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Banning Anticompetitive Contracts to Lower Health Care Costs

October 22, 2026

Health Savers Initiative

Over the next decade, the federal government is projected to spend \$25 trillion on health care while forgoing an additional \$7 trillion in employer sponsored health insurance-related tax breaks.¹ National Health Expenditures (NHE) are estimated to total \$6 trillion (19% of GDP) this year and grow to \$9 trillion (21% of GDP) by 2034.² One driver of rising health care costs is provider consolidation: mergers and acquisitions of providers into larger hospital systems. Consolidation drives up costs through many mechanisms, one of which is the use of “anticompetitive contracts.”

Anticompetitive contracts are agreements whereby dominant hospital systems or provider networks restrict the ability of insurers or purchasers to seek better prices as a condition of participation with an insurer, or vice-versa.³ Specifically, hospital systems may require insurers to contract with all affiliated providers if they want to contract with any affiliated providers or prevent insurers from steering patients to lower-cost care, while insurers may forbid providers from offering lower prices to other insurers.

Consolidated hospital systems and provider networks leverage anticompetitive contracts to reduce price pressure that may otherwise come from competition or insurers’ use of their negotiating power. These contracts increase health care prices, but do not appear to improve the quality of care.⁴

Much can be done to improve competition. One small step would involve banning anticompetitive contract provisions in health care systems. Banning anticompetitive contracting, in combination with other reforms such as improved [price transparency](#), [capping hospital prices](#), stronger antitrust enforcement, limits on provider non-compete clauses, [site-neutral payments in Medicare](#) and the [commercial market](#), could lower health care costs, reduce premiums, and lower federal deficits. Even on its own, a ban could help modestly lower costs for beneficiaries and the federal government.

Over the next decade (2027-2036), banning anticompetitive contracts could:

- Lower employer sponsored insurance premiums by **0.1%**
- Reduce National Health Expenditures (NHE) by roughly **\$25 billion**
- Reduce the federal deficit by **\$7 billion**

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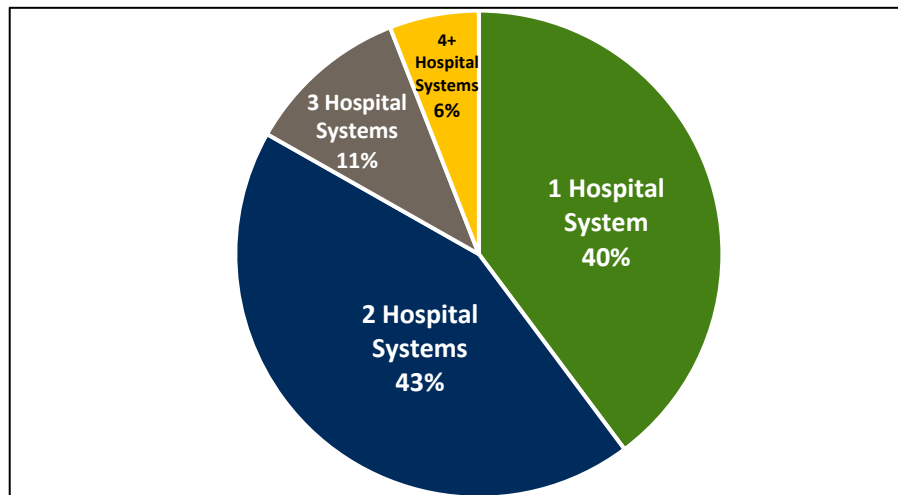
The Health Savers Initiative is a project of the Committee for a Responsible Federal Budget, Arnold Ventures, and West Health, which works to identify bold and concrete policy options to make health care more affordable for the federal government, businesses, and households. This brief presents options meant to be just some of many, but incorporates specifications and savings estimates so policymakers can weigh costs and benefits and gain a better understanding of whatever health savings policies they choose to pursue.



Health Care Consolidation Has Increased Prices

The health care landscape in the United States has become increasingly concentrated and consolidated in recent decades, as larger providers buy up smaller practices to form conglomerates known as hospital systems or health systems. For example, 83% of health care markets are highly concentrated – one or two hospital systems control three-quarters of the market or more.⁵ In 2010, 56% of hospitals were owned by a larger health system; by 2024, that increased to 69%, with a higher concentration of health system ownership in urban areas versus rural areas.⁶ And between 2012 and 2024, the share of physicians in private practice fell from 60% to just 42%.⁷

Fig. 1: One or Two Hospital Systems Control Over 75% of Metro Inpatient Hospital Markets



Source: KFF.

The more consolidated a hospital system becomes, the more it can leverage market power to increase prices without fear of competition. Studies on consolidation found that highly concentrated markets can raise prices from 6% to 65% compared to non-consolidated areas.⁸ Although there was some early optimism that mergers would improve health care quality and care coordination, this has not borne out in the data.^{9,10} Similarly, insurers have become increasingly consolidated. The U.S. Government Accountability Office found that from 2011 through 2019, there were 12 states with enrollment concentrated to a single insurer in 80% of cases, before declining slightly through 2024.¹¹

To address consolidation, both the Federal Trade Commission (FTC) and the Department of Justice (DOJ) have authority to block certain types of anticompetitive behaviors and monopoly formation to prevent market concentration.¹² However, the federal government has largely failed to block or reverse mergers and acquisitions. Over the past two decades, the FTC has only prevented 13 out of 1,300 hospital mergers – just 0.1%.¹³

As consolidation drives up prices insurers or other purchasers pay, they pass those costs along to consumers in the form of higher premiums and out-of-pocket spending. Insurance costs are then passed on to the U.S. Treasury through the tax code – which exempts compensation in the form of health care premiums from the income tax – among other health-related tax breaks. Higher commercial prices can also increase the cost of the [Federal Employees Health Benefits program](#), exchanges, Medicare, Medicaid, and other federal programs.¹⁴



Anticompetitive Contracts Strengthen Monopoly-Like Power and Boost Prices

In a competitive market, insurers use different strategies to keep provider prices in check. For example, insurers might offer lower cost sharing for lower-cost providers, exclude high-cost providers from their network, or steer patients towards lower-cost providers and treatments. These strategies reduce costs both by driving patients away from high-cost providers and by increasing insurers' leverage to negotiate lower prices.

These tools become less effective in consolidated markets, especially when hospital systems use anticompetitive contracts. Large hospital systems can leverage their market power and "must have" provider status in insurers' networks to secure contractual provisions that restrict insurers from using these cost-containment strategies against affiliated providers. In some markets, the opposite dynamic occurs, and dominant insurers use their market power to limit providers' ability to compete on price by offering lower prices to any other insurer.

Anticompetitive contracts can take several different forms, including:

All-or-Nothing Contracts: While insurers typically pick and choose which providers to include in a network to contain costs, all-or-nothing clauses require insurers to contract with *all* facilities in a health system if they want to include *any* facilities in the plan. For example, an all-or-nothing contract could mandate that all health system outpatient departments be in-network even if those outpatient departments offer higher cost, lower quality care. If an insurer walks away from this type of contract, they would lose "must have" large hospitals, making their network unattractive to members, or cause the insurer to fall out of compliance with requirements ensuring access to care, called "network adequacy" requirements.

Anti-Tiering and Anti-Steering Contracts: Insurers often place providers into different "tiers," with the top tier designated for providers who deliver the lowest price and highest quality care. Insurers then encourage or "steer" enrollees towards providers in the top tier by offering lower cost sharing, and away from lower tier providers by imposing higher cost-sharing. Under anti-tiering clauses, hospital systems can require that all their providers are placed in the top tier with the lowest cost sharing option. Under anti-steering contracts, insurers are unable to utilize lower cost sharing to drive members towards lower cost options.

Most Favored Nation (MFN) Contracts: MFN is an anticompetitive contracting tactic used by insurers when they have dominant market power in systems where providers also have significant market power, and which none-the-less can end up increasing provider prices. When insurers possess market power, they are able to demand lower prices from providers, but that only translates to lower premiums if there is competition in the market.¹⁵ Under these contracts, a hospital system must guarantee the insurer that they are contracting with them at the lowest price for a service that the hospital system offers to any insurer. Because large insurers are generally already the largest buyer in a market, the practical results of these contracts are usually to establish a price floor that increases the prices providers charge to other insurance companies.¹⁶



Some States Have Taken Steps to Address Anticompetitive Contracting

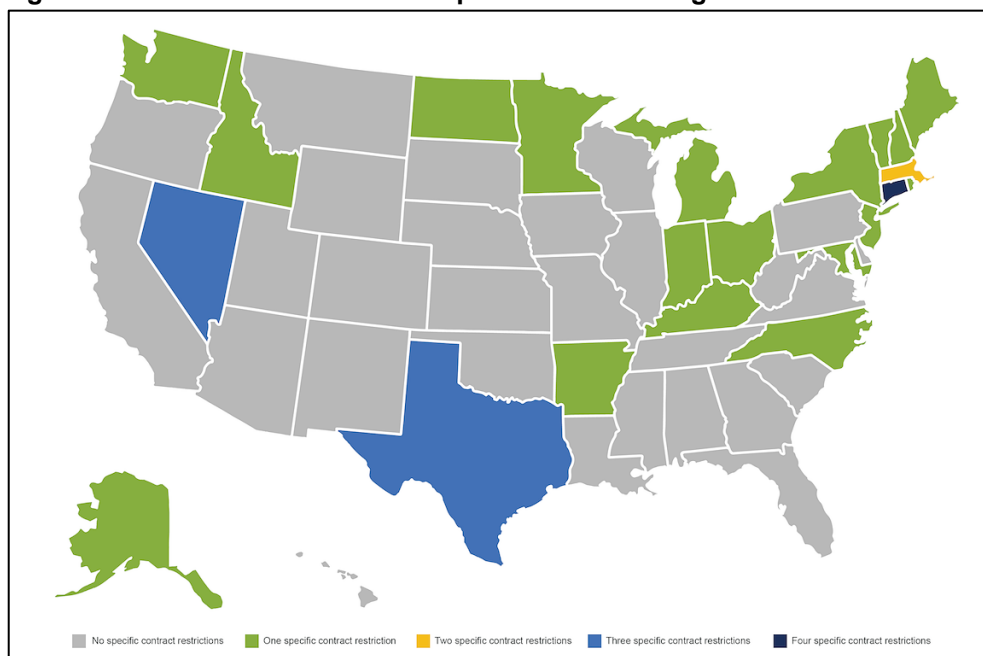
While the federal government has not enacted a broad statutory ban on anticompetitive provisions in plan-provider contracts, many states have taken action. As of 2025, 22 states have banned at least one form of anticompetitive contracts.¹⁷ Some states have banned multiple types of contracts – most significantly, Connecticut, Texas, and Nevada.

Since 2011, Connecticut has banned MFN contracts, adding a ban on anti-tiering, anti-steering, and all-or-nothing contracts in 2023.¹⁸ To date, Connecticut is the most restrictive state in the country on anticompetitive contracts.

Texas, meanwhile, has banned three out of the four contract provisions previously discussed, but still allows all-or-nothing contracts.¹⁹ Nevada passed a law in 2021 banning anti-tiering, anti-steering, and all-or-nothing contracts, but omitted MFN contracts from the ban.²⁰

Other states that have taken action against anticompetitive contracts have banned only MFN contracts. One state, Massachusetts, has banned two types of contracts: all-or-nothing and anti-tiering contracts. It is worth noting that states are not always successful at enforcing the restrictions put in place.

Fig. 2: States with Bans on Anticompetitive Contracting



Source: Georgetown University, Center on Health Insurance Reform.

While evidence is limited on how much each state has individually saved from banning these types of contracts, there is substantial evidence that these arrangements drive up costs. For example, in California, a hospital system with significant market power was able to utilize anticompetitive contracts to drive up inpatient hospital prices by 70% and outpatient prices by 17% to 55%.²¹



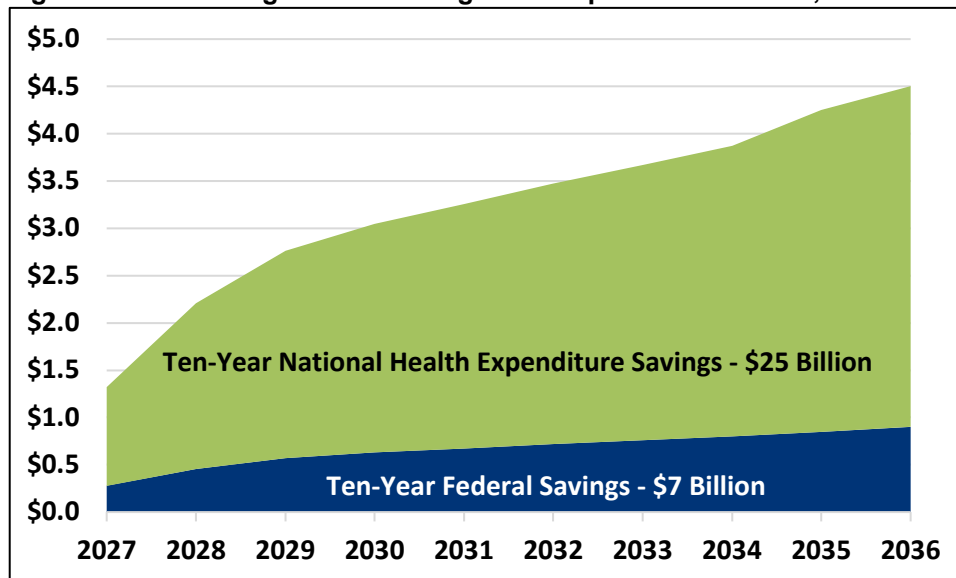
The Federal Government Could Ban Anticompetitive Contracts to Garner Savings

Federal limits on anticompetitive contracts could build on state efforts, lowering overall health care prices and reducing premiums and cost-sharing for employers and individuals. Because premiums are generally not taxed due to the Employer Sponsored Insurance (ESI) tax exclusion, lower premiums are likely to increase wages, leading to higher federal tax collections and lower deficits.

One legislative proposal, the “Healthy Competition for Better Care Act” (H.R. 6248) introduced by Representative Arrington (R-TX), would ban the use of all four types of anticompetitive contracts: all-or-nothing, anti-steering, anti-tiering, and MFN clauses.²² In 2024, the Congressional Budget Office (CBO) analyzed H.R. 3120 – the predecessor to H.R. 6248 containing similar provisions – and found that it would lower premiums by 0.1% and reduce the deficit by about \$5 billion through 2034, mainly due to higher tax collection.²³ The increased tax collection comes from employers shifting compensation to taxable wages and away from health care benefits.

Based on this information, we estimate that the proposal would reduce National Health Expenditures by **\$25 billion** from 2027 through 2036 while reducing deficits by approximately **\$7 billion**.^{24,25}

Fig. 3: Annual Savings from Banning Anticompetitive Contracts, in Billions



Source: Congressional Budget Office and Committee for a Responsible Federal Budget.

These savings are modest in part because many states already have or are expected to have their own bans, but also because the proposal would not reverse or prevent consolidation itself and only limits certain tools that come from monopoly-like power.²⁶ However, these bans could be coupled with other provisions to help empower the FTC and DOJ to prevent some consolidations, improve [price transparency](#), limit non-compete clauses for providers, and reduce incentives to consolidate – for example by [banning facility fees](#) and adopting [site-neutral payments](#) in Medicare, and [capping hospital prices](#).²⁷ CBO has estimated that a suite of policies to promote competition could lower prices by 1% to 3% – 10 to 30 times as much as banning anticompetitive contracts alone.²⁸



Conclusion

In recent decades, health care consolidation has allowed both providers and insurers to exercise significant market power through anticompetitive contracting practices. Such practices interfere with the market's ability to compete fairly based on price and quality. For example, when a clinic in a health system is guaranteed to be included in insurer networks through all-or-nothing clauses, that clinic loses its incentive to cut costs and attract consumers. Anticompetitive contracting not only drives up costs for individuals in the commercial market, but also for the federal government by shifting compensation to tax-free health care premiums rather than wages.

With National Health Expenditures and the national debt both near their all-time highs as a percentage of the economy and growing rapidly, lawmakers should consider all ideas to reduce federal health care spending – particularly policies that can lower cost without a meaningful impact on quality.

Although banning anticompetitive contracts would not fundamentally bend the health care cost curve, these reforms would represent an important step towards encouraging competition to lower costs and could be paired with additional reforms that could further drive down health care costs.



¹ Congressional Budget Office, “Federal Subsidies for Health Insurance Baseline,” February 2026, <https://www.cbo.gov/system/files/2026-02/51298-2026-02-healthinsurance.pdf>.

² Office of the Actuary, Centers for Medicare & Medicaid Services, “NHE Projections,” June 24, 2026, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>.

³ In this paper, we use “insurers” to refer collectively to insurance companies and organizations, as well as purchasers of health care services, such as large employers that self-insure.

⁴ Zachary Levinson, Jamie Godwin, Scott Hulver, Tricia Neuman, “Ten Things to Know About Consolidation in Health Care Provider Markets,” KFF, April 19, 2024, <https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/>.

⁵ Jamie Godwin, Zachary Levinson, Tricia Neuman, “One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2024,” KFF, 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/>.

⁶ Ibid.

⁷ Carol Kane, “Physician Practice Characteristics in 2024: Private Practices Account for Less than Half of Physicians in Most Specialties,” American Medical Association, <https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf>.

⁸ Government Accountability Office, “Health Care Consolidation: Published Estimates of the Extend and Effects of Physician Consolidation,” GAO-25-107450, September 22, 2025, <https://www.gao.gov/products/gao-25-107450>; Andrew Patzman, Manali Neeck, “Health Care Provider Consolidation,” Bipartisan Policy Center, January 29, 2026, <https://bipartisanpolicy.org/issue-brief/health-care-provider-consolidation/>.

⁹ Andrew Patzman, Manali Neeck, “Health Care Provider Consolidation,” Bipartisan Policy Center, January 29, 2026, <https://bipartisanpolicy.org/issue-brief/health-care-provider-consolidation/>.

¹⁰ A large study comparing consolidated hospitals to control hospitals showed no difference in readmission rates or mortality rates. Beaulieu, et al., “Changes in Quality of Care after Hospital Mergers and Acquisitions,” The New England Journal of Medicine, Volume 382, No. 1, January 1, 2020, <https://www.nejm.org/doi/full/10.1056/NEJMsa1901383>.

¹¹

This statistic refers to the large group market. Government Accountability Office, “Private Health Insurance: Market Concentration in 2024 Was Generally Higher Than in 2011,” October 16, 2026, <https://www.gao.gov/products/gao-27-108927>.

¹² Scott Hulver and Zachary Levinson, “Understanding the Role of the FTC, DOJ, and States in Challenging Anticompetitive Practices of Hospitals and Other Health Care Providers,” KFF, August 7, 2023, <https://www.kff.org/health-costs/understanding-the-role-of-the-ftc-doj-and-states-in-challenging-anticompetitive-practices-of-hospitals-and-other-health-care-providers/>.

¹³ In the 1990s, some believed that nonprofit hospitals would not engage in anticompetitive behavior to the same extent that for-profit entities. However, after evaluating one case in California, the FTC found that a nonprofit merger resulted in both higher prices and no improvement in quality of care. Michael Vita and Seth Sacher, “The Competitive Effects of Not-for-Profit Hospital Mergers, A Case Study,” Federal Trade Commission, May 1999, <https://www.ftc.gov/reports/competitive-effects-not-profit-hospital-mergers-case-study>; Zack Cooper, Andrea Harris, Mathilda Hill, “A Ranking of All 50 States By Hospital Consolidation,” Health Care Affordability Lab at Yale, March 9, 2023,



<https://www.healthcareaffordabilitylab.org/commentary-press-release-posts/a-ranking-of-all-50-states-by-hospital-consolidation>.

¹⁴ CBO, “The Prices That Commercial Health Insurers and Medicare Pay for Hospitals’ and Physicians’ Services,” January 2022, <https://www.cbo.gov/publication/57778>; Jakob Emrson, “Insurers Pay Higher Commercial Prices to Hospitals in their Medicare Advantage Network: Study,” Becker’s Payer Issues, May 12, 2025, <https://www.beckerspayer.com/payer/insurers-pay-higher-commercial-prices-to-hospitals-in-their-medicare-advantage-network-study/>.

¹⁵ Karyn Schwartz, Eric Lopez, Matthew Rae, Tricia Neuman, “What We Know About Provider Consolidation,” KFF, September 2, 2020, <https://www.kff.org/health-costs/what-we-know-about-provider-consolidation/>.

¹⁶ The Source on Healthcare Price and Competition, “Issue Brief: Most Favored Nations Clauses,” June 19, 2015, <https://sourceonhealthcare.org/issue-brief-most-favored-nation-clauses/>.

¹⁷ Georgetown University Center on Health Insurance Reforms, “Anti-Competitive Contract Restrictions,” October 2, 2025, <https://chir.georgetown.edu/state-oversight-of-hospitals/anti-competitive-contract-restrictions/>.

¹⁸ Connecticut State Assembly, “Substitute for H.B. No. 6669,” Session Year 2023, https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2023&bill_num=6669; <https://www.cga.ct.gov/2011/SUM/2011SUM00132-R02HB-06471-SUM.htm>.

¹⁹ Sabrina Corlette, Abigail Knapp, Stacey Pogue, “State Spotlight: Texas Confronts Anti-Competitive Tactics That Drive Up Health Care Costs,” Georgetown University Center on Health Insurance Reform, January 22, 2026, <https://chir.georgetown.edu/state-spotlight-texas-confronts-anti-competitive-tactics-that-drive-up-health-care-costs/>.

²⁰ Nevada Unfair Trade Practice Act, Chapter 598A, Contracts Involving Providers of Health Care, <https://www.leg.state.nv.us/nrs/NRS-598A.html>.

²¹ Johanna Butler, Katherine Gudiksen, Erin Fuse Brown, “Weighing Policy Trade-Offs: Overview of NASHP’s Model Prohibiting Anticompetitive Contracting,” National Academy for State Health Policy, September 29, 2022, <https://nashp.org/weighing-policy-trade-offs-overview-of-nashps-model-prohibiting-anticompetitive-contracting/>.

²² H.R. 6248, “Health Competition for Better Care Act,” 119th Congress, Introduced November 21, 2025, <https://www.congress.gov/bill/119th-congress/house-bill/6248>.

²³ Congressional Budget Office, “Cost Estimate: Health Care Legislation as Ordered Reported By House Committee on Education and the Workforce on September 11, 2024,” See H.R. 3120, November 12, 2024, https://www.cbo.gov/system/files/2024-11/hr3120_0.pdf.

²⁴ CBO also noted that the policy would reduce outlays for the Federal Employees Health Benefits Program.

²⁵ We based this estimate on CBO’s estimate of H.R. 3120 by projecting savings to 2036. These savings reflect employers shifting compensation to taxable wages and away from ESI premiums. Using a heuristic, we estimated the amount that such increased tax revenue would translate to reduced ESI premiums (that is, reduced NHE).

²⁶ Congressional Budget Office, “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services,” September 29, 2022, <https://www.cbo.gov/publication/58222>.

²⁷ S. 3822, “Break Up Big Medicine Act,” 119th Congress, Introduced February 10, 2026, <https://www.congress.gov/bill/119th-congress/senate-bill/3822/text>.

²⁸ Congressional Budget Office, “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services,” September 29, 2022, <https://www.cbo.gov/publication/58222>.