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HEALTHCARE CONSOLIDATION IS RAISING PRICES AND JEOPARDIZING CANCER CARE: Policymaker Recommendations

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EXECUTIVE SUMMARY

The price of cancer care—and, ultimately, the consumer cost of care—is rising at an alarming rate. Patients' out-of-pocket costs are increasing through higher deductibles, co-pays, co-insurance, and premiums. Thus, patients are less able to afford the care they need, which compels them to delay or even forego necessary treatment due to cost. A significant driver of the rising cost of healthcare in the U.S. is consolidation across and among hospitals, providers, and health systems.

Consolidation has an outsized impact on cancer patients, as more individuals receive cancer care from hospital-affiliated outpatient settings rather than independent physician offices.

Today, a handful of large health systems increasingly dominate several U.S. markets. This allows those systems, hospitals, and providers to demand higher reimbursement from commercial payers through concentrated market power. Market consolidation directly impacts patients' ability to afford care and services. When markets are highly concentrated, insurers and employers have reduced leverage to negotiate with providers to keep prices down and ensure that care is affordable for their members. Ultimately, insurers and employers pass the burden of provider price increases onto consumers through higher premiums, out-of-pocket costs, and reduced wages.

This paper considers several mechanisms by which state and federal policymakers can constrain market consolidation and, in doing so, address both system-wide and individual consumer healthcare costs. Policymakers should consider the following policy levers to combat consolidation:

At-A-Glance: Policymaking Recommendations

Strengthen anti-trust enforcement	• Increase funding for state and federal regulatory agencies to better monitor and regulate monopolistic behavior • Expand statutory authority for state and federal regulatory agencies to investigate mergers, including mergers of non-profit entities and mergers below the current annual acquisition value threshold • Clarify the authority of state and federal regulators to identify and challenge cumulative mergers and acquisitions
Reform pricing and reimbursement rules	• Enact site-neutral payment reforms that standardize provider reimbursement across care settings for routine services • Protect consumers from burdensome fees associated with care provided at hospitals and hospital-outpatient settings
Prohibit anticompetitive contracting terms	• Ban the use of anticompetitive contracting terms that harm patients and consumers • Empower state and federal regulatory agencies to evaluate the impact of anticompetitive contracting terms
Improve transparency standards	• Refine, expand, and enforce data reporting requirements for health systems to improve economic and community benefit transparency • Require health systems to report data to appropriate regulators concerning ownership, mergers and acquisitions, and any changes in ownership or controlling interest • Establish all-payer claims databases (APCD)

BREAKING DOWN PROVIDER CONSOLIDATION

01

The price of cancer care – and ultimately the consumer cost of care, has risen at a constant and alarming rate for years and is projected to continue to grow.[1] As a result, patients are expected to foot more of the bill for their care in the form of increased deductibles, cost sharing, and premiums. As employers and issuers alter their health insurance options for consumers and employees to help defray rising costs—frequently by shifting costs to their enrollees—patients are increasingly unable to afford care, which leaves them with no choice but to delay or even forego necessary treatments.

"Financial toxicity" presents its own set of significant threats to patient quality of life alongside the actual diseases and conditions that patients are battling. At the same time, rapid increases in treatment costs year after year for cancer and other disease areas will eventually strain the overall healthcare delivery system such that patients' access to high-quality care will be severely impacted.

In this country, a significant driver of persistent price increases for healthcare is increasing consolidation among hospitals and health systems.

Why consolidation matters

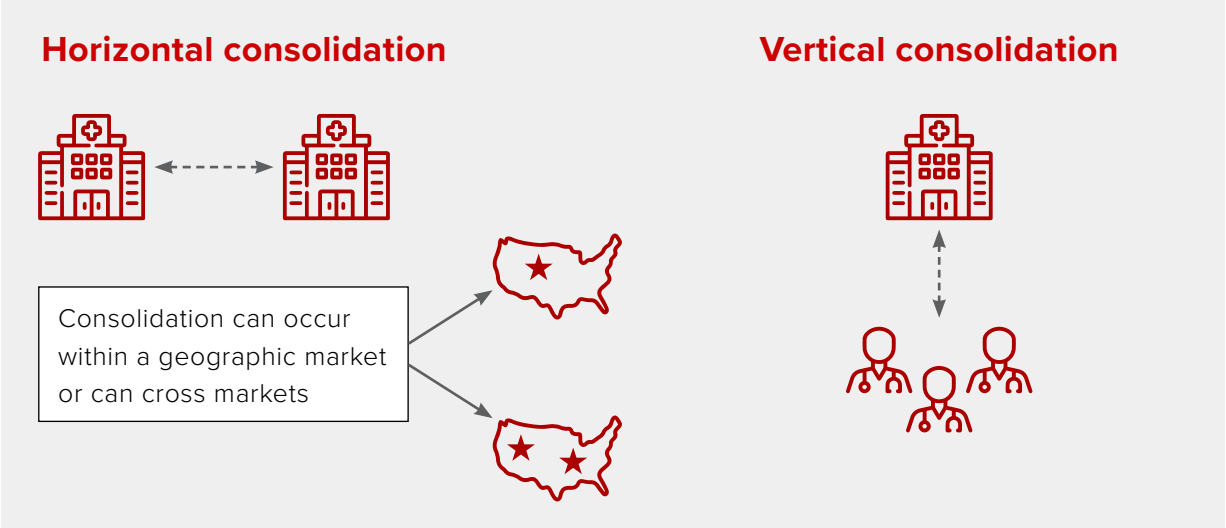
Historically, employers and health insurance plans have been able to assemble networks of providers and hospitals that provide affordable services for their enrollees by negotiating with available, competing providers within a given area. However, as consolidation has reduced competition between large facilities such as hospitals and concentrated smaller providers under the umbrella of large healthcare systems, fewer markets offer sufficient competition to serve as a lever for controlling costs. Between 1998 and 2021, over 1,800 hospital mergers led to a decrease of approximately 2,000 hospitals around the country. Meanwhile, more than half of all physicians in the country were employed by hospitals by 2020, which is an increase of nearly 20% since 2012.[2]

Put simply, a smaller number of enormous health systems increasingly dominate several U.S. markets, enabling hospitals and providers to demand higher reimbursement from commercial payers through monopolistic market power.[3] This has a significant impact on the patients served by these health systems. Ultimately, insurers and employers pass the burden of provider price increases onto consumers through higher premiums and out-of-pocket costs—and in the case of employers, reduced wages.[4]

With healthcare costs growing twice as fast as workers' wages,[5] it comes as no surprise that 46% of respondents in a 2022 national survey reported skipping or delaying care due to cost barriers.[6]

Experts generally agree that rising healthcare costs are primarily driven by increases in the prices charged by healthcare providers rather than high patient utilization of services.[7] Additionally, increased costs are not always correlated with cutting-edge care or better health outcomes.[8] These concerning cost trends are particularly problematic in the commercial market. In 2018, privately insured consumers and employers paid 247% of Medicare rates on average for the same inpatient and outpatient hospital services.[9]

Consolidation has an outsized impact on individuals receiving cancer care as more individuals receive cancer care from hospital-affiliated outpatient settings rather than physician offices.[10]



Types of consolidation

Consolidation in the healthcare industry can be either "horizontal" or "vertical." Horizontal consolidation refers to a merger or acquisition that occurs between directly competing entities offering the same services, such as in the case of a hospital merging with another hospital. Vertical consolidation (often referred to as "vertical integration") occurs when one type of entity purchases another that operates at a different stage in the healthcare delivery system, such as in the case of a hospital acquiring a physician practice. Clinically integrated networks, accountable care organizations, and other joint arrangements between healthcare entities that fall short of complete ownership can also influence market forces in ways similar to mergers and acquisitions.[11]

Consolidation can happen within or across markets. This distinction may make a difference in how the consolidation ultimately impacts prices and consumer affordability. Consolidation that occurs within a market could involve a merger between two hospital systems operating within the same geographic area, whereas consolidation occurring across markets could involve a hospital system operating in one geographic area merging with a hospital system that operates in a different geographic area. Research suggests that *both* types of consolidation drive up prices.[12]

While this paper focuses on provider and/or hospital system consolidation, the available data indicate that this type of consolidation has the most significant impact on rising prices. Moreover, the increasing horizontal consolidation across insurers is also worth noting. Unlike consolidation of providers, horizontal insurer consolidation has sometimes been found to *lower* prices by leveraging bargaining power.[13] Unlike the relatively unregulated ecosystem of hospital market consolidation, there are protections for ACA-regulated insurance plans that may mitigate the impact of consolidation on consumers. For instance, fully insured plans must meet medical-loss-ratio protections and individual and small group plans must meet network adequacy standards. There is, however, relatively little data on the impact of vertical integration between insurers and other health systems entities on prices, quality, and affordability.

Consolidation is Increasing

Provider consolidation has been on the rise in the U.S. for some time. The ten largest health systems in the country now control nearly a quarter of the national market.[14] As a result of the 1,887 hospital mergers announced between 1998 and 2021, the number of hospitals in the country fell from 6,000 to 4,000.[15] By 2017, a single hospital system had more than a 50% market share of hospital discharges in most markets.[16]

Vulnerable populations are more likely to feel the impacts of consolidation. The shuttering of independent and community hospitals has disproportionally reduced access to services for residents of rural areas[17] and urban neighborhoods of color.[18] Low-income communities are also more likely to live in highly concentrated hospital markets.[19]

Similarly, physician practices have also consolidated significantly over the past decade. Today, physicians are more likely to practice in larger groups than in smaller or independent practices, a trend that has been observed across different specialties.[20] Physicians are also increasingly being employed by hospitals. As of 2020, more than 50% of physicians were directly employed by hospitals, an almost 20% increase compared to 2012.[21] Further, hospitals are increasingly acquiring physician practices. As of 2018, close to half the physician practices in the country are owned by hospitals.[22]

Finally, the increasing role of private equity in healthcare has also accelerated provider consolidation.[23] Research has found that while private equity investments can provide an infusion of cash into hospital and provider systems, the business strategies at the heart of private equity ventures often prioritize short-term revenue generation over long-term sustainability, patient access, quality care, and affordability.[24] In addition, private equity firms often engage in end-runs around antitrust protections, for instance, through "roll ups," where the firm buys up multiple smaller companies one at a time, avoiding federal merger scrutiny.[25]

Private Equity and Provider Consolidation

Over the past decade, private equity firms have invested more than $750 billion into the U.S. healthcare system. Because of its focus on short-term revenue generation, private equity has added fuel to the fire of market consolidation and other anticompetitive practices, driving up prices and compromising patient access to quality care.

The Impact of Consolidation on Consumers

- Provider consolidation weakens competition
- Weakened competition erodes the ability of payers to control prices
- Increased provider prices are passed onto consumers in the form of higher premiums and cost sharing
- Vulnerable and marginalized communities who already struggle with access to healthcare are disproportionately impacted by the loss of community providers as more providers consolidate

CONSOLIDATION AND THE IMPACT ON CONSUMERS

02

As the pace of provider consolidation has increased, there has been more in-depth research to assess the impact of consolidation, including the effects of consolidation on prices, affordability, access and utilization, and quality. There has also been more attention to the health equity implications of consolidation, specifically the ways that consolidation disproportionately impacts particular communities.

Prices

Research on hospital mergers uniformly finds that they raise hospital prices, and this finding holds for both for-profit and nonprofit hospital mergers.[26] Post-merger, hospital prices have been estimated to increase by anywhere between 2.6%[27] and 13.2%.[28] For example, a study commissioned by the Indiana Legislative Services Agency found that prices at the 22 Indiana hospitals that participated in merger activity were 13.2% higher than the 18 hospitals that did not participate in such activity.[29] Although research finds that hospital mergers that occur within the same geographic market have the biggest impact on increased prices, cross-market consolidation can also drive up prices. For instance, one study estimated that cross-market mergers between hospitals located in the same state resulted in a 7–9% increase in prices.[30]

These price increases are not limited to hospital consolidation and studies have found that provider group mergers also raise prices.[32] Studies have consistently found that physicians in more consolidated markets charge more than those in less consolidated markets. These price differences can be considerably high. One study estimated that providers in counties with higher physician consolidation charged private Preferred Provider Organization (PPO) plans 8 to 26% more,[33]

Research on hospital mergers uniformly finds that they raise hospital prices, and this finding holds for both for-profit and nonprofit hospital mergers.[31]

while another found that practices in the most consolidated markets (i.e., those in the 90th percentile) charge 14 to 30% more in fees.[34] The specialty of the physician can also impact how big these price differences are, with one study that in the most consolidated markets, internal medicine physicians charged 16.1% higher prices for office visits compared to orthopedic physicians, who charged 8.3% higher prices.[35]

A growing evidence base also connects vertical consolidation to rising prices, with one study estimating the increase in hospital prices after a vertical hospital and provider group consolidation at 3–5%.[36] Vertical consolidation also increases physician prices. Estimates of the price increases vary across the studies, with a physician's specialty being a determining factor in how much their prices were affected by the integration.[37] For example, one study found that vertical integration increased primary care physicians' prices by 2.1–12% and specialty physicians' prices by 0.7–6%, with the greatest increases happening when physicians merge with larger health systems.[38]

Horizontal consolidation: This refers to a merger or acquisition that occurs between directly competing entities offering the same services, such as a hospital merging with another hospital.

Vertical consolidation: This occurs when one type of entity purchases another operating at a different stage in the healthcare delivery system, such as a hospital acquiring a physician practice.

Facility Fees

Under Medicare payment rules, which are also followed by many commercial payers, physicians who join a hospital can charge higher fees for the same services (known as "facility fees"). One study found that acquired physicians increased their prices by an average of 14.1% and that about half of this increase was attributable to the addition of facility fees.

The increase in physician prices after integrating with hospitals can be the result of several drivers. First, as with any other kind of consolidation, these types of mergers result in providers accruing market power allowing them to extract higher prices from payers. Second, these arrangements can take advantage of payment rules that allow for additional charges for services provided by a hospital system, allowing physician groups acquired by hospitals to impose hefty facility fees for services provided in outpatient settings.[39]

Another factor that drives up healthcare prices after physicians integrate with hospitals is that physicians steer or refer patients toward the hospitals with which they are affiliated.[40] Studies show that these hospitals can be costlier while not necessarily providing better care.[41]

Consumer Affordability

In addition to increasing prices, a growing evidence base points to higher hospital and/or physician market consolidation as a driver of premiums and out-of-pocket costs.

Four studies specifically researched the impact of hospital market consolidation on Affordable Care Act (ACA) Marketplace premiums and all four found that increased consolidation drives up Marketplace premiums.[42] Areas with the highest levels of hospital market consolidation were found to have annual premiums that were 5% higher on average compared to areas with the least concentrated hospital markets. Additionally, an increase from the 10th to 90th percentile of hospital consolidation was associated with an average increase of almost $200 in annual premiums for the second-lowest-cost silver-level plans. One study even estimated that reducing the level of hospital market consolidation to a "moderately competitive" level would bring premiums down by 2% (or more than 10% in some markets).[43]

A study assessing a hospital merger in Toledo, Ohio found that post-merger, out-of-pocket costs for inpatient childbirth increased by about 77%.

Like hospital mergers, physician group consolidation also increases premiums. One study found that an increase from the 10th to the 90th percentile of physician consolidation increased annual premiums for the second-lowest-cost silver-level Marketplace plans by almost $400 (nearly double the impact of hospital consolidation).[44]

Consolidation not only affects Marketplace premiums and cost-sharing[45] but also drives up employer-sponsored insurance premiums and deductibles. For instance, researchers found that, between 2010 and 2018, hospital mergers led to a $638 wage reduction for workers with employer-sponsored insurance, and employers responded to hospital mergers by offering less generous benefits and more high-de-

ductible health plans.[46] These decisions by employers might be driven by the fact that employers who purchase insurance plans end up paying higher premiums in highly concentrated provider markets.[47]

There are fewer studies assessing the impact of vertical consolidation on premiums and cost-sharing. While the emerging research on this topic is mixed, at least one study found that vertical integration in highly concentrated hospital markets was associated with a 12% increase in ACA Marketplace premiums.[48]

Equity

Consolidation—particularly hospital mergers—has an outsized impact on marginalized and disenfranchised communities. Research has found that those most affected by hospital downsizing and closings have been Black, Latino/Latinx, Indigenous, low-income, and LGBTQ+ people, as well as other people of color and women.[49] This is particularly true when mergers lead to the closure of key services not easily accessible elsewhere or where the merger involves the acquisition of independent hospitals by religiously affiliated systems whose doctrine limits the type of services offered.[50]

Access and Utilization

Hospital and physician consolidation also impacts patients' ability to access care when they need it. Studies aimed at evaluating access to services before and after hospital mergers have found that mergers led to reductions in access and utilization. In particular, two studies that examined the impact of small rural hospitals joining larger health systems found that post-merger, rural hospitals were more likely to eliminate or reduce the availability of certain service lines, including primary care, and that there was a reduction in the utilization of inpatient mental health services, outpatient nonemergency visits, and diagnostic imaging.[51] These studies demonstrate that hospital consolidation can harm patients' ability to seek and receive the care they need. These findings are particularly important in light of the arguments supporting rural hospital mergers to improve their financial sustainability.[52]

> *While there is some evidence suggesting that hospitals can improve their profitability through consolidation, given the evidence that points to drops in access, it is very likely that these gains are coming at the expense of patient access.*

One study found that access challenges post-hospital consolidation may be even more pronounced for low-income people. The study examined the impact of increasing hospital market consolidation on healthcare access for Medicaid patients in New York. Researchers found that as market consolidation of hospitals increased, the distribution of Medicaid admissions shifted away from non-profit hospitals to public hospitals, putting strain on systems that already serve a disproportionate number of low-income and uninsured individuals.[53] Researchers attributed this shift to the simple fact that once hospitals consolidate, they can negotiate higher reimbursement rates from private insurers, which are typically greater than Medicaid rates. Instead of investing the increased profits they receive from higher commercial reimbursement rates into providing care for low-income populations, consolidated hospital systems are moving away from safety-net care altogether.

Quality

Despite claims from hospitals and health systems that vertical consolidation will improve care coordination for their patients, there is little evidence suggesting that such consolidation improves the quality of care. In fact, the mix of available evidence leans toward the opposite conclusion, with numerous studies finding that consolidation has negatively impacted patient outcomes. One study in particular found that hospital mergers were associated with a 1.7% increase in inpatient mortality,[54] while two others associated mergers with a decrease in several quality metrics[55] and slower growth in patient satisfaction compared to hospitals that had not undergone mergers.[56] Similarly, studies comparing quality and outcome measures across different markets with higher and lower levels of provider consolidation tied higher levels of provider consolidation with increased mortality[57] and lower patient satisfaction.[58]

The same arguments for horizontal consolidation are often at the heart of vertical consolidation, namely, that the goal of consolidation is ostensibly to improve care coordination, quality of care, and health outcomes. However, studies delving into the effects of vertical integration have offered mixed results across different quality measures. While some studies point to improvements, a few studies even link these acquisitions to lower quality of care. For example, one study found that acquired physicians are financially incentivized to change how they provide care to save on costs and that this can increase the occurrence of post-procedure complications.[59] Other studies found that vertical integration caused an increase in readmission rates[60] and a decrease in patient satisfaction.[61]

POLICY PRIORITIES TO PROTECT CONSUMERS AND LOWER PRICES

03

Policymakers should consider mechanisms to regulate provider consolidation in ways that tamp down on anticompetitive practices and protect consumers. The following principles and priorities should guide their actions.

Strengthen anti-trust enforcement

Anti-trust protections are a critical but underused tool against anticompetitive and ultimately harmful provider consolidation. The Federal Trade Commission (FTC) and the Department of Justice (DOJ) work collaboratively to enforce a range of federal antitrust laws. Because of resource and regulatory constraints, federal regulators investigate a very small number of hospital mergers each year.[62] Current rules require entities to report mergers to the FTC and the DOJ which involve a transaction of at least $111.4M in 2023 (this amount is adjusted annually with inflation). However, many consolidations, especially those by provider groups, do not hit that threshold in a single acquisition, although they may reach it over time as acquisitions accumulate. In addition, neither the FTC nor the DOJ currently has statutory authority to investigate non-profit entities, leaving a significant gap in oversight.

The FTC and the DOJ released joint draft guidelines earlier this year to lay out a more robust vision for cracking down on anticompetitive horizontal, vertical, and, for the first time, cross-market mergers.[63] Now, it will be up to the administration to finalize these draft guidelines and empower both the FTC and the DOJ to use their authority to scrutinize mergers.

States have the potential to monitor the competitive health of markets within their borders and can engage in robust antitrust oversight and review; however, not all state antitrust agencies currently have the necessary authority.[64] State lawmakers should consider implementing or expanding antitrust laws to ensure that state regulators, such as attorneys general, have the tools and the mandate necessary to monitor and intervene in healthcare mergers.

To strengthen anti-trust enforcement, policymakers should consider the following actions:

- Increase funding for state and federal regulatory agencies to expand both agencies' capacity to investigate a wider swath of anticompetitive consolidation.
- Expand regulatory authority to investigate nonprofit mergers.
- Ensure that states have the authority to engage in necessary scrutiny and oversight of healthcare mergers and acquisitions.
- Allow the FTC and the DOJ to investigate a larger number of mergers by lowering the annual acquisition value threshold.
- Allow state regulators to review mergers that fall below the existing federal thresholds.

- Make it easier to challenge mergers by amending current law to allow for the effect of "cumulative" mergers and acquisitions to be taken into account, rather than each merger individually.[65]
- Direct the FTC and the DOJ to develop and utilize a robust health equity framework that takes into account the disproportionate impact of consolidation on medically underserved communities.[66]
- Ensure that state agencies have the mandate and the authority to scrutinize or challenge mergers and acquisitions, oftentimes even in the absence of federal action.[67]

Reform pricing and reimbursement rules

Pricing dynamics can incentivize anticompetitive consolidation and exacerbate the price increases associated with already consolidated markets. The incentive for provider consolidation is largely driven by unchecked pricing practices, allowing providers and hospitals to amass outsized market power and effectively set their own prices with employers and issuers that are divorced from value. For instance, under current law, providers are allowed to charge higher Medicare rates for services provided by off-campus hospital outpatient departments than for services in the same type of outpatient settings not affiliated with a hospital, and/or charge additional facility fees for those services once the office is hospital-affiliated. This incentivizes hospital acquisition of provider groups and can significantly drive up prices and consumer costs post-consolidation.

To curb predatory pricing practices, lawmakers should consider the following actions:

- Enact site-neutral payment legislation, thus creating parity between on-campus and off-campus hospital outpatient departments and independent physician offices in both the Medicare and commercial markets.[68]
- Protect consumers from burdensome fees associated with care provided at hospitals and hospital outpatient settings.

Prohibit anticompetitive contracting terms

The contracting terms between insurers and providers also contribute to an anticompetitive environment and exacerbate the price hikes that are associated with consolidation.[69] As consolidation empowers health systems to wield outsized market power in negotiations with payers, anticompetitive contract terms can further disadvantage competitors – with little ability for insurers to push back.

Though this paper is focused on the use of provider anticompetitive practices in combination with consolidation, both providers and insurers have used these provisions at the expense of a competitive healthcare market.

To strengthen competitive contracting arrangements, policymakers should consider the following actions:

- Ban the use of anticompetitive contracting terms that harm patients and consumers.
- Direct relevant agencies to evaluate the impact of anticompetitive contracting terms in their antitrust enforcement activities.

Improve transparency requirements

Timely, accurate, and complete data is essential for regulators to enforce appropriate oversight, for lawmakers to implement the right policies, and for patients to make informed decisions. That includes data on healthcare prices, claims, and utilization but also information on who owns and controls the facilities and providers within the health system. To date, efforts to increase transparency within the health system have met a number of challenges that leave a fragmented patchwork of incomplete information, hampering efforts to make meaningful progress on the challenges facing patients and consumers. For instance, despite efforts by both the Biden and Trump administrations to increase the transparency of hospital prices through price transparency regulatory requirements,[70] hospitals have been very slow to comply with these requirements.[71] Even with widespread noncompliance, few financial penalties have been levied on noncomplying hospitals to date, although enhanced scrutiny and oversight has resulted in an increase in the number of complying facilities.[72]

To strengthen transparency requirements, policymakers should consider the following actions:

- Use oversight and investigatory powers to hold hearings spotlighting the hospitals that have not complied with the existing transparency requirements.
- States should consider additional enforcement mechanisms, such as prohibiting hospitals that are not in compliance with the transparency requirements to collect debts.
- Enact new transparency requirements that require a range of health systems players (including hospitals, provider groups, surgical centers, and equity funds) to report the data on ownership, mergers and acquisitions, and any changes in ownership to key agencies, such as state or federal departments of health and human services.
- Establish state and federal all-payer claims databases (APCD) to better track prices across insurance markets.[73]
- States could pass additional laws to effectively mandate or enforce appropriate hospital compliance with federal transparency guidelines or add additional reporting and transparency requirements as necessary.[74]

CONCLUSION

04

It is clear that despite its touted goals of enabling health systems to better coordinate care for their members and creating systemwide efficiencies,[75] the reality is that provider consolidation might not do much of either. Not only does consolidation contribute to rising healthcare prices, premiums, and cost-sharing, but substantial evidence points to its negative impacts on the quality of care patients receive in heavily consolidated markets. Thus, this anticompetitive system impacts everyone, although it has the potential to do particular harm to individuals in need of cancer care and treatment who, by virtue of increased utilization of health services, are far more likely to feel the effects of price hikes.

Both state and federal governments have demonstrated some degree of commitment to addressing what is inherently a market failure and enacting laws and regulations that support a competitive healthcare market. Yet greater action is needed. It is time for policymakers to take a stronger approach to abuses of the system and put patient care, treatment, and affordability needs over corporate and health system profits.

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To learn more about this work, please contact advocacy@lls.org.

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