Competition in U.S. Health Care Markets

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I. Introduction

A. Background of the Healthcare Industry

The healthcare industry in the United States operates at the intersection of innovation, economics, and public policy, where market competition plays a pivotal role. Historically, robust competition in healthcare markets has driven innovation, improved access, lowered costs, and enhanced the quality of care. Competition has enabled advancements such as the development of groundbreaking treatments, the introduction of cost-effective generics, and the proliferation of healthcare delivery options tailored to diverse patient needs. These competitive dynamics have historically empowered patients by fostering choice and efficiency in the system.

However, the landscape has shifted significantly in recent decades. Consolidation across various segments of the healthcare sector has grown dramatically and undermined the benefits traditionally associated with competition. Overall, these are practices that diminish competitive pressures, leading to rising costs and reduced accessibility. Additionally, the growing complexity of healthcare delivery, coupled with regulatory barriers, has created environments where monopolistic behaviors thrive. Understanding how competition has eroded and the impact of this erosion on patients and the healthcare system is essential to addressing current challenges and shaping policies that restore balance and equity.

The implications of diminished competition stretch beyond economics; they affect the quality of care and access for millions of Americans. Reduced competition often results in higher premiums, limited provider networks, and fewer innovative solutions to pressing healthcare challenges. These issues disproportionately affect vulnerable populations, exacerbating health disparities. Therefore, restoring and preserving competition is not just an economic imperative but also a moral one, integral to improving health outcomes nationwide.

I. Introduction

B. Purpose of the Paper

This paper aims to examine the current state of competition in U.S. healthcare markets, identifying the key factors contributing to its decline. The analysis will focus on several critical areas: vertical integration in healthcare organizations, practices by insurance companies, hospital mergers and acquisitions, and the pricing mechanisms within the pharmaceutical sector. Each of these areas represents a unique facet of the broader competition crisis, with distinct causes, consequences, and potential solutions.

Vertical integration, where entities within different stages of the healthcare delivery system combine under one organizational structure, has reshaped how care is delivered and financed. While integration can lead to efficiencies, it often reduces competition and creates conflicts of interest that undermine patient care. Similarly, insurance company practices, including the concentration of market power and the use of restrictive provider networks, limit consumer choice and drive up costs.

Hospital mergers and acquisitions have transformed local healthcare markets, often leaving communities with fewer choices and higher prices. Consolidation among hospitals frequently leads to monopolistic or oligopolistic markets where patients and employers bear the financial burden.

Moreover, the misaligned incentives and lack of transparency in pharmaceutical pricing, complicate the landscape further by suppressing competition and shifting costs onto patients and employers.

By delving into these areas, the paper seeks to provide a comprehensive understanding of the challenges and propose potential pathways for fostering a more competitive and patient-centric healthcare system. The overarching goal is to illuminate the importance of competition and its role in creating a sustainable, equitable, and high-performing healthcare landscape.

II. Insurance Market

A. Growing Market Concentration in Insurance

The insurance industry has experienced significant market consolidation over the past two decades, resulting in fewer companies dominating the sector. This trend is particularly noticeable in the health insurance market, where mergers and acquisitions have reduced competition. Between 2010 and 2020, the number of large-scale insurers decreased as mergers created mega-companies, often through buying and/or creating new affiliated entities, each commanding substantial market share. Types of mergers and acquisitions by insurers included through pharmacy benefit managers (PBMs), group purchasing organizations (GPOs), provider groups, and pharmacies. These consolidations often result in monopolistic or oligopolistic environments, where a few players wield significant influence over pricing and policy offerings.

Insurance company mergers frequently lead to less competition, which has several downstream effects. Reduced competition in the health insurance market often correlates with higher premiums for consumers, as insurers face fewer incentives to keep prices competitive. Further, insurers and PBMs routinely place higher cost medications in preferred positions on their formularies, even when there are lower-cost and equally safe and effective competing options available. Certain formulary designs may have the effect of preferencing the insurers and PBMs' own affiliated pharmacies, even if an unaffiliated rival pharmacy may provide health plans with the same drugs at a better price. At the same time, consolidation of insurers can result in lower reimbursement rates for healthcare providers, such as physicians and hospitals, as insurers leverage their market power to negotiate reduced payments. These practices raise concerns about the potential decline in quality of care. With fewer choices available, consumers may face limited plan options, and providers may struggle to sustain services under constrained budgets.

Consolidation's impact extends beyond pricing. The lack of competitive pressure can stifle innovation in policy design and customer service. Moreover, the administrative complexities of larger organizations can introduce inefficiencies that affect both insurers and their customers. As the market becomes increasingly concentrated, the importance of regulatory oversight and antitrust measures grows to prevent anti-competitive practices that harm consumers and providers alike.

II. Insurance Market

B. Rising Cost of Insurance Premiums

The rising cost of insurance premiums is a pressing issue for individuals, families, and businesses across the United States. Over the past decade, health insurance premiums have consistently outpaced both inflation and wage growth, placing a significant financial burden on consumers. According to data from the Kaiser Family Foundation, the average family health insurance premium increased by over 55% from 2010 to 2020, while median wages grew by only 27% during the same period. This disparity highlights the unsustainable trajectory of insurance costs relative to household income.

A key driver of premium increases is the administrative costs associated with running insurance companies. These costs include marketing, underwriting, claims processing, and compliance with complex regulations. While some operational costs are necessary, these expenses often result in inefficiencies that inflate premiums. Additionally, profit margins for insurers have remained robust. For publicly traded insurers, shareholder demands for consistent financial returns can further drive premium increases.

Of course, the biggest cost driving insurance company premiums is the payment of provider and hospital claims. Many providers' costs increases are in excess of inflation, which has more often than not been the case for over 50 years. Part of this increase is accounted for by new medical technology procurement and the other part is increasing wages for medical providers, particularly in the years following the COVID-19 pandemic.[1]

Comparisons with broader economic indicators reveal the disproportionate growth in insurance premiums. For instance, while inflation has averaged approximately 2% annually over the past decade, insurance premiums have risen at a much faster rate.[2] Affordable Care Act (ACA) Marketplace insurers are proposing a median premium increase of 7% for 2025, similar to the 6% premium increase filed for 2024.[3] This divergence underscores the need for systemic reforms to address the structural inefficiencies and profit-driven practices that drive premium growth. Without intervention, the escalating cost of insurance risks undermining its accessibility and effectiveness as a critical component of the healthcare system.

[1] https://mn.gov/deed/newscenter/publications/trends/december-2022/post-pandemic.jsp

[2] https://www.gao.gov/blog/health-insurance-costs-are-increasing-markets-become-more-concentrated-fewer-insurance-companies-interactive-map

[3] https://www.kff.org/affordable-care-act/press-release/marketplace-insurers-are-proposing-a-7-average-premium-hike-for-2025/

II. Insurance Market

C. Example of Impact on Patients - Vertical Integration: Insurer and Pharmacy Benefit Managers (PBM) Practices

Vertical integration in the healthcare industry, particularly between insurers and Pharmacy Benefit Managers (PBMs), has further complicated the landscape for patients and providers. PBMs play a pivotal role in the drug supply chain, acting as intermediaries between insurers, pharmaceutical companies, and pharmacies. Their primary functions include negotiating drug prices, managing formularies (the list of approved drugs covered by insurance), and processing prescription claims. While these roles are intended to streamline drug distribution and reduce costs, the practices of PBMs often have the opposite effect.

Overview of PBM Functions

PBMs leverage their position in the supply chain to negotiate rebates and discounts from drug manufacturers in exchange for favorable placement on formularies. These rebates are purportedly designed to lower drug costs for insurers and consumers. However, PBMs frequently retain a significant portion of these rebates as profit, creating misaligned incentives that prioritize their financial gains over affordability for patients. Additionally, PBMs manage pharmacy networks and establish reimbursement rates for pharmacies, further influencing the cost and availability of medications.

Pricing Manipulations and Their Effects

PBM practices have been criticized for contributing to the rising cost of prescription drugs. Rebate structures, for example, often favor higher-priced drugs because the percentage-based rebates yield greater returns for PBMs. These incentives may negatively impact patient access to medicines and patient out-of-pocket costs. This practice impacts beneficiaries with deductibles or coinsurance, whose out-of-pocket costs are typically based on the list price. As a result, patients may face higher out-of-pocket costs for medications, particularly when lower-cost alternatives are excluded from formularies. One recent analysis found that over 1,100 drugs were excluded from the standard formularies of at least 1 of the 3 largest PBMs in 2022, a 961% increase from 2014. This dynamic undermines the purported goal of PBMs to reduce healthcare expenses.

II. Insurance Market

C. Example of Impact on Patients - Vertical Integration: Insurer and Pharmacy Benefit Managers (PBM) Practices

Hidden fees and rebates also exacerbate the lack of transparency in drug pricing. PBMs may impose fees on manufacturers, pharmacies, and insurers that are not disclosed to consumers, further inflating costs. For example, “clawback” fees—where PBMs charge pharmacies after a transaction has been completed—can lead to financial strain for smaller pharmacies and limit their ability to compete. There is also evidence to suggest that increased vertical integration of insurers and PBMs may provide leverage for larger PBMs to enter into complex and opaque contractual relationships that increase uncertainty in pharmacy reimbursements and may disadvantage smaller, unaffiliated pharmacies and the patients they serve. Such practices highlight the need for regulatory reforms to ensure accountability and fairness in the PBM sector.

Examples of PBM Contributions to Rising Prescription Drug Costs

One high-profile example involves insulin pricing, where PBM rebate structures have been implicated in the dramatic rise of costs for this life-saving medication. Manufacturer rebates for insulins have historically lowered the list price of commonly-used insulins by more than 80% on average. Despite these large discounts, patients continue to face exorbitant out-of-pocket costs as PBMs and their health plans shift more of the costs of medicines on to patients through the use of high deductibles and coinsurance. Moreover, patients are often blocked from accessing lower list price insulins and biosimilars due to PBM preferences for higher list prices and larger rebates. In fact, in recent years 3 of the largest PBMs have excluded a lower list price insulin in favor of high list priced options. Notably, when one manufacturer dropped the list price of a commonly used long-acting insulin brand product, PBMs dropped formulary access to the product. These practices not only burden patients financially but also jeopardize their health outcomes by creating barriers to access.

II. Insurance Market

C. Example of Impact on Patients - Vertical Integration: Insurer and Pharmacy Benefit Managers (PBM) Practices

Vertically integrated PBMs also have the ability and incentive to steer patients to their affiliated pharmacies, creating conflicts of interest that can disadvantage unaffiliated pharmacies and increase prescription drug costs. Recent reports found that PBMs paid their own mail-order pharmacies as much as 200 times more than the price at rival pharmacies for commonly prescribed cancer drugs, allowing them to bring in at least $1 billion in excess revenue and potentially raising the costs to patients,

The three largest PBMs also significantly mark up a wide range of lifesaving medicines according to reports from the Federal Trade Commission (FTC). The report found that 63% of the specialty generic drugs dispensed by PBM-affiliated pharmacies were marked up by more than 100%, and 22% had markups over 1,000% which steadily increased annual out of pocket costs for patients.

II. Insurance Market

D. Impact on Consumers/Patients

The rising cost of insurance premiums and the complex dynamics of vertical integration have significant implications for consumers and patients. Higher premiums directly impact access to care, as individuals and families may forego insurance coverage or choose plans with limited benefits to save on costs. This trend is particularly concerning for low- and middle-income households, which are disproportionately affected by premium increases.

Out-of-pocket expenses, including deductibles, copayments, and coinsurance, have also risen alongside premiums. For many patients, these costs create barriers to accessing necessary care, leading to delays in treatment or the abandonment of prescribed therapies. For example, individuals with chronic conditions such as diabetes or asthma may skip medications or doctor visits due to financial constraints, resulting in worsened health outcomes and increased long-term costs for the healthcare system.

Case studies illustrate the burden on consumers. One example involves a middle-income family facing a $1,500 monthly premium for employer-sponsored health insurance, coupled with a $5,000 annual deductible. Such costs leave little room in household budgets for other necessities, forcing families to make difficult trade-offs between healthcare and other expenses. Similarly, uninsured individuals often face exorbitant charges for medical services, further underscoring the need for policy interventions to address affordability.

In summary, the convergence of rising premiums, insurer and PBM practices, and market concentration underscores the challenges faced by consumers in navigating the healthcare landscape. These issues demand comprehensive reforms to ensure that insurance and healthcare services remain accessible, affordable, and equitable for all.

III. Health Systems

A. Trends in Hospital Mergers and Acquisitions

Over the past two decades, the healthcare landscape has been significantly reshaped by trends in hospital mergers and acquisitions. Consolidation among hospitals and health systems has accelerated, with large networks absorbing smaller, independent facilities at a record pace. By 2022, over 70% of hospital markets in the United States were considered highly concentrated, according to data from the American Hospital Association (AHA). Proponents of consolidation often argue that mergers drive efficiencies, reduce redundant services, and improve patient outcomes. However, critics contend that these mergers diminish competition and lead to higher costs without demonstrable improvements in care quality.

Market share statistics reveal the scale of consolidation. For instance, in 2019 alone, there were 92 hospital merger and acquisition deals, involving 1,400 facilities. The result is a healthcare system where fewer organizations wield disproportionate influence, raising concerns about monopolistic practices. As hospitals grow larger and more interconnected, they gain increased bargaining power with insurers, but this often translates into higher prices for consumers and employers. This trend underscores the need to critically examine the impact of consolidation on competition, pricing, and patient care.

III. Health Systems

B. Lack of Competition in Local Markets

Hospital consolidation has led to a lack of competition in many local markets, significantly limiting consumer choices. In several metropolitan areas, one or two health systems dominate the landscape, leaving patients with few alternatives for care. This concentration is particularly pronounced in rural areas, where a single health system often operates the only hospital for miles, creating a de facto monopoly. Without competitive pressure, these dominant systems have less incentive to lower prices or improve service quality.

For example, in Northern California, Sutter Health's market dominance has been linked to some of the highest healthcare costs in the nation. A study by the University of California, Berkeley, found that areas served by Sutter Health had prices for inpatient services that were 70% higher than those in Southern California, where more competition exists. Similarly, in rural Appalachia, hospital closures and consolidations have left entire communities without accessible healthcare, forcing residents to travel long distances for even basic services. These examples highlight the human and economic toll of reduced competition.

The lack of competition also has broader implications for innovation and quality. Hospitals in monopolized markets may lack the incentive to invest in advanced technologies, improve patient care protocols, or enhance customer service. The result is a healthcare system that prioritizes profit margins over patient needs, exacerbating disparities and undermining public trust.

III. Health Systems

C. Example of Impact on Patients - Profit Maximization is Fueling Hospital Consolidation: The 340B Drug Pricing Program and Its Misuse

Overview of the 340B Program

The 340B Drug Pricing Program was established in 1992 to provide financial relief to healthcare providers serving a disproportionate share of underserved and uninsured populations. The program requires pharmaceutical manufacturers to sell drugs at discounted prices to eligible hospitals and clinics (or "covered entities"), allowing these institutions to provide discounted medicines and other needed care to low-income and uninsured patients. Intended beneficiaries include low-income patients who rely on safety-net hospitals for essential care. The program's overarching goal is to improve access to affordable medications and support healthcare delivery in vulnerable communities.

Evidence of Abuse and Overuse

Despite its noble intentions, the 340B program has been plagued by allegations of abuse and overuse. Hospitals and health systems purchase drugs at the discounted price through 340B and can sell them to insured patients at the full negotiated rate. They then keep the spread between the low 340B acquisition cost and full commercial reimbursement to use as they see fit. There are no requirements for hospitals in the program to use the profit they generate from 340B to lower prices for low-income patients and/or expand care to vulnerable populations. This practice not only inflates healthcare costs but also diverts resources away from the low-income populations the program was designed to serve.

Instances of program abuse are widespread. A 2018 report by the Government Accountability Office (GAO) found that some participating hospitals used 340B savings to fund executive bonuses or facility expansions rather than improving patient care. Additionally, large health systems often acquire smaller, 340B-eligible hospitals to capitalize on the program's benefits, further fueling consolidation. This strategy distorts market dynamics, enabling larger systems to outcompete smaller, non-340B providers while contributing to rising drug prices overall.

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C. Example of Impact on Patients - Profit Maximization is Fueling Hospital Consolidation: The 340B Drug Pricing Program and Its Misuse

Impact on Drug Pricing and Access

The misuse of the 340B program has significant consequences for patients and the healthcare system. By prioritizing profit maximization, some hospitals drive up the cost of prescription drugs, exacerbating financial barriers for patients. For example, cancer patients are often overcharged for chemotherapy drugs due to hospitals marking up prices, even when their treatment is delivered at 340B-eligible facilities. These inflated costs undermine the program's mission and erode trust in the healthcare system.

Consequences for Patients and the Healthcare System

Patients bear the brunt of 340B abuses in several ways. High patient costs for drugs can force individuals to skip doses, delay treatments, or forgo medications altogether, jeopardizing their health outcomes. Moreover, the consolidation driven by 340B incentives can lead to reduced access to care in underserved areas, as smaller providers struggle to compete and eventually close their doors. The ripple effects extend beyond individual patients, straining public health resources and increasing costs for insurers and taxpayers. An additional concern is the predatory debt collection practices of 340B hospitals.[4] As these hospitals have merged and grown, patients may not have alternatives to hospitals with aggressive debt collection practices.

How 340B Abuse Affects Drug Availability and Costs for Patients

The impact of 340B abuses is particularly evident in rural and low-income communities. As hospitals consolidate and focus on maximizing 340B revenues, they may prioritize high-margin services over essential but less profitable ones, such as obstetrics or mental health care. This shift leaves patients with fewer options for comprehensive care, further entrenching disparities in health outcomes. The resulting landscape is one where profit-driven decisions undermine the availability of affordable, high-quality care for those who need it most.

[4] https://www.businesswire.com/news/home/20230309005351/en/New-Alliance-of-Health-Care-Leaders-Calls-on-Congress-to-Save-America%E2%80%99s-340B-Program

III. Health Systems

D. Impact on Prices and Quality of Care

Hospital consolidation has been consistently linked to price increases, often without corresponding improvements in quality of care. A comprehensive study by the National Bureau of Economic Research found that prices for inpatient services rose by an average of 12% following a hospital merger in already concentrated markets.[5] These price hikes disproportionately affect private insurers and self-insured employers, which ultimately pass the costs on to consumers through higher premiums and out-of-pocket expenses.

Quality outcomes in consolidated settings present a mixed picture. While some proponents argue that larger health systems can achieve economies of scale and standardize best practices, evidence suggests that these benefits are not uniformly realized. A 2017 study published in Health Affairs found that hospital mergers were associated with modest declines in patient satisfaction scores and no significant improvements in clinical outcomes.[6] This discrepancy raises questions about whether the purported efficiencies of consolidation translate into tangible benefits for patients.
Moreover, the emphasis on profit maximization in consolidated systems can undermine the patient-provider relationship. In many cases, patients feel like they are treated as revenue streams rather than individuals with unique healthcare needs. Addressing these challenges requires robust policy interventions to promote competition, enhance transparency, and prioritize patient-centered care over corporate profits.

[5] Zack Cooper, Stuart V Craig, Martin Gaynor, and John Van Reenen. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." Working Paper. National Bureau of Economic Research, December 2015. https://doi.org/10.3386/w21815
[6] https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556

IV. Pharmaceuticals

A. Review of Drug Investment and Innovation

Overview

The intellectual property (IP) system is a cornerstone of pharmaceutical innovation, designed to balance incentives for investment with the promotion of competition. By granting temporary exclusivity to inventors, IP rights allow companies time to generate rewards on investments made in research and development (R&D) while paving the way for future innovation. The system has been instrumental in driving significant advances in medicine, from lifesaving antibiotics to cutting-edge treatments for chronic diseases. Breakthroughs in cancer therapies, vaccines, and personalized medicine underscore the critical role of IP in fostering innovation that improves public health outcomes. At the same time, this system brings forth low-cost generic and biosimilar options after the exclusivity period ends, driving prices down substantially.

Investment and Innovation Driven by IP

Pharmaceutical innovation relies heavily on the protection and predictability provided by the IP system. Developing a new drug is a high risk and resource-intensive process, taking 10-15 years and an estimated $2.6 billion on average. These costs encompass early-stage research, preclinical testing, clinical trials, regulatory approval, and manufacturing. Investments in drug development are also associated with a high degree of uncertainty as only 12 percent of medicines ultimately make it FDA approval. But patent protections incentivize this investment by providing assurances that that companies can be protected from potential copy-cats for a limited period of time should a medicine ultimately prove successful. Like any other highly complex invention, medicines are typically covered by more than one patent. Additionally, protection starts at patent filing rather than upon regulatory approval of the product. On average, small-molecule branded medicines face generic competition just 13 years after FDA approval. This period of market exclusivity allows innovators to recover R&D expenditures on successful and failed investments and reinvest in the next generation of therapies.[7]

[7] Henry Grabowski, Genia Long, Richard Mortimer & Mehmet Bilginsoy. "Continuing trends in U.S. brand-name and generic drug competition," Journal of Medical Economics, August 2, 2021.

IV. Pharmaceuticals

A. Review of Drug Investment and Innovation

In addition to incentivizing private investment, the IP system encourages competition by establishing a clear pathway for generic and biosimilar market entry. IP creates transparency by requiring innovators to publicly disclose information about their inventions. Once patents expire, competitors can introduce lower-cost copy-cats, driving prices down and producing savings, while broadening access to high-quality medications. This successful framework, which fuels innovation while enabling the market entry of low-cost options to benefit patients and drive savings to the system over the long term, is a dynamic which is unique in healthcare and in comparison, to other sectors.

The result is a system where innovation thrives, and patients benefit from a broader range of treatment options. As discussed below, even before generic or biosimilar market entry, a drug often faces competition from other treatment options as IP encourages innovators to develop competing brands that differentiate in terms of patient benefits, further driving competition and decreasing net prices by as much as 60%.[8]

[8] Hernandez, I., Cousin, E. M., Wouters, O. J., Gabriel, N., Cameron, T., & Sullivan, S. D. (2024). Price benchmarks of drugs selected for Medicare price negotiation and their therapeutic alternatives. Journal of Managed Care & Specialty Pharmacy, 30(8), 762-772.

IV. Pharmaceuticals

B. Drug Prices & Competition in Medicine Development

Healthy Competition in Generic Markets

The U.S. IP framework enables generic and biosimilar drugs to play a vital role in ensuring affordable access to medications. Over 90% of prescriptions dispensed in the United States are for generics, which can cost 80-85% less than their brand-name counterparts. This robust competition is facilitated by the Hatch-Waxman Act, which streamlined the approval process for generics while preserving incentives for innovation. The result is a thriving generic market that saves the U.S. healthcare system over $300 billion annually.

Biosimilars, the generic equivalents of biologic drugs, are also contributing to cost reductions. Since the approval of the first biosimilar in 2015, competition in this sector has grown, leading to significant $36 billion savings for patients and payers. For example, competition from biosimilars has lowered prices on reference biologics by average of 56%, up to 150%.[9]

Declining Drug Prices Through Competition

Before drugs become generic, drugs compete for formulary coverage in ways that can decrease prices and increase choice for patients who may need multiple treatment options. Contrary to popular belief, net drug prices are declining in many therapeutic areas due to increased competition. When multiple brand-name drugs compete within the same class, manufacturers often offer significant discounts and rebates to secure market share. For instance, the arrival of new treatments for hepatitis C initially sparked concerns about high costs, but competition among brands quickly drove prices down, making the cures more accessible to patients. Similarly, many classes of chronic disease medicines—such as those treating diabetes, cardiovascular disease, and migraine, for example—are associated with high levels of discounts and rebates.

Generic and biosimilar competition further accelerates price reductions. The entry of generic statins, widely used to manage cholesterol, reduced costs by over 90%, transforming access to these essential medications. For example, Lipitor was launched in 1996 at $10 per pill but today you can get it for 7 cents a pill. As competition intensifies, patients benefit from lower prices without compromising the quality of care.

[9] https://biosimforum.wpengine.com/wp-content/uploads/Xcenda-ASP-One-Pager.pdf

IV. Pharmaceuticals

B. Drug Prices & Competition in Medicine Development

Drug Price Setting Policies Undermine Underlying IP Incentives

Critics argue that intellectual property protections drive high drug prices, but this assertion oversimplifies a complex issue. While patents and other regulatory exclusivities grant temporary market exclusivity, pricing is influenced by a range of factors, including the cost of development, market size, and healthcare reimbursement systems. Studies show that IP protections are not the primary driver of high drug prices; instead, they are essential for ensuring that pharmaceutical companies can continue to invest in R&D.

Furthermore, the global context underscores the importance of IP protections. In countries with weaker IP enforcement, innovation often lags due to limited incentives for investment. Strengthening the IP framework globally could unlock new opportunities for drug development and improve access to innovative treatments across markets.

Other policy efforts to regulate drug prices at the federal and state levels aim to address affordability concerns, but they often have unintended consequences and undermine IP protections. While well-intentioned, price controls can stifle innovation by reducing the financial incentives for R&D. However, we lack sufficient evidence to understand the magnitude and nature of these effects. Moreover, rigid pricing mechanisms may discourage competition by making it less attractive for new entrants to develop and market alternative treatments.

For example, legislation to cap insulin prices has sparked debate over its potential effects on competition. While price caps could provide immediate relief for patients, they may also disincentivize investment in next-generation insulin formulations. Concerns have been raised - even by CMS - that price setting may disrupt competitive dynamics that affect formulary coverage that could lead to unintended restrictions for patients.

IV. Pharmaceuticals

C. Example of Impact on Patients – Promising New Treatment Option That Will Become More Accessible Due to Competition

Case Study: GLP-1s

GLP-1 receptor agonists, a class of drugs used to treat type 2 diabetes and obesity, exemplify the interplay between innovation, investment, and competition. These drugs represent a breakthrough in metabolic health, offering improved glycemic control and weight loss benefits compared to earlier therapies. The development of GLP-1s required years of research and substantial financial investment, with companies navigating complex clinical trials and regulatory hurdles.

Investment in R&D

The development of GLP-1s illustrates the importance of sustained investment in pharmaceutical innovation. Early discoveries in the biology of incretin hormones laid the foundation for this class of drugs, but translating these findings into safe and effective treatments required significant resources. Leading manufacturers invested heavily in preclinical and clinical studies, ensuring the safety and efficacy of their products for millions of patients worldwide.

Current Competition and Future Price Reductions

Today, GLP-1s face increasing competition as new entrants join the market. This competition has already led to substantial discounting, making these drugs more accessible to patients. For example, a recent study showed the range in average discount from list price to net payment ranged from 48% to 79%.[1] Looking ahead, the anticipated entry of generics and biosimilars is expected to further reduce costs, broadening access to these life-changing treatments. By fostering a competitive environment, the IP system ensures that patients benefit from both innovation and affordability.

GLP-1s were also just recently selected for government price setting in Medicare. Questions have been raised regarding whether price setting will achieve the level of discounts market competition may ultimately bring to this class of drugs, and whether these drugs would have entered the market in the first place had price setting been in place at their time of development.

[1] https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf

IV. Pharmaceuticals

D. Impact on Patients

Benefits of More Treatment Options

The expansion of treatment options driven by competition delivers significant benefits to patients. Greater choice allows healthcare providers to tailor therapies to individual needs, improving outcomes and enhancing quality of life. For example, the availability of multiple GLP-1 formulations broadens options across different indications and enables patients to select options that align with their unique preferences, such as once-daily versus once-weekly dosing, side effects, comorbidities, or other clinical characteristics.

Promising Future Treatments

A robust competitive landscape promises continued innovation, with numerous groundbreaking treatments on the horizon. Advances in gene therapy, oncology, and rare disease management hold the potential to transform care for millions of patients. For instance, emerging gene-editing technologies are poised to deliver curative therapies for genetic disorders, while novel immunotherapies offer hope for previously untreatable cancers. Ensuring a supportive environment for competition and innovation is essential to realize these possibilities.

The Role of Limited Government Intervention

While government interventions can address immediate affordability concerns, preserving market-based incentives is critical for long-term progress. Policies that promote competition, streamline regulatory pathways, and protect intellectual property rights create a fertile ground for innovation. By fostering a balanced approach, policymakers can ensure that patients continue to benefit from cutting-edge therapies and affordable access to essential medications.

V. Conclusion

Summary of Findings

The U.S. healthcare market faces significant challenges due to declining competition and limited transparency in three primary sectors: hospitals, insurers, and pharmaceuticals. Hospital mergers and acquisitions have concentrated market power, often creating monopolistic conditions, particularly in rural and underserved areas. This trend has led to price increases without corresponding improvements in care quality. The insurance market has also seen substantial consolidation, with dominant players implementing restrictive practices like narrow networks and tiered formularies, limiting consumer choices and inflating costs. In the pharmaceutical sector, pricing mechanisms such as opaque rebate structures, Pharmacy Benefit Manager (PBM) practices, and government price setting can distort competition, leading to inflated drug costs. At the same time, IP rights encourage brand competition during a limited time of market exclusivity and enable growth of strong generic markets offering low prices. Despite select instances of highly publicized cases of outlier behavior that have extended market exclusivity periods beyond the average, on the whole, competition among brand products as well as in the generic and biosimilar drug markets has shown potential to reduce costs and expand access to innovative treatments that improve health, highlighting the importance of fostering competitive dynamics across the healthcare landscape. There are no equivalent means of controlling costs or increasing competition in other healthcare sectors.

Policy Takeaways

Addressing the erosion of competition in U.S. healthcare markets requires targeted regulatory and policy interventions. Policymakers should strengthen antitrust enforcement to prevent further consolidation among hospitals and insurers. Regulatory reforms should also address conflicts of interest in vertically integrated entities, such as insurer-owned PBMs, to promote transparency and accountability. Encouraging competition in the pharmaceutical sector involves ensuring generic and biosimilar drug approvals are accessible to patients on formularies, addressing misaligned incentives driving PBMs and insurers to prioritize profits by hindering patient access , and reforming the 340B program so that those price concessions do not fuel consolidation in the hospital sector. Additionally, government actions to cap drug prices and undermine IP rights must be carefully balanced to avoid disincentivizing innovation. Collectively, these measures aim to enhance affordability, expand access, and protect consumer interests without stifling the incentives that drive healthcare innovation.

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