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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Education and the Workforce

Subcommittee on Health, Employment, Labor, and Pensions

of the

U.S. House of Representatives

"Competition and Transparency: The Pathway Forward For a Stronger Health Care Market"

June 21, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions examines a number of ways to strengthen the health care market.

MERGERS AND ACQUISITIONS HELP HOSPITALS MANAGE CURRENT FINANCIAL PRESSURES

Hospitals and health systems have faced historic challenges in the last several years. Mergers and acquisitions are important tools that some hospitals use to manage financial pressures and increase access to care for patients.

A recent report released by the AHA details the extraordinary financial pressures continuing to affect hospitals and health systems, as well as access to patient care. The

report found expenses across the board saw double-digit increases in 2022 compared to pre-pandemic levels, including for workforce, drugs and medical supplies and equipment. Hospitals and health systems have seen input cost increases for other essential operational services, as well, such as IT, sanitation, facilities management, and food and nutrition.

In addition, a major source of financial pressure for hospitals are the costs of complying with a complex web of local, state and federal regulations, excessive commercial payer administrative requirements, and chronic underpayments by the Medicare and Medicaid programs. It is well documented that neither Medicare nor Medicaid covers the cost of caring for its beneficiaries, and hospitals often struggle to make up for these financial losses. Exacerbating this pressure is the fact that Medicare and Medicaid account for most hospital utilization. In fact, 94% of hospitals have 50% of their inpatient days paid by Medicare and Medicaid, and more than three quarters of hospitals have 67% Medicare and Medicaid inpatient days.[1]

Merging with a hospital system can help some hospitals ease these financial burdens and improve patient care by providing scale to help reduce costs associated with obtaining medical services, supplies and prescription drugs, and enable health systems to reduce other operational costs.

Perhaps most important, mergers can allow struggling hospitals to remain open. Without mergers, some hospitals could shutter, patients could lose access to care and communities could suffer. This is particularly important for rural hospitals, where mergers and acquisitions have played a critical role in preserving access to care for patients and communities. An AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 showed that even though most rural community hospitals are affiliated with a health system, less than half of the hospitals that have been closed were system affiliated. This would indicate that of all the challenges facing rural hospitals that contribute to closures, being part of a system is likely not one of them. Health systems typically acquire rural hospitals when these hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[2]

BENEFITS OF HOSPITAL MERGERS AND ACQUISITIONS

Hospital mergers and acquisitions can bring measurable benefits to patients and communities, including lower health care costs, improved quality and better access to health care.

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[1] https://www.aha.org/system/files/media/file/2022/05/fact-sheet-majority-hospital-payments-dependent-on-medicare-or-medicaid-congress-continues-to-cut-hospital-reimbursements-for-medicare.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/

Lower Health Care Costs

Acquisitions and mergers can help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Mergers with larger hospital systems can provide community hospitals the scale and resources needed to decrease costs by increasing administrative efficiencies and reducing redundant or duplicative services. A Charles River Associates analysis for the AHA shows that hospital acquisitions are associated with a statistically significant 3.3% reduction in annual operating expenses per admission at acquired hospitals, along with a 3.7% decrease in net patient revenue per adjusted admission.[3]

The same report shows that additional substantial savings come from improved IT systems and advanced data analytics. Consolidated hospitals can often better invest in IT infrastructure for both clinical and financial data that can be used to identify best practices for more cost-effective, integrated and streamlined care. These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals.

Improved Quality

Emerging research has demonstrated a clear association between consolidation and quality improvement. For example, one study found that a full-integration approach is associated with improvements in mortality and readmission rates, among other quality and outcome improvements.[4] Another study found significant reductions in mortality for a number of common conditions — including acute myocardial infarction, heart failure, acute stroke and pneumonia — among patients at rural hospitals that had merged or been acquired.[5]

Better Access to Care

Mergers and acquisitions can help some hospitals improve access to care by expanding the types of specialists and services available to patients. According to an analysis by the health care consulting firm Kaufman Hall, nearly 40% of affiliated hospitals added one or more services post-acquisition. Almost half of all hospitals acquired by an academic medical center added one or more service. Patients at hospitals acquired by academic medical centers or large health systems also gained improved access to tertiary and quaternary services.[6]

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open, thereby averting bankruptcy or even closure. When

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[3] https://www.aha.org/guidesreports/2021-08-18-hospital-merger-benefits-econometric-analysis-revisited-executive-summary
[4] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652
[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342
[6] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf

hospitals become part of a health system, the continuum of care can be strengthened for patients and the community, resulting in better care and decreased readmission rates.

This is particularly true in rural and underserved communities. Partnerships, mergers or acquisitions can be a means for creating more cohesive care, making it easier for patients to access specialists or services in the acquiring system. In this way, consolidation can ensure that care remains in the community.

INSURERS LEVERAGE THEIR VERTICAL AND HORIZONTAL MARKET POWER

The AHA appreciates that the subcommittee is examining various aspects of the health care industry in this hearing. To help reduce prices and increase quality, we urge the subcommittee to review how large, national commercial insurers have affected the health care system through rapid consolidation, particularly the increased vertical and horizontal integration that the commercial insurance market has experienced in recent years. For example, according to the Medicare Payment Advisory Commission (MedPAC), although initially thought to bring down costs, the vertical consolidation of insurers with providers (such as a nationally dominant Medicare Advantage plan purchasing large physician practices throughout the country) may not generate taxpayer savings.[7] Additionally, earlier this month the USC Schaeffer Center for Health Policy and Economics found that overpayments to Medicare Advantage plans now exceed 20% or $75 billion annually.[8] This example illustrates broader consolidation concerns within the commercial insurance market — where certain commercial insurers today rank in the top seven of the Fortune 500 list of largest companies by revenue. It also underscores the urgent need for reform.

Hospitals and health systems face significant pressure from these health insurance companies and private equity firms, which are leveraging their market power to drive up hospital and health system costs. For example, in nearly half of all markets, a single health insurer controls at least 50% of the commercial market.[9] Health insurers can use this market power to implement policies that compromise patient safety and raise costs, such as prior authorization delays, denying medically necessary coverage, or forcing patients to try potentially ineffective treatments or therapies.[10]

Moreover, commercial insurers have spent billions of dollars acquiring physician practices and other sites of care, amassing major market power through vertical

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[7] https://www.beckerspayer.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html
[8] https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments/
[9] https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-care-research
[10] https://www.aha.org/white-papers/2022-07-28-commercial-health-plans-policies-compromise-patient-safety-and-raise-costs

integration and steering patients to sites of care that they increasingly own through insurance benefit design that may not align with the best interests of patients.

UnitedHealth, under its subsidiary Optum, has acquired, for example, Crystal Run, Kelsey-Sebold and Atrius Health in the past three years and is now the largest employer of physicians nationwide, with over 70,000 employed or affiliated physicians.[11] In 2023 alone, CVS Health has announced plans to spend over $15 billion to acquire both Signify Health and Oak Street. Studies have shown that highly concentrated insurer markets are associated with higher premiums and that insurers are not likely to pass on to consumers any savings achieved through lower provider rates.[12] Though many contend that insurers like UnitedHealth Group (over $324 billion in revenue in 2022, covering over 46 million Americans) and Elevance (over $155 billion in revenue over the same period, covering over 47 million Americans) are helpless in their dealings with local hospitals and health systems, that is far from the truth.

MEDICARE SITE-NEUTRAL PAYMENT REDUCTIONS

The AHA strongly opposes additional site-neutral payment policies and appreciates the opportunity to clarify that the notion that hospitals engage in "dishonest billing" practices to optimize higher reimbursement rates is inaccurate and intentionally misleading. Hospitals cannot lawfully obfuscate the location of care delivery on their bills. Hospitals and other providers bill according to federal regulations, which require them to bill all payers — Medicare, Medicaid and private payers — using codes that indicate the location of where the service is provided. Additionally, current Medicare regulations require that beneficiaries who are treated in an off-campus hospital outpatient department (HOPD) receive a notification of their expected financial obligations and be informed that they will receive bills from both the doctor and hospital. This is not "dishonest billing" — it is simply following current federal regulations.

Existing site-neutral payment cuts have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries. According to MedPAC, overall Medicare hospital margins were negative 6.3% in 2021 after accounting for temporary COVID-19 relief funds. Without these funds, the overall Medicare margin for 2021 remained depressed at negative 8.2% after hitting a staggering low of negative 12.3% in 2020. On average, Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. Moreover, overall median hospital operating margins were negative throughout 2022 and into the beginning of 2023. Site-neutral cuts have already contributed to these shortfalls and any further expansion of these policies will exacerbate this situation and threaten patients' access to quality care.

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[11] https://www.beckerspayer.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html
[12] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548

Site-neutral policies also fail to account for the fundamental differences between HOPDs and other sites of care. The cost of care delivered in hospitals and health systems takes into account the unique benefits that they provide to their communities. This includes the investments made to maintain standby capacity for natural and man-made disasters, public health emergencies and unexpected traumatic events, as well as deliver 24/7 emergency care to all who come to the hospital, regardless of ability to pay or insurance status. This standby role is built into the cost structure of hospitals and is supported by revenue from direct patient care — a situation that does not exist for any other type of provider. Expanding site-neutral cuts to HOPDs and the outpatient services they provide would endanger the critical role they play in their communities, including access to care for patients.

Furthermore, hospital facilities treat patients who are sicker and have more chronic conditions than those treated in physician offices or ambulatory surgical centers.[13] Hospitals are better equipped to handle complications and emergencies, but this often requires the use of additional resources that other settings do not typically provide. Hospital facilities also must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care.

Some groups have suggested that hospitals are acquiring off-campus physician practices so that the hospital can "flip the sign" and receive a higher Medicare reimbursement for providing a similar service. However, this is a deliberate misrepresentation of the facts. Under current law, any off-campus HOPD that was not billing Medicare before November 2015 is no longer paid at the hospital outpatient prospective payment system rate. Instead, this HOPD is already paid at a site-neutral rate under the Medicare physician fee schedule (PFS) for nearly all services it furnishes.

Site-neutral policies are based on the flawed assumption that PFS payment rates are sustainable rates for physicians. However, the truth is much different. According to the American Medical Association, "Medicare physician payment has effectively been cut 26%, adjusted for inflation, from 2001–2023. …The discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is encouraging market consolidation and threatens to drive physicians out of rural and underserved areas."[14]

Additionally, physicians are increasingly turning to hospitals, health systems and other organizations for financial security, and to focus more on clinical care and less on the administrative burdens and cost concerns of managing their own practice.[15] The

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[13] https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristics-report
[14] https://www.ama-assn.org/practice-management/medicare-medicaid/advocacy-action-leading-charge-reform-medicare-pay
[15] https://www.merritthawkins.com/uploadedFiles/merritt-hawkins-2021-resident-survey.pdf

administrative and regulatory burden associated with public and private insurer policies and practices, coupled with inadequate reimbursement rates, are important barriers to operating an independent physician practice. A recent survey of physicians conducted by Morning Consult on behalf of the AHA found that over 90% of physicians think it has become more financially and administratively difficult to operate a practice and that 84% of employed physicians reported that the administrative burden from payers had an impact on their employment decision.[16]

These factors are creating unworkable environments forcing physicians to prioritize administrative duties over caring for patients. The result is increased burnout among physicians, and there are no signs of it stopping anytime soon.[17] Physicians are searching for alternative practice settings that reduce these burdens and provide adequate reimbursement, while allowing them to focus on patient care. Hospitals and health systems are a natural fit to help physicians alleviate many of these burdens.

CONCLUSION

The AHA appreciates your efforts to examine how to create a stronger health care market and looks forward to continuing to work with you to address these important topics on behalf of patients and communities.

[16] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition
[17] https://www.uhcprovider.com/en/resource-library/news/2023/new-requirements-gastroenterology-services.html