

How Congress Can Help to Reverse Hospital Market Consolidation

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KEY TAKEAWAYS

America's hospitals are consolidating rapidly, which means that a small number of hospital systems dominate a large share of the country's medical providers.

Competition among hospitals is weak, and this has led to higher costs for patients, less choice, and fewer incentives for medical providers to innovate.

The best solution is to allow for more competition by rolling back federal and state government policies that have contributed to the current consolidation.

America's hospital markets are consolidated, with a relatively small number of hospital systems dominating a large share of the market in any given geographical area. The right remedy for such a concentration of economic power is free-market competition, but competition in this sector of the economy is weak. The absence of strong competition increases consumer costs, decreases consumer choice, weakens provider incentives for innovation, and thus threatens the cost-effective delivery of medical care.

Squeezing the Consumer. The Medicare Payment Advisory Commission, the agency that advises Congress on Medicare reimbursement, reports that hospital consolidation, which affects the delivery of care, has been accompanied in recent years by health insurance market consolidation, which drives the financing and cost of care. The commission notes that

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“commercially insured patients appear to pay higher prices for insurance in consolidated markets.”¹ There also has been a dramatic decline in competition within the nation’s group and individual health insurance markets.²

Consumers are thus squeezed financially by the continuing increase in health care costs that this dual consolidation in health insurance and hospital markets has brought about. Moreover, “[h]ospital consolidation appears to be a trend that is not easily reversed once started. It may be very difficult to unwind mergers and create more competition in the markets, especially in markets where one system employs most physicians and controls most hospital beds.”³

Partial Remedies. Under current law, federal officials have two partial remedies that they can apply to hospital markets that are not competitive.

- The Federal Trade Commission (FTC) monitors anticompetitive business practices, studies the negative impact of market consolidation, and (along with the Department of Justice) enforces federal antitrust laws. While some suggest that there is a need for stepped-up FTC oversight of the nation’s hospital markets,⁴ this would be at best only a partial remedy inasmuch as government laws, rules, and regulations have increased consolidation and reduced competition.
- The Trump Administration’s hospital price transparency reforms, enabling consumers to compare prices for common medical procedures, took effect on January 1, 2021. However, many hospitals have not complied, and wide variations in pricing for common hospital procedures continue to hurt the uninsured while leaving patients without full ability to comparison shop for common hospital procedures.

A More Effective Approach. As noted, these are only partial remedies. More significant steps are needed to reverse the trend toward hospital consolidation and promote competition in the nation’s health care markets. For example, Congress should:

- **Encourage state officials to review, reform, or repeal certificate of need laws.** The overwhelming evidence in the professional literature demonstrates that these laws act as barriers to competition, protect the financial interests of existing hospitals and medical facilities, and neither control costs nor improve the quality of care. In fact, these anticompetitive measures *increase* patient costs as well as taxpayer costs. Because higher state health costs generate higher federal

health subsidies, Congress could adjust federal health care grants, payments, or subsidies to the states and provide some relief to federal taxpayers who are currently funding the additional costs imposed on them by these state-generated anticompetitive laws and regulations.

- **Include site neutrality in Medicare payment.** Whether a medical service is delivered in a physician’s office, a clinic, or a hospital setting, the Medicare payment for that service should be the same. President Donald Trump issued a rule to accomplish this on a limited basis.⁵ Congress should codify it and expand its application. Such a policy would level the playing field among providers and remove the financial disabilities for medical professionals who would compete with hospital systems.
- **Repeal the ACA restrictions on Medicare payment to physician-owned hospitals and specialty hospitals.** The current restrictions do little more than serve the special interests of large hospital systems and undercut consumer choice of high quality, specialty care.

The Growth of Consolidated Markets

Today, most Americans are compelled to secure medical care in uncompetitive hospital markets. In any given state, patients might have access to many hospitals, but many of these hospitals are owned and operated by a few hospital corporations. According to a major 2016 study by the Health Care Cost Institute, 72 percent of 112 American metropolitan areas studied had highly concentrated hospital markets.⁶ More recently, the Medicare Payment Advisory Commission reported that “[b]y 2017, in most markets, a single hospital system had more than a 50 percent market share of discharges.”⁷ Using its own metrics, the FTC concluded that by 2017, 90 percent of the nation’s hospital markets were “highly concentrated.”⁸

Hospital consolidation has accelerated since the enactment of the Affordable Care Act (ACA) of 2010.⁹ Between 1998 and 2017, there were 1,577 hospital mergers. Of that number, 456 occurred between 2013 and 2017, and another 90 were announced in 2018.¹⁰ Though most consolidation took place before 2000, largely through mergers and acquisitions, the pace of consolidation accelerated after enactment of the ACA. Touted as a measure that would introduce more robust competition into the health care markets, President Barack Obama’s national health law in fact did not improve competition in the hospital markets.¹¹

Moreover, hospital consolidation has been accompanied by hospital acquisition of independent medical practices: a large shift from independent physician practice to consolidated hospital-based medical practice. The Medicare Payment Advisory Commission found between 2003 and 2011, hospital employment of physicians increased by 55 percent.¹² From 2010 to 2016, according to Brent Fulton, an assistant adjunct professor in the University of California, Berkeley, School of Public Health, the share of primary care physicians alone working for hospital-based organizations or medical practices “increased from 28 to 44 percent—a dramatic increase of 57 percent.”¹³ By 2020, according to the American Medical Association, self-employed doctors accounted for only 44 percent of all “patient care” physicians in the United States.¹⁴

The Continuing Costs of Consolidation

Hospital market consolidation has been accelerating over the past three decades, and some industry analysts suggest that it has positive implications. This pattern is sometimes rationalized as a way to achieve the efficiencies of economies of scale, a normal outgrowth in the evolution of America’s large and complex system of public and private health care financing and delivery.¹⁵ It is sometimes argued that mergers and acquisitions and the centralization and integration of the delivery system that accompany them will secure greater efficiency of care delivery, reduce wasteful “excess capacity” in hospital systems, and improve the quality of medical care. Within consolidated markets, it is asserted, hospital executives can also secure better “leverage” in negotiations with doctors and other medical professionals.¹⁶

Medicare Payment Policy. Although a variety of independent factors have contributed to this consolidation, Medicare payment policy has played a powerful role. As the Medicare Payment Advisory Commission reports:

[W]hen hospitals acquire physician practices, Medicare payments increase due to facility fees that Medicare pays for physicians’ services when they are integrated into a hospital’s outpatient department. The potential for facility fees from Medicare and higher commercial prices encourages hospitals to acquire physician practices and have physicians become hospital employees.¹⁷

Medicare accountable care organizations (ACOs) are also contributing to this costly consolidation.¹⁸

Consumer Costs. As consolidation has grown, consumer costs have increased. According to Carnegie Mellon University Professor of Economics Martin Gaynor:

Extensive research evidence shows that consolidation between close competitors leads to substantial price increases for hospitals, insurers, and physicians, without offsetting gains in improved quality or efficiency. Further, recent evidence shows that mergers between hospitals not in the same geographic area can also lead to increases in price.¹⁹

In their own review of the professional literature, members of the Medicare Payment Advisory Commission similarly concluded that “[t]he effect of consolidation on prices varies from study to study and market to market, but most studies find consolidation leads to higher commercial prices.”²⁰ When hospitals secure physician practices, physicians charge hospital facility fees in addition to their own fees, which leads in turn to higher Medicare payment for hospital-owned practices than for independent medical practices. Thus, “[w]hen a physician practice integrates with a hospital outpatient department, both commercial prices and Medicare prices (defined...as physician payment plus facility fees) increase.”²¹

There is also little or no evidence that hospital consolidation improves the quality of medical care. This is true whether the quality measurement is a process measure, metrics on medical outcomes, mortality, or patient experiences. In a major study of hospital consolidation published in *The New England Journal of Medicine*, researchers concluded that “[h]ospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive.”²²

To secure higher quality of care at lower costs, policymakers should embrace a pro-competition policy. “Competition in health care markets benefits consumers,” according to the FTC, “because it helps contain costs, improve quality, and encourage innovation.”²³ Independent research in the professional literature routinely bears out this assessment. Writing in the *New England Journal of Medicine*, for example, researchers affirm that “[p]revious studies have generally shown that hospitalized patients have better outcomes in more competitive hospital markets than less competitive markets.”²⁴

In short, the more competitive the markets, the higher the quality of care and the lower the price of that care.²⁵

How Congress Can Promote Competition in Hospital Markets

1. **Encourage states to review, roll back, or repeal certificate of need laws.** Thirty-five states and the District of Columbia have

enacted certificate of need (CON) laws. Though varied in scope, virtually all of these laws require hospital executives, doctors, and other medical professionals to secure a certificate of need from a state government agency for permission to build new facilities or to expand or modify existing facilities. The theoretical assumption underlying these laws is that in health care, unlike other sectors of the economy, supply drives demand. Without an external restraint on supply, there will be an excess of supply, which in turn will generate an excess of demand, and the health care system will experience an increase in unnecessary costs.²⁶ Certificate of need laws that require permission for construction or expansion of medical facilities would provide the necessary restraint.

However valid this theory might have been in the 1970s when states started to enact these laws, it is outdated in the 21st century—a view that is shared by liberal and conservative analysts alike. Conservative analysts note that states with certificate of need laws have “overall health care costs” that are 11 percent higher than those of non-CON states.²⁷ James Baily of the Mercatus Institute at George Mason University notes that the demand for health services is inelastic and that certificate of need laws do not reduce spending “for any major type of provider” but may “increase spending on some types of health care.”²⁸ Writing in the *Journal of Health Care Finance*, researchers also conclude that these laws have no significant effect on containing hospital costs and may even increase those costs.²⁹

In perhaps the best summary of the professional literature on the subject, Brookings Institution scholars conclude that “CON laws end up protecting existing firms and erecting barriers to entry for new firms or existing firms entering new markets. Research has shown these regulations harm competition, leading to higher costs without improving quality, contrary to proponents’ claims.”³⁰ Their recommendation: “States that have CON regulations on the books [should] eliminate them. In some cases, these laws can be allowed to sunset. In others, repeal will be required.”³¹

Not surprisingly, the U.S. Department of Justice and the Federal Trade Commission, both of which are responsible for enforcing antitrust laws, have declared that state certificate of need laws are anticompetitive:

First, CON laws create barriers to entry and expansion, limit consumer choice, and stifle innovation. Second, incumbent firms seeking to thwart or delay entry or expansion by new or existing competitors may use CON laws to achieve that end. Third...CON laws can deny consumers the benefit of an effective remedy following the consummation of an anticompetitive merger. Finally, the evidence to date does not suggest that CON laws have generally succeeded in controlling costs or improving quality.³²

Even though certificate of need laws are within the jurisdiction of the states, as noted, the states that maintain them nonetheless impose a burden on federal taxpayers that is proportionately heavier than the burden imposed by states that do not maintain such laws. This is particularly true of the ACA's federal health insurance subsidies that automatically offset any increase in the cost of exchange coverage. The higher the state's health costs, including premium and insurance costs, the more taxpayers are required to fund ever larger federal subsidies.

Congress should require federal actuaries to review these laws and quantify their specific impact on different states. Based on that review and analysis, Congress should also consider making a proportional adjustment in such categories as Medicare hospital payments or federal insurance subsidies to offset the additional costs that these states impose on federal taxpayers. Within the context of future health reform, Congress should likewise make a proportional adjustment in any future federal insurance subsidies to offset the additional costs to federal taxpayers.³³

- 2. Include site neutrality in Medicare payment.** The \$926 billion Medicare program, which covers more than 62 million senior and disabled citizens, is the nation's largest payer for health care benefits and medical services. Given its sheer size, the program has a profound influence on patterns of medical practice in the private health care markets. Thus, a change in Medicare payment would be a significant step in reversing the current consolidation of care delivery in the hospital markets. Specifically, Congress could enact site neutrality—paying the same Medicare rate for medical treatments and procedures whether they are provided in an inpatient or outpatient setting or in a hospital, clinic, or doctor's office—in Medicare payment.

The Trump Proposal. In his fiscal year 2021 budget submission, former President Donald Trump offered several proposals for site neutrality payments, including payment for hospital outpatient medical procedures at the same rate as payment for such services when they are provided in a physician’s office.³⁴ The Trump policy was subsequently embodied in a Centers for Medicare and Medicaid Services (CMS) rule applying Medicare site neutrality to outpatient procedures, and the U.S. Supreme Court dismissed a major legal challenge to the rule.³⁵ The Health Policy Consensus Group recommends that:

Medicare should pay the same for services provided in a hospital-based setting as it does for the same service provided in a physician’s office or an ambulatory surgical setting.... While providers in different settings may choose to charge different prices for the same service, taxpayers should not be forced to pay more for the same procedure based on the site of care. Providers should face equal incentives to use taxpayer money most efficiently. Congress should start by codifying the [Trump] Administration’s initial efforts to require Medicare payments to be site neutral and go beyond it to ensure that Medicare is reimbursing the same amount for a service regardless of the setting in which it is provided.³⁶

Once again, the principle of site neutrality in Medicare payment has garnered wide support among liberal and conservative analysts alike. As noted by Emily Gee, senior health economist at the Center for American Progress, the *status quo* means that taxpayers are paying more than they should for medical services that could be performed in non-hospital settings. “[T]he differential between hospital and nonhospital rates financially incentivizes hospital systems to acquire physician practices,” according to Gee, “thereby leading to greater consolidation among providers. Medicare payments for procedures that can be safely performed in nonhospital settings such as ambulatory surgery centers or physician offices should not stack the deck in favor of hospitals.”³⁷ Though generally opposed to President Trump’s health policy agenda, Brookings Institution scholars nonetheless judged the former President’s Medicare site neutrality initiative to be a “sensible” proposal.³⁸

Such a change in Medicare payment policy would have a big spillover effect by levelling the playing field of competition in service delivery between hospital systems and alternative care delivery centers, such

as independent clinics and independent medical practices. It would also encourage private health insurers and state employee insurance agencies to adopt provider payment policies that mirror federal Medicare practices. The result would be to stimulate innovation in care delivery and improve the cost and efficiency of care for patients on the ground.

- 3. Repeal the ACA restrictions on Medicare payment to physician-owned hospitals and specialty hospitals.** Under Section 6001 of the ACA, Congress prohibited new physician-owned hospitals, mostly specialty hospitals, from participating in Medicare or Medicaid, thus cutting off vital revenue for the treatment of beneficiaries of these two giant federal entitlement programs.³⁹ While pre-ACA physician-owned hospitals secured a “grandfather” status under the law, these hospitals were henceforth allowed only limited expansions under specified conditions.⁴⁰

CMS Study. The debate over physician-owned specialty hospitals is not new. Pursuant to the passage of the Medicare Modernization Act of 2003, Congress authorized the CMS to conduct a study of several key issues, including “cherry picking” of patients by specialty hospitals, quality of care delivery, patient satisfaction, and provision of uncompensated care. In the case of cardiac specialty hospitals, for example, the CMS concluded that “the notion that specialty cardiac hospitals are transferring more severely ill patients to general hospitals was not supported by our study,” that “cardiac hospitals delivered high quality of care that was as good as or better than their competitor hospitals,” and that “[p]atient satisfaction was very high in both cardiac and orthopedic surgery hospitals.”⁴¹ Concerning hospital revenues devoted to uncompensated care, the CMS noted that unlike physician-owned specialty hospitals, the general, nonprofit community hospitals do not pay real estate, property, income, or sales taxes: “As a result, the total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care.”⁴²

Since that major CMS study, independent analyses have largely refuted the criticisms of these hospitals and confirmed their positive contributions. In a 2015 study of 2,186 acute care hospitals,

researchers writing in the *British Medical Journal* concluded that “POHs may treat slightly healthier patients, but do not systematically avoid patients with Medicaid and those from ethnic minority groups, and that overall costs of care, payments for care, and quality of care are similar between POHs and non-POHs.”⁴³ In a 2016 study examining the performance of 3,089 hospitals, researchers writing in the *Journal of the American College of Surgery* concluded that physician-owned surgical hospitals scored “significantly higher” on CMS performance metrics compared to other hospitals in the study.⁴⁴ That year, the Physician Hospitals of America (PHA), a trade association of physician-owned hospitals, reported that in the CMS “Quality Star Rating System,” 52 percent of the eligible physician-owned hospitals received a rating of four or five stars compared to just 27 percent of other hospitals.⁴⁵

In a comprehensive review of the professional literature on the subject, researchers writing for the Mercatus Center at George Mason University recently confirmed previous positive assessments of the performance of physician-owned hospitals. “Our systematic review found that specialty POHs generally provide higher quality care at a lower or comparable cost than do non-POHs,” the authors conclude. “Although the available evidence on general or community hospital POHs is generally more equivocal, it suggests that POHs are not higher cost or lower quality than non-POHs.”⁴⁶

Despite this continuing record of stellar performance, the ACA restrictions remain on the books. The national health law severely damaged this sector of the hospital industry and blocked the emergence of these hospitals as an independent competitive force in America’s health care delivery system.⁴⁷ According to PHA, “37 physician-owned hospitals were not built because of the [ACA] ban, 40 nearly finished construction projects were prevented, and 20 major expansion projects were canceled.”⁴⁸

It is past time for Congress to reverse course. Increasing specialization can be powerfully productive. As Harvard Business School Professor of Business Management Regina Herzlinger has argued, specialty hospitals—operating as “focused factories”—hold great promise in offering high-quality and cost-effective care.⁴⁹ This applies especially to physician-owned hospitals that specialize in cardiac, cancer, or

orthopedic care. A high volume of specialized care can secure higher-quality care and better medical outcomes and at less cost. Congress should lift the ACA ban and let these hospitals compete.

Conclusion

Hospital market consolidation is a problem for every American. The lack of competition in the nation's hospital markets undermines patient choice and increases consumers' costs. Conversely, strong market competition not only increases patient choice and controls costs, but also stimulates innovation in health care delivery and improves the quality of care.

Government policy at the federal and state levels has contributed to the current consolidation of America's hospital markets. At the state level, certificate of need laws have served as barriers to entry and broader competition and have failed in their ostensible mission to control costs or improve the quality of care delivered to state residents.

The ACA has blocked the emergence of physician-owned hospitals to compete with general hospitals, even though the preponderance of the professional literature shows that these hospitals deliver high-quality, specialized care at competitive prices. Likewise, Medicare payment is higher for medical services delivered in hospitals than in other settings and thus tilts the field of competition in favor of large hospital systems. Congress can change the ACA and Medicare payment problems directly and indirectly can encourage state officials to repeal outdated certificate of need laws.

Consumer-driven market competition can deliver what government bureaucracy cannot: fast, efficient, personalized, and patient-centered care. To realize these goals, federal and state officials need only remove costly government barriers and adopt pro-competition policies.

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Endnotes

1. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2020, p. 459, http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf (accessed September 7, 2021).
2. Heritage Foundation analysts have documented a sharp decline in choice and competition and a steep rise in health insurance costs within the individual markets in the years since the Affordable Care Act of 2010 was enacted. See Edmund F. Haislmaier and Abigail Slagle, "Obamacare's Health Insurance Exchanges in 2021: Increased Options, but Still Less than Pre-ACA," Heritage Foundation *Issue Brief* No. 6066, March 16, 2021, <https://www.heritage.org/sites/default/files/2021-03/IB6066.pdf>. Consolidation has characterized trends in the group health insurance market as well. In 2003, 40 states had no "dominant insurer," and only 11 had one "dominant" insurer. By 2010, 35 states had no "dominant" insurer, but the presence of a dominant insurer increased to 16 states. By 2017, the shift had become decisive: Only 30 states had no dominant insurer, but as many as 21 states did have such an insurer. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 465.
3. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 464.
4. See, for example, Gail Wilensky and Brian Miller, "Time to Consider a New Look at Physician-Owned Hospitals to Increase Competition in Health Care?" *JAMA*, Vol. 323, No. 19 (May 19, 2020), <https://jamanetwork.com/journals/jama/fullarticle/2766149> (accessed September 7, 2021); Alden Abbot and Kofi Ampaabeng, "Addressing Anti-Competitive Conduct and Consolidation in Healthcare Markets: The Roles of State and Federal Regulation and Antitrust Law," statement submitted to the Subcommittee on Competition Policy, Antitrust, and Consumer Rights, Committee on the Judiciary, U.S. Senate, Mercatus Center at George Mason University *Testimony*, May 25, 2021, p. 4, https://www.mercatus.org/system/files/abbott_and_ampaabeng_-_testimony_-_addressing_anticompetitive_conduct_and_consolidation_in_health_care_markets_the_roles_of_state_and_federal_regulation_and_antitrust_-_v1.pdf (accessed September 7, 2021); and President Joseph R. Biden, Jr., Executive Order 14036, "Promoting Competition in the American Economy," July 9, 2021, *Federal Register*, Vol. 86, No. 132 (July 14, 2021), pp. 36987-36999, <https://www.govinfo.gov/content/pkg/FR-2021-07-14/pdf/2021-15069.pdf> (accessed September 7, 2021).
5. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Centers Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity to Apply for Available Slots," Final Rule with comment period, *Federal Register*, Vol. 84, No. 218 (November 12, 2019), pp. 61142-61492, <https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf> (accessed September 16, 2021).
6. Health Care Cost Institute, "Health Marketplace Index," 2016, <https://healthcostinstitute.org/research/hmi-interactive> (accessed September 7, 2021). The Institute, self-described as "an independent, non-profit organization," has received significant financial support from the Robert Wood Johnson Foundation.
7. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 458.
8. *Ibid.*, p. 463.
9. H.R. 3590, Patient Protection and Affordable Care Act, Public Law 111-148, 111th Cong., March 23, 2010, <https://www.congress.gov/bill/111th-congress/house-bill/3590> (accessed September 9, 2021).
10. Martin Gaynor, "What to Do About Health Care Markets? Policies to Make Health Care Markets Work," The Brookings Institution, Hamilton Project *Policy Proposal* No. 2020-10, March 2020, p. 8, https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf (accessed September 7, 2021).
11. For a detailed discussion of the ACA's impact on consolidation, see Christopher M. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation," Heritage Foundation *Backgrounders* No. 2928, August 1, 2014, http://thf_media.s3.amazonaws.com/2014/pdf/BG2928.pdf.
12. Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2013, p. 33, http://www.medpac.gov/docs/default-source/reports/jun13_ch02.pdf?sfvrsn=0 (accessed September 7, 2021).
13. Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs*, Vol. 36, No. 9 (September 2017), p. 1534, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0556> (accessed September 7, 2021).
14. Press release, "AMA Analysis Shows Most Physicians Work Outside of Private Practice," American Medical Association, May 5, 2021, <https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice> (accessed September 7, 2021).
15. "Large organizations are turning to healthcare mergers and acquisitions to implement economies of scale strategies.... Kaufman, Hall & Associates' Managing Director Patrick Allen attributed the rise in health care mergers to health systems 'thinking strategically about how best to build the scale and capabilities needed to remain competitive in a rapidly changing environment.'" Jacqueline LaPointe, "Key Strategies for Health Systems to Achieve Economies of Scale," *RevcycleIntelligence*, August 31, 2017, <https://revcycleintelligence.com/news/key-strategies-for-health-systems-to-achieve-economies-of-scale> (accessed September 7, 2021).
16. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 457.
17. *Ibid.*, p. 458.

18. “On average, a national commercial insurer paid 4 percent more for office visits when provided by independent practices in health system-led ACOs in the Medicare Shared Savings Program (MSSP) compared to independent practices not part of an ACO.” Jacqueline LaPointe, “Soft Consolidation in Medicare ACOs Can Lead to Higher Prices,” *RevcycleIntelligence*, June 8, 2021, <https://revcycleintelligence.com/news/soft-consolidation-in-medicare-acos-can-lead-to-higher-prices> (accessed September 7, 2021).
19. Martin Gaynor, “Anti-Trust Applied: Hospital Consolidation Concerns and Solutions,” statement before the Subcommittee on Competition Policy, Antitrust, and Consumer Rights, Committee on the Judiciary, U.S. Senate, May 19, 2021, p. 2, https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf (accessed September 7, 2021).
20. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 459.
21. *Ibid.*, p. 462.
22. Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael Williams, “Changes in Quality of Care After Hospital Mergers and Acquisitions,” *The New England Journal of Medicine*, Vol. 382, No. 1 (January 2, 2020), pp. 51–59, <https://www.nejm.org/doi/10.1056/NEJMsa1901383> (accessed September 7, 2021).
23. Federal Trade Commission, “Competition in the Health Care Marketplace,” *Industry Guidance*, <https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care> (accessed September 7, 2021).
24. Beaulieu et al., “Changes in Quality of Care After Hospital Mergers and Acquisitions.”
25. These findings mirror those of similar research into the functioning of the nation’s health insurance markets: The more plans in a competitive area, the lower the premium costs.
26. “The basic assumption underlying CON regulation is that excess health care facility capacity results in health care price inflation.” National Conference of State Legislatures, “CON—Certificate of Need State Laws,” December 1, 2019, <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> (accessed September 7, 2021).
27. See Republican Study Committee, *A Framework for Personalized, Affordable Care: Republican Study Committee Health Care Plan, Part One*, 2019, p. 49, https://mikejohnson.house.gov/uploadedfiles/rsc_health_care_report.pdf (accessed September 7, 2021), and Jordan Bruneau, “The Great Healthcare CON,” Foundation for Economic Education, January 15, 2014, <https://fee.org/articles/the-great-healthcare-con/> (accessed September 7, 2021).
28. James Baily, “Can Health Spending Be Reined in Through Supply Constraints? An Evaluation of Certificate-of-Need Laws,” Mercatus Center at George Mason University *Working Paper*, July 2016, Abstract and p. 4, <https://www.mercatus.org/system/files/Bailey-CON-v1.pdf> (accessed September 7, 2021).
29. Patrick A. Rivers, Myron D. Fottler, and Jemima A. Frimpong, “The Effects of Certificate of Need Regulation on Hospital Costs,” *Journal of Health Care Finance*, Vol. 36, No. 4 (Summer 2010), https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/CON_modernization_workgroup/Articles/Article%2010.pdf (accessed September 16, 2021). In their discussion of the impact of these laws, the authors conclude: “Our results, as well as those of several previous studies, indicate that CNR [Certificate of Need Regulation] programs do not only fail to contain HC [hospital costs], but may actually *increase* costs as well.” *Ibid.*, p. 11. Emphasis in original.
30. Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg, “Making Health Care Markets Work: Competition Policy for health Care,” The Brookings Institution, April 2017, p. 23, <https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/> (accessed September 7, 2021).
31. *Ibid.*
32. U.S. Department of Justice and Federal Trade Commission, “Joint Statement of the Anti-Trust Division of the U.S. Department of Justice and the Federal Trade Commission on Certificate-of-Need Laws and Alaska Senate Bill 62,” April 2017, pp. 1–2, <https://www.ftc.gov/policy/advocacy/advocacy-filings/2017/04/joint-statement-federal-trade-commission-antitrust-division> (accessed September 7, 2021). It is noteworthy that these two federal agencies maintained this position consistently under the Administrations of Presidents George W. Bush, Barack Obama, and Donald Trump.
33. This would include, for example, reforms in ACA spending such as ending open-ended subsidies to insurance companies every time they raise prices and instead sending fixed-sum formula grants to states to fund safety-net programs. As part of such reforms, “Congress could consider adjusting a portion of the Health Care Choices formula grant to states based on whether they keep these laws in place.” Health Policy Consensus Group, *HealthCare Choices 20/20: A Vision for the Future*, November 18, 2020, p. 38, https://www.healthcarechoices2020.org/wp-content/uploads/2020/11/HealthCareChoices20_Proposal.pdf (accessed September 7, 2021).
34. Jacqueline LaPointe, “Trump Budget Eyes More Site-Neutral, Hospital Reimbursement Cuts,” *RevcycleIntelligence*, February 11, 2020, <https://revcycleintelligence.com/news/trump-budget-eyes-more-site-neutral-hospital-reimbursement-cuts> (accessed September 7, 2021).
35. See news release, “Supreme Court Declines to Take up AHA’s Site-Neutral Challenge,” American Hospital Association, June 28, 2021, <https://www.aha.org/news/headline/2021-06-28-supreme-court-declines-take-ahas-site-neutral-challenge> (accessed September 7, 2021).
36. Health Policy Consensus Group, *Health Care Choices 20/20: A Vision for the Future*, p. 39.
37. Emily Gee, “The High Price of Hospital Care,” Center for American Progress, June 26, 2019, <https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/> (accessed September 7, 2021).

38. See Matthew Fiedler, Loren Adler, and Christen Linke Young, "Health Care in President Trump's Fiscal Year 2021 Budget," *JAMA Health Forum*, February 13, 2020, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2761532> (accessed September 7, 2021).
39. For a detailed discussion of the issues surrounding the ACA restriction, see Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine, and Jesse Ehrenfeld, "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals," *Health Affairs*, Health Affairs Blog, April 12, 2021, <https://www.healthaffairs.org/doi/10.1377/hblog20210408.980640/full/> (accessed September 7, 2021).
40. Debra Shute, "Is It Time to Lift the Ban on Physician-Owned Hospitals?" *Medical Economics Journal*, Vol. 96, No. 9 (May 25, 2018), <https://www.medicaleconomics.com/view/it-time-lift-ban-physician-owned-hospitals> (accessed September 7, 2021).
41. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003*, 2005, p. iii, <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf> (accessed September 7, 2021).
42. *Ibid.*, p. iv.
43. David M. Blumenthal, E. John Orav, Anupam B. Jena, David M. Dudzinski, Sidney T. Le, and Ashish K. Jha, "Access, Quality, and Costs of Care at Physician Owned Hospitals in the United States: Observational Study," *British Medical Journal*, Vol. 351, No. 8023 (September 5, 2015), p. 13, <https://www.bmj.com/bmj/section-pdf/904450?path=/bmj/351/8023/Research.full.pdf> (accessed September 7, 2021).
44. Adriana G. Ramirez, Margaret C. Tracci, George J. Stukenborg, Florence E. Turrentine, Benjamin D. Kozower, and R. Scott Jones, "Physician-Owned Surgical Hospitals Outperform Other Hospitals in the Medicare Value-Based Purchasing Program," *Journal of the American College of Surgeons*, Vol. 223, No. 4 (October 2016), pp. 559–567, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5045811/> (accessed September 7, 2021).
45. Leslie Fossey, "Physician-Owned Hospitals Receive High Marks in New CMS Star Ratings," *The Lund Report*, July 29, 2016, <https://www.thelundreport.org/content/physician-owned-hospitals-receive-high-marks-new-cms-star-ratings> (accessed September 7, 2021).
46. Ted Cho, Andrew Meshnick, Jesse M. Ehrenfeld, and Brian J. Miller, "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review," Mercatus Center at George Mason University *Special Study*, September 2021, p. 16, <https://www.mercatus.org/publications/healthcare/cost-and-quality-care-physician-owned-hospitals-systematic-review> (accessed September 16, 2021).
47. "It is not clear how different the resultant spending would have been for specialty services if the government had pursued a more competition-oriented fix rather than the ACA's moratorium on physician-owned hospitals. It is just one more instance where the government has relied on regulation as opposed to giving competition a chance." Wilensky and Miller, "Time to Consider a New Look at Physician-Owned Hospitals to Increase Competition in Health Care?"
48. Shute, "Is It Time to Lift the Ban on Physician-Owned Hospitals?"
49. "Yes, I use the term 'factory' purposely to be provocative. The people in the factories made the changes. They figured out, and continuously figure out, how to improve the production process. It's not a top-down process; it's an organic process that's lead by people who actually do the work." See "A Conversation with Regina E. Herzlinger: 'Focused Factories' Will Provide Care," *Managed Care*, 2021, <https://www.managedcaremag.com/archives/1998/5/conversation-regina-e-herzlinger-focused-factories-will-provide-care/> (accessed September 7, 2021).