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CONSOLIDATION AND CORPORATE OWNERSHIP IN HEALTH CARE: TRENDS AND IMPACTS ON ACCESS, QUALITY, AND COSTS

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CONSOLIDATION AND CORPORATE OWNERSHIP IN HEALTH CARE: TRENDS AND IMPACTS ON ACCESS, QUALITY, AND COSTS

THURSDAY, JUNE 8, 2023

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Cantwell, Menendez, Carper, Brown, Bennet, Casey, Whitehouse, Hassan, Cortez Masto, Warren, Crapo, Grassley, Cornyn, Thune, Cassidy, Lankford, Young, Johnson, Tillis, and Blackburn.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Kripa Sreepada, Senior Health Advisor; and Tiffany Smith, Deputy Staff Director and Chief Counsel. Republican staff: Kellie McConnell, Health Policy Director; Gregg Richard, Staff Director; and Conor Sheehey, Senior Health Policy Advisor.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order.

This morning, we will be discussing corporatization and consolidation in the health-care system and the effect that it has on what American families pay, and how they get their care.

I have town hall meetings in all of my counties. I have had something like 1,050 of them so far. And the two challenges I hear constantly are: health care is too expensive, and it is just frigging impossible to understand all the word salad—you know, all the acronyms and all the confusion.

So, as the committee responsible for much of Federal health policy, including Medicare and Medicaid, the Finance Committee has a responsibility to identify the financial incentives that lead to increased corporatization in America's health-care system.

It is increasingly clear that these trends are increasing costs, in many cases without improving the quality of care that families and taxpayers pay for. Now, before we dive in, I am going to take just a couple of minutes and try to sort through some of the, as I call it, word salad that is relevant here.

So, people are going to hear a lot about something called vertical consolidation. Vertical consolidation is when one company buys an-

other company that operates in a different part of the health-care supply chain. For example, if a pharmacy benefit manager owns an insurance company and a chain of pharmacies, or if an insurance company buys up primary care physician practices, that is vertical consolidation.

The other side of the coin is horizontal consolidation, which occurs when one company buys another company that operates in the same part of the health-care supply chain. Let me also say this with respect to private equity—and we are going to be talking about that as well—private equity typically entails a group of investors buying a stake in a company in order to increase its financial value, by restructuring or changing the business practices of the target company.

So what we are going to do today is sort through what all this means for typical families who pay bills, and we are holding this hearing to examine whether these practices are hot-wiring our health-care system to favor mega-corporations at the expense of the patients and taxpayers. So, with those terms in mind, let me touch briefly on some examples of some of the practices that I have just mentioned.

A number of our colleagues on both sides of the aisle, Democratic Senators, Republican Senators, have been concerned about pharmacy benefit managers. Two months ago the Finance Committee held a hearing and came to the overwhelming conclusion that PBM business practices are driving up the cost of prescription drugs.

Since that time, Ranking Member Crapo and I and the members of this committee have been working in a bipartisan way to take on some of the key challenges facing consumers and taxpayers. When it comes to the PBMs, we are going to have more to say about it in the coming weeks, and it will be bipartisan.

I am going to put my full remarks about PBMs in the record. But I am just going to say as we move on to the other issues, pharmacy benefit managers are in a lot of ways Exhibit A for the consequences of consolidation in the health-care system.

In the 1990s, there were over 40 PBMs. In the last 2 decades, they have been slowly rolled up into mega-PBMs, and today the three largest PBMs now control more than 80 percent of claims for prescription drugs, and they are all among the top 15 largest companies.

As I said, I am going to put my full remarks in the record. But this is something that has hit my rural communities like a wrecking ball, and we are going to have to deal with it.

We also talked briefly about health-care costs and quality. Advocates for proposed mergers often say that they are going to lower health-care costs due to increased efficiency.

Time after time, it has simply not proven to be the case. When hospitals merge, the prices go up, not down. When insurers merge, premiums go up, not down. Quality of care is not any better with these higher costs. A deeply troubling study from last fall showed that medication adherence significantly decreased among communities of color and the elderly if they visited a primary care provider that was run by a hospital system, rather than an independent physician.

So the consequences of increased consolidation are just beginning to be understood, and there are going to be more to come. I will just make it clear—and again, I am going to be talking more about this—that I am increasingly concerned by the potential for abuse when it comes to the use of algorithms in American health care.

There already have been numerous reports of questionable claim denials by insurance companies using technology. Trends like these are going to require vigorous oversight.

Closing this morning, in terms of my opener, let me talk about private equity ownership. When a private equity firm buys out a nursing home, a physician group, a hospice agency, or any other part of health care, their goal is to restructure the business and sell it for a profit in a few years. The most straightforward way to do that is to increase prices and reduce costs, not exactly a winning proposition for patients or health-care workers.

Here is an example. A private equity firm bought up ManorCare. At the time, that was the second largest health-care provider in the country. The firm sold ManorCare's properties to a real estate company, which began charging rent to the nursing homes. These facilities just could not keep up, which led to a spiral of layoffs, health code violations, and closures.

Eventually ManorCare went bankrupt, but not before thousands of Americans lost their jobs or suffered in poor living conditions. And, what a surprise—something that I am sure everybody is going to be flabbergasted by—the private equity firm made a profit on their purchase. They make profits, they move on, and there is a trail of devastation left behind.

So, these are a few of the examples that we are looking at. I particularly want to thank Senator Crapo. He and I have been working on these health-care issues in a bipartisan way for years and years. We often say that this is all about increasing competition and choices. And, given the fact we are spending more than $4 trillion a year on American health care, the American people and taxpayers deserve it.

So, Senator Crapo, thank you for your cooperation on all of these matters. This is another area where we can work in a bipartisan way, and I look forward to your statement.

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Mr. Chairman, and I appreciate you holding this very important hearing.

Competition has the potential to drive down costs, improve quality, and increase options for consumers. In recent years, entrepreneurs and innovators have introduced new health-care products, services, and delivery models that have transformed the treatment landscape and revitalized our pursuit of these ideals.

Unfortunately, regulatory hurdles and other problematic policies have constrained our system's capacity to produce better and more affordable health-care results for Americans. Of particular note today, given our committee's jurisdiction, certain features of the

Medicare program have exacerbated rather than resolved these challenges.

In exploring and addressing these problems, we have the opportunity to build on our efforts to improve medication access and affordability by taking a broader look at the health-care system through similarly bipartisan consensus-building lenses. We will need to examine the drivers of consolidation, as well as its effects on care quality and costs, both for patients and for taxpayers.

We also need to develop focused bipartisan, bicameral solutions that reduce out-of-pocket spending while protecting access to life-saving services. This effort is particularly important for rural communities that already face overwhelming barriers to care. As we move forward with these goals, I see substantial opportunities for common-sense, comprehensive, and carefully tailored policies that prioritize patients from all walks of life.

Our work should acknowledge the complexity of the challenges at hand, as well as the risk of unintended consequences. Any legislation should also address the full scope of the challenge. An ad hoc, one-off approach to issues this significant, where trade-offs are inevitable, could harm rather than improve our health-care system.

As we look to strike a productive balance, we should consider not just consolidation but also quality, access, and innovation. To that end, hospitals will serve as a vital lifeline for communities across the country. Alignment of payment rates for certain services could provide patients with flexibilities and lower costs, in addition to advancing competition.

However, it is essential that any reforms preserve patient safety and bolster consumer access, especially in rural areas that are still reeling from hospital closures. Heavy-handed policies, regardless of the good intentions behind them, risk fueling rather than mitigating market concentration concerns. Efforts to curb consolidation must also address our unsustainable Medicare physician patient system, which has prompted waves of retirements and made independent practice untenable for far too many frontier providers.

Doctors, nurses, and other health professionals need predictability and sustainability. The trend of uncertain, 11th-hour stopgap measures accelerates untimely acquisitions, even for those who would prefer to remain in private practice. Savings from targeted site-of-care reforms could help to fund long-term improvements without driving up the deficit.

Expanding access to care also requires responsible regulatory relief. At the end of last year, my colleagues and I developed legislation to extend crucial critical flexibilities for seniors. These flexibilities ranged from comprehensive telehealth coverage to Hospital at Home.

These pivotal provisions have created a bridge through the end of next year, but without concerted congressional efforts, Medicare beneficiaries will face a cliff once these policies expire. Fortunately, all of these priorities enjoy broad bipartisan, bicameral support. Taken together, they reflect an opportunity for game-changing Medicare reform, with the potential to lower health-care costs, increase access, and enhance competition, benefiting patients and taxpayers alike.

Along with our mental health legislation, much of which was signed into law last year, as well as our work on the prescription drug supply chain, these conversations could create foundations for another effective, consensus-driven, and consumer-focused Finance Committee effort.

I look forward to today's discussion, and I thank our witnesses for being here today.

Thank you, Mr. Chairman.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. I thank my colleague and look forward to working with him.

We have some introductions to do. Dr. Zack Cooper is with us, an associate professor of public health at Yale. He has done extensive research focused on competition in hospital and insurance markets. He has published work in the *Quarterly Journal of Economics* and the *New England Journal of Medicine,* and he received his undergraduate degree from the University of Chicago and his Ph.D. from the London School of Economics.

Let the record show that he is also a professional colleague of Ms. Liz Jurinka, and Ms. Jurinka was the point person for this committee for a number of years on some of our key and bipartisan health-care initiatives.

For our new colleagues, one of the areas, and Senator Crapo remembers, that Chairman Hatch—and we so admired him—felt strongly about was updating the Medicare guarantee, because Medicare is no longer primarily an acute care program. It is a chronic care program, and Liz and colleagues on both sides of the aisle moved to update the Medicare guarantee for the 21st century. So we appreciate your being here, and her as well.

Shawn Martin is here. He is executive vice president and chief executive officer for the American Academy of Family Physicians. All of us here have valued the opportunity to work with you all, and we look forward to your input.

Dr. Karen Joynt Maddox will be our third witness. She is a practicing cardiologist at Barnes-Jewish Hospital, and associate professor at Washington University in St. Louis. My father at one time was on the staff of the *St. Louis Post-Dispatch,* so we welcome you.

Chris Thomas is here, and I think Senator Bennet will introduce Chris.

Senator BENNET. Thank you, Mr. Chairman.

Chris Thomas is the chief executive officer of Community Hospital in Grand Junction, one of the last independent hospitals in Colorado. As the health-care industry continues to consolidate hospitals in large health-care systems, under Chris's leadership, Community Hospital has stayed independent, fostering competition, lowering health-care costs, and improving quality of care for patients. During Chris's tenure as CEO, he has helped Community Hospital recruit nearly 50 new physicians in just 3 years, open a cardiovascular procedures center, and break ground on a regional cancer facility.

At the center of his work, Chris brings members of the community together. To help meet their needs to address the health-care workforce shortage crisis, I would say, on the west slope of Colo-

rado, Chris worked with Colorado Mesa University to expand its health education programs. He worked with the town of Palisade to open a new clinic, an acute care center in a community that has been in a health-care desert for decades.

Over the last 2 years, I have worked with Chris and Community Hospital to help secure funding for the Palisade clinic as well as a child-care center, to help the hospital retain its employees in the wake of the pandemic.

Chris has helped expand access to care and improve quality of life on the west slope of Colorado. But if we want independent hospitals like Community to survive, Congress has to do more to support them.

Chris has over 20 years of experience working in the health-care industry, both as an executive in a large health system and a small independent hospital. His perspective, I think, Mr. Chairman, will be invaluable for today's discussion.

I thank him for being here, and thank you, Mr. Chairman, for inviting him to be with us today.

The CHAIRMAN. Great.

Mr. Thomas, you know, when I played basketball, my mom would come to the games, and when the game was over, she would say, "I know you are going out with your friends. Make sure you are running with the right crowd." To have Senator Bennet and having him praise you this way, you are running with the right crowd. We welcome you.

Okay. Caroline Pearson is here, executive director of the Peterson Center on Healthcare. We have worked often with you and Michael Peterson and others on a variety of issues, particularly relating to innovation and competition. So we are glad that you could be here.

You are the senior vice president. You were previously the senior vice president for health care strategy at the University of Chicago, a nonpartisan health care research organization—the health care strategy at NORC, I guess would be typically the name. And your work has focused on passage and implementation of the Affordable Care Act and ensuring prescription drug access.

So we welcome you and note that you are a graduate from Harvard, with a BA in government. So, we have a terrific panel.

Let's start with you, Dr. Cooper.

STATEMENT OF ZACK COOPER, Ph.D., ASSOCIATE PROFESSOR OF PUBLIC HEALTH AND ASSOCIATE PROFESSOR OF ECONOMICS, YALE UNIVERSITY, NEW HAVEN, CT

Dr. COOPER. Thank you, Chairman Wyden, Ranking Member Crapo, and members of the committee. Thank you for holding this hearing, and thank you for giving me the opportunity to testify.

I chose to become a health economist because I wanted to engage with a sector of the economy that people engage with at their most vulnerable. And these days I am focusing my work on exploring how the U.S. health-care system impacts employment and economic opportunity for those working outside the health-care sector.

I am concerned. Over the last 2 decades, insurance premiums in the U.S. have gone up over 215 percent. This is markedly faster

than growth in median household income, and this is important for two reasons, particularly for this hearing.

The first is that provider consolidation is one of the leading drivers of health spending and health insurance premium growth right now. The second is that the changes that are happening across the health-care marketplace should have the lights on the dash for this committee blinking red. Because we rely on employer-sponsored health insurance to cover 150 million people or more in the U.S., increases in health insurance premiums are creating economic consequences far outside the health-care system.

Over the last 2 decades, there have been a thousand mergers or more among the country's approximately 5,000 hospitals. Not every merger in the hospital sector or elsewhere is problematic, but my best guess is that about 20 percent of hospital mergers have lessened competition and led to price increases.

Here is why this should concern us. Competition, the research clearly shows us, creates incentives for quality and innovation, and these are broadly the two outcomes I think we should really care about the most when we think about outcomes in the health-care sector.

We know from the research that hospitals that are more exposed to competition have literally lower death rates, and that when hospitals merge, there is no evidence that I am aware of, outside a small number of studies, that these mergers lead to quality improvements. If anything, the evidence suggests that mergers drive quality down.

Second, when hospitals that are nearby competitors merge, the literature tells us that this raises prices, and in turn that it raises health-care spending. What is critical is, this affects more than just insurance premiums.

So, for firms that offer employer-sponsored health insurance, when the price of insurance goes up, they broadly have three choices. They can lower the wages of workers, they can slow down hiring, or they can let workers go, and we see evidence of all three happening. Moreover, because of the tax exclusion for employer-sponsored health insurance, the burden of this rising health spending is falling disproportionately on non-college-educated workers.

So, there is some recent work that suggests that the impact of rising health spending on the privately insured is leading to economic inequality in the U.S., and the scale of those effects are on par with the size of the effects of outsourcing, trade, and automation.

It is not just the hospital sector that is undergoing consolidation. There is vertical integration between hospitals and physicians. Insurance markets are becoming more concentrated, physician markets are becoming more concentrated, PBMs are merging, and there are a series of other changes that are happening across the market that I think we need to better understand. One is the rise of health-care conglomerates, and second is the sort of steady increase of private capital, including private equity investment, into the health sector.

Now, I think there are things that we can do. The first is avoiding policies that I think are inadvertently driving consolidation. Here, there are two that come to mind. The first is the lack of site-

neutral billing in the Medicare program. The second is the 340B program. I think both are inadvertently leading hospitals and physicians to vertically integrate.

The second is, we really need to strengthen antitrust enforcement, and I think right now the agencies are pretty clearly underfunded. This means that there just simply are not cops on the beat and that there are mergers that are happening in the health sector and outside of the health-care sector that are raising prices across the country.

I think the third is that we need more data. The hospital price transparency rules and the transparency coverage rules, I think, are better than nothing, but compliance has been low. There is a lot of data that are missing, and there are things we need from those data sets to actually make them useful.

I think, at root, what we need is an all-payer claims database that gives us detailed information about admissions and discharges; information on provider ownership; and critically, the ability to measure quality. I cannot stress that enough. What really is going to underpin the function of health-care markets in the U.S. is the ability to measure providers' quality.

I want to end by thanking you for looking into these issues. I think health spending, these issues, they really matter to the American public, and I think there are concrete steps that we can take to make the U.S. health-care system better. So, thank you for giving me the opportunity to be here.

[The prepared statement of Dr. Cooper appears in the appendix.]

The CHAIRMAN. Thank you, Doctor. I know you are going to get questions here in a moment.

Mr. Martin?

STATEMENT OF R. SHAWN MARTIN, EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ACADEMY OF FAMILY PHYSICIANS, LEAWOOD, KS

Mr. MARTIN. Chairman Wyden, Ranking Member Crapo, and members of the committee, I am honored to be here today representing the 129,600 physician and student members of the American Academy of Family Physicians.

Family physicians, like all physicians, are at their best when they are in service to their patients and communities, not the interest of institutions or corporations. Hospitals and corporate entities, including payers and private equity, now own over half of physician practices and employ nearly three-quarters of physicians. Seventy-three percent of all AAFP members and 91 percent of new family physicians are now so employed. This is a sharp increase from just 59 percent of members in 2011.

In my remarks today, I would like to call attention to how we got here. Acquisition of family medicine practices has been fueled primarily by four issues: inadequate physician payment and systemic underinvestment in primary care; enrollment growth in public programs, including those administered by corporate entities; misaligned incentives that reward consolidation; and a legislative and regulatory compliance framework that overburdens family medicine practices without addressing rising prices and spending.

Together, these factors have led independent practices to consolidate, not from a position of opportunity, but to avoid economic ruin.

Consolidation or corporate investment in primary care is not inherently a bad thing. There is a tremendous amount of innovation taking place inside primary care. What distinguishes many successful organizations is that their revenue model is built around expanding and investing in primary care. These organizations have improved access to care in underserved communities, and fostered a supportive and fulfilling workplace for family physicians to do what they do best, which is care for their patients.

However, the lack of a competitive marketplace often enables profit-centered behavior that fails to put patients first. For example, more and more family physicians report frustration with the loss of clinical autonomy and interference in the physician-patient relationship, as corporate acquisition of practices rises and management, and not physicians, determine what services will be offered.

For many hospitals and payers, the motivation behind integrating primary care practices into larger, consolidated models is control of cash flow. Stakeholders have recognized that primary care, as the front door to the health-care system, can significantly influence utilization, referrals, and management of chronic illness.

While family physicians effectively help patients navigate care, address health-care concerns, and coordinate across the team, large vertically integrated organizations oftentimes leverage primary care to maximize revenue in other areas of their business. Evidence shows that these actions are often increasing costs without improving quality.

Our current system provides hospitals with several incentives to not only continue but reward these behaviors. This includes tax advantages, facilities fees for services safely provided in physician offices, and an annual inflationary payment update. Meanwhile, physician practices struggle with chronic underinvestment in primary care, overly burdensome regulatory documentation requirements, barriers to entry into value-based payment, and insufficient fee-for-service payment that has failed to keep pace with inflation and practice costs. Simply put, this is not a level playing field.

As the National Academies put it, it is time to pay for teams to care for people instead of simply delivering services. Enacting policies and directing more resources towards primary care-led organizations will yield the result we are all looking for, which is healthier communities.

Congress has a responsibility to act. A competitive health-care marketplace benefits patients. To start, Congress must reform Medicare and Medicaid fee-for-service payment, advance site-neutral payment policies, implement billing and price transparency legislation, and bolster support for primary care practices to enter into alternative payment models.

Additionally, while not squarely in the committee's jurisdiction, Congress should implement additional reforms to address consolidation, including improving Federal regulators' antitrust enforcement authorities and their resources, and restricting the use of unreasonable noncompete agreements in physician employment contracts.

In closing, if you hear one thing from me today, let it be this: the true value of health care is in the trusted relationships fostered between patients and physicians in exam rooms, not decisions made by executives in board rooms. We must realign incentives to enable successful, community-based, clinically autonomous primary care practices.

I thank you for the opportunity to be here.

[The prepared statement of Mr. Martin appears in the appendix.]

The CHAIRMAN. Thank you.

Let me also mention—so that people following this will have this information as well—one of the benefits of this committee is that we have senior members on the Judiciary Committee. And you mentioned the antitrust issues, and those are certainly very relevant. We have members who are knowledgeable lawyers and experienced on the committee.

Okay; Doctor, please.

STATEMENT OF KAREN E. JOYNT MADDOX, M.D., M.P.H., ASSOCIATE PROFESSOR, SCHOOL OF MEDICINE, WASHINGTON UNIVERSITY, ST. LOUIS, MO

Dr. MADDOX. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. My name is Karen Joynt Maddox, and I am a practicing cardiologist as well as a health policy researcher focused on Medicare payment policy. It is an honor to be here with you today, and I will preface my remarks by stating that what I say today is my own opinion and not the official position of my employer or institution.

So, what I have been asked to address today is corporatization, with specific attention given to issues around the growing presence of private equity in health-care markets. As you heard, this is an arrangement in which firms raise capital, invest in private companies, sell or exit these investments, and reap the financial benefits.

The data on private equity acquisitions in health care are sparser than one might hope, but we will try to sum up as follows. In the hospital industry, private equity makes up about 5 to 10 percent of the market, and the data would suggest that the effects of acquisition on quality, costs, and outcomes have been relatively small—small increases in financial performance and mixed evidence on quality and outcomes.

In the nursing home industry, private equity makes up just over 10 percent of the market, though the remainder of that market has a much higher proportion of for-profit players, and more recent data suggests that those acquisitions are associated with decreased staffing and worse health outcomes, including higher rates of emergency department visits and mortality.

In the physician practice sector, the data are significantly harder to come by, but private equity probably makes up 1 to 2 percent of the total market at present, though that is a place where this is shifting rapidly. Data suggests that private equity-acquired practices tend to shift towards care provided by advanced practice providers that increase their volume and price.

In Medicare Advantage, private equity plays a role in several ways, including in insurers themselves, but also in companies that provide services to those insurers, including managing patients in

primary care, home-based care, or post-acute care. Data suggests roughly 2- to 5-percent market penetration for the private equity within Medicare Advantage, though again, that is very difficult to quantify.

So, given the broad involvement of private equity in health care, there is not a chance to go back, where we remove this influence from the economic milieu of the field. While private equity is the latest major entrant, the U.S. health-care system is broadly based, and corporate profit-maximizing strategies cross subsectors of the market, even among ostensibly nonprofit actors.

Consequently, lawmakers should pursue an updated policy response and strategies that steer profit motives more broadly, so that competition can work and make things better rather than worse. Taking a structural approach to change would ensure that whatever form of corporatization comes next, it operates within a statutory and regulatory environment and prioritizes keeping people healthy and out of the hospital.

Sector-specific fixes will be needed, but there are two broad approaches that would apply to each. The first is to create a modernized data system by which to measure ownership and costs, as well as quality and access. There is opportunity to revise the Medicare cost reports, for example, a burdensome system of data collection that manages to collect more information than it needs, and less information than it should, at the same time.

We should move from a model of claims and electronic health record data collection and a release that is slow and reactive, to one that is streamlined and proactive. As long as the private sector can outpace the government on data and strategy, both groups will continue to try to win by gaming rather than by making serious investments in patients and health.

The second strategy is continued movement towards models of value-based payment that create clear guard rails and equity-centered, longer-term financial incentives. Rather than having the young, brilliant minds of the private equity firms around the country focus on ways to game fee-for-service, they should be at work finding ways to win at population health management. This requires a different data infrastructure and improvements in measurement of quality and equity, to make a system capable of meeting those needs, to create the guard rails.

Finally, all these objectives need to be pursued with careful attention to clinician burden and burnout, and above all else, centered around patients and their needs. But they are feasible and tangible. As a country, an updated policy response in terms of data and measurement could ensure that corporate interests are leveraged in the most positive ways possible.

Thank you for the opportunity to offer my perspective today and for your leadership in this important space, and I very much look forward to your questions.

[The prepared statement of Dr. Maddox appears in the appendix.]

The CHAIRMAN. Thank you. We look forward to that as well.

Mr. Thomas, you are next.

STATEMENT OF CHRIS THOMAS, FACHE, PRESIDENT AND CEO, COMMUNITY HOSPITAL, GRAND JUNCTION, CO

Mr. THOMAS. Thank you. I want to thank Chairman Wyden, Ranking Member Crapo, Senator Bennet—thanks for the introduction—and the distinguished members of the Senate. I have had the opportunity to work in the health-care field—sorry, Senator Bennet—for 33 years as a finance guy, working with and supporting talented people—nurses, doctors, housekeepers, our coders and billers—and it has been an extremely rewarding career, witnessing the advancements in technologies, watching our total joint patients walk out same day, and hearing the chime at our hospital as a new baby is born. I picked a great career, and I am honored every day to be a part of a great team.

For the past 16 years, I have been the CEO of an independent hospital in western Colorado. I am a firm believer in the value of independent, community-owned hospitals. Our ability to singularly focus on the well-being of our community is why I am here, why I have been here for the last 16 years, and why I plan to finish my career at Community Hospital.

I want to be clear: I am not implying that system hospitals do not care for their communities. What I am saying is that we have one priority at Community Hospital, and that is the Grand Valley of western Colorado.

One of the main reasons that I am so committed to our organization and our mission is that our board of directors has never, not once, asked me to make more money. They want me to make sure we meet the needs of our staff, our physicians, our community, and without hesitation, the well-being of our community.

In 2009, President Obama visited Grand Junction to celebrate the collaborative spirit of our health-care community. Our community continues to work closely together to meet the needs of our seniors and our underserved population, understanding at the same time, Grand Junction was one of the most expensive health-care markets in the country for the privately insured. The Grand Junction health-care market was dominated by single-source providers. The community had only one option for many physician specialties, and most hospital services were provided by only one hospital.

We at Community Hospital have proven that by competing when appropriate, partnering when the opportunity presents itself, we have, with the help of many others, lowered the cost of health care, improved access, and improved the quality of care. Our community now has a choice on where to see a specialist and even where to deliver a baby.

Competition is absolutely crucial. I know for a fact in our community that OB services are much stronger today than they were 10 years ago. I absolutely want every mom in Grand Junction to choose Community Hospital to deliver her baby, and I am sure the other hospital wants the same, and so we are working hard to win their trust.

Competition is not always the right path forward, however. For example, we were extremely fortunate in our community to have a great NICU in our community, and it happens to be at the other hospital. The NNPs cover both hospitals, and 100 percent of moms

who deliver at Community Hospital who may need that service can safely be transferred to that facility within 10 minutes.

There is absolutely no reason in a community our size that we would need two NICUs, and our community benefits from this collaboration. Fair competition is one of my greatest concerns, as our lack of Medicare designation at Community Hospital puts us at a tremendous financial disadvantage.

Community Hospital is the only hospital in western Colorado and eastern Utah that does not have a designation for Medicare. The result of this is receiving as much as 19.8 percent less from Medicare on a case mix-adjusted discharge than the sole community hospital that is located less than 5 miles from our facility. In my written statement, I described how we are partnering with the government agencies, our school districts, and our universities.

Additionally, we are working with the other independent hospitals in our region to secure the future for all of us. We are sending our surgeons to their facilities to keep care local, doing surgery in those facilities. Surgeries in small hospitals are a very big deal, and if we can keep that care local, it is a tremendous win for the patient and for those small hospitals.

We also work with the Western Healthcare Alliance, a service organization we all own. WHA helps us obtain many of the same efficiencies systems are gaining in areas like revenue cycle and group purchasing. Today, all independent hospitals are facing many challenges. Payers continue to make it more and more difficult for us to get paid. The threats from larger health systems acquiring assets in and around our communities are a few of the main items that are keeping us up at night.

In our region, a larger health system acquired the largest hospital and is now bringing their health insurance products into our market. If they are successful at growing the number of lives covered by their health insurance products, we fear they will block access to our hospitals through tiered products, driving more of the covered lives into their hospital.

Independent hospitals pride themselves on being a local community partner. They reinvest their dollars in the communities, they support local businesses, they keep their money in local banks, they buy from local vendors, utilize local contractors, and support other local not-for-profits.

Independent hospitals are an integral part of a healthy community. Our ability to be agile, serve the unique needs of our community, and serve as a champion for patient choice means we are critical to the future of local health care. If the few independent hospitals left are going to survive and improve the health and quality of the lives of the individuals in the communities we serve, we need the support of Congress.

Thank you very much for your time, and I look forward to your questions.

[The prepared statement of Mr. Thomas appears in the appendix.]

The CHAIRMAN. You lived up to Senator Bennet's praise.

Mr. THOMAS. Thank you.

The CHAIRMAN. All right. Ms. Pearson?

STATEMENT OF CAROLINE PEARSON, EXECUTIVE DIRECTOR, PETERSON CENTER ON HEALTHCARE, NEW YORK, NY

Ms. PEARSON. Chairman Wyden, Ranking Member Crapo, and members of the committee, I am Caroline Pearson, the executive director of the Peterson Center on Healthcare, which is a division of the Peter G. Peterson Foundation. Thank you for the opportunity to testify today on the important topic of health-care transparency.

Founded in 2014, the Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable care a reality for all Americans. At the Center, we believe that in order to advance more effective, accessible care for patients, health-care decision-makers, including policymakers, business leaders, and families, need more and better data to correct inefficiencies in the market and ultimately lower health-care spending.

Thanks to the regulations finalized by the previous and current administrations, along with the passage of the No Surprises Act by Congress, we now have an unprecedented level of health-care price transparency data. These actions are important steps towards democratizing information that was once proprietary. My testimony highlights important opportunities to allow this data to improve health-care system performance. I will also offer a series of recommendations to build on the progress made to date.

Sustained commercial price increases reflect market failures in health care. As you have heard from other witnesses, negotiations between providers and payers are heavily impacted by consolidation. Independent physician practices are increasingly rare, with 74 percent of doctors now employed by hospitals, insurers, and other corporate entities. These trends can produce power imbalances at the negotiating table that often result in higher prices and reduced affordability for employers, governments, and families.

In analyzing hospital price transparency data sets, the Peterson-KFF Health System Tracker has found that there is significant variation in hospital prices. Further, fewer than 1 in 10 Americans are aware that this data exists, and the data is extremely difficult to use.

For instance, when we look at hospital diagnostic colonoscopies, 96 percent of the negotiated rates reported by hospitals do not include enough information to explain the actual pricing. Further, 45 percent of negotiated rates do not specify a location, even though we know that site of service has an incredible impact on cost.

Information that is required to be released by the payers encounters similar challenges. These include enormous file sizes, poor data quality, and the inability to link to other data sets. But make no mistake: these technical challenges are not a reason to turn back, but instead, we need to build on the progress and commit to future improvements.

Ultimately, the impact of health-care data depends on more than just making it available. It must be used. The States are important potential users of price transparency data in their capacity as both purchasers and regulators. The Peterson-Milbank Program has provided a range of assistance to States that have implemented health care cost growth targets.

This work has shown that data transparency is a critical underpinning of State and private-market efforts to understand the fac-

tors driving spending growth and opportunities to address it. My written testimony provides a series of recommendations that build on the efforts of Federal and State Governments, as well as private stakeholders.

Let me highlight two of them. First, policymakers can act to improve the quality and depth of the price transparency data released by hospitals and payers. That could include requiring standardized formats and definitions, as well as releasing more data elements, including the prescription drug files. Rate information is currently available for commercial plans, and adding Medicaid managed care and Medicare Advantage would be an important additional step.

Second, Congress could take steps to advance all-payer claims data sets. Without the ability to understand utilization patterns, pricing data alone cannot fully address spending variation and improve market competition. Building on the progress of the Consolidated Appropriations Act of 2021, Congress and States should do more to encourage development of robust all-payer claims data sets.

In conclusion, health-care data transparency is necessary but not sufficient to reduce health-care spending and improve access and quality. Pricing data needs to be more available and useable, and be combined with other data sources like claims and benefit information. Such efforts will give policymakers and health-care stakeholders more powerful tools to achieve the goal that we all share: a more effective and efficient U.S. health-care system.

Thank you for having me today.

[The prepared statement of Ms. Pearson appears in the appendix.]

The CHAIRMAN. Thank you, and thanks to all of you. It has been a terrific way to start on this extraordinarily consequential issue.

Question for you, Dr. Cooper, if I might. I have been concerned that new evidence of issues relating to health-care consolidation not only pushes the cost up, but hurts workers. For example, when a small hospital is gobbled up by a large health-care system, the community can lose good-paying jobs, because the smaller hospital is often forced to lay off workers. As for the people who still work for the larger system, the wages can go down.

So let us put this through a prism for workers, all right? It strikes me that for workers, consolidation can mean layoffs go up and wages go down. Is that consistent with some of what you are seeing in your research?

Dr. COOPER. Yes, thank you. Thank you for the question, Chairman Wyden. You know, I want to separate what happens to health-care workers and what happens to non-health-care workers, because I think both are really important. So let's start with the health-care workers.

Two hospitals merge and they then become more powerful negotiators over the inputs to the hospital—workers—and we know there is pretty good evidence that when hospitals merge and gain bargaining power, they can do things like lower nurses' wages. And that we know is probably, in the long run, challenging for the nursing labor market.

When we think about what happens to workers outside the health-care system, similar things happen but through a slightly

different channel. Hospitals merge. If they gain bargaining leverage, this allows them to raise their prices. This raises insurance premiums, and in the presence of employer-sponsored health insurance, it just makes retaining workers for firms more costly.

When you make retaining workers for firms outside the health sector more costly, what happens? They lay off workers. I think what really scares me and has been eye-opening over the last couple of years I have been looking at this, is really the health consequences of job separations.

It can be fundamentally devastating for your health. So, the literature that is out there says that, by and large, 1 in 400 of the folks who lose their job die within a year. And so, I think there is this gross irony that hospitals are merging, this sector we rely on really to take care of us when we are at our most vulnerable.

It can create all of these reverberations downstream that actually are affecting health.

The CHAIRMAN. Great. Thank you very much, and I know we are going to follow up repeatedly this morning on issues relating to workers.

I have a question for you, Dr. Maddox. We spend a lot of time in this committee also looking at the intersection of technology and health-care policy, and I am the author of the Algorithmic Accountability Act with Senator Booker and Congresswoman Yvette Clarke.

I want to explore with you some of the issues relating to algorithms as it relates to consolidation. Now, the Kaiser Foundation has highlighted how many more people are being denied care in the individual market. They report that on average one in five in-network claims were declined.

Now, some plans deny nearly half of in-network claims. Public interest groups are now looking into this issue and reporting how algorithms are being used by major health insurers to rapidly deny health-care claims. This strikes me as an emerging area, and we ought to be asking some questions about it.

Now, if insurance companies are getting bigger and buying companies that specialize in developing algorithms, it strikes me they are going to be in a position to invest in new ways to deny care. That strikes me as a prescription for trouble. I would be interested in your thinking on this, and let us just start at 35,000 feet.

Should Americans be concerned, and what are the implications here for causing patients undue harm?

Dr. MADDOX. So, thank you, Chairman Wyden. That is a very insightful question and one that, I think, gets us to the heart of how to both preserve innovation and protect patients at the same time. I would entirely agree with you that we need more oversight and eventually regulation of those algorithms. It is a space that is moving too fast right now on the technological and business side for us to have the policy regulation in place to begin to deal with it.

We see this in a number of tech-enabled things in health that do not fit squarely into a device; it is a code or something like that. So, it is really a space in which we need quite a bit more oversight and really, understanding. I think what we should try to do is figure out how to harness the algorithms sort of for good rather than evil.

If Medicare fee-for-service has agreed to cover something, there is good evidence, and there is no reason why patients who meet certain criteria should be denied care. Algorithms should make prior authorization a 30-second enterprise and actually preserve patient access to care.

But right now, because it is being done in a sort of unregulated and unknown manner, we are seeing the people get out ahead who are in the business of trying to deny care. So I would say it is not the algorithms themselves. We could use those in a positive way. It is to say, how do we think about this from a policy standpoint, and put guard rails in place on what can and cannot be done?

The CHAIRMAN. So you are saying, you almost have a two-fer. A smart policy here, for example, might help us on this problem of denying authorization and all the challenges that both physicians and patients are facing.

Dr. MADDOX. Absolutely.

The CHAIRMAN. Very helpful; thank you.

Senator Crapo?

Senator CRAPO. Thank you, Mr. Chairman.

Mr. Martin, far too often, we see financial strain and administrative burdens leaving our independent practices with no choice but to join a large health-care system or close their doors entirely. The resulting access gaps can have devastating consequences, particularly for rural communities, as I mentioned in my opening statement.

What role do our Federal payment systems play in driving this dynamic, and what steps can we take to preserve the independent practices without burdening taxpayers through spending hikes?

Mr. MARTIN. Yes. Well, Ranking Member Crapo, thank you so much for that question. Family physicians—about 17 percent of family physicians practice in rural communities. We are by far the largest contributors to the rural physician workforce in America.

I think you partially provided my response in your question. There are two underlying factors. I think one is the investment of public programs, which have a disproportionate impact on commercial payment rates as well. It is undervaluing and underinvesting in sustainable practice models for primary care and other physicians, particularly those in rural communities where the balance between the public programs and commercial populations is tilted more towards the public programs.

I think second of all is—through no fault of anyone particularly—the regulatory framework that is applied to modern-day physician practices has been accumulating for decades, and it never goes away. As I said in my prepared remarks, I think the regulatory framework really has created an economic burden that has become unsustainable, coupled with the lack of appropriate investment in practices.

I think many physicians have fled independent practice for economic sustainability purposes, versus seeing necessarily an opportunity. I can continue on.

I mean obviously, the time constraints that come with the regulatory burden of modern-day practices lead to burnout and frustration, and a personal departure from the practice of medicine, from

the frustration standpoint. But I think that economic factors are significant, particularly in rural communities.

Senator CRAPO. Well, thank you.

And, Dr. Maddox, I think it was you who indicated that the data collection system that these doctors have to deal with generating and assisting with generates both too much and too little at the same time. Could you explain that concept?

Dr. MADDOX. Sure. Thank you, Ranking Member Crapo. Most of the data collection that we have is, as my colleague has stated, built on fairly old regulatory requirements. And so, the elements that are collected do not line up with what we want practices or hospitals to have access to for their own efficiency.

So, we have line items for how much you pay a chaplain or how much you pay a certain set of food service elements. We have no easy way to tell how much you spent on an electronic health record, or how much you have spent on collecting data for quality.

So there have been some fascinating recent studies suggesting just the millions of dollars and thousands of person-hours that it takes to collect quality data and turn it in to all of the various organizations that want it in different formats or different requirements.

There is a real public-private opportunity here to change that data collection, to harmonize how it is done, and to simultaneously collect less data, but actually make it serve both practice and regulatory purposes in a much more intentional way.

Senator CRAPO. Well, thank you. We may be asking you and the others here on the panel for your expertise to help figure out how exactly to do that. I think that this focuses on a critical piece.

In my last minute here, Dr. Cooper, you mentioned site-neutral billing. Several of you have mentioned site-neutral billing. Could you just expand on that a little bit? How do we fix that?

Dr. COOPER. Sure. Thank you, Ranking Member Crapo. You know, I think it is this idea of first doing no harm. So you know, the issue is, there are certain services that are often done in doctor's practices, where the Medicare program is actually reimbursing for those same services much more if that physician is owned by a hospital.

And so, what does that do? It just creates incentives for the physician to merge and the hospital to buy them. That does not need to be the case. So one of the things that MedPAC did in their 2022 report was lay out a number of services that are mostly done in doctor's practices, where we should not have the reimbursement rates be sort of differentially high.

There are a bunch of other services where we probably want higher payments for outpatient visits, and we should have those. But for the ones that can be done in doctor's practices, let us keep it that way.

Senator CRAPO. All right; thank you.

The CHAIRMAN. I thank my colleague, and I think—as is usually the case, Senator Crapo—you make an important point with respect to the fact, and Dr. Maddox confirmed this, that the system has not kept up with the times. She said, look, the data systems, the data sets practically feel like they are from the Dark Ages. So we are going to need some help on this.

Senator Grassley, you are next.

Senator GRASSLEY. Thank you.

I am leading in to Dr. Cooper. Since 2018, I have been calling on the Federal Trade Commission to conduct a study on drug middlemen, including pharmacy benefit managers. Last summer, FTC agreed to conduct such a study. Given there is little known about the actions of PBMs, their business practices are very opaque, as you know. I believe this study must be conducted timely.

So to you: is it important for the Federal Trade Commission to complete a study of PBMs in a timely manner, and if so, tell me why?

Dr. COOPER. Thank you, Senator Grassley. I absolutely agree with you that it is important that the FTC looks into pharmacy benefit managers. I think it is important that Congress does as well. It is this enormously opaque industry, and I think you want to think about it as sort of the Sam's Club for prescription drugs, right?

They are doing bulk purchasing, and sometimes that is good if they get better prices. The challenge is, the industry has gotten so consolidated that it is not clear they are passing any of those savings along to either the government or the customers. Sort of given what is happening in the environment around us, haze in the air, I think the FTC can help us get a better window into what is happening.

Senator GRASSLEY. And also for you: you stated in your written testimony the importance of better understanding the growing vertical integration of health insurers acquiring PBMs. Are these acquisitions resulting in lower drug prices at pharmacy counters and improved access to local pharmacists?

Dr. COOPER. So we think, when it comes to vertical integration, the answer right now is, we do not know, and it speaks to the need to investigate it. I think there are a lot of reasons we might think that vertical integration of pharmacy benefits managers and insurers makes sense.

So, we have seen studies that when you can coordinate medical and pharmacy benefits, you see drugs on formularies that you do not otherwise see, that are good for basically keeping people out of the hospital and increasing savings. The worry is that when insurers have so much market power and they integrate with a PBM, do any of those savings get passed along? I think that is what we need to study.

The other is, when they own pharmacies, the question is, does a totally vertically integrated unit let customers go to small independent pharmacies, or do they close off their rivals from accessing their pharmacies? I think we need to look into it.

Senator GRASSLEY. Yes.

Ms. Pearson, I am going to ask you about price transparency, but leading into that I have written to the Department of HHS, Treasury, and Labor about implementing prescription drug transparency regulations as required by the No Surprises Act's price transparency regulations.

Despite the response from the agencies, very little has changed. I believe in sunshine in these drug prices. So, you discussed in your written testimony the importance of implementing these sort of

drug transparency rules, and the need for this data. Why do you think the agencies are unwilling to publicly publish this data?

Ms. PEARSON. Thank you, Senator, for the question. I cannot speak to the motives of the agencies. Certainly, as the data is coming out, we have seen some of the challenges with data quality, and I expect that folks are trying to make sure that the data that they are receiving is robust and comprehensive.

There have also been a number of legal challenges, but certainly we believe that transparency across all services is going to be beneficial to really understanding the market and the cost drivers. And so I am very hopeful that we will begin to see more of that information in the future.

Senator GRASSLEY. Also for you: you stated in your written testimony that newly established price transparency data must be used in ways to benefit health care purchasing decisions. Have employers' groups or associations effectively used this data to negotiate better health insurance premiums?

Ms. PEARSON. Thank you, Senator. As you know, employers are the leading purchasers of health insurance in the country, and so they are a very important stakeholder in order to drive down cost. They have worked for years with their companies that support them to try to give more information to the employees, to really motivate people to shop and to pursue care with lower-cost providers.

That has been incredibly challenging. Lots of research has shown that it is very difficult for consumers to shop for services, first because many services that consumers need are not shoppable, right? It is not planned, and so there is simply not enough time to make those decisions.

Two, good information about the cost of services is hard to come by. People do not know what the episode of care is going to be. They do not know everything that they are going to need when they walk through the door. The No Surprises Act took a big step forward in requiring some of this information to be made public and to be put into the hands of patients, and so we commend that.

But ultimately, I think it is going to be really the physicians, whom the patients really depend on to advise them, putting the information into their hands, as well as putting it into the hands of the employers and the health insurers who are really responsible for negotiating rates and building provider networks around high-value providers.

The CHAIRMAN. I thank my colleague.

Senator Menendez is next, followed by Senator Cornyn, unless Senator Cantwell comes.

Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

Dr. Cooper, today the top three PBMs control 80 percent of the market. PBMs, which are vertically integrated with the largest Part D plan sponsors, entice plans to incentivize beneficiaries to use pharmacies that are owned and operated by the PBM. With vertical integration, both upstream and downstream, no one is protecting patients from paying too much at the counter.

A recent MedPAC presentation indicated that vertically integrated PBMs in Medicare Part D may be benefiting from higher re-

imbursements to their own pharmacies, while increasing cost to the Part D program. This has created a perverse incentive for PBMs to drive up costs for patients and limit patient access to pharmacies of their choice.

So, Dr. Cooper, do you agree with MedPAC that the vertical integration of PBMs could be causing patient harm and raising costs?

Dr. COOPER. Thank you for the question, Senator Menendez. You know, I think broadly, when firms gain market power, it is usually good for the firms and not so good for the people who buy things from the firms. And so, I think what we are going to have to be cautious about with vertical integration is, when all of these parties have market power, it can shortchange the end customer, in this case the patient.

I think it is really important that the FTC is carrying out their investigation of PBMs. I think one of the things that is hard is, in antitrust, you cannot unscramble the eggs too easily. Once these firms integrate, it is hard to take them apart.

So I think one of the things we need to think about is, who regulates the PBMs? What would happen if we said, for example, they had to be a fiduciary for the government and for patients?

Senator MENENDEZ. Yes. Well, when you insist on the higher price because you want to get a bigger percentage, you certainly are not helping either the consumer or, for that fact, the government when the government is paying.

And so, it just seems to me that this integration—there are basically three companies that control everything. How should we address this to ensure that patients are not overcharged for prescription drugs because of consolidation and the anticompetitive tactics of PBMs?

Dr. COOPER. So I think the first, Senator, is increasing competition in the sector. Now I think it is very, very hard now that it has become so concentrated. I think we need investigations to know exactly what is happening at these different entities.

I think the third is thinking strongly about whether there should be some fiduciary obligation for PBMs, so that they are really serving the end customers.

Senator MENENDEZ. Okay.

Let me ask you a separate question—actually to Ms. Pearson. Since health care price transparency rules were implemented by the Federal Government in the past few years, Americans have access to more information than they have ever had about the cost of health care. However, you have observed that transparency around health-care prices in and of itself does not significantly impact consumer behavior. Specifically, you have written that simply making prices transparent does not cause consumers to change their providers or their hospitals. What more must be done by hospitals, insurers, and providers in order for patients to benefit from additional transparency?

Ms. PEARSON. Thank you, Senator. So, in addition to the points I mentioned about the challenge for patients to actually shop for health care, the health insurance structure in our country certainly protects most consumers from the majority of their health-care costs, meaning that the actual fiscal impact on any individual fam-

ily from going to one provider to the other is relatively limited outside of the deductible period.

So I think we need to think holistically, not just about better information, but how do we use the tools of insurance benefit design, provider networks, and others to really help guide folks to the providers that are both lower-cost and still delivering high-value care?

Senator MENENDEZ. Thank you.

Finally, Dr. Cooper, last year the American Medical Association released a study outlining health insurance concentration across the country. Notably, AMA found that 75 percent of local markets were considered highly concentrated, according to Federal guidelines. Further, in 91 percent of markets, at least one insurer had a market share of at least 30 percent, and in 48 percent of markets, one insurer had a share of 50 percent or more.

Would increased consolidation, as health insurers amass more power in the market, have greater ability to lower payments to physicians? Is it your view that insurer consolidation leads to lower physician earnings and decreased work opportunities for physicians?

Dr. COOPER. Thank you for the question, Senator Menendez. You know, I think the evidence is pretty clear that when insurance companies merge and gain bargaining leverage, they do offer lower payment rates to both hospitals and physicians. In some instances, those can be below competitive rates.

I think what it speaks to—and we are hearing this about a lot of the different parts of the health system—is really the need for antitrust enforcement in this sector, to prevent it from becoming so consolidated.

Senator MENENDEZ. Thank you, Mr. Chairman. Thank you for holding the hearing.

The CHAIRMAN. I thank my colleague. And I just would like to say to colleagues that you can follow Senator Menendez's questions on these subjects with a straight line—and he and I have worked together on these issues for a long time. You look at, for example, his PBM questions, his transparency questions. It always comes down to, not the word salad that we were talking about that makes up most of the health-care lingo, but it is the measure of what do the policies do to help patients. And we are going to keep coming back to that, and I thank you for it.

Senator Cornyn?

Senator CORNYN. At last count, the United States spends 18.4 percent of our GDP on health care. That has all sorts of impacts. First of all, the average family spends $22,000 a year on employer-sponsored health-care plans, and we just have to look at what is happening to the fiscal health of the Federal Government to see the consequence of uncontrolled health-care costs.

Dr. Maddox, recently I was reading something from a physician who said that he had this reoccurring dream that someone was throwing eggs from the top of the building, and his job was to try to catch the eggs, when he realized the best way to stop the eggs from hitting the ground would be to go up and stop the person from throwing the eggs over the top.

I know that is kind of a funny way to talk about the fact that our health-care system is really a sick care system. And just for ex-

ample, adult-onset diabetes causes hundreds of billions of dollars in excess health-care cost because people simply do not control their weight and exercise. Maybe it is not that simple, but those are certainly components of it.

What do we need to do to not only save money, but to provide better outcomes for the American health-care system? The OECD, the Organisation for Economic Co-operation and Development—38 of the most advanced democracies and economies in the world—they spend half of their GDP on average from what the United States does. So how do we fix that?

Dr. MADDOX. That is a great question and a fascinating analogy. And as a cardiologist, I support the diet and exercise, and I am not sure how I feel about all the eggs. But I very much appreciate the question.

You know, I think the difference between many other countries and ours is the degree to which we focus on prevention, long-term outcomes, and to my colleague's point, to really invest in primary care. We have a system that pays more to do more, and not a system that pays more to keep people healthy.

Until we change the payment structures to award insurers, providers, all of the parts of the health-care system, for keeping people healthy, we will continue to pay for sick care.

Senator CORNYN. So we need to follow the money?

Dr. MADDOX. It is a complicated fix. This is very baked in to how we do things, but we need to invest very differently in health care.

Senator CORNYN. Well, it is really hard to unravel who gets paid for what in the health-care system. It seems to me the complexity is not a bug, it is a feature of our system, and I do not think it is an accident. People have figured out what the system is and how to maximize their return, and that is why you see so many big players get involved. That is why you see the consolidation. That is why you see so many other features that we are talking about here today.

But, Mr. Martin, your group's membership has played a critical role in things like care coordination efforts and looking at sustainable, value-based payment models. I remember talking during the Affordable Care Act debate about trying to pilot ways to pay doctors to help keep their patients healthy, as opposed to just treating them after they got sick.

Are there any viable payment models now that would actually work, that would both improve patient outcomes and reduce the amount of money that they have to pay?

Mr. MARTIN. Well, thank you, Senator. I think there are a number of innovative models that are being explored, and some have demonstrated efficacy that is greater than others. I think in total, the innovation in primary care is in its infancy in determining what the right approach would be.

I think there are two things that I would suggest to you. One is, the traditional fee-for-service construct is probably not congruent with the types of primary care and prevention in the health-care system that prevents the eggs from coming over the edge of the building. We need to create greater investment in a more prospective global perspective, to really support primary care in all settings.

Senator CORNYN. Well, if you will help us figure out how to do that, I would be very interested.

Mr. MARTIN. I will jump over the top. I am ready to go today.

Senator CORNYN. And I wondered, Dr. Maddox, do they even teach this in medical school?

Dr. MADDOX. They actually do not teach the payment part in medical school, Senator. We learn a lot about the doctoring part, and then get out into the real world and realize that there is a whole lot more to it. I think that actually might be why private equity and corporatization and consolidation has had such a fertile ground to go into, because doctors do not come out of medical school wanting to deal with this stuff.

We want to help people manage their diabetes and their obesity and their hypertension, not argue with an insurance company about whether something is covered. So, I think you have sort of hit the nail on the head there.

Senator CORNYN. Well, Mr. Chairman, it seems like if we are going to try to attack the excessive cost, the percentage of our GDP, the amount of money that families have to pay for health insurance premiums, that we are going to have to not only look at the consolidation issues and the transparency issues, but also how we actually compensate physicians and health-care providers for treating people, and how do we keep them healthier rather than just treating them after they develop chronic diseases.

The CHAIRMAN. I would just say to my colleague, you had me at "hello" on this, because there is no question that this is a sick care system, that prevention gets the short end of the stick.

Finally, after a year's worth of effort, this committee was one of the leaders in the effort to finally get an annual wellness visit in to Medicare, which was a start towards the kind of prevention ethic you are talking about. But I look forward to working very closely with you on it.

Okay. Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman, and thank you for this important hearing.

Dr. Cooper, I wanted to ask you about the vertically integrated PBM market that I believe creates a conflict and results in increased cost. Senator Grassley and I have legislation that we passed out of the Commerce Committee to try to address this, really giving us more transparency.

Do you agree that transparency reporting requirements like the ones in our bill to crack down on unfair, deceptive practices while ensuring patients receive the highest quality care are an important aspect?

Dr. COOPER. So, I think one of the challenges in the PBM industry is, we just do not see what is going on, and I agree with you, Senator, that not having transparency here sort of creates this ripe environment for a market that does not serve the end users.

I think I am really enthusiastic the FTC is looking into these transactions, and I think it speaks to the need for these sorts of investigations.

Senator CANTWELL. Thank you. When three PBMs control 80 percent of the market, they do not face as much competition. Do you think increased competition is part of the issue?

Dr. COOPER. Yes, Senator, I agree with your question. I think when a market is that concentrated, it is hard to think that, in a sense, the end customers are getting served effectively. The question is, what do you do once it has become so concentrated?

Senator CANTWELL. Thank you.

Mr. Thomas, abortion advocates in Washington State have suggested that when religious-affiliated hospitals and other hospitals merge, we should require a list of services that are provided or refused. Do you agree with that?

Mr. THOMAS. All right, first question; thank you. Yes, it is very concerning, and we had that discussion in our community as we explored potentially joining another religious-affiliated organization. So, we have a Catholic hospital in our community, and when we were considering the system, we were looking at whether we should join a Catholic system or an Adventist system, and those were big discussions in our community.

Our community was very, very concerned about the limitations on their health rights. So, as a board and as a hospital, we chose not to join the system for that reason, to make sure, in our community, we have options. We did not feel like having two religious-based organizations was going to benefit our community.

Senator CANTWELL. Thank you.

And, Mr. Martin, 4 years after mergers that significantly increased hospital concentration, nominal wages were 6.8 percent lower for nurses and pharmacy workers than they otherwise would have been. Another study has found that hospital mergers led to a 1-percent reduction in wages from 2010 to 2018.

During shortages, decreased wages are really the last thing that we want. I am concerned about this. Do you believe this is something—hospital mergers—that we should be looking at as to the impacts on workforce and evaluating that as part of the criteria?

Mr. MARTIN. Well, yes; thank you for the question. And Dr. Cooper certainly can speak to the labor issues better than I. But we do know, in marketplaces that are highly concentrated, that the ability for community-based physician practices and others to secure labor becomes more challenging, and that wages for physician services and others becomes less competitive.

You know, the payment rates to physicians under contracts tend to decrease below national benchmarks in highly concentrated areas of the country.

Senator CANTWELL. Thank you.

Mr. Chairman, I am so glad you are having this hearing. I think in general, we have seen this concentration of services, and we have seen a lot of concierge health care, and that means the wealthy get to have really good service and they go to those services, and then we are left with the Medicare/Medicaid population and trying to serve them in the remaining hospital.

The first thing that the hospital then tries to do is cut wages as a way to try to right the ship, given that their concentration is a Medicaid/Medicare population. So I think we have to look at these issues overall. We want competition; we want good health delivery systems. Obviously, in my part of the world we want the proper reimbursement rates, but we have had low reimbursement rates since the 1970s, and we still produce better outcomes.

So again, I am all for the value-based system, where you have a national standard. We get rewarded for doing better than that, and States that don't do as well should be penalized. Now, that is the way we get our whole system back into really cost-effective delivery and focus on outcomes.

So, thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague for once again showing the downside of the two tiers in American health care, and you put it very well.

Senator Lankford, you are next.

Senator LANKFORD. Mr. Chairman, thank you. Thanks to all of our witnesses and what you bring to the conversation today.

It is interesting. In my State, in Oklahoma, we have 4 million people. Two million of those live in urban areas, 2 million of those live in rural areas. For rural hospitals, some consolidation of administrative functions has been beneficial. Actually, they have back office somewhere else, and so they can focus on patient care in a very small community. I have also seen some other areas where a management company comes in, takes over a rural hospital, runs it and then drops it, and it has had major consequences in my State as well.

So, I have seen both sides of this and know that we've got to have some oversight in the process on this, so that we do not have rural hospitals especially that face consolidation and then just get abandoned at the end of the day as well.

Mr. Martin, I want to ask you specifically about some things that may be happening with CMS, or with just Federal policy, that may be encouraging consolidation. It was mentioned before earlier that for some procedures, x-rays for instance, some radiology, you get paid more if you are in a larger hospital than if you are independent. So that literally incentivizes moving towards consolidation.

So my question to you is, are there things that are happening with CMS or the regulatory environment that are actually incentivizing consolidation in places where it should not be incentivized?

Mr. MARTIN. Yes; thank you for the question, Senator Lankford. I think we have discussed a lot the impacts of site-neutrality payments and the facility fees, and they are an incentive for consolidation to take place, particularly between physician services and hospital institutions, because it provides an enhanced payment rate.

That enhanced payment rate is not the only incentive. Many hospitals also have tax advantages that allow them to accumulate revenue that they can use for mergers and acquisition activities that are not available to other players in the marketplace.

But I think there are two things that I would point you to that are direct competition between physicians and hospitals beyond site neutrality, and one is the simple fact that physician payments traditionally have failed to keep pace with inflation. So, physician payment rates are stagnant. Hospitals have access to facility fee payments, but they also have an inflationary update that takes place.

And then the second thing is, the institution's ability to shift care from one location to another once they have consolidated puts a great strain on rural communities. If they move maternity care to

a larger facility, that community and those physicians that provide that service in that community are basically left abandoned in many respects, which drives health disparities and other challenges in rural America.

Senator LANKFORD. Are you saying there is something in the CMS structure, the legal structure right now, that is incentivizing that move out of the rural areas into the urban areas for physicians?

Mr. MARTIN. Well, with maternity care, there are a number of factors that are contributing to why there is a centralization of that type of care away from rural communities, yes. There are payment rates and volume rates that are impacting physicians' ability to provide those services in rural communities.

Senator LANKFORD. A minority of counties in my State have OB/GYN services——

Mr. MARTIN. Yes.

Senator LANKFORD [continuing]. And that is continuing to accelerate. So, if I can drill down a little bit more. You are saying the way that the payment structure is working is actually pushing that towards the urban area, out of the rural area? What would you recommend as a fix for that?

Mr. MARTIN. So, not just payment structures, but also credentialing and privileging structures. So many family physicians and many corporate hospitals cannot be privileged, or the hospitals will not privilege them to provide those services in rural areas. They will only privilege individual physicians at larger facilities.

So there is a number—beyond money, there is a regulatory burden that is preventing access to care in many rural hospitals. It just goes back to my plea to please address the regulatory and subregulatory structure that is preventing physicians and nurses and other clinicians from really being able to provide care in many communities.

Senator LANKFORD. Well, I am a big believer in providing the options, because not every rural community is the same; not every urban community is the same. I have a bill that is the Rural Hospital Closure Relief Act. That particular bill extends the ability for it to be a Critical Access Hospital into more places and to give more flexibility into that arbitrary number that was created.

I know Senator Grassley has worked on other bills as well to be able to provide for rural health care. Some hospitals do want to have inpatient beds though, and that Critical Access Hospital provides them that option for that. We've got to provide options here, whether it is physician-owned, whether it is critical access, whatever it may be, to be able to provide that flexibility that is needed.

And if I can make just one quick comment on this. Dr. Cooper, you had mentioned that there is a possibility that PBMs and how they are currently structured could have a negative impact on independent pharmacies and rural pharmacies. I would go ahead and just say "yes," it has a negative effect on rural pharmacies and independent pharmacies.

I can bring you plenty of data in my State on what has happened in the unique coincidence that all the rules changed and the fees changed and the DIR comes out to a rural independent pharmacy, and then, within a week or so, they get a call from one of the big,

integrated PBM entities who says, "Wouldn't you like to join us instead?"

And so, I would say definitely it has that negative impact. Thank you.

The CHAIRMAN. I thank my colleague. I had not heard about your critical access legislation, but we will take a look at it.

Senator LANKFORD. I am doing it with a guy you do not get along with very well, Dick Durbin, and so maybe that is why you have not heard it. [Laughter.]

The CHAIRMAN. Running with the right crowd again. Good.

Okay. Senator Carper is next.

Senator CARPER. Thank you. I will mention that to Dick Durbin, so there you go. Welcome everybody. Nice to do important stuff, and we appreciate very much you joining us and sharing your thoughts and your insights.

I have a question for Dr. Zack Cooper. If I were to tell you how many times I have been called Tom Cooper, you would be amazed. My goal in life is to make sure people start calling you Zack Carper, then I will feel like I have finally made it.

One of my top priorities as a member of this committee, and Democrats' and Republicans', has been lowering the price of prescription drugs. I am grateful to have the opportunity to work with my colleagues on both sides of the aisle on provisions in the Inflation Reduction Act to, in part, lower the cost of prescription drugs.

I understand that we still have some more work to do and probably will for some time. One part of expanding access to prescription medications is ensuring patients have the resources to compare prices—to compare prices. Today, hospitals are required to provide certain price transparency disclosures for their patients, but prescription drug prices do not have similar transparency requirements, as I recall.

This lack of transparency is especially troubling when it comes to PBMs, pharmacy benefit managers, which are often able to secure cost savings but do not always shift those savings to pass them on to patients. I think Senator Grassley, in his questions, may have raised this already, along with Senator Menendez.

But, Dr. Cooper, can you just share with us more on how this committee can support and expand greater transparency when it comes to prescription drug costs, especially relating to the PBMs? I apologize for not being here. We all serve on multiple committees, as you know, and I cannot be in three places at once, but I try. So, take it away.

Dr. COOPER. Thank you, Senator Carper. I was going to call you Senator Cooper, and I tried to——

Senator CARPER. Dr. Carper, I've been called worse. [Laughter.]

Dr. COOPER. Yes, yes, yes; there you go. We will share in it.

You know, when I think about the PBM industry, sometimes we really do focus on this question of transparency. And for me, I think, in part, we are focusing on the transparency issues because there is so little competition in the industry.

So I think if it was a very, very competitive industry, we would sort of think that competition would actually lead the end user to get a pretty good deal. And so, I think transparency for transparency's sake—I do not know that that is really the missing ingre-

dient in this sector. I think we just really need to think about how to inject competition into it, so that it really serves the end users.

Senator CARPER. All right; thank you.

Mr. Thomas, raise your hand, please. All right; that is my first name. We are getting a good work out here, huh? [Laughter.]

Mr. THOMAS. Yes sir.

Senator CARPER. I have a question that I would ask you to respond to, and also to work with Dr. Cooper to respond to it as well. Delaware is a little State. I like to say it is the 49th largest State. We are just a tiny bit bigger than Rhode Island. We have three counties, and the largest county is called Sussex County.

People who go to the beaches, they are all down in Sussex County; more five-star beaches than any county in America, I think. But we raise a lot of corn, raise a lot of soybeans, but it is still a rural county. And I ask this question with Sussex County in mind.

Access to comprehensive health-care services can be essential, are essential in rural communities, including the ones I have just described in southern Delaware. Smaller hospitals, like a hospital called TidalHealth or Bayhealth in Delaware experienced great benefits from horizontal consolidation. However, research has shown that some mergers across the country have increased costs to Federal health plans and to patients. And I oftentimes say, "Find out what works; do more of that." And here is my question to Dr. Cooper or Mr. Thomas.

Can you share some best practices for merged facilities across the country, especially in rural communities, that are doing a great job—a great job of providing innovative and efficient services—without increasing the costs to Federal health plans or to patients, please?

Mr. THOMAS. So, thank you for the question.

Senator CARPER. Thank you.

Mr. THOMAS. So, one of the things that we have seen is, through some of the telemedicine—as small community hospitals, we do not have the resources to stand up some of these services. So, as we worked with some of our partners to bring some of those services to our community, we have seen tremendous benefits.

When I had the opportunity—we had five oncologists decide to leave the other hospital and join our facility. We were not in the cancer business, and so I was pretty worried about having a cancer system for my wife, if she ever needed services. So we reached out to the Huntsman Cancer Center in Salt Lake City, UT, and they were tremendous advocates for us, helping us set up that program, helping us oversee it.

So we have the best of the Huntsman Cancer Institute in Grand Junction, CO. There is no way we are going to be big enough to do bone marrow transplants and some of the most advanced cancer care. But with our partnership, we can get cancer care locally. We can do chemotherapy; we can do radiation therapy.

But then we can work with our partners to get them to the Huntsman Cancer Center for those types of services. So I think there are a lot of examples, Senator, of some of those collaborations that work. We do not need to be, I guess, purchased or become part of a system to achieve those gains, but there are a lot of opportuni-

ties out there to collaborate and work together, and those are two examples from our community.

Senator CARPER. Okay; thanks.

Dr. Cooper, very briefly, one more best practice that you could share with us.

Dr. COOPER. I think, Senator, I would echo your point, which is not all mergers are bad, and I think what Mr. Thomas was highlighting, which I agree with, is integrating telehealth into some of these smaller sites can basically mean the sites that cannot do everything for everyone have access to a broader infrastructure via sort of this hub-and-spoke model, where the small place gets the advantages of the big hospital that maybe is in a more urban area.

Senator CARPER. All right; good. Thanks. Thank you all again. It is an incredibly important subject, and we need your help, and we appreciate it. Thank you.

Senator JOHNSON. I think it is me, so I will begin——

Senator CARPER. I yield my time for the gentleman from Wisconsin.

Senator JOHNSON. So you know, we had a hearing yesterday, Small Business and Finance, about the IRS and our code, which is a mess. And one of the comments I made is, the solution being put forward is the little bills and stuff, so it is like putting a band-aid on a dying patient. I think we are kind of hearing the same thing here, quite honestly.

Again, I truly appreciate it. This is a nonpartisan hearing. This is excellent information, but in my brief time period, I want to—we have done a good job describing the problem, but I do not think we are properly diagnosing it. I do not think we are really getting down to the root cause, and you know, Dr. Cooper, you are the economist here.

Again, I believe in the magic of the invisible hand, right, where you have millions of consumers and hopefully thousands, tens of thousands of providers, and just magically, you do not need to do regulations on price transparency. It just happens, you know. Consumers get the best possible product, the best possible customer service, the best possible price. That is what a free market does.

We have largely driven consumers out of health care. It does not have to be this way. Is it not true that, decades ago, patients paid for 80–90 percent of their own health care? Now they pay about a dime. So, Ms. Pearson, what good is price transparency if consumers could not care less what it costs? That is the real problem, right?

Ms. PEARSON. We certainly have insulated consumers from the cost of most of their care, and that is going to affect their interest and ability to shop for care.

Senator JOHNSON. So again, that is just obvious. We have driven consumers out of health care, which means we have driven all the benefits of free market competition out of it, by and large.

Mr. Martin, you talked about—76 percent of physicians are employees. It was not that long ago that about 80 percent were independent, and they were at the top of the treatment pyramid. I think one of the huge problems in COVID is doctors were at the bottom of the treatment pyramid.

In this, protocols make sense, but during this pandemic, you want doctors using their medical judgment and coming up with a different theory of the case and being able to use their off-label prescription rights, but they did not do that. So I think, as we are looking for solutions, we need to look at some basic principles of what we need to do to get back to more consumerism and to get back to more providers.

So, Dr. Cooper, again, the current market is literally just a couple of consumers: Medicare and a few large insurance companies, right?

Dr. COOPER. Correct, yes, the really large payers.

Senator JOHNSON. And in terms of suppliers, now we have, what, half a dozen large hospital corporations? So you've got these, you know, a couple of consumers, a couple of suppliers, and shouldn't we be looking at that, rather than putting band-aids on the dying patient?

You know, I completely agree with you on regulatory burden. Well, as long as you have just a couple large buyers and one of them is the Federal Government, we do not have consumerism going on. So the Federal Government has been—the government regulates. They say, "Okay, well, this is not working. We are not getting a low enough price. So we are going to try and slap this band-aid on the dying patient." It is not going to help the patient live.

So, I guess my point is, let us figure out the basic principle in terms of the root causes, since we need to reintroduce consumers into this. I know it is not perfect, but to me it is a higher deductible or catastrophic insurance—I mean real insurance—and then somehow get consumers to pay for it, as much as we possibly can, in terms of health care. Any of you want to comment on that?

Mr. MARTIN. Well, I—just two quick points for me. I think there is a large amount of innovation that is really trying to drive a return to clinical autonomy. And clinical autonomy, you know, creates an empowered relationship between a physician and a patient or a clinician. I think that is really important, and I think the investment that allows that to happen is important.

The other thing is, the AFP and others have been very active in helping physicians, particularly family physicians, create direct engagements with both patients and also with businesses, through direct contracting models.

Senator JOHNSON. So, I just met with a group, and I have seen doctors that have just left the system.

Mr. MARTIN. Yes.

Senator JOHNSON. They have opted out of Medicare and they are just charging cash to farmers in Wisconsin, 55 bucks for a half-hour appointment. Now they need access to a hospital. So I guess one thing I want to hope that we do not do here is crush out that initiative. I heard one of my colleagues talk about, you know, concierge care.

I mean, I get that, but you know, we want people to have the freedom. We want doctors to have the freedom. Again, I want to see a shift. I want more doctors to become independent. I want more consumers in the health-care industry. I think that is the direction we need to move in terms of anything we do here.

Now first, do no harm. Let us go back to a model that would reintroduce consumers and give that choice, and give doctors the autonomy to put them back at the top of the treatment pyramid, as opposed to being crushed at the bottom of it.

Senator WHITEHOUSE [presiding]. Senator Brown?

Senator BROWN. Thank you, Senator Whitehouse and Chair Wyden. Thank you to both of you, Senator Whitehouse, Senator Wyden, on bringing to light some of these abuses and what this means to patients. Ohioans, as Rhode Islanders, want quality care at a price they can afford. What they are seeing now is the opposite of that.

Prices go up; too often patients do not get the care that they want, they need, they deserve. It is a system that is too often hurting, not helping. It is hurting Ohioans who simply need the care they deserve. It is hurting Medicare long-term, short-term. Long-term, it is hurting workers. The money that companies are chasing has to come from somewhere, obviously. It is often from the pockets of seniors and taxpayers. Some of the practices that these consolidated companies are engaging in to make these profits seem fishy, almost to be kind of fishy at best.

Some insurers are using their records to make patients appear as if they are actually sicker than they are. And why would an insurer do this? All so they can take more money from ordinary Ohioans by fleecing patients and taxpayers. And it is a lot of money. It is billions of dollars.

Mr. Martin, we will start with you. Can you explain why the integration of physician practices with insurers seems to make this practice worse? And give us suggestions on how to fix it, if you think it does make it worse.

Mr. MARTIN. Well, I think there are a couple of—thank you for that question, Senator Brown. I think first of all, I want to acknowledge that many insurers in the country are in a period of innovation with respect to primary care, and from a historical perspective are investing more money in primary care, which I view as a good thing.

I think the challenge that we face is, again, coming back to clinical autonomy. That investment and that innovation is coming oftentimes with a reduction in clinical autonomy at the point of care, in favor of business-driven decision-making that is impacting, oftentimes negatively, patient care and physicians' ability to provide patient care.

We see this in a variety of ways, whether it be prior authorization referral limitations, et cetera. But I think investment in primary care has to come with the clinical autonomy at the point of care for physicians to provide appropriate care to their patients.

Senator BROWN. Thank you. I see it—I chair the Banking, Housing, and Urban Affairs Committee. I have seen what private equity is doing in housing. When private equity inserts into health care, nurse staffing, we know it goes down. It helps make wealthy investors quick bucks they are looking for, on the backs, too often, of the nurses forced into work situations unsafe for them, unsafe for their patients.

When health companies merge, outside investors see health care solely as an opportunity to make money. Employees are laid off,

service quality goes down, health spending soars again, similarly to what they do in housing.

So, Dr. Cooper, you mentioned in your testimony that when health spending goes up, there is actually a negative health impact on workers with employer-sponsored health care. I thought that people with employer-sponsored health care were the lucky ones, those with the coverage to help them receive lifesaving treatment.

Yet you said in your testimony, increased health spending can lead to worse outcomes. These are people who do not work for the health-care system, people who do not work for a hospital or a doctor's office, but for that firm. Explain a little more of that to me.

Dr. COOPER. Sure. Thank you, Senator. So, you know broadly, what is happening is, when firms provide employer-sponsored health insurance, that is a form of compensation just like their wages. When health spending goes up, it broadly just raises the cost of retaining workers. When it becomes more costly to retain workers, you oftentimes let workers go.

The challenge is, we are seeing people get let go, and we are in the middle of the opioid epidemic. So, losing your job can be financially devastating to your health, and what the literature tells us is that 1 in 400 folks who lose their job die within a year.

That is really the big concern that I have, which is, as health spending goes up, it forces some folks to lose their job and ultimately, the consequences are severe.

Senator BROWN. Thank you.

Ms. Pearson, last question. Explain to us why transparency—and we all call for transparency in essentially everything—is sort of a sometimes shallow, sometimes not an answer to the question. Explain why transparency is not a singular solution to high health-care prices? How can increased transparency help make health care more accessible, more affordable when done right?

Ms. PEARSON. Yes, thank you, Senator. Transparency alone is certainly not the solution, but you know, I think, as we look for solutions and reach for solutions, we really believe that we should do that in a way that is thoughtful, well-informed, and understands markets.

We have a wide variety of health-care markets in this country, some quite consolidated, some more competitive, many rural. Understanding the nuances of each of those markets, how that is affecting pricing, and most importantly how it is affecting the care and quality for individuals and for patients—we need that information in order to be able to decide and make informed choices about what to do about spending.

Senator BROWN. Thank you.

Thank you, Senator Whitehouse.

Senator WHITEHOUSE. Thank you very much. It is now me, I guess, and then Senator Tillis.

What I would like to do is just tell you all a story, and ask for whatever response you care to propose as a response for the record. So, you have a chance to reflect and put your thoughts in writing.

Rhode Island is a State of a million people, and we have been working for a long time on trying to develop a statewide health-care system that meets the various fabled goals of the Triple Aim. We have been quite successful at it in a number of areas.

In a State of a million people, it is hard to run and right-size two major hospital systems. So, we pursued a merger between our two major hospital systems that would have created a single right-sized hospital system, in my view. That was two nonprofits, well-established, well-known trusted nonprofits merging, so there was not an issue of predatory action or investors bringing bad motives to health care. And they had agreed to create a community board, so there would be true community control over the new joint merged operation. Again, a right-sized nonprofit with a community board.

The Federal Trade Commission made what is, in my view, both a terrible and a fateful decision in disallowing that merger. Now we are forced to have to try to clean up that problem. It has put our existing hospitals back into the mode of predatory risk from out-of-State potential buyers, and from for-profit potential buyers.

I think that all the indications are that the hospitals would have been much more financially secure had the merger been allowed to proceed, and then we could have worked off that basis to complete the work of system reform that we have been engaged in for many, many years.

One of the lessons I took from that is that competition is very often a misguided purpose for the health-care system. The most obvious area where competition is useless is in emergency rooms, where you go with traumatic injuries and maybe even unconscious, and speed is of the essence.

There is no consumer competition there. What you want is to get fast to an emergency room where you will get really good care, period, end of story. If you get diagnosed with a complex illness, you are not a very good consumer there either. You need a system that will support you and guide you and provide the decision-making that is necessary, so that you and your family can deal with a complex and perhaps disabling illness.

And then in Rhode Island, we have done things like, we have built probably the best health information exchange that exists statewide, and we have the best, if not the only, all-payer claims database.

So, we have these really valuable tools. They do not exist if you do not have cooperation among the major players in health care, and they do not get used properly if you do not have cooperation among the major players in health care. So competition, again, is highly degrading to all of that.

We then set up common rules like ACOs—big fan of ACOs. I worked hard to get them into the Affordable Care Act. Rhode Island had two of the very best in the country, Integra and Coastal Medical. That does not work unless you've got cooperation, unless you have agreed-on rules, which in this case were decreed by Congress. And we are working very hard to get away from fee-for-service, which I think is just a bane in the current health-care system.

How you do that is obviously complicated, where you've got multiple payers that have to move together for it to be effective.

But I think when you have really well-running ACOs, trusting them to do a good job and peeling them off of fee-for-service, and peeling them out of things like advance approvals and payment

delays, trying to disable the systemic payment warfare between providers and insurers, which together creates a massive deadweight loss on the health-care system with very, very little, if any, value received——

And then you need accountability on things like hospital-wide infections and patient safety and quality measures. And all those things, again, can only be done if you are working in the spirit of cooperation, if you are trying to accomplish against a plan. And I think State leadership is very important, which is dramatically inhibited if all of your hospitals are owned by different out-of-State entities that will not even return the calls of State officials because they do not care in Minnesota or in California or in New York, what is going on in Rhode Island.

So that is our predicament. We are trying to work our way through it. Any thoughts and advice you have, I would appreciate.

My time has expired, so I will leave it there and hope that some of these baited hooks attract at least a nibble from some of our very talented witnesses.

Thank you.

The CHAIRMAN. Thank you, Senator Whitehouse, and your expertise in this area is much appreciated. Thanks for helping out this morning as well.

Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman, and I also want to say "thank you" to the witnesses. I was able to hear most of your statements, and the testimony has really been excellent. I am very, very grateful for that.

Chris—or Mr. Thomas—knows this, but this is a question that I have to ask, because for over a year, my office has been working with Community Hospital and Mr. Thomas's team to help understand our options for Medicare designation, a designation that would help increase reimbursement rates. You talked a little bit about this, because they seem in certain circumstances to support independence, their continued independence, their financial viability, during this really difficult economic climate.

Without the designation, the hospital is at a disadvantage, as he said, as it competes with the larger health-care system in the region. So, I may not get another chance in front of the Finance Committee to ask you this, and I know you are not going to get another chance to talk about it, Chris.

So, I wondered whether you could summarize Community Hospital's situation and describe the ways in which this new form of reimbursement would be helpful, and how consolidation has affected Coloradans in Grand Junction and beyond. So, do whatever you want, and take as much time as you need.

Mr. THOMAS. Thank you. Thank you for teeing that up, Senator Bennet.

Yes. We have just been one of those tweener hospitals that have fallen through the cracks. And so, we are too big to be a Critical Access Hospital. We are within 35 miles of another hospital, so we just have worked diligently with CMS to come up with a solution, to just get paid fairly or get equitable pay with our counterparts in the region, and we just have not been able to find an avenue.

We have tried the rural demonstrations, we have tried different programs through CMS, and we just do not fit. Unfortunately, the hospital that is 5 miles away from us was legislatively approved as a sole community provider in the 1980s. So, between the 1980s and now, we have been at a distinct disadvantage, and where that impacts our hospital is—we have talked about wages and prices.

In our community, there is some competition, and so wages are not being pushed down. In fact, it is the opposite. We have seen wages really grow, and I am fine with paying our nurses, and I want our nurses to be well-paid, and I want them to be there and stay and reduce our turnover. But when the other facility is receiving significantly more money from Medicare and Medicaid—and the State of Colorado bases Medicaid reimbursement on the Federal Medicare designation.

So, we get double-whammied on both of those, and currently about 70 percent of our patients receive services through Medicare or Medicaid. So, when our competitor has the ability to raise their wages $5 an hour, if I am going to keep my nurses, I have to also. So that puts a real burden on us, to try to figure out how to do that. We have, and we will continue to do that.

And so, we have reached out to Senator Bennet in trying to build a coalition to see if there is a new designation that represents the independent hospital. The other pickle we are in is Grand Junction—while we are way west, and I think most of you who are in Washington, DC would not consider Grand Junction an urban area—we were actually designated as urban.

We went over 50,000 people, I think two censuses ago, and so we also do not qualify for rural. So, while my colleagues in western Colorado—I very much appreciate their challenges—when I hear all this help you guys are going to do for rural, I get a little squeamish because it is, again, we are going to get overlooked in those situations.

Senator BENNET. Right, right.

Mr. THOMAS. And so we are working on it and trying to come up with that designation. We are just looking for parity, and I think as we look at what has been accomplished and what we can do with parity—I have met with some of our State representatives also.

At Community Hospital, if we can have a 3–4-percent margin, we are going to have enough money to put money in the bank, replace our equipment, take care of our community. We do not need a 12-, 15-, 18-percent margin to do what we need to do. I have even pledged that this number for us—we have about a $220-million net revenue budget—this is probably a $12- to $15-million-dollar deficit for us. Those are dollars we could put back and not cost-shift to our commercial-insured patients. We could work together to continue to bring the cost down for those folks, and I think that is the beauty of the independent hospital, is being able to sit down and have those discussions.

And so, we are working hard, and I have said, and I've got—my son is a fourth grader, and so he will graduate just before I turn 65. We adopted; we have three older children also. But before I retire, I am going to get this fixed.

Senator BENNET. That is an interesting—well, I encourage or agree with your optimism. It is much more optimistic than my view of these things, which always is, before I expire, I want to say I got this fixed. [Laughter.] But let us pick yours. Before you retire, we will get this done.

The CHAIRMAN. Let us just strike from the record anything about Senator Bennet expiring.

Senator BENNET. Yes, and we will. But I do think, really—and my time has expired as well. But I will just take the last second to say I hope we get to a day in this committee some time when people on this panel are not interested particularly in where stuff is delivered, but instead, what is being delivered, what quality is being delivered, at what kind of price is it being delivered, and that we are actually getting the benefits in our system of competition on the one hand, and we are avoiding some of the evils of consolidation on the other hand.

We are in a really challenging spot right now, so I think in the meantime, especially for the West, making sure we preserve what independent hospitals we have left, I think, is a really important part of what we need.

The CHAIRMAN. Senator Bennet is always way too logical, so I thank him for his thoughtful point. That is the key, the last point at the end. Take those $4 trillion and squeeze the most possible value you can out of it for the people.

Senator Young?

Senator YOUNG. I want to thank our witnesses for being here today. I have now been working on health-care policy for a number of years, and it is complicated. There are so many different types of providers, different payers, and we struggle with costs. They continue to go up.

Consolidation has been increasing costs. Dr. Cooper, I think, mentioned this earlier in his testimony. The health-care delivery system still needs reform, after many efforts that we have made to try and implement such reforms, to bend that proverbial cost curve over a period of time.

So, I am just going to ask you a general question, Dr. Cooper. What is Medicare's role in helping to bring about these sorts of changes, cost-saving changes, to our health-care system?

Dr. COOPER. Thanks for the question, Senator Young. You know, I think Medicare is the largest single purchaser in this ecosystem. In many ways, it is sort of setting the wake that everybody else is following behind. So often, what we will see is that what happens in Medicare dictates what happens in private markets.

So, if Medicare raises its reimbursement rates, private rates go up. So I think we just have to be really, really conscious about seeing what Medicare does and how it ripples throughout the system.

Senator YOUNG. So, to the extent there are particular reforms within the Medicare program, do you think it would be both responsible and also cost-saving? We are always welcoming those ideas. So please, do not hesitate to let me know.

Dr. COOPER. Of course, Senator, and thank you. You know, I will mention two, and then we can be in touch with your office. I think the first is, do no harm, and so that is where I have talked about

site-neutral billing and the need for it, so that we are not inadvertently incentivizing vertical integration in health care.

I think the second is, as Dr. Joynt Maddox has talked about, right now we pay episodically. I think the more we switch over to covering whole episodes of care and capitation—basically incentivizing providers to think about maintaining the health of their beneficiaries in the long term, supported by quality measures—the better we are going to do.

Senator YOUNG. Well, we will continue to sharpen the pencil and see how we can implement some of these things.

Mr. Martin, I really appreciate your comments and insight on physician practices, their role in the health-care system and communities in which they practice. As we have heard, there are barriers, challenges, and misaligned incentives within the system. As highlighted by our witnesses, we see consolidation across the health-care system and hear the different reasonings for why it exists. I want to explore how we can prevent consolidation from happening for those providers that truly prefer to remain independent.

Several years ago, in the Medicare Access and CHIP Reauthorization Act, or more commonly known as MACRA, Congress created a new approach to paying for medical care that financially rewards clinicians for delivering high-quality, cost-effective care. Can you discuss some of the limitations of MACRA and alternative payment models?

Mr. MARTIN. I think the first limitation of alternative payment models is just getting them available to enough physicians in the country. There are many areas of the country that still do not have access to alternative payment models beyond the MSSP program, which was created in the ACA.

I think MACRA has two competing challenges. Number one, it created an incredible incentive, particularly for community-based physicians, to move into alternative payment models. But it simultaneously strengthened fee-for-service, which created a disincentive. Quite honestly, fee-for-service is the legacy payment model, and many practices did not feel that there was enough motivation to move away from fee-for-service into an APM, and that continues to exist today.

Senator YOUNG. Mr. Martin, still with you.

Mr. MARTIN. Yes.

Senator YOUNG. What successes would you like to identify? What successes have we seen, and are any of these successes scalable or able to be replicated by others?

Mr. MARTIN. So I think one of the big successes—I do not know if it is from MACRA, but it occurred in the post-MACRA world—is really a lot of physician-led ACOs, primary care-led, physician-led ACOs, are demonstrating incredible capabilities to provide higher quality of care and begin to better manage a cost in the Medicare program, and that is spilling over into Medicaid and commercial markets in those areas.

So physician-led Accountable Care Organizations are performing extremely well in many parts of the country.

Senator YOUNG. Thank you, both of you.

The CHAIRMAN. Thank you.

Senator Hassan?

Senator HASSAN. Thank you, Mr. Chairman. I want to thank you and the ranking member for having this hearing, and to our witnesses, thanks so much for being here.

I want to start with a question to Mr. Thomas. As we have heard today, health system consolidation has led to unfair billing and pricing practices which drive up costs for patients. The law allows hospitals to charge facility fees to cover the cost of inpatient hospital care, and as some folks have already talked about this morning, some hospital groups are taking advantage of this when they buy and operate local physician practices.

Now hospitals are charging unfair facility fees for routine care provided at a local physician's office, sometimes miles away from the actual hospital. Yesterday, I joined Senator Braun in introducing a bipartisan bill that would help end this unfair practice. It would cut costs for patients getting routine care, and save the Federal Government billions of dollars.

Mr. Thomas, as the CEO of an independent hospital, you have made the decision not to impose these unfair facility fees, as I understand it. In your view, how do these fees impact costs that patients face when getting routine care in the community?

Mr. THOMAS. Thank you for the question, Senator. Probably 12–13 years ago, we started seeing physicians reach out to us, having trouble maintaining their own practices and reaching out to Community Hospital to join Community Hospital.

And as we explored whether we were going to get those clinics up as provider-based clinics—and I am talking family practice physicians, orthopedic physicians, those outpatient clinics that were physician-driven—we made the decision to not make them provider-based physicians.

I just did not see, in our community, how I could look at a patient and on Friday say their bill was 150 bucks, and on Monday because there is a different sign on the building, same chair, same doctor, that it was now going to be 350, 400 bucks.

And so we made the decision for our community not to do that. We have probably lost significant dollars, and maybe I would not be pushing Senator Bennet as hard to help me, but it was a decision for our community.

Now, at the same token, some of those we do charge. We did make our oncology clinic a provider-based clinic. The main reason we made that decision is because we also provide infusion services there. So, we are giving chemotherapy, and we have infusion nurses, and we have the chairs and all the things that go with those, and so the costs are higher in that clinic.

Additionally, the reason we did that was because of the 340B program, which is a lifeline to a community hospital. We receive about $12 million in benefits through that program that get passed on to our patients. But without being a provider-based clinic in that location, we would not have been eligible for the 340B program.

So we do have that, but that was a strategic decision that we made in our patients' best interest. It also—it helped the hospital too. But we just did not feel like, on those outpatient settings that were 10 miles away, that there was really any difference on Friday

when they were an independent practice, to Monday when they were owned by us.

Senator HASSAN. Well, thank you for that. And, Mr. Martin, I want to follow up on the same line with you. From the perspective of a family physician, what happens to patients when their local doctor's offices are bought by hospital groups?

Mr. MARTIN. Well, I think there are two immediate impacts. I think one, their cost sharing goes up. Oftentimes with the facility fees and others, whatever the cost sharing would be in their program would be more, which Mr. Thomas just spoke to. I think another is that, oftentimes the ability to seek and obtain services generally becomes more influenced by the institution, which sometimes influences the patient's behavior.

Referrals can occur more quickly and sometimes not, because the clinical autonomy again is oftentimes run through a different filter than if the practice was completely independent and engaging with the patient.

Senator HASSAN. Okay. So it definitely has an impact on the patient's experience, right? It is price, but it is also experience.

Mr. MARTIN. And I think that experience can be positive or negative, just depending upon the approach. I mean, I do not think it is always positive or always negative.

Senator HASSAN. And I know, Mr. Thomas, you want to weigh in. Could you do it quickly, because I wanted to get to a question for Dr. Cooper?

Mr. THOMAS. Yes, thank you. I just also want to—when we have acquired or these practices have joined us, we do have a challenge in the health-care system because our costs go up. I can tell you, every time I recruited or a physician has joined us, the first thing after they sign their contract is, they mention that their employees are underpaid, and I should pay them more.

They were paid okay when they were with them, but now with our overhead—so I think there is an argument that there is increased cost when we take over these clinics. That was one of the things we were able to overcome. But, guys, there is that tendency, because now they have our benefits where before they may not have benefits.

So, thank you for the time.

Senator HASSAN. Well, thank you.

And Dr. Cooper, I was going to follow up on something that Senator Brown was asking about, which is the role of private equity in health-care costs.

I will just note for the record and then follow up with you that Senator Cassidy and I led on getting—along with Senator Bennet and others—the No Surprises Act passed, which takes the patients out of the middle of these disputes between insurers and providers.

In the first year of the No Surprises Act, over one-third of all disputes initiated by health-care providers came from companies owned by private equity firms, and a good portion of those disputes were really dismissed outright.

So there is some concern that private equity spent millions of dollars trying to block us from passing the bill. So, I will follow up with you about the influence of private equity on driving up patient

costs in health care, and in particular, in kind of creating this churn in the dispute resolution process.

Thank you.

The CHAIRMAN. I thank my colleague, and I am very glad that she and Senator Brown are digging into this private equity issue, and I know Senator Warren has been very interested in that over the years as well.

Senator Warren?

Senator WARREN. Thank you, Mr. Chairman.

So, all across the economy, giant corporations buy up their competition in order to get bigger and rake in more profits, and our health-care system is no exception to that, particularly when it comes to Medicare Advantage, or MA, which lets private insurers administer the Medicare coverage.

The government pays insurance companies a set amount each year to cover an MA enrollee's health costs, and for sicker beneficiaries, the government pays at a higher rate. Makes sense; sicker patients cost more to insure. Except the insurers have figured out that they could make a lot more money by making all of their patients look sicker on paper.

And they do this by loading up their beneficiaries' charts with as many diagnoses as possible, a practice that is called "upcoding." Whatever the MA plan does not spend on care then, the company gets to pocket. So, in the last few years, the insurance companies that dominate MA have been gobbling up private care practices in multibillion-dollar acquisitions.

Mr. Martin, you represent the Academy of Family Physicians, so your members are on the front line of primary care. When an insurance company owns a primary care practice, it can push providers to squeeze out more profits per patient, often through games like the one I just described. Are your members experiencing this kind of pressure?

Mr. MARTIN. I cannot directly mention a member that has expressed to us that they are feeling this kind of pressure.

But what we do know, Senator Warren, is that our members express a lot of frustration and concern about the loss of clinical autonomy that is created through incentive programs, either explicit or indirect, that can occur in certain arrangements with employers of all types, whether that be an insurance company, or private equity, or others.

Senator WARREN. So, are we talking about things like pressures to meet quotas, for example?

Mr. MARTIN. I have never heard that term specifically, but there are volume pressures, there are referral pressures, there are utilization, both increased utilization and reduced utilization pressures.

Senator WARREN. Okay. So, volume pressures. In other words, find ways to get more action, get more things you can code—and I see other people nodding "yes" who have seen this; is that right?

So the insurance company buys up doctors' offices in order to own the link in the chain where doctors actually see patients. And then they give doctors bonuses, for example, if they add more diagnosis codes to the patient's chart. One of these giant conglomerates, CVS Health, even paid $8 billion for a chart review company to

send people into patient's homes in search of adding more codes to their files.

Now, this business model is wildly profitable for the insurance companies. Take UnitedHealth, the biggest health conglomerate in the U.S. and a major Medicare Advantage insurer. It is also the largest employer of physicians in the country. The HHS Inspector General found that in 2017 alone, UnitedHealth brought in $3.7 billion in MA overpayments, money it received in excess of what was legally justified by the actual health of their patients.

Today, it brings in even more revenue than America's largest bank. The insurance companies justify this consolidation by saying even if they make more money, they also make the overall health system more efficient. Dr. Martin, when insurance companies own doctor's offices, does it raise or lower health-care costs overall?

Mr. MARTIN. I think there would be—there are other experts here. I think that would depend upon the location. I think generally speaking, it would increase costs, and consolidation increases costs and reduces quality.

Senator WARREN. Yes, all right; like it does in other fields, right?

Mr. MARTIN. Yes.

Senator WARREN. So, we are watching costs go up here, and in the case of Medicare Advantage, those higher costs are borne by taxpayers by and large, through higher premiums and hundreds of billions of dollars in overpayments to the MA plans.

So, if vertically integrating insurers are not lowering cost, how about another angle? Dr. Martin, when doctors are having to focus on prioritizing profits for insurance companies through tactics like upcoding or quotas, how does that affect the ability to provide quality care to patients?

Mr. MARTIN. Well, Senator Warren, I would go back—I do want to acknowledge I think investments in primary care that are taking place are really important. I think that is an aspect that I would want to speak in favor of. I think it oftentimes comes with a reduction in clinical autonomy, and I know I sound like a broken record. But regulations, whether explicit or inexplicit, that interfere in physicians' ability to engage, or the care team to engage, in the best interests of the patient, are negative things.

And we would encourage and support guard rails and guidelines that restore clinical autonomy.

Senator WARREN. Okay. So we are talking about higher costs and worse patient outcomes and worse delivery of health care to patients. It is time for regulators to end this kind of vertical integration in health care. I am committed to reining in this aggressive profiteering to protect taxpayer dollars, and to make sure that patients get the care they need.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. And I know it has been a long hearing, and I thank you all for your patience. This is an important subject.

I want to talk a little bit about what we have done in Maryland, because I think we have an innovative approach that has allowed

hospitals to be able to be viable without the necessity of consolidation.

Maryland, as you may know, has a "total cost of care" model, where the reimbursement levels are established regardless of who is paying the bill. It is an all-payer system. What it means is that you do not have to be big in order to get a discounted, fair rate. You do not have to have that negotiating power which, in a lot of cases is why you see the consolidations of health providers in order to have a larger say in negotiating with the payers.

So that model seems to have worked well in our State to preserve the options. We have several smaller entities that still exist as hospitals in our State. We have had consolidation in our State.

So I guess my question is, from that type of a model, where we take away the necessity to be big to negotiate against payers because we have a regulated rate system, that also takes into account the total cost of care, so it rewards efficiency in care. How can we use that type of model to deal with some of the challenges that we have talked about here? Anyone want to talk about the nice thing about Maryland's system?

Dr. MADDOX. Sure. Thank you, Senator Cardin. You know, I think that the whole idea here is that we want people to compete on quality and on outcomes and on patient experience. We do not want people to be just competing on raising costs. When large insurers and large systems go back and forth to raise costs, the patients lose, because they are the ones without a seat at the table, so to speak.

So I fully agree with you that creating a system in which we can use good data infrastructure to monitor quality, to reward outcomes, and to let patients vote with their feet in the sense of quality—and not only where an insurance company says they can or cannot go—is the ideal system.

The barriers to implementation on a national level, as I'm sure you know, are many. But the concept there that we are putting competition where it needs to be and empowering people around quality and outcomes, as opposed to the bargaining table, is an exceptional one.,

Senator CARDIN. I expected that answer, I agree with that answer, but it was sort of a set-up question.

So let me tell you why. That is true, but we found that before we had an all-payer system, access to care in underserved communities was almost problematic because the profit motives were much more available in more affluent communities, and therefore, our facilities were located in more affluent communities.

So, access to care suffered. It was not because of quality; it was because of economics. So, our model protects against that by allowing the recognition that, first of all, we have an all-payer system, so you are not rewarded by the type of payer that you have. Secondly, we can use the regulated rate system to make sure we have access in all communities. So one of my concerns about consolidation is the impact it has on traditionally underserved communities, and we have found that, as we have gone through consolidation, it has made it more challenging in the underserved communities.

So how do you reconcile that answer, which was a good answer, with the need to make sure that we have access to care in all of our communities?

Dr. MADDOX. I mean, I completely agree. If you look at the history of hospital closures, both in urban and rural areas over the past few decades, they have accelerated in the places that have the lowest median income and the places with the highest proportion of minoritized patients. That has been seen time and again, both in rural and urban areas.

The economic model simply does not support independent hospitals, or hospitals owned by broader chains, staying afloat in areas where payment rates are low, and where many patients cannot pay.

So a system in which you are addressing that problem, through sort of shared responsibility for that payment, will inherently better support health equity and our pursuit of reducing disparities in a purely market-based system, to where hospitals open and close.

Senator CARDIN. I will just conclude on this point, Mr. Chairman. Maryland is one of the few States, urban States, that never had a charity hospital. We did not need it, because our rate system did not penalize providers, hospitals that were in communities with a large number of uncompensated care or Medicaid population. So we were able to overcome that problem with access to care.

So, we have great medical institutions, including Johns Hopkins, the University of Maryland Medical System, located in challenged communities, but they are not penalized as a result of it.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague. And for those who may not know this, Senator Cardin is the chair of our Health Care Subcommittee, and he constantly is focusing on innovative ways to help underserved communities.

His work, for example, in terms of dental coverage for underserved folks—and we know that Medicare has long been half a loaf and has missed so many priorities like dental—is hugely appreciated. I look forward to working with my colleague.

Senator Cortez Masto is next.

Senator CORTEZ MASTO. Thank you, Mr. Chairman, and thank you to the panel members.

I want to follow up on some of the questioning that Senator Warren started with, because I had similar concerns about Medicare Advantage and this vertical integration. I guess my question, Mr. Martin, is to you first.

The Affordable Care Act requires the MA plans to spend at least 85 percent, right, of premium revenue on health-care claims. But when these plans acquire related services like PBMs or physician practices and home health agencies, they are actually able to skirt some of these medical loss ratio requirements; is that not correct?

Mr. MARTIN. That is correct.

Senator CORTEZ MASTO. And so, can you talk a bit about this trend? What is the relationship between the medical loss ratio rules and increased vertical integration—and the impact?

Mr. MARTIN. Well, I thank you for the question, Senator Cortez Masto. I think diversification of services allows them to apply more services to the definition of the MLR as it exists today. The Acad-

emy supported MLR in its originating legislation and continues to support it today.

I think the intent of the MLR, from our perspective, was really to direct the maximum amount of financial resources to clinical care and services that support clinical care, and I think the definition of that has evolved since the passage of the law and is probably due for reexamination.

Senator CORTEZ MASTO. By us. Reexamination by Congress; really take a look at really the impact. Is it really having the intended impact of its original intent?

Mr. MARTIN. Yes; correct.

Senator CORTEZ MASTO. Okay; thank you.

I want to also jump back to some of the conversation earlier about private equity. From 2011 to 2019, the number of hospices that were owned by private equity nearly tripled as investors pursued growth potential and profitability in the end-of-life care. When States surrounding Nevada increased their oversight of this industry, hospice moved to Nevada, and we saw the number of hospices in Clark County more than double.

In fact, according to CMS's December 2022 hospice oversight report, Las Vegas had 110 certified hospices, and just in comparison, New York State had only 41. And some of the hospices are now being identified as these "churn and burn" hospices, and what I mean by that is, they are enrolling as many patients as possible until they are either audited or they reach Medicare's reimbursement rate.

Then they close their doors. They acquire a new license, along with a new Medicare billing number, transfer their patients, and start the whole process over again. Now we literally, in southern Nevada, have become the hot spot for these burn and churn hospices, so that they can make money off of our seniors.

So maybe, Dr. Maddox, let me start with you. With proper oversight of the hospice industry, I imagine we would see a decline in the number of profit-seeking enterprises. But heavy administrative burdens are what I see as also driving these mom and pop shops to join larger consolidated entities.

So how do we balance that need for strong regulation that protects our patients, with the importance of encouraging a competitive marketplace in this area?

Dr. MADDOX. So, thank you, Senator Cortez Masto, for that question. I think first, I 100 percent agree that the kind of really horrifying abuse and fraud that we see in this sector is outrageous and needs to be addressed aggressively.

I think the way that we prevent that from negatively impacting the kind of hyper-local patient-centered care that hospice inherently must be is by being smart about the regulations that are put in place. That means that we have better data on ownership, so that the same people cannot keep doing the same thing; that we have better up-front understanding of who owns what and what they are doing; that we create a better real-time data infrastructure to understand these things, so that we are not looking back 5 years later and saying, "What was the effect of private equity on that industry?"; and that we are watching on a quarterly basis to understand quality, outcomes, and patient experience in every

place that Medicare is touching with its dollars. It is well within the purview of Medicare to ask for information about the dollars that are being spent, and in some industries, that is quite underdeveloped.

It is difficult to think about data and hospice, right? Your patients die, and it is a tough thing to ask about, and it is a tough situation to be in. But we need to do a better job of developing low-burden data infrastructure to quarterly update our evaluation of every single entity providing care, particularly to vulnerable populations.

Senator CORTEZ MASTO. So, there is a role for us to play at the Federal level, along with at the State level——

Dr. MADDOX. Absolutely.

Senator CORTEZ MASTO [continuing]. State oversight in this area; correct?

Dr. MADDOX. Absolutely.

Senator CORTEZ MASTO. Thank you.

Mr. Thomas?

Mr. THOMAS. Yes, thank you, Senator. So, in our community in Grand Junction, CO, we have a community-based hospice that we have developed together. It is a not-for-profit. I sit on the board of directors. Most of the health-care leaders in our community do, and we are at risk of closing this facility.

So one of the successes I think you see in our community for keeping the cost of care down is, we have such a robust palliative and hospice care. We are taking care of people. We are making sure they communicate. We talk about end-of-life, that we are not—I do not want to say "wasting," but we are not spending unnecessary resources at the end of life.

As more and more rules come out to go after those bad apples, it is crushing us, and we are at risk of having to close our community-based hospice. We have already had to reduce our expenses 20 percent. It is just that trickle-down effect. We have a marvelous hospice system. It is called Hope West, and unfortunately, I am not sure—we have a new CEO who is just fabulous, and she is going to fight like hell to keep it open. But we are very worried about that and what it will do then to the cost of care in our community.

Senator CORTEZ MASTO. Thank you, and I know my time is up, Mr. Chairman. But I think this is an area we absolutely need to focus on when it comes to private equity and this idea where they identify these unique areas in health care.

Right now, it is hospice. It could be something else, and I think that is for us to kind of figure out, understand what is on the horizon as well, but how do we put regulations or supports in place that are not going to put hospice care, like Mr. Thomas talked about, out of business as well.

The CHAIRMAN. I want to thank my colleague for her leadership on this issue, and I was aware that you had been digging into this. The fact is that, as my colleague has said, there are substantial amounts of Federal funds here, and our oversight team here at the Finance Committee is looking now at private equity and hospice, and we very much appreciate working with my friend from Nevada, because these are hugely consequential issues.

I continue to believe that good quality care and smart policies for taxpayers are not mutually exclusive. We can do both, but it requires the kind of leadership my colleague is talking about, and I look forward to working with her.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

Mr. Martin, in your testimony, you discuss the significant administrative burden faced by physicians and the impact this can have on their ability to serve patients. I have heard from physicians in South Dakota and across the country about the burden of prior authorization, the hurdles it can create for patients to receive timely medical care.

As you may know, for several years I have led this legislation, along with Senator Brown, called the Seniors Timely Access to Care Act, that seeks to streamline the prior authorization process and address the burden prior authorization can have on physicians, and Medicare Advantage in particular.

Could you talk more about the impact that prior authorization has on a physician's administrative workload and how this impacts their ability to maintain their practice, and maybe more particularly, what impact does it have on smaller practices in rural areas?

Mr. MARTIN. Senator Thune, thank you so much for that, and thank you for your leadership on this issue. So I will give you a statistic. In the Medicare Advantage program, over 80 percent of prior authorizations are ultimately approved upon appeal. So you know, we have created an administrative complexity that is delaying care or access to care for patients.

It is creating incredible frustration and expense for physicians, and ultimately, for what? I mean, the product or the recommendation is ultimately approved. I think this is an assault on clinical autonomy for purposes that are not yet identified, and the impact on that is, physicians become frustrated.

The cost of maintaining staff to assist in this type of engagement, from a business perspective, is more impactful the smaller the practice. So you know, many rural physicians simply cannot afford to engage in this activity. They do not have the staff or the technology that allows them to do this.

It has consequences, and those consequences are, they ultimately pull back the amount of Medicare patients that they see as part of their panel, and they close or sell, and move into other clinical opportunities.

Senator THUNE. In your testimony, you discuss as well the different pressures faced by health-care providers in rural areas. As you know, in States like South Dakota with large rural areas, health-care providers face many challenges, including finding and retaining workforce, lower patient volumes, and often older and sicker populations.

There was a GAO report out in 2021 that found fewer physician practices in rural areas were participating in alternative payment models or value-based care arrangements. Value-based care can improve, as you know, patient outcomes, while also giving providers more flexibility to provide the right care at the right time.

So, could you talk about the barriers providers in rural areas face to participate in value-based arrangements, and how might we

be able to incentivize more participation for these providers in value-based care arrangements?

Mr. MARTIN. Yes. Thank you for that as well. So I think there are three important things impacting family physicians in rural areas.

One you have identified, which is a lack of access to what I would call an appropriate payment model. They are still very much on a fee-for-service chassis. We really need to move them to a capitated or global payment model that allows them to be multimodal and more patient-centered versus billing-centric.

The second thing is, we need to connect them to resources, higher-acuity resources, in a more real way. There is a lot of innovation through telemedicine, like Project ECHO and others. But rural physicians often find themselves isolated from the specialty care that their urban or suburban colleagues have, and that isolation puts a lot of downward pressure on them to provide comprehensive services, or to provide comprehensive services without the support that is readily available to them through technology and other aspects.

And then, I think the third thing to really drive improvements in rural access, particularly physician access, is removing some of the biases that exist in academic settings, where medical students in the earliest days of their career are not getting exposure to the joys of rural practice. They are often told how hard it is and how unfulfilling it is, and I think you could attest to this, Senator Thune. Many of the physicians who are practicing in rural South Dakota are frustrated, but they are very satisfied with the engagement they have with their patients and communities, and we need to tell that story in a different way.

Senator THUNE. Absolutely, and if I could just—my time is expiring—switch to Ms. Pearson quickly. Could you describe your experience with real-time benefit tools, and what barriers exist to consumers and providers fully adopting them? That is an issue that I have been involved with for some time, and I would be curious to know what your thoughts and perspectives are on that.

Ms. PEARSON. Thank you for the question, Senator. We have talked today about how consumers represent a very important but limited part of the process for using data and pricing to drive behavior. Certainly, tools like real-time benefit information can help consumers who are able, willing, and eager to shop for care, to do so in an informed way.

What we need to recognize is that there is a significant information asymmetry between an individual patient who is not a clinician, and as we have moved toward high-deductible health plans and other tools, we have seen that often patients forego preventive care that will keep them well. I know that is an issue that you have been very focused on, and I thank you for that.

So we need to set them up with the tools that really help them get the care they need at the right cost, but recognizing that they are not doctors.

Senator THUNE. Yes, thank you. Okay. Thank you, and I thank the panel. It has been a great panel; thank you.

The CHAIRMAN. I thank my colleague, and it is good to have a number of the Republican leadership here, because we are going to work on these issues in a bipartisan way.

Senator Cassidy?

Senator CASSIDY. Hey, thank you all; great panel.

I will focus on Dr. Cooper and Dr. Maddox. I could have done the others, but I am just going to choose you all in the interest of time. It seems like we almost have a kind of cross-cutting problem of consolidation and solutions of consolidation.

I say that because, when we see that hospitals or insurance companies purchase physician practices, in the case of hospitals, it drives up cost. In the case of insurance companies, it may drive down cost, but there is no evidence—some of that cost appears to be, in fact much of it appears to be retained by the insurance company.

Private equity, which is another subject of this, actually provides competition to that. The private equity group actually has the incentive for their physicians to do their care in the lowest-cost setting of care, as opposed to in a hospital where you could argue—and sometimes allegedly it is being used to support bricks and mortar.

Dr. Maddox, is that kind of a fair kind of framing or at least one way to frame this discussion?

Dr. MADDOX. Yes. I think, Senator, you have brought a very important nuance to the discussion, which is to say that, as long as people are competing with the right incentives, maybe it is a good thing to bring innovation and fresh eyes and new money into health care.

But in order for that to ultimately benefit patients, we have to make sure that they are competing in the right ground to do that. So, if that means investing in primary care, creating wrap-around services, keeping people out of the hospital, ultimately making them better—and that is a way that private equity can disrupt some of this consolidation—then there is potential for benefit.

We just have to create the policy circumstances such that that is where they focus, and not on the sort of profit maximization by driving up prices in ophthalmology or churn and burn hospice. It is a great nuance.

Senator CASSIDY. Dr. Cooper, would you add to that?

Dr. COOPER. Yes. So I think the first thing I would say is, not all mergers are bad. We have to look deal by deal. I think when it comes to private equity, there is some evidence of some of the acquisitions doing a decent job. So infertility services are an area where we have actually seen them do really well.

You can juxtapose that with, say, physician staffing companies in the emergency room space, where they were, I think, not working in the public interest. So, I think it is sort of creating sort of the environment where, when they enter, it is basically easier for them to make money doing good for patients than it is for sort of gaming the system.

Senator CASSIDY. I think that is actually well put. I saw in one of the articles I read that they decreased their staffing ratio, but their outcomes actually improved. And so it tells me that there are efficiencies that you can bring.

I met with some physician groups, who frankly are owned by private equity, and they started talking about the billing cycle. As a practicing physician, I never had a clue what a billing cycle was. But I suspect that Mr. Martin's staff people now do.

Mr. MARTIN. Yes, all too well.

Senator CASSIDY. Well, it brings that sophistication in that allows somebody to maintain a modicum of independence when otherwise they could not. Many physicians lack the sophistication for that.

Going to the quality, I think, Dr. Cooper and Dr. Maddox, you raise the point that quality maybe in one setting is not as good and in another setting improves with the intervention of private equity. I like the way you put it. You make more money if you take better care of patients. That is a good thing, of course, if you couple that with value-based arrangements.

So, Dr. Maddox, really quickly, what would you recommend as the way to structure it, so that if there is a disrupter that comes into the market breaking up the status quo, that the disrupter actually is incentivized to do the right thing and by, if you will, bringing in competition, incentivizes the status quo to do better?

Dr. MADDOX. That is a great question. I think the idea is that, if people compete on total cost of care models, where they win by keeping people out of the hospital and healthy over a prolonged period of time, not just for next week but when we are thinking about really investing in long-term health, we should want people to come in and disrupt that.

We have created a system that pays for people being sick, and not for people being well. So, if you put money in a space where, if you improve equity and keep people healthy and out of the hospital and beat chronic disease, you win, that is great.

Senator CASSIDY. So by that, you are actually agnostic as to what the entity is. Rather, you are kind of doubling down on the fact that we have to have economic incentives that are aligned.

Dr. MADDOX. Exactly. Economic incentives and the data to be able to monitor them. Right now, the private sector wins on data, and so they find the loopholes much faster than the regulators can close them. So we need to proactively design a system such that people are going toward very concrete, very clear, very positive results for patients.

Senator CASSIDY. Got it.

With that, I yield. Thank you.

The CHAIRMAN. I thank my colleague. I want to thank our panel for their patience. This has been an exceptionally good discussion.

You know, over the years, everybody tries to become marginally coherent in something, and health care has always been my first love, because since the days when I was director of the Gray Panthers, I always felt that if you and your loved ones did not have their health, everything else went by the boards.

And what was so good about this panel—and I want to commend the Republican staff as well, as I have already thanked the Democratic staff—this was a panel picked on a bipartisan basis. Senator Crapo and I have been talking about the roots of this issue, and there are lots of pieces to this puzzle.

I have tried to keep track of a fair number of them, but obviously costs to patients, layoffs to workers, escalating costs for taxpayers, private equity, PBMs, algorithms, health-care prevention—I sort of start running out of paper. But really exceptional testimony. I want to thank all of you and the fact that nobody said, "Okay, let us now have the Democratic solution to this question of corporatization."

But something that really made the case for—and I thought your point with respect to data, Dr. Maddox, really captured it in one example. I mean, a lot of these policies are not somebody got up at the Federal agency on such and such and said, "Let us be rotten to so and so." A lot of these policies stem from the fact they have not kept up with the times.

That was why I was talking about technology; Senator Cornyn's point with respect to prevention; my colleague, Senator Crapo, talking about incentives. I can literally go down the dais. But it was all about, let us think this through, and that is what we have tried to do.

So I thank all of you. Solutions are going to be first. That is what you heard today. I want to thank our witnesses, and we have a little bit of business for the committee.

Questions for the record will be due in a week, on Thursday, June 15th, by 5 p.m., and on top of it all, my gavel disappeared. [Laughter.] We will just excuse all of you, and we will thank you, and with that, the Finance Committee is adjourned.

[Whereupon, at 12:43 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ZACK COOPER, PH.D., ASSOCIATE PROFESSOR OF PUBLIC HEALTH AND ASSOCIATE PROFESSOR OF ECONOMICS, YALE UNIVERSITY

OVERVIEW [1]

In 2021, the United States (U.S.) spent $4.3 trillion—18.3 percent of Gross Domestic Product (GDP)—on health care.[2] To put that number in context, Germany is the fourth largest economy in the world and had a GDP of $4.2 trillion in 2021.[3] As a result, if the U.S. health-care system was a country, in dollar terms, it would be the fourth largest country in the world with an output larger than the entirety of the German economy.

The U.S. relies on private markets to provide health-care services and administer health insurance. In part, this reliance on markets is a function of the sheer scale of the U.S. health system. As a result, the health of the U.S. health system is a function of the health of the markets that underpin our health system.

As I'll argue, the provider markets that underpin our health system are becoming increasingly concentrated. This rise in concentration is harmful to the public. Increasing consolidation raises provider prices (thus increasing health spending) and harms access to health-care services (by increasing insurance premiums and out of pocket costs). In turn, rising health spending is putting pressure on government programs, lowering tax revenue, and leading to lower wages, job losses, and rising inequality among those with employer-sponsored insurance coverage. In short, efforts to guarantee the long-run sustainability of public insurance programs and rein in the growth of private insurance premiums cannot ignore rising consolidation and the shifting market landscape in the health-care sector.

It is near universally accepted by economists that even when employers contribute to their employees' insurance premiums, these premiums and the cost of health-care services are almost wholly borne by individuals and families, not by their employers or by insurers.[4] In 2021, annual premiums for family coverage via an employer-sponsored insurance plan were $22,221.[5] For context, a new Toyota Corolla, the

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[1] My thanks to Yale Ph.D. student Genna Liu for her excellent research assistance, which aided greatly in the preparation of this testimony.

[2] "National Health Expenditure Data," Centers for Medicare and Medicaid Services, 2021, *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData.*

[3] "GDP (current U.S.$)—Germany," The World Bank, *https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=DE.*

[4] Gruber, Jonathan, "The Incidence of Mandated Maternity Benefits," *American Economic Review,* 1994, Vol. 84(3), pp. 622–641; Baicker, Katherine, and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics,* 2006, Vol. 24(3), pp. 609–634 ("Baicker and Chandra, 2006"); Currie, Janet, and Brigitte C. Madrian, "Health, Health Insurance and the Labor Market," in *Handbook of Labor Economics,* 1999, Vol. 3, eds. Orley Ashenfelter and David Card, pp. 3309–3416 ("Currie and Madrian, 1999"); Gaynor, Martin, "Antitrust Applied: Hospital Consolidation Concerns and Solutions," Statement Before the Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights, U.S. Senate, 2021, *https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf* ("Gaynor Senate Testimony").

[5] "Employer Health Benefits 2021 Annual Survey," Kaiser Family Foundation, 2021, *https://www.kff.org/report-section/ehbs-2021-summary-of-findings/.*

12th highest selling car in the U.S., costs $21,700.[6] In other words, the average family in the U.S. is buying approximately a new car's worth of insurance each year, even if this purchase is obscured because their employer is purchasing insurance on their behalf.

The rising cost of health care in the U.S. is placing a financial burden on families and the Federal Government.[7] From 2000 to 2021, insurance premiums in the U.S. rose by 215 percent.[8] This increase in premiums was driven by an increase in health spending. By contrast, median earnings during this period grew by only 73 percent.[9] As a result, over the last 2 decades, the rising cost of health care has meant that families have had less money to spend on everything from food to housing to leisure and that the price of insurance has become out of reach for many.[10] And even with full insurance coverage, 44 percent of adults in the U.S. in 2018 were worried about affording a medical bill and 19 percent reported using up all or most of their savings on health-care costs.[11]

Historically, most of the discussion of provider consolidation in the U.S. has focused on the impact of, for example, hospital mergers on hospital prices. However, the way the U.S. funds health care for the privately insured—the ubiquity of and tax exclusion given to employer-sponsored health insurance—means that consolidation that increases health spending is driving decreases in tax revenue, lower wages, job losses, and economic inequality. Theory neatly predicts and empirical evidence highlights that when health spending on those with employer-sponsored coverage goes up, this is paid for by workers in the form of lower wages and job losses.[12] Job losses also impact health. A literature studying the effect of, for example, factory closures highlight that individuals who lose their job have an increased risk of death within a year, often from a suicide, an accident, or a drug overdose.[13] Debt, less tax revenue, lower wages, job losses, and death: these are the consequences of provider consolidation and rising health spending in the U.S.[14]

Moreover, as recent work highlights, because insurance premiums do not vary markedly across workers, when health spending goes up, employer-sponsored health insurance discourages the hiring of non-college educated workers, since insurance premiums make up a higher share of their costs of employment.[15] Indeed, Finkelstein et al. (2023) note, the scale of the effect of our employer-sponsored health in-

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[6] *See:* "2023 Corolla," Toyota, *https://www.toyota.com/corolla;* Capparella, Joey, 2022, "Top 25 Bestselling Cars, Trucks, and SUVs of 2021," *Car and Driver, https://www.caranddriver.com/news/g36005989/best-selling-cars-2021/*.

[7] Tax revenues go down when increases in premiums for employer-sponsored coverage lower wages and employment. Likewise, tax revenue goes down when rising health spending increases the tax subsidies required for health insurance plans sold on exchanges.

[8] Family coverage. "Employer Health Benefits 2021 Annual Survey," Kaiser Family Foundation, 2021, *https://www.kff.org/report-section/ehbs-2021-summary-of-findings/*.

[9] Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999–2021.

[10] Tolbert, Jennifer, Patrick Drake, and Anthony Damico, "Key Facts about the Uninsured Population," Henry J Kaiser Family Foundation, 2022, *https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/*.

[11] Peterson-KFF Health System Tracker, 2020; Montero, Alex, "Americans' Challenges with Health Care Costs," Henry J Kaiser Family Foundation, 2022 *https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/;* "Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored Health Insurance," Henry J Kaiser Family Foundation, September 15–October 9, 2018, *https://files.kff.org/attachment/Topline-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance.*

[12] Gruber, Jonathan, and Alan Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy,* 1991, Vol. 5, pp. 111–143; Baicker and Chandra, 2006; Gaynor Senate Testimony, Currie and Madrian, 2000.

[13] Sullivan, Daniel, and Till von Wachter, "Job Displacement and Mortality: An Analysis Using Administrative Data," *Quarterly Journal of Economics,* 2009, Vol. 124(3), pp. 1265–1306; Eliason, Marcus, and Donald Storrie, 2009, "Does Job Loss Shorten Life," *Journal of Human Resources,* Vol. 44(2), pp. 277–302; Venkataramani, Atheendar, et al., 2020, "Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States," *JAMA Internal Medicine,* Vol. 180(2), pp. 254–262.

[14] Cooper, Zack, et al., "Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-based Care in 2007–14," *Health Affairs,* 2019, Vol. 38(2), pp. 184–189; Cooper, Zack, et al., "Variation in Health Spending Growth for the Privately Insured From 2007 to 2014," *Health Affairs,* 2019, Vol. 38(2), pp. 230–236; Kluender, Raymond, et al., "Medical Debt in the U.S., 2009–2020," *JAMA,* 2021, Vol. 326(3), pp. 250–256; Case, Anne, and Angus Deaton, *Deaths of Despair and the Future of Capitalism,* 2020 ("Case and Deaton, 2020").

[15] Finkelstein, Amy, et al., "The Health Wedge and Labor Market Inequality," Brookings, 2023, ("Finkelstein et al., 2023"); Saez, Emmanuel, and Gabriel Zucman, *The Triumph of Injustice,* 2019; Case and Deaton, 2020.

surance system on wage inequality is similar in magnitude to the measured effects of the outsourcing of jobs, robot adoption, and the decline in real minimum wage.[16]

Most health-care services in the U.S. are furnished by private firms. Private providers compete to deliver care to publicly and privately funded patients. Likewise, the majority of the public receives their health insurance from a private insurer via a market where insurers compete against one another. Indeed, even in publicly funded programs, like Medicare and Medicaid, more than half of the coverage is provided by private insurers. We rely on pharmaceutical firms to develop and manufacture drugs; we rely on pharmacy benefits managers (PBMs) to help firms and purchasers build formularies; we rely on private firms to distribute the vast array of medical products we consume across the country.

Ultimately, the health of the U.S. health system is a function of the extent to which the underlying health-care markets in the U.S. are competitive. This competition disciplines the pricing of private firms and creates incentives for quality.[17] Markets are not perfect. Markets can fail and all markets, particularly those for health-care goods, insurance, and services, require oversight and external support to maintain competition. This oversight and support must include keeping health-care markets from becoming overly concentrated, providing the information that supports market participants (*e.g.,* quality and pricing information), and regulating parts of the market where competition will not produce efficient or equitable outcomes.

Markets in the health sector can function efficiently. Evidence clearly illustrates that when hospitals compete, hospitals deliver higher quality care and patients experience reductions in mortality.[18] In competitive markets, the hospitals with higher prices have better outcomes and those higher prices tend to be cost effective.[19] Similarly, higher-quality hospitals tend to grow more over time—a signpost of a functioning market.[20] This same logic applies to other sectors of the health system outside of hospitals, like the market for physician services or the market for private insurance.

However, ongoing changes in health-care markets over the last 2 decades should have the warning lights on our dashboard blinking red. The changes occurring in U.S. hospital markets parallel changes occurring in other parts of the U.S. health system.[21] From 2000 to the present, there have been well over 1,000 mergers among the Nation's approximately 5,000 hospitals.[22] Partly as a function of this consolidation, at present, nearly 90 percent of U.S. metropolitan areas have hospital markets that make them "highly concentrated" according to the 2010 Department of Justice and Federal Trade Commission Horizontal Merger Guidelines.[23] While not all mergers are harmful, evidence clearly shows that hospital mergers of neighboring facilities can raise prices (so too can so-called "cross market mergers" of hospitals in the same State).[24]

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[16] Finkelstein et al., 2023.

[17] Gaynor, Martin, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," *Journal of Economic Literature,* 2015, Vol. 53(2), pp. 235–284 ("Gaynor, Ho, and Town, 2015").

[18] Cooper, Zack, et al., "Does Hospital Competition Save Lives? Evidence from the English Patient Choice Reforms," *Economic Journal,* 2011, Vol. 121, pp. F228–F260 ("Cooper, et al., 2011"); Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper, "Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service," *American Economic Journal: Economic Policy,* 2013, Vol. 5(4), pp. 134–166 ("Gaynor, Moreno-Serra, and Propper, 2013"); Kessler, Daniel P., and Mark B. McClellan, "Is Hospital Competition Socially Wasteful?", *Quarterly Journal of Economics,* 2000, Vol. 115(2), pp. 577–615 ("Kessler and McClellan, 2000").

[19] Cooper, Zack, et al., "Do Higher-Price Hospitals Deliver Higher-Quality Care?" NBER Working Paper 29809, 2022 ("Cooper, et al., 2022").

[20] Chandra, Amitabh, et al., "Health Care Exceptionalism? Performance and Allocation in the U.S. Health Care Sector," *American Economic Review,* 2016, Vol. 106(8), pp. 2110–2144 ("Chandra, et al., 2016").

[21] Fulton, Brent D., "Health Care Market Concentration Trends in The United States: Evidence and Policy Responses," *Health Affairs,* 2017, Vol. 36(9), pp. 1530–1538 ("Fulton, 2017").

[22] Cooper, Zack, and Martin Gaynor, "Addressing Hospital Concentration and Rising Consolidation in the United States," *1% Steps for Health Care Reform, https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/.*

[23] Fulton, 2017.

[24] Gowrisankaran, Gautam, Aviv Nevo, and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *American Economic Review,* 2015, Vol. 105(1), pp. 172–203 ("Gowrisankaran, Nevo, and Town, 2015"); Cooper, Zack, et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics,* 2019, Vol. 134(1), pp. 51–107; Dafny, Leemore, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of*

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Like hospital markets, insurance markets in the U.S. are also generally regarded as highly concentrated.[25] More concentrated health insurance markets have higher premiums, and mergers of insurance companies raise premiums and lower payments to doctors.[26] Physician markets, while less easily observed, are also regarded as highly concentrated. Higher concentration in physician markets is also associated with higher prices, and mergers between physician practices have been found to raise prices.[27]

U.S. health-care markets are also evolving in new and distinct ways. There is increasing vertical integration: hospitals are acquiring physician practices, insurers are acquiring physician practices, and insurers are acquiring PBMs. There is a steady increase in private capital flowing into health-care markets (ranging from venture capital, to private equity, to publicly traded companies). Finally, there is the growing ubiquity of health-care conglomerates: large firms like Aetna CVS Health and UnitedHealth Group that have insurance businesses, own providers, own pharmacy benefits managers, and have huge proprietary data repositories. Collectively, these large acquisitions, mergers, and new deals are appropriately giving the public, and researchers like me, pause, as we seek to understand the effects of these arrangements in the near and long term. As such, I applaud the committee for hosting this hearing and its efforts to learn more about what drives consolidation in health-care markets, as well as what might be done to keep the U.S. health-care markets functioning efficiently.

In this testimony, I will outline the major changes occurring in U.S. health-care provider markets. I will also offer some recommendations on ways to address rising concentration and thwart abuses of market power.

LEARNING FROM THE CHALLENGES AND CHANGES IN HOSPITAL MARKETS

While studying the functioning of the U.S. hospital industry is vital in its own right, understanding the impact of reductions of competition in the hospital industry in the U.S. over the last 3 decades can provide important insights into the impact of competition and consolidation in the health sector more broadly. An analysis of the U.S. hospital industry highlights how competition can drive quality and illustrates how some mergers can be harmful to patients and wider communities.

The hospital industry accounts for 5.7 percent of U.S. GDP and 31.1 percent of health spending.[28] When discussing provider market power, it is important to distinguish between payments made to providers by the Medicare and Medicaid programs and payments made by commercial insurance plans offered by for-profit and not-for-profit insurers. At a high level, Medicare pays hospitals using regulated payments implemented by the Centers for Medicare and Medicaid Services. By contrast, for the privately insured, hospitals and insurers engage in bilateral negotiations over the prices for care for each insurance plan. The Medicaid program pays hospitals using a combination of negotiated and regulated prices.

During the 2000s, the Bureau of Labor Statistics found that hospital prices grew faster than prices in any other U.S. industry.[29] Ultimately, the prices hospitals negotiate with insurers are markedly higher than the regulated prices they are paid

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Economics, 2019, Vol. 50(2), pp. 286–325; Lewis, Matthew S., and Kevin E. Pflum, "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions," *RAND Journal of Economics,* 2017, Vol. 48(3), pp. 579–610.

[25] "Competition in Health Insurance: A Comprehensive Study of U.S. Markets," American Medical Association, 2022, *https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.*

[26] Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," *American Economic Review,* 2012, Vol. 102(2), pp. 1161–1185 ("Dafny, Duggan, and Ramanarayanan, 2012").

[27] Koch, Thomas, and Shawn Ulrick, "Price Effects of a Merger: Evidence From a Physicians' Market," *Economic Inquiry,* 2021, Vol. 59(2), pp. 790–802; Dunn, Abe, and Adam Hale Shapiro, "Do Physicians Possess Market Power?", *Journal of Law and Economics,* 2014, Vol. 57(1), pp. 159–193 ("Dunn and Shapiro, 2014"); Koch, Thomas, Brett Wendling, and Nathan E. Wilson, "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries," *Health Services Research,* 2018, Vol. 53(5), pp. 3549–3568 ("Koch, Wendling, and Wilson, 2018").

[28] National Health Expenditure Data, Centers for Medicare and Medicaid Services, 2021, *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata.*

[29] Bureau of Labor Statistics, Consumer Price Index and Producer Price Index data, *https://www.bls.gov/data/*.

by the Medicare program.[30] Commercial reimbursements have also risen much more quickly than Medicare payment rates. In the late 1990s, commercial payments to hospitals were only approximately 10 percent higher than Medicare reimbursements; by 2012, hospital payment rates from private insurers were 75 percent higher than Medicare rates.[31] At present, it is not uncommon for hospitals to be paid 200 percent or more of Medicare rates.[32] Here, it is vital to point out that most academic experts do not accept the idea of cost shifting—the concept that hospitals' payments from insurers are going up because of low payments from public payers.[33] Rather, the broad consensus is that the difference in the growth in prices hospitals negotiate with insurers reflects the impact of changes in providers' bargaining leverage and reductions in competition.

Economists are broadly concerned with rising market power across industries.[34] However, a literature dating back to the 1960s generated a conventional wisdom that questioned whether competition could function in the hospital sector and posited that nonprofit hospitals would behave differently from for-profit actors and not abuse their market power should they have it. More recently, a growing body of work highlights that competition between hospitals can incentivize quality and generate efficient prices, and that non-profit hospitals often behave similarly to for-profits.[35] A key takeaway from this literature: for markets to function, they must not become too highly concentrated, regardless of the tax status of market participants.

As Chandra et al. (2016) note, "a classic 'signpost of competition' in manufacturing industries is that higher productivity producers are allocated greater market share at a point in time and over time."[36] In other words, better firms grow more quickly. The authors then assess, via analyzing the Medicare program, whether higher-quality hospitals have higher market share and grow more quickly. The authors find that, when using measures of both outcomes (*e.g.*, mortality and readmissions) and process (*e.g.,* adherence to guidelines), higher-quality hospitals have greater market share and experience more growth in market share over time. They conclude that "health care may have more in common with 'traditional' sectors subject to market forces than often assumed."

In Cooper et al. (2022), my coauthors and I analyze whether higher-priced hospitals deliver higher-quality care—a simple test for assessing the extent to which the market for hospital care is functioning.[37] We have two notable findings. First, patient death rates are markedly lower at high-priced hospitals. However, this positive correlation between prices and quality is only present in hospitals in unconcentrated markets where there is scope for competition (*e.g.,* markets with a Herfindahl Hirschman Index (HHI) of less than 4,000). By contrast, in more concentrated markets, going to a higher-priced hospital raises health spending markedly with no effect on clinical outcomes. Second, we find that high hospital prices in competitive markets appear to be cost-effective given their association with better outcomes.

Several studies find that hospitals facing more competition have better outcomes. Kessler and McClellan (2000) study outcomes for Medicare beneficiaries and observe that patients receiving care from hospitals in the most concentrated (least competitive) markets had mortality rates that are 4.4 percent higher than patients receiving care at hospitals in less concentrated (more competitive markets).[38] Likewise, Cooper et al. (2011) and Gaynor, Moreno-Serra, and Propper (2013) study the effect of a set of reforms in the English National Health Service which gave patients a

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[30] Cooper, Zack, et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics,* 2019, Vol. 134(1), pp. 51–107.

[31] Selden, Thomas M., et al., "The Growing Difference between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs,* 2015, Vol. 34(12), pp. 2147–2150.

[32] Chernew, Michael E., Andrew L. Hicks, and Shivani A. Shah. "Wide State-Level Variation in Commercial Health Care Prices Suggests Uneven Impact of Price Regulation," *Health Affairs,* 2020, Vol. 39(5), pp. 791–799.

[33] Frakt, Austin B., "How Much Do Hospitals Cost Shift? A Review of the Evidence," *Milbank Quarterly,* 2011, Vol. 89(1), pp. 90–130; Glied, Sherry, "COVID–19 Overturned the Theory of Medical Cost Shifting by Hospitals," *JAMA Health Forum,* 2021, Vol. 2(6), e212128.

[34] Berry, Steve, Martin Gaynor, and Fiona Scott Morton, "Do Increasing Markups Matter? Lessons from Empirical Industrial Organization," *Journal of Economic Perspectives,* 2019, Vol. 33(3), pp. 44–68.

[35] Handel, Ben, and Kate Ho, "Industrial Organization of Health Care Markets," in *Handbook of Industrial Organization,* 2021, Vol. 5, eds. Kate Ho, Ali Hortaçsu, and Alessandro Lizzeri, pp. 521–614.

[36] Chandra, et al., 2016.

[37] Cooper, et al., 2022.

[38] Kessler and McClellan, 2000.

choice of their provider and forced hospitals to compete.[39] This is a setting with regulated price that is quite analogous to the markets hospitals face when offering care to Medicare beneficiaries. Both studies find that hospitals exposed to competition after these reforms lowered their mortality rates.

Consolidation in the Hospital Industry

From 1998 to 2017, as the American Hospital Association notes, there were 1,577 hospital mergers among the Nation's approximately 5,000 hospitals. There were 261 additional hospital mergers announced from 2018–2020. As Cooper et al. (2019) note, the vast majority of hospitals in the U.S. have either been directly involved in a merger or have been a neighbor to a merger. While some of the mergers that occurred had little or no impact on competition, many of the mergers that happened were between hospitals that were close competitors. My own calculations suggest that approximately 20 percent of mergers between 2000 and 2020 could be classified by the Department of Justice and Federal Trade Commission Horizontal Merger Guidelines as "presumed likely to enhance market power."[40]

There is now a large body of academic evidence on the impact of hospital mergers which yields four core conclusions.

- First, mergers of hospitals that are geographically proximate and are close substitutes to one another can lead to meaningful price increases.[41] The literature shows that it is not uncommon for hospital mergers to generate price increases of 20 percent or more and, in some cases, they can generate price increases of more than 50 percent. Recently, two studies have found that mergers of hospitals that are not geographically proximate but share common customers can raise prices by between 10 percent and 20 percent. Of note, both nonprofit hospitals and for-profit hospitals have been found to raise prices after mergers that lessen competition.[42]
- Second, the literature suggests that most mergers either have no effect on clinical quality or have led to modest reductions in clinical quality.[43]
- Third, the literature suggests that mergers of nearby competing hospitals tend not to reduce costs and that if there are cost reductions, it generally is not passed on to consumers.[44] By contrast, there is some evidence of 4 percent

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[39] Cooper, et al., 2011; Gaynor, Moreno-Serra, and Propper, 2013.

[40] U.S. Department of Justice and Federal Trade Commission, "Horizontal Merger Guidelines," Technical Report 2010.

[41] Town, Robert, and Gregory Vistnes, "Hospital Competition in HMO Networks," *Journal of Health Economics,* 2001, Vol. 20(5), pp. 733–752; Krishnan, Ranjani, "Market Restructuring and Pricing in the Hospital Industry," *Journal of Health Economics,* 2001, Vol. 2, pp. 213–237; Vita, Michael G., and Seth Sacher, "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study," *Journal of Industrial Economics,* 2001, Vol. 49(1), pp. 63–84; Gaynor, Martin, and William B. Vogt, "Antitrust and Competition in Health Care Markets," in *Handbook of Health Economics,* Vol. 1, eds. Anthony J. Culyer and Joseph P. Newhouse, pp. 1405–1487; Capps, Cory, David Dranove, and Mark Satterthwaite, "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics,* 2003, Vol. 34(4), pp. 737–63; Capps, Cory, and David Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs,* 2004, Vol. 23(2), pp. 17–181; Dafny, Leemore, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *Journal of Law and Economics,* 2009, Vol. 52(3), pp. 523–550; Haas-Wilson, Deborah, and Christopher Garmon, "Hospital Mergers and Competitive Effects: Two Retrospective Analyses," *International Journal of the Economics of Business,* 2011, Vol. 18(1), pp. 17–32; Tenn, Steven, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," *International Journal of the Economics of Business,* 2011, Vol. 18(1), pp. 65–82; Thompson, Aileen, "The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction," *International Journal of the Economics of Business,* 2011, Vol. 18(1), pp. 91–101; Gowrisankaran, Nevo, and Town, 2015.

[42] Gaynor, Martin, Kate Ho, and Robert J. Town, "The Industrial Organization of Health Care Markets," *Journal of Economic Literature,* 2015, Vol. 53(2), pp. 235–84.

[43] Beaulieu, Nancy D., et al., "Changes in Quality of Care After Hospital Mergers and Acquisitions," *New England Journal of Medicine,* 2020, Vol. 382(1), pp. 51–59; Romano, Patrick, and David Balan, "A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare," *International Journal of the Economics of Business,* 2011, Vol. 18(1), pp. 45–64; Capps, Cory, "The Quality Effects of Hospital Mergers," unpublished manuscript, 2005, Bates White LLC; Haas, Susan, Atul Gawande, and Mark E. Reynolds, "The Risks to Patient Safety from Health System Expansions," *JAMA,* 2018, Vol. 319(17), pp. 1765–1766.

[44] Craig, Stuart, Matthew Grennan, and Ashley Swanson, "Mergers and Marginal Costs: New Evidence on Hospital Buyer Power," *RAND Journal of Economics,* 2021, Vol. 52(1), pp. 151–178.

to 7 percent cost savings among mergers involving hospitals that are not competitors (and thus are deals that are less likely to raise prices).[45]

- Fourth, consistent with theory, in addition to impacting product markets (*e.g.,* the market for hospital services), mergers can give merging parties more bargaining power over their workers' wages (*e.g.,* it gives hospitals market power in input markets). Here, recent work by Prager and Schmitt found that mergers which resulted in large increases in concentration led to 1.7 percentage points slower wage growth for nurses and pharmacy workers.[46]

While my testimony is focused on the impact of market power among providers, it is worth noting that similar patterns can be observed in insurance markets. There are two peer-reviewed studies that examine the impact of insurance mergers.[47] Both studies found that premiums increased after the mergers in markets where the merging parties had the most overlap before the mergers occurred. One of these studies also found that insurance mergers led to a reduction in the payment rates to providers and, notably, did not find that these savings were passed on to consumers.[48]

PHYSICIAN MARKETS

There are approximately a million physicians in the U.S.[49] The market for physician services has experienced changes over the last 2 decades that, in many ways, parallel what happened in hospital markets.[50] During this period, physician markets have experienced horizontal mergers (*e.g.,* two physician practices merging), vertical integration (*e.g.,* hospitals or insurers buying physician practices), and an expansion in the share of physician practices owned by private equity (PE) firms. From 2010 to 2016, the increase in concentration in physician markets paralleled the rise in concentration among hospital markets.[51] At present, approximately 40 percent of U.S. markets are "highly concentrated" for primary care services. Likewise, over the last decade, the share of physicians employed by hospitals roughly doubled and reached nearly 40 percent.[52]

While both vertical and horizontal integration of physician practices could, in theory, lead to efficiency gains, the empirical evidence thus far suggests both types of transactions have raised the prices physicians negotiate with insurers and increased health spending on Medicare beneficiaries and the privately insured. For example, recently published work by economists at the FTC found that horizontal physician practice mergers led to increases of between 10 percent and 20 percent in the prices negotiated with insurers.[53] This finding builds on past work showing that physicians in more concentrated markets have higher prices.[54] Likewise, evidence on the effect of hospital acquisition of physician practices (*e.g.,* vertical integration) has found that these transactions raised prices, on average, by more than 10 percent and led to marked increases in both public and private health spending.[55] Notably, this literature has not found that the vertical integration of hospitals and physicians has led to improvements in quality and has found that acquired physicians tend to shift their patient referrals to their new acquiring entities.[56] At present, there is

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[45] Schmitt, Matt, "Do Hospital Mergers Reduce Costs?", *Journal of Health Economics,* 2017, Vol. 52, pp. 74–94.

[46] Prager, Elena, and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review,* 2021, Vol. 111(2), pp. 397–427.

[47] Dafny, Duggan, and Ramanarayanan, 2012; Guardado, Jose, David Emmons, and Carol Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra," *Health Management, Policy and Innovation,* 2013, Vol. 1(3), pp. 16–35.

[48] Dafny et al., 2012.

[49] "Professionally Active Physicians," Kaiser Family Foundation, January 2023, *https://www.kff.org/other/state-indicator/total-active-physicians/*.

[50] Fulton, 2017.

[51] Fulton, 2017.

[52] Fulton, 2017.

[53] Kock, Thomas, and Shawn Ulrick, "Price Effects of a Merger: Evidence from a Physicians' Market," *Economic Inquiry,* 2020, Vol. 59(2), pp. 790–802 ("Kock and Ulrick, 2020").

[54] Dunn and Shapiro, 2014.

[55] Cory Capps, David Dranove, and Chris Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics,* 2018, 59(2), pp. 139–152.

[56] Scott, Kristin W., et al., "Changes in Hospital-Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care," *Annals of Internal Medicine,* 2018, Vol. 168(2), pp. 156–157; Kock and Ulrick, 2020; Short, Marah Noel, and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review,* 2020, Vol. 77(6), pp. 538–548; Chernew, Michael, Zack Cooper, Eugene Larsen-Hallock,

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little evidence on whether insurer acquisition of physician practices impacts spending. However, we should be vigilant about whether these transactions lessen competition and how they impact risk-adjustment coding, particularly in the Medicare Advantage program.

ADDRESSING CONSOLIDATION IN THE HEALTH SECTOR

Provider consolidation has adversely impacted the American public, lowered tax revenue, and raised health spending for the publicly and privately insured. There are, however, a number of steps that could be taken to avoid unintentionally incentivizing consolidation, strengthen antitrust enforcement laws and enforcement, promote competition in existing markets, and expand data availability and create a national claims database.

Avoiding Incentivizing Consolidation

Steps could be taken to lessen the incentive for firms to consolidate.

1. Firms might be merging to try to defray high (fixed) administrative costs. Here, for example, duplicative quality reporting requirements across Medicare and private insurers, as well as claims forms that differ across insurers, can raise administrative costs for hospitals. This in turn might encourage mergers. As the Congressional Budget Office reports, in 2020, the Centers for Medicare and Medicaid Services used more than 2,000 quality metrics to oversee providers' performance.[57] Steps should be taken constantly to lower the administrative costs facing hospitals. Here, Harvard University Professor David Cutler has produced a detailed set of thoughtful recommendations for reducing administrative costs for hospitals, including establishing a clearinghouse for bill submission and simplifying prior authorization.[58]

2. At present, the Medicare program often pays more for health-care services if they are performed at hospital outpatient departments versus in a physician office. As a result, hospitals and physicians can receive higher payments and share the surplus post acquisition if the hospital buys the physician practice (*e.g.,* they vertically integrate). Academic research and MedPAC have suggested that this lack of site neutral payments encourages vertical integration and raises public and private health spending.[59] While Congress worked to address this in 2015, more could be done to expand site neutral payments to a wider array of outpatient services across hospital outpatient departments.

3. The 340B program provides hospitals with discounted access to infused medications. The program is designed to offset the costs of delivery of these products to certain low-income populations. However, one consequence of the program is that it can allow certain hospitals with a 340B waiver to acquire these products at cheaper prices than certain physician practices. As the Congressional Budget Office and a wide range of outside experts have noted, this can unintentionally incentivize hospitals to vertically integrate with physician practices that give their patients large quantities of infused products.[60] One strategy, proposed by scholars at the Brookings Institution and

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and Fiona Scott Morton, "Physician Agency, Consumerism, and the Consumption of Lower-Limb MRI Scans," *Journal of Health Economics,* Vol. 76(1); Lin, Haizhen Lin, et al., "Owning the Agent: Hospital Influence on Physician Behaviors," NBER Working Paper 28859, 2021.

[57] "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," Congressional Budget Office, September 2022, *https://www.cbo.gov/publication/58541;* Cutler, David, "Reducing Administrative Costs in U.S. Health Care," The Hamilton Project, March 10, 2020, *https://www.hamiltonproject.org/publication/policy-proposal/reducing-administrative-costs-in-u-s-health-care/* ("Cutler 2020").

[58] Cutler 2020.

[59] "Aligning Fee-for-Service Payment Rates Across Ambulatory Settings," in *Report to the Congress: Medicare and the Health Care Delivery System,* MedPAC, June 2022, *https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf;* Dranove, David, and Chris Ody, "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians," *American Economic Journal: Economic Policy,* 2019, Vol. 11(4), pp. 249–71.

[60] Desai, Sunita, and J. Michael McWilliams, "Consequences of the 340B Drug Pricing Program," *New England Journal of Medicine,* 2018, Vol. 378(6), pp. 539–48; "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Service," Congressional Budget Office, September 2022, *https://www.cbo.gov/publication/58541;* Adler, Loren, and Benedic Ippolito, "Procompetitive Health Care Reform Options for a Divided Congress," Brookings, 2023, *https://www.brookings.edu/essay/procompetitive-health-care-reform-options-for-a-divided-congress/* ("Adler and Ippolito, 2023").

the American Enterprise Institute to lower the incentives from the 340B program for providers to integrate, is to lower the scale of the 340B discounts.[61]

Strengthening Antitrust Enforcement Laws and Enforcement

1. There is broad agreement from experts that the antitrust enforcement agencies are significantly underfunded, and funding for the FTC and DOJ antitrust enforcement teams should be increased.[62] Over the last decade, merger filings have increased markedly more quickly than the agencies' enforcement budgets. Limited enforcement budgets make it challenging for the FTC to take the appropriate volume of enforcement actions, which means, in practice, that deals which do lessen competition are not being challenged. Recent legislation, for example, the Competition and Antitrust Law Enforcement Reform Act of 2021, would introduce large increases to the enforcement agencies' budgets.[63]

2. At present, the FTC is not allowed to pursue cases for anticompetitive conduct against not-for-profit firms (FTC Act, section 45(a)(2), section 44). Since the majority of hospitals in the U.S. are not-for-profit, this leaves a significant blind spot in enforcement and should be changed. Recent proposed legislation—Stop Anticompetitive Healthcare Act of 2022—would provide the FTC with enforcement activity over these nonprofit hospital actions.[64]

3. At present, the Hart-Scott-Rodino (HSR) Act exempts deals with relatively small merging parties from reporting those transactions to the FTC. Academic evidence suggests that there are virtually no enforcement actions against deals under HSR thresholds because they are not observed by regulators.[65] However, in the health sector, even small mergers in local healthcare markets can have big local effects. My own calculations in ongoing work with Stuart Craig, Zarek Brot-Goldberg, and Lev Klarnet suggest that more than 30 percent of hospital mergers are under HSR reporting thresholds and so too are the majority of physician horizontal and vertical acquisitions. Actions should be taken to lower the reporting thresholds, so that the vast majority of physician and hospital mergers are visible to the enforcement agencies.[66]

4. The DOJ and FTC should revise the guidelines for antitrust enforcement in the health sector. These were last issued in 1996 and the market has evolved significantly since then.[67] Revised guidelines that replace the withdrawn 1996 guidance could aid enforcement agencies, courts, and players in the health sector.

Both Harvard's Leemore Dafny and Carnegie Mellon's Martin Gaynor were officials at the FTC and have described additional, detailed steps in their past congressional testimony that could be taken to strengthen antitrust enforcement laws in the U.S.[68] One key area where they agree (and I support) is amending the Clayton Act to make it easier for enforcement agencies to challenge anticompetitive mergers. This could include shifting language that currently requires regulators to demonstrate that a merger "substantially" lessens competition to require regulators to demonstrate that a merger "meaningfully" lessens competition. Crucially, this type of shift would allow enforcement agencies to have more tools to address serial acqui-

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[61] Adler and Ippolito, 2023.

[62] Gaynor Senate Testimony; Dafny, Leemore, "How Health Care Consolidation is Contributing to Higher Prices and Spending, and Reforms that Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets," Statement Before the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021, *https://www.hbs.edu/ris/Profile%20Files/4.29.2021%20Dafny%20Oral%20Statement%20and%20Written%20Testimony%20Before%20U.S.%20House_47df362c-9f24-4ca3-a9aa-bebf5af8fa7a.pdf* ("Dafny House Testimony"); Baer, Bill, et al., "Restoring Competition in the United States," Washington Center for Equitable Growth, 2020, *https://equitablegrowth.org/research-paper/restoring-competition-in-the-united-states/* ("Baer, et al., 2020").

[63] "S. 225—Competition and Antitrust Law Enforcement Reform Act of 2021," *Congress.gov, https://www.congress.gov/bill/117th-congress/senate-bill/225.*

[64] "H.R. 9510—Stop Anticompetitive Healthcare Act of 2022," *Congress.gov, https://www.congress.gov/bill/117th-congress/house-bill/9510.*

[65] Wollman, Thomas, "Stealth Consolidation: Evidence from An Amendment to the Hart-Scott-Rodino Act," *American Economic Review: Insights*, 2018, Vol. 1(1), pp. 77–94.

[66] There are detailed suggestions on ways to achieve this in Baer, et al., 2020.

[67] "Statements of Antitrust Enforcement Policy in Health Care," U.S. Department of Justice and the Federal Trade Commission, August 1996, *https://www.justice.gov/atr/page/file/1197731/download.*

[68] Gaynor Senate Testimony; Dafny House Testimony.

sitions of small physician practice by larger firms (including hospitals and physician staffing companies), where individual transactions might not warrant individual scrutiny, but the collective series of transactions meaningfully impact a market.

Promoting Competition

1. Certificate of Need (CON) laws are State regulations that, for example, necessitate a regulator's permission for new firms to enter a health-care market (*e.g.,* to build a new hospital or outpatient facility), for facilities to purchase new equipment (*e.g.,* MRI scanners), or for facilities to expand (*e.g.,* to add more inpatient or outpatient beds). At present, 35 States and Washington, DC operate CON laws, although the scope of laws vary markedly across States.[69] Often, CON laws are a vehicle for incumbent firms to block the entry of rivals. The FTC and DOJ have put out a joint statement highlighting how CON laws tend to restrict competition in the health sector and that there is little evidence that they lower health spending.[70] The academic evidence supports the agencies' views on CON laws.[71] For example, Cutler, Huckman, and Kolstad (2010) show that the repeal of CON laws in Pennsylvania led to a redistribution of surgeries to higher-quality surgeons.[72] States should continue to either rescind CON laws or structure them in a manner that does not lessen competition. States should also focus on avoiding additional laws that also could unintentionally limit competition, including any willing provider laws, scope of practice laws, and licensing board decisions.
2. Increasingly, hospital/insurer contracts contain so-called "all or nothing" provisions, "anti-steering" provisions, and "anti-tiering" provisions. "All or nothing" provisions require that insurers include all a health system's sites in their network if they include any one site in their network. "Anti-tiering" and "anti-steering" provisions can require that insurers not take steps to increase cost sharing for certain hospitals or actively steer patients away from high-cost facilities. Collectively, these types of provisions can reduce competition and raise prices. States and Federal regulators should be mindful of these types of provisions and, where appropriate, strongly discourage their use or seek to take enforcement action against them for limiting competition. Likewise, Congress would be justified in exploring the possibility of banning these types of provisions in hospital/insurer contracts.

Expanding the Availability of Data and Creating a National Claims Database

1. The Hospital Price Transparency Rule and the Transparency in Coverage Rule have increased the availability of provider pricing information in the health sector. At present, however, there are concerns about hospitals' and insurers' compliance with reporting requirements.[73] Ultimately, it is vital that hospitals and other providers subject to reporting requirements adhere to the law and publicly post their data. Likewise, the data requirements could be expanded. At present, for example, the insurer data files list the prices each plan negotiates with providers. However, because the reporting requirements do not identify the volume of patients per plan or per procedure, it is extremely difficult to construct an average price per hospital. There are a handful of firms beginning to work with this data who have important insights about the ways that data reporting could be improved so that the data could be used more efficiently by patients, insurers, and providers.

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[69] "Certificate of Need Laws," National Conference of State Legislators, 2023, *https://www.ncsl.org/health/certificate-of-need-state-laws.*

[70] Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate of Need Laws and South Carolina House Bill 3250, January 11, 2016, *https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf.*

[71] Gaynor, Ho, and Town, 2015; Mitchell, Matthew, "Do Certificate-of-Need Laws Limit Spending?", Mercatus Working Paper, George Mason University, 2016.

[72] Cutler, David, Robert Huckman, and Jonathan Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," *American Economic Journal: Economic Policy,* Vol. 2(1), pp. 51–76.

[73] Kona, Maanasa, and Sabrina Corlette, "Hospital and Insurer Price Transparency Rules Now in Effect but Compliance Is Still Far Away," *Health Affairs Forefront,* September 12, 2022; "Price Transparency Impact Report," *Turquoise Health,* October 18, 2022; Ippolito, Benedic, "Improving Competition and Transparency in Health Care Markets," Statement Before the House Committee on Energy and Commerce Health Subcommittee, 2023, *https://www.aei.org/wp-content/uploads/2023/03/Ippolito_WrittenTestimony.pdf?x91208.*

2. At present, there is currently no national all-payer claims database that would allow policymakers, market participants, and researchers to observe utilization and prices for specific services across providers. While some States have created all-payer claims databases, many have not. We need a national claims database that would offer a national perspective on spending, pricing, and utilization across all the major funders of health-care services in the U.S. As health spending in the U.S. approaches 20 percent of U.S. GDP, a national data set should be considered an infrastructure investment akin to highways and roads that will aid market participants, further research, and help spur delivery innovations.

Again, thank you for the opportunity to testify today.

QUESTIONS SUBMITTED FOR THE RECORD TO ZACK COOPER, PH.D.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Collaboration between providers is beneficial in many areas of health care, including the treatment of chronic conditions like diabetes. Rhode Island's health information exchange, CurrentCare, is a public-private partnership that helps medical professionals access protected health information, such as prescriptions, lab tests, and hospital visits, from multiple sources in one secure statewide platform.

How can Congress encourage collaboration and innovation, like CurrentCare, across the health-care system?

Answer. Over the last 2 decades, the Centers for Medicare and Medicaid Services (CMS) have introduced a range of alternative payment models (APMs) that shift providers away from traditional fee-for-service arrangements. When providers and provider organizations, like Accountable Care Organizations (ACOs), receive a capitated payment to treat a patient (as opposed to fee-for-service payments), ACOs can identify the mix of service providers and care arrangements that would provide care to patients most efficiently. Where appropriate, ACOs can collaborate across organizations. My team and I have posted a review that includes our synthesis of evidence on programs like the Next Generation ACO Model and the Medicare Shared Savings Program. Both have demonstrated modest savings.[1] Ultimately, shifting away from fee-for-service arrangements and towards capitated payments to providers where providers bear two-sided risk is, in my view, the most effective pathway towards encouraging providers to create the most appropriately designed care organizations.

Question. As Mr. Martin from the American Academy of Family Physicians mentioned in his testimony, "a growing body of evidence demonstrates that physician-led accountable care organizations (ACOs) achieve greater savings than their hospital-led counterparts."[1] ACOs offer an alternative for primary care provider groups to remain independent, while focusing on innovation and value- based payment for patients.

How can Congress reduce the barrier to entry for independent primary care providers entering ACOs?

Answer. In order to have ACOs with independent physicians, there must be a pool of independent physicians willing to participate. However, over the last 2 decades, there has been a steady increase in vertical integration between hospitals and physicians.[2] One of the key drivers pushing physicians to vertically integrate with hospitals is the Medicare fee schedule, which, in some cases, reimburses physicians in hospital-owned practices at higher rates than independent physicians practicing at freestanding facilities.[3] When it is more financially lucrative to integrate with hospitals, it is harder to maintain independent primary care practices. The Medicare Payment Advisory Commission has issued recommendations to align payment rates

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[1] Zack Cooper et al. (2023). "Review of the Expert and Academic Literature Assessing the Impact of Medicare Access and CHIP Reauthorization Act of 2015." The Tobin Center for Economic Policy at Yale University, *https://tobin.yale.edu/sites/default/files/2023-06/20230413_MACRA%20Literature%20Review.pdf.*

[2] Dranove, David, and Chris Ody, "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians," *American Economic Journal: Economic Policy,* 2019, Vol. 11(4), pp. 249–71.

[3] Dranove and Ody, 2019.

across ambulatory care settings for a defined set of services, which they outline in a recent report.[4] Likewise, Senators Braun, Hassan, and Kennedy introduced bipartisan legislation called the Site-based Invoicing and Transparency Enhancement Act (S. 1869), which would equalize payments, where appropriate, across facilities. I support these recommendations and believe they would help preserve independent practices, who could, in turn, then participate in ACOs.

Question. As president and chief executive officer of Community Hospital Mr. Thomas articulated, operating an independent hospital allows "our ability to singularly focus on the well-being of our community and the needs of the patients within our service areas" and this "differentiates us from system hospitals."

How does consolidation that results in out-of-State ownership affect the health-care workforce, local community investment, and quality of care?

Answer. I am not aware of any evidence testing the effect of consolidation that results in out-of-State ownership relative to consolidation exclusively involving in-State owners. However, there is clear evidence that mergers of rival hospitals can lead to hospital price increases (which harm local communities) and lower wages for hospital employees.[5] Likewise, there is evidence that a lack of competition can harm hospitals' clinical quality.[6] Whether a hospital is acquired by an in-State or out-of-State rival, we should, in my view, support vigorous antitrust enforcement that preserves competition and thwarts anticompetitive mergers that lessen competition, harm patients, and lead to job losses outside the health sector.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Reducing prescription drug costs is one of my highest priorities. In 2023, seven of my drug pricing bills—that I'm a sponsor or original cosponsor of—have advanced out of the Judiciary, Commerce, and HELP Committees. Each adds more sunshine, accountability, and competition to the prescription drug industry. Namely requiring more accountability of drug companies and pharmacy benefit managers.

What policies under the Finance Committee jurisdiction, namely the Medicare and Medicaid programs, should we consider to hold PBMs accountable in order to reduce drug costs for seniors and taxpayers?

Answer. I agree with the vital need to promote the efficient pricing of pharmaceutical products. Unfortunately, at present, we have a limited view into the practices of pharmacy benefit managers (PBMs), which hinders our ability to craft effective policy. This is why I support the Federal Trade Commission's efforts to investigate the industry and the actions of the Finance Committee.

In addition, the degree of market concentration in the PBM industry is deeply concerning. At present, the PBM industry is dominated by three large firms. In such a concentrated industry, it is not clear that requiring transparency on, for example, rebates will fundamentally change the market dynamics in the sector or lead to lower prices (in fact, making rebates transparent might raise drug spending). As a result, one proposal the committee might consider is requiring PBMs to have a fiduciary duty to their clients (in this case the Medicare program). Ultimately, absent increasing competition in the sector, I am not optimistic that transparency alone will result in better outcomes for the end consumers in the PBM marketplace.

Question. State all-payer claims databases collect claims and enrollment data from multiple public and private payers that include transaction details such as the amount charged and actually paid for health-care services and procedures. Sepa-

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[4] "Aligning Fee-for-Service Payment Rates Across Ambulatory Settings," in *Report to the Congress: Medicare and the Health Care Delivery System,* MedPAC, June 2022, *https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.*

[5] Prager, Elena, and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review,* 2021, Vol. 111(2), pp. 397–427. "); Cooper, Zack, et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics,* 2019, Vol. 134(1), pp. 51–107.

[6] Gaynor, Martin, Kate Ho, and Robert J. Town, "The Industrial Organization of Health Care Markets," *Journal of Economic Literature,* 2015, Vol. 53(2), pp. 235–84; Cooper, Zack, et al., "Does Hospital Competition Save Lives? Evidence from the English Patient Choice Reforms," *Economic Journal,* 2011, Vol. 121, pp. F228–F260; Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper, "Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service," *American Economic Journal: Economic Policy,* 2013, Vol. 5(4), pp. 134–166; Kessler, Daniel P., and Mark B. McClellan, "Is Hospital Competition Socially Wasteful?", *Quarterly Journal of Economics,* 2000, Vol. 115(2), pp. 577–615.

rately, health information exchanges allow health-care professionals and patients to appropriately access and securely share medical information electronically. Both efforts enable improved patient outcomes and a better understanding of population health challenges. In you written testimony, you mentioned the benefits of all-payer claims databases and the need to build upon the existing work.

Given the State-to-State differences in all-payer claims databases, as well as the work of health information exchanges, are there certain States that have accomplished their goals of improving patient outcomes and understanding population health challenges more effectively using these data tools?

Answer. In my view, Massachusetts has been the State at the forefront of using data from their all-payer claims database to push forward health policy. Part of what has enabled the State's ability to maximize the use of its all-payer claims database is the Massachusetts Health Policy Commission (HPC). The HPC has been focused on using data to develop policy to reduce health spending growth and improve the quality of patient care in the State. The HPC was launched in 2012. It is an independent State agency that has significant policy and data analytics staff and is overseen by an 11-member Board of Commissioners.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Market-based competition has played a leading role in driving down prescription drug prices for patients, but misaligned incentives in our current system prevent patients from seeing any meaningful benefits at the pharmacy counter. I have been a longtime champion of biosimilars as a crucial tool for reducing prices for consumers and taxpayers. One recent study projected that biosimilars could generate savings of $180 billion in the next 5 years. However, Medicare Part D plans have resisted covering these low-cost medications, even when patients want them, and even when they come to market with discounts of well over 50 percent. The Office of the Inspector General found that greater biosimilar uptake in Part D would save seniors at least 12 percent in out-of-pocket costs, but the leading pharmacy benefit managers have largely preferred brand-name products or biosimilars with higher list prices. They then charge seniors based on those inflated prices, and they do not pass along the rebates they negotiate behind the scenes. A range of research suggests that plans and PBMs stand to gain from medications with higher sticker prices. Following the money has become harder and harder as these companies have consolidated over time, and patients foot the bill for artificially inflated costs.

How has insurer and PBM consolidation impacted patient access to lower-cost prescription drugs?

Answer. The PBM industry has become increasingly consolidated over the last decade. At present, the PBM industry is dominated by three large firms, who collectively account for over 75 percent of the market. High concentration in the PBM industry can blunt the incentives for PBMs to generate and pass savings along to their customers. In short, for firms that hire PBMs to manage their pharmacy benefits, their costs of switching PBMs are high and access to alternative PBMs is scarce. These high switching costs and lack of competition allow PBMs to generate supranormal profits. Increasingly, as you have noted, PBMs have become vertically integrated with insurers. While this creates a good opportunity for these vertically integrated organizations to align medical and pharmacy benefits (for example, placing drugs that reduce hospitalizations on preferred access lists), this sort of vertical integration can also mean that the savings on drugs are internalized by the combined insurer-PBM entities and not passed on to the end consumers.

Question. Where do we need additional transparency or other policy solutions to drive savings for seniors?

Answer. The business practices of PBMs are remarkably opaque. This is why I applaud the efforts of the Federal Trade Commission and the committee to investigate the PBM industry. Ultimately, if we have a better understanding of the industry, we can introduce more effective public policy. However, in my view, the root challenge in the PBM industry comes from the high degree of market concentration in the sector and not necessarily from the secretive contracting structures, which often draw scrutiny. This is why I think it is useful for the committee to study the merits of requiring PBMs to have a fiduciary duty to their clients.

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

Thank you, Mr. Chairman.

Competition has the potential to drive down costs, improve quality, and increase options for consumers. In recent years, entrepreneurs and innovators have introduced new health-care products, services, and delivery models that have transformed the treatment landscape and revitalized our pursuit of these ideals.

Unfortunately, regulatory hurdles and other problematic policies have constrained our system's capacity to produce better and more affordable results for Americans. Of particular note today—given our committee's jurisdiction—certain features of the Medicare program have exacerbated, rather than resolved, these challenges.

In exploring and addressing these problems, we have the opportunity to build on our efforts to improve medication access and affordability by taking a broader look at the health-care system through a similarly bipartisan, consensus-based lens.

We need to examine the drivers of consolidation, as well as its effects on care quality and costs, both for patients and taxpayers. We also need to develop focused, bipartisan, and bicameral solutions that reduce out-of-pocket spending while protecting access to lifesaving services. This effort is particularly important for rural communities that already face overwhelming barriers to care.

As we move forward with these goals, I see substantial opportunities for commonsense, comprehensive, and carefully tailored policies that prioritize patients from all walks of life.

Our work should acknowledge the complexity of the challenges at hand, as well as the risk of unintended consequences. Any legislation should also address the full scope of the challenges. An ad hoc, one-off approach to issues this significant, where tradeoffs are inevitable, could harm—rather than improve—our health-care system.

As we look to strike a productive balance, we should consider not just consolidation, but also quality, access, and innovation.

To that end, hospitals serve as a vital lifeline for communities across the country. Alignment of payment rates for certain services could provide patients with flexibilities and lower costs, in addition to advancing competition. However, it is essential that any reforms preserve patient safety and bolster consumer access, especially in rural areas still reeling from hospital closures.

Heavy-handed policies, regardless of the good intentions behind them, risk fueling—rather than mitigating—market concentration concerns.

Efforts to curb consolidation must also address our unsustainable Medicare physician payment system, which has prompted waves of retirements and made independent practice untenable for far too many front-line providers. Doctors, nurses, and other health professionals need predictability and sustainability.

The trend of uncertain 11th-hour stopgap measures accelerates untimely acquisitions, even for those who would prefer to remain in private practice. Savings from targeted site-of-care reforms could help to fund long-term improvements without driving up the deficit.

Expanding access to care also requires responsible regulatory relief. At the end of last year, my colleagues and I developed legislation to extend crucial flexibilities for seniors. These flexibilities range from comprehensive telehealth coverage to Hospital at Home. These pivotal provisions have created a bridge through the end of next year, but without concerted congressional efforts, Medicare beneficiaries will face a cliff once these policies expire.

Fortunately, all of these priorities enjoy broad bipartisan and bicameral support. Taken together, they reflect an opportunity for game-changing Medicare reform, with the potential to lower health-care costs, increase access, and enhance competition—benefiting patients and taxpayers alike.

Along with our mental health legislation, much of which was signed into law last year, as well as our work on the prescription drug supply chain, these conversations could create the foundation for another effective, consensus-driven, and consumer-focused Finance Committee effort.

I look forward to today's discussion, and I thank our witnesses for being here today.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF KAREN E. JOYNT MADDOX, M.D., M.P.H.,
ASSOCIATE PROFESSOR, SCHOOL OF MEDICINE, WASHINGTON UNIVERSITY

Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. My name is Dr. Karen Joynt Maddox, and I am a practicing cardiologist at Washington University in St. Louis as well as a health policy researcher with expertise in Medicare payment policy. It is an honor for me to be speaking with you today, and I will preface my remarks by stating that what I say today is my own opinion, and not the official position of my employer or institution.

The issue I have been asked to address today is corporatization in health care, with specific attention given to issues around the growing presence of private equity in health-care markets. Private equity is an arrangement in which firms raise capital, invest in private companies, sell or "exit" these investments, and reap the financial benefits.

The data on private equity acquisitions in health care are more sparse than one might hope, but can be summed up as follows. In the hospital industry, PE makes up 5–10 percent of the market, and the effects of acquisition on quality, costs, and outcomes are relatively minor—small increases in financial performance, and mixed evidence on quality and outcomes. In the nursing home industry, PE makes up more than 10 percent of the market, and at least more recent data suggest that acquisitions are associated with a decrease in staffing and worse health outcomes, including ED visits and mortality. In the physician practice sector, the data are hardest to come by, but PE is likely only 1–2 percent of the total market; data suggest that PE-acquired practices tend to shift towards care provided by advanced practice providers and increase volume and price. However, this is changing very rapidly, and our data are limited. In Medicare Advantage, PE plays a role in several ways, including in insurers themselves (Oscar, Clover) but also in a number of companies that provide services to manage patients, whether in primary care, home-based care, or post-acute care. While this makes it harder to quantify market impact and outcomes, data suggest a 2–5 percent market penetration overall.

Given the broad involvement of PE in health care, there is no "going back" in which we remove PE from the economic milieu. Indeed, while private equity is the latest major entrant, our health-care system is broadly based on corporate, profit-maximizing strategies, across sub-sectors of the market, even among ostensibly non-profit actors.

Instead, we should pursue an updated policy response and strategy to steer profit motives so that competition can make things better rather than worse. Taking a broad, structural approach to change would ensure that not only private equity, but whatever form of corporatization comes next, operates within a statutory and regulatory environment that prioritizes keeping people healthy, well, and out of the hospital.

To accomplish these goals, we may need sector-specific fixes, but broadly, policy in each sector should include two things.

The first strategy is to create a modernized data system by which to measure ownership and costs, as well as quality and access. For the former, there is opportunity within the hospital and nursing home sectors to revise the Medicare cost reports, a burdensome system of data collection that manages both to collect more information than it needs and simultaneously fail to collect much of the information that it should. For quality and outcomes measurement, we should move from a model of claims or EHR data collection and release that is slow and reactive to one that is streamlined and proactive. As long as insurers and hospital systems outpace CMS on data and strategy, we will continue to see both groups try to win by gaming rather than by making serious investments in health.

The second strategy is continued movement towards models of value-based payment that create clear guard rails and equity-centered, longer-term financial incentives. The increasing corporatization of health care drives an even more urgent need to continue to shift payment towards population health. Rather than having the young, brilliant minds of the private equity firms around the country focus on ways to win at fee-for-service, they should be at work finding ways to win at population

health management. This requires improvements in quality and equity measurement, changes to risk adjustment, explicitly rewarding access to care, and, of course, as I've already mentioned, modernizing underlying data infrastructure to make it capable of meeting these needs.

Finally, both of these objectives need to be pursued with careful attention to clinician burden and burnout, and above all else, centered around patients and their needs. But they are feasible and tangible strategies. As a country, we need an updated policy response to ensure that corporate interests are leveraged in the most positive ways possible.

I. INTRODUCTION

Corporatization in health care is not new, but has reached new heights over the past decade. In part, this is due to the recent growth in the involvement of private equity (PE) in health care. Private equity is an arrangement in which investment firms raise capital, invest in private companies, improve their financial performance, and then sell or "exit" these investments, reaping the consequent financial benefits. PE firms, unlike other types of for-profit involvement in health care, typically have defined (5–7 year) investment cycles, requiring that they achieve profits in a relatively short amount of time.

There has been a great deal of concern raised about PE involvement in health care, particularly in regards to the fundamental tension between patients' health and corporate profits. The need for short-term profit can lead to cost-cutting strategies that could be harmful, such as decreasing necessary staffing or discontinuing low-margin yet essential service lines. It may also incent dubious strategies for increasing revenue such as surprise billing, creating local monopolies to raise payment rates, or increasing the delivery of high-margin but less-essential health-care services like certain high-tech imaging procedures. Various legal aspects of PE acquisitions, including a lack of accountability for debt, also create concern about whether PE investments are creating patient-centered, sustainable value in their pursuit of short-term profit.

On the other hand, proponents of PE in health care point out that PE can bring needed innovation, access to capital, the potential for leveraging partnerships, deep knowledge of operational efficiency and best practices, and a track record of creating value across a wide range of industries. PE firms may bring a nimbleness and creativity to health-care delivery that more established institutions can't or won't pursue.

The broader context of corporatization in health care should also be noted. While PE has been a focus of concern recently, it is entering health-care markets in an existing milieu that includes for-profit entities, both as individual hospitals or facilities as well as organized into larger chains. As has been covered by other witnesses at this hearing, both vertical and horizontal consolidation are increasing, challenging our definitions of health-care markets and changing market dynamics. To be clear, corporatization isn't going away, and even if future regulations were put in place by the Federal Trade Commission, Department of Justice, or others, the vast majority of the existing infrastructure of our health-care system is built on profit motives. This is why we have shiny new hospitals in wealthy suburbs and crumbling, abandoned buildings in highly segregated urban areas and in disproportionately minority and poor rural areas.

It is well-documented that the United States, despite spending more than any other country on health care, has health outcomes that are suboptimal and highly inequitable. The mismatch between what profit motives in health care yield and what we value as a society are stark, but this mismatch is in part the result of policy that has failed to set appropriate guard rails and create the market circumstances that lead to the results we want. Health care is not a functional market in and of itself; the patient voice is the weakest at the bargaining table and loses time and again to the health systems and the insurers. It is the job of the government and of smart regulation to set the conditions for competition that help align incentives back where they belong—with the patient.

II. DATA ON THE EFFECTS OF PRIVATE EQUITY ACQUISITION

Due to data limitations, which are discussed in more detail below, much of the existing data regarding the effects of PE acquisitions of hospitals, nursing facilities, and physician practices has been done retrospectively, using large private or public claims databases. In some emerging sectors, such as long-term care and hospice, there is little evidence of the ultimate effects of acquisition because of the recent

nature of most of the events. Other limitations, in addition to the retrospective and sometimes cross-sectional nature of the studies, include difficulty in ascertaining when and by whom acquisitions are made, especially for smaller deals that fall below required reporting levels; distinguishing between different ownership models; and compiling data on proprietary elements such as negotiated prices.

In the hospital sector, from 2003–2017, 42 private equity deals led to the acquisition of 282 unique hospitals across 36 States.[1] Evidence generally suggests that PE-acquired hospitals raise list prices and charges, and improve financial performance, but have little consistent change in quality or outcomes of care, with studies finding small improvements in quality for some conditions and decrements for others.[2–5] Though less well studied, 91 PE-backed acquisitions of ambulatory surgical centers from 2011-2014 were similarly not associated with consistent differences in quality or outcomes.[6]

Evidence from the nursing and long-term care facility sector is more extensive, and perhaps more concerning. Though studies are mixed,[7, 8] some evidence suggests that PE acquisition of nursing homes may be associated with significant decreases in staffing, 1–2 percentage point increases in emergency department visits and hospitalizations,[9] and a 1–2 percentage point increase in mortality.[10] Another recent study reported that PE-owned nursing homes performed comparably to other facilities during COVID, however, in terms of cases or deaths.[11] One issue that complicates interpretation of the nursing facility literature is the high proportion of for-profit chains in this industry (~70 percent) and the high degree of variability in size, patient sociodemographic and case mix, market conditions, and capacity across the nursing facility landscape.[12] Further, because the majority of care in nursing facilities is paid by public payers (Medicare and Medicaid), pricing is less variable, and pursuing cost-cutting approaches may be a more dominant strategy.

The physician practice sector is the most difficult to summarize because it is the most variable in terms of structure, organization, and personnel, but evidence sug-

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gests that PE investment in this space is growing.[13, 14] In some specialties, such as ophthalmology, dermatology, gastroenterology, and urology that are both lucrative and highly fragmented, PE has made rapid inroads. By gaining market share or even local monopoly power, increasing charges, streamlining operations, cutting costs, changing staffing, and/or increasing the volume of high- margin procedures, there is ample opportunity for PE firms to achieve short-term profits.[15–21] However, there are scant data on the effects of PE acquisition of physician practices on patient outcomes. In urology, there is evidence that acquisition is associated with worse access to care for patients insured by Medicaid.[22] In other fields, such as anesthesiology and emergency medicine, surprise billing was a common strategy to increase revenues prior to recent legislation to curb this practice.[23] In primary care or larger multispecialty practices, strategies may focus on population health and care redesign more broadly, though again outcomes data are largely lacking.[24]

III. POLICY RESPONSES AND RECOMMENDATIONS

In order for Congress to achieve its goals of improving affordability, accessibility, quality, and ultimately health outcomes for the American people, there are at least two important policy responses that are feasible in the near term.

First, Congress should support the development of an updated, modernized data system that allows CMS and the government more broadly to track quality, access, costs, and consolidation in a proactive and timely fashion. Second, Congress should continue to support moves towards value-based and alternative payment models that incentivize population health.

A. Updating and Modernizing Data Collection and Use

Tracking Costs and Ownership

One current system that could be leveraged to create the data collection and transparency that are needed to monitor the impact of corporatization on costs and consolidation in health care is the Medicare cost reports. The cost reports are financial reports that Medicare-certified entities (including hospitals and nursing facilities) are required to provide on an annual basis, and include information on utilization, costs and cost centers, and facility characteristics. These reports provide minute detail on many elements of hospitals' spending and revenue, and are highly burdensome for hospitals and other entities to complete. They are also rarely audited, often missing data, and collected on different schedules based on hospitals' unique definitions of their fiscal years.

At the same time, the cost reports fail to collect information on crucial elements that are necessary for policymakers to know, including ownership, and spending is

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not collected in a way that allows for the consistent or comparable measurement of administrative costs or other key "buckets" such as electronic health records. These reports are overdue for an update, which provides an opportunity to simultaneously reduce burden and increase the utility of what is collected. A list of example measures is shown in Table 1.

Table 1: Cost and Ownership Measures

Domain	Examples
Ownership	What is the ownership stake of PE or other for-profit entities in each facility? What are the related "parent" organizations, if any?
Administrative waste	Do facilities or practices improve their internal cost structure in various domains of administrative waste?
Service provision	Do facilities stop providing low-margin services such as maternity care or mental or behavioral health care? Do they add high-margin services?

Many important results of PE acquisition, such as the specific negotiated fees commanded by providers, or the degree to which patients' out-of-pocket costs change with PE acquisition, are much harder to monitor, and would require additional data collection. Further, there is currently no equivalent data source to the cost reports for physician practices, which is a major gap though an understandable one given concern for reporting burden. However, with a modernized approach to the cost reports, policymakers would have a window on an annual basis into key elements of health-care costs and organization. This would allow a proactive approach to tracking acquisitions, as well as mergers, which could then be evaluated on a range of policy- relevant elements, selected for their importance.

Tracking Quality and Outcomes

Data collection and transparency should also be modernized in terms of quality and outcomes. The state of the knowledge on the impact of PE acquisitions on quality and outcomes, as outlined above, is largely based on retrospective studies conducted in the past 2–3 years, looking back at financial transactions from the early 2010s. We are 10 years too late to the game, and that is both unacceptable and avoidable.

If one were to log on to Hospital Compare right now, in June 2023, the quality and safety measures that one would see reported there reflect data collected in 2019–2021. But on the CMS research portal, Medicare patient data from December 2022 are already available. Indeed, CMS can access data from last week. The data already exist to proactively monitor hospital performance, but are not being optimally used. While claims data are processed within weeks, they are not used for monitoring quality or safety for years, and there is no proactive monitoring program set out to detect deviations in care that could follow acquisitions or other status changes at hospitals. A list of measures that could be monitored are shown in Table 2.

Table 2: Quality and Outcome Measures

Domain	Examples
Processes of care	Do facilities maintain safe practices and meet high expectations of fidelity to guidelines and appropriate care?
Outcomes of care	Do facilities maintain excellent outcomes across a range of metrics, including preventable acute-care use?
Experience of care	Do facilities or practices improve patient experience?

There is no technological reason that policymakers shouldn't be able to review data on hospital quality and outcomes on a quarterly basis. Our progress towards using electronic data for quality measurement has been far too slow, despite the technological infrastructure existing broadly. No other industry would be satisfied with performance data that are so old, particularly when the stakes are so high.

Tracking access and equity

Finally, as data collection and basic use are modernized to change how we measure key elements of the U.S. health-care system, we must also update *what* we measure. Glaringly missing from our monitoring systems are measures of equity and access. If we want to improve the health of our Nation, we must begin to include these crucial factors as part and parcel of what we measure—and ultimately reward—within our systems. Though this is an area where a great deal more work is needed in measure development and validation, examples of access and equity measures are shown in Table 3.

Table 3: Access and Equity Measures

Domain	Examples
Physical access to health care	Are existing physical locations closed, or new ones opened? How does this impact geographic access for key groups?
Adequate workforce	Do facilities maintain safe levels of staffing, and do they retain staff?
Access to basic services (also listed above)	Do facilities stop providing maternity care or mental health care because they are not profitable?
Access for all people	Do facilities stop providing care to people with Medicaid or those who cannot pay? Does patient racial or ethnic mix change?
Equity in outcomes	Are existing equity gaps based on income or race narrowed, or widened? Are outcomes for marginalized groups improved, or worsened?

B. Moving Towards Aligned Financial Incentives

Second, Congress should continue to push our health system towards population health. As long as we operate within a fee-for-service system, the most nimble actors will bring out the worst elements of that system, finding ways to profit from charging for more and more services, some of dubious value. We need look no farther than surprise billing to recognize that predatory practices are always a risk. As such, the increasing corporatization of health care drives an even more urgent need to continue to shift payment towards population health.

We have an opportunity to leverage value-based and alternative payment models to align our societal goals of achieving better health with our payment models, and thus redirect profit maximization in ways that are more closely linked to patients' health and well-being. These programs should be simplified and streamlined where possible, to reduce clinician burden as well as to reduce the incentives their burden and complexity create towards greater consolidation.

There is evidence that such incentives can lead to innovation in care delivery. For example, many PE-backed entrants into the primary care space are pursuing total costs of care models, including integration of mental and behavioral health and health-related social needs, betting on their ability to provide support and coordination to reduce unnecessary hospitalizations for disease progression or instability. This is the space in which we need people to think creatively and be willing to create new paradigms of care—and where financial incentives can help steer care delivery innovation in directions we think are most societally beneficial.

Different approaches might be needed in different sectors. In the hospital sector, it is likely that one reason PE acquisition has not been associated with a great deal of change is that the hospital market is already relatively mature. There are large, established systems also pursuing acquisitions, and the rules of the game in terms of value-based payment and other mandatory quality reporting programs are well-developed.

On the other hand, the nursing facility market is potentially much more problematic from a quality and outcomes standpoint. There are fewer established standards, and less auditing and monitoring; the patient population is also more vulnerable both medically and socially. There are over 15,000 nursing facilities, compared with around 6,000 hospitals (3,000 general medical acute-care hospitals paid under the Inpatient Prospective Payment System), ranging in size from a few beds to hundreds, and there is no equivalent of the Emergency Medical Treatment and Labor Act (EMTALA) to compel nursing homes to care for medically and socially complex patients. Better measurement and more targeted approaches to payment models are sorely needed, particularly as this sector grows with the aging population and their care needs.

In the physician practice sector, the effects of PE have varied quite a bit by specialty, and thus different approaches are probably needed in this regard. For highly fragmented markets like ophthalmology and dermatology, the primary approach has been to create local monopolies to increase negotiating power, driving up prices. There is less of an obvious role for population-based payment models in this context. On the other hand, value-based and alternative payment models hold tremendous potential for increasing investment and innovation in the primary care space, where there is great opportunity to save money by improving patient outcomes if incentives are properly aligned. In this environment, PE firms may give primary care or group practices the support they need to resist vertical integration, instead protecting their independence; if that independence is coupled with strong financial incentives for health and wellness, these financial arrangements may prove more attractive for patients and clinicians alike.

For any continued transition to value-based care to be feasible, not just the payment models need to change, but the expertise and approach underlying them. That means making intentional and careful improvements in quality and equity measurement, advancing the science of risk adjustment to be more accurate, more equitable, and less game-able, explicitly rewarding access to care, and, of course, as outlined above, modernizing underlying data infrastructure to make it capable of meeting these needs.

C. Additional Considerations

Each of the policy strategies stated above need to be pursued with careful attention to burden, in particular clinician burden and burnout. Access to health-care facilities means nothing if there are no clinicians to provide care. Health care is, at its core, an interpersonal, hyperlocal undertaking, and broad corporatization and consolidation threaten to further erode clinician well-being and autonomy. Clinician leadership should be prioritized, and strategies that both improve patient outcomes and release clinicians from burdensome micromanagement and utilization review should be studied and pursued where found to be fruitful.

IV. CONCLUSIONS

In conclusion, the ongoing corporatization of health care, including the rise of private equity across sectors, has the potential to increase costs and worsen quality, access, and outcomes. But it also presents an opportunity to modernize policy and create the data and payment infrastructure that can reorient profit-seeking behavior towards keeping patients healthy, well, and out of the hospital. Aligning incentives is the only way to move towards progress in our market-driven system, balancing competition and regulation in the most patient-centered way possible.

QUESTIONS SUBMITTED FOR THE RECORD TO KAREN E. JOYNT MADDOX, M.D., M.P.H.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Collaboration between providers is beneficial in many areas of health care, including the treatment of chronic conditions like diabetes. Rhode Island's health information exchange, CurrentCare, is a public-private partnership that helps medical professionals access protected health information, such as prescriptions, lab tests, and hospital visits, from multiple sources in one secure statewide platform.

How can Congress encourage collaboration and innovation, like CurrentCare, across the health-care system?

Answer. CurrentCare is a great example of a health information exchange that serves an important function for the people and providers of Rhode Island. I think

that some of the biggest barriers to active collaboration and innovation through a health information exchange like CurrentCare are not related to technology, but rather to a collective action problem. There is little business incentive for any system to share data with any other system without a mandate to do so, or at least a trusted broker to address the collective action. While the interoperability standards contained in various policies including HITECH, MACRA, and others theoretically create a requirement to exchange data, in reality these policies led to very uneven data sharing in the real world setting. Often States have many separate health information exchanges, many of which require a "pull" to get patient data rather than an automatic "push," and data from these exchanges often doesn't integrate into the electronic medical record. Unfortunately, patients are the ones who lose out, when they present to an emergency department or clinician's office and the treating clinician can't access medical information with which to provide the best possible care.

In my opinion, this is a problem that can best be solved with policies that require or incent data sharing. Full interoperability should be the end goal; participation in HIEs is a reasonable intermediary. As our health-care system gets more and more consolidated not within markets but across markets, the policies needed to permit data sharing become different. We need a strong central set of standards—much like the banking industry has for data elements and data privacy—that would allow hospitals or practices not just across town, but across the country to communicate seamlessly.

Another potential contributor to collaboration and innovation is for local and State leadership to encourage clinicians and health-care entities to work together rather than in competition around key areas for quality improvement. During COVID we saw local hospitals come together to share data—often for the first time—in service of public health. We need to translate that to facing other public health crises, like opioid use disorder, behavioral health needs, and obesity. While Federal policy is often needed to set fair and clear standards, health care is and always should be hyperlocal in its focus.

Question. As Mr. Martin from the American Academy of Family Physicians mentioned in his testimony, "a growing body of evidence demonstrates that physician-led Accountable Care Organizations (ACOs) achieve greater savings than their hospital-led counterparts." ACOs offer an alternative for primary care provider groups to remain independent, while focusing on innovation and value-based payment for patients.

How can Congress reduce the barrier to entry for independent primary care providers entering ACOs?

Answer. I agree that ACOs are a way for primary care groups to remain independent but participate in value-based payment. Indeed, independent practices may be able to act in ways that are more nimble or flexible than larger ones, and thus to achieve meaningful care redesign that moves closer to the type of patient-centered care they wish to provide. Small organizations typically outperform larger ones on patient experience and patient-centeredness, which are major strengths for these groups.

However, as currently organized, the barriers to participation are significant, particularly for small practices and groups. High-quality, interoperable electronic medical records, for example, can be prohibitively expensive. Most small groups do not have data abstraction or data entry staff to meet quality measure requirements. Few small practices have business leaders experienced in change management.

There are a few promising solutions. First, at the practice level, ACO programs can provide up-front funding for investment in data and other infrastructure needs. They can also provide learning collaboratives to help groups move ahead while learning from others' experiences. Both of these elements are features of prior programs to encourage ACO participation at the Centers for Medicare and Medicaid Innovation, such as the Advance Payment ACO Program. An updated program even more targeted to independent practices could be appealing if it promised stable income, much like programs that have been proposed for small rural hospitals.

More broadly, however, what is needed is streamlined quality measurement strategies and more public-private partnerships around paying for care. We need strategies that reduce burden and focus on key population health metrics.

To the former, Congress should help the medical community move away from burdensome manual data collection for quality measurement, and towards measure-

ment that is embedded in electronic health records. There has been little in the way of requirements for the major electronic health record vendors to provide real-time and exportable quality improvement and quality measurement tools, which should be pursued.

Congress should also seek to encourage public-private partnerships around quality measurement and program design for ACOs and other alternative payment models. A small practice that has 25 percent Medicare fee-for-service patients in an ACO program and 75 percent Medicare, Medicaid, and privately-insured patients in 10 other programs is going to struggle to move towards practice transformation—they're too busy sorting out the different quality measures and payment mechanisms for each payer. Creating simple, harmonized quality measures that represent key areas of public health need (hypertension, diabetes, obesity, mental health) and simple, harmonized payment structures could let clinicians focus on providing high-quality, holistic, patient-centered care instead of reading too many pages of fine print for too many different metrics and requirements from too many payers.

Question. As president and chief executive officer of Community Hospital, Mr. Thomas articulated, operating an independent hospital allows "our ability to singularly focus on the well-being of our community and the needs of the patients within our service areas" and this "differentiates us from system hospitals."

How does consolidation that results in out-of-State ownership affect the health-care workforce, local community investment, and quality of care?

Answer. This is unfortunately an area about which we know far too little. A lack of data on ownership, including mergers, acquisitions, and other management changes, has led to a paucity of data on the broader impacts of acquisition on a community. There is nothing in the published literature, to my knowledge, on whether the effects of out-of-State ownership on patients or communities differs from the effects of a more local merger or acquisition.

What data are available (*e.g.,* as reviewed in the MedPAC March 2020 Report to the Congress: Medicare Payment Policy)[1] largely suggest that consolidation is associated with higher total health-care costs. This is generally driven by the ability of the new larger entity to command higher prices, with no major impacts on quality or efficiency.

Health care is not immune to the pressures that have led to the closure of many small businesses across many sectors—think of our transition away from local grocery and general stores to our current landscape of Walmarts and Targets. The problem is that these large corporations don't have any particular community's interests at heart. If a larger corporation owns a small local hospital and that hospital is no longer profitable, it may be more likely to close if it doesn't serve a particular business purpose. However, we lack data on these issues, which represent an important area for future work.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. Insurance companies have been rapidly acquiring primary care practices, largely driven by a desire to maximize profits from Medicare Advantage enrollees.

When an insurance company owns a primary care practice, can the corporate owners put pressure on providers to increase profits? Please describe these pressures.

Answer. Yes, any owner can pressure providers to increase profits, via a variety of tactics. These tactics can include pressure to code higher levels of severity among the patients who are seen, pressure to change payer mix in a favorable way, or pressure to change referral patterns or utilization patterns in a favorable way. There are also pressures to increase volume overall.

The degree to which these pressures differ for practices owned by insurance companies versus practices owned by other entities (health systems, private equity groups), however, is unclear. Certainly there are examples where an insurance company is primarily interested in upcoding and comorbidity capture, with less interest in providing high-quality care. But there are also examples where an insurer and

[1] Medicare Payment Advisory Commission. March 2020 Report to the Congress: Medicare Payment Policy. 2020.

provider being under common ownership (and thus aligned) has led to better quality and more focus on primary care in an integrated delivery system model (Kaiser).

The fact that not only insurance-owned practices but also system- or equity-owned ones are engaging in profit-maximizing tactics does not excuse bad behavior from bad actors in the insurance industry; it hopefully serves to emphasize that solutions to these problems need to be broad in nature in order to be effective because of the profit motive inherent in our entire health-care structure. For example, payment models that focused on population health and keeping people healthy through innovative team-based care redesign would align incentives to a much greater degree than our current fee-for-service system.

Question. What effect do these tactics have on providers?

Answer. I am not aware of any studies that measure providers' experience with insurance company ownership, though I suspect that some of the rising burnout we see in medicine is related to an increasing corporatization and dehumanization of health care more broadly, a concern that industry surveys have also noted. For example, a survey conducted by athenahealth suggested that clinicians in practices that had gone through merger or acquisition had higher rates of burnout.[2] One issue in studying the effects of ownership changes is that getting data on practice ownership is quite difficult. This is an area that could be more easily investigated and tracked if Congress were to support CMS to create a modernized Medicare data infrastructure and quality/safety monitoring program.

Question. What effect do these tactics have on patients?

Answer. Little is known about the effects of ownership changes on patients, particularly in the context of insurance companies purchasing primary care practices. If there is pressure to see more patients per hour, that could certainly lead to worse quality, patient experience, and ultimately outcomes, but this isn't well-studied. On the other hand, if insurers and primary care providers are aligned as a result of a change in ownership, it could create the appropriate partnerships to focus on care redesign and keeping people healthy instead of focusing on delivering a high volume of high-margin services.

However, in part due to a lack of data on practice ownership, it is very difficult to track and monitor. It is also difficult to study since many of the owned practices are primarily for privately insured patients, rather than Medicare patients. This is an area that could be more easily investigated and tracked if Congress were to create a modernized Medicare data infrastructure and quality/safety monitoring program.

Question. What effect do these tactics have on taxpayers, as reflected in Medicare spending?

The major way that these tactics can influence Medicare spending is by inappropriately inflating the prices that are paid to Medicare Advantage plans to administer care for MA enrollees. If patients are coded to be sicker than they actually are, plans are being overpaid for their care. We have a great deal of data to suggest that MA plans code with a much higher intensity than is typically seen in fee-for-service.[3] While a number of fixes have been suggested, largely based on adding an upcoding adjustment factor to payments, this is a blunt and likely inadequate solution.

That said, the issue with MA overpayment isn't only related to fraudulent upcoding. While some upcoding is grossly fraudulent, some is simply more thorough and complete documentation that would not meet the bar for fraud. The problems with MA spending would best be addressed with a broader fix. Congress should move away from tying MA payment rates to spending in fee-for-service (which is facing its own issues with changes in coding associated with the growth of alternative payment models and consolidation),[4] and instead create a new risk adjustment and payment system based on modernized methodology, less upcodeable diagnostic criteria, and smarter and more automated fraud detection. The main barriers

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[2] Thornell C. Physicians report that organizational and technology changes are among the biggest burnout factors. 2021. *https://www.athenahealth.com/knowledge-hub/clinical-trends/physicians-report-organizational-technology-changes-among-biggest-burnout-factors.*

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[4] Post B, Norton EC, Hollenbeck BK, Ryan AM. Hospital-physician integration and risk-coding intensity. *Health Econ.* Jul 2022;31(7):1423–1437. doi:10.1002/hec.4516.

to doing so are not technological but rather related to the need for statutory change to MA that could modernize and improve the program. While changes to risk adjustment and benchmarking could be done within current statute, a more thorough fix would require broader legislation.

Question. Broadly, are there other examples of vertical consolidation in health care that may have adverse impacts on patients, providers, or payers?

Answer. All kinds of consolidation can have adverse impacts on patients and providers if they increase prices. For example, there are very good data to suggest that vertical consolidation between physicians and hospitals is associated with higher health-care prices and upcoding,[4, 5] which impacts patients (and all people regardless of whether they are currently using health-care services) in the form of higher premiums and lower wages.

For all of these issues, a lack of high-quality, real-time data with which to monitor quality, outcomes, and costs is a major hindrance to being able to make solid conclusions about the effects of these mergers, and thus a hindrance to designing good policy to protect patients and providers. Congress should work towards helping Medicare to create a more modernized quality and safety monitoring program with which to address these issues, in a proactive manner, rather than relying on post-hoc academic research to detect problems and raise concerns.

Pharmacy benefit managers are another important issue within consolidation, though that is not my personal area of expertise so I won't offer specific policy recommendations there.

Question. Health care deals involving private equity have accelerated in recent years. In your view, is private equity a major factor driving consolidation in health care? Please explain.

Answer. I think private equity is almost more of a symptom of the dysfunction in our health-care system rather than a driver of it. Private equity is typically industry-agnostic in that it goes where the money is; the mechanism by which money is made in private equity is by finding areas where the current actors in a system are failing to capture the maximum profit from that system. Health care is vulnerable to private equity because it is an entirely dysfunctional market that has since its beginning been populated by people who aren't profit-maximizers. Consider the family physician who did house calls, or the hospitals that provided charity care because it was their mission to do so. Private equity sees the inefficiencies created by those actors in the market and recognizes the opportunity for profit.

Private equity is not, however, the only profit-maximizing entity in the health-care system; to a greater and greater degree, health care is corporate, consolidated, and impersonal. Private equity likely makes up between 2 and 10 percent of most health-care sectors, with the greatest investment in the post-acute and hospice settings, and less in hospitals and physician practices. The remainder of those settings have a mix of nonprofit and for-profit entities that use a range of strategies to pursue profit, and are also consolidating.[6] Some settings, like hospice and nursing home care, are dominated by for-profit chains. Others, like outpatient practices, have a wide range of ownership arrangements and approaches.

Which is all to say: strategies to reduce consolidation shouldn't focus only on private equity, but instead on private equity as perhaps the boldest version of profit maximization within a system that is built on it. In the absence of an obvious solution to undo the consolidation that has already occurred, the major policy need is to continue to move towards payment arrangements that reward entities (private equity-backed or not) for keeping people healthy, rather than rewarding them for upcoding or forming local or regional monopolies that can drastically raise prices for privately insured patients.

Question. In your view, how does private equity ownership of physician practices, hospitals, and other health-care organizations affect patient access to care, including continuity of care?

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[5] Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *JAMA Intern Med.* Dec 2015;175(12):1932–9. doi:10.1001/jamainternmed.2015.4610.

[6] Beaulieu ND, Dafny LS, Landon BE, Dalton JB, Kuye I, McWilliams JM. Changes in Quality of Care after Hospital Mergers and Acquisitions. *N Engl J Med.* Jan 2 2020;382(1):51–59. doi:10.1056/NEJMsa1901383.

Answer. This is an area that is poorly studied, for reasons noted above: there is no public data on acquisitions that academic researchers can use to study private equity in a timely fashion, particularly in the physician practice setting. To my knowledge, there are no data examining whether acquisition of outpatient practices, for example, changes patients' access to physicians that they have previously seen. It is crucial that Medicare's data systems and approach to quality and safety be modernized in order to monitor these changes going forward.

That said, one very specific type of access issue is related to whether high-risk patients have access to care. When a hospital or practice is acquired, one way it could save money is by avoiding high-risk (and thus likely high-cost) patients and instead caring for lower-risk patients, or by shifting from caring for patients who are self-pay or on Medicaid towards patients with private pay or Medicare. Data examining these shifts in the hospital setting have not documented systematic moves towards low-risk patients, though there are studies suggesting a shift away from hospital-associated outpatient services. In theory acquired hospitals might move away from low-margin services (which tend to be used by patients with more social risk factors and less generous insurance coverage), though the evidence here is mixed. In urology, there is evidence that acquisition is associated with worse access to care for patients insured by Medicaid.[7] Again, better data on acquisitions would help researchers study these important issues.

Question. In your view, how does private equity ownership of physician practices, hospitals, and other health-care organizations affect health-care costs?

Answer. Private equity is almost certainly associated with higher costs, both at the individual patient level and also societally (see also next section).

At the individual patient level, private equity acquisitions generally lead to local consolidation and increased prices for common services as a result of an increase in negotiating power for the purchased entities. Better coding capture can also lead to the appearance of sicker patients, thus higher charges per patient day in acquired hospitals, and presumably also in other settings though this hasn't been studied as well across post-acute and outpatient settings. At the macro level, these increases in prices lead to increases in premiums, as insurance companies generally pass these costs along to consumers in the form of premium increases. The data for specific sectors are reviewed below.

Question. In your view, how does private equity ownership of physician practices, hospitals, and other health-care organizations affect quality of care?

Answer. Please note the below is pasted from my written testimony, which focused on this area.

The data on private equity acquisitions in health care are more sparse than one might hope, but can be summed up as follows. In the hospital industry, PE makes up 5–10 percent of the market, and the effects of acquisition on quality, costs, and outcomes are relatively minor—small increases in financial performance, and mixed evidence on quality and outcomes. In the nursing home industry, PE makes up more than 10 percent of the market, and at least more recent data suggest that acquisitions are associated with a decrease in staffing and worse health outcomes, including ED visits and mortality. In the physician practice sector, the data are hardest to come by, but PE is likely only 1–2 percent of the total market; data suggest that PE-acquired practices tend to shift towards care provided by advanced practice providers and increase volume and price.

However, this is changing very rapidly, and our data are limited. In Medicare Advantage, PE plays a role in several ways, including in insurers themselves but also in a number of companies that provide services to manage patients, whether in primary care, home-based care, or post- acute care. While this makes it harder to quantify market impact and outcomes, data suggest a 2–5 percent market penetration overall.

Due to data limitations, which are discussed in more detail below, much of the existing data regarding the effects of PE acquisitions of hospitals, nursing facilities, and physician practices has been done retrospectively, using large private or public claims databases. In some emerging sectors, such as long-term care and hospice, there is little evidence of the ultimate effects of acquisition because of the recent

[7] Nie J, Hsiang W, Marks V, et al. Access to Urological Care for Medicaid-Insured Patients at Urology Practices Acquired by Private Equity Firms. *Urology.* Jun 2022;164:112–117. doi:10.1016/j.urology.2022.01.055.

nature of most of the events. Other limitations, in addition to the retrospective and sometimes cross-sectional nature of the studies, include difficulty in ascertaining when and by whom acquisitions are made, especially for smaller deals that fall below required reporting levels; distinguishing between different ownership models; and compiling data on proprietary elements such as negotiated prices.

In the hospital sector, from 2003–2017, 42 private equity deals led to the acquisition of 282 unique hospitals across 36 States.[8] Evidence generally suggests that PE-acquired hospitals raise list prices and charges, and improve financial performance, but have little consistent change in quality or outcomes of care, with studies finding small improvements in quality for some conditions and decrements for others.[9–12] Though less-well studied, 91 PE-backed acquisitions of ambulatory surgical centers from 2011–2014 were similarly not associated with consistent differences in quality or outcomes.[13]

Evidence from the nursing and long-term care facility sector is more extensive, and perhaps more concerning. Though studies are mixed,[14, 15] some evidence suggests that PE acquisition of nursing homes may be associated with significant decreases in staffing, 1-2 percentage point increases in emergency department visits and hospitalizations,[16] and a 1–2 percentage point increase in mortality.[17] Another recent study reported that PE-owned nursing homes performed comparably to other facilities during COVID, however, in terms of cases or deaths.[18] One issue that complicates interpretation of the nursing facility literature is the high proportion of for-profit chains in this industry (~70 percent) and the high degree of variability in size, patient sociodemographic and case mix, market conditions, and capacity across the nursing facility landscape.[19] Further, because the majority of care in nursing facilities is paid by public payers (Medicare and Medicaid), pricing is less variable, and pursuing cost-cutting approaches may be a more dominant strategy.

The physician practice sector is the most difficult to summarize because it is the most variable in terms of structure, organization, and personnel, but evidence sug-

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gests that PE investment in this space is growing.[20, 21] In some specialties, such as ophthalmology, dermatology, gastroenterology, and urology that are both lucrative and highly fragmented, PE has made rapid inroads. By gaining market share or even local monopoly power, increasing charges, streamlining operations, cutting costs, changing staffing, and/or increasing the volume of high-margin procedures, there is ample opportunity for PE firms to achieve short-term profits.[22–28] However, there are scant data on the effects of PE acquisition of physician practices on patient outcomes. In urology, there is evidence that acquisition is associated with worse access to care for patients insured by Medicaid.7 In other fields, such as anesthesiology and emergency medicine, surprise billing was a common strategy to increase revenues prior to recent legislation to curb this practice.[29] In primary care or larger multispecialty practices, strategies may focus on population health and care redesign more broadly, though again outcomes data are largely lacking.[30]

Question. In your view, how does private equity ownership of physician practices, hospitals, and other health-care organizations affect health-care workers, including retention, wages, safety, and clinical autonomy?

Answer. As noted briefly above, there is evidence to suggest that staffing levels generally decrease following private equity acquisition in the hospital and nursing home setting. Less is known regarding retention, wages, safety, or clinical autonomy, for the reasons outlined above. There are few data on the actual acquisitions because of a lack of a system for collecting it, and no data to my knowledge on workers' experiences across the health-care industry with which to quantify these important questions.

The solutions that are needed are therefore at least twofold. First, we need better data on acquisitions and consolidation with which to track the effects of PE or other deals on quality, safety, and patient outcomes, in addition to staffing and workplace issues. Second, we need a payment system that rewards entities for keeping people healthy, rather than for fixing illnesses at a later stage. In addition, broader policy interventions around consolidation and competition are needed; if competition cannot be preserved, then price-setting regulations will ultimately be required to prevent a few mega-systems and mega-insurers from prioritizing their own profits over patient needs.

PREPARED STATEMENT OF R. SHAWN MARTIN, EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Chairman Wyden, Ranking Member Crapo, and members of the committee, my name is Shawn Martin, and I am the executive vice president and chief executive

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[26] Tan S, Seiger K, Renehan P, Mostaghimi A. Trends in Private Equity Acquisition of Dermatology Practices in the United States. *JAMA Dermatol.* Sep 1 2019;155(9):1013–1021. doi: 10.1001/jamadermatol.2019.1634.

[27] Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum.* Sep 2 2022;3(9):e222886. doi:10.1001/jamahealthforum.2022.2886.

[28] Bruch JD, Foot C, Singh Y, Song Z, Polsky D, Zhu JM. Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices. *Health Aff (Millwood).* Jan 2023;42(1):121–129. doi:10.1377/hlthaff.2022.00308.

[29] Fuse Brown EC. Stalled Federal Efforts to End Surprise Billing—The Role of Private Equity. *N Engl J Med.* Mar 26 2020;382(13):1189–1191. doi:10.1056/NEJMp1916443.

[30] Ikram U, Aung K-K, Song Z. Private Equity and Primary Care: Lessons from the Field. *NEJM Catalyst.* 2021;November 19, 2021.

officer of the American Academy of Family Physicians (AAFP). I am honored to be here today representing the 129,600 physicians and student members of the AAFP.

I would like to begin my testimony by stating that family physicians—in fact, all physicians—are at their best when they are in service to their patients and communities, not the interests of institutions or corporations. Furthermore, the foundation of our health-care system is the human interaction between patients and physicians inside exam rooms, not the business decisions made by executives in board rooms.

The focus of today's hearing is timely and important. Consolidation is transforming our health care system in negative and positive ways. In my comments, I will focus on the impact of vertical consolidation in primary care and the challenge of sustaining comprehensive, continuous primary care that is connected to the people and communities it serves in the midst of the extensive consolidation we see happening today.

Specifically, I will highlight:

- The principal factors and policy decisions that have led to the increasingly consolidated market of primary care practices;
- The urgent need to reform fee-for-service payment, which has chronically underinvested in and undervalued primary care;
- How well-designed, sustainable value-based payment models can support practices of all sizes in providing continuous, comprehensive, and coordinated primary care; and
- Opportunities for Congress to address misaligned incentives that reward consolidation and allow primary care to be leveraged to maximize profits rather than patient care.

Consolidation or private investment in primary care is not inherently bad. There is a tremendous amount of innovation taking place inside primary care, allowing primary care physicians to expand their capabilities, provide high-quality care to their patients and create a more rewarding practice environment. These new models are creating opportunities for primary care delivery organizations to not only survive but thrive as many of these groups bring important new resources to practices and are enabling primary care to be more readily available to historically underserved communities and populations. What distinguishes many of these organizations is that their revenue model is built primarily around expanding and investing in primary care—a space where our health-care system has not performed well over the past several decades.

Many of the most successful primary care delivery innovations are led by primary care physicians. A growing body of evidence demonstrates that physician-led Accountable Care Organizations (ACOs) achieve greater savings than their hospital-led counterparts.[1] One key driver of success is primary care: more primary care physicians and visits lead to greater savings.[2] Meanwhile, hospital-led ACOs may be unwilling to direct revenues away from hospital services to bolster primary care and perform better in ACO models.

The motivation behind the integration of primary care practices into larger, consolidated models is the same for both hospitals and insurers—control of cash flow. Vertical integration can allow primary care to become a leverage point for the pursuit of maximizing savings or profit somewhere upstream. For payers, controlling primary care allows them to oversee and manage care across a patient's care team and across care settings. For hospitals, it allows them to refer patients to their other employed specialists or seek treatments in their facilities that produce higher profit margins while also ensuring the patient's care (and costs) stay within a defined health system. In both situations, these organizations use primary care to meet other financial goals, redirecting revenue away from primary care and failing to invest in the primary care teams that patients benefit from most. Both hospitals and insurers are achieving their financial goals, but the patients and their primary care physicians, in many instances, are not benefiting from these financial windfalls.

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[1] Physician-Led Accountable Care Organizations Outperform Hospital-Led Counterparts. Avalere. 2019. Available at: *https://avalere.com/press-releases/physician-led-accountable-care-organizations-outperform-hospital-led-counterparts#:~:text=Avalere's%20analysis%20found%20that%20the,led%20ACOs%20(Figure%201).*

[2] Wakely Risk Insight for the Medicare Shared Savings Program: Performance Year 2021 Results. 2022. Available at: *https://www.wakely.com/sites/default/files/files/content/wakely-risk-insight-medicare-shared-savings-program-performance-year-2021-results.pdf.*

It is important to note that there are large health systems and health plans that are committed to the mission of longitudinal, person-centered primary care and are not only interested in leveraging primary care as a source of high-margin revenue. There are companies focused on bolstering primary care capacity, access, and investment in order to improve health outcomes for all populations and address equity within underserved communities. These organizations invest revenue into primary care, provide primary care teams with clinical autonomy, and are focused on meeting the needs of the communities they are located in.

There may be circumstances in which vertical integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. **Evidence has shown vertical integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes.**[3] One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.[4] Site-of-service payment differentials play a significant role in these inflated costs, as current payment policies allow hospitals to charge facility fees for outpatient services.

Despite these data, we continue to prop up a health care system with misaligned financial incentives that reward maximizing profits through consolidation when we should be significantly increasing our investment in primary care. This will require thoughtful implementation of well-designed, sustainable, value-based primary care payment models that support and ensure the success of practices of all sizes and ownership types, not just large practices owned by health systems and health plans with substantial capital.

INTRODUCTION

Family physicians are uniquely trained to care for patients across the lifespan, regardless of gender, age, or type of problem, be it biological, behavioral, or social *(https://www.aafp.org/about/policies/all/role-definition.html#Role%20Definition%20of%20Family%20Medicine)*. They serve as a trusted first contact for health concerns with training to address most routine health-care needs. The foundation of family medicine is primary care, defined as the provision of integrated, accessible health-care services by physicians and their health-care teams who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community *(https://www.aafp.org/about/policies/all/primary-care.html#Primary%20Care)*. Primary care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.

Primary care is the only health-care component where an increased supply is associated with better population health and more equitable outcomes, leading the National Academies of Sciences, Engineering, and Medicine (NASEM) to call it a common good.[5] Evidence clearly demonstrates that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations. Yet the United States has continuously underinvested in primary care, which only accounts for a mere 5 to 7 percent of total health-care spending in the country.[6, 7]

Our national, systemic underinvestment in primary care, coupled with overwhelming administrative burden and rising practice costs, has placed many independent practices in an unenviable position, struggling to envision a viable future where they can remain just that: independent. I acknowledge that independent practice is becoming increasingly challenging to define in today's market—but at its

[3] Schwartz K et al. "Issue Brief: What We Know About Provider Consolidation," Kaiser Family Foundation. September 20, 2022. *https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/*.

[4] Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. *JAMA*. 2014 Oct 22–29;312(16):1663–9. doi: 10.1001/jama.2014.14072. PMID: 25335148.

[5] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality PC: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. *https://doi.org/10.17226/25983.*

[6] Centers for Disease Control and Prevention. National Center for Health Statistics. Ambulatory Health Care Data. National Ambulatory Medical Care Survey (NAMCS). 2016. *https://www.cdc.gov/nchs/ahcd/index.htm.* Accessed February 9, 2023.

[7] Fulton B. Health Care Market Concentration Trends in the United States: Evidence and Policy Responses. 2017. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556.*

core, we're talking about practices that are primarily owned and led by physicians, whether it be solo clinics or a group or network of physician-owned practices that align themselves. Physicians are often forced to choose between the stability offered by health systems, payers, or other physician employers, and the autonomy and community focus of independent practice. Increasingly, family physicians report that independent practice is simply unsustainable. The available evidence supports their experiences: our current environment is driving and rewarding consolidation while at the same time draining resources from primary care.

Data confirms that physician employment is increasing and physician practice acquisitions have accelerated in recent years, including by vertically integrated systems, payers, and private equity companies. A 2017 study found that from 2010 to 2016, the share of primary care physicians working in organizations owned by a hospital or health-care system increased by a dramatic 57 percent—while the shares in independent solo practice or organizations owned by a medical group decreased.[8] A subsequent study published in 2020 found the share of primary care physicians affiliated with vertically integrated health systems increased from 38 percent to 49 percent from 2016 to 2018. In 2018, more than half of all physicians were affiliated with a health system.[9]

Similar data shows that hospitals and corporate entities, including health plans and private equity, now own over half of physician practices (hospitals own 26.4 percent and other corporate entities own 27.2 percent). From 2019 to 2021, there was a 43-percent increase in the number of corporate-employed physicians and an 86-percent increase in the percentage of corporate-owned physician practices.[10] In 2021, UnitedHealth Group—which already owns the Nation's largest commercial heath plan—became the largest employer of physicians in the country through its subsidiary company, Optum.[11]

The proportion of family physicians who are employed continues to grow each year, with 73 percent of all AAFP members and 91 percent of new family physicians (1 to 7 years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering only 59 percent of AAFP members reported being employed in 2011.

Family physicians who wish to remain in independent practice have transitioned into one of three practice models: physician-led care delivery organizations, physician-enabled care delivery organizations, or Direct Primary Care (DPC) practices *(https://www.aafp.org/about/policies/all/direct-primary-care.html).* We discuss the physician-led and physician-enabled care delivery organizations earlier in our statement. In the DPC model, practices contract directly with employers and patients to provide a broad range of primary care services in exchange for a monthly fee. Many family physicians have chosen DPC because it provides more stable, comprehensive payments for primary care than fee-for-service and enables them to spend significantly more time with patients by eliminating many administrative tasks. DPC can effectively alleviate many of the pressures that are undermining primary care practices and driving consolidation but remains out of reach for many patients who rely on their employer, Medicaid, CHIP, or other programs to make health care affordable. More comprehensive solutions are needed to bolster primary care practices and make primary care accessible for all.

For family physicians, choosing independent practice or employment by a health plan or health system should be just that—a choice. Unfortunately, our current system rewards consolidation through misaligned financial incentives and undermines community-based primary care. This means many primary care physicians become employed by a health plan or health system not because they want to, but because it feels like their only option.

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[8] Fulton B. Health Care Market Concentration Trends in the United States: Evidence and Policy Responses. 2017. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556.*

[9] Furukawa et al. Consolidation of Providers Into Health Systems Increased Substantially, 2016–18. Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00017.*

[10] Avalere Health, "COVID–19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2021." April 2022. Accessed at: *https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.*

[11] Insurers pave new vertically integrated provider model. Modern Healthcare. *https://www.modernhealthcare.com/operations/insurers-pave-new-vertically-integrated-provider-model.*

DRIVERS OF CONSOLIDATION AND VERTICAL INTEGRATION IN PRIMARY CARE

The principal factors fueling primary care integration with health systems and corporate entities such as insurers are financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Consolidation, in primary care and family medicine specifically, in the post-Balanced Budget Act of 1997 context, can be traced back to a set of legislative and regulatory policies:

- Physician Quality Reporting Initiative/System (PQRI/PQRS) "Value Over Volume."
- Health Information Technology for Economic and Clinical Health (HITECH) Act.
- Medicare Access and CHIP Reauthorization Act (MACRA).
- Medicare Physician Fee Schedule.

It is now clear that the economic pressures associated with complying with these policies, coupled with systemic underinvestment in primary care via the Medicare Physician Fee Schedule, initiated and continues to drive the loss of independent practices.[12, 13, 14] Over the past decade, most practices that have consolidated did so not from a position of opportunity, but to avoid economic ruin.

The Affordable Care Act (ACA) also contributed to the reshaping of our delivery system. While the ACA created mechanisms for consolidation, the law itself was significant in its support for community-based primary care practices in three ways: (1) Medicare Incentive Payments to primary care physicians; (2) Medicaid to Medicare payment parity for primary care; and (3) the Medicare Shared Savings Program (MSSP) which created a pathway for groups of physicians to aggregate outside of vertical integration options. Of those policies, only the MSSP program remains.

Together these policies took steps to advance value-based payment and electronic health record adoption and interoperability, but they also increased the cost of doing business for primary care practices without meaningfully addressing rising hospital prices and spending.

Providing high-quality, patient-centered primary care requires a care team, advanced data aggregation and analytics tools, and practice management staff and software. Each of these requires practices to make significant financial investments and commitments, but today's physician payment system fails to provide such support. Instead, independent practices struggle to make ends meet. Family physicians in private practice report months where they couldn't bring home a paycheck, ultimately succumbing to acquisition to avoid financial ruin. While some family physicians have reported positive experiences with being acquired by a health system or corporation, citing access to advanced tools and technology, additional administrative support, and other experts, many more physicians experience moral injury as they cope with loss of clinical autonomy and requests to prioritize organizational priorities over those of their patients.

For example, family physicians have experienced a narrowing of their scope of practice when their practice is acquired, or they become employed. An administrator or executive makes decisions about what services will be offered based on profitability, volume, and other factors, instead of considering how best to serve their patients and community. Family medicine is, at its core, about providing continuous, comprehensive care—limiting the scope of services offered by family physicians negatively impacts timely, equitable access to care and undermines family medicine's value and ability to meet patients' needs.

Workforce challenges also contribute to the state of financial insecurity for many independent practices. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034,[15] and recruitment of clinical staff remains a strug-

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[12] Sines CC, Griffin GR. Potential Effects of the Electronic Health Record on the Small Physician Practice: A Delphi Study. *Perspect Health Inf Manag.* 2017;14(Spring):1f. 2017. Available at *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5430134/*.

[13] Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum.* 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527.

[14] MedPAC March 2023 Report to the Congress: Medicare Payment Policy. Chapter 4. Available at: *https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.*

[15] IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: AAMC; 2021.

gle, at a time when physicians and their staff are dedicating nearly two business days just to completing burdensome administrative processes like prior authorization.[16, 17] In 2021, more than 20 percent of respondents in a primary care survey reported they were paying staff a salary above what they can afford to retain them.[18]

The shadow of student debt (on average $200,000 not including undergraduate studies)[19] looms over medical students and incentivizes them to pursue higher-paid specialties. Payment differentials among specialties have shown many fields receive two to two and a half times more income than primary care physicians, causing many medical students to choose subspecialty fields over primary care. Independent practices face significant challenges in recruiting newly trained physicians given the lack of financial resources to provide loan repayment and salary guarantees that larger health systems and employers can provide. **Congress should consider graduate medical education (GME) program reforms** *(https://www.aafp.org/content/dam/AAFP/documents/advocacy/workforce/gme/LT-SenateHELP-WorkforceRFI-031623.pdf)* **and increased funding** *(https://www.aafp.org/content/dam/AAFP/documents/advocacy/workforce/debt/LT-EducationSecretary-PSLF-081122.pdf)* **for existing loan forgiveness programs, such as the National Health Service Corps, for primary care physicians who chose to join independent practices in rural and other underserved areas as one solution for addressing these challenges.**

REFORMING FEE-FOR-SERVICE PHYSICIAN PAYMENT

The piecemeal approach fee-for-service (FFS) and the Medicare Physician Fee Schedule (MPFS) take to finance primary care undermines and undervalues the whole-person approach integral to primary care. The damage caused by the historical underinvestment in primary care and the failure of the MPFS and the subregulatory bodies who influence the valuation of physician services have undermined the stability of primary care practices and worsened consolidation. Across payers, physicians must document several unique screening codes, vaccine administration, other preventive services and counseling codes, an office visit, care management codes, integrated behavioral health codes, and several other services to justify payment for typical, comprehensive primary care, even though these services are all foundational parts of primary care. In addition to being administratively burdensome, this approach encourages carveouts of behavioral health, telehealth, and other services that are more accessible and effective when integrated in and coordinated within the patient's usual source of care.

FFS also undervalues the component parts of primary care, like care management and integrated behavioral health, and therefore fails to account for the complexity of primary care. The Medicare Payment Advisory Commission (MedPAC) has long advised policymakers to address the underpricing of primary care services in FFS and the NASEM consensus report confirmed that FFS does not adequately value or support the longitudinal, person-centered care that is the hallmark of primary care. For example, many patients benefit from regular care management and coordination services that are not billable under FFS *(https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care)*. **Together, the failings of FFS are jeopardizing many community-based primary care practices, driving consolidation, and eroding patients' timely, affordable access to primary care in their own neighborhood.**

Statutory budget neutrality requirements make matters even worse by requiring Medicare to offset increased investment in one area of medicine with cuts to others, pitting primary care and other specialties against each other instead of enabling Medicare to pay appropriately for all types of care. This dynamic has only exacerbated our underinvestment in primary care within the fee-for-service payment system: primary care's voice is drowned out as organized medicine competes for arbi-

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[16] American Medical Association, "2022 Prior Authorization Physician Survey." Accessed June 5, 2022. Available at: *https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.*

[17] Larry Green Center. Quick COVID Survey Series 35. 2022. Available at: *https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/623ca361a42fff66942aa83c/1648141153593/C19+Series+35+National+Executive+Summary+vF.pdf.*

[18] Larry Green Center. Quick COVID–19 Survey Series 34. 2021. Available at: *https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/623c7979ee9d8b335f58e79a/1648130425905/C19_Series_34_National_Executive_Summary_vF.pdf.*

[19] *https://www.forbes.com/advisor/student-loans/average-medical-school-debt/.*

trarily limited resources without adequate focus on the services that would drive population health improvements and health equity.

Fee-for-service is not the future of primary care—but it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates physicians to make more meaningful progress toward the future—one that rewards quality of care over volume of services. Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates threaten their long-term viability. This is especially true in rural and medically underserved communities, where simply participating in Medicare and Medicaid is economic detrimentally to independent practices. However, backing out would mean that these patients—who make up the greatest portion of a panel—are unlikely to access care elsewhere.

Rural communities are disproportionately impacted by insufficient FFS payments and the other pressure points fueling consolidation. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. Rural areas see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Because of the less-profitable patient population, studies have indicated that market concentration is higher in low-income areas.[20] For small, rural practices and hospitals, the effects of consolidation may be different. Mergers and acquisition can play an important role in preserving existing sites of care (and oftentimes, the only site) with insufficient margins. However, it also often results in the closure of service lines not deemed highly profitable—including primary care—and may worsen equitable access to care in these communities.[21]

One family physician in the Midwest shared his experience of trying to keep the doors open for his rural community practice. For more than 20 years, he provided care in the community he called home. He spent 50 percent of his time working in the emergency department at the local hospital simply to try and keep his primary care practice financially afloat. Unfortunately, it wasn't enough. In 2020, he closed his practice not due to COVID, but due to the financial instability, and left primary care entirely to seek refuge in the emergency department.

The Academy strongly urges the Committee to consider legislative solutions, including reforms to MACRA, that would address unsustainable FFS payment rates for physicians and promote community-based primary care, rather than incentivizing consolidation.

MACRA permanently repealed the sustainable growth rate (SGR) and set up the two-track Quality Payment Program (QPP) that emphasizes value-based payment. While the elimination of the SGR was lauded by the physician community at the time, **MACRA has left the majority of Part B clinicians in a similar state of financial insecurity as Medicare payment rates failed keep pace with practice costs amid a dearth of value-based payment model options.**

According to the American Medical Association's analysis of Medicare trustees report data, Medicare physician payment has been reduced by 26% when adjusted for inflation over the past 20 years.[22] Practically speaking, this means that physicians are struggling to cover the rising costs of employing their staff, leasing space, and purchasing supplies and equipment—let alone make investments to transition into new payment models. In 2023, Medicare pays $33.89 ($33.8872) per relative value unit under the Medicare physician fee schedule, which is less than the $36.69 ($36.6873) it paid when Medicare moved to a single conversion factor in 1998. If the 1998 amount had simply kept pace with inflation, it would be $68.87 today.

Both MedPAC and the board of trustees have recently raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending Congress provide payment updates for physicians. Specifically, the board of trustees warned that, without a sufficient update or change to the payment sys-

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[20] JAMA Health Forum—Health Policy, Health Care Reform, Health Affairs, JAMA Health Forum, JAMA Network, *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776056#:~:text=Reducing%20Health%20Disparities%20Requires%20Financing%20People%2DCentered%20Primary%20Care&text=Spurred%20by%20the%20nationwide,mobilizing%20to%20promote%20health%20equity.*

[21] O'Hanlon CE et al. "Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation," *Health Affairs.* December 2019. *https://doi.org/10.1377/hlthaff.2019.00918.*

[22] American Medical Association. Medicare updates compared to inflation (2001–2023). Available at: *https://www.ama-assn.org/system/files/medicare-updates-inflation-chart.pdf.*

tem, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[23]

Congress should heed these warnings. **The AAFP strongly urges the committee to pass legislation that would provide an annual update to the Medicare Physician Fee Schedule based on the Medicare Economic Index (MEI)** *(https://www.aafp.org/content/dam/AAFP/documents/advocacy/payment/medicare/LT-Congress-StrengtheningMedicareforPatientsandProvidersAct-040723.pdf).* This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

Since the passage of MACRA, it has become clear that stable, adequate fee-for-service payments are also a vital component to the value-based care transition, particularly for practices serving rural, low-income, and other underserved communities. Physician practices that struggle to keep their doors open cannot possibly transition into alternative payment models or hire care managers and behavioral health professionals. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows.

Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices, slow the adoption of value-based payment models, accelerate consolidation, and jeopardize patients' access to care. In October 2022, the Academy submitted robust recommendations to Congress on reforming MACRA to address challenges affecting our members and their patients *(https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-Congress-MACRA-RFI-102822.pdf).* The AAFP urges Congress to expeditiously consider additional reforms to MACRA and Medicare physician payment, such as relief from budget neutrality requirements, to modernize Medicare fee-for-service payments.

Medicaid payment improvements are critically needed, as well. On average Medicaid pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[24] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families enrolled in Medicaid, which has seen record high enrollment in recent years.

Evidence has indicated that increasing Medicaid payment rates improves access to care for beneficiaries. From 2013 to 2014, appointment availability increased following the ACA's increased Medicaid payment for primary care services, but decreased after Congress failed to reauthorize it.[25] States that had larger payment increases also had more improved appointment availability and child health outcomes.[26] **Therefore, the AAFP urges Congress to pass legislation to permanently raise Medicaid payment rates for primary care services to at least Medicare levels to better support physicians and their patients' access to care** *(https://www.aafp.org/content/dam/AAFP/documents/advocacy/payment/medicaid/LT-SenBrownMurray-EnsuringAccessPrimaryCareWomenChildrenAct-052721.pdf).*

VALUE-BASED PAYMENT AND ALTERNATIVE PAYMENT MODELS

Some independent primary care practices have found refuge in value-based payment. Alternative payment models, when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable revenue streams that provide the financial flexibility to provide truly patient-centered care. The AAFP has developed a set of Guiding Principles for Value-based Payment as

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[23] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed April 6, 2023: *https://www.cms.gov/oact/tr/2023.*

[24] *https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[25] v Decker, SL. "In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help." *Health Aff (Millwood),* vol. 31, no. 8, 2012, pp. 1673–9. doi: 10.1377/hlthaff.2012.0294. PMID: 22869644; PMCID: PMC6292513. *https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0294.*

[26] McKnight, R. "Increased Medicaid Reimbursement Rates Expand Access to Care." National Bureau of Economic Research, no. 3,2019. *https://www.nber.org/bh/increased-medicaid-reimbursement-rates-expand-access-care.*

a reference point for physicians and other stakeholders to evaluate whether primary care alternative payment models (APMs) are designed to meet their stated goal: improving patient health outcomes through quality improvement with accountability for health care spending *(https://www.aafp.org/about/policies/all/value-based payment.html)*.

Central to our principles is the idea that value-based payment for primary care should not be piecemeal codes and billing requirements for specific services as in fee-for-service but should rely primarily on population-based payments that provide predictable, prospective revenue streams capable of supporting continuous, comprehensive, and coordinated primary care delivered in the context of the community it serves. It is essential that policymakers and others recognize that this kind of primary care is not delivered exclusively in an exam room—whether that "room" is in person or virtual. Primary care physicians who are finding success under value-based payment talk about the importance of the "in-between spaces" and that the patient who's not on your visit schedule that day may be the one who needs you most. Successfully navigating these in-between spaces requires physician-led care teams enabled by actionable and timely data and information.

Finally, with many primary care practices contracting with seven to ten different payers, there should be alignment across public and private payers on important aspects of value-based payment, including measures of performance, data collection, and reporting requirements, to reduce unnecessary administrative burdens on practices. Models that heed these recommendations will more effectively support independent practices through continuous investment in primary care. **Federal policymakers should increase participation opportunities in primary care models that align with these principles and meet practices where they are, allowing them to gain a foothold in value-based payment. As a starting point, Congress should support CMMI demonstrations consistent with our principles, extend the Advanced Alternative Payment Model (AAPM) bonus, and provide CMS with authority to modify AAPM qualifying participant thresholds to ensure independent practices are not left behind.**

However, primary care practices face significant barriers to entering value-based payment models, even when aligned with our principles. Practices must ensure compliance with ever-changing federal regulations, negotiate value-based contracts with multiple commercial payers, establish and maintain a robust panel of attributed patients, acquire and effectively use data aggregation and analysis software to track patient utilization, treatment adherence, and identify outstanding needs. This creates an immediate high barrier to entry, forcing physicians to choose between remaining independent and stuck in a fee-for-service environment that fails to support the full scope of comprehensive, longitudinal primary care, or join with a larger practice, health system, or payer that can provide them with the tools and support they need to thrive in value-based arrangements. Federal policymakers should increase participation options in APMs that provide upfront or advance payments to enable the infrastructure investments and practice transformations necessary to succeed in value-based payment.

For these reasons, the AAFP has consistently advocated for Congress and CMS to bolster support for new practices entering APMs. For example, CMMI provided practices participating in the Comprehensive Primary Care Plus (CPC+) model with a robust data dashboard and other technical assistance that enabled new practices to join the model and successfully reduce hospitalizations. CMMI also partnered with state Medicaid agencies and commercial payers to drive alignment in the regions it was testing CPC+, which in turn provided practices with greater financial support across their contracts and accelerated care delivery innovations. Without these kinds of supports built into model participation, small primary care practices face significant barriers to entry and will be unable to move into value-based care. **Congress could consider providing CMMI with additional authority and funding specifically directed to supporting independent primary care practices entering into value-based payment arrangements.**

In the Medicare Shared Savings Program (MSSP), many independent primary care practices have successfully partnered with aggregators to remain independent and successfully participate in value-based payment models, in part because aggregators assist practices in aligning their contracts across payers and effectively reinvesting financial incentives into practice improvements. Aggregators are companies that bring independent practices together, typically to form an Accountable Care Organization (ACO), and provide technical support in model enrollment and compliance, data analytics, and practice improvement and care management. They do not

own the practices they work with. Aggregators are also increasingly assisting practices in securing value-based contracts with commercial payers and managed care organizations that align with the Medicare Shared Savings Program. These aggregators share in the savings accrued by the practices they partner with but enable practices to benefit from their tools and support, often without requiring upfront payment. Given the significant upfront investment, as well as new competencies and skills required to successfully participate in APMs, aggregators offer a viable pathway to remaining independent and financially operational for many practices.

To support independent practices' ability to participate in APMs that work for them, Congress should also consider providing CMMI with additional flexibility in how it evaluates the success of primary care models. Currently, Federal statue only allows CMMI to expand models that reduce healthcare spending and maintain quality, or improve performance on quality metrics without increasing spending. Demonstrating savings in primary care often takes several years, as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services, like care management.[27] The current statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional model successes. Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs, such as whether they successfully bring new physicians into value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, evaluate models both nationally and regionally. These additional criteria would allow CMMI to continue testing models that show early markers of success, as well as iterate upon them to meet current patient, clinician, and market needs.

While value-based payment can and should be used to buoy primary care practices, health systems, hospitals, payers, and other large companies will continue to enter these models. **Federal policymakers should take steps to ensure that value-based payment is being used as a tool to significantly increase our Nation's investment in primary care, not as a leverage point to increase profits in other business areas.** In other words, payments and financial rewards from APMs should be reinvested back into the primary care practice, not redirected to other service lines or books of business. The AAFP increasingly hears from family physicians that their employers—whether they are health systems, health insurers, or another type of employer—are using primary care as a management tool and are failing to reinvest financial gains into their primary care practices and clinicians. This prevents primary care practices from reaping the full benefits of APM participation, including practice improvements that can advance quality and bolster patient health outcomes. **The AAFP urges Congress to examine additional guard rails to ensure that hospital systems, integrated payers, and other physician employers participating in primary care APMs are required to reinvest the payments and incentives earned from high-quality primary care back into the practices that are performing successfully.**

REALIGNING INCENTIVES AND IMPROVING ENFORCEMENT

While value-based payment is one solution to which Congress should look in support of independent primary care, additional Federal action is needed to address current policies and incentives that reward increasing consolidation and sap resources from independent practices.

Congress should advance site-neutral payment, billing transparency, and price transparency legislation to address misaligned incentives that reward consolidation and undermine independent practices. Currently, hospitals are directly rewarded financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings and moving services into the hospital or hospital outpatient department setting. Medicare allows hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. Thus, the hospital increases its revenue by ac-

[27] Commonwealth Fund. Increasing Medicare's Investment in Primary Care 2022. Available at: *https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/increasing-medicares-investment-primary-care.*

quiring physician practices and beneficiaries are forced to pay higher coinsurance.[28] The AAFP has long advocated to advance site-neutral payments as a vital tool for stemming vertical consolidation and reducing beneficiary cost sharing *(https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-CMS-2020OPPS-091919.pdf)*.

The AAFP also supports legislation that advances billing transparency by requiring hospital outpatient departments to use distinct National Provider Identifiers (NPI) and claim billing forms from the hospital itself, as well as legislation to require hospital price transparency. Improving transparency within the Medicare program ultimately provides policymakers, researchers, and other stakeholders with the tools they need to implement meaningful solutions. Understanding the environment that is currently accelerating consolidation and acquisition of primary care practices is essential.

Finally, Congress should improve Federal regulators' enforcement authorities and resources to meet today's health-care consolidation needs. Antitrust authorities are currently constrained in a number of ways, including limited available data and resources, as well as a high threshold of pre-merger notification. In 2023, pre-merger notification to Federal antitrust authorities was required for transactions over $111.4 million, meaning that many acquisitions, particularly of physician practices, go unnoticed until the merger has been finalized.[29]

Relatedly, tax-advantaged hospitals are not currently subject to Federal antitrust enforcement or oversight of anticompetitive behaviors. In exchange for valuable tax exemptions, hospitals are required to provide charitable contributions to the community. However, data has shown that the highest income-generating tax-advantaged hospitals provided the lowest amount of charity care.[30] Tax exemptions for hospitals, which generated an estimated value of $28 billion in 2020, provide them with even greater capital and financial resources to purchase physician practices.

Greater transparency and strengthened antitrust statutes could help reduce the amount of anticompetitive consolidation in health care. Congress should ensure oversight agencies have the resources needed to be effective in researching and pursuing new and developing issues related to health care consolidation and competition.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP, I look forward to continuing to work with the committee to advance policies that support physician practices, invest in high-quality primary care, and ultimately ensure a health-care system that rewards value of care over volume of services.

QUESTIONS SUBMITTED FOR THE RECORD TO R. SHAWN MARTIN

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Collaboration between providers is beneficial in many areas of health care, including the treatment of chronic conditions like diabetes. Rhode Island's health information exchange, CurrentCare, is a public-private partnership that helps medical professionals access protected health information, such as prescriptions, lab tests, and hospital visits, from multiple sources in one secure statewide platform.

How can Congress encourage collaboration and innovation, like CurrentCare, across the health-care system?

Answer. The AAFP supports the development of an efficient health data ecosystem that prioritizes the needs of patients and their care teams and sees innovative, collaborative partnerships, such as health information exchanges, as being a necessary tool to help ensure the best possible delivery of care for patients across providers *(https://www.aafp.org/about/policies/all/information-technology.html)*. Congress should implement Federal incentives that support the application of uni-

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[28] Pst, B et al. Hospital-physician integration and Medicare's site-based outpatient payments. Avaialble at: *https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13613.*

[29] Adler L and Ippolito B. Procompetitive health care reform options for a divided Congress. Brookings Institution. 2023. Available at: *https://www.brookings.edu/essay/procompetitive-health-care-reform-options-for-a-divided-congress/*.

[30] Bai G, Yehia F, Anderson GF. Charity Care Provision by US Nonprofit Hospitals. *JAMA Intern Med.* 2020;180(4):606–607. doi:10.1001/jamainternmed.2019.7415.

form standards and a national system of interoperability that electronically connects patients with their family physicians and other care team members. It also important that Federal policies pertaining to health information technology (HIT) facilitate efficient information sharing without undue financial or administrative burden on physician practices, regardless of the size of the facility or care setting.

To encourage further collaboration and innovation in areas with the greatest need, Congress should prioritize financial and technical support for practices caring for historically underserved and marginalized populations and those at greatest risk for adverse health outcomes to advance equitable access to high-quality, connected care. Additionally, programs and incentives to support adoption of interoperable HIT systems should consider the unique needs of small, rural, and independent physician practices which have historically lagged in adoption due to resource constraints.

Data and information sharing should take a "push" rather than a "pull" approach. Patient health data and information should be proactively and automatically shared with their primary care physicians to promote coordinated care. Family physicians and primary care practices in pay-for-performance programs or value-based payment arrangements that include upside or downside financial incentives should have full access to accurate and up-to-date data on the cost and quality of care available to and accessed by their attributed patient population.

Question. As Mr. Martin from the American Academy of Family Physicians mentioned in his testimony, "a growing body of evidence demonstrates that physician-led Accountable Care Organizations (ACOs) achieve greater savings than their hospital-led counterparts." ACOs offer an alternative for primary care provider groups to remain independent, while focusing on innovation and value-based payment for patients.

How can Congress reduce the barrier to entry for independent primary care providers entering ACOs?

Answer. As I noted in my testimony, value-based payment models provide practices with additional financial support and flexibility to bolster care capacity and innovation while remaining independent. Value-based payment models better resource primary care practices for providing comprehensive, team-based primary care. But to accelerate the transition to value-based payment, primary care practices need a suite of model participation opportunities that are aligned across payers and meet practices where they are and help them advance into more advanced models with population-based payments. The AAFP has consistently advocated for Congress and CMS to bolster support for new practices entering APMs, including participation in ACOs. The AAFP continues to urge Congress to pass legislation that would improve Medicare's value-based care models and ACOs to ensure that these models continue to produce high quality care for the Medicare program and its beneficiaries.

This includes extending the Advanced Alternative Payment Model (AAPM) bonus, and providing CMS with authority to modify AAPM qualifying participant thresholds to ensure independent practices are not left behind, as well as implementing fair and accurate benchmarks for all ACOs.

Congress could consider providing CMMI with additional authority and funding specifically directed to supporting independent primary care practices entering into value-based payment arrangements. We've been pleased to see the Center for Medicare and CMMI recently advance regulations and new models that provide upfront funding to physician practices who want to enter into an APM. This upfront support enables practices to invest in the tools, technology, and staff they need to transition into value-based payment and meet patients' unique health needs.

Question. As president and chief executive officer of Community Hospital, Mr. Thomas articulated that operating an independent hospital allows "our ability to singularly focus on the well-being of our community and the needs of the patients within our service areas" and this "differentiates us from system hospitals."

How does consolidation that results in out-of-State ownership affect the healthcare workforce, local community investment, and quality of care?

Answer. Primary care is, by design, community-aligned and intended to serve the specific and unique needs of a community. As acknowledged in my testimony, consolidation is not inherently good or bad. There are some instances in which physician practice ownership by an out-of-State entity can provide them with necessary resources and supports that are not otherwise available to an independent practice. This may include access to advanced tools and technology, additional administrative support, and other experts.

However, out-of-State ownership may limit the understanding of or on-the-ground interactions with a community in a way that meaningfully informs an organization's decision-making and community investments. While an employed family physician will continue to have that understanding as a practitioner embedded in the community day to day, they often lose some degree of clinical autonomy and follow larger organizational priorities that may fail to acknowledge a community's unique needs, thereby running at odds with the fundamental principles of primary care and family medicine.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. With increasing consolidation in the health-care industry, noncompete agreements have become more common. A 2022 survey of employers in health care and social assistance found that 57.1 percent used noncompete agreements. In January 2023, The Federal Trade Commission proposed a rule to ban noncompete agreements that would impact workers in the health-care sector and across the economy.

In general, does vertical consolidation increase the prevalence of noncompete agreements?

Answer. In the simplest terms, vertical consolidation can mean that entities which utilize noncompete agreements own or employ an outsized (and still growing) portion of physicians practices and physicians. Therefore, more and more physicians are being subject to noncompete agreements, particularly in heavily consolidated markets around the country where one or two large entities own all the facilities and are thus the only real employer option for physicians. Based upon the data and trends cited in my written testimony about increases in the percent of employed family physicians, we know that the prevalence of noncompete agreements for family physicians has seen an uptick in the last several years.

Question. In your view, how do noncompete agreements affect: patient access to care; patient continuity of care; health-care costs; health-care workers, including wages, safety, and staffing levels; and competition, including for new market entrants.

Answer. As the landscape of employment for physicians' shifts toward employment, noncompete agreements in health care threaten to disrupt patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, stifle competition, and contribute to an increasingly concentrated healthcare market. Despite projected physician shortages, health-care employers enforce noncompete agreements that intentionally restrict physician mobility and workforce participation. As noted in the Federal Trade Commission's proposed rule on noncompetes this year, there is evidence that noncompete clauses increase consumer prices and concentration in the health-care sector.

As has been discussed in my written testimony and during the hearing, evidence indicates that consolidation increases health-care prices, does not improve quality, and can worsen access to care. The AAFP firmly believes that everyone should have affordable, equitable access to comprehensive, person-centered primary care and we are therefore concerned that noncompete clauses may be undermining progress toward improving individual and population health.

These concerns are exacerbated for family physicians who provide continuous, comprehensive care for patients over their lifespan. Continuity of care is known to improve outcomes, particularly for patients with complex chronic conditions. The significance of this issue is underscored by the recent "Health of U.S. Primary Care" scorecard that found that the primary care physician workforce is shrinking and gaps in access to care appear to be growing.[1] According to physician search firm, Merritt Hawkins, more than 90 percent of physician agreements they review include noncompete agreements.[2] More recently, noncompetes have been documented to prevent physicians from practicing medicine in their chosen communities when they want to change jobs, thus potentially limiting patients' access to their regular source of care.[3] Family physicians from across the country have expressed deep concerns about how noncompete agreements are forcing them to remain in undesirable em-

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[1] *https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/#.Y_YZnbwZMHw.twitter.*

[2] *https://www.merritthawkins.com/news-and-insights/blog/executive-order-impacts-physician-non-compete-clauses.*

[3] JAMA Health Forum. 2021;2(12):e214018. Doi:10.1001/jamahealthforum.2021.4018.

ployment situations which harm their financial and mental health or abandon their patients and travel long-distances or uproot their families to practice in a new geographic area.

PREPARED STATEMENT OF CAROLINE PEARSON, EXECUTIVE DIRECTOR, PETERSON CENTER ON HEALTHCARE

Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee, my name is Caroline Pearson, and I am the executive director of the Peterson Center on Healthcare ("the Center"), which is a division of the Peter G. Peterson Foundation. Thank you for the opportunity to testify before the committee today as you examine opportunities to lower costs and improve the quality, accessibility, and affordability of health care by advancing health-care transparency.

Founded in 2014, the Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable health care a reality for all Americans. We are working to transform health care in the United States into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale. The Center collaborates with a wide range of health-care stakeholders and engages in grant-making, partnerships, and research.

As the members of this committee know well, and has been well established by a plethora of research, our Nation's per capita spending on health care is more than twice the average of other comparable countries [1] and it is growing explosively.[2] Yet, outcomes for patients in the U.S. are worse than many other nations.[3] Fundamental to the Center's mission is a belief that in order to advance more effective, accessible care for patients, health-care decision-makers—including policymakers, business leaders, and families—need more and better data to correct inefficiencies in the market and ultimately lower health-care spending growth to more sustainable levels.

I joined the Center as its executive director in January of this year. Prior to the Center, I spent 20 years working in research and consulting on a range of health-care policy and business issues, including public and private insurance coverage, prescription drugs, and aging. I have conducted in-depth data analyses using health-care claims, administrative, and survey data. Most recently, I was the senior vice president of health-care strategy at NORC at the University of Chicago, a nonpartisan, nonprofit social sciences research institution. Before NORC, I spent 14 years at Avalere Health, a leading health care consulting and advisory firm, where I oversaw teams focused on policy, data analytics, and strategic communications. Based on my experience working with companies across the health-care industry, I believe the path to a better, lower cost, and more accessible U.S. health-care system depends on improving the availability and usability of health-care data, including price transparency data.

My comments today will focus on how the evidence generated from the Center's work, as well as other independent studies conducted over the last several years, points to the need for continued advancements in health care data transparency. By increasing transparency regarding health-care prices, spending, and utilization, improved health-care data can help facilitate better-functioning markets and, when necessary, help inform policymaking to address market failures. End users for this data may include consumers, payers, providers, legislators, and regulators. In fact, our research and grantmaking underscores that greater health care data availability and usability is a critical ingredient to enable further action that lowers spending growth, increases quality, and improves access to care.

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[1] The Peter G. Peterson Foundation. (July 2022). How Does the U.S. Healthcare System Compare to Other Countries? Retrieved from: *https://www.pgpf.org/blog/2022/07/how-does-the-us-healthcare-system-compare-to-other-countries.*

[2] The Peter G. Peterson Foundation. (April 2023). Healthcare Spending in the United States Remains High. Retrieved from: *https://www.pgpf.org/blog/2023/04/healthcare-spending-in-the-united-states-remains-high.*

[3] The Peter G. Peterson Foundation. Key Drivers of the National Debt. Accessed June 1, 2023. Retrieved from: *https://www.pgpf.org/the-fiscal-and-economic-challenge/drivers.*

Thanks to the regulations promulgated and implemented over the last several years by the previous administration, and then the current administration,[4] along with the passage of the No Surprises Act as part of The Consolidated Appropriations Act of 2021[5] by Congress, we now have an unprecedented level of health care price transparency and have taken important steps toward democratizing information that has previously been proprietary. My testimony today offers a series of recommendations to build on that progress.

My testimony summarizes some of the key findings from the Center's work and other research on how transparency can shape health-care markets. It also puts forth a range of policy options that Congress and the Executive Branch should consider to further advance discrete elements of health care data transparency, with an emphasis on how to improve the depth, breadth and usability of pricing data.

THE PETERSON CENTER ON HEALTHCARE SUPPORTS INCREASED TRANSPARENCY

The Center's grant-making portfolio provides us with ample evidence that additional health care data transparency that builds on the advancements already made at both the national and State level would be enormously beneficial. This portfolio includes the Peterson-Kaiser Family Foundation (KFF) Health System Tracker and the Peterson-Milbank Program for Sustainable Health Care Costs.

Launched in 2015, the Peterson-KFF Health System Tracker uses health-care data and sound research methods to track U.S. health system performance, across four domains: Health Spending, Quality of Care, Access and Affordability, and Health and Well-being. Since implementation of the hospital price transparency regulations produced new information about hospital prices in machine-readable files, Peterson-KFF researchers have used the newly available data to conduct analyses for public consumption. The researchers have leveraged the data that has become available as a result of the Hospital Price Transparency rules (CMS–1694–F, CMS–1717–F2, CMS–1753–FC), which require hospitals to post a single machine-readable file of their gross charges, discounted cash prices, payer-specific negotiated charges and de-identified minimum and maximum negotiated charges for all items and services offered by the hospital, and for hospitals to display the same information in plain language for consumers of at least 300 "shoppable services." These requirements went into effect on January 1, 2021.

The Peterson-KFF hospital price transparency research finds that:

- Hospital compliance with the reporting requirements is lagging, but growing;[6]
- Consumers have little to no awareness of the transparency requirements;[7]
- There is significant variation in hospital prices;[8] and
- The usability of this new data remains challenging.[9]

Peterson-KFF researchers were among the first to examine hospital compliance and found very few hospitals were providing their payer-negotiated rates in April

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[4] Originally proposed in 2019, the Hospital Price Transparency rule went into effect on January 1, 2021. CMS continues to propose modifications and changes via annual fee schedule updates. *See* CMS Hospital Price Transparency website for full review of Hospital regulations and current requirements. *https://www.cms.gov/hospital-price-transparency.* The Transparency in Coverage rule was finalized in 2020, and implementation for most self-insured group health plans and issuers of group and individual fully-insured plans began July 1, 2022. The rule phases transparency components for commercial insurance plans over time, with the final phase going live January 1, 2024. *See* CMS Transparency in Coverage website for full review of payer regulations and current requirements. *https://www.cms.gov/healthplan-price-transparency.*

[5] Public Law 116–260—Consolidated Appropriations Act, 2021. *https://www.govinfo.gov/app/details/PLAW-116publ260.*

[6] Kurani, N., Ramirez, G., Hudman, J., Cox, C., Kamal, R. (April 2021). Early results from Federal price transparency rule show difficulty in estimating the cost of care. *https://www.healthsystemtracker.org/brief/early-results-from-federal-price-transparency-rule-show-difficultly-in-estimating-the-cost-of-care/*.

[7] Kurani, N., Kearney, A., Kirzinger, A., Cox, C. (June 2021). Few adults are aware of hospital price transparency requirements. *https://www.healthsystemtracker.org/brief/few-adults-are-aware-of-hospital-price-transparency-requirements/*.

[8] Kurani, N., Rae, M., Pollitz, K., Amin, K., Cox, C. (January 2021). Price transparency and variation in U.S. health services. *https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/*.

[9] Lo, J., Claxton, G., Wager, E., Cox, C., Amin, K. (February 2023). Ongoing challenges with hospital price transparency. *https://www.healthsystemtracker.org/brief/ongoing-challenges-with-hospital-price-transparency/*.

2021, 3 months after the requirements went into effect.[10] Patient Rights Advocate, a nonprofit organization active in the pursuit of price transparency, issued its first hospital compliance report a few months after the Peterson-KFF researchers, and found only a 5.6-percent compliance rate among 500 hospitals reviewed.[11] In January of 2023, the Centers for Medicare and Medicaid Services (CMS) concluded that 70 percent of hospitals are compliant with the posting requirements for the price transparency rule,[12] though a competing report issued by Patient Rights Advocate in February 2023 found only 24.5 percent of hospitals were fully compliant with the posting requirements.[13]

In addition to compliance challenges, consumer awareness of the new price transparency data remains very low. Peterson-KFF research conducted in the spring of 2021 showed that only 9 percent of U.S. adults were aware that hospitals are subject to price disclosure requirements—a finding that was consistent across age groups, income levels, and health status. In that same study, the researchers also found that 85 percent of U.S. adults had not spent time researching the price of health services within the prior 6-month time frame, a finding that is consistent with other research that shows very few U.S. consumers price-shop for health care.[14]

Most recently, in February 2023, the Peterson-KFF research team's report on hospital price transparency focused on the data quality of the hospital-generated pricing data. The researchers concluded that the hospital price transparency data are associated with significant usability limitations, namely there is a lack of consistency in how hospitals describe service and care episode prices, data quality across the files is poor and critical pieces of information are missing from the files (Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code modifiers, contracting methods and payer type specification of commercial, Medicare, Medicaid).[15] For example, the research team examined charges and negotiated rates for a diagnostic colonoscopy—a procedure that is typically planned in advance, widely available in different settings in most geographies in the U.S., and therefore shoppable. Their analysis found that 96 percent of the negotiated rates for diagnostic colonoscopy included in the data set did not include associated standard CPT/HCPCS code modifiers that convey important information about the procedure that, in many cases, would affect pricing.[16]

The Peterson-KFF team also found that nearly half of the negotiated rates for diagnostic colonoscopy in the data currently lacks location specification—45 percent of negotiated rates for diagnostic colonoscopy have no location information provided.[17] This limits the utility of the data to demonstrate that, under current law, the same procedure performed by the same physician can cost much more or much less depending upon the physical setting in which it is performed (*e.g.,* a physician office, an Ambulatory Surgical Center, a hospital outpatient setting, or hospital inpatient setting).

Price transparency will continue as a focus of the Tracker research over the course of the coming year, and the team will start to use the Transparency in Coverage (TiC)[18] data sets from the Nation's payers to conduct new research briefs. Ef-

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[10] Kurani, N., Ramirez, G., Hudman, J., Cox, C., Kamal, R. (April 2021). Early results from Federal price transparency rule show difficulty in estimating the cost of care. *https://www.healthsystemtracker.org/brief/early-results-from-federal-price-transparency-rule-show-difficultly-in-estimating-the-cost-of-care/*.

[11] Patient Rights Advocate.org. (July 2021). Semi-Annual Hospital Price Transparency Report. *https://www.patientrightsadvocate.org/*.

[12] Seshamani, M., Jacobs., D. (February 2023). Hospital Price Transparency: Progress and Commitment to Achieving Its Potential. *Health Affairs Forefront. https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential.*

[13] Patient Rights Advocate.org. (February 2023). Semi-Annual Hospital Price Transparency Report. *https://www.patientrightsadvocate.org/february-semi-annual-compliance-report-2023.*

[14] Kurani, N., Kearney, A., Kirzinger, A., Cox, C. (June 2021). Few adults are aware of hospital price transparency requirements. *https://www.healthsystemtracker.org/brief/few-adults-are-aware-of-hospital-price-transparency-requirements/*.

[15] Lo, J., Claxton, G., Wager, E., Cox, C., Amin, K. (February 2023). Ongoing challenges with hospital price transparency. *https://www.healthsystemtracker.org/brief/ongoing-challenges-with-hospital-price-transparency/*.

[16] *Ibid.*

[17] *Ibid.*

[18] The Transparency in Coverage rule was finalized in 2020, and implementation for most self-insured group health plans and issuers of group and individual fully-insured plans began July

Continued

fective as of July 1, 2022, the TiC requires most self-insured and fully insured group and individual health insurance plans to post machine-readable files with the negotiated amounts for all covered items and services of in-network providers, and allowed amounts and billed charges from out-of-network providers. Further, insurers must create Internet-based price comparison shopping tools, first for 500 items and services in 2023, and then for all items and services in 2024, available to enrollees online, by phone or in paper form by request. Among the researchers that have started to use the TiC data, they are finding the files challenging to work with due to file size, data quality, and ability to link to other data sets.[19] Yet, they also see tremendous opportunity to explore questions with the data, and the Peterson-KFF team looks forward to adding thoughtful literature in the future.

Overall, our Peterson-KFF work demonstrates that the price transparency data that has become available over the last several years from our Nation's hospitals and payers, even in its imperfect form, is helping to improve the conditions for change. At the same time, it is also clear from our work and the work of other respected research organizations, that additional steps are needed to empower consumers, payers, and employers.

Since 2020, the Peterson-Milbank Program for Sustainable Health Care Costs has provided funding to States who wish to implement programs to reduce cost growth. The program provides technical assistance, analytic capacity, and communications resources to support States that have implemented health-care cost growth targets. Currently, the program assists leaders in 5 States (Connecticut, New Jersey, Oregon, Rhode Island, and Washington), by facilitating State-led policymaking that is data-informed and responsive to the unique dynamics at play in local and regional State markets driving health-care spending growth.

The Peterson-Milbank initiative has shown that data transparency is a critical underpinning of State and private market efforts to identify, understand and address market trends, including those factors driving health-care spending growth. In States pursuing cost growth targets, and in other States pursuing laws and infrastructure that create greater commercial pricing transparency, health-care pricing and utilization data can inform market understanding, policy decisions, and commercial negotiations on health-care price and quality.

The Center believes that transparent health-care pricing data will be impactful if that data can: enable more effective market negotiations; inform more competition-inducing policy actions; and change individual consumers' choices when enrolling in coverage and when accessing care. Research suggests that unlocking more effective market negotiations and informing policy action are the necessary precursors to unleashing the market power of consumers, since evidence to date finds that price transparency efforts targeting consumers have not yielded meaningful results.[20]

HOW DATA TRANSPARENCY CAN IMPROVE HEALTH SYSTEM PERFORMANCE

Market failures in health care, as evidenced by sustained commercial price increases, have emerged as a compelling theme supported by the literature. Provider-payer negotiations are driven by local market dynamics, where either payer strength or hospital system strength is exerted.[21] Independent physician practices are increasingly rare. In 2022, 74 percent of physicians were employed by hospitals, health systems, health insurers, or other corporate entities, a vertical consolidation trend that was accelerated during the COVID–19 pandemic.[22]

1, 2022. The rule phases transparency components for commercial insurance plans over time, with the final phase going live January 1, 2024. *See* CMS Transparency in Coverage website for full review of payer regulations and current requirements. *https://www.cms.gov/healthplan-price-transparency.*

[19] *Health Affairs Forefront* series. (2023). Provider Prices in the Commercial Sector. *https://www.healthaffairs.org/topic/bms150.*

[20] Mehrotra, A., Dean, K.M., Sinaiko, A.D., and Sood, N. (2017). Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information. *Health Affairs,* 36(8), 1392–1400. *https://doi.org/10.1377/hlthaff.2016.1471.*

[21] Gaynor, Martin. (2018). "Examining the Impact of Health Care Consolidation." Statement before the Committee on Energy and Commerce, Oversight and Investigations Subcommittee, U.S. House of Representatives. *SSRN Electronic Journal.* 10.2139/ssrn.3287848.

[22] Physicians Advocacy Institute. (April 2022). COVID–19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2021. Prepared by Avalere Health. *https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.*

The rapid consolidation of health-care organizations overall during the last 10–15 years has, in many markets, led to imbalances of power at the negotiating table.[23] Often, this dynamic has resulted in increased prices, hidden or unclear financial incentives, and a subsequent opaqueness that leaves employers, families, and individuals with high out-of-pocket costs and growth in health-care spending that is unsustainable.[24]

Health-care pricing data helps to identify poorly functioning markets, highlight areas where consolidation and other factors are increasing prices and, over time, can help invigorate and rebalance payer-provider negotiations to ultimately reduce costs for consumers. However, as the Peterson-KFF Health System Tracker researchers have found, data alone is not sufficient. Once released, not only does the pricing data need to be cleaned and organized,[25] it must then be applied in ways that benefit those making health-care purchasing decisions, including, but not limited to, payers, employers, consumers, and States. In some instances, the evidence suggests the pricing data can be deployed on its own—particularly if Congress and CMS act to improve the data quality and usability of the data files. However, in most instances, effective analysis requires combining pricing data with other data, including medical claims, financial reporting, contract terms, provider network data, and benefit design information.

Effective deployment could mean empowering a regional employer to use the pricing data, its own claims history, and benefit design data to work with its benefits broker to build a less expensive plan option with willing local hospitals and physician groups. Effective deployment also could mean combining pricing and medical claims data to understand which hospitals and physicians within their network have the best quality and price combination for maternity care, cardiac care, or colorectal screening, for example.

In other cases, policymakers may use the data to develop more pro-competitive policies, including increased oversight of mergers and acquisitions,[26] site-neutral payment policies,[27] and prohibitions on "data ownership."[28] Further, policymakers can use this data to make the case that restrictions on anti-competitive market contracting behavior produce greater competition.

Examples of such anti-competitive contracting practices include market dominant hospitals requiring all of their owned or affiliated hospital sites or physician offices to be in an insurance network, or none of them are in the network ("all or nothing" clauses[29]) and "anti-tiering/anti-steering," where insurers are prohibited to direct enrollees to certain providers in the network for either price or quality reasons, and "most favored nation" contracting provisions, where dominant insurers require the health-care provider that they not give an equal or more favorable price to any other

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[23] Cooper, Z., Craig, S.V., Gaynor, M., and Van Reenen, J. (2019). The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics.* 134(1), 51–107. *https://doi.org/10.1093/qje/qjy020.*

[24] Beaulieu, N.D., Dafny, L.S., Landon, B.E., Dalton, J.B., Kuye, I., and McWilliams, J.M. (2020). Changes in Quality of Care after Hospital Mergers and Acquisitions. *New England Journal of Medicine,* 382(1), 51–59. *https://doi.org/10.1056/NEJMsa1901383.* Cooper, Z., Craig, S.V., Gaynor, M., and Van Reenen, J. (2019). The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics,* 134(1), 51–107. *https://doi.org/10.1093/qje/qjy020.* Dafny, L., Ho, K., and Lee, R.S. (2019). The price effects of cross-market mergers: Theory and evidence from the hospital industry. *The RAND Journal of Economics,* 50(2), 286–325. *https://doi.org/10.1111/1756-2171.12270.* Koch, T., Wendling, B., and Wilson, N.E. (2018). Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries. *Health Services Research,* 53(5), 3549–3568. *https://doi.org/10.1111/1475-6773.12825.*

[25] Gaynor, M. (2018). "Examining the Impact of Health Care Consolidation." Statement before the Committee on Energy and Commerce, Oversight and Investigations Subcommittee, U.S. House of Representatives. *SSRN Electronic Journal.* 10.2139/ssrn.3287848.

[26] Mass. Gen. Laws. Ch. 6D § 13.; Conn. Gen. Stat. § 19a–486i; Wash. Rev. Code Ann. § 19.390.030; and Montague A.D., Gudiksen K.L., King J.S. State Action to Oversee Consolidation of Health Care Providers. The Milbank Memorial Fund. Published August 5, 2021. *https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers/.*

[27] American Action Forum (May 4, 2023). Site Neutral Payments. Retrieved from: *https://www.americanactionforum.org/insight/site-neutral-payments/.*

[28] *Bloomberg Law* (February 12, 2023). Owens and Minor Sues Anthem Blue Cross for Health Plan Claims Data. *https://news.bloomberglaw.com/employee-benefits/owens-minor-sues-anthem-blue-cross-for-health-plan-claims-data.*

[29] The Source on Healthcare Price and Competition. Provider Contracts. Accessed June 3, 2023. *https://sourceonhealthcare.org/provider-contracts/.*

insurer.[30] Some States also have responded to pricing data with stronger rate regulation at both the provider and insurer level. Researchers and policymakers have an important role in analyzing the data, combining the data, identifying necessary reforms, and evaluating the impact of various policy and market interventions.

BETTER PRICING INFORMATION CAN HELP INFLUENCE INDIVIDUAL CONSUMER CHOICES

The opportunity for health-care pricing information to impact consumer choices has been well studied. The Center examined more than 30 peer-reviewed articles and industry publications which, collectively, indicate either negligible or modest impacts of making prices available on individual consumer health care consumption behavior, and overall reduction in prices.[31] The reasons for this lack of effectiveness are attributable to health insurance benefit design that limit consumer price sensitivity outside of the deductible phase of the benefit, the tax benefits for employer-sponsored insurance that shields employees from the majority of the annual premium burden,[32] and a lack of effective price shopping tools offered by insurers to make price a strong driver in an individual consumer's care seeking behavior. That said, new and better data has the potential to stimulate the competition-inducing benefits of consumerism if new insurance designs and price-comparison tools are built to make prices clearer to consumers and prescribing clinicians at key decision-making points during care journeys. Thanks to advancements made by the No Surprises Act like payer price shopping tools, Good Faith Estimates, and Advanced Explanation of Benefits, individual consumer health-care shopping behaviors may produce different outcomes in the future.

POLICY OPTIONS

Having outlined the case for improved health care data and pricing transparency, I suggest six (6) specific policy recommendations to improve data transparency and enable a more efficient and effective health-care system.

1. Improve the quality of the price transparency data released by hospitals.

As described above, the hospital price transparency data currently available as a result of Federal laws and regulations suffers from a lack of completeness and standardization necessary to maximize its impact. The following changes by Congress or CMS would improve the utility of hospital price transparency files:

- Given the lagging compliance, Congress should consider providing CMS with the authority to increase the penalties for hospital noncompliance, and the flexibility to use other tools to improve compliance and accuracy of data.
- CMS should require hospitals to use a standardized format for their price transparency submissions and be much more prescriptive about what is required in each field.
- CMS should revisit the standardized format on a regular basis (not more often than annually) to ensure the fields remain relevant, and the data provided in those fields are useful to researchers, data analytics vendors, and end-users of the information.

2. Improve the quality of the payer data within the Transparency in Coverage rule.

As noted by researchers that have begun to use the TiC data, the data files submitted by payers are enormous,[33] and often filled with either duplicative data files, or pricing data for procedures that clinicians do not typically perform.[34] Like the hospital requirements, there are variables that require additional definitions or specifications to ensure the data and definitions populated are ultimately decipherable.

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[30] *Ibid.*

[31] Peterson Center on Healthcare Literature Review assessing the evidence base for price transparency effectiveness in health care, conducted June 2021.

[32] The Congressional Budget Office. (September 2022). Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services. *https://www.cbo.gov/publication/58541.*

[33] Georgetown University, Center on Health Insurance Reforms. Transparency in Coverage: Recommendations for Improving Access to and Usability of Health Plan Price Data. *https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.*

[34] Clarify Health. (December 2022). Confronting the Zombie Rate Apocalypse; Clarifying Payer Rates. *https://clarifyhealth.com/insights/institute/briefs/confronting-the-zombie-rate-apocalypse/.*

- CMS should examine this first wave of TiC data submissions to identify and implement ways to reduce the file sizes and to make them easier to utilize by researchers, policymakers, physicians, providers, and other health-care stakeholders.
- CMS should require standardized labeling of files so that users can see what provider/service codes are in each file, and they should require the use of standardized conventions for identifying providers (*e.g.,* via National Provider Identifiers (NPIs)).
- CMS should require that payers provide all detail necessary within the data files to make the key-pricing variable consistently useable by providing a means of describing how the prices were derived.
- To provide a more complete and accurate picture of market-negotiation dynamics, Congress should require payers to release both their Medicaid Managed Care (MMCO) and Medicare Advantage (MA) negotiated prices. Today, the Hospital Transparency rule provides some clarity into MMCO and MA negotiated rates, depending upon how hospitals are interpreting CMS requirements, but only commercial payers are subject to the TiC rules.

3. Release the prescription drug negotiated rate machine-readable file.

As finalized, the TiC rule required payers to release a machine-readable file that includes in- network negotiated rates and historical net prices for covered prescription drugs. CMS has indicated they are delaying this requirement,[35] and it has yet to be implemented. The administration was initially challenged in court over these provisions,[36] though the lawsuits were dropped. Payers and PBMs must now release this data to HHS,[37] but as of today, this data remains inaccessible to the public.

- CMS should release in-network negotiated rates and historical net prices for covered prescription drugs. Congress should consider providing CMS the authority to compel the release of this data if necessary.

4. Ensure adequate implementation of the No Surprises Act "Good Faith Estimate" and "Advanced Explanation of Benefits."

The "Good Faith Estimate" (GFE) and "Advanced Explanation of Benefits" (AEOB) provisions of the No Surprises Act require providers to issue GFEs directly to uninsured or self-pay consumers. In the case of an insured consumer, providers must issue GFEs to their health plan, if such an estimate is requested or upon scheduling of the service or procedure. Plans must take the GFE and turn it around to their enrollee and issue them an AEOB, which will include critical information in advance of the procedure to allow that enrollee to understand their potential financial liability for the procedure. These provisions were supposed to go into effect January 1, 2022. However, CMS, the Office of Personnel Management, the Employee Benefits Security Administration, the Department of Labor and the Department of Treasury have delayed enforcement of these rules, and most recently issued a request for information in September 2022 on these provisions.[38]

- Congress should work to ensure the Departments remain focused on implementing the requirements that must be met by providers and payers to issue GFEs and AEOBs so that consumers can use these tools to shop for care with the information they need up front to understand their financial obligations given their health plan benefit design.

5. Improve medical claims quality by requiring more detailed site-of-service fields.

- To more fully understand how provider site-of-service impacts prices, spending, and quality of care, Congress and CMS should require more detailed in-

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[35] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation part 49. August 2021. Pg. 2. *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.*

[36] Keith, K. *Health Affairs Forefront:* Following the ACA. (August 2021). Two New Lawsuits Challenge Insurer Price Transparency Rule. *https://www.healthaffairs.org/content/forefront/two-new-lawsuits-challenge-insurer-transparency-rule.*

[37] King, R. *Fierce Healthcare.* (December 2, 2021). PCMA pulls lawsuit over rebate disclosure rule after reaching deal with Biden administration. *https://www.fiercehealthcare.com/payer/pcma-pulls-lawsuit-over-rebate-disclosure-rule-after-reaching-deal-biden-admin.*

[38] The Federal Register. 87 FR 56905. (September 2022). Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals. *https://www.federalregister.gov/documents/2022/09/16/2022-19798/request-for-information-advanced-explanation-of-benefits-and-good-faith-estimate-for-covered* and *https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.*

formation from hospitals and physicians about the site-of-service on medical claims.

6. Advance all-payer claims databases.

Without the ability to understand utilization trends at the plan, provider, and location levels, pricing data transparency alone cannot fully explain pricing variation or produce better networks or competition.

- Congress and States should do more to encourage the development of all-payer claims databases so that purchasers—payers, employers, and States—have access to detailed utilization data that can be combined with pricing file data and network data to drive market changes.[39]

In closing, health-care data transparency is necessary but not sufficient to improve system performance and reduce health-care costs. Efforts to improve data availability and quality can enable better market performance and targeted policy-making efforts. Thank you for inviting me today to participate in this important hearing, and I look forward to answering your questions and continued dialogue.

QUESTIONS SUBMITTED FOR THE RECORD TO CAROLINE PEARSON

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Collaboration between providers is beneficial in many areas of health care, including the treatment of chronic conditions like diabetes. Rhode Island's health information exchange, CurrentCare, is a public-private partnership that helps medical professionals access protected health information, such as prescriptions, lab tests, and hospital visits, from multiple sources in one secure statewide platform.

How can Congress encourage collaboration and innovation, like CurrentCare, across the health-care system?

Answer. The Peterson Center on Healthcare has been a grant-making partner to Brown University and leaders in Rhode Island for a number of years, and we applaud the work the State has done to embrace reforms that encourage collaboration and innovation, including the creation of CurrentCare. Health information exchanges (HIEs) like CurrentCare hold great promise as tools to improve population-level and individual-level health by acting as health data utilities. HIEs allow for access to longitudinal patient clinical health record data in a timely and secure manner, reducing administrative and patient burden. Congress took important steps with the passage of the 21st Century Cures Act that, among many important reforms such as the prohibition of information blocking, required interoperability and created the Trusted Exchange Framework and Common Agreement (TEFCA), which will help "to establish universal interoperability across the country."[1] The evidence is growing that HIEs reduce costs and benefit patients by decreasing emergency department (ED) visits, decreasing intensive care unit (ICU) visits, and reducing duplicate imaging procedures.[2] Further, literature suggests that accessing data from an HIE in the 30 days following a hospital discharge was associated with a 57-percent lower adjusted odds of a readmission.[3]

Congress could do more to encourage or require secure data contributions into HIEs. According to the Office of the National Coordinator (ONC), one quarter of non-Federal acute care hospitals remain disengaged from sharing data via a HIE. In order to achieve the promise of full interoperability, the Congress could work to encourage the remaining hospitals to share clinical data with a HIE. Joining a HIE

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[39] Bipartisan Policy Center. (October 2022). Pg. 13. Improving and Strengthening Employer-Sponsored Insurance. *https://bipartisanpolicy.org/report/improving-employer-sponsored-insurance/*.

[1] The Sequoia Project. The Recognized Coordinating Entity. Accessed July 6, 2023. *https://rce.sequoiaproject.org/rce/faqs/*.

[2] Health Data Management. May 17, 2023. How Health Info Exchanges and Data Utilities Are Returning Demonstrable Benefits. *https://www.healthdatamanagement.com/articles/how-health-info-exchanges-and-data-utilities-are-returning-demonstrable-benefits.*

[3] Vest, J.R., Kern, L.M., Silver, M.D., Kaushal, R.; HITEC investigators. The potential for community-based health information exchange systems to reduce hospital readmissions. *J Am Med Inform Assoc.* 2015 Mar;22(2):435–42. doi: 10.1136/amiajnl-2014-002760. Epub 2014 Aug 6. PMID: 25100447. *https://pubmed.ncbi.nlm.nih.gov/25100447/*.

typically requires financial resources to connect, and workflow changes at point of care to use the data—Congress could address both of these challenges through targeted incentives, grants or penalties to those last hospital and health systems who remain on the sidelines of HIE contribution and use. Sharing data to a HIE requires using certified electronic health record (EHR) technology. While most hospitals and physician offices are now using certified EHRs, additional efforts could be made to encourage other provider types like behavioral health (BH) practitioners and post-acute care providers to use certified EHR technology. Closing this gap will help to ensure that HIE data is more complete and therefore more usable, particularly during emergent situations or during transitions of care (for example, during the hospital admissions or discharge processes). Congress could also ensure that entities like clinical and diagnostic labs report their data to HIEs. Finally, Congress could consider encouraging HIEs to develop patient facing portals. CurrentCare in RI has a patient portal, but this is not a universal step that HIEs take. While we know from our past price transparency work that very few patients have used their insurance cost-comparison portals to effectively shop for lower-priced care, recent patient surveys have found a growing interest among patients in accessing their clinical data securely and sharing their data with payers and providers.[4]

Question. As Mr. Martin from the American Academy of Family Physicians mentioned in his testimony, "a growing body of evidence demonstrates that physician-led Accountable Care Organizations (ACOs) achieve greater savings than their hospital-led counterparts." ACOs offer an alternative for primary care provider groups to remain independent, while focusing on innovation and value- based payment for patients.

How can Congress reduce the barrier to entry for independent primary care providers entering ACOs?

Answer. To reduce barriers to entry for independent doctors to participate in the ACO program, Congress should encourage CMS to finalize its examination of whether the design choices it makes when setting ACO benchmarks, savings calculations and quality/health outcome requirements are too onerous for independent practices to accept. Doctors seek employment models for a variety of reasons, and the administrative burden of alternative payment models is considered one of those drivers.[5] Policymakers could do more to encourage and enable participation by independent practices by looking for ways to further reduce participation hurdles and regulatory burdens. Second, Congress could strengthen Medicare's commitment and focus on encouraging primary care providers to enter the field. Congress could reexamine Medicare payment policy to look for the unintended ways Medicare may discourage physicians from becoming primary care doctors in the first place: the role of the Relative Value Scale Update Committee (RUC) of the American Medical Association (AMA), how fee-schedule-based policy values specialists more than primary care roles, and how Medicare graduate medical education (GME) financing policy affects the mix of graduating physicians. Third, Congress could create incentives for medical schools to teach medical students about evolving economic models and payment policies so that graduating physicians know what to expect and demand of any model, including those that move away from fee-for-service medicine.

Question. As president and chief executive officer of Community Hospital, Mr. Thomas articulated, operating an independent hospital allows "our ability to singularly focus on the well-being of our community and the needs of the patients within our service areas" and this "differentiates us from system hospitals."

How does consolidation that results in out-of-State ownership affect the healthcare workforce, local community investment, and quality of care?

Answer. From our perspective, these are research questions that would benefit from additional study related to both vertical and horizontal consolidation. From the limited research that does exist in this space, it typically has examined cross-State or cross-market horizontal consolidation among hospitals and hospital systems.

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[4] Heath, S. August 13, 2020. Consumer Interest in Patient Data Sharing Up After COVID–19. *Patient Engagement HIT. https://patientengagementhit.com/news/consumer-interest-in-patient-data-sharing-up-after-covid-19.*

[5] Friedberg M.W., Chen P.G., White C., Jung O., Raaen L., Hirshman S., Hoch E., Stevens C., Ginsburg P.B., Casalino L.P., Tutty M, Vargo C, Lipinski L. Effects of Health Care Payment Models on Physician Practice in the United States. *Rand Health Q.* 2015 Jul 15;5(1):8. PMID: 28083361; PMCID: PMC5158241. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158241/.*

These studies tend to find that cross market consolidation increases hospital prices [6] and have a neutral to negative effect on quality of care.[7]

QUESTION SUBMITTED BY HON. ELIZABETH WARREN

Question. In your testimony, you noted that most self-insured and fully insured group and individual health insurance plans post machine-readable files with the negotiated amounts for all covered items and services of in-network providers. Currently, Medicare Advantage plans are exempt from this requirement.

Do you think that requiring Medicare Advantage plans to post information consistent with their employer and individual market counterparts would be useful to researchers and others to understand market trends and other factors affecting cost growth? Please explain.

Answer. Yes, the Peterson Center believes that extending the machine-readable price transparency requirements to MA plans would be useful to researchers, policymakers, and others who are looking to use transparency data to improve market performance. Today, by virtue of the hospital price transparency requirements, where hospitals are required to post all negotiated rates with third-party payers, including MA plans, the market is gaining access to select MA negotiated rates. That data only extends to the negotiated rates for items and services provided by a hospital and leaves a data gap surrounding MA negotiated rates for other important services including physician services, post-acute care, and pharmacy benefit drugs. Further, researchers who have data use agreements with CMS can access MA encounter data, which provides utilization data but lacks pricing information. With this data, users could study: how price and utilization trends in MA differ from Medicare fee-for-service, including whether having an integrated MA-Part D plan produces materially different health outcomes or spending compared to non-integrated options; whether those MA plans that pay providers under capitated arrangements are better at keeping Medicare beneficiaries out of the hospital than other MA plans not contracting in this way; whether and how post-acute care negotiated rates differ across MA plans and compared to traditional Medicare; and whether negotiated rates change materially subsequent to the public release of MA pricing data files. For analysts to be able to use the data to answer these types of questions, special care must be taken to ensure that what MA plans are asked to release is meaningful and relevant given some of the structural differences between MA and commercial insurance markets. Specifically, within MA, global capitated arrangements (where payers pay contracted providers a per-member-per-month amount) are more prevalent than in the commercial markets, though exactly how prevalent is not well understood. CMS would need to ensure that data about MA negotiated rates and payment terms are made available in a format and with data dictionary definitions specified that would allow for meaningful translation by policymakers, researchers, consumers, and other users looking to make sense of this data and make it actionable. Once policymakers settled on the correct structure and definitions for an MA plan machine-readable file, releasing this data would advance the understanding of how MA plans negotiate with their network and supplier partners.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Reducing prescription drug costs is one of my highest priorities. In 2023, seven of my drug pricing bills—that I'm a sponsor or original cosponsor of—have advanced out of the Judiciary, Commerce, and HELP Committees. Each adds more sunshine, accountability, and competition to the prescription drug industry. Namely requiring more accountability of drug companies and pharmacy benefit managers.

What policies under the Finance Committee jurisdiction, namely the Medicare and Medicaid programs, should we consider to hold PBMs accountable in order to reduce drug costs for seniors and taxpayers?

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[6] Lewis, Matthew S., and Kevin E. Pflum. "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions." *The RAND Journal of Economics* 48, no. 3 (2017): 579–610. *https://doi.org/10.1111/1756-2171.12186.*

[7] Beaulieu N.D., Dafny L.S., Landon B.E., Dalton J.B., Kuye I., McWilliams J.M. Changes in quality of care after hospital mergers and acquisitions. *N Engl J Med.* 2020;382(1):51–59. doi:10.1056/NEJMsa1901383.

Answer. You and your colleagues in Congress and those who serve on the Senate Finance Committee are doing important work to reform PBM business practices that are believed to contribute to rising drug costs for seniors and taxpayers. As the independent analysts at the Congressional Budget Office and the Joint Committee on Taxation perform their work to understand whether proposed reforms increase overall net cost and premiums, we believe there are reforms that will emerge that will better align incentives in order to reduce costs.

There is a need for greater transparency between payers and PBMs than we currently are witnessing. All entities that contract with PBMs need ready access to the data points they require to ensure that incentives and costs are aligned with their interest. Requiring transparency around rebate amounts and payments to pharmacies would shed light on contracting processes not well understood, and provide access to net drug prices which have never been publicly available and vary widely from list prices. De-linking PBM compensation from drug prices is anticipated to change the incentives PBMs have in their negotiations with manufacturers and plan sponsors.

The committee could also explore banning spread pricing in Medicare Part D and in Medicaid; this is a step that a number of States have taken in Medicaid over the past several years. The committee could also create additional transparency requirements to understand PBM and plan sponsor negotiation tactics, formulary development and other contracting processes that have contributed to market realities where better deals on drugs for seniors and taxpayers are increasingly found on a cash-pay basis outside of their insurance all together.

Question. Disclosing the list price of prescription drugs in advertisements is a common-sense way to empower consumers. It also spurs competition, which leads to lower drug costs. A Government Accountability Office report found direct-to-consumer ads of prescription drugs may have contributed to increased Medicare costs. I've worked to pass legislation requiring drug companies to list the price of a drug in their ads. The Trump administration attempted to require it through rulemaking.

Why do you think drug companies oppose consumers knowing the list price of a prescription drug before they buy it? Could consumers benefit from knowing this price information?

Answer. The drug industry has historically opposed the release of list prices in ads because doing so ". . . in isolation is very confusing. It's misleading, lacks appropriate context, and isn't what patients want or need."[8] Consumers who have insurance rarely, if ever, pay a list price for any item or service they purchase using their insurance benefit, and that includes drugs. That said, list prices matter to consumers because list prices are often used in benefit designs as the basis for a consumer's cost-sharing liability. Consumers should also care about the list prices of drugs as high and rising list prices contribute to increases in health-care spending that all consumers pay for through rising premiums, lost wages, and taxes. As my testimony stated, pricing transparency across hospitals, health plans and pharmaceutical manufacturers is necessary, but not sufficient. Pricing data combined with other information like insurance benefit design and utilization, is most useful. In the cases of drugs specifically, net price data has historically been non-public data, and varies greatly from list prices thanks to rebates negotiated between manufacturer and PBM. Thus, we support the public release of machine-readable files for both list price data and net price data for pharmaceuticals. In turn, innovators, researchers, policymakers, and analysts can use that data to shed additional light on the relationship between list price and rebates on formulary placement and utilization. This will drive both market contracting change and policy change, which in turn, will impact what consumers pay for drugs.

Question. State all-payer claims databases collect claims and enrollment data from multiple public and private payers that include transaction details such as the amount charged and actually paid for health-care services and procedures. Separately, health information exchanges allow health care professionals and patients to appropriately access and securely share medical information electronically. Both efforts enable improved patient outcomes and a better understanding of population health challenges. In you written testimony, you mentioned the benefits of all-payer claims databases and the need to build upon the existing work.

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[8] Scott, D. October 15, 2018. Vox. Pharma's new plan to put more info—but not drug list prices—in TV ads. *https://www.vox.com/policy-and-politics/2018/10/15/17980334/phrma-drug-lobby-tv-ads-drug-prices-trump-voxcare.*

Given the State-to-State differences in all-payer claims databases, as well as the work of health information exchanges, are there certain States that have accomplished their goals of improving patient outcomes and understanding population health challenges more effectively using these data tools?

Answer. There are important examples of States effectively using the data that is generated from their all-payer claims databases (APCDs), and most of those examples are captured in section II, C. page 26 of Manatt Health's 2022 paper "Realizing the Promise of All-Payer Claims Databases: A Federal and State Action Plan."[9] This comprehensive report demonstrates that many States use their APCDs effectively to understanding population health challenges—examples include reports and data outputs that identify potentially avoidable emergency room visits (Virginia), out-of-pocket spending for pregnancy, delivery and post-partum care (Massachusetts), tracking opioid prescriptions and overdose trends (Utah); and trends in low-value care (Colorado). Most APCDs report on the cost of care, and many report on quality of care. Because of our interest in improving value, enhancing health outcomes, and better cost-effectiveness, we at the Peterson Center believe APCDs can be an important tool to facilitate high-performing health care. As our work with States that operate APCDs continues, we evaluate strengths and weaknesses of these models. As our knowledge in this area evolves and grows, we would be pleased to inform you of our findings and recommendations in the future.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. The U.S. is home to incredible and lifesaving drug innovation, but I remain concerned that some bad actors in the pharmaceutical industry use product hopping and patent thickets to limit competition from generic drugs and biosimilars. Product hopping takes advantage of the current FDA approval system to avoid pharmacy-level generic substitution, which can be done by making a minor reformulation of a drug. This practice allows a drug to get a new set of exclusivities that cannot be substituted for a generic. Patent thickets occur when a manufacturer deploys patents strategically to prevent competition by generic or biosimilar manufacturers. My bill, the Affordable Prescriptions for Patients Act of 2023, would put an end to these loopholes that drive up prices and prevent Texans from accessing cheaper drug options.

How does this sort of anticompetitive behavior further exacerbate consolidation in the health-care industry and create additional barriers to care for patients?

Answer. Unlike most other areas of the US health-care system, drug manufacturers face less price competition because of the unique patent regime at the Federal level that governs biopharmaceutical intellectual property. Certainly, innovators should gain access to an exclusivity period where they face limited pricing pressure given the investments required to bring a safe and efficacious product to market. However, as your question points out, several practices have emerged over the years that have led to unnecessarily high prescription drug costs while doing little to encourage innovations that could benefit patients. One example is the deployment of patent thickets. Patent thickets are used by some innovators to extend the market exclusivity period almost indefinitely, to the detriment of patients. Patent thickets reduce competition by slowing the development, approval, marketing and sales of generic drugs and biosimilars.[10] According to one recent analysis, the 1-year cost of patent thickets that result in delayed competition across 5 brand-name products ranges from $1.8 billion to $7.6 billion.[11] Further, patent thickets are one of many drivers that pushes biosimilars production overseas, which can lead to patient access issues downstream in times of geopolitical turmoil.[12] Patent thickets require significant resources to navigate and challenge in court, which also has a damp-

[9] McAvey, K. Manatt Health. December 2022. Realizing the Promise of All Payer Claims Databases: A Federal and State Action Plan. *https://www.manatt.com/insights/white-papers/2022/realizing-the-promise-of-all-payer-claims-database.*

[10] Brill, A., Robinson, C. January 2023. Patent Thickets and Lost Drug Savings. Matrix Global Advisors. *https://getmga.com/wp-content/uploads/2023/01/Patent_Thickets_Jan_2023.pdf.*

[11] *Ibid.*

[12] Brill, A., Robinson, C. May 2021. How Patent Thickets Constrain the US Biosimilars Market and Domestic Manufacturing. *http://www.getmga.com/wp-content/uploads/2022/04/PatentThickets_May2021_FINAL.pdf.*

ening effect on competition.[13] Your work and the work of your colleagues on this committee and in other congressional committees to reduce systemic abuses of the patent system, including the use of patent thickets, would represent a meaningful step in helping to make pharmaceuticals more affordable without materially impacting clinically meaningful innovation.

PREPARED STATEMENT OF CHRIS THOMAS, FACHE,
PRESIDENT AND CEO, COMMUNITY HOSPITAL

I want to thank Chairman Wyden, Ranking Member Crapo, and the distinguished members of the Senate Finance Committee for the opportunity to testify today. Over my 33-year career, I have had the opportunity to serve a wide variety of health-care facilities. Starting with long-term care facilities, two critical access hospitals, three not-for-profit health-care systems, and finally, for the past 16 years, I have been the CEO of a community-owned, independent, not-for-profit hospital in western Colorado. Community Hospital of Grand Junction, CO serves the largest metropolitan area between Denver, CO and Salt Lake City, UT. Though our county is classified as metropolitan, we primarily serve patients from rural and frontier counties. I am a firm believer in the value of independent, community-owned hospitals. Our ability to singularly focus on the well-being of our community and the needs of the patients within our service areas differentiates us from system hospitals. We have proven that by competing when appropriate and partnering when the opportunity presents itself, we can lower the cost of health care, improve access, and improve the quality of care our community receives. Fair competition is critical to the sustainability of these gains and must be maintained if we are going to continue to improve on all three fronts.

Prior to the growth and success of Community Hospital, Mesa County, CO was one of the top 10 most expensive counties in the Nation for hospital stays.[1] The Grand Junction health-care market was dominated by single-source providers. The community had only one option for most physicians' specialties and most hospital services were only provided by one hospital. Because we are an independent hospital, with local decision-making authority, we are able to nimbly move to address the needs of our community. We have a board of directors who live in our community; they are bankers, lawyers, business owners, and physicians. This allows them to make appropriate and timely decisions to help positively impact the lives of our friends and neighbors.

We have been able to address community needs, including adding multiple primary care providers, multiple specialists, and adding a clinic in an area that has been a health-care desert for decades. We are also developing an Early Childhood Education Center to address the severe child care shortage within Mesa County. We were able to complete these last two projects with the help of congressionally directed funds from Senators Bennet and Hickenlooper.[2] This is one example of how Federal action can expand access to care in rural communities and strengthen local economies.

As the second longest-serving hospital CEO in the State of Colorado, I moved to a hospital that had a tremendous foundation for compassionate care but was struggling to survive. Through innovations, the creativity of staff, local partnerships, and a supportive board, our hospital was able to grow from below 10-percent market share to our current 30-percent market share.

Providing safe, quality care and creating a great place to work for our friends, families, and neighbors is the one of the most important roles of an independent hospital's board of directors and their CEO. Independent hospitals have accomplished this by working directly with our communities to determine gaps in care, opportunities to expand care options and partnering with other local organizations to better care for our communities.

An example of these partnerships is our innovative, direct contract with our school district (the largest employer in our region) who was experiencing significant

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[13] US PIRG Education Fund. Health Care Report. April 19. 2023. The Cost of Prescription Drug Patent Abuse. *https://pirg.org/edfund/resources/the-cost-of-prescription-drug-patent-abuse/*.

[1] *https://www.denverpost.com/2015/12/21/grand-junction-is-among-the-most-expensive-places-for-hospital-stay/*.

[2] *https://www.bennet.senate.gov/public/index.cfm/2022/3/bennet-secures-over-121-million-for-colorado-projects-in- fy22-funding-bill.*

losses within their employee health plan. In addition to the district's financial challenges, our teachers were paying nearly half of their annual income on premiums and deductibles before any insurance benefits were available. As partners, we worked to lower their health-care costs, increase access, strengthen Community Hospital, and removed the insurance company's overhead costs. By the end of our partnership, the school district had a multimillion-dollar surplus, and their staff had one of the most robust benefit plans available within our community. Unfortunately, we have lost that contract to a larger, consolidated hospital in the region after they made significant price concessions that we were unable to match.

Community Hospital also partners with the local university and provides sports medicine to their student athletes and on-campus student health services, including reproductive health. During the COVID–19 pandemic, our chief medical officer and our infectious disease doctor participated daily with the leadership team from the university to implement surveillance strategies, preventative care options, testing protocols, and treatments for staff and students. Our university was one of the only universities in the country to stay open during the pandemic.[3]

Today, all independent hospitals face many challenges. Payers continue to make it more difficult to get paid for the services we provide, and threats from larger health systems acquiring assets in and around our communities are a few of the main items keeping us up at night. In our case, a larger health system acquired our main competitor and is bringing their health insurance products into our community. If they are successful at growing the number of lives covered by their health insurance products, we fear they could block access to our hospital through tiered products, driving their covered lives to their hospital.

Independent hospitals pride themselves on being a local community partner, exclusively supporting areas within their market. They reinvest their dollars into their communities, they support local businesses, keep their money in local banks, and they buy from local vendors, utilize local contractors and subcontractors and support other local nonprofits. At Community Hospital for example, over 90 percent of the money we spend on our construction projects stays within Mesa County.

As an independent hospital, we have been able to make sound decisions for our community but have been at a disadvantage in that we are the only hospital in our region that does not have a Centers for Medicare and Medicaid Services (CMS) designation. In 2021, we received 19.8 percent less from Medicare than the larger hospital in our market on a case-mix adjusted discharge basis. This is an area that Congress could help, by creating a CMS designation for independent hospitals.

As independent hospitals have looked at growth needs and opportunities, the need for more providers, especially in primary care, has been evident. Recruitment of these providers has been paramount for all independently owned hospitals. An interesting trend that we have seen is that as we meet with and recruit providers, they want to be employees of the hospital. The model of providers owning their own practices and doing the work to contract with each insurance company, to hire and maintain their own employees, and to maintain buildings, is no longer appealing to most physicians. We have seen that play out in our market as many independent practices have approached us to join Community Hospital.

We understand and appreciate the role system hospitals play in America. Their innovations, their commitment to research and education, and their support for communities that are unable to support their own health-care needs is critical. There is also a significant role for the independent hospital. In many cases, we are that alternative, that option for a more local approach. As we have experienced in Mesa County, options within health care generate real, positive improvements in the health and the well-being of our community. Consolidation is not the only option.[4]

CONCLUSION

Independent hospitals play a critical role in supporting their community's well-being. We are an integral part of a competitive health-care market. Our ability to be agile, serve the unique needs of our communities, and serve as a champion for patient choice, is critical to the future of local health care. If the few independent hospitals left are going to survive, care for our communities and continue to lower the cost of health care for our patients, we need support from Congress.

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[3] *https://www.nytimes.com/2021/05/17/health/coronavirus-broad-colorado-mesa-sabeti.html.*
[4] *https://hms.harvard.edu/news/care-costs-more-consolidated-health-systems.*

QUESTIONS SUBMITTED FOR THE RECORD TO CHRIS THOMAS, FACHE

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Collaboration between providers is beneficial in many areas of health care, including the treatment of chronic conditions like diabetes. Rhode Island's health information exchange, CurrentCare, is a public-private partnership that helps medical professionals access protected health information, such as prescriptions, lab tests, and hospital visits, from multiple sources in one secure statewide platform.

How can Congress encourage collaboration and innovation, like CurrentCare, across the health-care system?

Answer. Like Rhode Island, western Colorado has an innovative electronic health records system called Quality Health Network (QHN). QHN has been instrumental in saving time and money for our patients and providers. Congress can support collaboration, by encouraging electronic health records to interface with each other. Congress could roll out a proven electronic health record and offer it to clinics and hospitals free of cost. This would eliminate interface issues and costly training on multiple systems, which add cost to health care.

In areas such as western Colorado, collaboration takes many different forms. Community Hospital is located in an urban area, but primarily serves patients from rural and frontier counties. Through collaboration with the health-care centers and hospitals in these rural and frontier counties, we can support the preventative and urgent needs of our mutual patients. Examples of these collaborations include; Community Hospital sending surgeons to rural hospitals on a monthly basis to provide surgeries close to home. Working to not duplicate costly services and specialties. Offering choice when it is appropriate and can help drive the cost of care down, but partnering when it best serves the community, like a single Neonatal Intensive Care Unit.

Question. As Mr. Martin from the American Academy of Family Physicians mentioned in his testimony, "a growing body of evidence demonstrates that physician-led Accountable Care Organizations (ACOs) achieve greater savings than their hospital-led counterparts." ACOs offer an alternative for primary care provider groups to remain independent, while focusing on innovation and value-based payment for patients.

How can Congress reduce the barrier to entry for independent primary care providers entering ACOs?

Answer. The main barriers do not come from entry into ACOs, but rather, once a provider is enrolled in an ACO. These barriers come in multiple forms: staffing, EMR reporting, and time for reporting to be eligible for Quality Measure money. Small practices often struggle with these issues. There is also the barrier that the quality measures are often changed on a yearly basis, which feels like the goal posts being moved. Changing the measures to a longer time frame, *i.e.,* 3 to 5 years, could help this issue. Also, contracting with a third party to administer ACOs is often a barrier to small offices.

Payments to primary care physicians continue to be lacking thus driving many providers to higher paid specialties or to hospital employment. Updating the reimbursement schedules for primary care physicians is critical. Primary Care is the most cost-effective place in our health-care system for care to be provided, and we should acknowledge these providers.

However, moving reimbursement from the specialist is not the answer. Specialists will look to other sources to make up their cuts. They will either look to the hospitals to make up the difference or focus the efforts on higher paying procedures and drive up the overall cost of care. The specialist will not simply take the cut in reimbursement as a global system improvement, but focus on their own areas to maintain their compensation. Every action has a reaction and this will be the result of cutting compensation to specialist.

Question. As president and chief executive officer of Community Hospital, you articulated operating an independent hospital allows "our ability to singularly focus on the well-being of our community and the needs of the patients within our service areas" and this "differentiates us from system hospitals."

How does consolidation that results in out-of-State ownership affect the health-care workforce, local community investment, and quality of care?

Answer. When decisions are made at a local level in health care, the impact on the individuals who live/work there are considered, as well as the community as a whole. When health-care leadership have the opportunity to look their employees in the eyes at high school sports games, school pick-up, and in the grocery store, decisions can be made on a personal level. By living and serving in a community, health-care leadership can see and feel the impact that investment has in their community.

My experiences have been that when systems look to lower their costs, consolidation of services is often times the solution. By doing so, they move these services from the local market to a central location; *i.e.,* billing offices, Human Resources, accounting, and banking services are a few. By doing this, they eliminate jobs in the local market and move them to the central location. The loss of jobs in rural America can be devastating.

Systems will also try to maximize the efficiencies of services they provide by closing smaller, local services lines to grow volumes at the region facilities, taking away local options.

Not understanding the local culture and making decisions from outside of an area can impact workforce salaries, how money is invested via community benefit and sponsorships, and staffing based on acuity and need versus by metrics.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Roughly 15 percent of Texans live in rural communities, and health-care provider closures have become a growing problem in recent years. At least 21 rural hospitals across the State have shuttered in the past decade, while more than one-quarter of rural hospitals in Texas are currently at risk of closing. We need to find solutions to reverse this trend. Closures create access gaps and lead to less-competitive markets, which can trigger higher prices for patients. I joined a bipartisan group of my colleagues in reintroducing the Save Rural Hospitals Act earlier this year. This legislation would mitigate some of the current pressures facing rural providers, but these are comprehensive challenges, and they require a range of policy improvements.

What trends have you seen in the rural hospital market?

What can Congress do to address the heightened closure risks in these communities?

Answer. Work forces development! Developing programs and partnerships to help train our work force. Tuition reimbursement, mentorships, and residency programs that reward staff to work in rural facilities. Ongoing workforce support, such as child-care opportunities (80 percent of our workforce at Community Hospital is female) and affordable housing. Living and working in rural communities is truly a viable and preferred option for many Americans and we need to develop infrastructures to make this accessible.

Congress could allow more partnership opportunities between independent and rural health-care providers. In Western Colorado, the independent hospitals are working on ways to collaborate, expand services, reduce costs and build the foundation to compete against the national systems, private equity firms, and insurance companies. Any avenues that Congress can follow to reduce the regulatory burdens to accomplish these partnerships will pay dividends within rural health care across the country.

Again, by turning to reimbursement, the amount of additional dollars that would be required to preserve rural hospitals and those independent hospitals that support our rural communities is a very small percentage of the total dollars spent on health care across this country. Bringing back critical access reimbursement to a truly cost-based system and eliminating the sequestration provisions will bring back critical resources to our rural communities. Allowing CMS to establish new designations to provide rural and independent hospitals a level playing field will be critical.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The Finance Committee meets this morning to discuss corporatization and consolidation in the health-care system and the effect that has on what American families pay and how they get their health care.

When I hold town halls back home, the two challenges I hear about most often when it comes to health care are that it is too expensive and complex for a typical American family to navigate.

As the committee responsible for much of Federal health-care policy, including Medicare and Medicaid, the Finance Committee has a responsibility to identify the financial incentives that are leading to increased corporatization in America's health-care system. It's increasingly clear that these trends are increasing costs without improving the quality of care that families and taxpayers are paying for.

Before the committee dives in, I'd like to take a moment to define a few terms that will come up frequently during the hearing. Although they sound academic at first blush, these trends are having a direct impact on American families and health-care workers every day.

First is vertical consolidation. Vertical consolidation is when one company buys another company that operates in a different part of the health-care supply chain. For example, if a pharmacy benefit manager also owns an insurance company and a chain of pharmacies, or if an insurance company buys up primary care physician practices, that's vertical consolidation.

The other side of the coin is horizontal consolidation, which occurs when one company buys another company that operates in the same part of the health-care supply chain. When one hospital buys up a cross-town rival hospital, or two insurance companies merge, this is horizontal consolidation.

Finally, private equity. In the simplest terms, private equity typically entails a group of investors buying a stake in a company in order to increase its financial value by restructuring or changing the business practices of the target company.

While all of those terms sound like a whole lot of word salad to an American family working every day to pay the bills, the Finance Committee is holding this hearing to examine whether these practices are hot-wiring our health-care system to favor mega-corporations at the expense of patients and taxpayers.

With these terms in mind, I will briefly touch on several examples of some of the practices I outlined above.

I'll start with an area that the committee has already begun working to address—pharmacy benefit managers. Just over 2 months ago, the Finance Committee held a hearing that came to the overwhelming conclusion that PBM business practices are driving up the cost of prescription drugs. Since that time, Ranking Member Crapo and I, and the members of this committee, have been hard at work writing legislation that will take on some of the key challenges facing consumers and taxpayers when it comes to PBMs, and we'll have more to say about that in the coming weeks.

Pharmacy benefit managers are in many ways Exhibit A for the consequences of consolidation in the health-care system. In the 1990s, there were over 40 PBMs. In the last 2 decades, they've been slowly rolled up into mega-PBMs, and today the three largest PBMs now control more than 80 percent of claims for prescription drugs, and they are all among the top 15 largest companies in America.

Each of these companies is also affiliated with an insurance company and at least one pharmacy chain. This means PBMs can provide advantages to pharmacies they own, at the expense of other competing pharmacies. In many cases, this hurts community, independent pharmacies. In my part of the country, Bi-Mart, a regional pharmacy chain, closed its doors in dozens of communities, which had a particularly acute impact on rural areas where a pharmacy closure can turn a 45-minute drive for a prescription into a 2-hour trip.

Next I'd like to talk about health-care costs and quality. Advocates for proposed mergers often say they will bring lower health costs due to increased efficiency. Time after time, it has simply not proven to be the case. When hospitals merge, prices go up, not down. When insurers merge, premiums go up, not down. And quality of care is not any better with these higher costs. A deeply troubling study from last fall showed that medication adherence significantly decreased among commu-

nities of color and the elderly if they visited a primary care provider that was run by a hospital system rather than an independent physician.

The consequences of increased consolidation in health care are just beginning to be understood, and there will be more to come. I'm growing increasingly concerned by the potential for abuse when it comes to the use of big data and algorithms in health care. There have already been numerous reports of questionable claims denials by insurance companies using technology. Trends like these are going to require vigorous oversight and transparency to ensure Americans are protected.

I'll wrap up by speaking about private equity ownership in health care. When a private equity firm buys out a nursing home, physician group, hospice agency, or any other piece of the health-care system, their goal is to restructure the business and sell it for a profit in just a few years. The most straightforward way to do that is to increase prices and reduce costs, which is hardly a winning proposition for patients or health-care workers.

Here's one example. A private equity firm bought up ManorCare Health, which at the time was the second largest long-term care provider in the country. The firm sold ManorCare's properties to a real estate company, which began charging rent to these nursing homes. These facilities simply couldn't keep up, which led to a spiral of layoffs, health code violations, and closures. Eventually, ManorCare went bankrupt, but not before thousands of Americans lost their jobs or suffered in poor living conditions. Of course, the private equity firm made a profit on their purchase and moved on.

These are just a few examples of trends that have been growing in the health-care system over the past decade and more. The consequences are becoming more clear each year. I look forward to working with committee members to identify financial incentives that are leading to consolidation in health care and continuing our work to improve the health-care system by shoring up the workforce and improving mental health care for all Americans.

I want to thank our witnesses for joining the committee.

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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.

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

[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.*

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]

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.

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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.*
[9] *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769549.*

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

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[10] *https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0695.*
[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-out-patient-services-march-2015-report-.pdf; https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.*

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.

ALLIANCE TO FIGHT FOR HEALTH CARE
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June 8, 2023

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20515

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for the opportunity to submit the following comments for the hearing record in connection with the June 8, 2023, hearing, "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs." We applaud the committee for working to address health care costs and for the opportunity to share ways in which the committee can build on existing policy to lower health care costs for workers, employers, and the federal government.

The Alliance to Fight for Health Care is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups, and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an available and affordable option for working Americans and their families. The Alliance is dedicated to pursuing policies that increase competition and transparency to bring meaningful change—and cost savings—to our health care system and patients everywhere.

Employers want to address policies that, first and foremost, are driving up costs for patients. Between 2015–2019, prices for individuals with employer-sponsored insurance grew close to 18.3% while utilization grew just 3.6%. Growth in health care prices, and particularly inpatient hospital prices—which grew 24.6%—remains a persistent challenge to access and affordability. If we're going to help patients, we have to look at the problem.

A key variable in this equation is intensified market concentration and increasing consolidation. Many studies suggest that some forms of consolidation increase prices in the markets for both hospitals and physicians, as do certain forms of vertical integration among hospitals and physicians' groups. There is also a well-documented correlation between concentration in the provider market and prices, suggesting that some of the difference in prices in different areas is attributable to providers' market power. Unfortunately, due in part to perverse incentives that exist in the market today, the percentage of high- or very-highly concentrated markets has continued to grow in recent years. In 2010, the Congressional Budget Office (CBO) found that 63% of the 124 metropolitan statistical areas studied had highly or very highly concentrated hospital markets. By 2017, that share had risen to 70%, and the concentration of those already in the "highly concentrated" range intensified. The Alliance believes that we must address these perverse incentives through common-sense, bipartisan policies.

Further, the Alliance believes a hospital that is truly providing the highest quality care at the best prices should welcome additional transparency. Increased access to pricing and quality data will enable the market to work more effectively and efficiently, and support employer efforts to innovate, ultimately leading to better costs and quality outcomes for patients.

A recent Morning Consult poll on health care issues conducted on behalf of the Alliance found health care costs are the No. 1 concern among insured Americans.

What's more, 57% of insured adults said reducing health care costs should be Congress' top priority. But insured adults do not want to start over. Nearly 70% of insured adults, across the political spectrum, prefer to strengthen the existing system. Further, a majority of adults want Congress to work to lower the cost of health care for ALL Americans, not just those who receive coverage on the exchanges or in federal health care programs like Medicare and Medicaid.

The Alliance to Fight for Health care agrees. We want to work with the Congress to improve the U.S. health care system and reduce health care costs for ALL Americans by advancing policies to reduce health insurance premiums and increase affordability. And we come to the table with bipartisan ideas. We encourage Congress to continue the work of this committee to reduce costs, increase competition, and ultimately improve health outcomes for millions of American workers and their families by enacting polices to:

- Protect patients from paying hospital prices for doctors' office visits
- Remove restrictions preventing pro-patient competition in health care markets
- Align value-based care incentives to benefit patients across all health care markets

POLICY GOAL: PROTECT PATIENTS FROM PAYING HOSPITAL PRICES FOR DOCTORS' OFFICE VISITS

The Alliance supports lowering the cost of health care services through policy proposals such as site-neutral payment reform. Current Medicare and private health insurance payment policies pay more for services provided in hospital outpatient departments (HOPDs)—usually provider offices owned by but not located in the hospital. According to the Medicare Payment Advisory Commission (MedPAC), this disparity is incentivizing health care consolidation and higher-health care costs. As shown in an AMA survey, currently fewer than half of physicians now work in physician-owned practices, a trend that has sharply risen since 2012.

MedPAC discussed the payment disparity in their June 2022 report to Congress, "[I]n 2022, Medicare pays 141 percent more in a hospital outpatient department than in a freestanding office for the first hour of chemotherapy infusion." As noted by MedPAC, "partly in response to these incentives, in recent years hospitals have acquired more physician practices, and hospital employment of physicians has increased." MedPAC also notes that the resulting increased reimbursements are not linked to clear benefits, such as improved quality of care for beneficiaries, but they are linked to increased costs for patients.

Congress can build on site-neutral payment reform by requiring Medicare to align payment rates for certain services across the three main sites where patients receive outpatient care—HOPDs, ambulatory surgical centers (ASCs), and freestanding physician offices. MedPAC, in its June 2022 report, estimated expanding site-neutral payment policies in Medicare could generate $6.6 billion in annual savings for Medicare and taxpayers and lower cost-sharing for Medicare beneficiaries by $1.7 billion.

The savings if voluntarily adopted by the commercial market are likely even greater. New research by University of Minnesota economist Steve Parente conducted on behalf of the Alliance estimates that expanding site-neutral payment reform in Medicare and encouraging adoption in the commercial market could result in nearly $60 billion in savings annually in the commercial market.

Requiring transparency in reporting where care is provided (*i.e.,* a hospital or a physician's office) is another commonsense step that can help improve clarity for all consumers. These policies can all be designed to protect vulnerable rural or safety net hospitals, while protecting patients from climbing costs and consolidation. There is significant support for site-neutral payment reform. The Alliance's recent Morning Consult poll found 86% of insured adults, across political parties, believe health care costs should remain the same regardless of where the service is received.

Yesterday, Senators Hassan (D–NH) and Braun (R–IN) introduced the Site-based Invoicing and Transparency Enhancement (SITE) Act. The Alliance supports this legislation's dual-effort to address the patient burden created by consolidation by expanding site-neutral payments and billing transparency and to address our significant workforce shortages.

In addition, the Alliance supports H.R. 3417, the Facilitating Accountability in Reimbursement (FAIR) Act, recently introduced by Reps. Hern (R–OK) and Kuster (D–NH), which brings transparency into hospital billing to ensure patients pay for the service that is provided instead of the name on the door.

The Alliance supports several bills recently considered at a hearing in the House Energy & Commerce's Subcommittee on Health, that aim at addressing components of our payment system that encourage consolidation and increase prices for patients including:

- H.R.__, To amend title XVIII of the Social Security Act to provide for parity in Medicare payments for hospital outpatient department services furnished off-campus
- H.R.__, To require the Secretary of Health and Human Services to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation, and for other purposes
- H.R.__, To amend titles XI and XVIII of the Social Security Act to require each outpatient department of a provider to include a unique identification number on claims for services
- H.R.__, To amend title XVIII of the Social Security Act to require payment for all hospital-owned physician offices located off-campus be paid in accordance with the applicable payment system for the items and services furnished
- H.R.__, To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings
- H.R.__, To amend title XVIII of the Social Security Act to increase price transparency of diagnostic laboratory tests

We encourage the committee to address the problems that created by our federal payment system that are increasing costs for patients without improving their care by passing legislation such as the SITE Act to expand site-neutral payments.

POLICY GOAL: REMOVE RESTRICTIONS PREVENTING PRO-PATIENT COMPETITION IN HEALTH CARE MARKETS

Employers want to create health plan designs that provide extra help to people with chronic or costly health conditions to improve health outcomes. Market consolidation makes this difficult. Currently, "anti-tiering" and "anti-steering" clauses in contracts between providers and health plans restrict plans from creating innovative, high-value programs such as high-performance networks. Consolidated health systems use their market power to prevent employers from designing plans that allow patients to see higher-quality or lower cost providers. Passing legislation like the Healthy Competition for Better Care Act (118th S. 1451/H.R. 3120) would enable more group health plans and health insurance issuers to enter into agreements with providers that guide enrollees to high-value providers and provide incentives to encourage enrollees to seek higher-quality, lower cost care. This legislation also aims to allow for positive forms of integrated provider and payor functions to allow these models to continue delivering efficient, high-quality care. There is significant support for such proposals. Recent polling by the Alliance indicates that 85% of insured adults feel employers should be able to give employees who have enrolled in their company's health plan a discount for seeing a high-quality provider.

POLICY GOAL: ALIGN VALUE-BASED CARE INCENTIVES TO BENEFIT PATIENTS ACROSS ALL HEALTH CARE MARKETS

The Alliance believes that federal cost reduction and quality improvement efforts should seek to improve the health care market for all beneficiaries. Encouraging collaboration between public and private providers and payors could accelerate beneficial changes for all participants. Creating pathways to engage the group health market in CMS Innovation Center (CMMI) models more meaningfully will promote multi-payer collaboration and encourage public-private partnerships that improve quality, reduce costs, and advance the system as a whole. Encouraging system wide improvement, will reduce the disparity in care caused by a fractured health system with imperfect market-levers for improving patient care.

All patients should have a seat at the table in advance of future model development and be part of an open dialogue to promote coordination and learning to help improve the system together.

The Alliance supports meaningful steps toward introducing the necessary transparency, accountability, and consumer protections into our health care system to meaningfully reduce costs, improve outcomes, and drive towards value.

You can find a longer list of our recommended policies—including the barriers they aim to address—on our website at *www.fightforhealthcare.com.*

We strongly urge the Committee to use its authority to address federal payment policies that increase consolidation and improve transparency and competition to reduce health care costs for patients, while improving quality. The Alliance stands ready to work with you on a bipartisan basis to advance the health care system for all patients.

Respectfully,

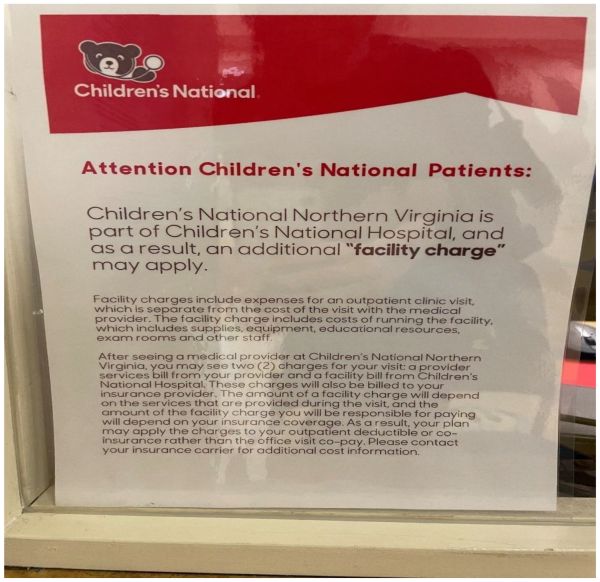
The Alliance to Fight for Health Care

APPENDIX

Same doctor. Same office. Should baby April pay more when they change the sign on the door?

When a physician's practice is bought by a larger hospital and the sign on the door changes, patients should not be forced to pay more. While the Alliance to Fight for Health Care appreciates the critical work hospitals do to care for patients and recognizes the challenges all sectors are facing given record-level inflation, patients should not be forced to pay hospital prices and hospital add-on fees for care that can be safely provided in doctors' offices. Site-neutral payment policies would reduce the incentives for hospitals to buy up physician practices, which will lower costs for patients.

This is an example of what happens to patients when a hospital buys their doctor's office. It shows a recent notice that baby April and her mom saw posted while checking in for their usual office visit last month. The office is over 11 miles from the hospital.



In case you missed it!

The News and Observer: "The health care didn't change. The office hasn't moved. Why is UNC now charging more?"

Sneaky fees are driving up health care costs for patients. A recent News & Observer article, "The health care didn't change. The office hasn't moved. Why is UNC now charging more?" highlights a growing trend of hospitals purchasing independent physician practices and clinics and charging patients more by adding so-called "facility fees."

The article describes how some UNC patients received a letter informing them that their dermatology clinic would be converted into a hospital-based clinic: "Almost everything about the health care at those clinics would stay the same, the letter assured patients. The location of the clinics, the doctors working there and the care they provided would not change." In fact, the only clear change, according to the letter, was an "additional 'facility fee' from UNC hospitals."

The article explains, "Health policy experts say this is an increasingly popular way for hospitals to get more money for providing the same care. By declaring free-standing clinics to be part of the hospital, they are able to tack on a facility fee, boosting their revenue."

The article quotes Ge Bai, a health policy researcher at the Johns Hopkins Bloomberg School of Public Health, who said, "It squeezes dollars from the pockets of patients and payers and channels them to the hospital's bank account."

The Alliance to Fight for Health Care opposes hospital tactics that increase the financial burden on the patient and encourages Congress to expand site-neutral payment policy, which aims to align payment rates for certain services that are commonly and safely provided in lower-cost care settings.

The News and Observer, March 13, 2023

THE HEALTH CARE DIDN'T CHANGE. THE OFFICE HASN'T MOVED. WHY IS UNC NOW CHARGING MORE?

By Teddy Rosenbluth

Last month, some UNC Health patients received a letter informing them that three outpatient dermatology clinics would be converted into "hospital-based clinics."

Almost everything about the health care at those clinics would stay the same, the letter assured patients. The location of the clinics, the doctors working there and the care they provided would not change.

What will change, the letter pointed out, is how patients are charged for that care.

Beginning on March 6, patients of the clinics have been charged an additional "facility fee" from UNC Hospitals.

This fee, which one health policy expert researcher called a "revenue-generating gimmick," will almost always result in a more expensive bill for the patient and their insurance provider, said several experts interviewed by the N&O.

Health policy experts say this is an increasingly popular way for hospitals to get more money for providing the same care. By declaring free-standing clinics to be part of the hospital, they are able to tack on a facility fee, boosting their revenue.

"It squeezes dollars from the pockets of patients and payers and channels them to the hospital's bank account," said Ge Bai, a health policy researcher at the Johns Hopkins Bloomberg School of Public Health.

A NATIONAL TREND

In North Carolina, hospital-based clinics are common.

UNC Health operates 75, Duke Health 35 and WakeMed 24, according to spokespeople from the health systems. All charge facility fees.

Hospitals argue that facility fees are necessary to afford running large medical facilities at all hours of the day and night.

But critics question whether that facility fee is necessary for some of these clinics, like UNC's dermatology offices, that keep regular hours and are miles away from a hospital. They point out that the health systems have many clinics that are not "hospital-based" and are able to operate without an added facility fee.

Hospitals have been purchasing and re-labeling independent physician clinics to boost revenues for the last decade or so, said Matthew Fielder, a health policy researcher at the USC-Brookings Schaeffer Initiative for Health Policy.

There is no statewide or national data on how many clinics have been "converted" into hospital departments in recent years.

However, a recent report to Congress found that people are increasingly seen by their doctors at places billed as hospital outpatient departments. The percentage of

appointments at that type of facility rose from 9.6% in 2012 to 13.1% in 2019, the analysis found. That's a 27% increase.

For patients, the change can result in hundreds or thousands of dollars added to their bills. One Ohio woman saw her portion of the bill for her arthritis injections increase from $30 to $354 after the clinic providing the injections was converted into a hospital department, Kaiser Health News reported.

Facility fees create a strong incentive for hospitals to buy up independent clinics and flip them into hospital clinics, said Barak Richman, a researcher at the Duke-Margolis Center for Health Policy.

This is particularly problematic in North Carolina, which has one of the most consolidated health care markets in the country.

"It's a widespread phenomenon," Richman said. "It has fueled consolidation for nothing but bad reasons."

Alan Wolf, a spokesperson for UNC Health, said the billing changes were necessary to keep up with wage and pharmaceutical inflation, which he said has "far exceeded reimbursement for dermatology services."

He said the change will allow the clinics to hire more staff and cut appointment wait times.

Fielder said he's unaware of any evidence that shows this type of reclassification meaningfully improves access to care.

"There is, on the other hand, abundant evidence showing that changes like these increase providers' revenues," he said. "UNC has delivered these services in a physician office setting until now, and many other providers are continuing to do so."

On the federal level, insurance companies have pushed for "site-neutral" Medicare billing, which would make clinic reimbursement rates the same regardless of whether they are independent or hospital-affiliated.

A report published last month by the Blue Cross Blue Shield Association found that adopting these policies could save the federal government, private health insurance companies and consumers a combined $471 billion over 10 years.

Bai said the best way to avoid facility fees at outpatient clinics is to call ahead and ask the billing department whether there will be a facility fee. If there is, she said patients could potentially find another provider.

However, she said this advice comes with an important caveat:

"The billing department might not be able to give a clear answer and patients might not have the time and energy to check when under stress."

UNC HEALTH

February 6, 2023

Dear Patient,

We are writing to let you know that UNC Dermatology and Skin Cancer Center's clinics will be converting to hospital-based clinics March 6, 2023.

We would like to let you know what this transition means for your future care. You will continue to see your same provider at the same location, and your provider will participate in the same insurance plans. You also will continue to have access to our highly skilled and compassionate care team. In addition, this transition allows our clinics to offer additional hospital-based resources and care that can only be obtained at an academic medical, teaching, and research facility such as UNC Hospitals. We look forward to providing our services to your and your family.

The names of our clinics will change to:
UNC Hospitals Dermatology and Skin Cancer Center at Southern Village
UNC Hospitals Dermatology and Skin Cancer Center at Raleigh
UNC Hospitals Dermatology and Skin Cancer Center at Hillsborough

Like our other hospital-based clinics, you (or your insurance provider) will be billed by both your provider and by the hospital. UNC Faculty Physicians will bill you for medical provider services such as those performed by a medical doctor, nurse practitioner or physician assistant. UNC Hospitals will bill you a facility fee, as well as for other services such as drugs or tests you receive during your visit. As a result

of this change, your financial responsibility could differ from your copay amount/ previous visits.

Your liabilities (charges) will be based on how your insurance processes claims based on the new hospital-based setting including deductibles, coinsurance and copays.

Our patient financial **representatives** at UNC Hospitals are available to assist you with understanding these billing changes. Pleas call our **Patient Accounts Department** at (984) 974–2222 or toll free at (800) 594–8624 if you need to speak with them.

Mohs surgery will now only be available at our Southern Village location, This service is not converting to a hospital-based clinic, and you will only be billed by UNC Faculty Physicians for Mohs surgical services. In addition, dermatopathology also is not converting to a hospital-based clinic, and you will only be billed by UNC Faculty Physicians for dermatopathology services.

Our providers and staff hope to make this transition as smooth as possible for you. You have a choice in medical providers, and we hope you will continue to rely on our practice for your healthcare needs. If you choose another healthcare provider, you will have full access to your medical records.

Thank you for trusting us with your care.

Teddy Rosenbluth covers science and health care for *The News and Observer* in a position funded by Duke Health and the Burroughs Wellcome Fund. The N&O maintains full editorial control of the work. This story was originally published March 13, 2023, 7:45 AM.

The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an effective and affordable option for working Americans and their families. The coalition (previously working as the Alliance to Fight the 40), led the successful effort to repeal the so-called 40% "Cadillac Tax" on health care coverage.

ALLIANCE FOR SITE NEUTRAL PAYMENT REFORM
https://www.siteneutral.org/

The Alliance for Site Neutral Payment Reform thanks Chairman Wyden, Ranking Member Crapo, and members of the Committee for the opportunity to submit this statement for the record of the Senate Finance Committee hearing on "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs."

The Alliance for Site Neutral Payment Reform is a coalition of patient advocates, providers, employers, and payers advocating for payment parity across sites of service in order to decrease Medicare and commercial spending, ensure patients receive the right care in the right setting, lower taxpayer and beneficiary costs and increase patient access and choice. Since our inception, the Alliance has worked collectively to urge Congress and regulators to advance site neutral payment policies to equalize payments across sites of service for all clinically appropriate outpatient services. The Alliance commends lawmakers on the Senate Finance Committee for exploring the impacts of consolidation on America's health care system and its contribution to rising costs and decreased access for patients. As the committee considers opportunities to empower patients and lower health care costs, the Alliance encourages lawmakers to consider site neutral payment reforms.

Payment policies supporting higher reimbursement in the hospital outpatient department (HOPD) setting have resulted in increased costs to patients, employers, and taxpayers. Services provided in the physician office setting are reimbursed according to the Medicare Physician Fee Schedule (PFS) and services provided in the HOPD setting are reimbursed according to the hospital outpatient prospective payment system (OPPS) and include a facility fee. As a result, patients, taxpayers, and Medicare pay more for the exact same service when it is delivered in the HOPD setting instead of an independent physician practice.

Multiple studies have shown that care delivered in the HOPD setting costs significantly more than in the physician office setting without providing any meaningful

improvement in quality of care or outcomes.[1] This is true for a wide variety of services; for example: chemotherapy: $326[2] vs. $140;[3] cardiac imaging: $5,148 vs. $2,862; colonoscopy: $1,784 vs. 1,322.[4] The increased cost to both patients and Medicare is substantial. Over a 3-year period, Medicare paid an additional $2.7 billion on services and patients spent $411 million more in out-of-pocket costs when four specific cardiology, orthopedic, and gastroenterology services were delivered in a hospital-owned setting.[5]

This trend is exacerbated in the commercial setting. A 2019 analysis by the Health Care Cost Institute[6] determined that the average price for a given service was always higher when performed in the HOPD setting and average prices rose faster in the outpatient setting compared to the physician office setting. For example:

- The average price for a level 3 diagnostic and screening ultrasound visit increased 4% in office settings from 2009 to 2017, from $233 to $241, and 14% in outpatient settings, from $568 to $650.
- The average price for a level 5 drug administration visit increased 15% in office settings from 2009 to 2017, from $220 to $254, and 57% in outpatient settings, from $423 to $664.
- The average price for a level 4 endoscopy upper airway visit increased 14% in office settings from 2009 to 2017, from $463 to $527, and 73% in outpatient settings, from $1,552 to $2,679.

In addition to higher costs to the healthcare system, higher reimbursement in the HOPD setting encourages the acquisition of office-based physician practices, reducing access to care in the lower cost community setting. The Medicare Payment Advisory Commission (MedPAC) June 2022 report concluded that Medicare's payment rates often vary for the same services provided to similar patients in different settings and "encourage arrangements among providers—such as the consolidation of physician practices with hospitals—that result in care being billed at the payment rates of the provider with the highest rates, increasing program and beneficiary spending without meaningful changes in patient care."

A 2019 Avalere analysis[7] for the Physicians Advocacy Institute (PAI) found that the share of physician practices owned by hospitals more than doubled from 2012 to 2018. The COVID–19 pandemic only worsened this trend as hospital systems and other corporate entities continued to drive consolidation by aggressively acquiring physician practices. In a subsequent study[8] for PAI, Avalere examined the impact of the COVID–19 pandemic on physician practice acquisition in 2019 and 2020. The study found 48,400 additional physicians left independent practice during the 2-year study, and, by the beginning of 2021, only 30% of physicians in the United States were practicing medicine independently. Fully 70% of physicians are now employed by hospital systems or other corporate entities such as private equity firms and health insurers. This consolidation impacts other aspects of patient care as physicians in integrated systems are also more likely to refer patients to the owning hospital, which can drive patients to lower quality, high-cost facilities.[9]

As this payment disparity grows and hospitals acquire more physician practices, care is actually shifting into the more expensive HOPD setting, reversing previous trends. The MedPAC June 2022 report also found that as hospitals acquire more physician practices and more physicians become employed by hospitals, large shifts in billing are seen in chemotherapy administration, echocardiography, cardiac imaging, and office visits. According to MedPAC, in 2012, only 35% of chemotherapy administration services were provided in HOPDs; by 2019, this figure rose to 51%.

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[1] *JAMA:* Organization and Performance of US Health Systems, January 2023.
[2] Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems for CY 2022 (CMS–1753–FC).
[3] Revisions to Payment Policies under the Medicare Physician Fee Schedule and Other Revisions to Part B for CY 2022 (CMS–1751–F).
[4] Avalere, PAI Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012–2018, February 2019.
[5] Avalere, PAI: Implications of Hospital Employment of Physicians on Medicare and Beneficiaries, November 2017.
[6] Health Care Cost Institute: Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices, April 2019.
[7] Avalere, PAI: Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012–2018, February 2019.
[8] Avalere-PAI, COVID–19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2020, June 2021.
[9] *Journal of Health Economics:* The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending, May 2018.

The physician and the patient should be at the center of the decision on setting of care. Instead, this anti-competitive behavior limits patients' ability to choose where they receive their healthcare and drives up unnecessary health care spending for patients, taxpayers, and the Medicare program. According to the Congressional Budget Office (CBO), this trend will only grow. In its May 2022 baseline, CBO projected OPPS payments would grow by over 100%[10] over the next decade; by comparison, PFS payments are only expected to grow by 20%. In comparison, according to the American Medical Association, when adjusted for inflation in practice costs, Medicare physician payment has actually declined 26% from 2001 to 2023.[11] This payment disparity is unsustainable and will only encourage further consolidation into the more expensive HOPD setting.

Congress previously recognized the negative consequences this payment disparity has on patients, taxpayers, and employers by directing CMS to institute site neutral payments for newly-built or newly-acquired off-campus provider-based HOPDs in the Bipartisan Budget Act of 2015 (BBA 2015). However, the majority of off-campus HOPDs are still able to bill Medicare at the much higher rate for the same services and still have a strong incentive to purchase physician practices and move them into existing HOPDs.

Republican and Democrat administrations have also recognized that expanding site neutral payment policies would reduce Medicare spending and premiums and cost-sharing for Medicare beneficiaries and included such proposals in their annual budget requests. The Alliance applauded the Centers for Medicare and Medicaid Services (CMS) for the reforms included in the 2019 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rule, which instituted site neutral payments for clinic visit services performed at off-campus HOPDs that were excepted from the site neutral requirements in BBA 2015.

The Alliance urges the Committee to build on these important reforms and advance payment parity in the outpatient setting by:

- *Eliminating the grandfathering provisions from BBA 2015 and expanding site neutral payments to all clinically appropriate outpatient services provided by off-campus HOPDs.* According to the MedPAC June 2022 report, only 0.8% of total OPPS spending is for services provided in off-campus HOPDs covered by BBA 2015 requirements. Clearly, this law is not fulfilling its goal of reducing consolidation. Congress should eliminate the grandfathering provisions and ensure site neutral payments apply to all off-campus HOPDs.
- *Extending site neutral payments to Part B drug administration.* More narrowly targeted than the above provision, this policy would immediately reduce out-of-pocket prescription drug costs for seniors because Medicare beneficiary cost-sharing is directly related to the Medicare payment rate for the drug and the administration of the drug. This policy is included in H.R. 3561, the PATIENT Act of 2023, which recently passed the House Energy and Commerce Committee by a bipartisan vote of 49–0.

On behalf of the Alliance for Site Neutral Payment Reform, thank you for the opportunity to submit comment. We look forward to working with you and your colleagues to improve health care for all Americans and protect access to high quality, cost-effective, community-based care. We are happy to serve as a resource and welcome any questions about the issues, concerns, and suggestions discussed above.

Sincerely,

The Alliance for Site Neutral Payment Reform

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June 21, 2023

The Honorable Ron Wyden
Chairman

The Honorable Mike Crapo
Ranking Member

[10] Medicare—CBO's Baseline as of May 2022.
[11] American Medical Association, Medicare Updates Compared to Inflation (2001–2023), April 2023.

U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

U.S. Senate
Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

I am writing on behalf of the American Academy of Ophthalmology about our shared concerns over the impact that consolidation is having on our nation's health care system. Specifically, we would like to provide our perspective on the consolidation of physician practices and steps that Congress could take to address factors that are driving the consolidation trend in our health care system. The Academy is the largest association of eye physicians and surgeons in the United States. A nationwide community of nearly 22,000 medical doctors, we protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public. We innovate to advance our profession and to ensure the delivery of the highest-quality eye care.

Historically, ophthalmology practices have been small businesses with more than 90% of our members in small practices, defined by Medicare as having 15 or fewer physicians. However, medical practice consolidation including ophthalmology has increased significantly in recent years.[1] While ophthalmology had largely escaped hospital and health system practice acquisitions in the past, the specialty is now experiencing growth in private equity consolidation.

Looking at consolidation more broadly across medicine, an AMA report stated that 2020 was the first year when less than half (49.1%) of patient care physicians worked in private practice. The report also noted that the decrease in private practice physicians appears to have accelerated in recent years.[2]

The Academy shares your concerns about consolidation and what it could mean for patient care. While private equity has a diversity of forms, some of our members are troubled that private equity consolidation is prioritizing profit over patient care through understaffing and incentivizing unnecessary procedures. Consistent with these concerns, the Medicare Payment Advisory Commission's (MedPAC) March 2021 report stated that hospitals and physician groups were driving up prices as they consolidated.[3]

As one of the primary physician specialties caring for Medicare beneficiaries, we support the oversight of Medicare spending. The Academy strongly believes the lack of fair updates to the Medicare Physician Fee Schedule is a major contributing factor to the consolidation trend. We believe Congress should review the current incentives for physicians to choose consolidation to ensure that Medicare policies are not inadvertently contributing to them.

Physician payments have fallen far behind inflation and increasing practice costs. In the past 22 years, Medicare physician payments have only seen a modest increase of 9 percent, averaging just 0.4 percent per year. Meanwhile, the expenses associated with running a medical practice have surged by 47 percent from 2001 to 2023. Adjusted for inflation's impact on practice costs, Medicare physician pay has declined 26 percent during the same period (2001 to 2023). This impact is unique to physician payments as nearly all other Medicare providers and suppliers receive an annual inflationary payment update. With this significant decline in real value, financial challenges have disproportionately impacted small, independent, and rural physicians, which can incentivize market consolidation.[4]

One possible solution to this, which would provide physicians with much needed fiscal stability, would be legislation ensuring an annual inflation-based payment update based on the full Medicare Economic Index (MEI). A full inflation-based update

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[1] Chen, E., Cox, J., Begaj, T., Armstrong, G., Khurana, R., Parikh, R. Private Equity in Ophthalmology and Optometry. *Ophthalmology.* 2020;127(4):445–455. doi:10.1016/j.ophtha.2020.01.007 *https://www.aaojournal.org/article/S0161-6420(20)30012-9/fulltext.*

[2] Kane, C. Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020. *Ama-assn.org. https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf.* Published 2021. Accessed June 22, 2021.

[3] Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy;* 2021:xiv. *http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf?sfvrsn=0.*

[4] Kaiser Family Foundation. What We Know About Provider Consolidation. September 2, 2020, *https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.* Accessed June 15, 2023.

would be a critical step towards resolving the problems created by ongoing yearly cuts to the Medicare Physician Fee Schedule (MPFS) that are plaguing our healthcare system.

Another key factor leading to greater consolidation is the mandated budget neutrality requirement in the Medicare Physician Fee Schedule. This policy is reducing reimbursement in critical healthcare areas that should be promoted under Medicare policy. As such, the mandated budget neutrality requirement is resulting in the Centers for Medicare & Medicaid Services undervaluing ophthalmology and other surgical services in the absence of legislation to enlarge the physician payment pool to rationally distribute physician payments.[5]

Finally, administrative and financial burdens dealing with prior authorization impose significant strain on physicians, which can lead to consolidation. Obtaining preapproval for medical treatments or tests before administering care to their patients is a time-consuming and costly procedure that often forces physicians and their staff to spend a significant portion of their week engaging in negotiations with insurance companies. In most cases the care is ultimately approved. This time would be better utilized in caring for patients.

The practice of prior authorization is rampant, and in 2018, the Office of the Inspector General (OIG) conducted a study that revealed an alarming trend in Medicare Advantage (MA) plans. It was found that MA plans overturned 75% of their own denials, strongly suggesting that the prior authorization process significantly delays medically necessary care. Furthermore, a more recent analysis conducted by the OIG demonstrated that the use of prior authorization by MA plans has led to the denial of medically necessary care that would have been covered under Medicare Fee-For-Service (FFS) for beneficiaries.

The Academy urges the Senate Committee on Finance to support legislation that establishes an electronic prior authorization (e-PA) program within Medicare Advantage (MA), and also require MA plans to provide real-time decision making when responding to requests for items and services. By implementing an e-PA program and ensuring timely decisions, Congress can help streamline the prior authorization process, reduce administrative burdens, decrease pressure for consolidation, and improve access to necessary care and services for patients.

To conclude, as your committee the impact that consolidation is having on the U.S. healthcare system and government health care spending, we hope you will consider solutions that implement an annual inflation-based payment update based on the full MEI, removes the mandated budget neutrality requirement, and lessens administrative and financial burdens on physicians by passing legislation to improves the prior authorization process within MA plans.

The Academy stands ready to work with you to address factors that are contributing to healthcare consolidation. The Academy is happy to serve as a resource for you and your staff. If we can ever be of assistance, please do not hesitate to contact the Academy's Washington Office.

Sincerely,

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Medical Director for Governmental Affairs

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June 22, 2023

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance

[5] Patel, S., Glasser, D., Repka, M., Berkowitz, S., Sternberg, P. Changes in Medicare Reimbursement for Commonly Performed Ophthalmic Procedures. *Ophthalmology.* 2021. *https://www.aaojournal.org/article/S0161-6420(21)00194-9/fulltext.*

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Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding the June 8, 2023 hearing, entitled, "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs." We deeply appreciate the opportunity to provide our comments and insights on how growing consolidation within the health care sector continues to affect the practice of emergency medicine (EM) and the patients we serve, and we are grateful for the Committee's bipartisan attention to this critical issue.

Emergency physicians serve the essential role of strengthening the health care safety net for our communities. They treat all patients who come through our doors, regardless of their insurance status or ability to pay. Over the years, certain laws have been put into place to help enforce and protect patients and the emergency health care safety net, including the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to provide a medical screening examination to every individual who "comes to the emergency department" seeking examination or treatment. The "prudent layperson" (PLP) standard, first established under the Balanced Budget Act of 1997, is another such law which allows people who reasonably think they are having an emergency to come to the emergency department (ED) without worrying about whether the services they receive will be covered by their insurance. Given this vital responsibility that EM plays in our health care system, ensuring that EDs across the country are appropriately staffed so they can provide care 24 hours a day, 7 days a week, 365 days a year is essential. Hospitals and EM groups have tried to achieve this goal in different ways, and as described further below, mergers and acquisitions have at times come into play.

ACEP has been carefully monitoring how the rapidly growing acquisition of EM practices has affected emergency physicians and the patients they serve. In less than ten years, the number of emergency physicians working in large, national groups increased from one in seven in 2012 to one in four in 2020.[1] Particularly, ACEP continues to hear about labor-related impacts of the acquisitions and mergers and the effect they have on physician wages, non-wage benefits and other aspects of emergency physicians' contracts with their employers, and physician autonomy in their medical decision-making. Our overall goal is to support emergency physicians and ensure that they are treated fairly by their employer and practice in an environment where they can serve their patients to the best of their abilities.

Emergency physicians work in a variety of employment models. While some are employed directly by hospitals, many are employed by independent entities that contract with the hospital to provide 24/7 ED coverage. These independent entities range in size, from small, independent democratic (*i.e.,* owned by the physicians) groups that may serve only one or two local hospitals to larger groups that staff EDs (and sometimes service lines of other specialties) nationwide. In recent years, physician practices, including independent EM practices, have been acquired by hospitals, health systems, and corporate entities (such as private equity and health insurance companies) at a relatively high rate. A recent study in Health Affairs found that between 2014 and 2018, there was an 89 percent increase in hospital and health system ownership of physician practices.[2] The pressures of staying financially viable during the COVID–19 pandemic seems to have accelerated this trend even further. According to a report from the Physicians Advocacy Institute (PAI), there was a sharp rise in the number of physician practices acquired by hospitals and corporate entities throughout 2019 and 2020—especially in the first half of 2020 as the pandemic began.[3] Now, PAI reports that 70 percent of physicians are employed by hospital systems or other private entities, meaning that only 30 percent of physicians practice independently.

There have been numerous assessments conducted to determine the effect of this consolidation on both health care costs and quality of patient care. For example, several years ago, Congress commissioned the Medicare Payment Advisory Commission (MedPAC) to assess whether provider consolidation has led to higher health care

[1] Pollock J.R., Hogan J.S., Venkatesh A.K., et al. Group Practice Size Consolidation in Emergency Medicine. *Annals of Emergency Medicine.* 2022;79(1):2–6. doi:10.1016/j.annemergmed.2021.07.122.

[2] *https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01007.*

[3] *https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.*

costs and affected quality of care. In 2020, MedPAC issued a report which looked at all of the available research at the time and concluded that consolidation leads to higher prices for commercially insured patients.[4] While provider consolidation leads to higher prices, MedPAC found that in areas where insurers have more market power, prices decrease—but those savings are not necessarily passed on to consumers in the form of lower premiums. MedPAC also looked at whether provider consolidation affects the quality of care that hospitals and clinicians provide but could not draw any definitive conclusions.

To gain specific and up-to-date information on how consolidation is affecting emergency physicians in particular, we used the opportunity of the recent call for comment by the Federal Trade Commission (FTC) and Antitrust Division of the Department of Justice (DOJ) to ask our members a series of structured and open-ended questions about their experiences with mergers and acquisitions. Specifically, for those members whose practice had undergone a merger recently, we asked questions about the merger, such as how they were notified about it, along with how that merger impacted their wages, non-cash benefits, right to due process, and autonomy for medical decision-making. We also asked for their general views about the labor-related impacts of mergers or acquisitions in emergency medicine. We received more than 110 responses to this questionnaire.

The results revealed numerous examples of where mergers had a significant effect on competitiveness in the EM labor market and harmed the emergency physician, notably in terms of their wages, workload and hours, and their ability (or lack thereof) to find or keep employment. Anecdotal quotes directly from emergency physician respondents are italicized below.

Wages

Overall, the impact on wages from these acquisitions seemed to vary. Sixty percent of respondents reported that their wages had been reduced, with around forty percent of them indicating a pay cut of more than 20 percent. Forty percent of respondents indicated that they experienced no change in pay or a pay raise after the merger. However, although these respondents' pay itself stayed the same or increased, in many instances their overall hours were cut, ultimately resulting in an overall wage decrease. Examples of responses included:

> "Roughly 25–30% reduction due to lowered hourly rate and fewer hours."
>
> "Compensation has remained flat or down. Under the democratic group, there were yearly cost of living and performance based increases. Those disappeared. Benefits like CME were cut. Performance demands increased, with productivity going from 1.9 patients per hour to 2.0 to 2.2 in the course of 2 years."
>
> "Actually a slight improvement with improved collections from insurance companies, they were screwing us before."
>
> "Increased current, decreased later earning potential."
>
> "Hourly rate increased but overall much worse when factoring in benefits, insurance, retirement."

Workload and Staffing

In addition to more direct wage impacts, physicians reported they were seeing more patients per hour without a commercial pay increase.

For example:

> "Huge pushes regarding patient disposition and turnaround times. I'm forced to see patients in the waiting room, violating HIPAA, due to these pushes, given that the hospital will not provide sufficient staff/space to bed them within the emergency department in order to maximize profits."
>
> "There are endless cuts to staffing and hours that cause significant patient safety concerns and poor patient experiences and outcomes. I feel like my medical license is being exploited by private equity to maximize profits to shareholders at the expense of my patients and coworkers."
>
> ". . . the schedule changed for the worse as there was significantly less physician coverage. It became very dangerous for the patients."

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[4] *https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf.*

"They incorporated metric based pay on items we do not control, such as length of stay in the ED. We do not control many things that affect length of stay, such as nursing, radiology, labs, etc. This has led to a metric that is impossible to meet, and in effect, a pay cut."

Ability to Find or Keep a Job

When asked how mergers and acquisitions affect competition in the local job market for emergency physicians, 63 percent of respondents to our questionnaire indicated that the presence of larger national groups (often called contract management groups, or CMGs) made it more difficult to find and/or keep a job.

"Merger made it harder to find jobs since the new group monopolized the market in my area. The monopoly essentially lowered over market value and drove down the pay significantly."

Many respondents remarked that they in fact had no job options other than the large national group that had acquired their practice due to regional consolidation and horizontal integration. Respondents felt pressured to conform to patient care practices that they believed were substandard and feared for their job security if they spoke out against the directives of the group:

"[Large national group] own[s] nearly all of the contracts in emergency departments within driving distance to my home. I essentially have no choice but to work for them as I have a family and cannot travel. I do not agree with their practices, but have to comply due to this CMG having a regional monopoly of ED contracts."

"Shortly after taking over, the corporation moved to cut physician hours [. . .] By cutting hours, it made it more difficult to get a job in the local area because there were not as many physicians required to perform the same services."

Signs of an Uncompetitive Labor Market to be Considered

The ability (or lack thereof) to find employment, the transition to less skilled employees, and the impact on wages are all factors that regulators must consider when assessing mergers and determining whether they create an uncompetitive labor market. Furthermore, it is important to assess the effects on other terms and conditions of employee contracts, particularly the right to due process. The FTC and DOJ should also consider the conditions by which employees were notified of the merger and the overall role they had in the process. Fifteen percent of respondents to our questionnaire stated that no rationale for the acquisition was ever provided. Many respondents received very little warning about the merger, and, in one case, the respondent was only notified three days prior to the new contract taking effect. Other respondents provided examples such as:

"Hospital administration misled my group, false point of meeting, to an offsite location and informed us our contract would not be renewed. Then the new company was waiting to try and recruit us on the spot."

"I was on vacation [overseas] and got an email saying I worked for [large national group] now. That's how I found out. We did not have any notice about it or say in the takeover [. . .] Within a year, 8 of the 14 doctors I worked with left the group. The people who stayed were tied down by family or a year from retirement."

Furthermore, emergency physicians do not have much of a choice but to go along with the terms of the merger. In some cases, their current EM group is their only employment option in the area. Further, some emergency physicians are forced to sign noncompete clauses in their contracts and told they cannot work at other health systems. From several respondents to our questionnaire:

"[Large national group A] within a year began cutting pay and hours and making weekly changes in working hours. Incredibly hard to find a job in this market due to 80–90% of all EP jobs in the greater [metropolitan area in large state] area controlled by two entities, [large national groups A and B] (both beholden to private equity) [. . .] The two have engaged in anticompetitive behavior to drive wages artificially low, force the integration and supervision of non-physician providers (PAs and NPs) in roles beyond their training, and incorporate restrictive covenants within contracts to limit any possible competition (non-compete agreements for emergency physicians, indemnification agreements, accelerated termination clauses, elimi-

nation of due process for termination, and proscriptions against directly competing for emergency department staffing contracts)."

"Just before the merger, the previous CMG had us sign contracts with fairly vicious non-compete clauses, in attempt, I suspect, to keep their contract with the hospital."

These are all definitive signs of uncompetitive behavior and are elements ACEP urged the FTC and DOJ to address in their guidelines.

Labor Market Characteristics Associated with Lessening Competition

The need to stay profitable and have leverage in negotiations with insurance companies make the EM labor market, and the market for health care providers (including both clinicians and facilities) in general, prime candidates for mergers and acquisitions and the potentially anti-competitive behavior that follows these transactions.

Hospital Consolidation

Responses to our questionnaire suggested a pattern of acquisition of many emergency physician groups being triggered by the *hospital* first being acquired by another entity. This pattern points towards a growing trend of vertical integration in addition to the ongoing horizontal integration. Some respondents noted the following:

"Very successful single contract of truly democratic EM physician group at the same hospital for 21 years. Hospital was acquired by a larger hospital system, and soon after, they replaced our group with a national corporate entity backed by private equity because this entity offered to provide hospitalist services at a substantially lower stipend than the existing hospitalist group as long as the hospital gave the entity the ED physician contract as well."

"My nonprofit hospital was taken over by [large for-profit hospital chain . . .] We were subsequently forced to sell our group to a contract medical group, which is backed by private equity."

"Big private equity group bought the hospital, contracted a private equity CMG for ED physicians."

"New hospital administration essentially forced the acquisition of our single democratic group that had provided services to the same hospital for over 20 years. CMG that provided services at the hospital system's other facilities was brought in."

"Our hospital wanted a bigger EM group with more resources. They allowed us to research and choose which group with which to merge."

It is a struggle for hospitals, especially those in rural areas, to remain solvent, much less profitable. More than 130 hospitals in rural areas have closed since 2010, and this number is growing due the effects of the COVID–19 pandemic. Nearly 900 rural hospitals—over forty percent of all rural hospitals in the country—have been identified as at risk of closing in the near future.[5]

Negotiation with Insurers

There are several major factors in the current EM practice environment that make it extremely difficult for smaller, independent EM practices to stay in business. With respect to our questionnaire, nearly 27 percent of respondents cited profit as the primary reason for acquisition—and these same individuals were often concerned that this came at the expense of quality of patient care.

The inability to negotiate fair contracts with insurance companies that have a large market share is at the top of the list of reasons that smaller EM practices struggle to stay in business. Ten percent of respondents employed by a large national physician group said that the main rationale for their smaller group moving forward with its acquisition was the inability to negotiate with insurers. Some independent practices struggle to even have insurance companies respond to exploratory inquiries, much less agree to work with them. Respondents noted that:

"Our independent EM group (120 providers) had our contract with the hospital system for 50 years. We managed 12 EDs in [state]. The hospital no longer wanted (could afford) to subsidize our services with a stipend at

[5] Center for Healthcare Quality and Payment Reform. The Crisis Facing Rural Healthcare. *https://ruralhospitals.chqpr.org.* Accessed April 2022.

> their hospitals. As part of this contract many of the EDs were small volume and included several critical access hospitals and most were not profitable. Because we were a smaller to medium size independent group, the insurance companies would not negotiate or give us better rates/payments. As such, we were forced out of our 50-year contract and the majority of our providers were forced to join the EM Mega group that won the contract and has the ability to negotiate better payment rates from insurers and is able to take bigger risks."
>
> "We were a democratic group of only boarded EM physicians. We were finding it increasingly difficult to acquire cost effective benefits, malpractice insurance and dealing with insurance companies."
>
> "Because we were a small group, insurers gave us very poor contract rates which led to low reimbursement and difficulty recruiting. Now our pay rates and benefits are better and we are competitive in our market."

The significant consolidation of health insurance companies has made contract negotiations even more difficult. The American Medical Association (AMA) published a comprehensive study in 2022 of health insurance concentration for 384 metropolitan statistical areas (MSAs), the 50 states, and the District of Columbia.[6] The report detailed some stark, but not shocking, results about the level of concentration of many health care markets across the country. The AMA found that:

- 73 percent of the MSA-level markets were considered highly concentrated according to federal guidelines set by the DOJ and FTC.[7]
- 46 percent of MSA-level markets and 14 states had one insurer with a share of 50 percent or more of the commercial health insurance market.[8]
- 57 percent of markets became more concentrated in 2020 compared to their concentration level in 2014.

According to the AMA's report, health insurer consolidation can lead to monopsony power.

Transition to a Less Skilled Workforce

Many emergency physicians noted that larger national groups tended to hire advanced practice providers (APPs) over emergency physicians. This may be due in part to an attempt to cut labor costs: for example, physician assistants (PAs) have a median annual pay of $115,390,[9] whereas emergency physicians have a median annual pay of around $350,000.[10] However, there is a vast difference in the education and training of physicians versus other health care professionals, including PAs. The well-proven pathways of education and training for physicians include medical school and residency, and years of caring for patients under the expert guidance of medical faculty. Physicians complete 10,000–16,000 hours of clinical education and training during their four years of medical school and three to seven years of residency training. Physician assistant programs are two years in length and require only 2,000 hours of clinical care—and these PA programs do not include a residency requirement. Anecdotally, emergency physicians found that when APPs were hired over physicians after mergers, patient safety decreased, and although labor cost to the hospital decreased, cost to the patient often increased due to overtesting and over-consultation. Some examples of respondents' concerns include the following:

> "[. . .] staffing policies that were extremely dangerous to the patients with over staffing of APPs and understaffing of physicians. Patients were hurt and likely killed because of these staffing policies by these contract management groups."
>
> "Shortly after taking over, the corporation moved to cut physician hours and instead increase the use of non physician providers in the emergency department such as PAs and NPs. By cutting hours, it made it more difficult to get a job in the local area because there were not as many physicians required to perform the same services."

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[6] *https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.*
[7] *https://www.justice.gov/atr/horizontal-merger-guidelines-08192010#2d.*
[8] *https://www.ama-assn.org/system/files/competition-in-health-insurance-market-share-largest-insurer.pdf.*
[9] *https://www.bls.gov/ooh/healthcare/physician-assistants.htm.*
[10] *https://www.merritthawkins.com/uploadedFiles/merritthawkins_2018_compensation_brochure.pdf.*

> "They are intentionally understaffing emergency departments as a driver of profit. Patient care is being dangerously impacted, as the physicians are being asked to see an unsafe number of patients because they do not want to staff the emergency departments appropriately."

These concerns are also reaffirmed by new data from Stanford University showing that hiring nurse practitioners (NPs) instead of physicians costs more money overall and results in poorer outcomes, especially for complex patients.[11] Researchers evaluated three years of data on emergency department visits at the Veterans Health Administration, where NPs were practicing without physician supervision. Unlike previous studies on the topic, this data was based on real world experience and the analysis is causal, not just correlative. The study found that relying on unsupervised NPs led to unnecessary tests and procedures, and hospital admissions. Overall, the study shows that NPs increase the cost of care in the emergency department by 7%, about $66 per patient. The study notes that "differences in training may play some role in productivity differences between NPs and physicians," and lower productivity was the primary contributor to these increased costs—nurse practitioners were more likely than physicians to order x-rays, CT scans, and seek formal consults. These choices also affect patient outcomes. NPs practicing without physician supervision increased length of stay in the emergency department by 11% and raised 30-day preventable hospitalizations by 20%, according to the study.

Medical Decision-Making

As noted above, emergency physicians complete 10,000–16,000 hours of clinical education and training during their four years of medical school and three to seven years of residency training. Therefore, they should be trusted to have the utmost expertise in medical decision-making, especially in the most urgent situations. However, 53 percent of respondents indicated that their medical decision-making autonomy was curtailed following the merger or acquisition of their practice. They noted that there was now "pressure to take short cuts [and] give inappropriate and potentially harmful care" to meet profit-driven metrics, that patients "are treated as numbers rather than individuals," and care is no longer patient-centered but "metric-centered." Some further examples from questionnaire responses include:

> "There are pressures from administration to avoid admitting certain patients that appear to relate to reimbursement reasons."

> "Worsened in that heavy handed pressure placed on meeting nonclinical metrics and removal of RVU payment for non-billable patients seen in the ER. Pressure on hospitalist to discharge all patients in 4 days which has led to significant increase in return visits and readmissions. Not to mention poor care and sicker patients in the community."

> "Directly, no change. Indirectly by increasing the required patients per hour, Press Gainey results, etc it resulted in a pressure to take short cuts, give inappropriate and potentially harmful care in the name of 'customer satisfaction'."

> "Worsen. We have already had several emails from our more recent director re: test utilization. Instead of getting to the root cause of why these tests were ordered, such as looking at the patients that the physicians felt required them and why, these remains essentially targeted the physicians who ordered the most of whatever test they would like us to perform less."

> "Worsened my ability to do medical decision-making. The rate at which we see patients, now in the 5–7 patients per hour sustained for up to 8 hours at a time is too much. We do not have the mental bandwidth to make so many decisions on so many patients in that short of a period of time. In addition, we are unable to spend any time at bedside with patients to elucidate histories or physicians that would help our MDM."

Due Process Rights

Over 50 percent of respondents indicated that their due process rights worsened or were eliminated after the merger, which can result in physicians being left unable to advocate for their patients or for their own mental well-being in fear of employer retaliation.

Due process plays a foundational role in ensuring a physician can carry out their promise to patients without fear of retribution or termination by their employer, so

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[11] *https://www.nber.org/papers/w30608.*

further erosion in contracts following acquisition is a significant concern. One respondent noted that their contract was terminated after attempting to address their practice's lack of personal protective equipment (PPE) in the midst of the COVID–19 pandemic. Among other questionnaire responses:

> "[The acquisition] worsened our right to due process because the corporate entity's contract with the hospital eliminated our rights as hospital medical staff physicians to be the same as other members of the medical staff with regard to a fair hearing before the medical staff's executive committee as our democratic group previously had."
>
> "The contracts with the new group have a clause that I will not resolve any 'disagreements' in court, but through a mediator."
>
> "We used to have due process but the acquisition forced us to give up those rights through a 3rd party agreement between the hospital and [large national group]."
>
> "[The acquisition] worsened our right to due process because the corporate entity's contract with the hospital eliminated our rights as hospital medical staff physicians to be the same as other members of the medical staff with regard to a fair hearing before the medical staff's executive committee as our democratic group previously had."

Physician Burnout

Even before the COVID–19 crisis, emergency physicians have historically had higher rates of career burnout and post-traumatic stress disorder (PTSD) than other medical specialties. According to a 2017 study published in the *Annals of Emergency Medicine,* upwards of 65 percent of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers.[12] Further, approximately 15 to 17 percent of emergency physicians and upwards of 20 percent of EM residents met the diagnostic criteria for PTSD in 2019. Throughout the pandemic, these unsettling trends in emergency medicine only worsened. A poll from ACEP and Morning Consult released on October 26, 2020 found that more than eight in 10 (87 percent) of emergency physicians reported feeling more stress since the start of the pandemic, with an additional 72 percent experiencing burnout on the job.[13]

Consolidation in the EM market may also contribute to this high rate of burnout. Overall, respondents associated consolidation with decreased morale and burnout among physicians. Many emergency physicians cite the current working conditions at large national groups as reasons for quitting medicine altogether, for they feel that they are trapped in a system that does not respect their autonomy or mental well-being and that there are no other options for their employment in the EM sector. The potential of a significant exodus of emergency physicians from the workforce threatens the maintenance of the healthcare safety net that emergency medicine provides. The following responses exemplify the frustration that many emergency physicians are experiencing now:

> "I no longer feel that the medicine I practice is safe or good, and that I am pushed to see more patients in less time to turn a profit. I feel this is at odds with the oaths I took as a physician, and sadly, am actively searching for ways out of medicine."
>
> "These corporations taking over medicine need to be stopped. They are taking away basic rights employees should have and they are mandating profit related changes that are bad for patients and physicians making the burn out worse than it already is."
>
> "Medicine has changed for the worse with the rise of these stockholder driven corporate groups. I don't recommend being a doctor to young people."
>
> "We are continually asked to do more with less resources, for less income, and work in unsafe environments, yet with the same liability. I am actively pursuing career opportunities outside of clinical medicine."

Conclusions and Recommendations

The personal anecdotes shared above truly reflect the non-financial-related effects of mergers and acquisitions on the practice of emergency medicine, and especially

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[12] *https://www.annemergmed.com/article/S0196-0644(17)30893-4/fulltext.*

[13] *https://www.emergencyphysicians.org/article/mental-health/poll-workplace-stigma-fear-of-professional-consequences-prevent-emergency-physicians-from-seeking-mental-health-care.*

individual emergency physicians themselves. All in all, with some notable exceptions, it appears that the current practice of consolidation in EM detrimentally affects physicians' interests and well-being, which in turn may affect their ability to serve their patients.

ACEP hopes that our members' experiences with mergers and acquisitions provide legislators and regulators with a comprehensive view of the labor-related impacts of mergers in emergency medicine and perhaps in health care more broadly. Based on these responses, we provide the following conclusions and recommendations for policymakers' consideration:

1. While there are some benefits to acquisitions and mergers, including the ability for EM practices to stay profitable and negotiate fairly with insurance companies, the potential anti-competitive labor-related effects must not be ignored since they could impact wages, non-cash benefits, right to due process, autonomy for medical decision-making, and the ability to serve patients.
2. The FTC and DOJ must ensure that their guidelines for evaluating mergers include a detailed assessment of these labor-related impacts.
3. Based on the revised guidelines, the FTC and DOJ must investigate those mergers and acquisitions that have led directly to anti-competitive and harmful practices, including, but not limited to:
    a. Reduced wages and/or non-cash benefits;
    b. Infringement of the right to due process;
    c. Interference with provider autonomy to make independent medical decisions that benefit their patients;
    d. Inability to find a job or undue imposed restrictions on ability to switch jobs;
    e. Practices, such as the use of a less-skilled health care workforce, that put profits over patient care.

ACEP is proud to have its own antitrust policy [14] in place to ensure that as a medical society it does not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or potential members. Rather, it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.

Once again, we appreciate the Committee's attention to this critical issue and the opportunity to share these comments with you. We would also welcome the opportunity to meet with you and committee staff to discuss our findings and questionnaire results in further detail. Should you have any questions, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record to the Senate Finance Committee to provide the hospital perspective on how hospital mergers and acquisitions can expand and preserve access to quality care. Given the broad focus of this hearing, we provide comments on a number of policies aimed at increasing access to quality and affordable care.

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[14] *https://www.acep.org/globalassets/new-pdfs/policy-statements/antitrust.pdf.*

MERGERS AND ACQUISITIONS HELP HOSPITALS MANAGE CURRENT FINANCIAL PRESSURES

Hospitals and health systems have faced historic challenges in the last several years. Mergers and acquisitions are important tools that some hospitals use to manage financial pressures and increase access to care for patients.

A recent report *(https://www.aha.org/costsofcaring)* released by the AHA details the extraordinary financial pressures continuing to affect hospitals and health systems, as well as access to patient care. The report found expenses across the board saw double digit increases in 2022 compared to pre-pandemic levels, including for workforce, drugs, medical supplies and equipment, as well as other essential operational services such as IT, sanitation, facilities management, and food and nutrition.

In addition, a major source of financial pressure for hospitals are the costs of complying with a complex web of local, state and federal regulations, excessive commercial payer administrative requirements, and the chronic underpayments by the Medicare and Medicaid programs. It is well documented that neither Medicare nor Medicaid covers the cost of caring for its beneficiaries, and hospitals often struggle to make up for these financial losses. Exacerbating this pressure is the fact that Medicare and Medicaid account for most hospital utilization. In fact, 94% of hospitals have 50% of their inpatient days paid by Medicare and Medicaid, and more than three quarters of hospitals have 67% Medicare and Medicaid inpatient days.[1]

Merging with a hospital system can help some hospitals ease these financial burdens and improve patient care by providing scale to help reduce costs associated with obtaining medical services, supplies and prescription drugs, and enable health systems to reduce other operational costs.

Perhaps most important, mergers can allow struggling hospitals to remain open. Without mergers, hospitals could shutter, patients could lose access to care, and communities could suffer. This is particularly important for rural hospitals, where mergers and acquisitions have played a critical role in preserving access to care for these patients and communities. An AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 shows that slightly more than half of the hospitals that closed were independent. Health systems typically acquire rural hospitals when these hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[2]

BENEFITS OF HOSPITAL MERGERS AND ACQUISITIONS

Hospital mergers and acquisitions can bring measurable benefits to patients and communities, including lower health care costs, improved quality and better access to health care.

Lower Health Care Costs

Acquisitions and mergers can help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Mergers with larger hospital systems can provide community hospitals the scale and resources needed to decrease costs by increasing administrative efficiencies and reducing redundant or duplicative services. A Charles River Associates analysis for the AHA shows that hospital acquisitions are associated with a statistically significant 3.3% reduction in annual operating expenses per admission at acquired hospitals, along with a 3.7% decrease in net patient revenue per adjusted admission.[3]

The same report shows that additional substantial savings come from improved IT systems and advanced data analytics. Consolidated hospitals can often better invest in IT infrastructure for both clinical and financial data that can be used to identify best practices for more cost-effective, integrated and streamlined care. These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals.

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[1] *https://www.aha.org/system/files/media/file/2022/05/fact-sheet-majority-hospital-payments-dependent-on-medicare-or-medicaid-congress-continues-to-cut-hospital-reimbursements-for-medicare.pdf.*

[2] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/.*

[3] *https://www.aha.org/guidesreports/2021-08-18-hospital-merger-benefits-econometric-analysis-revisited-executive-summary.*

Improved Quality

Emerging research has demonstrated a clear association between consolidation and quality improvement. For example, one study found that a full-integration approach is associated with improvements in mortality and readmission rates, among other quality and outcome improvements.[4] Another study found significant reductions in mortality for a number of common conditions—including acute myocardial infarction, heart failure, acute stroke and pneumonia—among patients at rural hospitals that had merged or been acquired.[5]

Better Access to Care

Mergers and acquisitions can help hospitals improve access to care by expanding the types of specialists and services available to patients. According to an analysis by the health care consulting firm Kaufman Hall, nearly 40% of affiliated hospitals added one or more services post-acquisition. Almost half of all hospitals acquired by an academic medical center added one or more service. Patients at hospitals acquired by academic medical centers or large health systems also gained improved access to tertiary and quaternary services.[6]

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open, thereby averting bankruptcy or even closure. When hospitals become part of a health system, the continuum of care can be strengthened for patients and the community, resulting in better care and decreased readmission rates.

This is particularly true in rural and underserved communities. Partnerships, mergers or acquisitions can be a means for creating more cohesive care, making it easier for patients to access specialists or services in the acquiring system. In this way, consolidation can ensure that care remains in the community.

Insurers Leverage Their Market Power

Hospitals and health systems face pressure from health insurance companies and private equity firms, which are leveraging their market power to drive up hospital and health system costs. For example, in nearly half of all markets, a single health insurer controls at least 50% of the commercial market.[7] Health insurers can use this market power to implement policies that compromise patient safety and raise costs, such as prior authorization delays, denying medically necessary coverage, or forcing patients to try potentially ineffective treatments or therapies.[8]

Moreover, commercial insurers and private equity have spent billions of dollars acquiring physician and other clinical practices. For example, UnitedHealth, under its subsidiary Optum, has acquired Crystal Run, Kelsey-Sebold and Atrius Health in the past three years. In 2023 alone, CVS Health has announced plans to spend over $15 billion to acquire both Signify Health and Oak Street.

Once acquired, they raise the rates that hospitals pay for these services, driving up costs. Studies have shown that highly concentrated insurer markets are associated with higher premiums and that insurers are not likely to pass on to consumers any savings achieved through lower provider rates.[9] Though many contend that insurers like UnitedHealth Group (over $324 billion in revenue in 2022, covering over 46 million Americans) and Elevance (over $155 billion in revenue over the same period, covering over 47 million Americans) are helpless in their dealings with local hospitals and health systems, the truth is far more complex.

MEDICARE SITE-NEUTRAL PAYMENT REDUCTIONS

The AHA strongly opposes additional site-neutral payment cuts, which threaten access to care. Existing site-neutral payment cuts have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries.

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[4] *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652.*
[5] *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342.*
[6] *https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf.*
[7] *https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-care-research.*
[8] *https://www.aha.org/white-papers/2022-07-28-commercial-health-plans-policies-compromise-patient-safety-and-raise-costs.*
[9] *https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548.*

According to Medicare Payment Advisory Commission (MedPAC), overall Medicare hospital margins were negative 6.3% in 2021 after accounting for temporary COVID–19 relief funds. Without these funds, the overall Medicare margin for 2021 remained depressed at negative 8.2% after hitting a staggering low of negative 12.3% in 2020. On average, Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. Moreover, overall median hospital operating margins were negative throughout 2022 and into the beginning of 2023. Site-neutral cuts have already contributed to these shortfalls and any further expansion of these policies will exacerbate this situation and threaten patients' access to quality care.

Site neutral policies also fail to account for the fundamental differences between hospital outpatient departments (HOPDs) and other sites of care. The cost of care delivered in hospitals and health systems takes into account the unique benefits that they provide to their communities. This includes the investments made to maintain standby capacity for natural and man-made disasters, public health emergencies and unexpected traumatic events, as well as deliver 24/7 emergency care to all who come to the hospital, regardless of ability to pay or insurance status. This standby role is built into the cost structure of hospitals and is supported by revenue from direct patient care—a situation that does not exist for any other type of provider. Expanding site-neutral cuts to HOPDs and the outpatient services they provide would endanger the critical role they play in their communities, including access to care for patients.

Additionally, hospital facilities treat patients who are sicker and have more chronic conditions than those treated in physician offices or ambulatory surgical centers. Hospitals are better equipped to handle complications and emergencies, but this often requires the use of additional resources that other settings do not typically provide. Hospital facilities also must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care.

Some groups have suggested that hospitals are acquiring off-campus physician practices so that the hospital can "flip the sign" and receive a higher Medicare reimbursement for providing a similar service. However, this is a deliberate misrepresentation of the facts. Under current law, any off-campus HOPD that was not billing Medicare before November 2015 is no longer paid at the hospital outpatient prospective payment system rate. Instead, this HOPD is already paid at a site-neutral rate under the Medicare physician fee schedule (PFS) for nearly all services it furnishes.

Site-neutral policies are based on the flawed assumption that PFS payment rates are sustainable rates for physicians. However, the truth is much different. According to the American Medical Association, "Medicare physician payment has effectively been cut 26%, adjusted for inflation, from 2001–2023. . . . The discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is encouraging market consolidation and threatens to drive physicians out of rural and underserved areas."[10]

Additionally, physicians are increasingly turning to hospitals, health systems, and other organizations for financial security, and to focus more on clinical care and less on the administrative burdens and cost concerns of managing their own practice.[11] The administrative and regulatory burden associated with public and private insurer policies and practices, coupled with inadequate reimbursement rates, are important barriers to operating an independent physician practice. A recent survey of physicians conducted by Morning Consult on behalf of the AHA found that over 90% of physicians think it has become more financially and administratively difficult to operate a practice and that 84% of employed physicians reported that the administrative burden from payers had an impact on their employment decision.[12]

These factors are creating unworkable environments forcing physicians to prioritize administrative duties over caring for patients. The result is increased burn out

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[10] *https://www.ama-assn.org/practice-management/medicare-medicaid/advocacy-action-leading-charge-reform-medicare-pay.*

[11] *https://www.merritthawkins.com/uploadedFiles/merritt-hawkins-2021-resident-survey.pdf.*

[12] *https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition.*

among physicians with no signs of stopping anytime soon.[13] Physicians are searching for alternative practice settings that reduce these burdens and provide adequate reimbursement, while allowing them to focus on patient care. Hospitals and health systems are a natural fit to help physicians alleviate many of these burdens.

PRICE TRANSPARENCY

Hospitals and health systems are committed to empowering patients with all the information they need to live their healthiest lives. This includes ensuring they have access to accurate price information when seeking care. Hospitals and health systems are working to comply with both state and federal price transparency policies, which are varied and sometimes conflicting. At the federal level, these include:

- **Hospital Price Transparency Rule.** As of Jan. 1, 2021, hospitals are required to publicly post via machine-readable files five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. The rule also requires hospitals to provide patients with an out-of-pocket cost estimator tool or payer-specific negotiated rates for at least 300 shoppable services.
- **Good Faith Estimates.** The No Surprises Act requires hospitals and other providers to share Good Faith Estimates with uninsured/self-pay patients for most scheduled services. Future regulations will require unaffiliated providers to combine their estimates for an uninsured/self-pay patient into a single, comprehensive Good Faith Estimate for an episode of care.
- **Advanced Explanation of Benefits.** The No Surprises Act requires insurers to share advanced explanations of benefits with their enrollees, though implementation is currently on hold pending rulemaking. Hospitals will need to provide Good Faith Estimates to health insurers to operationalize this policy.

Over the past several years, the AHA has offered hospitals and health systems substantial education and engagement on price transparency policies and, more generally, the patient financial experience. This includes:

- Establishing a CEO-level Price Transparency Task Force that helped guide the AHA in developing policies and sharing best practices with respect to price transparency and patient billing;
- Conducting member education through multiple member webinars, bi-weekly "office hours" with AHA and Healthcare Financial Management Association technical experts, issue briefs, member case studies and podcasts;
- Providing an implementation guide for members, including implementation checklists and FAQs;
- Conducting a three-part member webinar series on health care consumer expectations and experiences with the consulting firm Kauffman Hall;
- Hosting a multi-stakeholder intensive design process, which included providers, payers, patient advocates, technology vendors and others, to develop solutions to improve the patient financial experience of care;
- Supporting Centers for Medicare & Medicaid Services' (CMS) efforts to establish voluntary sample formats that hospitals may use to meet the federal requirement to make certain standard charges publicly available through a machine-readable file by connecting the agency with experts from the hospital field; and
- Updating the AHA's Patient Billing Guidelines, which include a focus on helping patients access information on financial assistance.

Hospital Price Transparency Rule

CMS has a process in place to ensure hospital compliance with the Hospital Price Transparency Rule through an internal audit process and by responding to public complaints and reviewing third-party compliance assessments. The agency found that in 2022, 70% of hospitals complied with both components of the Hospital Price Transparency Rule, including the consumer-friendly display of shoppable services information, as well as the machine-readable file requirements *(https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential)*. This is an increase from 27% in 2021. Moreover, when looking at each individual component of the rule, 82% of hospitals met the consumer-friendly display of shoppable services information requirement in 2022 (up from 66% in 2021) and 82% met the machine-readable file requirement (up from 30% in 2021).

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[13] *https://www.uhcprovider.com/en/resource-library/news/2023/new-requirements-gastroenterology-services.html.*

These numbers show significant progress on the part of hospitals and health systems—while acknowledging the work that remains—in implementing these requirements. The lower compliance rate in 2021, however, should not be interpreted as a lack of hospital commitment to transparency. Instead, it reflects the incredible challenges hospitals were experiencing in 2020 and 2021 in addressing the most acute phases of the COVID–19 public health emergency, which strained hospitals' staffs and required the diversion of personnel and financial resources. As the pandemic phase of COVID–19 wound down and hospitals were able to resume more standard operations, they are able to dedicate the resources necessary to build the full suite of price transparency tools.

In addition to the CMS report on compliance, we would draw your attention to a recent report from Turquoise Health that found about 84% of hospitals had posted a machine-readable file containing rate information by the end of first-quarter 2023, up from 65% the previous quarter *(https://turquoise.health/impact_reports)*.

Unfortunately, several third-party organizations repeatedly have claimed various rates of hospital compliance with federal price transparency policies that simply are not based on the facts. One such third-party—Patient Rights Advocate—released a paper that misconstrues, ignores and mischaracterizes hospitals' compliance with federal regulations *(https://www.patientrightsadvocate.org/february-semi-annual-compliance-report-2023)*. These groups ignore CMS' guidance on aspects of the rule, such as how to fill in an individual negotiated rate when such a rate does not exist due to patient services being bundled and billed together. In this instance, CMS has said a blank cell would be appropriate since there is no negotiated rate to include. Despite this, some outside groups still count any file with blank cells as "noncompliant." This is a fundamental misrepresentation of the rules and creates a stream of misinformation that is inaccurate and distracting to these important discussions and work.

Hospitals and health systems are eager to continue working toward providing the best possible price estimates for their patients. We ask Congress and the Administration to take the following steps to support these efforts, including:

- Review and streamline the existing transparency policies with a priority objective of reducing potential patient confusion and unnecessary regulatory burden on providers;
- Continue to convene patients, providers and payers to seek input on how to make federal price transparency policies as patient centered as possible; and
- Refrain from advancing additional legislation or regulations that may further confuse or complicate providers' ability to provide meaningful price estimates while adding unnecessary costs to the health care system.

CONCLUSION

The AHA appreciates your efforts to examine this issue and looks forward to continuing to work with you to address these important topics on behalf of patients and communities.

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. Senate Committee on Finance as part of the hearing entitled, "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs." The AMA commends the Committee for focusing on the critically important issue of consolidation in health care markets and the consequences for patients. This particular statement utilizes data to illustrate the harmful effects of health insurance and PBM consolidation, as well as the importance of lifting the current ban on physician-owned hospitals. In addition, the AMA is pleased to highlight a collection of bipartisan legislation that can help alleviate many of the negative effects of these interconnected policy issues.

I. Health Insurance Competition Study

An important question of public policy is whether health insurance markets are competitive or whether health insurers possess market power. If insurers exercise market power, health plan premiums would be higher, and payments to providers and the quantity of health care would be lower, in comparison to competitive health insurance markets. High market concentration tends to lower competition and facili-

tate the exercise of market power. Unfortunately, the majority of U.S. health insurance markets are highly concentrated, as documented in a comprehensive study of U.S. markets.[1] In fact, the share of highly concentrated commercial markets in metropolitan statistical areas (MSA) rose from 71 percent to 75 percent between 2014 and 2021.

There is high concentration among health insurers in most Medicare Advantage (MA) markets, as well. Seventy-nine percent of MA markets were highly concentrated in 2021. While MA markets have undergone a consistent, though gradual, decrease in average concentration since 2017, the decrease in average MA market concentration masks some merger activity that took place. By acquiring an insurer in another market where they do not already provide coverage, some MA insurers have been able to get bigger. Anthem accomplished this in commercial markets through its 2004 acquisition of WellPoint, as well as each of those merging parties' acquisition of other Blue Cross Blue Shield insurers before that.

Most health insurance markets are ripe for the exercise of health insurer market power, which, in turn, harms consumers and providers of care. These findings should prompt federal and state antitrust authorities to vigorously examine the competitive effects of proposed horizontal and vertical mergers involving health insurers.

Given the uncertainty in predicting the competitive effects of consolidation, some mergers that are allowed cause competitive harm. For example, in 2008 regulators authorized a merger between UnitedHealthcare and Sierra under the condition that UnitedHealthcare divest most of its MA business in the Las Vegas area. Nonetheless, premiums in the commercial health insurance markets in Nevada increased in the wake of the merger.[2]

After years of largely unchallenged consolidation in the health insurance industry, a few subsequent attempts to consolidate have received closer scrutiny. Most notably, in 2015 two mergers involving four of the largest health insurers in the country were announced. Anthem attempted to acquire Cigna, and Aetna sought to acquire Humana. To help identify markets where mergers would cause competitive harm, the AMA used data from previous editions of the *Competition in Health Insurance* study (referenced above in footnote 1) to assess their competitive effects. Specifically, the AMA calculated the changes in market concentration that would result from the mergers and, according to the Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines, classified markets based on how anti-competitive the mergers would be. The AMA's analysis found that the mergers would be deemed anticompetitive in numerous markets across the United States.[3] Consistent with the findings and after close to a year of antitrust scrutiny, the DOJ and attorneys general from multiple states sued to block both acquisitions.[4] The DOJ and state attorneys general ultimately prevailed after an intense battle in the courts, which found that the mergers would cause harm to consumers and violate antitrust law. As a result, both mergers were abandoned by the merging parties. The AMA's studies will continue to monitor competition in health insurance markets and be used to assess the competitive effects of proposed mergers among health insurers, as well as vertical mergers with firms in other parts of the supply chain such as PBMs.

II. Physician-Owned Hospitals

The U.S. health care system is a market-based system that is not working as well as it could; it faces issues such as high and rising prices, suboptimal quality of care, and poor pricing practices.[5] This is partly the result of significant consolidation oc-

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[1] Guardado, J., Kane, C. Competition in Health Insurance: A Comprehensive Study of U.S. Markets. American Medical Association Division of Economic and Health Policy Research. 2022. Available at *https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.* Accessed March 16, 2023.

[2] Guardado, J., Emmons, D., Kane, C. The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra. HMPI. 2013;1(3):16–35. Available at *https://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf.* Accessed March 16, 2022.

[3] *See https://www.ama-assn.org/about/competition-health-insurance-research.* Accessed March 16, 2023.

[4] *See* lawsuits announcement at *https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s.* Accessed March 16, 2023.

[5] Martin Gaynor, Antitrust Applied: Hospital Consolidation Concerns and Solutions, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights Subcommittee of U.S. Senate, 117th Cong. 6, 2 (May 19, 2021) (Martin Gaynor, Antitrust Applied).

curring in hospital markets around the country.[6] Many markets are now often dominated by one large, powerful health system, *e.g.,* Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[7] Consolidation has real-life consequences, as clearly laid out in a new book by Professors David Dranove and Lawton R. Burns about health care "megaproviders."[8] They found that in markets "where megaproviders dominate . . . , health care spending is higher, often much higher, and health care quality is no better, and sometimes lower."[9] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[10] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[11] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[12]

Consolidation is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health care costs.[13] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[14] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[15] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[16] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[17] Advocates for mergers argue that these mergers will be able to provide better care or lower costs; however, larger health care systems generally have neither superior health outcomes nor lower costs.[18] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[19] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[20] Many of the witnesses testifying before the Senate Finance Committee echoed these views.

Increased Hospital Concentration is Correlated with Worse Health Outcomes

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. Antitrust policy in health care markets

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[6] Martin Gaynor, Antitrust Applied, at 2; Emily Gee, The High Price of Hospital Care, Center for American Progress, *https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/*. (Accessed March 16, 2023), Martin Gaynor and Robert Town, The Impact of Hospital Consolidation-Update, the Synthesis Project, Robert Wood Johnson Foundation (June 2012).

[7] Martin Gaynor, Antitrust Applied, at 2.

[8] David Dranove and Lawton R Burns, Big Med: Megaproviders and the High Cost of Health Care in America, 178 (2021).

[9] Dranove, *supra,* at 178.

[10] Martin Gaynor, Antitrust Applied, at 5.

[11] Dranove, *supra,* at 178.

[12] Dranove, *supra,* at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, Antitrust Applied at 3.

[13] Martin Gaynor and Robert Town, *supra.*

[14] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured, 134 *The Quarterly Journal of Economics* 1, 51 (February 2019). *https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext.*

[15] D. Arnold and C.M. Whaley, Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages, RAND Corporation, 3 (2020).

[16] Martin Gaynor, Health Care Industry Consolidation, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).

[17] Martin Gaynor, Antitrust Applied, at 4.

[18] Patrick S. Romano and David J. Balan, A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare, 18 *International Journal of the Economics of Business* 1 (2011); Robert Lawton Burns, Jeffrey S. McCullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. Is the System Really the Solution? Operating Costs in Hospital Systems, 72 *Medical Care Research and Review* 3, 247 (2015). doi:10.1177/1077558715583789.

[19] Emily Gee, Provider Consolidation Drives Up Health Care Costs, Center for American Progress (last accessed July 14th, 2021), *https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/*.

[20] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service, 5 *American Economic Journal: Economic Policy* 4, 134 (2013). doi:10.1257/pol.5.4.134.

has a role to play in reducing the growth of disparities in health care access.[21] For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[22] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[23] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

Antitrust Enforcement has Not Been Adequate to Reinvigorate Markets

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. In their new book, Professors David Dranove and Lawton R. Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[24] The antitrust response has been inadequate, notwithstanding the significant resources dedicated to restoring competition in health care. For example, between 2010 and 2018, over half of antitrust cases brought by the FTC were focused on the health care industry.[25] Yet, antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision. Similarly, the FTC cannot take action against anticompetitive conduct by not-for-profit entities; this presents a significant problem, considering how many hospitals are run as not-for-profits.[26] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the cost of health care in the United States requires new remedies.

Congress Should Lift the Ban It Placed on Physician-Owned Hospitals

Fortunately, there is something Congress can do to inject competition into the highly concentrated hospital markets. One common sense first step would be passing H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023" in order to remove a crucial barrier to health care market entry that Congress itself erected. This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act (ACA) placed on Physician-Owned Hospitals (POHs). As explained by Joshua Perry, in An Obituary for Physician-Owned Specialty Hospitals *(https://heinonline.org/HOL/LandingPage?handle=hein.journals/healaw23&div=13&id&page),* 23 *Health Lawyer* 2, 24 (2010), prior to the enactment of the ACA, physicians enjoyed a "whole hospital exception" to the Stark law—meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital. However, provisions within section 6001 of the ACA (42 U.S.C. 1395nn) essentially eliminate the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, under current law the POH cannot expand its treatment capacity unless certain restrictive exceptions are met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new POHs that depend on Medicare reimbursement.

A 2020 report from Alexander Acosta, Alex M. Azar II, and Steven T. Mnuchin entitled, *Reforming America's Healthcare System Through Choice and Competition,* U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020), recommends that "Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals."[27] Congressional action would be especially welcome because **POHs have developed an enviable track record for high quality and low-cost care.**[28]

Opponents of POHs argue that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" which they ascribe to the physician owners. However, the evidence indicates that POHs do *not* cherry pick patients.

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[21] Town, et al., *supra,* at page 10.

[22] D.P. Kessler and M.B. McClellan, Is Hospital Competition Socially Wasteful?, 115 *Q J Econ.* 2, 577 (2000).

[23] T.B. Hayford, The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes, 47 *Health Services Research,* 1008 (2012).

[24] Dranove, *supra,* at 178.

[25] Martin Gaynor, Antitrust Applied, at 17.

[26] Martin Gaynor, Antitrust Applied, at 18.

[27] Alexander Acosta, Alex M. Azar II, Steven T. Mnuchin, Reforming America's Healthcare System Through Choice and Competition, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020).

[28] *Id.*

For example, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[29] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[30] Importantly, new economic research supports those findings. It finds strong evidence *against* cherry-picking by physician owners.[31]

Unfortunately, the POH ban forecloses the benefits of integrated, coordinated care delivery observed in vertically oriented self-referral models.[32] Benefits of self-referral in integrated delivery models include "one-stop shopping," improved sharing of clinical information, and better care delivery experienced by consumers. Critically, the ban on POHs is the wrong policy prescription to address potential concerns with self-referral models. There are other policy recommendations that do not sacrifice the benefits of POHs.[33]

Reversing the ACA-imposed ban on new construction or expansion of existing POHs will both stimulate greater competition and provide patients with another option to receive high quality health care services. An April 12, 2021 *Health Affairs* article entitled, "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals" *(https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/#%3A%7E%3Atext%3DReversing%20Hospital%20Consolidation%3A%20The%20Promise%20Of%20Physician%2DOwned%20Hospitals%2C-Brian%20J.%26text%3DEconomic%20theory%20holds%20that%20competition%2Ccare%20delivery%20is%20no%20exception),* explains how.

Much of the U.S. hospital market lacks competition and restoring the whole hospital exception to the Stark law is the right prescription. As a result, enactment of H.R. 977/S. 470 is essential to facilitating greater competition and permitting POHs to continue to provide high quality care to a broader patient population.

III. Pharmacy Benefit Managers

The lack of transparency surrounding pharmacy benefit managers and the impact it has on pharmaceutical costs to patients and the practice of medicine

The role of pharmacy benefit managers (PBMs) as "middlemen" among payers, pharmaceutical companies, and pharmacies goes beyond the negotiation of drug prices on behalf of their clients. PBMs also build retail pharmacy networks, adjudicate pharmacy claims, manage drug formularies (including tiering of drugs), design pharmacy benefits, and operate mail-order and specialty pharmacies. These capacities seem to give them much power in determining which drugs consumers take. The ability of patients and physicians to have the information they need to make key decisions regarding medications, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by these arrangements. A lack of transparency and competition in PBM markets could be driving drug prices up. Patients are facing insurmountable costs and administrative barriers to obtaining prescription drugs from a pharmacy, PBM, or through physician-administered treatments. The burden, however, is not solely caused by the escalating prices of pharmaceuticals, but the increase in medication utilization management policies, as well.

As a result, patients, unfortunately, may take greater clinical risks when treatments are cost prohibitive. If patients delay, forgo, or ration their pharmaceutical treatment, their health status may deteriorate, eventually requiring medical interventions in more costly care settings when their condition is at a more advanced stage of disease. Additionally, market-driven barriers to care perpetuate disparities rather than promote equity for marginalized populations.

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[29] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp. 36–55 (2005) (CMS Report). Available at *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.*

[30] *Id.*

[31] Ashley Swanson. Physician Investment in Hospitals: Specialization, Selection, and Quality in Cardiac Care. 80 *J Health Econ.* (2021).

[32] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals. *Health Affairs* (2021). Available at *https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/*.

[33] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals. Health Affairs (2021). Available at *https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/*.

Issues and concerns surrounding the impact of unfair conduct related to medication prices and access are not new. Not only is patient ability to afford medications affected, but the negative impacts on those affected by disparities have been exacerbated.[34] In a 2020 article published in the *Journal of Managed Care + Specialty Pharmacy,* the author notes that there has been a response to racial or ethnic disparities in medication use by placing a greater focus on social determinants of health. However, it is also acknowledged that "medication cost remains a formidable barrier to closing the disparities gap in medication use between Blacks and Whites, including both the uninsured and those having a pharmacy benefit." The author points to the significant correlation between wealth and race in this equation, and, furthermore, notes that racial disparities have been documented in the utilization of essential evidence-based drug therapies, including but not limited to antidepressants, anticoagulants, diabetes medications, drugs for dementia, and statins. The U.S. Bureau of Labor Statistics reports further reflect this trend. In fact, in 2018, patients earning poverty-level wages were likely to prioritize rent payments or costs for food as a necessary trade-off to out-of-pocket prescription costs that consume a higher percentage of their weekly earnings. The author notes that, while patient cost sharing may be lower than it was comparably in the 1990s, the comparison of costs "does not take into account prices paid by those without health insurance, or the deviation in patient out-of-pocket spending that is associated with current pharmacy benefit designs."

These barriers also undoubtedly impact the physician's ability to provide uninterrupted optimal patient- centric care. In these scenarios, physicians are forced to navigate complex, and resource intensive requirements imposed by health insurers and PBMs.

As a result, the AMA urges Congress to pass legislation that seeks to rein in unscrupulous PBM business practices. For example, the AMA supports S. 127, the "Pharmacy Benefit Manager Transparency Act of 2023," a bipartisan bill that promotes greater transparency of PBM operations and prohibits PBMs from engaging in unfair and deceptive reimbursement and payment practices.[35] The opaque nature of PBM negotiations and operations makes it exceedingly difficult for physicians to determine what treatments are preferred by a particular payer at the point-of-care, what level of cost-sharing their patients will face, and whether medications are subject to step therapy. We emphasize that this ultimately may lead to delays in necessary medication treatment, as well as a lack of clarity regarding specific formulary and cost-sharing responsibilities, which can lead to an inability to afford and access necessary medications.

In general, the AMA also strongly supports efforts on the part of Congress, the FTC, and the U.S. Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. In that vein, the AMA endorses S. 113, the "Prescription Pricing for the People Act," bipartisan legislation that requires the FTC to report about the anticompetitive practices, as well as other trends, within the pharmaceutical supply chain that impact the cost of pharmaceuticals.[36] The legislation also requires the FTC to provide recommendations to increase transparency within the drug supply chain in order to prevent anticompetitive practices. This bill is consistent with the bipartisan call for increased oversight and studies to prevent unfair or anticompetitive PBM practices.

Finally, the AMA supports S. 1375, the "Help Ensure Lower Patient (HELP) Copays Act."[37] This bipartisan legislation helps ensure copay assistance counts towards patient cost-sharing requirements in individual, small group, and employer-sponsored health plans. This crucial bill has a particularly positive impact on patients seeking specialty drugs and, in general, further protects individuals from harmful insurance and PBM practices that raise out-of-pocket prescription drug costs.

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[34] Kogut S.J. Racial disparities in medication use: imperatives for managed care pharmacy. *J Manag Care Spec Pharm.* 2020 Nov;26(11):1468–1474. doi: 10.18553/jmcp.2020.26.11.1468. PMID: 33119445; PMCID: PMC8060916.35 *https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-Senate-re-S-113-and-127-Acts-v3.pdf.*

[35] *https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-Senate-re-S-113-and-127-Acts-v3.pdf.*

[36] *Ibid.*

[37] *https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-House-re-HR-830-HELP-Copays-Act-v2.pdf.*

Market concentration and competition in PBM markets and the implications for drug prices

PBMs were created in the 1960s to help health insurers contain drug spending. PBMs can stimulate price competition among drug manufacturers by shifting demand among competing substitute drugs. In turn, manufacturers offer rebates to PBMs for their drugs to be placed favorably in a drug formulary, which PBMs are then supposed to pass on to insurers or employers. However, the PBM market needs to be competitive for rebates to be fully passed on to final consumers. Thus, it is critically important that PBM markets are competitive. Unfortunately, it is not clear whether PBMs are (fully) passing on those rebates. Indeed, some economists argue that consolidation in the PBM market, combined with opaque pricing, is one cause of higher pharmaceutical prices.[38]

In October 2022, the AMA released the findings[39] from a new analysis that suggests low levels of competition in local PBM markets across the United States where PBMs provide services to commercial health insurers. This analysis is the first to shed light on variations in market shares and competition among PBMs and on the extent of vertical integration between health insurers and PBMs at the local (state and MSA) levels.

According to the analysis, commercial insurers largely use an external PBM for three services: rebate negotiation; retail network management; and claims adjudication (rather than conducting them in-house). The analysis assessed market competition for those three PBM services and concluded that, at the national level, a handful of PBMs have a large collective market share. The 10 largest PBMs had a collective share of 97 percent; the four largest PBMs had a collective share of roughly 66 percent.

At both the state and MSA-levels, the analysis found a high degree of market concentration for each of the three PBM services assessed by the study. Specifically, more than three of four (about 78 percent) states had highly concentrated PBM markets; and more than four of five (85 percent) of MSA areas had highly concentrated PBM markets.

In terms of the extent of vertical integration between health insurers and PBMs, the study found that 69 percent of drug lives at the national level are covered by an insurer that is vertically integrated with a PBM. On average, 63 percent of state-level drug lives and 65 percent of MSA-level lives are vertically integrated. Six of the 10 largest PBMs are used exclusively by one insurer or a set of Blue Cross Blue Shield affiliates. Vertically integrated insurers may not allow non-vertically integrated insurer competitors to access their PBMs, or they could raise the cost of those PBM services. This could adversely affect non- vertically integrated insurers and ultimately patients through higher premiums.

Other research notes the increasing vertical integration of insurers, PBMs, specialty pharmacies, and providers, and provides an illustration of the major vertical business relationships among the largest companies in U.S. health care markets.

At this juncture, protecting patients and physicians from anticompetitive harm warrants attention as Congress and the Administration continue their work to protect patients and ensure prescription drugs remain affordable and accessible. The AMA urges careful monitoring, and intervention when needed, of both horizontal and vertical integration to ensure competition in PBM and health insurance markets and patient access to care. Physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have and continue to impose on their patients' care and remain concerned about the detrimental impact PBM business practices have on patients' access to and the cost of prescription drugs.

Conclusion

Competition is critical for well-functioning health care markets. When markets are not competitive and firms have market power, society is at a loss. Unfortunately, the majority of health insurance, hospital, and PBM care markets are not competitive. Mergers and acquisitions have contributed to these low levels of competition. Strong antitrust scrutiny of mergers in these markets is warranted. Also needed are policies that promote market entry, including lifting the statutory ban Congress im-

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[38] Garthwaite C., Scott Morton F. Perverse Incentives Encourage High Prescription Drug Prices. Chicago, IL: ProMarket. 2021.

[39] José R. Guardado, Competition in Commercial PBM Markeys and Vertical Integration of Health Insurers with PBMs, AMA Policy Research Perspectives (2022), *https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf.*

posed on physician-owned hospitals. These various policy interventions will promote greater competition, lower drug prices, and improve health care outcomes.

BETTER SOLUTIONS FOR HEALTHCARE

Chairman Ron Wyden (D–OR)
Ranking Member Mike Crapo (R–ID)
U.S. Senate
Committee on Finance

Dear Chairman Wyden and Ranking Member Crapo:

As hospital prices continue their unreasonable and alarming rise year over year, we are calling upon policymakers to prioritize market-based solutions to address the affordability crisis impacting American patients and their employers. We appreciate the June 8, 2023, bipartisan hearing entitled, "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs," and we call on Congress to take immediate action to rein in corporate hospital takeovers.

The escalating cost of healthcare services is a primary concern of businesses.[1] Since 2015, U.S. hospital prices have increased four times faster than workers' paychecks. Hospital services now represent the largest share of total healthcare spending, accounting for 44% of total spending for privately-insured Americans. When corporate hospital systems charge more for prescription drugs and treatments, healthcare costs go up. Hospital markups prioritize their bottom line over patients' health. For example, patients can be charged either $150 or $950 for the same blood test, depending on the facility they choose.

As Congress works to solve America's healthcare affordability crisis, we applaud your focus on the role that hospitals and corporate hospital systems play in driving up healthcare costs for patients, their employers, public sector purchasers, and the government. A lack of market competition, pricing transparency, and price markups have exacerbated significant market distortions and undercut the stability and sustainability of the system.

This is why we support legislative efforts that promote hospital competition through market-based solutions, enforce federal price transparency laws for hospital charges, rein in hospital price markups, and ensure honest billing practices by hospitals.

We look forward to working with you to drive the legislative proposals required to support our system's foundations, help fix areas that have become broken, and promote beneficial growth, innovation, and investment to protect the health of patients, employers, and their families across the country.

Sincerely,

Better Solutions for Healthcare

BLUE CROSS BLUE SHIELD ASSOCIATION
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Statement of David Merritt, Senior Vice President of Policy and Advocacy

The mission of Blue Cross and Blue Shield (BCBS) companies is simple: We want everyone to have access to high-quality, affordable and equitable health care. Unfortunately, costs for outpatient care have increased substantially over the last decade—fueled in part by the growing trend of large hospital systems acquiring independent physician practices. While this trend threatens accessibility and affordability for American families and businesses, there are solutions that can bring real relief to millions of people across the country. The Blue Cross Blue Shield Association (BCBSA) commends Chairman Wyden, Ranking Member Crapo, and members

[1] "Health Insurance, Labor, and Taxes Remain Top Issues for Small Business Owners in NFIB's Every-Four-Year Study." NFIB, 13 August 2020, *https://www.nfib.com/content/press-release/homepage/health-insurance-labor-and-taxes-remain-top-issues-for-small-business-owners-in-nfibs-every-four-year-study/*.

of the Senate Finance Committee for holding this important hearing to examine the impact of health care consolidation.

BCBSA is a national federation of 34 independent, community-based and locally operated BCBS companies that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS companies contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, purchase coverage on their own or obtain coverage through an employer. We are committed to delivering affordable access to high-quality care for every American.

BCBS companies work hard to keep health care costs as low as possible by negotiating lower prices with doctors, hospitals and drug companies. We also work with patients and providers to improve individual health through prevention, wellness, care coordination and chronic care management so that people receive the safest, most effective care possible. We are working with local and national partners to drive real solutions to make health care more affordable for everyone.

THE IMPACT OF HOSPITAL ACQUISITION OF PHYSICIAN PRACTICES ON HEALTH CARE COSTS

We know that the affordability crisis hits millions of Americans every day, from the patient who can't afford their medication to the employee who struggles to pay for a trip to the doctor. The average premium for an employer-provided family health insurance policy reached $22,221 in 2021, nearly triple what it was in 2001.[1] And the average employee contribution now accounts for 9% of the median household income.[2] The reason for this affordability crisis is clear: the alarming price increases for health care services and prescription drugs. We all know that as the price of delivering medical care goes up, so, too, does the cost to consumers. In fact, according to the Health Care Cost Institute, health care costs increased from 2016–2020 at roughly double the rate of general inflation—with underlying prices being the primary driver of higher health care spending.[3]

In 2021, nearly 70% of physician practices were owned by hospitals, health systems, private-equity firms, and other corporate entities—a 12% increase in just two years. And when corporate hospital systems acquire these independent practices, the prices they charge grow by an average of 14%.[4]

This is often a result of how hospitals bill for their services; specifically, they bill hospital outpatient rates for the same services that were previously billed at the rate for a physician office—rates that are often two to three times higher. These actions result in higher insurance premiums and higher cost-sharing for consumers. But no patient should pay more for the same service at the doctor's office simply because a hospital acquired the practice.

THE SOLUTION

Real affordability solutions must address the root causes of rising prices by addressing the practices that are fueling cost growth. Improved competition among hospitals and doctors would result in more reasonable prices, better health outcomes and, ultimately, lower premiums. We strongly support policies that will protect patients from paying higher costs for the same health care services by enacting policies that promote site- neutral payments and fair and transparent billing practices.

This can be accomplished by:

- **Expanding existing "site-neutral" payment policies.** Congress should eliminate the provision of the Balanced Budget Act of 2015 which exempts certain hospital outpatient departments (HOPDs) from Medicare billing limits established under the 2015 law. This will prevent HOPDs from charging patients more for the same medical services that cost less in other care settings, potentially saving patients, businesses and hardworking taxpayers hundreds of billions over the next decade. Recent estimates have shown that expanding site-

[1] Ellis P. "Affordability Solutions for the Health of America." Blue Cross and Blue Shield Association; January 2023. *https://www.bcbs.com/the-health-of-america/articles/affordability-solutions-white-paper.*

[2] *Ibid.*

[3] *Ibid.*

[4] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. *J Health Econ.* 2018 May; 59:139–152. Doi:10.1016/j.jhealeco.2018.04.001. Epub 2018 Apr 22. PMID: 29727744. The effect of hospital acquisitions of physician practices on prices and spending—PubMed *(nih.gov), https://pubmed.ncbi.nlm.nih.gov/29727744/.*

neutral payment policies would yield a combined savings of $471 billion over the 2024–2033 period for the Medicare program, private insurance premiums and enrollees' out-of-pocket costs *(https://www.bcbs.com/sites/default/files/file-attachments/affordability/BCBSA_Issue_Brief_Site_Neutral_Payment_Proposal_2.28.23.pdf)*. Importantly, eliminating this provision would not impact a wide range of care settings that are already exempt from site-neutral requirements, including critical access hospitals, rural emergency hospitals, rural health clinics, on-campus hospital outpatient departments, remote locations of a hospital, or dedicated emergency departments.

- **Requiring hospital billing and claims forms to accurately reflect where the patient care was delivered,** not just where reimbursement can be maximized. Congress should require individual doctor's offices within a big hospital system to use a separate National Provider Identifier (NPI) code—not the hospital's code. This will allow employers and health plans to differentiate between a hospital and non-hospital setting and apply the correct payment rates and patient cost-sharing.

BCBSA strongly supports bipartisan legislation introduced by Senators Maggie Hassan (D–NH) and Mike Braun (R–IN), the Site-based Invoicing and Transparency Enhancement (SITE) Act, which equalizes payments for identical services provided in a physician's office and hospital outpatient department and ensures appropriate billing requirements are in place to protect patients from higher cost sharing. BCBSA also strongly supports legislation introduced by Representatives Kevin Hern (R–OK) and Annie Kuster (D–NH), the Facilitating Accountability in Reimbursements (FAIR) Act, that would harmonize billing practices in off-campus hospital outpatient facilities to better reflect the site of care.

CONCLUSION

We support free markets and competition and work closely with hospitals and doctors across the country to cover and care for the people we serve together. That should include real solutions that deliver real affordability—and protect patients from paying more for the same health care service just because of where it was delivered or how it was billed. Again, BCBSA thanks the Senate Finance Committee for their leadership in holding today's hearing. We look forward to continuing to work with the committee and other lawmakers in Congress to advance commonsense solutions that expand site-neutral payments and eliminate billing discrepancies.

CONSUMERS FIRST
The Alliance to Make the Health Care System Work for Everyone
1225 New York Ave., NW, Suite 800
Washington, DC 20005

June 8, 2023

U.S. Senate
Committee on Finance

Chair Wyden and Ranking Member Crapo, on behalf of Consumers First and our undersigned allies we want to thank you for holding this important and timely hearing on transparency and competition in health care, and to offer our sincere appreciation to all of the witnesses and senators who are lifting up the impact that unaffordable health care costs have on people all across this country. As an alliance that brings together the interests of consumers, employers, labor unions, and primary care clinicians working to realign and improve the fundamental economic incentives and design of the health care system, Consumers First thanks you for being responsive to our call to action[1] and stands ready to support you as you embark on this critical work.

Our country is in the midst of a health care affordability crisis where consumers, employers, workers, and clinicians are struggling in a health care system whose payment and delivery structure incentivizes high cost, low quality care. Families are experiencing rising health insurance premiums, reduced access to care, and record levels of medical debt.[2]

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[1] *https://familiesusa.org/wp-content/uploads/2023/01/Consumers-First-letter-to-118th-Congress-final-1.23.23.pdf.*

[2] Gaynor, M. "Examining the Impact of Health Care Consolidation" Statement Before the Committee on Energy and Commerce, Oversight and Investigations Subcommittee, U.S. House

This crisis is overwhelmingly being driven by health care industry consolidation—particularly among hospitals—that has eliminated healthy competition and led to irrational health care prices and anticompetitive behavior.[3] Hospital prices have become highly problematic as the role of hospitals in our economy has shifted over the last 60 years from charitable institutions to corporate entities, resulting in a fundamental misalignment between the business interests of the hospital sector and the interests of our nation's families, workers and employers. The impact is stark:

- Since 2010, more than 1,600 hospitals have merged, and the number of doctor's offices being bought by health care monopolies has increased dramatically, with more than half of all physicians now being employed by hospital-owned practices.[4, 5, 6]
- Since 2015, hospital prices increased by more than 30 percent, accounting for one-third of U.S. health care spending, and growing *four times* faster than workers' paychecks.[7, 8, 9]
- High hospital prices result in one-quarter of a trillion dollars in waste each year, which accounts for a quarter of *all* waste annually generated by the US health system.[10]
- And importantly, hospital prices are not only high, but have become essentially irrational. In 2020, across all hospital inpatient and outpatient services, employers and private insurers paid on average 224 percent of what Medicare pays for the same services.[11]
- Prices at hospitals in concentrated markets are 12 percent higher than those in markets with four or more rivals without any demonstrated improvement in

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of Representatives. 2018. *https://www.researchgate.net/profile/Martin-Gaynor/publication/323228757_Examining_the_Impact_of_Health_Care_Consolidation_Statement_before_the_Committee_on_Energy_and_Commerce_Oversight_and_Investigations_Subcommittee_US_House_of_Representatives/links/5a874b89a6fdcc6b1a3ac6e9/Examining-the-Impact-of-Health-Care-Consolidation-Statement-before-the-Committee-on-Energy-and-Commerce-Oversight-and-Investigations-Subcommittee-US-House-of-Representatives.pdf.*

[3] Jaime S. King et al., Preventing Anticompetitive Healthcare Consolidation: Lessons From Five States (Source on Healthcare Price and Competition and Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California Berkeley School of Public Health, June 2020), *https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/;* Martin Gaynor, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," *Journal of Economic Literature* 53, no. 2 (June 2015): 235–284.

[4] "Chart 2.9: Announced Hospital Mergers and Acquisitions, 2005–2017," TrendWatch Chartbook 2018: Trends Affecting Hospitals and Health Systems (Washington, DC: American Hospital Association, 2018), *https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf.*

[5] Martin Gaynor, "Examining the Impact of Health Care Consolidation," statement before the U.S. House Committee on Energy and Commerce Oversight and Investigations Subcommittee, Washington, DC, February 14, 2018.

[6] Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment, 2012–2018," Physicians Advocacy Institute (PAI), February 2019, *http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-1.*

[7] Kurani, N. et al. How Has U.S. Spending on Healthcare Changed Over Time?. Health System Tracker, Peterson-KFF. 2022. *https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Contribution%20to%20change%20in%20total%20national%20health%20expenditures,%20from%202019-2020,%20by%20spending%20category.*

[8] Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services. Congressional Budget Office. 2022. *https://www.cbo.gov/publication/58222.*

[9] Desilver, D. For Most U.S. Workers, Real Wages Have Barely Budged in Decades. Pew Research Center. 2018. *https://www.pewresearch.org/fact-tank/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades/.*

[10] Shrank, W. et al. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA.* 2019. *https://jamanetwork.com/journals/jama/article-abstract/2752664.*

[11] Whaley, C. et al. Prices Paid to Hospitals by Private Health Plans. RAND. 2022. *https://www.rand.org/pubs/research_reports/RRA1144-1.html.*

[12] Cooper, Z. et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics.* 2019. *https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext&login=false.*

the quality or access to care.[12, 13, 14] All the while, the workforce in these concentrated markets suffers—wages for nurses and other health care workers decrease significantly after mergers and acquisitions.[15]

- Prices for the exact same service vary widely: A colonoscopy at a single medical center in Mississippi can range from $782 to $2,144 depending on insurance.[16] At one health system in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[17] Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento California.[18]

It is time to implement policy changes that will make the health care sector more competitive, make health care more affordable, and allow our nation's families to access the health and health care they deserve.

The Senate Finance Committee has a key role to play in both uncovering concerning health industry behavior through bipartisan oversight and hearings such as this one, and addressing those behaviors through legislation. We urge the Committee to consider well-vetted, bipartisan, and commonsense legislation that would remedy some of the most obvious health system failings, and to take on rising health industry consolidation among hospitals, insurers, and other health care organizations that enables anticompetitive behaviors, prevents healthy competition in markets and results in monopolies that have the ability to set outrageous and unjustifiable prices.

Site-neutral payments. One crucial policy area where this Committee can lead is addressing payment differentials across sites of service that financially incentivize further consolidation. This flaw in Medicare's current payment structure unnecessarily promotes care in more expensive settings with no corresponding improvement in quality or access while failing to appropriately pay some clinicians and other health care workers in non-hospital settings. Advancing comprehensive site-neutral payment reforms would be a welcome first step to crack down on industry gaming that uses misaligned payment incentives to drive up costs without investing in quality, and these policies are estimated to result in billions of dollars of savings for Medicare beneficiaries and the Medicare program.[19]

Additionally, we encourage you to work with colleagues on the other committees of jurisdiction on policy solutions related to price transparency, anticompetitive contracting clauses, and antitrust enforcement.

Price transparency. Unveiling prices is a critical step towards achieving truly affordable health care, improved health, and more competitive health care markets across the U.S. health care system. Price transparency pulls back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses. Further, unveiling prices can inform where the highest and most irrational prices are occurring in the health care system, so policymakers can implement more targeted policy solutions to bring down the cost of health care. We strongly support the administration's efforts to increase hospital price transparency and urge Congress to strengthen and codify the Hospital Price Transparency Rule.

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[13] Gaynor, M. Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets. Statement before the Committee on the Judiciary Subcommittee on Antitrust, Commercial, and Administration Law. U.S. House of Representatives. 2019. *https://www.congress.gov/116/meeting/house/109024/witnesses/HHRG-116-JU05-Bio-GaynorM-20190307.pdf.*

[14] The Impact of Hospital Consolidation on Medical Costs. NCCI Insights. 2018. *https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx.*

[15] Prager, E. Schmitt, M. Employer Consolidation and Wages: Evidence from Hospitals. American Economic Association. 2021. *https://www.aeaweb.org/articles?id=10.1257/aer.20190690.*

[16] Kliff, S. Katz, J. Hospitals and Insurers Didn't Want You to See These Prices. Here's Why. The Upshot. *The New York Times.* 2021. *https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.*

[17] Kliff, S. Katz, J. Hospitals and Insurers Didn't Want You to See These Prices. Here's Why. The Upshot. *The New York Times.* 2021. *https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.*

[18] National Chartbook of Health Care Prices. The Health Care Cost Institute. 2016. *https://healthcostinstitute.org/national-chartbook-health-care-prices-2015.*

[19] Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System Chapter 6, Aligning fee-for-service payment rates across ambulatory settings (June 2022), *https://www.medpac.gov/wpcontent/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf.*

Anti-competitive contracting. Anticompetitive practices and clauses in health care contracting agreements occur in a variety of places including between providers and insurers and in clinician and health care worker employment arrangements. In contracts between provider entities and insurers, large entities in highly consolidated markets have the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit access to higher-quality, lower-cost care. When anticompetitive terms are present in health care clinician and worker employment contracts, they can further stifle competition, lead to burnout exacerbating workforce shortages,[20] impede patient access to preferred providers and care, and in some cases lead to higher prices for health care services.[21]

Anti-trust enforcement. Congress should ensure that the Federal Trade Commission and U.S. Department of Justice Antitrust Division are appropriately resourced and have the legal tools needed to exert meaningful oversight of health care merger and acquisitions, including examining the impact on patient access to quality care.

Enacting these policies would set critical groundwork to reduce inflated spending throughout the system and make health care more affordable and value-driven for consumers.[22]

Consumers First and our undersigned allies look forward the discussion today and to working with you to enact bipartisan and commonsense improvements to our nation's health care payment and delivery system. Please contact Jane Sheehan, Director of Federal Relations at Families USA, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

Sincerely,

Consumers First Steering Committee

American Academy of Family Physicians
American Benefits Council
American Federation of State, County and Municipal Employees (AFSCME)
American Federation of Teachers
Families USA
Purchasers Business Group on Health

Supporting Organizations

ACA Consumer Advocacy
Alabama Arise
Allergy and Asthma Network
American Medical Student Association
American Muslim Health Professionals
Colorado Consumer Health Initiative
Community Catalyst
Connecticut Oral Health Initiative
Consumers for Affordable Health Care, Maine
Consumers for Quality Care
Florida Voices for Health
Georgian's for a Healthy Future
Health Access California
Health Care Voices
Utah Health Policy Project
Justice in Aging
MomsRising
National Association of Social Workers (NASW)
National Consumers League
National MS Society
National Partnerships for Women and Families
North Carolina Justice Center
Northwest Health Law Advocates
Pennsylvania Health Access Network (PHAN)
PIRG
Small Business Majority
Tennessee Justice Center
The ERISA Industry Committee
Third Way
Virginia Organizing

STATEMENT SUBMITTED BY JOHN R. DYKERS, JR., M.D.

Large Hospitals Reportedly Use Secret Deals to Hinder Competition

On its front page, *The Wall Street Journal* reports that hospital giants use a series of secret agreements to protect themselves and stop efforts to lower health care costs *(http://mailview.bulletinhealthcare.com/mailview.aspx?m=2018091902ama&*

[20] *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786894.*
[21] *https://www.aeaweb.org/articles?id=10.1257/app.20180078.*
[22] Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services. Congressional Budget Office. 2022. *https://www.cbo.gov/publication/58222.*

r=6144171-fdfb&l=036-40f&t=c). In some instances, hospitals can require that they be included in all health plans in their area, or prevent rivals which charge less from being included. Alternatively, they could obscure prices from consumers or limit attempts to audit claims. The article says U.S. health care spending is higher than other developed countries', and the problem is not that Americans are consuming more health care, but that what they pay for is increasingly more expensive.

The Duke Endowment sent me to the Kings Fund College in London to study the National Health Service. Met with the counterpart of Sec. HHS in the US and about a dozen of the undersecretaries over a week and saw first-hand how they chased their tail and justified their "book". Spent the next week in the boondocks in Hereford in the west of England with family docs, specialists, health departments. and hospitals. They used the "book" as a doorstop, and did what needed to be done for patients as best they could with restrictions from London. The University of New Mexico in 1977 sent me to study the health care delivery system in China, Hong Kong (still a colony) and the Philippines. So I have some bone fides to write the Act in addition to practicing in the trenches in Siler City for 46 years, initiating federal legislation with Senator Helms for the tobacco allotment buyout, state legislation for lowering legal limit of blood alcohol from .10 to .08, and encouraging testing for HIV/AIDS and establishing Drug Courts. Served 5 years on the NC Humanities Council and 2 in the Duke Medicine and Society Program on Death and Dying, 5 years on the NC Driver's License Review Board as Chairman of Physicians, two years as state chair for CME for the NC Academy of Family Physicians and 35 years as chair of CME for Chatham Hospital Thursday Morning Intellectual Society, and multiple stints as Chief of the Medical Staff and Chief of Obstetrics including directing the first nurse midwifery service in NC, Head of Ethics Committee, Death Review, Credentials, and Medicine and Pediatrics and Emergency Services. I have given the annual address to the Institute Of Medicine on our society's response to HIV, and lectured at the Institute of Government and to Bar Associations about DWI. I addressed conclaves in Bratislava, Czechoslovakia and Montreal, Canada on metronidazole and trichomoniasis.

The ACA won't even need to be repealed as it will atrophy from disuse as it is replaced by The Medical Care Restoration Act. Legislation designed to improve function can be brief; the Act is 4 pages. (Legislation designed to protect corrupt special interests is convoluted and obtuse, as Nancy Pelosi famously described ACA, "We'll have to pass it to see what it says," all 2000 pages.) The Medical Care Restoration Act is Conservative, Voluntary, and Universal. The Act controls costs by removing the hassle factor, returning the non-monetary rewards to practicing medicine, and facilitating the value efforts of many physician-sponsored programs such as Cornerstone. The Act returns the decision making to the Dr./Pt. relationship and ends defensive medicine, protects patients and taxpayers, and returns learning and caring for the patient to the practice of medicine, simplifying the payment process.

Medical Care Restoration Act, a Conservative Voluntary Universal Health Care initiative is permissive legislation, and all existing payment or health related functions will be allowed to thrive or atrophy as experience dictates.

Every adult wishing to be eligible to participate must choose a Primary Care Physician who may be any physician licensed to practice medicine in any of these United States and who is willing to accept for that person the role of Primary Care Physician as defined in this act. The Primary Care Physician must be an individual. Persons not having a Primary Care Physician as defined in this act will not by law be required to be seen in any Emergency Department, but may be seen by custom.

Every person under age 18, who wishes to participate, similarly must have chosen for them by their parent or legal guardian, a Primary Care Physician.

If a patient and Primary Care Physician agree to enter into such a relationship, they shall jointly notify the FEDERAL AGENCY for MEDICAL PAYMENT, hereby established by this act, as follows:

I, full name, address, and social security number, do hereby request, and I, full name, address, and social security number, do hereby agree to serve as Primary Care Physician for, full name, address and social security number, beginning, date.

Either party may rescind this agreement without cause by notifying the Federal Agency for Medical Payment as follows:

I, full name, address, and social security number, do hereby terminate my request/agreement to relate to, full name and social security number, as patient/Primary Care Physician.

After a first termination without cause, a patient may enter into another primary care agreement with a different primary care physician but cannot terminate that agreement without cause for 60 days. A third agreement cannot be terminated for 6 months, a fourth for 1 year and a 5th and any subsequent agreement for 2 years.

If at any time the primary care role is more appropriately assumed by another physician and it is mutually agreed by the current primary care physician, the patient, and the succeeding primary care physician, the change may be made, but the succeeding primary care physician/patient relationship may not be unilaterally terminated without cause for 2 years.

The primary care relationship may be terminated at any time for cause. Such termination returns both parties to the starting point of the schedule for terminations without cause. Death or retirement of the primary care physician or geographic relocation of either the physician or the patient that increases the travel requirements of the patient by more than 15 minutes returns the patient to the beginning of the choice process. Geographic relocation that decreases the travel requirement has no effect. Termination for non-compliance requires the referral of the patient for a hearing within 5 working days (plus travel time) before a 3-doctor panel of physicians who are experienced practice inspectors (Fraud and Abuse Protection AS DEFINED BELOW) and, the judgment of that panel must be rendered at that hearing and shall be binding. Any terminated patient shall have the right to appeal that decision to Federal Court, but is terminated pending judicial decision to the contrary. A decision not to terminate may also be appealed to Federal Court, and termination shall be held in abeyance until such appeal shall be adjudicated.

The Primary Care Physician and the Federal Agency for Medical Payment shall maintain a list of all patients cared for by the PCP, and FAMP shall pay the Primary Care Physician $40 for each patient on the list for all or any part of each month. The patient may pay to the physician a mutually agreeable incentive to fill that role and the physician may rebate to a patient all or part of listing fee. The PCP may delegate functions to other qualified persons and may pay others to perform the PCP functions but will retain authority and responsibility for all such functions. Physician charges for medical care, both primary and consultative, preventive care, acute illness, chronic disease management, surgery, diagnostic evaluation, mental health care, whatever effort is being made on behalf of the patient to most efficiently maintain or restore the patient to a reasonably obtainable functional level will be designated as "Professional services rendered" and will be documented by appropriate patient care records and will be billed to FAMP in dollars U.S. Other categories of care covered by this act will include, Hospital care (Inpatient, outpatient, elective and emergency) Nursing home care (Skilled, intermediate, domicile) Home care (Nursing, aides, IV's, O2, tests, structural modifications, whatever allows a patient to remain at home more efficiently than to be institutionalized), Medications (pills, shots, sprays, suppositories, creams, patches, ointment, gasses, by whatever means delivered), Therapeutic modalities (Physical therapy, Chiropractic, Massage therapy, acupuncture, electric shock therapy, whatever modality may be applied to the patient in an appropriate attempt at healing), Dental care and dentures, Podiatric care and special shoes and inserts, Optometrist and optician care and glasses and contact lenses, Audiology services and hearing aids, Durable and disposable medical equipment and supplies wherever used as permits improved function (beds, wheelchairs, walkers, artificial body parts, computer enhancements, canes, lifts, whatever most efficiently improves patient function and healing). Telephone, Email visits, telemedicine, and whatever technology allows suitable medical care to be delivered to benefit the patient.

All of these charges will be submitted by the provider to the primary care physician for approval, disapproval or modification by the primary care physician based on the value of the goods and services to the patient. The approved bill amount shall be submitted to the FAMP and the provider shall be paid 80% of that amount. Payments by FAMP are made ONLY by the authority of the individual PCP. The patient shall be responsible for the unpaid portion of the charges. Recognizing the capability for payment to be almost immediate if done electronically debiting the FAMP account and crediting the account of the provider, **the charge should leave the electronic system and pass through the brain of the PCP or designee and be reentered in order to establish responsibility for the number of dollars spent as being solely the responsibility/authority of the PCP.**

Other third-party payers may contract to pay all or a given part of the balance due, but they can't change the rules. Once a bill is approved by the primary care physician the dollar amount of the bill stands except as herein provided. Other third par-

ties may elect to insure only certain categories, but whether or not a given service fits any category shall be at the sole discretion of the primary care physician.

Federal Agency for Medical Payment shall receive bills approved by Primary Care Physicians and patients and pay them with funds appropriated by Congress to the US Treasury. FAMP will establish Fraud and Abuse Protection (FAP) composed of physicians with at least 25 years experience practicing direct patient care medicine. It shall be the responsibility of FAP to investigate all charges of fraud and abuse from whatever source. **(We have 60 years experience since medicare was started, a sound foundation for guidance for value received.)** The value of new treatments should be judged on the basis of their improvement of patient care as compared to the best available previous care. These may be compared to those for which a value has already been established,

All clinical records shall be available to a single investigating physician **(or designated agent)** from FAP, and such investigating physician shall make one of the following determinations:

(1) The care delivered was appropriate and was delivered at less than the expected cost and the Primary Care Physician shall receive a 6 inch 5 pointed plastic or metal GOLD STAR. This GOLD STAR may be displayed or not wherever and whenever the PCP shall choose.
(2) The care delivered was appropriate and the charges were appropriate and no further investigation or action is needed.
(3) The care was inappropriate and/or inadequate and the charges inappropriate and/or excessive. Reeducation and/or refund are appropriate.
(4) Care was foolish and/or charges were grossly excessive. Reeducation and refunds are required. Investigation of any or all of the bills and records of the PCP may be undertaken.
(5) A pattern of inappropriate care and/or overcharging is established and reeducation and/or refund are required and fines up to $20,000 are levied, and/or the physician and/or patient may be discharged from the program.
(6) A pattern of fraud exists and criminal charges are instituted. Patients and other providers colluding in such fraud shall also be prosecuted.

THERAPEUTIC MISADVENTURE

Replace "Consent" forms with "Request" forms.

Participating physicians and hospitals and other institutions/providers shall have the option to declare a Therapeutic Misadventure whenever they become aware any patient has been inadvertently harmed by medical care, OR when they reasonably become aware of harm from any medical or surgical act, or the omission of any action. Once a Therapeutic Misadventure has been declared, all subsequent medical care delivered to that patient as a result of that TM, shall be at the expense of all participating physicians, hospitals or other institutions/providers and none shall be liable to be sued for malpractice arising out of that TM. Whoever declares the **therapeutic misadventure,** physician or hospital or other institution/provider shall request an investigation by a physician from FAP of the institution or individual to determine whether or not the misadventure was human error of whatever type that could be avoided by changed behavior, or whether or not the cause was system error that could be avoided by changes in the system, or whether the TM was unavoidable. FAP will determine who, if anyone, will compensate the injured patient for lost wages and pain and suffering that arise from the declared Therapeutic Misadventure. The amount of such payment, if any, if not agreed upon by the parties involved, may be adjudicated by civil litigation. FAP may require changes or education or make any of the 6 determinations for care as have been established for charges.

CONFIDENTIALITY IS AUTOMATICALLY COMPROMISED BY INVESTIGATION WHERE CLINICAL RECORDS MUST JUSTIFY CHARGES AND APPROPRIATENESS.

Eighty percent payment is arbitrary but not irrational and may move in either direction. Our incentive for healthy lifestyles and good preventive care is motivated by our perception of the benefit of improved health versus the perceived suffering from leaving behind old habits. The 20% patient responsibility leaves room for market forces to function without predominating. Federal budget constraints, employer wellness programs, third party insurers, individual wealth or poverty, PCP collection/forgiveness practices, charitable organization payments, other government programs, and any other payment sources should all be allowed to function and grow or atrophy as experience evolves. Health Care Providers, physicians, pharmacists,

hospitals, et al. may forgive any part or all of the patient responsibility on a case-by case basis; however, the service must be worth the total charge when being evaluated by FAP. (It is ok to be charitable about the balance, but dismissing part of the balance must, in fact, be charitable.)

The $40 per patient per month fee is also arbitrary but not irrational and may move in either direction as experience dictates.

MEDICINE WITH MERCY AND GRACE, PA
201 S. Washington St., #401
Shelby, NC 28150

Chairman Wyden, Ranking Member Crapo, and Senate Committee Members,

Thank you for holding this hearing and for your attention to these topics that so vitally impact the well-being of Americans. I listened with intense interest to your comments and questions and to the statements of the eloquent witnesses. I heard many things that resound with my practical experience in many of the problematic milieus discussed. My history as a family medicine physician in a mostly rural area of North Carolina provides a very clear window on the trends and impacts you seek to understand. I would like to add the witness of a practicing primary care physician to the record along with an idea for a simple and direct solution. Some of these comments are excerpts from earlier communications. These field observations from the heat of the fray we have endured in locally owned and operated primary care and community-based hospice and palliative care practices provide an essential viewpoint that was missing from the live hearing. Hopefully, together we can find effective and prompt solutions.

The dilemma in American healthcare comes down to ignoring what science tells us about human motivation. Individuals are not solely driven by desire for profit. Corporations are driven by the need for profit, even among non-profits and social enterprises, to continue to exist. Considering only reward and penalty motivations in the design of reimbursement systems does not lead to creative work or the highest quality product or even the lowest cost and it does not deter fraud. Focusing primarily on cost reduction has not met any of the Triple Aims and has put the Quadruple Aim far out of reach. Even with perfect transparency in freely competitive markets, people do not always choose the lowest price, for many valid and desirable reasons. There are also always cheats in every market. The intentions of laws and regulations are subverted in many unimaginable ways by those organized solely to seek profit without the restrictions of individual conscience and the censure provided by local relationships and reputations. Burdening individuals working in physician-owned practices and locally administered hospitals, hospices, and congregate living facilities without providing the balance of alternative payment models intended in the ACA has demoralized a large portion of the healthcare workforce motivated by intrinsic drives, such as feeling satisfaction from using skills to help others. This has led to higher and higher costs in healthcare as more jobs are focused on proving and keeping reimbursement and services or finding ways to game the system to get unfair reimbursement, than on doing the work that serves people well.

A capitalist market depends on the freedom to choose, but also on the capacity and responsibility to learn from mistakes. Healthcare markets require reinforcement of the invisible hand to ensure that benevolence is prioritized by entities given exemptions from taxes and people have protection from harm from bad actors in the market. Market forces of individuals making choices from various intrinsic as well as extrinsic motivations, not government, regulator, or managed care forces, bring the market to the lowest cost per unit of satisfaction. Individuals need free choice in how our own healthcare dollars are spent for our individual benefit and satisfaction based on measures most important to each of us. Physicians and pharmacists chosen by patients need autonomy to serve within the resources available in each community.

The ACA, the implementation of it by CMS and the understanding of it by the populace has been twisted by self-interested forces. CMS has neglected its role to advance APMs that were meant to balance the burdens and incentivize innovations by medical workers investing in their own communities. At the same time government has handed control of the whole healthcare market to commercial insurance plans through the allowances of aggressive sales tactics in the Medicare Advantage Plans, Medicaid MCOs, and establishment of exclusive networks. Any solution must inherently provide a balancing hand that protects independent small business

health enterprises lead by healthcare professionals and ensures that conglomerates such as hospitals, insurers, and pharmacy corporations use our natural, intellectual, financial, and physical resources in a beneficial way so that people have equal access to the resources for basic human needs, without treading on the relationships between patients and their chosen professional providers.

Most of the current healthcare reform designs are focused on how to set up overreaching management and regulation. Those who have experienced the changes in the Medicare system as fewer and fewer senior citizens can afford what is known as "Traditional Medicare" understand that a single payer "Medicare for All" system is not viable, does not even exist for current Medicare beneficiaries, and will not solve the problems we face. We need to re-group on the ground, with how we want the actual delivery of care to look and feel. Reimbursement systems need to recognize the third drive of intrinsic motivation by supporting physician autonomy and trust in the accountability of professional responsibility to patient-consumer individual relationships. Reimbursements financed by taxpayers through government agencies must be structured to encourage corporate managers in all the vertical and horizontal types of business and corporate payers to move to value-based collaborative business models. Data systems must be modernized and connected in the same way medical records interoperability has been required, to report on patient outcomes from comprehensive expenditures across the spectrum of care, rather than narrow quality measures that cost a lot to count from only fragments of care.

An Analysis of Trends, Responses, and Impacts in an Existing Value-Based System

The Medicare hospice benefit requires delivery of care through a multi-disciplinary team reimbursed through prospective payments. It is our closest example of a nationally operating value-based model. This benefit provides highly satisfying experiences, even in times of grief and stress, for patients and families, hospice workers and volunteers, and community donors who feel good about providing something that helps others. When those teams are operating effectively and are bonded well with patients, the overall costs of care are also reduced. The trends, responses, and impact of changes in the reimbursement system and penalties enacted by CMS to control the rising total costs as more hospices opened and more patients accepted the benefit provides a realistic crucible within which to consider the forces, responses and consequences that have led to consolidation in healthcare markets in general. Sadly, this is another example of how attempts to prove accountability have led to more consolidation and more difficulty in identifying bad actors. We can follow how the consequences of legislation and regulation affect cost, quality, and patient experience differently, sometimes oppositely, of what is intended or desired.

Within the past 30 years, our communities have seen the rise and acceptance of the hospice philosophy. **People have witnessed the power of an integrated team directed at whole-person and family well-being.** In the last 15 years, regulators have focused on lowering costs and controlling bad actors in this market. Medicare increased scrutiny and penalties, sets up bounty hunter systems to reclaim payments, revised the benefit to lower total costs to Medicare which reduced revenues to hospices, **regardless of and without calculating the net benefits** to patients, families and communities receiving highly satisfying care, relief from suffering, dignified deaths, and satisfying work for healthcare professionals. It is predictable that such focus would lead to consolidation among locally operated hospices that previously observed county boundaries and had cooperative relationships aimed at service to people. Consolidation builds larger entities that attract more audits. The energy of employees previously aimed at service and practice improvement is redirected toward defending reimbursement for work already performed. Reduction in revenues leads to cuts in staff and additional service lines such as massage therapy that can reduce the amount of opiate required for pain control, art and spiritual therapies that relieve anxiety. This has allowed bad actors and private equity groups to waste our personal charitable investments and clear our communities of locally competitive, regionally cooperative, autonomously operated hospices developed by entrepreneurs, volunteers, and donors with intrinsic motivations to help one another. I can provide a more detailed analysis if interested—it causes this document to exceed 10 pages.

Medical practices of any type managed from afar do not have the connections in the community that give the mutual satisfaction of participation in a beneficial enterprise or the accountability to present the best effort. They also lack strong relationships with physicians, pharmacists, agencies and local hospital staff, ethics committees and inpatient palliative care teams that can be useful in educating patients about advance directives and delivering consistent messaging about choices in

where and how care is delivered to avoid costly ER and EMS calls and futile, expensive treatments.

Impact on Primary Care Practices and the Goal for Transition to Value-Based-Care

These same forces have caused and allowed the same consequences for entrepreneurial physicians and their staff in independent primary care practices during the same 15 years. At the same time, primary care practices have pulled the weight of adopting the requirements of the ACA without all the benefits intended within the legislation to balance that weight.

Corporations have been quick to spot and wield opportunities for profit under the guise of promoting quality or safety. Vertically integrated businesses answer only to their corporate masters and focus on partial successes now rather than whole person wellness for the future. It is wasteful and dysfunctional to employ professionals at the highest level of training to implement increasingly extensive prior authorization requirements that purposely slow or obstruct production of the goods for sale—in this market the "goods" are healing for improved function and quality of life—for the sake of lower costs for that single competitor in the market. That doesn't lower costs for the main payers in the whole market: the American workers and businesses who have paid into the Medicare Trust and paid taxes to federal and state governments. This system incentivizes physicians who never see the patients affected by their denials of services. Those patients are the taxpayers who foot the bill for the corporate medical directors' jobs. Meanwhile the professionals who do see patients face to face and fulfill their obligation as advocate for patients are tied up in literally hours of work (an average of 2 days per week) that often requires a physician's direct participation to gain reversals of denied services. This process and other managed care tactics limit access to primary care in multiple ways: professionals leave patient-facing work due to mounting frustrations; those that remain are available for fewer encounters and often must adjust their practice style, spending less time with each patient to meet other demands and still have time for their own families. Corporations clinging to fee-for-service reimbursement and investments in costly MIPS/MACRA processes (that also demand time and attention from physicians during encounters with patients) have often eschewed the chronic and complex care management billing codes because the cost of capturing data reasonably could exceed the payment. Therefore, physician employees don't get credit in compensation quotas for services to patients outside fully billable encounters, such as performing peer to peer reviews for prior authorizations or calling patients personally to explain complicated results. The system incentivizes physicians to stop providing high quality service. These are the ways that cost-containment and profit-seeking factors lead to lower quality care and lower patient and provider satisfaction.

Cost containment by corporations does not translate to reduction in healthcare costs to the nation. Managers must ensure a profit to their stockholders after salaries to their executives and administrators, none of whom directly contribute to care. Also, in Medicare Advantage Plans commercial insurers strip further profits from the Medicare system. Some of the "savings" to the Medicare Trust come from the denial of services and treatments to the current beneficiaries. Those people do not at first realize they are gambling with their lives; those denials often result in suffering and sometimes result in death. People are catching onto this. Those costly "savings" to the Medicare Trust are also negated by tactics to inflate complexity of care—sending physician extenders to patients homes to search for more complex diagnoses to increase payments from Medicare and sometimes scaring patients with false diagnoses or paying extra money ($150/assessment is offered by Inovalon) to primary physicians through contracted agencies to provide separate written assessments to "update our records". Physicians have been witnesses to all of this at the same time heavy burdens of accountability have been applied to them. This system is unethical and immoral. It has resulted in the demoralization of our most highly trained corps of healthcare workers.

In places that qualify as rural, consolidated hospital corporations replace specialists living in and contributing to those communities with their own less available service lines and telemedicine encounters from within their exclusive silos, without any real continuity over time, even when live providers are available in that locale. Corporate networks have also hijacked the intent of HIPAA to block sharing of patient information procured in conglomerates from independent providers and other agencies serving the same patients, even within their own vertical silo. All these tactics add to the time burdens and frustrations of primary care teams.

In retrospect, it feels as if CMS has participated in the attack on independent practices. Perhaps CMS believed that physician owned practices were not attending to quality measures and were too gullible to sales tactics of pharmaceutical companies. Perhaps legislators directing CMS were convinced by corporate lobbyists that physicians were abusing the use of self-managed lab services. Those physician-managed lab services gave same day, real-time results that helped determine quickly and decisively when patients did or did not need higher levels of care. In consolidated healthcare, when outpatient physicians need same-day lab results to make treatment decisions, the emergency department is the only choice. This adds exponentially to the cost of care for the patient and the payers, pads profits for the corporations that own both settings, without any benefit to patient. It is now also almost impossible to schedule same-day outpatient radiology tests such as ultrasounds to rule out deep vein thromboses, so patients must weigh the risks of waiting against the expense of ER visits. Although I can't prove this, it appears that some consolidated exclusive networks providing outpatient radiology services through centralized scheduling, give preferential treatment to patients within their network.

Instead of using the massive amounts of data collected over many years of reimbursements on all types of services to provide comprehensive patient-directed cost and outcomes data that would help physicians learn what works well and what doesn't, CMS has produced narrow-focused punitively driven reports to which no response is acknowledged, and no explanation given. Some of these reports are commissioned from politicized pseudo-scientists as "tools for education" to the already highly trained professional scientists who practice medicine. A first-year medical student can spot the statistical flaws in these reports. It is embarrassing that a product of our government couldn't make it past the first-draft stage in an undergraduate research project. CMS also spends more money contracting with corporations to provide the education deemed necessary to reform the "outliers" in these analyses without even attempting to understand the possible confounders that might have been at play in the results, ignoring another basic tenet of science.

Such failures to measure and compare the benefit gained, or lost, from the cost savings have plagued most of the government analyses about healthcare. We have been misled by focusing primarily on costs in dollars while ignoring costs in individual lives.

The primary motivations that drive medical professionals are reverence for life and a desire to help people live longer and better lives. Medical professionals spend large amounts of time and money to learn and maintain skills and sacrifice time with their families to serve other people in ways that few other professions demand. CMS needs to employ a system of reimbursement that can discern physicians from profiteers. Patients can tell the difference.

In 1983 75.8% of patient care physicians had an ownership stake. In 2016, two years after meaningful use of electronic medical records was required by the ACA, and a year before the PTAC hearing on the AAFP's APC–APM, for the first time, less than half (49%) of primary care physicians owned their own practices. This is a similar percentage to the AMA data for all patient care physicians and in that data, family physicians were the second most likely specialty to be employees rather than owners. By 2018, there were fewer physician owners (45.9%) than employees (47.4%). In 2021 only 26% of practices were owned by physicians. Over this same time, despite the intense focus on reducing costs through managed care organizations, total healthcare costs have risen, and satisfaction has fallen. It is obvious what is missing.

People have witnessed the thievery and felt the loss of trusted relationships and the fear of bankruptcy from the misfortune of illness. The anger that stems from these threats is at the root of the divisions in this country.

My experience as a hospice physician and director of a well-established community based palliative care program led me to study other team-based, integrated, or collaborative models of care. This led to an idea that I believe provides a fitting and practical solution, reinforcing the recommendations from the witnesses assembled in person at this hearing, and relying on the work of many dedicated health professionals across this nation and around the world. I tested this idea, investing my own savings in an independent collaborative practice that formed flexible and shifting interdisciplinary teams with partners in other health and social agencies to serve individuals identified from local population sets as having gaps in care. This team practice was designed to help all other local practices, hospitals, and agencies to serve all people equally well and deliver better care at lower costs while also capturing all the possible current fee for service reimbursements using the CPT chronic

care, complex chronic care codes and mental health collaborative care codes to share among those who did the work for each patient, preparing us all to transition to value-based reimbursements. The pandemic and exclusive networks interrupted that trial before we could organize as a community, but everyone who witnessed it knows the model is effective.

An Irrefutable Strategy

In 1968 the economist E. F. Schumacher observed: "what is possible, . . . and unbelievably urgent now . . . is the conscious utilization of our enormous technological and scientific potential for the fight against misery and human degradation; . . . a fight in intimate contact with actual people, with individuals, families, small groups, rather than states and other anonymous abstractions. And this presupposes a political and organizational structure that can provide this intimacy. . . . We must learn to think in terms of an articulated structure that can cope with a multiplicity of small-scale units."

In pursuit of the Triple Aim the people of this nation have only become more oppressed by higher costs, generally worsening outcomes, and lower satisfaction. We don't need reform. **We need a revolution that turns this expensive and overbearing "managed care" model inside out to create a "well-articulated assembly of small scale, semi-autonomous units" of doctors, patients, communities, pharmacies, and hospitals, administered locally, and reimbursed fairly within a political and organizational structure that is accountable to the people and supports the intimacy necessary for healing relationships.**

In our quest to form a more perfect union, we have waged furious struggles against oppression from without and aided other countries in similar struggles to be free. We have also persisted in oppressive behaviors against one another in this beautiful land, but never have we had the mass oppression of such large segments of our citizens and our businesses as our economic and healthcare systems subject us now. We would do well to think back on the turning point of our other Revolution: The Battle of Kings Mountain. Many in the opposing forces were fellow colonists who differed in beliefs and allegiances in the same way that Americans differ now. A timely broad-based bipartisan response that corrects the tremendous unfairness in the healthcare market can save us from the violence these divisions have led to in our past.

On signs at the Kings Mountain Battleground National Historic site, we can learn the secret of colonists' success. "Personal leadership proved crucial here." Lieutenant Colonel John Sevier and Colonel Isaac Shelby laid plans to respond to Ferguson's direct threat and "convinced the North Carolina state officer in charge of the money raised from public lands sales to loan the public money to fund the expedition", on personal pledges that they would be responsible for the loan. Colonel Campbell "made time to visit every corps while marching to Kings Mountain. Face to face, he had urged each man to do his duty." **Those leaders used intelligence, experience, and knowledge of soldiers in their troops from their local areas to prevail over nearly impossible odds. We can use the same approach through primary care physician leaders to create a better, affordable healthcare system.**

This essay presents a strategy to swiftly rebuild trust and provide accountability by supporting consumer choice among physician-led primary care teams in transparent and competitive local markets. Every side in our fractured society is demanding it, albeit in different ways. The imbalance in the healthcare market contributes greatly to the redistribution of wealth we have experienced and the anger that has erupted in this nation. This ubiquitous problem requires a cooperative solution.

Where We Are and What We Have

Leaders must bring the results of work and experience in communities across the nation to use in the fight to forge a better system. The idea proposed here is simple and would not be difficult or costly to implement. Many of the features are already in place. Such strategies from medical workers in positions to see the battlefield deserve prompt deliberation and the attention of our best agencies and finance committees for more intense exploration and development.

Legislators responding to this crisis in 2023 should recognize the irony that in 2017, when the first primary care alternative payment model was being evaluated by the PTAC, then-president Donald Trumps' complex tax cuts were being whisked through the legislative process. That highly developed APM plan, supported by evidence-based medicine and years of research began an intensely deliberate process that still has not reached an end. On the day of this Senate committee hearing,

CMS finally announced a 10-year trial of a new primary care APM to be offered in **10 states** to assist independent primary care practices move to a value-based payment model, **beginning in 2024.** The inadequacy of this response should be obvious.

A competitive, transparent, and secure solution is to allow people to choose and directly pay primary care physician teams assembled on the principles of the proven collaborative care models through the ACA Marketplace. Carve out primary care services from insurance coverage.

Envision how healthcare would look and feel if we provided cost-effective, high-quality, highly satisfying care from community-wide collaborative practices and **allowed a choice on the established healthcare marketplace for each person to direct their own monthly payments to their own physician-led primary care collaborative team that is linked to specialists for case review recommendations and to local networks addressing social determinants of health or other Medicare benefits as the patient needs or qualifies for them.** Payments would be directed from a government single payer to support those who need subsidies or elderly and disabled populations.

Prospective payments directly to physician-led primary care teams that use integrated collaborative methods to coordinate, manage and provide defined components of primary care, and additional prospective payments to providers of specialty care for specific populations integrated through those primary teams (behavioral health, women of child-bearing age, intellectually or developmentally disabled, substance use disorders, dementia, homebound patients of any age or combination of problems, palliative care/hospice, or SDOH providers covering other gaps in care in particular communities) would be far less costly than insuring against the inevitable. The primary care teams should remain central and lasting to continue through transitions to other CMS benefit/reimbursement models. Hospice and PACE benefit models could be changed to require that primary care physician-led teams remain central with the patient and layer in the expertise of those specialist teams when needed and appropriate to share the reimbursements for that expertise through the primary care team. This would preserve important relationships and retain comprehensive knowledge of the patient and family, reduce costs and distress to patients of transitions between services, provide a comprehensive historical view for accord in decisions about prognosis and safety at home, with full knowledge of community resources to help people remain at home, and provide inherent accountability between partners working for different entities in certifying and recertifying services.

Considering the urgency of our need for corrections in our whole economy as a result of the COVID–19 pandemic, and the complexity and length of time for the APM trials that CMS has not advanced fast enough, Congress should fast-track a "direct pay" model through the ACA Health Marketplace to include anyone qualifying for Medicare, Medicaid or ACA subsidies, or anyone unable to receive subsidy at the Medicaid level of income but living in a state that did not accept expansion of Medicaid. Participants direct payments to their selected primary care provider who is enrolled with Medicare and willing to participate in mandatory approved training for leading multidisciplinary integrated primary care teams, collaborating with social agencies and hospitals, with encouragement for all communities to support and build community-wide collaborative relationships among existing providers.

Decisions made or delayed today about who to trust and how to use tax dollars have immense and long reaching impact. In 2017 the PTAC empowered by CMS essentially chose not to trust the motivations of individual licensed professionals who ran small businesses employing local people in interesting and fulfilling jobs. By 2021, only 26% of patient care physicians retained the autonomy in ownership to fully serve and advocate for patients. The flip side of that statistic is that 74% of patient care physicians are in the ethical bind of serving two masters. That doesn't lead to good patient advocacy. In a report on 3/27/23 from the Center for American Progress, "Tax Cuts Are Primarily Responsible for the Increasing Debt Ratio", the author Bobby Kogan, states that "without the Bush and Trump tax cuts, debt as a percentage of the economy would be declining permanently. Instead, these tax cuts have added $10 trillion to the debt since their enactment and are responsible for 57 percent of the increase in the debt ratio since 2001, and more than 90 percent of the increase in the debt ratio if the one-time costs of bills responding to COVID–19 and the Great Recession are excluded. . . . While these one-time costs increased the level of debt, they did nothing to affect the trajectory of the debt ratio . . . right up until before the Bush tax cuts were made permanent, the CBO was projecting that, even with an aging population and ever-growing health care costs, revenues

were nonetheless expected to keep up with program costs." Whether one accepts that analysis of the available facts by the CBO as true or not, United States taxpayers simply cannot afford the grift in our current healthcare system. Congress rushed into tax cuts that increased our debt ratio while CMS delayed alternative payment models that could have saved our healthcare system and millions of lives. We also can't afford more delays.

Additional wrap-around insurance coverage could be offered at an additional premium from a menu of selections for medications, tests, specialty care and hospitalizations or catastrophic health events. Any insurance executives worth their million-dollar salaries should be able to develop these ancillary products to compete and survive in the marketplace without riding on the backs of taxpayers and workers to provide profits to their shareholders. Fair payments to providers and equitable sharing of total costs from those with ability to pay to cover services for those unable to pay could be calculated using outcomes versus expected historical data. Credits could be given to those who complete Advance Directives that select a "Slow Medicine", less aggressive approach, or those who reduce their own risk profile by modifying lifestyle or showing compliance with treatments. Physician teams and patients who accept responsibility for part of the risk will have incentives to change behaviors and transform lives.

Communities can establish collaborative partnerships to cover any gaps in care, available for all providers to link with through care coordinators trained for each primary care practice (regardless of ownership: independent private practices, rural health centers, health departments, hospital-owned practices), and connected with school nurses, community agencies including law enforcement, and nursing and assisted living facilities. Care coordinators who maintain in person relationships with patients can be trained through patient navigator certification programs at community colleges and supported by networks operating like the Community Care of North Carolina health partners/provider network for NC Medicaid. This would provide less costly, more effective, and more satisfying access to specialists of all types, especially in rural areas where specialty care is often limited or unavailable. It would provide a simple but highly articulated system of communication when problems are identified in any environment.

The opiate crisis and primary care crisis could be simultaneously solved with this integrated and responsive system of care. Social problems such as homelessness and addiction have a better chance for successful and cost-effective solutions in such a collaborative framework. See articles on Houston's success with such collaborative efforts. Primary providers in each community could be trained in MAT (Medication Assisted Treatment used in combination with counseling and behavioral therapies for treatment of substance use disorders) to provide Office Based Opiate Treatment (OBOT) collaborating through integrated links to other primary providers and behavioral health partners in Opiate Treatment Programs (OTP). (Refer also to projects such as University of North Carolina ECHO based on an earlier project in New Mexico using the collaborative care model to assist primary care providers in MAT.)

ACCOUNTABILITY

Primary care physicians are accountable to patients who are the payers and the directors of stipend funds when they qualify. Each partner on the team is accountable to the others and to the patient. This does not require expensive methods of proving integrity or layers of cost managers to contain costs. Allowing patients to remain with well-known primary care provider teams when they choose hospice or PACE benefits avoids risks by retaining knowledge of their history, smooths transitions and provides multi-disciplinary support for prognostication that can avoid distressing discharges or find unique community resources to keep people safe at home. The transition among appropriate benefit programs could be seamless and nearly invisible for patients. Simply shift or add the experts in that discipline to their existing team. Fraud in such a system of care and distribution of benefits would be nearly non-existent because it would require collusion among all the participants in the competitive cooperative. Patients could change the provider their payment is directed to through the ACA marketplace if any complaints or issues cannot be resolved through normal discourse between members of the team and other partners. A succinct piece of legislation called the Medical Care Restoration Act has been advanced by a retired colleague, John R. Dykers, Jr. MD of Siler City, NC with similar ideas and some additional measures of protection.

IMPLEMENTATION

This system could be phased in through a test period by governmental payers (*i.e.,* worker and taxpayer supported programs: CMS, state Medicaid programs, and ACA subsidies), to physician-led practices in communities that desire to participate and work to establish the necessary collaborative partnerships and system of care coordinators. The Behavioral Health Integration (BHI) Collaborative of 8 professional medical associations formed by the AMA already has accumulated training materials to provide a roadmap for integrating behavioral and mental health with medical services. *(https://www.ama-assn.org/topics/behavioral-health-integration-bhi-collaborative).* The Primary Care First APM offered in 26 states with 2 cohorts, one starting in 2021 and one starting in 2022, produced a First Annual Report in December 2022. *(https://innovation.cms.gov/data-and-reports/2022/pcf-first-eval-rpt).* CMS announced another primary care APM, Making Care Primary (MCP) model in June 2023 to be offered in 8 (or possibly 10 states) beginning in July 2024. *(https://innovation.cms.gov/innovation-models/making-care-primary).* This slow and deliberate pace in advancing methods, already proven many times over to be effective, does not keep abreast of the pirates in private enterprise. We will not win a turning point at this rate. We need leaders in Congress to direct CMS to marshal forces and resources to build and launch these primary care community collaboratives at the same pace we build weapons and ammunition for warfare.

One could think of this as an alternative to CMS payments and premiums routed to commercial insurers for coverage through Medicare Advantage Plans or taxpayer funds routed to private insurers for ACA subsidy beneficiaries. Pay for actual care instead of insurance coverage. If successful, and as more physician-led teams and communities are prepared, it can be expanded to *everyone*.

Private insurance companies competing for business to insure against catastrophic events or severe illnesses that can be estimated from actuarial data will be motivated to lower costs. The "wrap around" coverage could be purchased by individuals, by employers as benefits for employees, or by government programs for the disabled or temporarily disadvantaged. Surgeries, oncologic treatments, advanced specialty care, hospital and emergency care and any other services outside the defined primary or integrated specialty services could continue as fee for service or bundled payments, and could require authorization/approval from payers, as services outside the defined set in the original APC-APM were described. **This removes the excessive burdens of our current system on taxpayers to provide profit margins to private insurers, and on doctors to obtain authorizations from a multitude of payers.** We could achieve the ideal of the Triple Aim for everyone, without the collapse of any part of our current economic system and with less burden for taxpayers.

This system of monthly payments funneled through the ACA marketplace from individuals (supported by subsidies, when eligible, through Medicare/Medicaid for the elderly, disabled, disadvantaged or terminally ill), to primary care teams retains individual choice in the free market and guarantees ease of administration, removes burdens from physicians, assures accountability among the various participants and provides universal access to high-quality care. Such a system would be far less costly than providing insurance coverage for primary care, as we have been attempting to do without success.

Such an amalgamation of ideas and strategies collected from people working across the nation could simultaneously solve economic, tax, insurance, and healthcare crises. Like the Overmountain Men, we have traveled far and exhausted our provisions, but **we can win this battle and save our country by using our wits and our courage, where we are, with what we have.**

Parts of the essay describing this vision were originally written in 2018. Since then, we have weathered a pandemic and continue to struggle with the wide-reaching effects of political discord. The costs of our current health services are crippling our nation. Only the top 1% are invulnerable to these costs and risks. Shifting dollars to pay for "managing care" only diverts funds to abstractions which cannot provide healing or promote desirable growth.

Conscious utilization of our enormous potential to fight against misery and human degradation is medically emergent now, for our people and for our businesses. Solutions to these problems require the finest, fiercest focus of our best minds from many fields, deliberating with the honest transparency that science demands. **We must band together with leaders who listen and think before they speak, to use our resources conscientiously and frugally in the fight against misery and degradation.**

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References and Additional Notes:

E.F. Schumacher quotations are collected from a 1968 essay published in "This I Believe and Other Essays", 6/1/1997, marking the anniversary of his death. Similar ideas were included in his book "Small Is Beautiful, Economics as if People Mattered", Chapter 5: On the Question of Size, 1973.

Website links are provided to other documents acknowledging the sponsoring agency or author.

Quotes about the Battle of Kings Mountain are from signage at the Kings Mountain National Military Park. Special thanks to National Park Rangers and volunteers at the Kings Mountain and Cowpens National Battlefields and for the Overmountain Victory National Historic Trail.

These are sources that will help with understanding the components of this vision for a better system:

The Affordable Care Act (ACA) and the ACA Marketplace and the Collaborative Care Model for behavioral health care described by The University of Washington on their AIM website: *(https://aims.uw.edu),* and the video, Daniel's Story that illustrates the model and the Primary Care First (PCF) alternative payment model options introduced by CMS in April 2019 *(https://innovations.cms.gov/initiatives/primary-care-first-model-options/)* are references. These models began further testing in some states in 2020. The American Academy of Family Physicians (AAFP) proposed one of the alternative payment models recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to CMS in December 2017. The AAFP's APM was compiled with others by CMS Innovations department to develop the PCF model options.

The supporting documentation and data presented by the AAFP for the APC–APM (Advanced Primary Care-Alternative Payment Model; *https://aafp.org*) provides background information to understand the benefits, logistics and necessity for alternative reimbursement systems for primary care. The Primary Care First models include principles of the Collaborative Care Model developed at The University of Washington, but it also depends on commercial insurance payer participation and the same burdens and inefficiencies of the current system. After more details of the options for participation in PCF were made available, concerns were noted by many involved in developing and endorsing the AAFP version (APC–APM) that the PCF APM does not include enough support for independent primary care practices. The set of practices and payers who committed to participate is available on *https://innovation.cms.gov/innovation-models/primary-care-first-model-options.* It appears that all regions where it was offered had practices that accepted participation except Montana and Alaska. Data from these trials were not yet available in early versions of this essay, but as referenced above, have now been reported in December 2022.

Again, action by CMS to develop and test these models has not proceeded at pace to balance the alacrity with which they allowed commercial insurers to raid Medicare or our weak anti-trust protections in healthcare allowed hospital corporations to consume practices and disconnect participants by centralizing services, routing communications through call centers, and stripping specialists from communities to be replaced by telehealth encounters. The pandemic finally forced CMS to accept telehealth encounters from the home location for reimbursement to primary care providers, but still contains many pitfalls, and, although Congress has protected that access, is still at risk of being rescinded. The largest pitfall is the requirement for a video portion when signal and comfort with use of electronic devices is lacking in many places. CMS has not provided an equal "playing field" in this market. EHR software vendors use this requirement to extract fees that are prohibitive for small practices. Still, the freedom in collaborative teams allows for physician autonomy and creative solutions, such as using a care navigator familiar with the patient as an AV tech when telehealth visits are necessary.

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Introduction

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to submit this written statement for today's hearing on consolidation and corporate ownership in health care. PCMA is the national association representing America's pharmacy benefit companies, which administer prescription drug plans and operate home delivery and specialty pharmacies for more than 275 million Americans with health coverage through public and private employers, labor unions, retiree plans, Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) program, and the exchanges established by the Affordable Care Act (ACA). Our members work closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes for patients.

Health plan sponsors hire PCMA's members primarily to secure savings and provide choice and specialized expertise on pharmacy benefit design, coverage, and delivery. PCMA's diverse membership works closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes. These savings allow employers and labor unions to keep offering quality drug benefits to their employees and retirees across America—ensuring that premiums are affordable, and patients have choices and access to pharmacies where they can get the drugs they need at a price they can afford.

Pharmacy benefit companies, also known as pharmacy benefit managers or PBMs, lower prescription drug costs for patients and a wide range of health plan sponsors—specifically by:

- Negotiating rebates from brand drug companies and discounts from pharmacies to reduce costs for patients, their families, and health plans—saving payers and patients an average of $1,040 per patient per year.[1]
- Encouraging the use of more affordable alternatives to brand drugs, such as generics and biosimilars.
- Offering services that benefit patients, such as home delivery, which saves patients time and money while increasing access and care coordination.
- Managing and helping patients access high-cost specialty medications.
- Reducing waste, preventing potentially harmful drug interactions, and improving adherence.
- Providing clinical support in the form of services to plan enrollees, internal clinical expertise to support business operations, and assembling clinical experts to evaluate drug therapies and make coverage recommendations to plan sponsors.

Pharmacy benefit companies support a competitive market for prescription drugs. In this statement we review the policies PCMA members support to encourage a competitive market for prescription drugs, as competition is the most effective way to drive down high drug prices. We also discuss ways pharmacy benefit companies work to generate value for the U.S. health care system.

As an industry, we welcome any opportunity to discuss and advance ways to improve the prescription drug marketplace so Americans can better afford their prescription drugs, and we believe any attempt at understanding the factors driving drug costs must include an examination of the entire supply chain, including drug companies, large pharmacy collectives known as Pharmacy Services Administrative Organizations (PSAOs), wholesale distributors, employer benefit consultants, pharmacies, and all others with impact on the cost of prescription drugs. For instance, there is irrefutable evidence of certain drug companies repeatedly abusing the patent system to keep more affordable alternatives from entering the marketplace, which allows those companies to arbitrarily set and increase prescription drug prices. We encourage the committee to review all these entities and potential anti-competitive practices as it assesses how to improve the prescription drug market.

Pharmacy Benefit Companies Support Policies to Encourage Competition as the Best Way to Lower Prescription Drug Costs

Pharmacy benefit companies encourage use of the most affordable drugs for patients by providing prescribers with information about less expensive generic alternatives, setting performance standards for pharmacies to encourage generic fills and adherence, and ensuring patients are aware of lower cost alternatives. Due in large part

[1] Visante. 2023. *https://www.pcmanet.org/wp-content/uploads/2023/01/The-Return-on-Investment-ROI-on-PBM-Services-January-2023.pdf.*

to these efforts by PBMs, 90 percent of prescriptions are filled with generics.[2] Pharmacy benefit companies also support increased uptake of biosimilars by preferring both the brand and a biosimilar to ensure patients and providers have the incentive to choose lower-cost options and the choice to continue with a drug from which they may be reluctant to switch.

Pharmacy benefit companies offer programs to keep out-of-pocket costs low and work with those providing insurance to encourage patients through formulary design and cost-sharing incentives to use the most affordable drugs, which are usually generics. Generic dispensing has grown over the past decade as more generics have entered the market and patients have responded to health plan designs encouraging their use.[3] PBMs also employ other tools designed to deliver high-quality drug benefits while bringing down costs.[4] For many brand drugs, PBMs negotiate directly with drug manufacturers who compete for formulary placement by offering a type of discount called rebates.[5] For drugs on a preferred tier of a plan's formulary (list of covered drugs), patients typically have lower-cost sharing.[6] As competing products enter the market, PBMs gain the flexibility to leverage competitor products to negotiate deeper drug discounts for patients and employers.[7]

To enhance competition and enable pharmacy benefit companies to further drive down drug costs, PCMA encourages policymakers to do the following:

1. **Ensure a competitive Medicare Part D prescription drug market.** Care should be taken to incentivize production of competing products and improve the functionality of the prescription drug market as the drug pricing provisions of the Inflation Reduction Act are implemented. Competition in Part D also includes that which occurs among pharmacies participating in preferred cost-sharing networks.
2. **Stop patent abuse.** Addressing drug companies' abuses of the patent system that allow them to block competition by extending monopoly pricing well beyond their products' original patent expirations would increase access to lower cost generics and go a long way toward reducing drug costs for patients and families.
3. **Reserve market exclusivities for true innovation.** Addressing overlong exclusivity periods for biologics and orphan indications will create more competition and lead to lower overall drug costs for patients.
4. **Ensure drugs can compete fairly.** Preventing practices like "shadow pricing" and abuses of the U.S. Food and Drug Administration's citizen petition process will improve the competitive market.
5. **Promote generic and biosimilar competition.** The most effective way to reduce prescription drug costs is to increase competition in the marketplace.

The PBM Market is Diverse and Competitive

Savings from pharmacy benefit companies benefit health plans, employers, retirees, and patients directly. Pharmacy benefit companies save health plans, including Part D plan sponsors and employers (and their enrollees), an average of $1,040 per person per year.[8] The PBM market is dynamic, diverse, and growing. In 2019, there were 66 full-service pharmacy benefit companies active in the market.[9] As of March 2023, there are 73 full-service pharmacy benefit companies in the U.S., with six new PBMs entering the market since 2021.[10] In addition to these full-service companies, there are many companies that provide narrower PBM services to customers, with some catering to specific sectors, such as workers' compensation.

Prior to the shift in focus of the Federal Trade Commission (FTC), which has recently moved away from consumer protection, the commission evaluated the PBM

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[2] AAM. 2021. *https://accessiblemeds.org/sites/default/files/2021-10/AAM-2021-US-Generic-Biosimilar-Medicines-Savings-Report-web.pdf.*

[3] FDA. 2021. *https://www.fda.gov/drugs/buying-using-medicine-safely/generic-drugs.*

[4] Pharmacy Benefit Management Institute (PBMI). 2020. *https://www.pcmanet.org/wp-content/uploads/2021/01/Solving-America%E2%80%99s-High-Drug-Cost-Problem_whitepaper_FINAL2.pdf.* PBMI. 2017. *www.pbmi.com/research.* PBMI. 2016. *www.pbmi.com/research.*

[5] Foley Hoag. 2019. *https://foleyhoag.com/publications/ebooks-and-white-papers/2019/march/the-history-of-rebates-in-the-drug-supply-chain.*

[6] CBO. 2020. *https://www.cbo.gov/system/files/2022-01/57050-Rx-Spending.pdf.*

[7] *Ibid.*

[8] Visante. 2023. *https://www.pcmanet.org/wp-content/uploads/2023/01/The-Return-on-Investment-ROI-on-PBM-Services-January-2023.pdf. https://www.pcmanet.org/wp-content/uploads/2023/01/The-Return-on-Investment-ROI-on-PBM-Services-January-2023.pdf.*

[9] PCMA. The PBM Marketplace is Highly Competitive. March 2019. *https://www.pcmanet.org/wp-content/uploads/2019/04/Competitive-PBM-Marketplace.pdf.*

[10] PCMA. 2023. *https://www.pcmanet.org/the-pbm-marketplace-is-more-competitive-not-less/.*

industry numerous times and found it to be appropriately competitive. In 2005, the commission issued a report showing that PBM ownership of pharmacies does not result in higher costs for consumers. The chair at the time noted, "Health insurers manage their drug costs by choosing among a variety of PBM services and service providers," and "Data in the report demonstrate that PBMs' use of owned mail-order pharmacies generally is cost-effective for plan sponsors."[11]

Additionally, in 2012, the FTC completed an investigation evaluating the potential impact of a proposed merger between two PBMs, Express Scripts and Medco. As a result, the commission observed that the "market for the provision of full-service PBM services to health care benefit plan sponsors is moderately concentrated and consists of at least 10 significant competitors," and further found that "competition for accounts is intense, has driven down prices, and has resulted in declining PBM profit margins—particularly in the large customer segment."[12] Over the 11 years since that investigation, the market for full-service PBMs has grown, with 73 full-service pharmacy benefit companies of varying sizes operating across the nation in a variety of markets in 2023.

Preserving the competitiveness of the PBM market is as important as ensuring competitiveness in all other aspects of the prescription drug supply and payment chain. Transparency that helps patients and payers is necessary across the entire supply chain. PBMs support and practice actionable transparency that empowers patients, their physicians and pharmacists, those sponsoring health coverage, and policymakers to make informed decisions that can lead to lower prescription drug costs. Thus, the PBM industry supported legislation enacted in 2018 to empower pharmacists to share information with patients about lower out-of-pocket cost alternatives.

Pharmacy benefit companies provide health plans, employer plan sponsors, and consumers with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. As part of their requests for proposals when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the transparency and information they want to receive, as well as their audit rights, and those terms are formalized in their contracts.

In recent years, Congress has added more requirements for PBMs to report to federal agencies, as well as public reporting in more aggregated form. In both cases, these laws included appropriate protections for confidential data to avoid encouraging tacit collusion, and PCMA supported that approach. We have also supported legislation that is now law, which provides congressional support agencies, including Congressional Budget Office (CBO), Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Medicaid and CHIP Payment and Access Commission (MACPAC), with access to Medicare and Medicaid claims-level data to ensure the committee is able to perform appropriate oversight.

As the Congress considers how best to preserve the competitiveness of the PBM market, we encourage consideration of the administrative burdens extensive, unharmonized, duplicative reporting requirements create for smaller PBMs. While larger PBMs may be able to adapt, smaller PBMs may find these new regulations overly burdensome or wholly unworkable, forcing them to either close their doors or consolidate; effectively reducing the competitive market for PBMs. It is also important to note that these added reporting burdens on top of the existing requirements could lead to higher costs for people taking prescription drugs.

In addition, while supporting PBM clients' right to request pricing information, we caution the committee against publicly reporting competitively sensitive pricing information such as manufacturer and pharmacy price concessions, which would lead to lower price concessions and higher costs through tacit collusion for both plan sponsors and patients. As the CBO cautioned in the early years of the Medicare prescription drug benefit:

> The disclosure of drug rebates could affect Medicare spending through two principal mechanisms. First, disclosure would probably make rebates less varied among purchasers, with large rebates and small rebates tending to converge toward some average rebate. Such compression, for reasons dis-

[11] FTC. 2005. *https://www.ftc.gov/news-events/news/press-releases/2005/09/ftc-issues-report-pbm-ownership-mail-order-pharmacies.*

[12] FTC. 2014. *https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-erisa-advisory-council-u.s.department-labor-regarding-pharmacy-benefit-manager-compensation-fee-disclosure/140819erisaadvisory.pdf.*

> cussed below, would tend to reduce the rebates that PDPs received and thus would raise Medicare costs. Second, for a range of medical conditions, drugs appropriate for treatment are available from only a few manufacturers; disclosure of drug-by drug rebate data in those cases would facilitate tacit collusion among those manufacturers, which would tend to raise drug prices.[13]

More recently, in February of this year, the U.S. Department of Justice Antitrust Division withdrew three outdated antitrust policy statements related to enforcement in health care markets. As Principal Deputy Assistant Attorney General Doha Mekki remarked:

> Courts have long recognized that the exchange of competitively-sensitive information can subvert the competitive process and harm competition. . . . The Second Circuit explained in Todd that "[p]rice exchanges that identify particular parties, transactions, and prices are seen as potentially anticompetitive because they may be used to police a secret or tacit conspiracy to stabilize prices. . . . Where competitors adopt the same pricing algorithms, our concern is only heightened. Several studies have shown that these algorithms can lead to tacit or express collusion in the marketplace, potentially resulting in higher prices, or at a minimum, a softening of competition."[14]

Indeed, there are numerous examples of tacit price collusion across multiple markets, from airline tickets and gasoline to credit card interchange fees, to cell phone text messaging and roaming rates, or real estate and travel agent commissions.[15]

Pharmacy Benefit Companies Support Plan Sponsors' Ability to Choose What Works for Them

Public and private health plan sponsors vary dramatically in size, resources, and function, serving diverse populations. No Medicare Part D plan sponsor, public or private employer, union, retiree health plan, pension fund, or other health plan is required to hire or use a pharmacy benefit company, but virtually all do, and the vast majority are pleased with the services their pharmacy benefit companies provide, with employers reporting about 80 percent satisfaction with the cost-saving, health-improving services provided by their PBM.[16] Each of those plan sponsors knows more about their financial resources and plan participants than any other entity, and they need the ability to design plans tailored to the unique needs of their participants. As health plan sponsors strive to create accessible, affordable benefits that meet the needs of the populations they cover, policymakers should avoid mandates that could increase costs and decrease quality.

Health plans choose their PBMs through a highly competitive bidding process. Some may base selection criteria on pharmacy benefit companies' scale, ability to negotiate deep discounts, or effectiveness managing the risk of price changes. Others may base selection criteria on pharmacy benefit companies' innovative care management programs or different levels of service. For small employers, many of whom may struggle to provide health insurance to employees, PBMs both lower their overall drug costs and provide cost predictability, enabling them to stretch their benefit dollars even further.

According to a GAO report from 2019, PBMs provided services through about 600 Part D plan contracts.[17] Working with PBMs, these contracts account for 801 standalone prescription drug plans (PDPs) for beneficiaries enrolled in original Medicare.[18] Beneficiaries with Medicare Advantage (MA) typically have their medical benefits and prescription drug benefits (MA–PDs) integrated into one of nearly 4,000 available plans.[19]

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[13] *https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/03-12-drug%20rebates.pdf.*

[14] DOJ. 2023. *https://www.justice.gov/opa/speech/principal-deputy-assistant-attorney-general-doha-mekki-antitrust-division-delivers-0.*

[15] University of San Francisco. 2010. *https://digital.sandiego.edu/cgi/viewcontent.cgi?article=2677&context=sdlr.*

[16] PSG. 2022. Customer Satisfaction Report. *https://www.psgconsults.com/research.*

[17] GAO. 2019. *https://www.gao.gov/assets/gao-19-498.pdf.*

[18] Kaiser Family Foundation. 2023. *https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/.*

[19] Kaiser Family Foundation. 2023. *https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look.*

Pharmacy Benefit Companies Support a Robust and Competitive Market for Pharmacies

The structure of a health plan's provider and participating pharmacy network is one of the most important elements of health benefit design. In working with their pharmacy benefit companies, plans exercise careful judgment to construct pharmacy networks that meet beneficiary needs, balancing breadth of coverage, access, quality, and cost-efficiency, often on a multi-jurisdictional basis.

There are many types of pharmacies—retail, specialty, hospital, clinic, home care, mail-order, compounding, and assisted living or long-term care—to name a few. These pharmacies offer different levels of expertise and services to ensure patients are getting what they need to secure the best health outcomes. In fact, there are more than 60,000 retail pharmacies in the United States, including 23,000 independent community pharmacies. Health plans with a variety of sites of care in their pharmacy networks promote access, affordability, and value. For example, the right mix of brick-and-mortar retail, mail, and specialty pharmacies improves adherence to therapy and patient safety.

Pharmacists are skilled health care practitioners who are often more convenient to access than doctors in a hospital, private practice, or other clinical setting. To better contain drug costs and improve access to quality patient care, pharmacy benefit companies support laws and regulations that allow pharmacists to "practice at the top of their license," based on their specific expertise. Pharmacy benefit companies continue to call on policymakers to enact legislation enabling pharmacists, where appropriate, to perform diagnostic testing, prescribe indicated medication, and administer vaccines to expand access to care. This includes support for endowing pharmacists with Medicare provider status and the ability to bill for certain services directly under Medicare Part B.

Pharmacies large and small are important partners in delivering care to patients, and where a patient acquires a drug can impact its cost significantly. Pharmacy benefit companies negotiate with pharmacies to establish networks that support consumer choice while offering high quality care at competitive prices. Most pharmacy networks provide patients with a variety of options allowing them to get the drugs they need where they need them. Policies that restrict pharmacy benefit companies' ability to develop such networks drive costs up, while well-managed networks offer savings to both plan sponsors and enrollees. For instance, some states have passed laws constraining pharmacy networks, to the detriment of employers, Medicare Part D, and union plan sponsors. Such regulation sometimes even seeks to intrude into Medicare Part D despite federal pre-emption, which should prohibit states from acting on exclusive areas of federal regulation. These pharmacy network restrictions could lead to a patchwork of inconsistent state laws, creating administrative burdens for plan sponsors offering benefits across state lines and boosting costs for employer and Part D sponsors, which can result in higher beneficiary cost-sharing and premiums.

The Medicare Program Ensures a Competitive and Robust Pharmacy Market with Beneficiary Protections

Medicare Part D plans must comply with rigorous pharmacy network adequacy standards to ensure broad beneficiary access. To meet these standards, Part D plans need a robust and competitive retail pharmacy industry. CMS requires that:

- In rural areas, at least 70 percent of beneficiaries live within 15 miles of a retail pharmacy participating in a plan sponsor's network;
- In suburban areas, at least 90 percent of beneficiaries live within 5 miles; and
- In urban areas, at least 90 percent of beneficiaries live within 2 miles.

Preferred Pharmacy Networks

Health plan sponsors may create specific networks of pharmacies to provide drugs to their enrollees at competitive prices. "Preferred cost sharing pharmacy networks" have proven very popular for Medicare Part D plan sponsors. Currently, 98 percent of Part D stand-alone plans (PDPs) and 52 percent of Medicare Advantage plans (MA–PDs) employ these networks.[20] Under these arrangements, enrollees who choose particular pharmacies pay lower cost-sharing for covered drugs. Pharmacies agree to participate and meet certain quality metrics because they are likely to see higher patient volumes. Beneficiaries picking up prescriptions in preferred pharmacies typically save $6 to $8 per prescription, with total plan savings of about 2

[20] Drug Channels. 2022. *https://www.drugchannels.net/2022/11/preferred-pharmacy-networks-in-2023s.html.*

percent.[21] Research looking at the implementation of preferred pharmacy networks from 2010–2016 found that non-LIS beneficiaries saved about $129 per year when using them.[22] CMS pays careful attention to these arrangements. The cost-sharing differences cannot be "so significant as to discourage enrollees in certain areas (rural areas or inner cities for example) from enrolling in that Part D plan—even if it otherwise meets the retail access standards." Generally, Part D plan pharmacy networks, including those with preferred cost-sharing pharmacies, are very broad and inclusive of nearly all pharmacies in their service area.

In the private market, nationally, 76 percent of employers report using a tailored pharmacy network, and their employees typically save about 38 percent out-of-pocket using in-network vs. out-of-network pharmacies.[23]

Mail-Service Pharmacy

Mail-service pharmacies employed by PBMs do not "crowd out" retail pharmacies. They do not count toward meeting Part D's retail pharmacy access requirements. In addition, to the extent that Part D plans offer mail-service pharmacy, they must also ensure enrollees have reasonable access to the same benefits at network retail pharmacies. In addition, "any increase in cost sharing must be limited to the 'differential in charge' to the plan in terms of any difference between higher contract rates at a network retail pharmacy as opposed to a network mail-order pharmacy for that benefit." "Enrollee cost-sharing for an extended-day supply at retail must never exceed what the enrollee would have paid at the same retail pharmacy had the enrollee had his or her prescription filled in multiple 1 month supply increments at retail pharmacy rates." Medicare also requires that availability of benefits at retail rather than mail-order pharmacies does not increase government costs.

Specialty Pharmacy

In general, there are few situations in Part D where a beneficiary can only get their prescribed medication from a specialty pharmacy. Part D sponsors may only restrict access to Part D drugs if (1) the FDA has restricted distribution to certain facilities or physicians; or (2) appropriate dispensing of the Part D drug requires extraordinary special handling, provider coordination, or patient education that cannot be met by a network pharmacy. In addition, specialty pharmacy designation cannot be based solely on the placement of a Part D drug in a specialty or high-cost tier. Finally, Part D sponsors may not require network pharmacies to qualify as specialty pharmacies if the network pharmacy is capable of appropriately dispensing the drug in question. These designations differ from the "specialty tier," which is a designation Part D plans can use in their benefit designs for certain drugs above a specified cost threshold.

"Any Willing Pharmacy" Requirements

Part D also has an "any willing pharmacy" requirement that permits participation in a Part D plan network by any pharmacy that is willing to accept the sponsor's standard contracting terms and conditions—which also must be "reasonable and relevant". Medicare Part D's preferred cost-sharing pharmacy networks, discussed above, have been instrumental in helping to keep Part D premiums low and pharmacy quality high. Watering down the payment terms and quality performance requirements in the standard terms that must be offered would dilute the incentives for pharmacies to sign on as preferred vendors. Beneficiary costs would rise, as would plan and government costs. We urge the committee to avoid expanding the "any willing pharmacy" requirements in such a way that would increase beneficiary cost sharing and premiums and reduce the quality of pharmacy care.

Understanding the Role of Wholesalers and PSAOs is Critical

As the committee considers the factors impacting the competitiveness of the drug supply chain, it is important to understand the role of PSAOs. PSAOs negotiate pharmacy network contracts with PBMs and perform fundamental back-office operations for the pharmacies they contract with, and the relationships between large wholesaler-owned PSAOs and independent pharmacies are complex and worthy of scrutiny.

The largest PSAOs are subsidiaries of the three largest wholesalers, which also typically operate the equivalent of networks of pharmacy franchises, providing branding, organization support, and back-office support. The significant role large whole-

[21] Starc and Swanson. 2021. *https://onepercentsteps.com/wp-content/uploads/brief-pppn-210208-1700.pdf.*
[22] Xu, Trish, and Joyce. 2022. *https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13973.*
[23] PBMI. 2020. "2019 Trends in Drug Benefit Design."

salers play in the prescription drug supply chain and the often-symbiotic relationship wholesalers have with independent pharmacies is just beginning to be explored and shining a light on this relationship is exposing potential areas of concern, underscoring the need for Congress to examine all players in the supply chain that have a direct impact on the price of prescription drugs. For example, the PSAO marketplace is dominated by the "Big Three" wholesalers, AmerisourceBergen, Cardinal Health, and McKesson. Unlike pharmacy benefit companies, PSAOs operate with no state or federal regulation or oversight, and according to PBM reporting data, demand higher rates for drug reimbursement for independent pharmacies than PBMs offer for non-independent retail and chain pharmacies.

Approximately 83 percent of independent pharmacies use PSAOs to negotiate favorable contracts with pharmacy benefit companies.[24] While some claim otherwise, the independent pharmacy market is stable and profitable. Data shows that over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5 percent.[25] Over the last 5 years, the number of independent pharmacies has increased 0.5 percent, indicating a stable marketplace. In fact, independent pharmacies' financials have also been stable. From 2016 to 2020, the average per prescription gross profit margin for independent pharmacies ranged from 20.8 percent to 21.1 percent, showing little fluctuation.[26]

Data from the lobby group for independent pharmacy, the National Community Pharmacists Association (NCPA), agrees that the independent pharmacy market is stable, growing 0.4 percent over the last year,[27] and it is the only sector of retail pharmacy that has experienced growth over the last 10 years. The same report finds that between 2020 and 2021, the average independent pharmacy location dispensed ten percent more prescriptions, gross profit margins increased to 23.3 percent, and average sales per location were up more than $570,000—in excess of $4 million. As noted, by leveraging the power of large pharmacy collectives to negotiate with pharmacy benefit companies on their behalf, independent pharmacies can secure favorable contract terms, and on average, higher reimbursements than chain drugstores.[28] PSAOs and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions' Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allows pharmacies to access their contracted pharmacy measures, track their own performance against those measures, and compare benchmark measures of their contracts across plans and against other pharmacies.

Conclusion

Pharmacy benefit companies exist to reduce drug costs for plan sponsors and, most importantly, for the patients our companies serve. In doing this work, pharmacy benefit companies generate tremendous value for society, estimated at $145 billion annually,[29] and, when taking Medicare savings into account as well as other programs and the commercial market, save payers and patients an average of $1,040 per person per year.[30] Much of this value is generated by the savings pharmacy benefit companies negotiate with pharmaceutical manufacturers and pharmacies. Pharmacy benefit companies also lower prescription drug costs by promoting the use of generic medications, encouraging better pharmacy quality, and offering things like home delivery of medications. Through their work, pharmacy benefit companies lower the cost of health coverage, reduce drug costs, and support better and more affordable prescription drug access for patients, which means more people can get on and stay on the medications they need. For many years, evidence has shown a

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[24] Health Evaluations. 2021. *https://www.pcmanet.org/wp-content/uploads/2021/01/PSAO-Report_Health-Evaluations.pdf.*

[25] PCMA. 2023. *https://www.pcmanet.org/the-independent-pharmacy-marketplace-is-stable-2023/.*

[26] Drug Channels. 2022. *https://www.drugchannels.net/2022/02/five-things-to-know-about-state-of.html.*

[27] NCPA. 2022. *https://ncpa.org/newsroom/news-releases/2022/10/02/ncpa-releases-2022-digest-report.*

[28] Health Evaluations. 2021. *https://www.pcmanet.org/wp-content/uploads/2021/01/PSAO-Report_Health-Evaluations.pdf. See also:* Milliman. 2020. *https://cdn.ymaws.com/www.floridapharmacy.org/resource/resmgr/docs_2021_legislative_session/milliman_report.pdf;* Ohio Medicaid. 2018. *https://www.gongwer-oh.com/public/130/pbmredacted.pdf;* Ohio Department of Medicaid. 2019. *https://medicaid.ohio.gov/wps/wcm/connect/gov/2ef5a8b4-0f15-4ef4-8883-11fd6238e101/ODM-HDS-Summary.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-2ef5a8b4-0f15-4ef4-8883-11fd6238e101-nAkMJJ4.*

[29] National Bureau of Economic Research. 2022. *https://www.nber.org/papers/w30231.*

[30] Visante. 2023. *https://www.pcmanet.org/wp-content/uploads/2023/01/Pharmacy-Benefit-Managers-PBMs-Generating-Savings-for-Plan-Sponsors-and-Consumers-January-2023.pdf.*

return of 10:1 on investments in pharmacy benefit company services for their private sector and government partners.[31] As a result, pharmacy benefit companies will lower the cost of health care by $1 trillion over the next 10 years.[32]

As we have indicated, PCMA welcomes the opportunity to further engage with the committee and looks forward to working collaboratively with Congress and other stakeholders to build on the existing private market framework to address prescription drug affordability challenges and improve functionality for patients.

UNITED STATES OF CARE

Chairman Wyden and Ranking Member Crapo,

On behalf of United States of Care (USofCare), thank you for holding the June 8th hearing on Hospital Consolidation and Corporate Ownership in Health Care to understand the trends in our health care system that are leading to higher costs for patients without creating a corresponding increase in value or quality of care.

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges—solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels.

Research Reveals How the Hospital Pricing Crisis Affects Everyday People

To build toward a more equitable health care system, we must first learn how people understand and experience inequities in the health care system. From our unique people-centered listening and research, we know that, across demographics, people are concerned about their ability to afford the care they need. **In fact, USofCare's listening research reveals that affordability is people's foremost concern with the health care system, and 87% of people support eliminating out-of-pocket costs for receiving basic treatment and services for health care needs.**[1]

People feel the pinch of skyrocketing health care prices, and part of our organization's charge is to understand what the drivers of those prices are and advocate for durable, common sense policies that bring pricing into alignment with peoples' needs. Financial incentives in the current health care system have incentivized hospitals to amass market power through consolidation, resulting in highly concentrated markets that hike up prices for consumers—and, indirectly, for everyone—through higher insurance premiums.[2] Even people who are financially secure worry they will not be able to afford the care they need in the future. As we conduct our policy work on behalf of everyday people, USofCare is concerned about the growing body of research over the last three decades that reinforces how market trends in the hospital sector are the primary driver of increased health prices.

Facility Fees are a Standard Practice in Hospital Billing, But They Shouldn't Be

Consolidation and concentration of hospital systems across the country have resulted in market distortions that put undue financial burden on people seeking care with no meaningful improvement in quality. For example, one study showed that when hospitals acquire doctor's offices, it leads to an average price increase of 14% for the same service.[3] As you are aware, hospitals are charging privately-insured pa-

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[31] Visante. 2023. *https://www.pcmanet.org/wp-content/uploads/2023/01/The-Return-on-Investment-ROI-on-PBM-Services-January-2023.pdf.*

[32] Visante. 2023. *https://www.pcmanet.org/wp-content/uploads/2023/01/The-Return-on-Investment-ROI-on-PBM-Services-January-2023.pdf.*

[1] United States of Care, United Solutions for Care: Affordability Overview. May 2022. *https://unitedstatesofcare.org/wp-content/uploads/2022/05/USOC_PolicyAgenda_Affordability_v3.pdf.*

[2] Schwartz, Karyn, et al. What We Know About Provider Consolidation, KFF, 2 September 2020. *https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.*

[3] Avalere-PAI Physician Employment Trends Study, National and Regional Physician Employment Changes, 2012–2018. February 2019. *https://www.physiciansadvocacyinstitute.org/Por-*

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tients exorbitant amounts compared to Medicare. Due in large part to hospital market power, employers and private insurers paid 224% more than what Medicare would have paid for the same hospital inpatient and outpatient services in 2020 alone.[4]

These price increases are the result of hospital market power and give license for health systems to tack on hidden "facility fees" at newly-acquired off-campus outpatient locations, making health care unaffordable for many people and families. Often these fees come as a surprise to patients, are not covered by insurance, and even billed to patients who seek care in-network to minimize out-of-pocket costs.

Market incentives are pushing hospitals to engage in practices that yield higher profits for the hospital through higher costs for the consumer. This imbalance between profit incentives and patient value builds distrust in the health care system. USofCare knows from our facility fee reform advocacy work in Colorado and Maine that states are leading the way with solutions that effectively address increasing prices through transparency and reigning in unfair billing practices. Congress can learn from newly-passed state policies in states to limit facility fees that hospitals can charge patients.

State Momentum Proves Facility Fee Legislation is a Popular, Sorely-Needed Reform

Momentum is growing across state legislatures to reign in these surprise costs. Connecticut[5] has led the way in banning facility fees for telehealth services and many outpatient office visits, and requires hospitals to notify patients of any allowable fees prior to point of service. In December 2022, New York[6] became the first state to ban facility fees specifically for preventive care, while Indiana[7] passed a sweeping ban on facility fees in May 2023 that limits what billing forms providers and institutions can use. Legislation to establish patient notification requirements and limit facility fees for preventive services in Colorado[8] was recently signed into law, and bills have progressed in Massachusetts,[9] North Carolina,[10] and Texas.[11]

State legislatures are making meaningful progress towards limiting facility fees by passing legislation that eliminates these fees or addresses some of the root causes of the market consolidation driving up health care costs. Voters see that the current health care system is incentivizing increasingly higher prices and there is broad bipartisan support among voters for policy intervention. Recent polling demonstrates that voters support policies that states have taken to reduce hospital costs and are more concerned that Congress won't take enough action to limit hospital prices, not that they will go too far. The most widely supported proposals among voters include: requiring hospitals to publicly disclose their prices (87%), limiting outpatient fees to the same price charged by doctors in the community (85%), and preventing hospitals from engaging in business tactics that reduce competition (75%).[12] States' success at passing broadly supported legislation to limit facility fees is proof of one area where Congress can find a bipartisan solution that corrects this pervasive market distortion.

- **Colorado's Facility Fee Legislation Includes a Notification Requirement** Colorado ranks tenth highest[13] in the nation in terms of patients' out-of-pocket hospital costs. Unexpected medical bills to cover "facility fees" have further in-

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tals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117.

[4] Whaley, Christopher et al., Report: Prices Paid to Hospitals by Private Health Plans. RAND Corporation. July 2022. *https://www.rand.org/pubs/research_reports/RRA1144-1.html.*

[5] "SB663/Public Act No. 21–129." State of Connecticut. 2021. *https://www.cga.ct.gov/2021/ACT/PA/PDF/2021PA-00129-R00SB-00683-PA.PDF.*

[6] "S2521C/A3470". State of New York. 2021. *https://www.nysenate.gov/legislation/bills/2021/S2521.*

[7] "HB1004". State of Indiana. 2023. *https://iga.in.gov/legislative/2023/bills/house/1004.*

[8] "HB23–1215". State of Colorado. 2023. *https://leg.colorado.gov/bills/hb23-1215.*

[9] "H1187." State of Maine. 2023. *https://malegislature.gov/Bills/193/H1187/BillHistory.*

[10] "SB321/H367". State of North Carolina. 2023. *https://www.ncleg.gov/BillLookup/2023/S321.*

[11] "HB1692/SB1275." State of Texas. 2023. *https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB1692.*

[12] New Poll: Majority of Voters Support Aggressive Congressional Action to Lower Hospital Prices. Arnold Ventures. March 2023. *https://www.arnoldventures.org/stories/new-poll-majority-of-voters-support-aggressive-congressional-action-to-lower-hospital-prices.*

[13] Colorado Department of Health Care Policy and Financing. "Hospital Insights Report 2022." *HCPF,* 5 March 2022. *https://hcpf.colorado.gov/sites/hcpf/files/HospitalInsightsReport-032822.pdf.*

creased these costs, forcing some people to delay or forego medical care entirely. What's more, these fees don't guarantee any additional quality of care compared to identical services offered at an independent clinic with no facility fees. USofCare testified [14] in support of HB23–1215,[15] which was signed into law by Colorado Lieutenant Governor Dianne Primavera on May 30, 2023. The law will require health care providers to notify patients when they charge a facility fee at the time the appointment is made, prohibits providers from collecting facility fees from patients seeking preventive services, and creates a steering committee to study the impact of facility fees on patients and the Colorado health care system. The results of the study are due by October 2024.

- **Maine as a Case Study: Rural States Where Consolidation Allows Facility Fees to Take Hold**
  More than one third [16] of Mainers have reported delaying medical care due to the cost of health care, which remains some of the most expensive [17] in the country. One of the main drivers of increasing health care costs can be traced to health care consolidation [18] in Maine and nationwide, which has led to less competition and higher prices for patients, usually with no corresponding increase in quality of care. In Maine, patients have reported [19] seeking critical low-cost care that became unaffordable with the inclusion of hundreds of dollars in unexpected facility fees. USofCare submitted testimony [20] in support of LD 1795,[21] common sense legislation that would establish reasonable limits on facility fees charged to patients by hospitals and health systems. An amended version of this legislation would authorize a taskforce to collect data and make recommendations to understand how to limit facility fees and make billing more transparent for Mainers. This is an important step towards understanding how pervasive facility fees are across Maine's hospital system. Limits on facility fees lower people's out-of-pocket costs, while also serving as a tool to disincentivize hospital acquisitions of outpatient facilities that do little to improve families' access to care.

Congress Can Secure Lower Hospital Prices through Federal Reforms on Site Neutrality

USofCare is an instrumental partner to many state advocacy organizations pushing health care reforms that deliver affordable, dependable, and quality health coverage for people. Through our state advocacy, USofCare sees states passing innovative policy solutions to effectively address increasing hospital prices through transparency and reigning in unfair billing practices. We are excited to have recently endorsed the SITE Act and see it as a federal extension of our state policy advocacy, building on the success that several states have recently taken up to address rising hospital prices and a necessary realignment of economic incentives that stops placing an undue cost burden on people.

Provisions within the SITE Act make meaningful reforms that will lower costs for people through preventing off-campus emergency departments from charging higher rates than on-campus emergency departments when standalone emergency facilities are located in close proximity to a hospital campus including the parent hospital of

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[14] United States of Care. Colorado House Health and Insurance Committee: 3/24/23 Public Hearing and United States of Care's Support." United States of Care, 24 March 2023. *https://unitedstatesofcare.org/wp-content/uploads/2023/03/CO-Facility-Fees-Testimony-website.pdf.*

[15] "HB23–1215". State of Colorado. 2023. *https://leg.colorado.gov/bills/hb23-1215.*

[16] "Maine Residents Struggle to Afford High Healthcare Costs; COVID Fears Add to Support for a Range of Government Solutions Across Party Lines. *Healthcare Value Hub,* January 2022. *https://www.healthcarevaluehub.org/advocate-resources/publications/maine-residents-struggle-afford-high-healthcare-costs-covid-fears-add-support-range-government-solutions-across-party-lines.*

[17] Masterson, Les. "Most and Least Expensive States for Health Care, Ranked." Forbes, 8 November 2022. *https://www.forbes.com/advisor/health-insurance/most-and-least-expensive-states-for-health-care-ranked/.*

[18] Medicare Payment Advisory Commission. "Report to Congress: Medicare Payment Policy." MedPAC, 13 March 2020. *https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf.*

[19] Lawlor, Joe. "Hidden charges, denied claims: Medical bills leave patients confused, frustrated, helpless." *The Portland Press Herald,* 21 August 2022. *https://www.pressherald.com/2022/08/21/hidden-charges-denied-claims-medical-bills-leave-patients-confused-frustrated-helpless.*

[20] United States of Care." Public Hearing and United States of Care's Support for LD 1795, 9 May 2023. *https://unitedstatesofcare.org/wp-content/uploads/2023/05/USofCare-Maine-Testimony-LD1795-facility-fees-FINAL.pdf.*

[21] "LD1795." State of Maine. 2023. *https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0720&item=1&snum=131.*

such emergency department. This will directly address the consolidation of hospitals through mergers and acquisitions of competing entities to justify the addition of surprise fees like facility fees.

As you know, Indiana now has a law that prohibits the practice of using facility fees in a manner that is similar to the SITE Act. Connecticut passed a law in 2021 prohibiting facility fees for most services provided outside of the hospital.[22] Last month, Colorado passed a bill limiting these hidden costs for preventive services.[23] States are tackling this issue,[24] and with the introduction of the SITE Act, Congress is poised to scale up the impact state reforms have on people by driving change in how hospitals do business nationwide. We hope to see the Committee work to pass the SITE Act to ensure that health care is affordable for people.

In Addition to the SITE Act, Congress can Go Further to Reign in Hospital Prices

Federal legislation can go further to limit facility fees, and we know that people support strong action to reign in these out of control prices. According to a 2023 survey, 89% of voters say it is important for Congress to take action to reduce hospital prices; 60% say it is very important.[25] Given the market incentives that exist for the hospital sector today, policymakers must intervene at the federal and state levels to reform the hospital and provider reimbursement system to align fair pricing for people seeking medical services, regardless of where those services are provided. Federal policy solutions ought to ensure that people are insulated from exorbitant costs and aim for transparency in pricing and costs of hospital prices. Policies must also require compliance across all provider types through enforcement -some states do this through prohibiting collections process for patient medical debt for providers not in compliance with facility fee disclosure notices.

- **Price transparency policies must include patient notification of facility fees** so that upon booking an appointment with a provider, patients are made aware of additional fees not related to a medical service. In January 2021, the Hospital Price Transparency Rule went into effect, requiring hospitals in the United States to make publicly available the price for items and services they charge. As hospitals comply with the 2021 Hospital Price Transparency Rule, facility fees should be included and clearly defined in the total price estimate as being a facility fee.[26] The lack of transparent information on prices makes it challenging for consumers to shop for services and limits competition. Maryland[27] has enacted Facility Fee Right-to-Know Act, also known as Facility Fee Disclosure, effective July 1, 2021, requires hospitals to provide certain formal notifications and disclosures to patients, both oral and written, related to hospital outpatient clinic charges or facility fees. A transparency provision would require that those providers notify patients that they charge the fee and include it on an itemized bill.
- **Price transparency policies must prevent providers from adding facility fees to telehealth services.** Since January 2021, the federal No Surprises Act has protected patients from unexpected medical bills. However, patients are unexpectedly seeing facility fees included in their telehealth visits. One Colorado family[28] shared how in 2021, they attended a telehealth appointment for which they received a $700 medical bill and an additional nearly $850 bill for the facility fee. States like Colorado have discussed policy solutions to prohibit facility fees for primary care visits, telehealth appointments, and preventive

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[22] Connecticut Law: Chapter 368v-HealthCareInstitutions. August 2021. *https://www.cga.ct.gov/current/pub/chap_368v.htm#sec_19a-508c.*

[23] Colorado Law: Signed, HB 23–1215. May 2023. *https://leg.colorado.gov/sites/default/files/2023a_1215_signed.pdf.*

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care services that are exempted from cost sharing. Connecticut has gone the furthest, banning facility fees for basic off-campus doctor visits and for telehealth appointments through June 2024.

- **Price transparency policies must enforce hospital facility fee disclosure.** Medical debt is the most aggressively collected form of consumer debt in the United States; Americans face an estimated $81 billion to $140 billion [29] in medical debt. More than 100 million adults have medical or dental bills they are paying off over time or that are past due and nearly three in four adults with past-due medical debt (72.9%) reported owing at least some of that debt to hospitals.[30] Hospital consolidation and unexpected fees are undoubtedly driving up hospital prices and costs for patients. Hospitals must face consequences for not limiting facility fees in line with federal legislation. Pending legislation in Texas [31] would allow the state to audit a provider for compliance and establish penalties for noncompliance. As Congress passes legislation to limit facility fees, there must be a strong enforcement of regulations such as by preventing non-compliant hospitals from processing outstanding medical debt.

Conclusion

Addressing the underlying forces that drive up prices for people is key to delivering a more affordable health care system. Over the last three decades, people have navigated an increasingly complex and costly health care landscape, punctuated by large industry players from across the sector consolidating with one another to generate market share and power.[32] While these mergers aspired to create greater care coordination, efficiencies, and economies of scale, the end result is a lack of competition, which people experience in the form of increased hospital prices and decreased access to services without a clear improvement in quality of care. States have demonstrated effective strategies and policies to advance legislation to enact site-neutral payment reform and limit facility fees.

USofCare will continue to work with state partners to advance policy that promotes affordable health care for people, and we stand ready to engage with Congress as it navigates these policy solutions for federal uptake. It is critical that Congress advance policy solutions that meaningfully deliver on affordable health care for people.

Please contact Lezah Calvin, Senior Manager of Federal Affairs, at LCalvin@usofcare.org for further information and to let us know how we can best be of service to you.

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