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EXAMINING THE IMPACT OF HEALTH CARE CONSOLIDATION

WEDNESDAY, FEBRUARY 14, 2018

House of Representatives

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Gregg Harper [chairman of the subcommittee] presiding.

Members present: Representatives Harper, Griffith, Burgess, Brooks, Collins, Barton, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Peters, and Pallone (ex officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight & Investigations; Adam Buckalew, Professional Staff Member, Health; Zachary Dareshori, Staff Assistant; Lamar Echols,

Counsel, Oversight & Investigations; Margaret Tucker Fogarty, Staff Assistant; Ed Kim, Policy Coordinator, Health; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Natalie Turner, Counsel, Oversight & Investigations; Hamlin Wade, Special Advisor, External Affairs; Jeff Carroll, Minority Staff Director; Evan Gilbert, Minority Press Assistant; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Zach Kahan, Minority Outreach and Member Services Coordinator; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

Mr. Harper. The subcommittee convenes this hearing entitled "Examining the Impact of Health Care Consolidation."

I want to welcome our witnesses, who will be introduced in more detail momentarily. The chair will now recognize himself for purposes of an opening statement.

The price of health care in the United States has steadily risen for several decades. In 2016, U.S. health care spending was estimated to be around $3.3 trillion and the gross domestic produced related to health care spending was 17.9 percent, an increase from 17.7 percent just the year before.

Data shows that the increasing costs of health care are ultimately passed along to American workers and families. This trend is concerning for all Americans and is an issue the committee will continue to examine here today and in the future.

While there are numerous factors contributing to the rising cost of health care, reports and studies show consolidation is a contributing factor.

Consolidation is not a new phenomenon. It has been occurring for decades among hospitals, doctors, the pharmaceutical industry, and insurance companies.

To date, most studies and data have focused on hospital and insurer consolidations. The effects of cross-market consolidations and other types of vertical consolidations are less clear.

Horizontal hospital consolidation -- the consolidation of hospitals into a single larger system -- has grown at a rapid pace this past decade.

According to the Medicare Payment Advisory Commission, MedPAC, hospital markets are now highly consolidated. In 2012, MedPAC found that a single hospital system counted for a majority of Medicare discharges and 146 of 391 metropolitan areas.

Similarly, a researcher found that in 2016, 90 percent of metropolitan areas were highly concentrated for hospitals. Through vertical consolidation hospitals have also acquired a significant number of physician practices over the past decade.

A recent analysis shows that the number of physicians employed by hospitals increased by 49 percent between 2012 and 2015. The Government Accountability Office found that between 2007 to 2014 the number of vertically consolidated physicians nearly doubled, from 9,600 to 182,000.

There also appears to be a significant amount of consolidation in the health insurance industry. The estimated nationwide market share of largest four insurers increased from 74 percent in 2006 to 83 percent in 2014.

Recently, the U.S. Department of Justice successfully blocked two mergers between major health insurance companies, noting that the mergers would violate antitrust laws and would lead to higher health care costs for consumers.

Given DOJ's success in challenging these mergers, some analysts have speculated that we will start seeing more vertical integration in the health care space.

Additionally, the FTC -- Federal Trade Commission -- has recently been successful challenging horizontal mergers of providers that supply similar services in geographic proximity.

However, the FTC and DOJ do not appear to regularly challenge vertical consolidations. Since 2000, the FTC and DOJ have challenged only 22 total vertical mergers.

The move towards consolidation raises questions as to what is really meant and what this really means for patients. Hospitals and providers contend that consolidation makes facilities more efficient by eliminating duplicative services, reducing administrative burdens, and improving quality of care.

Physicians are incentivized for many reasons to consolidate with hospitals including more payment stability and less financial and regulatory burdens.

Many experts point to Medicare paying more for the same services at hospitals than at a physician's office as a leading factor in providers consolidating with hospitals.

While many benefits of consolidation are difficult to measure, the majority of studies and literature shows that horizontal hospital consolidation leads to higher prices.

For example, according to MedPAC, horizontal consolidation

of hospitals has contributed to the discrepancy between prices Medicare pays hospitals and what commercial insurers pay.

In fact, a study found that in 2012, the average private price was 75 percent higher than Medicare prices after hospitals consolidate. Additionally, a 2018 study looked at hospital and physician consolidations. It found that from 2007 to 2013 almost 10 percent of physician practices reviewed were acquired by a hospital.

After being acquired the services offered by physicians increased an average of 14 percent in response to the growing number of consolidations in the health care industry.

In October of 2017, the Trump administration issued an executive order to foster greater competition in the health care markets and directing the administration to promote competition in and limit excessive consolidation in the health care system.

Health and Human Services was directed to collect public comments on these issues and we look forward to hearing and learning what innovative solutions HHS discovers during this process.

Consolidation in the health care industry raises many important questions relating to competition and innovation. For instance, why has consolidation increased during the past decade?

Is consolidation good for patients? What changes? Could

Congress or HHS make to encourage competition and innovation in health care?

I welcome and thank the witnesses for being here. We look forward to their testimony. At this time, the chair will recognize the ranking member of the subcommittee, Ms. DeGette.

Ms. DeGette. Thank you so much, Mr. Chairman.

As we will hear from the witnesses today, we have seen a long-term trend in consolidation in the health care sector where the market has become increasingly dominated by fewer and fewer companies.

This trend goes back 20 years or more and, frankly, it had real impacts on consumers. Excessive consolidation leaves consumers with few choices, which not only limits their care options but also has the potential to raise prices.

And it's not just individual consumers who are paying more. When Medicare's expenditures go up, then taxpayers suffer as well.

You know, it's important to note consolidation is not per se negative. Hospital mergers can enable providers to combine resources and improve coordination of care.

But if increased market power allows them to raise their prices with no competitive alternatives, then entire communities can suffer.

We have also seen increasing numbers of hospitals acquiring

physician practices. 2016 marked the first time that less than half of physicians own their own practice. Again, this can result in increased expenditures when the same services are now provided but at higher prices.

Although hospitals point to the reduced inefficiencies and regulatory burdens on physicians that can result from these acquisitions, it's really clear that the delivery of care is changing and not always to the benefit of patients and payers.

Likewise, when insurance companies are able to pull their market power to negotiate lower rates, there can be positive results. But not so when they push the other competitors out of the market or when the savings are not passed on to consumers.

For example, last year we saw the courts strike down two mergers between large insurers. These companies were already among the biggest players in the market and it was recognized that the merged companies would stifle competition and innovation.

It's really possible that we're going to see more attempted mergers of this kind and consumers need to get advocates on their behalf.

These issues affect all segments of the health care market including prescription drugs. As you know, Mr. Chairman, I've long been concerned about the rising price of drugs and insulin in particular.

Congressman Tom Reed and I were the co-chairs of the Diabetes Caucus and we are in the process of conducting an inquiry into insulin prices.

Our early findings suggest that consolidation across different parts of the so-called drug supply chain is indeed affecting what patients pay for their medications.

The problem has ramifications not just for consumers who rely on these medicines but also for the employers and public and private insurance companies that pay for them.

And so as we talk about these issues, it's important to know that pharmacy benefit managers have also seen this sort of consolidation we are going to hear about today.

PBMs have an enormous influence in the prescription drug market and yet the entire market is dominated by just a few of them.

So I am eager to hear the witnesses' thoughts on these issues. It's going to be my line of questioning so you can start to think about that now and what we can do to address it.

Frankly, we also need more innovative solutions that have potential to upend the inefficiencies in the market. Amazon, J.P. Morgan, and Berkshire Hathaway recently made news when they announced a joint venture to release -- to reduce health care costs for their companies.

Well, it remains to be seen how effective this merger will

be but it does show that there is a need in the market for innovation.

Mr. Chairman, these are complex issues and we're not going to solve them today, even with our best efforts. While I recognize there can be legitimate and even good reasons for consolidation, the long-term trends are alarming and the need for new approaches is clear.

I look forward to hearing from the witnesses about the research tells us are these underlying problems, what the real-world effects are, and what we can do to help.

And with that, I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Mr. Walden, for purposes of an opening statement.

The Chairman. Well, thank you, Chairman Harper. We appreciate your leadership on these issues.

As you mentioned in your opening statement, health care costs continue to rise in the United States. We are all paying higher costs.

In 2016 alone, the U.S. spent about $3.3 trillion -- that's more than $10,000 per person -- on health care. And as I've said on numerous occasions, this committee is dedicated to investigating all of the cost drivers in our health care system from top to bottom.

For example, we have been looking at 340B drug pricing program for the past two years and just last month we issued our report. Pretty comprehensive on the findings and recommendations.

Last December, the Health Subcommittee held a hearing examining the drug supply chain and the impact each participant's supply chain has and the ultimate cost to patients.

And today we want to explore consolidation in the health care industry and the impact consolidation has on consumers. Mergers and acquisitions are changing the health care landscape across the United States and over the past few years there is been a continuous stream of horizontal and vertical merger announcements between hospitals, insurers, physician groups, pharmaceutical companies, pharmaceutical benefit managers, pharmacies, and other health care firms, and those are just the deals we know about.

Some mergers are so small they don't make it onto the congressional radar screen and in the aggregate, however, even these small mergers could have an impact on consumers -- sometimes positively, sometimes negatively.

So one of the central questions that I hope we explore today is what does this consolidation mean for patients. My principle is put the consumers first and you'll have pretty good policy because that means you've got competition, drives innovation and

choice, and should drive down price.

On the one hand, consolidation is potentially good for patients by reducing the cost of care and improving outcomes through improved efficiencies and better care coordination. It can be that.

On the other hand, we are concerned that some consolidation could actually lead to higher prices for patients, doesn't lead to improved quality of care and so we want to hear both perspectives today and what the right public policy position should be.

So today, we also want to explore how consolidation impacts innovation. Last month we all heard the news that Amazon, Berkshire Hathaway, and J.P. Morgan are going to partner, try to improve employee satisfaction, reduce health care costs for their United States employees.

That sure caught my attention because if you want to talk about disruptors I think at least Amazon you'd put at the top of the list of how to disrupt things that are otherwise bureaucratically constrained.

And with the horsepower Berkshire Hathaway and J.P. Morgan, something big could happen in this space and it needs to.

Although we still know very little about their plans, I am intrigued by this partnership and we will continue to monitor it closely and when they are ready to come share information with

us we will be all open arms to hear how it's going to work.

Similarly, a group of several hospital systems recently announced their decision to enter the generic drug industry and develop a not-for-profit generic drug company. One thing I'd like to hear more about today is whether consolidation makes it more or less likely that we will see innovation in the health care market.

And finally, we also need a better understanding of what's driving consolidation, whether Congress should be trying to do anything about it.

We have heard a lot about how disparities in payments across sites of service may result in market consolidation and as a result Congress took a step toward equalizing payment rates across different sites of care through the Bipartisan Budget Act of 2015.

But we continue to hear about some of these inequities in payment rates. And as I mentioned earlier, the committee has been closely examining the 340B program.

During this work, we found 340B program creates an incentive for hospitals to acquire independent physician offices that are not eligible for 340B discounts, especially in the oncology space.

One report showed there was a 172 percent increase in the consolidation of community oncology practices since 2008. A recent article in the New England Journal of Medicine found, among

other things, that the 340B program has been associated with hospital consolidation in hematology oncology.

So there is evidence by these examples the committee needs to carefully review these types of policies and ensure that any federal policies that create incentives for consolidation are appropriate and ultimately benefit patients and consumers.

I now yield to Dr. Burgess the remainder of my time.

Mr. Burgess. Well, thank you, Mr. Chairman, and I want to take a moment to acknowledge one of our witnesses this morning, Dr. Dafny, who's the daughter of Nachum Dafny, who taught me neuroscience a long time ago at the University of Texas Medical School at Houston for -- affectionately known by the acronym UTMSH by its friends.

But I understand Dr. Dafny is still acting in teaching and so I was grateful to learn that this morning and certainly want to welcome Dr. Dafny to our -- to our subcommittee.

Mr. Chairman, I also have a unanimous consent request. It's probably just an oversight that we don't have a witness here talking about physician ownership of facilities.

So I have a paper from Health Affairs. It was published March of 2008 and while that was 10 years ago it does not diminish the overall brilliance and the keen insights provided in this paper and it was actually written by your humble chairman of the Health Subcommittee.

So I ask unanimous consent to put that into the record.

Mr. Harper. Without objection.

Ms. DeGette. Wait a minute. I am going to have to reserve --

[Laughter.]

Ms. DeGette. I am going to reserve a point of order on that.

Mr. Harper. It was questionable, but without objection, it is admitted.

With that, the chair will now recognize Mr. Pallone, the ranking member of the full committee, for the purposes of an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

The issues we will hear about today are critical for understanding the health care market. We have continued to see a long-term trend of consolidation in the health care industry including among providers and insurers, and it's important we look at these trends with careful scrutiny.

While consolidation is not necessarily a bad thing, it's important we understand the implications for consumers. I often worry, Mr. Chairman, that the people who do the consolidation want to say that it's great and rosy and they do, you know, put out all kinds of propaganda and literature and billboards saying how great it is but that doesn't necessarily mean it's the case.

For example, when insurance companies merge they often cite

the advantages of increased market power to reduce administrative costs and negotiate lower prices. However, that has not always been the result.

In fact, research has shown that some insurer mergers have led to increased premiums for consumers, and this is something we need to be watching very closely.

If the insurance market becomes dominated by fewer companies that only grow bigger, consumers will not benefit. For example, in 2016 the Department of Justice had to intervene in Aetna's acquisition of Humana as well as Anthem's acquisition of Cigna.

The courts determined that those deals would have hurt competition and innovation and one year ago today the two mergers were called off.

Although those mergers were cancelled, these trends are continuing and have been building for quite some time. Fifteen years ago, most states saw a third of their market controlled by a single insurer.

That consolidation continues to accelerate to the point where in 2014 the top four insurers controlled 83 percent of the market nationwide.

More recently, CVS Health announced that it would acquire the insurer Aetna. While it's still too early to tell what this merger will mean for consumers, it certainly raises questions about how competitive the market will be and how these types of

vertical consolidations will affect the delivery of care.

Instead of the market being dominated by a few large companies, it's important for consumers to have choices when picking their insurance plans. This insures not only a wider array of health benefits to fit their needs, but also brings down consumer costs.

For instance, the Department of Health and Human Services found that higher numbers of insurers were associated with slow growth in insurance premiums.

Providers have also not been immune to these consolidation trends. Between '98 and 2015, there were over 1,400 hospital mergers and acquisitions. Certainly, that's the case in my state of New Jersey.

In 2015, the number of hospitals involved in such deals was more than three times what it was in 2008. Now, some consolidation in the market may be inevitable.

But just as we critical examine insurance mergers with an eye to the impact on consumers, our first concern with provider consolidation should also be with the patients who will be affected. Hospitals often point to the advantages of consolidation such as reduced costs of capital and benefits of scale.

However, we have also seen some evidence that mergers can lead to increased prices for hospital care. The GAO has found

that it's also true in vertical consolidations when hospitals acquire physician practices Medicare expenditures can go up as care is provided in more expensive hospital outpatient settings.

And prices should not be our only concern. While a larger hospital system may be able to provide more services, it's not at all clear that provider consolidation necessarily leads to better quality of care.

So these are complex issues and I look forward to hearing what the latest research says about the long-term trends in consolidation and, most importantly, what the effects are for consumers.

And unless one of my colleagues wants the time, I'll yield back, Mr. Chairman.

Mr. Harper. The gentleman yields back.

I ask unanimous consent that the members' written opening statements be made part of the record and without objection they will so be entered into the record.

I would now like to introduce our panel of witnesses for today's hearing. Today we have Dr. Martin Gaynor, the E.J. Barone University professor of economics and health policy at Carnegie Mellon University. Welcome, sir. We are glad to have you with us today.

Next is Leemore Dafny. Dr. Leemore Dafny, who is the Bruce V. Rauner professor of business administration at Harvard

Business School. Welcome, Dr. Dafny. We are honored to have you with us.

And finally, Dr. Kevin Schulman, professor of medicine, visiting scholar at Harvard Business School and associate director of the Duke Clinical Research Institute. We welcome you as well.

I want to thank each of you for being here, providing testimony to us and insight into this important topic and we look forward to the opportunity to discuss health care consolidation today.

And I know that you're aware that the committee is holding and investigative hearing and when so doing we have the practice of taking testimony under oath.

Do any of you have an objection to testifying under oath?

Seeing none, the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel.

Do you desire to be accompanied by counsel during your testimony today?

Everyone has responded in the negative.

In that case, if you would please rise, raise your right hand, and I will swear you in.

[Witnesses sworn.]

Thank you. They all have responded affirmatively and thank you for that. You're now under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code and you may now give a five-minute summary of your written testimony.

And at this point, I will recognize Dr. Gaynor first for the purpose of his opening statement.

Sir, you have five minutes.

STATEMENTS OF MARTIN S. GAYNOR, E.J. BARONE UNIVERSITY PROFESSOR OF ECONOMICS AND HEALTH POLICY, HEINZ COLLEGE, CARNEGIE MELLON UNIVERSITY; LEEMORE S. DAFNY, BRUCE V. RAUNER, PROFESSOR OF BUSINESS ADMINISTRATION, HARVARD BUSINESS SCHOOL; DR. KEVIN A. SCHULMAN, VISITING SCHOLAR, HARVARD BUSINESS SCHOOL, ASSOCIATE DIRECTOR, DUKE CLINICAL RESEARCH INSTITUTE

STATEMENT OF MR. GAYNOR

Mr. Gaynor. Thank you.

Chairman Harper, Ranking Member DeGette, members of the subcommittee and the committee, thank you for holding a hearing on this vitally important topic and for giving me the opportunity to testify in front of you today.

I am an economist who has been studying the health care sector and specifically health care markets and competition for nearly 40 years. I am the E.J. Barone University professor of economics and public policy at the Heinz College of Public Policy at Carnegie Mellon University in Pittsburgh, Pennsylvania.

I served as the director of the Bureau of Economics of the Federal Trade Commission in 2013 and 2014 during which time I was involved in the many health care matters that came before the commission.

I've also served the Commonwealth of Pennsylvania as a member of the Governor's Health Care Advisory Board and as co-chair of

its working group on stoppable health care.

The U.S. health care system is based on markets. The system will work only as well as the markets that underpin it. These markets do not function as well as they could or should.

Prices are high and rising. They're incomprehensible and egregious -- pricing practices. Quality is suboptimal and the sector is sluggish and unresponsive, in contrast to the innovation and dynamism which characterize much of the rest of our economy. Lack of competition has a lot to do with these problems.

There has been a great deal of consolidation in health care. There have been over 1,500 hospital mergers in the past 20 years with nearly 700 since 2010.

The result is that many local areas are now dominated by one large powerful health care system such as Boston with Partners Health, Pittsburgh with University of Pittsburgh Medical Center, and the San Francisco Bay area with Sutter.

Insurance markets are also highly consolidated. The two largest insurers have 70 percent or more of the market and more than one-half of all local insurance markets.

Physician services markets have also become increasingly consolidated. Two-thirds of specialized physician markets are highly concentrated and 29 percent for primary care physicians.

There have been a very, very large number of acquisitions of physician practices by hospitals, so much so that one-third

of all physicians and 44 percent of primary care physicians are now employed by hospitals.

There are a number of reasons for this consolidation and, of course, they vary across transactions. These include attempts to enhance or entrench market position in order to maintain or increase rates, revenue and profits to protect market share. There are also what one could call Newton's Third Law of Consolidation -- for every action there is an equal and opposite reaction. If payers consolidate, then insurance companies feel they must consolidate to protect their position.

Providers then feel they must consolidate and so on, and you can have a vicious cycle, not a virtuous cycle, of consolidation for strategic reasons, not for reasons to improve the quality of care or help patients.

Their responses to financial incentives unintended in payment policies, specifically site-specific payments for the same physician service, can be double or larger if a physician practice is owned by a hospital, and the 340B program makes drug discounts available to hospitals but not to independent physician practices.

There are legitimate efforts to achieve scale for lower cost, avoid unnecessary duplication, accepting risk-based payments, better coordinate care, facilitate investments in care coordination and quality.

There are also concerns about the future. There's been a great deal of upheaval in health care over the past few years for a variety of reasons and sometimes entities feel that they are protecting themselves by consolidation.

Last, one should be aware that there is a global merger wave happening and there are many mergers throughout our economy. So there are undoubtedly factors that are not specific to health care but that have to do with what's happening in the economy as a whole.

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 enhanced efficiency.

Further, recent evidence shows that mergers between hospitals not in the same geographic area can also lead to increases in price. Just as seriously if not more so, evidence shows that patient quality of care suffers from lack of competition.

Lack of competition and consolidation entrenches existing modes of organization and delivery of care and prevents the emerging of new and innovative ways of organizing care.

Policies are needed to support and promote competition in health care markets. This includes policies to strengthen choice and competition and ending distortions that unintentionally

incentivize consolidation.

Now, there's no one policy that will achieve all of these. Rather, we need a constellation of policies that will work to mutually reinforce each other.

These include focussing and strengthening antitrust enforcement, ending policies that unintentionally incentivize consolidation, ending policies that hamper new competitors and impede competition, promoting transparency so employers, policy makers, and consumers have access to information about health care costs and quality.

We are facing a great challenge to our health care system. If left unchecked, consolidation could undermine our best efforts to control costs, improve care, and make our system more responsive and dynamic.

We need new and vigorous policies to encourage beneficial organizational change and innovation. If we fail, we will like have an even more expensive less responsive health system that will be exceedingly hard to change.

In my opinion, this is the number-one priority for health care. The time to act is now.

Thank you.

[The prepared statement of Mr. Gaynor follows:]

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Mr. Harper. Thank you, Dr. Gaynor.

The chair will now recognize Dr. Dafny for five minutes for the purposes of an opening statement.

Thank you.

STATEMENT OF MS. DAFNY

Ms. Dafny. Chairman Harper, Ranking Member DeGette, Representative Burgess, thank you for the kind remarks regarding my father, your professor at the University of Texas Medical School, Dr. Nachum Dafny, and all members of the subcommittee and committee.

I thank you for the opportunity to testify before you today on the subject of health care industry consolidation. My name is Leemore Dafny and I am an academic health economist with longstanding research interests in competition and consolidation across a range of health care sectors.

I am currently the Bruce Rauner professor of business administration at the Harvard Business School and the John F. Kennedy School of Government.

Previously, I was the deputy director for health care and antitrust at the Bureau of Economics at the Federal Trade Commission. I serve on a panel of health advisors to the Congressional Budget Office and as a board member of not-for-profit research organizations including the American Society of Health Economists and the Healthcare Cost Institute.

As you're aware, we have seen consolidation within and across a vast array of health care sectors, including hospitals, health insurers, and pharmaceutical companies.

There is a substantial academic literature that finds horizontal mergers of competing health care providers tend to raise prices and very limited evidence to suggest there are offsetting benefits to patients in the form of improved quality.

Economists, myself included, also find that less competition among health insurers tends to raise premiums. We have less extensive evidence on combinations across different sectors.

But the evidence we have to date also finds systematic price and spending increases, in particular, after hospital systems acquire additional hospitals in the same state and after hospitals acquire physician practices.

In a nutshell, research to date suggests that consolidation in the health care industry on average has not yielded benefits for consumers.

Yet, I expect we'll continue to see consolidation. What drives consolidation is the expectation of a reward for the merging parties and their stakeholders. Those rewards are not likely to fall dramatically without some action. I see four primary rewards for consolidation.

First, merging parties often improve their bargaining position and that enhanced bargaining position can enable them to raise price and to spend the extra on either margin or mission, if they're so inclined.

Second, merging parties often believe that scale economies will produce cost savings -- again, fuelling margin or mission.

Third, there are reimbursement rules and programs implemented by the Centers for Medicare and Medicaid Services, CMS, that rewards certain kinds of consolidation.

And fourth, many merging parties believe common ownership will produce integrated care which will enable them to realize synergies across the many products and services that patients require.

As I note in my written testimony, there isn't much evidence to support the beliefs regarding scale economies or integrated care, although every potential transaction needs to be evaluated on its own merits.

Merging for a better bargaining position or to game loopholes created by CMS is not value creating and often reduces value.

Achieving more competitive markets may in fact involve consolidation but only of the value creating variety. There are steps Congress can take to promote more competitive markets.

I believe it's a worthwhile investment to create public databases containing information about the ownership and financial links among different health care providers and net commercial prices for their services.

This database could form the basis for regularly scheduled reports and public hearings on industry consolidation and its

effects.

My counterparts with expertise on the pharmaceutical industry can advise on a similar transparency effort with respect to prescription drugs.

Second, additional funds could be appropriated to the federal enforcement agencies for enforcement-focused research.

Third, CMS could develop alternatives to its current policies, potentially reducing the benefits for consolidation that has already been consummated.

Fourth, and most aggressive, Congress could provide financial incentives or impose regulatory requirements for employers to utilize or develop so-called private exchanges where employees can shop for their preferred health plans and make choices that reflect their own preferences.

If consumers won't pay for a higher priced product that doesn't offer greater value to warrant a price premium, the incentive to merge so as to raise price will be diminished.

Health care is poised to capture one in five dollars in the U.S. economy by 2020. The usual checks in place to impede anti-competitive consolidation are muted in most health care sectors.

To borrow from the medical vernacular, watchful waiting is not, in my opinion, the wisest approach to pursue. Sometimes a surgical intervention is necessary.

672 [The prepared statement of Ms. Dafny follows:]

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Mr. Harper. Thank you very much, Dr. Dafny.

The chair will now recognize Dr. Schulman for the purposes of an opening statement for five minutes.

Welcome.

STATEMENT OF DR. SCHULMAN

Dr. Schulman. Thank you very much. Thank you, Congressman Harper, Ranking Member DeGette, and members of the subcommittee and committee for inviting me to talk with you today.

I would like to address the impact of hospital consolidation on innovation in health care markets. We've been talking about this already this morning, and I am going to frame my remarks around two different types of innovation.

One is called organizational innovation, or how firms improve their performance over time, and the second is called disruptive innovation, or how markets evolve over time, and we've talked about those.

First, I would like to discuss a concept called business architecture where the manner in which firms make decisions that allow them to generate predictable performance over time.

A business architecture is the product of leadership, culture, strategy, and internal organizational controls and processes. The ability of organizations to develop stable business architectures is one of the most revolutionary business concepts of the last century, compared to the chaos of the 19th century.

There is a down side to this construct, however, and then often a business architecture it's the way we make decisions needs

the rigidity of business models that can be very difficult to dislodge.

This lens of business architecture is critical to our assessment of health care policy related to hospitals. For the last decade, we have pursued an approach of asking hospitals to create new models of care to drive down health care costs.

In essence, we have asked them to replace their stable business architectures that have made them successful as fee-for-service providers. This would be a dramatic transformation if any business would achieve this goal.

The business architecture of many hospitals revolves around admitting patients for treatment, especially patients with commercial insurance or those who require surgery.

The hospital is treated as a profit center. In other words, the more the service is provided, the better financially for the system.

In these models, providers and hospital networks exist to provide patient referrals for inpatient care. Hospital mergers extend this model by making clinical services even more costly in multi-hospital systems.

To better understand the rigidity of the hospital business architecture, we asked a sample of two financial officers about their planning for business transformation.

We wanted to understand what types of investments would be

required to pivot from a fee for service business model to the most extreme value-based payment model capitation.

We found that none of the leaders we interviewed had a clear estimate of the investment that would be required for the same transformation and observed the crosshair sample that were significant disagreements about how a change in payment models would impact essential components of the budget models.

Despite almost a decade to prepare for this transformation, there is little evidence of the development of the concrete business plans that would be required to successfully carry out business architecture change.

One approach to organizational change is to create a new leadership role tasked with innovation -- a chief innovation officer. These leaders could help guide the transformation of the delivery system to new models of care that we all desire.

Eighty percent of the largest health systems in the United States have created such a role and we surveyed a majority of these individuals.

While the respondents were all enthusiastic and committed to innovation, we were very concerned after this research. These roles were not structured or budgeted for success.

For example, one of these respondents reported that their role was strategic -- in other words, that they were responsible for this change. Their median annual budget was only $3 million.

It's unlikely that investments of this magnitude are -- can change business architectures within these enormous multi-billion-dollar organizations.

Large hospital systems can have other impacts on innovation. Vertically integrated organizations are good at developing standard business processes but are not necessarily conducive to the type of physician-driven innovation that could drive new care models.

In part, this concern could explain why there's little evidence of the quality of care improving when hospitals pursue physician employment models.

One way to reconcile these findings is to realize that rather than pursue business transformation that we have been seeking hospitals have been actively pursuing an agenda related to market power.

The impacts of market power on business strategy and hospital investments can now sustain impact over long periods of time.

The other type of innovation I would like to discuss is disruptive innovation or changes in business models within markets. Clay Christensen has described how technology innovation allows business innovation to bring about cost and quality improvements for consumers.

At the core, Christensen suggests that business architecture of existing firms is so rigid that they can't respond to market

changes that they plainly see and so are replaced by new entrants in a process of created destruction within markets.

Hospital-led organizations are the type of large inefficient firms theory suggests should be replaced. If you wake up with a sore throat, would you rather go to a hospital and pay for parking, wait to be seen, or just have a telemedicine consult to tell you whether or not you need antibiotics?

The lack of disruptive innovation is a critical shortfall in the healthcare market. Not only could disruptive innovation drive development of novel clinical services for patients, but would shake up the market to spurt existing hospitals to more fully embrace and innovation agenda.

One recent study said -- suggested that 50 percent of increase in health care costs since 1996 is related to service and price intensity.

This is the pattern of costs that would be expected to result from the migration of clinical services to the hospital-based business model with all of this consolidation.

However, all of this is a tremendous price for American consumers to pay for the failure of an innovation agenda in health care.

Thank you.

[The prepared statement of Dr. Schulman follows:]

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Mr. Harper. Thank you, Dr. Schulman, and thanks to each of you for the summary of your testimony.

It's now time for the members to ask questions. Each member will have five minutes and as chair I will recognize myself for five minutes and begin.

And I will start with you, Dr. Gaynor, if I may. As you have heard today, obviously, the costs of health care has steadily risen over the past several decades and one of the factors that certainly we are looking at is the -- that's contributing are the number of consolidations that have occurred in the health care industry the past decade.

So my two questions for you, Dr. Gaynor, what impact has consolidation had on patient cost, quality of care, and access to care, and are there any indications to you that patients are better off after consolidation or with that?

Mr. Gaynor. Thank you, Chairman Harper.

So the research evidence shows very clearly that consolidation between hospitals that are close competitors lead to very substantial price increases. Depending on the exact situations, it could be as high as 50 percent but not -- not at all.

For insurers, again, there's extensive evidence that consolidation among insurers leads to higher premiums and for physician practices, again, consolidation between physician

practices that are close competitors lead to higher prices, in some cases substantial. And last, the acquisitions of physician practices by hospitals lead to higher prices for physician services and more spending.

The evidence on the quality of care I would say is mixed. But overall it does not show gains for patients in terms of quality of care.

If anything, there is some evidence that shows that clinical quality of care for patients can suffer when there's less competition between hospitals or doctors, and we do not see, again, consistent evidence of more coordination of care or lower costs of care.

So this harms patients, first, because the costs of care are higher. As we know, that when the costs of care get higher, employers pay higher fringe benefit costs and those get shifted back onto workers in the form of lower total compensation.

Where it's lower wages, paying more out of pocket for health insurance or having less generous health insurance, the average American household hasn't seen an increase in their real standard of living --- that of health care costs -- in quite some time.

So it doesn't appear on average that there are benefits that are being realized and there are real costs.

Mr. Harper. Thank you.

And Dr. Dafny, should we be concerned about the increased

numbers of consolidation in the health care industry?

Ms. Dafny. Chairman Harper, thank you for the question.

Given the data that Professor Gaynor has just described and that is described in our testimony, I would indeed be concerned, on average.

I keep adding the on average because every consolidation needs to be considered on its merits and there are a number of consolidations that are occurring right now that are pretty novel and I wouldn't propose that those be quashed just because on average consolidation hasn't --

Mr. Harper. Sure. So you can point to some successful outcomes of some of these consolidations. Is that what you're saying?

Ms. Dafny. I would like to be able to point to some successful consolidations. I wrote -- I co-authored a paper with a physician friend of mine, Dr. Tom Lee, called "The Good Merger" about what would be the characteristics of a good merger and I am often asked can you spotlight one for us, and I am searching still for a very nice example of it.

But I am sure that they exist.

Mr. Harper. Would the criteria be, if we -- as we look at these and try to see whether they are positive or negative, is it better outcome for the patient? Shouldn't that be at the heart of whether it is successful or not?

Ms. Dafny. At the heart of whether it is successful, you'd have to consider multiple dimensions. I would certainly place patient outcomes at the top of the list. But it wouldn't be the only dimension I would score it.

Mr. Harper. Cost possibly?

Ms. Dafny. Cost would be pretty significant and not just the cost to the hospitals themselves but the prices that they -- whether they pass through any cost savings.

Mr. Harper. Do you believe that the health -- the consolidations will continue to increase in the future?

Ms. Dafny. Undoubtedly.

Mr. Harper. Okay. Is there any type of health care consolidation that we don't know enough about to determine its impact on patients?

Ms. Dafny. We don't know enough, in my view, about the kind of consolidation across the care continuum, if you will. In theory, if you combine hospitals and physicians and post-acute care providers and perhaps even some pharmacy elements, you might get an integrated package product that could be superior to the piecemeal approach that we have.

We don't know enough about whether that is likely to work and also whether the markets are competitive enough that the price of that product would be affordable for their value.

Mr. Harper. Thank you very much.

At this time, the chair will recognize the ranking member, Ms. DeGette, for five minutes for questions.

Ms. DeGette. Thank you so much, Mr. Chairman.

Dr. Dafny, I know the members of this subcommittee would love to have a copy of your paper, "The Good Merger." If you could provide that to us that would be great.

Ms. Dafny. With pleasure.

Ms. DeGette. Thanks. And then we'll help you continue to search for a good example.

As I said in my opening statement, my colleague, Tom Reed, and I have been looking into insulin prices and I think that our investigation, the facts we've learned, have broad implications from the consolidation issues here today.

For example, the three largest PBMs control over two-thirds of the prescription drug market, and Dr. Dafny, you noted in your prepared testimony that consolidation enables PBMs to improve their bargaining position with drug companies.

But wouldn't it be fair to say that PBM consolidation also might likely result in increased prices for prescription drugs like insulin?

Ms. Dafny. I would say that we ought to do a merger retrospective on the most recently large PBM merger and see how that affected downstream prices to consumers.

But to the extent that a merger -- that we've had more

consolidation, I would expect but I haven't seen formal statistical evidence to suggest that prices would rise.

Ms. DeGette. Dr. Gaynor, I know you have got some expertise in this as well. What's your view?

Mr. Gaynor. Well, I agree with my colleague. I think -- I think, just as you suggested, Ranking Member DeGette, there is concern. We now really only have three PBMs in effect in this market, and once numbers get that small it is cause for concern.

But I agree with Professor Dafny. At this point, I do not know of direct evidence on that. But it is time for a retrospective and the Federal Trade Commission, of course, has authority through Section 6(b) of the Federal Trade Commission Act to conduct studies of this sort in the public interest. So that would certainly be a beneficial thing to pursue.

Ms. DeGette. That's a good avenue.

I mean, in general, if a market becomes too concentrated with one provider system that could potentially lead to increases in prescription drug prices. Is that correct?

Mr. Gaynor. Yes.

Ms. DeGette. Okay. Now, these inefficiencies in the market we think are also affecting employer-based health insurance.

Dr. Dafny, you said the consumers in employer-based plans need to have more choices. What can we do to encourage that?

Ms. Dafny. As you are aware, the majority of employers offer only one choice when they sponsor health insurance to their employees.

Now, larger employers who employ more than half of employees tend to offer a little bit more -- two, maybe three choices. But that's not a very large set and therefore they tend to cater to the average consumer, don't allow you to vote with your feet for the kinds of tradeoffs you want to make.

What could you do? Well, it is possible to encourage employers to offer more choices, particularly through a private exchange, which wouldn't be terribly different from what a public exchange would be.

I am not a legal expert as to the mechanisms you would use. But there's ERISA. There should be some possibility there. Many years ago it was required to offer an HMO to employees in order to encourage that possibility and one could imagine minor tax preferences for the variety that you offer.

Ms. DeGette. That's an interesting suggestion.

Dr. Gaynor, back to you. A lot of people have been talking about entirely new approaches to providing health care to consumers, and we are all abuzz here about this news that Amazon is making that it's entering the health care business.

You know, I know these ventures are still in their infancy. But do you have any thoughts about the potential of Amazon or

some of these other initiatives to improve the consumer experience and bring down costs.

Mr. Gaynor. Sure. Thank you.

Let me give one hand, other hand -- a typical economist kind of response. So on the one --

Ms. DeGette. We'd be disappointed if you didn't.

Mr. Gaynor. Right. Harry Truman is reported to say, could somebody find me a one-handed economist.

So on the one hand, and this is the positive, a very positive aspect of this development is that executives at major corporations in the United States are paying attention to health care costs.

For decades, health care costs have been a real issue for business in the United States. But, typically, it's the domain of human resources and executives. The C-Suite hired management really have not paid a lot of attention to this.

So to have Amazon, J.P. Morgan, Berkshire Hathaway stand up and say this is important, we are going to do something, is very, very encouraging.

They're certainly -- it's potentially a very innovative thing. I wish it the best of success. I hope it succeeds. We need more.

Having said that, it's not clear to me exactly what they would do. Even these companies are small relative to the overall

size of the system.

They are very powerful entrenched providers and insurers and pharma companies. That can be very hard for any one employer, let alone three large employers, to deal with.

And last, again, this is the other hand here -- we have seen some of this before if you've been around long enough -- and I think I have enough grey in my beard to qualify on that account -- employers have stood up in public before and said we are going to be doing something about this and yet here we are.

Ms. DeGette. Yes. Okay. Thanks. Thanks, Mr. Chairman.

Mr. Harper. Gentlewoman yields back.

The chair will now recognize the gentleman from Texas, Mr. Barton, for five minutes.

Mr. Barton. Thank you, Mr. Chairman, and thank you for holding this important hearing.

You know, there's a saying that people like myself that run for public office and have been around awhile kind of live by and it's called no good deed goes unpunished.

Congress keeps trying to do the right thing in health care. We've adopted two policies that we thought were positive but in terms of cost they don't seem to have helped much.

One is we have a Medicare differential reimbursement between physician services provided in a physician's office and physician services provided in a hospital setting.

We pay a higher rate because of the increased overhead charges if a physician works for the hospital and provides the services in the hospital.

And it appears to me that a lot of these consolidations where hospitals are purchasing physician group practices are simply to get the higher reimbursement rate.

Now, that's a simplification but it sure looks that.

The other program where we've kind of been bitten in the bottom is the 340B program. We set up a system for certain hospitals that could get a discount under the 340B program. But they didn't have to pass that discount on to their patients, and we've had an explosion of hospital pharmacies applying and being accepted into the 340B program and the oversight group that's supposedly auditing this have admitted that they don't have the personnel to really audit the program and that the cost of the program is going through the roof.

So my question is would it be practical and possible that if in the case of these physician practices being purchased by hospitals we adopted a regulation or perhaps a statute that said Medicare is going to pay the lower of the reimbursement rate before the merger instead of they always pay higher? Would that be practical to do something like that?

Anybody can answer it.

Ms. Dafny. I am happy to take it, Representative Barton.

You have described the extended game of whack-a-mole that Congress I playing with various health care sectors and probably other sectors as well and I want to return -- I will answer your question but I want to return to the point before if we had a competitive downstream market.

You might not have to play that game as much because market forces would walk away from health plans that overpaid for the same service rendered in a hospital than in a lower cost site of service.

So the original program was designed to cover costs and hospitals are more costly and so you paid them more. But as you have noted, now it's being exploited.

It's my understanding that Medicare has in place the policy already for future acquisitions to not be able to bill at the hospital rate but to bill at their initial rate or the lower rate.

The real question, I think, is about rolling back. Do you say over a certain period of time we are going to move towards site-neutral payments so as not to continue to encourage more spending in this inefficient way but recognizing that hospitals have revenue streams and employment and other things so recognizing there may need to be some other forum by which hospitals are compensated but not in a way that distorts their incentives of where to supply services.

Mr. Harper. Okay.

Mr. Gaynor. If I may just add something to -- on top of what Professor Dafny said. One thing we see very commonly is that there are important spillover effects from the Medicare program onto what private health insurers do.

And so a lot of private health insurers followed Medicare in adopting higher payments for hospital-based or hospital owned practices.

So the salutary effects of reform to Medicare payment would be not just on the Medicare program itself although, obviously, that would be hugely beneficial, but could actually have larger effects that would affect what private insurers do because right now private insurers continue with these larger payments.

Then there are still incentives, in spite of what Medicare has done for a hospital as to acquired physician practices.

Mr. Barton. Finally, on 340B, what if we adopted a statute or regulation that said whatever the discount is it has to be passed through to the patient?

Dr. Schulman. I think that would provide a huge incentive to go back to a practice model that we had that was much less expensive for consumers.

When 340B was passed in 1992, there were 90 safety net hospitals that were eligible. There are now over 2,000 hospitals that are eligible.

Drugs, expensive medications in 1992 were hundreds of

dollars. They are now $100,000, and so, you know, if you can make $25,000 per drug on this discount it's just an tremendous incentive to distort the market.

Mr. Barton. I know my time had expired. But let me ask Dr. Dafny, Baylor Scott & White merger -- good or bad?

Ms. Dafny. You know, I am under oath. But also I don't have evidence. I do have a quote, though -- a paraphrase of a quote. I was surprised to read the CEO in charge of the transaction after the fact said well, once we are merged we are going to figure out what efficiencies might be there.

In my world, I prefer you to consider that before you make a deal like this.

Mr. Barton. Well, they're both in my district, you know, when they were separate. Now that they're merged the biggest hospital actually in my district is the Baylor Scott & White Hospital in Waxahachie and everybody loves them.

With that, I yield back.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentleman from New York, Mr. Tonko, for five minutes for questions.

Mr. Tonko. Thank you, Mr. Chair, and welcome to our witnesses.

I would like to start with the consolidation of providers and how that affects consumer prices.

Dr. Dafny, in your testimony you state, and I quote, horizontal mergers of competing health care providers tends to raise prices. And it's not just hospitals. You note that physician market concentration has also led to higher prices.

Dr. Dafny, can you briefly explain how these different types of mergers can have harmful effects as they relate to consumer prices?

Ms. Dafny. Okay. So on a hospital side, let me start with that.

On the hospital side, hospitals have bargaining power vis-a-vis the insurers if they're unique in some way such that excluding them from an insurer network would force the insurer to have to lower premium or not be able to make sales.

If two competing hospitals that are attractive to enrollees and are substitutable for one another decide to merge, then the insurer can't play them off against each other when negotiating rates.

The insurer is likelier to need to include that joint entity in the insurer network and therefore they can bargain for a higher prices. Higher prices for health care services are then likely to be passed through as higher premiums.

In the case of physician practices, there are a few different factors at play. Often, that's more of a vertical transaction upstream. The hospital is acquiring the physician downstream

for a variety of reasons.

One is, as Representative Barton was talking about, in order to be able to charge higher prices because the physician is not affiliated with a hospital, and that's just kind of a mechanistic element of Medicare and of other private insurance programs.

Another motivation can be to funnel more physician referrals upstream to your hospital. And then finally, to the extent that there's a horizontal element so now you have many more, say, of a specialty group, you can do the same thing.

Negotiate to have that cardiology group included in an insurance network. They can charge a higher price and there is evidence that I cited here that there are higher commercial insurance prices as a result of hospital acquisitions of multiple physicians.

Mr. Tonko. Thank you. Thank you.

When providers merge, they often cite the potential to leverage their combined size to reduce costs. However, Dr. Dafny, you have explained that there actually isn't much evidence to support this theory in practice.

So why is that and why are there insufficient incentives for providers to drive down costs?

Ms. Dafny. So I might aspire to reduce my costs following a merger. But at the same time, if I gain market power I am going to have less of a market incentive to be efficient and be able

to bring my price down. So there's that less incentive to achieve it.

And then it's quite possible that there's a lack of know-how to get it done. I do cite one study by a student of mine who finds some cost reductions when a hospital system out of the area of another hospital acquires the target and can bring costs down.

However, my own research shows, using a similar sample, that they bring prices up if they acquire a hospital in the same state.

So even if costs go down, those don't seem to be passed through to consumers and most studies don't find evidence that costs do go down.

Mr. Tonko. Okay. And again to Dr. Dafny, is the Medicare program particularly vulnerable to that -- to some of these problems or do we see this in private insurance plans as well?

Ms. Dafny. Medicare, as you know, has administered prices so they're not as vulnerable to the post-merger price negotiations. But if you eliminate your rivals then you also eliminate or reduce the incentive to compete on other dimensions that patients value.

So that's one point. The second point is that, of course, Medicare has its rules that we discussed that reward certain kinds of consolidation and so they'd be vulnerable in that respect as well.

Mr. Tonko. Thank you.

And with the time that I have left, I would like to turn to consolidation amongst insurers and how they tend to raise premiums.

You did a study of what we call mega merger and found that premiums increased not just for enrollees of these insurers but even for enrollees of rival insurers.

Can you tell me how these sorts of mergers can have that ripple effect throughout the -- throughout the insurance market?

Ms. Dafny. Absolutely. It's what you'd expect in any oligopolistic market where there are just a couple of competitors.

By merging, you're able to raise your price because those customers who really like the product that you're offering can't get -- can't get one from your substitute, assuming you merge with a substitute. And then that relaxes price competition for your rivals.

So it's kind of a double whammy. It is not just when hospitals merge, seeing a raised price. It's not just their prices that go up. It spills over to others in the marketplace.

Mr. Tonko. Thank you very much, and with that I yield back, Mr. Chair.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentleman from Virginia, the vice chair of the subcommittee, Mr. Griffith, for five minutes.

Mr. Griffith. Thank you very much, Mr. Chairman.

Dr. Gaynor, you touched on it a little bit earlier. A lot of us have concerns about having only basically three PBMs left in the market after all the mergers, and in fact in 2015 at a Judiciary Committee hearing Professor Thomas Greene suggested it was time, just as you did, maybe for the FTC to take a look at the PBM market and the effects of consolidation. Even FDA Commissioner Scott Gottlieb has mentioned in that same hearing that he was concerned that PBMs were using their increased market power to prevent other market participants from growing or merging. So I appreciate your comments this morning.

And Mr. Chairman, I have and would ask unanimous consent to submit a letter I have received from the National Community Pharmacists Association outlining their concerns about PBM consolidation and the impact it is having on independent pharmacists.

Mr. Harper. Without objection.

Mr. Griffith. Thank you, Mr. Chairman.

Is there anything you wanted to expand on that before I move to the next subject, Dr. Gaynor?

Well, thank you. I appreciate you answering those questions from Ms. DeGette. As often in some of these occasions, she and I tend to be going after the same area.

Dr. Dafny, I have a merger that has just occurred. It's

a little bit unusual because the concerns primarily were can we keep the hospital systems afloat.

Two hospitals, East Tennessee and Southwest Virginia, merged. We are waiting to see if costs go up. People are very concerned about it.

It just happened -- finalized last month. They are now Ballad Health. I would love to see your article on the good merger so I can start looking at some of those numbers.

But the concern there was one of the hospitals actually went under in one of the two systems. They're two fairly large systems, by our standards, in rural America that merged. I think they have 21 hospitals now.

So they're pretty good sized. They're hoping they can stay afloat. That was our concern. It wasn't for financial reasons that they were going to make more money. It's can they survive. Any comments? Do you know anything about that merger?

Ms. Dafny. If I may, I am familiar with that transaction. In fact, I authored a public comment on it which may have been cosigned by my colleague here, Dr. Gaynor.

Mr. Griffith. Were you pro or con?

Ms. Dafny. I was concerned.

Mr. Griffith. Okay.

Ms. Dafny. Concerned because the hospitals sought and were granted, as you're aware, a certificate of public advantage

because the federal enforcement authorities were concerned that there was effectively mergered a monopoly in many of these areas.

And when you say the hospitals did so because they were concerned that they would remain afloat, what goes off in my head is a bell that says price increase, price increase -- how are you going to remain afloat unless you -- unless you thought your cost reductions could be so substantial jointly than apart you might be trying to use your stronger negotiating position to wrest higher prices from commercial payers and that would make the economic environment less competitive.

I am aware the FTC did an extensive investigation and if they were to -- if they had found those cost projections credible I believe the wouldn't have tried to challenge the transaction. So I am concerned.

Mr. Griffith. Yes. A number of my constituents are concerned but we also want to make sure we have hospitals because if you shut one down it's not like there's another one right around the corner.

It's usually around a mountain and down a mountain and up another mountain before you can get to the next hospital and that creates concerns as well.

But I appreciate that. Dr. Gaynor, you had something? Or Dr. Schulman.

Mr. Gaynor. If I may just add something. The use of

certificates public advantage to shield merging parties from anti-trust scrutiny I think is not the right policy. I certainly understand the vulnerabilities and the concern over communities in these kinds of situations.

But there are other ways to achieve these goals and, of course, as is well known, there is a failing firm defense for anti-trust scrutiny. So that is taken into account. And the concerns that my colleague expressed certainly apply.

Mr. Griffith. And I appreciate that.

Dr. Schulman, I want to -- I want to blow things up. I want you to think about it because I don't have time to get an answer per se. But I want you to think about ways we can help blow up and make the market more innovative.

I really like that part of your statement and your concerns. telemedicine -- I think a big part of that is being held back by the CMS payment model and the fact it takes an act of Congress to get some new payment arrangements.

I think we have to take a look at the Stark Act. I have rural areas that are under-served, where I have room in a nursing home. But they can't set up an opportunity there for somebody from the community to come in.

I know we don't want them colluding on the nursing home patient. But we have space there that the community could use in an underserved area that we can't because we can't have

telemedicine in the nursing home for a hospital an hour and a half away.

Can you give us advice -- and I am out of time -- but can you give us advice on what laws we need to change to make the system for reimbursement on CMS more efficient to recognizing that there are new ways to do this?

Dr. Schulman. Yes, absolutely. I think we have a limited amount of time. But the idea -- when I got my board -- you know, my licensure in North Carolina, they basically explicitly told me unless I saw the patient, you know, I would be in violation of the medical practice.

So, you know, that's not the world that we live in today. We need to experiment with these kinds of innovation models, see which ones work and then deploy them.

Mr. Griffith. Well, if you have language I would be very interested in it because I would like to blow up the way we do the reimbursements so we can blow up the medical system and make costs come down.

I yield back, Mr. Chairman.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentleman from California, Mr. Peters, for five minutes.

Mr. Peters. Thank you.

Just following on Mr. Griffith's comment, in the veterans

health care -- mental health care field, I see a huge opportunity for telemedicine and you have got all sorts of issues with reimbursements but also with cross-state licensing and I would certainly be -- enjoy working with the gentleman on figuring out ways to loosen that up.

I had some questions about transparency and markets and Mr. Gaynor, you talked about no publicly available data on total U.S. health care costs and utilization or prices on specific -- for specific services or providers.

Do you have an idea about the first steps you'd advise Congress to help -- to take -- to help federal state authorities achieve that kind of transparency about cost and quality?

Mr. Gaynor. Sure. Thanks for asking the question.

There -- at present the issue is not that the data aren't there. The data exist. We have great data from the Medicare program. CMS has done a great job with this. Medicaid resided at the state level and in private -- private parties hold the data as well.

But on the private side, it's not easy to access and it's not easy to access in an aggregate way. So finding a way to encourage, support, finance these activities. So one possibility we provide financing for a national data warehouse.

Mr. Peters. But for what? What would it look like? So --

Mr. Gaynor. Right.

Mr. Peters. -- you know, I would want to know what the money was being spent on.

Mr. Gaynor. Of course. Of course.

So one question is what is actual total health care spending for the United States at any given point in time. Right now, we rely on estimates done very skilfully by the national health expenditure accounts at CMS. But they don't actually have comprehensive data from the private side.

So for Congress and the U.S. government, just knowing what that is, drilling down into those data, knowing what various things cost, being able to compare Medicare, private, Medicaid, and various issues. For businesses, being able to get that information. It's surprising, but many businesses don't know what things cost, let alone individuals.

Mr. Peters. Well, with regards to that side of it rather than the regulatory side of it, which is sort of these aggregates you describe, can we expose the markets to this information in a way that helps consumers and users make better choices?

Mr. Gaynor. Well, sure. The saying a little sunshine can be the best disinfectant I think is very real and I can give my hometown of Pittsburgh as an example.

We know that we have UPMC dominating the entire market. But nobody knows actually what the prices are for anything. My

colleagues, Zack Cooper and Stuart Craig and John Van Keenan, studied this issue using data from about a third of all people with private health insurance in the United States and we found huge amounts of variation for simple things like an MRI of your knee -- 600 percent variation in a geographic market but nobody knew that before.

Mr. Peters. And Dr. Dafny, I guess you had some comments about this too with respect to information about ownership and financial links.

Ms. Dafny. I do, and I have a bit of a response to your preceding question, if I may. Two acronyms -- APCD and HPC. So the --

Mr. Peters. Air Pollution Control District? Sorry.

[Laughter.]

Ms. Dafny. Probably not an exclusive acronym.

Mr. Peters. Right.

Ms. Dafny. All Payer Claims Database and the Health Policy Commission. So my new home state of Massachusetts, I've only been there a year and a half -- uses its All Payer Claims Database to create summary measures across different hospitals of average commercial prices and not just for certain kinds of procedures but also for an entire patient life that is attributed to a given system of care. So this state has decided to take the date that it has access to and put out transparent reports on it which

enables the public to weigh in on all sorts of consolidation, both one that the dominant system partners was trying to do a couple years ago.

Everybody used the HPC data to make their public comments and such. The deal did not happen, and right now there's another big deal that is under consideration and many parties are using that the HPC put out to try to assess that transaction.

So I think making the data available possibly through an All Payer Claims Database and possibly through state agencies that -- who are responsible for monitoring including notifications of material transactions, which is what the HPC does.

Mr. Peters. So assuming that we have additional consolidation, though, any thoughts on exposing prices to consumers that can help them? Is there an example of someone doing that well?

Yes. I got four seconds.

Mr. Gaynor. New Hampshire. Well, I agree with what Professor Dafny said about Massachusetts. They've done a great job not just assembling the data but using it in a meaningful way and bringing it to bear.

New Hampshire also has an All Payer Claims Database and there is some recent evidence on that by a young scholar named Zack Brown who's joining the Economics Department at the University

of Michigan that shows that consumers actually did use the All Payer Claims Database for shopping and it did drive prices down, and further, that providers responded to that because they knew there were some people out there looking.

You don't have everybody in the market informed; just enough so that sellers know that somebody might not come to them if the prices are competitive.

And it did have -- it did have impacts. But I think we are still in the infancy of these things.

Mr. Peters. Thank you. My time is expired. Thank you, Mr. Chairman.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentleman from Texas, Dr. Burgess, for five minutes.

Mr. Burgess. Thank you, Mr. Chairman.

Well, as you might imagine from my opening comments, I am interested in one of the things that's kind of been left out of this discussion is physician ownership of facilities.

And we live in a world where, unfortunately, it is possible for hospitals to own doctors but it is not possible for doctors to own hospitals, at least it hasn't been since March 19th of 2010 when the Affordable Care Act was signed into law.

So having come from a world -- my dad started a physician-owned hospital. It was in a pretty rural area of north

Texas. I don't think there would have been a hospital there if he and six or seven of his partners had not decided to take the financial risk and do that. So I think it was -- there was a positive aspect to that as far as the delivery of care.

But have we really gone to the point where no longer is it reasonable, feasible, or desirable for physicians to own the facilities in which they practice?

And I will ask everyone that question. So, Dr. Gaynor, we'll start with you and then we'll come down the -- down the line.

Mr. Gaynor. Well, as you know, historically, physicians did own lots of hospitals, particularly smaller ones in rural areas, and that changed over a long period of time for a variety of reasons.

I don't know specific evidence on the impacts of physician ownership in part because you said it's so rare. But there is some evidence on a related area having to do with ACOs and it seems that physician-led ACOs do tend to be more effective than in hospital-led ACOs.

So I don't want to make a great leap from there to physician ownership of all kinds of facilities. But that might suggest that there could be some gains from that.

I think we want think carefully about this. But I don't know that it's sensible to completely exclude a large group of knowledgeable participants in the health care system from

engaging in a certain way and possibly doing some innovative and beneficial things.

Mr. Burgess. Yes, I agree with you. It makes no sense to -- by virtue of the academic degree that I hold I am excluded from a certain type of business process. But lawyers and even registered nurses could engage in that practice.

Dr. Dafny, do you have anything you'd like to add?

Ms. Dafny. I concur with Dr. Gaynor on this. I would say that I am aware of the moratorium on physician-owned speciality hospitals that would limit competition in the market place. And so all else equal is likely to lead to worse service and higher prices.

That said, I would say two things. One is that I am concerned about self-referrals not just in that context, in general. So one would want to have controls in place to try to address that.

The second is that there is research. I am not -- it's not at the top of my head now -- that suggests some cream skimming. You would typically want to send the cases that are riskier to a full-service hospital.

So I would just say -- so I wouldn't be surprised if that were true and that might well be really efficient. I would just say that then we ought to make sure that there are mechanisms to reimburse the hospitals appropriately.

Mr. Burgess. I would just -- and I do refer you to the

article from Health Affairs from 10 years ago because it is so well written and so concise and puts the argument forward so reasonably.

But there -- I will just tell you from my own experience if I had a relatively minor case to do on a Friday morning, if I scheduled that in the hospital I would be behind an orthopaedic procedure and possibly some other procedure and then, by golly, if I didn't start by noon or 1:00 o'clock I could get bumped from an appendectomy in the emergency room and I might spend all day waiting to get that case done.

If it's scheduled at a physician-owned outpatient center, Doctor, we are glad to see you -- your case is ready, and literally before I've done the dictation on the first case the next case is ready to go.

So when time is so critical, if I've got a case that reimburses at a lower rate -- say, it's a self-pay or Medicaid patient, do I want to go to the facility where I am going to burn all day waiting to get it done or do I want to go to the facility where it's going to be done quickly and then I can get onto the next.

So Dr. Schulman, I've come to you with the time I have left.

Dr. Schulman. Yes. So I think you're -- at some level the generalization of this is a broader question. What's the optimal structure of the delivery system?

You know, if we go back 20 years ago, this hearing would have been about how do doctors and insurance companies work together to keep patients out of hospitals. We spent a decade working on that.

Our rhetoric has changed and we are worried about now the tremendous costs that are coming from thinking about health care being centered in hospitals.

And so maybe the pendulum has really swung way too far and the way we can save money for Medicare and everything else is by addressing utilization, paying freestanding physicians to keep patients out of hospitals and the big challenge is now the capital that's required to do all these things with the regulatory controls, with electronic health records and everything else, is very rarely available to individual physicians.

Mr. Burgess. And then the other thing that's left out of this discussion is the advancing complexity of what we are able to do, things -- tools that are available today that people hadn't even thought of 20 or 25 years ago when I was in medical school. It is indeed a new world and in some cases it's very expensive. But I, for one, am grateful some of those things are available.

Mr. Chairman, I will yield back and thank you for the recognition.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentlewoman from Florida,

Ms. Castor, for five minutes.

Ms. Castor. Thank you, Mr. Chairman, and thank you to the witnesses who are here today.

I would like to start by addressing an implication that was left and I just want to make sure the record is clear. We've heard an argument that the 340B program, which helps bring vital medications to the country's most vulnerable patients, has somehow caused consolidation in the health care industry and since we are citing Health Affairs articles I wanted to make sure for the record we cite the 2017 health affairs article that found little evidence that the expansion of hospital 340B eligibility contributed to hospital acquisitions of physician practices.

Instead, researchers found that the increase in consolidation trends were tied to much broader trends and I think that is clear and you don't have to be a health care expert to understand that.

But I wanted to ask you, Dr. Gaynor, considering that 340B is such a small portion of the overall health care sector in America, isn't it fair to say that there are larger market forces at play that are driving hospital consolidation?

Mr. Gaynor. Thanks for the question.

Certainly, with regard to hospitals. With regard to physician practices, the effects -- you're correct -- are not going to be broadly across physician practices because it doesn't

touch all kinds.

But oncology in particular there is evidence that the 340B program does lead to consolidation and I think the issue has been not about the program itself -- I think it's broadly agreed it's a beneficial and important program -- but really how the payments should be structured.

Ms. Castor. And how -- we -- and I think we all agree on greater transparency would be beneficial. But I just wanted to make sure that the implication was not left that 340B is driving -- is the large driver of hospital consolidation. And yes, we have some issues involving oncology practices with --

Mr. Gaynor. Yes. Yes, indeed.

Ms. Castor. Okay.

Mr. Gaynor. Agreed.

Ms. Castor. So as we consider the trends of consolidation in health care overall, it is important to keep the focus on the patients and any cost savings that can be achieved and that these consolidations are not going to cost consumers more.

So my takeaway from your testimony today is there's not a lot of evidence that demonstrates that mergers are resulting in improved care and cost savings.

Dr. Dafny, you said you're still searching for examples of where consolidation has helped improve the quality of care overall and you note that generally one of the arguments in favor of

mergers is that they should enable more integrated care, which has been a goal of overall health care reforms, and that's rather appealing. That's an appealing argument.

What does the research say about how effective mergers have been in improving integration of care and why?

Ms. Dafny. Thank you for the question, Representative Castor.

When it comes to looking for a good merger, I am looking for one that's good on potentially multiple dimensions. So quality would just be one of those dimensions -- better quality but a huge price increase may not be worthwhile.

You asked about whether mergers have led to more integrated care and I will tell you that I have not seen research that has addressed that question directly.

I will -- apart from when hospitals acquire physicians and to the extent that you might think that physicians then would try to keep patients out of the hospital and the hospital would be compensated for that somehow through the joint venture because they would be bearing some of the total risk for the span of that population.

You might think spending would go down and that is not what has happened. So to the extent that that's a measure of how -- what the impact is of mergers on integrated care then it's not very positive.

I will add that if you thought that these mergers were about integrating care, you ought to see a lot more across different kinds of providers than the same old provider but in lots of different areas or next door.

Ms. Castor. Okay.

Dr. Gaynor, could you speak a bit further to this distinction and explain why benefits integration may help or hurt consumers?

Mr. Gaynor. Sure. Well, just to follow up on this, consolidation is not integration. The acquisition -- it's transactions are very involved. They're a big deal.

But in some sense, that's the easy part. Once the acquisition has happened, bringing the two entities together and integrating is really hard and, unfortunately, we have just not seen that.

So why don't patients see the benefits of this, as my colleague just said, we don't tend to see more integrated care. We don't tend to see higher quality. So it just hasn't tended to be there for patients to realize and informally one thing that market participants have said is the following.

Raising prices is easy. Lowering costs is hard. And there's a lot of truth to that. Driving down costs, integrating care, improving the quality of care is actually really, really hard work. It's not easy.

Whereas, if one obtains a better negotiating position than

going around and getting a higher price is substantially easier than that.

So, unfortunately, I think that the payoffs and the incentives move in such a way that they've led market participants to take the high prices and not do the hard work.

I do want to be clear, though. This is not every transaction. I am not characterizing every transaction this way. I feel that there are good mergers out there as well. But, again, maybe we'll find one one of these days. But I can't point to one specifically.

Ms. Castor. Thank you very much.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from New York, Mr. Collins, for five minutes.

Mr. Collins. Thank you, Mr. Chairman. I want to thank our witnesses. I think there's a lot of agreement across the board and concern about consolidations and the like not having the impact we wanted on health care cost.

But back to a good merger. I have a very rural district -- you know, eight counties with a declining population, thanks to our governor. We keep losing people in New York.

So we look for a good merger. I have four, five, or six -- I am going to call them a merger -- I don't know, merger versus acquisition -- but rural hospitals that, frankly, would have gone

out of business had they not merged with a much larger health care system, either the city of Buffalo or city of Rochester, which reached out and took, in many cases, ownership and bought the hospital short of that hospital shutting down and in doing so also were able to then extend orthopaedic services, cardiology services that, frankly, that small rural hospital wasn't even able to provide beforehand.

So when you say we are searching for a good merger, isn't that an example of a good merger, having a large health care system buy an effectively bankrupt rural hospital that was unique but, frankly, was not offering a full menu of services?

Ms. Dafny. It might well be. I would say that only a tiny fraction of mergers generate competition concerns. Fewer than 3 percent have the -- trigger FTC investigations.

So when I say I am looking for examples, it's because case studies have yet to be published to consider all the factors. Just keeping a hospital open in and of itself is not enough, in my view, for it to be good. That was realized again through price increases that made health care less affordable for people in the region.

So I would need to do a more thorough analysis to address your question.

Mr. Collins. Well, I know you're from Boston and nothing -- not putting it aside, if you get out to rural America and it's

a two-hour drive -- two hours -- from, you know, Wyoming County or Orleans County, New York, into the city of Buffalo and there's a single hospital and literally because of a decline in population, whether it's the number of births or otherwise, they don't have the ability to drive that revenue and certainly not provide, you know, the oncology, the cardiology services to suggest you can't see a benefit when -- if that hospital shuts down and those people have to drive an hour and a half to the next hospital, I am a little bit dumbfounded that you can't see the obviousness of that. And not to be insulting, unless -- I mean, Boston you can get your -- other than the traffic -- so I am truly concerned you can't see the obviousness of that benefit.

Dr. Schulman. Yes, I think -- I think we've all said, you know, each of these has to be examined on their own. North Carolina is facing a lot of the same issues. We are losing hospitals in all the rural counties, the same way in Virginia.

But at the same time, you have to look at what's happening to the behavior of the consolidating systems. We are debating right now a merger of two very large systems. The rationale was they're going to improve access to rural health care but there's really actually no evidence that in fact the planning is there.

If in fact they don't do that after the mergers there's no

recourse, and we have talked about a certificate of public advantage. One of the hospitals that has operated under certificate of public advantage for a long time was Mission Hospital in Asheville, North Carolina.

That certificate of public advantage is now expired and the first thing they did was terminate their contract with the largest insurer in asking for rate increases.

So, you know, I think each of these markets has to be looked at separately. But we -- you know, so there are advantages and rural health care is a huge challenge.

So of that is because the hospitals in the city offer much higher prices -- salaries to their starting docs.

Ms. Dafny. I mean, I will add to that, if I may.

The technology of health care has changed. It used to be the case there wasn't much you could do for patients except for put them in the nearby hospital, quarantine them, and comfort them and so every area had one.

But as now we've grown more specialized it may well not be an interest of those patients to have or orthopaedic advanced cardiology, oncological services at low scale.

So just to say that the hospital is open and has expanded services, as I said, wouldn't be enough for me to assess whether that --

Mr. Collins. Well, so, again, not to belabor the point,

but what they've done is they'll send an orthopaedic one day a week to that rural hospital now that the patient's -- you know, whether it's a knee or a hip can now see a doctor 10 minutes away and not two hours away.

So, again, not to be confrontational but for somebody that lives in a very rural area as I do we can't get hung up on, you know, what's the price if there is no service. You know, talk about, you know, you can't put a price on that when there is no service.

So I think you should look more into these rural -- call them mergers or acquisitions because in my case it's that or nothing.

So thank you very much. I yield back.

Mr. Griffith. [Presiding.] The gentleman yields back.

I now recognize Ms. Schakowsky of Illinois for five minutes.

Ms. Schakowsky. Thank you. I want to apologize to our witnesses and just say I am the ranking member on another subcommittee so I had to be there.

Let me just say, or maybe just ask, I mean, I am assuming that when we are talking about rural hospitals that the -- that those states that have expanded Medicaid that that has been helpful in many communities that would otherwise be under served.

Does anybody just want to say anything to that? I don't know. Okay. You don't have to.

I want to -- all of you have acknowledged that we've seen rapid consolidation in hospitals. Specifically, this trend has resulted in a 22 percent increase in religious hospitals between 2001 and 2016. I don't know if research has been done on this but this is a big concern for me. As we see more and more religious hospitals merge with nonreligious hospitals, many times the nonreligious hospitals are forced to observe religious prohibitions, particularly restrictions limiting access to a full range of reproductive services by denying abortion care, birth control, fertilization treatment, and I am concerned that consolidation limits access to reproductive care, particular for women, communities of color, and LGBT people.

Currently, one in six hospital beds are subjected to religious restrictions. Because hospitals treat the most serious health conditions like women suffering from miscarriages or ectopic pregnancies, I worry that accepting these restrictions in consolidation are causing hospitals to put business considerations before comprehensive patient care.

So my question -- anyone could answer -- Dr. Dafny listed it as someone but anyone can answer -- does your work touch on an increase in religious and nonreligious hospital mergers acquiring or strategic acquisition or strategic partnerships?

Ms. Dafny. My published research does not address that. I am aware of two findings that are relevant and I could tell

you about them.

One is there is a researcher at Kansas University, David Slusky, who has in fact shown that acquisitions of formerly nonreligious hospitals by specifically Catholic Health Care Systems has led to a reduction in this slew of reproductive services that you described, would support that concern about the availability of those services.

What isn't known is whether these patients then go elsewhere to receive some of those services.

Ms. Schakowsky. If it's -- if it's available in their communities.

Ms. Dafny. If it's available.

And then the second is in my own study, which is not -- is through -- in the midst of a referee process, we have a section analysis that we did actually comparing the acquisition of hospitals by religious versus nonreligious systems and the price increases that we find on average are not present for the acquisitions by the religious hospital systems.

Ms. Schakowsky. Yes, Dr. Gaynor.

Mr. Gaynor. Yes, thanks. Thanks, Representative Schakowsky. That's an excellent question.

Broadly speaking, when a merger is being considered by an anti-trust enforcement agency the questions about impacts on consumers and consumer welfare and the points that you raise are

certainly relevant and should be taken into account because price matters a great deal, of course.

But what services are available to people and where and what the alternatives are as well as quality of care are also vitally important.

Ms. Schakowsky. I hope that will be part of the considerations when we look at the issue of consolidation because, you know, a lot of people think a hospital is a hospital and don't know that the services they may want -- they may be delivering a baby, would like to have a tubal ligation at the same time, find that that is not possible and require another procedure somewhere else if they can possibly get it.

So what effect do you think these mergers could have on access to full range of health care services? Do they disproportionately affect some groups more than others?

I mean, I think probably what you have said would agree that, obviously, women but I think it's also often people of color and LGBTQ community.

As we think about ways to evaluate these mergers then I am assuming that you all agree that other factors should be considered to ensure the full range of services that are maintained for reproductive health and are there any red flags that would indicate the consolidation would result in reduced access to reproductive health services. I think you answered

with the Kansas study. Any comments on that?

And so let me ask this then. What steps can we take to incentivize that a full range of reproductive health care services are maintained?

Dr. Schulman. You know, I think we talked a little bit before about the organization of care, more generally, and at some level one of your questions is, you know, how do I -- why are we organizing all the care around hospitals, especially women's services which can be done in ambulatory settings, can be done in doctors' offices.

Why did we let them get acquired by the hospital and so how do you have a diversity of services in a community where there are different kinds of care models to address the needs of the entire population.

Ms. Schakowsky. If they're available. I mean, we are talking about overall access to these kinds of procedures which I think lots of women want and my time is up. But I think this is -- this cannot be shoved under the table as just another thing, since women are the majority of the population.

And I yield back.

Mr. Harper. [Presiding.] The gentlewoman yields back.

The chair will now recognize the gentleman from Michigan, Mr. Walberg, for five minutes.

Mr. Walberg. Thank you, Mr. Chairman, and thanks to the

panel for being here.

Dr. Gaynor, on September 9th, 2011, the Ways and Means Health Subcommittee held a hearing on health care industry consolidation. You were a witness at that hearing.

You testified on some of these issues and on consolidation since that time. What's changed in these last seven years? Give us some hope.

Mr. Gaynor. I have more gray hair.

Mr. Walberg. At least you have hair.

[Laughter.]

Mr. Gaynor. Thank you.

Mr. Walberg. Be gentle on the rest.

Mr. Gaynor. So yes. Unfortunately, I reviewed that testimony while preparing for this hearing and I wish I had good news. But if anything, I would say that consolidation has accelerated.

One might wonder, actually, how hospitals or doctors or insurers are finding anybody left to consolidate with. Almost 30 percent of all hospitals are -- have been involved in one or more transactions.

But it's accelerated and like I said, I think we are finding a lot of insurance markets, hospitals, physician practice markets that are more and more concentrated.

So there becomes less and less choice and less and less

competition, and seven years ago, I think, we were hoping again that we'd see some of this consolidation would lead to integration, lead to some new innovative forms of organizations and delivery, and as my colleagues, Dr. Schulman and Dr. Dafny have said, we just haven't seen that. There are a few instances here and there.

But it just hasn't happened. So I guess I will put the dismal in the dismal science, being an economist, and things have gotten worse, not better. I wish I could report differently.

Mr. Walberg. At least I don't feel out of -- out of the normal then. In my district, I can't think of a hospital that hasn't gone through some type of consolidation all across my seven-county district and even with the medical practices individual doctors. They're consolidating together in their own clinics, creative, until they get -- until they get pulled into a hospital.

One concern that we've heard is that regulators only scrutinize consolidation when a single proposed merger is seen as large enough to attract attention based on how consolidated the market will become if it goes through.

The issue, however, is that a large number of small mergers and acquisitions might not attract government attention but eventually may limit competition in the market. So Dr. Gaynor, is it true that some physician acquisitions may be so

small that federal anti-trust enforcers might not even know about increases in provider concentration in some markets?

Mr. Gaynor. So thanks for the question.

Yes, that's certainly possible because they're small enough that there's not mandatory reporting requirements under Hart-Scott-Rodino acquisition law.

But I think it's important to be aware that the agencies scrutinize these things, that they look for reports in the media that they're actually market participants that report on things that seem troubling to them, and the number the FTC, for example, has pursued physician consolidations -- one in southeast Pennsylvania recently, another out on the West Coast -- that did not meet the reporting requirements were relatively small.

There is this -- a very tough issue about that you just identified. What happens if the initial acquisition is not that big -- it doesn't look troublesome and then the next one and the next one. But then, unfortunately, you have got a problem.

Mr. Walberg. Especially as you think of rural areas, as my colleague mentioned.

Mr. Gaynor. Right. Right. Again, rural areas have their own special qualities. We do want to -- want to make sure that folks that live there have access to the kind of care that they need at a reasonable -- at a reasonable price. But we do have to be concerned about untoward effects there.

So I think that looking at potential competition impacts if important. But I will be honest, that's challenging. We don't want to deny acquisitions or mergers that are potentially beneficial and we don't want to get overly speculative.

But these things do need to be taken into account. Now, ultimately the courts -- if you go to court on this -- are the arbiters on this and I think that's actually in reality a very tough standard with the courts.

Dr. Schulman. In our -- in our state, North Carolina, there's two very large health systems that are trying to merge and what's really remarkable is that no one's in charge of the private health insurance market.

You know, so we have impacts on Medicaid, impacts on Medicare, impacts on Blue Cross/Blue Shield North Carolina but there's not one office or commission like there is in Massachusetts that's responsible for monitoring the market.

So we are out trying to collect primary data to see what the impacts of these mergers might be. The idea of having an all payer database so that you knew that this cardiology practice is the only one left in this county and is about to get acquired would be really critical information to intervene long before you get to the Federal Trade Commission.

Mr. Walberg. Thank you. My time is expired. I yield back.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentlewoman from Indiana, the chair of the Ethics Committee, Mrs. Brooks, for five minutes.

Mrs. Brooks. Thank you, Mr. Chairman.

I have a question, Dr. Dafny, because we started to talk a little bit about federal enforcement and I don't think we've talked very much about federal enforcement.

In your written testimony, you indicate that federal enforcement authorities have interpreted their enforcement authority in such a way that it's limited in scope.

And I am a former U.S. attorney. Not that I was involved in these kinds of issues but something that caught my interest. More specifically, you indicated it's difficult to define markets in nonhorizontal transactions.

Do you think we are likely to see more nonhorizontal transactions in the health care market as the Department of Justice and the FTC continue to successfully challenge traditional horizontal mergers? Can you talk a bit more about the enforcement landscape?

Ms. Dafny. Absolutely, Representative Brooks. Thanks for the question.

I have great interest in these consolidations and in the ability or rather how limited the ability is of anti-trust enforcement to ensure competitive markets.

As you're aware, anti-trust enforcers have very narrow laws

to enforce, and I mentioned in my testimony and will restate here that their interpretation of Section 7, the Clayton Act, which is the statute that is used to challenge mergers, is that they must define the relevant market in which competition would be diminished by the transaction which, if you don't dwell on it too long, sounds like a perfectly sensible thing to do.

But if you're an anti-trust enforcer and you're versed in all the judicial precedents, then you realize whatever market you propose in one case could affect markets you might propose in another case.

So the Federal Trade Commission has successfully won merger challenges by demonstrating that many hospital markets are quite small and a merger of rivals in a relatively narrow area, even if there are many competing providers in the general vicinity, can lead to significant price increases because people would like to be able to go to their nearest or very nearby hospital.

When you talk about nonhorizontal now we are -- suppose the different hospitals in different towns in a state seek to merge, then they arguably would not be in the same relevant anti-trust market for purchase -- for the patients who are going to the hospital.

But an insurer facing a conglomerate that has a substantial presence throughout the state may then have to pay a higher price to that consortium of hospitals because the insurer has a broader

market and wants to be sure that it can offer multi-site employers a comprehensive broad network.

So defining the relevant market when it comes to negotiating with insurers that might be different than the market that you might use when you're thinking about patients accessing hospitals.

And as a result, because of the way this has been interpreted, the federal anti-trust authorities seem very reticent to bring cases that involve combinations across different sectors across different towns.

Mrs. Brooks. So what type of tools do you think or knowledge might be necessary for federal enforcement authorities to, you know, examine these proposed mergers or the mergers?

What -- and I think you mentioned it, the public database. Or what are some tools that you think would be helpful?

Ms. Dafny. I think trying -- the bigger mountain of evidence that one can build to support that this might be problematic if in fact it is will be helpful, which is one of the reasons I called for more enforcement-focused research. When I left the Federal Trade Commission it was the first project I started to do.

But there are not -- there's not such a great volume of people who are trying to do enforcement-focused research. So I would put the data out there and allocate resources to the authorities so they can investigate this and this is not just in hospitals.

This is in pharmaceutical companies. If you merge but you're not making the same therapeutic line somehow is competition diminished either in subsequent introductions or through the prices that you negotiate because you often negotiate with the same purchasers. There's a host of cross-market questions that I think need to be investigated.

Mrs. Brooks. Dr. Gaynor.

Mr. Gaynor. Representative Brooks, very excellent question and it's a broad issue. It's very important in health care. But it's important for the entire economy.

So one thing that can be done and actually needs to be done is to revise the vertical merger guidelines. If I recall, and my memory is not wonderful, I think they were last revised in 1984, and it's always been important.

But particularly with so much consolidation at the horizontal level the vertical issues, in my view, become even more prominent and salient in health care but actually much more broadly as well.

So that's one very concrete thing that can be done and I think would help address this issue.

Mrs. Brooks. Thank you.

Dr. Schulman, do you have any opinion on it?

Dr. Schulman. Nothing.

Mrs. Brooks. Thank you. I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from Georgia, Mr. Carter, for five minutes.

Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. I have a great deal of respect for your academic achievements and for your expertise in this area and I thank you for that.

There is currently a proposed merger between two companies, Luxottica -- and they are an Italian company that makes eyeglass frames -- and another company, Essilor, which is a French company that makes the lens itself.

So here we have a proposed merger between these two companies. They will be owning not only the eyeglass frames but also the lens as well, and oh by the way, they will also own EyeMed, which is the second largest vision insurer in the country, and oh by the way, they also own retail outlets such as Pearle Vision Center, such as Lenscrafters.

All fine businesses, but now you have this vertical integration, if you will, of a company that owns just about everything in that -- in that area and now they will have the ability to drive market to their different companies.

I wanted to ask you, Dr. Dafny, from a free market principle, does this make sense? I mean, is this the kind of thing we need

to increase competition?

I understand that competition dictating health care prices or corporations that dictate prices because they control the market. Which one -- which one works better?

Ms. Dafny. I will be -- I will be the economist again and say, you know, there are two sides of this. But what you described, the vertically-integrated offering, might well be much more efficient than the piecemeal offering.

So this could be beneficial. The question is by combining are they somehow lessening competition because might they withhold their frames from other purchasers, right?

Mr. Carter. And that's exactly why I have a bill -- imagine that -- H.R. 1606, the DOC Access bill, which addresses this -- to address the free market principles and to have competition.

Full disclosure -- prior to becoming a member of Congress I was a practicing pharmacist for over 30 years. I have witnessed firsthand the impact that PBMs and the consolidation of PBMs and drugs stores have had on patients.

Now, this is something I -- this may be the trainee training the trainer here. Okay. This is the part that I think that I have seen firsthand that perhaps you haven't seen -- the impact on the patient.

In my 30 years of practice of pharmacy, I was a retail

pharmacist and I serviced generations of families -- grandparents, parents, children, and grandchildren -- and I've seen that and they've become trustful of me and trustful of their community pharmacist, of their independent pharmacist, and you build up that relationship.

And I've had them walk into my business when I was still practicing literally in tears, saying, "I've got to go to another drug store. My family has used your drug store all our lives. My grandparents, my parents, they've used your pharmacies. I've used it for my children and for my grandchildren. Now I've got to go to another pharmacy because my insurance company owns that pharmacy and they're telling me I have to go over there."

That's the real life impact that we see through this consolidation. You mentioned before that PBMs control over 80 -- there are three PBMs that control over 80 percent of the market share.

Now, if you look at the mission statement of the PBMs it will say that they are there to lower drug prices. I want to ask you how is that working out?

If it's working out well, Dr. Schulman, why is the president identifying escalating prescription prices as being one of the things that we need to address in this country?

Dr. Schulman. I think, you know, we've been talking about PBMs a little bit today. This is the least transparent business

model of any of the things we've been talking about in the country.

So in 2015, there were approximately $115 billion passed back from pharmaceutical manufacturers to PBMs and to drug distributors. Some of that was passed back to employers. Almost none of that was passed back to consumers.

Mr. Carter. And do we know how much was passed back to employers?

Dr. Schulman. We don't know.

Mr. Carter. We don't, because -- Dr. Gaynor, you said earlier that sunlight was the best transparency out there. It's infected out there. We have no transparency. Dr. Dafny, you said you were with the FTC. Why does the FTC not look into this? Why are they not doing something about this?

Ms. Dafny. I mean, the FTC has jurisdiction to do certain things. They could do a study, and one thing we mentioned was a study of the effects of the last transaction that they did not challenge -- a big merger in the --

Mr. Carter. And this is getting worse before it gets better. Now all of a sudden we see where CVS Caremark is going to buy Aetna.

Ms. Dafny. In fact, your description of the dental consolidation sounded very much like that integration.

Mr. Carter. That was not intentional. But nevertheless,

the point that I want to make here is that I think the one thing we may be missing is the impact it has on patients.

This does have an impact on patients. When you talk about having trust between the health care provider and a patient that is invaluable.

That -- between a doctor and a patient that relationship is so hard to build and yet we have insurance company -- and listen, I used to call these guys crooks and I still do when I get upset.

But they're not really crooks. They're smart business people. They're exploiting the system that we here in Congress are not doing our job. We are not -- we are not making the changes that should be made to prevent this from happening and it frustrates me.

Dr. Schulman. Well, the -- we've talked about the impact to patients from a lot of these consolidations. The research that we've been talking about in terms of costs and quality most of that used claims data.

Very little of that actually interviewed patients to see what happens in town when basically they raise the parking price at the hospital to --

Mr. Carter. And you know it does impact them. It impacts accessibility. It impacts compliance.

Ms. Dafny. I know your time is expired but I have to say

this, which is patients are an afterthought when it comes -- if they even get to be an afterthought -- when it comes to discussions of consolidation. I've been privy to a number of them.

Mr. Carter. Thank you.

Mr. Gaynor. Just one -- one last plug to reinforce what you said is that all these things interact in a way that makes things worse. So the issues with choice of pharmacy are compounded by lack of choice, lack of competition in health insurance.

If folks could say to the health insurance company, go take a hike -- I will go to another insurer that's offering me access to the pharmacy, then you bet you'd get access to these pharmacies. But if the insurers don't have to compete they won't.

Mr. Carter. Mr. Chairman, thank you for your indulgence.

Mr. Harper. Thank you very much. The gentleman from Georgia yields back.

The chair will now recognize the gentleman from Pennsylvania, Mr. Costello, for five minutes.

Mr. Costello. Thank you, Mr. Chairman.

Dr. Gaynor, during the '90s, the FTC had lost multiple hospital merger cases but since then it appears that they have successfully challenged multiple hospital mergers after refining their approach.

Can you describe what the FTC did as a part of this

retrospective study and how the FTC's approach to hospital merger review has changed?

Mr. Gaynor. Yes. Representative Costello, thank you for the question. Good to see a fellow Pennsylvanian here, albeit --

Mr. Costello. Some people would suggest that western Pennsylvania and eastern Pennsylvania, we --

Mr. Gaynor. Yes. Yes. Albeit from that other part of the state.

Anyhow, yes. So as you -- as you note, the FTC encountered a string of losses in the courts in which merging hospitals defended the mergers on a variety of bases, either geographic markets that were very, very broad so there were lots of potential competitors in those supposed markets that were saying, we are not for profit -- we wouldn't do anything naughty.

And the FTC, rather than prospectively going after mergers, took a break, commissioned a number of studies that looked at mergers that actually occurred and -- between Evanston Northwestern Hospital and Highland Park Hospital in the suburbs of Chicago, between a number of hospitals in Wilmington, North Carolina, between Summit and Sutter in the Bay Area, and what those studies found is that those mergers which had already happened, which had been consummated and been consummated for a number of years, led to very substantial prices increases.

I think some of the price increases from the Bay Area merger were 40 or 50 percent or higher -- Evanston Northwestern as well.

And they didn't stop there. They looked at quality of care for patients because that's vitally important, and they did not see evidence of improvements and quality of care. Some declines, some no change.

So what that did is that gave them an evidence base to go into mergers to try and block a merger prospectively, which would change the presumption.

Now, the other thing that happened at the same time is that researchers in academia have been undertaking a lot of studies because data had become more widely available and that added to the evidence base as well.

And then the first merger they went after was a retrospective rather than a prospective -- Evanston Northwestern and Highland Park.

So that's how they swung things around. It was a concerted effort by then-Chairman Ramirez and the staff at the FTC.

Mr. Costello. Thank you.

Dr. Dafny, in your testimony you indicated you will expect that we will continue to see more consolidation. Why do you think we'll continue to see more consolidation?

Will we see it more, do you predict, in standard horizontal consolidation or will be start to see it more in vertical

arrangements?

Then the final point is if you could lend any observations on the health insurance industry and how either through acquisition of assets that then creates an insurance company or an insurance company acquiring assets by way of hospital and physician practices. What kind of dangers might be inherent in that?

Ms. Dafny. Okay. I will try to address those questions in the time remaining.

I believe we'll see more consolidation because the factors that are encouraging it don't seem to be changing. I went through some of the rewards in my testimony but include the fact that if you merge you often have a better bargaining position, can raise your prices.

You might be able to reduce your costs or think you could reduce your costs even though there's not much evidence that that actually happens.

And there are some administrative reasons. Medicare and private insurers reward certain kinds of consolidations -- say, enabling hospitals to charge more for the same service that might be supplied by a physician independently more cheaply. So I think that the factors that are driving the consolidation are still present.

I do believe that because the Federal Trade Commission, the

Department of Justice have been pretty active in horizontal merger enforcement in health care that we are seeing more vertical or nonhorizontal consolidation.

You're seeing hospital systems merging across different geographic areas and their answer would be because we think we can do that and we think we'll be better together, and the concern is to the extent that they compete then they might have less of an incentive to be better once they've taken out a potential entrant or arrival.

On the insurance side -- now we are out of time -- I would say that the results of research on insurance mergers also show premium increases when there's less competition in a market -- that a hospital or a group of providers that bears risk is going to be performing a lot of the functions of an insurance company.

But so long as they can't offer health plans then they may not be able to pass all the savings along to patients.

Mr. Costello. How about access to care?

Ms. Dafny. What about access?

Mr. Costello. Well, in terms -- is there -- is there concerns over limiting access to care on that patient?

Ms. Dafny. Well, I think if you have got -- if you eliminate essential health benefits you would -- you would have a concern or allow the purchase of nonqualified plans or not enforce the

individual mandate, I think you may have more access issues.

Mr. Costello. Thank you. I yield back.

Mr. Harper. The gentleman yields back.

That concludes our hearing. We want to say a special thank you to each of you for taking the time. It's very informative -- very important topic for the future of health care.

And at the end of the day, we should be considering patient care and outcomes and improved cost for those patients as we look -- as we look at this ahead.

I remind members that they have 10 business days to submit questions for the record and I ask that the witnesses agree to respond promptly should you have any questions.

With that, the hearing is adjourned.

[Whereupon, at 12:20 p.m., the committee was adjourned.]