Statement

of

Michael F. Cannon, M.A., J.M.

Director of Health Policy Studies
Cato Institute

before the

Subcommittee on Competition Policy,
Antitrust, and Consumer Rights,
Committee on the Judiciary,
United States Senate

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Re: "Antitrust Applied: Hospital Consolidation Concerns and Solutions"

Chair Klobuchar, Ranking Member Lee, and Members of the Subcommittee:

My name is Michael F. Cannon. I am the director of health policy studies at the Cato Institute. Thank you for inviting me to testify today.

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Introduction

The U.S. health sector is not serving consumers as it should or could. Excessive, often unconscionable prices threaten to wipe out the health savings account (HSA) balances and other savings of even insured Americans.[1] Low-quality care costs lives and eludes quality-improvement efforts.[2]

Provider consolidation is an important contributor to both these deficiencies. To be clear, not all consolidation is harmful to consumers. Consolidation that enables integrated health care delivery can reduce costs while improving quality and convenience. The economics literature nevertheless finds that most consolidation among hospitals, physicians, and insurance companies increases prices and/or reduces quality. My co-panelist Prof. Martin Gaynor has written a highly readable summary of the evidence.[3]

Inefficient consolidation, however, is not merely a driver of higher prices and lower quality. It is also a symptom of a greater problem. By and large, inefficient consolidation is the result of government interventions that disable the normal market mechanisms of entry, cost-consciousness, and competition from doing what they do in other sectors of the economy: improving quality while reducing prices.

How Government Intervention in Health Care Markets Encourages Consolidation

Federal and state governments intervene in health care markets in various ways, always with the stated purpose of improving quality and/or reducing costs. Such interventions

[1] See Charles Silver and David Hyman, *Overcharged: Why Americans Pay Too Much for Health Care* (Cato Institute, 2018).

[2] See Jacqueline Pohida & Michael F. Cannon, "Would Medicare for All Mean Quality for All? Medicare's Negative Impact on Health Care Quality," forthcoming.

[3] Martin Gaynor, "What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work," Brookings Institution Policy Proposal 2020-10, March 2020.

encompass regulation of health professionals, medical facilities, and health insurance issuers; subsidies for health insurance and medical care, including direct government purchasing of both; and special tax preferences for health-related uses of income.

These interventions often produce unintended consequences. Among other effects, they create incentives for the type of consolidation that gives producers the ability to charge higher prices than they could in competitive markets. I will briefly discuss three categories of government intervention into the health sector that encourage inefficient provider consolidation.

Government regulation. Complying with government regulations generally imposes high fixed costs but low marginal costs. Regulation therefore puts larger firms at a competitive advantage and smaller firms at a disadvantage because the former can spread the fixed costs of compliance over a larger quantity of outputs than the latter can. Government regulation therefore gives larger firms a built-in price advantage that inhibits entry, that grows as the firm grows, and that encourages firms to merge with their competitors.

Government regulation also rewards large firms in other ways. The Patient Protection and Affordable Care Act's (ACA) "minimum loss ratio" (MLR) regulations require insurers in the individual and small-group markets to spend no more than 20 percent of premium revenue on administrative expenses and quality-improvement activities. The cap for large-employer plans is 15 percent of premium revenue. "The fixed costs of complying with the ACA's MLR and other insurance regulations will weigh more heavily on smaller insurers and increase the costs of entry by new insurers…The MLR rules could encourage insurers to consolidate to obtain product portfolios more likely to meet the minimum MLR requirements (e.g., from pooling expenses or reducing statistical volatility in MLRs), or simply to achieve additional economies of scale in administration."[4]

So-called "certificate of need" (CON) laws, which dozens of states have enacted, also encourage consolidation by protecting incumbent providers from competition from new market entrants.

Government encouragement of excessive insurance. A second category are various government policies that encourage consolidation by encouraging more comprehensive health insurance than consumers would choose on their own. The tax exclusion for employer-sponsored health insurance and laws that require consumers to purchase minimum levels of coverage both have this effect.

Insurance reduces price competition by "remov[ing] the incentive on the part of individuals, patients, and physicians to shop around for better prices for hospitalization

[4] Scott E. Harrington, "Medical Loss Ratio Regulation under the Affordable Care Act," *Inquiry,* Vol. 50, No. 1, (2013), p. 21.

and surgical care."[5] This fact also constrains insurers' ability to negotiate lower prices. Insurers' main tool in this regard is to exclude a provider, drug, or device from coverage in order to demand greater price concessions. Dissatisfaction among enrollees who prefer the provider, drug, or device that an insurer excludes—and who bear only a small share of the cost if the insurer accedes to a higher price—generally tempers insurers' ability to employ such strategies.

The tax exclusion for employer-sponsored health insurance exacerbates this problem in two ways. First, it encourages workers to demand and employers to provide on average more comprehensive health insurance than workers value. The more comprehensive health insurance plans are, the larger a share of their medical care consumers will purchase via their health insurance. This effect increases the share of medical spending for which insurance reduces price competition. Second, because workers generally do not select and pay for their health insurance themselves, the savings from insurers' strategies to negotiate lower prices are not salient to enrollees. Enrollees therefore exhibit greater dissatisfaction with such strategies and further constrain insurers' ability to negotiate lower prices.

Both of these effects—insurers purchasing a larger share of medical spending and greater enrollee resistance to insurers' negotiating strategies—increase the incentives for health care providers to consolidate, because they allow providers to demand even higher prices from insurers, who face strong incentives to accede to providers' demands rather than face a backlash from enrollees.

Government purchasing. The third category is government purchasing of medical care and the pricing errors that follow. Medicare often pays more for the same service when the patient receives it in a hospital versus a physician's office. "When a cardiologist in private practice provided a level II echocardiogram without contrast," for example, "Medicare paid $188. But, when a doctor connected to a hospital performed the same test in an outpatient context, the payment was $452.89. That's an additional $265 that the hospital and doctor can share—including an additional $212 from taxpayers and $53 from the patient—to their mutual advantage."[6]

Such "site-of-service differentials"—a fancy name for government pricing errors—encourage hospitals and physician practices to consolidate in order to capture and split the benefits of those excessive Medicare prices. Once those firms merge, not only do taxpayers pay more for the same services via the Medicare program, but those firms' greater market power allows them to increase prices for private payers as well.

[5] Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review*, Vol. 53, No. 5. (Dec., 1963), p. 962.

[6] Silver and Hyman, *Overcharged*, p. 181.

Eliminate Government Interventions that Encourage Consolidation

To reduce costs and improve the quality of medical care, policymakers must undo state and federal interventions that encourage consolidation. I concur with Prof. Gaynor that states should at a minimum drastically curtail CON laws, "any willing provider" laws, and clinician-licensing regulations that inhibit "entry and the advance of innovative ways of organizing and delivering care," and that Congress should curtail "network adequacy" laws that inhibit competition among both insurers and providers.[7] Merely adjusting these regulations, however, would leave in place significant government interventions that encourage consolidation. Making health care markets work for consumers requires significant reform across many fronts.

State-Level Reform. States should outright repeal all CON laws and "any willing provider" laws. Despite their laudatory stated goals, in practice these regulations do little more than protect providers from competition at the expense of consumers.

States should likewise either repeal clinician-licensing laws or overhaul them in a manner that prevents them from blocking new categories of health professionals; innovations in medical education; or innovations in health care delivery such as affordable primary care, interstate telehealth, and integrated delivery systems. I concur with Prof. Gaynor's recommendation that "states that have not done so already should adopt licensure reciprocity across states."[8] Another approach would add flexibility to clinician licensing by having states certify multiple private organizations that would perform the functions of state licensing boards.[9] Still another approach would be simply to eliminate government licensing of clinicians, a form of regulation whose anti-competitive effects reduce access to care and which adds little if anything to the quality protections that would exist in its absence.[10]

Federal Reform. In addition to repealing federal "network adequacy" laws, Congress should eliminate the government price controls that give rise to such laws. Both the Medicare Advantage program and the ACA prohibit insurers from charging actuarially fair premiums to enrollees. While the stated purpose of such regulations is to eliminate discrimination against patients with preexisting conditions, these regulations merely shift such discrimination to the level of benefit design, where it becomes even more harmful.[11]

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[7] Gaynor, pp. 20-21.

[8] Gaynor, p. 21.

[9] See Shirley V. Svorny and Michael F. Cannon, "Health Care Workforce Reform: COVID-19 Spotlights Need for Changes to Clinician Licensing," Cato Institute Policy Analysis No. 899, August 4, 2020.

[10] See Shirley V. Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care," Cato Institute Policy Analysis No. 621, September 17, 2008.

[11] See Michael F. Cannon, "Is Obamacare Harming Quality? (Part 1)," *Health Affairs* (blog), January 4, 2018; Michael F. Cannon, "How to Ensure Quality Health Coverage (Part 2)," *Health Affairs* (blog), January 5, 2018; and Michael F. Cannon, "Obamacare Makes Discrimination against Those with Preexisting Conditions Even Worse," *Washington Examiner*, December 7, 2020.

The purpose of "network adequacy" laws is to counteract the perverse incentives those price controls create. Eliminating those price controls eliminates the need for them.

Making health care markets work for consumers also requires allowing consumers to control the $4 trillion that fuels the U.S. health sector. Congress should reform Medicare,[12] Medicaid,[13] and the tax treatment of health insurance[14] to give enrollees and workers control over the health care dollars that the federal government and employers currently control. Converting the current tax exclusion to one for contributions to expanded HSAs would deliver the largest effective tax cut in living memory.[15]

With such reforms, consumers would personally reap the benefits of lower prices and would demand price competition from both insurers and health care providers in a way that consumers who are spending other people's money simply do not. Moreover, the health care sector would respond to consumers in a way it simply does not today. An experiment in California, for example, found that whereas hospitals' market power forced insurance companies to accede to excessive prices for hip and knee replacements, in just two years cost-conscious consumers forced high-cost hospitals to cut their prices by 37 percent—an average reduction of $16,000 per procedure.[16] If we want to challenge the market power of consolidated providers, we need to let consumers control the money.

Conclusion

Consolidation among hospitals and other players in the health care sector is a serious concern. Inefficient consolidation, however, is primarily a result not of market forces but of ill-advised government interference in health care markets.

This subcommittee can steer the health care debate toward pro-competitive policies that would make health care better, more affordable, and more secure for all Americans, particularly the most vulnerable.

I thank you and look forward to your questions.

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[12] See Pohida and Cannon, forthcoming.

[13] See Michael F. Cannon, "Medicaid and the State Children's Health Insurance Program," in *Cato Handbook for Policymakers*, 8th edition (Cato Institute, 2017).

[14] See Michael F. Cannon, "The Tax Treatment of Health Care," in *Cato Handbook for Policymakers*, 8th edition (Cato Institute, 2017).

[15] Cannon, "The Tax Treatment of Health Care."

[16] James C. Robinson and Timothy T. Brown, "Increases in Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery," *Health Affairs*, Vol. 32, No. 8 (August 2013), and author's calculations.