Federation of American Hospitals®
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STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives
Budget Committee

Re: "Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation"
May 23, 2024

The Federation of American Hospitals (FAH) is pleased to provide the following feedback to the House Budget Committee in response to the May 23rd hearing entitled "Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation." We appreciate the Committee's focus on examining key drivers of consolidation in health care and we share the Committee's commitment to finding solutions to improve access to care while lowering health care costs.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. Tax-paying hospitals account for approximately 20 percent of community hospitals nationally.

The nation's health care landscape is, by necessity, shifting towards integrated systems and coordinated care, and mergers create sustainable market conditions for hospital care and services. This shift has occurred organically within the health care industry and has been further fueled by health care policies that promote a more patient-centered, value-based health care delivery and payment system. To help further the Committee's goal of understanding consolidation in health care, the Federation of American Hospitals offers the following comments.

Positive Effects of Hospital Integration

Hospital integration is in large part a response to inadequate, below the cost-of-care, public sector funding for hospitals, forcing hospitals to adapt to real-world economic and financial factors. The priority of any integration is to keep hospitals open, preserve or expand patients' access to care and continue to provide consistent, quality care around the clock to every patient treated in a

hospital. By pursuing mergers and other integration efforts, hospitals are able to maintain their presence in communities, share and scale up best practices, and protect patients' access to essential and affordable quality care, especially in rural communities.

Additionally, increasingly complex health care regulatory and administrative requirements such as those regarding electronic health records, cybersecurity, quality programs, and, increasingly, payer administrative. Prior authorization delays and denials of care in Medicare Advantage, for example, are extremely resource intensive and difficult for an individual hospital or an individual physician or small group practice to navigate.

There have been multiple studies that point to the positive effect on quality as well as reduction in mortality associated with hospital mergers. For example, a study recently published in JAMA Network Open concluded that hospital mergers improve health outcomes in rural hospitals.[1] The researchers, who are affiliated with IBM Watson Health and the Agency for Healthcare Research and Quality, compared data from 172 merged rural hospitals and 266 comparison hospitals and found that in-hospital mortality rates were lower after the rural hospitals completed mergers. Researchers noted, "Mergers may enable rural hospitals to improve quality of care through access to needed financial, clinical, and technological resources, which is important to enhancing rural health and reducing urban-rural disparities in quality."

In addition, the American Hospital Association (AHA) has released numerous studies indicating that hospital integration benefits patients by providing higher quality care at a lower cost. A 2021 study reinforced the conclusions of previous reports: hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost.[2] Specifically, a previous 2018 study found that mergers of hospitals within 30 miles of each other generated savings of more than $6.6 million in annual operating expenses at acquired hospitals.[3] The studies also determined that hospital acquisitions lead to improvements on key indicators of quality.

Empirical analysis continues to show a statistically significant reduction in inpatient readmission rates and a composite readmission/mortality outcome measure.[4] Further, in 2013, the Center for Healthcare Economics and Policy released a comprehensive analysis of hospital integration studies, including 75 studies spanning the years 1996-2013, as well as 36 primary sources. The Center's analysis outlines improvements in health care for communities that result from mergers, including:

- Significant benefits to communities and patients in markets where hospitals remain open.
- Preserved and expanded access to essential medical care.

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[1] Jiang HJ, Fingar KR, Liang L, Henke RM, Gibson TP. Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals. JAMA Netw Open. 2021;4(9):e2124662. doi:10.1001/jamanetworkopen.2021.24662

[2] Hospital Merger Benefits: An Econometric Analysis Revisited, conducted by economists at Charles River Associates, Sean May, Monica Noether and Ben Stearns, August 2021, and sponsored by the American Hospital Association.

[3] In Hospital Mergers: Foundation for a Modern, Efficient and High-Performing Health Care System of the Future, conducted by Charles River Associates, 2018, and sponsored by the American Hospital Association.

[4] See Footnote 3

- Improved service offerings and quality of care
- Sustained and necessary investment in technology, facilities and health IT
- Sensible reduction in excess capacity
- More competitive health care markets

As the health care landscape continues to evolve and providers accelerate efforts to improve patient outcomes and lower costs through coordinated care, the FAH will continue its efforts to inform the Committee about health care competition and hospital integration. It is imperative that this issue is put in proper context, and focus is placed more holistically on the total landscape. The FAH is happy to discuss in further detail the positive effects of integration.

Impact of Insurer Consolidation

As the Committee works to improve affordability in our nation's health care system, we urge further scrutiny on insurer consolidation, which is occurring both horizontally and vertically in the market, with insurers buying other insurers, but also acquiring physician practices and other parts of the delivery system. According to a recent study about consolidation in health care by the Association of American Medical Colleges, the top three largest group insurers control an average of 82.2% of the market share in each state, nearly twice the combined average market share of each state's largest health systems.[5] Further, a 2023 study conducted by the American Medical Association found that the majority of U.S. health insurance and Medicare Advantage markets are highly concentrated.[6] Additionally, health insurance companies have been a significant driver of physician practice acquisitions. In fact, one insurance company now employs or is affiliated with 10% of all physicians across the country.[7]

It is clear from these studies that a discussion of competition in healthcare cannot be complete without considering the roles of private healthcare insurers, whose impact across the health care industry and on patients was profoundly demonstrated by the February 21, Change Healthcare, cyberattack. Change Healthcare is the nation's largest processor of medical claims – and a subsidiary of UnitedHealth Group, the nation's largest commercial health insurer. This cyberattack left Change Healthcare, unable to perform basic functions essential to hospital operations, including coverage verifications, clinical decision support, or the submission and payment of claims.

UnitedHealth Group's experience with Change Healthcare is directly relevant to any policy discussion about the effects of consolidation in healthcare. Insurers are the quintessential "intermediaries" and financial "middlemen" that stand between patients and their medical providers. Insurers dictate which providers a patient may see, what services those providers may perform, how much those providers will be paid, and what hoops the providers will have to jump through to care for their patients. Mergers and acquisitions involving insurers therefore potentially raise a myriad of complex competition issues. Insurer acquisitions of healthcare providers can raise

[5] https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-market-power-matters
[6] Competition in Health Insurance: A comprehensive study of U.S. markets, American Medical Association (2023 Update).
[7] https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/

grave questions of whether the combined organization will have the ability and incentive to disadvantage rival insurers and/or the ability and incentive to disadvantage rival providers.

Our members experience this power concentration every day through insurer practices that arbitrarily and inappropriately deny, limit, modify, or delay the delivery of or access to services and care for patients, including Medicare beneficiaries.

In fact, their experience was affirmed by an Office of the Inspector General (OIG) April 2022 report, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (hereinafter, OIG Report).[8] The OIG Report identifies a pattern by which Medicare Advantage Organizations (MAOs) apply utilization controls to improperly withhold coverage or care from Medicare Advantage (MA) beneficiaries. Specifically:

- Improper prior authorization denials. The OIG found that thirteen percent of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- Improper denials for lack of documentation. The OIG found that in many cases, beneficiary medical records were sufficient to support the medical necessity of the services provided.
- Improper payment request denials. The OIG found that eighteen percent of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (i.e., inpatient versus observation), improperly down code claims, deploy inappropriate pre- and post-payment denial policies, and deny claims for previously approved services. These activities are often carried out by way of MAOs' downstream at-risk physicians and contracted hospitalists. These activities limit MA beneficiaries' access to the care to which they are entitled under the Social Security Act.

Insurer consolidation must not go unchecked as the forgoing practices demonstrate that these abusive practices have an adverse impact on patient care.

Maintain Current Ban on Self-Referral to Physician-Owned Hospitals (POH)

To ensure the continued viability of hospitals, it is imperative that the federal government maintain a level playing field that fosters true competition in the market. Under current law, a prohibition on physician-owned hospitals (POHs) helps ensure that full-service community hospitals can continue to meet their mission to provide quality care to all the patients in their communities. Any weakening or lifting of the ban on self-referral to POHs would only cause harm to existing full-service facilities and is not a solution to improving competition in the provider marketplace.

[8] https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/

In fact, POHs are mired in conflicts of interest and the empirical record is clear that these conflicts of interest arrangements of hospital ownership and self-referral by owner physicians promote unfair competition and result in cherry-picking of the healthiest and wealthiest patients. Data from the health care consulting firm Dobson | Davanzo shows that POHs, when compared to other hospitals:

- Cherry-pick patients by avoiding the less profitable Medicaid and uninsured patients;
- Treat fewer medically complex patients; and
- Provide fewer emergency services and often rely on publicly funded 911 services and acute care, community hospitals for these services for their own patients.[9]

Thus, current law is key to fair competition and ensuring that full-service community hospitals can continue to meet their mission to provide quality care to all patients in their communities. Weakening or unwinding the current ban opens the door to the very behaviors that Congress sought to prevent.

We thank the Committee for their efforts to take a holistic look at integration in both the hospital and insurer market, and we look forward to working with the Committee on this critical issue.

[9] https://www.aha.org/fact-sheets/2023-03-28-select-financial-operating-and-patient-characteristics-pohs-compared-non-pohs-fact-sheet