

The Harms of Hospital Mergers and How to Stop Them

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In 2019, HCA Healthcare, the country's largest hospital chain, bought nonprofit hospital system Mission Health of western North Carolina. Mission's CEO, Ronald Paulus, described the move as "a tremendous win for the people and communities we serve."¹ The for-profit HCA has 185 hospitals and 1,800 clinics across the United States and United Kingdom, and its \$1.5 billion acquisition included facility improvements, expanded charity care, and protections for rural communities. "We're looking forward to investing in western North Carolina and helping ensure Mission Health's 133-year tradition of caring for communities throughout the region continues for many years," HCA CEO Sam Hazen said when the deal closed.²

However, nearly immediately after the buyout, Mission raised prices by 10%, started charging patients surprise fees, and reduced its staff and their pay.³ "Every single department in that hospital that is designed to help the patient ... is critically and unethically and inhumanely understaffed," a nurse at the system's main hospital said during a public meeting in February 2020.⁴ Patients have reported longer wait times in the emergency room and their hospital beds without assistance and getting sick from unsanitary facilities.⁵ Hundreds of physicians have walked out, with one oncologist saying that previously Mission "was run primarily by doctors and nurses and now it's being run

¹ "HCA Healthcare Completes Purchase of Mission Health," HCA Healthcare, February 1, 2019, <https://investor.hcahealthcare.com/news/news-details/2019/HCA-Healthcare-Completes-Purchase-of-Mission-Health/default.aspx>.

² Ibid.

³ "Hospital Executive Compensation: A Decade of Growing Wage Inequality Across Nonprofit Hospitals," <https://www.shpnc.org/nonprofit-hospital-executive-pay-report/download?attachment>; Neil Cotiaux, "Confused Mission Health patients want answers about surprise fee," Carolina Public Press, February 10, 2020, <https://carolinapublicpress.org/29815/confused-mission-health-patients-want-answers-about-surprise-fee/>.

⁴ Mark Barrett, "Mission criticized on staff shortages, patient care," Mountain Xpress, February 12, 2020, <https://mountainx.com/living/mission-criticized-on-staff-shortages-patient-care/>.

⁵ Barbara Durr, "On the decline: Quality of care concerns rise at Mission Hospital," Citizen Times, May 31, 2021, <https://www.citizen-times.com/story/news/local/2021/05/31/quality-care-concerns-rise-mission-hospital-staffing-decline/5249489001/>.

by businessmen,” and “patient suffering is off their radar.”⁶ Paulus, meanwhile, got a \$4 million paycheck in his final year as Mission’s chief executive overseeing the acquisition, 727% more than his starting salary nine years prior.⁷

The HCA-Mission case is a common one in the United States. Executives and some government officials claim that hospital mergers are necessary to prevent financially strapped hospitals from going bankrupt or to help providers deliver care more efficiently through economies of scale. However, the reality is that hospital consolidation causes a range of harms and is contributing to the nation’s healthcare crisis. Patients have worse outcomes and limited access to care, owing in large part to the closures of entire hospitals or essential departments like maternity and pediatric wards, especially in marginalized communities.⁸

Despite the consequences, deals like the HCA-Mission acquisition are occurring at rapid speed across the country. Whereas 10% of community hospitals were part of larger health systems in 1970, that share grew to 67% in 2019.⁹

HOW DID WE GET HERE?

The U.S. hospital and physician landscape has historically been defined by independent providers. But with the skyrocketing cost of healthcare services by the 1970s and 1980s, insurers increasingly made patients pay deductibles and for out-of-network care to discourage overuse and pressure hospitals and doctors to lower their prices. Hospitals and other providers responded with a wave of mergers and acquisitions in the 1990s.¹⁰ The FTC and Justice Department attempted to stop many of these deals but faced a series of losses in court, resulting in a decade of government inaction against hospital consolidation.¹¹

6 Barbara Durr, “How Many Doctors Have Left Mission? HCA Won’t Say,” Asheville Watchdog, March 23, 2022, <https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/>.

7 “Hospital Executive Compensation.”

8 Nicolas Shanosky, Daniel McDermott, and Nisha Kurani, “How do U.S. healthcare resources compare to other countries?,” Person-KFF Health System Tracker, August 12, 2020, <https://www.healthsystemtracker.org/chart-collection/u-s-health-care-resources-compare-countries/#Acute%20care%20hospital%20beds%20per%201,000%20population,%202017>; “AHA report: Rural hospital closures threaten patient access to care,” American Hospital Association, September 8, 2022, <https://www.aha.org/news/headline/2022-09-08-aha-report-rural-hospital-closures-threaten-patient-access-care>; Elizabeth Dougherty, “If You Build It,” Harvard Medicine, <https://hms.harvard.edu/magazine/rural-health/if-you-build>.

9 Brent Fulton, Daniel Arnold, et al., “The Rise of Cross-Market Hospital Systems and Their Market Power in the U.S.,” Health Aff, November 2022, <https://pubmed.ncbi.nlm.nih.gov/36343312/>.

10 Yevgeniy Feyman and Jonathan Hartley, “The Perils of Hospital Consolidation,” National Affairs, Summer 2016, <https://www.nationalaffairs.com/publications/detail/the-perils-of-hospital-consolidation>.

11 Cory Capps, Laura Kmitch, et al., “The Continuing Saga of Hospital Merger Enforcement,” Antitrust Law Journal, 2019, https://www.bateswhite.com/media/publication/176_Capps_2019_CONTINUING_SAGA_OF_HOSPITAL_MERGER_ENFORCEMENT.pdf; Kelly Slaughter, “Remarks of Federal Trade Commissioner Rebecca Kelly Slaughter,” Center for American Progress, May 14, 2019, https://www.ftc.gov/system/files/documents/public_statements/1520570/slaughter_-_hospital_speech_5-14-19.pdf.

A new merger frenzy began during the Obama administration. Looking to enact a universal health insurance program, the White House assumed that a landscape of disjointed providers was inefficient and should be replaced by highly coordinated networks run on shared data, with hospitals or large physician groups at the center. The government pushed for “integration across the continuum of care” by offering financial incentives in the 2010 Affordable Care Act (ACA).¹²

Soon after, hospital mergers shot up. While the annual number of announced buyouts peaked at 60 in the few years before the ACA was signed into law, they rose to 74 in 2010, 86 in 2011, and hit 115 in 2017.¹³ The FTC did have success challenging some of them on the grounds that they eliminated competition, but its efforts were insufficient to deter the uptick in mergers.¹⁴

Rapid consolidation continues today, but there are many opportunities to push back, especially at the local level. State regulators have the authority to intervene and block proposed mergers, with or without support from federal agencies like the FTC. Lawmakers can pass legislation to enhance their powers, and community members can exert pressure on both enforcers and their representatives to act.

WHAT ARE THE HARMS FROM HOSPITAL MERGERS?

There is robust evidence that hospital mergers cause an array of problems, whether between direct competitors or not. In fact, one of the architects of the Obama administration’s healthcare policy, Bob Kocher, later acknowledged that advocating for hospital mergers and acquisitions was a mistake, noting in 2016, “Well, the consolidation we predicted has happened: Last year saw 112 hospital mergers (up 18% from 2014). Now I think we were wrong to favor it.”¹⁵

1. HIGHER PRICES

Executives often claim that merging hospitals will combine services and administrative functions, allowing them to eliminate redundancy and thereby save money. Nevertheless, patients frequently see prices go up.

¹² Robert Kocher, Ezekiel Emanuel, and Nancy-Ann DeParle, “The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges,” *Annals of Internal Medicine*, October 19, 2010, <https://www.acpjournals.org/doi/10.7326/0003-4819-153-8-201010190-00274>.

¹³ “Hospital Consolidation: Trends, Impacts & Outlook,” NIHCM Foundation, January 1, 2020, <https://nihcm.org/publications/hospital-consolidation-trends-impacts-outlook>.

¹⁴ *Ibid.*

¹⁵ Bob Kocher, “How I Was Wrong About ObamaCare,” *The Wall Street Journal*, July 31, 2016, <https://www.wsj.com/articles/i-was-wrong-about-obamacare-1469997311>.

One economic article found that mergers between 2007 and 2011 among nearby hospitals resulted in prices rising by more than 6%, and prices at monopoly hospitals for patients with employer-sponsored insurance are 12% higher than those in markets with at least four competitors.¹⁶ In a striking example, a merger between Evanston Northwestern and Highland Park hospitals in Chicago led to price increases reaching 65%.¹⁷ And as economist Martin Gaynor of Carnegie Mellon University has testified, the harm is not temporary. “Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem,” he said.¹⁸ The problem also does not change if the merging hospitals are structured as non- or for-profits.¹⁹

Separately, mergers between hospitals in separate geographic locations (“cross-market” mergers) are on the rise and may lead to higher prices too. Harvard Business School economist Leemore Dafny found that merging hospitals within the same state but in separate markets increased prices by 6-10%.²⁰ Clemson University economist Matthew S. Lewis also discovered that hospitals acquired by an out-of-market buyer raised prices by 17% more than independent hospitals between 2000 and 2010.²¹ Researchers found that 55% of hospital mergers between 2010 and 2019 were in distinct markets.²²

2. WORSE HEALTH OUTCOMES

Research consistently shows that hospital consolidation results in worse outcomes for patients. The elimination of competition reduces incentives to improve quality of care.

A notable 2000 study, for example, found that one-year mortality for heart attack patients with Medicare coverage was much higher in concentrated hospital markets.²³ Later research similarly showed that hospital mergers in New York and California resulted in higher mortality rates for heart attack patients.²⁴

16 Zack Cooper, Stuart Craig, et al., “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” *Q J Econ*, February 2019, <https://pubmed.ncbi.nlm.nih.gov/32981974/>.

17 Martin Gaynor, “Antitrust Applied: Hospital Consolidation Concerns and Solutions,” Statement before the Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights, May 19, 2021, https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf.

18 Ibid.

19 Ibid.

20 Leemore Dafny, Katie Ho, and Robin Lee, “The Price Effects of Cross-Market Hospital Mergers,” March 18, 2016, <https://www.kellogg.northwestern.edu/docs/faculty/dafny/price-effects-of-cross-market-hospital-mergers.pdf>.

21 Matthew Lewis and Kevin Pflum, “Hospital systems and bargaining power: evidence from out-of-market acquisitions,” *RAND Journal of Economics*, Fall 2017, <https://www.jstor.org/stable/26305455>.

22 “The Rise of Cross-Market Hospital Systems and Their Market Power in the U.S.”

23 “Antitrust Applied: Hospital Consolidation Concerns and Solutions.”

24 Ibid.

A study by economist Zack Cooper found that greater hospital spending only leads to better outcomes in competitive markets. “What was striking is that when patients went to high-priced hospitals in concentrated markets, their spending went up by 52% but they did not get better outcomes. So this spending was really just wasteful,” Cooper remarked.²⁵

Researchers at Harvard Medical School and Harvard Business School found that outcomes such as readmissions, mortality, and timely antibiotic treatment did not improve post-acquisition. Moreover, patient ratings of their in-hospital experiences declined. “Our findings call into question claims that hospital mergers are good for patients — and beg the question of what we are getting from higher hospital prices,” said author J. Michael McWilliams.²⁶

Lastly, a groundbreaking study arrived at similar results while looking at the impacts of reforms to the English National Health Service, which paid hospitals fixed prices but required patients to be given the choice of five different hospitals.²⁷ This made quality of care the primary basis for competition between hospitals in the United Kingdom. Researchers found that those located in more concentrated markets had higher mortality rates than hospitals that had to compete more against local rivals.

3. SHUTDOWNS AND REDUCED ACCESS

Hospital acquisitions often lead to shutdowns of hospital departments or specialized care units. For instance, a study by Rachel Mosher Henke, senior director of research at IBM Watson Health, found that post-merger rural hospitals were more likely to close maternal/neonatal and surgical care units than independent ones between 2007 and 2018.²⁸

When acquiring other hospitals, large healthcare systems “often move to close services like intensive care, labor and delivery, psychiatric care, and cardiac surgery,” said Lois Uttley, former senior advisor at the Hospital Equity and Accountability Project. “It forces people to travel out of their communities and poses really serious navigation issues for patients, especially those who are disabled, elderly, non-English speaking, and without their own cars.”²⁹

25 Mike Cummings, “A Yale economist on taming rising hospital prices while maintaining quality,” *YaleNews*, March 7, 2022, <https://news.yale.edu/2022/03/07/yale-economist-taming-rising-hospital-prices-while-maintaining-quality>.

26 *Ibid*

27 Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, “Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service,” *American Economic Journal: Economic Policy*, 2013, <https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.5.4.134>.

28 Rachel Mosher Henke, Kathryn Fingar, et al., “Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas,” *Health Affairs*, October 2021, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00160>.

29 Hoag Levins, “Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality,” *University of Pennsylvania Leonard Davis Institute of Health Economics*, January 19, 2023, <https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/>.

4. LOWER WAGES FOR HOSPITAL STAFF

In addition to patients and payers, hospital staff can experience harms following mergers and acquisitions, particularly since they may lose bargaining power relative to employers. The employers, in turn, gain what's known as "monopsony" power, or increased leverage as a buyer of labor. In a 2019 paper published by the Washington Center for Equitable Growth, economists found that following mergers, nurses and pharmacy workers see 1.7% slower annual wage growth than their peers in more competitive markets.³⁰

As economist Martin Gaynor testified in the Senate, "The extent to which such a merger will cause labor market harms depends on the alternatives that workers have in terms of the other types of other jobs available and where they are located. ... Workers who have specialized skills that are not readily transferable to other employers in other sectors are more likely to be harmed."³¹

5. LOWER WAGES AND POORER COVERAGE FOR PRIVATELY INSURED EMPLOYEES

Even workers unaffiliated with two merging hospitals can see impacts to their compensation and benefits. Increased prices resulting from consolidation can lead to non-hospital employees who receive health coverage through work to shoulder a larger portion of the costs. This can come either through higher premiums that are subsidized with cuts to employees' wages or new insurance plans with greater cost-sharing requirements. A 2020 study by health economist Daniel Arnold at the University of California, Berkeley, found that combinations between competitors lowered wages between 2010 and 2018 by \$637, or 1%.³² The greater healthcare spending resulting from consolidation and other factors also led to a 15% increased enrollment in high-deductible health plans from 2010 to 2016. These plans put a larger burden on patients to pay for upfront healthcare costs before insurance coverage kicks in.³³

6. REGULATORY FORUM-SHOPPING

State officials should consider that out-of-state purchases effectively allow hospitals to shop for regulatory environments they find more favorable to their interests. In such cases, an acquired hospital can avoid scrutiny of its potentially predatory behavior from its own state by seeking a buyer in another state with weaker law enforcement. This appears to be

30 Elena Prager and Matt Schmitt, "Employer consolidation and wages: Evidence from hospitals," Washington Center for Equitable Growth, February 2019, <https://equitablegrowth.org/working-papers/employer-consolidation-and-wages-evidence-from-hospitals/>.

31 "Antitrust Applied: Hospital Consolidation Concerns and Solutions."

32 Daniel Arnold and Christopher Whaley, "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages," RAND, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

33 Ibid.

the case in South Dakota-based Sanford Health’s proposed acquisition of Minnesota-based Fairview Health Services, which is currently being investigated by Minnesota Attorney General Keith Ellison. State officials have had to keep Fairview under close watch due to its illicit fee-collection methods, but in South Dakota, Sanford has operated with impunity.

THE WORST CASE: UNIVERSITY OF PITTSBURGH MEDICAL CENTER

The University of Pittsburgh Medical Center (UPMC), a nonprofit system that dominates the hospital sector in Pennsylvania, may be the most egregious example of hospital consolidation in the country. Through a series of mergers and acquisitions and new construction over the past decade, UPMC has grown from a 12- to 40-hospital chain and insurance network that employs about 92,000 people, making it the largest nongovernmental employer in the state. In local areas like Allegheny County and Pittsburgh, UPMC owns more than 60% of the hospital beds and employs more than 65% of hospital workers.³⁴

As the research would predict, UPMC’s great market power has delivered poor results for community members, in terms of healthcare costs, quality of and access to care, and workplace conditions. For example, UPMC has bought and then shut down entire hospitals, like Pinnacle Lancaster and Susquehanna Sunbury, as well as closed departments in other ones. While reducing access to care, these moves allow UPMC hospitals to consolidate power over healthcare services. UPMC is also known for overcharging patients and payers, then demanding higher reimbursement from insurance plans that compete with its own. Meanwhile, its insurance company tries to push nonaffiliated medical providers out of the market by refusing to make them in-network,³⁵ or refusing to provide care to patients with outside insurance coverage.³⁶

A recent survey showed that 93% of hospital workers in Pittsburgh said they contemplate leaving their jobs at least once a month. UPMC has also been the subject of more than 150 unfair labor practice filings at the National Labor Relations Board over the past 10 years, as workers have looked to organize.³⁷ Despite all these harms, as a nonprofit and public charity, UPMC is exempt from certain taxes, making \$50 million annually in real estate carveouts in Allegheny County, Pennsylvania, alone.

34 “Critical Condition: How UPMC’s Monopoly Power Harms Workers and Patients,” American Economic Liberties Project, January 2023, http://www.economicliberties.us/wp-content/uploads/2023/01/AELP_2022_UPMC_Report_R2-3.pdf.

35 Ibid.

36 Rebecca Pifer, “UPMC, Highmark ink 10-year contract after years of fighting,” Healthcare Dive, June 25, 2019, <https://www.healthcaredive.com/news/upmc-highmark-ink-10-year-contract-after-years-of-fighting/557498/>.

37 “Critical Condition: How UPMC’s Monopoly Power Harms Workers and Patients.”

DEBUNKING ARGUMENTS FOR HOSPITAL MERGERS

Executives and policymakers favoring consolidation often make claims that mergers and acquisitions will help struggling hospitals, especially in poor, rural areas, get the funding and supplies they need and avert closure. Such arguments are intended to raise public sympathy and deter antitrust regulators from initiating a lawsuit. However, these “flailing firm” defenses rarely succeed when enforcers choose to challenge the merger in court.³⁸

To justify an acquisition, merger proponents also frequently portray hospitals as in greater financial distress than they actually are. For example, in the proposed Sanford-Fairview acquisition, Fairview Hospital has insisted it’s losing money, but its 2021 financial statement shows that its \$132 million operating loss on \$6.4 billion in revenue stems from depreciation and amortization and is offset by nearly \$167 million in investment income.³⁹

Furthermore, such claims are typically grounded in the idea that rural hospitals don’t make as much revenue as those in wealthier, urban areas. These hospitals serve sparse, high-need populations whose lack of adequate insurance coverage or increased enrollment in Medicaid results in lower compensation for patient services. But this ignores that these hospitals, as the exclusive medical providers for their communities, have significant control over prices, get to buy expensive drugs at discounted rates through the 340B program, and receive better reimbursement rates from government payers than their urban peers. It is these advantages that make them an attractive target for profit-seeking buyers.

Further, many of the hospitals closing in rural areas today are not independent, and their floundering state is caused by financial extraction by private equity rather than unavoidable circumstances. According to the Private Equity Stakeholder Project, at least 130 rural hospitals are owned by private equity, accounting for roughly 7% of rural community hospitals in the United States today. Nevertheless, private equity-owned entities made up 50% of the six rural hospitals that closed in 2021 and 2022.⁴⁰

38 Jeffrey Perry and Richard Cunningham, “Effective Defenses of Hospital Mergers in Concentrated Markets,” *Antitrust*, Spring 2013, https://www.weil.com/-/media/files/pdfs/effective-defenses-of-hospital-mergers_by_jeff_perry.pdf.

39 “Consolidated Financial Statements and Supplementary Information: Fairview Health Services Years Ended December 31, 2021 and 2020,” Ernst & Young LLP, April 2022, <https://emma.msrb.org/P11592185-P11228601-.pdf>.

40 “Fast Facts on U.S. Hospitals, 2022,” American Hospital Association, accessed March 13, 2023, <https://www.aha.org/statistics/fast-facts-us-hospitals>; “Private Equity Descends on Rural Healthcare,” Private Equity Stakeholder Project, January 2023, https://pestakeholder.org/wp-content/uploads/2023/02/PE_Rural_Health_Jan2023-compressed.pdf.

SOLUTIONS: STATE AND LOCAL

Among government actors, state and local authorities are proving to be the most active defenders of a competitive marketplace for hospitals.

1. REQUIRE STRICTER ANTITRUST REVIEWS OF PROPOSED MERGERS

Under federal law, mergers are illegal where the “effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”⁴¹ However, when merging or acquiring, companies only need to report the transaction to the Federal Trade Commission if it is valued over a certain amount, \$111.4 million as of 2023,⁴² and the Federal Trade Commission is not allowed to share the information from those notifications with state attorneys general.⁴³ As a result, stretched federal antitrust regulators are often not even notified about potentially harmful hospital mergers and acquisitions, and they are not allowed to share the necessary information with state and local enforcers, who are best positioned to challenge the illegal merger.

However, legislators can pass laws mandating that any hospitals or other healthcare providers seeking to merge in their state inform the state attorney general’s office. Unlike federal law, which only requires notification for large transactions, even small healthcare combinations can be threatening and should be subject. An example of such a measure is the Pennsylvania Open Markets Act⁴⁴ or Washington state’s notification system based on HBI607,⁴⁵ both of which require nearly all healthcare transactions to be reported to the state attorney general and for any healthcare merger notifications provided to the Federal Trade Commission to be shared with the state attorney general.

2. AUTHORITY TO BLOCK MERGERS THAT HARM QUALITY OF CARE

While antitrust law prohibits mergers with anticompetitive effects, state authorities do not have clear oversight to review the health and care effects of mergers on their own terms, such as the potential loss of service to underserved populations, limited access to care, or other community impacts.

⁴¹ 15 U.S. Code § 18 - Acquisition by one corporation of stock of another, Cornell Law School Legal Information Institute, accessed March 13, 2023, <https://www.law.cornell.edu/uscode/text/15/18>.

⁴² “HSR threshold adjustments and reportability for 2023,” Federal Trade Commission, February 16, 2023, <https://www.ftc.gov/enforcement/competition-matters/2023/02/hsr-threshold-adjustments-reportability-2023>.

⁴³ See *Mattox v. FTC*, 752 F.2d 116 (5th Cir. 1985) and *Lieberman v. FTC*, 771 F.2d 32 (2d Cir. 1985)

⁴⁴ Representative Sara Innamorato, House Bill 2677, Pennsylvania General Assembly, Regular Session 2021-2022, <https://www.legis.state.pa.us/CFDOCS/billInfo/billInfo.cfm?year=2021&body=H&type=B&bn=2677>.

⁴⁵ “Healthcare Transactions Notification Requirement,” Washington State Office of the Attorney General, accessed March 13, 2023, <https://www.atg.wa.gov/healthcare-transactions-notification-requirement>.

State legislatures can pass laws that grant the attorney general clear authority to solicit input, review healthcare mergers, and block any consolidations based on comprehensive examinations of the health and equity effects of the healthcare merger. Model legislation would be the proposed Keep Our Care Act in Washington state.⁴⁶

3. REPEAL CERTIFICATE OF PUBLIC ADVANTAGE AND CERTIFICATE OF NEED LAWS

Today, many states have certificate of public advantage (COPA) laws, which exempt hospital mergers from antitrust laws in exchange for increased state oversight. North Carolina, for example, granted Mission a COPA in the 1990s. According to the FTC, “oversight is an inadequate substitute for competition among hospitals.” By repealing COPA laws, state legislators will enable antitrust regulators to review proposed mergers for anti-competitive effects and take remedial action to protect patients and workers.⁴⁷

In addition, most states have certificate of need (CON) laws requiring anyone who wants to build new healthcare facilities to get government approval first. Dating back to the 1970s, CON laws were intended to prevent unnecessary spending on redundant services but have effectively allowed legacy hospitals to avoid competition. They can also restrict antitrust regulators’ ability to stop a merger or demand a divestment from combining hospitals. By repealing CON laws, state legislators can restore competitive pressures to hospital markets, which research shows results in higher quality, more affordable care.

However, while CON laws are generally harmful, in many individual circumstances, existing certificates of need are the only form of public oversight available for a hospital system. As such, any elimination of CON laws should grandfather in any individual certificates currently covering operating hospitals.

4. BAN ANTI-COMPETITIVE CONTRACTING TERMS WITH INSURERS

Especially as hospitals in different geographic markets combine to increase their leverage against insurers, it’s crucial that regulators stop them from inserting anti-competitive language into contracts. Some of the most concerning terms are known as “all-or-nothing” and tying clauses, in which insurers must include all of a hospital system’s facilities in their networks.

⁴⁶ “Keep Our Care Act Resource Center,” ACLU Washington, accessed March 13, 2023, <https://www.aclu-wa.org/KOCA>; House Bill 1809, Washington State Legislature, 2021-2022, <https://app.leg.wa.gov/billsummary?BillNumber=1809&Chamber=House&Year=2021>

⁴⁷ “FTC Policy Perspectives on Certificates of Public Advantage,” Federal Trade Commission, August 15, 2022, https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf.

In 2020, California regulators reviewing a proposed merger between Cedars-Sinai and Huntington hospitals, which operated in separate markets, found they could demand such language in their negotiations with insurers. After the hospitals challenged imposed price caps on insurer rates in court, the parties settled with a 10-year ban on all-or-nothing contracting. Other state regulators could follow this example.⁴⁸

SOLUTIONS: FEDERAL

The Biden administration has taken a new approach to healthcare and antitrust regulation, putting market competition front and center. The FTC and federal lawmakers could implement several reforms to aid the White House's efforts:

1. ELIMINATE NONPROFIT EXEMPTION FROM FTC ACT

Today, nonprofit hospitals are free from certain antitrust regulations in the FTC Act. Reps. Pramila Jayapal (D-WA) and Victoria Spartz (R-IN) have introduced a bill called the Stop Anticompetitive Healthcare Act to reverse this exemption, which would subject consolidated systems like UPMC to closer federal scrutiny.⁴⁹

2. CREATE NEW FTC TASK FORCE

In the early 2000s, the FTC established a task force that reformed its approach to challenging hospital mergers. This allowed it to reverse the losing streak it had in the 1990s and succeed in blocking several proposed mergers in the 2010s. A new task force could allow the FTC to present research demonstrating the anti-competitive effects of mergers between hospitals in different markets and thus substantiate challenges against such deals.

⁴⁸ Amy Gu, "Cedars-Sinai/Huntington Cross-Market Affiliation Settle with Revised Competitive Impact Conditions," *The Source on Healthcare Price & Competition*, August 16, 2021, <https://sourceonhealthcare.org/cedars-sinai-huntington-cross-market-affiliation-settle-with-revised-competitive-impact-conditions/>.

⁴⁹ "Jayapal and Spartz Introduce Bill to Stop Hospital Anticompetitive Behavior," *Congresswoman Pramila Jayapal*, December 13, 2022, <https://jayapal.house.gov/2022/12/13/jayapal-and-spartz-introduce-bill-to-stop-hospital-anticompetitive-behavior/>.

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