to consolidate with physicians.

Sources have documented an increase in vertical integration between physicians and hospitals over time (Kane, 2023). While direct evidence of the effect of Medicare's policy on this trend is modest, MedPAC (2022) has highlighted consistent effects. For example, from 2015 to 2019, the volume of chemotherapy administration rose 27.8 percent in HOPDs, in which payments are higher, while falling 5.4 percent in clinician offices, in which payments are lower. One paper showed that integrating with a hospital would increase Medicare payments per physician per year by 78 percent for primary care doctors, 74 percent for medical specialists, and 224 percent for surgeons (Post et al., 2021), suggesting that financial incentives are substantial. The paper finds evidence that larger payment differences are associated with greater hospital-physician integration.

Recently, Medicare adopted site-neutral payments in a small number of cases—namely for clinic visits at off-campus HOPDs and any visit at off-campus HOPDs established after November 2, 2015 (note that such entities can expand over time) (for a discussion, see Adler et al., 2018). Policymakers could expand this policy to include nonclinic visits at off-campus HOPDs built before 2015 and certain services at on-campus HOPDs to reduce incentives to vertically integrate. The CBO (2022) has argued that if site-neutral payments were expanded in this way, "consolidation would become less financially appealing."

The Transparency of Hospital Billing Act (2022) would require Medicare to adopt site-neutral payments based on the physician fee schedule for all off-campus HOPD services. Because these services are already being delivered away from the hospital, proponents argue that they are unlikely to use hospital-specific resources. MedPAC (2023) has also suggested adopting site-neutral payments in all HOPDs (including on campus) for services that can be safely delivered outside a hospital. One approach identified services based on whether they were most commonly delivered outside an HOPD (e.g., in a freestanding physician's office or ambulatory surgery center).

The House of Representatives recently passed the Lower Costs, More Transparency Act (2023), which would impose site-neutral payments in a small number of cases—such as drug administration services in off-campus facilities. The CBO (2023) estimated that this would reduce federal spending by roughly $3.7 billion over 10 years and would likely have a small effect on consolidation incentives.

A related policy would require that hospitals use separate billing codes for off-campus facilities. This would allow commercial insurers to better identify where services are delivered and potentially allow them to adjust payments across sites of service. This proposal was included in the Lower Costs, More Transparency Act. It was also included in the SITE Act (2023), which has been introduced in the Senate. The CBO (2023) anticipated that this would slightly reduce healthcare costs. Relatively small savings likely reflect the fact that this additional transparency does not fundamentally alter the bargaining power of hospitals or insurers.

Opponents of these types of policies often argue that lower hospital reimbursement could trigger hospital closures and reduced access (Pollack, 2024). This possibility would be affected by the scale of the policy change and other design features. Meanwhile, proponents of the site-neutral policy typically argue that the financial vulnerability of some hospitals is not a sufficient justification to oppose site-neutral payments for all hospitals. Some policies attempt to address concerns about certain vulnerable hospitals. For example, MedPAC (2022) has modeled a stop-loss policy that would limit financial losses for hospitals with a large share of low-income patients (see Ippolito et al., 2023, for a discussion of related options). Policymakers could presumably target other types of hospitals where viability and access challenges are most pronounced (e.g., rural areas). Such limits would reduce how much the policy dissuades consolidation but also attenuate potential financial challenges for hospitals. Alternatively, policymakers could apply site-neutral reforms to all providers and use a distinct mechanism to target additional assistance to financially vulnerable hospitals (Adler et al., 2023). This may attenuate consolidation incentives more fully while also addressing access and equity concerns.

Another argument is that HOPDs treat sicker patients on average, which justifies higher payments (Pollack, 2024). There is some disagreement about whether this is true. For example, MedPAC (2022) has argued that patient severity has minimal effects on HOPD costs when considering the specific services that are candidates for site-neutral payments.

340B Reform

The 340B program requires that drugmakers give mandatory discounts on outpatient drugs to certain "qualified entities," including disproportionate share hospitals and smaller provider groups, such as critical-access hospitals. By giving these hospitals an advantage on the acquisition costs of drugs, the

program provides an incentive to vertically integrate with physicians, particularly if they administer or prescribe large amounts of expensive outpatient medicines.

Required 340B discounts are large, with recent data suggesting they are around 50 percent of the gross (or list) price of a drug (Fein, 2023). These discounts are intended to support care for vulnerable populations and are not required to be passed along to public or private insurers, allowing qualified entities to earn significant profit margins. The resulting profit need not be used in any specific way, and there is limited oversight into its use (US Government Accountability Office, 2011).

This program has grown markedly over time. From 2015 to 2022, purchases by covered entities at discounted prices grew from $12.2 billion to $53.7 billion (the prediscount value of sales grew from $32.6 billion to $106.0 billion during this time) (Fein, 2023). This growth is largely attributable to the Affordable Care Act, which allowed covered entities to contract with an unlimited number of pharmacies to dispense drugs.

Because they can purchase drugs for lower prices than a standalone physician's office, 340B entities have an incentive to integrate with physicians. One study found that qualifying for the 340B program led hospitals to employ more physicians in specialties that prescribe high numbers of infusion drugs, including hematologist-oncologists, ophthalmologists, and rheumatologists (Desai & McWilliams, 2018). They did not observe evidence that these hospitals provided more care to low-income patients. The US Government Accountability Office (2015) has also noted that 340B hospitals prescribe more (or more expensive) drugs than non-340B hospitals. This is consistent with 340B encouraging the aforementioned integration but not proof of it. However, one other study found little evidence that 340B had encouraged vertical integration. A summary of the literature suggests that qualifying facilities respond to program incentives in margin-motivated ways (e.g., strategic consolidation) in a number of cases, though some work has found positive effects in areas like providing safety net care (Levengood et al., 2024).

Policymakers could alter the program so that discounts were based on patient eligibility rather than distinguishing at the provider level (e.g., tying discounts to the number of low-income patients treated). The CBO (2022) has indicated that this change may attenuate consolidation incentives but that the magnitude of this effect is uncertain. Provider groups are generally opposed to reforms that might reduce eligibility for the 340B program and argue that the program is central to their provision of safety net care (Pollack, 2024).

Increasing Price Transparency

Several mechanisms exist by which increasing price transparency might improve competition. In some cases, better information about prices may allow individuals to more effectively choose lower-cost providers in some cases. It may also allow employers to better assess the plans offered by insurers and be more informed purchasers (e.g., by making the cost of including a dominant hospital more salient). Greater price transparency may also affect policymaking by informing legislative proposals and directing more attention to markets that are heavily consolidated.

It is possible that price transparency may not spurn much additional competition but rather lead to a compression of prices. Public prices may make insurers less willing to accept higher prices once they know their competitors are getting lower ones. On the other hand, hospitals may be unwilling to offer

certain payers low prices if it will trigger other payers to demand similar rates. The net effect of these forces is unclear. It also may not reduce the market power held by dominant providers in already-consolidated markets. Certain features of healthcare markets may also attenuate the mechanisms through which transparency may increase competition. The vast majority of healthcare is purchased by consumers who are heavily insured, meaning they pay a small share of the marginal cost of care. In addition, they may face incentives that are independent of a specific provider's price (e.g., if they owe a flat copay). A large portion of healthcare is consumed in urgent situations in which price shopping may not be feasible. Finally, research shows that consumers use existing transparency tools infrequently (Mehrotra et al., 2017; Sinaiko & Rosenthal, 2016).

Two recent regulations—the Hospital Price Transparency Rule (45 C.F.R § 180) and the Transparency in Coverage Rule (85 C.F.R §72158)—have meaningfully increased price transparency. The Transparency in Coverage rule requires commercial insurers to publish contracted rates for all health care services and some out-of-network payments. It also requires that plans create internet-based tools that allow enrollees to estimate their cost-sharing obligations. The Hospital Price Transparency Rule requires that hospitals post data files that include payer-specific and cash prices for services as well as provide prices of shoppable services in a consumer-friendly format. Some observers have highlighted potential challenges to using these data. For example, it can be difficult to forecast the price of an episode of care that involves many services. Moreover, commercial insurers can use different payment structures that may make it difficult to translate these prices into estimates for cost of care (Hulver et al., 2024).

While these rules are already in effect, Congress could codify them as the Lower Cost, More Transparency Act would do. Doing so would ensure that a future administration does not repeal them. It would also give Congress an opportunity to make some improvements aimed at increasing compliance and expanding the information contained in them (e.g., by including information about volume of services in the Transparency in Coverage rule). It would also provide an opportunity to reduce duplicate reporting across the two rules, which increases administrative costs on market actors (Adler et al., 2023).

State Policy Options to Increase Competition

States can use a number of policy levers to increase competition within healthcare provider markets—some of which overlap with federal authority and some of which are distinct. First, lawmakers could give state attorneys general greater oversight of proposed mergers and acquisitions. Second, they could limit certain contracting practices that may impede competition. Third, they can seek to increase competition by expanding the supply of providers through policies like certificates of need or scope of practice regulation. Finally, they can increase price transparency in these markets.

Increasing State Oversight of Mergers and Acquisition

While federal antitrust agencies play a central role in competition policy, state attorneys general can also do more to enforce antitrust laws at the state level. State policymakers could consider a number of policies that would give them (and potentially state health agencies) greater knowledge of proposed mergers and acquisitions within their borders and an increased ability to impede those that may raise competitive concerns.

Specifically, states could require that a larger share of proposed mergers be reported to the state attorney general and state health agency. Alerting state authorities to proposed mergers and acquisitions could give them a better chance to contest ones that raise antitrust concerns. As noted above, federal antitrust regulators are currently notified of certain mergers or acquisitions only if they have a value above $119.5 million (adjusted over time for inflation). In practice that excludes the majority of transactions. States could require reporting for transactions that fall below this threshold.

States have enacted policies along these lines in recent years. Many states require that all hospital mergers be reported (Fuse Brown, 2020), while only a few states require it of transactions involving nonhospital entities (Hughes & Murphy, 2023). In cases in which states have such requirements, notice is typically required 30 to 90 days before a merger is consummated (Montague et al., 2021). States without such premerger reporting could consider implementing it.

State policymakers could go a step further by requiring that the attorney general proactively approve proposed transactions without needing to go to court. When establishing a premerger approval process, lawmakers will typically outline key parameters for the process. These can include rules about which transactions are subject to preapproval, a timeline for preliminary and/or comprehensive reviews, and the criteria used to evaluate transactions, which could include the effects on market competition.

States can choose to apply oversight only to for-profit entities, as some states historically have done (Hughes & Murphy, 2023). Doing so would likely be subject to debate since research finds that transactions involving nonprofits can still raise antitrust concerns (Tenn, 2011). States could also attach conditions to the mergers they approve, including reporting requirements, divestiture, or rate controls on the resulting entity. The latter would likely be the subject of more notable debate because prior efforts at rate regulating postmerger entities is mixed (see the Reconsidering Certificates of Public Advantage section).

A number of states have some type of review authority, but only a few—notably, Connecticut, Oregon, and Rhode Island—have policies that include comprehensive review based on competitive effects that apply to a broad range of transactions (Montague et al., 2021). In addition to the models developed in those states, the National Academy for State Health Policy (2021) has model legislation for states considering such a policy.

One paper has evaluated the effects of different levels of state oversight (Fulton et al., 2021). States with the most comprehensive oversight challenged the largest share of mergers and typically imposed conditions on those that were allowed. However, the paper did not find evidence that states with the strictest oversight had less hospital market consolidation or lower prices over time, possibly because most mergers were ultimately allowed.

Proponents of these policies would likely argue that state action would be more effective if it included more structural remedies to address consolidation in these cases, such as requiring more divestitures or greater oversight of the postmerger entity. Opposition to these policies is likely to include provider groups that argue that broad reporting or premerger approval regimes impose significant costs on normal market activity that raises little antitrust concern (e.g., California Hospital Association, 2022). In addition, these policies impose administrative burdens on state governments.

Prohibiting Potentially Anticompetitive Contracting Practices

Within their boundaries, states have the same authority as federal entities to regulate potentially anticompetitive contracting practices—including antisteering, antitiering, and all-or-nothing contracting provisions. A number of states have banned the use of at least some contracting practices. Four states restrict antisteering and antitiering provisions in contracts as well as all-or-nothing provisions, and two states are considering such restrictions (The Source on Healthcare Price and Competition, n.d.). Limited evidence exists on the effectiveness of these state efforts, which engender the same kind of support and opposition as federal proposals.

Reconsidering Certificate of Need Laws

Certificate of Need (CON) laws require that a state entity approve the entry of new healthcare providers or capital expenditures by existing providers. These laws were motivated by concerns that unchecked healthcare investment could trigger inefficient and inequitable spending. Proponents worried that if too much supply was built, providers would pass along costs to consumers. Moreover, providers might be unlikely to direct investments to areas of unmet need (e.g., rural or poorer areas). Relaxing these restrictions could potentially trigger more providers to enter markets.

Thirty-five states and the District of Columbia currently maintain a CON law, while three additional states operate a variation on a CON (National Conference of State Legislatures, 2024). In these states, new capital expenditures or market entry are reviewed by a state agency along a number of dimensions, including projected need and likely effects on costs. Many states temporarily relaxed their CON laws in response to the COVID-19 pandemic (Erickson, 2021).

Opponents of these arrangements argue that they can stifle competition. A potential entrant may be directly blocked from entering a market or dissuaded from attempting to enter by the cost of navigating the CON process. Critics also argue that existing dominant providers may be able to exert influence over the CON process to impede entry of potential competitors (Ohlhausen, 2015).

A recent review found that these laws are associated with fewer healthcare facilities and may contribute to higher costs (Liu et al., 2022). Their effects on quality and access are less clear.

States with CON laws could consider repealing their laws entirely or more incrementally. For example, states could reduce administrative burdens by simplifying application processes or lowering fees. They could also remove CON requirements for certain types of facilities or schedule them to sunset over time (Mitchell, 2021).

Reconsidering Certificates of Public Advantage

Certificate of Public Advantage (COPA) laws establish a process through which states can shield mergers from federal antitrust oversight by placing the postmerger entity under state supervision. In such an arrangement, states approve proposed mergers if they believe the benefits would outweigh the effects of less competition.

State supervision of the consolidated entity is meant to mitigate the harms of lower competition and can include features like price regulation, charity care requirements, or quality improvements (US Department of Health and Human Services et al., n.d.). Federal antitrust regulators are prohibited from challenging mergers approved under a COPA due to the state action doctrine (FTC, 2022).

Proponents of COPAs argue that well-designed state oversight can be effective, especially in markets where hospitals may close absent a merger. For example, Indiana recently enacted a COPA law targeted at rural counties (Indiana Code Title 16-21-15-1).

Critics of COPAs argue that they are likely to increase healthcare costs by allowing mergers that raise significant antitrust concerns (FTC, 2022; Gaynor, 2020; US Department of Health and Human Services et al., n.d.). If state oversight is ineffective or temporary, the postmerger entity could use its consolidated market power to raise prices. Moreover, some argue that federal antitrust agencies already consider the financial viability of merging hospitals, suggesting they are not necessary to protect transactions in which a hospital's closure is otherwise likely (FTC, n.d.).

Garmon and Bhatt (2022) evaluated the long-term effects of four mergers that were allowed under a COPA and found that hospitals were able to raise prices while under state supervision in two cases. Moreover, state supervision of the postmerger entity was abandoned after lobbying efforts in three cases, resulting in higher prices.

Nineteen states have active COPA laws (Hulver & Levinson, 2023), while five states have repealed prior laws (Gu, 2021). States could repeal their COPA laws if they have no hospitals under an active agreement. Otherwise, states could stop issuing any new COPAs while continuing oversight of existing agreements.

Scope of Practice Regulation

State scope-of-practice (SOP) laws govern what services healthcare providers can perform and the extent to which they can practice independently. These rules apply to various advance practice providers, including registered nurses, nurse practitioners, and physician assistants. These laws are meant to ensure providers practice in ways commensurate with their training. However, overly restrictive SOP laws could limit competition among qualified providers with little effect on quality. Critics of SOP expansion, on the other hand, argue that it can harm patients because advance practice providers have less training than physicians (American Medical Association, 2024).

States vary significantly in the restrictiveness of their SOP laws. For example, twenty-eight states allow full practice authority for nurse practitioners, which permits them to evaluate and diagnose patients without physician oversight, including the ability to prescribe medicines (American Association of Nurse Practitioners, 2023). Five states allow physician assistants to independently practice and prescribe medicines, while most require supervision or collaboration with a physician (National Conference of State Legislatures, n.d.). In response to COVID-19, many states temporarily relaxed their SOP restrictions (Bae & Timmons, 2022).

Researchers have extensively investigated the effects of SOP laws on various outcomes, with most published papers focusing on nurse practitioners. In general, evidence suggests that expanding SOP tends to increase patient access, likely lowers spending, and does not lower quality (Bae & Timmons, 2022).

Improving Price Transparency

States have the ability to enact laws that would increase price transparency in broadly similar ways as federal policymakers. For example, Arizona, Indiana, and Virginia codified the hospital

transparency rule, while other states have established penalties for hospitals not in compliance with federal requirements (Davenport & Pitsor, 2023).

States could also establish an all-payer claims database, which includes claims and enrollment data for all insurers in the state. These data include information about services delivered, prices, and characteristics of individuals receiving care. One notable limitation is that states may not require self-insured plans, which cover the majority of those with employer-sponsored coverage, to submit data due to federal preemption (see Gobeille v. Liberty Mutual Insurance Company, 2016). Twenty-five states currently have an all-payer claims database with required contributions in effect or implementation (All-Payer Claims Database Council, n.d.).

Pricing data from transparency laws or an all-payer claims database could be used as the basis for consumer-facing price comparison tools aimed at increasing competition among "shoppable" services (the NH HealthCost website (https://nhhealthcost.nh.gov/) is an existing example).

Conclusion

To address the challenges of increasing consolidation, state and federal policymakers have a number of options for promoting competition. These include increasing the supply of health care providers, enhancing oversight of mergers and acquisitions, increasing transparency, and altering features of public programs that encourage consolidation. While such policies hold promise for improving how health care markets function, they are likely to attract significant opposition from established providers and should be weighed against potential tradeoffs.

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Ten Things to Know About Consolidation in Health Care Provider Markets

Zachary Levinson, Jamie Godwin, Scott Hulver, and Tricia Neuman

National health spending totaled $4.5 trillion in 2022—17% of gross domestic product (GDP)—and is projected to grow faster than GDP through 2031, contributing to higher costs for families, employers, states, and the federal government. As policymakers consider a variety of strategies to make health care more affordable, they have been increasingly attentive to consolidation in health care markets—including mergers and acquisitions of health care providers—and the potential effects of consolidation on the cost and quality of care and other outcomes. Consolidation may allow providers to operate more efficiently, and could help struggling providers keep their doors open in underserved areas, but also often reduces competition. A substantial body of evidence has found that consolidation has led to higher prices, but the evidence on quality is unclear.

In response to concerns about the effects of consolidation and reduced competition on prices and quality, the Federal Trade Commission (FTC) recently authorized a lawsuit to block a hospital acquisition in North Carolina. And, just last month, the FTC, Department of Justice, and Department of Health and Human Services issued a request for information (RFI) seeking input on the effects of consolidation involving health care providers and related products and services as part of a broader effort to clamp down on anticompetitive practices.

This issue brief identifies ten things to know about consolidation in health care provider markets, touching on topics such as the different types of consolidation, trends, ways in which consolidation can be beneficial or harmful for patients and other consumers, some key findings from existing research, and policy options for increasing competition. This brief focuses on consolidation among health care providers, rather than health insurers, and builds on a 2020 KFF issue brief on provider consolidation. More recent research has not altered the key takeaways pulled from that brief.

Efforts to promote more competitive provider markets could help address health spending and affordability issues, but also entail a number of challenges, given that many markets are already highly concentrated and that some regions cannot support competitive markets. Some have considered more direct regulation of prices and spending, and the two approaches could play complementary roles when addressing rising health care costs, such as by encouraging providers to compete on quality when prices are regulated.

1. Consolidation in health care markets can take many forms and involve various types of providers

Health care consolidation often refers to scenarios where hospitals and other health care entities join together under common ownership through either a merger or acquisition (referred to as "mergers" in this brief). There are three main types of mergers:

- **Horizontal mergers** occur when there is consolidation between entities that offer the same or similar services, such as when a health system acquires a hospital or when two physician practices that provide overlapping services merge. For instance, in August 2023, Oregon Health & Science University and Legacy Health—two of the largest health systems in the Portland area—announced plans to merge.
- **Vertical mergers** occur when there is consolidation between entities that offer different services along the same supply chain, such as when a hospital or health plan acquires a physician practice. For instance, in May 2023, the health system HCA Healthcare announced a deal to acquire 41 urgent care centers in Texas, where HCA already had a large presence. Some mergers may entail both vertical and horizontal consolidation (e.g., if a health system acquires a physician practice that provides services offered by the system's existing physician group).
- **Cross-market mergers** occur when there is consolidation between two providers that operate in different geographic markets for patient care. For example, in March 2024, Kaiser Permanente closed its merger with Geisinger Health through a new organization called Risant. These systems operate in different regions of the United States, with Kaiser Permanente operating in five states in the West (including California) and Georgia, Maryland, Virginia, and DC and Geisinger operating in Pennsylvania.

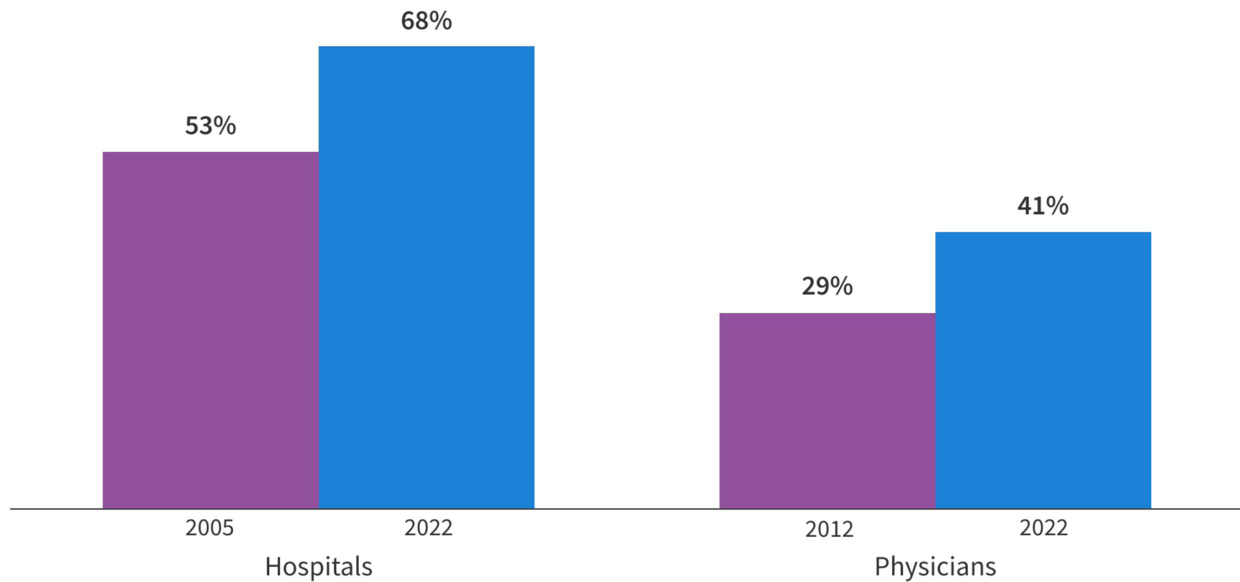
Aside from merging, health care entities can form other types of affiliations without necessarily changing ownership, which may also have implications for patient care. Examples include the creation of accountable care organizations (i.e., groups of doctors, hospitals, and other providers who form partnerships to collaborate and share accountability for the cost and quality of care delivered to their patients) and joint ventures (i.e., agreements to collaborate on a particular goal, such as a health system and group practice that work together to create a new ambulatory surgery center). These affiliations can raise similar issues as mergers and are sometimes referred to as "soft" forms of consolidation.

2. There has been a large amount of consolidation in provider markets over the past 30 years

Provider markets have become increasingly consolidated over the past 30 years. Following a wave of consolidation in the early- and mid-1990s, there were 1,573 hospital mergers from 1998 to 2017 and another 428 hospital and health system mergers announced from 2018 to 2023. The share of community hospitals that are part of a larger health system also increased from 53% in 2005 to 68% in 2022 (see Figure 1). Relatedly, the share of physicians working for a hospital or in a practice owned at least partially by a hospital or health system increased from 29% in 2012 to 41% in 2022.

Figure 1

An Increasing Share of Hospitals Are Affiliated With Health Systems and an Increasing Share of Physicians Are Affiliated With Hospitals or Health Systems



Note: Hospital numbers reflect the share of community hospitals that are part of a larger health system, as defined by the American Hospital Association (AHA). Physician figures reflect the share of surveyed physicians that reported working for a hospital or in a practice owned at least partially by a hospital or health system.

Source: KFF analysis of AHA hospital data from the AHA Annual Survey Database and the AHA Trendwatch Chartbook, 2021 and of American Medical Association (AMA) physician data from the AMA report "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022."

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Consolidation has also contributed to the emergence of large health systems. For example, the ten largest health systems (see Table 1) accounted for about one in five (22%) of nonfederal general acute care hospital beds in 2022. These systems are the size of large corporations. For example, HCA Healthcare, which operates the largest number of nonfederal general acute care hospital beds in the country, had greater operating revenues than each of Netflix, Uber, and Starbucks in 2023. AdventHealth, the smallest of the ten largest health systems in terms of beds, had greater operating revenues than Zoom and Lyft combined in 2023 (as did Community Health Systems, the smallest of the ten largest systems in terms of operating revenues). Consolidation, which often occurs between providers based in the same region, has also contributed to highly concentrated markets where patients have limited options among large provider organizations.

Table 1

Ten Largest Health Systems Based on the Number of Hospital Beds in 2022

System Name	Hospital Beds in 2022	FY 2023 Operating Revenue	Ownership	States with System Hospitals
HCA Healthcare	38,015	$65.0B	For profit	*19 states* AK, CA, CO, FL, GA, ID, IN, KS, KY, LA, MO, NC, NH, NV, SC, TN, TX, UT, VA
CommonSpirit Health	17,148	$34.5B	Nonprofit	*18 states* AR, AZ, CA, CO, GA, IA KS, KY, MN, ND, NE, NV, OH, OR, SD, TN, TX, WA
Ascension Health	16,241	$28.3B	Nonprofit	*13 states* AL, CT, FL, IL, IN, KS, MD, MI, NY, OK, TN, TX, WI
Trinity Health	14,621	$21.6B	Nonprofit	*17 states* CA, CT, DE, FL, GA, IA, ID, IL, IN, MA, MD, MI, NJ, NY, OH, OR, PA
Tenet Healthcare	12,822	$20.5B	For profit	*12 states* AL, AZ, CA, FL, MA, MI, OK, PA, SC, SD, TN, TX
Advocate Health*	10,528	$28.2B	Nonprofit	*6 states* AL, GA, IL, NC, SC, WI
Community Health Systems	9,850	$12.5B	For profit	*16 states* AK, AL, AR, AZ, FL, GA, IN, MO, MS, NC, NM, OK, PA, TN, TX, WV
Providence	9,445	$28.7B	Nonprofit	*7 states* AK, CA, MT, NM, OR, TX, WA
Kaiser Permanente	9,217	$100.8B	Nonprofit	*3 states* CA, HI, OR
AdventHealth	8,038	$16.8B	Nonprofit	*9 states* CO, FL, GA, IL, KS, KY, NC, TX, WI

Note: Bed counts and states of operation are for nonfederal general acute care hospitals, derived from Medicare cost reports, grouped into systems based on the 2022 AHRQ Compendium of US Health Systems. All hospitals participating in Medicare are required to submit cost reports. Operating revenues encompass relevant amounts from every component of a given health system, including hospitals, other providers, and, in some cases, health plans (the largest example being Kaiser Permanente). Operating revenues are as reported in financial statements. *Operating revenues for Advocate Health reflect the sum of revenues for Advocate Aurora Health and Atrium Health in 2022, which merged in that year.

Source: Bed counts, ownership, and states of operation were obtained from RAND Hospital Data, 2022. Operating revenues were obtained from audited financial statements.

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Today, many provider markets are highly concentrated, particularly markets for hospital care. One study estimated that the vast majority (90%) of metropolitan statistical areas (MSAs) had highly concentrated hospital markets in 2016, while another estimated that the share of metro areas with highly concentrated hospital markets increased from 71% to 77% over the period from 2017 to 2021 (differences in magnitudes across these studies likely reflect their distinct methods, including market definitions). The former also found that most MSAs (65%) had highly concentrated specialist physician markets in 2016, and nearly two in five (39%) had highly concentrated markets for primary care physicians. Physician markets may have become more concentrated in recent years due to the ongoing trends in consolidation described above.

3. Corporations such as CVS, Amazon, and UnitedHealth and private equity firms have recently acquired many physician practices

In addition to hospitals and health systems, other types of entities have also been involved in a large number of acquisitions in recent years:

- **Corporate buyers.** Corporations that have not traditionally specialized in the provision of health care services—including large national companies such as CVS, Amazon, and UnitedHealth—have acquired many physician practices in recent years. The share of physicians employed by corporate entities increased over a three-year period from 15% in January 2019 to 22% in January 2022. Optum, a division of the insurer UnitedHealth, now employs or is affiliated with about 10% of all practicing physicians. Some policymakers have expressed concern about the role that large corporate buyers could have in increasing consolidation and reducing competition, which could lead to higher costs and reduced quality, although evidence is not yet available on this trend.
- **Private equity firms.** Private equity is a form of corporate ownership that often entails relying on loans to acquire a business, taking it private (if not so already), and attempting to increase its value with the goal of selling it at a profit in three to seven years. One common strategy is to consolidate providers through a series of mergers and acquisitions. Private equity provider acquisitions have increased by a large amount since 2010—e.g., with physician practice deals increasing more than six-fold from 2012 to 2021—though deals have slowed somewhat since a peak in 2021. Some policymakers have expressed concern about the role of private equity in consolidation and the effect of the short-term profit motive of private equity firms on the prices, quality, and financial standing of acquired providers.

4. A substantial body of evidence shows that consolidation has led to higher prices, but the evidence on quality is unclear

Consolidation could in principle benefit consumers in some instances and be harmful in others. On the one hand, consolidation could allow providers to operate more efficiently, such as by obtaining supplies at

steeper discounts (by purchasing them in greater volume); sharing resources (such as medical imaging equipment); and achieving the scale necessary to participate in value-based payment programs. These potential efficiencies could in turn benefit patients, for example, if they lead to higher quality care or reduced costs (e.g., if providers share savings through lower prices), and the latter could benefit health plan enrollees more generally to the extent that it leads to lower plan spending and premiums. On the other hand, consolidation often reduces market competition and therefore the pressure on providers to lower prices or invest in quality improvement. Critics have also questioned the extent to which mergers allow providers to operate more efficiently. Efficiencies may depend, in part, on the degree to which providers integrate their operations, which can be complex and may or may not be a priority.

The following discussion describes key findings from the research.

A substantial body of research shows that consolidation has led to higher health care prices, as noted in a 2020 KFF issue brief on provider consolidation. The evidence that consolidation leads to higher prices is strongest for hospitals, though studies that have evaluated physician and hospital-physician consolidation have also tended to find that they are associated with higher prices. Studies that have looked specifically at consolidation among nonprofit hospitals—which account for 58% of all community hospitals—have found price increases as well. A RAND Corporation review from 2022 (which also informs other sections of this brief) found that estimated price increases associated with hospital mergers have ranged from 3 to 65 percent. The large variation in estimated price increases may reflect differences in the types of mergers that were evaluated (e.g., the extent to which they reduced competition), the context of these mergers (e.g., the competitiveness of local insurance markets), and methodology. In addition to increases in the prices that commercial insurers pay providers, consolidation can also lead to higher Medicare reimbursement rates, as the program often provides greater reimbursement for a given service when provided in a hospital outpatient department versus a freestanding physician office (see discussion of site-neutral payment reforms below).

Relatedly, studies have typically found that consolidation leads to higher health care spending, which could increase costs for families, employers, states, and public programs, like Medicare and Medicaid. Several studies have found that consolidation leads to higher spending, which reflects both the price and volume of care. This includes studies evaluating hospital consolidation and hospital-physician consolidation. Only a small number of studies have evaluated physician consolidation, with mixed results. Increases in health care spending can be passed onto health plan enrollees through higher premiums and workers with employer-sponsored insurance through lower wages. Notably, a couple of studies have found an association between consolidation and premium increases, and one study found that hospital mergers led to decreases in wages among non-health care workers with employer health plans.

The evidence on the effect of provider consolidation on the quality of patient care is unclear. The evidence on the impact of horizontal and vertical consolidation on quality has been mixed, as described in a 2020 KFF issue brief and 2022 RAND Corporation review. For example, most of the research on horizontal hospital consolidation has found no difference[1] in or a negative impact on quality. Among other

analyses, one study found that increased market concentration was associated with higher risk-adjusted one-year mortality rates for heart attacks and another found that hospital mergers were associated with a small decrease in patient experience measures and no changes in 30-day readmission and mortality rates (with inconclusive findings regarding clinical process measures). However, some studies have included mixed or positive findings relating to hospital consolidation. For example, a study funded by the American Hospital Association found that mergers were associated with decreases in 30-day readmission rates but no change in 30-day mortality rates (though an earlier version of the study found decreases in mortality rates as well).

The evidence is also mixed on the effects of vertical hospital-physician consolidation on quality. For example, one fairly recent study found that clinical process and patient experience measures were "marginally" higher for patients when their primary care physician was part of a system, another study found no difference in patients' 30-day readmission rates when their primary care physician was part of a large system, and a third study found that complications following colonoscopies were higher for patients when their gastroenterologist was part of a system (though the evidence was less clear for clinical process measures).

Interpreting the evidence on quality is further complicated by the fact that there are many dimensions and measures of quality that have been or could be used to assess the effects of consolidation and that it could take time for changes in quality to materialize. Additionally, it is likely that the effects of consolidation vary based on the extent to which providers have integrated their operations and across different patient populations.

5. Mergers between hospitals and health systems can lead to higher prices even when entities operate in different markets

While policymakers and regulators have historically focused on consolidation within the same region, many mergers have occurred between hospitals and health systems that operate in different regions, as discussed in a KFF issue brief, including several multi-billion dollar deals over just the past couple of years. The small number of studies that have focused on cross-market mergers have estimated price increases ranging from 6% to 17%, even though these deals entail hospitals and health systems that are not competing against each other in the same area. There are a few reasons why cross-market mergers might lead to price increases. For instance, a combined health system with providers in, say, different areas of a state may be able to use its dominant position in one market to negotiate higher prices in another when contracting with a given health plan (e.g., a state employee plan with enrollees that reside in several markets). As another example, a large system that, say, acquires a small hospital may have more expertise in bargaining with insurers, which it could use to negotiate for higher prices.

6. The impact of consolidation on the availability of health care services for rural and other underserved patients is unclear

Consolidation could in principle have mixed implications for access to care. For example, it is conceivable that the acquisition of a small, financially struggling, rural hospital by a large health system based in another region could increase the availability of services in the community in some instances and reduce it in others. On the one hand, being acquired could benefit the hospital financially—such as by providing access to a wide range of resources, managerial expertise, and capital—which could help the hospital keep its doors open and maintain or expand the services it offers. On the other hand, the system that acquires the rural hospital may be less responsive to the needs of the local community, such as when deciding whether to close the hospital or to stop offering certain services, such as maternity care (an outcome supported by some research, as described below).

A small number of studies have evaluated the association between consolidation with rural hospital closures and service eliminations, with mixed results. Two studies found that rural hospitals that merged with other hospitals or health systems were more likely to eliminate certain service lines, such as obstetrics care, and another study found that independent hospitals (urban and rural) that joined a health system were more likely to stop offering inpatient pediatric services. One study found that system affiliation was associated with a lower likelihood of closing among rural hospitals with weaker finances but a higher likelihood among those with stronger finances.

A small number of studies have evaluated the association between consolidation and access to care among Medicaid patients, also with mixed results. On the one hand, two studies found that physician practices were more likely to accept Medicaid patients after becoming affiliated with a health system. This may be because the broader system has a commitment or obligation to treat patients regardless of their ability to pay (e.g., for emergency care) or because efficiencies allow providers to treat more patients. On the other hand, one study found that increases in hospital market concentration were associated with fewer Medicaid admissions and a shift in care from nonprofit to public hospitals. This could be because increases in commercial prices resulting from greater market concentration may lead private hospitals to focus more on commercial versus Medicaid patients. Another study found that system affiliation was associated with a decrease in Medicaid as a percentage of all hospital discharges, although that study also found that the number of beds in a hospital or health system was associated with an increase in Medicaid discharges as a share of the total.

A small number of studies have evaluated the effect of consolidation on hospital charity care and total community benefits, with mixed results. For example, one study found no association between the acquisition of independent hospitals and charity care or total community benefit spending overall but a decrease in the latter when focusing on hospitals acquired by an out-of-state system. Another study found that the association of higher market concentration with hospital charity care varied depending on the method used, with an increase under one approach and no difference under another. One study found

that higher market concentration was associated with higher income thresholds for charity care eligibility, which effectively increases the number of patients who could qualify for charity care in a hospital.

7. Hospital consolidation can lead to lower wages for some skilled workers, such as nurses, but the broader evidence on employment and compensation effects is limited

Consolidation could in principle have both benefits and drawbacks for health care workers. On the one hand, consolidation could increase the negotiating leverage of hospitals and their ability to extract concessions from workers. For example, in 2023, a coalition of labor unions filed a complaint with the DOJ that UPMC, a large health system in Pennsylvania, had used its market power to suppress the wages of nurses and other health care workers, increase workloads, and restrict the ability of health care workers to seek better employment elsewhere. Mergers could also lead to layoffs, for example, to the extent that providers consolidate their staff and operations. On the other hand, health care workers could benefit from hospital mergers in some scenarios where consolidation allows hospitals to remain open and operate more efficiently. For example, the acquisition of a struggling rural hospital by a health system could help the facility sustain its operations in certain circumstances, which could protect jobs and possibly bolster wages.

A couple of studies have found that hospital consolidation has led to lower wages for some skilled workers, such as nurses, though the implications of other studies on health care worker wages are less clear. For example, one study found that hospital mergers were associated with lower wages for nurses and pharmacy workers and for skilled nonmedical workers following mergers that caused large increases in market concentration (but not for unskilled workers). Research from the Center for Economic and Policy Research also found that increases in hospital market concentration were associated with lower wages for nurses in small metropolitan statistical areas. An earlier study did not find consistent evidence when evaluating nurses' wages but did find that hospital mergers in California were associated with greater work effort (as measured by patient caseload). A small number of studies that looked more broadly at the financial impact of consolidation, including average compensation across all hospital workers, have produced mixed results.

Some studies find that hospital consolidation has led to reductions in staffing, though others have not, and the evidence is unclear on whether mergers avert closures, which could preserve jobs. A small number of studies have analyzed the effects of hospital consolidation on employment, with some finding an association with reduced staffing levels. For example, one study evaluating independent hospitals in New York found an association between joining a system and a reduction in employment, especially among employees with overhead and support functions. However, other studies have found no differences or inconsistent or unclear results. Additionally, as noted above, there is no clear evidence regarding the effect of mergers on hospital closures. If mergers lead to efficiencies that prevent closures, they may help preserve jobs.

8. The FTC, the DOJ, and state antitrust agencies each play a role in challenging consolidation and other potentially anticompetitive practices

Federal and state antitrust agencies each play a role in challenging consolidation and other potentially anticompetitive practices of health care providers and other businesses, as described in a KFF issue brief. At the federal level, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) share responsibility for enforcing federal antitrust laws, including the Sherman Act, the Clayton Act, and the FTC Act. State attorneys general (AG) offices also have the authority to bring action under federal antitrust law, as well as under state statutes, which sometimes expand upon federal law. Antitrust agencies challenge mergers, acquisitions, and other practices that may hinder competition (such as the use of anticompetitive contract clauses). They do so to promote competitive markets, often for the benefit of consumers (such as patients and health plan enrollees).

There are at least a few challenges that may limit the ability of the federal government and states to foster competitive provider markets through antitrust enforcement:

- **It is difficult to break up mergers after they have already occurred, and many provider markets are already highly concentrated.** Breaking up a merger after providers have already consolidated can be difficult. At the same time, regulating the behavior of merged providers—such as through restrictions on the prices they charge—may be difficult to monitor and enforce on an ongoing basis.
- **Some regions cannot support competitive provider markets.** For instance, rural communities may not have enough residents to support several providers that offer the same service.
- **Antitrust litigation can be complex and expensive.** Without adequate funding, it may be impractical to challenge a large number of provider business practices that raise anticompetitive concerns.
- **Antitrust agencies may have difficulty staying ahead of market trends.** For example, it could take time for the government to develop strong guidelines for challenging vertical or cross-market mergers and to accumulate enough evidence to convince courts that these practices harm competition. In the meantime, these mergers will likely continue.
- **The benefits of competitive provider markets for individuals with health insurance will depend in part on the competitiveness of health insurance markets.** One study estimated that most MSAs (57%) had highly concentrated insurance markets in 2016. When insurance markets are not competitive, cost savings from competitive provider markets might not be fully passed along to consumers.

The FTC and DOJ have recently signaled an interest in expanding their scrutiny of different types of mergers. For example, in December 2023, the agencies released updated merger guidelines that indicate that they may challenge a broader range of deals. Among other changes, the guidelines expand the definition of highly concentrated markets, rely on a lower threshold for identifying large changes in market concentration, consider the combined effect of a series of acquisitions (e.g., of a health system acquiring

several small physician practices over time), add an explicit discussion of the agencies' views on how workers may be negatively impacted when their employers merge, and touch on cross-market mergers.

The FTC and DOJ have also indicated an interest in challenging provider acquisitions by private equity firms and private payers. For instance, the agencies, along with HHS, specifically mentioned these types of entities in a March 2024 request for information on the effects of transactions involving health care providers and related products and services. Further, in September 2023, for the first time, the FTC challenged a common strategy of private equity firms that entails amassing market power through a series of physician practice acquisitions.

9. Site-neutral payment reforms, if enacted, could reduce incentives for vertical consolidation by lowering the rates at which acquired providers bill Medicare

Policymakers have expressed interest in aligning Medicare reimbursement rates for outpatient services across care settings through "site-neutral payment reforms," which could directly lower program costs and reduce the incentive for hospitals to buy up physician practices. Under current payment rules, Medicare reimbursement is often higher for a given outpatient service when provided in a hospital outpatient department versus a freestanding physician office or ambulatory surgical center. Two studies have found that these payment differences are associated with an increase in hospital-physician consolidation, which can allow providers to bill Medicare at higher rates.

Through legislation and rulemaking, Medicare has aligned payments for office visits across freestanding physician offices and off-campus hospital outpatient departments—which often resemble physician offices—as well as for other services for relatively new off-campus facilities. Policymakers have considered other site-neutral reforms with varying scope that would extend to additional sites of care and services. Proponents of these reforms assert there are no grounds to pay different amounts for the same service based on site of care (physician office or outpatient hospital department) while hospitals and other opponents counter that patients treated in hospital outpatient settings have greater needs than patients in physician settings and that their cost structure justifies higher payment rates.

10. Policymakers have considered a number of options to increase the competitiveness of provider markets

Several policies have been proposed to rein in provider consolidation or increase the competitiveness of provider markets in other ways:

- **Strengthen antitrust enforcement.** This approach would make it easier for the FTC and DOJ to enforce antitrust law. Specific policies include: requiring more providers to report planned mergers, lowering the legal standards by which mergers are deemed anticompetitive, and mandating that providers receive approval from the government before merging. Other proposals to strengthen antitrust enforcement include: eliminating state Certificate of Public Advantage (COPA) laws (which some states use to shield mergers from federal antitrust challenges in exchange for state regulation), increasing the scope of antitrust law (such as by giving the FTC full authority to regulate nonprofit providers and outlawing anticompetitive contracting clauses), and providing greater resources to agencies that enforce antitrust law.
- **Reduce incentives for health care providers to consolidate.** This could include site-neutral payment reforms (as described above), changes to the 340B program (which currently allows certain providers acquired by a 340B entity to purchase drugs at a substantial discount), and efforts to reduce the administrative burden of government regulations on providers (which may incentivize small practices that have difficulty shouldering these requirements to merge with other providers).
- **Increase price transparency.** Greater price transparency could help patients, plans, and employers shop for health care providers (e.g., to receive care from or include in provider networks) and may in turn encourage greater competition among providers. As discussed in a KFF issue brief, information about hospital and other health care prices remains elusive, despite recent federal transparency rules.
- **Allow more providers to enter the market.** This could include reforming state Certificate of Need (CON) statues (which can be used to limit, for example, the construction of new health care facilities) and scope of practice laws (which regulate what work various health care professionals, such as nurse practitioners, are allowed to perform).

Each of these proposals would involve tradeoffs that would be important to consider.

Endnotes

[1] References to no differences, no changes, or no associations in this issue brief indicate that there were no statistically significant differences.

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This publication is available at
https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets

Appendices

- Working Group Participants
- Special Guests
- Program Staff and Acknowledgment
- Program Conveners

Cochair

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Antitrust Chief (Retired)
California Office of the Attorney General

Kathleen Foote, JD, is retired from the California Attorney General's Office where she was antitrust chief from 2001 until January 2023. There she led a team at the center of the rise of the importance of state attorneys general within the global antitrust enforcement community. Key healthcare-related achievements included a ground-breaking 2018 challenge to a dominant Northern California provider (California ex rel. Becerra v. Sutter Health) and the co-founding of UC Berkeley's Petris Center on Health Care Markets and Consumer Welfare. Foote was named Antitrust Attorney of the Year by the California Bar's Antitrust and Unfair Competition Law Section in 2013 and received the American Antitrust Institute's Alfred E. Kahn Award for Antitrust Achievement. She has held leadership roles in the ABA's Section of Antitrust Law and is past chair of the Multistate Antitrust Task Force of the National Association of Attorneys General, which coordinates joint multistate and state-federal investigations and litigation.

Cochair

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Holly Vedova, JD, was director of the FTC's Bureau of Competition under Chair Lina Khan from 2021 to 2023. In that role, she oversaw the bureau's nearly 400 lawyers and staff in bringing merger and civil non-merger competition enforcement actions. Vedova had principal responsibility in carrying Chair Khan's priorities for the competition mission in the agency. Prior to becoming director, Vedova served as an attorney advisor to former FTC Commissioner Rohit Chopra, analyzing recommendations from the Bureau of Competition and advising on all aspects of the FTC's competition mission. She also served as an attorney advisor to four other FTC commissioners, both Democrat and Republican, and as counsel to the director of the Bureau of Competition. Earlier in her career, Vedova spent two years in private practice as in-house antitrust counsel to a large pharmaceutical corporation.

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Loren Adler, MS, is a fellow and associate director at the Center on Health Policy at the Brookings Institution. He is currently a member of the Advisory Committee on Ground Ambulance and Patient Billing, established by the No Surprises Act, and serves as an associate editor of the Health Affairs Scholar journal. His research focuses on a range of topics in health care economics and policy, including private equity and payer acquisitions of physician practices, provider consolidation, surprise billing, Medicare Advantage, and prescription drug pricing. Previously, Adler served as research director for the Committee for a Responsible Federal Budget and as a senior policy analyst for the Bipartisan Policy Center.

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Claire Brockbank, MS, is director of policy and strategy for the 32BJ Health Fund, a Taft-Hartley fund serving almost 200,000 covered lives. She is responsible for the fund's efforts to drive down hospital prices, including a multi-stakeholder campaign to draw attention to the central role that hospital prices play in health care costs and to drive action to lower those prices through public policy, operational innovation, and direct interaction with hospitals. Prior to joining the 32BJ Health Fund, Brockbank served as CEO of Peak Health Alliance, a health care purchasing cooperative in Colorado. As the lead architect of the development and launch of Peak, Brockbank was responsible for leveraging data and community organizing to lower premiums by approximately 35 percent in its first two years of operation. Peak also pioneered innovative benefit designs to channel access to more value-driven services.

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Erin C. Fuse Brown, JD, MPH, is the Catherine C. Henson Professor of Law and director of the Center for Law, Health & Society at Georgia State University College of Law. In July 2024, she will join the faculty of Brown University School of Public Health and the Center for Advancing Health Policy through Research as a professor of health services, policy, and practice. Fuse Brown specializes in health care legal and policy translation. Her research focuses on health care consolidation, consumer protection in health care, and corporatization of health care. She has published articles in legal, health policy, and medical journals about hospital prices, medical billing and collection, medical debt, health care competition and consolidation, and state health reforms. She has consulted with the National Academy for State Health Policy, Milbank Memorial Fund, and state and federal policymakers about legal and policy strategies to protect health care consumers, control health care costs, and address health care consolidation.

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Caitlin Carroll, PhD, is an assistant professor at the University of Minnesota in the Division of Health Policy and Management. Her research focuses on the economics of health care provider markets, with a particular interest in understanding consolidation, provider behavior, and optimal policy design in rural areas. Current projects include research on the consequences of rural hospital closure and merger, the influence of payment reform on health care delivery, and the effects of malpractice allegations against physicians. Earlier, Carroll worked at the Urban Institute on the Health Insurance Policy Simulation Model.

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Eileen Cody, BSN, served in the Washington State House of Representatives for almost 30 years. As chair of the House Health Care and Wellness Committee, she dedicated her legislative career to achieving affordable, quality health care for all state residents and led the effort to implement the Affordable Care Act at the state level. Among her other legislative priorities were patient safety, mental health parity, public health services, and the universal purchase of vaccines. A nurse certified in both rehabilitation nursing and multiple sclerosis care, Cody worked for four decades at Group Health Cooperative, now Kaiser Permanente, in Seattle. She is a founding member of District 1199 NW/SEIU Hospital and Health Care Employees Union.

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Jamie Crooks, JD, is a founding partner of Fairmark Partners, LLP, a plaintiffs' antitrust and consumer protection firm that specializes in using innovative private litigation to address the harmful effects of health care consolidation on patients, workers, and small businesses. His cases have been covered by The New York Times, The Wall Street Journal, Axios, and Bloomberg. He also litigates cases relating to algorithmic discrimination, mismanagement of employee health care benefits, and workers' rights. A former clerk to U.S. Supreme Court Justice Anthony Kennedy, Crooks specializes in developing novel approaches to using antitrust and consumer protection laws to address inequities in health care and the broader economy. Prior to founding Fairmark, Crooks practiced at O'Melveny & Myers, LLP, where he was a member of the firm's appellate and cybersecurity practices.

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Emily R. Gee, PhD, is senior vice president for inclusive growth at the Center for American Progress. In her role, she oversees economic policy, health policy, and the Women's Initiative. Prior to joining American Progress, Gee was an economist in the Office of the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services. She also served as an economist on the staff of the Council of Economic Advisers in the Obama White House. She has been quoted and her work has been cited in The New York Times, The Washington Post, Politico, and Forbes. Gee is a member of the Health Care Services board of the National Academies of Science, Engineering, and Medicine.

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Katie Gudiksen, PhD, MS, is executive editor for The Source on Healthcare Price and Competition, a grant-funded research team at the University of California, College of the Law, San Francisco. Gudiksen is an expert in health care reform and the drivers of health care costs, with a special interest in market consolidation and state policies to address market power. She has helped draft model legislation, provided technical assistance to state legislative staff in multiple states, presented to various state agencies and officials, and testified as an expert witness at state legislative hearings, and informational sessions.

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Patrick Keenan, MS, develops data and analysis at the Pennsylvania Health Access Network (PHAN) to lower prices, improve affordability and access, and drive quality and equity in coverage and care for patients. Starting in 2013, he built PHAN's statewide consumer assistance program that has enrolled 38,000 individuals in coverage and resolves 10,000 issues each year. These patient interactions shape PHAN's policy agenda. Keenan leads coalition work on lowering prescription drug prices and on hospital reforms and has helped achieve victories on banning surprise medical bills and strengthening consumer protections. He serves on several state workgroups, testifies before state government, and is a trusted source for the media. Prior to joining PHAN, Keenan spent more than a decade developing and managing community based programs and interventions.

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Charles Miller, JD, works to improve the affordability and accessibility of health care in Texas as senior policy advisor for Texas 2036. In 2020, he led a team that developed the Health Coverage Policy Explorer, an interactive online tool that allowed policymakers and the public to explore the costs and effectiveness of policy scenarios to increase the number of insured Texans. Going into the 2025 Texas legislative session, Miller is working to understand who are the uninsured in Texas and the barriers they face to obtaining care, improving the options that employers and the state have in designing health benefit plans to maximize the affordability of quality care. During the past two legislative sessions, he worked on bills and efforts to improve health insurance markets, optimize price transparency, and improve the efficiency and value of the health care industry in Texas. Miller joined Texas 2036 after serving as a budget and policy advisor for Governor Greg Abbott, advising on issues including health care, insurance, workforce development, and others. He previously practiced insurance defense litigation.

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Barak Richman, JD, PhD, is the Katharine T. Bartlett Professor of Law and Business Administration at Duke University. As of July 2024, he will be the Alexander Hamilton Professor of Business Law at George Washington University. From 1994 to 1996 Richman handled international trade legislation as a staff member of the US Senate Committee on Finance, then chaired by Senator Daniel Patrick Moynihan. His primary research interests include the economics of contracting, new institutional economics, antitrust, and health care policy. Richman has testified before Congress regarding competition policy and hospital consolidation and coauthored the American Antitrust Institute's white papers on health care competition policy. He is a founding faculty member of Duke University's Margolis Center on Health Policy, a senior fellow at the Kenan Institute for Ethics, and a senior scholar at the Clinical Excellence Research Center at Stanford Medical School.

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Editor-in-Chief
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Alan Weil, JD, MPP, has held the position of editor-in-chief of Health Affairs, the nation's leading health policy journal, since 2014. Previously, he was executive director of the National Academy for State Health Policy (NASHP), director of the Urban Institute's Assessing the New Federalism project, and executive director of the Colorado Department of Health Care Policy and Financing. He is an elected member of the National Academy of Medicine and has been a member of the Medicaid and CHIP Payment and Access Commission (MACPAC), a trustee of the Consumer Health Foundation (now iF, A Foundation for Radical Possibility), a member of the Kaiser Commission on Medicaid & the Uninsured, a member of the Commonwealth Fund Commission on a High Performance Health System, and a member of the Institute of Medicine's Board on Health Care Services.

ZACHARY LEVINSON

Project Director
KFF

Zachary Levinson, PhD, MA, MPP, is the Project Director of the KFF Project on Hospital Costs, examining the business practices of hospitals and their impact on costs and affordability. Levinson has conducted research and analysis relating to the financial performance of hospitals and health systems, health care prices and reimbursement, hospital market consolidation, provider relief funding during the COVID-19 pandemic, and other topics that have bearing on access to affordable health care. His work has been published in Health Affairs, Health Services Research, JAMA, American Journal of Public Health, and Healthcare. Prior to joining KFF, Levinson was an associate economist at the RAND Corporation. He also worked at KFF earlier in his career as a policy analyst with the Program on Medicare Policy.

TRICIA NEUMAN

Senior Vice President; Executive Director, Program on Medicare Policy;
Senior Advisor to the President
KFF

Tricia Neuman, DSc, MS, is senior vice president at KFF and executive director of its Program on Medicare Policy, where she oversees policy analysis and research pertaining to Medicare and health coverage and care for aging Americans and people with disabilities. Her areas of interest include the health and economic security of older adults, the role of Medicare Advantage plans, Medicare and out-of-pocket spending trends, prescription drug costs, payment and delivery system reforms, and policy options to strengthen Medicare. Author of numerous papers related to Medicare, Neuman has presented expert testimony before congressional committees and independent commentary to national media outlets. Prior to joining KFF in 1995, Neuman served on the professional staff of the Ways and Means Subcommittee on Health in the US House of Representatives and on the staff of the US Senate Special Committee on Aging.

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KFF

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