Courage to Learn: Health Care

The 2010 Affordable Care Act made health care integration and consolidation an explicit goal. By the end of the Obama administration, however, at least one of the framers of the ACA realized that "having every provider in health care 'owned' by a single organization is more likely to be a barrier to better care." Despite this realization, it was too late—hospitals, provider groups, insurers, pharmaceutical manufacturers, group purchasing organizations, retail pharmacies, and pharmacy benefit managers (PBMs) all continued to consolidate.

As a result of this consolidation, health care spending is rising faster than U.S. GDP, while the rate of growth in health care worker wages remains far below that of CEO compensation. The pharmaceutical industry is calcified; much of the existing innovation happens at smaller firms before the technology is acquired by one of the largest. Through it all, patients face higher bills, less access to care, and an industry that has abandoned a patient-centered approach in pursuit of ever-higher shareholder returns.

Key Facts

- By 2017, a Politico analysis estimated that two-thirds of all U.S. hospitals were part of a chain.
- From 2005-2015, CEO compensation at major, nonprofit hospitals rose by 93 percent, compared to only 8 percent for the average health care worker wage.
- From 2010 to 2015, Sanofi, Novo Nordisk, and Eli Lilly raised their insulin prices by 168 percent, 169 percent, and 325 percent, respectively; the three are essentially the only manufacturers of insulin in the U.S.
- By 2017, just four group purchasing organizations controlled 90 percent of all U.S. generic drug purchases from manufacturers.
- Retail pharmacy prices on a basket of generic drugs are up to nine times higher than the same basket of drugs at an independent pharmacy.

Recommended Policies

- Break up health care monopolies in the concentrated hospital, insurer, drug, and pharmacy markets.

- Protect community and independent medical practices from having to consolidate or close by offering additional COVID-19 relief measures and other funding.
- Pass legislation requiring that metropolitan hospitals with monopoly control over a region cap their prices at Medicare rates.
- Allow Medicare to negotiate for lower drug prices.
- Implement pharmaceutical patent reform. End pay-for-delay arrangements and allow manufacturers a single patent period, known as a "one-and-done" policy.
- Foster competition in generic medications markets by encouraging federal and state intervention in the procurement process and by setting price caps for drugs like insulin.
- Repeal the federal anti-kickback safe harbor rule that protects group purchasing organizations (GPOs) and pharmacy benefit managers (PBMs) from litigation around the hefty rebates they receive; these entities should be forced to negotiate on behalf of hospitals and patients, respectively, not their own profits.
- Prohibit private equity ownership of hospitals and medical practices, as such ownership prioritizes short-term profits at the expense of patient well-being.

Further Reading

- "The Role of Monopoly in America's Prescription Drug Crisis" by Michael Bluhm, December 2019
- "Behind the Coronavirus Threat, a Middleman Destroying Prescription Drug Markets" by Dave Dayen, February 2020
- "The Avoidable Tragedy of Low Hospital Capacity in New York City" by Olivia Webb, May 2020
- "Examining the Impact of Health Care Consolidation," testimony before Congress by Martin Gaynor, PhD, February 2018

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