American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on the Budget

of the

U.S. House of Representatives

"Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation"

May 23, 2024

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) writes to share the hospital perspective on the ways hospital mergers and acquisitions can expand and preserve access to quality care.

MERGERS AND ACQUISITIONS HELP HOSPITALS MANAGE ONGOING FINANCIAL PRESSURES

Hospitals and health systems continue to experience significant financial pressures that challenge their ability to provide 24/7 care for the patients and communities they serve. Mergers and acquisitions allow some hospitals use to manage these pressures and increase access to care for patients.

A recent report released by the AHA details the extraordinary financial pressures continuing to affect access to patient care. In 2023, hospitals and health systems again sustained substantial expenses due to high costs for labor, drugs and supplies, ongoing workforce challenges and growing administrative burdens. At the same time, hospitals and health systems increasingly encounter the twin challenges of navigating onerous

commercial insurer practices that deny and delay payment for care provided to patients, while reimbursements from Medicare and Medicaid have failed to keep pace with mounting costs.

Merging with a hospital system can help some hospitals ease these financial burdens and improve patient care. Among other benefits, mergers are a tool that expand access to care for patients and allow hospitals to achieve the scale and increase the efficiency in purchasing medical services, supplies and prescription drugs. Mergers also help to reduce other operational costs through shared service models for departments like information technology (IT), human resources, finance and compliance. Hospitals and health systems should be permitted to pursue the type of arrangements that work best for their patients and community, including independent status, mergers or other partnerships.

BENEFITS OF HOSPITAL MERGERS AND ACQUISITIONS TO PATIENTS AND COMMUNITIES

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

Better Access to Care

Mergers and acquisitions also play a critical role in preserving access to care, especially for patients and hospitals in rural or other underserved communities. In particular, they 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.[1]

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open and serving their communities, thereby averting bankruptcy or even closure. When hospitals become part of a health system, the acquired hospital can more easily and cohesively access services and specialties available at other hospitals within the system. As a result, the continuum of care is strengthened for patients and the community, resulting in better care, increased access to specialty care and decreased readmission rates overall.

This is particularly true in rural and underserved communities. Health systems typically acquire hospitals in these communities when the hospitals are under financial distress. The results are demonstrable. Research has shown that rural hospitals are less likely to

[1] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf

close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[2]

Improved Quality

Emerging research has demonstrated a clear association between consolidation and quality improvement, indicating that hospital mergers and acquisitions may lead to better quality of care. 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.[3] This is due to quality improvement in part due to the integration of information technology and analytic-driven interventions, both made possible by leveraging the health systems resources in the acquired hospital. 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.[4]

Lower Health Care Costs

Mergers and acquisitions help reduce health care costs and are an effective tool for hospitals to operate more efficiently and cope with escalating costs. For example, 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.[5]

The same report shows that additional benefit come from improved IT systems and advanced data analytics. Merged 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 but scalable for larger systems.

INSURERS LEVERAGE THEIR MARKET POWER AT THE EXPENSE OF HOSPITALS AND HEALTH SYSTEMS

Hospitals and health systems face significant pressure from health insurance companies, which are leveraging their market power in a way that drives 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.[6] Commercial health insurers can — and do — use this market power to increase health insurance premiums as

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/
[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652
[4] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342
[5] https://www.aha.org/guidesreports/2021-08-18-hospital-merger-benefits-econometric-analysis-revisited-executive-summary
[6] https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-care-research

research has found that marketplace insurance premiums grow faster in areas with less insurer competition.[7] Commercial insurers also have used their market power to implement policies that compromise patient safety and raise costs for hospitals and patients alike, such as prior authorization delays, denying coverage for medically necessary care, or forcing patients to try potentially ineffective treatments or therapies.[8]

Due to burnout associated with commercial insurer policies like prior authorization and low reimbursement rates, most physicians are choosing to become employed rather than operate their own practices. While a disproportionate amount of attention has been placed on hospitals' acquisition of physician practices, large commercial insurers including CVS Health and UnitedHealth Group have recently spent billions of dollars acquiring practices. In fact, non-hospital entities including health insurers have acquired 90% of physician practices over the last five years.[9] We urge this committee to examine the costs and impact on health care access and affordability associated with this widespread acquisition of America's physicians by corporate health insurance companies.

We are concerned that the scope of major commercial insurers increases costs in the heath care system. 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.[10] We urge Congress to examine these issues and their impact on health care delivery for patients across the country.

MISGUIDED LEGISLATIVE PROPOSALS WILL REDUCE ACCESS TO CARE

We are concerned that certain legislative proposals that claim to increase competition in health care — including those that would create additional Medicare site-neutral payment cuts and ease growth restrictions on physician-owned hospitals — would jeopardize access to care for patients.

Site-neutral Payment Reductions

The AHA strongly opposes efforts to expand site-neutral payment cuts. Current Medicare payment rates appropriately recognize that there are fundamental differences between patient care delivered in hospital outpatient departments (HOPDs) compared to other settings. HOPDs provide important access to care for Medicare beneficiaries, many of which are more likely to be sicker and more medically complex than those

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[7] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0054
[8] https://www.aha.org/white-papers/2022-07-28-commercial-health-plans-policies-compromise-patient-safety-and-raise-costs
[9] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf
[10] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548

treated at physicians' offices, while also being held to stricter safety and regulatory requirements.

The cost of care delivered in hospitals and health systems considers the unique benefits they provide to their communities, which are not provided by other sites of care. This includes investments made to maintain standby capacity for natural and manmade disasters, public health emergencies and unexpected traumatic events, as well as delivering 24/7 emergency care to all who come to the hospital.

Existing site-neutral payment cuts have already created significant financial challenges for many hospitals and health systems. This is largely because Medicare underpays hospitals for the cost of caring for patients. The latest analysis shows that on average Medicare pays only 82 cents for every dollar of hospital care provided to Medicare beneficiaries, leaving hospitals with nearly $100 billion in Medicare shortfalls in 2022 alone. As a result, two-thirds of all hospitals reported negative Medicare margins in 2022. Any additional site-neutral cuts would exacerbate these financial challenges and further reduce access to essential care and services in communities.

Physician-owned Hospitals

America's community hospitals and health systems welcome fair competition, where health care entities can compete based on quality, price, safety and patient satisfaction. But physician-owned hospitals (POH) — where physicians select the healthiest and best-insured patients and self-refer those patients to facilities in which they have an ownership interest — represent the antithesis of competition.

POHs provide limited emergency services, are ill-equipped to respond to public health crises, and they increase costs for patients, other providers, and the federal government. The Congressional Budget Office, the Medicare Payment Advisory Commission and the Centers for Medicare & Medicaid Services all have concluded that physician self-referral leads to greater per capita utilization of services and higher costs for the Medicare program, among other negative impacts.

The AHA strongly opposes any changes to current law that would either expand the number of POHs or ease restrictions on the growth of existing facilities. Allowing more POHs in rural areas could be particularly destabilizing because these areas already have a limited patient population, with hospitals struggling to maintain fixed-operating costs.

GREATER COMMERCIAL INSURER ACCOUNTABILITY IS NEEDED

We urge Congress to address harmful practices from commercial insurers like prior authorization that lead to delays in patient care and increase costs and burdens to hospitals and health systems. Inappropriate denials for prior authorization and coverage of medically necessary services are a pervasive problem among certain plans in the Medicare Advantage program. This results in delays in care, wasteful and potentially

dangerous utilization of fail-first requirements for imaging and therapies, and other direct patient harms. These practices also add financial burden and strain to the health care system through inappropriate payment denials and increased costs to comply with plan requirements.

The AHA supports regulations and legislative solutions that streamline and improve prior authorization processes, including the Improving Seniors' Timely Access to Care Act, which would codify many of the reforms in the Interoperability and Prior Authorization final rule.

CONCLUSION

The AHA appreciates your efforts to examine this issue and looks forward to continuing to work with you.