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TESTIMONY

ADDRESSING ANTICOMPETITIVE CONDUCT AND CONSOLIDATION IN HEALTHCARE MARKETS: THE ROLES OF STATE AND FEDERAL REGULATION AND ANTITRUST LAW

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Antitrust Applied: Hospital Consolidation Concerns and Solutions

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Chair Klobuchar, Ranking Member Lee, and distinguished members of the Subcommittee on Competition Policy, Antitrust, and Consumer Rights.

We welcome the opportunity to submit a statement for the record that highlights key considerations in addressing anticompetitive conduct and consolidation in healthcare markets.[1]

In this statement for the record, we will focus on three key points:

1. Consolidation in past decades has been a function of various state and federal regulations.
2. The Federal Trade Commission (FTC) has a long and successful track record of challenging anticompetitive mergers under current statutes and guidelines, but it is unable to prosecute all anticompetitive conduct in the healthcare sector owing to statutory restrictions on the FTC regarding nonprofit hospitals.
3. Legal reforms unrelated to antitrust are key to substantially improving healthcare competition.

CONSOLIDATION IN PAST DECADES HAS BEEN A FUNCTION OF VARIOUS STATE AND FEDERAL REGULATIONS

For the better part of the past three decades there has been a trend toward concentration in healthcare markets, especially hospital markets. In 1990, 65 percent of metropolitan areas had highly concentrated

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The ideas presented in this document do not represent official positions of the Mercatus Center or George Mason University.

hospital markets, and this number jumped to 77 percent in 2006.[2] Since the passage of the Affordable Care Act (ACA), there has been a significant increase in the pace of consolidation. As of 2019, 90 percent of all metropolitan area hospital markets were highly concentrated.[3] When an industry is highly concentrated, it means there is enhanced market power for the dominant firms.

In the years leading up to the ACA's passage, approximately 50–60 hospital mergers were consummated per year.[4] After the ACA was passed, there was a rapid spike in mergers, from 76 in 2010 to a high of 115 in 2017.[5] This consolidation occurred amid no significant entry of new hospitals. In the mid-1990s there were approximately 5,000 hospitals in the United States, and by 2012 that number had been reduced to just greater than 2,200.[6]

This concentration alone is not necessarily concerning, but when viewed through the lens of a market concentration index, which measures the degree of concentration within a business sector in a defined geographical area, concern becomes more warranted. The Herfindal-Hirshman Index (HHI) is a measure of the concentration within a market. A number less than 1,500 indicates a sector that is unconcentrated; a number between 1,500 and 2,500 indicates a sector that is moderately concentrated; and a number greater than 2,500 indicates a sector that is highly concentrated.[7] The average HHI in relevant hospital markets in the United States rose from 2,054 in 2000 to 2,676 in 2017, an increase of 622.[8]

This increase in concentration has been associated with higher prices. Between 2007 and 2011 the price of care for those with private insurance rose by 6 percent when merging hospitals were geographically close.[9] Between 2013 and 2016 the proportion of price increases associated with concentration jumped to 9 percent in California.[10] Merging hospitals that were geographically distant—i.e., not within the same market—did not increase prices. The attorney general of Massachusetts has found similar, geographically dependent results,[11] and other studies have reported even larger price increases of 14 percent.[12]

The ACA's role in these increases in price and consolidation is causal, mediated by ACA-generated federal subsidies. Much of hospitals' expenses are fixed. Regardless of how many patients a hospital sees, it must procure and maintain infrastructure to care for them.[13] Public spending under Medicare and Medicaid favors the generalized care that is available at larger hospital centers. Reimbursement for

2. Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs* 36, no. 9 (2017): 1530.
3. Fulton, "Health Care Market Concentration."
4. American Hospital Association, *Trendwatch Chartbook 2016*, 2016, 27, chart 2.9; Lawrence E. Singer, "Considering the ACA's Impact on Hospital and Physician Consolidation," *Journal of Law, Medicine, and Ethics* 46, no. 4 (2018): 913.
5. Singer, "Considering the ACA's Impact," 914.
6. Christopher M. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation" (Backgrounder No. 2928, Heritage Foundation, Washington, DC, August 1, 2014), 3.
7. US Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, August 2010.
8. Lijia Zheng, "The Pace, Driving Force, and Impact of Hospital Mergers After ACA," in *2020 4th International Conference on Economics, Management Engineering and Education Technology*, ed. Suling Wang (Beijing, China: Francis Academic Press, 2020).
9. Dalia Sofer, "The Cult of the Colossus: A Dramatic Rise in Hospital Mergers and Acquisitions," *American Journal of Nursing* 120, no. 5 (2020): 19–20.
10. Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices," *Health Affairs* 37, no. 9 (2018): 1414.
11. Office of the Attorney General of the Commonwealth of Massachusetts, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17*, October 2019.
12. Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (2018): 139–52.
13. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation," 9.

many procedures is higher at these large hospital centers than at smaller providers.[14] In states where Medicaid expanded, there was an increase in operating margin of large hospital systems.[15]

This increase in operating margin and increase in subsidies for large hospital systems causes consolidation. Smaller providers not affiliated with hospital systems are reimbursed at a lower rate for the same services, causing their operating margin to be smaller. Even though these smaller providers treat fewer patients, their fixed costs per patient are similar.[16] For smaller providers, integrating with a large hospital system can immediately increase their profitability and operating margin without changing their quality of care.

Finally, implementation of the Accountable Care Organization (ACO) standard has created an incentive to consolidate. The ACO system, whose formation was encouraged by the ACA, is seen as a one-stop shop for all patient healthcare needs.[17] This packaging of services for Medicare enrollees allows hospitals to be reimbursed for a wide array of services, regardless of which services are provided to patients.[18] If a patient requires less care than the ACO standard dictates, then the hospital can pocket some of the leftover funds. However, when a patient is incredibly ill, the physician may be reimbursed only at a flat rate, according to the ACO standard, regardless of how much care was provided.[19] This increase in risk for working with Medicare patients is too great for some single practitioners, which drives hospitals to consolidate into larger systems that can bear the risk on their balance sheets.

Besides the ACA, various state laws create barriers to entry and antitrust immunity for health sector consolidations, such as laws that require certificates of need (CON) and certificates of public advantage (COPA). CON laws generally require healthcare providers to obtain approval from a state agency before initiating construction projects and capital expenditures related to healthcare. CON laws, originally championed by the federal government, aim to slow the rising cost of healthcare by preventing the unnecessary duplication of services and by determining whether a community really needs the proposed capital expenditure.[20] Evidence shows that CON laws have restricted entry, constrained growth, and reduced capacity, leading to a more concentrated healthcare market.[21] Therefore, Congress repealed the federal mandate for states to establish CON laws.[22] Additionally, The FTC and US Department of Justice have concluded that CON laws "can prevent the efficient functioning of health care markets" and thus have recommended that states repeal or retrench them.[23] Yet in spite of all the

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14. Pope, 9.
15. Michael Rosko et al., "Predictors of Hospital Profitability: A Panel Study Including the Early Years of the ACA," *Journal of Health Finance* 44, no. 3 (2018): 1–23.
16. Rebecca R. Roberts, et al., "Distribution of Variable vs Fixed Costs of Hospital Care," *JAMA* 281, no. 7 (1999): 644–49.
17. Robert Fifer, "Health Care Economics: The Real Source of Reimbursement Problems," American Speech-Language-Hearing Association, July 2016, https://www.asha.org/Articles/Health-Care-Economics-The-Real-Source-of-Reimbursement-Problems/.
18. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation," 9.
19. Pope, 16.
20. "CON-Certificate of Need State Laws," National Conference of State Legislatures, December 1, 2019, https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.
21. Jon M. Ford and David L. Kaserman, "Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry," *Southern Economic Journal* 59, no. 4 (1993): 790; Examining the Impact of Health Care Consolidation, Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 115th Cong. 12 (2018) (statement of Martin Gaynor, E. J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University).
22. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), repealed, Pub. L. No. 99-660 § 701, 100 Stat. 3799 (1986).
23. Federal Trade Commission and US Department of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250*, January 2016, 1. Specifically, CON laws undermine competition by (1) "creat[ing] barriers to entry and expansion, limit[ing] consumer choice, and stifl[ing] innovation"; (2) enabling "incumbent firms seeking to thwart or delay entry or expansion by new or existing competitors"; and (3) "deny[ing] consumers the benefit of an effective remedy following the consummation of an anticompetitive merger" (as happened in the FTC's Phoebe Putney hospital merger case). The Mercatus Center has produced

evidence that CON laws do not slow down the rise in healthcare costs, 35 states still had them, as of January 2020.[24]

COPA laws exempt organizations from antitrust laws "in return for commitments to make public benefit investments and control healthcare cost growth."[25] The FTC currently is studying the effect of COPAs on prices and quality of, access to, and innovation in healthcare services.[26] As a general proposition, targeted antitrust immunity, as in the case of COPAs, encourages anticompetitive collaborations (including, of course, anticompetitive consolidations) that harm consumer welfare.[27]

Some studies have shown that when hospitals consolidate, the wages of nonphysician workers grow at a slower rate.[28] Because state licensing laws also limit the ability of healthcare workers to move across state lines, most workers have no choice but to stay rather than move to other states. Some states have attempted to improve the mobility of healthcare workers by joining licensure compacts, which allow healthcare workers to easily move between states. However, these compacts do not cover all professions and not all 50 states participate, leaving workers vulnerable.

At the same time that federal regulations encourage hospital consolidation, state and local laws prevent new hospitals and other healthcare facilities from being built, and patients ultimately suffer as prices rise and quality remains stagnant at best. It is important that the committee reviews the role of state and local laws that further restrict competition in healthcare.

THE FTC HAS A LONG AND SUCCESSFUL TRACK RECORD OF CHALLENGING ANTICOMPETITVE MERGERS UNDER CURRENT STATUTES AND GUIDELINES, BUT IT IS UNABLE TO PROSECUTE ALL ANTICOMPETITIVE CONDUCT IN THE HEALTHCARE SECTOR OWING TO STATUTORY RESTRICTIONS REGARDING NON-PROFIT HOSPITALS

Between 2000 and 2018, nearly 49 percent of all merger enforcement actions taken by the FTC related to the healthcare sector.[29] These actions followed the FTC's substantial refinement of its approach to assessing market definition and nonprofit anticompetitive effects in hospital merger reviews.[30] Before a December 2020 district court decision not to enjoin the merger of two Philadelphia area hospitals, the

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substantial scholarship documenting the economically harmful features of CON laws. Matthew D. Mitchell, Ann Philpot, and Jessica McBirney, "The State of Certificate-Of-Need Laws in 2020," Mercatus Center at George Mason University, February 19, 2021, https://www.mercatus.org/publications/healthcare/con-laws-2020-about-update.

24. Mitchell, Philpot, and McBirney, "The State of Certificate-Of-Need Laws in 2020."

25. Amanda Hunt, "When Antitrust Fails: Limiting Consumer Harm from Healthcare Consolidation" (Easy Explainer No. 16, Altarum Institute, October 2019). For a deeper look into the harmful effects of COPA statutes, see Federal Trade Commission, *Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System*, September 2020.

26. Federal Trade Commission, "FTC to Study the Impact of COPAs," press release, October 21, 2019, https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas.

27. Christine A. Varney, "Antitrust Immunities" (remarks, 11th Annual Conference of the American Antitrust Institute, Washington, DC, June 24, 2010); Examining the Impact of Health Care Consolidation, Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 115th Cong. 12 (2018) (statement of Martin Gaynor, E. J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University).

28. Elena Prager and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* 111, no. 2 (2021): 397–427.

29. Nathan E. Wilson, "Editor's Note: Some Clarity and More Questions in Health Care Antitrust," *Antitrust Law Journal* 82, no. 2 (2019): 435. Of the 154 merger enforcement actions, 75 relate to healthcare.

30. Rebecca Kelly Slaughter, "Antitrust and Health Care: Providers Policies to Promote Competition and Protect Patients" (remarks, Antitrust and Health Care: Providers Policies to Promote Competition and Protect Patients, Center for American Progress, Washington, DC, May 14, 2019), 3.

FTC won every hospital merger case it undertook for the better part of two decades.[31] This win rate is evidence of diligent analysis on the part of the FTC, demonstrating its ability to combat anticompetitive hospital mergers successfully under existing legal authority.

More generally, current statutory antitrust law standards are fully equal to the task of promoting competition and consumer welfare. Therefore, it would be inappropriate to recommend a broad overhaul of antitrust statutes to expand the scope and scale of FTC antitrust enforcement. Existing agency guidance, including the 2020 *Vertical Merger Guidelines*,[32] provides ample support for appropriate, evidence-based, economically sound enforcement. Overhauling antitrust statutes would transform enforcement norms and judicial analysis, generating enormous private-sector uncertainty. Such uncertainty would deter innovation, harming consumers and the American economy. The claims by some that broad-based sweeping changes are needed owing to reduced competition in the American economy and ineffective antitrust enforcement have not been proven.[33]

Antitrust enforcement focuses on the specific facts of a case to determine whether conduct in the instance at hand is likely to undermine competition and reduce consumer welfare. Proposals that seek to broadly condemn a certain practice risk rendering illegal (and deterring businesses from pursuing) specific beneficial manifestations of that practice. Before legislating, Congress should seriously weigh whether, in attacking a particular practice, the benefits of eliminating targeted harmful conduct will likely be outweighed by the costs of condemning and deterring specific instances of such conduct that could have benefited consumers through innovation, among other things.

However, as one of us recently discussed in previous testimony before the House Subcommittee on Antitrust, Commercial, and Administrative Law,[34] fully preserving the FTC's ability to protect consumer welfare requires reforms to the FTC's nonmerger enforcement capabilities. Under Section 7 of the Clayton Antitrust Act of 1914, the FTC can challenge anticompetitive mergers whether the hospitals are for profit or nonprofit. The same cannot be said for nonmerger anticompetitive conduct. The Federal Trade Commission Act of 1914 limits the ability of the FTC to pursue action against nonprofit corporations.[35]

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31. David Maas and Douglas E. Litvack, "FTC's Hospital Merger Win Streak Ends," Davis Wright Tremaine, LLP, March 4, 2021, https://www.dwt.com/insights/2021/03/ftc-hospital-merger-defeat. The FTC decided by a 4-0 vote not to appeal this decision.
32. US Department of Justice and Federal Trade Commission, *Vertical Merger Guidelines*.
33. Esteban Rossi-Hansberg, Pierre-Daniel Sarte, and Nicholas Trachter, "Diverging Trends in National and Local Concentration" (working paper no. 18-15R, Federal Reserve Bank of Richmond, Richmond, VA, April 29, 2020). The authors find that the expansion of national firms into local markets has been a factor both in increasing concentration at the national level and in decreasing concentration at the local level. Carl Shapiro, "Antitrust in a Time of Populism," *International Journal of Industrial Organization* 61 (2018): 722. The author states that a table examining trends in the revenue share of the 50 largest firms (CR50) contained in a 2016 Council of Economic Advisers Report on competition and market power "is not informative regarding overall trends in concentration in well-defined relevant markets that are used by antitrust economists to assess market power, much less trends in competition in the U.S. economy." David Autor et al., "The Fall of the Labor Share and the Rise of Superstar Firms" (NBER Working Paper No. 23396, National Bureau of Economic Research, Cambridge, MA, May 2017. According to the authors, increases in concentration reflect a reallocation of output toward large, productive firms that could be the result of globalization and technological change, as opposed to weakened competition and lax antitrust enforcement. Gregory J. Werden and Luke M. Froeb, "Don't Panic: A Guide to Claims of Increasing Concentration," *Antitrust Magazine* 33, no. 1 (2018): 74–79.
34. Alden F. Abbott, "Lack of Resources and Lack of Authority over Nonprofit Organizations Are the Biggest Hindrances to Antitrust Enforcement in Healthcare" (Testimony before the US House Committee on the Judiciary, Subcommittee on Antitrust, Commercial, and Administrative Law, Mercatus Center at George Mason University, Arlington, VA, April 29, 2021).
35. Specifically, the FTC may enforce Section 5 of the Federal Trade Commission Act, which forbids "unfair methods of competition" against "persons, partnerships, or corporations." The Federal Trade Commission Act defines the term "corporation" as an entity "organized to carry on business for its own profit or that of its members," thereby placing a major obstacle in the path of FTC enforcement against nonprofits. To be sure, the FTC has asserted the power to act when nonprofit status has in effect been a sham device to shield actual for-profit activities. See In re Ohio Christian College, 80 F.T.C. 815, 1972 FTC LEXIS 223 (F.T.C. July 29, 1970). And a federal court recognized the FTC's authority over a nonprofit that acted in concert,

In September 2019 testimony before the Subcommittee on Competition Policy, Antitrust, and Consumer Rights, then-FTC Chair Joseph Simons stated, "We're very interested in looking at unilateral conduct by hospitals, that are problematic under the antitrust laws. . . . But, generally when we do that, we find that they're nonprofits, and we don't have jurisdiction over them. . . . That's another reason why we've been asking the Congress to eliminate our exemption for nonprofits."[36]

The FTC staff has profound expertise in healthcare markets, developed over decades. It is high time it be given statutory authority over nonprofit entities to enable it to apply this expertise fully to all aspects of healthcare antitrust enforcement.

MAJOR LEGAL REFORMS UNRELATED TO ANTITRUST ARE KEY TO IMPROVING THE EFFECTIVENESS OF HEALTHCARE COMPETITION

Although this hearing centers on antitrust and consolidation, the antitrust treatment of healthcare-related transactions is only the tip of the healthcare policy iceberg. Major improvements to the competitive condition of the healthcare sector require far more than enhanced antitrust enforcement.

We have already touched upon the manner in which the ACA, CON laws, and COPA laws have artificially promoted anticompetitive healthcare consolidation. A more far-reaching and comprehensive 2018 study by the US Department of Health and Human Services focused on (1) healthcare workforce and labor markets, (2) healthcare provider markets, (3) healthcare insurance markets, and (4) consumer driven healthcare.[37] Furthermore, the Mercatus Center at George Mason University continues to carry out far-reaching studies on American healthcare reform.[38] We commend to you the thoughtful comprehensive analyses and proposals discussed by the Department of Health and Human Services and Mercatus as you evaluate what should be done to enhance healthcare competition and consumer choice in the United States.

in profit-making activities, with a for-profit entity. See FTC v. AmeriDebt, Inc., 343 F. Supp. 2d 451 (D. Md. 2004). Nevertheless, the FTC is, at best, severely hampered when it seeks to bring an enforcement action under Section 5.

36. Steven Porter, "Nonprofit Hospitals and Antitrust Enforcement: Should FTC Have Jurisdiction?," *HealthLeaders*, September 17, 2019.

37. US Department of Health and Human Services, *Reforming America's Healthcare System through Choice and Competition*, May 2018.

38. "Healthcare," Mercatus Center at George Mason University, accessed May 18, 2021, https://www.mercatus.org/tags/healthcare.