Effects of Banning Hospitals' Anti-Steering, Anti-Tiering, and All-or-Nothing Contracts

The Council of Economic Advisers

June 2026

BLUF: We estimate that banning hospital's anti-competitive contracts would have these effects:

- Hospital and physician prices fall 18 percent in directly affected markets, averaging approximately $4,100 in savings per inpatient admission.
- Employer-sponsored insurance (ESI) premiums fall 6.5 percent in directly affected markets, saving workers and employers approximately $1,755 per family and $606 per individual per year.
- National aggregate premium savings are approximately $45 billion per year. Because these premiums are fully borne by workers, savings flow to employees through lower premium contributions and higher take-home wages.
- Rural workers and independent rural hospitals are net beneficiaries. Experience shows that system owned rural hospitals remain viable after these contracts are removed, while rural workers gain from lower premiums and independent rural hospitals gain stronger negotiating positions.

Executive Summary

Anti-steering, anti-tiering, and all-or-nothing bundled contracting are mechanisms by which dominant hospital systems insulate themselves from price competition: anti-steering prohibits insurers from directing patients toward lower-cost providers; anti-tiering is one form of anti-steering that bars insurers from placing the dominant system in a less favorable benefit tier; and all-or-nothing contracting requires insurers to accept every hospital and affiliated physician in the system or none at all. The DOJ's February 2026 complaint against OhioHealth and March 2026 complaint against New York-Presbyterian allege that anti-steering restrictions are anticompetitive. Both cases are pending.

This memo develops estimates of the hospital price and health insurance premium reductions that would follow a nationwide ban on all three mechanisms collectively. We estimate that a ban would reduce hospital and affiliated-physician prices by 18 percent (with a plausible range of 11 to 26 percent), averaging ~$4,100 per inpatient admission, in directly affected markets through three channels: restored insurer bargaining leverage, patient sorting to lower-cost providers, and over time, additional price concessions as removing the clauses allows competing systems to become more credible alternatives to insurers. After scaling by the hospital and affiliated-physician share of total employer-sponsored insurance (ESI) spending (approximately 57 percent) and applying a 70 percent pass-through rate, ESI premiums in directly affected markets would fall by an estimated 6.5 percent (ranging from 4 to 9 percent).

In directly affected markets, that premium reduction corresponds to savings of ~$1800 ($1,100 to $2,500) per family annually and ~$600 ($380 to $860) per individual (2025 dollars). Because the economic incidence of ESI premiums falls on workers, these savings flow to employees through some combination of lower out-of-pocket premium costs and higher take-home wages. Reduced hospital prices also raise payroll and employment at non-health-care employers and increase federal income tax receipts, with gains concentrated among lower- and middle-income workers. We estimate that 24 percent of Americans covered by ESI are in markets where these clauses are binding and consequential. Scaling our estimates to account for that indicates that nationwide ESI premium savings of 1.6 percent, amounting to ~$45 billion ($29 to $63 billion) per year.

The expected effects vary by market structure. In markets with a dominant system and competitive insurers, we expect premium reductions of 4 to 6 percent. Where both the hospital system and insurer have

market power, the estimated reduction is 2 to 3 percent. In more competitive markets with lower clause prevalence, 1 to 2 percent.

For rural communities, multi-market systems may use anti-steering and all-or-nothing contracts to extend urban market power to rural hospitals, elevating prices in those communities. A ban could reduce premiums for rural workers and employers, improve the negotiating position of independent rural hospitals, and impose minimal pressure on system-owned rural hospitals.

The Contracting Mechanisms

The Department of Justice's civil antitrust complaints against OhioHealth (February 2026) and New York Presbyterian (March 2026) focus attention on contracting mechanisms that dominant hospital systems use to insulate themselves from price competition: anti-steering clauses, anti-tiering clauses, and all-or-nothing bundled contracting.[i] This memo develops estimates of the effects on hospital-insurer prices and on ESI premiums that would follow a nationwide ban on these types of restrictions.

Anti-steering clauses prevent insurers from offering patients financial incentives—lower copays, reduced deductibles—to choose lower-cost providers. Anti-tiering clauses specifically require the insurer to place the dominant system in the most favorable cost-sharing tier regardless of price, restricting the insurer's ability to make enrollees sensitive to differences between hospitals' prices through plan design. All-or-nothing bundled contracting requires the insurer to include all of the dominant system's hospitals and affiliated physicians in-network or none at all, blocking selective contracting and preventing rivals from gaining the patient volume they need to compete. These three clause types typically appear together.[3]

Banning them would operate through several channels. First, negotiated prices: restoring insurer bargaining leverage produces lower negotiated prices. Second, patient sorting: banning anti-tiering and anti-steering would shift volume toward lower-cost providers, reducing average realized prices even holding negotiated rates fixed. This channel will be amplified where price transparency tools are available. Third, rival growth: once patients have greater incentives to choose alternatives, prices will fall further as competing systems accumulate volume and become more credible alternatives for insurers. A fourth mechanism spills over to other geographic markets. All-or-nothing and anti-steering clauses can allow a system that is dominant in one market to drive up prices in other markets. Banning these clauses would delink the ability of one hospital's market power from driving up the prices negotiated in other markets.

Prevalence and Scaling

We estimate that approximately 24 percent of ESI-covered lives are in markets where these clauses are binding and produce measurable effects. This estimate has two components. First, we estimate that 40 percent of ESI covered lives are in markets that meet the conditions necessary for the contracting clauses to exist and have impact. A 2024 study found that 37 percent of metropolitan areas had hospital Herfindahl-Hirschman Index (HHI) concentration measures below 5,000, which we use as a heuristic to indicate that viable alternatives could exist in the market.[ii] Our range reflects uncertainty due to three sources. First, the study excludes rural areas which may have sole hospitals, suggesting need for a downward adjustment. Second, the report indicates that markets with larger populations have lower concentration, suggesting the

need for an upward adjustment to convert from a share of metropolitan areas to a share of ESI covered lives. From these data and adjustments, we estimate 40 percent as our midpoint, ranging from 35-45 percent.

The second component is the share of dominant-system contracts that actually contain one or more of the three clause types in binding form. We have no direct population-level data on this because hospital-insurer contracts are confidential. The litigation record documents confirmed usage in at least five major markets across diverse geographies—Charlotte (Atrium Health), Northern California (Sutter Health), western North Carolina (HCA/Mission Health), Columbus (OhioHealth), and New York City (New York-Presbyterian)— and insurer testimony in multiple proceedings suggests these terms are widespread in concentrated markets, but a precise prevalence rate is unobservable.[iii,iv,v] We treat 50 to 70 percent as a working range, with 60 percent as the midpoint. Combining these two components yields 24 percent of ESI covered lives (40 percent of markets × 60 percent clause prevalence). We note that we defined markets based on Metropolitan Statistical Areas and have not attempted to define markets in ways that would necessarily align with those that may apply for antitrust purposes.

Estimated Effects by Channel

Negotiated prices. Three estimates from the published literature bracket this channel. One study documents hospital price changes of up to 10 percent following changes in insurer bargaining structure.[vi] A second study finds that under insurer-optimal network formation, a close analog to a ban on all-or-nothing contracting, hospital prices are approximately 12 percent lower than under a full-network mandate.[vii] A third finds that monopoly-market hospital prices are 12 percent above markets with four or more competitors[viii]—an equilibrium premium consistent with the level of market power that these clauses help sustain. We use a central estimate of 6 to 10 percent hospital price reduction.

Patient sorting. Research finds that tiered-network plans that impose a single flat copay that varies predictably by hospital tier and make price differences visible and salient to patients generate savings of 8 to 17 percent of baseline hospital spending within three years of introduction.[ix] To adapt this estimate for our context, we feature the 8 percent estimate, with a range of 5 to 12 percent. Our reason is that the Massachusetts copay setting provides simpler price signals than ESI plans nationwide, where coinsurance and deductibles make out-of-pocket prices harder to observe. We note that this effect is expected to grow over time as price transparency tools improve,[x] further enhancing the gains from eliminating anti-tiering and anti-steering clauses.

Restored bargaining leverage. Once a dominant system can no longer bundle its facilities or prevent steering, competing systems gain access to patient volume they were previously locked out of, becoming more credible alternatives for insurers over time. This strengthens the insurer's threat of replacement in bilateral bargaining, further reducing the dominant system's negotiated prices beyond the immediate effect captured in the negotiated prices channel. We derive the range for this channel from two sources. The first simulates insurer-optimal network formation—the direct counterfactual to all-or-nothing contracting—and finds that equilibrium hospital prices across the full network are approximately 12 percent lower than under a full network mandate. Because this is a full equilibrium result, it already reflects the resulting prices of all hospitals under the new competitive environment.[xi] The second measures actual price increases of 7 to 9 percent following cross-market hospital mergers that bundle facilities across markets

(the same mechanism but in reverse).[xii] Because these competitive dynamics take time to materialize, we apply a discount of 30 to 50 percent to the larger number, yielding an estimate of 3 to 7 percent over the medium-term horizon. Because this channel and the negotiated price channel both work through the bargaining mechanism and are partly overlapping, we apply a judgment-based discount of approximately 3 percentage points.

Physician spillover. The contracting clauses in question apply to the hospitals' affiliated physician groups.[xiii] As of January 2024, 55.1 percent of physicians nationally were employed by hospitals or health systems.[xiv] Hospital-affiliated physicians' allowed amounts—the actual negotiated prices paid by commercial insurers—are estimated to be 11 to 26 percent higher than those of independent peers.[14] We estimate a 10 percent reduction (ranging from 8 to 12 percent) on affiliated physician spending, modestly below the hospital estimate given that professional fees carry less facility-leverage.

Premium pass-through. When hospital prices fall, insurer costs fall by a corresponding amount. Whether those savings reach enrollees depends on how competitive the insurance market is. In a competitive insurance market, insurers pass savings through to enrollees nearly in full, because any insurer that retains cost reductions as margin will lose enrollment to rivals offering lower premiums. Where insurers have market power—as is common in concentrated local markets[xv]—they can retain a share of cost reductions as profit. In competitive insurer markets, theory indicates that we should expect the pass-through to approach 90 to 100 percent. Applying judgement to weight across market structures, we use a central estimate of 70 percent pass-through, with a range of 55 to 85 percent. Pass-through is toward the lower end in markets where both the hospital system and the insurer have market power.

We convert the estimated effects on hospital and affiliated-physician prices to total ESI premiums by scaling the share of ESI spending in each affected category. Hospital facility spending (inpatient plus outpatient) is 45 percent of total per-person ESI spending, comprised of 17 percent inpatient and 28.1 percent outpatient facility.[xvi] Non-facility physician and professional services are approximately 21 percent of ESI spending.[xvii] In the concentrated markets we analyze, approximately 55.1 percent of physician spending is at dominant-system affiliated practices, giving an affected physician share of 11.6 percent (21 percent × 55.1 percent). This yields a combined affected spend share of 56.6 percent of total ESI spending (45 percent hospital + 11.6 percent affiliated physicians). As a cross-check, HCCI estimates that total spending on hospital care including both facility and professional fees was 56 percent of ESI spending in 2020.

At our central estimates—18 percent hospital price reduction and 10 percent physician price reduction— the total insurer cost reduction in affected markets before pass-through is 9.3 percent ((18% × 45%) + (10% × 11.6%)). Applying 70 percent pass-through yields a 6.5 percent premium reduction in affected markets, with a range of 4.1 to 9.2 percent.

We next convert these percentage savings to 2025 dollars. Scaled to the full ESI population, since these clauses affect about 24 percent of ESI lives, the national average premium reduction is ~1.6, ranging from 1.0 to 2.2 percent. Applied to total ESI expenditure of approximately $2.9 trillion,[xviii] this implies total premium savings of ~$5 billion per year, with a range of $29 to $63 billion per year across the range of channel values described above. Adjusting either our estimated share of markets affected or our estimated clause prevalence by ten percentage points input moves this estimate by $3 to $5 billion per year. A more

conservative near-term assessment that accounts for incomplete enforcement yields approximately $25 billion, with a range of $20 to $35 billion per year. As a final sensitivity check, holding the channel estimates at their central values but varying the calculations across all plausible combinations of hospital share (42 to 48 percent of ESI spending) and physician affiliation rate (50 to 60 percent) yields national premium reduction of ~1.5 percent and aggregate savings of approximately $35 billion, with a range of $30 to $40 billion.

In terms of dollar savings for inpatient hospital facility prices specifically, we rely on two methods. First, applying our estimated 11 to 26 percent price reduction (central: 18 percent) to the average commercial price of an inpatient stay at system-affiliated hospitals of approximately $23,000 (December 2025 dollars) yields savings of $2,530 to $5,980 per admission, with a central estimate of ~$4,100.[xix] Second, HCCI reports per-enrollee inpatient facility spending of approximately $1,100; dividing by an estimated 0.05 inpatient admissions per ESI enrollee per year[xx] implies an average price of approximately $22,000 and applying the same price reduction range yields savings of a central estimate of ~$3,960 per admission. The two approaches agree within rounding, with estimated savings of ~$4,000 per inpatient admission.

Expected Differences across Market Types

We describe scenarios that bound the range of outcomes and discuss how we expect outcomes to differ across markets. The numeric estimates reflect judgment decisions based on industrial organization theory of hospital and insurance markets, and hospital-insurer bargaining.

1. Large multi-market systems whose flagship facilities insurers cannot viably exclude. In these markets all three channels operate at full strength. We estimate that restoring insurer bargaining leverage reduces negotiated hospital prices by 6 to 10 percent; lifting anti-tiering and anti-steering restrictions shifts patient volume toward lower-cost providers, adding 3 to 5 percent; and over the medium term, rival systems that gain access to patient volume they were previously locked out of become more credible alternatives for insurers, contributing an additional 2 to 4 percent. Channels 1 and 3 are partially overlapping and work through bargaining between hospitals and insurers, so the combined effect is less than the simple sum. Applying a partial overlap discount yields an estimated net hospital price reduction of 8 to 14 percent. Applying the spend-share and pass-through steps from Section III, we estimate premium reductions in these markets of 4 to 7 percent.
2. Competitive multi-hospital markets. Anticompetitive clauses are less common in these markets — present in roughly 30 to 40 percent of contracts — and where present, the bargaining leverage effect may be more limited because usually no single system is dominant. Channels 1 and 2 operate partially, and we estimate hospital price reductions of 4 to 6 percent where clauses are binding. Scaling by the 30 to 40 percent clause prevalence within this market type, we estimate the market-wide premium reduction at 1 to 2 percent. This may understate effects, however, if having multiple rival hospitals makes steering and tiering clauses more widely used and/or more impactful.
3. Truly independent sole-community hospitals with no nearby system competitor. Where no credible competitive alternative exists, the insurer cannot threaten exclusion regardless of contractual terms, and restoring the legal right to exclude changes nothing in practice. All three channels are inoperative with respect to inpatient hospital competition. These markets are excluded from the national scaling.

Independent Hospitals, Rural Hospitals, and Rural Communities

Independent hospitals. A nationwide ban on anti-steering, anti-tiering, and all-or-nothing contracting would directly benefit any hospital that can serve as a credible alternative to a dominant system. Banning anti-steering and anti-tiering clauses would enable insurers to offer patients financial incentives (e.g., lower copays) to choose lower-cost or higher-value providers. Banning all-or-nothing bundled contracting would restore insurers' ability to negotiate selectively with each facility on its own merits so that independent hospitals can compete for network inclusion based on price and quality. Together, the three bans would equip independent hospitals to convert their market value into higher patient volume. Independent rural hospitals, in particular, would benefit as the ban would curb multimarket systems' ability to extend urban market power to protect elevated prices at their systems' rural hospitals.

System-owned rural hospitals. Large systems that use all-or-nothing contracts often include rural hospitals as part of the bundle. This allows cross-market bundling, rather than the local hospital's market power, to determine prices in rural communities. The clearest documented example is HCA/Mission Health in western North Carolina, where all-or-nothing, anti-steering, and anti-tiering clauses covered all Mission hospitals across seven counties—Buncombe, Macon, Madison, McDowell, Mitchell, Transylvania, and Yancey—where HCA held 70 to 90 percent market share. Local governments alleged these contracts left insurers with no leverage to negotiate lower prices anywhere in the region, because losing any one county meant losing access to Mission's Asheville facilities.[xxi]

Hospital systems argue that all-or-nothing contracts are necessary to cross-subsidize rural and safety-net facilities from urban surpluses. The Sutter Health settlement provides countervailing evidence.[xxii] Sutter agreed in 2021 to halt all-or-nothing contracting and anti-steering practices across its 24-hospital Northern California system, including rural facilities. Since then, Sutter Amador Hospital in Jackson has been named a Top 100 Rural and Community Hospital for five consecutive years, and Sutter has continued expanding rural primary care and behavioral health in rural counties after the settlement took effect. Rural operations survived because operational commitments, nonprofit tax status, and community benefit obligations existed independent of higher commercial prices due to all-or-nothing contract leverage and anti-steering clauses. On net, the evidence from past experience indicates that removing these contracts from rural system hospitals brings down those hospital prices and insurance premiums even while the hospitals remain viable and open.

Rural workers and coverage access. In 2023, 47.8 percent of rural residents were covered by ESI, compared to 56.0 percent in urban areas; uninsured rates were 8.4 percent in rural areas versus 7.8 percent nationally.[xxiii] Where large systems use anticompetitive contracts to sustain elevated commercial premiums, rural workers pay more for coverage and rural employers spend more on benefits. The premium reductions estimated in Section II would directly lower costs for rural workers and employers in affected markets, increasing takeup rates and expanding access to coverage.

Wages, Employment, and Federal Income Tax Receipts

Decades of health economics research has demonstrated that ESI premiums are paid by workers in the form of lower wages, effectively passing through increases in healthcare costs. Two recent papers add relevant insights. First, competition-reducing actions (hospital mergers, specifically) by hospitals raise

hospital prices in ways that are fully borne by workers in the form of lower wages.[xxiv] Second, hospital price increases raise unemployment and depress federal income tax receipts.[xxv25] The study estimated that a 1 percent increase in hospital prices reduces non-health-care payroll and employment by 0.4 percent, reduces county labor income by 0.27 percent, increases unemployment flows by 1 percent, and lowers federal income tax receipts by 0.4 percent. These disemployment effects are concentrated among lower- and middle-income workers. Linearly extrapolating these estimates to our analysis and context indicates that a ban that reduces hospital prices by 11 to 26 percent in directly affected markets would raise non-health-care payroll and employment by approximately 4 to 10 percent in those markets and generate corresponding increases in federal income tax receipts, excluding any reductions in tax revenues from healthcare providers. These employment and fiscal effects are above and beyond the national aggregate premium savings estimates in Section II.

Conclusion

A nationwide ban on anti-steering, anti-tiering, and all-or-nothing contracting would reduce hospital and affiliated-physician prices by an estimated 11 to 26 percent in directly affected markets. After scaling by the affected share of ESI spending and applying a pass-through rate, ESI premiums fall by an estimated 4 to 7 percent in those markets, yielding savings or higher wages of $1,100 to $2,500 per family per year. Additionally, lower hospital prices raise non-health-care payroll and employment and generate additional federal tax receipts. Scaled to the full ESI population, we estimate that nationwide savings would be $29 to $63 billion per year. For rural America, we expect that eliminating these contracting clauses will lower premiums and raise wages for rural workers, improve the position of independent rural hospitals for insurers, and impose minimal pressure on system-owned rural hospitals.

---

i. OhioHealth complaint filed February 20, 2026, U.S. District Court for the Southern District of Ohio. DOJ press release: https://www.justice.gov/opa/pr/justice-department-sues-ohiohealth-anticompetitive-healthcarecontracts-increase-costs-ohio New York-Presbyterian complaint filed March 26, 2026, U.S. District Court for the Southern District of New York. DOJ press release: https://www.justice.gov/opa/pr/justice-department-sues-newyork-presbyterian-hospital-anticompetitive-contracts-increase

ii. KFF. "One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2024." March 27, 2026. https://www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas/

iii. OhioHealth complaint filed February 20, 2026, U.S. District Court for the Southern District of Ohio. DOJ press release: https://www.justice.gov/opa/pr/justice-department-sues-ohiohealth-anticompetitive-healthcarecontracts-increase-costs-ohio New York-Presbyterian complaint filed March 26, 2026, U.S. District Court for the Southern District of New York. DOJ press release: https://www.justice.gov/opa/pr/justice-department-sues-newyork-presbyterian-hospital-anticompetitive-contracts-increase

iv. Source on Healthcare Price and Competition, UC Hastings / UC Berkeley Petris Center, "Key Issues: Provider Contracts," updated January 2026, https://sourceonhealthcare.org/provider-contracts/

v. Sutter Health settlement, final approval August 27, 2021 (People of California ex rel. Becerra v. Sutter Health, No. CGC-18-564978). Settlement halted all-or-nothing contracting and anti-steering practices system-wide. Post-settlement rural viability: Sutter Amador Hospital in Jackson, California named Top 100 Rural and Community Hospital by The Chartis Center for Rural Health for five consecutive years (2021–2025). Rural service expansion post-settlement: Sutter Health, https://vitals.sutterhealth.org/sutter-health-expands-rural-health-care-accessthrough-strategic-community-investments/

vi. Kate Ho and Robin S. Lee, "Insurer Competition in Health Care Markets," *Econometrica* 85, no. 2 (2017): 379–417, https://doi.org/10.3982/ECTA13570

[vii]Kate Ho and Robin S. Lee, "Equilibrium Provider Networks: Bargaining and Exclusion in Health Care Markets," *American Economic Review* 109, no. 2 (2019): 473–522, https://doi.org/10.1257/aer.20171288

viii. 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," *Quarterly Journal of Economics* 134, no. 1 (2019): 51–107, https://doi.org/10.1093/qje/qjy020

ix. Elena Prager, "Healthcare Demand under Simple Prices: Evidence from Tiered Hospital Networks," *American Economic Journal: Applied Economics* 12, no. 4 (2020): 196–223, https://doi.org/10.1257/app.20180422

x. Executive Order 14221, "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information," February 25, 2025. https://www.govinfo.gov/content/pkg/FR-202502-28/pdf/2025-03440.pdf Centers for Medicare & Medicaid Services, CY 2026 OPPS and Ambulatory Surgical Center Final Rule, Hospital Price Transparency Policy Changes, effective January 1, 2026 (enforcement delayed to April 1, 2026), https://www.cms.gov/newsroom/fact-sheets/cy-2026-opps-ambulatory-surgical-center-finalrule-hospital-price-transparency-policy-changes

xi. Kate Ho and Robin S. Lee, "Equilibrium Provider Networks: Bargaining and Exclusion in Health Care Markets," *American Economic Review* 109, no. 2 (2019): 473–522, https://doi.org/10.1257/aer.20171288

xii. Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of Economics* 50, no. 2 (2019): 286–325, https://doi.org/10.1111/1756-2171.12270

xiii. For example, the OhioHealth complaint specifically states that their contracts include physicians. OhioHealth complaint filed February 20, 2026, U.S. District Court for the Southern District of Ohio. DOJ press release: https://www.justice.gov/opa/pr/justice-department-sues-ohiohealth-anticompetitive-healthcarecontracts-increase-costs-ohio New York-Presbyterian complaint filed March 26, 2026, U.S. District Court for the Southern District of New York. DOJ press release: https://www.justice.gov/opa/pr/justice-department-sues-newyork-presbyterian-hospital-anticompetitive-contracts-increase

xiv. Physicians Advocacy Institute and Avalere Health, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023," April 2024, https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAIAvalere%20Physician%20Employment%20Trends%20Study%202019-

2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d As of January 1, 2024, 55.1 percent of physicians were employed by hospitals or health systems nationally.

xv. Leemore S. Dafny, "Are Health Insurance Markets Competitive?" American Economic Review 100, no. 4 (2010): 1399–1431, https://doi.org/10.1257/aer.100.4.1399. Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," American Economic Review 102, no. 2 (2012): 1161–1185, https://doi.org/10.1257/aer.102.2.1161.

xvi. Chris Frenier, "Assessing the Landscape of Hospital Outpatient Department Care," Health Care Cost Institute, February 17, 2026, https://healthcostinstitute.org/all-hcci-reports/assessing-the-landscape-of-hospital-outpatientdepartment-care/. Inpatient facility spending: 17% of total ESI spending (2022); outpatient facility spending: 28.1% (2022); combined hospital facility: approximately 45%.

xvii. HCCI Staff, "HCCUR Data Point: Use and Spending on Clinician Services in Hospital and Non-Hospital Settings," Health Care Cost Institute, August 23, 2022, https://healthcostinstitute.org/all-hcci-reports/hccur-datapoint-use-and-spending-on-clinician-services-in-hospital-and-non-hospital-settings/. Total professional services: 31% of per-person ESI spending in 2020 ($1,743 of $5,607); of which approximately 31% occurred in facility settings and 69% in non-facility settings (physician offices). Non-facility professional services — the component relevant to hospital-employed physician contracting — represent approximately 21% of total ESI spending. https://healthcostinstitute.org/all-hcci-reports/hccur-data-point-use-and-spending-on-clinician-services-inhospital-and-non-hospital-settings/. Total professional services: 31% of per-person ESI spending in 2020 ($1,743 of $5,607); of which approximately 31% occurred in facility settings and 69% in non-facility settings (physician offices). Non-facility professional services — the component relevant to hospital-employed physician contracting — represent approximately 21% of total ESI spending. https://healthcostinstitute.org/all-hcci-reports/hccur-datapoint-use-and-spending-on-clinician-services-in-hospital-and-non-hospital-settings/. Total professional services: 31% of per-person ESI spending in 2020 ($1,743 of $5,607); of which approximately 31% occurred in facility settings and 69% in non-facility settings (physician offices). Non-facility professional services — the component relevant to hospital-employed physician contracting — represent approximately 21% of total ESI spending. https://healthcostinstitute.org/all-hcci-reports/hccur-data-point-use-and-spending-on-clinician-services-inhospital-and-non-hospital-settings/. Total professional services: 31% of per-person ESI spending in 2020 ($1,743 of $5,607); of which approximately 31% occurred in facility settings and 69% in non-facility settings (physician offices). Non-facility professional services — the component relevant to hospital-employed physician contracting — represent approximately 21% of total ESI spending.

xviii. KFF, 2025 Employer Health Benefits Survey, October 2025, https://www.kff.org/health-costs/2025-employerhealth-benefits-survey/. ESI covers approximately 154 million nonelderly people

xix. Jessica Y Chang, Kathryn Martin, Commercial inpatient hospital price growth driven by system affiliation and nonprofit-status hospitals, *Health Affairs Scholar*, Volume 2, Issue 11, November 2024, qxae140, https://doi.org/10.1093/haschl/qxae140

xx. Debra Bozzi, Katie Martin, Aditi Sen, ESI Enrollees Paid $853 on Average Out-of-Pocket for Health Care in 2020, But Some People Paid Over Four Times as Much, Health Care Cost Institute, 2021, https://healthcostinstitute.org/all-hcci-reports/esi-enrollees-paid-853-on-average-out-of-pocket-for-health-carein-2020-but-some-people-paid-over-four-times-as-much/. HCCI reports that 3 percent of ESI enrollees had at least one inpatient admission in 2020. The 0.05 admissions-per-enrollee rate adjusts upward from the 3 percent figure to account for enrollees with multiple admissions in a year, and is consistent with per-enrollee inpatient spending of $1,100 ÷ $22,000 per admission = 0.05.

xxi. HCA Healthcare and Mission Health settled consolidated antitrust lawsuits filed by the City of Brevard, City of Asheville, Buncombe County, and Madison County, August 2025. Complaints alleged all-or-nothing, anti-steering, anti-tiering, and gag clause violations across seven western North Carolina counties where HCA held 70 to 90 percent market share. Settlement includes commitment to operate Transylvania Regional Hospital through at least 2032. See Healthcare Dive, August 14, 2025; Becker's Hospital Review, August 13, 2025. (Gary Melnick and Katya Fonkych, "Are 'All or Nothing' Contracts by Hospital Systems Anti-Competitive? Evidence from a Recent Antitrust Lawsuit," *Journal of Hospital Management and Health Policy* (2024), https://doi.org/10.21037/jhmhp-24-59 also supports related Sutter analysis.)

xxii. Sutter Health settlement, final approval August 27, 2021 (People of California ex rel. Becerra v. Sutter Health, No. CGC-18-564978). Settlement halted all-or-nothing contracting and anti-steering practices system-wide. Post-settlement rural viability: Sutter Amador Hospital in Jackson, California named Top 100 Rural and Community Hospital by The Chartis Center for Rural Health for five consecutive years (2021–2025). Rural service expansion post-settlement: Sutter Health, https://vitals.sutterhealth.org/sutter-health-expands-rural-health-care-accessthrough-strategic-community-investments/

xxiii. Rural Health Research Gateway, "Health Insurance Coverage in Rural and Urban Areas in the U.S., 2023," based on 2024 American Community Survey data, https://www.ruralhealthresearch.org/publications/1737

xxiv. Daniel Arnold and Christopher Whaley, "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages," SSRN Working Paper, September 2025, https://ssrn.com/abstract=4959256

xxv. Zarek Brot-Goldberg, Zack Cooper, Stuart V. Craig, Lev R. Klarnet, Ithai Lurie, and Corbin L. Miller, "Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers," NBER Working Paper 32613, 2024, https://doi.org/10.3386/w32613