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ANTITRUST APPLIED: HOSPITAL CONSOLIDATION CONCERNS AND SOLUTIONS

HEARING BEFORE THE SUBCOMMITTEE ON COMPETITION POLICY, ANTITRUST AND CONSUMER RIGHTS OF THE COMMITTEE ON THE JUDICIARY UNITED STATES SENATE ONE HUNDRED SEVENTEENTH CONGRESS

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WEDNESDAY, MAY 19, 2021

UNITED STATES SENATE.
SUBCOMMITTEE ON COMPETITION POLICY, ANTITRUST,
AND CONSUMER RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 2:34 p.m., in Room 226, Dirksen Senate Office Building, Hon. Amy Klobuchar, Chair of the Subcommittee, presiding.

Present: Senators Klobuchar [presiding], Blumenthal, Lee, Hawley, Blackburn, and Grassley.

Also present: Senators Durbin and Grassley.

OPENING STATEMENT OF HON. AMY KLOBUCHAR, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Chair KLOBUCHAR. All right. Thank you very much for being here for this important hearing. I thank Senator Lee, especially, and his staff, for helping us to plan and spearhead this hearing. Today we're going to be focusing—and I also thank Senator Durbin, the Chairman, for being here already. It couldn't be a more important and timely topic. Today we're going to focus on the impact of hospital consolidation on patients' healthcare costs, healthcare workers, and healthcare innovation.

All Americans deserve access to quality, affordable healthcare, and we know there is a lot of work to make that a reality. We can lower cost to consumers by addressing skyrocketing prescription drug prices. To bring down those prices, I have introduced bipartisan legislation to expand access to cost-saving generic drugs, deter pharmaceutical companies—it's a bill that Senator Grassley and I have—from blocking cheaper generic alternatives, and I know Senator Lee has actually done work on this as well with the CREATES Act. Also allowing personal importation of more affordable drugs from Canada. I believe we also should allow Medicare to negotiate for the best possible price for prescription drugs.

Healthcare is a personal matter for everyone, and that's why we need to look at hospital competition and consolidation. Hospitals are a growing area of cost in our healthcare system. It's about \$1 of every \$3 we spend on healthcare in this country. The expenditures for hospitals hit \$1.2 trillion in 2019, and that figure is growing fast, up by more than 6 percent compared to the year before. We can't address a challenge of healthcare costs in this country

without also including hospitals in the conversation. That's why we're here today.

The rise in concentration in the American economy goes across industries, from cat food to caskets, and hospitals are no exception. We have had about 1,600 hospital mergers in this country in the last 20 years. Ninety percent of all metropolitan areas have highly concentrated hospital markets. We've also seen hospitals buying physician practices at a fast pace, and now about one-third of all doctors work for a hospital. Many hospitals actually charge more for doctor services when they can say they own the doctors' practices. That results, of course, in higher cost.

Hospital mergers can reduce choices for patients about where to receive the care as emerging hospitals align with one powerful insurer or another. That can suddenly leave those who have developed meaningful relationships with their doctors to fend for themselves. When someone is sick, one of the last things they want to hear is that their hospital has been bought and they no longer have access to the doctors they trust who have been treating them for years.

These are real human costs, and we need to talk about how they relate to hospital consolidation and market power. Especially if you have more and more doctors working for the hospitals, you could see that happening more easily.

I am particularly grateful to have Beth McCracken with us as a witness today. Beth is a cancer patient from Pennsylvania who lost access to her doctors in the aftermath of a turf dispute involving a hospital acquisition causing her and her family incredible stress during a difficult time and quite possibly delaying her diagnosis until her cancer had progressed. Beth, we look forward to hearing from you remotely, and thank you for being with us today and giving patients a voice in this important conversation.

Financial costs are important as well, but it is the human cost that I feel particularly strongly about—that with the antitrust and competition policy problems associated with hospital mergers. We know there can be advantages to hospitals merging, like the possibility of reducing overhead cost. The research does show, however, that hospital mergers can result in higher prices.

A 2018 study found that hospital prices are 12 percent higher in monopoly markets compared to those with four or more competing hospitals. Mergers of hospitals in the same market raised prices by an average of 6 percent. Hospital mergers can also reduce incentives to innovate in the way that they deliver care as Dr. Miller will explain in his testimony.

Hospital systems are major employers in many communities. Sometimes they are the largest employer. The Bureau of Labor Statistics estimates that over 5 million Americans work in hospitals. We must also consider the effects of hospital consolidation on healthcare workers. A recent economic study found that for the mergers that increased hospital concentration the most, wages for nursing and pharmacy workers were 6.8 percent lower than they would have been absent the merger.

As in other markets, consolidation can drive a vicious cycle. Insurers merge, resulting in bargaining power against hospitals. That pressures the hospitals to merge too so they can combat the power

of insurers. It repeats and repeats. A vicious cycle. It's a cycle of consolidation, and we see it throughout the economy as one side tries to accumulate power through mergers only to be thwarted by the response of its trading partners to merge as well. In any case, we must make sure, first of all, that our Federal agencies have the resources to investigate these types of cases.

I'm very pleased, and I want to thank Senator Durbin that the bill Senator Grassley and I have, to change the merger fee structure, passed on a voice vote out of the Senate Judiciary Committee just last week. It will give our agencies, the Department of Justice to Antitrust, as well as FTC, additional resources that they need while taking on Facebook and Google, the biggest companies the world has ever known, trillion and trillion dollar companies, that can't then also look at important topics like healthcare consolidation or online travel or pharmaceuticals or so many other areas.

We also need to reform our antitrust laws. When mergers are anticompetitive, they must be stopped. That's why I have proposed legislation to reform merger law and make it easier to stop anticompetitive merger before their effects hurt consumers in the form of higher costs or lower quality care. We also have to be able to look backward. We can do that now. That's what the breakup of AT&T was about. However, we can make it easier to look backward by giving our agencies the tools they need to do it. That's also part of my bill that is industry wide.

We now are going to explore these issues in the hearing. I want to thank our witnesses, but first I'd like to turn it over to Senator Lee for his opening remarks. Senator Lee.

**OPENING STATEMENT OF HON. MICHAEL S. LEE,
A U.S. SENATOR FROM THE STATE OF UTAH**

Senator LEE. Thank you, Madam Chair. Today's discussion is really important. While there are certainly differing views on how these things play out and drastically different views on the state of competition in hospital markets, there are a couple of observations that I think are more or less universally shared. First, recent decades have witnessed a massive number of hospital mergers, and second, that almost every hospital market is now moderately to highly concentrated.

Concentration doesn't always lead to higher prices and lower quality, but it can and it frequently has in hospital markets. Multiple studies have identified case after case of direct competitors merging, and then after merging, raising prices for patients and for insurers, many times with no accompanying improvement in quality of care or in patient outcomes.

The same dynamic often plays out when a hospital buys a physician group, another practice that has become increasingly common. Vertical integration is ordinarily expected to result in some efficiencies and quality improvements that can benefit consumers, but when hospitals buy physician practices, we often simply see price increases.

For students of basic economics much of this is unsurprising, but it is compounded by the particularly vulnerable position in which most consumers in these markets often find themselves. There are patients facing life-threatening injuries and illnesses. For some of

them, their course of treatment will reshape their health and finances, sometimes for the rest of their lives and amidst these challenges, we absurdly expect them to behave as rational consumers, comparing the options in the market, that is, when they're fortunate enough to have any options, and then attempting to make life or death decisions, sometimes with minimal information. For all these reasons, it's absolutely crucial that policymakers understand how we can improve competition in hospital markets.

Antitrust enforcement is one obvious and certainly important tool. Consumers rely heavily on State and Federal competition authorities to protect hospital markets from anticompetitive mergers and anticompetitive conduct, but antitrust enforcement is only a remedial tool.

How can we address the drive to consolidate in the first place? Those of us in Congress need not look terribly far in order to provide some answers to that question. You know, we—we understand that the largest drivers of hospital consolidation often come from Government interventions in healthcare, including many interventions cooked up within these very halls.

At times, Medicare reimbursement rules make the same medical service more profitable for hospital-owned physician practices than for independent physicians, incentivizing hospitals to acquire physician practices and for the physicians themselves to sell out. Stark Laws and related CMS rules, limiting physician self-referrals intended to prevent overutilization and to prevent excessive billing, have also pushed hospitals and physician practices in many, many instances to merge.

Then, let's not forget Obamacare. The very premise behind accountable care organizations is the notion that bigger is better, that vertical integration will allow healthcare providers to achieve better coordination of care for patients. Yet we've gotten—what we've obtained, what we've actually seen as an outcome, often has been the additional consolidation and higher prices without corresponding improvements to quality. Obamacare also functionally banned the creation or expansion of physician-owned practices—or of physician-owned hospitals rather—depriving hospital markets of competition from physicians attempting to improve the care that they offer and also to lower prices.

Things are not necessarily better at the State level. Occupational licensing, something that I've been passionate about for years, continues to harm competition. When market incumbents collude to exclude new competition, under the pretense of State action, everyone loses. I hope Congress can fix the problem by passing the Restoring Board Immunity Act.

In addition, Certificate of Need laws in many States prevent the entry of new hospital competitors or expansion of existing facilities. In some States, permission to open a new hospital is subject to approval by market incumbents themselves and this kind of dynamic produces predictable results, predictable results that are not good and that do not favor the consumer, but rather favor, quite predictably, market incumbents.

The theme here is perverse and it's disheartening. Government steps in to restructure the healthcare market, pushing market participants to consolidate in the process, and then shows up to punish

them for trying to consolidate. It's bad for patients, it's bad for providers, and it's bad for hospitals. It also means just as higher healthcare costs are passed on to insurers and employers and then ripple across the rest of the economy, that antitrust enforcement resources dedicated to these problems aren't available to address competition concerns throughout the rest of the economy.

Again, to make this perfectly clear, Congress is appropriating taxpayer money for antitrust enforcement, that is then being syphoned off to fix competition problems of Congress's own making. This is something we've got to grapple with. We can't ignore this problem. I hope today's hearing will help to shed light on these problems so that Congress, patients, providers, regulators, and antitrust enforcers alike can all work together to improve competition in hospital markets. I look forward to hearing from each of our witnesses on how best to accomplish that shared goal. Thank you, Madam Chair.

Chair KLOBUCHAR. Very good. I'm going to introduce the witnesses and then swear them in. We begin with Martin Gaynor. He is an economics professor at Carnegie Mellon University, former Director of the Bureau of Economics at the FTC. His research focuses on competition and incentives in healthcare and on antitrust policy. He's also a founder of the Healthcare Cost Initiative, an independent, nonpartisan nonprofit devoted to advancing knowledge about U.S. healthcare spending.

Ms. Beth McCracken is a patient who lives in Pittsburgh, Pennsylvania, and she will testify about her experiences when hospitals and insurers limited access to her doctors.

Michael Cannon, director of health policy studies at the Cato Institute. Previously, he served as a domestic policy analyst for the U.S. Senate Republican Policy Committee. He is a member of the Board of Advisors at Harvard Health Policy Review.

Mr. Rodney Hochman is the president and CEO of Providence St. Joseph Health, a company with 51 hospitals and nearly 1,000 clinics in Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. He's also chair of the American Hospital Association.

Ahmer Qadeer is the director of strategic initiatives for the Service Employees International Union.

Mr. Brian Miller is an internist and health policy expert and an assistant professor at the Johns Hopkins School of Medicine. He previously served as a special advisor to the FTC's Office of Policy Planning, assisting in merger review and enforcement in the healthcare center—sector.

If you could stand, including our witnesses remotely.

[Witnesses are sworn in.]

Chair KLOBUCHAR. Thank you. All right. Why don't we get started? We'll first start with Dr. Martin Gaynor.

**STATEMENT OF PROFESSOR MARTIN GAYNOR,
E.J. BARONE UNIVERSITY PROFESSOR
OF ECONOMICS AND PUBLIC POLICY, CARNEGIE
MELLON UNIVERSITY, PITTSBURGH, PENNSYLVANIA**

Professor GAYNOR. Thank you. Chair Klobuchar, Ranking Member Lee, and Members of the Subcommittee, thank you for holding

a hearing on this vitally important topic and for giving me the opportunity to testify in front of you today.

I'm an economist who has been studying the healthcare sector, and specifically healthcare markets and competition, for nearly 40 years. I'm a professor of economics and public policy at the Heinz College of Public Policy at Carnegie Mellon University. I served as the Director of the Bureau of Economics at the Federal Trade Commission during 2013, 2014, during which time I was involved in the many healthcare matters that came before the commission.

Over the next few minutes, I will briefly summarize for the Committee the basic facts about healthcare markets, the considerable research evidence on competition in healthcare, and my views on steps that can be taken to help make these markets work for the benefit of consumers.

Healthcare is a very large and very important sector of our economy. Not only is the healthcare sector nearly one-fifth of the economy and larger than the entire economy of France, but it has a critical impact on our health and well-being. Hospitals are the largest part of the sector and at over \$1 trillion one of the largest industries in the entire U.S. economy.

Our healthcare system is based on markets, so the system will work only as well as these markets that underpin it. Unfortunately, these markets do not function as well as they could or should. Prices are high and rising. There are egregious pricing practices, quality is suboptimal, and the sector is sluggish and unresponsive in contrast to the innovation and dynamism which characterize much of the rest of our economy. Lack of competition has a lot to do with these problems.

There's been a great deal of consolidation in healthcare. There have been nearly 1,600 hospital mergers over the past 20 years. The result is a majority of local areas are now dominated by one large, powerful health system, for example Partners in Boston, UPMC in Pittsburgh, and Sutter in the San Francisco Bay Area. Moreover, there have been tens of thousands of physician practice acquisitions by hospitals, resulting in over one-third of physicians now working in hospital-owned practices.

This massive consolidation in healthcare has not delivered for Americans. It has not given us better care or enhanced efficiency. It has not given us greater responsiveness or better service. On the contrary, extensive research evidence shows that consolidation between close competitors results in higher prices and patient quality of care suffers from lack of competition, including a substantially increased risk of death.

Hospital mergers can also harm competition in labor markets. This can depress wages, distort hiring decisions, and harm incentives for investment in human capital. Recent evidence shows impacts of hospital mergers that are consistent with these concerns. There are also concerns about anticompetitive conduct. Firms who have acquired market power want to keep it, since dominant health systems use restrictive contracts with insurers to try to hamper the free flow of patients to competitors, thereby harming competition and enhancing their market power.

There are also extensive reports of health systems engaging in data blocking, impeding the flow of patient information providers

outside the system. This has the potential to harm competition by making it more difficult for patients to switch providers. That most hospital markets are dominated by one large health system, there is considerable potential for this kind of conduct to seriously harming competition. All of this is causing serious harm to patients and to the healthcare system as a whole.

Policies are needed to support and promote competition in healthcare markets. These include ending or reforming policies that unintentionally incentivize consolidation, ending or reforming policies that hamper new competitors and impede competition, focusing and strengthening antitrust enforcement. In particular, give the DOJ and FTC the resources they need so they can not only do more enforcement in existing areas, but can proactively invest to address new and developing issues. Kudos for passing a bill that does exactly that.

In addition, permit the FTC to enforce against anticompetitive conduct by not-for-profits, require simple reporting of small transactions that fall below the Hart-Scott-Rodino reporting requirements, so that the enforcement agencies can track physician practice mergers and hospital acquisitions of physician practices. Adopt legislation to strengthen antitrust enforcement as, for example, in the Competition and Antitrust Law Enforcement Reform Act of 2021, introduced by Senator Klobuchar.

Have the FTC and DOJ issue revised guidelines for antitrust enforcement in healthcare. The guidelines were last issued in 1996. A lot has changed since that time and a refreshed and revived set of healthcare guidelines will provide important guidance to market participants and courts.

Last, establish a national healthcare data base; that's comprehensive publicly available data on U.S. healthcare spending, utilization, prices, and ownership. This is a critical investment in our national infrastructure that will make vitally important information available to businesses, Government, and citizens. Thank you.

[The prepared statement of Professor Gaynor appears as a submission for the record.]

Chair KLOBUCHAR. Thank you very much and right on time. Next up we have Beth McCracken, patient. Beth.

**STATEMENT OF BETH McCRACKEN,
PATIENT, PITTSBURGH, PENNSYLVANIA**

Ms. McCRACKEN. Giving me the opportunity to share this—my story. In western Pennsylvania we have two major health insurance companies, Highmark and UPMC. In the 1990s, a decade before Obamacare, UPMC began buying hospitals and doctors' practices in the region, creating an integrated system whereby they were both the insurer and the provider. Among the hospitals they acquired were the Eye & Ear Hospital of Pittsburgh and the Hillman Cancer Center.

By 2012, UPMC owned tax-exempt real estate in Allegheny County worth \$1.6 billion. As a public charity, it avoided paying \$42 million in property taxes to municipalities, schools in the county. This nontaxpaying nonprofit, built on taxpayer dollars, made over a billion dollars in 2020.

In 2013, Highmark bought a troubled hospital system and created an integrated system known as the Allegheny Health Network. UPMC took umbrage at Highmark stepping into their territory and declared that Highmark subscribers could no longer utilize UPMC providers and facilities. Because UPMC had been at the game longer, they controlled the vast majority of specialized services in the Pittsburgh area. Thousands of patients were on the brink of losing access to their physicians.

The Pennsylvania legislature intervened and negotiated a consent decree whereby patients who were under treatment as of June 2014 could continue to see their doctors for a period of 5 years. The consent decree was set to expire on June 30th, 2019, at which time all crisscross system services would cease.

In 2013, I began experiencing severe pain in the left side of my face and extending into my left ear. I was diagnosed with trigeminal neuralgia and referred to UPMC Neurosurgery Associates. Two brain surgeries, multiple procedures and medications did not stop the pain. The neurosurgeon wanted me to see—wanted to refer me to UPMC Eye & Ear Institute; however, I have Highmark Insurance through my wife's employer, and I was barred from access to any additional UPMC providers.

Over the next 2 years I saw five in-network ENTs, all of whom told me that the nerve condition was causing the pain. Then in early 2018, my dermatologist discovered evidence of cancer in my ear. I had been misdiagnosed all along.

With the cancer diagnosis I fell into an exception in the consent decree, and I was again referred to Eye & Ear Institute, but because of the insurance issues I requested to stay in-network. I had surgery in July 2018, but by that time the cancer had spread too far for that surgeon's expertise. He couldn't even identify what type of cancer it was. At this point I was told I had to see the experts at Eye & Ear.

In December 2018, they identified a rare cancer and in early 2019 I underwent a 14-hour operation followed by 6 weeks of radiation at the Hillman Cancer Center. The pain was finally gone, but so was one of my ears. I could not help but believe that had I had access to the doctors at Eye & Ear sooner, I might actually still have them both. It took 6 years for me to find a team of doctors who were able to help me, only to face the reality that I would soon lose them when the UPMC Highmark decree was set to expire. This included my team at Hillman Cancer Center. I was told that my only option was the Cleveland Clinic, which was a 2-hour drive from Pittsburgh. The idea of being cutoff from my doctors was terrifying.

Patients, local leaders, and advocates banded together demanding that UPMC negotiate with Highmark to guarantee access to the providers and services that were in patients' best interest. Highmark was willing to negotiate, but UPMC refused. With Attorney General Josh Shapiro's involvement at the 11th hour an agreement was reached, and a 10-year contract was signed. That agreement finally allowed me to quit fighting for my healthcare and to begin caring for my health.

These integrated systems are spreading across the country. In the future you may find yourself back in the private sector, subject

to whatever insurance is available to you. The lack of access to care because of the insurance card you carry can literally be a matter of life and death. Giant nonprofits could not be permitted to care more about their profit share than they do about patient care.

Finally, a PET scan in October 2019 revealed that the cancer had metastasized to my lungs. With this cancer, if metastasis occurs, it typically occurs 5 to 10 years after the initial diagnosis. Mine occurred within the same year. I believe that the delays described allowed that to happen.

As I stated previously, denial of access to the proper care can literally be a matter of life and death. I have always said that this is not just about me. It's about the thousands like me. If my legacy can be that I helped even one person avoid that happening to—what happened to me, then I can be proud that I did something important and significant in my lifetime. Thank you very much.

[The prepared statement of Ms. McCracken appears as a submission for the record.]

Chair KLOBUCHAR. Thank you very much, Beth, for speaking out. Next up, Michael Cannon, who's the director of health policy studies at the Cato Institute.

STATEMENT OF MICHAEL CANNON, DIRECTOR OF HEALTH POLICY STUDIES, CATO INSTITUTE, WASHINGTON, DC

Mr. CANNON. Thank you very much, Chair Klobuchar, Ranking Member Lee, Members of the Subcommittee and the broader Committee for inviting me to testify today.

The U.S. health sector is not serving consumers as it should or could. Excessive, often unconscionable, prices threaten to wipe out savings of even insured Americans. Low quality care costs lives and eludes quality improvement efforts, and inefficient provider consolidation is an important contributor to both these deficiencies. The economics literature finds that most consolidation among hospitals, physicians, and insurance companies increases prices and/or reduces quality.

Inefficient consolidation, however, is not merely a driver of high prices and lower quality, it is also a symptom of a greater problem. By and large, inefficient consolidation is the result of Government interventions that disable the normal market mechanisms of entry, cost consciousness, and competition from doing what they do in other sectors of the economy, improving quality while reducing prices. Simply put, Government does not need new powers to combat hospital consolidation. Government merely needs to stop encouraging consolidation. Many Government interventions often produce unintended consequences. Among other effects, they create incentives for the type of consolidation that gives producers the ability to charge higher prices than they could in competitive markets.

I want to briefly discuss three categories of Government intervention into the health sector that encourage inefficient provider consolidation: Government regulation, Government encouragement of excessive insurance, and Government purchasing of medical care.

First, government regulation. Complying with Government regulations generally imposes high fixed costs but low marginal costs,

which encourages consolidation. Many healthcare-specific regulations create specific incentives to consolidate. These—this category of regulations includes the Affordable Care Act’s minimum loss ratio regulations and so-called State Certificate of Need laws which require new entrants into the market to obtain permission from the Government before they can compete.

The second category is Government encouragement of excessive insurance. There are various Government policies that encourage consolidation by encouraging more comprehensive health insurance than consumers would choose on their own. These include both the tax exclusion for employer-sponsored health insurance and laws that require consumers to purchase minimum levels of coverage. “Insurance reduces price competition,” the economist Kenneth Arrow wrote, “by removing the incentive on the part of individuals, patients and physicians to shop around for better prices for hospitalization and surgical care.” Encouraging consumers to purchase more coverage than they would prefer means that we pay for more medical care through health insurance. That reduces the number of buyers in the healthcare market and encourages producers to consolidate.

Finally, number three, Government purchasing of medical care. This third category, in Government purchasing of medical care, results in pricing errors. The Medicare program, when it purchases medical care, it sets the prices that the program is going to pay for medical goods and services. Medicare, inevitably, gets those prices wrong. Senator Klobuchar referred to one way that Medicare gets those prices wrong when she mentioned that she supports having Medicare negotiate with pharmaceutical manufacturers in order to reduce the prices that Medicare pays. This is a tacit admission that Medicare overpays.

Medicare overpays in many other categories as well and what we call sight of service differentials, which is really just a fancy name for Government pricing errors, encourage hospitals and physician practices to consolidate in order to capture and split the benefits of the excessive Medicare prices that the program pays to hospitals over and above the prices that it pays to physicians for those same services. Once those firms merge, not only do taxpayers pay more for the same services via the Medicare program, but those firms’ greater market power allows them to increase prices on private payer as well.

What do we do about this? As I mentioned at the outset, Government doesn’t need more power in order to reduce inefficient hospital consolidation. It just needs to stop encouraging such consolidation. States can do so by repealing Certificate of Need Laws and Any Willing Provider Laws. They can do so by repealing or overhauling clinician licensing laws so that they no longer block new categories of health professionals’ innovations in medical education and innovations in healthcare delivery.

At the Federal level, though, it might be a much heavier lift. The Federal Government should, as Professor Gaynor recommends, repeal network adequacy laws. I would go a little farther than Professor Gaynor and advocate that the Congress repeal the Government price controls that give rise to the—such law. We can find

those price controls in the Medicare Advantage program and in the ACA.

Ultimately, in order to reduce the incentives Congress creates for consolidation, Congress will need to reform Medicare, Medicaid, and the tax treatment of health insurance to change who controls the \$4 trillion that this country spends on healthcare. Make that person the consumer and consumers will be more cost conscious and impose greater price discipline on the healthcare industry than they do when Government encourages excessive levels of health insurance. I thank you very much for your time, and I look forward to your questions.

[The prepared statement of Mr. Cannon appears as a submission for the record.]

Chair KLOBUCHAR. Thank you very much, Mr. Cannon. Next up, Dr. Ronald Hochman, who is the president and CEO of Providence and Chair of the American Hospital Association.

**STATEMENT OF RODNEY HOCHMAN, PRESIDENT
AND CEO OF PROVIDENCE ST. JOSEPH HEALTH,
CHAIR OF THE AMERICAN HOSPITAL ASSOCIATION,
RENTON, WASHINGTON**

Dr. HOCHMAN. Good afternoon, Chair Klobuchar, Ranking Member——

Chair KLOBUCHAR. You want to talk a little louder? We can't hear you.

Dr. HOCHMAN. Good afternoon——

Chair KLOBUCHAR. There you go. Perfect. Perfect.

Dr. HOCHMAN. You got me here. Good afternoon, Chair Klobuchar, Ranking Member Lee, and Members of the Subcommittee. I'm Dr. Rod Hochman, Chair of the Board of Trustees for the American Hospital Association. I'm pleased to be here today representing our nearly 5,000 member hospitals, health systems, and other healthcare organizations.

Thank you for your support as our hospitals and health systems have cared for millions of patients with COVID over the past 17 months. Our healthcare workers are heroes, and they continue to serve on the front lines of the pandemic. I've served in the medical field for 42 years as an immunologist and rheumatologist, and I currently serve as the president and CEO of Providence, an integrated, not-for-profit health system serving the western United States.

Providence treated the Nation's first confirmed COVID case on January 20th, 2020. In those early days we knew much less about the virus, but we knew we needed to act fast and decisively save lives and protect our caregivers and communities. Thanks to our scale and integration, we brought our clinicians together virtually every morning to share learnings and best practices. We rapidly scaled up telehealth capabilities, going from 70,000 virtual visits in 2019 to 1.7 million in 2020, and we were able to carefully manage our PPE supply, predicting the next hot spots, and shipping supplies to those areas. Integrated health systems throughout the Nation undertook similar efforts to help their communities. Let me give you a few examples.

Barnes-Jewish Christian Healthcare, an integrated system with 14 hospitals serving the metropolitan St. Louis and surrounding

States, used its scale to purchase large quantities of PPE that was in short supply at the pandemic's inception. The PPE helped keep BJ's staff safe. It also allowed the health system to prepare for a surge of COVID patients and protect those patients who did not have the virus.

Atrium Health, an integrated system with 42 hospitals serving North Carolina and several adjacent States, formed a public-private partnership that included Honeywell and Charlotte Motor Speedway to provide 1 million doses of COVID vaccine by July. Hundreds of Atrium's physicians, advanced practice providers, and other employers—employees volunteered their time to make this vast mass vaccination effort a success.

These and other efforts by integrated hospital systems would not have been possible without the scale and scope to ramp up quickly and deploy the enormous amounts of resources to respond to this unprecedented crisis. As a physician with four decades of experience caring for patients, I can tell you that the integration is key to strengthening healthcare in this country and ensuring every community, whether rural, urban, or suburban, has access to affordable, evidence-based care.

As you know, our rural hospitals are facing a crisis. Integration has been critical in supporting access to care in rural communities. Integrating with larger systems gives many rural facilities' access to supplies, capital and technology, needed to continue serving their communities. Without this integration, many rural hospitals would be forced to close their doors. We know from experience and research by the Charles River Associates that integration actually reduces operating cost, improves quality, and does not increase revenues per admission. That last part is worth underscoring because it is inconsistent with claims that hospital transactions are all about acquiring market power to increase prices.

The fact is that the price most consumers pay for healthcare is reflected in the premiums set by the commercial insurance companies that face little competition. Data from the American Medical Association shows a steady progression of consolidation to now nearly 75 percent of all commercial health insurance markets and when an insurance market is highly concentrated, insurers reduce provider payments and do not pass those savings on to consumers. This is why health systems have increasingly engaged in alternative arrangements to lower costs, increase quality and convenience for consumers.

One example is the Henry Ford Health System in Michigan which entered into a direct contract arrangement with General Motors. To win that contract, Henry Ford had to demonstrate its ability to change care delivery, offer comprehensive clinical and administrative connectivity, and take on the growing financial risk and meet quality requirements. This would be impossible without integration.

I'm extremely proud of the 6 million women and men, our nurses, doctors, housekeepers, security and administrative teams, and so many more, who work at America's hospitals and health systems. Each and every day they care for patients, comfort families, and protect communities. Thank you for the opportunity for being here today, and I look forward to your questions.

[The prepared statement of Dr. Hochman appears as a submission for the record.]

Chair KLOBUCHAR. Thank you. Thank you very much. Thank you, Dr. Hochman. Next up is Ahmer Qadeer. With the——

Mr. QADEER. Thank you.

Chair KLOBUCHAR [continuing]. SEIU, and thank you.

**STATEMENT OF AHMER QADEER,
DIRECTOR OF STRATEGIC INITIATIVES,
SERVICE EMPLOYEES INTERNATIONAL
UNION, NEW YORK, NEW YORK**

Mr. QADEER. Thank you, Senator Klobuchar, Senator Lee, Members of the Subcommittee and Committee. Thank you for holding a hearing today on this important topic and for giving me the opportunity to testify before you today. My name is Ahmer Qadeer, and I'm here on behalf of the Service Employees International Union, SEIU. SEIU is the largest union of healthcare workers in our country. Our union represents more than a million healthcare workers, including physicians, nurses, service and maintenance workers and many other hospital-based employees. I'm testifying today to comment on how concentration in hospitals may impact the wages, benefits, working conditions of healthcare workers.

Health systems have been consolidating at a brisk pace with consolidation particularly acute at the largest health systems. Between 2013 and 2018, the average size of health systems was stable, but at the largest systems, those with over 30 hospitals, the average number of hospitals increased significantly. In short, in health systems, as in many other parts of the economy, big firms are getting bigger.

Consider a description from Samuel Hazen, the CEO of HCA Healthcare Incorporated, the largest hospital system in the country. Mr. Hazen told investors on his firm's first quarter 2021 conference call, "We are operating at an all-time high on market share. We're pushing the overall market share for the company across 43 domestic markets into the low 27 percent zone." A very high-water mark.

Another HCA executive told investors that company hospitals were an important part of the communities in which they operate and often one of the biggest employers. There is substantial empirical evidence that when employment is concentrated among fewer firms and workers had fewer employment options, it leads to lower wages.

A 2017 study demonstrated that moving from the 25th percentile of concentrated labor markets to the 75th percentile is associated with a 15 to 25 percent decline in wages. Simply put, as employer concentration rises, wages fall.

A 2020 study estimated that more than 10 percent of the U.S. work force are likely in labor markets where employer concentration suppressed wages by at least 2 percent. Furthermore, several million workers are in markets where employer concentration suppressed wages by at least 5 percent. The research on employer concentration in the hospital industry is consistent with findings about the broader economy.

An American Economic Review article examined the effects of hospital mergers between 2000 and 2010 on the wages of hospital

workers. The study looked at more than 1,300 hospitals and found that mergers that increased hospital concentration to high levels reduced the wages of nurses and other healthcare occupations. The negative effects of employer concentration are not limited to wages, but also include benefits and working conditions. Workers in concentrated labor markets are more likely to experience wage theft, health and safety code infractions, and other contraventions of labor laws.

Excessive employer concentration does not just lead to lower wages and benefits, but also diminishes the quality of life of workers, their families, and their communities. For instance, Pittsburgh's one of the most highly concentrated hospital markets in the country and UPMC the largest health system. Workers at UPMC described wages and benefits so low that many workers rely on food stamps and incur medical debt.

Leslie Poston, an administrative assistant, described, "UPMC is my employer, my insurer and my healthcare provider, not to mention the largest private sector employer in Pennsylvania. They know how much I make and that I'm thousands of dollars in debt to the hospital I work at." Poston and other UPMC workers describe circumstances where wages and benefits are so low that the hospital's employees need charity to meet their basic needs.

Antitrust regulation has not been an effective bulwark against the negative labor market effects of employer consolidation. As Senator Klobuchar pointed out in her book, there are notable instances where antitrust laws protected workers. African-American doctors brought suit under the Sherman Act to force integration at Chicago Hospitals. SEIU brought suit against hospitals for colluding to depress wages for nurses. These are isolated examples, and much more can be done to expand the available policy tools for promoting fair and competitive labor markets.

Let me touch on some specific solutions that would address the concerns of workers in healthcare and other segments of the economy. One, requiring that all merger reviews include an analysis of labor market impacts.

Two, because there's a limited history of antitrust labor law and labor enforcement, we need bright-line standards established for anticompetitive consolidation and practices in labor markets.

Three, directives prohibited—prohibiting anticompetitive worker restraints, such as noncompete restrictions, are important to counteract key ways that employers abuse their power over workers.

Antitrust enforcement in labor markets need not be all or nothing. Negative labor market effects can be offset by collective bargaining, wage boards, sectoral standards for working conditions, broad based bargaining and other labor market supports can attenuate negative impacts of employer concentration. It is important at this moment to strengthen antitrust law to explicitly protect competition in labor markets through readily available tools, including merger reviews, providing clear causes of action for monopsony, and preventing employer abuses, such as restrictions on workers seeking the best job they can find.

Throughout the COVID-19 pandemic, healthcare workers have cared for us. They have tended our families. They have kept us alive. In communities across the country, we clapped for healthcare

workers as they ended their shifts, but they deserve much more than praise and gratitude. They deserve living wages, good benefits, and safe workplaces. Empirical research shows that excessive employer consolidation can undermine these conditions.

I hope you'll consider strengthening antitrust applications that have the potential to protect workers from abusive employer concentration. Thank you. I look forward to your questions.

[The prepared statement of Mr. Qadeer appears as a submission for the record.]

Chair KLOBUCHAR. Thank you. Thank you very much. Next up, and our last witness, is Dr. Brian Miller.

**STATEMENT OF BRIAN MILLER, ASSISTANT
PROFESSOR OF MEDICINE, JOHN HOPKINS
SCHOOL OF MEDICINE, WASHINGTON, DC**

Dr. MILLER. Thank you. Chairwoman Klobuchar, Ranking Member Lee, and distinguished Members of the Subcommittee. My name is Brian Miller, and I practice hospital medicine at the Johns Hopkins Hospital in Baltimore, where I care for hospitalized patients with a variety of ailments, including COVID. I serve as an Assistant Professor of Medicine and Business at the Johns Hopkins University.

I thank you for holding this hearing today on hospital consolidation, an issue of long-standing interest to me as both a practicing physician and as someone whose mother has experienced the harms of hospital consolidation. Today I will focus on the harms of hospital consolidation, combatting consolidation and promoting market entry through a forum of anticompetitive laws.

The FTC and DOJ do excellent work. The issue is that they cannot combat consolidation that is driven by other Government policies and laws that place a finger on the scale in favor of consolidation. My colleagues today have characterized the many harms of consolidation in the hospital markets, which comprise 31 percent of healthcare spending in 2019.

I wanted to highlight a harm that has not been mentioned: a loss of innovation from a lack of competition. This is best illustrated through the low labor productivity growth in the hospital industry from 1993 to 2017, which averaged 0.4 percent per year, according to the Bureau of Labor Statistics, and was negative 1.5 percent annually from 2001 to 2007.

In looking for competition policy solutions, I agree with my colleague Michael Cannon of the Cato Institute that the lack of site neutral payment is a Government pricing error driven by a fee-for-service system that pays different rates for the same service provided at different types of facilities, which drives consolidation amongst hospitals and physician practices as a form of payment policy arbitrage.

A partial fix was attempted through the Bipartisan Budget Act of 2015. CMS attempted to fix the problem once and for all with the 2019 payment policy rule and was sued by industry and lost in court. CMS again tried to fix this problem in 2020 and has succeeded so far in court challenges from industry, while industry is now appealing to the Supreme Court. Congress can support CMS in fixing this by providing clear statutory authority to fix this pay-

ment policy arbitrage issue which drives physician hospital consolidation.

Stark Law is another area in which we can combat consolidation. Driven by research on imaging, physical therapy, and other self-referral services in the 1980s and 1990s, showing higher utilization with physician self-referred services, Government picked the winner and banned physicians from self-referral for designated health services, placing its finger on the scale in favor of corporate-owned enterprises who do engage in self-referral.

In 2021 the world is different with over one-third of Medicare and one-half of Medicaid spending directed to plans as a form of risk adjusted capitation. Plans use tools such as prior authorization and prepayment claims editing to address fraud, waste, and abuse. Congress can help by re-examining the function of Stark Laws and repealing those that are clearly anticompetitive.

Finally, physician-owned hospitals represent one of the few policy levers by which we can encourage market entry in the hospital market. The story here is similar. The hospital industry raised concerns about cherry-picking patients and hospitals favoring private insurance. These are payment policy issues, not competition issues, and the evidence from Government studies was mixed, showing, for example, that the total community benefit from physician-owned hospitals is greater than that of general hospitals when taxes are included.

Foreclosure effects are significant. In 2010 alone, 75 projects did not meet the deadline, and \$2.5 billion in economic activity was lost. This provision is inconsistent with goals of the ACA of expanding coverage, improving quality, and lowering costs.

In conclusion, rigid Government interventions distort markets and favor consolidation. The Government should not favor one market participant over another, and we need to use the right tools, regulatory solutions for regulatory problems. Changing the anti-trust statutes is the wrong tool to treat the problem of consolidated hospital markets. Thank you, and I look forward to your questions.

Chair KLOBUCHAR. Thank you to all the witnesses. I think I'll start out with Professor Gaynor. You've written extensively about the negative impacts of excessive hospital consolidation on the price and quality of hospital services. We know these impacts can impose significant costs on our healthcare system and more importantly on patients.

Last week, as I noted, we passed out the bill that Senator Grassley and I have, with bipartisan support, to raise merger filing fees on the largest transactions. I guess I'd start out with you, Professor Gaynor, and if you could answer. How does this help? Why would increasing enforcement resources help improve enforcement against anticompetitive hospital mergers? Do you think more can be done that hasn't been done?

Professor GAYNOR. Senator Klobuchar, thank you for the question. Yes. I do think more can be done. The agencies are working flat out. They are strained with the resources that they have. The—simply the amount of horizontal merger filings have—it's skyrocket—skyrocketing over time, and the agencies' budgets have been flat. That does not take into account any other kind of enforcement issues nor the kinds of studies that are necessary for

them to do their jobs well now and the future. They absolutely need more resources in order to keep up with the issues that they're facing, both in the hospital sector, but more broadly.

Chair KLOBUCHAR. Dr. Miller, you spent time working at the FTC. Do you think additional resources would help to improve hospital enforcement?

Dr. MILLER. Thank you, Senator Klobuchar. I have to agree. The hospital mergers group often works 14 hours a day, and they regularly pass on transactions due to a lack of staffing. I think that additional funding and staff would help with enforcement.

Chair KLOBUCHAR. Very good. We don't agree on everything, but we agree on that. I guess that's a "yes" or "no." Yes.

Dr. MILLER. Yes.

Chair KLOBUCHAR. Okay. Good. I note that that bill would actually decrease the costs on small hospital—on small—any mergers of any kind—increase it on the big mega mergers. Something I answered questions of from Senator Cruz last week.

Ms. McCracken, based on your experience as a patient, how do you think things should have gone? What do you think patients in your situation should expect when they approach a hospital system seeking medical care?

Ms. MCCRACKEN. Initially, when my neurosurgeon said, "You need treatment X at—you need to see physician X at facility X," I should have been able to go and see who that doctor thought was the best provider for me to see at that point, and the—it's just as simple as that. I should have just been able to walk down two floors in the exact same hospital and gone to the Eye & Ear Institute because he felt that that was the best place for me to be.

Senator KLOBUCHAR. Good. Professor Gaynor, her experience, Ms. McCracken's experience, makes me think about patients in rural areas. In your opinion, how can consolidation affect healthcare services in rural communities?

Professor GAYNOR. Thank you for the question, Senator Klobuchar. I think that our fellow citizens who live in rural communities are particularly vulnerable. If there's consolidation there, and if prices go up, then they have to travel a long way to wherever the next alternative is. They're left without really good alternatives.

Moreover, another thing that frequently happens when there are acquisitions or mergers within rural areas, is that services are completely eliminated or reduced in some areas, which also leaves our fellow citizens living in those places quite vulnerable. If obstetric services get cut and you live 2 hours or more from the next closest place with obstetric services, then you're in a very tough situation.

Chair KLOBUCHAR. Very good. Professor Gaynor, one more thing. What sorts of effects do the restrictions, contract restrictions with insurers that restrict them from designing plans that could reduce cost—what kind of effects do those have?

Professor GAYNOR. Those can be really harmful to competition. I think it's important to understand how competition in the healthcare sector works. Competition on price occurs via insurers and hospitals negotiating. If a hospital is important to have in the network and they offer value for what they're giving, then they'll be included in the network and that's—it's those negotiations that

drive the prices, and then who's in the network has to do with what the choices are for enrollees.

That's why this can be particularly pernicious. If dominant hospitals impose restrictions on insurers such as you are not permitted to inform your enrollees about lower cost options or better value options, you are not permitted to take our hospitals and put them in a less favored tier because they are more expensive or maybe they're not even as good. Restrictions like these are intended to restrict choice by individuals, weaken competitors and weaken competition. They can be very, very damaging.

Chair KLOBUCHAR. Okay. Thank you. Mr. Qadeer, I've long been concerned about the impact of mergers on labor markets. We've been hearing increasing concerns about monopsony effects from consolidation, including in the case of healthcare workers, which you described some of these concerns in your testimony. Do you think that Federal and State antitrust enforcers are doing enough to address potential harms to the labor markets from health system mergers? What would you like to see, and do you think giving the agencies, an earlier question I asked, greater resources would help?

Mr. QADEER. There's a real gap in enforcement between labor cases and product cases. There's a—there—since the 1960s there's—there isn't been about 2,300 product cases and less than a hundred, less than a hundred, labor market cases. In general, I would say there isn't enough enforcement in labor markets. Certainly, I think that more resources could help.

The kinds—kinds of things that we think need to happen in antitrust law, to ensure fair competition in labor markets, are requiring—require merger reviews to have an analysis of labor markets, establishing kind of clear, bright-line standards for anticompetitive consolidation and practices, and then—and then efforts to restrict—to end the restrictions on the ways that employers can abuse their power over workers with noncompete restrictions and other kinds of vehicles.

Chair KLOBUCHAR. Thank you very much. Next up, Senator Lee.

Senator LEE. Thanks so much, Madam Chair. Mr. Cannon, let's start with you. You mentioned in your testimony the fact that in many instances State licensing officials, State licensing laws of one sort or another, are used to block new categories of healthcare providers or, in some instances, other kinds of innovations in healthcare or how it's provided.

There are a lot of cases in which these State licensing boards themselves are asked to either license and authorize or not authorize, not license what would, if approved, be new competitors to them thus creating a perverse incentive because if these boards approve them then they've got new competitors to deal with, and they've got to react by some combination of lowering prices and offering superior quality.

This is one of the many reasons why I've long supported efforts to bring about reform in occupational licensing. I was wondering if there are any specific reforms that you'd recommend in this area, and are there some States that are doing it right that other States ought to try to emulate?

Mr. CANNON. Thank you for the question, Senator. Yes. There are things that both the Federal and State governments can do in this area. There's not much the Federal Government can do in my view because occupational licensing occurs at the State level. States have the power to do that under, you know, their general police powers and the Federal Government does not really have authority to interfere with State regulation of clinicians unless those regulations act as a barrier to trade between the States. The commerce power, the Congress calls it the Constitution, gives Congress the power to make commerce regular between States.

One reform that we have discussed at the Cato Institute is to— for Congress to pass a law that redefines the locus of the practice of medicine from the location of the patient to that of the provider. If Congress did this then what this would essentially do is tear down barriers to interstate telemedicine because right now I can—I live in Virginia. I could travel to New York to see a specialist, but unless that specialist is licensed in the Commonwealth of Virginia, that specialist could not provide me a telemedical consultation over the internet. They would be violating Virginia's licensing laws because Virginia defines the location of the practice of care as where I am—the patient am sitting.

If the Federal Government redefines that for the purposes of State occupational licensing laws, as the location of the physician, then that physician could see patients in Virginia, patients all across the country, via telemedicine. That's one important step that I think the Federal Government could take.

Senator LEE. States, just to be clear, States, overwhelmingly if not universally, do define it that way. They—right? They define it as—

Mr. CANNON. As the location of the patient.

Senator LEE. Yes.

Mr. CANNON. Yes.

Senator LEE. Yes.

Mr. CANNON. We have seen some activity at the State level that has been very encouraging at the beginning of the COVID-19 pandemic. Policymakers, Governors of both political parties—I think even Democrats may have been better on this score than Republicans—have recognized that a lot of these clinician licensing laws, regulations, block access to care for people, and so they rolled them back for the duration of the public health emergency, including restrictions on telemedicine.

Some States have even gone so far as to enact reforms that would recognize the licenses issued by other states—Arizona is one—so that if you are and this is, this goes beyond the health professions. If you have a license to practice medicine or a nursing license from another State, if you come to Arizona, you can fill out a form and essentially obtain an Arizona license. That tears down the barrier to competition that Arizona's clinician licensing laws create.

We at the Cato Institute have advocated eliminating clinician licensing laws entirely because while their stated purpose is to improve the quality of care and they do that in some instances, on the whole they either don't add much to the quality protections that would exist in the absence of licensing—I would argue that in

many cases they reduce the quality of care—but they most certainly, as Governors around the country have implicitly agreed, they certainly block access to care by raising prices and blocking competition. There's a lot of opportunity for reform here at both the Federal and State levels.

Senator LEE. Someone told me once that a pilot once licensed to fly a jet airplane, in theory by law, by virtue of an occupational license, could fly a 747 if the owner of a 747 wanted to entrust that pilot with that, such that the license itself becomes less important in certain fields than other qualifications above and beyond the license. Is there some parallel here in some cases to the healthcare industry?

Mr. CANNON. Most of the quality protections that protect patients in our healthcare sector from incompetent physicians or other medical professionals don't come from clinician licensing. They come from the medical malpractice system. They come from hospital credentialing, board certification, and so forth. Licensing adds—I say licensing adds very little if anything to the quality of protections that would exist in its absence.

Senator LEE. Thank you. Dr. Miller, we hear a lot about the high cost of healthcare and the lack of transparency in hospital markets. These can seem like abstract, esoteric or even academic issues. Can you describe to us how choice and competition end up impacting patients?

Dr. MILLER. Thank you, Senator Lee. They definitely do, and I would say a lack of choice and competition is one of the biggest harms. The labor—lack of innovation—we think about patients with heart failure. They're admitted to the hospital through the emergency room. They come up to the floor. We prescribe diuretics. Take fluid off. Get them off oxygen. Much of the processes through which the hospital works and which clinical care operates have not changed since my late father graduated from medical school in 1973.

We cheat—treat heart failure the same way. A nurse charts the urine output on paper and then puts it in electronic health record. They did that in 1973 and they do that in 2021. The reason this has not changed is because innovation, which is the lifeblood of competition, has not occurred due to consolidation. Thank you.

Senator LEE. Thank you. Thank you, Madam Chair.

Chair KLOBUCHAR. Very good. Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Madam Chair, and thank you for having this hearing, Senator Klobuchar and Ranking Member Lee, on this really profoundly important topic that literally touches every American's lives.

I want to focus for the moment on private equity deals and their impact on quality of care and the financial incentives that go into healthcare decisions regarding financing and economics. Private equity deals in healthcare, including hospitals, have nearly tripled over the past decade, up from 41 billion in 2010 to 120 billion in 2019. The total over the last 10 years has been 750 billion of private equity going into about 100 hospital deals in the last 3 years alone.

Consolidation is a core part of the private equity business model through roll-up and buy and bill strategies. Loans finance the vast

majority of the 750 billion spent on private equity healthcare during the last decade. Those deals mean that the private equity funds, the ones who engage in control, are not on the hook for the loans. Instead, private equity funds structure the deal so that the acquired healthcare providers are responsible for repaying the debt that the private-equity funds used to purchase them.

This structure has far-reaching, dramatic, profound consequences for our healthcare system. Large hospital chains, under private equity management, have been forced to sell off and close hospitals to meet their debt burden. The incentives and self-interest of the private equity funds drive the finances rather than respect and care for the patients who are there or the professional staff who assure quality care.

Let me ask you, Professor Gaynor, how significant of a role does the burdening of hospitals with debt play in the closure of hospitals or the need for hospitals to merge with larger systems to stay afloat, in other words, the consolidation of healthcare?

Professor GAYNOR. Senator Blumenthal, thank you for the question. Let me mention actually a report that was just released the other day by Laura Alexander of the American Antitrust Institute and Richard Scheffler at University of California Berkeley that goes into a lot of detail on some of these things.

I'd say that there is real concern about the role and the impact of private equity in healthcare exactly as you indicated because the model is to come in, take over an underperforming firm, turn things around, at least on certain balance sheets quickly, and then sell it for a profit. Private equity investors are not in that for the long term. That can work in some circumstances, but healthcare is quite a different matter. That's one.

I don't think we know at this point the extent to which private equity has played a role in consolidation. That's something I think we need to know more about. Moreover, I'd add to that that we need to know more about the behavior of private equity-owned firms. There's evidence that suggests that private equity firms, not surprisingly, are hyper-responsive to the competitor environment. If the market is competitive, they will be very aggressive, but if it's less competitive, they will take every advantage of profit opportunities, more so even than typical investor-owned firms. I think it's an important issue. Thank you.

Senator BLUMENTHAL. Thank you. That's an excellent answer, and I might just say that my question is, in part, based on that study by the American Antitrust Institute, but really the point of the question is we need to know much more about the real-life impacts of these private equity deals. Their incentives are not aligned with patient care, in fact, not aligned with necessarily professional care.

The private equity companies don't want to run these hospitals long term. Often their business model is to buy the hospitals, consolidate them, merge them and then sell the resulting entities at a profit. The private equity model generates short term revenue. It has long term consequences for patients often at the expense of the viability of the hospital. I'll just give you one example.

Private equity companies have been known to buy hospitals only to sell of their underlying real estate, the basic real estate, that

underlies the hospitals, forcing the hospital to lease back their own facilities from real estate investment trusts and leaving the hospitals financially vulnerable.

A particularly egregious case of a private equity company stripping a hospital of its real estate is that of the Hahnemann University Hospital in Philadelphia, which was purchased in 2018 by Paladin Healthcare, a private equity fund. The company invested no money, none, in improving the hospital and shut it down 18 months later with a plan to sell the real estate in a rapidly gentrifying neighborhood and leaving the neighborhood without a key healthcare provider.

My point is that these private-equity investments in healthcare markets have gone unchecked and unreviewed for far too long in staggering numbers with absolutely profoundly important consequences. I strongly believe that Congress needs to study this relationship, as you suggested.

I, again, thank the Chair for focusing on this issue as a matter of antitrust law, but it's also fundamental healthcare interests as well that are at stake. Thank you, Madam Chair.

Chair KLOBUCHAR. Thank you very much. Next up we have Senator Hawley.

Senator HAWLEY. Thank you, Madam Chair. Thank you for holding this hearing. I want to—Professor Gaynor if I could just start with you. I want to pick up right where Senator Blumenthal just left off. Let me ask you about some of the research as it relates to private equity backed mergers and acquisitions. Does any of the research that you have seen or conducted, reviewed, indicate that private equity backed mergers or acquisitions in this industry have any relevance to patient outcome, access to healthcare, or otherwise improve the long-term financial viability of hospitals?

Professor GAYNOR. Yes. Thanks for the question. This is an area, I just, I think I'm reiterating, where we need to know a lot more. I think we're starting to get evidence on this. Actually, there's more evidence now, to my knowledge, from the nursing home industry than from hospitals, but we don't have extensive evidence yet. There are reasons to be concerned, I think, just thinking about the business model, but this is an area where we definitely need more evidence to have good information about this.

Senator HAWLEY. Yes. I certainly, I agree with that, and I have to say I am concerned. I'm concerned about the—the possibility that private equity and their intervention here is actually helping drive consolidation in a way that is unhealthy for this industry, and that is particularly—can be particularly harmful for rural communities like many that make up my State.

I want to shift and ask you now, if I could, Professor Gaynor, about rural healthcare access. You noted in your testimony, and this caught my attention, that hospital mergers lead to or can enhance monopsony power in labor markets, and that this can depress wages—this is your testimony—below the efficient level, distort hiring decisions, and in the long run, harm incentives for investment in human capital. I would be particularly interested to hear your thoughts on the effects of hospital mergers, monopsony power, in rural markets. Can you say something about that?

Professor GAYNOR. Thanks. That's an excellent question. In some ways it's a mirror image of the issue that occurs in product markets. If workers in rural areas have few alternatives in order to find employment, they would have to travel a longer distance, then employers in that area have more market power as buyers, more monopsony power.

If you have, say, and this is typical in many places, say, a hospital is one of the biggest employers in town, or there are two hospitals, and now there's a merger or they're acquired by another entity, then where do the people in those communities have to turn for employment? Wages start getting pushed down, or they just don't rise as much. Working conditions change, number of hours offered or required, so on and so forth. If the next available employment is hours away, then you don't have a lot of alternatives and that gives the employer a lot of monopsony power. That can cause substantial damage in those markets as well.

As I said, it's not only wages. I mean, wages are obviously very important, and hours, but then it affects investment in human capital, which affects productivity. That affects individuals, but it affects the entire economy. There can really be far-reaching consequences.

Senator HAWLEY. Do you think it might also reflect retention rates in the industry and, as you said, if in a rural community—it certainly is true that the town that I grew up in that we had a hospital located in my town, only one. It was a very small town. It was the only one in the county, I believe, the only hospital in the county.

There's not a lot of options there for employees at that hospital to go to other hospitals, but if there's not investment—if their wages are being held down—if there's not a lot of investment in them, if the quality of work is poor, then they may leave the industry altogether and may try to find a job in a completely different sector. I mean, do you see any of that? Do you worry about that because of the effects of consolidation in rural America?

Professor GAYNOR. Oh. Sure. As a matter of fact, it can cause people to leave the geographic area entirely. Even, you know, monopsony power or market power of any kind, isn't infinite. You can't depress the wage to zero. You can't raise the price of a product to infinity. At some point the wages get low enough, people will leave. Either they will go to another employer in the same area, or they will leave that area and migrate elsewhere. Of course, if that starts to happen, then that has ripple effects on the entire town, the entire area, because you start to lose people who were earning money, and that affects the businesses in that area, and it can have really profound negative consequences.

Senator HAWLEY. What do you think might be the effect on access to care, healthcare access, and quality of care in these rural settings if we start to see this sort of cycle begin and play out?

Professor GAYNOR. Yes. It could be—it could be a vicious cycle. I want to be clear that I am talking about this deductively. I don't know of evidence that specifically shows these effects, but it makes sense that if you get a cycle like this started, then it can feed on itself and you can get what are basically tipping points where things were all right, and they start going downhill, and all of it's

starting—they just start going downhill very rapidly. There is a real potential for that.

Senator HAWLEY. Let me ask you, finally, just a broader question about healthcare costs and wage stagnation. Research suggests that rising healthcare costs have been a major contributing factor to wage stagnation for working class people in our country in the last few decades. My question is, what impacts are—do you—does the data show that rising healthcare costs have had on worker compensation packages and wage growth? Can you give us a sense of that? Do you know?

Professor GAYNOR. Yes. Just briefly to set this up, here's what happens. Suppose there's a merger between hospitals that are close competitors. Their market power is enhanced. They raise prices substantially. Who pays for that initially? It's the private health insurers in the area. They then turn around and raise their premiums to employers, and then employers pass that on to their workers.

Either wages are not what they otherwise would be. Usually, it's wages grow a lot more slowly, or workers pay a larger share of the cost of the premium, or the generosity of the health insurance gets reduced. It may also even affect hours or whether people are employed as well. It cycles all the way around from the higher hospital prices in affecting the wallets of workers.

It's not like buying a quart of milk. Right? If a supermarket raises the price of a quart of milk by 25 cents, you and I see that immediately when I go to the cash register, but nonetheless it still comes around.

What does the evidence show? The evidence shows that that's exactly what happens and there's actually a recent study by some folks at Rand that shows that hospital mergers, I think, on average in their study, led to something like a \$521 increase in prices, and that led to approximately the same size—sorry, in prices—same size decrease in workers' wages.

Yes. Workers are directly affected. You can look at charts that show what's happening to workers' wages growing very slowly. Health insurance, health costs are going like this. Health premiums are going like this. All of that is evidence consistent with healthcare costs being born in large part by workers and affecting their wages.

Senator HAWLEY. Thank you, Madam Chair.

Chair KLOBUCHAR. Very good. I think Senator Grassley, is he going to—

Senator GRASSLEY. Thank you, Senator Klobuchar.

Chair KLOBUCHAR. You're remote. There's your voice. Voice of God. Thank you, Senator Grassley.

Senator GRASSLEY. Thank you. Say, as you know, I was a larger largely rural State, and I'm particularly interested in how these mergers and acquisitions affect rural hospitals in our communities. I'm going to ask Professor Gaynor a question and I think I should be fair to Dr. Hochman and ask him if he wants to react to what's—Professor Gaynor says.

In Dr. Hochman's testimony, Professor Gaynor, he references studies that show reduction in costs related to merged hospitals. However, in your testimony, you reference studies that showed the

opposite is true. Could you help me understand what is actually happening with costs to the consumers?

Professor GAYNOR. Thank you for the question, Senator Grassley. First, the costs—the cost that I think I referred to, and I suspect that Dr. Hochman referred to, are the costs of the firm operating costs. The consumer are what comes on down. Those are not exactly the same thing.

Let me start with the latter. When hospitals that are close to each other and are close competitors merge, prices go up, 5 percent, 10 percent, 20 percent, 40, 50, in some cases 65 percent. As I just said in responding to Mr. Hawley, that comes back, and that comes out of workers' pockets. Some studies show dollar for dollar. That's one.

As far as what happens to the costs, there's a lot of research evidence, and that research evidence on average does not show that costs are reduced. There are some studies that do show cost reductions. There's actually, I'd say, a very good study that was published in a scientific journal a couple years ago that does show significant cost reductions from hospital mergers. This is an important exception, not from mergers that are hospitals in the same market. In other words, not when hospitals are competitors.

As far as the studies that Dr. Hochman referred to, done by Charles Rivers Associates, those were commissioned by the American Hospital Association. Those were paid for by the American Hospital Association. Those were not subjected to any scientific review whatsoever, and they are not consistent with the scientific evidence done by independent researchers and subject to rigorous scientific review.

Senator GRASSLEY. Dr. Hochman, would you like to respond, or should I go on to my next question?

Dr. HOCHMAN. Oh, no. I'd love to have a chance to respond.

Chair KLOBUCHAR. Yes. He should. He hasn't been able to respond yet, so. I'll ask, I'll give him a chance as well. Go ahead.

Dr. HOCHMAN. I've got a long list here because it's really interesting. First of all, I want to thank you so much for all that you've done for hospitals and particularly for rural hospitals, Senator Grassley. It's made all the difference in the world and particularly, you know, for the critical access hospitals which I know you've championed. We have 14 of them in our system, and without your work we would not be able to have them exist.

Thank you so much for that support and, as you know, as the American Hospital Association had before COVID-19 as one of its top priorities, rural hospitals in the United States. This is not an issue around consolidation. The fact is that rural hospitals have been struggling. We've lost a 126 over the last 10 years. We lost 20 last year. They're in difficult financial situation, and we think there's a number of different ways that we can help rural hospitals, one of which is association with larger systems, but it's not the only solution to that issue.

The second is, I—you know, I'm listening to the so-called studies and I, you know, respectfully, Professor Gaynor, we just don't buy the data. You know, I, as someone who's spent 42 years in the front line of healthcare, taking care of patients, working in health systems, I think all of my colleagues are stunned at hearing what

we're hearing here. On the labor front, we have a scarcity of labor. My labor costs are going up.

Chair KLOBUCHAR. Dr. Hochman. Dr. Hochman.

Dr. HOCHMAN. Yes.

Chair KLOBUCHAR. I promise I'll let you answer those questions when Senator Grassley—I want to give Senator Grassley a chance to finish up asking his questions. Is that okay? Then you can go back—

Dr. HOCHMAN. Sure.

Chair KLOBUCHAR [continuing]. After that. Okay. Senator Grassley, you can have the time you need. Thank you.

Senator GRASSLEY. This should also be to Dr. Hochman, and this will probably be my last question, and I'll submit some for answer in writing. Last Congress I reached out to two different nonprofit hospitals to ask them about their billing and collection practices. Those hospitals were University of Virginia Medical Center Charlottesville and the Methodist Le Bonheur Healthcare Hospital in Memphis.

Those hospitals had news stories written about them because of their aggressive debt collection practices against low-income patients even though they were nonprofit hospitals. After those stories broke and after I sent my letters, those hospitals changed their debt collection practices. They also decreased the fees that they would charge different low-income patients.

Here's my question to you, Dr. Hochman. How widespread are the aggressive debt collection practices such as lien enforcement on homes and wage garnishments by other nonprofit hospitals throughout the country?

Dr. HOCHMAN. Senator, we couldn't agree with you more in that, you know, particularly if the AHA and my own health system, we put forward in April of last year new standards for all of the things around billing and collections, getting rid of all those egregious processes, such as liens and others and really establishing the base that at 200 percent of the, you know, net poverty level those patients should not be billed for anything that happens. In my own system it's up to 400.

I think all that work I think that has to be something that the AHA is strongly looking at. I—we can share with you all the guidelines that we have put in place as standard practice for all hospitals in the United States.

Senator GRASSLEY. Thank you, Madam Chairman.

Chair KLOBUCHAR. Thank you, Senator Grassley. Dr. Hochman, I promised I was going to let you finish up your answer. You were—I think you were addressing some of the labor issues because I know that you haven't had a chance to answer some of these—

Dr. HOCHMAN. Sure.

Chair KLOBUCHAR [continuing]. Questions that have been raised.

Dr. HOCHMAN. I mean, I—

Chair KLOBUCHAR. Mm-hmm.

Dr. HOCHMAN. Thank you so much, Senator. You know, on labor, you know, labor's our most important element. I mean, we couldn't have fought through this pandemic without all of our, you know, all of the labor folks that we've had. What we've found is the scar-

city of labor. Actually, during COVID-19 we were struggling hard in order to get enough nurses. One of the things that we wanted help on is that we there were some egregious practices on the part of a number of the staffing companies that were raising our prices to get traveling nurses.

We just don't see it. You know, whether it's our food service workers, they are a precious commodity for us. We have seen, if anything, steady increases in the labor costs which went to wages and better benefits—and we've seen when, in the case of Yale New Haven, when they merged with Saint Raphael Health System, they saved 500 jobs and were able to get benefits that were far better than what was in place before. I just—from the front line, I would say this as someone who's been out in the trenches in healthcare, we're just not seeing it on the labor side.

Chair KLOBUCHAR. All right. Do we have another Senator that wanted to—no. Okay. Senator Lee and I will just finish up here. There's a vote pending. Mr. Qadeer, do you want to respond on the labor issue?

Mr. QADEER. I appreciate Dr. Hochman saying that labor and workers are the most important element and that we couldn't have gotten through the pandemic without them. We certainly agree on that.

I think the study I referenced in my testimony, one of the things that makes it so remarkable is that, as Dr. Hochman was saying, there is a scarcity of healthcare workers, and despite that scarcity—I mean, this study took place in the midst of markets where there were—where there was a scarcity of labor of healthcare workers and nurses in particular, and yet the findings are still robust that hospital consolidation creates monopsony power which depresses wages—right—and the findings were that wages don't rise as much in labor markets where hospitals are consolidated as compared to wages in other types of markets.

Chair KLOBUCHAR. Okay. Senator Lee.

Senator LEE. Thank you so much. Okay. I'm going to try to move quickly through this round. We'll have to make it something of a lightning round since they've just called a vote.

Chair KLOBUCHAR. Yes. Senator Lee, you take your time. I think Senator Blackburn is going to ask questions maybe—

Senator LEE. Oh.

Chair KLOBUCHAR [continuing]. In 5 minutes or so. Just go ahead. Go ahead.

Senator LEE. Fantastic. Dr. Miller, we'll start with you. Why not just allow physicians to pool capital and compete against hospitals?

Dr. MILLER. Thank you, Senator Lee. I think that's exactly what we should be doing. We had a earlier discussion about private equity investing in hospitals causing harm to patients, also investing in practices in medical groups. Indeed, the American Antitrust Institute came out with a report on this today. I think the answer is not less competition. The answer is more competition.

Senator LEE. Right. That would certainly provide that, wouldn't it?

Dr. MILLER. Absolutely.

Senator LEE. By people who know the industry fairly well, and therefore know where prices could be reduced and also know where quality could be improved.

Dr. MILLER. Exactly. They could pool their capital and the—for example, the rural physician could have access to capital and operate—open and operate a hospital in a market which is not served or underserved by their nonprofit and for-profit competitors.

Senator LEE. Mr. Cannon, you talk in your testimony a little bit about how Federal policy, including Federal tax policy, ends up affecting the type of health insurance that people purchase. Among other things, you refer to the fact that by creating the advantageous tax treatment for employer sponsored tax—in employer sponsored health insurance, you end up incentivizing people purchasing more. How does this affect competition, and what do you think we ought to be doing to improve competition by looking at tax policy?

Mr. CANNON. Both by virtue of distorting the after-tax price of employer-sponsored insurance relative to other uses of income by lowering the after-tax price and by virtue of the fact that in an employer-sponsored insurance plan, it feels like it's someone else's money that the employer is spending, even though, as Professor Gaynor mentioned, it's really the worker's money that the employer is spending.

Both of these effects of the tax preference for employer sponsored insurance encourage employers to purchase for their workers more comprehensive insurance than those workers would choose on their own. This is fairly noncontroversial among economists. What that means—

Senator LEE. I assume that's compounded also by regulatory requirements we put on top of those.

Mr. CANNON. Correct. There are lots of mandated benefit laws at both the State and Federal level that require consumers to purchase insurance that they don't want.

The effect of this is consumers are more heavily insured. Less of the money that they're spending on their healthcare is coming directly out of their own pocket. It's coming from an insurance company or their employer, so they don't really care as much as they would if that were their money on the line. There is significant evidence that shows if you reduced these excessive levels of coverage, then you can actually reduce prices because excessive insurance encourages excessive prices for medical care because the consumer doesn't care about those prices anymore and insurers are not very good at keeping those prices down.

If you pare back the excessive coverage then what happens is you do get price competition, price competition that could even overcome the effects of hospital consolidation. There were a series of experiments conducted about 10 years ago by Safeway, by CalPERS, the California Public Employee Retirement System, that made patients—that pared back excessive coverage, that made patients more cost conscious when they were consuming things like lab tests and even hip and knee replacements, in the case of the CalPERS experiment. The prices for hip and knee replacements—they did this because the prices for hip and knee replacements across the State of California varied from \$12,000—the hospital charges var-

ied from \$12,000 to \$60,000, and the insurance companies could not get those really high prices down largely because those hospitals had such market power.

When they made the consumers conscious about the cost of their hip and knee replacements, amazing things happened. The consumer started asking about price information from the hospitals. They got the price information and, over a 2-year period, the high price hospitals in California reduced their prices for hip and knee replacements by 37 percent. That's \$16,000 per procedure. When do we ever see, well, price reductions at all in healthcare, but price reductions of that magnitude over so short a period of time?

It happened because these insurance companies did an experiment where they pared back the excessive coverage they had been providing, and consumers got broader access to, or got access to—they didn't reduce access to care for any of these consumers the way the experiment was conducted, but they did reduce the prices of these services, the consumers were able to tame the hospitals with market power in the ways that insurers wouldn't because it was the consumers themselves deciding, "Well, I'll go someplace else."

Senator LEE. What skin in the game did the consumer have in that circumstance?

Mr. CANNON. What—

Senator LEE. Why did they care whether it was \$12,000 or \$50,000?

Mr. CANNON. Fancy health policy term for it is reference pricing, but what the insurance company did was it said, "We will pay \$30,000 for a hip or knee replacement, and you can go to whatever hospital you want to go to. If they charge you more than \$30,000, you're paying 100 percent of that marginal cost." All of a sudden, consumers had an incentive to go to the lower priced hospitals or demand lower prices from the high-priced hospitals, and they did both and both things occurred. There was a big shift in volume away from the high-priced hospitals and the high-priced hospitals had to reduce their prices.

Senator LEE. Based on your review of that case study, is there anything there indicating a diminution in quality as consumers—

Mr. CANNON. No.

Senator LEE [continuing]. Shifted toward lower priced alternatives?

Mr. CANNON. No. The insurers picked \$30,000 because they could not determine any quality-based reason to pay a hospital any more than that for those procedures.

Senator LEE. Okay. There—are there any policy proposals that we can take from that example that we ought to fold in to Federal healthcare policy?

Mr. CANNON. You want to eliminate incentives that the Federal Government creates for excessive levels of health insurance that abet those sorts of excessive prices that consolidated markets or concentrated markets give rise to. The way you do that is by reforming those two features of the tax exclusion for employer-sponsored insurance that I measured—mentioned before. You can do so by converting it to an exclusion for money that the worker takes and puts into a health savings account that they could then use to

purchase health insurance or medical care on a tax-free basis just as employers now use—or can purchase health benefits on a tax preferred basis.

Senator LEE. I've run out of time. I appreciate the Chair for letting me take that, but I think it's very important. You're—what you're talking about is allowing that favorable tax treatment to follow the consumer rather than the employer. Individuals rather than big corporations creates better competition, lowers prices, increases quality.

Mr. CANNON. Exactly.

Senator LEE. Thank you.

Chair KLOBUCHAR. All right. Senator Blackburn, who's remote.

Senator BLACKBURN. Thank you, Madam Chairman.

Chair KLOBUCHAR. Thank you.

Senator BLACKBURN. To our witnesses, thank you for a very spirited debate. This has been helpful today. Rural hospitals have been one of my focuses. I wanted to come to Dr. Hochman for just a little bit on this issue. We know that rural hospitals are facing a shortage of health professionals and resources, and COVID has really exacerbated the problems in our rural areas. Sometimes, what we have seen in Tennessee, is sometimes these hospitals are relying on transfers from larger health systems to care for patients' intensive needs.

Dr. Hochman, I'd love for you to discuss for just a few seconds how healthcare systems have come around some of these rural facilities that are in underserved areas and have really kind of helped stand with them during COVID.

Dr. HOCHMAN. Thank you very much, Senator Blackburn. You know, I think, you know, what we've seen during COVID is that the rural hospitals needed our help. Whether they were affiliated or part of our network, we hooked up a number of our rural hospitals with telehealth to get the specialists out there. I think telehealth is one of the things that's going to be incredibly important to rural healthcare. The other—go ahead.

Senator BLACKBURN. Go ahead.

Dr. HOCHMAN. Then the other thing I think we need to help our rural healthcare partners with is making sure, ensuring that they can get the doctors and professionals that they need out there because people want to get care close to home. If we lose rural healthcare, we're going to lose something that—people want to get care in the communities they live—and also looking at the different models of rural healthcare. What services are needed? What are the, you know—so if someone's is a little bit sicker, how do we ensure that they're able to move seamlessly without an effect on the patient if they need care somewhere else?

Senator BLACKBURN. Sometimes that takes a larger facility being able to work in coordination with those community health centers in order to get them in there.

Mr. Cannon, let me ask you this. You know, you talk about telehealth. We talk about getting healthcare workers into rural areas. Senator Durbin and I have been working on that. We have legislation that would do that. Let's look at Senator Klobuchar's bill. If this bill were to pass and be signed into law, what effect would it have on our rural communities that are facing hospital closures?

Mr. CANNON. I apologize, Senator, I'm not familiar enough with the bill to provide an opinion.

Senator BLACKBURN. Okay. Thank you for that. If you would look at the bill, and then I will submit that to you for a response in writing.

Mr. CANNON. I would be happy to do so.

Senator BLACKBURN. That sounds good. Dr. Hochman, let me come back to you. What other options do our rural communities have in seeking adequate healthcare if their local hospital struggles to remain open and is at risk of closing and there is not a larger hospital group that they can come under that umbrella?

Dr. HOCHMAN. We're going to need some flexible funding support for those hospitals so they're able to—be able to keep their services in their community. We think there are some public-private funding opportunities for those local hospitals. I think we got to be really innovative about rural healthcare. Before the pandemic, that's what we were spending a lot of our time and energy on was trying to figure those pieces out. I think it's doubly so.

You know, rural hospitals as well, as you know, mental health problems are paramount, right? They're having to serve all the patients in those communities. I think whatever we see in other hospitals is magnified so greatly in the rural community that we really need to put a full court effort on all of that. That's what we think. It deserves different funding options, different ways to pay for care, different ways to provide personnel and training and the use of telehealth as well.

Then also, not necessarily being taken over by large hospitals that we see, let's say in a place like Tennessee, but how do they affiliate in a way that they can be supported so that they can stay independent and take care of their patients?

Senator BLACKBURN. Yes. We hear a good bit about that from our rural communities. Another thing that is discussed often is the average out-of-pocket cost that a patient pays and over the past decade the escalation rate of that out-of-pocket cost.

Mr. Cannon, let me ask you this. How has intervention by the Federal Government into the healthcare delivery system and, especially if we're talking about the last decade, through the Affordable Care Act, how has that caused escalation in cost? How has it caused consolidation of insurance and affected access to care?

Mr. CANNON. As I mentioned in my written testimony and mentioned in my remarks, economist Kenneth Arrow explained, 50 years ago, that insurance increases prices because it reduces the incentives for patients, providers to shop around for lower-cost hospital and surgical care and other types of care as well.

To the extent the Affordable Care Act expanded health insurance coverage—there are many benefits to expanding health insurance coverage—but to the extent it did that, it made patients less cost conscious about the care that they are consuming, encouraged, then, people who were insured to consume more care than they did, but—than they would have otherwise, and required them, as mentioned with Senator Lee, to purchase types of coverage that they—types of coverage they would not have wanted to purchase.

The main takeaway is that we already paid for a larger share of healthcare in this country through third parties than just about

any other OECD country except for maybe one or two. Patients are more insulated from the cost of their care here in this country than in other countries. What that does is it puts upward pressure on prices and encourages sort of consolidation that we're talking about here.

The Affordable Care Act has been part of that, not only on the financing side, we've been discussing coverage levels, but also on some of the regulations that the Affordable Care Act introduced. The minimum loss ratio regulations that I mentioned in my testimony, the pre-existing conditions provisions in the ACA also encourage consolidation in various ways and I think have, you know, similar effects of other regulations that encourage consolidation on prices.

Senator BLACKBURN. Thank you. Thank you, Madam Chairman. I've got a couple of other questions. I'll submit those for written response. Thanks.

Chair KLOBUCHAR. Perfect. Thank you very much, Senator Blackburn. I think we're coming to an end here. I just—I had one last question here for Dr. Gaynor. As I look at some of the things that could happen here that are straightforward, we had some good discussions about the resources where there's some bipartisan support. We've talked about some of the labor issues, the consolidation, what's been happening by looking backward, looking forwards. We talked about the financing at length. A number of Senators asked about that and the effect on that as a driver.

My question, Dr. Gaynor, one last thing, I don't think we've discussed is in 1996, the Department of Justice, I think people have mentioned this, and Federal Trade Commission issued a lengthy series of guidelines about their approaches to antitrust enforcement in healthcare, covering mergers, data sharing agreement and multi-provider networks. That's quite a while ago. A lot has changed. Do you think the agency should issue new guidelines on hospital antitrust enforcement and if so, what should those guidelines include?

Professor GAYNOR. Thank you, Senator Klobuchar. A very able summary. One could have said, "Healthcare. Who knew it was so complicated?" Yes, the agencies did coordinate on guidelines. As a matter of fact, they included talking about things like, guess what, A.C.O.s and other things. It's been a long time. A lot has changed. I think it would be a very worthwhile investment for the Antitrust Division and for the Federal Trade Commission to sit down and update and revise those guidelines.

One thing, of course, is simply incorporating what we know about horizontal mergers, both on the efficiencies side, what the evidence really says, and on the potential harm side, and make a clear statement about what that means, what the agency's stances will be. They'll be very valuable to market participants. They'll get a clear signal from the agencies, and it will be valuable to the courts.

Also, nonhorizontal mergers, we've talked a lot about this, particularly hospital acquisitions of physician practices. That's something that's very different now than it was in 1996. The same kind of thing. What do we know about these things? What are the Agencies' stances on this? Anticompetitive conduct, we've talked about

that a bit. That's also something that is a much more prominent issue now than it was then. I think that updating those guidelines, talking about that, providing clarification, would be very important and very valuable.

I want to be clear. It's not really for the agencies' sake primarily. It's important to market participants. Everybody has to know what's expected, what the rules of the road are, and it will help courts as well. Courts have a very hard time with antitrust in general and with healthcare in particular, and I think this kind of thing can also help the courts function better. Thank you.

Chair KLOBUCHAR. Okay. Last word, Dr. Hochman. Do you want to—would you like to see those guidelines change? I have a feeling you'd say to change them in a different way, but—

Dr. HOCHMAN. Yes. I would.

Chair KLOBUCHAR [continuing]. Do you want to respond?

Dr. HOCHMAN. Yes. Absolutely. I think they need updating. I would also say that, you know, there's a pretty vigorous process that goes in place. Again, speaking from the front lines and when Vice President Harris was the Attorney General in California, we dealt with a lot of issues with her, and I've got to tell you they were very vigorous in terms of what we should or shouldn't do. We're seeing a lot of that. I think, you know, for the audiences that, you know, there's many, many deals that never go through because they shouldn't go through.

To think that the enforcement process that we have today is inadequate is wrong. You know, I think, you know, there's always things I think that could be done better, and I think we'd submit to you some ideas that we would have for how to make this better. Overall, I think we need to understand that there is a pretty rigorous process in place that exists both at the FTC level, but also at the attorney general level. I know Senator Blumenthal, we've got a lot of former attorney generals that are there, and they're pretty vigorous about deciding what makes sense and what doesn't make sense.

I just leave—need to leave you with one thought and I—you know, I know I'm a minority here, but I can tell you consolidated systems have saved lives during COVID. Doctors work together. Scientifically, the quality gets better. I'm sorry. For those of you, you know, who are kind of listening to this, I just don't buy it. The quality has gotten better when doctors, hospitals work together for patients.

Remember that our sole objective in my 42 years is the health of the communities that we're dealing with. We care most about the patients. That's what we're there to do, and to serve the communities that we're in. I have to really greatly differ with some of the opinions that you've heard. We'd be glad to give you some more of our information as we take care of the COVID pandemic, which is still in place as we speak today. Thank you, Senator Klobuchar.

Chair KLOBUCHAR. All right. Thank you very much. We are going to keep the Record of this hearing open for a week, and I'm sure there will be more to come on all of this, but I want to thank all of our witnesses, both those remote and those in the room. It was a vigorous discussion. We had a lot of Senators participate, both the Chair and the Ranking Member were here, which meant a lot.

Senator Lee and I will move forward together on this. Thank you very much.

Chair KLOBUCHAR. The hearing is adjourned.

[Whereupon, at 4:28 p.m., the Subcommittee was adjourned.]

[Additional material submitted for the record follows.]

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Statement

of

Michael F. Cannon, M.A., J.M.

**Director of Health Policy Studies
Cato Institute**

before the

**Subcommittee on Competition Policy,
Antitrust, and Consumer Rights,
Committee on the Judiciary,
United States Senate**

May 19, 2021

**Re: "Antitrust Applied: Hospital
Consolidation Concerns and Solutions"**

Chair Klobuchar, Ranking Member Lee, and Members of the Subcommittee:

My name is Michael F. Cannon. I am the director of health policy studies at the Cato Institute. Thank you for inviting me to testify today.

The Cato Institute is a 501(c)(3) non-partisan, non-profit, tax-exempt educational foundation dedicated to the principles of individual liberty, limited government, free markets, and peace. Cato scholars conduct independent research on a wide range of policy issues. To maintain its independence, the Cato Institute accepts no government funding. Cato receives approximately 80 percent of its funding through tax-deductible contributions from individuals. The remainder of its support comes from foundations, corporations, and the sale of books and other publications. The Cato Institute does not take positions on legislation.

Introduction

The U.S. health sector is not serving consumers as it should or could. Excessive, often unconscionable prices threaten to wipe out the health savings account (HSA) balances and other savings of even insured Americans.¹ Low-quality care costs lives and eludes quality-improvement efforts.²

Provider consolidation is an important contributor to both these deficiencies. To be clear, not all consolidation is harmful to consumers. Consolidation that enables integrated health care delivery can reduce costs while improving quality and convenience. The economics literature nevertheless finds that most consolidation among hospitals, physicians, and insurance companies increases prices and/or reduces quality. My co-panelist Prof. Martin Gaynor has written a highly readable summary of the evidence.³

Inefficient consolidation, however, is not merely a driver of higher prices and lower quality. It is also a symptom of a greater problem. By and large, inefficient consolidation is the result of government interventions that disable the normal market mechanisms of entry, cost-consciousness, and competition from doing what they do in other sectors of the economy: improving quality while reducing prices.

How Government Intervention in Health Care Markets Encourages Consolidation

Federal and state governments intervene in health care markets in various ways, always with the stated purpose of improving quality and/or reducing costs. Such interventions

¹ See Charles Silver and David Hyman, *Overcharged: Why Americans Pay Too Much for Health Care* (Cato Institute, 2018).

² See Jacqueline Pohida & Michael F. Cannon, "Would Medicare for All Mean Quality for All? Medicare's Negative Impact on Health Care Quality," forthcoming.

³ Martin Gaynor, "What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work," Brookings Institution Policy Proposal 2020-10, March 2020.

encompass regulation of health professionals, medical facilities, and health insurance issuers; subsidies for health insurance and medical care, including direct government purchasing of both; and special tax preferences for health-related uses of income.

These interventions often produce unintended consequences. Among other effects, they create incentives for the type of consolidation that gives producers the ability to charge higher prices than they could in competitive markets. I will briefly discuss three categories of government intervention into the health sector that encourage inefficient provider consolidation.

Government regulation. Complying with government regulations generally imposes high fixed costs but low marginal costs. Regulation therefore puts larger firms at a competitive advantage and smaller firms at a disadvantage because the former can spread the fixed costs of compliance over a larger quantity of outputs than the latter can. Government regulation therefore gives larger firms a built-in price advantage that inhibits entry, that grows as the firm grows, and that encourages firms to merge with their competitors.

Government regulation also rewards large firms in other ways. The Patient Protection and Affordable Care Act's (ACA) "minimum loss ratio" (MLR) regulations require insurers in the individual and small-group markets to spend no more than 20 percent of premium revenue on administrative expenses and quality-improvement activities. The cap for large-employer plans is 15 percent of premium revenue. "The fixed costs of complying with the ACA's MLR and other insurance regulations will weigh more heavily on smaller insurers and increase the costs of entry by new insurers...The MLR rules could encourage insurers to consolidate to obtain product portfolios more likely to meet the minimum MLR requirements (e.g., from pooling expenses or reducing statistical volatility in MLRs), or simply to achieve additional economies of scale in administration."⁴

So-called "certificate of need" (CON) laws, which dozens of states have enacted, also encourage consolidation by protecting incumbent providers from competition from new market entrants.

Government encouragement of excessive insurance. A second category are various government policies that encourage consolidation by encouraging more comprehensive health insurance than consumers would choose on their own. The tax exclusion for employer-sponsored health insurance and laws that require consumers to purchase minimum levels of coverage both have this effect.

Insurance reduces price competition by "remov[ing] the incentive on the part of individuals, patients, and physicians to shop around for better prices for hospitalization

⁴ Scott E. Harrington, "Medical Loss Ratio Regulation under the Affordable Care Act," *Inquiry*, Vol. 50, No. 1, (2013), p. 21.

and surgical care.”⁵ This fact also constrains insurers’ ability to negotiate lower prices. Insurers’ main tool in this regard is to exclude a provider, drug, or device from coverage in order to demand greater price concessions. Dissatisfaction among enrollees who prefer the provider, drug, or device that an insurer excludes—and who bear only a small share of the cost if the insurer accedes to a higher price—generally tempers insurers’ ability to employ such strategies.

The tax exclusion for employer-sponsored health insurance exacerbates this problem in two ways. First, it encourages workers to demand and employers to provide on average more comprehensive health insurance than workers value. The more comprehensive health insurance plans are, the larger a share of their medical care consumers will purchase via their health insurance. This effect increases the share of medical spending for which insurance reduces price competition. Second, because workers generally do not select and pay for their health insurance themselves, the savings from insurers’ strategies to negotiate lower prices are not salient to enrollees. Enrollees therefore exhibit greater dissatisfaction with such strategies and further constrain insurers’ ability to negotiate lower prices.

Both of these effects—insurers purchasing a larger share of medical spending and greater enrollee resistance to insurers’ negotiating strategies—increase the incentives for health care providers to consolidate, because they allow providers to demand even higher prices from insurers, who face strong incentives to accede to providers’ demands rather than face a backlash from enrollees.

Government purchasing. The third category is government purchasing of medical care and the pricing errors that follow. Medicare often pays more for the same service when the patient receives it in a hospital versus a physician’s office. “When a cardiologist in private practice provided a level II echocardiogram without contrast,” for example, “Medicare paid \$188. But, when a doctor connected to a hospital performed the same test in an outpatient context, the payment was \$452.89. That’s an additional \$265 that the hospital and doctor can share—including an additional \$212 from taxpayers and \$53 from the patient—to their mutual advantage.”⁶

Such “site-of-service differentials”—a fancy name for government pricing errors—encourage hospitals and physician practices to consolidate in order to capture and split the benefits of those excessive Medicare prices. Once those firms merge, not only do taxpayers pay more for the same services via the Medicare program, but those firms’ greater market power allows them to increase prices for private payers as well.

⁵ Kenneth J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *The American Economic Review*, Vol. 53, No. 5. (Dec., 1963), p. 962.

⁶ Silver and Hyman, *Overcharged*, p. 181.

Eliminate Government Interventions that Encourage Consolidation

To reduce costs and improve the quality of medical care, policymakers must undo state and federal interventions that encourage consolidation. I concur with Prof. Gaynor that states should at a minimum drastically curtail CON laws, “any willing provider” laws, and clinician-licensing regulations that inhibit “entry and the advance of innovative ways of organizing and delivering care,” and that Congress should curtail “network adequacy” laws that inhibit competition among both insurers and providers.⁷ Merely adjusting these regulations, however, would leave in place significant government interventions that encourage consolidation. Making health care markets work for consumers requires significant reform across many fronts.

State-Level Reform. States should outright repeal all CON laws and “any willing provider” laws. Despite their laudatory stated goals, in practice these regulations do little more than protect providers from competition at the expense of consumers.

States should likewise either repeal clinician-licensing laws or overhaul them in a manner that prevents them from blocking new categories of health professionals; innovations in medical education; or innovations in health care delivery such as affordable primary care, interstate telehealth, and integrated delivery systems. I concur with Prof. Gaynor’s recommendation that “states that have not done so already should adopt licensure reciprocity across states.”⁸ Another approach would add flexibility to clinician licensing by having states certify multiple private organizations that would perform the functions of state licensing boards.⁹ Still another approach would be simply to eliminate government licensing of clinicians, a form of regulation whose anti-competitive effects reduce access to care and which adds little if anything to the quality protections that would exist in its absence.¹⁰

Federal Reform. In addition to repealing federal “network adequacy” laws, Congress should eliminate the government price controls that give rise to such laws. Both the Medicare Advantage program and the ACA prohibit insurers from charging actuarially fair premiums to enrollees. While the stated purpose of such regulations is to eliminate discrimination against patients with preexisting conditions, these regulations merely shift such discrimination to the level of benefit design, where it becomes even more harmful.¹¹

⁷ Gaynor, pp. 20-21.

⁸ Gaynor, p. 21.

⁹ See Shirley V. Svorny and Michael F. Cannon, “Health Care Workforce Reform: COVID-19 Spotlights Need for Changes to Clinician Licensing,” Cato Institute Policy Analysis No. 899, August 4, 2020.

¹⁰ See Shirley V. Svorny, “Medical Licensing: An Obstacle to Affordable, Quality Care,” Cato Institute Policy Analysis No. 621, September 17, 2008.

¹¹ See Michael F. Cannon, “Is Obamacare Harming Quality? (Part 1),” *Health Affairs* (blog), January 4, 2018; Michael F. Cannon, “How to Ensure Quality Health Coverage (Part 2),” *Health Affairs* (blog), January 5, 2018; and Michael F. Cannon, “Obamacare Makes Discrimination against Those with Preexisting Conditions Even Worse,” *Washington Examiner*, December 7, 2020.

The purpose of “network adequacy” laws is to counteract the perverse incentives those price controls create. Eliminating those price controls eliminates the need for them.

Making health care markets work for consumers also requires allowing consumers to control the \$4 trillion that fuels the U.S. health sector. Congress should reform Medicare,¹² Medicaid,¹³ and the tax treatment of health insurance¹⁴ to give enrollees and workers control over the health care dollars that the federal government and employers currently control. Converting the current tax exclusion to one for contributions to expanded HSAs would deliver the largest effective tax cut in living memory.¹⁵

With such reforms, consumers would personally reap the benefits of lower prices and would demand price competition from both insurers and health care providers in a way that consumers who are spending other people’s money simply do not. Moreover, the health care sector would respond to consumers in a way it simply does not today. An experiment in California, for example, found that whereas hospitals’ market power forced insurance companies to accede to excessive prices for hip and knee replacements, in just two years cost-conscious consumers forced high-cost hospitals to cut their prices by 37 percent—an average reduction of \$16,000 per procedure.¹⁶ If we want to challenge the market power of consolidated providers, we need to let consumers control the money.

Conclusion

Consolidation among hospitals and other players in the health care sector is a serious concern. Inefficient consolidation, however, is primarily a result not of market forces but of ill-advised government interference in health care markets.

This subcommittee can steer the health care debate toward pro-competitive policies that would make health care better, more affordable, and more secure for all Americans, particularly the most vulnerable.

I thank you and look forward to your questions.

¹² See Pohida and Cannon, forthcoming.

¹³ See Michael F. Cannon, “Medicaid and the State Children’s Health Insurance Program,” in *Cato Handbook for Policymakers*, 8th edition (Cato Institute, 2017).

¹⁴ See Michael F. Cannon, “The Tax Treatment of Health Care,” in *Cato Handbook for Policymakers*, 8th edition (Cato Institute, 2017).

¹⁵ Cannon, “The Tax Treatment of Health Care.”

¹⁶ James C. Robinson and Timothy T. Brown, “Increases in Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery,” *Health Affairs*, Vol. 32, No. 8 (August 2013), and author’s calculations.



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Testimony
of the
American Hospital Association
for the
Subcommittee on Competition Policy, Antitrust, and Consumer Rights
of the
Committee on the Judiciary
of the
U.S. Senate
“Antitrust Applied: Hospital Consolidation Concerns and Solutions”

May 19, 2021

Good afternoon Chair Klobuchar, Ranking Member Lee and members of the Subcommittee. I am Dr. Rod Hochman, Chair of the American Hospital Association's (AHA) Board of Trustees, and I am pleased to be here today representing our nearly 5,000 member hospitals, health systems and other health care organizations across the country. On behalf of the AHA, I thank you for your support as our hospital and health system teams cared for the millions of patients with COVID-19 over the past year and a half. Our hospitals and health care workers are heroes, and they continue to serve on the front lines of this pandemic as we gather today.

I have served in the medical field for 42 years as an immunologist and rheumatologist, and I currently serve as president and CEO of Providence, a 52-hospital, integrated, not-for-profit health system located throughout the West – from Alaska to Texas.

I know we have a shared commitment to ensuring patients have access to the lifesaving care that caregivers in our hospitals provide. I am particularly pleased to have the opportunity to share with you how our caregivers at hospitals, and hospital systems in particular, serve patients and communities around the nation, in addition to their heroic efforts on the front lines of the COVID-19 pandemic. I've known for a long time, but



COVID-19 has underscored, that hospitals are the lifeline of our communities. We are this nation's most trusted public health safety net.

Hospitals continue to care for all the patients who walk through their doors and to meet the challenges present in the communities they serve. Whether those challenges include a surge in COVID-19 patients, treating victims of addiction, mass violence, accidents or natural disasters, or an increase in maternal deaths or cancer, hospitals are stalwarts of their communities. Serving all of these community needs – and many others – requires more integration than ever. Integration is necessary to assure that both the human and financial capital is available to stand up, reconfigure or even reimagine the services needed and how best to deliver them in a field facing increasing competition.

The hospital field is awash with new entrants, such as commercial health insurers that own physician practices and technology companies offering services that compete with those provided by integrated hospital systems. Many of those competitors do not play by the same rules as hospitals and health systems or even pretend to serve the entire community. This increases the pressure on integrated hospital systems to fill in the gaps for a ragged public health infrastructure and to serve everyone in the community, including those the technology companies would leave behind.

Hospital mergers and acquisitions also enjoy an enormous amount of scrutiny from the federal antitrust agencies and state attorneys general. The AHA has been critical of the approach and framework the Federal Trade Commission (FTC) has employed to review hospital transactions. The FTC continues to challenge any transaction it believes presents anticompetitive risks and until recently had an impressive track record in the courts. However, the transactions challenged publicly only tell part of the story as the FTC has many tools to discourage hospitals moving forward with a transaction before it gets to court.

There are many reasons for mergers and acquisitions in the hospital field. Often they are prompted by financial pressures that can limit a hospital's ability to marshal the resources needed to effectively care for its community, especially small and rural critical access hospitals. The numbers alone tell the story: 136 rural hospitals have closed since 2010,ⁱ inpatient admissions have been declining for years, and Medicaid and Medicare rates are perpetually below the cost of providing care. Those combined underpayments amounted to \$75.8 billion in 2019, according to the AHA.

At the same time, hospitals' expenses continue to grow. Prescription drug spending per hospital admission increased 18.5% between fiscal years 2015 and 2017.ⁱⁱ Private staffing firms and agencies are leveraging workforce shortages to drive up labor costs, a trend that has been exacerbated dramatically by the COVID-19 pandemic – a topic AHA requested the FTC investigate to no avail.^{iii,iv,v}

Commercial health insurer consolidation contributes substantially to increasing providers' costs in ways that do not benefit consumers. Seventy-four percent of metropolitan statistical area (MSA)-level markets were highly concentrated in 2019, up from 71% in 2014.^{vi} In fact, in nearly half of all markets (48%), one insurer's share is at

least 50%. And peer-reviewed studies have found that when an insurance market is highly concentrated, insurers reduce provider payments and do not pass savings along to the consumer.^{vii} In addition, some of the insurers are using leverage gained by acquisitions that went unchallenged by the federal antitrust agencies to increase costs for hospitals and health systems with myriad rules that create hurdles to care. These do not benefit patients and needlessly increase hospitals' costs.^{viii}

As health insurers have grown, they have diversified their health care portfolios to provide products and services in ways that circumvent medical loss ratio limits on profit, including in technology, analytics, pharmacy and care delivery. For example, UnitedHealth Group directs a substantial amount of premium dollars to itself through its growing network of employed, affiliated and managed providers – it currently has 53,000 providers and plans to grow by at least 10,000 more by the end of this year.^{ix} And insurers' acquisition of pharmaceutical benefit managers are contributing to the increase in hospital and health system drug spending. In fact, three of the largest pharmacy benefit managers are owned by health insurers: Caremark (CVS Health), Express Scripts (Cigna), and OptumRx (UnitedHealth Group).^x

THE BENEFITS OF BEING PART OF A HEALTH SYSTEM

Being a member of a health system brings measurable benefits to patients and health system employees: lower health care costs, improved patient care, better access to health care providers, and increased investment in technology and equipment.

Lower Health Care Costs

Mergers with larger hospital systems can provide community hospitals the scale and resources needed to decrease costs.^{xi} Various studies confirm that increased administrative efficiencies and reduction of redundant or duplicative services contribute to merger-related cost reductions.^{xii, xiii}

For example, hospital mergers between 2009 and 2014 “were associated with a 2.5% reduction in operating expense per adjusted admission at the acquired hospitals.”^{xiv} And extending the analysis through 2017 finds a 2.3% reduction in annual operating expenses per admission at acquired hospitals, and an approximately 1.5% to 3.5% reduction in total expenses through consolidation of administrative and supply chain operations.^{xv} Another study of hospital transactions between 2000 and 2010 found “evidence of economically and statistically significant cost reductions at acquired hospitals” averaging between 4% and 7%.^{xvi}

Moreover, additional substantial savings come from improved information technology (IT) systems and advanced data analytics. Consolidated hospital systems can often better invest in IT infrastructure for both clinical and financial data that can then be used to identify best practices for more cost-effective, integrated and streamlined care.^{xvii} These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals. Hospital systems can spread the costs over a larger patient population while also performing more sophisticated analyses given the larger patient database to identify patterns and improve care. In a survey of hospital

executives involved in mergers, implementing or upgrading clinical information systems was the most common use of new capital received by the acquired hospital.^{xviii}

In addition, hospitals realize the cost benefits of mergers quickly, with hospitals largely reporting reduced operating expenses one year after the merger.^{xix} And the benefits have a lasting impact, with studies finding cost savings still evident four years after consummation of the merger and lower cost growth rates and lower price growth rates at merging hospitals compared to non-merging hospitals over an extended period.^{xx}

Unfortunately, consumers do not always benefit when hospitals are able to reduce costs because commercial insurance consolidation has allowed insurers to pocket those savings instead of passing them on to consumers. This was laid bare when the Department of Justice challenged the attempted merger of Cigna with Anthem.

Increased Ability to Make Needed Capital Investments and Effectively Deploy Other Resources

Financially distressed hospitals often cannot effectively recruit clinical staff, upgrade technology or offer specialty services, relative to their financially stable peers. Acquiring-hospitals often provide capital infusions to address these issues, as evidenced by the almost 80% of respondents in one survey who reported significant capital investments in the acquired hospital after the transaction.^{xxi} These investments result in improved services.

Mergers also can help hospitals “respond to marketplace needs and can help ameliorate resource constraints,” including physical space, capital and personnel.^{xxii} With reduced patient volumes and financial difficulties, community hospitals often have excess capacity.^{xxiii} Significant excess capacity can result in higher operating costs per patient, but reduction or elimination of excess capacity may be difficult to achieve absent mergers or consolidation.^{xxiv} When a transaction involves an academic medical center it may be because those organizations often have capacity constraints that can be addressed by a merger with a community hospital.

More efficient allocations of resources also facilitate treatment of patients in less costly settings. For example, integration of community hospitals with academic medical centers or hospital systems allows the health system to admit patients to the facility best suited for their needs and decrease costs of care. Patients using the academic medical center for less complex services instead could be treated at the community hospital, easing capacity constraints at the academic medical center, potentially lowering patients’ costs, and often providing a more convenient location for the patients. The academic medical center could then reutilize existing space for the specialist, tertiary and quaternary services not available at community hospitals.

Greater Ability to Participate in Payments Linked to Outcomes

Scale and capital investment also are key conditions that hospitals and health systems must meet in order to take on risk and participate in alternative payment models. Provider payment is moving away from volume-based systems in an effort to focus on patient outcomes while reducing costs. Realignment care around these incentives requires scale in order to take on financial risk. Moreover, these efforts would not be

possible without analytics and key investments in health technology. Hospital and health system mergers will help boost participation in these models, which in turn will drive down the cost of care and improve health outcomes.

More Stability and Opportunities for Hospitals' Workforce

Hospitals are often anchors for their communities and key economic contributors. Hospitals are jobs creators, and hire employees to serve in many roles, both skilled and unskilled. For example, the Saint Raphael campus added 541 employees following its 2012 merger with Yale New Haven Health. Hospitals are perpetually working to fill clinical positions, including physicians and nurses, where shortages are common and projected to get worse. That was never truer than during the pandemic when skilled nurses treating COVID-19 patients were in short supply and private nursing staffing agencies were charging double and even triple their usual fees to obtain their services.

Measuring workers' benefits on the basis of salary alone fails to account for benefits that can make hospitals the best places to work in any community. Hospitals and health systems provide many other benefits such as retirement plans, life and other insurance coverage, subsidized child care and tuition reimbursement, to name a few. Mergers and acquisitions can provide new benefits, as well as growth or promotional opportunities. For example, Yale New Haven Health reports that over 1,100 employees of Saint Raphael Hospital were able to take part in career ladders to further advance their careers as a result of their merger in 2012.

Quality Improvements Fueled by Mergers

Mergers can provide community hospitals with the necessary scale to use sophisticated data analytics, identify best practices and implement innovations such as telemedicine. Data-driven development of best practices can reduce the rates of readmission and mortality in merged hospitals.

For example, one hospital system in the Northeast was able to better deploy their surgical staff according to expertise and experience following an acquisition, which led to improved health outcomes.^{xxv} Statistically significant empirical results include a decrease of 1.1% in the 30-day readmission for heart attacks and a decrease of 1.7% in the mortality rate for pneumonia.^{xxvi} Other quality improvements following a hospital acquisition include increased Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, reduced readmissions, reduced physician appointment wait times and reduced mortality.^{xxvii}

The Pandemic Confirmed the Value of Health Systems' Integration

The COVID-19 pandemic has highlighted many of the benefits of being part of a health system. Hospitals and health systems were faced with multiple COVID-19 surges that pushed resources to capacity. Integrated health systems were well positioned to deploy their resources to procure equipment in short supply, utilize IT systems to triage equipment and staff, reconfigure space to focus on infected patients and separate them from others, participate in large scale targeted research, and perhaps most importantly, redeploy the workforce needed to meet these rapidly changing needs in multiple locations.

As COVID-19 case surges occurred throughout the country, health systems with multiple hospitals were able to transfer patients from one facility to another depending on their respective volume levels and available hospital and intensive care unit (ICU) beds. This was especially true for health systems with smaller, rural hospitals that had fewer ICU beds and staff trained to treat infected patients. Having the ability to look across a system and identify where there was available capacity was immensely important to ensuring that patients got needed care and that resources were used efficiently.

This wasn't just limited to transfers of patients. Faced with unprecedented workforce challenges, health system leaders often were able to develop flexible staffing strategies to address patient surges in emergency departments, ICUs, and medical and surgical units. This extended beyond clinical staff. Health systems often were able to redeploy administrative staff to the front lines in roles such as unit clerks and vaccination processing teams.

Health systems also were able to deploy their resources and size to quickly mobilize dedicated supply chain teams responsible for tracking down personal protective equipment and other supplies and purchase them in bulk to avoid shortages. Often these efforts were on a global scale, as system staff looked for supply sources outside their typical chains around the world. In some cases, health systems were able to invest directly in domestic manufacturers to actually produce supplies.

In addition, health systems often were able to develop in-house testing capabilities, drastically expanding and supplementing often dangerously strained local and state public health efforts. Many systems that established testing sites were later infusion centers and more recently vaccination sites.

The ability to harness data and analytics to understand current trends, predict future needs and quite often expand care capacity also was essential during the year. Again, health systems often were able to use their existing data and IT infrastructure to meet these rapidly changing needs.

CONCLUSION

Some critics are quick to dismiss the benefits of hospital mergers and acquisitions. As a physician with over four decades of experience caring for patients, I can tell you that integration is the key to ensuring every community, whether rural, urban or suburban, has access to the same high standard of affordable, evidenced-based care. The ability of health systems to marshal financial and human resources during the pandemic to save lives and protect communities illustrates vividly their enduring value. And unlike other sectors of health care, communities can be assured that there is vigorous oversight by every level of government to assure those benefits are actually delivered to the patients hospitals and health systems serve. We look forward to discussing with you our shared goal of ensuring that hospitals remain a vital source of care for everyone in their communities, and that they can meet whatever new challenges arise as we work to advance health in America.

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- ⁱ <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>
- ⁱⁱ <https://www.aha.org/system/files/2019-01/aha-drug-pricing-study-report-01152019.pdf>
- ⁱⁱⁱ <https://www.modernhealthcare.com/labor/healthcare-providers-face-high-costs-demand-agency-staff-covid-19-rages>
- ^{iv} <https://www.reuters.com/article/us-health-coronavirus-usa-nurses/coronavirus-drives-up-demand-and-pay-for-temporary-u-s-nurses-idUSKBN2180HF>
- ^v <https://www.aha.org/lettercomment/2021-02-04-aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-and>
- ^{vi} <https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-insurance-research>
- ^{vii} <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548>
- ^{viii} <https://www.aha.org/lettercomment/2021-03-17-aha-urges-doj-investigate-unitedhealth-groups-acquisition-change>
- ^{ix} <https://www.bloomberg.com/news/articles/2021-03-05/unitedhealth-s-deal-machine-scoops-up-covid-hit-doctor-groups>
- ^x James L. Madara. 2018. Letter to the Honorable Makan Delrahim, Assistant Attorney General, regarding The Acquisition of Aetna, Inc. by CVS Health Corporation.
- ^{xi} <https://www.aha.org/2019-09-04-charles-river-associates-report-hospital-merger-benefits>
- ^{xii} Schmitt, M.: “Do Hospital Mergers Reduce Costs?” *Journal of Health Economics*, vol. 52 (2017).
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- ^{xiv} <https://www.aha.org/guidereports/2017-01-24-hospital-merger-benefits-views-hospital-leaders-and-econometric-analysis>
- ^{xv} <https://www.aha.org/2019-09-04-charles-river-associates-report-hospital-merger-benefits>
- ^{xvi} Schmitt, M.: “Do Hospital Mergers Reduce Costs?” *Journal of Health Economics*, vol. 52 (2017)
- ^{xvii} <https://www.aha.org/2019-09-04-charles-river-associates-report-hospital-merger-benefits>
- ^{xviii} <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf>
- ^{xix} <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf>
- ^{xx} Margaret E. Guerin-Calvert & Jen A. Maki, FTI Consulting, Hospital Realignment: Mergers Offer Significant Patient and Community Benefits (2014).
- ^{xxi} <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf>
- ^{xxii} Margaret E. Guerin-Calvert & Jen A. Maki, FTI Consulting, Hospital Realignment: Mergers Offer Significant Patient and Community Benefits (2014).
- ^{xxiii} <https://www.aha.org/2019-09-04-charles-river-associates-report-hospital-merger-benefits>
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Brian Miller, M.D., M.B.A., M.P.H. is a practicing hospitalist at the Johns Hopkins Hospital and a health policy researcher at the Johns Hopkins University School of Medicine and Johns Hopkins Carey Business School, where serves as an Assistant Professor of Medicine and Business (courtesy). He is an expert witness and consultant for the FTC Bureau of Consumer Protection on health insurance and is a member of the CMS Medicare Evidence Development & Coverage Advisory Committee, the UNC-NC State Biomedical Engineering Department Industrial Advisory Board, and the Keck Graduate Institute School of Medicine Dean's Advisory Council.

Dr. Miller also serves as adjunct faculty at the UNC Kenan-Flagler School of Business, where he teaches insurance design in the MBA program. He previously served as a Medical Officer in the Office of New Drugs at the Center for Drug Evaluation and Research at the FDA, where he was one of two physician reviewers who completed the pre-market review of valbenazine, a first-in-class, breakthrough new molecular entity indicated for tardive dyskinesia. He completed both an Internal Medicine residency at Georgetown University Hospital and a Public Health Residency at Johns Hopkins University, comprised of a federal regulatory rotational program with postings at CMS, FTC, FCC, and FDA.

Dr. Miller has experience with healthcare merger review, healthcare finance innovation, and pharmaceutical product review. He previously served as a Special Advisor in the FTC Office of Policy Planning and concurrently as an in-house physician expert for the Bureau of Competition, assisting in merger review and enforcement in health systems, retail drug stores, and pharmaceutical products, including the FTC's successful action blocking the \$7 billion Advocate - NorthShore merger. Prior to the FTC, Dr. Miller was a Fellow at the CMS Innovation Center, where he co-managed the ACO Investment Model, a \$114 million project focused on ACOs in rural areas. He is board-certified in General Preventive Medicine/Public Health and Internal Medicine and is licensed to practice medicine in DC and Maryland.

Testimony of Brian J. Miller, M.D., M.B.A., M.P.H.

Assistant Professor of Medicine and Business (Courtesy)
The Johns Hopkins University School of Medicine
The Johns Hopkins Carey Business School

Before the

U.S. Senate Committee on the Judiciary
Subcommittee on Competition Policy, Antitrust, and Consumer Rights

On

“Antitrust Applied: Hospital Consolidation Concerns and Solutions.”

May 19, 2021

Chairwoman Klobuchar, Ranking Member Lee, and distinguished members of the Subcommittee on Competition Policy, Antitrust, and Consumer Rights:

My name is Brian Miller and I practice hospital medicine at the Johns Hopkins Hospital. As an academic health policy researcher, I serve as an Assistant Professor of Medicine and Business (Courtesy) at the Johns Hopkins University School of Medicine and the Johns Hopkins Carey Business School. My research focuses on healthcare competition and payment policy and is based upon my prior regulatory experience at the Federal Trade Commission, Federal Communications Commission, U.S. Food and Drug Administration, and the Centers for Medicare and Medicaid Services. Through my role as a faculty member, I regularly engage with regulators, policymakers, and businesses in search of solutions to help create a better healthcare system for all.

In my testimony today, I will focus on three areas:

1. The harms of hospital consolidation
2. Combatting consolidation through competition policy
3. Promoting market entry through reform of anti-competitive laws

1. The Harms of Hospital Consolidation

Healthcare market consolidation has long been a focus of competition policy, and today's hearing explores the story of hospital and care delivery consolidation. Hospital care comprised 31% of annual health spending or \$1.192 trillion in 2019.¹ With 90% of metropolitan statistical areas representing highly concentrated hospital markets,² as defined by a Herfindahl-Hirschman index (HHI) greater than 2,500,³ hospital consolidation remains a focus of both study and action for policymakers, regulators, and competition authorities. The harms of hospital consolidation are many and well-documented, affecting consumers of all types, including patients, physicians, and payers, the latter group including health plans, employers, and governments. Harms include both traditional economic considerations such as higher prices in addition to non-price efficiency losses such as quality of care decrements.

It is well-documented that consolidation leads to higher prices for healthcare services.⁴ Patients experience these higher costs in a variety of ways, including higher cost-sharing payments and higher health insurance premiums^{5,6} reflecting rising hospital prices. Other losses are more difficult to quantify albeit are very real: research by Beaulieu and colleagues⁷ has demonstrated a lack of quality benefits from hospital mergers, in addition to decrements in patient experience.

Physicians also experience losses from a lack of operational control, as clinical practice shifts from an "owner-operator" model to scaled enterprises, with those making decisions about how care is delivered positioned an increasing distance from the exam room. According to the National Academy of Medicine's report on physician

¹ Marin AB, Hartman M, Lassman D, et al. National Health Care Spending In 2019: Steady Growth For The Fourth Consecutive Year. *Health Affairs*. 2021;1:14-24. doi: 10.1377/hlthaff.2020.02022

² Fulton BD. Health Care Market Concentration Trends In the United States: Evidence And Policy Response. *Health Affairs* 2017;36(9):1530-1538. doi: 10.1377/hlthaff.2017.0556

³ U.S. Department of Justice and Federal Trade Commission. Horizontal Merger Guidelines. August 19, 2010. Pg19. <https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf>

⁴ Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *Quarterly Journal of Economics* 2019;134(1):51-107. doi: 10.1093/qje/qjy020

⁵ Boozary AS, Feyman Y, Reinhard UE, Jha AK. "The Association Between Hospital Concentration And Insurance Premiums in the ACA Marketplaces." *Health Affairs* 2019;4:668-674. doi: 10.1377/hlthaff.2018.05491

⁶ Trish EE, Herring BJ. How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums? *J Health Econ* 2015;42:104-111. doi: 10.1016/j.jhealeco.2015.03.009

⁷ 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*. 2020 Jan 2;382(1):51-59. doi: 10.1056/NEJMsa1901383.

burnout,⁸ this loss of control over the practice environment is a significant contributing factor to the nationwide epidemic of physician burnout.

Payers, employers, state governments, and the federal government experience harms too in the form of greater costs for purchased health benefits, and respond to rising premiums by increasing consumer cost sharing,⁹ suppressing wage growth,^{10,11} narrowing care networks,¹² or—if possible—decreasing plan benefits.

Another significant harm of hospital consolidation is frequently lost amongst the cascade of the aforementioned concerns: a loss of innovation. Competition is the lifeblood that powers our vibrant economy, driving both incremental and disruptive innovation. Broader economic indicators support a story of hospital consolidation, with labor productivity in hospitals remaining nearly flat over the past twenty years, even with periods of negative labor productivity growth—or year over year decreases in productivity¹³ (see **Figure 1** in **Appendix**).

What does this mean for patients and physicians and how does this compare to other health sectors such as the life sciences? The pharmaceutical and medical device industries have produced a plethora of innovation with over 1,200 new molecular entities approved since 1950^{14,15} and new disruptive technologies such as cardiac catheterization, angioplasty, and stenting, which revolutionized how we treat heart attack patients in the 1980s and 1990s. In contrast, much of the “daily activities” that we complete as clinicians and experience as patients in hospital and ambulatory care settings have not changed.

Many claim—and reasonably so—that some of this is due to regulatory barriers. But there are many examples where operations do not change as the organizations experience little to no competitive pressure. A simple example is the patient with heart failure, wherein fluid builds up and sometimes we have to hospitalize patients due to worsening symptoms (e.g. weight gain and shortness of breath with a subsequent need for supplemental oxygen) in order to remove fluid in the hospital with intravenous diuretics. Some patients are aware of their decline and undergo a planned admission, while many others are unaware until they are *in extremis* in their local emergency room, and are subsequently admitted to the hospital. Diuretics are prescribed by physicians and administered by nurses to the patient one to three times daily. Nurses manually record a patient’s fluid intake, while a technician records the patient’s urine output—the net of these numbers represents the patient’s “progress” (or lack thereof) for the day. This is a manual process, and these data are then entered into a computer three to six times daily. In the setting of the intensive care unit, this can occur every one to two hours. This is just one of the many manual, labor-intensive processes that has not changed in over fifty years.

⁸ National Academy of Medicine. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. See Ch6, Pg101 <https://www.nap.edu/catalog/25521/taking-action-against-clinician-burnout-a-systems-approach-to-professional>

⁹ “The average single coverage annual deductible among covered workers with a deductible has increased 25% over the last five years and 79% over the last ten years.” See: 2020 Employer Health Benefits Survey. Kaiser Family Foundation October 8, 2020. <https://www.kff.org/report-section/ehbs-2020-summary-of-findings/>

¹⁰ Baicker K, Chandra A. The Labor Market Effects of Rising Health Insurance Premiums. *Journal of Labor Economics* 2006;24(3). doi: 10.1086/505049

¹¹ Arnold, Daniel and Christopher M. Whaley, Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. Santa Monica, CA: RAND Corporation, 2020. https://www.rand.org/pubs/working_papers/WRA621-2.html

¹² Polsky D, Cidav Z, Swanson A. Marketplace Plans With Narrow Physician Networks Feature Lower Monthly Premiums Than Plans With Larger Networks. *Health Affairs* 2016;35(10):1842-1848. doi: 10.1377/hlthaff.2016.0693

¹³ Bureau of Labor Statistics. A Closer Look: Private Community Hospitals. 2013. https://www.bls.gov/lpc/hospitals_2013.htm See Appendix for Figure 1

¹⁴ Munos, B. Lessons from 60 years of pharmaceutical innovation. *Nat Rev Drug Discov* 8, 959–968 (2009). <https://doi.org/10.1038/nrd2961>

¹⁵ More recent data suggest a still robust innovation rate, with and as recently as 2010-2018 as many as 41 new drugs and 12 new biologics annually. Darrow JJ, Avorn J, Kesselheim AS. FDA Approval and Regulation of Pharmaceuticals, 1983-2018. *JAMA*. 2020;323(2):164–176. doi:10.1001/jama.2019.20288

While 90% of metropolitan areas¹⁶ are considered highly concentrated by U.S. Department of Justice Guidelines, even moderately concentrated marketplaces can be a challenge for consumers and economic measures do not tell the entire story of healthcare delivery consolidation. I use my own experience here as an example. My mother is 70 years old and is unlucky in that she is both a widow and suffers from advanced Alzheimer's that is progressing rapidly. Some days she cannot walk, is incontinent, has to be spoon fed, and does not recognize me. My sister and I have attempted to respect her wish to her remain in her home with minimal medical intervention.

Recently she developed a urinary tract infection, became confused, and fell at home. Weakened, my mother was bedbound unless carried around the house by my uncle. A short antibiotic course was ineffective and rather than hospitalize her or take her to urgent care, my sister and I reasoned, as clinicians ourselves, that her primary care physician may wish to try one more oral antibiotic or otherwise make her comfortable. It took five phone calls during regular business hours on the part of my sister, a hospital pharmacist, and myself, a practicing physician, to reach a covering physician to get her the antibiotic prescription that she needed.

While in some ways I am understandably dissatisfied with this level of service, I mention this not to critique the delivery system that provides care to my mother. Rather it is to highlight the problem that she faces as a patient-consumer and that my sister and I face as her proxies: in the moderately concentrated market in which she lives, her current care ecosystem is her only option for integrated care delivery. This is precisely where the problem is: many patients like my mother have specific needs only met through mass-customized, integrated care delivery and do not have meaningful choice. This problem does not change whether the monopoly or market participant is government, non-profit, or for-profit—the ills of monopoly remain unchanged. I recognize my mother's many advantages—most do not have two clinicians as children, one of them a healthcare policy expert—and worry about other patients.

It is thus clear to many of differing perspectives that the hospital industry is gravely ill, suffering from the effects of consolidation and a lack of competition. As policy experts, we have a variety of tools in our black bag. Last month, testifying in front the House of Representatives on similar issues, colleagues highlighted multiple bipartisan reforms, including addressing Federal Trade Commission (FTC) jurisdictional issues over non-profits¹⁷ along with the need for increased agency staff and funding.¹⁸ At the end of his written testimony, Alden Abbott, a Senior Research Fellow at the Mercatus Center, alluded to how "major legal reforms unrelated to antitrust are key to improving the effectiveness of healthcare competition."¹⁹ It is these sorts of bipartisan policy prescriptions that I wish to turn to, as this is where competition policy has historically struggled: combatting consolidation and encouraging market entry.

2. Combatting Consolidation through Competition Policy

Policymakers have multiple competition policy levers to address pre-existing consolidation, here I will focus on two of the largest levers available: payment site neutrality and Stark Law reforms.

Site-Neutral Payment

Site-neutral payment is a payment policy issue of longstanding bipartisan interest. What is it? Simply put, it means paying the same amount for the same service provided, regardless of where it is provided. While sensible,

¹⁶ Fulton BD. Health Care Market Concentration Trends In the United States: Evidence And Policy Response. *Health Affairs* 2017;36(9):1530-1538. doi: 10.1377/hlthaff.2017.0556

¹⁷ *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: U.S. House of Representatives Committee on the Judiciary, 107th Congress (2021) (Testimony of Leemore S. Dafny, Ph.D.)*. Pg12 <https://docs.house.gov/meetings/JU/JU05/20210429/112518/HHRG-117-JU05-Wstate-DafnyL-20210429.pdf>

¹⁸ *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: U.S. House of Representatives Committee on the Judiciary, 107th Congress (2021) (Testimony of Alden Abbott)* Pg1 <https://docs.house.gov/meetings/JU/JU05/20210429/112518/HHRG-117-JU05-Wstate-AbbottA-20210429.pdf>

¹⁹ *T 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: U.S. House of Representatives Committee on the Judiciary, 107th Congress (2021) (Testimony of Alden Abbott)* Pg5 <https://docs.house.gov/meetings/JU/JU05/20210429/112518/HHRG-117-JU05-Wstate-AbbottA-20210429.pdf>

implementation is challenging due to the litany of payment systems under the Medicare Fee For Service program. This is best illustrated through a tangible example.

If a physician sees a new patient and has a 15 minute visit, the physician can bill Medicare under the physician fee schedule for an evaluation and management service. If a hospital purchases that same practice and designates the practice as a provider-based facility (either on campus or off campus, with the boundary at 250 yards and less than 35 miles, respectively),²⁰ the provider-based facility bills as a hospital outpatient department. Functionally, the hospital submits a claim, billing Medicare under the outpatient prospective payment system (OPPS),²¹ in addition billing separately for the professional service component and receiving reduced reimbursement as a facility fee. Considering the 15 minute office visit, the physician fee schedule payment rate for calendar year 2017 (CY2017) was \$109.46 for a new patient, while if delivered in a hospital outpatient setting the total would be \$184.44, or \$106.56 for the ambulatory payment classification (APC) under the OPPS and \$77.88 for the facility fee.²² This higher total reimbursement is beneficial for hospitals while simultaneously detrimental for patients, who experienced higher Part B coinsurance amounts due to larger bills for the same service.

Understandably, this payment policy loophole drove hospital acquisition of physician practices. Recognized as a problem by MedPAC²³ and the Office of Inspector General,^{24,25} a partial fix was included as part of the Bipartisan Budget Act of 2015. The Act prohibited *new* off-campus provider-based hospital outpatient facilities from receiving higher payment²⁶ after January 1, 2017. Provider-based facilities had to continue to meet minimal requirements for clinical and financial integration.

Recognizing the persistent problems posed by the lack of payment site neutrality, the Trump administration attempted to correct the problem, including a degree of cuts to previously grandfathered off-campus facilities, proposing a reduced OPPS payment.^{27,28} Policy experts noted this distinction,²⁹ and unsurprisingly the hospital industry sued. After a series of appeals, the hospital industry won initially in 2019.³⁰ CMS again attempted implementation of payment

²⁰ 42 CFR § 413.65 - Requirements for a determination that a facility or an organization has provider-based status. <https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:2.0.1.2.13#se42.2.413.165>

²¹ MedPAC. Payment Basics: Outpatient Hospital Services Payment System. 2020.

http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_opd_final_sec.pdf

²² See example in Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs *Federal Register* 2018.

<https://www.federalregister.gov/documents/2018/11/21/2018-24243/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center#p-1580>

²³ MedPAC. Report to Congress: Medicare Payment Policy. 2020. http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf

²⁴ Office of Inspector General. Hospital Ownership of Physician Practices. 1999. Available at: <https://oig.hhs.gov/oig/reports/oci-05-98-00110.pdf>

²⁵ Office of Inspector General. CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain. 2016. Available at: <https://oig.hhs.gov/oig/reports/oci-04-12-00380.pdf>

²⁶ H.R. 1314 - Bipartisan Budget Act of 2015. Sec. 603. Treatment of Off-Campus Outpatient Departments of a Provider. 114th Congress (2015-2016). <https://www.congress.gov/bills/114th-congress/house-bill/1314>

²⁷ Centers for Medicare & Medicaid Services. "CMS Finalizes Rule that Encourages More Choices and Lower Costs for Seniors." 2018. <https://www.cms.gov/newsroom/press-releases/cms-finalizes-rule-encourages-more-choices-and-lower-costs-seniors>

²⁸ Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. 2018, Available at: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24243.pdf>

²⁹ Wilensky. "Medicare's Move Toward Site-Neutral Payment." Healthcare Financial Management Association. 2018. <https://www.hfma.org/topics/hfm/2019/january/62678.html>

³⁰ Minemyer P. Judge strikes down Trump administration's site-neutral payments. *Fierce Healthcare* September 17, 2019. <https://www.fiercehealthcare.com/hospitals-health-systems/judge-strikes-down-trump-administration-s-site-neutral-payments-rule>

site neutrality for calendar year 2020 payment rules, and the hospital industry sued again³¹ and lost,³² with CMS proposing implementation while the hospital industry has now appealed to the U.S. Supreme Court.³³

The Committee for a Responsible Federal Budget estimated that full implementation of site neutral payment would save Medicare \$217 to \$279 billion over the next decade,³⁴ an estimate inclusive only of direct payment policy effects. Full implementation of site neutral payment would eliminate payment policy arbitrage as a rationale for hospitals' purchase of clinics. Given repeated industry-driven legal challenges to site neutral payment, Congress could save the Medicare program money and increase competition in ambulatory care markets by providing CMS with clear statutory authority for site neutral payment, rendering this debate null.

Stark Law Reforms

Rising Medicare program expenditures in the 1980s and a series of academic studies demonstrating increased utilization of physician-owned services prompted oversight and eventual regulation of these clinical operational practices. As is typical, the devil is in the details.

A 1992 study in *JAMA* by Jean Mitchell, Ph.D. and Elton Scott, Ph.D. of physician-owned, joint-venture freestanding physician therapy and rehabilitation facilities³⁵ found both shorter visits and a greater mean number of visits (16 v. 11) for physician-owned, joint-venture physical therapy sites as compared to non-joint-venture facilities. Unsurprisingly this pattern of practice was associated with higher revenue, noting that outcomes were not assessed so it is unclear what was most clinically appropriate. A 1990 study in the *New England Journal of Medicine* found a similarly concerning finding of increased utilization when primary care physicians completed in-office radiology services.³⁶

From this place of valid concerns regarding budgetary sustainability of Medicare, inappropriate utilization or induced demand, and ethical concerns, a series of reforms were passed in both statute^{37,38} and rulemaking^{39,40,41} collectively known as Stark Law. In accordance with Stark Law, physicians are prohibited from making referrals for designated health services (DHS) to an entity in which they have a financial relationship and subsequently billing Medicare. What is considered a DHS is wide-ranging, including radiology and imaging services to home health services to durable medical equipment and supplies. While there are exceptions to Stark Law, including recent attempts to promote value-

³¹ Reuter E. Hospitals sue CMS again over site-neutral payments. *MedCity News* January 14, 2020.

<https://medcitynews.com/2020/01/hospitals-sue-cms-again-over-site-neutral-payments/>

³² American Hospital Ass'n v. Azar, No. 20-5193 (D.C. Cir. 2020)

[https://www.cadc.uscourts.gov/internet/opinions.nsf/B8E3F76510742B95852585B600531146/\\$file/19-5048-1854504.pdf](https://www.cadc.uscourts.gov/internet/opinions.nsf/B8E3F76510742B95852585B600531146/$file/19-5048-1854504.pdf)

³³ American Hospital Association v. Becerra, No. 20-1113 (U.S. Supreme Court. 2021)

<https://www.aha.org/system/files/media/file/2021/02/AHA-Petition-2-10-Final.pdf>

³⁴ Committee for a Responsible Federal Budget. Equalizing Medicare Payments Regardless of Site-of-Care. (2021).

<https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care>

³⁵ Mitchell JM, Scott E. Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics. *JAMA*. 1992;268(15):2055–2059. doi:10.1001/jama.1992.03490150107033

³⁶ Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office practice--a comparison of self-referring and radiologist-referring physicians. *N Engl J Med*. 1990 Dec 6;323(23):1604-8. doi: 10.1056/NEJM199012063232306.

³⁷ H.R.3299 - Omnibus Budget Reconciliation Act of 1989. 101st Congress (1989-1990).

³⁸ H.R.2264 - Omnibus Budget Reconciliation Act of 1993. 103rd Congress (1993-1994).

³⁹ Health Care Financing Administration. Medicare Program: Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships. *Federal Register* 2001;66(3):856-965.

<https://www.govinfo.gov/content/pkg/FR-2001-01-04/pdf/01-4.pdf>

⁴⁰ Centers for Medicare & Medicaid Services. Medicare Program: Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II). *Federal Register* 2004;69(59):16054-16146.

<https://www.govinfo.gov/content/pkg/FR-2004-03-26/pdf/04-6668.pdf>

⁴¹ Centers for Medicare & Medicaid Services. Medicare Program: Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase III). *Federal Register* 2007;72(171):51012-51099.

<https://www.govinfo.gov/content/pkg/FR-2007-09-05/pdf/07-4252.pdf>

based care,⁴² implementation remains challenging, with the most recent value-based care rulemakings on Stark and Anti-Kickback Law enumerated at 191⁴³ and 212 pages, respectively.⁴⁴ Regulatory costs and understanding remains well outside the operating purview of small and mid-sized businesses such as private practices, mid-sized health systems, and many rural facilities.

The world in which Stark Law was passed and today's healthcare landscape are very different. The 1980s marked the peak of fee for service (FFS) medicine, soon followed by the rise of managed care. Today, 39% the Medicare program enrollment is in Medicare Advantage, a risk-adjusted capitated public-private program.⁴⁵ Nearly 76% of Medicaid enrollees take part in managed care programs,⁴⁶ with 46% of Medicaid spending channeled through risk-adjusted capitation paid to a Medicaid managed care organization.⁴⁷ Other markets are making the transition to capitated models at varying speeds. Incentives within a capitated model are very different, as the health plan or integrated delivery system loses money from fraud, waste, and abuse—including inappropriate utilization or induced demand.

Even outside of capitated payment models, FFS medicine today is very different, as with technology payers have new tools to survey for and prevent inappropriate use, including utilization review, prior authorization, and automatic prepayment claims editing. Furthermore, benefit design can be adjusted in some settings to use market forces to control for inappropriate utilization or induced demand, including bundling, first introduced as part of the part of the prospective payment system based upon the diagnosis-related group (DRG) for Medicare hospitalizations⁴⁸ or the application of per diem rates for services such as home care.⁴⁹

Yet Stark Law persists in a changed world. What function does it now serve? In applying a competition policy framework, one must also examine the harms of Stark Law. At the time Stark Law and self-referral were debated as policy questions, experts raised concerns regarding rigidity of the law, quality of care, and the downsides of limiting physician agency.⁵⁰ Unfortunately, some of these harms have come to pass.

Patients, many of whom experience challenges with both health⁵¹ and health insurance literacy,⁵² depend upon both health systems and their physicians to make decisions about their health, goals, and efficient and effective use of healthcare products and services. Limiting shared decision-making for either corporations or physicians transfers these

⁴² Centers for Medicare & Medicaid Services. Modernizing and Clarifying the Physician Self-Referral Regulations Final Rule (CMS-1720-F). November 20, 2020. <https://www.cms.gov/newsroom/fact-sheets/modernizing-and-clarifying-physician-self-referral-regulations-final-rule-cms-1720-f>

⁴³ Centers for Medicare & Medicaid Services. Medicare Program: Modernizing and Clarifying the Physician Self-Referral Regulations. *Federal Register* 2020;85(232):77492-77682. <https://www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26140.pdf>

⁴⁴ Centers for Medicare & Medicaid Services. Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements. *Federal Register* 2020;85(232):77684-77895. <https://www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26072.pdf>

⁴⁵ Freed M, Damico A, Neuman T. A Dozen Facts About Medicare Advantage in 2020. *Kaiser Family Foundation* 2020. Available at: <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>

⁴⁶ Medicaid Enrollment in Managed Care by Plan Type. *Kaiser Family Foundation* 2018.

<https://www.kff.org/medicaid/state-indicator/enrollment-by-medicare-mc-plan-type/>

⁴⁷ Total Medicaid MCO Spending. *Kaiser Family Foundation* 2019. <https://www.kff.org/other/state-indicator/total-medicare-mco-spending/>

⁴⁸ Iglehart JK. Medicare begins prospective payment of hospitals. *N Engl J Med*. 1983 Jun 9;308(23):1428-32. doi: 10.1056/NEJM198306093082331. PMID: 6405277.

⁴⁹ MedPAC. Payment Basics: Home Health Care Services Payment System. 2015.

<http://www.medpac.gov/docs/default-source/payment-basics/home-health-care-services-payment-system-15.pdf>

⁵⁰ Morreim EH. Conflicts of Interest: Profits and Problems in Physician Referrals. *JAMA*. 1989;262(3):390-394. doi:10.1001/jama.1989.03430030078038

⁵¹ Kutner M, Greenberg E, Jin Y, et al. The Health Literacy of America's Adults Results From the 2003 National Assessment of Adult Literacy. *U.S. Department of Education* 2006.

⁵² Norton M, Hamel L, & Brodie M. Assessing Americans' Familiarity with Health Insurance Terms and Concepts. *Kaiser Family Foundation*. (2014). <https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/>

burdens onto patients, ironically on those least equipped to deal with it i.e. those with the greatest medical and socioeconomic burdens. It could be the 90 year-old cancer patient with newly diagnosed pancreatic cancer who is looking for a surgical oncologist and radiation oncologist who together will “take a chance on me but not prolong my life if things go poorly” while also providing wraparound social support and home care services. Or perhaps it is the morbidly obese heart failure patient with a bad back and knees, barely able to walk and dependent upon Social Security Disability Income, Medicare, and Medicaid who wants to get the “most bang for my buck at the physical therapist” having previously been disabled and bedridden in a skilled nursing facility. These are the patients to whom Stark Law transfers the burdens of care navigation: those who already have the greatest burdens to bear.

Finally, Stark Law presupposes that corporations are less self-interested parties than physicians. In many cases, corporations mandate or otherwise enforce corporate self-referral upon physicians, scrutinizing and scoring providers on the basis of “within system” versus external referrals. Yet this very activity can be part of the key to offering integrated care delivery, as organizations can coordinate and systematize care for complex patients, and with recent changes in payment policy, better integrate remote telehealth and in-person services across specialties and care sites. When physician-owned and -operated organizations attempt to construct integrated care delivery, they face prohibitions imposed through Stark Law, while corporations face regulatory oversight. Regulation, not prohibition, is the appropriate mechanism for combating waste, fraud, and abuse.

Faced with high compliance costs, many physician organizations choose not to compete in these markets, or alternatively merge with hospital organizations, furthering consolidation in the pursuit of integrated care delivery. Lost competition hurts patients through higher prices, quality decrements, and innovation losses when a need for regulation is replaced with a ban on competition for a single market participant. Policymakers can address this by re-examining Stark Law, repealing outdated provisions, and placing physician and corporate enterprises on an equal footing.

3. Promoting market entry through reform of anti-competitive laws

Physician-owned hospitals (POHs) represent a powerful lever through which policymakers can promote market entry.⁵³ Currently, new POHs are statutorily excluded from participation in the Medicare program, a policy with both a long history and recent legislative efforts aimed at its repeal in 2017⁵⁴ and 2019.⁵⁵

Physician-Owned Hospitals

In an effort to improve clinical operations and drive both improved patient experience and medical quality, physicians pooled their capital and opened hospitals beginning in the 1980s. Concerns rapidly emerged, including accusations of POHs “cherry picking” healthy patients leaving community hospitals with sicker patients, adverse selection against Medicare and Medicaid patients, skimping on charity or uncompensated care, and favoring of commercial payers among other concerns. Both academic and government-sponsored reports revealed complexity in this marketplace not entirely consistent with these claims. For example, a 2003 Government Accountability Office (GAO) study found that surgical-specialty POHs served fewer Medicaid patients while cardiac hospitals served—unsurprisingly given the natural history of cardiac disease—more Medicare patients than did general hospitals.⁵⁶ It is worth noting here that the GAO compared physician specialty hospitals to corporate or non-profit *general* hospitals.

Claims regarding charity care are to be viewed with similar skepticism: CMS staff research found that while a small sample of cardiac and orthopedic surgical specialty hospitals provided less uncompensated care than their non-profit competitors, when tax payments were considered the total aggregate community benefit was larger, representing 3.74% of revenue for cardiac POHs, 7.23% of revenue for orthopedic POHs, and 0.87% of revenue for non-profit

⁵³ Miller BJ, Moffit RE, Ficke J, Marine J, Ehrenfeld J. Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals. *Health Affairs Blog* April 12, 2021. doi: 10.1377/hblog20210408.980640

⁵⁴ H.R.1156 - Patient Access to Higher Quality Health Care Act of 2017. 115th Congress (2017-2018). <https://www.congress.gov/bills/115/congress/house-bill/1156>

⁵⁵ H.R.3062 - Patient Access to Higher Quality Health Care Act of 2019. 116th Congress (2019-2020). <https://www.congress.gov/bills/116/congress/house-bill/3062>

⁵⁶ Government Accountability Office. Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served. (2003). <https://www.gao.gov/assets/gao-03-683r.pdf>

community hospitals.⁵⁷ Finally, lost in the policy discussion of the time was that POHs are a market split equally between community hospitals and specialty surgical hospitals, the latter of which is comprised of three primary sub-markets cardiac, orthopedic, and general surgical hospitals.⁵⁸

Based upon this litany of concerns, policymakers implemented an 18-month moratorium in 2003 and eventually a ban on new POHs (and existing POHs from expanding) from participating in the Medicare program by closing the “whole hospital exception,”⁵⁹ functionally prohibiting new POHs from entering the marketplace. POHs could apply to CMS for an exception, either as a high Medicaid facility or an applicable hospital as defined by other criteria related to local population and bed supply, a market entry barrier that hospitals with other ownership structures do not face. Executed as part of 2010 Patient Protection and Affordable Care Act (ACA),⁶⁰ a ban on a single market participant is inconsistent with the goals of the ACA, which aimed to expand insurance coverage, undertake a series of insurance reforms, and support quality improvement efforts. Economic consequences are real, with significant market forecloses in 2010 as over 75 new hospitals either planned or under development were prematurely terminated, representing nearly \$2.5 billion in economic losses at the time of the law’s passage in 2010.⁶¹ One can only imagine the consequences of a now lost decade of hospital construction and potential innovation in clinician-driven care delivery.

Even if we take at face value the hospital industry’s concerns that POHs are cherry-picking healthier patients—a claim on which the evidence is mixed—this is a problem best addressed by payment policy. Payers, public and private, can modify payment rates in order to adjust for differential patient acuity and complexity. CMS did just that in response to concerns regarding overpayment of specialty hospitals, and in 2007 updated the inpatient prospective payment system (IPPS) in order to better account for complicating conditions and case mix index.⁶²

The law now serves a different purpose: functioning as an anti-competitive ban on market entry for a single market participant for what many would agree were problems of regulation and payment policy. Flagged as a competition policy issue in the White House Report on Choice and Competition in healthcare markets,⁶³ Congress can rectify the anti-competitive effects of Section 6001 by repealing it. Finally, concerns about this marketplace can and should be addressed by policymakers and regulators, ensuring that regulatory solutions are used for regulatory problems.

⁵⁷ See table 6.1 from

Centers for Medicare & Medicaid Services. (2005). Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pg. 58. Available at: <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf>

⁵⁸ Blumenthal DM, Orav EJ, Jena AB, Dudzinski DM, Le ST, Jha AK. Access, quality, and costs of care at physician owned hospitals in the United States: observational study. *BMJ*. 2015 Sep 2;351:h4466. doi: 10.1136/bmj.h4466. PMID: 26333819; PMCID: PMC4558297.

⁵⁹ Previously Stark Law provided a safe harbor entitled the “whole hospital exception,” wherein a physician could refer Medicare or Medicaid patients to a hospital where the physician had a financial interest if the physician was authorized to perform services at the hospital and had a financial interest in the entire hospital. See: Cole CM. Physician-Owned Hospitals and Self-Referral. *AMA Journal of Ethics* 2013;15(2):150-155.

⁶⁰ H.R.3590 - Patient Protection and Affordable Care Act. Sec. 6001. Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. 111th Congress (2009-2010). https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/Section_6001_of_the_ACA.pdf

⁶¹ Impact of Implementation of Section 6001. *Physician Hospitals of America* 2011. https://cdn.vnaws.com/www.physicianhospitals.org/resource/resmgr/docs/Economic_Impact_of_Section_6.pdf

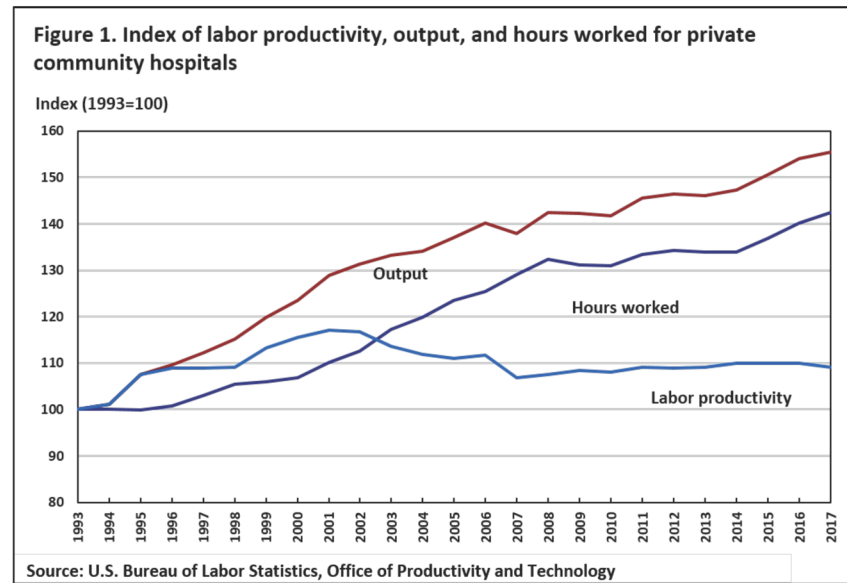
⁶² Center for Medicare & Medicaid Services. Improving Medicare’s Hospital Inpatient Prospective Payment System to Better Recognize the Costs of Care. 2007. <https://www.cms.gov/newsroom/fact-sheets/improving-medicare-hospital-inpatient-prospective-payment-system-better-recognize-costs-care>

⁶³ US Dept. of HHS, US Dept. of the Treasury, US Dept. of Labor. Reforming America’s Healthcare System Through Choice and Competition. 2018. Pg.74. <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>

4. Conclusions

One of the great joys of competition policy is that it is uniquely bipartisan: everyone is trying to get to the same place, just with different ideas of how best to get there. Every patient deserves choice in how, when, and where they receive their care. Payment policy choices such as the maintenance of differential payment for the same service delivered at different care sites drive hospital-physician practice consolidation, and should be rectified through the full implementation of site neutral payment. While implemented with the best of intentions, now archaic legal barriers like Stark Law and the ban on new physician-own hospitals participating in the Medicare program now serve to favor one market participant through exclusion of another, preventing meaningful competition between corporate- and physician-owned and operated delivery systems. Congress can correct these ills and help make healthcare markets more functional.

Appendix



Source: Figure 1 from "A Closer Look: Private Community Hospitals" Bureau of Labor Statistics.
https://www.bls.gov/lpc/hospitals_2013.htm

Martin Gaynor is the E.J. Barone University Professor of Economics and Public Policy at Carnegie Mellon University and was Director of the Bureau of Economics at the U.S. Federal Trade Commission in 2013-2014. He is one of the founders of the Health Care Cost Institute, an independent non-partisan nonprofit dedicated to advancing knowledge about U.S. health care spending, and served as the first Chair of its governing board. He is also an elected member of the National Academy of Medicine and of the National Academy of Social Insurance, President of the American Society of Health Economists, a Research Associate at the National Bureau of Economic Research, and an International Research Fellow at the University of Bristol.

His research focuses on competition and antitrust policy, both in health care markets, and more generally. He has written extensively on this topic, testified before Congress, the Federal Trade Commission, and advised the governments of the Netherlands, the United Kingdom, and South Africa on competition issues. Gaynor is on the Pennsylvania Health Care Cost Containment Council and co-chaired the state's workgroup on shoppable care. He is a mentor for the Research in Color Foundation.

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

by

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Washington, D.C.
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Summary of Statement

- Health care is a very large and important sector of our economy. Not only is the health care sector nearly 1/5th of the economy, it has a critical impact on our health and wellbeing.
- Hospitals account for over 31 percent of total health spending and nearly 5.6 percent of gross domestic product (GDP). This makes hospitals one of the largest industries in the entire economy.
- By contrast, physician services constitute approximately 20 percent of health spending and 3.6 percent of GDP, pharmaceuticals account for 9.7 percent of health spending and 1.7 percent of GDP, and health insurance is 6.3 percent of health spending and approximately 1 percent of GDP.
- The U.S. health care system is based on markets. The system will work only as well as the markets that underpin it.
- These markets do not function as well as they could, or should. Prices are high and rising, there are egregious pricing practices, quality is suboptimal, and the sector is sluggish and unresponsive, in contrast to the innovation and dynamism which characterize much of the rest of our economy.
- Lack of competition has a lot to do with these problems.
- There has been a great deal of consolidation in health care. There have been nearly 1,600 hospital mergers in the past twenty years, with over 450 since 2012. The result is that the majority of local areas are now dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).
- There were nearly 31,000 physician practice acquisitions by hospitals from 2008-2012, and over 33 percent of all physicians are now in hospital owned practices.
- Extensive research evidence shows that consolidation between close competitors leads to substantial price increases for hospitals, insurers, and physicians, without offsetting gains in improved quality or enhanced efficiency. Further, recent evidence shows that mergers between hospitals not in the same geographic area can also lead to increases in price. Just as seriously, if not more, evidence shows that patient quality of care suffers from lack of competition. Last, competition affects the form of payment – hospitals with fewer competitors negotiate more favorable forms of payment and reject those they dislike. This poses a serious challenge for payment reform.
- Research evidence shows not-for-profit hospitals exploit market power just as much as for-profits.

- It is also possible that hospital mergers lead to, or enhance monopsony power in labor markets. This can depress wages below the efficient level, distort hiring decisions, and in the long run, harm incentives for investment in human capital. Recent evidence shows impacts of hospital mergers consistent with these concerns.
- There are also concerns about anticompetitive conduct. Firms who have acquired market power have an incentive to maintain or enhance it.
 - Some dominant health systems have been using restrictive contracts with insurers to try to hamper the free flow of patients to competitors, thereby harming competition and enhancing their market power.
 - There are extensive reports of health systems engaging in “data blocking” – impeding the flow of patient information to providers outside the system. This has the potential to harm competition by making it more difficult for patients to switch providers.

Now that most hospital markets are dominated by one large health system, there is considerable potential for this kind of conduct seriously harming competition.

- This is causing serious harm to patients and to the health care system as a whole.
- Policies are needed to support and promote competition in health care markets. This includes ending distortions that unintentionally incentivize consolidation, and policies to strengthen choice and competition.
- These include:
 - End policies that unintentionally incentivize consolidation.
 - End policies that hamper new competitors and impede competition.
 - Focus and strengthen antitrust enforcement. In particular:
 - * Give the DOJ and FTC the resources they need to be effective, not just to do more enforcement in existing areas, but to be able to proactively invest to address new and developing issues.
 - * Permit the FTC to enforce against anticompetitive actions by not-for-profits.
 - * Require simple reporting of small transactions that fall below the Hart-Scott-Rodino reporting requirements, so that the enforcement agencies can track physician practice mergers and hospital acquisitions of physician practices.
 - * Adopt legislation to reform and strengthen the antitrust laws, so the antitrust enforcement agencies will be better able to prevent and deter harmful mergers and conduct.
 - Create a public, national health care database on spending, utilization, prices, and ownership so government, employers, and consumers have access to accurate and complete information about health care costs.

Statement

Chair Klobuchar, Ranking Member Lee, and Members of the Subcommittee, thank you for holding a hearing on this vitally important topic and for giving me the opportunity to testify in front of you today.

1 My Background

I am an economist who has been studying the health care sector, and specifically health care markets and competition, for nearly 40 years. I am a Professor of Economics and Public Policy at the Heinz College of Public Policy at Carnegie Mellon University in Pittsburgh. I served as the Director of the Bureau of Economics at the Federal Trade Commission during 2013-2014, during which time I was involved in the many health care matters that came before the Commission. I also serve the Commonwealth of Pennsylvania as a member of the Pennsylvania Health Care Cost Containment Council and served as Co-Chair of its Working Group on Shoppable Health Care.

Much of my research is directly relevant to the topic of this hearing. My project with colleagues Zack Cooper, Stuart Craig, and John Van Reenen exploits newly available data on nearly 90 million individuals with private, employer sponsored health insurance nationwide to examine variation in health care spending and prices for the privately insured ([Cooper et al., 2019](#)). One of our key findings is that hospitals that have fewer potential competitors nearby have substantially higher prices. For example, monopoly hospitals' prices are on average 12 percent higher than hospitals with 3 or more potential competitors nearby. The prices of hospitals who have one other nearby potential competitor are on average 7.3 percent higher. We also examine all hospital mergers in the United States over a five year period, and find that the average merger between two nearby hospitals (5 miles or closer) leads to a price increase of 6 percent. Further, our evidence shows that prices continue to rise for at least two years after the merger. Last, we find that hospitals that face fewer competitors can negotiate more favorable forms of payments, and resist those they dislike – a serious issue for payment reform.

My paper with William Vogt ([Gaynor and Vogt, 2003](#)) examines the impact of a merger to near monopoly between hospitals. We find that the merger would led to substantial prices increases (up to 53 percent) by the merging hospitals, and the hospitals' not-for-profit status would not have restrained price increases. In work with Carol Propper and Rodrigo Moreno-Serra and with Stephan Seiler, we examine the impact of a reform of the English National Health Service (NHS) designed in create patient choice and enhance competition among hospitals. Prices are set administratively in the NHS, so competition is over quality or other non-price dimensions of service. We find that after the reform, hospitals that had more nearby competitors improved their quality (reduced patient mortality) more than hospitals that had few competitors near them ([Gaynor et al., 2013](#)), and that patients exercised more choice due to the reform and hospitals responded to that by improving their quality ([Gaynor](#)

et al., 2016).

My papers with Katherine Ho and Robert Town, “The Industrial Organization of Health Care Market,” (Gaynor et al., 2015), with Robert Town, “Competition in Health Care Markets,” (Gaynor and Town, 2012a), and “The Impact of Hospital Consolidation: Update” (Gaynor and Town, 2012b) are also relevant to the topic of this hearing. In those papers my co-authors and I review the research evidence on health care markets and competition. We find that there is extensive evidence that competition leads to lower prices, and often improves quality, whereas consolidation between close competitors does the opposite.

My recent policy brief with Zack Cooper (Cooper and Gaynor, 2021) is directly relevant to the topic of this hearing. In this policy brief we identify problems that are impeding the effective functioning of health care markets and propose a number of simple, actionable policies to address the problem. I have also provided detailed analysis and actionable proposals in a recent piece for the Hamilton Project (Gaynor, 2020) and in pieces with Farzad Mostashari and Paul Ginsburg (Gaynor et al., 2017a,b).

It is also notable that there is a great deal of overlap between the analysis and recommendations in these pieces and recent reports by the Departments of Health and Human Services, Treasury, and Labor (Azar et al., 2018), Center for American Progress (Gee and Gurwitz, 2018), and the American Enterprise Institute and the Brookings Institution (Aaron et al., 2019).

2 Introduction

Health care is a very large and important industry. Health care spending is now over \$3.8 trillion (\$11,582 per person) and accounts for 17.7 percent of national income (measured as gross domestic product; GDP) – nearly one-fifth of the entire U.S. economy and larger than the entire economy of France (Martin et al., 2021). Hospital services are a large part of the U.S. economy. In 2019, hospital care alone accounted for 31.4 percent (almost one-third) of total health spending and 5.6 percent of GDP – approximately the same size as the entire information sector or retail trade sector, and larger than the construction or transportation sectors. By comparison, physician services comprise 20.3 percent of health spending and 3.6 percent of GDP (Martin et al., 2021), pharmaceuticals account for 9.7 percent of health spending and 1.7 percent of GDP, and health insurance is 6.3 percent of health spending and approximately 1 percent of GDP. The share of the economy accounted for by these sectors has risen dramatically over the last 30 years. In 1980, hospitals and physicians accounted for 3.6% and 1.7% of U.S. GDP, respectively, while the net cost of health insurance in 1980 was 0.34% (Martin et al., 2011).

Of course, health care is important not only because of its size. Health care services can save lives or dramatically affect the quality of life, thereby substantially improving well being and productivity.

As a consequence, the functioning of the health care sector is vitally important. A well functioning health care sector is an asset to the economy and improves quality of life for the citizenry. By the same token, problems in the health care sector act as a drag on the economy and impose a burden on individuals.

The U.S. health care system is based on markets. The vast majority of health care is privately provided (with some exceptions, such as public hospitals, the Veterans Administration, and the Indian Health Service) and over half of health care is privately financed (Martin et al., 2021). As a consequence, the health care system will only work as well as the markets that underpin it. If those markets function poorly, then we will get health care that's not as good as it could be and that costs more than it should. Moreover, attempts at reform, no matter how important or clever, will not prove successful if they are built on top of dysfunctional markets.

There is widespread agreement that these markets do not work as well as they could, or should. Prices are high and rising (Rosenthal, 2017; National Academy of Social Insurance, 2015; New York State Health Foundation, 2016; White, 2017; Kronick and Neyaz, 2019; White and Whaley, 2019), they vary in seemingly incoherent ways, there are egregious pricing practices (Cooper and Scott Morton, 2016; Rosenthal, 2017; Garmon and Chartock, 2017; Kliff, 2019; Cooper et al., 2020), there are serious concerns about the quality of care (Institute of Medicine, 2001; Kohn et al., 1999; Kessler and McClellan, 2000), and the system is sluggish and unresponsive, lacking the innovation and dynamism that characterize much of the rest of our economy (Cutler, 2010; Chin et al., 2015; Herzlinger, 2006).

One of the reasons for this is lack of competition. The research evidence shows that hospitals that face less competition charge higher prices to private payers, without accompanying gains in efficiency or quality. Moreover, the evidence also shows that lack of competition can cause serious harm to the quality of care received by patients, even substantially increasing the risk of death.

It's important to recognize that the burden of higher provider prices falls on individuals, not insurers or employers. Health care is not like commodity products, such as milk or gasoline. If the price of milk or gasoline goes up, consumers experience directly when they purchase these products. However, even though individuals with private employer provided health insurance pay a small portion of provider fees directly out of their own pockets, they end up paying for increased prices in the end. Insurers facing higher provider prices increase their premiums to employers. Employers then pass those increased premiums on to their workers, either in the form of lower wages (or smaller wage increases) or reduced benefits (greater premium sharing, greater cost sharing, or less extensive coverage) (Gruber, 1994; Bhattacharya and Bundorf, 2005; Baicker and Chandra, 2006; Emanuel and Fuchs, 2008; Baicker and Chandra, 2006; Currie and Madrian, 2000; Anand, 2017). Employers may also respond to these increases in their costs of employing workers by reducing workers' hours or the number of workers. A recent study (Arnold and Whaley, 2020) finds that "hospital mergers lead to a \$521 increase in hospital prices, a \$579 increase in hospital spending among

the privately insured population and a ... \$638 reduction in wages.”

The burden of private health care spending on U.S. households has been growing, so much so that it’s taking up a larger and larger share of household spending and exceeding increases in pay for many workers. Figure 1 illustrates this. Workers’ contributions to health insurance premiums grew 259 percent from 1999 to 2018, while wages grew by only 68 percent ([Henry J. Kaiser Family Foundation, 2020](#)). Figure 2 illustrates that middle class families’ spending on health care has increased 25 percent since 2007, crowding out spending on other goods and services, including food, housing, and clothing. Health insurance fringe benefits for workers, chief among which is health care, increased as a share of workers’ total compensation over this same period, growing from 12 to 14.5 percent, while wages stayed flat (see [Monaco and Pierce, 2015](#), Table 1).

As documented below, there has been a tremendous amount of consolidation among hospitals. It’s important to be clear that consolidation can be either beneficial or harmful. Consolidation can bring efficiencies – it can reduce inefficient duplication of services, allow firms to combine to achieve efficient size, or facilitate investment in quality or efficiency improvements. Successful firms may also expand by acquiring others. If firms get larger by being better at giving consumers what they want or driving down costs so their goods are cheaper, that’s a good thing (big does not equal bad), so long as they don’t engage in actions to then attempt to limit competition. On the other hand, consolidation can reduce competition and enhance market power and thereby lead to increased prices or reduced quality. Moreover, firms that have acquired market power have strong incentives to maintain or enhance it. This leads to the potential for anticompetitive conduct by firms that have acquired dominant positions through consolidation.

3 Consolidation

There has been a tremendous amount of consolidation in the health care industry over the last 20 years. A recent paper by [Fulton \(2017\)](#) documents these trends and shows high and increasing concentration in U.S. hospital, physician, and insurance markets. Figure 5 illustrates these trends from 2010 to 2016, using the Herfindahl-Hirschman Index (HHI) measure of market concentration.¹

The American Hospital Association documents 1,577 hospital mergers from 1998 to 2017, with 456 occurring over the five years from 2013 to 2017. Figure 3 illustrates the number of mergers and the number of hospitals involved in these transactions from 1998 to 2017. A trade publication documents an additional 261 announced hospital mergers from 2018-2020 ([Kaufman Hall, 2021](#)).

¹The HHI is equal to the sum of firms’ market shares. It reaches a maximum of 10,000 when there is only one firm in the market. It gets smaller the more equal are firms’ market shares and the more firms there are in the market.

While some of these mergers may have little or no impact on competition, many include mergers between close competitors, especially given that hospital markets are already highly concentrated. Figure 4 shows that almost half of the hospital mergers occurring from 2010 to 2012 were between hospitals in the same area.² Further, as indicated below, recent evidence indicates that even mergers between hospitals in different may lead to higher prices.

As a result of this consolidation, the majority of hospital markets are highly concentrated, and many areas of the country are dominated by one or two large hospital systems with no close competitors (Cutler and Scott Morton, 2013; Fulton, 2017).³ This includes places like Boston (Partners), Cleveland (Cleveland Clinic and University Hospital), Pittsburgh (UPMC), and San Francisco (Sutter). Mergers that eliminate close competitors cause direct harm to competition. In addition, once a firm has obtained a dominant position it has an incentive to maintain or enhance it, including by engaging in anticompetitive practices.

Moreover, there have been a very large number of acquisitions of physician practices by hospitals. In 2006, 28 percent of primary physicians were employed by hospitals. By 2016, that number had risen to 44 percent (Fulton, 2017). The American Medical Association reports that 33 percent of all physicians were employed by hospitals in 2016, and less than half own their own practice (Kane, 2017). Fulton (2017) finds that increased concentration in primary care physician markets is associated with practices being owned by hospitals. Venkatesh (2019) documents nearly 31,000 physician practice acquisitions by hospitals from 2008-2012, and that over 55 percent of physicians are in hospital owned practices.

It's important to note that the vast majority of physician practice mergers and many hospital acquisitions of physician practices are not reported to the federal antitrust enforcement agencies, because these transactions are too small to fall under the Hart-Scott-Rodino reporting guidelines (Capps et al., 2017).⁴ Consideration should be given to adopting simple, streamlined reporting requirements for smaller transactions so that the enforcement agencies are able to properly track them and consider whether any are of concern.

There are a number of possible motivations for hospital mergers. Among these are an attempt to increase market power, and thereby enhance negotiating positions with private insurers, a desire to reduce costs, a desire to enhance quality, a desire to enhance coordination or integration of care, reactions to the mergers of rival hospitals or of insurers, an attempt to achieve protection against an uncertain environment, and spending excess cash.

²The areas used are Core Based Statistical Areas. For a definition see (p. A-15 in U.S. Census Bureau, 2012)

³Fulton (2017) reports that 90 percent of Metropolitan Statistical Areas (MSAs) were highly concentrated for hospitals. The U.S. antitrust enforcement agencies define an HHI of 2,500 or above as "highly concentrated" (Federal Trade Commission and Department of Justice, 1992). My co-authors Zack Cooper, Stuart Craig, John Van Reenen, and I have calculated that the largest health system has over 50 percent of the market in 62 percent of areas in the country (commuting zones).

⁴Wollmann (2018) shows that a change in the Hart-Scott-Rodino reporting thresholds led to many transactions not being reported to the agencies, and therefore for most of those transactions to escape antitrust scrutiny.

In addition to the foregoing reasons, Medicare payment policy creates an incentive for physician practices to be owned by hospitals, since Medicare pays providers substantially more⁵ for the same physician service if the practice is owned by a hospital than if it's independent (Forlines, 2018; Dranove and Ody, 2019).

Separately, the federal 340b program creates incentives for consolidation between some hospitals and physician practices. The 340b program permits eligible hospitals to purchase drugs for their patients at a substantial discount. It can therefore be very profitable to hospitals and physician practices for hospitals to own physician practices that provide a lot of physician administered drugs to their patients, since the hospital obtains the drugs at a substantial discount through the 340b program, and both the discount and the revenues are captured by the combined hospital-physician practice. Desai and McWilliams (2018) show the 340b program is associated with substantially more physician practices in certain specialties being owned by hospitals.

4 Evidence on the Impacts of Consolidation

There is now a considerable body of scientific research evidence on the impacts of hospital consolidation (see Gaynor et al., 2015; Tsai and Jha, 2014; Gaynor and Town, 2012a,b; Dranove and Satterthwaite, 2000; Gaynor and Vogt, 2000; Vogt and Town, 2006, for reviews of the evidence).

4.1 Impacts on Prices

4.1.1 Hospital Mergers

There are many studies of hospital mergers. These studies look at many different mergers in different places in different time periods, and find substantial increases in price resulting from mergers in concentrated markets (e.g., Town and Vistnes, 2001; Krishnan, 2001; Vita and Sacher, 2001; Gaynor and Vogt, 2003; Capps et al., 2003; Capps and Dranove, 2004; Dafny, 2009; Haas-Wilson and Garmon, 2011; Tenn, 2011; Thompson, 2011; Gowrisankaran et al., 2015). Price increases on the order of 20 or 30 percent are common, with some increases as high as 65 percent.⁶

These results make sense. Hospitals' negotiations with insurers determine prices and whether they are in an insurer's provider network. Insurers want to build a provider network

⁵It can be more than twice as much, e.g. <https://www.siteneutral.org/wp-content/uploads/2019/02/116th-Congress-Site-Neutral-House.pdf>.

⁶These include estimates of price increases of 64.9 percent due to the Evanston Northwestern-Highland Park merger in the Chicago area, 44.2 percent due to the Sutter-Summit merger in the San Francisco Bay area, and 65.3 percent due to the merger of Cape Fear and New Hanover hospitals in Wilmington, North Carolina.

that employers (and consumers) will value. If two hospitals are viewed as good alternatives to each other by consumers (close substitutes), then the insurer can substitute one for the other with little loss to the value of their product, and therefore each hospital’s bargaining leverage is limited. If one hospital declines to join the network, customers will be “almost as happy” with access to the other. If the two hospitals merge, the insurer will now lose substantial value if they offer a network without the merged entity (if there are no other hospitals viewed as good alternatives by consumers). The merger therefore generates bargaining leverage and hospitals can negotiate a price increase.

Overall, these studies consistently show that when hospital consolidation is between close competitors it raises prices, and by substantial amounts. Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem. Moreover, there is no difference between not-for-profit and for-profit hospitals in the extent to which they raise prices due to increased market power.

There is also more recent evidence that mergers between hospitals that are not near to each other can lead to price increases. Quite a few hospital mergers are between hospitals that are not in the same area (see Figure 4). Many employers have locations with employees in a number of geographic areas. These employers will most likely prefer insurance plans with provider networks that cover their employees in all of these locations. An insurance plan thus has an incentive to have a provider network that covers the multiple locations of employers. It is therefore costly for that insurer to lose a hospital system that has hospitals in multiple locations – their network would become less attractive. This means that a merger between hospitals in these different locations can increase their bargaining power, and hence their prices.

There are two recent papers find evidence that such mergers lead to significant hospital price increases. [Lewis and Pflum \(2017\)](#) find that such mergers lead to price increases of 17 percent. [Dafny et al. \(2019\)](#) find that mergers between hospitals in different markets in the same state (but not in different states) lead to price increases of 10 percent.

Understanding the competitive effects of cross-market hospital mergers is an important area for further investigation, and determining appropriate policy responses ([Brand and Rosenbaum, 2019](#)).

4.1.2 Hospital Acquisitions of Physician Practices

Studies that examine the impacts of hospital acquisitions of physician practices find that such acquisitions result in significantly higher prices and more spending ([Capps et al., 2018](#); [Neprash et al., 2015](#); [Baker et al., 2014](#); [Robinson and Miller, 2014](#)). For example, [Capps et al. \(2018\)](#) find that hospital acquisitions of physician practices led to prices increasing by an average of 14 percent and patient spending increasing by 4.9 percent.

4.2 Impacts on Quality

Just as important, if not more, than impacts on prices are impacts on the quality of care. The quality of health care can have profound impacts on patients' lives, including their probability of survival.

4.2.1 Hospital Mergers

A number of studies have found that patient health outcomes are substantially worse at hospitals in more concentrated markets, where those hospitals face less potential competition.

Studies of markets with administered prices (e.g., Medicare) find that less competition leads to worse quality. One of the most striking results is from [Kessler and McClellan \(2000\)](#), who find that risk-adjusted one year mortality for Medicare heart attack (acute myocardial infarction, or AMI) patients is significantly higher in more concentrated markets.⁷ In particular, patients in the most concentrated markets had mortality probabilities 1.46 points higher than those in the least concentrated markets (this constitutes a 4.4% difference) as of 1991. This is an extremely large difference – it amounts to over 2,000 fewer (statistical) deaths in the least concentrated vs. most concentrated markets.

There are similar results from studies of the English National Health Service (NHS). The NHS adopted a set of reforms in 2006 that were intended to increase patient choice and hospital competition, and introduced administered prices for hospitals based on patient diagnoses (analogous to the Medicare Prospective Payment System). Two recent studies examine the impacts of this reform ([Cooper et al., 2011](#); [Gaynor et al., 2013](#)) and find that, following the reform, risk-adjusted mortality from heart attacks fell more at hospitals in less concentrated markets than at hospitals in more concentrated markets. [Gaynor et al. \(2013\)](#) also look at mortality from all causes and find that patients fared worse at hospitals in more consolidated markets.

Studies of markets where prices are market determined (e.g., markets for those with private health insurance) find that consolidation can lead to lower quality, although some studies go the other way. In my opinion the strongest scientific studies find that quality is lower where there's less competition. For example, [Romano and Balan \(2011\)](#) find that the merger of Evanston Northwestern and Highland Park hospitals had no effect on some quality indicators, while it harmed others. [Capps \(2005\)](#) finds that hospital mergers in New York state had no impacts on many quality indicators, but led to increases in mortality for patients suffering from heart attacks and from failure. [Hayford \(2012\)](#) finds that hospital mergers in California led to substantially increased mortality rates for patients with heart disease. [Cutler et al. \(2010\)](#) find that the removal of barriers to entry led to increased market shares for low mortality rate CABG surgeons in Pennsylvania. [Haas et al. \(2018\)](#)

⁷Concentrated markets have fewer competitors or are dominated by a small number of competitors, e.g., one large hospital.

find that system expansions (such as those due to merger or acquisition) can pose significant patient safety risks. [Short and Ho \(2019\)](#) find that hospital market concentration is strongly negatively associated with multiple measures of patient satisfaction.

4.2.2 Hospital Acquisitions of Physician Practices

Research on the effects of hospital ownership of physician practices does not find evidence of improved quality. [McWilliams et al. \(2013\)](#) find that larger hospital owned physician practices have higher readmission rates and perform no better than smaller practices on process based measures of quality. [\(Scott et al., 2018\)](#) find no improvement in quality of care at hospitals that acquired physician practices compared to those that did not. [Koch et al. \(2020\)](#) do not find significant effects of hospital ownership of physician practices on Medicare patients’ health outcomes. [Short and Ho \(2019\)](#) also find a limited effect of hospital ownership of physician practices on Medicare quality measures, but find that increased market concentration is strongly associated with reduced quality. Further, the testimony of Dr. Kenneth Kizer in a recent physician practice merger case (Federal Trade Commission and State of Idaho v. St. Luke’s Health System, Ltd, and Saltzer Medical Group, P.A.) documents that clinical integration is achieved with many different forms of organization, i.e., that consolidation isn’t necessary to achieve the benefits of clinical integration.⁸

4.2.3 Patient Referrals

There has been concern about the possible impact of hospital ownership of physician practices on where those physicians refer their patients, and whether that is in the patients’ best interests ([Mathews and Evans, 2018](#)). A number of studies have found that patient referrals are substantially altered by hospital acquisition of a physician practice. ([Brot-Goldberg and de Vaan, 2018](#)) find that if primary care physicians in Massachusetts are in a practice owned by a health system they are substantially more likely to refer to an orthopedist within the health system that owns the practice. They also estimate that this is largely due to anti-competitive steering. ([Venkatesh, 2019](#)) examines Medicare data and finds a 9-fold increase in the probability that a physician refers to a hospital once their practice is acquired by the hospital. Hospital divestiture of a practice has the opposite effect (Figure 6). A study by [Walden \(2017\)](#) also employs Medicare data and finds that hospital acquisitions of physician practices “increases referrals to specialists employed by the acquirer by 52 percent after acquisition”, and reduces referrals to specialists employed by competitors by 7 percent. [Whaley et al. \(2021\)](#) find evidence of a substantial shift of referrals to hospitals as a result of hospital ownership of physician practices, and [Young et al. \(2021\)](#) find that hospital acquisitions of physician practices led to increases in inappropriate referrals for diagnostic imaging.

⁸<https://www.ftc.gov/system/files/documents/cases/131021stlukedemokizer.pdf>

4.2.4 Labor Market Impacts, Monopsony Power

It is also possible that health care consolidation can have impacts on labor markets. Consolidation that causes competitive harm in the output market does not necessarily cause harm to competition in the input market (monopsony power is the term for market power in buying inputs). For example, two local grocery stores may merge to monopoly in an area, but they purchase frozen food items on a national market with lots of competition. Conversely, it is possible that a merger may have no harm to competition in the output market, but cause competitive harm in an input market. For example, consider two coal mines located in the same area that merge. Coal is sold on a national market, so the merger will not cause competitive harm. However, if the coal mines are the largest (or only) employers in the area, then the merger will cause harm to competition in the labor market.

In the case of health care, however, both the output market for health care services and the input market for labor are local. As a consequence, a merger that causes harm to competition in the market for health care services has nontrivial potential to harm competition in the labor market. The extent to which such a merger will cause labor market harms depends on the alternatives that workers have in terms of the types of other jobs available and where they are located. Nonspecialized workers, such as custodians, food service workers, and security guards are less likely to be affected by a merger, since their skills are readily transferable to other employers in other sectors.⁹ Workers who have specialized skills that are not readily transferable to other employers in other sectors are more likely to be harmed. For example, consider a town with two hospitals, a large automobile assembly plant, and multiple retail and service establishments. If the two hospitals merge to monopoly, hospital custodians and security guards will have alternatives at the assembly plant or at the retail or service establishments. As a consequence, competition for these workers may be little affected by the merger. Nurses and medical technicians, however, have nowhere else to turn in the local market, so there will be substantial harm to competition for health care workers.

There are a number of papers that have demonstrated the presence of monopsony power in the market for nurses (see e.g., [Sullivan, 1989](#); [Currie et al., 2005](#); [Staiger et al., 2010](#)). These papers demonstrate that hospitals possess and exercise monopsony power in the market for nurses. They do not, however, provide direct evidence on the impacts of consolidation. A recent paper, however, looks directly at the impacts of hospital mergers on workers' wages. [Prager and Schmitt \(2021\)](#) look at the impacts of 84 hospital mergers nationally between 2000 and 2010. They find that hospital mergers that resulted in large increases in concentration substantially reduced wage growth for workers with industry specific skills, but not for unskilled workers. They find that "Following such mergers, annual wage growth is 1.1 percentage points slower for skilled non-health professionals and 1.7 percentage points slower for nursing and pharmacy workers than in markets without mergers." This suggests that hospital mergers can harm competition in the labor market for workers with skills specific to

⁹However, even workers with readily transferable skills can be harmed by a merger if the merged firm is the dominant employer overall in an area.

the hospital industry.

The impacts of consolidation on labor markets (and input markets generally) is an area where study is needed to understand the nature of the impacts of consolidation and evidence of those effects. Moreover, antitrust authorities need to know to what extent merger enforcement focused on output markets addresses potential input market competitive harms, and to what extent input markets require a separate focus. Further, if the agencies are to pursue enforcement in this area they need to develop economic and legal approaches to this issue.

4.3 Impacts on Costs, Coordination, Quality

It is plausible that consolidation between hospital, physician practices or insurers, in a number of combinations, could reduce costs, increase care coordination, or enhance efficiency. There may be gains from operating at a larger scale, eliminating wasteful duplication, improved communications, enhanced incentives for mutually beneficial investments, etc. However, it is important to realize that consolidation is not integration. Acquiring another firm changes ownership, but in and of itself does nothing to achieve integration. Integration, if it happens, is a long process that occurs after acquisition.

While the intuition, and the rhetoric, surrounding consolidation, has been positive, the reality is less encouraging. The evidence on the effects of consolidation is mixed, but it's safe to say that it does not show overall gains from consolidation (Neprash and McWilliams, 2019). Merged hospitals, insurers, physician practices, or integrated systems are not systematically less costly, higher quality, or more effective than independent firms (see Burns and Muller, 2008; Burns et al., 2015; Goldsmith et al., 2015; Burns et al., 2013; McWilliams et al., 2013; Tsai and Jha, 2014).

For example, Burns et al. (2015) find no evidence that hospital systems are lower cost, Goldsmith et al. (2015) find no evidence that integrated delivery systems perform better than independents, Koch et al. (2018) find higher Medicare expenditures for cardiology practices in consolidated markets, and McWilliams et al. (2013) find higher Medicare expenditures for large hospital-based practices. In contrast, Schmitt (2017) finds evidence of significant cost savings (4-7 percent) due to hospital mergers, with the exception of mergers of hospital in the same market (and thereby likely competitors). Gaynor et al. (2021) examine the merger of two large hospital chains. They find that the acquisition led to adoption of a new electronic medical record system, and similarity of management practices, but neither the profitability of the acquired hospitals or the acquiring hospitals increased, nor did patient outcomes improve. Beaulieu et al. (2020) report that "Hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive."

After more than 3 decades of extensive consolidation in health care, it seems likely that the promised gains from consolidation would have materialized by now if they were truly there.

5 Anticompetitive Conduct

Firms that acquire a dominant market position usually wish to keep it. The incentive to maintain or enhance a dominant position can be beneficial when it leads the firm to deliver value to consumers in order to keep or gain their business. This can result in lower prices, higher quality, better service, or enhanced innovation. There may also be strong incentives for such firms to engage in anticompetitive practices in order to disadvantage competitors or make it difficult for new products or firms to enter the market and compete.

There are prominent instances of firms in the health care industry engaging in what appear to be anticompetitive tactics. Cooper et al. (2019) find that hospitals with fewer potential competitors are more likely to negotiate contracts with insurers that have payment forms that are more favorable to them (e.g., fee for service) and reject payment forms they dislike (e.g., DRG based payment). While this is not an anticompetitive practice, it suggests that hospitals with market power are able to negotiate contracts with insurers that contain anticompetitive elements. This indeed is the issue in some recent antitrust cases. These cases revolve around the use of restrictive clauses in hospital contracts with insurers.¹⁰

These clauses prevent insurers from using methods to direct their enrollees to less costly or better hospitals. One of these methods is called tiering - a practice where enrollees pay less out of their own pockets for care received from providers in a more favorable group ("tier"), and pay more if they see a provider in a less favorable tier. Insurers use tiering to give enrollees incentives to obtain care at less costly or higher quality providers. This system thus gives providers an incentive to do the things it takes to be in the more favorable tier, and is a way to promote competition. Another method is steering - enrollees are directed to providers who are preferred, due to lower costs or higher quality. Steering also promotes competition - providers have incentives to agree to lower prices or provide better quality or service in order to be in the preferred group. A third method employed by insurers is transparency - providing enrollees with information about the costs or quality of care at different providers. The intent is to provide enrollees with the information they need to choose the right provider, and by doing so to give providers incentives to compete on those factors.

In both of the antitrust suits mentioned above, the health systems had negotiated clauses in their contracts with insurers which prohibited the insurers from using any of these methods to try to direct patients to lower cost or better providers. The clauses prohibiting the use of these methods are called "anti-tiering," "anti-steering," and "gag" clauses. The concern with the use of these restrictive clauses is that they harm competition by preventing insurers by using methods that provide incentives to providers to compete to attract patients. The lawsuit by the DOJ against Carolinas Health System was settled, with the health system

¹⁰United States and the State of North Carolina v. The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System, <https://www.justice.gov/atr/case/us-and-state-north-carolina-v-c-harlotte-mecklenburg-hospital-authority-dba-carolinas>; People of the State of California Ex Rel. Xavier Becerra v. Sutter Health, <https://oag.ca.gov/news/press-releases/attorney-general-becerra-sues-sutter-health-anti-competitive-practices-increase>

agreeing not to use these restrictive clauses.¹¹ The California Attorney General’s lawsuit against Sutter Health System was also settled, with a similar outcome.¹²

At present there is no systematic evidence on the extent to which anti-tiering, anti-steering, and gag clauses are being employed by health systems in their contracts with insurers, nor analysis of their impacts. This is an area which needs investigation to document the extent of the practice and its impacts.

Another practice that raises concerns is “data blocking” (Savage et al., 2019). Data blocking is a practice in which health systems impede or prevent the flow of patients’ clinical data to providers outside their system. It also refers to a practice by electronic medical record (EMR) providers to impede the flow of data to rival EMR systems via lack of compatibility. Data blocking by providers makes it more difficult for patients to go to rival providers, locking them in, since their medical information doesn’t go with them. Reducing patient mobility across providers harms competition and benefits incumbents. While there are extensive reports of data blocking, there isn’t systematic evidence on the extent of the practice, or on its impacts. Study is needed to understand the nature of data blocking, and the extent to which it leads to harm to competition or to efficiencies.

6 Policies to Make Health Care Markets Work

As I have discussed, hospital consolidation, and hospital acquisitions of physician practices, have not delivered on lower costs, improved coordination of care, or enhanced quality. What has happened is that consolidation between close competitors has reduced competition, leading to higher prices and harming quality. Perhaps even worse, reduced competition tends to preserve the status quo in health care by protecting existing firms and making it more difficult for new firms to enter markets and succeed. This leads to excessive rigidity and resistance to change, as opposed to the innovation and dynamism that we need in health care.

In spite of these problems, there are a few simple things that can be done to support and enhance competition in health care markets.

6.1 Reform Policies that Unintentionally Harm Competition

- There are a number of federal and state policies that have the unintended effect of encouraging consolidation or limiting competition. These policies can be reformed to remove these unintended negative effects.

¹¹<https://www.justice.gov/atr/case-document/file/1111581/download>.

¹²<https://oag.ca.gov/news/press-releases/attorney-general-becerra-secures-preliminary-approval-settlement-sutter-health>.

- One key set of actions is to end federal payment policies that unintentionally provide incentives for consolidation. Reforming these policies to put an end to incentives that artificially encourage consolidation will help preserve independent competitors and competition.
- Another set of things that can be done to reduce unintended incentives to consolidate is to reduce administrative burdens that generate more costs than benefits. One example of these is quality reporting. Multiple entities: Medicare, Medicaid, multiple private insurers require provider reporting of a large set of quality measures. Coordination among payers could reduce administrative burden and thereby reduce incentives to consolidate.
- Some states have regulations that unintentionally make it difficult for new firms to enter or artificially alter the negotiating positions of providers and payers. These include certificate of need laws, any willing provider laws, scope of practice laws, and licensing board decisions. Negative impacts of these laws can particularly affect residents of rural areas, where access to alternative suppliers (e.g., via telehealth and appropriate services from nurse practitioners or pharmacists) is particularly scarce. States should examine these laws and practices to make sure they are narrowly tailored to benefit the public and do not unintentionally protect incumbents and harm competition.
- This also applies to state certificate of public advantage legislation. These laws, when passed, shield merging parties from federal antitrust scrutiny and impose state supervision. If certificates of public advantage continue to be issued, omitting provisions that exempt merging parties from antitrust scrutiny will help to preserve competition.¹³

6.1.1 Strengthen Antitrust Enforcement

- Antitrust enforcement in health care by federal and state governments, both horizontal and vertical, needs to be continued and enhanced. Approximately one-half of the merger challenges brought by the FTC from 2010-2018 were in health care [Wilson \(2019\)](#).
 - There is widespread agreement that the FTC and the Antitrust Division of the DOJ need substantially more resources.¹⁴ If we expect the antitrust enforcement agencies to do more in health care without reducing their efforts in the rest of the economy, then they will need more resources. The demands on the agencies

¹³The FTC is currently conducting a study of certificates of public advantage, <https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas>.

¹⁴See for example, the Competition and Antitrust Law Enforcement Reform Act of 2021 introduced by Senator Amy Klobuchar, which incorporates substantial increases in the agencies' budgets https://www.klobuchar.senate.gov/public/_cache/files/e/1/e171ac94-edaf-42bc-95ba-85c985a89200/375AF2AE44F2AF97FB96DBC6A2A839F9.sil21191.pdf.

have risen in terms of number of merger filings, while their inflation adjusted appropriations have declined (see Figure 7). The decline in resources relative to demands not only makes it hard for the agencies to address antitrust issues as they arise, it makes it extremely difficult for them to allocate the necessary resources to proactively invest in important new and developing areas.

- In addition, at present the FTC is prohibited from enforcing against anticompetitive conduct by not-for-profit firms (FTC Act, Section 45(a)(2), Section 44). This prevents the FTC from investigating possible anticompetitive conduct in the hospital sector, since the majority of hospitals are not-for-profit. While the DOJ can investigate anticompetitive conduct by not-for-profits, this leaves the country with only one of its antitrust enforcement agencies (and the one with the greatest expertise in health care) able to address this important issue. Removing these restrictions on the FTC will enable it to function to the full extent of its capabilities to protect competition and consumers in health care markets.
- Requiring parties in small transactions to report in a simple, streamlined way will enable the agencies to track the many small transactions in health care involving physician practices (both horizontal and vertical) that at present are not reported and many of which escape antitrust scrutiny.
- Even with the preponderance of evidence concerning the competitive harms of mergers between hospital that are close competitors, the FTC has faced substantial difficulties in court, even when it appears to be an “open and shut” case.¹⁵ Moreover, these cases require extraordinary expenditure of resources, straining the abilities of the agencies to address other, equally pressing, matters. Legislation to strengthen the antitrust laws, as in the Competition and Antitrust Law Enforcement Reform Act of 2021 cited above, will do a great deal to help improve competition in health care markets by strengthening the antitrust enforcement agencies’ positions in dealing with harmful health care mergers, and serving to deter harmful mergers.
- Have the FTC and DOJ issue revised guidelines for antitrust enforcement in health care. These guidelines provide important guidance to firms and courts about the nature of competition, harms to competition, and efficiencies in health care. The guidelines were issued in 1996.¹⁶ Much has changed since that time, and a refreshed and revived set of health care guidelines can help market participants, courts, and the agencies.
- Health care consolidation has the potential to harm competition not only in the market for health care services (output), but in labor markets (input). There is some recent evidence demonstrating that mergers that result in large increases in

¹⁵https://www.ftc.gov/system/files/documents/public_statements/1520570/slaughter_-_hospital_speech_5-14-19.pdf

¹⁶<https://www.justice.gov/atr/page/file/1197731/download>

concentration adversely affect wage growth for workers with skills specific to the hospital industry. While this is welcome evidence, more investigation and study is required to learn more about the impacts of health care consolidation on labor markets and to develop antitrust theories and evidence.

6.2 Improve Information About Health Care Markets

- At present there are no national, publicly available data on total U.S. health care costs and utilization, prices for specific services or providers, or health care ownership arrangements. Data and information are now as vital a part of our national infrastructure as are our bridges and roads. It's time to invest in a national health care data warehouse that brings together private and public data to inform employers, policymakers, and consumers. This information would be vitally important to the Department of Health and Human Services, States, employers, consumers, and the antitrust agencies.

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Figure 1: Growth in Health Insurance Premiums, Deductibles, Wages, and Inflation (Source: Kaiser Family Foundation)

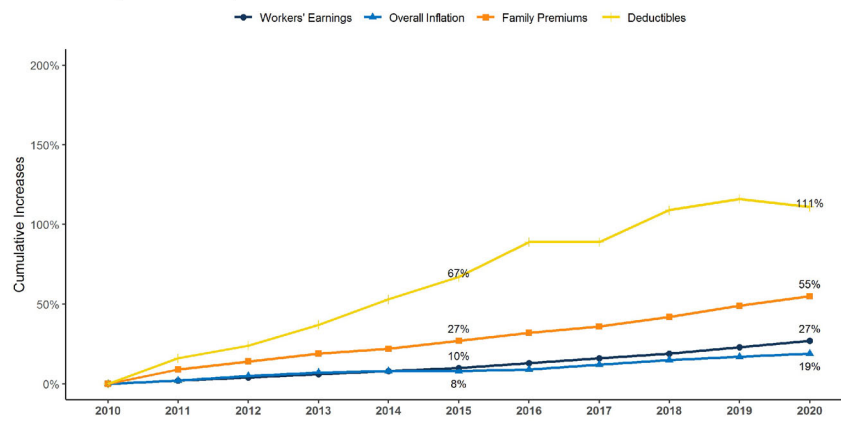
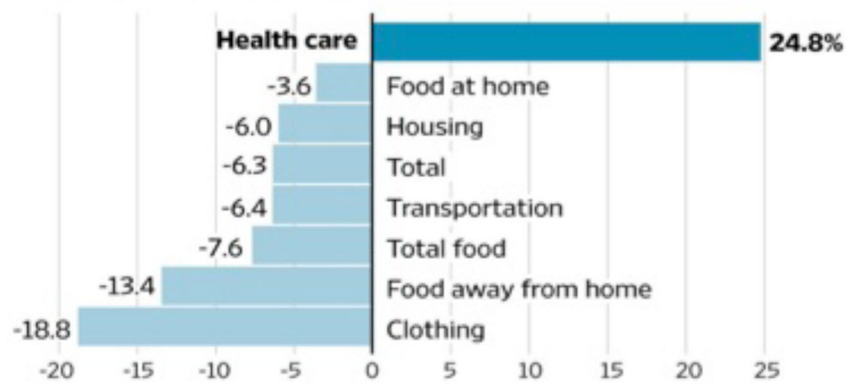


Figure 2: Change in Household Spending on Health Care and Other Basics

A Bigger Bite

Middle-class families' spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

Percent change in middle-income households' spending on basic needs (2007 to 2014)



Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department
THE WALL STREET JOURNAL.

Figure 3: Number of Hospital Mergers, 1998-2017 (Source: American Hospital Association)

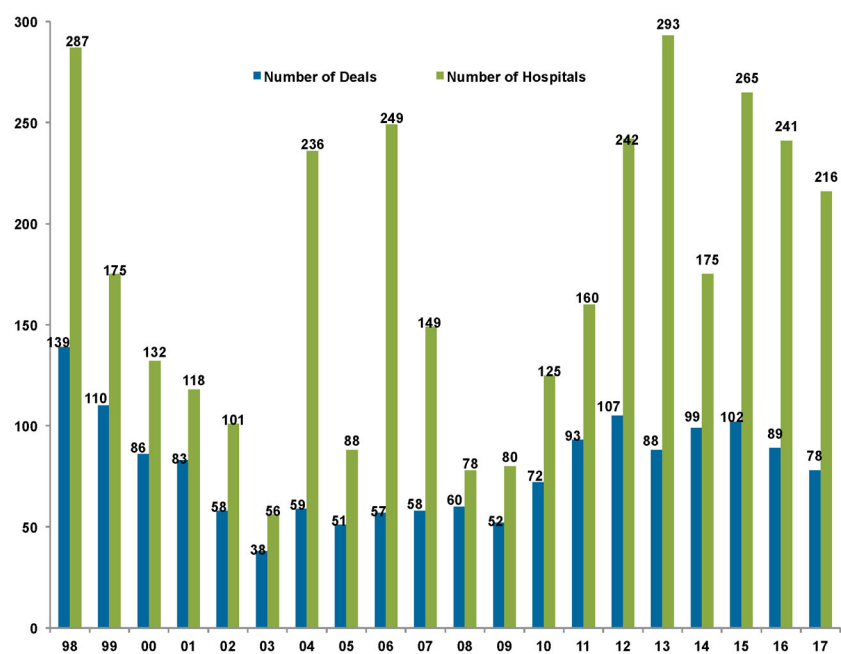


Figure 4: Percent of Mergers Between Hospitals in Same Area, 2010-2012 (Source: [Dafny et al., 2019](#))

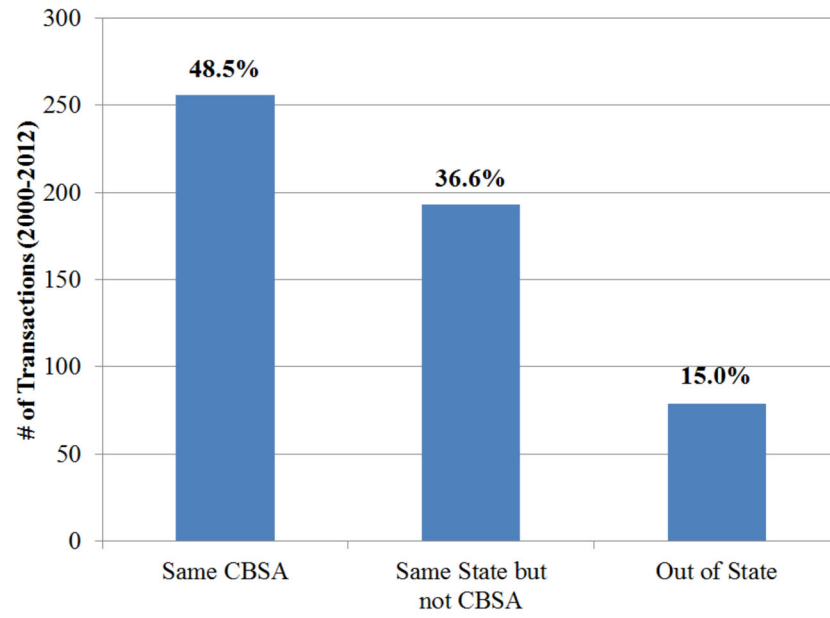


Figure 5: Market Concentration (HHI) for hospitals, physicians, and insurers, 2010-2016
(Source: [Fulton \(2017\)](#))

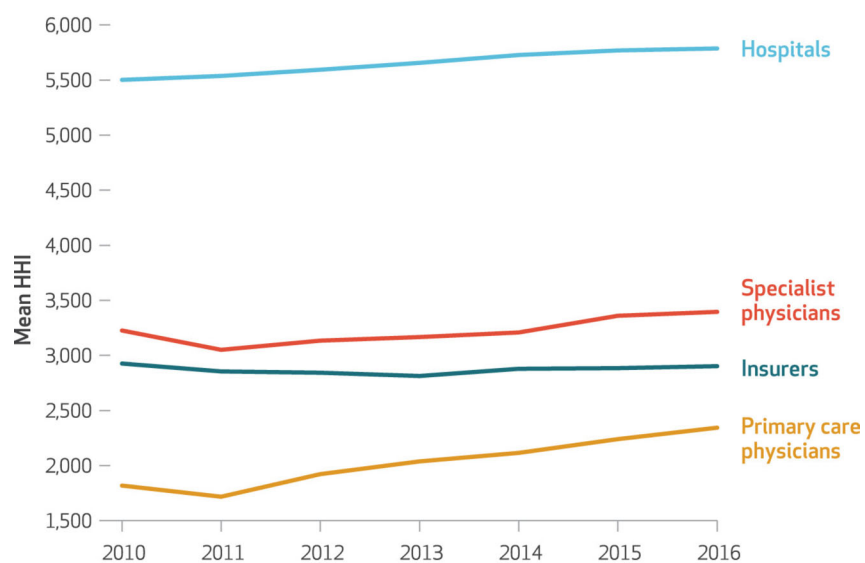


Figure 6: Effects on Physician Referrals of Hospital Practice Acquisitions and Divestitures
(Sources: [Venkatesh, 2019](#); [Mathews and Evans, 2018](#))

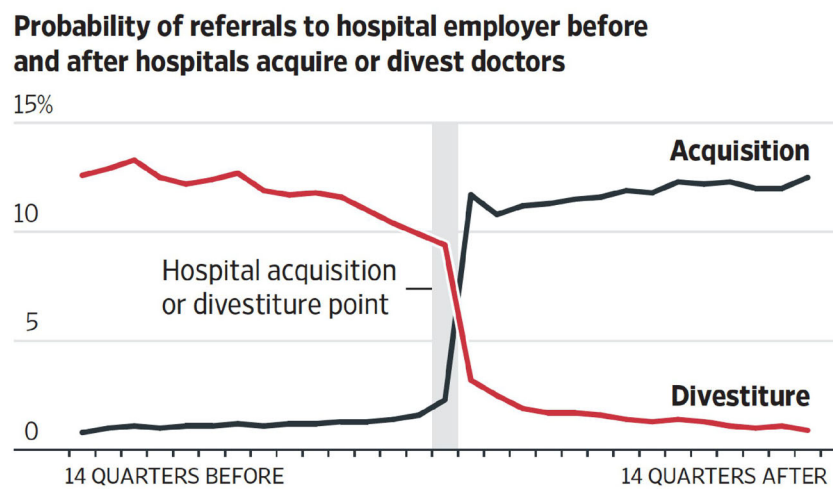
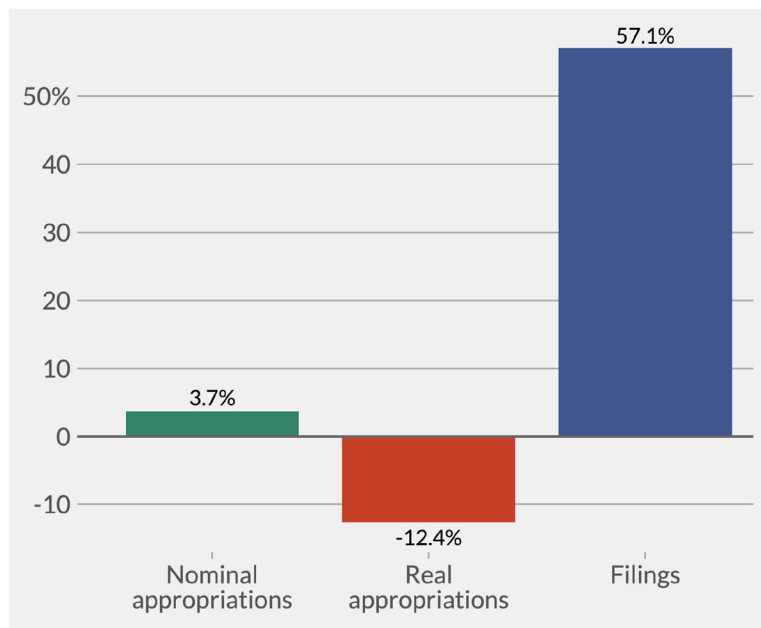


Figure 7: DOJ, FTC Appropriations vs. Merger Filings, 2010-2016
(Source: Courtesy Michael Kades, Washington Center for Equitable Growth, <https://equitablegrowth.org/presentation-merger-enforcement-statistics/>)





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Rod Hochman Bio **5/13/2021**

Rod Hochman, M.D., is chair of the American Hospital Association Board of Trustees and president and CEO of Providence, a not-for-profit health system serving the Western U.S. The son of immigrants, Dr. Hochman grew up in Brooklyn, New York, and later became a practicing physician serving in the medical field for 42 years, specializing in immunology, rheumatology and internal medicine. Today, he is a leading voice for transformation in health care, committed to advancing quality, affordability and access to care for all, especially those who are most vulnerable.

At Providence, Dr. Hochman leads an organization of 120,000 caregivers who deliver high quality care to more than 5 million patients a year in 52 hospitals, more than 1,000 clinics, and hundreds of programs and services in Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. Providence was the first health system in the U.S. to admit a patient with COVID-19 in January 2020 and has served more than 154,000 patients with COVID-19 since the pandemic began.

Last year, Providence provided more than \$1.7 billion in uncompensated care and other community benefits. Under Dr. Hochman's leadership, the organization has invested \$100 million to improve mental health and well-being through the establishment of the Well Being Trust. The organization has also committed \$50 million to improve health equity.

Rod has been named among the most influential people in health care by Modern Healthcare several years in a row. He was awarded the 2020 Lifetime Achievement Award by the Puget Sound Business Journal. In 2019, the National Center for Healthcare Leadership honored him as the recipient of the Gail L. Warden Leadership Excellence Award. He was also named the 2015 Innovator of the Year by Press Ganey and is the recipient of the 2017 Partners in Care Foundation Vision and Excellence in Health Care Leadership Award.

Rod is a former chair of the board of trustees for the Catholic Health Association. He served as a clinical fellow in internal medicine at Harvard Medical School and Dartmouth Medical School, and received his bachelor's degree and medical degree from Boston University.



Antitrust Applied: Hospital Consolidation Concerns and Solutions

Statement before the Judiciary Committee
Subcommittee on Competition Policy, Antitrust, and Consumer Rights
U.S. Senate

by

Ahmer Qadeer
Director of Strategic Initiatives
Service Employees International Union

May 19, 2021

Senator Klobuchar, Senator Lee, and Members of the Subcommittee, thank you for holding a hearing on this important topic and for giving me the opportunity to testify before you today.

I am the Director of Strategic Initiatives at the Service Employees International Union (SEIU). SEIU is the largest healthcare union in the country. Our union represents more than a million healthcare workers including physicians, nurses, service and maintenance workers and many other hospital-based employees. I am testifying today to comment on how concentration in hospitals may impact the wages, benefits, working conditions of SEIU members as well as millions of other healthcare workers.

Over the last ten years health systems have been consolidating at a brisk pace, with consolidation particularly acute at the largest health systems. Deloitte estimated that between 2013 -2018 the average number of hospitals in health systems was stable, but in the largest systems (those with over 30 hospitals) the average number of hospitals increased significantly.¹ In short, among health systems, as in many other parts of the economy, big firms are getting bigger.

Consider a description from Samuel Hazen, the CEO of HCA Healthcare Inc, the largest hospital system in the country. Hazen said to investors during his firms' 2021 Q1 conference call, "We are operating at an all-time high on market share... we're pushing the overall market share for the company across the 43 domestic markets into the low 27 percent zone, so a very high watermark".² HCA's CFO also told investors that HCA hospitals were an important part of the fabric of the communities in which they operate and often one of the biggest employers in the community.³

There is substantial empirical evidence that when employment is concentrated among fewer firms and workers have fewer employment options it leads to lower wages for workers. A 2017 study demonstrated that moving from the 25th percentile of concentrated labor markets to the 75th percentile is associated with a 15-25 percent decline in wages. Simply put as employer concentration rises, wages fall.⁴

A 2020 study estimated that more than 10 percent of the US workforce are likely in labor markets where employer concentration suppressed wages by at least 2 percent. Furthermore several million workers are in markets where employer concentration

¹ Deloitte Insights, Tracy Prevost, Ion Skillrud, Wendy Gerbhardt, and Debanshu Mukherjee, The Potential for Rapid Consolidation of Health Systems (December 10, 2020) available at

<https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html>

² HCA Healthcare, Inc. NYSE:HCA FQ1 2021 Earnings Call Transcripts, (April 22, 2021) S&P Global Market Intelligence, comments by Samuel P. Hazen pg. 13.

³ HCA Healthcare, Inc. Presents at Raymond James 41st Annual Institutional Investors Conference, (March 3, 2020) S&P Global Market Intelligence, page 4.

⁴ José Azar, Ioana Marinescu, Marshall I. Steinbaum (2020). *Labor Market Concentration*. Journal of Human Resources, available: https://www.nber.org/system/files/working_papers/w24147/w24147.pdf. David Arnold (2021) *Mergers and Acquisitions, Local Labor Market Concentrations, and Worker Outcomes*, available: <https://darnold199.github.io/jmp.pdf>.

suppressed wages by at least 5 percent.⁵ The research on employer concentration in the hospital industry is consistent with empirical findings about the broader economy.

An American Economic Review article examined the effects of hospital mergers between 2000 and 2010 on the wages of hospital workers. The study looked at more than 1,300 hospitals and found that mergers that increased hospital concentration to high levels reduced the wages of nurses and other healthcare occupations.⁶

The negative effects of employer concentration are not limited to wages, but also include benefits and working conditions. A 2021 paper demonstrated that workers in concentrated labor markets are more likely to experience wage theft, health and safety code infractions, and other contraventions of labor laws.⁷ I want to emphasize that excessive employer concentration does not just lead to lower wages and benefits but also diminishes the quality of life of workers, their families and their communities.

For instance, Pittsburgh is one the most highly concentrated hospital markets in the country and UPMC the largest health system in the area. Workers at UPMC describe wages and benefits so low that many workers rely on food stamps and incur medical debt. Leslie Poston, an administrative assistant described, "UPMC is my employer, my insurer, and my healthcare provider — not to mention the largest private sector employer in Pennsylvania. They know how much I make and that I'm thousands of dollars in debt to the hospital I work at." Poston and other UPMC workers describe circumstances where wages and benefits are so low that it creates a need for charity among the hospital's employees.⁸

In spite of the problems caused by labor market concentration, labor market antitrust litigation against employers is rare. Since 1960 there have been fewer than 100 labor market cases but over 2,300 product market cases.⁹ Not a single labor market case brought under Section 2 of the Sherman Act survived summary judgment.¹⁰ This "litigation gap" is exacerbated by the lack of attention to labor market effects in the

⁵ Anna Stansbury, Gregor Schubert and Bledi Taska, (2021) Employer Concentration and Outside Options, available: <https://scholar.harvard.edu/stansbury/concentration-options>. Anna Stansbury, *Employer concentration suppresses wages for several million U.S. workers: antitrust and labor market regulators should respond* (January 26, 2021) available: <https://equitablegrowth.org/employer-concentration-suppresses-wages-for-several-million-u-s-workers-antitrust-and-labor-market-regulators-should-respond/>.

⁶ Elena Prager and Matt Schmitt, (2021) *Employer Consolidation and Wages: Evidence from Hospitals*, American Economic Review available: <https://www.aeaweb.org/articles?id=10.1257/aer.20190690>.

⁷ Ioana Elena Marinescu, Yue Qiu, Aaron Sojourner (2020) Wage Inequality and Labor Rights Violations available: <http://www.marinescu.eu/publication/marinescu-wage-2020/>.

⁸ Sarah Boden, UPMC Workers Say Debt To Their Employer An Example Of Hospital System Exploiting Tax-Exempt Status. 90.5 WESA & seiu.org/2020/02/27/seiu-announces-150-million-national-investment-in-2020-cycle-with-pennsylvania-as-one-of-eight-top-targeted-states/

⁹ Eric A. Posner, *Why the FTC Should Focus on Labor Monopsony, Pro Market* (November 5, 2018), available at <https://promarket.org/2018/11/05/ftc-should-focus-labor-monopsony/>.

¹⁰ See Marinescu, Ioana Elena and Posner, Eric A., *Why Has Antitrust Law Failed Workers?*, 105 CORNELL L. REV. 1343, 1365 (2020), available at <https://ssrn.com/abstract=3335174>.

current Horizontal Merger Guidelines.¹¹ Indeed, despite decades of increasing consolidation in the hospital sector there is no record of a hospital merger ever being blocked based on anti-competitive labor market impacts.

Antitrust regulation has not been an effective bulwark against the negative labor market effects of employer consolidation. Antitrust laws have weakened dramatically over the last several decades because courts have reinterpreted antitrust statutes increasingly narrowly. A defining feature of “modern” antitrust law is a singular focus on the consumer welfare standard to the exclusion of myriad other forms of harm including anti-competitive employer concentration and conduct in labor markets.

As Senator Klobuchar pointed out in her book there are notable instances where antitrust laws protected workers. In the 1960’s African-American doctors brought suit under the Sherman Act to force staff integration at Chicago hospitals. In 2006, SEIU brought suit against hospitals for colluding to depress wages for nurses.¹² But these are isolated examples. Much more could be done to expand the available policy tools for promoting fair and competitive labor markets.

Let me touch on some specific solutions that would address the concerns of workers in healthcare and other segments of the economy. An important step would be requiring that all merger reviews include an analysis of labor market impacts. Because there is a limited history of antitrust labor enforcement it is also important that bright-line standards are established for anti-competitive consolidation and practices in labor markets. Additionally, directives prohibiting anti-competitive restraints such as worker non-compete restrictions and other vertical restraints are important to counteract key ways that employers abuse their power over workers, exacerbate power imbalances and further distort competition in labor markets.

Empowering workers lessens the negative labor market impacts of consolidation. Antitrust enforcement in labor markets need not be an all or nothing endeavour. Negative labor market effects can be offset by collective bargaining agreements. Likewise wage boards, sectoral working standards for working conditions, broad-based bargaining and other labor market supports can attenuate the negative impacts of employer concentration. But, at this moment, it is important to strengthen antitrust law to explicitly protect competition in labor markets, through readily available tools including merger reviews, providing clear causes of action for monopsony, and preventing employer abuses such as restrictions on workers seeking the best job they can find.

Throughout the Covid-19 pandemic healthcare workers have cared for us. They have tended our families. They have kept us alive. In communities across the country we clapped for healthcare workers as they ended their shifts. But they deserve much more than praise and gratitude. They deserve living wages, good benefits, and safe

¹¹ *Horizontal Merger Guidelines* (Revised April 8, 1997). Department of Justice / Federal Trade Commission, available at <https://www.justice.gov/atr/horizontal-merger-guidelines-0>.

¹² Amy Klobuchar, *Antitrust: Taking on Monopoly Power from the Gilded Age to the Digital Age*, Alfred P. Knopf, New York, 2021 see pages 195 & 231.

workplaces. Empirical research shows that excessive employer consolidation can negatively impact wages and working conditions. I hope you will consider strengthening antitrust applications that have potential to protect workers from exploitation and abusive employer concentration.

Questions for the Record

Senator Mike Lee

To Mr. Cannon:

- 1) Two days after our hearing, the New York Times reported that some hospitals may be using funds they received under the CARES Act Provider Relief Fund to buy up their competitors.¹ I am concerned that the government has yet again directly facilitated consolidation in the hospital industry. Do you share these concerns, and how can policymakers avoid such mistakes in the future?
- 2) During the hearing you suggested that it would be both appropriate from a constitutional standpoint and beneficial from a policy standpoint for Congress to encourage the proliferation of interstate telehealth services by redefining the locus of care as that of the physician rather than as that of the patient. Can you expand on this?
- 3) In your written testimony, you state that, “Congress should reform... the tax treatment of health insurance to give enrollees and workers control over the health care dollars that the federal government and employers currently control. Converting the current tax exclusion to one for contributions to expanded HSAs would deliver the largest effective tax cut in living memory.” Please expand on this idea and detail for the subcommittee precisely how these “expanded HSAs” would work and what benefits you expect them to provide.

¹ <https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html>

Questions for Beth McCracken

1. One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?
2. I am particularly interested the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?
3. Is it possible that government regulations actually caused the consolidation of hospitals?
4. Looking past antitrust remedies and enforcement, are there are other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?
5. How have federal government healthcare policies—again, looking at them holistically— influenced the closure of hospitals in rural and underserved areas?
6. Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.
7. Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

**Senator Chuck Grassley, Ranking Member
Questions for the Record**

Question for Professor Gaynor

**Martin Gaynor: Response to Question from Senator Grassley
(Note: My response follows the Senator's question and is in *italics*.)**

1. The FTC currently does not have jurisdiction under the FTC Act to enforce against anticompetitive conduct for most non-profit organizations, such as non-profit hospitals. There have been arguments over the years for a need to grant the FTC the authority to examine anticompetitive behavior of non-profit hospitals. Professor Gaynor, in your testimony you recommend removing these restrictions on the FTC. What effect do you believe that would have on the healthcare marketplace?

At present only the Antitrust Division of the Department of Justice is authorized to enforce against anticompetitive conduct by nonprofit firms. As you point out, the FTC does not have authority to pursue anticompetitive conduct by nonprofits. This means that only one of our antitrust enforcement agencies can address these kinds of problems. It has come to pass that many areas of our country are now dominated by a single large, powerful health care system, most frequently a nonprofit. This means that anticompetitive conduct has become the major concern and threat to competition, not horizontal merger, because in large parts of the U.S. consolidation has already happened. Therefore, in my opinion, it makes sense to have both of our antitrust enforcement agencies empowered and available to address these issues, which could be quite substantial.

**Antitrust Applied:
Hospital Consolidation Concerns and Solutions**

**Hearing before the Senate Committee on the Judiciary, Subcommittee on Antitrust,
Competition Policy, and Consumer Rights**

May 19, 2021

RESPONSES TO QUESTIONS FROM SENATOR BLUMENTHAL

Martin Gaynor

Note: My responses follow the Senator's questions and are in *italics*.

Questions for Professor Gaynor

1. Hospital systems are increasingly buying solo and small group physician practices. These acquisitions often go undetected by antitrust enforcers because merging companies fall below federal reporting requirements. These unreported and unreviewed acquisitions add up quickly – accounting for a more than 30% increase of hospital-owned physician practices since the mid-2000s.
 - a. A few states require reporting of healthcare mergers below the federal thresholds to their state Attorney General's office. Would a comparable federal policy address this creeping consolidation?

It would help, because federal antitrust enforcement agencies would have comprehensive information about such mergers, whereas present they have little to none. Reporting of "small" mergers that fall below the Hart-Scott-Rodino threshold should be required, in a simple, streamlined way. This would allow the U.S. antitrust enforcement agencies to monitor these mergers and investigate those where there may be cause for concern.

- b. Would you support a federal reporting requirement for smaller acquisitions where the acquiring firm has made a series of such acquisitions over a defined period of several years?

Yes. It can be the case that when there are a series of smaller acquisitions none of them appears to be a concern individually, but there can be a cumulative affect that harms competition.

- c. Aside from reporting, what other steps can be taken to alleviate the problem of creeping consolidation?

More enforcement, and more aggressive enforcement, overall. This cannot be done without a substantial increase in the budgets of the antitrust enforcement agencies. The agencies' budgets, adjusted for inflation, have barely increased in years. As a consequence they are barely able to keep up with existing enforcement areas, and do not have the capacity to pursue new agendas. A

substantial increase in resources is needed to permit the agencies to address the problem of creeping consolidation.

In addition, these issues should be addressed in the merger guidelines. The agencies are currently in the process of revising these guidelines. This is an area that should be included in the new, revised, version of the merger guidelines. Two things in particular the agencies may wish to consider on this topic are as follows. When there is a current acquisition that follows a number of prior acquisitions: 1) consider the impacts of past acquisitions, 2) consider the cumulative impacts of past acquisitions and the current one.

2. As you have written, despite the FTC's strong record in hospital merger challenges, more than 1,600 hospital mergers have been consummated in the last 20 years, and over 90% of metropolitan areas are "highly concentrated."
 - a. What explains this dichotomy of litigation successes and policy failures?

In my opinion one of the main reasons is that the antitrust enforcement agencies simply have not been able to keep up. As I mentioned above, their budgets haven't grown (adjusted for inflation) in years. Even if only a small fraction of the 1,600+ hospital mergers that have occurred over the last 20 years are likely to be problematic, the antitrust enforcement agencies simply do not have the resources to address them.

- b. Would broad antitrust reform rectify this problem, or would a targeted, sector-specific policy solution be more beneficial?

I think both are required. We need more, and more aggressive enforcement, and this includes a recognition by the courts of modern theories and evidence on competition and market power. However, many areas in the U.S. have become extremely consolidated, to the point that they are now dominated by one large, powerful health care system. Situations like this are very difficult for antitrust to address. In my opinion it's time for policymakers to consider options that include direct monitoring and oversight, including the possibility of price regulation.

3. The FTC is prohibited from challenging anticompetitive practices of non-profit entities, which make up more than half of all United States hospitals.
 - a. How does the FTC's non-profit exemption affect patient care and costs?

I don't think we know precisely how the prohibition on the FTC enforcing against anticompetitive conduct by nonprofit firms affects patient care and costs. However, at present only the Antitrust Division of the Department of Justice is authorized to do this. In addition, as I mentioned above, many areas of our country are now dominated by a single large, powerful health care system. The concern in areas like this is primarily anticompetitive conduct, not horizontal merger, because consolidation has already happened. As a consequence, it makes sense to have both of our antitrust enforcement agencies empowered and available to address these issues, which could be quite substantial.

4. In 2019, the Trump Administration's Center for Medicare and Medicaid Services issued a final rule on hospital price transparency, but with penalties capped at \$300 per day, noncompliance has rendered the rule meaningless.
 - a. What can be done to ensure full compliance with both the hospital price transparency rule and upcoming insurance price transparency rule?

One thing that can be done is to increase the penalties for noncompliance substantially, to the point where they matter to hospitals. The penalties could be scaled to the size of the hospital/health system, since it may take larger penalties to induce larger hospitals/health systems to comply, and vice versa.

Another approach is to create a national health care data warehouse, funded and overseen by the federal government. This is the information age, and data are part of our national infrastructure, just like roads, bridges, railroads, and airports. Health care is a vitally important part of our society – it's time to invest in the information infrastructure we need for this critical sector.

Questions for the Record

Senator Mike Lee

Martin Gaynor: Response to Question from Senator Lee
(Note: My response follows the Senator's question and is in *italics*.)

To Prof Gaynor:

- 1) Two days after our hearing, the New York Times reported that some hospitals may be using funds they received under the CARES Act Provider Relief Fund to buy up their competitors.¹ I am concerned that the government has yet again directly facilitated consolidation in the hospital industry. Do you share these concerns, and how can policymakers avoid such mistakes in the future?

I am not knowledgeable enough about specific evidence on this point to respond to this question.

¹ <https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html>

Questions for Professor Martin Gaynor

Martin Gaynor: Response to Questions from Senator Tillis
(Note: My responses follow the Senator's questions and are in *italics*.)

1. One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?

There is extensive research evidence that mergers of hospitals that are close competitors cause prices to increase substantially, thereby substantially increasing the cost of care. As hospital markets have become increasingly consolidated, there are fewer competitors left, so it's more likely that mergers are between close competitors, thereby causing substantial harm to competition and driving up health care costs.

It's important to note that when health care costs increase, these are incorporated by insurers into higher premiums, and that employers who provide insurance to their workers pass those higher expenses on to their employees in the form of smaller (or no) pay increases, increased shares of health insurance premiums, or reduced health insurance benefits.

2. I am particularly interested the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?

The impacts of mergers on rural and underserved communities may be particularly acute, because those communities often face a severe loss of competition due to hospital mergers. That can result not only in higher prices and costs, but reduced quality of care, and the loss of important health care services for those communities.

3. Is it possible that government regulations actually caused the consolidation of hospitals?

There are multiple factors that have led to consolidation in the hospital sector – one cannot say specifically which factors have been the primary drivers of this phenomenon. There are ways some government programs pays providers (specifically Medicare site-specific payments for physician services and the way the 340B program pays providers) that have encouraged certain kinds of consolidation.

4. Looking past antitrust remedies and enforcement, are there are other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?

Antitrust is a key part of preserving and promoting competition. If the U.S. antitrust enforcement agencies are to be able to do their jobs they need substantially more funding – their budgets, adjusted for inflation, have essentially been stagnant for years. More resources are needed so the agencies can do their jobs preserving competition and protecting consumers.

However, at present many geographic areas in the U.S. have become extremely consolidated, to the point that they are now dominated by one large, powerful health care system. Situations like this are very difficult for antitrust to address. In my opinion it's time for policymakers to consider options that include direct monitoring and oversight, including the possibility of price regulation.

Information will be needed to do this, and that means a national health care database will be needed. An investment will have to be made in this critical resource. This is the information age, and data are part of our national infrastructure, just like roads, bridges, railroads, and airports. Health care is a vitally important part of our society – it's time to invest in the information infrastructure we need for this critical sector.

5. How have federal government healthcare policies—again, looking at them holistically— Influenced the closure of hospitals in rural and underserved areas?

I am not knowledgeable enough about specific evidence on this point to respond to this question.

6. Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.

The research evidence shows that lack of hospital competition has a negative impact on patient quality of care. This evidence is most clear for Medicare patients. The evidence is more mixed for privately insured patients, but in my opinion the best evidence shows negative impacts on the quality of care for privately insured hospital patients due to lack of competition.

7. Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

This is a claim commonly made by merging parties. However, I am not aware of evidence that shows that mergers lead to this result. Overall, the research evidence does not demonstrate that hospital mergers systematically lead to more integrated care, or better care, or less expensive care.



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September 26, 2022

The Honorable Richard Durbin
Chairman
Committee on the Judiciary
U.S. Senate
224 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Durbin:

I am writing in response to your request to address questions for the record related to Rodney Hochman's, M.D., participation in the May 19, 2021 Senate Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights hearing entitled "Antitrust Applied: Hospital Consolidation Concerns and Solutions." Please find responses to questions submitted from Subcommittee Ranking Member Lee, Senator Tillis, and Ranking Member Grassley.

If you have any questions about this information, please contact Jason Kleinman, AHA's senior associate director of federal relations, at jkleinman@aha.org.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Melinda Hatton', written in a cursive style.

Melinda Hatton
General Counsel



Questions for the Record
Rodney Hochman, M.D., President and CEO, Providence
U.S. Senate Judiciary Committee
Subcommittee on Competition Policy, Antitrust, and Consumer Rights
“Antitrust Applied: Hospital Consolidation Concerns and Solutions”
May 19, 2021

In response to Subcommittee Ranking Member Lee’s question

1. Two days after our hearing, the New York Times reported that some hospitals may be using funds they received under the CARES Act Provider Relief Fund to buy up their competitors.¹ I am concerned that the government has yet again directly facilitated consolidation in the hospital industry. Do you share these concerns, and how can policymakers avoid such mistakes in the future?

Answer:

Mergers and acquisitions typically take years to develop. Moreover, hospitals and health systems drew down Provider Relief Fund (PRF) reimbursements under strict rules requiring them to demonstrate financial losses related to COVID-19. These funds, all of which providers are held accountable for under law, have allowed hospitals to continue to serve all who need care. There is a reporting and auditing process underway under which hospitals receiving more funds than their COVID-19-related expenses and lost revenue are required to return the excess funding. According to data from the Office of the Assistant Secretary for Planning and Evaluation, changes in ownership of hospitals have occurred less frequently during the pandemic than they did in the years before.² Any mergers that occurred concurrent to PRF distributions are more likely coincidental rather than causal.

During the height of the COVID-19 pandemic, some hospitals found that being part of larger, established health systems that potentially had more resources with which to navigate the Public Health Emergency, was an important part of their efforts to meet the many pandemic-related challenges. Health systems were able to adapt and even draw from within their own teams to secure the staffing resources needed when specific geographic areas were experiencing surges. Flexing and reallocating staff when needed allowed them to stand-up expanded intensive care units to meet the influx of COVID-19 patients and to create vaccination clinics. These systems can also provide the ability to offer financially distressed hospitals, including many in metropolitan and rural areas, a vital lifeline that can enable them to stay afloat, maintain access to care for patients and expand the breadth of services and programs offered to their communities.

Each hospital and health system came into the pandemic with their own particular financial challenges, but every one of them played an integral role in caring for patients and protecting their communities. Cherry-picking financial data is not reflective of the many immense

¹ <https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html>

² <https://aspe.hhs.gov/sites/default/files/documents/4d960147d5fd8e2ea9af508f115ca7b7/aspe-datapoint-change-ownership-pecos.pdf>

struggles and challenges facing the hospital field, including a historic workforce shortage crisis, along with spiking input costs for supplies, equipment, drugs and labor, and near-historic levels of inflation.

In response to Senator Tillis' questions

1. One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?

Answer:

According to the Bureau of Labor Statistics, hospitals' price growth averaged about 2% annually over the past decade. The change in hospital prices over time is less than other parts of the health care system, and recently far lower than general inflation. In contrast, the annual premium for employer-based family coverage has increased 4.5% on average since 2010.³

Mergers have been shown to reduce the cost of care. For example, a 2021 analysis by the Charles River Associates found that mergers and acquisitions were associated with a 3.3% decrease in operating expenses per adjusted admission, and a 3.7% decrease in net patient revenue per adjusted admission.⁴ Hospitals generally report that these reductions are the result of achieving economies of scale that can reduce the cost of acquiring medical equipment, prescription drugs and supplies. Researchers have also found that mergers allowed hospitals to share and implement best practices, including standardized care protocols, across multiple sites, resulting in reduced average length of stay for a variety of conditions.⁵ Many hospitals and health systems also report that mergers and acquisitions improve access to capital (including reducing the cost of borrowing). Many hospitals and health systems may be organized differently and therefore the goals and effects of mergers and acquisitions may not be uniform across every transaction.

Additionally, it's clear that when provider rates are reduced, insurers do not pass these savings on to consumers. Most insurance markets are highly concentrated, and in about 46% of all markets, one insurer controls half or more of the insurance market.⁶ Insurers leverage their market share to demand lower prices from health care providers, including hospitals. However, studies have shown that insurers do not pass these cost savings onto consumers.⁷ In fact, while health care service use plummeted over the course of the pandemic, insurers raised premiums and reported record profits.⁸ For example, UnitedHealth has reportedly spent as much on acquisitions, including home health and behavioral health services providers, in the second quarter of 2022 as it did during the entire year in 2021.⁹

³ <https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/>

⁴ <https://www.aha.org/guidesreports/2021-08-18-hospital-merger-benefits-econometric-analysis-revisited-executive-summary>

⁵ <https://www.aha.org/guidesreports/2017-01-24-hospital-merger-benefits-views-hospital-leaders-and-econometric-analysis>

⁶ <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf>

⁷ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548>

⁸ <https://www.fiercehealthcare.com/payers/which-insurer-was-most-profitable-q2-answer-wont-surprise-you>

⁹ <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2022/UNH-Q2-2022-Release.pdf>

Recent increases in the cost of care have been driven by inflation as well as increases in the cost of labor, medical supplies, equipment and prescription drugs. Labor expenses, which account for around half the cost of providing care or more, are 19% higher than pre-pandemic levels.¹⁰ A substantial portion of that increase is due to exorbitant price increases for contracted staff that appear to be closely coordinated. The American Hospital Association (AHA) has urged the federal antitrust authorities to investigate these price increases, although no public action has been taken.¹¹ This is an antitrust issue contributing to price increases that the committee may wish to examine more closely. As our nation considers approaches to reducing the cost of care, these areas are playing a much larger role in the current landscape than mergers and acquisitions.

2. I am particularly interested the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?

Answer:

Mergers can prevent rural hospitals from closing. Access to capital is important to stabilizing a vulnerable hospital or advancing an innovative one. For some rural hospitals, a variety of models — including partnerships, collaborations, mergers or affiliations — create additional financial stability, enhance operations, spur innovation and improve outcomes at scale. Research indicates that these options are important lifelines for rural hospitals, increasing access to much-needed capital. It's also shown not to drive closures.

Health systems typically acquire rural hospitals when rural hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals.¹² Moreover, acquired hospitals typically form new links or partnerships with larger health systems, which promotes access to specialists, telehealth and other care for rural patients.¹³ For example, Morehead Memorial (N.C.), was acquired by UNC Health Care and renamed UNC Rockingham Health Care. At the time of closing, UNC pledged a \$20 million capital investment over three years after the acquisition; most recently, the hospital acquired a \$3.8 million linear accelerator for its cancer center.

Moreover, partnerships, mergers or acquisitions may help improve access to care for patients in rural and underserved communities. Some hospitals and health systems may pursue various partnerships, mergers or acquisitions as a way of creating a more cohesive continuum of care. It can make it easier for patients to access specialists in the acquiring system, or access services provided by that system. In this way, consolidation ensures that care remains in the community.

¹⁰ <https://www.aha.org/costsofcaaring>

¹¹ <https://www.aha.org/lettercomment/2021-02-04-aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-and>

¹² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/>

¹³ <https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf>

Mergers have not been shown to impose additional costs on rural or underserved communities. The bulk of rural hospital revenue comes from government payers, of which Medicare comprises nearly half. Both Medicare and Medicaid reimburse less than the cost of providing care to patients with Medicare and Medicaid coverage. Because rural hospitals are more likely to serve a population that relies on Medicare and Medicaid, rural hospitals are not able to offset low public program payment rates with revenue from patients with commercial coverage, which often has higher reimbursement rates than government payers.

3. Is it possible that government regulations actually caused the consolidation of hospitals?

Answer:

There are many motivations for mergers and acquisitions in the hospital field. Often they are prompted by financial pressures that can limit a hospital's ability to maintain the resources needed to effectively care for its community. While local and federal regulations are largely intended to ensure that patients receive safe, high-quality care, health care providers are subject to many ever-changing regulations at the federal, state and local level (in addition to commercial insurers' policies and procedures) that result in more and more time and other resources for regulatory compliance, which takes providers away from patient care and raises costs for patients and hospitals.

Additionally, it is broadly acknowledged that payment rates for Medicare and Medicaid, established through federal and state regulations, are set below the costs of providing care. Combined underpayments from Medicare and Medicaid to hospitals were \$100 billion in 2020, up from \$76 billion in 2019. 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% of their inpatient days paid for by Medicare and Medicaid. Since these are fixed payments, hospitals are unable to fully absorb the tremendous inflationary forces they are currently facing. Merging with a hospital system can help some hospitals ease this financial burden and improve patient care.

4. Looking past antitrust remedies and enforcement, are there are other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?

Answer:

It is essential that Congress look holistically at the entire healthcare system when regulating anticompetitive practices. This means that Congress and the Executive Branch must enact and enforce laws against health insurers and pharmaceutical companies when they harm consumers through anticompetitive practices.

The Department of Justice and Federal Trade Commission, for example, should begin vigorously enforcing the Competitive Health Insurance Reform Act of 2020, which limits the

antitrust exemption available to health insurance companies under the McCarran-Ferguson Act, and Congress should be prepared to conduct oversight hearings to make sure that this recent law fulfills its promise. Likewise, Congress should investigate ostensibly coordinated efforts by pharmaceutical companies to place conditions that seek to limit access to the 340B program to the detriment of patients on their fulfillment of statutory obligations to offer 340B pricing on outpatient drugs, and investigate some conditions imposed by commercial insurance companies that inappropriately deny prescription drugs (among other limitations) to patients.¹⁴

5. How have federal government healthcare policies — again, looking at them holistically — influenced the closure of hospitals in rural and underserved areas?

Answer:

As the country recovers from the COVID-19 pandemic, we have a unique opportunity to examine how some federal policies have helped rural hospitals, and how some have imposed undue burden that leads to rural closures.

As discussed above, most federal regulations impose additional costs on hospitals. While rural hospitals are generally subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for other facilities and greater reliance on Medicare and Medicaid means rural hospitals' revenue might not cover this higher cost of compliance. The volume of regulation, pace of change and complexity of the regulatory framework almost requires scale to implement — and rural areas lack scale. Public payer reimbursement rates are also set through regulation, and are broadly acknowledged to set below the cost of providing care to Medicare and Medicaid beneficiaries. Rural providers rely disproportionately on these payers, so federal payment policies have a large effect on them.

Most importantly, we've seen that federal investment in rural hospitals helped reduce closures. Federal policies, including the CARES Act and Medicare Advanced and Accelerated Payments, provided much needed support for rural hospitals. As a result, there were only two reported rural hospital closures in 2021 according to the UNC Sheps Center, in comparison to 2020 when 19 rural hospitals closed. Financial pressures in 2022, including the exhaustion of COVID-19 relief funds and skyrocketing costs for labor, medical supplies, equipment and prescription drugs, are a serious concern, and likely put more rural hospitals at risk of closure.

Other federal policies have played an important role in reducing the risk of hospital closures:

- Medicaid expansion has been linked to fewer rural hospital closures and reduced costs for Medicaid patients. The majority (74%) of rural closures have occurred in states where Medicaid expansion was not in place or had been in place for less than a year.
- The Medicare-dependent Hospital (MDH) and enhanced Low-volume Adjustment (LVA) programs provide vital support to rural hospitals to offset financial vulnerabilities associated with being rural, geographically isolated and low volume. The AHA supports bipartisan legislation to extend these programs before they are set to expire on Sept. 30, 2022.

¹⁴ <https://www.aha.org/white-papers/2022-07-28-commercial-health-plans-policies-compromise-patient-safety-and-raise-costs>

- Telehealth flexibilities, granted under waivers during the COVID-19 pandemic, have allowed rural hospitals to see new patients and provide important health care. Certain flexibilities should be made permanent, including lifting geographic and originating site restrictions, expanding practitioners who can provide telehealth and allowing hospital outpatient billing for virtual services, among others.
- Although implementation is still underway, we recognize that the Rural Emergency Hospital model has enormous potential to help avoid rural hospital closures. The AHA has also voiced support for this model and has advocated for implementation policies that seek to realize the model's full potential.

6. Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.

Answer:

Mergers can provide community hospitals with the necessary scale to use sophisticated data analytics, identify best practices and implement innovations such as telemedicine. Data-driven development of best practices can reduce the rates of readmission and mortality in merged hospitals. For example, one study found that acquisitions were associated with statistically significant improvements in quality measured as decreases in the overall outcome composite index (where a negative estimate indicates improved quality) and the 30-day readmission rate index.

Moreover, a recent study of rural hospital mergers and acquisitions, published by JAMA Network Open in September 2021, 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.¹⁵ In a separate study, authors concluded a full-integration approach to hospital consolidation was associated with improvement in quality outcomes and patient experience.¹⁶

Acquired hospitals often offer expanded services. One study found that nearly 4 in 10 (38%) of acquired hospitals added one or more services post-acquisition.¹⁷ Patients at hospitals acquired by academic medical centers or large health systems also gain improved access to tertiary and quaternary services.

7. Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

Answer:

¹⁵ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342>

¹⁶ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652>

¹⁷ <https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf>

Research shows that mergers can both preserve and enhance access to care for patients; particularly in small, rural communities or for financially vulnerable organizations. The value of integrated health systems was seen clearly during the pandemic, particularly those in rural areas that otherwise might have succumbed to the devastating financial effects of COVID-19.

Mergers can produce important cost savings allowing for investments in medical innovation and providing the scale needed to take on investments to upgrade services, recruit and deploy additional staff to an acquired hospital. Benefits of mergers often include a strong foundation for coordinated care, including implementing system-wide best practices, the ability to improve operations across the combined entities and bring specialty services or management capabilities to hospitals in new communities, which expands access to healthcare services and enhances operational efficiencies.

Additionally, data shows that mergers have given hospitals and health systems the scale needed to support consumer-centric strategies that enhance the patient experience of care as well as make investments in the advancement of care delivery, technology and population health infrastructure.

In response to Ranking Member Grassley's question

1. I'm a strong proponent of transparency and providing additional information to consumers. Every customer in America is entitled to know what they must pay before first buying a product or service. This should include medical care. In January of this year a final rule from HHS went into effect requiring hospitals to disclose prices for common items and services. I've cosponsored legislation to codify these regulations. Dr. Hochman, do you agree that price transparency is important to consumers and are your member hospitals providing this information to your patients?

Answer:

Hospitals and health systems across the country support price transparency efforts that ensure patients have access to the information they seek when preparing for care. The AHA has been actively engaged in identifying and promoting best practices in patient billing, including adopting and updating guidelines for the field in 2003, 2006, 2012 and, most recently, 2020.¹⁸ The AHA's Patient Billing Guidelines underscore hospitals' commitment to ensuring that conversations about financial obligations do not impede care, while recognizing that determinations around financial assistance require mutual sharing of information by providers and patients. Additionally, they balance needed financial assistance for some patients with the hospital's broader fiscal responsibilities in order to keep their doors open for all who may need care in a community.

Understanding potential costs is an important aspect of the patient experience, which is why the AHA has educated members on best practices and tools that aid patients and align with the new federal price transparency policy, including around "shoppable services" that can be met through the use of a patient cost estimators. Hospitals and health systems have been able

¹⁸ <https://www.aha.org/standardsguidelines/2020-10-15-patient-billing-guidelines>

to increase adoption of these tools largely due to growth in availability of technological resources at multiple price points and with increased functionality. In particular, this "next generation" of price transparency tools are easier for hospitals to implement and for consumers to navigate. However, implementation and maintenance requires significant organizational effort across many different departments and can take over a year to establish; these efforts are worthwhile, though, to ensure patients have clear information about every aspect of their health care decisions, including their expected out-of-pocket costs.

The price transparency policies in the No Surprises Act focus on providing tailored cost information to patients. We commend Congress for passing this legislation and are already working with CMS to ensure these policies are appropriately implemented. While we support these policies and believe they will better inform patients of their financial obligation, implementation will not be easy. New standards are needed for the implementation of the advanced explanation of benefit, with industry-wide buy-in and adoption. It is critical that the government ensure alignment across the various federal price transparency requirements in order to avoid patient confusion that could harm, not help, patients' ability to use cost information to inform decisions about their care. The AHA will continue to support hospitals as they work to help patients understand their anticipated costs for care.

Attachment—Additional Questions for the Record

Senate Committee on the Judiciary, Subcommittee on Competition Policy, Antitrust, and
Consumer Rights, hearing entitled
"Antitrust Applied: Hospital Consolidation Concerns and Solutions"
May 19, 2021

Brian J. Miller, M.D., M.B.A., M.P.H., Assistant Professor of Medicine, The John Hopkins
University School of Medicine and Nonresident Fellow, American Enterprise Institute

The Honorable Michael S. Lee (R-UT)

- 1) Two days after our hearing, the New York Times reported that some hospitals may be using funds they received under the CARES Act Provider Relief Fund to buy up their competitors.¹ I am concerned that the government has yet again directly facilitated consolidation in the hospital industry. Do you share these concerns, and how can policymakers avoid such mistakes in the future?

I share these concerns. A large portion of the CARES Act Provider Relief Funds² were provided without a specific requirement as to use, did not screen providers as to geography (rural, urban, suburban), or assess differential need. Distribution was frequently based total net patient revenue and partially on Medicare fee for service revenue. Consequently, many large and already financially stable health systems such as the Cleveland Clinic³ and the Mayo Clinic⁴ received CARES Act funds while reporting record 2021 operating income during the pandemic. For example, the Mayo Clinic raised over \$1 billion in philanthropy⁵ despite having over \$18 billion in investment asset⁶ and despite this received and subsequently returned half of its CARES Act funds.⁷ At the same time, the Cleveland Clinic had over \$12 billion in long term investments⁸ and even during the height of the pandemic had a \$650M million credit line and \$447 million in investment income, yet turned a net profit due to CARES Act funds.⁹ It is unclear why such institutions needed or need financial support from the federal government.

¹ <https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html>

² "The Provider Relief Fund: Frequently Asked Questions." CRS April 7, 2022. Available from: <https://sgp.fas.org/crs/misc/R46897.pdf>

³ <https://www.beckershospitalreview.com/finance/cleveland-clinic-s-operating-income-more-than-triples-in-2021.html>

⁴ <https://www.beckershospitalreview.com/finance/mayo-clinic-operating-income-jumps-to-1-2b.html>

⁵ <https://newsnetwork.mayoclinic.org/discussion/mayo-clinics-2021-achievements-affirm-bold-forward-strategic-vision-staff-dedication/>

⁶ <https://cdn.prod-carehubs.net/n7-mcnn/7bcc9724adf7b803/uploads/2022/02/2021-Mayo-Clinic-Consolidated-Financial-Report.pdf>

⁷ <https://www.beckershospitalreview.com/finance/mayo-clinic-returns-nearly-half-its-federal-covid-19-aid.html>

⁸ <https://my.clevelandclinic.org/-/scassets/files/org/about/financial-statements/cchs-2021-w-ob-nonob.pdf?la=en>

⁹ <https://www.fiercehealthcare.com/hospitals/cleveland-clinic-posts-49m-profit-for-first-nine-months-2020-as-covid-19-hampers-finances>

Subsequent corporate action denotes that business continued as usual with respect to expansion of specialty services, growth, and mergers. In the case of Mayo, the corporation purchased 288 acres around its existing site to expand its specialty footprint.¹⁰ The Cleveland Clinic purchased a hospital from the Sisters of Mercy Health System in the Clinic's home Ohio market of December of 2020,¹¹ and opened a private hospital in London in 2022.¹² Other health systems engaged in similar corporate behavior, with CommonSpirit Health, a large West Coast health system, expanding its existing Washington state presence through its purchase of Virginia Mason.¹³

In order to future mistakes, any direct federal funding/subsidization should be specifically required to be used for direct clinical uses in the future, with policymakers strictly enumerating use of funds similar to the following: clinical labor, information technology infrastructure, existing facility improvements, and purchase of medical equipment for existing medical facilities directly for the provision of emergency care in a pandemic or for the creation of emergent, temporary medical care sites reasonably expected to be used for less than 180 days. Policymakers should add specific language that funds should not be utilized for the purchase of new facilities, long-term investment projects, or executive compensation. Finally and arguably most importantly, inclusion of specific language denoting eligibility through an assets test with specific requirements (e.g. long-term investment assets must be less than \$500 million or 25% of the annual gross operating expenses average over the prior 3 years, whichever is lower) would ensure that any funds go to the facilities that need it most.

The Honorable Thomas Tillis (R-NC)

1. One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?

Hospital mergers drive consolidation and raise prices. Research shows that mergers result in higher prices for health care services.¹⁴ Higher prices resulting from hospital mergers are then reflected in higher insurance premiums for consumers.^{15,16} Despite these broad national studies

¹⁰ <https://ktar.com/story/4811192/mayo-clinic-buys-288-acres-for-expansion-around-phoenix-hospital/>

¹¹ <https://www.fiercehealthcare.com/hospitals/cleveland-clinic-makes-deal-sisters-charity-to-acquire-mercy-medical-center>

¹² <https://www.fiercehealthcare.com/providers/cleveland-clinic-opens-private-london-hospital-near-buckingham-palace>

¹³ <https://www.fiercehealthcare.com/hospitals/chi-franciscan-virginia-mason-finalize-acquisition-deal-and-roll-out-new-name>

¹⁴ Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *Quarterly Journal of Economics* 2019;134(1):51-107. doi: 10.1093/qje/qjy020

¹⁵ Boozary AS, Feyman Y, Reinhard UE, Jha AK. "The Association Between Hospital Concentration And Insurance Premiums in the ACA Marketplaces." *Health Affairs* 2019;4:668-674. doi: 10.1377/hlthaff.2018.05491

¹⁶ Trish EE, Herring BJ. How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums? *J Health Econ* 2015;42:104-11. doi: 10.1016/j.jhealeco.2015.03.009

and summaries thereof,¹⁷ local evidence suggests a similar story. In 2018, both UNC and Atrium Health considered merging, with the State Attorney General questioning whether such a transaction would raise prices and create a monopoly.¹⁸ The transaction was later abandoned based upon these and other concerns.¹⁹ More recent examples include HCA's acquisition of Mission Health, now the subject of suits alleging monopolization resulting in higher prices for consumers^{20,21} and state oversight concerns into how the deal was undertaken.²² Outside of nonpartisan academic and policy research, research conducted for the purposes of investigative journalism reveals the effects of local mergers in various geographies: higher prices for consumers.²³

2. I am particularly interested the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?

Mergers raise costs regardless of their locality. Many merging rural entities utilize a "failing firm thesis," that a merger is necessary in order to save an otherwise failing business. Yet, a study characterizing 380 rural hospital mergers in the early 2000s denoted that some hospitals closed post-merger.²⁴ Long standing academic and policy research denotes that competition reduces costs and improves quality in the market for health care services. Ensuring that rural and underserved communities benefit experience and from competition for critical health care services is even more important.

3. Is it possible that government regulations actually caused the consolidation of hospitals?

Absolutely. Many government policies drive consolidation of hospitals and health care delivery in general. From 2010 to 2017, there were over 778 hospital mergers,²⁵ with research denoting that now over 90% of hospital markets are now considered consolidated.²⁶ The last several decades of hospital mergers coincided with a wave of accelerating hospital acquisition of

¹⁷ <https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>

¹⁸ <https://www.fiercehealthcare.com/finance/atrium-health-university-north-carolina-merger-ag-wants-details>

¹⁹ <https://www.fiercehealthcare.com/finance/atrium-health-unc-health-care-merger-talks-suspended>

²⁰ <https://www.citizen-times.com/story/news/2021/08/10/hca-mission-anti-trust-class-action-lawsuit-claims-higher-prices-lower-quality/5544976001/>

²¹ <https://www.fiercehealthcare.com/providers/hca-healthcare-faces-another-antitrust-lawsuit-tied-2019-mission-health-merger>

²² <https://www.northcarolinahealthnews.org/2022/03/20/hca-deal-was-rigged-ag-office-concerned/>

²³ <https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html>

²⁴ https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/08/Rural-Hospital-Mergers.pdf

²⁵ Shwartz K, Lopez E, Rae M, Neuman T. "What We Know About Provider Consolidation." *Kaiser Family Foundation* September 2, 2020. Available from: <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>

²⁶ Fulton BD. Health Care Market Concentration Trends In the United States: Evidence And Policy Response. *Health Affairs* 2017;36(9):1530-1538. doi: 10.1377/hlthaff.2017.0556

physician practices, driving vertical consolidation of care delivery.²⁷ Multiple federal policies drove and continue to drive both horizontal and vertical consolidation in care delivery.

The lack of site neutral payment, or paying the same amount for the same service provided, regardless of where it is provided, drove hospital acquisition of many other components of care delivery, resulting in the creating of large health system oligopolies or even monopolies covering hospital care, ambulatory care, and home health.

Secondly, the 340B drug pricing program is a significant driver of consolidation, both horizontal and vertical. While well-intentioned when created in 1992 – it provides access to low cost pharmaceuticals intended for underserved patients – both the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Patient Protection Affordable Care Act expanded scope of eligibility. Currently, over 50,000 clinical sites²⁸ including over 2,500 hospitals²⁹ participate in the program.

At its core, the 340B program allows safety net hospitals (now comprising a universe of hospitals far broader than that) to purchase pharmaceuticals at an artificially low price, yet has no restrictions on their use. That is, the drug does not have to follow the patient, and discounted drugs can be administered to patients regardless of their ability to pay or insurance coverage. Understandably, this has driven consolidation across the care delivery supply chain.

Research has demonstrated that expanded facility eligibility for the 340B program is not associated with increased provision of charity care.³⁰ Other work has demonstrated how the growth of the 340B program has driven hospital acquisition of physician practices in hematology/oncology and ophthalmology without engendering expanded access to care for low-income populations.³¹ Still other work has suggested that the program exists primarily as a wealth transfer from the pharmaceutical industry to the hospital industry in addition to being a potential driver of consolidation.³²

In summary, policymakers should look to close payment policy arbitrage loopholes, or opportunities for the health system to buy various components of care delivery and bill higher for the same service or product based upon arbitrary rules. Policymakers should remove the government's foot from the accelerator driving consolidation.

²⁷ Nikpay S, Richards MR, Penson D. "Hospital-Physician Consolidation Accelerated In the Past Decade In Cardiology, Oncology." *Health Affairs* 2018;37(7):1123-1127.

²⁸ Mulligan K. "The 340B Drug Pricing Program: Background, Ongoing Challenges and Recent Developments." *USC Leonard D. Schaeffer Center for Health Policy and Economics* October 14, 2021.

²⁹ Fein A. "New HRSA Data: 340B Program Reached \$29.9 Billion in 2019; Now over 8% of Drug Sales." *Drug Channels* June 9, 2020. Available from: <https://www.drugchannels.net/2020/06/new-hrsa-data-340b-program-reached-299.html>

³⁰ Desai SM, McWilliams JM. 340B Drug Pricing Program and hospital provision of uncompensated care. *Am J Manag Care*. 2021 Oct;27(10):432-437. doi: 10.37765/ajmc.2021.88761.

³¹ Desai S, McWilliams JM. Consequences of the 340B Drug Pricing Program. *N Engl J Med*. 2018 Feb 8;378(6):539-548. doi: 10.1056/NEJMs1706475

³² Conti RM, Bach PB. The 340B drug discount program: hospitals generate profits by expanding to reach more affluent communities. *Health Aff (Millwood)*. 2014 Oct;33(10):1786-92. doi: 10.1377/hlthaff.2014.0540

4. Looking past antitrust remedies and enforcement, are there are other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?

There are multiple levers that the government can use to improve enforcement and promote market entry, the latter representing unorthodox levers. First, to improve enforcement, policymakers can provide the Federal Trade Commission (FTC) statutory authority for addressing anti-competitive practices by non-profit hospitals. Currently, these cases are handled by the Department of Justice Antitrust Division due to a lack of FTC authority over these non-profit entities, despite the FTC handling and having experience with related merger enforcement in hospital and health system merger cases. Correcting this would ensure efficiency in antitrust oversight and enforcement.

Secondly, policymakers can undertake multiple efforts at the federal level to promote hospital and health system market entry with an aim to improving competition. This does not discount the need for state level reforms, such as addressing Certificate of Need processes that restrict facility entry at the local level. First, as part of the ACA, a statutory prohibition on new physician-owned hospitals (POH)s from participating in the Medicare program was implemented. Further, existing POHs were prohibited from expanding. POHs exist in two primary markets: general acute care or community hospitals and specialty hospitals (cardiac, orthopedic, and general surgical). Recent evidence demonstrates that physician-owned cardiac hospitals have similar costs and higher quality to their community hospital competitors, while physician-owned orthopedic specialty hospitals have lower costs and higher quality. Physician-owned community hospitals are similar in cost and quality performance to their non-physician owned (i.e. non-profit and for-profit) community hospital counterparts.³³ In order to improve competition by promoting the creation of new hospitals, policymakers could reverse the ban on new or expanded POHs from Medicare, building off of evidence that competition improves quality and lowers costs.

Stark Law reform offer a final opportunity to promote market entry. With early research demonstrating concerns that physicians engaged in inappropriate self-referral – a form of fraud, waste and abuse that policymakers rightly sought to avoid – researchers supported and policymakers enacted a series of reforms enshrined in statute and subsequent rulemaking prohibiting physicians from making referrals for designated health services to an entity in which they have a financial relationship and subsequently billing Medicare. Notably, corporate self-referral is frequently a soft or hard requirement as part of clinical practice when physicians are employed as part of a health system, with an aim to support integrated and coordinated high quality care. While a series of exceptions to Stark Law remain, including recent efforts by the prior administration, Stark Law remains a statutory impediment to value-based contracting for all market participants and to the creation of physician-owned and -operated integrated care

³³ Cho T, Meshnick AB, Ehrenfeld JM, Miller BJ. "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review." *Mercatus Center at George Mason University* Arlington, Virginia. September 7, 2021.

delivery enterprises. The payment world of today is vastly different from that of the 1980s and 1990s when Stark Law was passed: nearly 76% of Medicaid beneficiaries are part of a managed care program with 46% enrolled in risk-adjusted capitated managed Medicaid³⁴ while nearly half Medicare beneficiaries are enrolled in Medicare Advantage, a risk-adjusted capitated public-private program. Unlike fee for service Medicare and Medicaid, these managed care programs have built in utilization review tools to identify, manage, and combat fraud, waste, and abuse.

Thus, re-examining the challenges and benefits of self-referral for all market participants is needed, along with the creation of either exceptions, modifications, or wholesale repeal of Stark Law (noting that providers would still be subject to anti-kickback statutes, which have criminal liability).

5. How have federal government healthcare policies—again, looking at them holistically— Influenced the closure of hospitals in rural and underserved areas?

Rural hospitals frequently operate in economically depressed regions and have a less favorable payer mix (i.e. higher share of Medicaid and Medicare). Thus, with fewer financial resources, such institutions are more sensitive to the cost of regulation and compliance. For example, it is well-documented that rural areas suffer from a shortage of mental health care (psychiatrists, psychologists, and both clinics and hospitals) in addition to a significant burden of unmet mental health needs.³⁵ Yet, at the same time, compliance costs are significant, with a study denoting that 62 inpatient facilities spent an estimated 4.8% of annual revenue on compliance.³⁶ For a business section with operating margins in the 0 – 3% range, the costs of regulatory compliance can mean the difference between being a going concern or filing for bankruptcy.

Each type of regulation adds an additional cost from preparation, process, consulting, and auditing. CMS and other agencies frequently add new requirements without simultaneously examining whether prior regulations are still meaningful and necessary, thus increasing costs for hospitals. While industry estimates of the cost of regulatory are likely overestimated at \$1,200 per patient admission,³⁷ the concern that costs are real and significant is valid and is one of several significant drivers of rural hospital financial distress.

6. Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.

A recent study in the *New England Journal of Medicine* completed a study of hospital mergers using Medicare claims and Hospital Compare data. The study authors found no difference in

³⁴ Total Medicaid MCO Spending. Kaiser Family Foundation 2019. <https://www.kff.org/other/state-indicator/total-medicare-mco-spending/>

³⁵ <https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf>

³⁶ <https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf>

³⁷ <https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf>

quality subsequent to mergers as measured by 30-day readmission or 30-day mortality rates, and unfortunately did find a decrement in patient experience.³⁸

A subsequent study looking at specifically rural hospitals in the open access journal JAMA Network Open found small but significant improvements in quality associated with rural hospital mergers.³⁹ Unfortunately, this study suffers from several critical flaws that undermine the policy significance of its results and are noted by the authors:

1. Imbalances in the two groups (merged v. non-merged) hospitals persisted after matching merged hospitals to non-merged controls. This suggests that the comparison groups were not the same. Denoted in Supplement eTable 1,⁴⁰ merged hospitals were on average larger, less likely to be a critical access hospital, and more likely to be a private nonprofit as opposed to a public hospital. These differences were significant, for example 19.8% of the merged hospitals group were public hospitals as opposed to 54.3% of the initial comparison hospitals. These and other characteristics suggest that the groups were starkly different, and that statistical adjustment after the fact does not account for what is a wholly inaccurate comparison.
2. Another important challenge noted by the authors is that their study spans the change from ICD-9 to ICD-10 diagnostic coding, which affects use and measurement of quality indicators. This is a significant confounder of quality improvement analyses.
3. Finally, the authors note that after mergers, hospitals could curtail service lines or transfer high risk patients to urban centers driving the appearance of higher quality of rural facilities when in fact risk is shunted. As transfers and service line reductions were not measured, this is a significant draw back to this study.

In response to this study, other researchers studied and found that high risk / high mortality service lines such as surgery and obstetrics/gynecology services were closed after mergers and correlated with increasing demand in neighboring areas, lending credence to the aforementioned concern.⁴¹

7. Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of

³⁸ <https://www.nejm.org/doi/full/10.1056/NEJMsa1901383>

³⁹ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342>

⁴⁰

https://cdn.jamanetwork.com/ama/content_public/journal/jamanetworkopen/938760/zo1210722suppl_prod_1631288531.09998.pdf?Expires=1665695460&Signature=K77vinGPc2IZylxRavFCH2WyRdtXuSFMsn6p-M5ougme-wSmtt6hgEM1V4i2IHx4n2P1xXvO3BWYXekJDTwlgeEli29cD9zyPmo1kEKxULPDaKJ23aUn6V6o8LOn1bYGRFbXOmSawALWJwX1vPqvqVKOwsH8K3dSD0c68JKfCPMjt15rCiPa3822PmL-60Ws56AuYmXmp2LlyESAa9jEJo4tyG6PIpsd6SDOY7RmuhMkPdrzc0bli-HL9yfUEhSqM4g6fQoejUST7UXNIvKRSwmNpjvcWVZmuZqzcoKJgoymBuEzTWG-zcQ87QX7fLhh7Bj~HG6oURgnQj7pY~g__&Key-Pair-Id=APKAIE5G5CRDK6RD3PGA

⁴¹ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00160>

more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

Many mergers are purported to increase access to comprehensive, integrated care as a tradeoff between reduced choice. However, access to comprehensive, integrated care can be achieved by other mechanisms such as contracting, joint ventures, or other tools to improve clinical alignment.

For example, consider two local hospitals looking to improve access to integrated care for joint replacements. Instead of merging two separate hospitals, both hospitals could together create a joint venture to create an ambulatory surgery center for outpatient total hip and knee replacements. The joint venture surgery center could contract with a local orthopedic group for surgical coverage or create its own independent medical group for staffing. A physical therapy clinic could be purchased, built from the ground up, or contracted. Home care coverage for after-surgical care such as home physical therapy could come from one of many local, regional, or national home care companies. For patients with rheumatologic diseases, orthopedic surgeons could refer such patients to rheumatologists at either hospital. Care coordination could be promoted by offering the joint venture surgical center and other physicians access to the same electronic health record platform and technological support through contracting or at preferred rates under a valued-based arrangement. Patients evaluated to need inpatient care after joint replacement could be referred to either hospital.

Such a hypothetical scenario would preserve competition and simultaneously promote coordinated, integrated care. Mergers are frequently not required to achieve clinical operational and population-level health goals.

September 9, 2022

Attached please find responses to the Questions for the Record sent to Ahmer Qadeer for the hearing entitled "Antitrust Applied: Hospital Consolidation Concerns and Solutions" on Wednesday, May 19, 2021.

Sincerely,

Ahmer Qadeer

Responses to Senate Judiciary Committee, Subcommittee on Competition Policy, Antitrust, and Consumer Rights, Questions to Ahmer Qadeer, Director of Strategic Initiatives, Service Employees International Union

One need to look no further than HCA Healthcare Inc.'s (hereinafter "HCA") 2019 acquisition of the nonprofit Mission Health System (hereinafter "Mission") in Sen. Tillis' home state of North Carolina to see how hospital mergers and acquisitions adversely impact local communities. Our answers to the Senator's questions, as presented below, will mainly center around this case study.

1. **Q:** One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?

A: A wide body of research has shown that provider consolidation leads to higher health care prices, especially for private insurance. One analysis found that prices at hospitals acquired by out-of-market hospital systems increase by about 17% more than unacquired, stand-alone hospitals.¹ The purchase of Mission Health System by the out-of-state healthcare conglomerate HCA, is a stark case study of this exorbitant jump in healthcare costs following consolidation. HCA's activity illustrates the negative outcomes of hospital mergers, acquisition and market consolidation because increasing market share to bolster aggressive pricing is a central piece of HCA's overall operating strategy. A *Modern Healthcare* article from 2018 explained that "[s]ize and dominant market share have enabled HCA to negotiate higher prices from health insurers."² The article identifies HCA's clear expansion strategy: "When expanding into new territories, HCA eyes areas where it will dominate in terms of market share, which it can leverage into negotiating power to secure better rates from insurers."³ Ultimately, "HCA's aggressive pricing, enabled by its market share and patient volume, is a major factor in its financial success."⁴

HCA's Acquisition of Mission Bolsters its Dominance & Aggressive Pricing Strategy

In 2019, HCA Healthcare – the nation's largest hospital system⁵ – acquired Mission Health, a non-profit health system based in Asheville, North Carolina.⁶ With this transaction, HCA acquired the dominant hospital system in the Western North Carolina market,⁷ which had effectively operated as a legislatively authorized monopoly for over twenty years due to its possession of a Certificate of Public Advantage

¹ <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>

² Shelby Livingston, "HCA's success over 50 years banks on sticking with the basics," *Modern Healthcare*, October 06, 2018.

³ <https://www.modernhealthcare.com/article/20181006/NEWS/181009941/hca-s-success-over-50-years-banks-on-sticking-with-the-basics>

⁴ Shelby Livingston, "HCA's success over 50 years banks on sticking with the basics," *Modern Healthcare*, October 06, 2018.

⁵ <https://www.modernhealthcare.com/article/20181006/NEWS/181009941/hca-s-success-over-50-years-banks-on-sticking-with-the-basics>

⁶ Becker's Hospital Review, "100 of the largest hospitals and health systems in America | 2021," March 23, 2022.

⁷ <https://www.beckershospitalreview.com/100-of-the-largest-hospitals-and-health-systems-in-america-2021.html>

⁸ Asheville Watchdog, "Attorney General's office had 'great concerns' Mission-HCA deal was rigged 'from the beginning,'" March 20, 2022. -

<https://www.northcarolinahealthnews.org/2022/03/20/hca-deal-was-rigged-ag-office-concerned>

⁹ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21),

p.40

("COPA"). The COPA immunized Mission from State and Federal antitrust liability, while subjecting Mission Health to enhanced state oversight. The COPA arrangement with the State had ended in 2016. However, even after the COPA repeal, no new hospitals have opened in its service area.⁸ As a result, Mission allegedly holds monopoly market share of 70% or more in 7⁹ different counties¹⁰ - in some counties and zip codes allegedly reaching as high as over 90%.¹¹ It is against this backdrop that HCA implements its "aggressive" pricing strategy. As noted *Modern Healthcare* following HCA's purchase of Mission: "Mission ... fits with HCA's long standing strategy of scooping up facilities that dominate their markets, which helps the company negotiate better rates with health insurers."¹² Unsurprisingly, this has resulted in exorbitant prices for communities in Western North Carolina.

Ongoing Antitrust Lawsuits against HCA/Mission

HCA/Mission's extractive behavior in Western North Carolina has recently landed the company as a defendant in multiple antitrust lawsuits. To date, local residents and municipalities have filed three antitrust lawsuits against HCA/Mission in less than a year - each one alleging that HCA/Mission is unlawfully using its monopoly power to extract supracompetitive rates from insurers.¹³

First, in August of 2021, a group of Western North Carolina residents filed a class action lawsuit against HCA/Mission.¹⁴ Soon after, in June 2022, the City of Brevard, North Carolina also filed suit. Another class-action suit was filed this past July, this time jointly by the City of Asheville and Buncombe County.¹⁵ Most recently, Brevard and Asheville and Buncombe have filed to consolidate their cases due to the similarities in their arguments.¹⁶ Another Western North Carolina County, Madison County, has also announced it will be joining in on the class action antitrust lawsuit filed by Buncombe and Asheville.¹⁷

The suits allege, among other things, that HCA/Mission has abused its unregulated monopoly power by engaging in unlawful, anti-competitive tactics to bolster its power with insurers, extract higher rates, and force health plans to cover a wider range of its services. Specifically, they accuse HCA/Mission of

⁸<https://info.ncdhhs.gov/dhsr/coneed/comments/2022/june/Buncombe-Acute-Care-Beds-Project-ID-B-12232-22-Mission-Hospital-Comments-by-AG-Josh-Stein.pdf>

⁹ Yancey (90.9%), Madison (90%), Buncombe (86.6%), Mitchell (85.4%), Transylvania (78.7%), McDowell (76.4%) and Macon (74.7%). Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21)

¹⁰ <https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/>

¹¹ Certificate of Need Application for acute care beds submitted by MH Mission Hospital, LLLP. June 15, 2022, p. 54-57; Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 61

¹² Tara Bannow, "HCA finalizes Mission Health purchase," *Modern Healthcare*, February 01, 2019.

¹³ <https://www.modernhealthcare.com/article/20190201/NEWS/190209999/hca-finalizes-mission-health-purchase>

¹⁴ <https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/10171852002/>

¹⁵ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 3

¹⁶ Buncombe County, City of Asheville v. HCA Healthcare, Mission Health (Case No: Case No. 1:22-cv-147, United States District Court - Western District of North Carolina, filed 07/27/22);

¹⁷ <https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/10171852002/>; <https://mountainx.com/living/hca-mission-lawsuit-asheville-buncombe/>

¹⁸ <https://www.citizen-times.com/story/news/2022/08/05/asheville-buncombe-brevard-lawsuits-v-hca-could-become-single-case/10241496002/>

¹⁹ <https://wlos.com/news/local/lawsuit-against-hca-healthcare-madison-county-will-join-buncombe-county-asheville-mission-attorney-confirms>

engaging in “all or nothing”¹⁸ offers, anti-steering and anti-tiering contractual provision,¹⁹ and “gag clauses” to aggressively negotiate for higher prices from insurers.²⁰ The plaintiffs also accuse HCA/Mission of failing to comply with the federal hospital price transparency rule that took effect in January 2021. The transparency rule requires that all US hospitals “provide clear, accessible pricing information online about the items and services.”²¹ The lawsuits allege that “HCA has however failed to fully disclose this information in a timely, complete, and understandable manner,”²² which has “kept community members, regulators, and the general public from learning of the grossly inflated, monopolistic prices that are being charged.”²³ While the complaints allege that, under non-profit ownership, Mission engaged in anti-competitive behavior to raise prices, the suits assert that HCA “has further exploited the system’s market dominance by raising prices and cutting costs in ways that have harmed quality of care.”²⁴ Specifically, they claim that under HCA’s ownership, “prices rose at an even higher rate than the State average, while at the same time HCA cut staffing to dangerously low levels to further increase its profit.”²⁵ Ultimately, the suits allege that HCA’s “conduct has restricted competition in the health care markets defined herein, thereby substantially and artificially inflating health care prices paid by plaintiffs and proposed class member health plans...”²⁶

Notably, both North Carolina's Attorney General Josh Stein and State Treasurer Dale Folwell filed separate *amicus* briefs in support of the Plaintiff residents in *Davis et al. v. HCA Healthcare and Mission Health System*.²⁷ Some excerpts from which include:

- From State Treasurer Folwell: “The hospitals should be held accountable to comply with the Transparency Rule and with the antitrust law. In the area of a person’s healthcare, transparency and honesty are imperative and any other corporate approach frankly amounts to nothing more than a pattern of deceit.” The *amicus* brief goes on to say, “... The ever-

¹⁸ City of Brevard, North Carolina v. HCA Healthcare and Mission Health System (Case No. 1:22-cv-114, United States District Court - Western District of North Carolina, filed 06/03/22), p. 34-35; “When a hospital system is the only entity in a given region to offer a product or service that health plans must include in their networks to be viable, that hospital system can refuse to sell services to health plans, or sell only with a significant price penalty, unless those health plans also agree to purchase other services from the hospital system, including services that the health plan would otherwise purchase from a different hospital system or set of providers for lower prices. Either orally during negotiations or in the contracts themselves, a hospital system can give the health plan what effectively is an “all-or-nothing” choice: Include everything the hospital system wants to sell at the price the hospital system dictates or pay much higher penalty prices or even get nothing at all.”

¹⁹ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 64; Many insurers utilize steering arrangements that involve encouraging plan enrollees to use lower-cost facilities instead of a higher cost facility or provider through plan language or by making the patient’s personal financial responsibility (through out-of-pocket costs or copays) higher for use of the higher cost facility. Mission allegedly requires insurers “not to use steering or tiering language, or to use weaker language or provisions than the insurers would have desired to use, as a condition of obtaining access to Defendants’ ‘must have’ Mission Hospital-Asheville for their commercial health plans.”

²⁰ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 64; In which insurers are prohibited from revealing their Mission contract terms, preventing “competitors, insurers, and consumers from understanding in a transparent manner the pricing and other terms and arrangements being used by Defendants.”

²¹ CMS, “Hospital Price Transparency,” <https://www.cms.gov/hospital-price-transparency>

²² The rule is, of course, meant to improve care accessibility by allowing consumers to shop around for services and understand the cost of care before receiving services. Unfortunately, a February 2022 report by PatientRightsAdvocate.Org revealed that HCA is still not meeting these standards. In fact, the researchers found that 0% of HCA’s hospitals were in compliance. PatientRightsAdvocate.org, “Semi-Annual Hospital Price Transparency Compliance Report,” February 2022. <https://www.patientrightsadvocate.org/semi-annual-compliance-report-2022> at 3.

²³ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 64

²⁴ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 37

²⁵ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 44-45

²⁶ Buncombe County, City of Asheville v. HCA Healthcare, Mission Health (Case No: Case No. 1:22-cv-147, United States District Court - Western District of North Carolina, filed 07/27/22);

<https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/101718520-02/>; <https://mountainx.com/living/hca-mission-lawsuit-asheville-buncombe/>

²⁷ <https://www.citizen-times.com/story/news/2022/08/01/north-carolina-attorney-general-josh-stein-treasurer-dale-folwell-buncombe-asheville-hca-lawsuit/10183195002/>

increasing costs being charged with these multi-state behemoths like HCA HealthCare are of high concern."²⁸

- From Attorney General Stein: "Healthcare costs place significant burdens on patients and their families who are often already dealing with stressful medical situations. In Asheville and the surrounding area—which is part of Mission Health's self-described service area—the cost of healthcare has become exorbitant. According to Plaintiffs' Complaint, residents of western North Carolina are sometimes paying up to 50 percent more for treatment than residents elsewhere in the state."²⁹ The *amicus* brief goes on to say: "[H]ospital consolidation further reduces choice. One of the few ways patients can control the price of their own healthcare is to choose a more affordable provider within the patient's network, if more than one choice exists. Plaintiffs allege that Mission Health robbed them of even that. According to Plaintiffs, Mission Health leveraged its overwhelming market share (between 70 and 90 percent) in acute inpatient treatment in the Asheville area to require insurers to agree to contract provisions that would prevent them from trying to direct patients to more affordable providers. These provisions, which prohibit the insurer from encouraging or incentivizing patients to use lower-cost providers, allow Mission Health to negotiate prices with insurers without fear of price competition. Insurers, unsurprisingly, pass some or all of Mission Health's high prices on to patients in the form of higher premiums, co-pays, deductibles, and other costs. In short, this case involves critical issues of competition and healthcare affordability that have a significant impact on consumers."³⁰

Mission's Charges Jump Significantly Following HCA's Acquisition

HCA has a track record of raising charges at its acquired hospitals, enabled by its strategic grabs for market share. For example, following HCA's purchase of two Georgia hospitals (Memorial Satilla Health in 2017³¹ and Memorial Health University Medical Center in 2018),³² both went from having below-average charge-to-cost ratios to above-average charge-to-cost ratios after they were bought by HCA.³³ Overall, HCA's hospital markups are generally more than twice the national average, and many HCA hospitals have markups as high as 12 or 13 times the cost of care.³⁴

A hospital's charge-to-cost ratio "is calculated as a hospital's total gross charges divided by its total Medicare-allowable cost."³⁵ Gross charges refer to a hospital's sticker price for each service—the price before private insurers' allowable amounts and predetermined Medicare and Medicaid rates. Medicare-allowable costs include costs associated with providing care to all patients, as reported on the

²⁸Amicus Brief filed in Support of Plaintiffs by State Treasurer, Dale Fowell - *Davis et al. v. HCA Healthcare and Mission Health System* (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 12/13/21) Retrieved from https://drive.google.com/file/d/1DD8nHMEVdK_IToxs89VIRDyGBCPOuLbX/view, p9

²⁹Amicus Brief filed in Support of Plaintiffs by State AG Josh Stein - *Davis et al. v. HCA Healthcare and Mission Health System* (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 12/13/21) Retrieved from <https://drive.google.com/file/d/1CoJlqb4-T1t6FAwaxGp4KuX4rKCNQaA5/view>, p2

³⁰Amicus Brief filed in Support of Plaintiffs by State AG Josh Stein - *Davis et al. v. HCA Healthcare and Mission Health System* (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 12/13/21) Retrieved from <https://drive.google.com/file/d/1CoJlqb4-T1t6FAwaxGp4KuX4rKCNQaA5/view>, p3

³¹Saunders, Jessica, "Hospital giant HCA acquires 231-bed hospital in Waycross, Ga.," *Atlanta Business Chronicle*, May 3, 2017, <https://www.bizjournals.com/atlanta/news/2017/05/03/hospital-giant-hca-acquires-231-bed-hospital-in.html>

³²Skutch, Jan, "HCA completes \$456 million purchase of Memorial Health," *Savannah Morning News*, Feb. 1, 2018, <https://www.savannahnow.com/story/news/2018/02/01/hca-completes-456-million-purchase-memorial-health/13839711007/>

³³SEIU analysis of Medicare cost report data

³⁴Based upon SEIU analysis of Medicare Cost Reports.

³⁵Ge Bai and Gerard F. Anderson, "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios," *Health Affairs*, June 2015. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1414#:~:text=The%20charge%2Dto%2Dcost%20ratio%20is%20calculated%20as%20a%20hospital's%20total%20Medicare%2Dallowable%20cost>

hospital's Medicare cost reports. Therefore, a hospital's charge-to-cost ratio demonstrates how much higher a hospital's charges are compared to what it actually costs to provide that service. A higher ratio signals considerable profit motives.

We can see these high charges, as enabled by monopoly power, at play at Mission Hospital, Mission Health's flagship hospital in Asheville, NC. Based on our analysis of Medicare cost report data, Mission Hospital's charges increased significantly following HCA's acquisition, to the point that:

- Prior to HCA's acquisition, Mission Hospital's charge-to-cost ratio had consistently fallen below the average charge-to-cost ratio across all North Carolina hospitals, but shot up the year of the acquisition (in 2019) to above the state average;
- Mission Hospital's charge-to-cost ratio had been increasing at a rate relatively in line with the state average (in terms of percent change each year) but, following HCA's acquisition, began increasing at a much more rapid rate, one in the double digits;
- Mission Hospital's charge-to-cost ratio previously fell consistently below the national average but, as of 2020, is now significantly above the national average;
- While both the state and national average charge-to-cost ratio decreased from 2019 to 2020, Mission Hospital's increased by 14%, with the hospital now under HCA's ownership.

As of 2021, the most recent data we have, Mission has a charge-to-cost ratio of 539%. In other words, Mission charges approximately 5.4 times what it actually costs to deliver care.³⁶

These shockingly high ratios serve as an indication of the exorbitant amounts consumers are being expected to pay out-of-pocket, of course disproportionately harming uninsured and underinsured patients. Numerous studies find a link between what a hospital charges and its actual prices. *The Quarterly Journal of Economics* published a study in 2019 of claims data from three of the five largest private US insurers. The study found that "23% of hospitals' inpatient cases have prices set as a share of hospitals' charges."³⁷ Moreover, "Prices at monopoly hospitals are 12% higher than those in markets with four or more rivals. Monopoly hospitals also have contracts that load more risk on insurers (e.g., they have more cases with prices set as a share of their charges)."³⁸ A 2016 study published in *Health Affairs* "using 2013 nationally representative hospital data from Medicare" found that, a one-unit increase in the charge-to-cost ratio was associated with a \$64 increase in patient revenue per adjusted discharge, suggesting that "hospitals still consider the chargemaster price to be an important way to enhance revenue."³⁹

Additionally, high charges particularly harm uninsured patients, especially uninsured patients who are not covered by a hospital's charity care policy. Uninsured patients do not have the luxury of having a large company negotiate down a hospital's prices on their behalf. Therefore, uninsured patients are often forced to take on the entire sticker price, or only a slightly discounted version of it.⁴⁰ Of course, the higher a hospital's sticker price, the more significant the financial burden.

³⁶ SEIU Analysis of Medicare cost report data

³⁷ Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107. https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf

³⁸ Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107. https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf

³⁹ Ge Bai and Gerard F. Anderson, "US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues," *Health Affairs*, September 2016. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0093>

⁴⁰ Melanie Evans, Anna Wilde Mathews, and Tom McGinty, "Hospitals Often Charge Uninsured People the Highest Prices, New Data Show," *The Wall Street Journal*, July 6, 2021. <https://www.wsj.com/articles/hospitals-often-charge-uninsured-people-the-highest-prices-new-data-show-11625584448>

Ultimately, high hospital prices translate into higher health insurance premiums - for individuals, employers, and public purchasers. When hospitals can charge private insurers supracompetitive rates due to a lack of competition in the market, these prices are passed onto individual patients in the form of higher premiums. This is what we are seeing happen in Western North Carolina. Due to Mission's monopoly power, "insurance premiums within Mission Health's service area are 30% higher than premiums in nearby counties, and over 50% higher than premiums in the State's other large metropolitan areas."⁴¹ Importantly, this also harms public purchasers of health insurance. For example, the City of Brevard argues in its suit that since it is the purchaser for its employees' (and their families') health insurance coverage, Mission's behavior harms the city through its higher-than-average prices that force it to pay higher premiums.⁴² North Carolina Treasurer Dale Folwell pointedly explained in his *amicus* brief mentioned above: "[a] significant part of the state's budget goes to health care . . . It is impossible to give appropriate raises to valued employees or take on new employees when so much funding has been budgeted for healthcare... The ever-increasing costs being charged with these multi-state behemoths like HCA HealthCare are of high concern."⁴³

2. Q: I am particularly interested in the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?

A: Mergers can impose significant burdens on rural and underserved communities. For example, HCA's acquisition of Mission Health has significantly impacted underserved communities in Western North Carolina, particularly those communities that are uninsured and underinsured.

HCA Makes Drastic Changes to Mission's Charity Care Policy Following Takeover

Since the acquisition, many have taken issue with HCA's drastic changes to Mission's charity care policy. In fact, the policy changes prompted community complaints to North Carolina AG Josh Stein, inquiries from AG Stein to HCA about the policy,⁴⁴ and even a lawsuit.⁴⁵ The policy changes include the following:

- The conditions covered by the policy for those under 200% of the Federal Poverty Level changed from non-emergent to emergent-only conditions, thereby narrowing the type of care for which patients can receive assistance.⁴⁶
- Mission's new policy is unclear as to what services actually qualify under "emergent care" across hospitals—every provider interprets this term slightly differently, and HCA does not make available a list of diagnoses, procedures, or circumstances that it interprets to meet this criterion.⁴⁷

⁴¹ NC DOJ Letter to HCA 16 March 2022, <https://www.scribd.com/document/567469487/NC-DOJ-Letter-to-HCA-16-March-2022>

⁴² City of Brevard, North Carolina v. HCA Healthcare and Mission Health System (Case No. 1:22-cv-114, United States District Court - Western District of North Carolina, filed 06/03/22)

⁴³ Derek Lacey, "NC Treasurer files interest in HCA antitrust suit; plaintiffs reiterate concerns, North Carolina Business Group on Health, <https://ncbeh.org/nc-treasurer-files-interest-in-hca-anti-trust-suit/>

⁴⁴ Stein Letter to HCA, February 25, 2020, <https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-02252020.pdf> at 3.

⁴⁵ Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 21

⁴⁶ Citizen Times, "Patient care to staff safety: Concerns over HCA's management of Mission run deep | OPINION," February 11, 2020.

<https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/>

⁴⁷ Brian Gordon, "Patient criticisms and HCA's response: What to know about Mission charity care," Citizen Times, <https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

- Mission's policy is now only applied retroactively.⁴⁸ Prior to HCA's acquisition of Mission, patients were pre-approved to receive charity care benefits for up to a year,⁴⁹ during which all of their medical bills were automatically covered by the policy.⁵⁰ Under HCA's ownership, charity care is "episodic"—patients must re-apply for coverage with each new bill.
- HCA's policy requires that a patient's bill exceeds \$1,500 to qualify for coverage.⁵¹ The idea that an individual or family earning 200% of the federal poverty level (Mission's income eligibility threshold for a full write-off—e.g. \$33,975 for an individual or \$55,500 for a family of four) or less can afford to pay a \$1,400 medical bill, or even a \$500 medical bill, is absurd. An analysis conducted by Urban Institute reveals that the median medical debt currently in collections in some of the counties served by Mission includes: \$667 in Buncombe County, \$687 in Madison County, and \$533 in Yancey County.⁵² A survey released in January 2021 revealed that only "39% of Americans [surveyed] can afford a \$1,000 unexpected expense."⁵³ And, "for households making less than \$30,000, just 21[%] have a rainy-day fund to cover \$1,000."⁵⁴ Clearly healthcare consumers in the multicounty service area served by Mission struggle with paying medical bills less than \$1,500. Mission states that it may provide charity care to applicants with bills under this minimum only under "extenuating circumstances," however, this is also determined on a case-by-case basis.⁵⁵

Community members, patients that rely on charity care assistance, and local leaders, have therefore expressed serious concern about Mission's ability to meet its obligations to its low-income patients. For example, Harmony Owen, a resident of West Asheville, mother of two, and patient of Mission, explained to the *Asheville Citizens Times* that her family has now relied on charity care pre- and post-acquisition, and prefers the old policy. "We used charity care prior to the switchover several times, both myself and my husband," Ms. Owen said. "Before, it was definitely more accessible and easier to apply."⁵⁶ Ms. Owen specifically told the *Asheville Citizen Times* that having to reapply for each bill "[has] been a very huge strain on our family because of our finances."⁵⁷ And because Mission' is the dominant healthcare provider in the region, patients like the Owens do not have alternative options for care. Patients are forced to rely on Mission's hard to navigate policy.

3. Q: Is it possible that government regulations actually caused the consolidation of hospitals?

⁴⁸ Citizen Times, "Patient care to staff safety: Concerns over HCA's management of Mission run deep | OPINION," February 11, 2020.

⁴⁹ Citizen Times, "Patient care to staff safety: Concerns over HCA's management of Mission run deep | OPINION," February 11, 2020.

⁵⁰ Brian Gordon, "Patient criticisms and HCA's response: What to know about Mission charity care," Citizen Times,

<https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/>

⁵¹ Brian Gordon, "Patient criticisms and HCA's response: What to know about Mission charity care," Citizen Times,

<https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

⁵² Urban Institute, "Debt in America: County-Level Medical Debt," 2022. <https://datacatalog.urban.org/datasets/debt-america-2022>.

⁵³ Lorie Konish, "Just 39% of Americans could pay for a \$1,000 emergency expense," CNBC, January 11, 2021.

⁵⁴ Jeff Ostrowski, "Survey: Fewer than 4 in 10 Americans could pay a surprise \$1,000 bill from savings," Bankrate, January 11, 2021.

⁵⁵ <https://www.bankrate.com/banking/savings/financial-security-january-2021/>

⁵⁶ "Charity Financial Assistance Policy for Uninsured and Underinsured Patients," MISSION HEALTH, <https://missionhealth.org/wp-content/uploads/2021/04/Charity-care-update-Oct-2020-recd-April-2021.pdf>, Item 9(A): "Patients with more than a \$1,500 patient liability that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than \$1,500 may be reviewed and a charity write-off applied."

⁵⁷ Brian Gordon, "Patient criticisms and HCA's response: What to know about Mission charity care," Citizen Times,

<https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

⁵⁸ Brian Gordon, "Patient criticisms and HCA's response: What to know about Mission charity care," Citizen Times,

<https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

A: There are certain regulations that have helped facilitate the consolidation of hospitals. One such example is the “Certificate of Public Advantage,” or COPA laws. In fact, the FTC has been vocal about the dangers of “the use of COPAs to shield otherwise illegal hospital mergers.”⁵⁸ These laws are a significant example of government regulation actually permitting and promoting hospital consolidation.

Certificate of Public Advantage “COPA” Laws

Some states have allowed hospital mergers that would otherwise violate antitrust laws to occur under “Certificate of Public Advantage” (COPA) laws. Under such laws, states “allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation.”⁵⁹ The state often then imposes certain terms and conditions on the recipient hospital or health system, such as price controls, quality and staffing commitments, and profit margin caps. COPA laws thus attempt to “replace competition among healthcare providers with regulatory oversight by state agencies.”⁶⁰ In doing this, state-enacted COPA laws limit the FTC’s ability to challenge otherwise problematic consolidation. In other words, COPA laws allow hospitals to operate as unlawful monopolies, shielded from federal oversight, in exchange for agreeing to certain rules set by the state. As a recent FTC policy paper notes, “indeed, most COPAs that have been approved so far resulted in a single hospital monopoly.”⁶¹

Hospitals who lobby for COPA laws claim that such laws enable the many promised benefits of hospital mergers - like cost savings and efficiencies that bolster clinical improvements - while preventing the well-established harms of competition loss.⁶² However, research has demonstrated otherwise, showing that COPA laws do not prevent hospitals from exploiting their market power. Instead, “[i]n the long run, hospital mergers shielded with COPAs often lead to higher prices and reduced quality from unconstrained provider market power.”⁶³ To date, the FTC knows of “nine states that have approved hospital mergers pursuant to such legislation: North Carolina, South Carolina, Montana, Maine, Minnesota, and most recently, West Virginia, Tennessee, Virginia, and Texas.”⁶⁴ However, three of those states - North Carolina, Montana, and Minnesota - have repealed their COPAs, along with “the underlying legislation so that hospitals in these states are no longer allowed to obtain COPAs.”⁶⁵ A 2020 paper by Chris Garmon, a professor at University of Missouri-Kansas City and former FTC economist, and Kishan Bhatt of the Princeton School of Public and International Affairs notes, “COPA-regulated hospitals have a strong incentive to evade regulation and pursue the removal of the COPA. Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality.”⁶⁶ We can see this exact situation in Mission Health.

History of Mission’s Monopoly as a Case Study of Ineffective COPA Laws

⁵⁸ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁵⁹ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶⁰ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶¹ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶² https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶³ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶⁴ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶⁵ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁶⁶ Garmon, Christopher and Bhatt, Kishan, Certificates of Public Advantage and Hospital Mergers: Evidence from Maine, Montana and South Carolina (June 24, 2020).

In 1995, Mission Hospital and St. Joseph's Hospital, the only two private acute care providers in Asheville, decided to enter into a partnership.⁶⁷ While the deal created monopoly market share for the combined systems that would have otherwise led to antitrust challenges, Mission and St. Joseph's were able to carry out the relationship under a Certificate of Public Advantage (COPA). In 1998, Mission sought to purchase St. Joseph's and all of its assets, and the COPA was, in turn, amended to permit the acquisition. The merged entity, renamed "Mission Health System," was thus permitted to operate as a monopoly under the COPA, "subject to certain terms and conditions – including margin, cost, and physician employment caps, as well as quality and contracting commitments."⁶⁸

Operating under these terms, Mission significantly expanded its footprint over the next twenty years (1995 to 2015), buying up multiple hospitals in surrounding counties and acquired many physician groups. In 2015, however, the state legislature repealed the COPA as a result of lobbying efforts by Mission Health.⁶⁹ The COPA officially ended in September of 2016, "leaving no meaningful competitive or regulatory constraint on Mission Health's monopoly market power."⁷⁰

HCA, the largest and most profitable hospital chain in the country, saw Mission's monopoly power with minimal regulatory constraint as an opportunity. Barak Richman, a law professor at Duke University who specializes in antitrust healthcare law, asserted of the deal, "I think the value of Mission to HCA increased dramatically after the COPA ended and that's just simple economics."⁷¹ With the COPA no longer in place, there is nothing stopping HCA from engaging in monopolistic and harmful behavior.

Mission Health COPA Studies

Two separate studies of inpatient hospital services prices at Mission Health demonstrate that, even under a COPA that purported to quell the effects of monopoly power, prices rose significantly more at Mission compared to peer hospitals. First, a study of prices from "1996 to 2008 shows that Mission Health increased its prices by at least 20% more than peer hospitals"⁷² during that period under the COPA. A second study of price changes during the remaining years of the COPA "found an average price increase of 25% through 2015, driven by large increases several years into the COPA period."⁷³ Therefore, the above research suggests that "state COPA oversight did not prevent Mission Health from raising prices more than similar hospitals."⁷⁴ Furthermore, when the COPA was repealed, Western North Carolina was left with a monopoly health system that now had essentially free reign to increase prices, cut services and staffing, and maximize profits, all at the expense of a community that has few other

⁶⁷ U.S. Federal Trade Commission, Bureau of Competition, Bureau of Economics, Office of Policy Planning, "Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System," September 11, 2020.

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf

⁶⁸ U.S. Federal Trade Commission, Bureau of Competition, Bureau of Economics, Office of Policy Planning, "Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System," September 11, 2020.

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf

⁶⁹ U.S. Federal Trade Commission, Bureau of Competition, Bureau of Economics, Office of Policy Planning, "Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System," September 11, 2020.

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf

⁷⁰ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁷¹ <https://wlos.com/news/local/lawsuit-against-mission-health-could-have-an-impact-nationwide-says-law-professor>

⁷² https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁷³ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁷⁴ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

options for care. The second study also “found prices increased by another 38% after the COPA was repealed in 2015 and before Mission Health was acquired by HCA Healthcare.”⁷⁵ And, we know from our analysis of charge-to-cost ratios pre and post-2019 (discussed in response to Question 1 above), that this has likely gotten even worse since HCA’s acquisition.⁷⁶ In fact, a recent RAND Corporation analysis of hospital claims data⁷⁷ found that Mission Hospital-Asheville, Mission Health’s flagship hospital charged commercial insurers an average of 305% above the Medicare price for General Acute Care Services, compared to the North Carolina average of 211% above Medicare.⁷⁸

Ultimately, COPA laws have created many situations similar to that in Western North Carolina - a monopoly health system that has eroded consumer choice, increased prices, and jeopardized care quality. And HCA has capitalized on the fallout of an unsuccessful COPA law, at the expense of the local community. Unfortunately, in these cases, the policy decisions of state lawmakers have empowered hospital consolidation and harmed necessary competition.

4. Q: Looking past antitrust remedies and enforcement, are there other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?

A: There are several actions that Congress should consider taking to address the dangers of hospital mergers and acquisitions. One is to move away from the “consumer welfare” standard framework in reviewing mergers and acquisitions. Another is to eliminate Certificate of Public Advantage (COPA) laws.

Amending Antitrust Standards

The prevailing framework used by antitrust enforcement agencies (hereinafter “Agencies”) to assess whether mergers should be allowed is the “consumer welfare standard,” despite the fact that this standard appears nowhere in antitrust statutes like the Sherman or Clayton Acts. Under this standard, Agencies typically only examine whether consumers would benefit and operate under the assumption that “consumers are more important than all other economic agents, and that no anti-competitive behavior employed by a monopolist or a cartel can be unwound unless and until it can be shown to harm consumers, typically in the form of higher prices.”⁷⁹ As a result, this standard fails to address a wide range of implications from a merger, such as whether it would monopolize an industry, harm workers, or curb innovation.⁸⁰

What’s more, even experts cannot agree on the standard’s meaning or its implications. According to Jonathan Kanter, the U.S. Assistant Attorney General for the Antitrust Division,

⁷⁵ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁷⁶ SEIU Analysis of Medicare cost report data

⁷⁷ RAND compared the prices negotiated from 2018 to 2020 by hospitals and private health plans—i.e. the total “allowed amounts (amount paid to a health care provider per service, including amounts paid by the health plan and any amounts due from the patient, such as deductibles, copayments, and coinsurance)” —to the rates set by Medicare.; “We gathered claims data, including provider identifiers and allowed amounts, for enrollees in employer-sponsored health plans from three types of data sources: self-insured employers; state-based all-payer claims databases from Arkansas, Colorado, Connecticut, Delaware, Maine, New Hampshire, Oregon, Rhode Island, Utah, and Washington; and health plans that chose to participate. Together, those data sources include claims data for hospital services provided by more than 4,000 hospitals in 49 states and Washington, D.C.” Christopher M. Whaley, Brian Briscoe, Rose Kerber, Brenna O’Neill, Aaron Kofner, “Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative”: RAND Supplemental_Material (Excel File – Notes and Background Tab), RAND Corporation. 2022. <https://doi.org/10.7249/RAA1144-1>

⁷⁸ Christopher M. Whaley, Brian Briscoe, Rose Kerber, Brenna O’Neill, Aaron Kofner, “Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative.” RAND Corporation. 2022. <https://doi.org/10.7249/RAA1144-1> (data pulled from Excel File - Table 1. Hospitals and Table 3. States)

⁷⁹ <https://prospect.org/economy/antitrust-can-address-racial-inequities/>

⁸⁰ <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

“The consumer welfare standard gets a lot of discussion in narrow antitrust circles and I think it’s important, something I’d like to address. In my experience if you ask five antitrust lawyers, ‘What does the consumer welfare standard mean,’ you will get six different answers. The whole idea of there being a standard is that there be agreement as to what it means. We’re sitting here thirty, forty years later and there’s still no agreement as to what it means.”⁸¹

Thus, companies can always find expert testimony supporting their claims that their specific deal will “create efficiencies and reduce consumer costs.” According to economist Hal Singer, “the consumer welfare standard has [even] been used to thwart many attempted interventions.”⁸² This results in turning “competition policy into a question of competing economic models rather than a question of power.” Kanter even cautioned that, “We must be mindful that economics—and expertise, more broadly—are merely tools to understand facts relevant to a particular case.”⁸³ As such, we believe that the current “consumer welfare standard” tool falls short in capturing the full picture of merger cases. It is essential to move away from the “consumer welfare standard” and to codify a more expansive, inclusive standard that not only protects consumers, but protects workers as well. The labor market should be given consideration when merger proposals are reviewed. Because there is a limited history of antitrust labor enforcement it is important that bright-line standards are established for anti-competitive consolidation and practices in labor markets. We recommend the following measures.

A. Review mergers for labor market concentration

Proposed mergers are reviewed only for their effects on product markets, and not for their effects on labor markets. Mergers should be examined for their impact on labor market concentration and blocked if they would increase labor market concentration to levels that harm workers.

Moreover, labor markets become significantly less competitive at lower levels of concentration than product markets. Agencies should establish a lower market share threshold at which a firm is presumed to have market power. Research suggests an employer possesses market power if it controls 20 percent of a labor market. We urge 20 percent as the concentration threshold for labor markets in merger guidelines.

B. Require pre-merger review for potential increases in labor market concentration

Labor market-related merger filing triggers should be established that would require merging parties to file for pre-merger review based solely on whether the merger would increase concentration in the local labor markets that would be affected by the proposed merger. Filing triggers could include, for example, the total number of workers affected, the total workers in a local labor market as a percentage of that labor market’s population, or an HHI-like analysis of local labor market concentration. The triggers and any merger analysis should recognize the existence of particular mobility frictions for specific occupational groups such as licensed occupations, or occupations that have specific and narrow skill requirements.

C. Preserve existing collective bargaining agreements by merging parties

⁸¹ <https://mattstoller.substack.com/p/peeking-in-the-economists-pool>; <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

⁸² <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

⁸³ <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

In some mergers, the acquiring party seeks to void existing collective bargaining agreements in the course of the transaction. Allowing merging parties to nullify existing collective bargaining agreements undermines workers' statutorily guaranteed labor rights and the federal policy of guaranteeing these rights to promote labor peace. In addition, collective bargaining agreements mitigate the effects of increased labor market concentration because they prevent employers from exercising unilateral power over workers covered by the agreement. Therefore, Agencies should insist that any existing collective bargaining agreements must be respected and preserved in the course of a merger, as well as continue to consult with affected labor unions on the transaction.

D. Utilize collective bargaining as a counterweight to increased employer power

Collective bargaining requires employers to bargain over wages and working conditions with their employees, ensuring workers share power to co-determine their working conditions. In this way, collective bargaining mitigates employer power in labor markets. In mergers that would increase the employer concentration in local labor markets, collective bargaining should be considered as a remedy for such increases. In the event that workers are unorganized, a proposed remedy should include a fair process by which the affected workers can choose whether they want union representation. Tools such as collective bargaining agreements with anti-discrimination clauses, grievance procedures, as well as community benefits agreements have allowed workers in monopsonistic industries like coal, auto, and steel to level the playing field and make change over time, transforming dangerous poverty jobs (like hospital jobs) into work that builds communities.

Empowering workers lessens the negative labor market impacts of consolidation. Likewise wage boards, sectoral working standards for working conditions, broad-based bargaining and other labor market supports can attenuate the negative impacts of employer concentration.

E. Prohibit balancing away competitive harms to workers

Although it is contrary to black-letter antitrust law, some courts permit defendants to rebut showings of competitive harm by showing procompetitive benefits like lower prices, including in markets other than the market where the harm occurred. Parties should be permitted to prove an antitrust violation by showing anti-competitive harm from a dominant firm's conduct in a labor or product market, and firms should not be able to defend, or rebut, evidence of abusive conduct by offering a pro-competitive justification, whether the benefit occurs in the same market or not. Merger guidelines should establish that procompetitive benefits will not offset harms to competition.

Workers are subject to many harms from consolidated employer power, and these extend even beyond wages and benefits. We propose the inclusion of labor market considerations in merger guidelines. Employer claims to "efficiencies" from consolidation should be scrutinized for whether these would be realized by simply transferring a greater burden to individual workers.

Eliminate or Strictly Regulate COPA Laws

As explained above, COPA laws enable dangerous hospital monopolies with the promise of effective state regulation. However, ultimately, "competition has proven to be more reliable and effective than COPAs for controlling healthcare costs while preserving quality of care, including in rural areas facing

economic challenges.”⁸⁴ The FTC has recognized that “There are certainly circumstances where a bona fide regulatory approach that has the side effect of limiting competition may be an appropriate way to implement important public policy goals. Yet, the available evidence shows COPAs do not achieve the purported policy goals of reducing healthcare costs and improving quality.”⁸⁵ For the reasons explained above, FTC staff has recommended that: state lawmakers not enact COPA laws; in states where COPA laws already exist, states should repeal these laws provided there is not an active COPA currently in place; and, in states where there is already an active COPA in place, states should not approve any new COPA applications.⁸⁶ Unfortunately, under current federal law, the FTC cannot currently do much more than recommend against these laws.⁸⁷

Therefore, we urge federal limitations on state COPA laws. We recognize COPAs may be a good idea in extremely limited circumstances, but stringent minimum guidelines must be met. These guidelines must include active oversight by state and federal regulators, limitations on pricing changes, service alterations, and capital expenditures, and specific binding agreements to unwind mergers and consolidations when these conditions are not met.

5. Q: How have federal government healthcare policies—again, looking at them holistically—influenced the closure of hospitals in rural and underserved areas?

A: Uneven government support of safety-net hospitals, convoluted financing of U.S. healthcare, and unchecked competitive advantages and expansions by wealthier hospital players has influenced the closure of hospitals in underserved areas. Taken together, these factors endanger care for underserved, low-income populations.

Growing Divide Between Wealthy Hospitals and Poor Safety-Nets

Safety-net hospitals are generally hospitals with a stated mission or mandate of serving low-income populations, regardless of patients’ insurance coverage, ability to pay or immigration status. Safety-nets usually will not turn away patients who cannot pay and have high numbers of uninsured and Medicaid patients.⁸⁸

Safety-net hospitals typically depend on public funding,⁸⁹ but researchers say that “every time the government does shell out a dollar, it’s underpaying for what the services actually cost.”⁹⁰ For example, Medicaid reimbursements to hospitals are often much lower than those of private insurers — a disparity that has made it more difficult for safety nets to cover their costs and stay afloat.⁹¹ As a result, the disparity between safety-nets and their much wealthier competitors (e.g. for-profits, non-profits etc.) has been growing for the past two decades as medical costs have increased, but “the political will to pay for healthcare for the poor has not kept pace.”⁹²

Current Financing of Safety-Nets Falls Short

⁸⁴ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁸⁵ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁸⁶ https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

⁸⁷ <https://www.modernhealthcare.com/mergers-acquisitions/ftc-wants-states-scrap-certificate-public-advantage-laws>

⁸⁸ <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

⁸⁹ <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

⁹⁰ <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggled-covid-wealthy-hospitals-millions-profits/>

⁹¹ <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

⁹² <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggled-covid-wealthy-hospitals-millions-profits/>

But even funding measures meant to aid safety nets, such as Disproportionate Share Hospital (DSH) payments for example, currently fall short due to its uneven distribution and lack of transparency. Since Medicaid often does not pay enough to cover the costs of care – leaving hospitals about \$19 billion short every year – the government gives hospitals additional Medicaid funding called “supplemental” or “DSH” payments to help offset losses and costs of caring for the uninsured.⁹³ States distribute this funding to hospitals that theoretically meet one of two federal standards: either by serving a higher percentage of Medicaid patients than the state average, or by having at least 25% of their patients qualify as low-income.

But due to variations in each state's Medicaid program, states do not have to give all of the funding to hospitals that meet the federal criteria. As a result, the congressional commission overseeing Medicaid found there's “no clear relationship between the hospitals that get DSH payments and the hospitals with the highest proportions of low-income or uninsured patients.” According to Bruce Siegel, the president and CEO of America's Essential Hospitals, some of “those hospitals that are really faithful to their mission are not getting the support they need, while other organizations who may treat relatively very few Medicaid or uninsured patients still receive support.”⁹⁴

There's also a lack of transparency surrounding the DSH program. The latest report on how states distribute DSH money is reportedly from 2015. According to Paula Chatterjee, an assistant professor of general internal medicine at the University of Pennsylvania, that years-long lag means “we don't have a lot of understanding of how state and local governments are deciding to support those hospitals,” she said. “Where does that funding come from? Does it change from year to year? We actually don't know the answers to those questions.”⁹⁵

Wealthier Hospital Players Squeeze Out Safety-Nets

According to an investigation by *NPR and Frontline*, “the growth of hospital chains and the subsequent consolidation of the industry have created a progressively more competitive environment, making it harder for safety-net hospitals to live up to their mission and stay afloat.”⁹⁶ The *NPR/Frontline* investigation cites the case study of the Chattanooga, Tennessee market, where a county-owned safety-net hospital named Erlanger Hospital is struggling to compete with two other players in town, the non-profit Memorial Hospital and HCA's for-profit Parkridge Hospital. The investigation found that “in 2019, the year before COVID, HCA's Parkridge reported \$78 million in operating profit, a margin of almost 24%. Memorial took in \$40 million, a nearly 7% margin. Erlanger lost about \$13 million.”⁹⁷ This HCA hospital has the luxury of treating more profitable, “private pay” patients, while safety-nets shoulder the responsibility of treating poorer, underserved populations. According to former U.S. Senator and former Chattanooga Mayor, Bob Corker, “By having a safety-net hospital in the market, where more of the lower-pay, no-pay patients are going to go, ends up being of benefit to the other facilities.”⁹⁸

In fact, this was not the first time HCA has been accused of trying to capture private pay patients. In 2015, HCA's TriStar system tried to build a freestanding Emergency Department near the Old Hickory Boulevard exit on Interstate 65 in Brentwood, Tennessee. Two non-profits, Williamson Medical Center

⁹³ <https://www.pbs.org/wgbh/frontline/documentary/the-healthcare-divide/transcript/>

⁹⁴ <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

⁹⁵ <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

⁹⁶ <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

⁹⁷ <https://www.pbs.org/wgbh/frontline/documentary/the-healthcare-divide/transcript/>

⁹⁸ <https://www.pbs.org/wgbh/frontline/documentary/the-healthcare-divide/transcript/>

and Vanderbilt University Medical Center, opposed that project arguing “it was a tactic to lure away the wealthy, insurance card-carrying patients who live in Williamson County.” They claimed “HCA has used freestanding emergency departments as proving grounds for potential hospitals in the past, and [...] alleged the company planned to do the same in Brentwood.”⁹⁹

What’s more, the COVID pandemic has only exacerbated this divide, as “hospitals that treat more ‘profitable’ patients have often pulled further ahead, while many of those that treat more patients who are on Medicaid or are uninsured have fallen further behind.”¹⁰⁰ According to *NPR and Frontline*, these are often the same hospitals that have been seeing influxes of COVID-19 patients from communities disproportionately impacted by the disease. According to Dr. Brad Spellberg, chief medical officer at LAC+USC Medical Center, a safety-net hospital, “We serve a community of working poor. We serve people who are working essential jobs. ... We are expected to care for the patients the other hospitals won’t care for.”¹⁰¹ It is no surprise then that hospital chains like HCA, who are profiting off the backs of safety net hospitals, are doing quite well during the pandemic. In 2020, for example, HCA had posted a \$3.8 billion profit, more than it made in 2019.¹⁰² In 2021, HCA’s profits jumped to \$6.96 billion¹⁰³ despite the pandemic.

6. Q: Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.

A: As noted above, while many claim that provider consolidation leads to better quality care, research has actually indicated the opposite. Studies suggest that market consolidation—particularly for horizontal consolidation—can actually lead to lower quality care.¹⁰⁴ Thus, it is no surprise that community members, patients, staff, and local and state leaders have consistently voiced concerns over the quality of care provided by Mission Health following HCA’s acquisition of the health system.

Community Repeatedly Voices Concerns about Diminished Quality of Care at Mission Post-HCA Takeover

As of September of 2021, North Carolina’s Attorney General had received 290 complaints about Mission Health since HCA’s acquisition of the system in February of 2019.¹⁰⁵ In contrast, in 2017, prior to the sale of the health system to HCA, the Attorney General received just seven complaints.¹⁰⁶ Notably, *WLOS ABC-News 13* conducted an analysis of the complaints submitted to Attorney General Stein between April 2020 and April 2021 and found that nearly a quarter were related to concerns over quality of care.¹⁰⁷

Some common themes have emerged from these concerns, including:

⁹⁹ <https://www.bizjournals.com/nashville/news/2021/05/27/freestanding-ed-tristar-century-farms-will-open.html>

¹⁰⁰ <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

¹⁰¹ <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

¹⁰² <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggled-covid-wealthy-hospitals-millions-profits/>

¹⁰³ HCA 2021 10K, p. 75, (See: Net Income attributable to HCA Healthcare, Inc.) Accessible at <https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000119312522046707/d32297d10k.htm>

¹⁰⁴ <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>

¹⁰⁵ Clarissa Donnelly-DeRoven, “AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story” Asheville Citizens Times, September 20, 2021.

¹⁰⁶ <https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-asheville-hca-mission/8370318002/>

¹⁰⁷ Karen Zatkulak, “A concerning number,” Attorney General describes recent Mission Health complaints filed,” WLOS ABC-News 13, June 8th 2021.

<https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed>

¹⁰⁷ Karen Zatkulak, “A concerning number,” Attorney General describes recent Mission Health complaints filed,” WLOS ABC-News 13, June 8th 2021.

<https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed>

- Understaffing- Because labor is the largest cost driver for hospitals, lowering staffing levels boosts profitability. HCA's profits are astonishingly strong—with \$6.96 billion in profits in 2021 alone,¹⁰⁸ despite the pandemic; and since 2010, the company has paid out more than \$29 billion to investors in dividends and share repurchases.¹⁰⁹ Thus, HCA has more than enough resources to properly staff its facilities for the sake of patient care and worker safety. Yet, time and again the company fails to do so.

Staffing is a problem across HCA hospitals, with a pattern of lower than average staffing ratios at HCA's facilities nationwide.¹¹⁰ In 2020, HCA hospitals had about 33% fewer full-time equivalent ("FTE") staff per adjusted occupied bed ("FTE rate", or "staffing rate") than the national average for acute care and critical access hospitals.¹¹¹ This ratio measures the total number of staff at a facility compared to the total volume of patients in a year. The trend of lower FTE rates at HCA hospitals is consistent over time. Between 2014 and 2020, the HCA system's staffing rate was between 29% and 33% below the national average.

Patient and staff testimonials show that Mission Health is, unfortunately, no different. HCA does not allocate the proper resources at its hospitals to provide high-quality care. Examples include:

- o Forrest Johnson, who presented to Mission Hospital's emergency room after falling and breaking her leg told the *Asheville Watchdog* that she laid "for nearly six hours in the emergency room without water, ice, a blanket, a pillow to elevate her leg, food, or pain medication." She explained "I just had a very busy nurse... He just didn't have the time to care for me," and recalled that the nurse had apologized that he would not be able to check on her every 15 minutes as would normally be expected of him because of under-staffing."¹¹²
- o A complaint submitted in 2021 to the Attorney General by a Mission employee stated: "I do not feel safe in my practice and I do not feel safe for my patients," and claimed that some patients "are having to sit in their own excrement for hours because our floor is expecting 1 CNA to look after 44 patients."¹¹³
- o A nurse described the staffing situation in her unit to the *Asheville Watchdog*, explaining that on a unit with several dozen beds, nurses are assigned six or seven patients, which is double their usual workload, and are only provided one CNA when protocols require four: "It's just not safe. It's led to an increase in falls, and I believe people are getting sicker ... patients are lying in their own feces for up to an hour ... and they are not getting their meds for hours."¹¹⁴

¹⁰⁸ HCA 2021 10K, p. 75, (See: Net Income attributable to HCA Healthcare, Inc.) Accessible at

<https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000119312522046707/d32297d10k.htm>

¹⁰⁹ Based on an analysis of HCA's filings, press releases, investor presentations and an article by Pitchbook.

¹¹⁰ Based upon SEIU analysis of Medicare Cost Report data for short-term general acute care hospitals and critical access hospitals. FTE Rate compares the number of staff (full time equivalents) to the volume of patients. The formula is: Full time equivalents/ (Adjusted inpatient days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities

¹¹¹ Based upon SEIU analysis of Medicare Cost Report data for short-term general acute care hospitals and critical access hospitals. FTE Rate compares the number of staff (full time equivalents) to the volume of patients. The formula is: Full time equivalents/ (Adjusted inpatient days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities. These averages are weighted averages.

¹¹² Barbara Durr, "Quality of Care Concerns Rise at Mission Hospital," *Asheville Watchdog*, May 20, 2021.

<https://avjwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/>

¹¹³ Clarissa Donnelly-DeRoven, "AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story" *Asheville Citizens Times*, September 20, 2021.

<https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-asheville-hca-mission/8370318002>

¹¹⁴ Barbara Durr, "Quality of Care Concerns Rise at Mission Hospital," *Asheville Watchdog*, May 20, 2021.

<https://avjwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/>

- Cuts in service - HCA has cut or eliminated services at Mission, which has forced workers to perform tasks outside their scope and affected patient care. A *Fortune Magazine* article published in March 2022 revealed that, after acquiring Mission, HCA chose to eliminate many of Mission's Health Unit Coordinators, forcing other staff to pick up the slack for this reckless decision. Nurses also told the publication that "they often ended up delivering food and emptying trash bins after HCA outsourced the hospital's food service and janitorial functions."¹¹⁵ One nurse who submitted a complaint to the AG's office explained to *News 13*: "When we say that patient care is number one and then we're cutting services that allow for us to provide better patient care, that just doesn't add up to me and I couldn't be a part of that."¹¹⁶

Regulatory Enforcement due to Care Breakdowns at Mission Post-HCA Takeover

What's more, lapses in care following HCA's takeover of Mission prompted CMS to send Mission Hospital a letter threatening to terminate its Medicare contract in November of 2020.¹¹⁷ According to CMS, this drastic measure of terminating a provider agreement is "generally a last resort after all other attempts to remedy the deficiencies at a facility have been exhausted."¹¹⁸ In other words, threats of contract termination from CMS are rare.¹¹⁹ Therefore, when CMS does choose to take this action, it is clearly in response to something very serious.

However, this is not the first time CMS has threatened to terminate its contract with an HCA hospital, suggesting a system-wide pattern of poor behavior. HCA's Good Samaritan Hospital in San Jose received a "Notice of Termination" from CMS in July of 2021.¹²⁰ In a 65-page inspection report detailing a series of deficiencies,¹²¹ regulators noted that management had failed to address "serious, systemic, and recurring issues."¹²²

7. **Q:** Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

A: HCA has a track record of shuttering community clinics and safety net services, as well as driving physicians away following its acquisition of local community hospitals. Both of which deeply affect a community's access to care in general, let alone access to comprehensive integrated care.

Mission Clinic Closures Post-HCA Takeover

¹¹⁵ Ericka Fry, "America's largest hospital company is booming. So why is one community trying to run it out of town?", *Fortune*, March 31, 2022. <https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/>

¹¹⁶ Karen Zatkulak, "A concerning number," Attorney General describes recent Mission Health complaints filed," *WLOS ABC-News 13*, June 8th 2021. <https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed>

¹¹⁷ Jennifer Emert, "What changes have been made since Medicare threatened to cut Mission Hospital's contract?" *WLOS ABC-News 13*, May 5, 2021. <https://wlos.com/news/local/news-13-investigates-what-changes-have-been-made-since-medicare-threatened-to-cut-mission-hospital-contract>

¹¹⁸ Rebecca Carballo, <https://www.houstonchronicle.com/business/article/houston-hospital-medicare-feds-violations-16688960.php>

¹¹⁹ Jennifer Emert, "What changes have been made since Medicare threatened to cut Mission Hospital's contract?" *WLOS ABC-News 13*, May 5, 2021. <https://wlos.com/news/local/news-13-investigates-what-changes-have-been-made-since-medicare-threatened-to-cut-mission-hospital-contract>

¹²⁰ Candice Nguyen and Michael Bott, "Medicare Agency Hits Good Samaritan Hospital With 'Notice of Termination'," *NBC Bay Area*, July 13, 2021. <https://www.nbcbayarea.com/investigations/exclusive-good-samaritan-hospital-hit-with-immediate-jeopardy-notice-by-regulators/2593774/>

¹²¹ <https://www.documentcloud.org/documents/21044034-good-sam-cms-report>

¹²² Candice Nguyen, Michael Bott and Mark Villarreal, "Good Samaritan Hospital Leadership Blasted in Medicare Agency Report," *NBC Bay Area*, September 23, 2021. <https://www.nbcbayarea.com/investigations/good-samaritan-hospital-leadership-blasted-in-medicare-agency-report/2633470/>

Since HCA's takeover, Mission Health has shuttered at least two of its primary care outpatient clinics.¹²³ These clinics played a vital role in providing care access. Dr. Tim Plaut, a former physician with the Mission Candler clinic, notes that the closure of a safety net clinic such as Candler has "created a lot of hardship for our patients." Dr. Plaut "estimates that more than 7,000 patients total, many uninsured or underinsured, were treated at the two clinics."¹²⁴ He worries that some patients "fell through the cracks" in the transition to other providers because when physician offices shutter, patients may have trouble accessing transportation to travel to another clinic further away. He states, "Our practice in Candler was one of the original safety nets through Mission and we took care of a lot of Medicaid and Medicare; we had homeless folks and severe mental illness."¹²⁵ Dr. Kate Rasche, a former family medicine physician with Mission adds, "HCA was more focused on seeing financial data from the clinics rather than seeing it as part of the big picture of keeping the region healthy."¹²⁶ Perhaps HCA's questionable conduct is best summed up by Geoff Noblitt, a patient at the former Mission Candler clinic: "The closing of this office with no notice to the community, the staff that works there or the patients they serve, show that HCA cares nothing about their patients or the community," said Noblitt. "The little people get crushed under big corporate greed again. It's messed up."¹²⁷

Mass Exodus of Physicians Following HCA's Takeover of Mission

What's more, according to the *Asheville Watchdog*, more than 200 physicians have left the Mission Health System following HCA's takeover in 2019.¹²⁸ Mission physicians reportedly departed the system for a range of reasons, including frustrations with declining patient care, understaffing, the imposition of HCA's corporate metrics, and HCA's focus on profits above all else.¹²⁹ Here is what some current and former Mission doctors had to say about HCA's approach to physician relationships and patient care:

- "Unfortunately, the change in ownership has shifted this system's priority away from the health of Western North Carolina to the health of the stockholders."¹³⁰ HCA was "Restructuring physician contracts to where it's fully based on how many patients you see and how high of a level you bill them versus focusing some on quality outcomes and some on productivity ... the portion of pay that was for quality metrics and things like that was significantly decreased and the focus on how many patients you were seeing was increased."¹³¹ — Dr. Kate Rasche, Family Medicine
- "HCA 'was run primarily by doctors and nurses and now it's being run by businessmen.' And, 'Patient suffering is off their (HCA management's) radar.'¹³² — Dr. Martin Palmeri, Oncology

¹²³ Mackenzie Wicker. "Mission Health to stop primary care services in Biltmore Park, Candler." Asheville Citizen Times. Sept. 16, 2020. -

<https://www.citizen-times.com/story/news/local/2020/09/16/mission-health-stop-primary-care-services-biltmore-park-candler/5818247002/>

¹²⁴ Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. -

<https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

¹²⁵ Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. -

<https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

¹²⁶ Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. -

<https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

¹²⁷ Mackenzie Wicker. "Mission Health: What has changed under HCA Healthcare and why?" Asheville Citizen Times. Sept. 27, 2020. -

<https://www.citizen-times.com/story/news/local/2020/09/27/mission-health-and-hca-what-has-changed-and-why/5852325002>

¹²⁸ Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog. March 23, 2022,

<https://awatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/>

¹²⁹ Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog. March 23, 2022,

<https://awatchdog.org/how-many-doctors-have-left-mission-hca-wont-say>

¹³⁰ Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. -

<https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

¹³¹ Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. -

<https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

¹³² Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog. March 23, 2022,

<https://awatchdog.org/how-many-doctors-have-left-mission-hca-wont-say>

- Many patients are skeptical “that HCA has their best interests in mind as a for-profit company.”¹³³
— Dr. Ben Aiken, Primary Care
- An anonymous doctor told the Asheville Watchdog that nurses in the emergency room are caring for more patients while management concentrates on meeting minimum standards and “metrics.” “When HCA came in, there were so many emails on metrics,” he said. “We’ve gone from providing amazing care to mediocre care.”¹³⁴

HCA's actions following its acquisition of Mission Health suggests that hospital consolidation by a company like HCA – which seemingly places a greater emphasis on profit above community needs – can alienate physicians, staff, and patients and deeply affect a community's access to care.

Conclusion

In closing, perhaps North Carolina Attorney General Josh Stein summed up these antitrust issues best with the following: “Lack of competition and inordinate market power can provide a health care provider with countless other ways to increase costs and harm consumers, especially in light of the complex, byzantine nature of our health care system.”¹³⁵ As such, we appreciate the efforts by Congressional leaders to take a closer look at these issues and we thank you for this opportunity to share our perspective.

¹³³ Barbara Durr and Sally Kestin, “How Many Doctors Have Left Mission? HCA Won’t Say,” Asheville Watchdog, March 23, 2022, <https://awlwatdog.org/how-many-doctors-have-left-mission-hca-wont-say>

¹³⁴ Barbara Durr and Sally Kestin, “How Many Doctors Have Left Mission? HCA Won’t Say,” Asheville Watchdog, March 23, 2022, <https://awlwatdog.org/how-many-doctors-have-left-mission-hca-wont-say>

¹³⁵ <https://info.ncdhhs.gov/dhsr/coneed/comments/2022/June/Buncombe-Acute-Care-Beds-Project-ID-B-12232-22-Mission-Hospital-Comments-by-AG-Josh-Stein.pdf>



TESTIMONY

ADDRESSING ANTICOMPETITIVE CONDUCT AND CONSOLIDATION IN HEALTHCARE MARKETS: THE ROLES OF STATE AND FEDERAL REGULATION AND ANTITRUST LAW

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US Senate Committee on the Judiciary, Subcommittee on Competition Policy, Antitrust, and Consumer Rights
Antitrust Applied: Hospital Consolidation Concerns and Solutions

May 19, 2021

Chair Klobuchar, Ranking Member Lee, and distinguished members of the Subcommittee on Competition Policy, Antitrust, and Consumer Rights.

We welcome the opportunity to submit a statement for the record that highlights key considerations in addressing anticompetitive conduct and consolidation in healthcare markets.¹

In this statement for the record, we will focus on three key points:

1. Consolidation in past decades has been a function of various state and federal regulations.
2. The Federal Trade Commission (FTC) has a long and successful track record of challenging anticompetitive mergers under current statutes and guidelines, but it is unable to prosecute all anticompetitive conduct in the healthcare sector owing to statutory restrictions on the FTC regarding nonprofit hospitals.
3. Legal reforms unrelated to antitrust are key to substantially improving healthcare competition.

CONSOLIDATION IN PAST DECADES HAS BEEN A FUNCTION OF VARIOUS STATE AND FEDERAL REGULATIONS

For the better part of the past three decades there has been a trend toward concentration in healthcare markets, especially hospital markets. In 1990, 65 percent of metropolitan areas had highly concentrated

¹ Alden Abbott's research focuses primarily on antitrust and competition policy. Kofi Ampaabeng specializes in curating data and generating policy-relevant insights from data.

hospital markets, and this number jumped to 77 percent in 2006.² Since the passage of the Affordable Care Act (ACA), there has been a significant increase in the pace of consolidation. As of 2019, 90 percent of all metropolitan area hospital markets were highly concentrated.³ When an industry is highly concentrated, it means there is enhanced market power for the dominant firms.

In the years leading up to the ACA's passage, approximately 50–60 hospital mergers were consummated per year.⁴ After the ACA was passed, there was a rapid spike in mergers, from 76 in 2010 to a high of 115 in 2017.⁵ This consolidation occurred amid no significant entry of new hospitals. In the mid-1990s there were approximately 5,000 hospitals in the United States, and by 2012 that number had been reduced to just greater than 2,200.⁶

This concentration alone is not necessarily concerning, but when viewed through the lens of a market concentration index, which measures the degree of concentration within a business sector in a defined geographical area, concern becomes more warranted. The Herfindal-Hirschman Index (HHI) is a measure of the concentration within a market. A number less than 1,500 indicates a sector that is unconcentrated; a number between 1,500 and 2,500 indicates a sector that is moderately concentrated; and a number greater than 2,500 indicates a sector that is highly concentrated.⁷ The average HHI in relevant hospital markets in the United States rose from 2,054 in 2000 to 2,676 in 2017, an increase of 622.⁸

This increase in concentration has been associated with higher prices. Between 2007 and 2011 the price of care for those with private insurance rose by 6 percent when merging hospitals were geographically close.⁹ Between 2013 and 2016 the proportion of price increases associated with concentration jumped to 9 percent in California.¹⁰ Merging hospitals that were geographically distant—i.e., not within the same market—did not increase prices. The attorney general of Massachusetts has found similar, geographically dependent results,¹¹ and other studies have reported even larger price increases of 14 percent.¹²

The ACA's role in these increases in price and consolidation is causal, mediated by ACA-generated federal subsidies. Much of hospitals' expenses are fixed. Regardless of how many patients a hospital sees, it must procure and maintain infrastructure to care for them.¹³ Public spending under Medicare and Medicaid favors the generalized care that is available at larger hospital centers. Reimbursement for

2. Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs* 36, no. 9 (2017): 1530.

3. Fulton, "Health Care Market Concentration."

4. American Hospital Association, *Trendwatch Chartbook 2016*, 2016, 27, chart 2.9; Lawrence E. Singer, "Considering the ACA's Impact on Hospital and Physician Consolidation," *Journal of Law, Medicine, and Ethics* 46, no. 4 (2018): 913.

5. Singer, "Considering the ACA's Impact," 914.

6. Christopher M. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation" (Backgrounder No. 2928, Heritage Foundation, Washington, DC, August 1, 2014), 3.

7. US Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, August 2010.

8. Lijia Zheng, "The Pace, Driving Force, and Impact of Hospital Mergers After ACA," in *2020 4th International Conference on Economics, Management Engineering and Education Technology*, ed. Suling Wang (Beijing, China: Francis Academic Press, 2020).

9. Dalia Sofer, "The Cult of the Colossus: A Dramatic Rise in Hospital Mergers and Acquisitions," *American Journal of Nursing* 120, no. 5 (2020): 19–20.

10. Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices," *Health Affairs* 37, no. 9 (2018): 1414.

11. Office of the Attorney General of the Commonwealth of Massachusetts, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17*, October 2019.

12. Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (2018): 139–52.

13. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation," 9.

many procedures is higher at these large hospital centers than at smaller providers.¹⁴ In states where Medicaid expanded, there was an increase in operating margin of large hospital systems.¹⁵

This increase in operating margin and increase in subsidies for large hospital systems causes consolidation. Smaller providers not affiliated with hospital systems are reimbursed at a lower rate for the same services, causing their operating margin to be smaller. Even though these smaller providers treat fewer patients, their fixed costs per patient are similar.¹⁶ For smaller providers, integrating with a large hospital system can immediately increase their profitability and operating margin without changing their quality of care.

Finally, implementation of the Accountable Care Organization (ACO) standard has created an incentive to consolidate. The ACO system, whose formation was encouraged by the ACA, is seen as a one-stop shop for all patient healthcare needs.¹⁷ This packaging of services for Medicare enrollees allows hospitals to be reimbursed for a wide array of services, regardless of which services are provided to patients.¹⁸ If a patient requires less care than the ACO standard dictates, then the hospital can pocket some of the leftover funds. However, when a patient is incredibly ill, the physician may be reimbursed only at a flat rate, according to the ACO standard, regardless of how much care was provided.¹⁹ This increase in risk for working with Medicare patients is too great for some single practitioners, which drives hospitals to consolidate into larger systems that can bear the risk on their balance sheets.

Besides the ACA, various state laws create barriers to entry and antitrust immunity for health sector consolidations, such as laws that require certificates of need (CON) and certificates of public advantage (COPA). CON laws generally require healthcare providers to obtain approval from a state agency before initiating construction projects and capital expenditures related to healthcare. CON laws, originally championed by the federal government, aim to slow the rising cost of healthcare by preventing the unnecessary duplication of services and by determining whether a community really needs the proposed capital expenditure.²⁰ Evidence shows that CON laws have restricted entry, constrained growth, and reduced capacity, leading to a more concentrated healthcare market.²¹ Therefore, Congress repealed the federal mandate for states to establish CON laws.²² Additionally, The FTC and US Department of Justice have concluded that CON laws “can prevent the efficient functioning of health care markets” and thus have recommended that states repeal or retrench them.²³ Yet in spite of all the

14. Pope, 9.

15. Michael Rosko et al., “Predictors of Hospital Profitability: A Panel Study Including the Early Years of the ACA,” *Journal of Health Finance* 44, no. 3 (2016): 1–23.

16. Rebecca R. Roberts, et al., “Distribution of Variable vs Fixed Costs of Hospital Care,” *JAMA* 281, no. 7 (1999): 644–49.

17. Robert Fifer, “Health Care Economics: The Real Source of Reimbursement Problems,” *American Speech-Language-Hearing Association*, July 2016, <https://www.asha.org/Articles/Health-Care-Economics-The-Real-Source-of-Reimbursement-Problems/>.

18. Pope, “How the Affordable Care Act Fuels Health Care Market Consolidation,” 9.

19. Pope, 16.

20. “CON-Certificate of Need State Laws,” National Conference of State Legislatures, December 1, 2019, <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

21. Jon M. Ford and David L. Kaserman, “Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry,” *Southern Economic Journal* 59, no. 4 (1993): 790; Examining the Impact of Health Care Consolidation, Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 115th Cong. 12 (2018) (statement of Martin Gaynor, E.J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University).

22. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), repealed, Pub. L. No. 99-660 § 701, 100 Stat. 3799 (1986).

23. Federal Trade Commission and US Department of Justice, *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 2016, 1. Specifically, CON laws undermine competition by (1) “creat[ing] barriers to entry and expansion, limit[ing] consumer choice, and stifl[ing] innovation”; (2) enabling “incumbent firms seeking to thwart or delay entry or expansion by new or existing competitors”; and (3) “deny[ing] consumers the benefit of an effective remedy following the consummation of an anticompetitive merger” (as happened in the FTC’s Phoebe Putney hospital merger case). The Mercatus Center has produced

evidence that CON laws do not slow down the rise in healthcare costs, 35 states still had them, as of January 2020.²⁴

COPA laws exempt organizations from antitrust laws “in return for commitments to make public benefit investments and control healthcare cost growth.”²⁵ The FTC currently is studying the effect of COPAs on prices and quality of, access to, and innovation in healthcare services.²⁶ As a general proposition, targeted antitrust immunity, as in the case of COPAs, encourages anticompetitive collaborations (including, of course, anticompetitive consolidations) that harm consumer welfare.²⁷

Some studies have shown that when hospitals consolidate, the wages of nonphysician workers grow at a slower rate.²⁸ Because state licensing laws also limit the ability of healthcare workers to move across state lines, most workers have no choice but to stay rather than move to other states. Some states have attempted to improve the mobility of healthcare workers by joining licensure compacts, which allow healthcare workers to easily move between states. However, these compacts do not cover all professions and not all 50 states participate, leaving workers vulnerable.

At the same time that federal regulations encourage hospital consolidation, state and local laws prevent new hospitals and other healthcare facilities from being built, and patients ultimately suffer as prices rise and quality remains stagnant at best. It is important that the committee reviews the role of state and local laws that further restrict competition in healthcare.

THE FTC HAS A LONG AND SUCCESSFUL TRACK RECORD OF CHALLENGING ANTICOMPETITIVE MERGERS UNDER CURRENT STATUTES AND GUIDELINES, BUT IT IS UNABLE TO PROSECUTE ALL ANTICOMPETITIVE CONDUCT IN THE HEALTHCARE SECTOR OWING TO STATUTORY RESTRICTIONS REGARDING NON-PROFIT HOSPITALS

Between 2000 and 2018, nearly 49 percent of all merger enforcement actions taken by the FTC related to the healthcare sector.²⁹ These actions followed the FTC’s substantial refinement of its approach to assessing market definition and nonprofit anticompetitive effects in hospital merger reviews.³⁰ Before a December 2020 district court decision not to enjoin the merger of two Philadelphia area hospitals, the

substantial scholarship documenting the economically harmful features of CON laws. Matthew D. Mitchell, Ann Philpot, and Jessica McBirney, “The State of Certificate-Of-Need Laws in 2020,” Mercatus Center at George Mason University, February 19, 2021, <https://www.mercatus.org/publications/healthcare/con-laws-2020-about-update>.

24. Mitchell, Philpot, and McBirney, “The State of Certificate-Of-Need Laws in 2020.”

25. Amanda Hunt, “When Antitrust Fails: Limiting Consumer Harm from Healthcare Consolidation” (Easy Explainer No. 16, Altarum Institute, October 2019). For a deeper look into the harmful effects of COPA statutes, see Federal Trade Commission, *Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System*, September 2020.

26. Federal Trade Commission, “FTC to Study the Impact of COPAs,” press release, October 21, 2019, <https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas>.

27. Christine A. Varney, “Antitrust Immunities” (remarks, 11th Annual Conference of the American Antitrust Institute, Washington, DC, June 24, 2010); Examining the Impact of Health Care Consolidation, Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 115th Cong. 12 (2018) (statement of Martin Gaynor, E. J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University).

28. Elena Prager and Matt Schmitt, “Employer Consolidation and Wages: Evidence from Hospitals,” *American Economic Review* 111, no. 2 (2021): 397–427.

29. Nathaniel E. Wilson, “Editor’s Note: Some Clarity and More Questions in Health Care Antitrust,” *Antitrust Law Journal* 82, no. 2 (2019): 435. Of the 154 merger enforcement actions, 75 relate to healthcare.

30. Rebecca Kelly Slaughter, “Antitrust and Health Care: Providers Policies to Promote Competition and Protect Patients” (remarks, Antitrust and Health Care: Providers Policies to Promote Competition and Protect Patients, Center for American Progress, Washington, DC, May 14, 2019), 3.

FTC won every hospital merger case it undertook for the better part of two decades.³¹ This win rate is evidence of diligent analysis on the part of the FTC, demonstrating its ability to combat anticompetitive hospital mergers successfully under existing legal authority.

More generally, current statutory antitrust law standards are fully equal to the task of promoting competition and consumer welfare. Therefore, it would be inappropriate to recommend a broad overhaul of antitrust statutes to expand the scope and scale of FTC antitrust enforcement. Existing agency guidance, including the 2020 *Vertical Merger Guidelines*,³² provides ample support for appropriate, evidence-based, economically sound enforcement. Overhauling antitrust statutes would transform enforcement norms and judicial analysis, generating enormous private-sector uncertainty. Such uncertainty would deter innovation, harming consumers and the American economy. The claims by some that broad-based sweeping changes are needed owing to reduced competition in the American economy and ineffective antitrust enforcement have not been proven.³³

Antitrust enforcement focuses on the specific facts of a case to determine whether conduct in the instance at hand is likely to undermine competition and reduce consumer welfare. Proposals that seek to broadly condemn a certain practice risk rendering illegal (and deterring businesses from pursuing) specific beneficial manifestations of that practice. Before legislating, Congress should seriously weigh whether, in attacking a particular practice, the benefits of eliminating targeted harmful conduct will likely be outweighed by the costs of condemning and deterring specific instances of such conduct that could have benefited consumers through innovation, among other things.

However, as one of us recently discussed in previous testimony before the House Subcommittee on Antitrust, Commercial, and Administrative Law,³⁴ fully preserving the FTC's ability to protect consumer welfare requires reforms to the FTC's nonmerger enforcement capabilities. Under Section 7 of the Clayton Antitrust Act of 1914, the FTC can challenge anticompetitive mergers whether the hospitals are for profit or nonprofit. The same cannot be said for nonmerger anticompetitive conduct. The Federal Trade Commission Act of 1914 limits the ability of the FTC to pursue action against nonprofit corporations.³⁵

31. David Maas and Douglas E. Litvack, "FTC's Hospital Merger Win Streak Ends," Davis Wright Tremaine, LLP, March 4, 2021, <https://www.dwt.com/insights/2021/03/ftc-hospital-merger-defeat>. The FTC decided by a 4-0 vote not to appeal this decision.

32. US Department of Justice and Federal Trade Commission, *Vertical Merger Guidelines*.

33. Esteban Rossi-Hansberg, Pierre-Daniel Sarte, and Nicholas Trachter, "Diverging Trends in National and Local Concentration" (working paper no. 16-15R, Federal Reserve Bank of Richmond, Richmond, VA, April 29, 2020). The authors find that the expansion of national firms into local markets has been a factor both in increasing concentration at the national level and in decreasing concentration at the local level. Carl Shapiro, "Antitrust in a Time of Populism," *International Journal of Industrial Organization* 61 (2018): 722. The author states that a table examining trends in the revenue share of the 50 largest firms (CR50) contained in a 2016 Council of Economic Advisers Report on competition and market power "is not informative regarding overall trends in concentration in well-defined relevant markets that are used by antitrust economists to assess market power; much less trends in competition in the U.S. economy." David Autor et al., "The Fall of the Labor Share and the Rise of Superstar Firms" (NBER Working Paper No. 23396, National Bureau of Economic Research, Cambridge, MA, May 2017). According to the authors, increases in concentration reflect a reallocation of output toward large, productive firms that could be the result of globalization and technological change, as opposed to weakened competition and lax antitrust enforcement. Gregory J. Werden and Luke M. Froeb, "Don't Panic: A Guide to Claims of Increasing Concentration," *Antitrust Magazine* 33, no. 1 (2018): 74-79.

34. Alden F. Abbott, "Lack of Resources and Lack of Authority over Nonprofit Organizations Are the Biggest Hindrances to Antitrust Enforcement in Healthcare" (Testimony before the US House Committee on the Judiciary, Subcommittee on Antitrust, Commercial, and Administrative Law, Mercatus Center at George Mason University, Arlington, VA, April 29, 2021).

35. Specifically, the FTC may enforce Section 5 of the Federal Trade Commission Act, which forbids "unfair methods of competition" against "persons, partnerships, or corporations." The Federal Trade Commission Act defines the term "corporation" as an entity "organized to carry on business for its own profit or that of its members," thereby placing a major obstacle in the path of FTC enforcement against nonprofits. To be sure, the FTC has asserted the power to act when nonprofit status has in effect been a sham device to shield actual for-profit activities. See *In re Ohio Christian College*, 80 F.T.C. 815, 1972 FTC LEXIS 223 (F.T.C. July 29, 1970). And a federal court recognized the FTC's authority over a nonprofit that acted in concert,

In September 2019 testimony before the Subcommittee on Competition Policy, Antitrust, and Consumer Rights, then-FTC Chair Joseph Simons stated, “We’re very interested in looking at unilateral conduct by hospitals, that are problematic under the antitrust laws. . . . But, generally when we do that, we find that they’re nonprofits, and we don’t have jurisdiction over them. . . . That’s another reason why we’ve been asking the Congress to eliminate our exemption for nonprofits.”³⁶

The FTC staff has profound expertise in healthcare markets, developed over decades. It is high time it be given statutory authority over nonprofit entities to enable it to apply this expertise fully to all aspects of healthcare antitrust enforcement.

MAJOR LEGAL REFORMS UNRELATED TO ANTITRUST ARE KEY TO IMPROVING THE EFFECTIVENESS OF HEALTHCARE COMPETITION

Although this hearing centers on antitrust and consolidation, the antitrust treatment of healthcare-related transactions is only the tip of the healthcare policy iceberg. Major improvements to the competitive condition of the healthcare sector require far more than enhanced antitrust enforcement.

We have already touched upon the manner in which the ACA, CON laws, and COPA laws have artificially promoted anticompetitive healthcare consolidation. A more far-reaching and comprehensive 2018 study by the US Department of Health and Human Services focused on (1) healthcare workforce and labor markets, (2) healthcare provider markets, (3) healthcare insurance markets, and (4) consumer driven healthcare.³⁷ Furthermore, the Mercatus Center at George Mason University continues to carry out far-reaching studies on American healthcare reform.³⁸ We commend to you the thoughtful comprehensive analyses and proposals discussed by the Department of Health and Human Services and Mercatus as you evaluate what should be done to enhance healthcare competition and consumer choice in the United States.

in profit-making activities, with a for-profit entity. See *FTC v. AmeriDebt, Inc.*, 343 F. Supp. 2d 451 (D. Md. 2004). Nevertheless, the FTC is, at best, severely hampered when it seeks to bring an enforcement action under Section 5.

36. Steven Porter, “Nonprofit Hospitals and Antitrust Enforcement: Should FTC Have Jurisdiction?,” *HealthLeaders*, September 17, 2019.

37. US Department of Health and Human Services, *Reforming America’s Healthcare System through Choice and Competition*, May 2018.

38. “Healthcare,” Mercatus Center at George Mason University, accessed May 18, 2021, <https://www.mercatus.org/tags/healthcare>.

May 19, 2021

Chair Alex Padilla
Committee on the Judiciary
Subcommittee on Immigration, Citizenship, and Border Safety
Washington, DC 20515

Ranking Member John Cornyn
Committee on the Judiciary
Subcommittee on Immigration, Citizenship, and Border Safety
Washington, DC 20515

Regarding Hearing Titled: “The Essential Role of Immigrant Workers in America”

Dear Chair Padilla and Ranking Member Cornyn:

Alianza Nacional de Campesinas (National Farmworker Women’s Alliance, “Alianza de Campesinas” herein) submits this statement for the record for the Senate Judiciary Subcommittee on Immigration, Citizenship, and Border Safety hearing entitled, “*The Essential Role of Immigrant Workers in America*”, held on May 12. On behalf of farmworker and rural-serving organizations, we write to express our strong support for a pathway to citizenship for our nation’s 11 million undocumented immigrants, including farmworker women and their families, as part of a just, equitable recovery from the COVID-19 pandemic.

Alianza de Campesinas is the first national farmworker women’s organization in the United States founded and led by farmworker women, and those who hail from farmworker families. A coalition of 15 grassroots, farmworker organizations across 11 states and the District of Columbia, Alianza de Campesinas advocates for the civil, constitutional, and human rights of our country’s more than 700k farmworker women, and other women workers, who form the backbone of our farm and food systems.

Despite being deemed “essential”, farmworker women and other workers laboring on the frontlines of this pandemic have not been extended essential protections and supports¹, including legal status. At least half² of our country’s nearly 3 million farmworkers are undocumented and live in constant fear of being of being separated from their families and communities. These anxieties are heightened among women farmworkers experiencing domestic violence³, sexual assault⁴, and other abuses⁵ who fear deportation for reporting their abusers, thereby undermining their access to safety and justice.

¹ Alianza Nacional de Campesinas and Rural Coalition, “[Pandemic Response to Protect and Increase Resilience in the Food and Farm System](#),” August 31, 2020.

² U.S. Department of Agriculture, Economic Research Service, [Farm Labor: Legal Status and Migration Practices of Hired Crop Farmworkers](#), April 22, 2020.

³ Runge, Robin R. “[Failing to Address Sexual and Domestic Violence at Work: The Case of Migrant Farmworker Women](#),” American University Journal of Gender Social Policy and Law 20, vol 20, no. 4, 2012, pp. 871-897.

⁴ Oxfam America, [Working in Fear: Sexual Violence Against Women Farmworkers in the United States: A Literature Review](#), 2015.

⁵ Southern Poverty Law Center, [Injustice On Our Plates](#), November 8, 2010.

The pandemic has exposed and exacerbated the vulnerabilities and inequities in our farm and food systems - our collective health, security, and well being depends on the critical work of farmworker women and other women workers. It is therefore imperative that Congress include a pathway to citizenship for farmworker women and their families as part of the nation's economic recovery efforts. As Manuela Ramirez, organizer with our member organization Lideres Campesinas and former farmworker who worked in the fields for 20 years, shared:

"[We] know the problems that farmworker families are experiencing due to the lack of legal status and it's heartbreaking to know that during this pandemic, these problems have worsened with the many abuses they suffer in the workplace, such as wage theft and lack of respect for their rights. This is why I support any law that defends and legalizes these farmworkers so that they can have a dignified life in this country!"

Accordingly, Alianza de Campesinas supports and pushes for the following legislative proposals:

- The U.S. Citizenship Act of 2021 ([S.348/H.R. 1177](#)), which would provide a pathway to citizenship for our country's approximately 11 million undocumented immigrants, including an expedited path for farmworkers, people with Deferred Action for Childhood Arrivals (DACA), and those with Temporary Protected Status (TPS) or Deferred Enforced Departure (DED). The bill advances significant reforms to our immigration system by prioritizing family unity, promoting immigrant and refugee integration, expanding humanitarian protection channels, recognizing migrant workers as fundamental members of our communities, and strengthening protections for survivors and other vulnerable populations.
- The Citizenship for Essential Workers Act of 2021 ([S.747/H.R.1909](#)), which would create an expedited pathway to citizenship for nearly 5 million undocumented essential workers and their families. The bill would include workers in health care, agriculture, construction, food, energy, emergency response, care-giving, and other essential critical infrastructure sectors.

Thank you for your consideration of this statement. If you have any questions, please contact Maria De Luna, National Policy and Advocacy Coordinator, at mariadeluna@campesinasunite.org and Mily Trevino-Sauceda, Executive Director, at mily@campesinasunite.org.

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Promoting, educating, and advocating for exceptional patient-centered care through physician leadership.

**Physician Hospitals of America
Statement for the Record
Subcommittee on Antitrust, Commercial, and Administrative Law
Committee on the Judiciary
Hearing on “Treating the Problem: Addressing Anticompetitive Conduct and Consolidation in
Health Care Markets”
April 29, 2021**

Physician Hospitals of America (PHA) is pleased to submit this statement for the record for the April 29, 2021 hearing on health care market consolidation before the Subcommittee on Antitrust, Commercial, and Administrative Law. PHA promotes, educates, and advocates for exceptional patient-centered care through physician leadership, on behalf of our physician-owned hospital (POH) members across the United States.

Physician-led hospitals represent leaders in hospital care, offering the highest quality of care at lower cost than their competitors, and filling a critical need for health care access. POHs also provide a competitive alternative for patients who want the choice of where they receive care, and preserve the doctor-patient relationship by giving physicians greater autonomy in patient care decisions.

With growing consolidation in hospital markets, competition from physician-owned hospitals could offer communities and patients a market-based solution to address rising costs while advancing high quality services. A recent *Health Affairs* article authored by experts, including physician members of the American Medical Association, American Academy of Orthopaedic Surgeons and American College of Cardiology,¹ described the lack of competition in hospital markets, and cited the “well-documented, specific harms of provider consolidation.” The authors warned that consolidation leads to a “lack of quality benefits,” worse patient experiences, “physician burnout due to a loss of control over the practice environment, and higher hospital prices driving rising insurance premiums and ultimately rising costs to consumers.”

Similar findings were highlighted by the Medicare Payment Advisory Commission (MedPAC) in its March 2020 analysis of health care consolidation, which found that most hospital markets are dominated by a single hospital system that had more than a 50% share of discharges. MedPAC added that hospital consolidation “permits hospitals to leverage higher prices from commercial payers,” and emphasized that “commercially insured patients appear to pay higher prices for care and higher prices for insurance in consolidated markets.” The Commission also found that hospital acquisition of physician practices “increases Medicare spending” and financial liability for Medicare beneficiaries.

Since enactment of the Affordable Care Act (ACA), physician-led hospitals have been severely restricted in their ability to offer health care competition by providing essential services to their

¹ “Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals,” *Health Affairs*, April 12, 2021, <https://www.healthaffairs.org/doi/10.1377/hblog20210408.980640/full/>. The article represents the personal views of the authors.

communities. Section 6001 of the ACA placed an effective moratorium on opening and expanding POHs, which halted the ability of physician-led hospitals to expand nationwide.

The expert authors of the April 2021 *Health Affairs* article listed the initial damaging consequences of the ACA POH prohibition on competition and investment:

- 45 hospital expansion projects, representing over \$275 million in economic activity, were stopped; and
- Over 75 new hospitals that were planned or under development, representing \$2.2 billion in economic losses, were terminated.

Furthermore, the *Health Affairs* authors highlight growing evidence about the value of the physician-led hospital model. They emphasize the benefits of “integrated, coordinated care delivery” seen with certain self-referral models, including:

- “one-stop shopping,”
- “improved sharing of clinical information,” and
- “an improved consumer experience of care delivery.”

The *Health Affairs* authors also warned that the COVID-19 pandemic has worsened the competitive environment for health care consolidation, while the POH prohibition also has consequences for health care delivery in a public health emergency. According to the authors, the ACA prohibition reduces the potential flexibility POHs offer from increased hospital bed capacity “in a country that faced pandemic-driven shortages of hospital and intensive care unit beds.

In fact, the value of physician-owned hospitals can be seen clearly in the responses by PHA members to the limited temporary waiver offered by the Centers for Medicare & Medicaid Services (CMS) to enable POHs to increase hospital surge capacity during the public health emergency. Physician-led hospitals have stepped up to offer critical services to patients, including: directly treating COVID-19 infected patients; providing surgical services to relieve other hospitals that are dealing with a COVID surge; adding ICU capacity; adding other capacity to assist their region/ community respond to patient needs during the pandemic; and offering COVID-19 testing, among other services.

As Congress seeks answers to reduce the burden of spiraling health care costs on Medicare, patients, and other public and private programs and payers, physician-led hospitals urge Congress to allow us to be part of the solution by enacting H.R. 1330, the Patient Access to Higher Quality Health Care Act of 2021. This bipartisan bill authored by Reps. Michael Burgess, M.D. (R-TX) and Vicente Gonzalez (D-TX) would repeal the ACA ban on physician-owned hospitals and advance competition, high quality patient care and improved health care efficiencies.