

Health Care Consolidation

The Changing Landscape of the U.S. Health Care System

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Health Care Consolidation: The Changing Landscape of the U.S. Health Care System

Testimony of Cheryl L. Damberg¹
The RAND Corporation²

Before the Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

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Chairman Buchanan, Ranking Member Doggett, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony for the record. My name is Cheryl Damberg, and I am a senior economist at the nonprofit, nonpartisan RAND Corporation. My research focuses on tracking the evolution of health systems and examining their cost and quality performance. I appreciate the opportunity to discuss the important topic of health care consolidation, a phenomenon that is dramatically reshaping the structure of health care markets in the United States. Consolidation in any industry raises concerns about reducing competition, because without competition, prices go up, incentives to innovate are reduced, and quality goes down, reducing value for consumers.³ In health care, consolidation is a key factor contributing to the exponential growth in health spending by U.S. taxpayers, employers, and consumers.

I will first describe the state of consolidation across four key sectors of the U.S. health care market: providers, insurers, pharmacy benefit managers (PBMs), and private equity. Then, I will share what is known about the impacts of this consolidation on cost, quality of care, and health

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³ M. Susan Ridgely, "Does Vertical Integration Improve or Imperil U.S. Health Care?" *RAND Blog*, November 16, 2021, <https://www.rand.org/blog/2021/11/does-vertical-integration-improve-or-imperil-us-health.html>.

outcomes. While proponents of consolidation have argued that consolidation leads to increased efficiency, lower administrative costs, and improved quality of health care, our research (and that of other investigators) has not shown any consistent evidence of cost or quality benefits to consumers.

How Is Consolidation Reshaping U.S. Health Care Markets?

Over the past several decades, the health care delivery landscape has undergone rapid and continual change. Consolidation in the health care market is endemic and is happening in all parts of the health care delivery system. Across the United States, health care markets are dominated by a few large players, and the footprints of these players continue to expand.⁴

Consolidation can occur in different forms.⁵ One form is **horizontal consolidation**, in which two “like” organizations come together and integrate. One example is two hospitals consolidating through a merger. Another example is two health systems consolidating, such as the 2022 merger of Advocate Aurora Health and Atrium Health. This particular merger created a mega health system that operates 67 hospitals and more than 1,000 ambulatory care sites in six states.⁶

Hospital consolidation has been occurring over multiple decades.⁷ Between 1998 and 2021, the American Hospital Association reported 1,887 hospital mergers.⁸ By 2017, in most markets, a single hospital system had more than a 50-percent market share of hospital discharges,⁹ reducing competition.

Another form of consolidation is **vertical consolidation**, in which different types of health care organizations consolidate. In economics, *vertical integration* is defined as the combination of two or more stages of production normally operated by separate companies into one company. In health care, this term is often applied, for example, when hospitals or health systems employ physicians or acquire physician practices.

While both horizontal and vertical consolidation are occurring among providers, hospital consolidation has largely been supplanted by what is now the dominant trend in the market: vertical integration, in which health systems have been acquiring physician groups, other acute care providers (such as ambulatory clinics and ambulatory surgery centers [ASCs]), and post-

⁴ Brent D. Fulton, “Health Care Market Concentration Trends in the United States: Evidence and Policy Responses,” *Health Affairs*, Vol. 36, No. 9, September 2017.

⁵ Jodi L. Liu, Zachary M. Levinson, Annetta Zhou, Xiaoxi Zhao, PhuongGiang Nguyen, and Nabeel Qureshi, “Consolidation Trends and Impacts in Health Care Markets,” RAND Corporation, RR-A1820-1, 2022, https://www.rand.org/pubs/research_reports/RRA1820-1.html.

⁶ Samantha Liss, “Advocate Aurora and Atrium Complete Merger, Creating \$27B System,” Healthcare Dive, December 2, 2022.

⁷ Martin Gaynor, “New Health Care Symposium: Consolidation and Competition in US Health Care,” *Health Affairs*, March 1, 2016.

⁸ Hoag Levins, “Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality: A Penn LDI Virtual Seminar Unpacks the Challenging Contradictions of This Continuing Trend,” University of Pennsylvania Leonard Davis Institute of Health Economics, January 19, 2023.

⁹ Medicare Payment Advisory Commission, *Medicare Payment Policy: Report to the Congress*, March 2020.

acute care providers (such as home health agencies). Furthermore, insurers have been vertically consolidating with provider entities over the past decade. Currently, the largest employer of physicians in the United States is not a health system, but rather Optum, a subsidiary of the insurer UnitedHealth Group with more than 700,000 employed or aligned physicians.¹⁰

In addition to mergers and acquisitions, new, “softer” forms of vertical consolidation are emerging that are largely invisible to policymakers and for which we do not understand the impacts. Instead of buying practices and directly employing physicians, health systems are entering into contractual relationships with physician groups, independent physician practices, and hospitals to form clinically integrated networks, allowing the health systems to expand and increase the flow of patients to the health system to garner more revenue and to allow previously independent hospitals and providers to obtain higher payment rates negotiated by the larger health system with insurers. RAND recently published a report on clinically integrated networks, noting that these softer forms of consolidation pose similar risks of furthering spending growth without yielding improved quality performance.¹¹ These soft forms of consolidation are not commonly captured in the regulatory filing data, leaving regulators and researchers blind to monitor their impacts.

I will now describe the state of consolidation across four key sectors of the U.S. health care market: (1) providers, (2) insurers, (3) PBMs, and (4) private equity.

Providers

A key trend over the past decade is the substantial vertical consolidation of previously independent physician groups and physician practices into hospitals and health systems. This trend has dramatically increased over the past decade and continues unabated. Research conducted by my colleague Christopher Whaley indicates that the percentage of physician practices owned by hospitals and health systems has doubled over the past decade, nearing half of all physicians—both primary care and specialty physicians (see Figure 1).¹² A key reason for provider consolidation is so that hospitals and health systems can accrue bargaining leverage and, in turn, achieve higher prices from commercial payers, as well as direct patient volume to higher-priced system hospitals and providers.

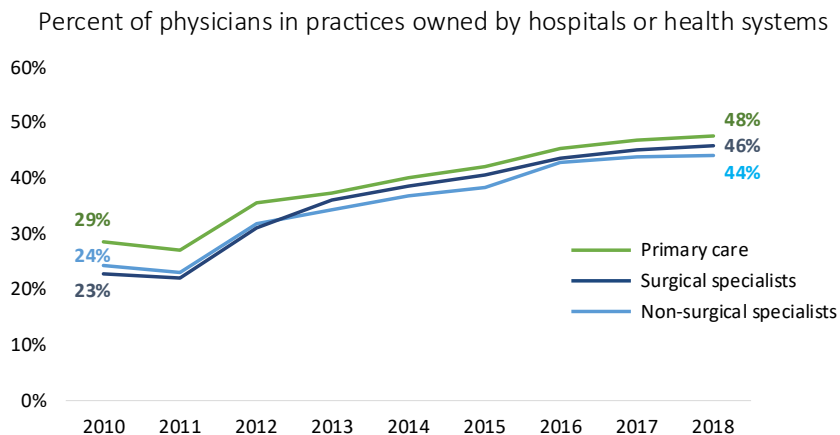
¹⁰ Jakob Emerson, “Meet America’s Largest Employer of Physicians: UnitedHealth Group,” *Becker’s Healthcare*, February 16, 2023.

¹¹ M. Susan Ridgely, Justin W. Timbie, Laura J. Wolf, Erin Lindsey Duffy, Christine Buttorff, Ashlyn Tom, and Mary E. Vaiana, *Consolidation by Any Other Name: The Emergence of Clinically Integrated Networks*, RAND Corporation, RR-A370-1, 2020, https://www.rand.org/pubs/research_reports/RR-A370-1.html.

¹² Christopher M. Whaley, Daniel R. Arnold, Nate Gross, and Anupam B. Jena, “Physician Compensation in Physician-Owned and Hospital-Owned Practices,” *Health Affairs*, Vol. 40, No. 12, December 2021.

Figure 1. Consolidation of Physician Practices into Hospital and Health Systems

The health care market is being drastically transformed



SOURCE: Adapted from Whaley et al., 2021.

Insurance Market

Although a substantial amount of insurer consolidation occurred in the 1990s and early 2000s, insurer horizontal merger activity continues to take place. Most insurance markets are concentrated, as described in a 2022 American Medical Association study, which found that 75 percent of metropolitan statistical area–level commercial insurance markets were highly concentrated: Ninety-one percent of the markets had one insurer holding at least 30 percent of the market share, and 46 percent of the markets had one insurer holding at least 50 percent of the market share, restricting competition.¹³ Yet insurers are trying to further consolidate, making concentration worse. For example, in 2015, Anthem announced a \$54 billion merger deal with Cigna, while Aetna announced a \$38 billion merger deal with Humana. (Both deals were blocked.) While insurance concentration can enhance insurer bargaining power with providers, it also limits the incentives to develop innovative insurance products and pass savings to patients and premium holders.¹⁴

Beyond insurer-to-insurer horizontal consolidation, insurers over the past decade have been vertically integrating with providers, including hospitals, physician practices, nursing homes, home health agencies, pharmacies, and ASCs. This form of integration between insurers and providers raises concerns of price increases and access barriers for patients covered by rival insurers.

¹³ American Medical Association Division of Economic and Health Policy Research, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2022.

¹⁴ Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review*, Vol. 102, No. 2, April 2012.

Pharmacy Benefit Managers

Consolidation has also been occurring among PBMs, which have been merging horizontally with each other and vertically with insurers and with pharmacies. Over the past few years, the PBM market has become highly consolidated, with three PBMs—CVS Health, Express Scripts, and OptumRx—controlling more than 76 percent of the market. The three firms each operate their own mail-order pharmacies, and CVS owns the nation’s largest drugstore chain. In 2017, CVS acquired health insurer Aetna, while, in 2019, Cigna acquired Express Scripts.

PBMs have vertically integrated with Medicare Part D prescription drug plans. As MedPAC recently reported, the share of total Medicare Part D enrollment attributable to the top five plan sponsors increased from 53 percent in 2010 to 74 percent in 2021. One key function of PBMs is to negotiate discounts with drug manufacturers to reduce the drug costs for payers and consumers. Having the plan, the PBM, and the pharmacy consolidated under one entity potentially creates conflicting incentives that may raise health spending by driving patients to use higher-priced drugs in exchange for discounts from the drug manufacturers and preferred placement on the plan’s formulary or may lower costs through greater leverage in negotiations with drug manufacturers. Currently, there is a lack of visibility into prices between the upstream and downstream entities because PBMs are not required to disclose the rebates they receive from drug makers or the spread between what they are paid by insurers to fill a prescription and how much they pay to the pharmacy filling the prescription. PBMs also engage in anticompetitive behavior, as they steer patients to their own pharmacies and reduce reimbursements to independent pharmacies to drive them out of business.

Private Equity

Lastly, private equity has taken a large and growing stake in the American health care system, with investment growing from \$41.5 billion in 2010 to \$119.9 billion in 2019.¹⁵ Private-equity firms have acquired physician practices, ASCs, hospitals, nursing homes, and home health care providers. Much private-equity activity reflects leveraged buyouts in which a private-equity firm relies heavily on loans to acquire ownership of an organization (such as a hospital system), takes the organization private, attempts to improve the value of the organization, and aims to sell it at a profit within three to seven years. A key concern with private-equity acquisition is that the owners are focused on short-term revenue generation by engaging in financial arbitrage. They do so by providing more services, shifting toward a more highly compensated mix of services and procedures, or raising prices.¹⁶ Private-equity firms consolidate health care providers to gain bargaining leverage to obtain higher payment rates from payers, thereby driving increases in health spending and undermining competition, rather than making investments to deliver higher-quality care more efficiently. Because of their private nature, most private-equity acquisitions

¹⁵ Richard M. Scheffler, Laura M. Alexander, and James R. Godwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, American Antitrust Institute and Petris Center, May 18, 2021.

¹⁶ Medicare Payment Advisory Commission, “Congressional Request: Private Equity and Medicare,” *Report to the Congress: Medicare and the Health Care Delivery System*, June 2021.

operate without effective oversight, as the acquisitions are not reportable to antitrust or financial regulatory authorities under current law. A recent study examined the effects of private-equity investment in dermatology practices, a commonly targeted specialty for private-equity firms.¹⁷ Private-equity acquisition was associated with dermatologists seeing up to 17 percent more patients after two years and charging 3 to 5 percent more for routine visits. The private-equity firms targeted their acquisitions at larger practices that saw more commercially insured patients—where the private equity–owned practice can negotiate higher prices, unlike in Medicare.

Why Are Providers Vertically Integrating?

In a recent study, we asked C-suite executives of health systems why they were vertically integrating by acquiring physician practices. They gave the following reasons:

- To gain size—that is, more patients to be able to spread financial risk so that the health system can successfully participate in value-based payment contracts, such as Accountable Care Organizations. However, a recent study found little evidence to support the idea that providers have responded to the rapid growth of new payment models by forming larger organizations to assume financial risk and succeed under these models.¹⁸
- To have greater leverage in price negotiations with payers. The potential for increased payments motivates independent physicians to vertically integrate. Independently practicing physicians have little bargaining power, and they can boost the payments they receive when they are part of a health system that has more negotiating power.
- To direct more patient traffic to their hospitals to offset loss of revenue due to policy changes, such as financial penalties for hospital readmissions, and the pressure that value-based contracts place on systems to reduce the total cost of care—reductions that come through reduced hospital utilization.
- To improve their ability to coordinate patient care across multiple settings and providers and to manage population health. Although improvements in care coordination and clinical quality are often stated as motivations for consolidation, the existing research finds no improvements in quality and potentially worse outcomes for vulnerable patient populations.¹⁹
- To gain leverage in highly concentrated markets and because they cannot afford to be left behind as their competitors gain size and market share.

From the perspective of those being acquired, mergers with hospital and health systems allow them to obtain higher payment rates and to deal with increasing regulatory requirements—such

¹⁷ Robert Tyler Braun, Amelia M. Bond, Yuting Qian, Manyao Zhang, and Lawrence P. Casalino, “Private Equity in Dermatology: Effect on Price, Utilization, and Spending,” *Health Affairs*, Vol. 40, No. 5, May 2021.

¹⁸ Hannah T. Neprash, Michael E. Chernew, and J. Michael McWilliams, “Little Evidence Exists to Support the Expectation That Providers Would Consolidate to Enter New Payment Models,” *Health Affairs*, Vol. 36, No. 2, February 2017.

¹⁹ Jonathan S. Levin, Swad Komanduri, and Christopher Whaley, “Association Between Hospital-Physician Vertical Integration and Medication Adherence Rates,” *Health Services Research*, Vol. 58, No. 2, April 2023.

as having certified electronic health record and quality reporting requirements—that affect the costs of operating small practices. A potentially important driver of physician consolidation is that recent regulations (both federal regulations and insurer requirements) make it very hard to run a practice. Consolidating is a way to outsource that component and focus on practicing medicine.

However, the research by Christopher Whaley and colleagues shows that there is no direct financial benefit to physicians of vertically integrating, as vertical integration with hospitals or health systems is associated with, on average, 0.8 percent lower income compared with income received by independent physicians.²⁰ Vertical integration of physician practices with hospitals or health systems is associated with lower income for nonsurgical specialists, no difference in income for primary care physicians, and slightly higher income for surgical specialists.

Why Are Insurers Vertically Integrating?

Over the past decade, insurers have been shifting away from solely providing insurance to reinventing themselves as health care delivery organizations. This transformation has been spurred by several factors, including periodic threats of a single-payer health system putting private insurers out of business; the ongoing shift to value-based payments, which require the ability to manage financial risk and coordinate care delivery across the continuum of care; and competition from fully integrated, full-risk population-health delivery systems, which have achieved high levels of quality performance in both the commercial insurance market and Medicare Advantage, allowing these integrated delivery systems to gain market share and substantial quality bonuses under value-based payment arrangements.

However, the major reason why insurers are vertically integrating with providers of all types of care delivery is to control more of the production of health care and, in turn, capture the revenues created along the production path.²¹ UnitedHealth Group is one example of an insurer that has expanded into the delivery of health care through vertical integration, with its Optum, Inc., subsidiary that includes pharmacy and care delivery services. In 2017, Optum accounted for 44 percent of UnitedHealth Group's profits.

Federal law requires insurers to spend 80 to 85 percent of the premium dollar on health care services, known as the *medical loss ratio* (MLR), while retaining 15 to 20 percent for administrative costs and profit. Insurers can retain more of the premiums they collect when they own the providers that are paid by the total premium dollar. Vertically integrated insurers are accruing more revenue than the 15 to 20 percent of the MLR by using an accounting tool called *intercompany eliminations*,²² which allows the parent organization in a vertically integrated organization to transfer revenue earned from one part of the company (such as physician groups or a specialty pharmacy) back to the parent organization—in this case, the insurer. The insurer

²⁰ Whaley et al., 2021.

²¹ Bob Herman, “Profits Swell When Insurers Are Also Your Doctors,” Axios, July 16, 2021.

²² AccountingTools, “Intercompany Eliminations Definition,” February 6, 2023; Code of Federal Regulations, Title 26, Internal Revenue; Chapter I, Internal Revenue Service, Department of the Treasury; Subchapter A, Income Tax; Part 1, Income Taxes; Effects on Corporation; Section 1.1502-13, Intercompany Transactions.

eliminates from its financial statement revenues, costs of goods sold, and profits from one entity to another within the insurer's group of organizations. This creates strong incentives for the insurer to steer its members toward its own providers to maximize profit.

What Is Known About the Impact of Consolidation on Cost and Quality of Health Care?

Proponents of vertical integration have argued that integration will lead to benefits, including increased efficiencies through the lowering of administrative costs through economies of scale; the ability to devote more resources to improving care delivery infrastructure, such as clinical care redesign, more quality-improvement staff, investment in interoperable health information technology capabilities to improve communication, and investment in enhanced analytics; and improved clinical integration and coordination of care across providers within a health system, resulting in improved quality of care and better patient outcomes.

However, evidence shows that vertical integration of hospitals or health systems with physician practices does not lower spending and does not improve quality of care.²³ Instead, vertical integration leads to increased spending due to shifts from lower-cost to higher-cost treatment settings and due to increases in payment rates to providers because of increased negotiating power.²⁴ Increases in payment rates can translate to higher premiums paid.²⁵ Quality does not improve.

Let me share a few examples of what our research has found:

- Shifting care to the hospital outpatient department following vertical integration creates an “arbitrage opportunity” to increase payments to the health care organization.²⁶ For many types of services, such as imaging procedures, cataract surgeries, and colonoscopies, providing the same service in the hospital is much more expensive than providing it outside the hospital, such as in a freestanding imaging center or an ASC. This is because the hospital receives both the physician professional fee and the hospital

²³ Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, “Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending,” *Health Affairs*, Vol. 33, No. 5, May 2014; Levin, Komanduri, and Whaley, 2023; J. Michael McWilliams, Michael E. Chernew, Alan M. Zaslavsky, Pasha Hamed, and Bruce E. Landon, “Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries,” *JAMA Internal Medicine*, Vol. 173, No. 15, August 2013; Ridgely, 2021; Kirstin W. Scott, E. John Orav, David M. Cutler, and Ashish K. Jha, “Changes in Hospital-Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care,” *Annals of Internal Medicine*, Vol. 166, No. 1, January 3, 2017.

²⁴ Cory Capps, David Dranove, and Christopher Ody, “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending,” *Journal of Health Economics*, Vol. 59, May 2018; Hannah T. Neprash, Michael E. Chernew, Andrew L. Hicks, Teresa Gibson, and J. Michael McWilliams, “Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices,” *JAMA Internal Medicine*, Vol. 175, No. 12, December 2015.

²⁵ 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*, Vol. 37, No. 9, September 2018.

²⁶ Michael E. Chernew, “Disparities in Payment Across Sites Encourage Consolidation,” *Health Services Research*, Vol. 56, No. 1, February 2021.

facility fee for the service provided. To illustrate, having cataract surgery performed in the hospital outpatient department costs about \$6,200, as compared to \$1,500 in an ambulatory surgery setting. These site-of-care payment differentials are larger among commercial payers. In a recent study by Christopher Whaley and colleagues, vertical integration changed patient referrals, shifting them away from ASCs to hospital outpatient departments, where providing the treatment was more expensive.²⁷ After integration, vertically integrated surgeons were 10 percent less likely to send patients to an ASC and 18 percent less likely to use an ASC at all.

- We observe similar changes for the Medicare population. For ten common lab and imaging services, vertically integrated physicians shifted referrals from freestanding testing providers to hospital-based testing facilities, which were more expensive. Across the ten procedures, vertical integration led to a \$73 million increase in Medicare spending.²⁸
- In unpublished research, my team compared the quality and total cost of care performance of physician organizations that were vertically integrated with health systems to physician organizations that were independent. Our study used Medicare data, and we examined physician groups nationally. In brief, we found no differences in quality performance. Total cost of care was similar between physician groups that were vertically integrated and those that were not, averaging \$10,000 per year per beneficiary.

Studies examining the effects of horizontal consolidation of hospitals show that consolidation leads to higher commercial prices. The literature largely shows no effect on or declines in quality of care,²⁹ even though the stated goal of consolidation is to improve clinical outcomes. I provide examples from two studies:

- A 2019 study examined the cost and quality impacts on rural hospitals following horizontal consolidation with hospital systems.³⁰ After consolidation, rural hospitals experienced a significant reduction in on-site diagnostic imaging technologies, the availability of obstetric and primary care services, and outpatient nonemergency visits, losing important access to these services. No changes were observed in patient-reported experience with care and 30-day all-cause readmissions to the hospital. However, rural hospitals experienced a significant increase in operating margins (by 1.6 to 3.6 percentage points from a baseline of -1.6 percent).

²⁷ Michael R. Richards, Jonathan Seward, and Christopher Whaley, "Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets," RAND Corporation, WR-A621-1, 2020, https://www.rand.org/pubs/working_papers/WRA621-1.html.

²⁸ Christopher M. Whaley, Xiaoxi Zhao, Michael Richards, and Cheryl L. Damberg, "Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration," *Health Affairs*, Vol. 40, No. 5, May 2021.

²⁹ Cory S. Capps, "The Quality Effects of Hospital Mergers," unpublished manuscript, Bates White LLC, 2005; David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," *American Economic Journal: Economic Policy*, Vol. 2, No. 1, February 2010; Tamara B. Hayford, "The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes," *Health Services Research*, Vol. 47, No. 3, Part I, June 2012.

³⁰ Claire E. O'Hanlon, Ashley M. Kranz, Maria DeYoreo, Ammarah Mahmud, Cheryl L. Damberg, and Justin Timbie, "Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation," *Health Affairs*, Vol. 38, No. 12, December 2019.

- In another recent study of hospital horizontal consolidation, the researchers found that hospital acquisition was associated with a decline in patient-reported experience with care and no improvements in quality (as measured by hospital readmissions, mortality rates, and clinical processes of care).³¹

Studies examining the effects of horizontal consolidation of insurers show that as insurers gain market power, they are able to obtain lower prices from providers.³² While lower prices paid to providers should translate into lower premiums, evidence shows that insurers with greater market share charge higher premiums when faced with less competition.³³

Why Are We Not Seeing the Promised Benefits of Vertical Integration in Improving Quality of Care and Health Outcomes?

Consolidation is not clinical integration, which requires sharing of information, coordinated and streamlined transitions between care settings, and effective handoffs.³⁴ Organizations have figured out how to financially and structurally integrate, but clinical integration has proven challenging.

Health system leaders told us that clinical integration largely has not been achieved and that care is not standardized across entities within their systems, despite the promise of better integration and care coordination when the different actors delivering care operate under one organization.³⁵ They stated that changing physician practice patterns is challenging, involving changes in leadership and culture, as well as information transfer. Executives recognize that they need to advance clinical integration, but accomplishing it is many years out, and in the meantime, we will be paying more for care with no improvement in quality. Executives emphasize that they continue to operate in a fee-for-service payment world; the pace at which value-based payment is being implemented may be too slow to support the desired transformation of health care delivery.

³¹ Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams, “Changes in Quality of Care After Hospital Mergers and Acquisitions,” *New England Journal of Medicine*, Vol. 382, No. 1, January 2, 2020.

³² Glenn A. Melnick, Yu-Chu Shen, and Vivian Yaling Wu, “The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices,” *Health Affairs*, Vol. 30, No. 9, September 2011; Richard M. Scheffler and Daniel R. Arnold, “Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets,” *Health Affairs*, Vol. 36, No. 9, September 2017.

³³ Erin E. Trish and Bradley J. Herring, “How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?” *Journal of Health Economics*, Vol. 42, July 2015.

³⁴ Thomas C. Tsai and Ashish K. Jha, “Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?” *JAMA*, Vol. 312, No. 1, July 2, 2014.

³⁵ M. Susan Ridgely, Christine Buttorff, Laura J. Wolf, Erin Lindsey Duffy, Ashlyn K. Tom, Cheryl L. Damberg, Dennis P. Scanlon, and Mary E. Vaiana, “The Importance of Understanding and Measuring Health System Structural, Functional, and Clinical Integration,” *Health Services Research*, Vol. 55, Supp. 3, December 2020.

Conclusion

In closing, health care consolidation is a major problem in the U.S. health system. It reduces competition and contributes to increased health care spending. It also has not yielded improvements in quality or health outcomes for patients. When hospitals and doctors face less competition, they charge higher prices without improvements in quality. This is also true for insurers, which charge higher premiums when faced with less competition. Lack of competition stifles innovation that could reduce spending or improve patient outcomes. Competition creates incentives to have both lower prices and higher quality; consolidation removes the quality-improvement incentive and, thus, leads to worse outcomes.³⁶

³⁶ Zack Cooper, Stephen Gibbons, Simon Jones, and Alistair McGuire, “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms,” *Economic Journal*, Vol. 121, No. 554, August 2011; M. Gaynor, “Competition and Quality in Hospital Markets: What Do We Know? What Don’t We Know?” *Economie Publique*, Vol. 15, No. 2, 2004; Martin Gaynor, “What to Do About Health-Care Markets? Policies to Make Health-Care Markets Work,” Hamilton Project, undated; Daniel P. Kessler and Mark B. McClellan, “Is Hospital Competition Socially Wasteful?” *Quarterly Journal of Economics*, Vol. 115, No. 2, May 2000.