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Statement for Hearing on "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs"

Senate Finance Committee

June 8, 2023

Every American deserves access to affordable, high-quality health care. With this commitment, AHIP[1] thanks the Committee for its attention to the issue of consolidation in health care, and their goal of supporting competitive markets which are essential to improving affordability for patients.

Promoting Healthy Competition

The American health care system has been tested in extraordinary ways in recent years, and it has proved resilient and durable, thanks to unprecedented collaboration between the private sector and the government. Yet, Americans continue to see health care prices escalate year after year, a direct result of health system and drug manufacturer markets where there is little to no competition. In markets where competition exists – for example, when there are several, independent local hospitals, or low-cost generic drugs – private negotiations work to make health care more affordable, spur innovations such as value-based agreements and integrated care models, and provide Americans with more choices for their care. We support the bipartisan momentum of the Committee toward greater affordability and access through robust competition that is essential to providing Americans with more choices, better quality, and lower costs. We are committed to working with the Committee as well as other health care leaders to take decisive action to achieve these goals.

AHIP has developed detailed policy prescriptions to improve health care competition with the launch of our Healthier People through Healthier Markets initiative in 2022.[2] These proven solutions are based on four clear commitments to American families, communities, and businesses:

1. Improving patient choice.
2. Protecting patients, consumers, and businesses from overpaying for care.
3. Improving transparency.
4. Stopping drug pricing games.

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to committed to ensuring that Americans have access to affordable, comprehensive, high-quality, and equitable coverage and care.

[2] https://www.ahip.org/healthier-people-healthier-markets

To achieve those commitments, we encourage the Committee to consider our policy suggestions to hold consolidated health systems, short term-focused private equity funds, and the dialysis duopoly accountable for the role they play in limiting competition and driving up health care prices – which together threaten affordability and access for everyone.

Holding Consolidated Health Systems Accountable

Concentrated health systems stifle competition and limit the ability for health insurance providers to negotiate lower prices for patients. Growing research also consistently finds that the consolidation of health care providers into health systems with market power is a primary driver of the high costs of health care in the United States. [3] Numerous studies show that prices increase between 20% and 60% following the merger of two neighboring hospitals with no statistically significant impacts on quality.[4]

Additionally, some health systems leverage their significant market shares by requiring contracts with all affiliated facilities, which prevents the ability of health insurance providers to direct patients to alternative sites of care with lower-cost and higher-quality care. These anti-competitive contract terms, in the form of "anti-steering," "anti-tiering," and similar contract provisions, protect providers' highly-inflated costs – costs that all Americans pay through higher premiums and out-of-pocket costs.[5]

Market-based Solutions

Based on these trends, AHIP urges the Committee to consider the following:

1) Encourage the Federal Trade Commission (FTC) to take enforcement actions when such provider contract provisions violate antitrust laws.
2) Address anti-competitive contract terms, for example by enacting provisions such as those in S. 1451, the Healthy Competition for Better Care Act.[6] Any legislative solution should also recognize that there are beneficial forms of integration of provider and payer functions, which should be outside the scope of such legislation and instead should be fostered to promote efficient, high quality care models.

The Need for Transparency in Private Equity Acquisitions

By 2018, private equity represented 45% of health care mergers and acquisitions. [7] Evidence suggests that private equity firms' acquisition of providers in certain health care services, such as air ambulance, emergency room care, and some physician specialty markets, is undermining affordability, access, and choice for Americans.[8]

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[3] https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf
[4] https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf
[5] https://www.ahip.org/documents/202205-AHIP_HPHM-WhitePaper-v03.pdf
[6] https://www.congress.gov/bill/118th-congress/senate-bill/1451
[7] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769549
[8] https://www.ahip.org/documents/202205-AHIP_HPHM-WhitePaper-v03.pdf

When some private equity firms that are focused on short-term financial gains acquire control over a market's important specialties or ambulance providers, a common strategy is to exercise their power by refusing to participate in networks to demand higher prices from health insurance providers. For example, in a study published in *JAMA* of over 500 control hospitals, 204 private equity acquired hospitals showed an increase in $407 in total charge per inpatient day.[9] The outcome is drastically higher costs for the same care results in higher out-of-pocket costs and higher premiums for patients.

The changes made when short term-focused private equity firms acquire these types of practices are also leading to poorer patient outcomes. By contrast, in other more long-term-focused entities, decisions about staffing and other entities are guided by a goal of providing patients with care that is both high-quality and efficient. Unfortunately, private equity firms focused on short-term returns are more likely to reduce headcount and make other changes in a manner that does not consider the longer-term implications for patients.

Market-based Solutions

In light of the growing body of evidence that consolidation from certain short-term-focused private equity firms is forcing health care prices to rise and jeopardizing patient care, we suggest that the Committee:

1) Encourage the Department of Health and Human Services (HHS) to identify local markets for air or ground ambulance, emergency room physicians, or other specialties for which there is evidence of (1) high levels of concentration and (2) substantial backing by private equity firms. HHS should, as a condition of participation in Medicare, require hospitals in those local markets to report annually on any contracts with those private equity backed providers, including the type of compensation structure and any incentives.
2) Enact legislation to require public reporting of all private equity or hedge fund purchases of air or ground ambulance providers or facilities, emergency room physicians, and other specialty groups where there is evidence of high levels of concentration or low levels of network participation. Public reporting should include notification to existing patients and health insurance providers with existing contracts.
3) Direct the Government Accountability Office (GAO) and the FTC to conduct studies of the anti-competitive impacts of private equity and hedge fund acquisition of air or ground ambulance, emergency room physicians, and others as appearing to demonstrate high levels of concentration in a meaningful number of local markets.

Limiting Consolidation in Dialysis Markets

Limited competition in dialysis markets also contributes to rising health care costs. Two companies control nearly 75% of the market for dialysis services available to Medicare beneficiaries.[10] Medicare spends more than $130 billion on patients with kidney disease, which is more than 24% of total Medicare spending. Additionally, while patients with end-stage renal

[9] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769549
[10] https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0695

disease (ESRD) represent only 1% of Medicare beneficiaries, they account for 7% of Medicare spending.[11] Commercial markets also see the impacts from the dialysis duopoly, paying one of the two large dialysis providers an average of 4 times more per treatment than CMS did in 2017.[12]

Market-based Solutions

1) Take steps to improve and expand access to home dialysis, including by reintroducing the Improving Access to Home Dialysis Act.
2) Congress should avoid unnecessary legislation that would incentivize dialysis providers to increase charges to employers.

Advancing Site-Neutral Payments

Enacting site-neutral payments across outpatient sites of service can help drive improved affordability for everyone. Historically, Medicare has paid a higher amount for comparable services when performed in hospital outpatient departments versus physician offices. In addition to higher reimbursement rates, hospital-owned locations can charge a facility fee along with professional service fees for even low complexity services that can be safely performed at physician offices for a lower cost. Patients should not pay more for the same service furnished with the same quality of care simply because a hospital owns their physician's office.

Payment differentials across sites of service create two problems for the health care system. First, it results in increased costs to patients and their health insurance providers for individual services at the point of care. Second, the prospect of higher reimbursement rates paid to hospital-affiliated practices is seen as a contributing factor to consolidation, as hospitals have an economic incentive to purchase independent physician offices to receive higher rates at those locations.[13] Implementing site-neutral payments for outpatient care has the potential to drive savings across markets, drive affordability for consumers, and remove incentives to consolidate.

Market-based Solutions

Solutions that permit comparable payment for comparable services encourage an efficient and competitive market that works for patients and consumers, including:

1) Requiring separate national provider identifier enumeration for off-campus hospital outpatient departments to strengthen implementation of site neutral payment policies.
2) Removing the exception for grandfathered hospital-based locations such that these sites are subject to site neutral payments.
3) Prohibiting the assessment of facility fees for outpatient care that can be safely performed at physician offices unless a special exception applies.

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[11] https://www.kidney.org/advocacy/legislative-priorities/federal-investment#:~:text=The%20Medicare%20program%20spends%20more,on%20patients%20with%20kidney%20disease

[12] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2732689

[13] https://www.gao.gov/assets/gao-16-189.pdf; https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-3-hospital-inpatient-and-outpatient-services-march-2015-report-.pdf; https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

4) Narrowing the definition of free-standing emergency departments to those that provide most services on an unscheduled basis and requiring patient disclosure notices.

Conclusion

Every patient deserves access to the care they need at a cost they can afford. We commend the Committee for examining this important issue given the number of legislative and regulatory opportunities to improve competition in health care. Targeted efforts to increase health care competition and ensure site-neutral payments for physicians will drive more choices for patients and lower costs for health care services. We look forward to working with the Committee to find market-based solutions that lower health care prices for all Americans.