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ISSUE BRIEF

Promoting Choice and Competition to Improve Healthcare

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Executive Summary

The U.S. healthcare system is plagued with a growing healthcare affordability crisis. Sustainably addressing this crisis requires reforms that establish well-functioning competitive markets.

In practice there has been a strong connection between competition and the cost of healthcare – prices are lower when the competitive environment is stronger and higher when competition is weaker. And this relationship holds whether the health services provided are hospital care, physician services, or health insurance services. Documenting this relationship

- Gaynor (2019), summarizing the literature, noted that reduced hospital competition led to substantial prices increases "on the order of 20 or 30 percent", "with some increases as high as 65 percent."[1]
- A 2022 JAMA Network analysis concluded that, relative to independent primary care physicians, the costs for office care visits were 11 percent higher at primary care physician offices associated with hospital systems.
- A 2022 Rand study that found less competition in the health insurance market is associated with both less compensation for providers and higher premium costs for beneficiaries.[2]

The U.S. healthcare system is also rife with administrative waste – some estimates claim that up to one-third of all expenditures are due to administrative costs. The most efficient way to address these costs is through regulatory reforms that encourage competition by lessening the burdens on providers and encouraging the adoption of technological advancements. And there are many technological solutions that are readily available and widely used in other competitive markets.

For instance, electronic clearinghouses have a demonstrated track record of managing transactions in other industries at a fraction of the costs currently being spent by the U.S. healthcare system. Adopting such technologies to the healthcare system offers the promise of significantly reduced administrative costs while also improving the quality of care.

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Problematically, the notion that less competition can improve outcomes is encouraging harmful policies. California's recent actions exemplify what's at stake. The state Department of Health Care Services (DHCS) is limiting competition for plans tailored to the dual-eligible population, which are patients who are eligible for both Medicare and Medicaid (called Medi-Cal in California). These plans are called Medi-Medi plans, which are a type of Medicare Advantage plan that is exclusively available to dual-eligibles.

This new rule harms competition by limiting the number of allowable insurers within each county. It actively obstructs organizations that are currently serving dual-eligible beneficiaries from serving new regions or expanding the number of beneficiaries they are currently serving.

For example, Kaiser Permanente and Alameda Alliance for Health are the only two plans allowed to serve Medi-Medi patients in Alameda County. In Orange County, the two authorized Medi-Medi plans are CalOptima and Kaiser Permanente. In Butte County, only one plan – Partnership HealthPlan – is available to patients with Medi-Medi plans.

These changes block insurers that are already serving the dual eligible population in California from expanding their services including Alignment Health Plan, Central Health, SCAN Connections, and United Healthcare. The exclusion of Alignment Health and SCAN are noteworthy as these smaller competitors were widely praised in a July 2025 congressional hearing evaluating the Medicare Advantage program for their focus on "quality and value".[3] They are also already serving a significant share of the 300,000 dual-eligibles enrolled in California's Medi-Medi plans.[4]

These restrictions on competition will likely cause several problems to the detriment of this vulnerable population. Most directly, the state is prohibiting service from health plans that are successfully serving this vulnerable population, denying beneficiaries of widely preferred options. The reduction in insurance competition will also put upward pressure on costs that will ultimately increase total state expenditures or reduce the available services that the dual-eligible population can receive. Either way, the environment is worsened because DHCS is limiting competition.

Rather than thwarting competition, policymakers at the federal and state level should focus on repealing the rules and regulations that harm competition and encourage consolidation.

Markets work best when policies incentivize transparency and competition. Healthcare is no different. By empowering competition, policymakers can incentivize innovations and efficiencies that will improve quality and promote greater healthcare affordability.

> "Rather than thwarting competition, policymakers at the federal and state level should focus on repealing the rules and regulations that harm competition and encourage consolidation.

Introduction

Choice and competition drive economic progress. This notion is uncontroversial when applied to markets such as automobiles, technology, or retail. And for good reasons. In a 2015 study on automobile competition, for instance, the authors found that reducing competition by "increasing the distance between Honda dealerships by thirty miles raises the price paid by consumers [on a Honda Accord] by about $500."[5]

Beyond driving down costs, more producers competing with one another spur innovations and increase product quality. Consumers benefit tremendously from this market process. Despite this widely held understanding of competition's benefits, these lessons are too often lost when applied to the healthcare sector.

> "Beyond driving down costs, more producers competing with one another spur innovations and increase product quality.

Advocates for greater government intervention in the healthcare system argue that increased patient choice is associated with worse outcomes and higher overall healthcare spending, particularly for the Medicare and Medicaid program. These arguments, to the extent that private and government payers rely on these positions to restrict consumer choice, threaten patient outcomes.

This *Issue Brief* rebuts the arguments that limiting healthcare competition improves outcomes and demonstrates why expanding competition is essential for improving healthcare affordability.

The Narrow Choice Narrative Is Fundamentally Flawed

Advocates of a single payer healthcare system, the extreme anti-competition position, argue that a government-controlled single payer healthcare system will generate significant cost savings through two pathways. First, a single payer system eliminates the need for the entire private insurance industry and will thus generate significant administrative savings by jettisoning the costs associated with all these unnecessary organizations. Second, by consolidating all payers into one negotiating entity, a single payer healthcare system will exert greater leverage on providers. Utilizing this leverage, a single payer system is better positioned to reduce the costs of care.

The arguments for narrowing patient choices through narrow- or tiered-networks, while less extreme, are based on the same logic that single-payer advocates use. Narrow networks help payers, especially those with a dominant market position, to control costs and lower overall healthcare spending.[6] For example, Mazurenko, Taylor, and Menachemi (2022) performed a review of studies concluding that "narrow and tiered networks are associated with reduced overall healthcare costs for most cost-related measures."[7]

In practice, these arguments are fundamentally flawed. They violate basic economic logic and are empirically refuted when outcomes are properly measured. In most markets expanded choice and competition are essential for incentivizing efficiencies that improve outcomes while reducing costs. Healthcare markets are no different. The theory that narrowing choices improves outcomes for patients is the epitome of static thinking. It misdiagnoses why healthcare affordability improves and why it worsens.

Productivity, Not Consolidation, Will Control Costs

Starting with the administrative costs, the U.S. clearly spends an excessive amount of money on healthcare administration. According to a 2023 analysis by the Commonwealth Fund,

> *OECD Health Statistics data show the U.S. spent $1,055 per person on "governance and health system financing administration" in 2020, compared with the OECD 12 average of $193 per person. We multiplied the difference in per capita spending by the size of the 2020 U.S. population to estimate potential savings of $285.6 billion, or about 7 percent of 2020 U.S. NHE.*[8]

Other estimates of the total amount of U.S. healthcare spending that is devoted toward administrative costs are even higher.[9] Cutler (2020), for example, found that "administrative costs account for one-quarter to one-third of health-care spending in the United States."[10]

These studies demonstrate that the U.S. healthcare system is undoubtedly plagued with excessive administrative costs. It does not follow, however, that reducing consumer choice will reduce administrative costs and improve patient outcomes. Addressing excessive administrative costs is not a matter of the number of providers and payers. Instead, the current system is rife with inefficiencies that are best addressed directly through technological and organizational changes that can appreciably reduce administrative costs.

For instance, Cutler suggests that, based on their empirical benefits, a clearinghouse applied to the healthcare industry can significantly reduce administrative costs.[11] These technologies are already commonly used in other sectors and generate significant administrative savings.

Thanks to the use of clearinghouses in the banking industry, "the cost of administering banking transfers is trivial (roughly $300 million annually compared to more than $50 trillion transferred annually)." Applied to the Universal Product Codes (UPC) used on most consumer goods, a system used by over 1 million businesses in more than 100 countries can be run by a nonprofit with a budget of $35 million.[12] There are also many administrative changes that can generate significant savings including simplifying the prior authorization process and promoting greater data interoperability.

> **"Studies demonstrate that the U.S. healthcare system is undoubtedly plagued with excessive administrative costs.**

The key takeaway from these examples is that reducing administrative costs is not a question of establishing a single payer or mandating narrower networks. It is a matter of adopting the widely available cost reducing technologies and organizational reforms that can appreciably reduce the U.S. healthcare system's administrative costs. Implementing these changes is not easier with less competition as advocates of less choice might advocate. Lessons from other markets demonstrate that the reverse is true – competition drives organizations to adopt innovative technologies and more efficient organizational structures. In other words, reducing competition and choice are less likely to lower administrative costs and are more likely to experience additional cost increases that significantly raise total expenditures.

Less Competition Leads to Higher Costs

As with all markets, when the healthcare industry empowers robust competition, the cost of delivering care is lower and the affordability of health insurance is greater. As Gaynor (2019) notes in testimony to Congress,

> *the health care system will only work as well as the markets that underpin it. If those markets function poorly, then we will get health care that's not as good as it could be and that costs more than it should. Moreover, attempts at reform, no matter how important or clever, will not prove successful if they are built on top of dysfunctional markets.*
>
> *There is widespread agreement that these markets do not work as well as they could, or should. Prices are high and rising, they vary in seemingly incoherent ways, there are egregious pricing practices, there are serious concerns about the quality of care, and the system is sluggish and unresponsive, lacking the innovation and dynamism that characterize much of the rest of our economy.*
>
> *One of the reasons for this is lack of competition. The research evidence shows that hospitals and doctors who face less competition charge higher prices to private payers, without accompanying gains in efficiency or quality. Research shows the same for insurance markets. Insurers who face less competition charge higher premiums and may pay lower prices to providers. Moreover, the evidence also shows that lack of competition can cause serious harm to the quality of care received by patients.*[13]

Ironically, the problems that the advocates of less competition are attempting to solve are a direct result of poorly functioning markets. Reforms that reduce competition will only undermine the vibrancy of the healthcare markets and worsen the cost and quality problems afflicting the U.S. healthcare system. And this connection between less competition, higher prices, and lower quality is evident across the healthcare system including health insurance markets, physicians, and hospitals.

Take the delivery of healthcare at hospitals. There were more than 2,000 hospital mergers between 1998 and 2023.[14] Along with the increased hospital consolidation, the number of "physicians working for a hospital or a practice owned at least partially by a hospital or health system increased from 29 percent in 2012 to 41 percent in 2022."[15]

As a direct result of this consolidation most healthcare markets lack competition today. A 2017 *Health Affairs* study found that, for 2016, "90 percent of Metropolitan Statistical Areas (MSAs) were highly concentrated for hospitals, 65 percent for specialist physicians, 39 percent for primary care physicians, and 57 percent for insurers."[16]

> **"Reforms that reduce competition will only undermine the vibrancy of the healthcare markets and worsen the cost and quality problems afflicting the U.S. healthcare system.**

Hospital consolidation has consequences. As Gaynor (2019) documents, the studies examining the impact of hospital mergers "in different places in different time periods" found that reduced competition leads to substantial prices increases.[17] Price increases "on the order of 20 or 30 percent are common, with some increases as high as 65 percent."[18]

A 2022 review of the literature by Rand found "strong evidence that hospital horizontal consolidation is associated with higher prices paid to providers and some evidence of the same for vertical consolidation of hospitals and physician practices. Health care spending is likely to increase in tandem with these price increases."[19]

A study by Cooper et. al. (2019) found that "prices at monopoly hospitals are 12% higher than those in markets with four or more rivals."[20] The authors also examined "the 366 mergers and acquisitions that occurred between 2007 and 2011" finding "that prices increased by over 6% when the merging hospitals were geographically close (e.g., 5 miles or less apart), but not when the hospitals were geographically distant (e.g., over 25 miles apart)."

As the Rand study concluded, a similar dynamic holds for physicians – as the competitiveness of the physicians' market decreases overall healthcare costs increase. Koch and Ulrich (2020), examined the impact from a merger of orthopedic physicians in Pennsylvania, finding that due to the merger's adverse impact on the competitive environment, prices paid by insurers increased by as much as 10 percent to 20 percent while prices were unchanged in the control group.[21]

A 2025 NBER Working Paper examined the impact on prices when hospitals acquire physicians' practices. Their study, which focused "on childbirths, the most ubiquitous admission among the privately insured," found that "on average, these mergers led to price increases for hospitals and physicians of 3.3 percent and 15.1 percent, respectively."[22]

"These studies confirm that competition matters in healthcare - the more competitive the market, the lower prices are."

A 2022 analysis published in JAMA Network similarly found that declining competition raises overall healthcare costs.[23] The authors found that relative to independent primary care physicians, the costs for office care visits were 11 percent higher at primary care physician offices that are associated with hospital systems. These findings are troubling as nearly one-half of all primary care physicians are now affiliated with a hospital system.

These studies confirm that competition matters in healthcare – the more competitive the market, the lower prices are. Less competition does not just raise costs either; it may also be associated with lower quality of care – although the evidence is more mixed. A study from 2000 found that "patients in the least competitive fourth of hospital markets experienced approximately 1.5 percentage points higher mortality after heart attacks than those in the most competitive areas."[24]

A more recent study in 2020 similarly found a decline in quality following a decline in the competitive market – in this case, patient experiences modestly declined in those hospitals that were acquired by other hospitals but there were no detectable changes in readmission or mortality rates.[25]

The negative impacts from suppressing competition are not confined to the delivery of healthcare. Uncompetitive markets also raise the costs of health insurance, as distinct from the delivery of care. And there is little doubt that the health insurance markets are becoming more concentrated.

A 2024 analysis by the American Medical Association (AMA) examined the concentration of health insurance markets by locality, finding

> *that the vast majority of U.S. health insurance markets are highly concentrated. In fact, health insurance markets have remained stubbornly highly concentrated over time, with the vast majority of them being so in the last 10 years. The share of commercial markets that are highly concentrated was 95 percent in both 2014 and 2023 and hovered between 95 percent and 96 percent over that 10-year period.*[26]

The Government Accountability Office (GAO) concurs with the AMA's assessment finding that "market concentration generally increased from 2011 through 2022, with three or fewer insurers holding at least 80 percent of the market share for the individual and employer group markets in at least 35 states."[27]

The growing concentration is disconcerting due to the strong empirical connection between declining competition in health insurance markets and rising premiums. For example, Guardado et al. (2013) evaluated the impact on premiums following a larger merger of health insurers in Nevada. The authors concluded "that premiums in Nevada markets increased by 13.7 percent after the merger relative to the control group. Our findings suggest that the merging parties exploited the market power gained from the merger."[28]

Two studies published in the *American Economic Review* journal also confirm that there are important cost benefits from encouraging a more competitive health insurance market. Dafny (2010) found evidence that the local markets with the most market concentration (e.g., they have the lowest amount of competition) experienced greater premium increases than the markets with greater competition.[29] Dafny, Duggan, and Ramanarayanan (2012) directly examined the connection between premium costs and market concentration finding that the average premiums were significantly higher in the markets with less competition.[30]

> "The number of counties with robust competition in the exchanges has been declining, raising costs and lowering the quality of health insurance."

The aforementioned Rand (2022) study also examined the impact of declining competition in the health insurance market. While noting that there is less direct evidence, the authors found that "in existing studies, horizontal consolidation of commercial insurers is associated with lower prices paid to providers as insurers gain market power in negotiations with providers. However, the lower prices paid to providers do not appear to be passed onto consumers, who face higher premiums following insurer consolidation."[31] This finding is noteworthy. Less competition in the health insurance market is associated with both less compensation for providers and higher premium costs for beneficiaries.

Insurance plans acquired through the Affordable Care Act marketplace are not exempt from these trends. The number of counties with robust competition in the exchanges has been declining, raising costs and lowering the value of health insurance.[32]

The same trends are also impacting Medicare Advantage. A Kaiser Family Foundation study that examined the competitiveness of Medicare Advantage found that "most (89 percent) Medicare Advantage enrollees were in highly concentrated markets, with another 4 percent of Medicare Advantage enrollees in very highly concentrated markets."[33] Less competition in Medicare Advantage diminishes cost-containing incentives and raises concerns that premiums will rise.

The Bias Against Competition Encourages Bad Policy

That less competition worsens outcomes should be unsurprising. Unfortunately, the idea that less competition can improve outcomes is encouraging harmful policies. California's recent actions with respect to CalAIM and the dual-eligible population (patients eligible for both Medicare and Medicaid – which is called Medi-Cal in California) exemplify what's at stake.

According to the state, "California Advancing and Innovating Medi-Cal (CalAIM) is a far-reaching, multi-year plan to transform California's Medi-Cal program and to make it integrate more seamlessly with other

social services. The goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, especially those with the most complex needs."[34] A worthy goal.

The problem arises, however, because the Department of Health Care Services (DHCS) decided that limiting the commercial plan choice for the dual-eligible population would simplify the contracting process and save money.

Dual-eligible beneficiaries are patients who qualify for both Medicare (because they are over age 65 or have a qualified disability) and Medicaid (because they are lower-income). Generally speaking, Medicare covers the healthcare expenses such as physicians, hospitals, labs, and drugs. Medi-Cal covers the other expenses including Medicare Part B premiums, copays, adult day health care, skilled nursing facility care, dental, and in home supportive services. California's total estimated dual-eligible population is approximately 1.7 million people.[35]

Unsurprisingly, the dual-eligible population is particularly vulnerable and can often have complex medical needs. To streamline and improve the coordination across these benefits, CalAIM established health plans that private insurers and public-private partnerships could provide that coordinated care across Medicare and Medi-Cal (i.e., Medi-Medi Plans). Medi-Medi plans are a type of Medicare Advantage plan exclusively available to dual-eligibles. Medicare Advantage plans are a popular private health insurance alternative for seniors who choose to receive their benefits from a private health insurer rather than the traditional fee for service model run by the federal government. Medicare Advantage plans are widely viewed as a successful (yet still flawed) option that improves Medicare's outcomes.

"To realize more savings for the state, California should be promoting greater consumer choice and competition in CalAIM's dual-eligible program – encouraging more private plans to compete in each county.

Beginning in 2026, Medicare Advantage plans that are currently providing high quality care to these low-income seniors are prohibited from enrolling additional members because DHCS has limited competition to one commercial health plan option per county and that plan must have a previous Medi-Cal contract. This decision is clearly based on the flawed theory that reducing the number of health insurer competitors will lead to reduced administrative costs and will not put upward pressure on overall costs.

To realize more savings for the state, California should be promoting greater consumer choice and competition in CalAIM's dual-eligible program – encouraging more private plans to compete in each county. Encouraging greater competition is not difficult either because the more stringent rules are not simply blocking out theoretical competitors. These new rules are actively obstructing organizations that are currently serving dual-eligible beneficiaries from serving new regions or expanding the beneficiaries they are currently serving.

For example, Kaiser Permanente and Alameda Alliance for Health are the only two plans allowed to serve Medi-Medi patients in Alameda County. In Orange County, the two authorized Medi-Medi plans are CalOptima and Kaiser Permanente. In Butte County, only one plan – Partnership HealthPlan – is available to patients with Medi-Medi plans.

Consequently, patients in these counties cannot receive plans from insurers that already serve the dual eligible population in California including Alignment Health Plan, Central Health, SCAN, and United Healthcare. The exclusion of Alignment Health and SCAN are noteworthy as these smaller competitors were widely praised in a July 2025 congressional hearing "for focusing on quality and value".[36] They are also already serving a significant share of the 300,000 dual-eligibles enrolled in California's Medi-Medi plans.[37]

Several problems are likely to arise to the detriment of this vulnerable population because California is reducing competition. Most directly, the state is prohibiting service from Medicare Advantage health plans that are successfully serving the population. Given that a large share of the current Medi-Medi population choose providers that will now be prohibited from expanding their services, patients are being denied a preferred insurance provider.

Based on the research reviewed above, the reduction in insurance competition will also lead to higher costs. These higher costs will ultimately increase total state expenditures or reduce the available services that the dual-eligible population can receive. Either way, the environment is worsened because of the rule change.

Rather than actively discouraging more rigorous competition, the better solution is to allow innovative, specialized plans to be awarded a state Medicaid contract so they can continue to enroll and provide services to more dual-eligible beneficiaries.

Conclusion and Policy Implications

Proponents of narrow networks and single payer healthcare argue that cutting out competitors generates savings by eliminating profits and slashing administrative costs. Additionally, these cost reductions will, allegedly, generate large systemic healthcare savings without lowering the quality of care that patients receive.

These claims are simply inconsistent with experience. Competition is just as beneficial to the healthcare and health insurance markets as it is to other markets – it incentivizes greater efficiencies and innovations that can improve healthcare affordability and quality. And the empirical data demonstrate that, whether it is physicians, hospitals, or health insurers, systemic costs have significantly increased when market competitiveness has declined. This increase in costs from declining competition is disconcerting given the trend toward greater consolidation that has been occurring across the entire healthcare system.

> **“ Policymakers at the state and federal level should focus on repealing the rules and regulations that encourage consolidation.**

In response to these trends, policymakers at the state and federal level should focus on repealing the rules and regulations that encourage consolidation. For example, California’s decision to limit competition in their Medi-Medi plans is counterproductive. Policymakers should remove these restrictions and instead encourage more providers to compete to serve Medi-Medi beneficiaries.

At the federal level, overly burdensome regulations are punishing smaller providers and insurers and encouraging consolidation. These burdens include the excessive administrative costs independent providers must manage and the monetary disincentives created by federal government programs.[38] Removing these federally created disincentives will help reinvigorate the declining competitive environment.

More broadly, as Gaylor (2019) noted in his congressional testimony, “the health care system will only work as well as the markets that underpin it.” Markets work best when policies incentivize competition. Competitive markets incentivize innovations and efficiencies that improve quality while simultaneously promoting greater affordability – the ultimate goal for the healthcare sector.

Endnotes

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Wayne H. Winegarden, Ph.D. is a Senior Fellow in Business and Economics at the Pacific Research Institute and director of PRI's Center for Medical Economics and Innovation. He is also the Principal of Capitol Economic Advisors.

Dr. Winegarden has 25 years of business, economic, and policy experience with an expertise in applying quantitative and macroeconomic analyses to create greater insights on corporate strategy, public policy, and strategic planning. He advises clients on the economic, business, and investment implications from changes in broader macroeconomic trends and government policies. Clients have included Fortune 500 companies, financial organizations, small businesses, state legislative leaders, political candidates and trade associations.

Dr. Winegarden's columns have been published in the *Wall Street Journal, Chicago Tribune, Investor's Business Daily,* Forbes.com, and Townhall.com. He was previously economics faculty at Marymount University, has testified before the U.S. Congress, has been interviewed and quoted in such media as CNN and Bloomberg Radio, and is asked to present his research findings at policy conferences and meetings. Previously, Dr. Winegarden worked as a business economist in Hong Kong and New York City; and a policy economist for policy and trade associations in Washington D.C. Dr. Winegarden received his Ph.D. in Economics from George Mason University.

About PRI

The Pacific Research Institute (PRI) champions freedom, opportunity, and personal responsibility by advancing free-market policy solutions. It provides practical solutions for the policy issues that impact the daily lives of all Americans, and demonstrates why the free market is more effective than the government at providing the important results we all seek: good schools, quality health care, a clean environment, and a robust economy.

Founded in 1979 and based in San Francisco, PRI is a non-profit, non-partisan organization supported by private contributions. Its activities include publications, public events, media commentary, community leadership, legislative testimony, and academic outreach.

Center for Business and Economics

PRI shows how the entrepreneurial spirit—the engine of economic growth and opportunity—is stifled by onerous taxes, regulations, and lawsuits. It advances policy reforms that promote a robust economy, consumer choice, and innovation.

Center for Education

PRI works to restore to all parents the basic right to choose the best educational opportunities for their children. Through research and grassroots outreach, PRI promotes parental choice in education, high academic standards, teacher quality, charter schools, and school-finance reform.

Center for the Environment

PRI reveals the dramatic and long-term trend toward a cleaner, healthier environment. It also examines and promotes the essential ingredients for abundant resources and environmental quality: property rights, markets, local action, and private initiative.

Center for Health Care

PRI demonstrates why a single-payer Canadian model would be detrimental to the health care of all Americans. It proposes market-based reforms that would improve affordability, access, quality, and consumer choice.

Center for California Reform

The Center for California Reform seeks to reinvigorate California's entrepreneurial self-reliant traditions. It champions solutions in education, business, and the environment that work to advance prosperity and opportunity for all the state's residents.

Center for Medical Economics and Innovation

The Center for Medical Economics and Innovation aims to educate policymakers, regulators, health care professionals, the media, and the public on the critical role that new technologies play in improving health and accelerating economic growth.

Free Cities Center

The Free Cities Center cultivates innovative ideas to improve our cities and urban life based around freedom and property rights—not government.

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