

**Testimony of Erin C. Fuse Brown, J.D., M.P.H.**

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Subcommittee on Competition Policy, Antitrust, and Consumer Rights

Hearing on Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing  
Economic Resiliency

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Chair Klobuchar, Ranking Member Lee, and members of the subcommittee, thank you for inviting me to testify today. My name is Erin Fuse Brown. I am the Catherine C. Henson Professor of Law and Director of the Center for Law, Health & Society at Georgia State University College of Law. As of July 1, I will be joining the faculty of the Brown University School of Public Health as a Professor of Health Services, Policy, & Practice with the Center for Advancing Health Policy through Research. My research examines a range of topics of health law and policy, including health care competition, consolidation, and consumer protections.

My testimony<sup>1</sup> focuses on health care competition policy and how consolidation increases the vulnerability of the U.S. health care system. I commend this committee's interest in bolstering competition policy to protect the resilience of the health care system. I will make four main points:

- The U.S. health care system was built on a private market model that depends on fair competition and functioning markets to provide health care services. Yet, as health care markets become increasingly consolidated and uncompetitive, the system is increasingly vulnerable to market and systemic failures.
- The high levels of health care market consolidation are harmful to the public: They increase prices for health care items and services, reduce affordability, diminish employees' wages, and hamper health care access, quality, and equity.
- Health care consolidation also makes the health system more fragile. Large, consolidated health care conglomerates are becoming "too big to fail." Our dependence on health care monopolies without competitors or redundancies makes the health system vulnerable. When the health care system suffers a shock or an attack, the effects cost lives, livelihoods, and billions of dollars to the economy.
- There are several options both Congress and others in the federal government could consider to promote fair competition and resilience of the health care system.

### **The health care system relies on fair competition to discipline the affordability and supply of health care, but consolidation has rapidly reshaped health care markets.**

The U.S. health system was built on a private market model to provide health care items and services and fair competition to constrain prices, improve quality, drive innovation, and ensure patient access. Yet, the vast majority of health care market sectors—including hospitals, physicians, insurers, pharmacies, and the middlemen in between—have become highly concentrated. And consolidation of the health care market is the key driver of excess health spending in the U.S.

The high and rising cost of health care in the United States threatens the economic stability and well-being of households, businesses, employers, state and local governments, and communities. In 2022, the U.S. spent \$4.5 trillion on health care, which translates to \$13,493 per person, and 17.3% of Gross Domestic Product (GDP).<sup>2</sup> Health care spending exceeds that of nearly every other sector of the economy, including defense, transportation, education, or energy.

There are three main types of consolidation—horizontal, vertical, and cross-market—all of which have been increasing and have had documented anticompetitive effects on the health care market. In addition to consolidation among incumbent health care institutions, corporate investors such as private equity funds, retailers such as Amazon, and health insurance giants such as

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<sup>1</sup> My thanks to Jared Perkins, Assistant Director of Health Policy Strategy at the Center for Advancing Health Policy through Research at Brown University School of Public Health, Hayden Rooke-Ley, and Arlene Correa for their assistance in the preparation of this testimony.

<sup>2</sup> CMS. (n.d.). *NHE Fact Sheet*. Accessed May 29, 2024, from <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>

UnitedHealth, have contributed to rapid health care consolidation.

*Horizontal consolidation* refers to combinations among entities offering the same type of service in the same geographic region. This is consolidation among direct competitors. Historically, competition policy and enforcement have focused on horizontal mergers among hospitals or among insurers, yet both markets have become highly concentrated. In the 1990s, the FTC's attempts to block hospital mergers largely failed, allowing hospital market consolidation to go unchecked for nearly a decade.<sup>3</sup> Today, more than 90% of hospital markets are highly concentrated.<sup>4</sup> A single insurer commands more than 50% of the market in two-thirds of U.S. metro areas.<sup>5</sup> Private equity (PE) firms have aggressively entered the health care market, pursuing a serial acquisition strategy to “roll up” physician practices.<sup>6</sup> In some areas, a single PE firm controls in excess of 50% of the market for physician specialties.<sup>7</sup>

*Vertical consolidation.* Vertical consolidation refers to combinations among entities that offer different types of products or services in the production process, i.e., among entities that do not directly compete with one another. In health care, vertical consolidation includes hospital acquisitions of physician practices or insurance mergers with pharmacies, pharmacy benefit managers (PBMs), and providers. UnitedHealth Group's acquisition of Change Healthcare, the claims data and payment processing firm, was challenged (unsuccessfully) as a vertical merger.<sup>8</sup> As a result of vertical consolidation, more than three-quarters of physicians are employed by hospitals or other corporate entities, such as insurers or private equity groups.<sup>9</sup>

Increasingly, health care consolidation consists of non-horizontal transactions, to which antitrust enforcement policies are largely blind. Acquisitions of physician practices, for instance, are too small in dollar value to be reported under the Hart-Scott-Rodino (HSR) Act, with a threshold of \$119.5 million in 2024.<sup>10</sup> Current payment policies, such as the site-of-service payment differential under which Medicare and private insurers pay more for outpatient services in hospital-settings than in physician offices, further incentivize hospital-physician vertical consolidation.<sup>11</sup>

Another revenue strategy drives insurers' vertical acquisition of primary care providers. As Medicare moves toward total-cost value-based payments, such as capitation, and away from fee-for-

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<sup>3</sup> King JS, Chang SM, Montague AD, Gudiksen KL, Gu AY, Arnold D, Greaney TL. (2020). Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States. *The Source on Health Care Price and Competition*. <https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/>

<sup>4</sup> Fulton BD. (2017). Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Affairs (Project Hope)*, 36(9), 1530–1538. <https://doi.org/10.1377/hlthaff.2017.0556>

<sup>5</sup> Lubell J. (2024, January 10). 95% of U.S. health insurance markets are “highly concentrated.” *AMA*. Accessed April 18, 2024 from, <https://www.ama-assn.org/delivering-care/patient-support-advocacy/95-us-health-insurance-markets-are-highly-concentrated>

<sup>6</sup> Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum*. 2022;3(9):e222886. <https://doi.org/10.1001/jamahealthforum.2022.2886>

<sup>7</sup> Abdelhadi O, Fulton BD, Alexander L, Scheffler RM. (2024). Private Equity-Acquired Physician Practices And Market Penetration Increased Substantially, 2012-21. *Health Affairs (Project Hope)*, 43(3), 354–362. <https://doi.org/10.1377/hlthaff.2023.00152>

<sup>8</sup> United States v. UnitedHealth Grp. Inc., 630 F. Supp. 3d 118, 131 (D.D.C. 2022), dismissed, No. 22-5301, 2023 WL 2717667 (D.C. Cir. Mar. 27, 2023). <https://www.justice.gov/atr/case/us-et-al-v-unitedhealth-group-inc-and-change-healthcare-inc>

<sup>9</sup> Physicians Advocacy Institute. (Updated April 2024). *PAI-Avalere Report on Physician Employment Trends and Acquisitions of Medical Practices: 2019-2023*. <https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023>

<sup>10</sup> Capps C, Dranove D, Ody C. (2017). Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene. *Health Affairs* 36 (9): 1556–63. <https://doi.org/10.1377/hlthaff.2017.0054>

<sup>11</sup> Richards MR, Seward J, Whaley CM. (2020). Treatment consolidation after vertical integration | Evidence from outpatient procedure markets. *RAND*. [https://www.rand.org/pubs/working\\_papers/WRA621-1.html](https://www.rand.org/pubs/working_papers/WRA621-1.html)

service reimbursement, primary care practices hold the key to increased profitability. Insurers buy primary care practices with a sizable number of patients covered by Medicare Advantage, because the clinicians can increase the insurers' capitated payments for each patient's care by upcoding the patient's diagnoses for risk adjustment.<sup>12</sup> Insurers further increase revenues by steering the patients to the insurer's other products, such as their affiliated pharmacy. Primary care providers are attractive acquisition targets because they offer insurance companies access to patients and their data, both for risk-coding purposes and as potential customers for other lines of service.

*Cross-market consolidation* refers to mergers among entities in different geographic markets. The number of large health systems pursuing cross-market mergers has been increasing, leading to mega-systems that exert market power across multiple regions or states.<sup>13</sup> A prominent example is Ascension, a massive Catholic health system encompassing 140 hospitals across 19 states and the District of Columbia.<sup>14</sup> Antitrust enforcement policy has historically treated cross-market mergers as unthreatening to competition because the merging entities do not compete in the same geographic markets.<sup>15</sup> As a result, cross-market mergers have increased unabated and enforcers have been reluctant to bring challenges. An opening was created, however, by the DOJ/FTC 2023 Merger Guidelines, which contain additional tools that enforcers may use against multi-market contracts and tying behavior at issue in cross-market mergers.<sup>16</sup>

### **Health care consolidation harms patients, purchasers, employers, and their communities without yielding meaningful benefits.**

Consolidation in any industry is worrisome as it can diminish competition. With less competition, health care prices rise, affordability and access decline, and quality stagnates. The weight of the empirical literature shows horizontal hospital consolidation substantially increases hospital prices from 20–40%, depending on the degree of concentration and market power.<sup>17,18,19</sup> Economic evidence suggests that cross-market hospital mergers can increase hospital prices by an estimated 6–16%.<sup>20,21,22</sup> Estimates of the price increases from vertical hospital-physician consolidation range from

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<sup>12</sup> Shah S, Rooke-Ley H, Fuse Brown EC. (2023). Corporate Investors in Primary Care—Profits, Progress, and Pitfalls. *New England Journal of Medicine*. 2023;388:99-101. <https://doi.org/10.1056/NEJMp2212841>

<sup>13</sup> Fulton BD, Arnold DR, King JS, Montague AD, Greaney TL, Scheffler RM. The Rise Of Cross-Market Hospital Systems And Their Market Power In The US: Study examines the increase in cross-market hospital systems and their market power in the US. *Health Affairs* 41, no. 11 (2022): 1652-1660. <https://doi.org/10.1377/hlthaff.2022.00337>

<sup>14</sup> Ascension. (n.d.). *About Us*. <https://about.ascension.org/about-us>

<sup>15</sup> King JS, Montague AD, Arnold DR, Greaney TL. Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power. *Hastings LJ* 74 (2022): 1057. <https://www.hastingslawjournal.org/wp-content/uploads/2-King-final.pdf>

<sup>16</sup> Gudiksen KL, King JS. (2024). The Final 2023 Merger Guidelines: Will Small Changes From The Draft Version Make A Difference?. *Health Affairs Forefront*. <https://www.healthaffairs.org/content/forefront/final-2023-merger-guidelines-small-changes-draft-version-make-difference>

<sup>17</sup> Dafny L. (2009). Estimation and Identification of Merger Effects: An Application to Hospital Mergers. *The Journal of Law & Economics*. <https://doi.org/10.1086/600079>

<sup>18</sup> Haas-Wilson D, Garmon C. (2011). Hospital Mergers and Competitive Effects: Two Retrospective Analyses. *International Journal of the Economics of Business*, 18(1), 17–32. <https://doi.org/10.1080/13571516.2011.542952>

<sup>19</sup> Gaynor M, Town R. (2012). Competition in Health Care Markets. *The Center for Market and Public Organisation*. <https://www.bristol.ac.uk/media-library/sites/cmpo/migrated/documents/wp282.pdf>

<sup>20</sup> Lewis MS, Plüm KE. (2017). Hospital systems and bargaining power: evidence from out-of-market acquisitions. *The RAND Journal of Economics*, 48: 579-610. <https://doi.org/10.1111/1756-2171.12186>

<sup>21</sup> Dafny L, Ho K, Lee, RS. (2019). The price effects of cross-market mergers: theory and evidence from the hospital industry. *The RAND Journal of Economics*, 50: 286-325. <https://doi.org/10.1111/1756-2171.12270>

<sup>22</sup> Arnold DR, King JS, Fulton BF, Montague AD, Gudiksen KL, Greaney TL, Scheffler RM. (2024). New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality. *Health Services Research*. DOI: <https://doi.org/10.1111/1475-6773.14291>

14–33.5%, depending on the market concentration and specialty.<sup>23,24</sup> Vertical consolidation also increases health spending through the exploitation of the site-of-service payment differential and the ability to steer referrals to affiliated, higher cost options.

The high costs of consolidation have largely come without gains in health care quality. There is little evidence that consolidation improves the quality of patient care, which is often touted as a justification for integration. The quality of care provided in noncompetitive markets is no better, and may be worse, than in competitive markets.<sup>25,26</sup> For instance, hospital-physician vertical consolidation may reduce clinicians’ incentives to compete on quality, leading to worse medication adherence and health outcomes for older patients and those from racial or ethnic minorities.<sup>27</sup>

The economic impact of health care consolidation is extensive—depressing wages, inhibiting job creation, and stifling economic development. The higher provider prices from consolidation fuel higher insurance premiums and out-of-pocket costs, which are taken from workers’ wages. Researchers have found that hospital mergers are associated with a \$521 increase in prices, \$579 increase in spending among the privately insured, and a \$638 reduction in wages.<sup>28</sup> High health care costs are one of the largest expenses for a business and can dampen profitability and the ability to recruit or retain employees.<sup>29,30</sup> Health care is consuming a greater share of the resources of households, businesses, and governments—resources that cannot be invested in other pursuits.

## Loss of competition threatens the resilience of the health care system

Health care consolidation threatens the stability and sustainability of the health care system. Our dependence on large health care conglomerates without meaningful competition or redundancies makes the health system vulnerable to systemic shocks, failures, and loss of essential community health care providers. Three examples from the headlines provide stark illustration.

### Example 1: Cyberattack of UnitedHealth Group and Change Healthcare

On February 21, 2024, the U.S. health system was struck by a cyberattack on Change Healthcare, the payment processing arm of UnitedHealth Group (United). The attack was perpetrated by AlphV, the same group that engineered the ransomware attack on the Colonial gas pipeline in 2021.<sup>31</sup> The Change cyberattack paralyzed the health system, halting payments, prior authorizations, and pharmacy orders, and created a cash-flow crisis for health care providers across the country. Pharmacies were unable to fill prescriptions, physician practices and clinics canceled appointments

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<sup>23</sup> Capps C, Dranove D, Ody C. (2018). The effect of hospital acquisitions of physician practices on prices and spending. *Journal of health economics*, 59, 139–152. <https://doi.org/10.1016/j.jhealeco.2018.04.001>

<sup>24</sup> Carlin CS, Feldman R, Dowd B. (2017). The impact of provider consolidation on physician prices. *Health economics*, 26(12), 1789–1806. <https://doi.org/10.1002/hec.3502>

<sup>25</sup> Liu JL, Levinson ZM, Zhou A, Zhao X, Nguyen PG, Qureshi N. (2022). Environmental Scan on Consolidation Trends and Impacts in Health Care Markets. *RAND Corporation*. [https://www.rand.org/pubs/research\\_reports/RRA1820-1.html](https://www.rand.org/pubs/research_reports/RRA1820-1.html)

<sup>26</sup> Beaulieu ND, Chernew ME, McWilliams JM, et al. (2023). Organization and Performance of US Health Systems. *JAMA* 329(4): 325–35. <https://doi.org/10.1001/jama.2022.24032>

<sup>27</sup> Levin JS, Komanduri S, Whaley C. Association between hospital-physician vertical integration and medication adherence rates. *Health Serv Res*. 2023; 58(2): 356-364. <https://doi.org/10.1111/1475-6773.14090>

<sup>28</sup> Arnold D, Whaley CM. (2020). Who Pays for Health Care Costs?: The Effects of Health Care Prices on Wages. *RAND Corporation*. [https://www.rand.org/pubs/working\\_papers/WRA621-2.html](https://www.rand.org/pubs/working_papers/WRA621-2.html).

<sup>29</sup> Gupta A, Kapur A, Machado-Pereira M, Singhal S. (2022, October 20). US inflationary pressures could significantly raise annual employer healthcare costs and impact vulnerable household finances. *McKinsey & Company*. <https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-threat-to-employee-healthcare-benefits>

<sup>30</sup> Hughes S, Gee E, Rapfogel N. (2022, November 29). Health Insurance Costs are Squeezing Workers and Employers. *CAP* 20. <https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/>

<sup>31</sup> Goldsmith JC. (2024, March 15). Will the Change Healthcare Incident Change Health Care?. *Health Affairs Forefront*. <https://doi.org/10.1377/forefront.20240314.298538>

and procedures as the cyberattack wore on for weeks.

United is the largest health care company in the country: it owns the largest insurance company, the largest employer of physicians (Optum), the third-largest PBM (Optum Rx), and its own specialty and mail-order pharmacies. Acquired by United in 2022 for \$13 billion, Change Healthcare operates the country's largest claims data clearinghouse, processing 15 billion claims totaling more than \$1.5 trillion per year.<sup>32</sup> Change processes half of all health care transactions, including claims between insurers and providers outside of United, so a ransomware attack on Change dealt a crippling blow to the entire health system.

The U.S. Department of Justice (DOJ) unsuccessfully sued to block United's acquisition of Change. The court was unconvinced by the concern that the nation's largest health insurer would now control more than half of all the claims data and payment processing in the country. Focusing on a narrow antitrust inquiry of whether the acquisition would substantially lessen competition in particular markets, Judge Nichols was persuaded by United's assertions that it would implement firewalls to prevent it from accessing competitor data for anticompetitive advantage, despite prior experience to the contrary.<sup>33</sup> Yet the 2024 cyberattack showed that United and Change's combined size, power, and embedded role throughout the health system pose both a competitive and existential risk to the U.S. health care system.

The fallout from the Change cyberattack continues to ripple onward. Providers have not been made whole for the backlog of frozen payments, and United's short-term loans and offers to acquire financially distressed practices have been criticized as inadequate and opportunistic. Untold numbers of patients missed prescriptions, diagnostic tests, or necessary treatments due to the disruptions from the cyberattack.<sup>34</sup> And one report estimates that 85 million patients' personal health information and medical records were compromised, stolen, or destroyed in the breach.<sup>36</sup>

United was not the only major health care corporation to come under cyberattack this year. On May 9, Ascension, the third-largest health system in the country, suffered a cyberattack from a group called Black Basta.<sup>35</sup> Although Ascension has not said how many facilities were involved, the attack affected the company's electronic health records system, patient access portal, and systems to order procedures, tests, and medications.<sup>36</sup> Affected hospitals had to divert ambulances, cancel procedures, and enter orders by hand—resulting in delays and reduced safety measures.<sup>40</sup>

One takeaway from the UnitedHealth and Ascension cyberattacks is that large, interconnected health care conglomerates are enticing targets, and their scale and scope make the entire health system vulnerable.<sup>37</sup> The volume and sophistication of ransomware attacks have increased and disrupted patient care beyond the target entity.<sup>38</sup> Entire regional or national health systems can be brought down by targeting one node of a large company, akin to shutting down a regional power grid, a major oil

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<sup>32</sup> Gilbert D, Diamond D, Rowland C, Bellware K. (2024, March 3). Health-care hack spreads pain across hospitals and doctors nationwide. *The Washington Post*. <https://www.washingtonpost.com/business/2024/03/03/change-health-care-hack-hospitals/>

<sup>33</sup> Podkul C. (2022, November 16). What Will UnitedHealth's New Trove of Claims Data Mean for Consumers?. *ProPublica*. <https://www.propublica.org/article/united-healthcare-change-acquisition-claims-records>

<sup>34</sup> Abelson R. (2024, February 26). A Cyberattack on a UnitedHealth Unit Disrupts Prescription Drug Orders. *The New York Times*. <https://www.nytimes.com/2024/02/26/health/cyberattack-prescriptions-united-healthcare.html>

<sup>35</sup> Abelson R. (2024, May 23). Fallout From Cyberattack at Ascension Hospitals Persists, Causing Delays in Patient Care. *The New York Times*. <https://www.nytimes.com/2024/05/23/health/cyberattack-ascension-hospitals-patient-data.html>

<sup>36</sup> Ascension. (2024). Cybersecurity Event Update. Accessed May 29, 2024 from <https://about.ascension.org/cybersecurity-event>

<sup>37</sup> Kayyem J. (2024, March 6). The U.S. Health System's Single Point of Failure. *The Atlantic*. <https://www.theatlantic.com/ideas/archive/2024/03/change-healthcare-alfhv-blackcat-hackers/677650/>

<sup>38</sup> Abouk R, Powell D. Ransomware Attacks, ED Visits and Inpatient Admissions in Targeted and Nearby Hospitals. *JAMA*. Published online May 29, 2024. <https://doi.org/10.1001/jama.2024.7752>

pipeline, or air transportation data system. Ransomware attackers know that the restoration of critical infrastructure will command a large payout.<sup>39</sup> A cyberattack is but one of the systemic shocks facing the nation’s health care infrastructure—supply chain disruptions, pandemics, severe weather events, and critical worker shortages pose additional threats. During the COVID-19 pandemic, financial and operational strain on hospitals led to excess patient deaths and harm.<sup>40</sup> Allowing interconnected health systems to become too big to fail creates a substantial vulnerability when these entities face systemic shocks.

Although my testimony is focused on consolidation among health care providers and payers, a similar dynamic has threatened the pharmaceutical supply chain. For instance, the FTC and HHS issued a request for information in February regarding how consolidation and anticompetitive conduct among drug purchasing organizations and wholesalers contribute to shortages of generic drugs.<sup>41</sup> Market concentration among the global manufacturers of active pharmaceutical ingredients (APIs), which are critical to producing generic drugs, make the pharmaceutical supply chain vulnerable to price spikes, shortages, and market failure.<sup>42</sup> Without domestic producers or adequate competition, global disruptions from the COVID-19 pandemic or Hurricane Maria’s damage to health care manufacturing producers in Puerto Rico, triggered nationwide shortages of APIs, IV bags, and other critical health care items and equipment.<sup>43</sup>

The lesson is that loss of competition and redundancy—the transmission of key data, funds, or supplies through a single or small number of pipes—makes the U.S. health system and the health of all Americans vulnerable when a critical pipeline fails.

## **Example 2: Vertically consolidated insurance entities can steer patients to their own subsidiaries and drive out independent physicians and pharmacies**

Beyond cybersecurity threats, vertically consolidated insurance companies can engage in a range of anticompetitive tactics that harm patients. Like United, pharmacy giant CVS and its insurance company Aetna, operate the largest PBM (Caremark), and have spent billions acquiring primary care and in-home care providers. Other major insurers, Cigna and Humana, have pursued similar vertical consolidation strategies. Thus, it is increasingly likely that a patient’s insurance plan, primary care physician, pharmacy, and PBM will be part of the same health care conglomerate.

While such consolidation can promise care coordination and convenience, it can also enable the entity to anticompetitively steer patients to their own subsidiaries, driving independent practices and pharmacies out of the market. For example, more than one lawsuit has alleged that UnitedHealth cut reimbursements or terminated contracts with independent physician practices to shift patients to

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<sup>39</sup> Noah Barsky, UnitedHealth Paid Hackers \$22 Million, Fixes Will Soon Cost Billions, *Forbes*, Apr. 30, 2024, <https://www.forbes.com/sites/noahbarsky/2024/04/30/unitedhealths-16-billion-tally-grossly-understates-cyberattack-cost/?sh=6d9994ec5aab>.

<sup>40</sup> French, G., Hulse, M., Nguyen, D., Sobotka, K., Webster, K., Corman, J., Aboagye-Nyame, B., Dion, M., Johnson, M., Zalinger, B. and Ewing, M. (2022), Impact of hospital strain on excess deaths during the COVID-19 pandemic—United States, July 2020–July 2021. *Am J Transplant*, 22: 654–657. <https://doi.org/10.1111/ajt.16645>

<sup>41</sup> FTC. (2024, February 14). *FTC, HHS Seek Public Comment on Generic Drug Shortages and Competition Amongst Powerful Middlemen*. <https://www.ftc.gov/news-events/news/press-releases/2024/02/ftc-hhs-seek-public-comment-generic-drug-shortages-competition-amongst-powerful-middlemen>

<sup>42</sup> Socal MP, Ahn K, Greene JA, Anderson GF. Competition And Vulnerabilities In The Global Supply Chain For US Generic Active Pharmaceutical Ingredients: Study examines the competition and vulnerabilities in the global supply chain for US generic active pharmaceutical ingredients. *Health Affairs* 42, no. 3 (2023): 407-415. <https://doi.org/10.1377/hlthaff.2022.01120>

<sup>43</sup> Ecker J. (2018, February 20). How Neglect of Puerto Rico Sparked a National IV Bag Shortage. *The American Prospect*. <https://prospect.org/environment/neglect-puerto-rico-sparked-national-iv-bag-shortage/>

affiliated Optum practices and pressure the independent practice to sell to Optum.<sup>44</sup> If the physicians refuse, UnitedHealth can make it difficult for patients to follow their doctor.<sup>45,46</sup> Insurers that own PBMs use similar strategies to cut payments to local pharmacies and steer patients to their own mail-order and chain pharmacies.<sup>47</sup> Rural communities have borne the brunt of the loss of independent pharmacies, decreasing access to in-person pharmacy services and medications.<sup>48,49</sup> These tactics drive out local independent pharmacies and practices, diminish patient access and choice of providers, and disrupt longstanding care relationships.

### **Example 3: Steward Health Care and the Pitfalls of Private Equity Investment**

Private equity acquisitions of hospitals and nursing homes leaves facilities financially gutted. PE firms that acquire health care facilities typically profit from selling the entities' building to a real estate investment trust (REIT), leasing the property back to the health care entity, and cutting costs through staff reductions.<sup>50</sup> These sale-leasebacks generate transaction fees for the PE fund, transfer the entity's most valuable assets to the REIT, and place the entity in a financially precarious position of owing escalating lease payments to service the debt placed on them by the PE firm.<sup>51</sup>

The PE playbook of consolidation and asset-stripping is exemplified by the crisis facing Steward Health Care, the for-profit 33-hospital system, which filed for bankruptcy on May 9, 2024. Steward began in 2010, when PE firm Cerebus Capital acquired 9 community hospitals in Massachusetts. Within a few years, Steward closed one hospital and sold the hospital properties to a REIT, loading the hospitals with debt and escalating lease payments on assets the hospitals previously owned. The proceeds funded Steward's acquisition of 36 more hospitals across 10 states. In 2020, Cerebus exited Steward, having made \$800 million in profits and leaving the health system in financial ruin. Steward cut staff and supplies, fell behind in rent, and threatened to close hospitals before declaring bankruptcy. The 8 Massachusetts hospitals serve a disproportionate share of low-income and vulnerable patients, and closure would be catastrophic for their communities.

Unfortunately, Steward is not unique. Other examples of PE-driven sale-leasebacks include HCR Manorcare (owned by PE firm Carlyle Partners) a large nursing home chain that filed for bankruptcy in 2018,<sup>52</sup> as well as Prospect Medical Holdings, in which PE-firm Leonard Green used

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<sup>44</sup> Rooke-Ley H. (2024, April 30). Medicare Advantage and Vertical Consolidation in Health Care. *American Economic Liberties Project*. <https://www.economicliberties.us/our-work/medicare-advantage-and-vertical-consolidation-in-health-care/>

<sup>45</sup> Complaint. *Emanate Health v. Optum Health*. 2023 (<https://www.documentcloud.org/documents/24174225-govuscourtscacd90626710>)

<sup>46</sup> Galewitz P. (2020, February 23). An insurance titan is dropping hundreds of N.J. physicians to enrich itself, doctors and patients charge. *NJ.COM*. <https://www.nj.com/healthfit/2020/02/an-insurance-titan-is-dropping-hundreds-of-nj-physicians-to-enrich-itself-doctors-and-patients-charge.html>

<sup>47</sup> CMS. (2023, December 14). *CMS Letter to Plans and Pharmacy Benefit Managers*. <https://www.cms.gov/newsroom/fact-sheets/cms-letter-plans-and-pharmacy-benefit-managers>

<sup>48</sup> Hawryluk M. (2021, November 15). How Rural Communities Are Losing Their Pharmacies. *KFF Health News*. <https://kffhealthnews.org/news/article/last-drugstore-how-rural-communities-lose-independent-pharmacies/>

<sup>49</sup> Elliot E. (2023, June 30). Why Independent Pharmacies Remain a Pillar for Access, Community Health. *Pharmacy Times*. <https://www.pharmacytimes.com/view/why-independent-pharmacies-remain-a-pillar-for-access-community-health>

<sup>50</sup> Bruch JD, Katz T, Ramesh T, Appelbaum E, Batt R, Tsai TC. Trends in Real Estate Investment Trust Ownership of US Health Care Properties. *JAMA Health Forum*. 2022;3(5):e221012. Published 2022 May 13. <https://doi.org/10.1001/jamahealthforum.2022.1012>

<sup>51</sup> Batt R, Applebaum E, Katz T. The Role of Public REITs in Financialization and Industry Restructuring (Institute for New Economic Thinking Working Paper No 189). Published online July 9, 2022. <https://doi.org/10.36687/inetwp189>

<sup>52</sup> Whoriskey P, Keating D. (2018, November 25). Overdoses, bedsores, broken bones: What happened when a private-equity firm sought to care for society's most vulnerable. *The Washington Post*. [https://www.washingtonpost.com/business/economy/opioid-overdoses-bedsores-and-broken-bones-what-happened-when-a-private-equity-firm-sought-profits-in-caring-for-societys-most-vulnerable/2018/11/25/09089a4a-ed14-11e8-baac-2a674e91502b\\_story.html](https://www.washingtonpost.com/business/economy/opioid-overdoses-bedsores-and-broken-bones-what-happened-when-a-private-equity-firm-sought-profits-in-caring-for-societys-most-vulnerable/2018/11/25/09089a4a-ed14-11e8-baac-2a674e91502b_story.html)



the sale-leaseback strategy on acquired hospitals in Rhode Island, Connecticut, Pennsylvania, and California.<sup>53</sup> In each instance, the PE firm earned substantial profits, sold off the assets, and exited the investment, leaving the health care entity in financial distress, thereby threatening patient access in the communities they serve.<sup>54</sup> The PE sale-leaseback model illustrates how consolidation of health facilities increases vulnerability to loss of essential health care facilities.

## Options to improve fair health care competition and health system resilience

There are several options Congress and the federal government could consider to protect fair competition and health system resilience.

### 1. Strengthen Antitrust Oversight of Health Care Consolidation

The first option is to enhance FTC and DOJ's authority under the antitrust laws to provide stronger oversight of harmful health care consolidation. Several of these provisions are reflected in S.4308.

- **Increase funding for antitrust agency enforcement.** Funding for antitrust enforcement has not kept pace with the increasing scope of health care merger activity. The result is that anticompetitive mergers and acquisitions go unchallenged. Each enforcement action is hugely resource-intensive, so despite recent increases in funding for antitrust agencies, more resources are needed to provide appropriate oversight of ongoing health care consolidation.
- **Amend the standard to make it easier to block anticompetitive mergers under Section 7 of the Clayton Act.** Replace the current standard, which prohibits mergers whose effects “may be substantially to lessen competition,” with a standard where mergers may be blocked if they “create an appreciable risk of materially lessening competition.”
- **Remove current limits on FTC's antitrust oversight authority over nonprofits and insurers.** Existing law limits the FTC's authority to oversee the full range of health care consolidation, including the exemption of nonprofits from FTC jurisdiction and the inability to study insurers under §6(b) of the Federal Trade Commission Act.
- **Increase antitrust scrutiny of serial transactions, vertical, and cross-market consolidation.** Many health care acquisitions fall below the HSR reporting thresholds, and thus go unreviewed. Reforming the HSR reporting threshold to capture more of these transactions would provide more visibility to enforcement authorities. This could be done by lowering the HSR reporting threshold for health care transactions or combining the value of serial transactions to trigger reporting. Despite mounting evidence of their anticompetitive impacts, challenging non-horizontal mergers is more difficult than horizontal mergers because of the dearth of precedent. The FTC should use its authority under the Merger Retrospective Program to study vertical and cross-market mergers and develop economic models and legal strategies to challenge these mergers moving forward.
- **Heighten review for transactions involving entities that are systemically critical.** Antitrust review of mergers involving entities that are “too big to fail”—that is, critical to the functioning of the health care system—should be subject to stricter standards. If they are allowed to proceed, transactions involving systemically critical entities should be subject to

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<sup>53</sup> Elkind P, Burke D. (2020, September 30). Investors Extracted \$400 Million From a Hospital Chain That Sometimes Couldn't Pay for Medical Supplies or Gas for Ambulances. *ProPublica*. <https://www.propublica.org/article/investors-extracted-400-million-from-a-hospital-chain-that-sometimes-couldnt-pay-for-medical-supplies-or-gas-for-ambulances>

<sup>54</sup> Ballou B. (2023, April 28). Private Equity Is Gutting America — and Getting Away With It. *The New York Times*. <https://www.nytimes.com/2023/04/28/opinion/private-equity.html>

heightened conditions for government oversight, cybersecurity, emergency planning, and other safeguards to protect the resilience of critical infrastructure.<sup>55</sup>

## 2. Consider a Glass-Steagall for Health Care

Despite the risks that vertical health care consolidation poses to competition, antitrust enforcers have struggled to prove this to courts, as illustrated by the DOJ's failed challenge to United's acquisition of Change. To address systemic risk posed by vertical health care consolidation, Congress could prohibit payer-provider integration—a Glass-Steagall for health care.<sup>47</sup> The Glass-Steagall Act, passed in 1933 during the Great Depression but repealed in the 1990s, prohibited banks from operating both commercial and investment banks because it was thought to pose a systemic risk. A Glass-Steagall for health care would create a structural bar against vertical consolidation of insurers and providers, recognizing the inherent conflict and risk from controlling both sides of this relationship. It would ban insurers and PBMs from owning pharmacies, including mail-order and specialty pharmacies, and ban insurers from owning medical providers.

## 3. Improve price and ownership transparency

To address the problem of PBM patient-steering and preferential payment to related pharmacies, one option is to require transparency of PBM reimbursement rates for related vs. independent pharmacies, member cost-sharing, formulary design, or marketing incentives to steer patients to their own subsidiaries. Congress could call on the FTC or others to study the effects of vertical consolidation and anticompetitive conduct in the pharmaceutical supply chain.

Policymakers, researchers, and the public currently lack comprehensive data on who owns or controls health care entities and physician practices, which are often organized through complex corporate structures that obscure the identity of the owner or control entity and prevent accountability.<sup>56</sup> Providing a centralized national database to enhance transparency of provider ownership and control will enable better understanding of the extent and effects of vertical consolidation in health care, including changes in prices, utilization, and quality of care. While steps have been taken to improve ownership transparency in nursing homes, significant gaps remain for much of the health care system and supply chain, hindering effective oversight and accountability.

## 4. Close payment loopholes that encourage vertical consolidation

- **Expand site-neutral payment policy.** To blunt incentives for and cost-increases from vertical consolidation, policymakers could expand site-neutral payment policy within and beyond Medicare to commercial insurance markets to require the same payment for the same outpatient service, regardless of where it is provided.<sup>57</sup>
- **Reduce Medicare Advantage overpayments.** Medicare Advantage's (MA) risk-adjusted payment policy allows insurers to use vertical consolidation to increase capitated payments. By acquiring physicians and their patient data, insurers can maximize diagnosis coding to inflate risk-adjusted MA payments. United's acquisition of Change supercharged these efforts, giving United and its subsidiaries access to diagnosis codes, claims histories, and other information for tens of millions of patients. In MA, inappropriate risk adjustment accounts

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<sup>55</sup> Grotto E. (2024, March 29). Joshua Corman unpacks the consequences of the Change Healthcare cyberattack on an HFMA podcast episode. *Healthcare Financial Management Association*. <https://www.hfma.org/technology/cybersecurity/joshua-corman-unpacks-the-consequences-of-the-change-healthcare-cyberattack-on-an-hfma-podcast-episode/>

<sup>56</sup> Singh Y, Fuse Brown EC. (2022, September 23). The Missing Piece In Health Care Transparency: Ownership Transparency. *Health Affairs Forefront*. <https://doi.org/10.1377/forefront.20230921.886842>

<sup>57</sup> Adler L, Fiedler M, Ippolito B. (Updated 2023, May 25). Assessing recent health care proposals from the House Committee on Energy and Commerce. *Brookings*. <https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/>

for \$54 billion in overpayments per year, relative to traditional Medicare.<sup>58</sup> Although CMS has taken steps to target inappropriate coding and risk adjustment in MA, more forceful congressional action is needed to adjust MA payment policy to curb the overpayments that are fueling insurer acquisitions of primary care providers.<sup>59</sup>

- **Limit intercompany transfers.** Insurance companies also use vertical consolidation to evade medical loss ratio (MLR) rules, which are intended to cap insurers' profits and administrative costs and ensure that at least 85% of premium revenue is spent on patient care. But vertical consolidation allows insurers to evade MLR caps by moving profits to the provider side of the ratio through "intercompany transfers"—paying its own subsidiary pharmacies, PBM, or providers above-market prices and booking them as medical costs.<sup>60</sup> UnitedHealth reportedly pays a quarter of its premium revenue to itself in intercompany transfers.<sup>61</sup> To limit MLR gaming, Congress could require disclosure of transfer prices and establish benchmarks to ensure that conglomerates are paying market rates to subsidiary companies and not discriminating against independent providers.

## 5. Protect and invest in independent practices, pharmacies, and critical health care suppliers to promote competition and resilience

In an already-consolidated market, it is not enough to prevent further market concentration. Policies should also invest in independent health care providers, pharmacies, and additional producers of APIs and critical supplies to encourage market entry, promote competition, and preserve access to key health care items and services. Investment could include additional sources of capital, enhanced Medicare and Medicaid payments to primary care providers, and greater resources for rural clinics, Federally Qualified Health Centers, and student loan incentives for clinicians who work in rural or health professional shortage areas. These affirmative investments in competition could support communities and a resilient health care system.

It is critical for policymakers, businesses, and the public to grasp the urgency and magnitude of the threat that health care consolidation poses, not just to health care affordability and access, but to the very existence and long-term stability of the health care system.

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<sup>58</sup> Medicare Payment Advisory Commission. January 2024 Status Report, January 12, 2024 (<https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>)

<sup>59</sup> Fuse Brown EC, Williams TC, Murray RC, Meyers DJ, Ryan AM. Legislative and regulatory options for improving Medicare Advantage. *Journal of Health Politics, Policy and Law* 48, no. 6 (2023): 919-950. <https://doi.org/10.1215/03616878-10852628>

<sup>60</sup> Frank RG, Milhaupt C. (2023, March 24). Medicare Advantage spending, medical loss ratios, and related businesses: An initial investigation. *Brookings*. <https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/>

<sup>61</sup> Editorial Board. (2023, November 24). Elizabeth Warren Has an ObamaCare Epiphany. *The Wall Street Journal*. <https://www.wsj.com/articles/obamacare-medical-loss-ratio-elizabeth-warren-mike-braun-letter-healthcare-pbm-af77e284>