

Market Concentration in Health Care

Government Is the Problem, Not the Solution

BY MICHAEL F. CANNON

The U.S. health sector is not serving consumers as it should or could. Opaque, excessive, and often unconscionable prices both reduce access to care and threaten to wipe out the health savings account (HSA) balances and other savings of even insured Americans.¹ Low-quality care costs lives, while bad policy confounds efforts to improve quality.² Market concentration contributes to these deficiencies.

Markets for hospitals, physician services, and health insurance have exhibited increasing concentration over time. “By 2017, in most markets, a single hospital system had more than a 50 percent market share of discharges.”³ In 2016, markets for specialist physicians exhibited what federal antitrust authorities consider a high degree of concentration in 65 percent of metropolitan areas. Markets for primary-care physicians exhibited high concentration in 39 percent of metropolitan areas. Hospitals are also driving consolidation in markets for physician services. From 2006 to 2016, the share of primary-care physicians who worked for hospitals rose from 28 percent to 44 percent. By 2012,

more than 55 percent of all physicians worked for hospitals. In 2016, 57 percent of health insurance markets exhibited high concentration; in 2018, 75 percent did.⁴

While integrated health care delivery can reduce inputs and improve outcomes, convenience, and other dimensions of quality, the economics literature finds that most consolidation among hospitals, physicians, and insurance companies is *inefficient* consolidation that unnecessarily increases prices and reduces quality:

The research evidence shows that hospitals and doctors who face less competition charge higher prices to private payers, without accompanying gains in efficiency or quality. Research shows the same is true for insurance markets. . . . Moreover, the evidence also shows that lack of competition can cause serious harm to the quality of care received by patients.⁵

Mortality from heart attacks and other causes, for example, is lower in more-competitive hospital markets and



MICHAEL F. CANNON is the Cato Institute's director of health policy studies.

falls when policymakers introduce competition into less-competitive markets.⁶ Research also finds that mortality is lower in more-competitive cardiologist markets and that hospital acquisitions of physician practices do not improve quality.⁷ Increasing competition in health care markets may literally be a matter of life and death.

Consolidation also correlates with price opacity. Hospitals in unconcentrated markets are three times as likely to comply with federal requirements that they publish transparent prices for all services as hospitals in highly concentrated markets.⁸

Inefficient consolidation is largely the result of government interventions that disable the normal market mechanisms of entry, cost-consciousness, and competition from doing what they do in other sectors of the economy: improving quality while reducing prices. Government does not need new powers to combat inefficient provider consolidation. It merely needs to stop encouraging such consolidation.

To improve health care quality and reduce health care prices, state and federal legislators must repeal or drastically overhaul regulations, tax distortions, and entitlement programs that encourage producers to consolidate. Eliminating harmful regulation and letting consumers control the \$4 trillion that fuel the U.S. health sector would restore the normal market mechanisms of entry, competition, and price-consciousness that combat inefficient consolidation.

GOVERNMENT INTERVENTION IN HEALTH CARE ENCOURAGES MARKET CONCENTRATION

State and federal governments intervene in health care markets in various ways and always with the ostensible purposes of improving quality and/or reducing costs. Such interventions include regulation of health professionals, medical facilities, and health insurance issuers; special tax preferences for health-related uses of income (and implicit penalties on other uses of income); and subsidies for health insurance and medical care, including direct government purchasing of both. The unintended consequences of these interventions often include incentives for producers to consolidate to charge higher prices than they could in competitive markets.

Regulation

Nearly all government regulation inadvertently encourages inefficient consolidation. In general, regulation imposes high fixed costs but low marginal costs. When two firms merge, their total cost of complying with government regulations therefore falls.

Regulation thus creates an artificial incentive for firms to consolidate. It places larger firms at a competitive advantage because they can spread the higher fixed costs of regulation over a larger quantity of outputs than smaller firms can. The fixed costs of regulatory compliance inhibit entry, grant larger firms a price advantage that grows as the firm grows, and therefore encourage firms to merge with their competitors. The greater the overall regulatory burden, the greater the incentives for inefficient consolidation.

What is true of regulation generally is true of health care and health insurance regulation in particular. The Patient Protection and Affordable Care Act's (Obamacare's) "minimum loss ratio" (MLR) rules, for example, require insurers who sell health insurance to small businesses and consumers to spend no more than 20 percent of premium revenue on administrative expenses and quality-improvement activities. Large-employer plans may spend no more than 15 percent. These and similar regulations encourage consolidation:

The fixed costs of complying with the[se] . . . and other insurance regulations will weigh more heavily on smaller insurers and increase the costs of entry by new insurers. . . . The MLR rules could encourage insurers to consolidate to obtain product portfolios more likely to meet the minimum MLR requirements (e.g., from pooling expenses or reducing statistical volatility in MLRs), or simply to achieve additional economies of scale in administration.⁹

Some regulations both add to the overall burden of government regulation and create specific barriers to entry that increase consolidation in health care markets. Clinician-licensing laws and the attendant scope-of-practice regulations disproportionately hinder the entry of integrated, prepaid group plans like Kaiser Permanente, which compete on price by making fuller use of midlevel clinicians. To enter new markets, such systems must develop new

workflows to conform to each state’s different and ever-changing scope-of-practice rules. Insurance-licensing laws and regulation of medical facilities create similar barriers.

Some government regulation appears to exist for the *purpose* of encouraging inefficient provider consolidation. Thirty-five states require health care providers to obtain a “certificate of need” (CON)—that is, a permission slip from government—before entering or expanding their presence in a market. Twenty-eight states impose CON requirements on hospitals.¹⁰ CON regulation appears to do little other than increase market concentration by blocking entry:

A reasonably large body of evidence suggests that CON has been used to the benefit of existing hospitals. Prices and costs were higher in the presence of CON, investor-owned hospitals were less likely to enter the market, multihospital systems were less likely to be formed, and hospitals were less likely to be managed under for-profit contract.¹¹

Nor does CON regulation appear to improve quality.¹² The Federal Trade Commission and Department of Justice write, “CON programs risk entrenching oligopolists and eroding consumer welfare.”¹³ Twenty-two states suspended their CON regulations during the COVID-19 pandemic, an implicit acknowledgment that CON regulation reduces access to care.¹⁴

Excessive Insurance

A second category of government intervention that encourages inefficient consolidation is policies that make consumers insensitive to prices for health insurance and medical care. These policies include the tax exclusion for employer-sponsored health insurance and regulations that require consumers to purchase certain types or levels of coverage.

Consumer price-consciousness acts as a check on providers’ ability to amass market power and charge excessive prices. To the extent consumers are price-conscious, they respond to excessive prices by switching to lower-price providers.

Health insurance makes consumers less price-sensitive. It “removes the incentive on the part of individuals, patients, and physicians to shop around for better prices for hospitalization and surgical care”¹⁵ because the savings go to the

insurance company rather than to the consumer. It therefore encourages inefficient consolidation by diminishing the market’s ability to punish it.

Health insurance nevertheless increases efficiency on balance. While the moral-hazard effect of health insurance inevitably leads to higher medical prices, premium-paying consumers balance the marginal costs of moral hazard (including inefficient consolidation) against the marginal benefits of risk protection. To the extent consumers pay the premiums themselves, many will support or tolerate efforts by insurers to steer them toward lower-cost providers in exchange for lower premiums.

Government policies that encourage excessive levels of coverage upset that balance and lead to inefficient consolidation by making insured consumers less price-sensitive. Obamacare’s “essential health benefits” mandate and more than a thousand mandated-coverage requirements at the state level require consumers to purchase more coverage than they otherwise would.¹⁶ These regulations diminish the market’s ability to punish inefficient consolidation both by blocking entry into health insurance markets and by making consumers even less price-conscious when consuming medical care.

The tax exclusion for employer-sponsored health insurance diminishes price-consciousness when consumers purchase both medical care *and* health insurance.¹⁷ The exclusion leads workers to demand excessive coverage in at least two ways. First, it reduces the after-tax price of health insurance relative to other goods and services. That price distortion leads workers to demand more coverage than they otherwise would. Second, it creates the illusion that employers, rather than workers themselves, bear most of or all the cost of employee health benefits. That illusion leads workers to demand more coverage than they would if they knew they bear the full cost.¹⁸

The exclusion therefore encourages inefficient consolidation in at least two ways. First, encouraging excessive coverage diminishes the market’s ability to punish inefficient consolidation. Second, insulating workers from the price of their health insurance makes workers less likely to tolerate efforts by insurers to punish inefficient consolidation by steering enrollees toward lower-price providers.

Both of these effects—insurers purchasing a larger share of medical spending and greater enrollee resistance to insurers’ negotiating strategies—increase the rewards for

inefficient provider consolidation. They allow providers to demand even higher prices from insurers, who face strong incentives to accede rather than face a backlash from their price-insensitive enrollees.

Government Purchasing

A third category is government purchasing of medical care. The pricing errors that inevitably accompany government price-setting and purchasing provide powerful incentives for producers to merge and consolidate.

Medicare itself sets the total price it pays doctors and hospitals for each individual service. Medicare often pays more when similar patients receive the same service in a hospital versus a physician's office. "When a cardiologist in private practice provided a level II echocardiogram without contrast," for example, "Medicare paid \$188. But, when a doctor connected to a hospital performed the same test in an outpatient context, the payment was \$452.89. That's an additional \$265 that the hospital and doctor can share—including an additional \$212 from taxpayers and \$53 from the patient—to their mutual advantage."¹⁹

Such "site of service" pricing errors occur throughout Medicare:

In 2012, Medicare paid an average of \$1,300 for colonoscopies performed in doctors' offices, but it shelled out \$1,805—39 percent more—when these procedures were delivered at hospitals. . . . When a hospital gives a lung cancer patient a dose of Alimta, its fee is about \$4,300 larger than a doctor with an independent practice would receive. For Herceptin, a drug given to women with breast cancer, the site-of-service differential is about \$2,600. And for Avastin, when used to treat colon cancer, it is \$7,500.²⁰

Figure 1 shows Medicare's site-of-service price differentials when similar enrollees received identical evaluation and management services in hospitals versus physicians' offices in 2013.

Looking only at evaluation and management services in just eight states, Medicare's site-of-service pricing errors cost taxpayers \$1.3 billion and Medicare enrollees \$334 million from 2010 through 2017.²¹ Equivalently, just this one category of

site-of-service pricing errors created \$1.6 billion in incentives for providers in those states to consolidate.

Site-of-service differentials could be appropriate if hospitals were treating patients who require more services than a physician's office can provide. In many cases, however, such as evaluation and management (E&M) office visits, patients are similar across settings and generally do not require the more-intensive services hospitals offer. Higher payments for hospitals are therefore not appropriate because "hospitals should not need to maintain standby capacity for E&M office visits that are not provided in an emergency department, nor should requirements to stabilize patients presenting at the emergency room affect the costs of furnishing E&M office visits."²² Indeed, Medicare pays higher prices even when patients continue to receive the same services in the same physician's office simply because a hospital purchased the physician's practice.²³

Congress and the Centers for Medicare & Medicaid Services have taken steps to reduce site-of-service pricing errors.²⁴ Even if existing reforms had been in place from 2010 to 2017, however, site-of-service pricing errors for evaluation and management would still have cost taxpayers and Medicare enrollees \$200 million in those eight states.²⁵ Put differently, existing reforms to evaluation and management pricing errors would have left in place \$200 million in incentives for providers in those states to consolidate. Not only are existing "site neutrality" reforms inadequate but the federal government has suspended some of them for the duration of the COVID-19 public health emergency.²⁶

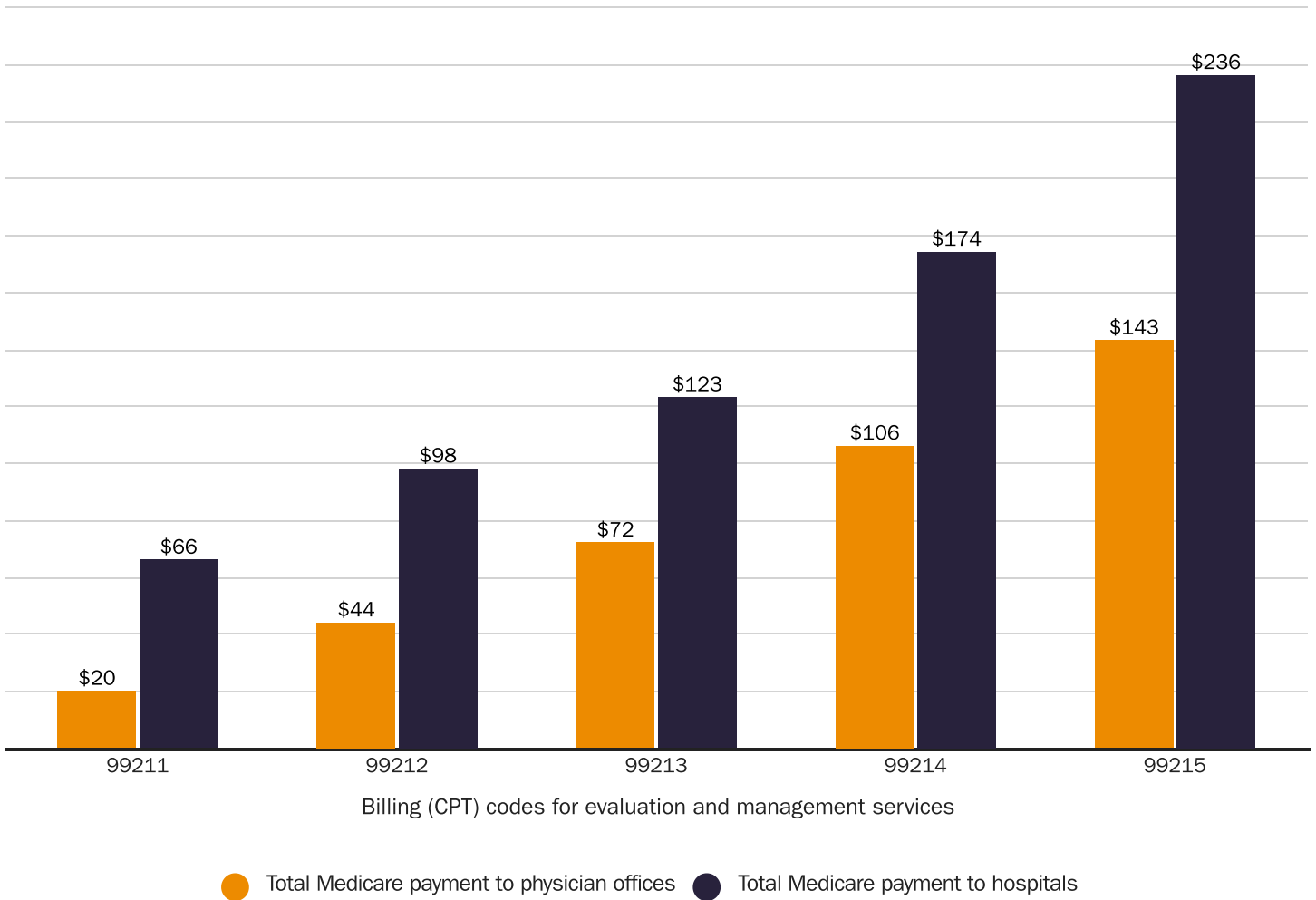
Medicare's persistent pricing errors encourage providers to consolidate to capture and split the benefits of the excessive prices Medicare sets and pays. Once those firms merge, taxpayers pay more for the same services via the Medicare program, enrollees pay more out of pocket, and those firms' greater market power allows them to increase prices for private payers.

STOP ENCOURAGING INEFFICIENT CONSOLIDATION

Inefficient consolidation is a result of government failure, not market failure. Government therefore is not the solution to inefficient consolidation in health care. Government is the problem. If state and federal lawmakers want

Figure 1

Medicare drives provider consolidation by paying more for the same services when hospitals buy physician practices (2013)



Source: Tammy Worth, "Hospital Facility Fees: Why Cost May Give Independent Physicians an Edge," *Medical Economics*, August 6, 2014.
Note: CPT = Current Procedural Terminology.

to combat inefficient consolidation, they should stop doing so much to encourage it.

Don't Expand Government

Most proposals to address inefficient consolidation involve additional government intervention into the health sector. Such proposals gain currency not because they would benefit consumers but because they would benefit special interests.

Legislators and bureaucrats gravitate toward and promote additional government interventions out of their own self-interest. Additional government power further increases their own power and status.

Industry interests gravitate toward and promote proposals that would let them use government to punish their rivals or that would let them benefit at the expense of taxpayers. The health insurance lobby says the solution to inefficient consolidation is to expand antitrust powers and enforcement.²⁷ Incidentally, those proposals would allow health insurers to use government to punish hospitals. Many physicians argue that the solution to inefficient consolidation is to expand Medicare. Specifically, they argue that Medicare should subsidize physician-owned hospitals and that doing so would encourage entry in hospital markets.²⁸ Indeed, it might. It would also happen to benefit, at the expense of taxpayers, the physicians who own those hospitals.

History instructs that such approaches are likely to backfire. Dozens of government interventions—including government regulation generally, health care regulation, tax policy, and entitlements—have had the unintended consequence of encouraging inefficient consolidation in health care markets. Additional government regulation is more likely to encourage such consolidation or produce other unintended consequences than it is to fix the problem.

Reduce Regulatory Burdens across the Board

To curb inefficient consolidation, government should outright repeal or drastically curtail regulations that encourage it. Eliminating *any* government regulation with high fixed costs and low marginal costs would reduce incentives for health care providers, insurers, and other producers to consolidate and would increase competition by removing barriers to market entry. The scope for competition-enhancing deregulation is vast.²⁹ Since 1976, federal regulators have issued more than 208,000 final regulations. In 1960, the *Code of Federal Regulations* comprised fewer than 23,000 pages. By 2020, it contained nearly 186,000 pages.³⁰ The costlier the regulation, the more that eliminating it would remove incentives for inefficient consolidation and encourage competition.

Repeal State Laws That Encourage Market Concentration

States should repeal regulations including CON, clinician-licensing laws, and insurance-licensing laws. States should also repeal or drastically curb regulations that impede entry and competition, such as “any willing provider” laws and “network adequacy” regulation. Despite their laudatory ostensible goals, in practice these regulations do little more than protect providers from competition at the expense of consumers.

Authorities such as the Federal Trade Commission, the Department of Justice, and antitrust economist Martin Gaynor recommend repealing CON laws entirely.³¹ Repeal would reduce barriers to entry for more-efficient providers, thereby reducing market concentration and health care prices.

States should likewise repeal clinician-licensing laws. Such laws inhibit innovations including affordable primary care, interstate telehealth, and integrated delivery systems. The anti-competitive effects of clinician licensing reduce access to care while adding little if anything to the quality protections that would exist in its absence.³²

If repealing clinician-licensing laws is politically infeasible, states should overhaul such laws in a manner that prevents them from blocking new categories of health professionals, innovations in medical education, or innovations in health care delivery. “States that have not done so already should adopt licensure reciprocity across states, in order to facilitate entry and the advance of innovative ways of organizing and delivering care.”³³ In addition, states should certify multiple private organizations to perform the functions of state licensing boards.³⁴

Gaynor argues that states should further increase competition and curb excessive prices by repealing “any willing provider” regulations and curtailing network-adequacy regulation.³⁵ Any-willing-provider regulations protect high-price providers from price competition by preventing insurers from steering enrollees toward more-efficient providers. The result is higher prices and premiums. Network-adequacy regulations inhibit competition among both insurers and providers and “can also undermine attempts by insurers to promote competition” and lower prices.³⁶

Akin to clinician-licensing laws, state insurance-licensing laws block entry by health insurance products available in other jurisdictions. They contribute to market concentration and higher premiums by protecting incumbent insurers from competition by new entrants. They further increase premiums by denying consumers the opportunity to escape unwanted regulatory costs. Of particular moment, they block entry by products from U.S. territories, where Obamacare’s costliest regulations do not apply and insurers can therefore offer lower-cost, higher-quality health plans.

If repealing insurance-licensing laws is politically infeasible, states can increase competition in their insurance markets by deeming as in compliance with their regulations any health plan that American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, or the U.S. Virgin Islands license for sale. In 2019, just two insurers—Blue Cross Blue Shield and Centene—controlled 92 percent of Florida’s

individual health insurance market.³⁷ Freeing Florida consumers to purchase any health plan that U.S. territories license for sale would open the market to competition from additional carriers such as Aetna, UnitedHealthcare, and Humana, each of which already does business in the territories and has provider networks in Florida.³⁸

It would also reduce premiums and improve the quality of health insurance. Plans that are free from Obamacare regulations have premiums that are often 70 percent lower and offer broader provider networks.³⁹

Repeal or Overhaul Federal Policies That Encourage Market Concentration

Most government interventions that encourage inefficient consolidation occur at the federal level. Congress therefore has an even larger role to play in removing anti-competitive policies than states do.

To start, Congress should repeal federal network-adequacy regulations and the “community rating” price controls that give rise to them. The purpose of network-adequacy regulation is to counteract the unintended consequences of community rating. Through the Medicare Advantage program and Obamacare, Congress prohibits insurers from charging actuarially fair premiums to enrollees. The stated purpose of those price controls is to eliminate discrimination against patients with preexisting conditions. Instead, community rating merely shifts discrimination against the sick to the level of benefit design, where it is even more harmful.⁴⁰ Eliminating the price controls that give rise to state and federal network-adequacy regulations would eliminate the need for those regulations.

Most important, Congress should reform the tax code and Medicare to make consumers fully price-conscious. Converting the current tax exclusion to an exclusion for contributions to larger, more flexible HSAs would let workers control \$1 trillion of their earnings each year that employers currently control. It would also deliver the largest effective tax cut in living memory.⁴¹ Reforming Medicare using “public option” principles would transform it into a cash-transfer program similar to Social Security.⁴²

Each of these reforms would partly restore the market’s ability to punish inefficient consolidation. If consumers

controlled the majority of the \$4 trillion that fuel the U.S. health sector, they would punish inefficient consolidation and excessive prices because they personally would reap the benefits of switching to more-efficient providers. Patients would not pay hospitals twice as much as what a physician’s office charges for the same service, like Medicare does. “If patients were spending their own dollars, they wouldn’t go to more expensive providers when cheaper ones were available, and just as good.”⁴³

Empirical evidence confirms that price-conscious consumers can overcome producers’ market power. In California, market power allows many hospitals to charge excessive prices for hip and knee replacements. Insurers have little choice but to pay those excessive prices; the fact that their enrollees are price-insensitive leaves insurers unable to steer them toward lower-price hospitals. Why should enrollees go along when they see no benefit?

An experiment that made patients who received hip or knee replacements price-conscious changed the behavior of both the patients and high-price hospitals. Once consumers personally reaped the benefit of shopping for lower prices, one-sixth of patients who received hip or knee replacements switched from high-price hospitals to low-price hospitals. That loss of market share led high-price hospitals to cut prices by 37 percent over two years—an average price reduction of \$16,000 per procedure.⁴⁴ Figure 2 shows that prices fell across all hospitals by roughly 20 percent and that in similar experiments, price-consciousness reduced prices by up to 32 percent after two years for knee and shoulder arthroscopies, cataract removals, colonoscopies, CT and MRI scans, and laboratory tests.⁴⁵ These experiments illustrate how excessive health care prices have become, that price-unconsciousness is allowing those excessive prices to persist, and that price-consciousness can defeat providers’ market power.

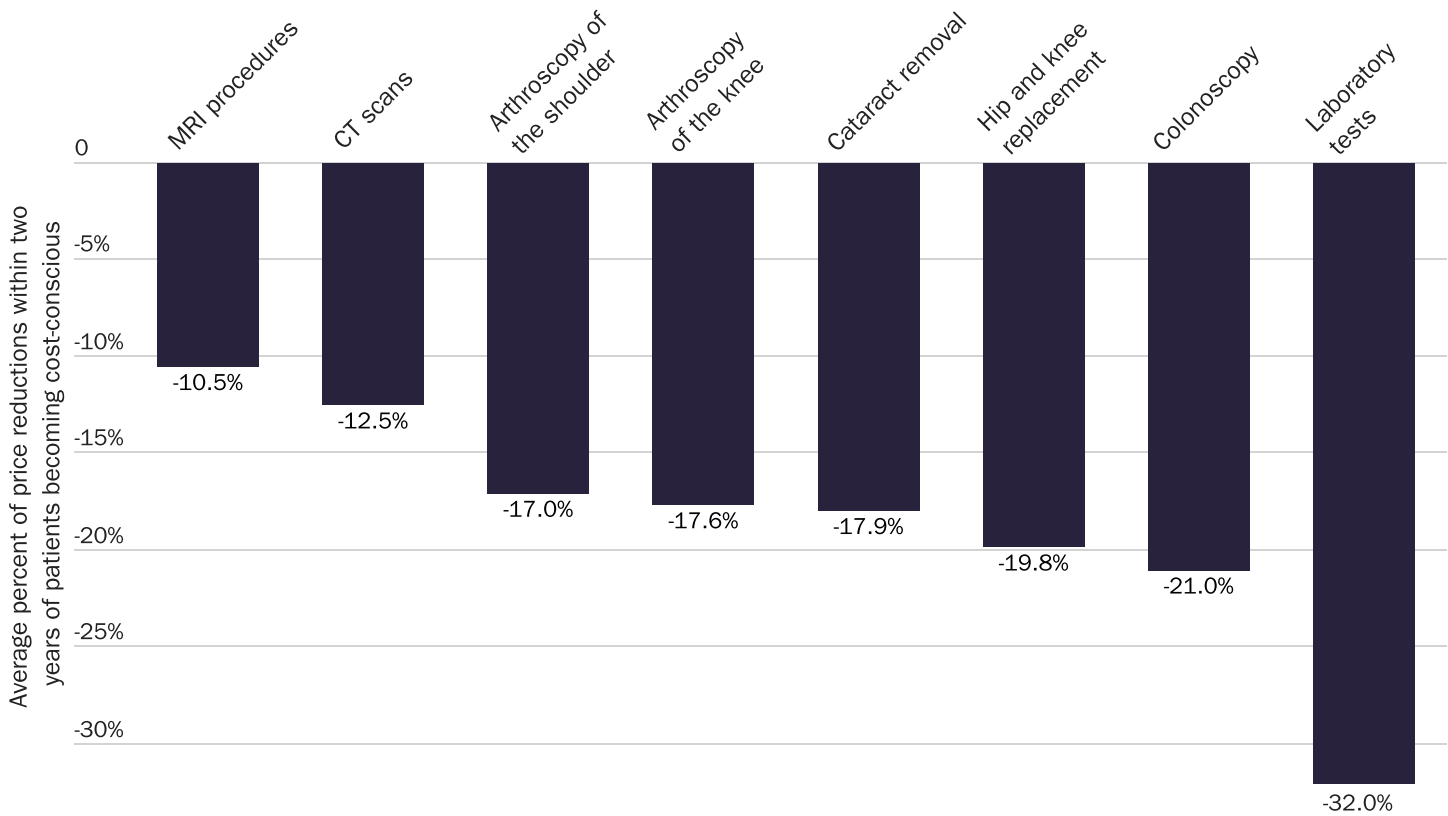
CONCLUSION

Inefficient consolidation among hospitals and other producers in the health sector is primarily a result not of market forces but of ill-advised government interventions into health care markets.

Government does not need any new powers to make health care better, more affordable, and more secure for all

Figure 2

Price-consciousness in health care defeats market power, lowers prices



Source: James Robinson, Timothy Brown, and Christopher Whaley, “Reference Pricing Changes the ‘Choice Architecture’ of Health Care for Consumers,” *Health Affairs* 36, no. 3 (March 2017).

Americans, including for the most vulnerable. State legislatures and Congress need only stop encouraging inefficient consolidation.

Sweeping, wholesale reform is rare. Yet merely tweaking

the government interventions that encourage inefficient consolidation would continue to leave consumers in the lurch. Eliminating anti-competitive government policies in health care may literally be a matter of life and death.

NOTES

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20. Silver, *Overcharged*, pp. 180–1.
21. Amy J. Frontz, *Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 through 2017 Than They Paid to Freestanding Facilities in the Same States for the Same Type of Services*, Office of Inspector General Report no. A-07-18-02815 (Washington: Department of Health and Human Services, June 2022), p. 8.
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