STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Ways & Means

Subcommittee on Health

Re: Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

May 17, 2023

Division of Legislative Counsel

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Ways & Means Subcommittee on Health as part of the hearing entitled, "Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets." The AMA commends the Subcommittee for focusing on the critically important issue of consolidation in health care markets and the consequences for patients. This particular statement utilizes data to illustrate the harmful effects of health insurance and pharmacy benefit manager consolidation, as well as the importance of lifting the current ban on physician-owned hospitals. In addition, the AMA is pleased to highlight a collection of bipartisan legislation that can help alleviate many of the negative effects of these interconnected policy issues.

I. Health Insurance Competition Study

An important question of public policy is whether health insurance markets are competitive or whether health insurers possess market power. If insurers exercise market power, health plan premiums would be higher, and payments to providers and the quantity of health care would be lower, in comparison to competitive health insurance markets. High market concentration tends to lower competition and facilitate the exercise of market power. Unfortunately, the majority of U.S. health insurance markets are highly concentrated, as documented in a comprehensive study of U.S. markets.[1] In fact, the share of highly concentrated commercial markets in metropolitan statistical areas (MSA) rose from 71 percent to 75 percent between 2014 and 2021.

There is high concentration among health insurers in most Medicare Advantage (MA) markets, as well. Seventy-nine percent of MA markets were highly concentrated in 2021. While MA markets have undergone a consistent, though gradual, decrease in average concentration since 2017, the decrease in average MA market concentration masks some merger activity that took place. By acquiring an insurer in another market where they do not already provide coverage, some MA insurers have been able to get bigger. Anthem accomplished this in commercial markets through its 2004 acquisition of WellPoint, as well as each of those merging parties' acquisition of other Blue Cross Blue Shield insurers before that.

[1] Guardado, J., Kane, C. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. American Medical Association Division of Economic and Health Policy Research. 2022. Available at https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf. Accessed March 16, 2023.

Most health insurance markets are ripe for the exercise of health insurer market power, which, in turn, harms consumers and providers of care. These findings should prompt federal and state antitrust authorities to vigorously examine the competitive effects of proposed horizontal and vertical mergers involving health insurers.

Given the uncertainty in predicting the competitive effects of consolidation, some mergers that are allowed cause competitive harm. For example, in 2008 regulators authorized a merger between UnitedHealthcare and Sierra under the condition that UnitedHealthcare divest most of its MA business in the Las Vegas area. Nonetheless, premiums in the commercial health insurance markets in Nevada increased in the wake of the merger.[2]

After years of largely unchallenged consolidation in the health insurance industry, a few subsequent attempts to consolidate have received closer scrutiny. Most notably, in 2015 two mergers involving four of the largest health insurers in the country were announced. Anthem attempted to acquire Cigna, and Aetna sought to acquire Humana. To help identify markets where mergers would cause competitive harm, the AMA used data from previous editions of the *Competition in Health Insurance* study (referenced above in footnote 1) to assess their competitive effects. Specifically, the AMA calculated the changes in market concentration that would result from the mergers and, according to the Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines, classified markets based on how anti-competitive the mergers would be. The AMA's analysis found that the mergers would be deemed anticompetitive in numerous markets across the United States.[3] Consistent with the findings and after close to a year of antitrust scrutiny, the DOJ and attorneys general from multiple states sued to block both acquisitions.[4] The DOJ and state attorneys general ultimately prevailed after an intense battle in the courts, which found that the mergers would cause harm to consumers and violate antitrust law. As a result, both mergers were abandoned by the merging parties. The AMA's studies will continue to monitor competition in health insurance markets and be used to assess the competitive effects of proposed mergers among health insurers, as well as vertical mergers with firms in other parts of the supply chain such as PBMs.

II. Physician-Owned Hospitals

The U.S. health care system is a market-based system that is not working as well as it could; it faces issues such as high and rising prices, suboptimal quality of care, and poor pricing practices.[5] This is partly the result of significant consolidation occurring in hospital markets around the country.[6] Many markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[7] Consolidation has real-life consequences, as clearly laid out in a new book by Professors David Dranove and Lawton R. Burns about health care

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[2] Guardado, J., Emmons, D., Kane, C. *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*. HMPI. 2013;1(3):16-35. Available at https://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf. Accessed March 16, 2022.

[3] See https://www.ama-assn.org/about/competition-health-insurance-research. Accessed March 16, 2023.

[4] See lawsuits announcement at https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s. Accessed March 16, 2023.

[5] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, 2 (May 19, 2021) (Martin Gaynor, *Antitrust Applied*).

[6] Martin Gaynor, *Antitrust Applied*, at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/. (Accessed March 16, 2023), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

[7] Martin Gaynor, *Antitrust Applied*, at 2.

"megaproviders."[8] They found that in markets "where megaproviders dominate…, health care spending is higher, often much higher, and health care quality is no better, and sometimes lower."[9] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[10] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[11] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[12]

Consolidation is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health care costs.[13] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[14] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[15] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[16] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[17] Advocates for mergers argue that these mergers will be able to provide better care or lower costs; however, larger health care systems generally have neither superior health outcomes nor lower costs.[18] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[19] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[20] Many of the witnesses testifying before the House Ways and Means Health Subcommittee echoed these views.

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[8] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021).

[9] Dranove, *supra*, at 178.

[10] Martin Gaynor, *Antitrust Applied*, at 5.

[11] Dranove, *supra*, at 178.

[12] Dranove, *supra*, at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, *Antitrust Applied* at 3.

[13] Martin Gaynor and Robert Town, *supra*.

[14] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 The Quarterly Journal of Economics 1, 51 (February 2019). https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext.

[15] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, RAND Corporation, 3 (2020).

[16] Martin Gaynor, *Health Care Industry Consolidation*, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).

[17] Martin Gaynor, *Antitrust Applied*, at 4.

[18] Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 International Journal of the Economics of Business 1 (2011); Robert Lawton Burns, Jeffrey S. Mccullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. *Is the System Really the Solution? Operating Costs in Hospital Systems*, 72 Medical Care Research and Review 3, 247 (2015). doi:10.1177/1077558715583789.

[19] Emily Gee, *Provider Consolidation Drives Up Health Care Costs*, Center for American Progress, (last accessed July 14th, 2021), https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/.

[20] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service*, 5 American Economic Journal: Economic Policy 4, 134 (2013). doi:10.1257/pol.5.4.134.

Increased Hospital Concentration is Correlated with Worse Health Outcomes

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. Antitrust policy in health care markets has a role to play in reducing the growth of disparities in health care access.[21] For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[22] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[23] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

Antitrust Enforcement has Not Been Adequate to Reinvigorate Markets

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. In their new book, Professors David Dranove and Lawton R. Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[24] The antitrust response has been inadequate, notwithstanding the significant resources dedicated to restoring competition in health care. For example, between 2010 and 2018, over half of antitrust cases brought by the FTC were focused on the health care industry.[25] Yet, antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision. Similarly, the FTC cannot take action against anticompetitive conduct by not-for-profit entities; this presents a significant problem, considering how many hospitals are run as not-for-profits.[26] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the cost of health care in the United States requires new remedies.

Congress Should Lift the Ban It Placed on Physician-Owned Hospitals

Fortunately, there is something Congress can do. Low-hanging fruit would be passing H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023" in order to remove a crucial barrier to health care market entry that Congress itself erected. This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act (ACA) placed on Physician-Owned Hospitals (POHs). As explained by Joshua Perry, in *An Obituary for Physician-Owned Specialty Hospitals*, 23 Health Lawyer 2, 24 (2010), prior to the enactment of the ACA, physicians enjoyed a "whole hospital exception" to the Stark law—meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital. However, provisions within section 6001 of the ACA (42 U.S.C. 1395nn) essentially eliminate the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, under current law the POH cannot expand its treatment capacity unless certain restrictive exceptions are met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new POHs that depend on Medicare reimbursement.

A 2020 report from Alexander Acosta, Alex M. Azar II, and Steven T. Mnuchin entitled, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human

[21] Town, et al., *supra*, at page 10.
[22] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q J Econ. 2, 577 (2000).
[23] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).
[24] Dranove, supra, at 178.
[25] Martin Gaynor, *Antitrust Applied*, at 17.
[26] Martin Gaynor, *Antitrust Applied*, at 18.

Services, U.S. Department of Treasury, U.S. Department of Labor (2020), recommends that "Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals."[27] Congressional action would be especially welcome because **POHs have developed an enviable track record for high quality and low-cost care**.[28]

Opponents of POHs argue that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" which they ascribe to the physician owners. However, the evidence indicates that POHs do *not* cherry pick patients. For example, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[29] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[30] Importantly, new economic research supports those findings. It finds strong evidence *against* cherry-picking by physician owners.[31]

Unfortunately, the POH ban forecloses the benefits of integrated, coordinated care delivery observed in vertically oriented self-referral models.[32] Benefits of self-referral in integrated delivery models include "one-stop shopping," improved sharing of clinical information, and better care delivery experienced by consumers. Critically, the ban on POHs is the wrong policy prescription to address potential concerns with self-referral models. There are other policy recommendations that do not sacrifice the benefits of POHs.[33]

Reversing the ACA-imposed ban on new construction or expansion of existing POHs will both stimulate greater competition and provide patients with another option to receive high quality health care services. An April 12, 2021 *Health Affairs* article entitled, *Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals*, explains how.

Much of the U.S. hospital market lacks competition and restoring the whole hospital exception to the Stark law is the right prescription. As a result, enactment of H.R. 977/S. 470 is essential to facilitating greater competition and permitting POHs to continue to provide high quality care to a broader patient population.

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[27] Alexander Acosta, Alex M. Azar II, Steven T. Mnuchin, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020).

[28] *Id.*

[29] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (2005) (CMS Report). Available at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.

[30] *Id.*

[31] Ashley Swanson. *Physician Investment in Hospitals: Specialization, Selection, and Quality in Cardiac Care.* 80 J Health Econ. (2021).

[32] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.

[33] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.

III. Pharmacy Benefit Managers

The lack of transparency surrounding pharmacy benefit managers and the impact it has on pharmaceutical costs to patients and the practice of medicine

The role of pharmacy benefit managers (PBMs) as "middlemen" among payers, pharmaceutical companies, and pharmacies goes beyond the negotiation of drug prices on behalf of their clients. PBMs also build retail pharmacy networks, adjudicate pharmacy claims, manage drug formularies (including tiering of drugs), design pharmacy benefits, and operate mail-order and specialty pharmacies. These capacities seem to give them much power in determining which drugs consumers take. The ability of patients and physicians to have the information they need to make key decisions regarding medications, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by these arrangements. A lack of transparency and competition in PBM markets could be driving drug prices up. Patients are facing insurmountable costs and administrative barriers to obtaining prescription drugs from a pharmacy, PBM, or through physician-administered treatments. The burden, however, is not solely caused by the escalating prices of pharmaceuticals, but the increase in medication utilization management policies, as well.

As a result, patients, unfortunately, may take greater clinical risks when treatments are cost prohibitive. If patients delay, forgo, or ration their pharmaceutical treatment, their health status may deteriorate, eventually requiring medical interventions in more costly care settings when their condition is at a more advanced stage of disease. Additionally, market-driven barriers to care perpetuate disparities rather than promote equity for marginalized populations.

Issues and concerns surrounding the impact of unfair conduct related to medication prices and access are not new. Not only is patient ability to afford medications affected, but the negative impacts on those affected by disparities have been exacerbated.[34] In a 2020 article published in the *Journal of Managed Care + Specialty Pharmacy*, the author notes that there has been a response to racial or ethnic disparities in medication use by placing a greater focus on social determinants of health. However, it is also acknowledged that "medication cost remains a formidable barrier to closing the disparities gap in medication use between Blacks and Whites, including both the uninsured and those having a pharmacy benefit." The author points to the significant correlation between wealth and race in this equation, and, furthermore, notes that racial disparities have been documented in the utilization of essential evidence-based drug therapies, including but not limited to antidepressants, anticoagulants, diabetes medications, drugs for dementia, and statins. The U.S. Bureau of Labor Statistics reports further reflect this trend. In fact, in 2018, patients earning poverty-level wages were likely to prioritize rent payments or costs for food as a necessary trade-off to out-of-pocket prescription costs that consume a higher percentage of their weekly earnings. The author notes that, while patient cost sharing may be lower than it was comparably in the 1990s, the comparison of costs "does not take into account prices paid by those without health insurance, or the deviation in patient out-of-pocket spending that is associated with current pharmacy benefit designs."

These barriers also undoubtedly impact the physician's ability to provide uninterrupted optimal patient-centric care. In these scenarios, physicians are forced to navigate complex, and resource intensive requirements imposed by health insurers and PBMs.

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[34] Kogut SJ. *Racial disparities in medication use: imperatives for managed care pharmacy*. J Manag Care Spec Pharm. 2020 Nov;26(11):1468-1474. doi: 10.18553/jmcp.2020.26.11.1468. PMID: 33119445; PMCID: PMC8060916.[35] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-Senate-re-S-113-and-127-Acts-v3.pdf.

As a result, the AMA urges Congress to pass legislation that seeks to rein in unscrupulous PBM business practices. For example, the AMA supports S. 127, the "Pharmacy Benefit Manager Transparency Act of 2023," a bipartisan bill that promotes greater transparency of PBM operations and prohibits PBMs from engaging in unfair and deceptive reimbursement and payment practices.[35] The opaque nature of PBM negotiations and operations makes it exceedingly difficult for physicians to determine what treatments are preferred by a particular payer at the point-of-care, what level of cost-sharing their patients will face, and whether medications are subject to step therapy. We emphasize that this ultimately may lead to delays in necessary medication treatment, as well as a lack of clarity regarding specific formulary and cost-sharing responsibilities, which can lead to an inability to afford and access necessary medications.

In general, the AMA also strongly supports efforts on the part of Congress, the FTC, and the U.S. Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. In that vein, the AMA endorses S. 113, the "Prescription Pricing for the People Act," bipartisan legislation that requires the FTC to report about the anticompetitive practices, as well as other trends, within the pharmaceutical supply chain that impact the cost of pharmaceuticals.[36] The legislation also requires the FTC to provide recommendations to increase transparency within the drug supply chain in order to prevent anticompetitive practices. This bill is consistent with the bipartisan call for increased oversight and studies to prevent unfair or anticompetitive PBM practices.

Finally, the AMA supports H.R. 830, the "Help Ensure Lower Patient (HELP) Copays Act."[37] This bipartisan legislation helps ensure copay assistance counts towards patient cost-sharing requirements in individual, small group, and employer-sponsored health plans. This crucial bill has a particularly positive impact on patients seeking specialty drugs and, in general, further protects individuals from harmful insurance and PBM practices that raise out-of-pocket prescription drug costs.

Market concentration and competition in PBM markets and the implications for drug prices

PBMs were created in the 1960s to help health insurers contain drug spending. PBMs can stimulate price competition among drug manufacturers by shifting demand among competing substitute drugs. In turn, manufacturers offer rebates to PBMs for their drugs to be placed favorably in a drug formulary, which PBMs are then supposed to pass on to insurers or employers. However, the PBM market needs to be competitive for rebates to be fully passed on to final consumers. Thus, it is critically important that PBM markets are competitive. Unfortunately, it is not clear whether PBMs are (fully) passing on those rebates. Indeed, some economists argue that consolidation in the PBM market, combined with opaque pricing, is one cause of higher pharmaceutical prices.[38]

In October 2022, the AMA released the findings from a new analysis[39] that suggests low levels of

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[35] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-Senate-re-S-113-and-127-Acts-v3.pdf.

[36] Ibid.

[37] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-House-re-HR-830-HELP-Copays-Act-v2.pdf

[38] Garthwaite C., Scott Morton F. Perverse Incentives Encourage High Prescription Drug Prices. Chicago, IL: ProMarket. 2021.

[39] José R. Guardado, Competition in Commercial PBM Markeys and Vertical Integration of Health Insurers with PBMs, AMA Policy Research Perspectives (2022), https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf.

competition in local PBM markets across the United States where PBMs provide services to commercial health insurers. This analysis is the first to shed light on variations in market shares and competition among PBMs and on the extent of vertical integration between health insurers and PBMs at the local (state and MSA) levels.

According to the analysis, commercial insurers largely use an external PBM for three services: rebate negotiation; retail network management; and claims adjudication (rather than conducting them in-house). The analysis assessed market competition for those three PBM services and concluded that, at the national level, a handful of PBMs have a large collective market share. The 10 largest PBMs had a collective share of 97 percent; the four largest PBMs had a collective share of roughly 66 percent.

At both the state and MSA-levels, the analysis found a high degree of market concentration for each of the three PBM services assessed by the study. Specifically, more than three of four (about 78 percent) states had highly concentrated PBM markets; and more than four of five (85 percent) of MSA areas had highly concentrated PBM markets.

In terms of the extent of vertical integration between health insurers and PBMs, the study found that 69 percent of drug lives at the national level are covered by an insurer that is vertically integrated with a PBM. On average, 63 percent of state-level drug lives and 65 percent of MSA-level lives are vertically integrated. Six of the 10 largest PBMs are used exclusively by one insurer or a set of Blue Cross Blue Shield affiliates. Vertically integrated insurers may not allow non-vertically integrated insurer competitors to access their PBMs, or they could raise the cost of those PBM services. This could adversely affect non-vertically integrated insurers and ultimately patients through higher premiums.

Other research notes the increasing vertical integration of insurers, PBMs, specialty pharmacies, and providers, and provides an illustration of the major vertical business relationships among the largest companies in U.S. health care markets.

At this juncture, protecting patients and physicians from anticompetitive harm warrants attention as Congress and the Administration continue their work to protect patients and ensure prescription drugs remain affordable and accessible. The AMA urges careful monitoring, and intervention when needed, of both horizontal and vertical integration to ensure competition in PBM and health insurance markets and patient access to care. Physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have and continue to impose on their patients' care and remain concerned about the detrimental impact PBM business practices have on patients' access to and the cost of prescription drugs.

Conclusion

Competition is critical for well-functioning health care markets. When markets are not competitive and firms have market power, society is at a loss. Unfortunately, the majority of health insurance, hospital, and PBM care markets are not competitive. Mergers and acquisitions have contributed to these low levels of competition. Strong antitrust scrutiny of mergers in these markets is warranted. Also needed are policies that promote market entry, including lifting the statutory ban Congress imposed on physician-owned hospitals. These various policy interventions will promote greater competition, lower drug prices, and improve health care outcomes.