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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Finance

of the

U.S. Senate

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

June 8, 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 to the Senate Finance Committee to provide the hospital perspective on how hospital mergers and acquisitions can expand and preserve access to quality care. Given the broad focus of this hearing, we provide comments on a number of policies aimed at increasing access to quality and affordable care.

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, medical supplies and equipment, as well as other essential operational services such as IT, sanitation, facilities management, and food and nutrition.

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

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

Perhaps most important, mergers can allow struggling hospitals to remain open. Without mergers, hospitals could shutter, patients could lose access to care, and communities could suffer. This is particularly important for rural hospitals, where mergers and acquisitions have played a critical role in preserving access to care for these patients and communities. An AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 shows that slightly more than half of the hospitals that closed were independent. Health systems typically acquire rural hospitals when these hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[2]

BENEFITS OF HOSPITAL MERGERS AND ACQUISITIONS

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

Lower Health Care Costs

Acquisitions and mergers can help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Mergers

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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/

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

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open, thereby averting bankruptcy or even closure. When hospitals become part of a health system, the continuum of care can be strengthened for patients and the community, resulting in better care and decreased readmission rates.

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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

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

Insurers Leverage Their Market Power

Hospitals and health systems face pressure from health insurance companies and private equity firms, which are leveraging their market power to drive up hospital and health system costs. For example, in nearly half of all markets, a single health insurer controls at least 50% of the commercial market.[7] Health insurers can use this market power to implement policies that compromise patient safety and raise costs, such as prior authorization delays, denying medically necessary coverage, or forcing patients to try potentially ineffective treatments or therapies.[8]

Moreover, commercial insurers and private equity have spent billions of dollars acquiring physician and other clinical practices. For example, UnitedHealth, under its subsidiary Optum, has acquired Crystal Run, Kelsey-Sebold and Atrius Health in the past three years. In 2023 alone, CVS Health has announced plans to spend over $15 billion to acquire both Signify Health and Oak Street.

Once acquired, they raise the rates that hospitals pay for these services, driving up costs. Studies have shown that highly concentrated insurer markets are associated with higher premiums and that insurers are not likely to pass on to consumers any savings achieved through lower provider rates.[9] Though many contend that insurers like UnitedHealth Group (over $324 billion in revenue in 2022, covering over 46 million Americans) and Elevance (over $155 billion in revenue over the same period, covering over 47 million Americans) are helpless in their dealings with local hospitals and health systems, the truth is far more complex.

MEDICARE SITE-NEUTRAL PAYMENT REDUCTIONS

The AHA strongly opposes additional site-neutral payment cuts, which threaten access to care. Existing site-neutral payment cuts have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries.

According to Medicare Payment Advisory Commission (MedPAC), overall Medicare hospital margins were negative 6.3% in 2021 after accounting for temporary COVID-19 relief funds. Without these funds, the overall Medicare margin for 2021 remained depressed at negative 8.2% after hitting a staggering low of negative 12.3% in 2020. On

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[7] https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-care-research
[8] https://www.aha.org/white-papers/2022-07-28-commercial-health-plans-policies-compromise-patient-safety-and-raise-costs
[9] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548

average, Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. Moreover, overall median hospital operating margins were negative throughout 2022 and into the beginning of 2023. Site-neutral cuts have already contributed to these shortfalls and any further expansion of these policies will exacerbate this situation and threaten patients' access to quality care.

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

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

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

Site-neutral policies are based on the flawed assumption that PFS payment rates are sustainable rates for physicians. However, the truth is much different. According to the American Medical Association, "Medicare physician payment has effectively been cut 26%, adjusted for inflation, from 2001–2023…The discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is encouraging market consolidation and threatens to drive physicians out of rural and underserved areas."[10]

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[10] https://www.ama-assn.org/practice-management/medicare-medicaid/advocacy-action-leading-charge-reform-medicare-pay

Additionally, physicians are increasingly turning to hospitals, health systems, and other organizations for financial security, and to focus more on clinical care and less on the administrative burdens and cost concerns of managing their own practice.[11] The administrative and regulatory burden associated with public and private insurer policies and practices, coupled with inadequate reimbursement rates, are important barriers to operating an independent physician practice. A recent survey of physicians conducted by Morning Consult on behalf of the AHA found that over 90% of physicians think it has become more financially and administratively difficult to operate a practice and that 84% of employed physicians reported that the administrative burden from payers had an impact on their employment decision.[12]

These factors are creating unworkable environments forcing physicians to prioritize administrative duties over caring for patients. The result is increased burn out among physicians with no signs of stopping anytime soon.[13] Physicians are searching for alternative practice settings that reduce these burdens and provide adequate reimbursement, while allowing them to focus on patient care. Hospitals and health systems are a natural fit to help physicians alleviate many of these burdens.

PRICE TRANSPARENCY

Hospitals and health systems are committed to empowering patients with all the information they need to live their healthiest lives. This includes ensuring they have access to accurate price information when seeking care. Hospitals and health systems are working to comply with both state and federal price transparency policies, which are varied and sometimes conflicting. At the federal level, these include:

- **Hospital Price Transparency Rule.** As of Jan. 1, 2021, hospitals are required to publicly post via machine-readable files five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. The rule also requires hospitals to provide patients with an out-of-pocket cost estimator tool or payer-specific negotiated rates for at least 300 shoppable services.
- **Good Faith Estimates.** The No Surprises Act requires hospitals and other providers to share Good Faith Estimates with uninsured/self-pay patients for most scheduled services. Future regulations will require unaffiliated providers to combine their estimates for an uninsured/self-pay patient into a single, comprehensive Good Faith Estimate for an episode of care.
- **Advanced Explanation of Benefits.** The No Surprises Act requires insurers to share advanced explanations of benefits with their enrollees, though

[11] https://www.merritthawkins.com/uploadedFiles/merritt-hawkins-2021-resident-survey.pdf
[12] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition
[13] https://www.uhcprovider.com/en/resource-library/news/2023/new-requirements-gastroenterology-services.html

implementation is currently on hold pending rulemaking. Hospitals will need to provide Good Faith Estimates to health insurers to operationalize this policy.

Over the past several years, the AHA has offered hospitals and health systems substantial education and engagement on price transparency policies and, more generally, the patient financial experience. This includes:

- Establishing a CEO-level Price Transparency Task Force that helped guide the AHA in developing policies and sharing best practices with respect to price transparency and patient billing;
- Conducting member education through multiple member webinars, bi-weekly "office hours" with AHA and Healthcare Financial Management Association technical experts, issue briefs, member case studies and podcasts;
- Providing an implementation guide for members, including implementation checklists and FAQs;
- Conducting a three-part member webinar series on health care consumer expectations and experiences with the consulting firm Kauffman Hall;
- Hosting a multi-stakeholder intensive design process, which included providers, payers, patient advocates, technology vendors and others, to develop solutions to improve the patient financial experience of care;
- Supporting Centers for Medicare & Medicaid Services' (CMS) efforts to establish voluntary sample formats that hospitals may use to meet the federal requirement to make certain standard charges publicly available through a machine-readable file by connecting the agency with experts from the hospital field; and
- Updating the AHA's Patient Billing Guidelines, which include a focus on helping patients access information on financial assistance.

Hospital Price Transparency Rule

CMS has a process in place to ensure hospital compliance with the Hospital Price Transparency Rule through an internal audit process and by responding to public complaints and reviewing third-party compliance assessments. The agency found that in 2022, 70% of hospitals complied with both components of the Hospital Price Transparency Rule, including the consumer-friendly display of shoppable services information, as well as the machine-readable file requirements. This is an increase from 27% in 2021. Moreover, when looking at each individual component of the rule, 82% of hospitals met the consumer-friendly display of shoppable services information requirement in 2022 (up from 66% in 2021) and 82% met the machine-readable file requirement (up from 30% in 2021).

These numbers show significant progress on the part of hospitals and health systems — while acknowledging the work that remains — in implementing these requirements. The lower compliance rate in 2021, however, should not be interpreted as a lack of hospital commitment to transparency. Instead, it reflects the incredible challenges hospitals were experiencing in 2020 and 2021 in addressing the most acute phases of the COVID-19 public health emergency, which strained hospitals' staffs and required the diversion of personnel and financial resources. As the pandemic phase of

COVID-19 wound down and hospitals were able to resume more standard operations, they are able to dedicate the resources necessary to build the full suite of price transparency tools.

In addition to the CMS report on compliance, we would draw your attention to a recent report from Turquoise Health that found about 84% of hospitals had posted a machine-readable file containing rate information by the end of first-quarter 2023, up from 65% the previous quarter.

Unfortunately, several third-party organizations repeatedly have claimed various rates of hospital compliance with federal price transparency policies that simply are not based on the facts. One such third-party — Patient Rights Advocate — released a paper that misconstrues, ignores and mischaracterizes hospitals' compliance with federal regulations. These groups ignore CMS' guidance on aspects of the rule, such as how to fill in an individual negotiated rate when such a rate does not exist due to patient services being bundled and billed together. In this instance, CMS has said a blank cell would be appropriate since there is no negotiated rate to include. Despite this, some outside groups still count any file with blank cells as "noncompliant." This is a fundamental misrepresentation of the rules and creates a stream of misinformation that is inaccurate and distracting to these important discussions and work.

Hospitals and health systems are eager to continue working toward providing the best possible price estimates for their patients. We ask Congress and the Administration to take the following steps to support these efforts, including:

- Review and streamline the existing transparency policies with a priority objective of reducing potential patient confusion and unnecessary regulatory burden on providers;
- Continue to convene patients, providers and payers to seek input on how to make federal price transparency policies as patient centered as possible; and
- Refrain from advancing additional legislation or regulations that may further confuse or complicate providers' ability to provide meaningful price estimates while adding unnecessary costs to the health care system.

CONCLUSION

The AHA appreciates your efforts to examine this issue and looks forward to continuing to work with you to address these important topics on behalf of patients and communities.