



TO: Department of Justice
Department of Health and Human Services
Federal Trade Commission

FROM: Lovisa Gustafsson, M.B.A., *Vice President, Controlling Health Care Costs*
Christina Ramsay, M.P.H., *Program Officer, Policy*
Sara Federman, *Senior Program Assistant, Policy*

DATE: May 14, 2024

RE: Docket No. ATR 102; Request for Information on Consolidation in Health Care

Thank you for the opportunity to submit comments in response to your [request for information](#) on the effects of consolidation in health care.

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most underserved communities.

Below we offer comments—informed by research from Fund-supported grantees and other experts—on the effects of certain transactions conducted by private equity, health systems, and private payers, as well as the opportunities for government action.¹

Health care markets have become increasingly concentrated in the past few decades. In 2016, 90% of metropolitan areas had highly concentrated hospital markets, 65% had highly concentrated specialist physician markets, 39% had highly concentrated primary care physician markets, and 57% had highly concentrated insurance markets.² In 2016, about three-fifths of Americans lived in metro areas that drew concern and scrutiny based on changes in concentration between 2010 and 2016.³ Within the last decade, this trend of consolidation has only continued. For instance, a more recent study of 183 metro areas found that between 2017 and 2021, prices rose in 98% of metro areas and hospital system concentration rose in close to 70% of metro areas.⁴ Commercial insurance market concentration has also continued to grow; 73% of metropolitan statistical areas were highly concentrated in 2022, compared to 71% in 2014, according to the American Medical Association.⁵ New types of arrangements—including

¹ The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

² B. D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs*, Sept. 2017 36(9):1530–38. <https://doi.org/10.26099/e365-2k72>.

³ Ibid.

⁴ "Hospital Concentration Index: An Analysis of U.S. Hospital Market Concentration," Health Care Cost Institute, updated Jun. 2023, <https://healthcostinstitute.org/hcci-origins/hmi-interactive#HMI-Concentration-Index>.

⁵ American Medical Association, *Competition in Health Insurance: A comprehensive study of U.S. markets* (AMA, 2023), <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf>.

private equity-led acquisitions and less obvious forms of vertical consolidation—are also proliferating and implicating different sectors of the health care system.⁶

Consolidation, mergers, and acquisitions in health care markets are typically justified as efforts to reduce total spending and improve patient outcomes by obtaining efficiencies and increasing care coordination. However, the evidence does not support these assertions.⁷ Instead, we see a variety of profit-maximizing behaviors across non-profit, for-profit, and investor-backed companies, such as raising prices, increasing treatment intensity, and shifting providers out of network—without demonstrating lower costs or better outcomes for patients.

Transactions Conducted by Private Equity

Private equity (PE) has long been active in hospital, nursing home, and home care settings, but acquisitions of physician practices have skyrocketed recently—especially in high-margin practices like dermatology, urology, gastroenterology, cardiology, and anesthesiology.⁸ Between 2012 and 2021, the number of PE acquisitions of physician practices increased from 75 to 484 deals—over a six-fold increase.⁹

PE can offer independent physicians and small practices an alternative to selling themselves to hospitals and help them deal with administrative overhead that detracts from time spent caring for patients.¹⁰ While some innovative examples hold promise, it’s easier and more common for private owners to focus on high-margin services and increase health care prices and utilization—and thus costs—to both patients and society.¹¹ A 2023 report found statistically significant price increases due to PE acquisition in 8 out of the 10 specialties studied, ranging from 16% in oncology to 4% in primary care and dermatology.¹² Moreover, there is no evidence to suggest that PE ownership leads to systematic improvements in care quality. Acquired facilities face financial pressures to pay rent or repay loans from PE firms selling off assets (e.g., selling a health care facility to another investor and obligating the provider to lease it back),

⁶ Cheryl L. Damberg, “Health Care Consolidation: The Changing Landscape of the U.S. Health Care System,” (Submitted Testimony, Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives, Hearing on “Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets,” May 17, 2023), https://www.rand.org/content/dam/rand/pubs/testimonies/CTA2700/CTA2770-1/RAND_CTA2770-1.pdf.

⁷ RAND Health Care, *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets* (Prepared for the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services, August 2022), <https://aspe.hhs.gov/sites/default/files/documents/0d2c04fec395bc8c573c5b20c189cdd0/enviromental-scan-consolidation-hcm.pdf>.

⁸ David Blumenthal, “Private Equity’s Role in Health Care” (explainer), Commonwealth Fund, Nov. 17, 2023. <https://doi.org/10.26099/3kcn-8j78>

⁹ Richard M. Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*, (American Antitrust Institute, the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley, and the Washington Center for Equitable Growth, July 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

¹⁰ Lovisa Gustafsson, Shanoor Seervai, and David Blumenthal, “The Role of Private Equity in Driving Up Health Care Prices,” *Harvard Business Review*, published online Oct. 29, 2019. <https://hbr.org/2019/10/the-role-of-private-equity-in-driving-up-health-care-prices>.

¹¹ Blumenthal, “Private Equity’s Role in Health Care”; Alexander Borsa et al., “Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review,” *BMJ* 382 (July 2023), <https://doi.org/10.1136/bmj-2023-075244>.

¹² Scheffler et al., *Monetizing Medicine*.

as well as from taking out debt. These pressures raise concerns over possible bankruptcy and closures, as exemplified by the recent Steward Health Care bankruptcy filing, which has concerning implications for access to care and equity—especially for facilities in poor and rural communities.

Physician management companies (PMCs), often backed by PE, have increasingly contracted with health care facilities to offer staffing and management services, particularly in anesthesiology. Facilities may find these contracts appealing because they can outsource the work of recruitment, billing, and scheduling.¹³ PMCs argue that they can increase revenue and decrease costs for facilities, by virtue of their size and managerial expertise.¹⁴ A 2022 cohort study compared the prices paid to anesthesia practitioners in outpatient facilities that did vs. did not contract with PMCs.¹⁵ Researchers found that prices paid to practitioners in PMC-contracted facilities significantly increased, with allowed amounts having increased by 16.5% and unit prices by 18.7%.¹⁶ These amounts were even higher if the PMC received PE investment (26.0% and 25.6% for allowed amounts and unit prices, respectively).¹⁷ This research raises concerns over PMCs and PE firms putting upward pressure on in-network prices, thereby potentially contributing to higher premiums and cost-sharing for patients.¹⁸

Greater transparency into physician practice acquisitions and ownership changes would help researchers, policymakers, and regulators better understand and respond to the changing competitive landscape. Most PE transactions in health provider markets are small enough to fall below the threshold for reporting and regulatory scrutiny.¹⁹ PE firms regularly use a “roll up” strategy, in which they buy one practice and then use that practice to amass additional practices—each falling under the reporting thresholds.²⁰ Such transactions can have a cumulatively substantial impact on competition and warrant greater attention.²¹

Transactions Conducted by Health Systems

In the past decade, the vertical integration of physician practices with hospitals and health systems has significantly altered the provider market landscape. From 2010 to 2016, the share of office-based physicians who worked in hospital-owned organizations increased from 30 to 48 percent.²² During that same period, the percentage of primary care providers working in practices owned by a hospital or health system increased by 57%.²³ This trend has only continued in recent years: between 2012 and 2022, the proportion of physicians working in private practices wholly owned by physicians fell from 60

¹³ Ambar La Forgia et al., “Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Providers,” *JAMA Internal Medicine* 182, no. 4 (April 2022): 396-404, <https://doi.org/10.1001%2Fjamainternmed.2022.0004>.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Scheffler et al., *Monetizing Medicine*.

²⁰ Ibid.

²¹ Ibid.

²² Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, “Consolidation Trends In California’s Health Care System: Impacts On ACA Premiums and Outpatient Visit Prices,” *Health Affairs* 37, no. 9 (September 2018): 1409-1416, <https://doi.org/10.1377/hlthaff.2018.0472>.

²³ Brent D. Fulton, “Health Care Market Concentration Trends In The United States: Evidence and Policy Responses,” *Health Affairs* 36, no. 9 (September 2017): 1530-1538, <https://doi.org/10.1377/hlthaff.2017.0556>.

to 47 percent.²⁴ Theoretically, vertical integration could facilitate infrastructure development and care coordination by aligning multiple provider types to provide more efficient and holistic care—but most integration appears to be more driven by the desire for increased leverage in the marketplace, as opposed to care improvements.²⁵

A national study found that market-level hospital-physician vertical integration was associated with higher physician prices for primary care, orthopedics, and cardiology office visits.²⁶ However, it was not associated with changes in the use of facility fee billing, which suggests that site-neutral payments alone would not curb price growth resulting from vertical integration.²⁷ Given that the literature does not suggest that vertical integration is associated with significant improvements in quality, these price increases warrant close review.²⁸

A California-specific study found that increased vertical integration from 2013 to 2016 in highly concentrated hospital markets was associated with a 12 percent increase in Affordable Care Act (ACA) Marketplace premiums.²⁹ For physician outpatient services, the increase in vertical integration was also associated with a 9 percent increase in specialist prices and a 5 percent increase in primary care prices.³⁰ As the researchers note, if dominant hospital systems acquire enough physician practices in a specialty, they can increase their own market power and foreclose competition from—or increase costs for—rival hospitals.³¹ The cost- and competition-related implications of these transactions must be scrutinized alongside further research on their quality implications.

Transactions Conducted by Private Payers

Insurers' acquisitions of physician practices, other providers, PBMs, and pharmacies integrating with PBMs often escape federal scrutiny. With so little transparency into how these companies operate, there is ample opportunity for merged entities to engage in gaming and anticompetitive actions that disadvantage other market players, decrease options for consumers, and increase health care spending.³² Examples include:³³

- A health plan can manipulate its medical loss ratio by shifting statutorily prohibited profits to a different business unit within the same company.

²⁴ Carol K. Kane, *Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022* (American Medical Association, July 2023), <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>.

²⁵ Martha Hostetter and Sarah Klein, "Making Health Care Consolidation Work for Patients: An Interview with Commonwealth Fund President David Blumenthal," *Transforming Care*, Commonwealth Fund, Nov. 7, 2022. <https://doi.org/10.26099/q48p-me17>; Damberg, "Health Care Consolidation."

²⁶ James Godwin et al., "The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 58 (March 2021), <https://doi.org/10.1177%2F0046958021991276>.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Scheffler, Arnold, and Whaley, "Consolidation Trends In California's Health Care System."

³⁰ Ibid.

³¹ Ibid.

³² Lovisa Gustafsson and David Blumenthal, "The Pandemic Will Fuel Consolidation in U.S. Health Care," *Harvard Business Review*, Mar. 9, 2021. <https://hbr.org/2021/03/the-pandemic-will-fuel-consolidation-in-u-s-health-care>.

³³ Ibid.

- Dominant providers can offer lower rates preferentially to their parent insurer, thereby disadvantaging rival insurance plans and ultimately making it more difficult for the other plans to compete based on the premiums they charge and driving them out of the market.
- Insurers can adopt practices that maximize their PBM revenue, while driving up costs for patients, employers, and the government.
- Dominant “must-have” providers can extend anticompetitive contract terms to acquired physician practices.

Gaining insight into these arrangements would require further data collection from an agency with subpoena power, such as the FTC or DOJ. Congress may also request agency investigations into such arrangements.

Opportunities for Government Action

There are several steps that the federal government could take to further evaluate and mitigate the adverse effects of consolidation in the health care market. The Commonwealth Fund’s Task Force on Payment and Delivery System Reform issued the following recommendations:³⁴

- AHRQ (or GAO at the request of Congress) should study the impact of “payviders”—integrated payer and provider groups—on quality, equity, access, and cost of care.
- FTC and DOJ should evaluate the effect of PBM mergers and acquisitions, retail pharmacy chains, pharmacy services administrative organizations (PSAOs), and insurers on drug purchasing, distribution, and pricing. FTC has already launched an inquiry into PBMs and required them to provide information on their business practices; the agency could expand upon its work to examine the roles of the aforementioned entities.³⁵
- FTC and DOJ should prohibit or restrict use of anticompetitive contract provisions, including anti-tiering and anti-steering provisions, nondisclosure agreements, and all-or-nothing provisions.
- Congress should require all health care entities to report merger-and-acquisition activities, regardless of amount or value, to state attorneys general. This policy would aid states in tracking and analyzing these transactions if needed or desired.
- Congress should expand the FTC’s ability to enforce antitrust laws against noncompetitive behavior in the health care industry—for example, by authorizing investigations into, and actions against, smaller mergers and anticompetitive behaviors by not-for-profit firms.

Thank you for the opportunity to respond to your request for information. We’re happy to discuss these comments at your convenience.

³⁴ Commonwealth Fund Task Force on Payment and Delivery System Reform, *Six Policy Imperatives to Improve Quality, Advance Equity, and Increase Affordability* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7mvp-m252>.

³⁵ Federal Trade Commission, “FTC Launches Inquiry Into Prescription Drug Middlemen Industry” (Press release, June 7, 2022), <https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry>.