STATEMENT

of the

American Medical Association

U.S. House of Representatives

Committee on Energy and Commerce, Subcommittee on Health

Re: Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care

March 28, 2023

Division of Legislative Counsel

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Statement for the Record

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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 Energy and Commerce Subcommittee on Health as part of the hearing entitled, "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care." The AMA commends the Subcommittee for focusing on the critically important issue of consolidation in health insurance, hospital, and pharmacy benefit manager (PBM) markets and the consequences for patients.

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, than if health insurance markets were competitive. 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] The share of commercial markets in metropolitan statistical areas (MSA) that are highly concentrated 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, such as Anthem did 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.

Most health insurance markets are ripe for the exercise of health insurer market power, which harms consumers and providers of care. These findings should prompt federal and state antitrust

[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.

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 a merger between UnitedHealthcare and Sierra was allowed 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, we 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. We found that the mergers would be deemed anticompetitive in numerous markets across the United States.[3] Consistent with our 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. Our studies will continue to monitor competition in health insurance markets and be used to assess the competitive effects of proposed mergers among health insurers.

II. 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 AMA believes that the role of PBMs as "middlemen" among payers, pharmaceutical companies, and pharmacies goes beyond the negotiation of drug prices on behalf of their clients. The ability of patients and physicians to have the information they need to make key decisions regarding medication, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by these arrangements that are driving medications prices without a clear and justifiable reason. Patients today 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 cost of pharmaceuticals, but the increase in medication utilization management policies due to those higher costs as well. As a result, patients 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. In a health care delivery system in which racial and ethnic health care disparities are known to exist, market-driven barriers to care perpetuate disparities

[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.

rather than promote equity for marginalized populations.

Issues and concerns surrounding the impact of unfair market forces on medication costs and access are not new; it is, however, of increasing concern that not only is patient affordability affected, but also the negative impacts felt by those affected by disparities have been exacerbated.[5] 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 with more 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. Statistics reported from the U.S. Bureau of Labor Statistics reflect that, 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.

The AMA has supported recently re-introduced legislation that promotes greater transparency of PBM operations and prohibits PBMs from engaging in unfair and deceptive reimbursement and payment practices.[6] 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 being unaware of specific formulary and cost-sharing responsibilities, which can lead to an inability to afford and access necessary medications.

The AMA 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. The call for increased oversight and studies to prevent unfair or anticompetitive PBM practices is overwhelmingly welcomed.

In October 2022, the AMA released the findings from a new analysis[7] that reflects the widespread lack of 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 state and

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[5] 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.

[6] 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

[7] 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.

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 is another layer of complexity that warrants attention as Congress and the Administration continue to work through these issues 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.

III. 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.[8] This is partly the result of significant consolidation occurring in hospital markets around the country.[9] Many markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[10] Consolidation has real-life consequences, as clearly laid out in a new book by Professors David Dranove and Lawton R. Burns about health care

[8] 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*).

[9] 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).

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

"megaproviders."[11] 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."[12] 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.[13] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[14] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[15]

Consolidation is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health costs.[16] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[17] 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.[18] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[19] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[20] 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.[21] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[22] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[23]

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

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[11] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021). (Dranove)
[12] Dranove, *supra*, at 178.
[13] Martin Gaynor, *Antitrust Applied*, at 5.
[14] Dranove, *supra*, at 178.
[15] Dranove, *supra*, at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, *Antitrust Applied* at 3.
[16] Martin Gaynor and Robert Town, *supra*.
[17] 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.
[18] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, RAND Corporation, 3 (2020).
[19] 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).
[20] Martin Gaynor, *Antitrust Applied*, at 4.
[21] 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.
[22] 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/.
[23] 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.

of disparities in health care access.[24] For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[25] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[26] 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."[27] 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 brough by the FTC were focused on the health care industry.[28] 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.[29] Similarly, the FTC cannot even enforce against anticompetitive conduct by not-for-profits; this presents a significant problem, considering how many hospitals are run as not-for-profits.[30] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the high 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 removing barriers to health care market entry that Congress itself has erected. This includes the elimination of the restraint 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 can be met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals 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 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

[24] Town, et al., *supra*, at page 10.
[25] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q J Econ. 2, 577 (2000).
[26] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).
[27] Dranove, supra, at 178.
[28] Martin Gaynor, *Antitrust Applied*, at 17.
[29] C. Capps, David Dranove, and C. Ody, *Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene*, 36 Health Affairs 9, 1556 (2017).
[30] Martin Gaynor, *Antitrust Applied*, at 18.

hospitals."[31] Congressional action would be especially welcome because **physician-owned hospitals have developed an enviable track record for high quality and low-cost care**.[32]

Reversing the ACA-imposed ban on new construction or expansion of existing physician-owned hospitals 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.

In sum, much of the U.S. hospital market lacks competition and restoring the whole hospital exception to the Stark law is the right prescription.

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.

[31] 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).

[32] *Id.*