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THE VOICE FOR HEALTH CARE CONSUMERS

May 2, 2023

The Honorable Brett Guthrie, Chair
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

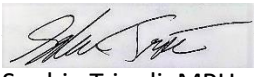
The Honorable Anna Eshoo, Ranking Member
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

Thank you again for the opportunity to testify before the House Energy and Commerce Health Subcommittee at the March 28 hearing "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care." After the hearing, members of the Committee submitted questions for the record, which I've answered below.

If any committee members or staff would like to discuss these issues further, please contact Jane Sheehan, Director of Federal Relations at Families USA (JSheehan@familiesusa.org). It's an honor to support the committee's critical work to expand and improve access to high quality, affordable health care. Please don't hesitate to be in touch if there is anything more we can do to be of service to that shared mission.

Sincerely,



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Answers to Questions for the Record

House Energy and Commerce Health Subcommittee
Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care
March 28, 2023

Questions for the Record from the Honorable Cathy McMorris Rodgers

1. ***I was encouraged to read in the 2023 Medicare Trustees Report that CMS actions, including the removal of hip and knee procedures off the "inpatient only list" and allowing patients to receive and doctors to perform additional services in the more efficient and less expensive outpatient setting, have reduced total Medicare expenditures and contributed to extending the program's solvency a little longer through 2031. How should Congress think about additional actions to enhance patient and provider choices by encouraging more services to be safely administered in the outpatient setting?***

Ensuring the solvency of the Medicare Trust Fund is vital to our efforts to make high-quality, affordable care accessible to all consumers. Inpatient settings are the most expensive settings in which health care services are delivered, and they should be reserved for the treatment of patients that need more intensive levels of care, whether due to severity of the health condition or clinical determination of need for extended observation and/or treatment necessitating a longer hospital stay.[1] Moving additional medical services to less expensive outpatient settings, when clinically safe and appropriate, is an important step to reducing high health care costs and ensuring health care resources are used effectively.

Importantly, Congress should continue to focus their legislative efforts on policy solutions that address the underlying drivers of unaffordable health care such as unchecked provider consolidation, particularly among hospitals, that allows large health care corporations to leverage market power to drive up prices.[2] This includes addressing underlying distortions in payment systems such as site of service payment differentials that incentivize hospitals to buy independent physicians' offices and rebrand them as outpatient facilities in order to generate higher reimbursements and increase prices.[3] Policy solutions that address these broken financial incentives such as site neutral payment are critical to increase competition and lower health care costs for the American people.

We also encourage Congress to consider additional reforms to Medicare that would shore up the Medicare Trust Fund, such as strengthening oversight of improper billing and upcoding in Medicare Advantage plans.[4]

a. Would allowing more procedures to be done in outpatient settings, like Ambulatory Surgery Centers, enhance competition among providers and encourage hospitals to compete with ASCs and other hospitals who offer outpatient services?

The U.S. health care system should be designed to ensure medical services are delivered in the safest, most effective, and least expensive care setting possible. This is a fundamental principle in the efficient allocation of health care dollars and resources.[5]

Under the current Medicare payment system, hospitals and other health care facilities are reimbursed at a higher rate for medical services performed in hospital outpatient departments (HOPDs) and other "provider-based" outpatient facilities than for the same services performed in a physician's office or ambulatory surgical center (ASC), even when the services can be delivered safely in either setting.[6,7,8,9] These misaligned payment incentives entice large hospital corporations and health systems to drive care delivery into higher-cost settings, often resulting in hospitals buying up doctors' offices in order to rebrand them as HOPDs to get higher reimbursements. This practice leads to increasingly anticompetitive markets where large hospital corporations have outsized market power and can demand higher prices for all consumers.[10]

The broken payment incentives driving care towards higher-cost HOPDs not only contribute to anticompetitive markets and higher health care costs overall, but also have direct negative financial impacts on individual patients.[11] For example, Medicare beneficiaries pay higher copays at hospital outpatient departments than they do in physician offices. Ultimately this means patients are getting hit financially in multiple ways – in the form of higher copays for specific services, and again in the form of higher premiums and expenses resulting from excess costs to Medicare that occur when HOPDs are paid more than twice as much as physicians for the same service.[12]

b. Does research and existing data suggest patients would still be able to receive quality and safe care for certain additional services in outpatient settings?

Research points to a number of medical services that can be safely and effectively delivered in lower cost settings such as a physician's office instead of a more expensive hospital-based setting.[13] In fact, a variety of medical services that were once exclusively delivered on an inpatient basis are routinely being delivered safely and effectively in outpatient and ambulatory settings, including endoscopies, colonoscopies, and cataract surgeries.[14] Based on MedPAC analysis and recommendations, we urge Congress to enact site neutral payment policies for select medical services that can be safely delivered in multiple care settings, ending the longstanding distortion in the Medicare payment system that incentives big hospital corporations to buy physician practices and shift health care services to higher cost settings.[15]

<u>Questions for the Record from the Honorable Frank Pallone, Jr.</u>

Hospital mergers and acquisitions have been increasing. 90 percent of metropolitan hospital markets in the U.S. are highly concentrated, and many regions are dominated by a single system. Studies suggest health care in industry consolidation is driving up the prices of health care services for families.

1. ***Can you describe some of the trends you are seeing and explain the incentives for growing industry consolidation?***

At its core, our nation's affordability crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set prices that have little to do with the quality of the care they offer. These high and irrational prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to push our nation's families to the brink of financial ruin.[16]

America's health care affordability crisis stems from high, rising, and variable prices across a wide range of health care goods and services, including prescription drugs and diagnostic tools such as MRIs and CT scans. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in our country as in the United Kingdom and almost twice as expensive as in Germany.[17] The average price of a hospital-based MRI in the United States is $1,475.[18] That same scan costs $503 in Switzerland and $215 in Australia.[19] These higher prices for an identical service are the main driver of the dramatic increase in per capita health care spending in our country, where health care accounted for nearly 20% of the nation's GDP in 2020, far exceeding health care spending by any other industrialized country.[20]

These irrational and unjustifiable prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to flourish.[21] This consolidation has taken place without meaningful regulatory oversight or intervention, and is becoming more acute.[22] In fact, there are few truly competitive health care markets left, with 95% of metropolitan statistical areas (MSAs) having highly concentrated hospital markets, nearly 80% of MSAs having highly concentrated specialist physician markets, and 58% of MSAs having highly concentrated insurer markets.[23]

- **Hospital consolidation:** Hospital mergers are occurring more frequently both within and across health care markets, leading to higher prices in both cases. According to the American Hospital Association, there were 1,577 hospital mergers from 1998 to 2017.[24,25]An estimated 40% of those mergers took place from 2010 to 2015.[26]

- **Insurance consolidation:** Insurance markets are not as highly concentrated as providers, but there is evidence of markets with little competition between insurers. Between 2006 and 2014, the four-firm concentration ratio —the extent of market control held by the four largest firms, Aetna, Blue Cross Blue Shield, United and Anthem — for the sale of private insurance increased from 74% to 83%.[27]

- **Vertical Integration:** The number of hospital-acquired physician practices grew from 35,700 in 2012 to more than 80,000 in 2018.[28] Over this same time period, the percentage of physicians employed by a hospital or health system nearly doubled, from 25% to 44%.[29] Recent research found that over 55% of physicians are now employed in hospital-owned practices.[30] This trend was accelerated by the COVID-19 pandemic, which exacerbated the financial vulnerabilities of independent and smaller physician practices and threatened the near collapse of entire sectors of the health care system — particularly primary care.[31] Nearly 23,000 physicians left independent practice to work for a hospital or other corporate entity after the onset of the COVID-19 pandemic, while hospitals and other corporate entities acquired nearly 21,000 additional physician practices from 2019 to 2020, representing a 25% increase in corporate-owned practices.[32]

Nowhere is the negative impact of consolidation more evident than the rising cost of hospital stays and services, which have increased dramatically in the last decade and make up a large portion of increasing health care costs overall.[33,34,35] These cost increases have occurred despite lower hospital utilization and are largely due to escalating prices, which are the result of hospitals buying other hospitals and community doctors to eliminate competition and form big health care corporations and medical monopolies.[36,37]

Americans in many communities have watched as their local hospitals became health systems, and those health systems were bought by large health care corporations. What most in the public and policymaking

community have not realized is how much this has destroyed any real competition in our health care sector; allowing hospitals to dramatically increase their prices every year.[38,39] Between 1990 and 2023, hospital prices have increased 600% - and just since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.[40,41,42,43]

<u>High and Irrational Prices Fueled by a Lack of Transparency</u>

Importantly, hospital prices are not only high, but have become essentially irrational:

- In 2020, across all hospital inpatient and outpatient services, employers and private insurers paid on average 224% of what Medicare pays for the same services.[44]

- Prices at hospitals in concentrated markets are 12% higher than those in markets with four or more rivals without any demonstrated improvement in the quality or access to care.[45, 46,47] All the while, the workforce in these concentrated markets suffers - wages for nurses and other health care workers decrease significantly after mergers and acquisitions.[48]

- Prices for the exact same service vary widely, sometimes even within a single hospital system:
    - A colonoscopy at a single medical center in Mississippi can range from $782 to $2,144 depending on insurance.[49]
    - At one health system in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[50]
    - Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento California.[51]
    - The price of an MRI at Mass General Hospital in Boston Massachusetts ranged from $830 to $4,200 depending on the insurance carrier.[52]

What's more, consumers and employers, who are the ultimate purchasers of health care, have limited insight into what the prices of health care services are, until after they've received a bill. For the majority of Americans – 66% – who receive health care through private insurance,[53] health care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[54] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[55] Health care is one of the only markets in the U.S. economy in which consumers are blinded to the price of a service until they receive a bill after the services is delivered.[56] It is the epitome of a broken market that threatens the financial security of American families and fails to serve their needs.

2. **Can you briefly describe how consolidation impacts affordability and quality of care for consumers?**

Unchecked industry consolidation, particularly among large hospital corporations, has allowed hospitals to dramatically increase their prices every year.[57] Between 1990 and 2023, hospital prices have increased 600% - and just since 2015, hospital prices have increased as much as 31% nationally, now accounting for

nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.[58,59,60,61]

Commercial health care prices are not only high but also vary widely across the United States because of this unchecked industry consolidation. Two individuals living in two different cities, even those in close proximity and with a similar cost of living, can be paying significantly different prices for health care with no connection to input costs or care quality. For example, the average price for a knee replacement for a patient in Tucson, Arizona, is $21,976, while the same procedure costs about $38,000 more in Sacramento, California.[62] Patients in New Mexico pay about 25% above the national average of health care prices, while those in Arizona pay 15% below the national average.[63] Prices also can vary significantly within a U.S. health care market — even within a single hospital system. For example, the price of an MRI at Mass General Hospital in Boston, Massachusetts, ranged from $830 to $4,200, depending on the insurance carrier.[64]

These irrational and unjustifiable prices, largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to flourish, are directly harming the financial security and health and well-being of Americans across the country.[65] Almost half of all Americans have reported having to forgo medical care due to the cost, and almost a third have indicated that the high cost of medical care is interfering with their ability to secure basic needs like food and housing,[66] and over 40 percent of American adults – 100 million people – face medical debt.[67] High and rising health care costs are a critical problem for national and state governments, and affect the economic vitality of middle-class and working families, crippling the ability of working people to earn a living wage. Today's real wages — wages after accounting for inflation — are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[68] At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.[69]

3. ***Recent investigations into hospital closures have raised concerns about the role of private equity in health care. Can you describe how private equity arrangements may impact affordability and patient access to care?***

The role of private equity in driving unaffordable health care and impacting patient access to care is most evident around the abusive practice of surprise medical billing, where many private equity firms built an entire business model around keeping certain providers out of network in order to balance bill America's families.[70] There is also evidence that private equity ownership of hospitals is creating conditions that lead to poorer quality of care and worse patient outcomes.[71] One study found that private equity owned hospitals have lower patient satisfaction scores and fewer full time equivalent employees per occupied bed, the latter of which is consistently associated with lower quality care and poorer patient health outcomes.[72,73]

There are numerous examples of private equity firms buying up hospitals, diverting resources away from medical care and into administrative spending, often in the form of fees to the private equity firms themselves, and then closing critical hospital services or entire facilities.[74,75] The result is reduced access and availability of key health care services for marginalized and medically underserved communities such as those based in rural areas.[76,77,78]

Questions for the Record from the Honorable Robin Kelly

1. Can you discuss how the final rule can help policymakers better understand the drivers of healthcare costs and implement policies to improve affordability?

The Hospital Price Transparency Rule is a critical step towards meaningful health care price transparency, for the first-time requiring hospitals to release negotiated rates with insurers. In order to be useful for consumers, all hospitals must comply with the rule and CMS must standardize how hospitals report this information to maximize its effectiveness.

Unveiling the prices of health care goods and services allows consumers and employers to become better informed, empowered purchasers of health care. It also enables researchers and policymakers to analyze prices in U.S. health markets in order to make targeted policy decisions that drive high-value care across the health care system.[79] The most critical pricing information to support that work is the negotiated rate for a service, which is widely recognized as the underlying price of health care goods and services.[80] But revealing prices alone is not enough. To provide a comprehensive view into U.S. health care markets and truly drive healthy competition, price must be paired together with data on quality so that consumers, employers, policymakers, and researchers can assess the actual value of health care services and goods.[81]

Unveiling health care prices and quality data has the power to disrupt the status quo by shifting market dynamics. It would force the health care sector to compete based on rational prices and quality of care rather than predicating success on the ability to buy up competition, price gouge, and generate a high volume of high-priced services that do not improve patient health. This shift is essential to align the business interests of the health care sector with the financial security and health outcomes of our nation's families.

2. What are some examples of industry gaming that is clouding the pricing data?

Hospitals are deploying various tactics to either buck price transparency requirements outright or make the information they disclose very hard to understand.[82] Many hospitals have posted no information on negotiated rates at all.[83] Some hospitals post incomplete required information (that is, using "NA" or blanks).[84] And other hospitals post prices in the form of a percentage of Medicare payment (for example, "120% of Medicare") or as a percentage of gross charges, even though the Hospital Price Transparency rule explicitly requires hospitals to list the standard charges, including negotiated rates for each individual item or service, rather than listing those prices as a percentage of a second value such as a Medicare payment rate wherever possible.[85]

Please see a recent Families USA report on price transparency for additional discussion of industry gaming of price transparency reporting.

Questions for the Record from the Honorable Angie Craig

According to a recent analysis published in the Minneapolis Star Tribune entitled "A Minnesota family's desperate search for care reveals state's mental health crisis", reimbursement for mental health generally is lower than for other diagnoses.

1. ***Can you explain this trend?***

Unfortunately, Minnesota's experience is echoed in many other states that are experiencing acute shortages of behavioral health providers and behavioral health inpatient beds. Underpayment of behavioral health care relative to physical health care, by both commercial insurers and Medicaid, results in many providers staying out-of-network.[86,87] This effectively makes behavioral health care inaccessible to millions of people. There are many facets to addressing this critical problem in the health care system including strengthening the behavioral health workforce, building sustainable and adequate reimbursement, and improving access to mental health and behavioral health care services. One critical dimension of solving this problem is putting in place stronger network adequacy standards, and enforcement of both mental health parity and network adequacy requirements. With 163 million people living in mental health professional shortage areas, there is also an urgent need to invest in the development of the mental health workforce.[88]

2. ***That same analysis suggests that health plans for people in Medicaid paid significantly less than commercial health insurers for mental health diagnoses. Can you explain that?***

In general, Medicaid reimburses providers for health care services at a lower payment rate compared to commercial insurance. And across both types of payors, payment rates for mental health services in particular are often lower than payment rates for equivalent non-mental health services. For example, in Medicaid, psychiatrists in many states are paid less than primary care providers for delivering similar services.[89] Although states directly set reimbursement rates for providers in fee-for-service Medicaid, most people who receive Medicaid are in managed care plans, and these plans are the ones setting rates for behavioral health providers.

States and the federal government have an important role to play in ensuring people who rely on Medicaid for health care have access to the behavioral health services that they need. For example, they can set standards for network adequacy and strengthen oversight and enforcement. California is an example of a state that recently has stepped up its standards to ensure that networks have enough mental health professionals that are accepting new patients.[90]

3. ***How can we increase competition across the health care sector to bring down costs for patients?***

There are a number of promising reforms that Congress should institute to promote healthy competition across the U.S. health care system and bring down costs for patients. One crucial way Congress can address provider consolidation and encourage health care competition is through passing legislation that strengthens the Hospital Price Transparency rule, including by sharpening data requirements and establishing standard formats, eliminating loopholes for hospitals, and further increasing penalties to

encourage greater hospital compliance. Price transparency regulations are an important tool to pull back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in hospital pricing abuses.

Congress should also address payment differentials across sites of service that incentivize further consolidation and are a major driver of unaffordable care for America's families. Market inefficiencies that come from site-specific payment rates are a significant problem, which if addressed, could save American families and payers billions of dollars.[91] These site payment differentials drive care delivery from physician offices to higher-cost hospital outpatient departments.[92] This shift is a major driver of higher spending on health care services which require lower resources such as office visits and minor procedures.[93] And importantly, these payment differentials create a financial incentive for hospitals to consolidate by buying physician offices and rebranding them as off-campus outpatient hospital departments (HOPDs) and facilities in order to receive higher payments.[94]

Lastly, Congress should take a closer look at anticompetitive practices and clauses in health care contracting agreements, which occur in a variety of places including between providers and insurers and in clinician and health care worker employment arrangements.[95] In contracts between provider entities and insurers, large entities in highly consolidated markets have the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit access to higher-quality, lower-cost care. When anticompetitive terms are present in health care clinician and worker employment contracts, they can further stifle competition, lead to burnout exacerbating workforce shortages,[96] impede patient access to preferred providers and care, and lead to higher prices for health care services.[97]

4. ***As I am sure you are well aware, medical debt can be crushing, and Minnesotans are feeling the weight just as many other Americans are. How can comprehensive health care price transparency give my constituents financial certainty and peace of mind that they won't be bankrupted by their care?***

Every person should have the right to know what a health care procedure costs at a hospital or health care facility, whether it is an X-ray, an MRI, or a surgery. Health care is one of the only sectors in the U.S. economy where consumers and purchasers are blinded to the price of a service until after that service has been delivered and they receive a bill.[98] For the two thirds of Americans who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans, and based on which organization has more market power.[99] These health care prices — often referred to as negotiated rates — are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[100] This lack of transparency is alarming, particularly given that high and rising health care prices are the primary driver of our nation's health care affordability crisis.[101]

Price transparency holds the promise of unveiling underlying prices of health care services and goods so that consumers and employers can be better informed and empowered purchasers of health care, and so that researchers and policymakers can analyze prices in U.S. health markets to make targeted policy decisions that drive high-value care into the health care system. The most critical pricing information is

the negotiated rate, which is widely recognized as the underlying price of health care services and goods.[102] Unveiling price data will force the health care sector to compete based on rational prices rather than by buying up doctors' offices to price gouge and generate a high volume of high-priced services that do not improve patient health. Unveiling health care prices has the power to disrupt the status quo market dynamics – a shift that is essential to align the business interests of the health care sector with the financial security and health outcomes of our nation's families.

[1] For instance, according to Medicare's Two-Midnight Rule, inpatient care is generally covered if the patient requires a hospital stay that is longer than two midnights, with certain exceptions. Otherwise, the expectation is for patients whose stays are shorter than two midnight to be treated with outpatient care. For more information, see *Fact Sheet: Two Midnight Rule,* CMS, October 13th, 2015, https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

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