Documents for the Record – 04.26.23 HE Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

Majority:

- April 25, 2023, letter from Americans for Prosperity
- April 25, 2023, letter from Taxpayers Protection Alliance
- April 25, 2023, letter from Better Solutions for Healthcare
- April 26, 2023, letter from Association for Clinical Oncology
- April 26, 2023, letter from American Academy of Family Physicians
- April 26, 2023, letter from the Ambulatory Surgical Center Association
- April 25, 2023, bipartisan letter of support for site neutral from various organizations and individuals, submitted by Rep. Bucshon
- April 26, 2023, statement from Infusion Providers Alliance
- April 26, 2023, testimony from the Large Urology Group Practice Association
- April 26, 2023, letter from the National Taxpayers Union
- April 22, 2023, statement from the Physicians Advocacy Institute
- April 26, 2023, statement from the Partnership to Empower Physician-Led Care
- April 24, 2023, statement from the Alliance for Regenerative Medicine
- April 26, 2023, letter from NFIB
- April 26, 2023, statement from Consumers First Coalition
- April 22, 2023, statement from the Physicians Advocacy Institute submitted by Rep. Burgess
- February 5, 2023 Document entitled, "Hospital Competition And Restrictions On Physician-Owned Hospitals" submitted by Rep. Burgess
- April 24, 2023, statement from Texas Medical Association submitted by Rep. Burgess
- CMS Eligibility for Non-Citizens in Medicaid and CHIP submitted by Rep. Harshbarger
- April 26, 2023, statement from AHIP
- April 25, 2023, letter from Careviso
- HealthCare.gov info on Immigration Status and the Marketplace submitted by Rep. Harshbarger
- April 26, 2023, statement from Connecticut State Medical Society submitted by Rep. Burgess
- April 25, 2023, statement from California Medical Association submitted by Rep. Burgess
- April 26, 2023, statement from North Carolina Medical Society submitted by Rep. Burgess
- April 25, 2023, statement from Nebraska Medical Association submitted by Rep. Burgess
- April 26, 2023, statement from the South Carolina Medical Association submitted by Rep. Burgess
- April 26, 2023, statement from the Tennessee Medical Association submitted by Rep. Burgess

Minority:

- April 24, 2023, letter from the Greater New York Hospital Association
- April 25, 2023, letter from the Healthcare Association of New York State (HANYS)
- April 19, 2023, letter from national, state, and local organizations
- April 26, 2023, letter from the American Academy of Family Physicians
- April 20, 2023, letter from the Disability and Aging Collaborative & the Consortium for Constituents with Disabilities
- April 24, 2023, statement from 30 patient organizations
- April 24, 2023, statement from 6 leading physician groups
- April 19, 2023, statement from ACAP CEO
- April 25, 2023, letter from the Federation of American Hospitals
- April 26, 2023, statement from Partnership for Employer-Sponsored Coverage (P4ESC)
- April 25, 2023, letter from Arnold Ventures and others
- April 26, 2023, letter from PIRG
- April 25, 2023, letter from Alliance of Safety-Net Hospitals
- April 25, 2023, letter from National Down Syndrome Congress
- April 26, 2023, statement from Consumers First: The Alliance to Make the Health Care System Work for Everyone
- April 25, 2023, letter from Americans for Prosperity (same as Republican submitted doc)
- April 26, 2023, statement from the American Academy of Pediatrics

April 25, 2023

Dear Members of Congress:

On behalf of the undersigned organizations and individuals, we urge you to advance reforms that promote site-neutral payments in Medicare and site of service billing transparency in commercial health insurance. These commonsense reforms would end disastrous subsidies for hospital consolidation and deliver lower costs to patients.

The federal government subsidizes hospital monopolies by paying higher reimbursements to physician practices and outpatient facilities when they merge with hospitals. Medicare pays hospital-owned facilities significantly higher rates — between 106 percent and 217 percent more — than independent medical practices and other outpatient facilities for the exact same services, including chemotherapy, cardiac imaging, and colonoscopies. Commercial insurers also pay higher rates for hospital-owned facilities in many cases. These higher payments create an enormous incentive for hospitals to acquire independent practices and charge patients and taxpayers high prices.

These wasteful subsidies have dramatically contributed to hospitals buying up community physician practices and reducing patient choices. Between 2013 and 2018, the share of physician practices that were hospital-owned more than doubled from 14 percent to 31 percent. By 2020, over half of physicians worked directly for a hospital or worked at a physician practice that was owned by a hospital, according to an analysis from the American Medical Association.

As hospitals buy up physician practices, they use market power and "dishonest billing" to raise prices for patients and taxpayers. "Dishonest billing" is when hospitals secretly reclassify a doctor's office they own as a hospital-based setting in order to charge patients and taxpayers higher prices. An analysis by Northwestern University found the price of physician services increases 14 percent after a hospital purchases a physician practice.

It is crucial that Congress end pro monopoly subsidies. Lawmakers should require Medicare to reimburse hospital-owned outpatient facilities at the same rate as independent outpatient facilities for services that can safely be delivered in a physician's office. Furthermore, Congress should promote billing transparency and address billing policies that enable hospitals to dishonestly bill patients.

Promoting billing transparency and site-neutral payments is an important step to lowering the cost of health care. The Congressional Budget Office estimates that ending Medicare's policy of paying hospital-owned facilities higher rates than independent physician offices will save taxpayers more than $140 billion over ten years. Doing so would also substantially reduce premiums and cost-sharing for Medicare beneficiaries, cumulatively by $94 billion over the next ten years according to estimates from the nonpartisan Committee for a Responsible Federal Budget.

We urge you to take swift action to enhance hospital competition and ensure more patients can afford the health care they need.

Sincerely,

Americans For Prosperity
Chief Government Affairs Officer and Senior Vice President
Americans for Prosperity

Loren Adler, Brookings Institute*
Dr. Brian Miller, American Enterprise Institute (AEI)*
Mark Miller, Arnold Ventures
Texas Public Policy Foundation
Americans For Tax Reform
Josh Gordon, Committee for a Responsible Federal Budget (CRFB)
Goldwater Institute
Progressive Policy Institute
Heartland Institute
Third Way
James Madison Institute
Independent Women's Voice
National Taxpayers Union
FreedomWorks
John Locke Foundation
Cardinal Institute
Docs 4 Patient Care Foundation
Nevada Policy Institute
Jackson W. Hammond, American Action Forum
Avik Roy, Foundation for Research on Equal Opportunity

*Affiliations are listed for identification purposes only and do not indicate the organization's support for the position outlined in the letter.

TAXPAYERS PROTECTION ALLIANCE

April 25, 2023

The Honorable Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone Jr.
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brett Guthrie
Chair, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Anna Eshoo
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair Rodgers, Chair Guthrie, Ranking Member Pallone, Ranking Member Eshoo, and Members of the House Committee on Energy and Commerce:

The Taxpayers Protection Alliance (TPA) is writing today to give voice to the millions of taxpayers and consumers we represent ahead of the Health Subcommittee's upcoming legislative hearing that will consider legislation to bring additional oversight to the 340B program as well as pharmacy benefit managers (PBMs).

As you know, massive PBMs take advantage of their position as healthcare middlemen and use their power to negotiate huge kickbacks in the form of rebate savings from drug manufacturers. Despite these rebates being worth more than $200 billion per year, patients and taxpayers fail to see the savings because they are often kept by the PBMs instead of passed along to Medicaid programs.[1] Congress must reform the regulatory structure of PBMs so that rebates result in less government spending and lower patient costs.

Among the legislation that will be considered at this hearing, TPA is proud to endorse H.R. 1613, the Drug Price Transparency in Medicaid Act, introduced by Representative Buddy Carter (R-Ga.). This bill saves $1 billion over the next decade by eliminating spread pricing in Medicaid managed care programs. It also increases transparency over PBMs serving taxpayer-funded plans, by requiring National Average Drug Acquisition Costs) reporting to the Centers for Medicare & Medicaid Services by all pharmacies participating in state Medicaid programs. We hope the subcommittee will vote to advance this important legislation.

However, PBMs should not be the only focus of this hearing. Big hospital networks are similarly acting to erode transparency and maximize profits. The 340B program was originally intended to help low-income patients afford prescription drugs by providing discounted drugs to eligible health centers. Evidence now shows that 340B hospitals profit up to 10 times more by administering drugs under the program and pocketing the discount savings.[2] Hospitals can use the money as they please and often funnel it into facilities in more affluent neighborhoods. This is certainly the opposite of the program's intended effect.

Thank you for holding this important hearing to bring transparency and accountability to PBMs and large hospitals. Clearly, 340B hospitals and PBMs have strayed from their original intent and now serve as significant contributors to rising healthcare costs for taxpayers. Members of your committee must be assertive in demanding accountability for taxpayer-supported hospitals and PBMs. They have been taking advantage of your constituents for far too long.

Sincerely,

David Williams
President

[1] https://www.washingtontimes.com/news/2022/oct/18/prescription-drug-pricing-reform-must-rein-in-phar/
[2] https://www.pacificresearch.org/new-study-340b-providers-reap-big-profits-should-be-reformed-to-ensure-at-risk-patients-receive-affordable-care/

better solutions
for healthcare™

Chairman Brett Guthrie (R-KY)
Ranking Member Anna Eshoo (D-CA)
House Committee on Energy and Commerce
Subcommittee on Health

Dear Chairman Guthrie and Ranking Member Eshoo:

As healthcare prices continue their unsustainable rise year over year, we are calling upon policymakers to prioritize market-based solutions to address the affordability crisis impacting American workers and their employers. We appreciate the upcoming bipartisan hearings and roundtables to examine these important issues, and we call on Congress to take immediate action on these burdens facing employers and employees.

The escalating cost of healthcare services is a primary concern of businesses.[1] Both employees and their employers have been hurt by a 600% increase in hospital prices since 1990. Hospital services now represent the largest share of total healthcare spending, accounting for 44% of total spending for privately-insured Americans. Higher cost care settings can impose considerable financial burden on patients through higher out-of-pocket payments at the point of care and potentially higher health insurance premiums. It should be no surprise that the cost of employer-provided health coverage has increased by 43% in the last 10 years, with hospitals serving as the leading driver behind rising costs.

As Congress works to solve America's healthcare affordability crisis, we applaud your focus on the role that hospitals and large health systems play in driving up healthcare costs for consumers, employers, public sector purchasers, and the government. A lack of market competition, pricing transparency, and price mark-ups have exacerbated significant market distortions and undercut the stability and sustainability of the system.

We ask the committee to advance legislation that promotes and encourages market-based solutions and fair dealing among all stakeholders to address the uncontrollable rise of healthcare costs and reduce costs for all Americans. We look forward to working with you to drive the legislative proposals required to support our system's foundations, help fix areas that have become broken, and promote beneficial growth, innovation, and investment to protect the health of consumers, employers, and their families across the country.

Sincerely,

Better Solutions for Healthcare

[1] "Health Insurance, Labor, and Taxes Remain Top Issues for Small Business Owners in NFIB's Every-Four-Year Study." *NFIB*, 13 August 2020, https://www.nfib.com/content/press-release/homepage/health-insurance-labor-and-taxes-remain-top-issues-for-small-business-owners-in-nfibs-every-four-year-study/.

Lori J. Pierce MD, FASCO
Chair of the Board
Association for Clinical Oncology

Statement prepared for:
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health

Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care

April 26, 2023

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." ASCO is pleased that the U.S. House of Representatives Committee on Energy and Commerce is working in a bipartisan manner to examine legislative solutions to improve the affordability of care and transparency, as these are top concerns for the oncology community.

ASCO represents more than 45,000 oncology professionals who care for people living with cancer. ASCO works to ensure that all individuals with cancer have access to high quality, equitable care; that cancer delivery systems support optimal cancer care; and that our nation supports robust federal funding for research on the prevention, screening, diagnosis and treatment of cancer.

Pharmacy Benefit Managers
Cancer drugs are a critical component of treatment for many cancer types as well as for the prevention and control of symptoms. They also represent an increasing component of cancer care costs. While Pharmacy Benefit Managers (PBMs) were originally created to serve as third-party administrators of pharmacy claims, they now leverage their market power to obtain lower prices on drugs, often without passing those savings along to patients.

Further, ASCO members have reported that some patients have had their medication or dosage changed by PBMs without prior approval by or in consultation with the treating physician. PBMs are also increasingly shifting drug dispensing away from physicians and toward pharmacies they own, which can negatively impact patient access to treatment. In these ways, PBMs are interfering with the doctor-patient relationship and lowering the quality of care for people with cancer.

ASCO supports efforts to shed light on PBM practices and prohibit unfair or deceptive practices that impact patients with cancer. For a more detailed understanding of our policy on this issue, we invite you to read the "ASCO Policy Brief: Pharmacy Benefit Managers" by our affiliate, the American Society of Clinical Oncology.

340B Drug Pricing Program

ASCO also appreciates the committee highlighting legislative solutions to increase transparency and adherence within the 340B Drug Pricing Program. The Program aims to expand access to high-quality care for uninsured, underinsured, and low-income patients across the nation, but especially in areas with gaps in care.

ASCO members provide cancer care both within 340B-covered entities and in non-340B practices and institutions and are devoted to ensuring that all Americans have meaningful access to the services necessary to prevent, diagnose, and treat cancer. To this end, our affiliated organization, the American Society of Clinical Oncology (Society), published its "Policy Statement on the 340B Drug Pricing Program" in 2014, which includes several recommendations to enhance the Program to ensure it achieves the original congressional intent of promoting timely access to health care services for uninsured, underinsured, and low-income Americans regardless of the setting of care. ASCO continues to advocate for the Program and its necessary reforms and hopes lawmakers will consider these recommendations as they navigate the policymaking process.

ASCO is eager to share our members' experience with the 340B Drug Pricing Program and PBMs and our perspectives on how the Program and PBM practices could be refined. We are committed to working with you as Congress continues to have meaningful dialogue about these issues. If you have any questions, please contact Megan Tweed, Associate Director of Congressional Affairs, at Megan.Tweed@asco.org.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 26, 2023

The Honorable Brett Guthrie
Chairman
Health Subcommittee, House Committee
on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee, House Committee
on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to express our appreciation for the Subcommittee's continued interest in transparency and competition in the health care sector by holding today's legislative hearing titled "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The AAFP shares your commitment to advancing policies that promote transparency and competition, and we write to offer our policy recommendations from the family medicine perspective.

The AAFP strongly believes that all individuals have a right to access timely, high quality, and affordable essential health care services, including comprehensive primary care. Unfortunately, family physicians encounter patients who struggle to make ends meet every day, and the escalating costs of health care have led many patients to delay or forgo needed care. Rising health care costs for patients have been driven in part by increases in anticompetitive practices and consolidation, which inflate health care prices without improving quality.

Last month, the AAFP provided recommendations in advance of the Subcommittee's initial hearing on this topic. The Academy has long advocated to Congress in support of policies that will strengthen our nation's investment in primary care and improve patients' access to affordable health care. We have also supported efforts to improve the patient experience through increased transparency. Building upon our previous recommendations, we continue to urge Congress to address health care costs and consolidation by supporting payment methods that promote competition, improving administrative burden through transparency, and limiting the use of anti-competitive contracting practices that harm clinicians and patients.

Physician Payment Reform

In comments submitted to the Federal Trade Commission (FTC) this month, the AAFP highlighted the drastic increase in physician employment over the last several years, which has been propelled in part by practice and hospital consolidation. There have been at least 1,600 known hospital mergers in the United States between 1998-2017.[i] Meanwhile, a significant shift from physicians as owners of independent practice has been occurring over many years across all medical specialties. The most recent American Medical Association (AMA) Physician Practice Benchmark Survey (2020) reported that for the first time, less than half of physicians (49.1%) delivered care in independent practice (meaning organizations wholly owned by physicians) and the proportion of physicians who have an

ownership stake in their practice is shrinking as well. Just 24% of AAFP members report that they are sole or partial owners in their practice setting. The proportion of family physicians who are employed continues to grow each year with 73% of all AAFP members and 91% of new physicians (1-7 years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering that only 59% of AAFP members reported being employed in 2011.

Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates and the continuing consolidation of insurers and large health systems threatens their long-term viability. **Evidence indicates that consolidation increases health care prices and insurance premiums, as well as worsens equitable access to care for patients in rural and other medically underserved communities**.[ii,iii] Therefore, we appreciate the Committee's consideration of legislation that would require the Department of Health and Human Services (HHS) to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation. **We urge Congress to go further, however, and take tangible action to reform the current Medicare payment structure that fails to appropriately pay physicians and spurs consolidation.**

The Academy continues to recommend that Congress promote payment methods that boost competition in the marketplace and create greater choice for patients. Despite evidence indicating that additional investments in primary care would improve population health and advance health equity, primary care has been historically underfunded in the U.S. Medicare and Medicaid have historically undervalued primary care. In the short-term, inadequate payment rates mean that primary care physicians lack the resources needed to provide comprehensive, continuous care for their patients and may be forced to accept fewer Medicare or Medicaid patients, close their practices, or sell to a health system or corporation. In the long-run, payment distortions between primary and specialty care will continue to drive more physicians to go into higher paid specialties, worsening the maldistribution of the physician workforce. A recent Medicare Payment Advisory Commission (MedPAC) analysis highlighted that the median compensation remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties – underscoring concerns about the mispricing of fee schedule services and its impact on the primary care pipeline.[iv]

Medicare's current physician payment system is undermining physicians' ability to provide high quality, comprehensive care – particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. In October, the Academy submitted robust recommendations to Congress on ways to reform the Medicare Access and CHIP Reauthorization Act (MACRA) to address challenges affecting our members and their patients. Since then, both MedPAC and the Board of Trustees have raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending that Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[v]

Congress should heed these warnings. **The AAFP strongly urges Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to provide for an annual update to the Medicare Physician Fee based on the Medicare Economic Index (MEI).** This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

Additionally, the Academy strongly supports the Centers for Medicare and Medicaid Services (CMS) plan to implement a new add-on code for complex evaluation and management (E/M) visits: G2211. The G2211 code recognizes the inherent complexity of primary care office visits and provides commensurate Medicare payment. We were disappointed that Congress elected to delay implementation of that code, and **we urge Congress to support full implementation of G2211 in the CY 2024 Medicare physician fee schedule.**

The AAFP also supports site neutral payment policies that would establish payment parity across care settings and has called for an expansion of site neutrality to all on-campus and off-campus hospital-based departments, as well as other facilities. We have repeatedly urged Congress to build upon past efforts to increase site neutrality, including in our aforementioned remarks for last month's hearing. We support reducing payment differences between sites of service since it enables patients to make more informed healthcare decisions by making costs more transparent and would reduce patient cost-sharing. As such, site neutral payment encourages patient choice based on quality rather than cost. It is the AAFP's policy that patients should have reasonable freedom to select their physicians, other providers, and healthcare settings. Importantly, whenever making a choice, patients and caregivers must be well-informed on the options available and possible effects of, and responsibilities involved with, each option.

Therefore, we appreciate the Subcommittee's consideration of several discussion drafts today that would implement site neutral payment policies. The AAFP encourages Congress to continue exploring ways to advance site neutral payment policies with careful consideration so as not to further incentivize or accelerate consolidation.

Congress must also act to bolster the primary care physician pipeline by enacting Medicaid payment parity. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[vi] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Price Transparency and Administrative Burden

As acknowledged above, **the AAFP recognizes the value of transparency in health care and has long supported federal policies promoting price transparency**. These policies improve data collection and enable patients and their health care teams to compare prices across facilities and insurers. As our members seek opportunities to enter into value-based care arrangements, it is critical they have access to information on clinicians' and facilities' costs and quality performance to ensure they make informed decisions with their patients when making referrals.

The Academy appreciates and supports the Subcommittee's continued efforts to improve price transparency for patients. **However, primary care services, which are most often low-cost and high-value, are not the drivers of high, distorted health care prices.** The AAFP has repeatedly shared concerns regarding the administrative burdens imposed on primary care practices by the recently implemented good faith estimate (GFE) requirements and proposed advanced explanation of benefits (AEOB) requirements, resulting from the No Surprises Act (NSA). Congress did not intend for the NSA to impose burdensome regulatory requirements on primary care practices, which are already overwhelmed with administrative tasks. We urge Congress to ensure new price transparency reporting requirements are narrowly designed to target services and sectors that are driving price increases and do not impose burdensome new requirements on primary care practices.

One of the proposals considered during today's hearing seeks to promote transparency of common ownership interests under Parts C and D of the Medicare Program. We caution against moving forward with this legislation which may pose a similar risk once implemented.

Specifically, **the AAFP is concerned that the legislation as currently written would exacerbate already high rates of administrative burden among primary care physicians and subject them to undue reporting requirements.** Administrative burden is one of the leading causes of practice closures and physician burnout. Processes like prior authorization and step therapy already take up significant physician and staff time, with a 2022 American Medical Association survey reporting that physicians and their staff spend almost two business days each week completing prior authorizations.[vii]

The AAFP recently applauded CMS's 2024 Medicare Advantage (MA) and Part D final rule, which increases transparency of prior authorization under Medicare Advantage Plans. Instead of applying additional reporting requirements to physician practices contracting with MA plans and pharmacy benefit managers, **the AAFP strongly encourages Congress to build upon this momentum and prioritize codifying efforts to improve the transparency of and reduce overall use of prior authorization processes under Medicare Advantage plans, in addition to other insurers.** We also urge Congress to pass the Safe Step Act (H.R. 2630 / S. 652), which promotes transparency from health plans by requiring the development of a clear, transparent exception process to step therapy for patients and providers.

Finally, the AAFP supports policies such the Medical Loss Ratio (MLR) requirements on health plans offering coverage in the individual market, which requires they submit data on the proportion of premium revenues spent on clinical services and quality improvement. This helps ensure health care resources are focused on patient care rather than insurer profits or administrative expense. These federal policies have helped advance affordability and improve equitable access to comprehensive health care coverage in the individual market.

Stop Anti-Competitive Contracting Practices that Harm Clinicians and Patients

Congress should also prohibit the use of noncompete agreements in physician contracts. Noncompete agreements in health care impede patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, and stifle competition. Despite projected physician shortages, many health care employers still intentionally restrict physician mobility and workforce participation via noncompete agreements.

Currently, noncompete agreements are enforced through a patchwork of state laws. Twelve states deem noncompete agreements unenforceable and against public policy; however public awareness of these laws remains low, and employers still intimidate employees with the threat of legal action. Thirty-eight states allow noncompete agreements in some form, judging enforceability on factors including job type, legitimacy of business interests, and reasonableness of duration, scope, and distance. Family physicians from across the country have expressed deep concerns about how noncompete agreements are forcing them to remain in undesirable employment situations which harm their financial and mental health or abandon their patients and travel long-distances or uproot their families to practice in a new geographic area. **The AAFP urges Congress to pass legislation to ban noncompete clauses in physician employment contracts to ensure patients have access to their physicians and to allow physicians to freely practice medicine in their communities.**

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with the Subcommittee on policies that support primary care physicians and their patients through improved transparency and competition. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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[i] Gaynor, M. What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work, Policy Proposal No. 2020–10, The Hamilton Project.
[ii] Yerramilli P, May FP, Kerry VB. Reducing Health Disparities Requires Financing People-Centered Primary Care. JAMA Health Forum. 2021;2(2):e201573. Available at: https://jamanetwork.com/journals/jama-health-forum/articleabstract/2776056
[iii] O'Hanlon CE, et al. Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation. December 2019. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00918
[iv] Medicare Payment Advisory Commission. (2021, March). Chapter 4 -Physician and other health professional services. Retrieved February 10, 2023, from https://www.medpac.gov/wpcontent/uploads/2021/10/mar21_medpac_report_ch4_sec.pdf.
[v] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed April 6, 2023: https://www.cms.gov/oact/tr/2023
[vi] 7 Zuckerman, S., Skopec, L., & Aarons, J. (2021, February 01). Medicaid physician fees remained substantially Below fees paid by Medicare in 2019. Retrieved February 9, 2023, from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611.
[vii] American Medical Association, "2022 AMA prior authorization (PA) physician survey." Accessed April 22, 2023. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

ASCA Comments on Energy and Commerce Health Subcommittee Legislative Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Healthcare"

April 26, 2023

Chairman Guthrie and Ranking Member Eshoo:

The Ambulatory Surgery Center Association (ASCA), representing more than 6,000 Medicare-certified surgery centers in the United States, is pleased to provide comments on the Energy & Commerce Subcommittee on Health legislative hearing on specific legislation to increase transparency and competition in healthcare. Ambulatory surgery centers (ASCs) provide high-quality care and cost savings to patients and healthcare payers. As Medicare pays ASCs about half as much as hospital outpatient departments (HOPDs) for performing identical procedures, surgery centers save the program considerable sums. From 2011 to 2018, ASCs saved Medicare $28.7 billion as a lower-cost site of care and are projected to save an additional $73 billion between 2019 and 2028.[1] Forecasted savings, however, are threatened by problematic Medicare policies that result in continually declining reimbursement and other factors that limit Medicare beneficiaries' access to efficient outpatient surgical and procedural care in the surgery center setting.

Our community welcomes the opportunity for a discussion on the important topics of cost, transparency and competition and the important role that our centers can play as an increasing number of patients seek outpatient services for a myriad of surgical specialties such as gastroenterology, ophthalmology, orthopedics and urology, all performed in a convenient setting for the beneficiary and at a lower price than competitors.

On its face, the phrase "site neutrality" has been construed as a catch-all to include a number of policy proposals that our community of healthcare providers and patients would support. However, we are particularly concerned with draft legislation before the committee -- : "**H.R. ___,** To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings", which would slash ASC payments to the physician office rate if just a plurality – not majority – of care is offered in the physician office.
A foundational element of the surgery center model is that ASCs are the proper setting for appropriate patients—that subset of the Medicare population without the comorbidities that would dictate they receive care in a hospital. Similarly, there are beneficiaries who benefit from receiving care in the highly-regulated ASC environment over that of a physician's office. Using payment policy to drive patient care to a lower-cost, unregulated environment will present risks to patients that are not addressed in this legislation.

As an example, ASCs would see their reimbursement cut from $3,600 to $1,500 for urologic procedure Cystourethro w/implant because physician offices volume was 35.8 percent, barely beating out HOPD volume at 35.5 percent and ASC volume at 28.6 percent. The Committee should modify this policy to require at least a *majority* (i.e. 50.1 percent) of care to be provided in the site-of-service for that site's payment policy to apply. Even with that, a policy to ensure that

[1] "Study: Reducing Medicare Costs by Migrating Volume from HOPDs to ASCs," *Advancing Surgical Care*, www.advancingsurgicalcare.com/reducinghealthcarecosts/costsavings/reducing-medicare-costs.

patients with higher risk profiles can be seen in the appropriate setting, with additional reimbursement for that setting to defray costs, should be considered. In that vein, the bill appears to limit downside payment cuts to hospitals but not ASCs. Those rules should apply equally to both sites of care and not just limit impact of reimbursement cuts to hospitals but not ASCs.

More fundamentally, the Committee should consider policies that encourage migration from the more expensive setting to the ASC setting rather than simply cutting provider payment rates. As such, we recommend your consideration of the Outpatient Surgery Quality and Access Act (H.R. 972), which more fundamentally ties ASC reimbursement to the HOPD payment system by codifying the current identical market basket update for both settings and includes ASC volume with hospital outpatient volume for purposes of applying a single scalar to ASC payments. The bill also provides important transparency for patients by requiring HHS to publish a comparison of quality measures across both sites of care. Most importantly, it would provide the same beneficiary copayment cap in the ASC setting that now only applies to the HOPD setting so that patients are not dissuaded from getting care in the more efficient setting.

We share your goals to create more access for patients to affordable health care while saving money on procedures that can be done more efficiently in lower-cost settings. As Congress contemplates advancing site-neutral policies, ASCA suggests several essential design features:

Focus on the patient's perspective on services that can be done in a less costly setting than the hospital.

Access to more sites of care will increase competition between providers, drive costs down, and create better outcomes for patients. This will save Medicare more dollars in the short and long term. Surgery centers have an increasing role in this space considering the growing number of outpatient surgeries every year.

Include the Co-Pay Cap Provision of *Outpatient Surgery Quality and Access Act.*

A beneficiary access problem arises because Congress enacted a beneficiary copayment cap in the HOPD setting equal to the inpatient deductible when it enacted the Hospital Outpatient Prospective Payment System on the theory that beneficiaries should never be penalized for getting care in the more efficient setting. But, there is no similar copayment cap in the ASC setting.

A beneficiary typically has a coinsurance responsibility of 20 percent of the procedure's cost when that procedure is performed in an ASC. When a beneficiary receives the same procedure in an HOPD, the copay is capped at the inpatient deductible amount, which is $1,600 for 2023, and the hospital is made whole by the Medicare program.

Without a similar co-pay cap in the ASC setting, a perverse result is that many patients choose the higher cost setting for certain procedures because their beneficiary copayments are capped even though the cost to Medicare is substantially higher than if the beneficiary received care in the ASC.

The co-pay cap provision of the Outpatient Surgery Quality and Access Act of 2023 (H.R. 972) applies the same framework to ASCs that exists in HOPDs, providing the same cap on a

beneficiary's ASC copay that exists in the HOPD setting. We believe patients will naturally opt for lower cost settings if their out-of-pocket liability is similarly capped in the surgery center. If even a small percentage of patients migrate to the ASC setting, the cost of the cap more than pays for itself and just a 5-10 percent migration for these procedures would produce hundreds of millions in net savings to the Medicare program.

Establishing the same co-pay cap in the ASC setting will increase patient access to care and ultimately decrease costs to Medicare and its beneficiaries. Notably, the current lack of a co-pay cap in the ASC setting penalizes part B Medicare patients lacking supplemental coverage. This is an area where a racial disparity in access has been observed, with only 40 percent of black beneficiaries being covered by supplemental insurance in contrast to 72 percent of white beneficiaries.[2]

Numbers at a Glance:

Total knee arthroplasty (27447) and total hip arthroplasty (27130) are two prominent procedures that would benefit from the copay cap policy fix. Additionally, a spine code with significant ASC commercial volume but low Medicare volume (22551), and a dialysis circuit code (36906) are provided below for comparison. For reference, the difference in patient responsibility for each of the codes is listed below[3]:

- 27447: $2,054 (+ $236 over HOPD)
- 27130: $2,067 (+ $248 over HOPD)
- 22551: $2,097 (+ $192 over HOPD)
- 36906: $2,281 (+ $623 over HOPD)

ASC Covered Procedures List

To further increase cost savings, we must increase the list of procedures that can be performed in an outpatient setting. While one draft bill before the committee would reform the inpatient only list for certain musculoskeletal hospital procedures, that reform is not meaningful unless the corollary reform is made to establish an HOPD and ASC payment for those procedures and allow ASCs to provide those procedures by significantly expanding or reforming the ASC-payable list.

Total shoulder (23472) is a prime example of a procedure is not currently payable in ASCs but is ready for migration considering the high success rates of other total joint replacements in the ASC setting generally. There are currently 370 total codes that are payable in HOPDs but not ASCs by Medicare. Congress should allow ASCs to provide any surgical procedures permitted in the HOPD.

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[2] 2 Brunt, Christopher S. "Supplemental Insurance and Racial Health Disparities under Medicare Part B." Health Services Research, John Wiley and Sons Inc., Dec. 2017, www.ncbi.nlm.nih.gov/pmc/articles/PMC5682138/.

[3] https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates

April 25, 2023

Dear Members of Congress:

On behalf of the undersigned organizations and individuals, we urge you to advance reforms that promote site-neutral payments in Medicare and site of service billing transparency in commercial health insurance. These commonsense reforms would end disastrous subsidies for hospital consolidation and deliver lower costs to patients.

The federal government subsidizes hospital monopolies by paying higher reimbursements to physician practices and outpatient facilities when they merge with hospitals. Medicare pays hospital-owned facilities significantly higher rates — between 106 percent and 217 percent more — than independent medical practices and other outpatient facilities for the exact same services, including chemotherapy, cardiac imaging, and colonoscopies. Commercial insurers also pay higher rates for hospital-owned facilities in many cases. These higher payments create an enormous incentive for hospitals to acquire independent practices and charge patients and taxpayers high prices.

These wasteful subsidies have dramatically contributed to hospitals buying up community physician practices and reducing patient choices. Between 2013 and 2018, the share of physician practices that were hospital-owned more than doubled from 14 percent to 31 percent. By 2020, over half of physicians worked directly for a hospital or worked at a physician practice that was owned by a hospital, according to an analysis from the American Medical Association.

As hospitals buy up physician practices, they use market power and "dishonest billing" to raise prices for patients and taxpayers. "Dishonest billing" is when hospitals secretly reclassify a doctor's office they own as a hospital-based setting in order to charge patients and taxpayers higher prices. An analysis by Northwestern University found the price of physician services increases 14 percent after a hospital purchases a physician practice.

It is crucial that Congress end pro monopoly subsidies. Lawmakers should require Medicare to reimburse hospital-owned outpatient facilities at the same rate as independent outpatient facilities for services that can safely be delivered in a physician's office. Furthermore, Congress should promote billing transparency and address billing policies that enable hospitals to dishonestly bill patients.

Promoting billing transparency and site-neutral payments is an important step to lowering the cost of health care. The Congressional Budget Office estimates that ending Medicare's policy of paying hospital-owned facilities higher rates than independent physician offices will save taxpayers more than $140 billion over ten years. Doing so would also substantially reduce premiums and cost-sharing for Medicare beneficiaries, cumulatively by $94 billion over the next ten years according to estimates from the nonpartisan Committee for a Responsible Federal Budget.

We urge you to take swift action to enhance hospital competition and ensure more patients can afford the health care they need.

Americans For Prosperity
Loren Adler, Brookings Institution*
Dr. Brian Miller, American Enterprise Institute (AEI)*
Texas Public Policy Foundation
Mark Miller, Arnold Ventures
Americans For Tax Reform
Josh Gordon, Committee for a Responsible Federal Budget (CRFB)
Goldwater Institute
Progressive Policy Institute
Heartland Institute
Third Way
James Madison Institute
Independent Women's Voice
National Taxpayers Union
FreedomWorks
John Locke Foundation
Cardinal Institute
Docs 4 Patient Care Foundation
Nevada Policy Institute
Jackson W. Hammond, American Action Forum
Avik Roy, Foundation for Research on Equal Opportunity

**Affiliations are listed for identification purposes and do not indicate the organization's support for this issue.*

INFUSION PROVIDERS ALLIANCE

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IPA Comments on Energy & Commerce Health Subcommittee Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

April 26, 2023

The Infusion Providers Alliance (IPA) is pleased to offer testimony for the House Energy & Commerce Health Subcommittee hearing entitled "Lowering Unaffordable Drug Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The IPA's testimony specifically addresses:

- A modified approach to site neutrality legislation that aligns payment rates across sites of care based on volume;
- Support for a Part B co-payment cap rate for physician offices and freestanding infusion centers; and
- Support for oversight of the pharmacy benefit management industry

Background on the Infusion Providers Alliance

The IPA is the leading voice for in-office and freestanding ambulatory infusion providers, with nearly 1,000 community-based, non-hospital infusion sites across 43 states. IPA members represent two types of settings: physician offices and freestanding ambulatory infusion centers. Our facilities are major access points of safe and efficient care for non-cancer patients with complex chronic health conditions like Crohn's Disease, Multiple Sclerosis, rheumatoid arthritis, and many others. Most importantly, our facilities offer a more convenient, more efficient, safer, and less expensive alternative for patients than receiving infusions in the hospital and, in many cases, the home setting.

Site Neutrality

The Health Subcommittee is considering draft legislation that would implement MedPAC's recommendations to align HOPD rates for certain services that can be provided safely at other sites of care with the physician fee schedule (PFS) and/or ambulatory surgery center (ASC) payment rates. As such, that approach would cut reimbursement to hospitals to the physician office rate for procedures or services that are performed at a higher volume outside the hospital and leave the physician office rate unaffected. For example, Medicare's payment of $325.64 to hospitals for complex drug administration (CPT 96413) would be cut to the physician office level of $140.16.

While the IPA is supportive of the Energy & Commerce Committee's efforts to reduce payment disparities between different sites of care for the same services for patients, we believe simply cutting the hospital payment to the physician office rate is not the most thoughtful or effective approach. Instead, we suggest reducing the payment disparities between sites-of-service but not entirely equalizing the payments. As such, the committee should consider a policy that produces net savings to Medicare by modestly reducing the hospital payment and modestly increasing the physician office payment. Such a policy provides greater incentive for the more efficient setting to adopt more volume and continue to do so over time, while also not being overly punitive to the hospitals.

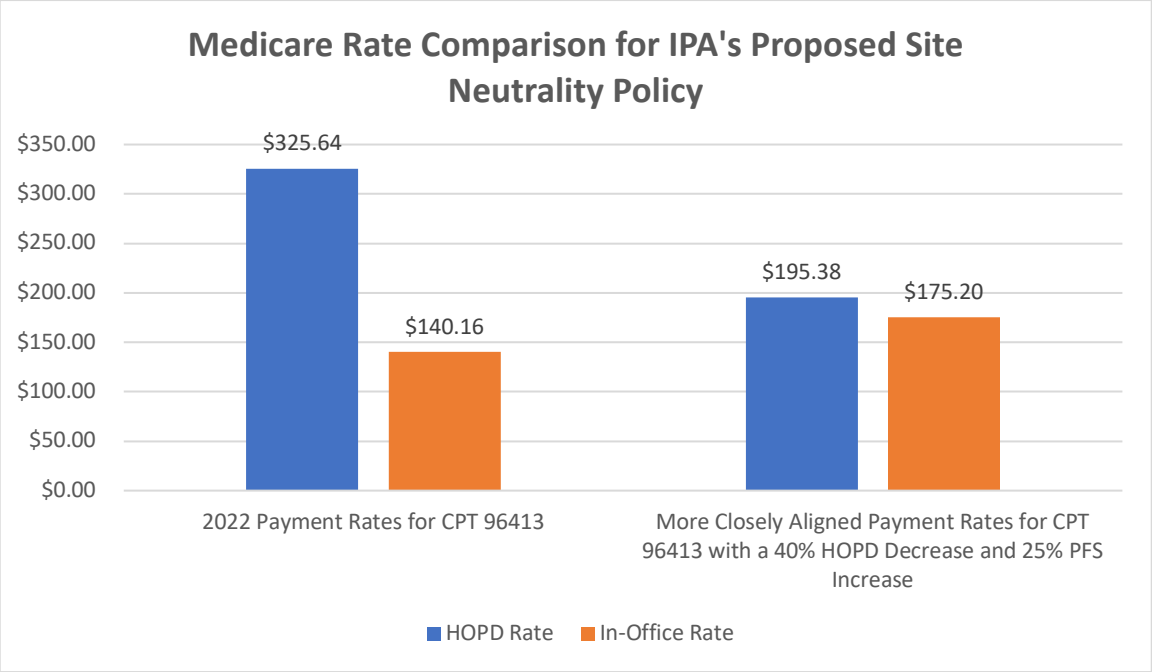
Importantly, this policy change would more closely align the appropriate payment rates between hospital outpatient departments (HOPDs) and physician offices while generating savings for Medicare, which are the goals of site neutrality policies. It would also provide incentives for physician practices and freestanding infusion centers

to expand their capacity, remain independent and counter troubling consolidation trends whereby hospitals are rapidly acquiring physician practices and other outpatient providers.

More adequate payment for the professional services provided for drug administration is warranted because the current professional fee covers only a fraction of the cost of drug administration and means these providers are largely reliant on the add-on payment related to the cost of the Part B drug. According to a study by the National Infusion Center Association, current administration fee payments only cover a fraction of actual costs required to furnish infusion services.[1] In addition, providers face an indefinite Medicare payment freeze under the PFS while hospitals continue to receive market basket updates compounding between 2-4% annually. Additionally. freestanding infusion centers and physician offices, unlike hospitals, are not eligible for 340B discounts, which puts them at an even further disadvantage. All these factors, coupled with the rapidly increasing practice expenses due to inflation and health care workforce shortages, makes this payment situation untenable for the long-term and will likely result in reduced patient access to these vital physician-administered drugs unless Congress acts to promote access to more efficient settings. In short, we believe Congress can pursue a policy that addresses the payment disparities, encourages competition and results in net savings without entirely equalizing payments by simply cutting reimbursement to hospitals.

Hypothetical volume data for the complex drug administration code CPT 96413, referenced above, can be used to demonstrate this proposal and the savings it would still generate for Medicare. If the code was used 100,000 times in 2022 and 52% of that use was in physician offices compared to 48% in HOPD setting, then this proposal would apply. The current $325.64 HOPD payment rate would be reduced by 40% to $195.38 and the $140.16 PFS rate would be increased by 25% to $175.20. This would greatly reduce the payment disparity, as illustrated below.

Medicare would still receive savings, because total Medicare reimbursement for the 100,000 times that CPT code 96413 was used in 2022 (using current payment rates) would total ~$22.9 million (~$15.6 million for HOPDs and ~$7.3 million for physician offices). However, with the 40/20 percent changes, Medicare reimbursement would be reduced to total ~$18.5 million overall (~$9.4 million for HOPDs and ~$9.1 million for physician offices). Medicare would still see a net savings of about $4.4 million.



[1] Medical Benefit Drug Economics: The Price of Furnishing Part B Drugs". National Infusion Center Association

Part B Co-Payment Cap Rate

The IPA supports the draft legislation that would cap the beneficiary copayment for expensive Part B drugs in the physician office at the HOPD cap. This policy will protect patients and encourage migration to the more cost-effective setting. Our organization has long advocated for a statutory cap for Part B drugs equal to the current hospital inpatient deductible, which is currently $1,600 per encounter.[2] While beneficiaries receiving care at HOPDs have a cap on their cost-sharing, those who receive the identical Part B drug in physician offices face unlimited 20 percent co-insurance liability. This results in higher OOP liability for patients for certain high-cost Part B drugs, even though Medicare saves money when they receive their care at physician offices and outpatient infusion centers. The bill addresses the perverse incentives to provide care in the more expensive hospital setting and also assists patients needed, nondiscretionary access to their complex medications. It is also worth noting that this issue primarily impacts those beneficiaries who lack supplemental coverage, and about 50% of that population have incomes below 200% of the federal poverty level and are more likely to be black, disabled, and have functional limitation.[3] Implementing this legislation and putting forth a cap on Part B OOP costs for beneficiaries would help to alleviate this issue and make medications more affordable for fee-for-service Medicare beneficiaries.

PBM Transparency

While we recognize the role that PBMs play in the healthcare continuum, we believe there are far too many instances where certain PBM practices can be opaque, overreaching and supersede the valid clinical decisions of healthcare professionals and the clinical needs of patients. The reporting requirements of the Health Subcommittee's legislation will impose much-needed transparency on the industry.

The IPA again wants to thank the Subcommittee for taking on the important issues of transparency and competition in health care. We look forward to working with the Subcommittee, full Committee, and the rest of Congress to implement meaningful change to site neutrality and provider reimbursement, in order to benefit patients across the country and improve access to affordable health care.

[2] The Infusion Providers Alliance. IPA Comments to the Health Futures Task Force Treatments Subcommittee. March 11, 2022. https://www.infusionprovidersalliance.org/wp-content/uploads/2022/03/IPA-comments-to-GOP-Treatments-Subc.pdf

[3]Nolan Sroczynski and Juliette Cubanski, "Medicare Part B Drugs: Cost Implications for Beneficiaries in Traditional Medicare and Medicare Advantage" (Kaiser Family Foundation, March 15, 2022). https://www.kff.org/medicare/issue-brief/medicare-part-b-drugs-cost-implications-for-beneficiaries-in-traditional-medicare-and-medicare-advantage/.

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April 26, 2023

LUGPA Testimony to the Energy & Commerce Committee

"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

Chairman Guthrie and Ranking Member Eshoo, the Large Urology Group Practice Association (LUGPA) is honored to submit this testimony to the Energy & Commerce Committee "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." LUGPA represents 150 urology group practices in the United States, with more than 2,100 physicians who, collectively, provide more than one-third of the nation's urology services. However, our focus on public policy is on assisting all independent physician practices and the patients we care for.

This testimony builds on the our previous statement of March 28, in which we provided detailed information and concrete policy ideas to address hospital acquisition of physician practices and made suggestions to promote greater competition, transparency and patient choice in the delivery of health care. Specifically, in today's testimony, we address several of the bills before the committee:

1) **Capping Beneficiary Copayments for Physician-Administered Drugs:** LUGPA supports the draft legislation, which equalizes the amount beneficiaries pay for physician-administered drugs by capping beneficiary copayments in the physician office at the HOPD cap. This policy is particularly pertinent to expensive drugs whose copayment burden hinder beneficiary access and act as an impediment to care delivery in the more efficient office setting. LUGPA, along with several other groups, previously suggested this policy in our comments to the GOP Healthy Futures Task Force.

2) **Expanding site neutrality for grandfathered, hospital-owned off-campus physician practices:** LUGPA supports the draft legislation, which expands upon the 2015 Bipartisan Budget Act, that required that new outpatient departments of hospitals be paid by Medicare and Medicare beneficiaries at the same rate as other outpatient providers (physician offices, non-hospital outpatient surgical centers) for the identical services provided in those settings. The discussion draft extends this policy to off-campus outpatient hospital departments that existed prior to 2015, addressing the illogical reimbursement at a much higher rate for precisely the same service based solely on facility ownership. This closes a critical loophole in the law and is a policy long supported by LUGPA and redresses the unintended windfall that this resulted in for hospital systems.

3) **Site-Neutrality for Procedures with Plurality of Care:** LUGPA believes the bill to limit payments to the site-of-service that has the plurality of services, as suggested by MedPAC, should be modified. In particular, we encourage the Committee to consider an alternative policy that narrows but does not entirely eliminate payment disparities between settings of care. Ultimately, policy should promote behavior which promotes innovation, improvements in quality and high-quality care delivery in the most cost-efficient setting. Congress could still achieve substantial net budget savings by pursuing a "carrot and stick" approach that both encourages more care in the physician office/ASC setting and while deterring costly care in the hospital setting by modestly increasing payments in the less costly settings of care and modestly cutting reimbursement in the hospital setting. Additionally, adopting this policy makes the physician office setting more viable over the long-term and will encourage even greater migration, particularly since that payment system is confronting indefinite payment freezes while hospitals continue to receive robust, compounding payment updates.

4) Reform of Inpatient-Only List: LUGPA thanks the committee for including this important issue that puts clinical decisions in the hands of practicing physicians rather than bureaucrats. LUGPA believes the draft bill's phase-out of the inpatient-only list, currently applicable to certain musculoskeletal services, should be expanded to apply to all procedures on the inpatient-only list, as was proposed by CMS several years ago by the previous Administration, but with limited implementation. In addition, the bill should ensure there are associated payments in Hospital Outpatient Prospective System and the ASC payment system to provide these procedures. Finally, CMS should either eliminate the ASC-payable list and let ASCs perform all procedures physician bring to that facility or alternatively add all outpatient procedures to the ASC-payable list.

5) PBM and 340B Transparency: LUGPA is in strong support of greater PBM and 340B transparency, as we believe negotiated rebates and statutory discounts are not reaching the patients and the current pharmaceutical pricing schemes are negatively distorting pricing behavior by pharmaceutical manufacturers.

We thank the committee for advancing these bold ideas and look forward to working with the committee on the particulars of these bills as the process moves forward.

Sincerely,

Evan R. Goldfischer, MD, MBA
President

April 26, 2023

The Honorable Brett Guthrie
Chair, House Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member, House Energy and Commerce Subcommittee on Health
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair Guthrie, Ranking Member Eshoo, and Members of the Subcommittee:

On behalf of National Taxpayers Union (NTU), the nation's oldest taxpayer advocacy organization, I write to thank you for holding this hearing, "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."[1] Several of the bills under consideration by the Subcommittee today could help government officials, health plan sponsors, consumers, and taxpayers better understand the costs they bear within the complex pharmaceutical supply chain, and could empower public and private actors tasked with managing health coverage obtain a better deal for beneficiaries and American taxpayers on health goods and services.

About National Taxpayers Union

NTU is the nation's oldest taxpayer advocacy organization, founded in 1969 and dedicated to the mission of achieving favorable policy outcomes using the most effective pro-taxpayer team on Capitol Hill and in the states. NTU has been engaged on matters of health policy since our founding, specializing in complex issues like generic drug competition, Centers for Medicare and Medicaid Innovation reform, health savings account (HSA) expansion, and more. Recently, we published two major papers concerning America's pharmaceutical supply chain.

The first, "How Pharmacy Benefit Managers Impact Taxpayers and Government Spending," explores the impact PBMs have on the publicly-funded major health programs, namely Medicare and Medicaid. In the paper, NTU also shares narrowly-tailored policy recommendations intended to help Congress and other stakeholders gain better access to the information and data needed to negotiate the best deals for goods and services possible for the American taxpayers funding these programs – importantly, without upending the ecosystem that has enabled the private health care sector to offer innovative and life-saving interventions.[2]

[1] House Committee on Energy and Commerce. "Health Subcommittee Legislative Hearing: 'Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care.'" April 26, 2023. Retrieved from: https://energycommerce.house.gov/events/health-subcommittee-legislative-hearing-1 (Accessed April 20, 2023.)
[2] Lautz, Andrew. "How Pharmacy Benefit Managers Impact Taxpayers and Government Spending." NTU, January 23, 2023. Retrieved from: https://www.ntu.org/publications/detail/how-pharmacy-benefit-managers-impact-taxpayers-and-government-spending (Accessed April 20, 2023.)

The second paper, "How Much is Medicine Worth to the American Taxpayer? A Cost-Benefit Analysis," addresses a key question missing from recent policy debates concerning prescription drug costs and pricing in the U.S. health care system. Policymakers have been laser-focused on costs – often conflating costs with distortive or unrepresentative drug list prices – and have ignored the financial and fiscal benefits medicines provide American consumers and taxpayers. Our paper attempts to introduce a more fulsome cost-benefit analysis, using the recent COVID-19 vaccines as just one example of a medical innovation whose benefits vastly outstrip its costs.[3]

Legislation Considered in Today's Hearing

Several bills considered in today's important hearing appear to align, in some cases partly, with recent policy recommendations shared in NTU's two papers.

H.R. 2679 would require insurers and pharmacy benefit managers (PBMs) to submit information to plan sponsors on a plan's gross spending on prescription drugs, its total amounts received in rebates, fees, and discounts, and its net spending on prescription drugs. Some of the information would also need to be shared with the non-partisan Government Accountability Office (GAO) for further study. NTU has been urging policymakers to ensure that plan sponsors are equipped with more information on their plan's drug spending, gross and net of rebates, and it appears H.R. 2679 would make progress in providing plan sponsors with useful data to ensure they are getting bang for their buck in their relationships with PBMs. To the extent GAO can aggregate this data and report to policymakers and plan sponsors on data trends, such reporting could guide future policymaking that affects the pharmaceutical supply chain.

H.R. 1613 would prohibit spread pricing in Medicaid managed care, require a pass-through rebate model in Medicaid managed care plans, require a Department of Health and Human Services (HHS) survey of retail community pharmacy drug prices, and require an HHS report to Congress on specialty drug coverage and reimbursement in Medicaid programs. We would urge lawmakers and the Subcommittee to proceed with caution on a total ban of spread pricing in Medicaid managed care; this would be a significant policy development, and it is difficult to predict how PBMs would seek to make up for lost revenue elsewhere in their Medicaid, other government-funded, or commercial lines of business. A 50-state study of spread pricing trends in Medicaid, conducted by GAO and/or the HHS Office of Inspector General, could arm lawmakers with more data and guide targeted, effective policymaking in this area. To that end, we support the reporting and survey provisions of H.R. 1613, which could help identify important pricing trends at retail community pharmacies and in specialty pharmacies throughout the Medicaid program(s).

The legislation to "**amend title III of the Public Health Service Act to ensure transparency and oversight of the 340B drug discount program**" is a meritorious bill being considered at today's hearing. NTU has watched trends in the 340B Drug Pricing Program with some alarm. In 2020 we wrote:

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[3] Lautz, Andrew; and Sepp, Pete. "How Much is Medicine Worth to the American Taxpayer? A Cost-Benefit Analysis." NTU, March 27, 2023. Retrieved from: https://www.ntu.org/publications/detail/how-much-is-medicine-worth-to-the-american-taxpayer-a-cost-benefit-analysis (Accessed April 20, 2023.)

> "...the 340B program is still operating under unclear and confusing rules, designed for a much smaller program that was first created in 1992. Numerous independent audits and investigations have found that the Health Resources and Services Administration (HRSA), which oversees the 340B program, not only lacks the authority to conduct necessary and proper oversight and enforcement of 340B rules but also falls short on its existing oversight responsibilities."[4]

To the extent providers participating in the 340B Program are extracting discounts for patients the 340B Program was never intended to serve, or using extra revenue made possible by the discounts in the 340B Program to significantly expand services to communities the 340B Program is not supposed to serve, NTU would advocate for lawmakers to step in and place guardrails on 340B and its future growth. Our 2020 letter above outlines a variety of policy recommendations for 340B Program reform, and we support the legislation considered by the Subcommittee today. The bill would require 340B-eligible providers to submit to HHS audits (at HHS expense) and could help policymakers better determine how revenue derived from the 340B Program is being used by providers.

Though it does not affect the pharmaceutical supply chain NTU wishes to re-express its support for **H.R. 977**, which would undo the Affordable Care Act (ACA) ban on physician-owned hospitals. As we wrote in March 2020, at the start of the COVID-19 pandemic:

> "At a time when hospitals are expected to experience significant restraint due to an influx of COVID-19 patients, policymakers should look at loosening up the Affordable Care Act (ACA)'s restrictions on physician-owned hospitals (POHs). The ACA effectively halted the construction of new POHs and 'generally prohibited [existing POHs] from expanding facility capacity.' The Trump administration has called for repealing the rules, writing that according to the Physician Hospitals of America '37 planned hospitals have not been constructed, and over 30,000 planned healthcare jobs have gone uncreated' because of these restrictions."[5]

Finally, we are encouraged to see legislation that makes progress towards site-neutral payments in Medicare which – if implemented properly – could save taxpayers and Medicare beneficiaries tens of billions of dollars in the next decade. A coalition led by Americans for Prosperity and including NTU wrote, in a letter published April 25, 2023, that:

> "Promoting billing transparency and site-neutral payments is an important step to lowering the cost of health care. The Congressional Budget Office estimates that ending Medicare's policy of paying hospital-owned facilities higher rates than independent physician offices will save taxpayers more than $140 billion over ten years. Doing so would also substantially reduce premiums and cost-sharing for Medicare beneficiaries, cumulatively by $94 billion over the next ten years according to estimates from the nonpartisan Committee for a Responsible Federal Budget."[6]

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[4] Lautz, Andrew. "340B Program Must Be Reformed to Achieve Its Intended Purpose." NTU, October 21, 2020. Retrieved from: https://www.ntu.org/publications/detail/340b-program-must-be-reformed-to-achieve-its-intended-purpose (Accessed April 20, 2023.)

[5] Lautz, Andrew. "Health Policy Options Congress and State Lawmakers Should Consider to Combat COVID-19." NTU, March 18, 2020. Retrieved from: https://www.ntu.org/publications/detail/health-policy-options-congress-and-state-lawmakers-should-consider-to-combat-covid-19 (Accessed April 20, 2023.)

[6] Americans for Prosperity. "Bipartisan Support for Site Neutral Payment Reform." April 25, 2023. Retrieved from: https://americansforprosperity.org/wp-content/uploads/2023/04/Bipartisan-Support-For-Site-Neutral-Payment-Reform.pdf (Accessed April 26, 2023.)

While we do not support every bill or every provision being considered in the Subcommittee's hearing today, we are encouraged by the directions taken in the legislation mentioned above and the Subcommittee's broad focus on improving transparency in the health sector. We look forward to working with you throughout the 118th Congress to advance bipartisan, pro-taxpayer, and pro-competitive health reforms.

Sincerely,

Andrew Lautz
Director of Federal Policy, NTU

Nicholas Johns
Policy and Government Affairs Manager, NTU

CC: The Honorable Cathy McMorris Rodgers, Chair, House Committee on Energy and Commerce
The Honorable Frank Pallone, Jr., Ranking Member, House Committee on Energy and Commerce
The Honorable Larry Bucshon, Vice Chair, House Energy and Commerce Subcommittee on Health
Members of the House Energy and Commerce Subcommittee on Health

U.S. House of Representatives
Energy and Commerce Subcommittee on Health
Hearing on
"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"
April 22, 2023

The Physicians Advocacy Institute ("PAI") is pleased to offer this statement of support of the U.S. House of Representative's Subcommittee on Health's hearing today entitled *"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."* We commend this Subcommittee for tackling issues demanding urgent attention, the need to increase competition and transparency in today's health care system.

PAI is a nonprofit organization that was established to advance fair and transparent policies in the healthcare system to sustain the profession of medicine for the benefit of patients. PAI's Board of Directors is comprised of CEOs of the California Medical Association, Connecticut State Medical Society, North Carolina Medical Society, Medical Society of the State of New York, Nebraska Medical Association, South Carolina Medical Association, Tennessee Medical Association and Texas Medical Association.

PAI is a vocal advocate for increased competition in the healthcare marketplace. We urge the Subcommittee's consideration of legislation to reverse longstanding federal policies that have exacerbated the trends of widespread consolidation and diminishing competition in today's healthcare system, preventing physician-led organizations from competing with larger corporate interests. We call the Subcommittee's attention to federal policies that have spurred consolidation and undermined physicians' ability to maintain private medical practices or compete on a level playing field with corporate-owned hospitals. These policies include: (1) the failure of Medicare payments to physicians to reflect inflation and other growing costs of delivering care; (2) the federal moratorium on physician-owned hospitals ("POHs"); and (3) the longstanding payment policies that incentivize care delivery in hospital-owned settings, even when the physician office setting is more efficient.

As noted by the Subcommittee in the hearing notice, today's highly consolidated healthcare marketplace has resulted in higher costs for patients and payers alike while diminishing choice and innovation. Physicians have been unable to sustain private medical practices and are experiencing an alarming loss of professional satisfaction practicing medicine in this environment, leading many to retire early.

Most importantly, this lack of competition is antithetical to the best interests of patients. True patient-centered healthcare requires that patients have choices for where to seek medical care, including the ability to choose healthcare delivery options led by physicians, rather than large conglomerates. Armed with full information regarding their options, we believe that many patients would choose to seek medical care in settings that physicians own, operate and lead clinical decision-making, rather than those owned and operated by corporations whose primary fiduciary obligation in many cases is to their shareholders.

We believe that physicians' extensive education and training, along with their ethical obligations to patients, make them well equipped to organize care delivery to optimize both quality and efficiency. Physicians are uniquely positioned to recognize advances in medical treatments and therapies that offer patients better value and higher quality outcomes as compared with entities owned and operated by non-clinicians. For these reasons, **we strongly urge this Subcommittee's support for H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023**, which would eliminate an arbitrary barrier to entry for physician-owned hospitals ("POHs") to compete in the healthcare market.

The Trend of Consolidation in the Market for Physician Services

Over the past decade, the trend of industry-wide consolidation has transformed virtually every aspect of the delivery of health care in this country. In addition to the sustained trend of "horizontal" consolidation that has created ever larger and more powerful insurers, hospitals and health systems, the last decade has also seen intensive "vertical" consolidation that has resulted in massive corporate entities that often own and control both the financing and delivery of health care in the U.S.

This consolidation trend is particularly pronounced in the physician service sector, driven by over a decade of sustained acquisitions of independent physician practices by hospitals and health systems as well as corporate entities including large national health insurers and private equity and venture capital firms. The nation's largest pharmacies and Amazon have entered this market by employing physicians to deliver primary care services to their customers.

PAI and Avalere Health have closely studied the trend of consolidation, which has drastically transformed where and how physicians practice medicine over the past decade. The statistics show a dramatic shift away from physicians practicing in independently owned medical practices in favor of employed settings, with these key findings:

- In 2012, roughly one quarter of physicians were employed by hospitals and health systems, which owned only 13.6% of physician practices. By the start of 2022, a stunning 74% of physicians were employed by hospitals/health systems and other corporate entities, and over half of physician practices were owned by these entities.

- There was a sharp uptick in these consolidation trends during the months following the onset of the Covid-19 pandemic. 2021 alone saw growth of 19% in physician employment, underscoring

the impact of the pandemic on physicians' ability to sustain private practices. Between 2019 and 2021, an additional 58,200 physicians became hospital employees.

- These consolidation trends have occurred nationwide, with all regions of the nation experiencing sustained growth in physician employment and practice acquisitions, with some regional variations in terms of acquiring entities.

The drivers of these consolidation trends in the physician service market are well known. Hospitals, insurers and these other corporate entities that are acquiring physician practices view employing physicians as critical to succeeding in the marketplace. Certain economic drivers are straightforward: Insurers' payment policies – led by Medicare – have created strong financial incentives favoring the delivery of services in hospital-owned outpatient settings to the detriment of independently-owned physician practices. Once patients receive services in a hospital-owned setting, they are more likely to stay within that system for other treatments and tests. This results in higher spending, as demonstrated by an Avalere study that found significantly higher Medicare spending across full "episodes of care" for three common services (colonoscopies, echocardiograms and evaluation and management services) when the initial service was delivered in the hospital outpatient setting versus the physician office setting. This "site of service" payment differential has created powerful incentives for large, well-financed hospitals to expand their outpatient services, a key aspect of hospital-driven consolidation.

To be clear, Congress cannot solve this problem simply by cutting hospital reimbursement while continuing to underinvest in physician payment. As noted below, physician reimbursements under Medicare have not kept up with the costs of delivering care. As such, we urge this Subcommittee to recognize the need to establish a sustainable, site-neutral approach to establishing payments for outpatient services for Medicare beneficiaries that reflect the cost of delivering care most efficiently.

In addition to the higher reimbursement incentives in fee-for-service reimbursement, value-based payment models often favor larger integrated providers over smaller physician practices. PAI strongly supports policies to allow physicians to participate in the Medicare Quality Payment Program and other value-based arrangements and has developed comprehensive educational tools for physicians to enable this successful transition.

Why Congress and CMS Must Revamp the Current Approach to Medicare Physician Payment

In many areas of the country, particularly in small communities and urban centers, physician-led practices are the backbone of the health delivery system for Medicare beneficiaries. At a time when many rural and urban Medicare beneficiaries face challenges finding physicians to manage their care or provide specialty services, the current approach to physician payment in the Medicare system is unsustainable. Each year, the physician fee schedule faces deep cuts due to statutory policies (e.g., budget neutrality, PAYGO, etc.), forcing Congress to act at the eleventh hour to act to avoid further access issues for Medicare beneficiaries. This long-term financial instability in the Medicare physician payment system has contributed to the ongoing trend of marketplace consolidation, which raises systemwide costs and directly impacts access

to care for many patients. PAI urges Congress and the Centers for Medicare and Medicaid Services (CMS) to prioritize payment reforms such as those included in H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," to prevent further erosion of physician-led practices that participate in Medicare.

Why Congress Should Lift the Misguided Moratorium on Physician-Owned Hospitals

We commend the Subcommittee for recognizing H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023, authored by Rep. Michael Burgess, M.D. (R-TX) and Rep. Henry Cuellar (D-TX), as a legislative solution that will provide much-needed competition for hospital services while lowering health care costs and enhancing care quality. This bipartisan bill would reverse a policy embedded in the 2010 Patient Protection and Affordable Care Act (ACA), championed by a powerful hospital lobby, that established a moratorium on new or expanded physician-owned hospitals. This moratorium has had the dramatic effect of eliminating physicians' ability to establish community or specialty hospitals to compete with larger, corporate-owned hospitals based on quality and cost. Removing the misguided moratorium will enhance competition and give physicians an ability to invest in hospitals in their communities, which is particularly important for small and rural communities that are rapidly losing their hospitals.

Eliminating this competitive force has driven costs higher while depriving patients of an important choice in today's increasingly corporatized healthcare system – namely, care that is delivered in hospital setting owned and operated by physicians. The resulting lack of competition in the hospital service sector, exacerbated by increasing consolidation, has resulted in higher costs for patients and greater government spending. In many markets, large hospitals exert monopoly power both upstream (by dictating contractual terms and payment rate for physician and other provider services) and downstream (by raising costs for patients and payers). These anticompetitive policies and behaviors perpetuate market dominance by restricting new market entrants or competitors. It is no wonder that healthcare costs and spending continue unabated, given the extent of consolidation and lack of competition that prevails today.

Hospital industry interests have long maintained - with no supportive evidence - that physician-owned hospitals "cherry-pick" healthier patients and increase healthcare costs by driving utilization higher. These arguments ignore that the very same incentives and checks relating to overutilization apply to all types of hospital owners. In fact, there is one critical distinction that favors physician ownership. In most cases, these corporate entities' primary focus is to maximize profits for shareholders or sustain positive bond ratings, *not* with the patients whom they serve. In stark contrast, physicians have an ethical responsibility to provide the best possible care to their patients.

Doctors, whether at the bedside or the forefront of scientific innovation, are highly capable of envisioning new healthcare procedures, decreasing expenses, and enhancing the level of patient care as has been proven by several independent, peer reviewed studies. Numerous analyses by researchers and overseers of the Medicare and Medicaid program have found that

physician-owned hospitals excel at treating patients competitively regarding cost, quality, and patient satisfaction as documented in a sample of studies below.

*Physician-owned hospitals can compete on **cost:***

- A 2021 study published by the Mercatus Center at George Mason University concluded that physician-owned hospitals offer high quality and lower or equivalent cost services versus comparable hospitals.
- A study published in the peer-reviewed BMJ medical journal —funded with internal resources from the Harvard School of Public Health—revealed that patients in physician-owned hospitals are equally likely to treat Medicaid patients and had similar numbers of chronic diseases and predicted mortality as patients in other facilities—demonstrating that they can effectively manage chronic diseases and reduce the risk of mortality, regardless of the patients' insurance status.

*Physician-owned hospital can compete on **quality**:*

- A study published in the Hospitalist using data from the American Hospitals Association's annual survey showed that physician-owned hospitals had lower readmission rates than non-physician-owned hospitals.
- A study published in the Journal of the American College of Surgeons found that physician-owned surgical hospitals outperform other hospitals in Medicare value-based purchasing program.
- In one of the DRGs for the Centers for Medicare and Medicaid Innovation (CMMI) joint replacement demonstration: 72% of participating physician-owned hospitals producing savings – much more than the 52% of non-physician-owned hospitals achieving this goal; and over 44% of participating physician-owned hospitals received an "excellent" quality score, significantly higher than the 16.4% rate for non-POHs.
- The Medicare Payment Advisory Commission (MedPAC) acknowledged that physician-owned hospitals can provide high-quality care. In a report to Congress, MedPAC stated that "physician-owned hospitals tend to score highly on patient satisfaction and quality measures" (MedPAC, 2018).

*Physician-owned hospitals can compete on **patient satisfaction**:*

- A study published in Health Affairs found that physician-owned specialty hospitals provide generally high-quality care to satisfied patients and greater community benefit than nonprofit providers.
- Physician-led hospitals have higher patient satisfaction according to CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHP) Survey. According to CMS' (HCAHPS) data, 96 percent of PHA members have 4- or 5-star consumer ratings, compared to less than 40 percent of non-physician owned hospitals.

Physician-owned hospitals can introduce competition in an otherwise costly and highly consolidated health system. With growing consolidation in hospital markets, competition from physician-owned hospitals could offer communities and patients a market-based solution to address rising costs while advancing high quality services. A recent Health Affairs article authored by physician members of the American Medical Association, American Academy of Orthopedic Surgeons, and American College of Cardiology, described the lack of competition in hospital markets, and cited the "well-documented, specific harms of provider consolidation." The authors warned that consolidation leads to a "lack of quality benefits," worse patient

experiences, “physician burnout due to a loss of control over the practice environment, and higher hospital prices driving rising insurance premiums and ultimately rising costs to consumers.”

Similar findings were highlighted by the Medicare Payment Advisory Commission (MedPAC) in its March 2020 analysis of health care consolidation, which found that most hospital markets are dominated by a single hospital system that had more than a 50% share of discharges. MedPAC added that hospital consolidation “permits hospitals to leverage higher prices from commercial payers,” and emphasized that “commercially insured patients appear to pay higher prices for care and higher prices for insurance in consolidated markets.” MedPAC also found that hospital acquisition of physician practices “increases Medicare spending” and financial liability for Medicare beneficiaries. Indeed, the current Administration specifically cites hospital consolidation and subsequent rising health costs as a concern yet overlooks the most obvious way to increase healthcare options: letting doctor-owned and managed facilities grow as they did before the 2010 physician ownership ban.

Physician-owned hospitals could offer a hospital option in rural and other high need areas. Enabling physicians to build and own hospitals could help stem a growing trend of rural hospital closures that impacts not just cost and quality of care, but also employment in rural areas where hospitals are the economic hub. When hospital systems shut down a hospital in rural America today because of poor performance, physicians who see more potential in that hospital are prohibited to respond by buying it. Unfortunately, many areas that have already experienced hospital closures have missed out on such opportunities because once physicians and medical personnel move away from a community, it is highly unlikely they will return. Removing the physician ownership moratorium immediately could help save many now failing community hospitals as well as costs related to delayed and long-distance care in the absence of a nearby hospital. The Centers for Medicare and Medicaid (CMS) in fact acknowledged this need by proposing, but unexplainably not finalizing, a rule that would have relaxed hospital ownership restrictions in high need areas. CMS further acknowledged the value of physician-owned hospitals when it issued a limited temporary waiver to enable them to increase hospital surge capacity during the public health emergency. As a result of that waiver, physician-owned hospitals willingly stepped up by directly treating COVID-19 infected patients and adding ICU and other capacity to assist their communities’ response during the pandemic.

As Congress seeks answers to reduce the burden of spiraling health care costs on Medicare, patients, and other public and private programs and payers, PAI urges Congress to allow physicians to be part of the solution by enacting H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023.

Conclusion

PAI appreciates the opportunity to submit this statement of support and reiterates its vision for a healthcare system where physicians can maintain independent medical practices and organize and lead healthcare delivery options, including physician owned hospitals, for the benefit of American patients.

PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

STATEMENT FOR THE RECORD

"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

U.S. Committee on Energy and Commerce Subcommittee on Health

April 26, 2023

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care for independent physicians and practices to reduce costs, improve quality, empower patients and physicians, and increase access to care through a competitive health care provider market. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country.

We believe that physicians – especially independent physician practices – are the lynchpin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. In our vision of the future, this important piece of the health care system not only survives, but thrives as a result of policies that place independent physicians on a level playing field with other providers and opportunities to test new payment and delivery innovations in models that are adapted for their unique circumstances.

Increasing consolidation in the provider market creates greater urgency to ensure that value-based models are a path to sustainability for practices and physicians who are currently independent and wish to remain so, as well as for providers who are not currently independent but wish to make a change in their practice setting. We support legislative action that creates parity across practice settings; aligns incentives to enable a range of providers to move toward value-based care; and prohibits and/or dis-incentivizes anti-competitive behavior.

We commend the Committee for its consideration of this important issue, and putting forth legislation and proposals to increase transparency and competition in health care. Our comments below provide evidence of the detrimental impact of increasing provider consolidation, support and feedback on legislative proposals, and additional areas where we urge Congressional action.

1. **Provider Consolidation Continues to Accelerate, Leading to Higher Costs Without Measurable Improvements in Quality.**

    - A March 2023 study by the Harvard Kennedy School found that when physicians integrated with a hospital, they changed their care practices and increased their throughput, resulting in increased complications and worse patient outcomes. Moreover, integration increased rates of reimbursement by about 48 percent.
    - A March 2023 study by researchers from the National Bureau of Economic Research and Harvard Medical School found significantly higher costs for care, with only marginally better care, provided to patients in health systems compared to those at independent practices or hospitals. Physician services delivered within health systems cost between 12 percent and 26 percent more, and system-based hospital services cost 31 percent more, compared with care delivered by independent hospitals.
    - A January 2023 study found that, in 2018, health system physicians and hospitals delivered a marginally better performance on clinical quality and patient experience measures but

spending and prices were substantially higher. This was especially true for small practices, and researchers concluded that the small quality differentials combined with large price differentials suggest that health systems have not realized their potential for better care at equal or lower cost.

- A January 2023 report by the Commonwealth Fund found that two hospital systems accounted for more than half of traditional Medicare inpatient hospital spending in 85 percent of hospital referral regions (HRRs) and accounted for more than three-quarters of spending in 35 percent of the HRRs. In 10 states plus D.C., two hospital systems account for the majority of Medicare inpatient hospital spending in the entire state.
- An April 2022 analysis by Avalere Health and the Physicians Advocacy Institute (PAI) found a nearly 24 percent increase in the percentage of employed physicians during the COVID-19 pandemic (January 2020 to January 2022). By January 2022, the study found that 74 percent of physicians were employed by a hospital or corporate-entity.
- Trends in corporate ownership, such as insurers and private equity firms, are now outpacing hospitals and health system-ownership of physician practices, according to the Avalere Health and PAI analysis. Corporate ownership of physician practices increased over 50 percent from January 2019 to January 2022, while hospital ownership increased by eight percent. By January 2021, over 26 percent of physician practices were owned by hospitals and 22 percent of physician practices were owned by corporate entities, such as insurers and private equity firms.
- A Kaufman Hall review of merger and acquisition (M&A) activity between hospitals and health systems in the second quarter of 2022 found that M&A revenue hit a record high in, with 13 transactions generating $19.2 billion. Highlighting the degree of consolidation in the industry, the average size of the smaller party was nearly $1.5 billion, which was more than double the record-setting average size of $619 million at the end of 2021.
- A September 2020 Kaiser Family Foundation brief examining health care consolidation looked at a number of studies, including one examining Medicare beneficiary patterns of health care utilization, which found that "patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital." The brief also noted that quality of care does not improve and sometimes gets worse following both vertical and horizontal consolidation. For vertical consolidation, one study of 15 integrated delivery networks found no evidence of better clinical quality or safety scores compared to competitors outside the networks, and another study found that hospital-based provider groups had higher per beneficiary Medicare spending and higher readmission rates compared to smaller groups.
- A March 2020 report by the Medicare Payment Advisory Commission (MedPAC) found that in most markets by 2017, a single hospital system accounted for over 50 percent of inpatient admissions. Incentives for physicians to join larger practices include higher commercial prices and increased efficiencies. In 2018, nearly 57 percent of physicians worked in small physician practices (10 or fewer physicians). Additionally, recent studies highlighted in the report found that provider consolidation with hospital/health systems led to an increase in commercial prices from three percent to 14 percent, however efficiencies are not increasing with higher total spending as was originally assumed given the potential for improved coordination via consolidated practices. This report also highlighted the following findings on quality as a result of hospital-physician integration:
    - Patients were more likely to choose a high-cost, low quality hospital when their provider was employed by the hospital.

- Physicians whose practices were acquired by hospitals were more likely to bill for more services in the hospital setting and fewer in the office setting.
- Hospital acquisitions of a physician practice had little effect on improved outcomes on a range of issues, such as mortality, acute circulatory conditions, and diabetes complications (Koch et al. 2019).
- Vertical integration had a limited effect on quality metrics reported by CMS (Short and Ho 2019).

2. Comments on Legislation and Proposals Under Consideration.

- Competition and Consolidation: As highlighted above, consolidation in the health care sector continues to increase at an alarming rate, leading to higher costs without measurable improvements in quality. With that in mind, we applaud the Committee for putting forth legislation that would require the Secretary of Health and Human Services to explicitly examine the impact on provider and payer consolidation during the rulemaking process pertaining to payment systems, rate schedules, or other reimbursement, as well as CMS Innovation Center model evaluations.

  We are supportive of the following discussion draft, and urge the Committee to work with stakeholders to identify appropriate evaluation criteria for CMS Innovation Center models. We believe appropriate criteria could include accountable care organization (ACO) ownership structure and specific policies related to the model themselves that might favor larger entities:

  - **H.R. ___**, To require the Secretary of Health and Human Services to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation, and for other purposes

- Site-Neutral Payment Policy: As outlined in a recent Brookings Institution brief, a broader set of site neutral payments would further reduce Medicare spending, beneficiary costs, and incentives for hospitals to purchase physician practices. MedPAC estimates that aligning payments across sites of care for the list of services identified would have saved Medicare $6.6 billion and beneficiaries an additional $1.7 billion if in place in 2019, even before accounting for the potential dynamic effects on vertical consolidation.

  We applaud the Committee for putting forth legislation that would build upon existing site-neutrality rules and create more fairness in the payment system by passing legislation to ensure CMS pays the same rates across practice settings. We are supportive of the following legislative discussion drafts:

  - **H.R. ___**, To amend title XVIII of the Social Security Act to require payment for all hospital-owned physician offices located off-campus be paid in accordance with the applicable payment system for the items and services furnished
  - **H.R. ___,** To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings

  However, we are concerned that a four-year lookback period to determine the services for which site neutral payments apply may incentivize even more services to be rendered in the inpatient setting and drive further consolidation between hospitals and physician practices. We

encourage Committee staff to ensure site neutral legislation does not have the unintended consequence of driving more consolidation.

Further, we believe site neutral payment policies should be accompanied by an increase to reimbursement for Part B services given that reimbursement for these services is currently inadequate. We also urge the Committee to consider the tools available to ensure that that cuts to facilities are not disproportionately passed along to clinicians

Inpatient Only List: The inpatient only (IPO) list currently includes over 1,500 Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes, which are services automatically approved for Medicare Part A coverage and must be performed in a hospital. We are supportive of CMS working with stakeholders to implement measured, clinically-based reforms to the IPO list. Eliminating services from the list that can be safely performed in outpatient settings will level the playing field between various sites of service, resulting in more cost-effective care.

We are supportive of the following legislative discussion draft, but urge the Committee to ensure that any reforms to the IPO list are made transparently with appropriate stakeholder input and opportunity for comment:

- **H.R.___**, To phase out certain services designated as inpatient-only services under the Medicare program.

3. Additional Congressional Action That is Needed to Promote Competition.

- Physician Payment Reform: To give independent practices and physicians a chance to remain independent if they choose to, reimbursement structures for federal programs such as Medicare must keep pace. Because many value-based care models continue to be built on the FFS chassis, Medicare fee-for-service (FFS) payment rates and policies are integral to the success of CMS' value-based care models. A recent survey found average physician pay fell by 2.4 percent from 2021 to 2022, at a time when physicians are facing significant challenges, including economic strains, a growing shortage, and high rates of work-related burnout.

  Congress must invest in the Medicare physician fee schedule to ensure that providers are appropriately reimbursed for their services and to ensure that reimbursement accounts for rising overhead costs and inflation.

- Transparency and Antitrust Enforcement: As outlined by the Brookings Institution, antitrust authorities are currently constrained in a number of ways, including limited available data and resources, as well as a high threshold of pre-merger notification. In 2023, pre-merger notification to federal antitrust authorities was required for transactions over $111.4 million, meaning that many acquisitions, particularly of physician practice, go unnoticed until the merger has been finalized. Greater transparency and strengthened antitrust statutes could help reduce the amount of anticompetitive consolidation in health care.

Congress should ensure that oversight agencies such as the Federal Trade Commission have the resources needed to be effective in researching and pursuing new and develop issues related to health care consolidation and competition.

- Leverage Physician-led Payment Models to Drive Quality and Cost Outcomes: There is an urgent need for Congress to ensure that value-based care models are fully leveraged as an option to keep provider markets competitive. Getting providers off the fee-for-service chassis enables them to provide higher-quality, more coordinated care for their patients, and provides financial predictability and stability. Through models such as Comprehensive Primary Care+ and the Medicare Shared Savings Program, physician-led groups have demonstrated their ability to drive results in the form of increase outcomes and reduced costs by moving away from utilization-based approaches to the payment and delivery of health care.

  Congress should urge CMS to prioritize physician-led models, and should extend the MACRA bonus for providers participating in advanced alternative payment models (AAPMs). Congress should also consider approaches to MACRA reform that focus on the doctor-patient relationship, and leverage the unique capability of physician-led groups to transform health care for the benefit of patients.

*****

We hope you will consider this evidence and recommendations as Congress looks to take action to address consolidation in the provider market. Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you (kristen@physiciansforvalue.org).

Sincerely,

Kristen McGovern
Executive Director

April 24, 2023

The Honorable Brett Guthrie
House Energy & Commerce Committee
Health Subcommittee
U.S. House of Representatives
2434 Rayburn House Office Bldg.
Washington, DC 20510

The Honorable Anna Eshoo
House Energy & Commerce Committee
Health Subcommittee
U.S. House of Representatives
272 Cannon House Office Bldg.
Washington, DC 20510

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of our nearly 500 members – including emerging and established biotechnology companies, academic and medical research institutions, and patient organizations – the Alliance for Regenerative Medicine (ARM) applauds you for introducing H.R. 2666, the "Medicaid VBPs for Patients (MVP)" Act.

Advancing value-based payment arrangements for cell and gene therapy has been a long-standing priority for ARM, and we view the MVP Act as a step in the right direction to promoting access to cell and gene therapies for the Medicaid patients that need them.

We look forward to continuing our work with you and the other bill sponsors, along with your colleagues in the Senate, to improve the value-based payment landscape through meaningful legislative reform that supports patient access to transformative cell and gene therapies.

Sincerely,

/s/

Mark Battaglini
Chief Strategy Officer
Alliance for Regenerative Medicine

CC: Cathy McMorris Rodgers, Chair, Energy and Commerce Committee
Frank Pallone Jr., Ranking Member, Energy and Commerce Committee

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April 26, 2023

The Honorable Brett Guthrie
Chairman
Subcommittee on Health
House Energy & Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

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

Dear Chairman Guthrie, Ranking Member Eshoo, and Members of the House Energy & Commerce Subcommittee on Health,

On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business advocacy organization, we applaud the subcommittee's focus on lowering healthcare costs and promoting transparency and competition in healthcare.

Small businesses play a critical role in creating jobs and driving economic growth. For nearly 40 years, NFIB members have identified the rising cost of health insurance as their top concern.[1] However, Congress has failed to address the causes of rapidly rising health insurance costs.

A recent NFIB survey found that 56% of small employers currently offer health insurance to employees while 44% do not.[2] The data clearly shows that the most significant reason small employers do not offer health insurance is cost, with 65% of respondents reporting cost as the primary reason.[3] Furthermore, 98% of small employers are concerned that the cost of providing health insurance to their employees will become unsustainable in the next 5-10 years.[4]

Small business owners are forced to make difficult decisions in response to this unaffordability crisis. Businesses offering health coverage must often pass the costs along to their customers. Nearly half of small employers (46%) report raising their prices to keep up with rising health insurance costs. Moreover, almost half of small employers now earn less due to health insurance

[1] Holly Wade & Andrew Heritage, *Small Business Problems and Priorities*, NFIB Research Center, 2020, https://assets.nfib.com/nfibcom/NFIB-Problems-and-Priorities-2020.pdf.
[2] Holly Wade & Madeleine Oldstone, *Small Business Health Insurance Survey*, NFIB Research Center, March 2023, https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf.
[3] *Ibid.*
[4] *Ibid.*

premium increases over the last five years.[5] Since 2014, certain counties have witnessed small business premiums skyrocketing by as high as 140%.[6]

Healthcare unaffordability impacts our entire economy. Sixty-three percent of employers believe offering health insurance to recruit and retain employees is a very or moderately important factor in their business.[7] As small businesses struggle to rebound from crippling inflation, worker shortages, and looming supply chain disruptions, it is critical that they can compete with larger firms in attracting and retaining talent. Health costs make remaining competitive difficult for small employers as they do not enjoy the same regulatory flexibilities and economies of scale as large firms.

NFIB recommends that Congress implement policies that lower healthcare costs for small employers and their employees while expanding choice and flexibility in benefit offerings and reducing regulatory burdens.

Promote Price Transparency and Price Certainty

Small businesses support price transparency. In a recent NFIB member ballot, more than three-quarters (77%) of small business owners support requiring insurers to provide price information for healthcare services. And small businesses can benefit greatly from greater price transparency. When healthcare providers and insurers are required to disclose the costs of their services and treatments, small businesses can make more informed decisions about which plans and providers to choose. This enables them to negotiate better rates with their insurers and avoid overpaying for healthcare services. According to a study by the RAND Corporation, improving hospital price transparency could decrease hospital spending by as much as $26.6 billion per year.[8]

Additionally, small business owners would benefit from moving the market toward site-neutral payment policies in the commercial market, which studies find would reduce health expenditures and result in lower premiums and cost-sharing.[9] Specifically, lawmakers should prohibit off-campus hospital outpatient departments (HOPDs) from billing add-on hospital fees leading to lower out-of-pocket costs and disincentivizing consolidation in the market. Prohibiting the billing of additional hospital fees would also result in greater transparency regarding the price charged for a given procedure on and off a hospital campus.

Promote Beneficial Competition

Small businesses can also benefit from greater competition in the healthcare industry. Consolidation in local healthcare markets can be particularly harmful to small employers, which may already have limited options for providers in their area. According to the Congressional Budget Office (CBO), hospital markets have become more highly concentrated in recent years, with the

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[5] *Ibid.*

[6] Internal Revenue Service. *Instructions for Form 8941, Credit for Small Employer Health Insurance Premiums*, 2022, pp. 10-30, https://www.irs.gov/pub/irs-pdf/i8941.pdf.

[7] Holly Wade & Madeleine Oldstone, *Small Business Health Insurance Survey*, NFIB Research Center, March 2023, https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf.

[8] Jodi L. Liu, Zachary M. Levinson, Nabeel Qureshi, and Christopher M. Whaley, *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans*. RAND Corporation, 2021, https://www.rand.org/pubs/research_reports/RRA805-1.html.

[9] *Moving to Site-Neutrality in Commercial Insurance*, Committee for a Responsible Federal Budget, February 14, 2023, https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

share of concentrated systems increasing from 63% to 70%.[10] Consolidation undoubtedly has resulted in higher prices in the commercial market: A 2020 review of published research by the Medicare Payment Advisory Commission (MedPAC) concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices."[11]

The same is true of Pharmacy Benefit Managers (PBMs), which continue to consolidate further and negatively impact employers and their employees through higher prescription drug costs. The three largest PBMs control at least 80% of the health plan pharmacy benefit market,[12] and control, through PBM-affiliated pharmacies, more than 65% of total prescription revenues ($122.2 billion in 2021) from pharmacy-dispensed specialty drugs. In contrast to other claims that consolidation would help consumers with greater efficiencies and lower prices, it has only resulted in less transparency and made the system more opaque. PBM reform is necessary to lower prescription drug costs. By increasing transparency, limiting spread pricing, allowing patient choice, and encouraging competition, PBMs can be incentivized to be better partners to small employers and patients generally.

Small business owners support lowering healthcare costs through increased competition. In a recent NFIB member ballot, more than 80% of small business owners support legislation to rein in healthcare consolidation and anti-competitive business practices.

NFIB remains committed to partnering with you to ensure that small businesses and their employees can access affordable health insurance coverage: When small businesses thrive, our communities thrive.

We greatly appreciate your consideration of these vital policy issues and look forward to working with you to protect and defend the small business community.

Sincerely,

Kevin Kuhlman
Vice President, Federal Government Relations
NFIB

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[10] *S.1895, Lower Health Care Costs Act Cost Estimate*, Congressional Budget Office, July 16, 2019, https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

[11] *March 2020 Report to the Congress: Medicare Payment Policy*, MedPAC, March 13, 2020, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf.

[12] Adam J. Fein, *DCI's Top 15 Specialty Pharmacies of 2021—And Three Factors That Will Reshape 2022*, May 4, 2022, https://www.drugchannels.net/2022/05/dcis-top-15-specialty-pharmacies-of.html.

CONSUMERS F1RST

The Alliance to Make the Health Care System Work for Everyone

Statement for the Record

House Committee on Energy and Commerce

Subcommittee on Health

Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

Prepared by *Consumers First: The Alliance to Make the Health Care System Work for Everyone*

April 26, 2023

Chairs McMorris Rodgers and Guthrie and Ranking Members Pallone and Eshoo, on behalf *of Consumers First* and our undersigned allies we want to thank you for holding this important and timely hearing on legislative solutions to increase transparency and competition in health care.

As an alliance that brings together the interests of consumers, employers, labor unions, and primary care clinicians working to realign and improve the fundamental economic incentives and design of the health care system, *Consumers First* thanks you for building off of the robust discussion of last month's Health Subcommittee hearing to pursue meaningful policy solutions to address our nation's affordability crisis and rein in irrational and abusive health care prices driven overwhelmingly by industry - and principally hospital - consolidation. We stand ready to support you as you continue this critical work.

As we wrote in our March 28, 2023 Statement for the Record[i], consumers, employers, workers, and clinicians are struggling in a health care system whose payment and delivery structure incentivizes high cost, low quality care. Rising consolidation, particularly among hospitals, has eliminated healthy competition and led to irrational health care prices and anticompetitive behavior.[ii]

A number of the solutions being considered today would make important strides towards addressing some of the most obvious health system failings that have enabled anticompetitive behaviors, prevented healthy competition, and resulted in monopolies that set outrageous and unjustifiable prices. We are particularly interested in today's discussion around codifying and strengthening price transparency rules and expanding site neutral payments, which track recommendations from our March 28 statement.

Price transparency pulls back the curtain so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses. Moving towards achieving full transparency of health care prices is a critical step towards driving value in the U.S. health care system and ensuring our nation's families receive affordable, high-quality health care.

We are also encouraged by the Committee's consideration of legislation to implement site-neutral payment policies across the board, and legislation to eliminate site-dependent reimbursement distortions that incentivize acquisition of non-hospital patient access points. This flaw in Medicare's current payment structure unnecessarily promotes care in more expensive settings while failing to appropriately pay some clinicians and other health care workers in non-hospital settings. Advancing comprehensive site-neutral payment reforms would be a welcome first step to crack down on industry gaming that uses misaligned payment incentives to drive up costs without investing in quality, and these policies are estimated to result in billions of dollars of savings for Medicare beneficiaries and the Medicare program.[iii]

These policies and others under consideration by Energy and Commerce would set critical groundwork to reduce inflated spending throughout the system and make health care more affordable and value-driven for consumers.[iv] We encourage you to work with your colleagues on this committee and the other committees of jurisdiction to advance these solutions without delay.

Consumers First and our undersigned allies look forward the discussion today and to working with you to enact bipartisan and commonsense improvements to our nation's health care payment and delivery system. Please contact Jane Sheehan, Director of Federal Relations at Families USA,

JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

Sincerely,

Consumers First Steering Committee

American Academy of Family Physicians
American Benefits Council
American Federation of State, County & Municipal Employees
Families USA
Purchaser Business Group on Health

Supporting Organizations

ACA Consumer Advocacy
Alabama Arise
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Pennsylvania Health Action Network
PIRG
Small Business Majority
Swope Health Services: Minority Women and Children
Tennessee Health Care Campaign
Tennessee Justice Center
Third Way
Utah Health Policy Project
Virginia Organizing

[i] Consumers First Statement for the Record, House Energy and Commerce Subcommittee on Health Hearing on "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care" March 28, 2023 https://familiesusa.org/wp-content/uploads/2023/03/Final-CF-Statement-for-the-Record-for-EC-Transparency-and-Competition-32823.pdf.

[ii] Jaime S. King et al., Preventing Anticompetitive Healthcare Consolidation: Lessons From Five States (Source on Healthcare Price and Competition and Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California Berkeley School of Public Health, June 2020), https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/; Martin Gaynor, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," Journal of Economic Literature 53, no. 2 (June 2015): 235–284.

[iii] Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System Chapter 6, Aligning fee-for-service payment rates across ambulatory settings (June 2022), https://www.medpac.gov/wpcontent/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf.

[iv] *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services.* Congressional Budget Office. 2022. https://www.cbo.gov/publication/58222

U.S. House of Representatives
Energy and Commerce Subcommittee on Health
Hearing on
"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"
April 22, 2023

The Physicians Advocacy Institute ("PAI") is pleased to offer this statement of support of the U.S. House of Representative's Subcommittee on Health's hearing today entitled *"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."* We commend this Subcommittee for tackling issues demanding urgent attention, the need to increase competition and transparency in today's health care system.

PAI is a nonprofit organization that was established to advance fair and transparent policies in the healthcare system to sustain the profession of medicine for the benefit of patients. PAI's Board of Directors is comprised of CEOs of the California Medical Association, Connecticut State Medical Society, North Carolina Medical Society, Medical Society of the State of New York, Nebraska Medical Association, South Carolina Medical Association, Tennessee Medical Association and Texas Medical Association.

PAI is a vocal advocate for increased competition in the healthcare marketplace. We urge the Subcommittee's consideration of legislation to reverse longstanding federal policies that have exacerbated the trends of widespread consolidation and diminishing competition in today's healthcare system, preventing physician-led organizations from competing with larger corporate interests. We call the Subcommittee's attention to federal policies that have spurred consolidation and undermined physicians' ability to maintain private medical practices or compete on a level playing field with corporate-owned hospitals. These policies include: (1) the failure of Medicare payments to physicians to reflect inflation and other growing costs of delivering care; (2) the federal moratorium on physician-owned hospitals ("POHs"); and (3) the longstanding payment policies that incentivize care delivery in hospital-owned settings, even when the physician office setting is more efficient.

As noted by the Subcommittee in the hearing notice, today's highly consolidated healthcare marketplace has resulted in higher costs for patients and payers alike while diminishing choice and innovation. Physicians have been unable to sustain private medical practices and are experiencing an alarming loss of professional satisfaction practicing medicine in this environment, leading many to retire early.

Most importantly, this lack of competition is antithetical to the best interests of patients. True patient-centered healthcare requires that patients have choices for where to seek medical care, including the ability to choose healthcare delivery options led by physicians, rather than large conglomerates. Armed with full information regarding their options, we believe that many patients would choose to seek medical care in settings that physicians own, operate and lead clinical decision-making, rather than those owned and operated by corporations whose primary fiduciary obligation in many cases is to their shareholders.

We believe that physicians' extensive education and training, along with their ethical obligations to patients, make them well equipped to organize care delivery to optimize both quality and efficiency. Physicians are uniquely positioned to recognize advances in medical treatments and therapies that offer patients better value and higher quality outcomes as compared with entities owned and operated by non-clinicians. For these reasons, **we strongly urge this Subcommittee's support for H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023**, which would eliminate an arbitrary barrier to entry for physician-owned hospitals ("POHs") to compete in the healthcare market.

The Trend of Consolidation in the Market for Physician Services

Over the past decade, the trend of industry-wide consolidation has transformed virtually every aspect of the delivery of health care in this country. In addition to the sustained trend of "horizontal" consolidation that has created ever larger and more powerful insurers, hospitals and health systems, the last decade has also seen intensive "vertical" consolidation that has resulted in massive corporate entities that often own and control both the financing and delivery of health care in the U.S.

This consolidation trend is particularly pronounced in the physician service sector, driven by over a decade of sustained acquisitions of independent physician practices by hospitals and health systems as well as corporate entities including large national health insurers and private equity and venture capital firms. The nation's largest pharmacies and Amazon have entered this market by employing physicians to deliver primary care services to their customers.

PAI and Avalere Health have closely studied the trend of consolidation, which has drastically transformed where and how physicians practice medicine over the past decade. The statistics show a dramatic shift away from physicians practicing in independently owned medical practices in favor of employed settings, with these key findings:

- In 2012, roughly one quarter of physicians were employed by hospitals and health systems, which owned only 13.6% of physician practices. By the start of 2022, a stunning 74% of physicians were employed by hospitals/health systems and other corporate entities, and over half of physician practices were owned by these entities.

- There was a sharp uptick in these consolidation trends during the months following the onset of the Covid-19 pandemic. 2021 alone saw growth of 19% in physician employment, underscoring

the impact of the pandemic on physicians' ability to sustain private practices. Between 2019 and 2021, an additional 58,200 physicians became hospital employees.

- These consolidation trends have occurred nationwide, with all regions of the nation experiencing sustained growth in physician employment and practice acquisitions, with some regional variations in terms of acquiring entities.

The drivers of these consolidation trends in the physician service market are well known. Hospitals, insurers and these other corporate entities that are acquiring physician practices view employing physicians as critical to succeeding in the marketplace. Certain economic drivers are straightforward: Insurers' payment policies – led by Medicare – have created strong financial incentives favoring the delivery of services in hospital-owned outpatient settings to the detriment of independently-owned physician practices. Once patients receive services in a hospital-owned setting, they are more likely to stay within that system for other treatments and tests. This results in higher spending, as demonstrated by an Avalere study that found significantly higher Medicare spending across full "episodes of care" for three common services (colonoscopies, echocardiograms and evaluation and management services) when the initial service was delivered in the hospital outpatient setting versus the physician office setting. This "site of service" payment differential has created powerful incentives for large, well-financed hospitals to expand their outpatient services, a key aspect of hospital-driven consolidation.

To be clear, Congress cannot solve this problem simply by cutting hospital reimbursement while continuing to underinvest in physician payment. As noted below, physician reimbursements under Medicare have not kept up with the costs of delivering care. As such, we urge this Subcommittee to recognize the need to establish a sustainable, site-neutral approach to establishing payments for outpatient services for Medicare beneficiaries that reflect the cost of delivering care most efficiently.

In addition to the higher reimbursement incentives in fee-for-service reimbursement, value-based payment models often favor larger integrated providers over smaller physician practices. PAI strongly supports policies to allow physicians to participate in the Medicare Quality Payment Program and other value-based arrangements and has developed comprehensive educational tools for physicians to enable this successful transition.

Why Congress and CMS Must Revamp the Current Approach to Medicare Physician Payment

In many areas of the country, particularly in small communities and urban centers, physician-led practices are the backbone of the health delivery system for Medicare beneficiaries. At a time when many rural and urban Medicare beneficiaries face challenges finding physicians to manage their care or provide specialty services, the current approach to physician payment in the Medicare system is unsustainable. Each year, the physician fee schedule faces deep cuts due to statutory policies (e.g., budget neutrality, PAYGO, etc.), forcing Congress to act at the eleventh hour to act to avoid further access issues for Medicare beneficiaries. This long-term financial instability in the Medicare physician payment system has contributed to the ongoing trend of marketplace consolidation, which raises systemwide costs and directly impacts access

to care for many patients. PAI urges Congress and the Centers for Medicare and Medicaid Services (CMS) to prioritize payment reforms such as those included in H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," to prevent further erosion of physician-led practices that participate in Medicare.

Why Congress Should Lift the Misguided Moratorium on Physician-Owned Hospitals

We commend the Subcommittee for recognizing H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023, authored by Rep. Michael Burgess, M.D. (R-TX) and Rep. Henry Cuellar (D-TX), as a legislative solution that will provide much-needed competition for hospital services while lowering health care costs and enhancing care quality. This bipartisan bill would reverse a policy embedded in the 2010 Patient Protection and Affordable Care Act (ACA), championed by a powerful hospital lobby, that established a moratorium on new or expanded physician-owned hospitals. This moratorium has had the dramatic effect of eliminating physicians' ability to establish community or specialty hospitals to compete with larger, corporate-owned hospitals based on quality and cost. Removing the misguided moratorium will enhance competition and give physicians an ability to invest in hospitals in their communities, which is particularly important for small and rural communities that are rapidly losing their hospitals.

Eliminating this competitive force has driven costs higher while depriving patients of an important choice in today's increasingly corporatized healthcare system – namely, care that is delivered in hospital setting owned and operated by physicians. The resulting lack of competition in the hospital service sector, exacerbated by increasing consolidation, has resulted in higher costs for patients and greater government spending. In many markets, large hospitals exert monopoly power both upstream (by dictating contractual terms and payment rate for physician and other provider services) and downstream (by raising costs for patients and payers). These anticompetitive policies and behaviors perpetuate market dominance by restricting new market entrants or competitors. It is no wonder that healthcare costs and spending continue unabated, given the extent of consolidation and lack of competition that prevails today.

Hospital industry interests have long maintained - with no supportive evidence - that physician-owned hospitals "cherry-pick" healthier patients and increase healthcare costs by driving utilization higher. These arguments ignore that the very same incentives and checks relating to overutilization apply to all types of hospital owners. In fact, there is one critical distinction that favors physician ownership. In most cases, these corporate entities' primary focus is to maximize profits for shareholders or sustain positive bond ratings, *not* with the patients whom they serve. In stark contrast, physicians have an ethical responsibility to provide the best possible care to their patients.

Doctors, whether at the bedside or the forefront of scientific innovation, are highly capable of envisioning new healthcare procedures, decreasing expenses, and enhancing the level of patient care as has been proven by several independent, peer reviewed studies. Numerous analyses by researchers and overseers of the Medicare and Medicaid program have found that

physician-owned hospitals excel at treating patients competitively regarding cost, quality, and patient satisfaction as documented in a sample of studies below.

*Physician-owned hospitals can compete on **cost:***

- A 2021 study published by the Mercatus Center at George Mason University concluded that physician-owned hospitals offer high quality and lower or equivalent cost services versus comparable hospitals.
- A study published in the peer-reviewed BMJ medical journal —funded with internal resources from the Harvard School of Public Health—revealed that patients in physician-owned hospitals are equally likely to treat Medicaid patients and had similar numbers of chronic diseases and predicted mortality as patients in other facilities—demonstrating that they can effectively manage chronic diseases and reduce the risk of mortality, regardless of the patients' insurance status.

*Physician-owned hospital can compete on **quality**:*

- A study published in the Hospitalist using data from the American Hospitals Association's annual survey showed that physician-owned hospitals had lower readmission rates than non-physician-owned hospitals.
- A study published in the Journal of the American College of Surgeons found that physician-owned surgical hospitals outperform other hospitals in Medicare value-based purchasing program.
- In one of the DRGs for the Centers for Medicare and Medicaid Innovation (CMMI) joint replacement demonstration: 72% of participating physician-owned hospitals producing savings – much more than the 52% of non-physician-owned hospitals achieving this goal; and over 44% of participating physician-owned hospitals received an "excellent" quality score, significantly higher than the 16.4% rate for non-POHs.
- The Medicare Payment Advisory Commission (MedPAC) acknowledged that physician-owned hospitals can provide high-quality care. In a report to Congress, MedPAC stated that "physician-owned hospitals tend to score highly on patient satisfaction and quality measures" (MedPAC, 2018).

*Physician-owned hospitals can compete on **patient satisfaction**:*

- A study published in Health Affairs found that physician-owned specialty hospitals provide generally high-quality care to satisfied patients and greater community benefit than nonprofit providers.
- Physician-led hospitals have higher patient satisfaction according to CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHP) Survey. According to CMS' (HCAHPS) data, 96 percent of PHA members have 4- or 5-star consumer ratings, compared to less than 40 percent of non-physician owned hospitals.

Physician-owned hospitals can introduce competition in an otherwise costly and highly consolidated health system. With growing consolidation in hospital markets, competition from physician-owned hospitals could offer communities and patients a market-based solution to address rising costs while advancing high quality services. A recent Health Affairs article authored by physician members of the American Medical Association, American Academy of Orthopedic Surgeons, and American College of Cardiology, described the lack of competition in hospital markets, and cited the "well-documented, specific harms of provider consolidation." The authors warned that consolidation leads to a "lack of quality benefits," worse patient

experiences, “physician burnout due to a loss of control over the practice environment, and higher hospital prices driving rising insurance premiums and ultimately rising costs to consumers.”

Similar findings were highlighted by the Medicare Payment Advisory Commission (MedPAC) in its March 2020 analysis of health care consolidation, which found that most hospital markets are dominated by a single hospital system that had more than a 50% share of discharges. MedPAC added that hospital consolidation “permits hospitals to leverage higher prices from commercial payers,” and emphasized that “commercially insured patients appear to pay higher prices for care and higher prices for insurance in consolidated markets.” MedPAC also found that hospital acquisition of physician practices “increases Medicare spending” and financial liability for Medicare beneficiaries. Indeed, the current Administration specifically cites hospital consolidation and subsequent rising health costs as a concern yet overlooks the most obvious way to increase healthcare options: letting doctor-owned and managed facilities grow as they did before the 2010 physician ownership ban.

Physician-owned hospitals could offer a hospital option in rural and other high need areas. Enabling physicians to build and own hospitals could help stem a growing trend of rural hospital closures that impacts not just cost and quality of care, but also employment in rural areas where hospitals are the economic hub. When hospital systems shut down a hospital in rural America today because of poor performance, physicians who see more potential in that hospital are prohibited to respond by buying it. Unfortunately, many areas that have already experienced hospital closures have missed out on such opportunities because once physicians and medical personnel move away from a community, it is highly unlikely they will return. Removing the physician ownership moratorium immediately could help save many now failing community hospitals as well as costs related to delayed and long-distance care in the absence of a nearby hospital. The Centers for Medicare and Medicaid (CMS) in fact acknowledged this need by proposing, but unexplainably not finalizing, a rule that would have relaxed hospital ownership restrictions in high need areas. CMS further acknowledged the value of physician-owned hospitals when it issued a limited temporary waiver to enable them to increase hospital surge capacity during the public health emergency. As a result of that waiver, physician-owned hospitals willingly stepped up by directly treating COVID-19 infected patients and adding ICU and other capacity to assist their communities’ response during the pandemic.

As Congress seeks answers to reduce the burden of spiraling health care costs on Medicare, patients, and other public and private programs and payers, PAI urges Congress to allow physicians to be part of the solution by enacting H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023.

Conclusion

PAI appreciates the opportunity to submit this statement of support and reiterates its vision for a healthcare system where physicians can maintain independent medical practices and organize and lead healthcare delivery options, including physician owned hospitals, for the benefit of American patients.

HOSPITAL COMPETITION AND RESTRICTIONS ON PHYSICIAN-OWNED HOSPITALS

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The general trend in U.S. healthcare markets in recent years has been consolidation of providers. This consolidation has occurred in various ways: hospital and health system mergers, hospital and health system acquisition of physician practices, physician practice mergers, and a general trend toward a salary model for physicians rather than ownership of independent practices. Consolidation crosses both inpatient and outpatient markets. Economic and policy research has identified economic harms associated with hospital consolidation including lessened competition and higher prices—those charged directly by providers and those reflected in health insurance premiums.[1] Other consumer harms can include patient experience decrements and a lack of gains in medical quality.[2] These harms also can extend upstream into healthcare labor markets, as reflected by a recent epidemic of physician burn-out, which has been attributed to a loss of control over the clinical practice environment.[3]

Few effective policy tools have been identified that might stall or reverse these trends. Some in the literature have suggested various approaches, such as increased agency resources for

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[1] *E.g.*, FED. TRADE COMM'N, FTC POLICY PERSPECTIVES ON CERTIFICATES OF PUBLIC ADVANTAGE 2-4 (Aug. 15, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf; Karyn Schwartz et al., *What We Know About Provider Consolidation*, KFF (Sep. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

[2] *See, e.g.*, Nancy Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382(1) N. ENGL. J. MED. 51 (Jan. 2, 2020), https://www.nejm.org/doi/full/10.1056/NEJMsa1901383.

[3] *See, e.g.*, NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE ET AL., TAKING ACTION AGAINST CLINICIAN BURNOUT: A SYSTEMS APPROACH TO PROFESSIONAL WELL-BEING 81 (2019).

antitrust enforcement,[4] revisions to the antitrust laws and merger guidelines,[5] rate setting for all payers (commercial and government),[6] and global budgets (where providers receive a fixed payment for a patient population)[7] or other forms of price regulation (e.g., administrative pricing, price caps, price growth gaps).[8] Regulations that are not carefully tailored to address specific market failures risk interfering with important benefits of competition, such as competition to lower costs for consumers, to increase output and access, or to improve the quality of medical treatments and the patient-clinician experience. The antitrust agencies have recognized economic harms that can arise when regulations interfere with competition.[9]

Noting the importance and value of robust competition, this paper takes a different approach, focusing on one of the sparing few counter trends to hospital consolidation from recent history: physician-owned hospitals (POHs). We offer a competition policy perspective that focuses on restrictions on market competition created by the recent ban on POH growth and expansion. In doing so, this paper addresses three kinds of markets where hospitals exercise increasing market power and where that market power is strengthened by the POH ban: markets to provide patients/consumers hospital services, markets for the sale of hospital services to payors, and markets where hospitals compete for physician services.[10] This analytic approach quickly bears fruit. Because hospital market power can be exercised both upstream against

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[4] *See, e.g.*, *Antitrust Applied: Hospital Consolidation Concerns and Solutions: Hearing Before the Senate Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights*, 117 Cong. 17-18 (May 19, 2021) (statement of Martin Gaynor, E.J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University). Brian Miller, a co-author of the present paper, also testified at this hearing regarding harms of hospital consolidation and potential legal and policy reforms. *See id.* (testimony of Brian Miller, Assistant Professor of Medicine at the Johns Hopkins University School of Medicine).

[5] *See, e.g.*, *id.* at 18 (statement of Martin Gaynor).

[6] *See, e.g.*, Robert Murray & Robert A. Berenson, *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?*, URBAN INSTITUTE (Nov. 2015), https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf.

[7] *See, e.g.*, Troyen A. Brennan, *Maryland Hospital All-Payer Model: Can It Be Emulated?*, HEALTH AFFAIRS FOREFRONT (May 31, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220526.939479/; Maximilian Pany et al., *Price Regulation, Global Budgets, and Spending Targets: A Road Map to Reduce Health Care Spending, and Improve Affordability*, KFF (May 31, 2022), https://www.kff.org/health-costs/report/price-regulation-global-budgets-and-spending-targets-a-road-map-to-reduce-health-care-spending-and-improve-affordability/.

[8] *See, e.g.*, *Capping Hospital Prices*, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET (Feb. 23, 2021), https://www.crfb.org/papers/capping-hospital-prices; Michael E. Chernew et al., *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market, Policy Proposal 2020-08*, THE HAMILTON PROJECT (March 2020), https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf.

[9] *See, e.g.*, U.S. DEP'T OF JUST. & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Executive Summary, p. 5 (July 2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf ("Restrictions on entry and extensive regulation of other aspects of provider behavior and organizational form can bar new entrants and hinder the development of new forms of competition."); *see also* Exec. Order No. 14036, 86 C.F.R. 36987 (July 9, 2021) ("Agencies can and should [promote a competitive marketplace by] . . . rescinding regulations that create unnecessary barriers to entry that stifle competition.").

[10] This paper uses the term "markets" to describe various services affected by the ban on physician-owned hospitals. This paper does not purport to define relevant antitrust markets in the legal sense of the term and takes no position on whether any specific services in any particular geographic areas would in fact constitute relevant antitrust markets.

physicians and downstream against insurers and consumers, physicians have unique incentives to defeat this market power. In doing so, physicians can benefit both themselves and downstream consumers. Moreover, physicians are particularly well-positioned to identify and act on hospital market opportunities for entry and innovation, given their unique role in providing and directing care, their relationships with relevant market participants, and their access to capital.[11] These opportunities may range from the need for an additional general acute care hospital in a local market to recognizing ways of improving clinical operations and the patient surgical/procedural experience through facility specialization. As mere employees of dominant hospital systems, physicians may not have the incentive or ability to seize these opportunities, but by becoming the owners of general acute care or specialty hospitals, they are incentivized and able to do so. When they were not denied access to the marketplace, POHs grew rapidly from 67 in the early 2000s to approximately 250 by 2010 (in a country of just over 6,000 hospitals), despite otherwise high barriers to entry in these markets.[12]

However, this market entry story came to an abrupt and enduring halt following intense lobbying by incumbent healthcare providers and regulatory scrutiny. A peripheral provision in the 2010 Patient Protection and Affordable Care Act (ACA) effectively prohibited expanding existing POHs or opening new ones. This provision, a biproduct of legislative horse trading, was entirely inconsistent with the laudable goals of the ACA, which were to expand coverage and promote competition in insurance markets to drive down costs and improve quality. The coming years offer new opportunities to revisit health care policy in Congress and bolster widespread goals to lower costs and improve quality and innovation through increased competition in healthcare markets.

For those in the U.S. health policy community concerned about consumer harms resulting from the growth of health system market power and the shrinking role of physicians in leading and designing patient care, our paper urges a reevaluation of the prohibition on new or expanded POHs. POHs present an opportunity to inject more competition into patient/consumer markets, U.S. payor markets, and markets for physician services. Competition in these markets is vital for reducing costs and improving quality. This not only benefits healthcare consumers—which eventually includes all of us, but also taxpayers providing publicly-financed health benefits that cover nearly one in two Americans. It also benefits physicians through increased competition for their services and greater opportunities for entrepreneurship and innovation in patient care.

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[11] *See, e.g.*, Will Maddox, *Physicians Buy Out Steward Health Care From Private Equity Group*, D MAGAZINE (June 5, 2020), https://www.dmagazine.com/healthcare-business/2020/06/physicians-buy-out-steward-health-care-from-private-equity-group/ (describing physician purchase of Steward Health Care from private equity investors); Neil Badlani, *Ambulatory surgery center ownership models*, 5(2) J. Spine Surg. 195 (Sep. 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790806/pdf/jss-05-S2-S195.pdf (noting physicians are frequent developers and investors in other health care service areas, such as ambulatory surgery centers).

[12] *Fast Facts on U.S. Hospitals, 2021*, AMERICAN HOSPITAL ASSOCIATION (Jan. 2021), https://www.aha.org/system/files/media/file/2021/01/Fast-Facts-2021-table-FY19-data-14jan21.pdf.

This paper proceeds as follows. Part I provides an overview of the seemingly inexorable trends towards further consolidation among healthcare providers and the related competition concerns this consolidation raises. Part II discusses the factors which position POHs well as potential market entrants. Part III describes how the accrual of market power by incumbent hospitals and health systems accentuates the incentives and importance of physicians to identify opportunities for market entry and innovation. Part IV describes the growth of POHs and the subsequent ban on further growth and expansion. Part V then discusses the effects of the POH ban on competition in healthcare markets, potential benefits of relaxing the ban, and more narrowly tailored policy options for addressing concerns associated with physician ownership short of an outright ban. Lastly, Part VI concludes the paper with our recommendation that Congress consider removing the ban on POHs or at least relaxing it.

I. Trends and Competition Concerns in Hospital Markets

For decades, concern has been building about consolidation among health care providers, from standalone hospitals up through health systems with multiple hospitals and other related businesses (e.g., clinics, ambulatory surgery centers, and home health care agencies). Multiple threads of evidence suggest that market concentration in healthcare provider markets is high and growing, with implications for the accumulation and misuse of market power.

There were 1,412 hospital mergers from 1998 to 2015, with 561 occurring from 2010 to 2015.[13] In 2010, 28 percent of primary physicians were employed by hospitals.[14] By 2016, that number had risen to 44 percent.[15] Larger physician practices have been growing larger while smaller practices have been growing smaller.[16] According to recent data, over 90% of metropolitan statistical areas have been estimated as consolidated for hospitals, 65% for specialist physicians, and 39% for primary care physicians.[17]

For many physician specialties, this trend continues apace. From 2016 to 2018, the share of physicians affiliated with vertically integrated health systems increased by 11 percentage

[13] *Examining the Impact of Health Care Consolidation*: *Hearing before the Committee on Energy and Commerce, Oversight and Investigations Subcommittee*, 115th Cong. 6 (2018) (statement of Marvin Gaynor, E.J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University).
[14] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Responses*, 36 HEALTH AFFAIRS 1530 (Sep. 2017).
[15] *Id.*
[16] *Examining the Impact of Health Care Consolidation*: *Hearing before the Committee on Energy and Commerce, Oversight and Investigations Subcommittee*, 115th Cong. 6-7 (2018) (statement of Marvin Gaynor, E.J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University).
[17] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Responses*, 36 HEALTH AFFAIRS 1530 (Sep. 2017) (relying on the Herfindahl-Hirschman Index (HHI) as an indicator of high concentration given its use by the U.S. antitrust agencies to help screen mergers).

points with over half of physicians affiliated with vertically integrated health systems.[18] This trend is also pronounced in procedural practice areas involving physician-owned specialty hospitals like cardiology and orthopedics.[19]

Evidence suggests the effects of this consolidation are not benign. In general, competition produces lower prices, higher quality, higher output, and more innovation.[20] If increased consolidation is paired with high entry barriers, the combination can reduce competition and enhance market power of incumbent market participants. Sure enough, courts find high entry barriers in hospital markets, when the issue is even contested, as discussed further in Part III.A.[21] Not surprisingly then, research finds that mergers and increased consolidation in hospital markets are associated with higher prices,[22] patient experience decrements, and lack of quality improvements,[23] which are passed on to consumers in the form of lower wages due to increased hospital and subsequently employer-sponsored health insurance costs.[24]

In addition to its effect on payor markets and consumers, hospital consolidation can also affect upstream markets. The antitrust agencies have long been concerned that the "Enhancement of market power by buyers, sometimes called 'monopsony power,' has adverse effects comparable to enhancement of market power by sellers."[25] Indeed, buyer market power

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[18] Michael F. Furukawa et al., *Consolidation of providers into health systems increased substantially, 2016-18*, 39 HEALTH AFFAIRS 1321 (Aug. 2020).
[19] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Responses*, 36 HEALTH AFFAIRS 1530 (Sep. 2017).
[20] *See, e.g.*, Nat'l Soc. Of Pro. Engineers v. United States, 435 U.S. 679, 695 (1978) ("The Sherman Act reflects a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers."); *see also* Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").
[21] *See, e.g.*, FTC v. ProMedica Health System, 2011 WL 1219281, No. 3:11-cv-47 (N.D. Ohio 2011) (finding high entry barriers into the hospital market on a motion for a preliminary injunction); Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 788 (9th Cir. 2015) (noting the court made "uncontested finding of high entry barriers" in suit challenging merger of two Idaho healthcare providers).
[22] Martin Gaynor, Robert Town, *The Impact of Hospital Consolidation - Update*, THE SYNTHESIS PROJECT (2012).
[23] Nancy D. Beaulieu et al., *Changes in quality of care after hospital mergers and acquisitions*, 382 NEW ENGLAND JOURNAL OF MEDICINE 51 (2020).
[24] *See* Daniel Arnold & Christopher Whaley, *Who pays for health care costs? The effects of health care prices on wages*, RAND CORPORATION (2020), https://www.rand.org/content/dam/rand/pubs/working_papers/WRA600/WRA621-2/RAND_WRA621-2.pdf; Martin Gaynor, Robert Town, *The Impact of Hospital Consolidation - Update*, THE SYNTHESIS PROJECT (2012); Jean Abraham, Martin Gaynor & William Vogt, *Entry and Competition in Local Hospital Markets*, 55 J. INDUS. ECON. 265 (2007).
[25] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 1 (2010) [hereinafter HMG], www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf. *See also* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, 1992 MERGER GUIDELINES § 0.1 (1992) (applying an "analogous" legal framework to "monopsony concerns"), https://www.justice.gov/sites/default/files/atr/legacy/2007/07/11/11250.pdf. Note that the 2010 HMG are currently being updated by the Agencies.

over labor markets has been the source of increased antitrust scrutiny and litigation,[26] including cases addressing market power over healthcare service providers such as physicians.[27] Recent trends suggest closer scrutiny of physician service markets is appropriate. As hospital markets have consolidated, physician employment has changed, with 50.2% of physicians reporting being employed (as opposed to in private practice) in 2020, with 40% of physicians reporting working directly for a hospital or in a practice with at least partial health system ownership.[28] Physician-hospital consolidation, especially in the form of integrated delivery systems, has been found to increase both prices for physician services[29] and utilization,[30] yet physicians do not necessarily benefit in the form of increased wages under a model where they are salaried employees. Further research examining 803 hospitals that switched to an employment model compared to 2,085 control hospitals demonstrated that acquisitions of physician practices were not associated with improvements in quality,[31] a finding that runs counter to efficiency arguments made by health systems that pursue these mergers.[32]

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[26] *See e.g.*, United States v. Bertelsmann SE & Co. KGaA, No. CV 21-2886-FYP, 2022 WL 16949715, at *1, *36 (D.D.C. Nov. 15, 2022) (noting the "government's case sounds in 'monopsony,' a market condition where a buyer with too much market power can lower prices or otherwise harm sellers," that "[e]ssentially, the government alleges that the merger will increase market concentration in the publishing industry, which will allow publishing companies to pay certain authors less money for the rights to publish their books," and finding that the government "has properly defined a relevant market."); U.S. DEP'T OF JUST. & FED. TRADE COMM'N, ANTITRUST GUIDANCE FOR HUMAN RESOURCE PROFESSIONALS (Oct. 2016), https://www.justice.gov/atr/file/903511/download; Press Release, U.S. Dep't of Just., Health Care Company Pleads Guilty and is Sentenced for Conspiring to Suppress Wages of School Nurses (Oct. 27, 2022), https://www.justice.gov/opa/pr/health-care-company-pleads-guilty-and-sentenced-conspiring-suppress-wages-school-nurses.

[27] *E.g.*, United States v. Anthem, Inc., 236 F. Supp. 3d 171, 187 (D.D.C. 2017), *aff'd* United States v. Anthem, Inc., 855 F.3d 345 (D.C. Cir. 2017) (noting "plaintiffs allege that the newly formed company will use its market power to pressure doctors, hospitals, and other providers to lower their prices, so the merger will result in harm to competition in the market for the purchase of healthcare services, or a monopsony" though not reaching this claim because the court found in plaintiff's favor on other grounds); Press Release, U.S. Dep't of Just., Justice Department Comments on Settlement in Private "No-Poach" Class Action That Allows Government to Enforce Injunction Against Duke University, Court's Final Judgment Allows Antitrust Division to Enforce Injunction Barring University from Maintaining or Entering into Unlawful Agreements not to Compete for Employees (Nov. 8, 2019), https://www.justice.gov/opa/pr/justice-department-comments-settlement-private-no-poach-class-action-allows-government (discussing successful challenge to agreements between two universities not to compete for each other's medical faculty).

[28] Carol Kane, *Recent Changes In Physician Practice Arrangements: Private Practice Dropped To Less Than 50 Percent Of Physicians In 2020*, AMERICAN MEDICAL ASSOCIATION POLICY PERSPECTIVES (2021), https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf.

[29] Caroline S. Carlin et al., *The impact of provider consolidation on physician prices*, 26 HEALTH ECONOMICS 1789 (Dec. 26, 2017) (finding higher physician prices post acquisition of clinics).

[30] Christopher M. Whaley et al., *Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration*, 40(5) HEALTH AFFAIRS 702 (May 2021).

[31] Kirstin W. Scott et al., *Changes in hospital–physician affiliations in U.S. hospitals and their effect on quality of care*, 166 ANNALS OF INTERNAL MEDICINE 1 (2016).

[32] The Federal Trade Commission is also undertaking an econometric study of physician-hospital consolidation using data from six health plans. Press Release, Fed. Trade Comm'n, *FTC to Study the Impact of Physician Group and Healthcare Facility Mergers* (January 14, 2021), https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers.

As consolidation worsened lockstep with increasing physician employment, physician labor markets have experienced worrisome use of anti-competitive practices. As a stark example, two university-based medical schools, the University of North Carolina at Chapel Hill and Duke University, were alleged to enter into a no-poach agreement with one another—an agreement to not compete for the services of each other's physicians. This ultimately led to a class action lawsuit, intervention by the Antitrust Division,[33] and a $54.5 million settlement.[34] Increased monopsony power may also have led to the expanded use of non-compete agreements in physician employment. Non-compete agreements in labor markets were the subject of 2019 Department of Justice[35] and 2020 Federal Trade Commission[36] workshops, given their potential to decrease labor mobility, reduce competition, and suppress wages. More recently, non-competes have been the subject of successful FTC enforcement actions[37] and a proposed rulemaking banning non-competes.[38] There are reasons to think their potential anti-competitive effects in physician labor markets likely outweigh the purported benefits,[39] especially if their use or the strictness of their terms increases in concentrated labor markets, rather than in competitive labor markets. Unfortunately, the potential exercise of market power in physician labor markets can be further exacerbated by regulations, such as states that restrict the use and portability of medical licenses issued by other states and thus reduce the ability of physicians to move or offer services across state lines.[40]

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[33] Order Granting the United States of America's Unopposed Motion to Intervene, Danielle Seaman v. Duke University et al., No. 15-462 (M.D.N.C. May 22, 2019); *see also* Statement of Interest of the United States of America, Danielle Seaman v. Duke University et al., No. 15-462 (M.D.N.C. March 7, 2019).

[34] Jake Satisky, *Duke agrees to pay $54.5 million to settle class action lawsuit*, THE CHRONICLE, May 25, 2019, https://www.dukechronicle.com/article/2019/05/duke-university-settles-class-action-lawsuit-for-54-5-million.

[35] *Public Workshop on Competition in Labor Markets*, U.S. DEP'T OF JUST. (Oct. 27, 2022), https://www.justice.gov/atr/events/public-workshop-competition-labor-markets.

[36] *Non-Competes in the Workplace: Examining Antitrust and Consumer Protection Issues*, FED. TRADE COMM'N (Jan. 9, 2020), https://www.ftc.gov/news-events/events-calendar/non-competes-workplace-examining-antitrust-consumer-protection-issues.

[37] *See* Press Release, F.T.C., FTC Cracks Down on Companies That Impose Harmful Noncompete Restrictions on Thousands of Workers (Jan. 4, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/01/ftc-cracks-down-companies-impose-harmful-noncompete-restrictions-thousands-workers (describing FTC legal actions against firms for imposing non-competes on security guards and employees at glass container manufacturers); In the Matter of DaVita, Inc. and Total Renal Care, Inc., 2021 F.T.C. File No. 211-0013, https://www.ftc.gov/system/files/documents/cases/davita_order_9_24_final.pdf (agreeing to drop physician non-competes as part of a merger remedy)..

[38] Non-Compete Clause Rule, 88 Fed. Reg. 3482 (proposed Jan. 19, 2023) (to be codified at 16 CFR Part 910).

[39] Letter from James L. Madara, MD, Executive Vice President, CEO, American Medical Association to Joseph J. Simons, Chair, Federal Trade Commission (Feb. 7, 2020), https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-2-7-Letter-to-Simons-re-Non-Compete-in-the-Workplace.pdf; Louis Garcia, *Lose-Lose: Noncompete Agreements Hurt Doctors and Patients*, AMERICAN ACADEMY OF FAMILY PHYSICIANS NEWS BLOG, FRESH PERSPECTIVES: NEW DOCS IN PRACTICE (March 3, 2021), https://www.aafp.org/news/blogs/freshperspectives/entry/20210303fp-noncompete.html.

[40] *See U.S. State Participation in the Compact*, INTERSTATE MEDICAL LICENSURE COMPACT, https://www.imlcc.org/#map (last visited Dec. 26, 2022); *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, FEDERATION OF STATE MEDICAL BOARDS (Dec. 21, 2022), https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-

This paper is far from the first to report on these alarming and persistent consolidation trends in healthcare markets. This paper is distinct in noting that the upstream and downstream effects are linked outcomes of this consolidation phenomenon and in noting that the upstream and downstream effects could be helpfully linked in countering this consolidation trend. In particular, POHs may be uniquely effective in intensifying competition in the markets for the employment of physicians and for the provision of physician hospital services to the benefit of payers and consumers in downstream markets. Part II explores this potentially unique role for POH entry.

II. Physician-Owned Hospitals as a Source of Additional Entry and Innovation

Physicians are particularly well-positioned and incentivized, given their unique role, to identify and act on hospital market opportunities for entry and innovation through the physician-ownership model. First, physicians work at the forefront of the science, practice, and business of medicine, which helps them identify opportunities for entry and innovation that might not occur to others. Second, the physician-ownership model gives physicians the incentive to pursue those opportunities by allowing them to profit from entry and innovation, and by providing them more ways to attract and retain physicians, especially in the face of monopsony power. This part addresses these factors in turn and then illustrates how this was reflected in an FTC investigation of a hospital acquisition of a POH.

A. The Unique Role of Physicians in Providing and Directing Care Helps Them Identify Opportunities for Hospital Market Entry and Innovation

Physicians have specialized technical and practical knowledge that can help identify opportunities for hospital market entry and for improving patient care and hospital management decisions, which when paired with ownership may help drive innovation and improve hospital outcomes.

Physicians are at the forefront of the science and practice of medicine. This is reflected in their extensive training, in their research and publications on medical science and medical practice, and in the role of physicians in directing care for a patient on a team of providers. Physicians also frequently have management experience from helping run hospital departments. Physicians also are the only licensed healthcare providers who can perform most surgeries and procedures, prescribe most medicines, etc. Other licensed healthcare providers (PAs, NPs, etc.) are frequently limited by their training or by laws that restrict their practice or require physician

covid-19.pdf (listing only 8 states that still have telehealth out-of-state licensure waivers due to the COVID-19 emergency).

oversight.[41] Lastly, physicians are likely to have access to capital, reflected in their relatively high incomes, educational attainment, and social capital.[42]

Physicians also are at the forefront of the business of medicine. Even when physicians are salaried professionals employed by hospitals, they still help patients navigate the medical benefits and the pecuniary costs of important medical decisions.[43] And physicians are deeply familiar with the paperwork necessary to receive reimbursement for various services from public and private payers. They are likely acutely aware of the demand for various medical services they provide and who else is competing to provide those services in a local market. Physicians are also at the nexus of marshalling staff for providing complex services or procedures, as well as managing and referring patients for follow-on care. As a result, physicians are expert in which providers are needed to address a range of patient's needs within a given specialty, as well as the identities of many such providers in a given market. In participating in these markets, physicians often have observations and insights accrued in the day-to-day of medical practice on what is working well in a given market, what is working poorly, and where are opportunities for improvement. This is actionable information for improving hospital services. Indeed, research finds that, while hospitals infrequently employ physicians as CEOs,[44] physician hospital executives are associated with improved quality of hospital services without an associated loss in profits.[45]

A physician's training and practical experiences should likewise provide actionable information for starting one's own business. Indeed, the world of venture capital investing provides a useful comparison. Venture capital investors are often hesitant to invest in start-ups without a technical founder. As Marc Andreessen of the venture capital firm Andreesen Horowitz has explained, "[W]e would have a hard time funding a startup without a strong technical founder. I'd go so far as to say that it is irresponsible to start a technology company

[41] *See e.g.*, FED. TRADE COMM'N, COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES 1 (March 2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (noting that "even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition").

[42] *See, e.g.*, Will Maddox, *Physicians Buy Out Steward Health Care From Private Equity Group*, D MAGAZINE (June 5, 2020), https://www.dmagazine.com/healthcare-business/2020/06/physicians-buy-out-steward-health-care-from-private-equity-group/ (describing physician purchase of Steward Health Care from private equity investors); Neil Badlani, *Ambulatory surgery center ownership models*, 5 J. SPINE SURG. S195 (Supp. 2 Sep. 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790806/pdf/jss-05-S2-S195.pdf (noting physicians are frequent developers and investors in other health care service areas, such as ambulatory surgery centers).

[43] Brian Miller et al., *Price Transparency: Empowering Patient Choice and Promoting Provider Competition*, 44 J. MED. SYST. 80 (Mar. 5, 2020); Brian Miller et al., *Redefining the Physician's Role in Cost-Conscious Care: The Potential Role of the Electronic Health Record*. 322(8) JAMA 721, July 12, 2019, *https://jamanetwork.com/journals/jama/article-abstract/2738366*.

[44] *Should Hospital CEOs Be Physicians?*, BHM HEALTHCARE SOLUTIONS (Feb. 27, 2015), https://bhmpc.com/2015/02/hospital-ceos-physicians/ (noting that only 5% of hospital CEOs are physicians).

[45] Michael C. Tasi et al., *Does physician leadership affect hospital quality, operational efficiency, and financial performance?*, 44(3) HEALTH CARE MANAGEMENT REV. 256 (July 9, 2019).

without a technical founder, for all but a very small number of non-technical entrepreneurs."[46] Likewise, start-up incubators like Y Combinator encourage non-technical entrepreneurs to find a technical co-founder: "You first need to understand how important it is to have a technical co-founder. . . . [I]f you plan to fundraise, any investor will think this."[47] This view is also supported by empirical research, including one study finding that start-ups that have technical founders and hire businesspeople are more likely to succeed than the reverse.[48] In the hospital context, entrepreneurial physicians are like technical founders. While non-physician investors can and do benefit when they hire physicians,[49] the experience of venture capital investors suggests new hospital ventures may benefit from having physician owners rather than just physician employees.

B. The Physician-Ownership Model Provides Incentives and Opportunities for Market Entry and Innovation

Physician ownership builds on a historic culture of entrepreneurship and helps align incentives to promote greater use of physician expertise in improving hospital services and market outcomes for consumers. These incentives should be strongest in markets where physicians are not regularly utilized in leadership by local hospitals and where local hospitals have market power over upstream physicians and downstream consumers—many U.S. markets.

Physicians have always been entrepreneurs in healthcare. For example, 70 percent of physicians had an ownership stake in their medical practices in the 1980s, and despite steady declines, 43 percent still have an ownership stake in their practices as recently as 2018.[50] As

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[46] *How important is it to have a technical cofounder, in order to get funding from a VC or an incubator/seed program in Ecommerce?*, QUORA (2011) (response of Marc Andreessen), https://www.quora.com/How-important-is-it-to-have-a-technical-cofounder-in-order-to-get-funding-from-a-VC-or-an-incubator-seed-program-in-Ecommerce.

[47] Adora Cheung, *How to Find a Technical Co-Founder*, Y COMBINATOR (last visited Dec. 25, 2022), https://www.ycombinator.com/library/3i-how-to-find-a-technical-co-founder.

[48] Martin Murmann, *The Startups Most Likely to Succeed Have Technical Founders Who Quickly Hire Businesspeople*, HARVARD BUSINESS REVIEW (Nov. 06, 2017), https://hbr.org/2017/11/the-startups-most-likely-to-succeed-have-technical-founders-who-quickly-hire-businesspeople; Bettina Müller & Martin Murmann, *The Workforce Composition of Young Firms and Product Innovation - Complementarities in the Skills of Founders and Their Early Employees* (Centre for European Economic Research Discussion Paper No. 16-074, 2016), https://ftp.zew.de/pub/zew-docs/dp/dp16074.pdf.

[49] Michael Tasi et al., *Does physician leadership affect hospital quality, operational efficiency, and financial performance?*, 44(3) HEALTH CARE MGMT. REV. 256, July/Sep. 2019, https://journals.lww.com/hcmrjournal/Abstract/2019/07000/Does_physician_leadership_affect_hospital_quality,.8.aspx.

[50] *See, e.g.*, Carol K. Kane and David W. Emmons. *New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment*, AMERICAN MEDICAL ASS'N, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf; Apoorva Rama, *2012-2018 Data on physician compensation methods*, American Medical Ass'n, https://www.ama-assn.org/system/files/2020-12/data-physician-compensation-methods.pdf.

another example, physicians pioneered ambulatory surgery centers over the past 50 years,[51] which are freestanding sites responsible for more than half of all U.S. outpatient surgeries. Physicians continue to have an ownership stake in approximately 90 percent of ambulatory surgery centers,[52] and these sites continue to gain market share by competing aggressively on cost and quality with other providers of outpatient care, including hospitals.[53]

Physician ownership of hospitals pairs control by physician experts with market incentives to optimize delivery of healthcare services and costs. Healthcare economics and competition agencies have long recognized that healthcare providers are market participants who respond to market incentives.[54] That is true, whether a hospital is for-profit or nonprofit.[55] Physicians likewise are responsive to market incentives, whether they be owners or practitioners. Indeed, many recent innovations in healthcare financing are directed at attempting to align the incentives of frontline providers and their institutions with improved health outcomes for patients.[56]

The difference is that the physician-ownership model gives physician experts the incentive and ability to act and profit from novel ideas, incremental improvements, or market opportunities themselves. With ownership foreclosed by statute, the innovating physician may have to wait and see whether non-physician investors or non-profit organizations will identify the same opportunity, choose to act on it, or empower the physician to act on it as part of the hospital staff. Moreover, a salary model may give the innovating physician no incentive to pursue ideas on hospital-wide improvements in management or care. A salaried physician may even face professional disincentives against pursuing innovation if existing management is not receptive.

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[51] *Ambulatory Surgery Centers: A Positive Trend in Healthcare*, AMBULATORY SURGERY CENTER ASS'N, https://www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/apositivetrendinhealthcare (last visited Dec. 3, 2022).
[52] *Id.*
[53] *Id.*
[54] *See, e.g.*, U.S. DEP'T OF JUST. & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Executive Summary, pp. 4-5, July 2004, https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.
[55] *See, e.g.*, FTC v. Univ. Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991), *citing* Nat'l Collegiate Athletic Ass'n v. Board of Regents, 468 U.S. 85, 100 n.22 (1984) (noting "the Supreme Court has rejected the notion that nonprofit corporations act under such a different set of incentives than for-profit corporations that they are entitled to an implicit exemption from the antitrust laws."); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) (concluding institutional form is irrelevant to merger analysis).
[56] Sylvia M. Burwell, *Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care*, 372 N. ENGL. J. MED. 897 (March 5, 2015), https://www.nejm.org/doi/full/10.1056/nejmp1500445; Jordan M. VanLare & Patrick H. Conway, Value-Based Purchasing — National Programs to Move from Volume to Value, 367 N. ENGL. J. MED. 292 (July 26, 2012), https://www.nejm.org/doi/full/10.1056/nejmp1204939; Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment*, COMMON WEALTH FUND ISSUE BRIEFS (Feb. 10, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits.

Physician ownership may improve system-wide performance at general acute care hospitals, and in fact, about 55 percent of POHs are general acute care hospitals.[57] After all, medical schools educate and train physicians with a foundation that spans medical specialties. And physicians may hit upon innovations or market trends from the vantage point of a single specialty that would likewise improve aspects of management and care across many specialties. Physicians as practitioners may be better attuned to ideas for operational efficiency that produce measurable results. Indeed, physician control over operations is associated with increased nurse staffing at POHs as compared to non-profit or investor-owned general acute care hospitals.[58]

Doctors Hospital at Renaissance (DHR) is a general acute care POH that illustrates how physician ownership can help general acute care hospitals rapidly respond to market needs. DHR originated as a 2-room ambulatory surgery center in 1997 and has grown with the needs of the region and is now a 530-bed general acute care POH with over 60 clinics.[59] Serving a high-need market at the Texas-Mexico border, it embodies the principle of taking ideas from the "bedside to the board room," and recently expanded its scope of services to offer kidney transplants, as the only hospital in the region to do so and all while serving a patient population where over two-thirds of patients are covered by Medicaid and Medicare.[60] Further, DHR rapidly adapted during the COVID-19 pandemic, converting its rehabilitation hospital into a 102-bed COVID hospital in 10 days, a speed of innovation facilitated by its physician leadership that saw the urgent need.[61] Finally, recognizing challenges with physician recruitment in the Rio Grande Valley region, DHR planned, received accreditation for, opened, and runs multiple medical residency programs, creating a physician labor force for an underserved region.[62]

Aurora BayCare Medical Center, jointly owned by physicians and a non-profit health system, illustrates another general acute care POH. It is a high-performing hospital as measured by cost per discharge and by patient satisfaction, and it also was able to adapt quickly to demand during the COVID-19 pandemic, temporarily going from 167 to 238 beds.[63]

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[57] *See* Daniel M. Blumenthal et al., *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, 351 THE BMJ h4466 app. 8 (Sep. 2, 2015), https://www.bmj.com/content/bmj/351/bmj.h4466.full.pdf (main article) and https://www.bmj.com/content/bmj/suppl/2015/09/01/bmj.h4466.DC1/blud025729.ww1_default.pdf (Data Supplement).

[58] *Id.* at 3 tbl. 1.

[59] Interview by Brian Miller with Doctors Hospital at Renaissance Board Chairman Carlos Cardenas, M.D. (June 2021).

[60] *Id.*

[61] *Id.*

[62] *Id.* This is particularly important in a region like the Rio Grande Valley because just over half of physicians practice in the region where they completed their training. *See* https://www.ama-assn.org/medical-residents/transition-resident-attending/where-new-physicians-practice-3-key-postresidency

[63] Interview by Brian Miller with Aurora BayCare Medical Center President Daniel Meyer (July 2021).

Physicians, who practice within a specialty, are especially well-suited to identify market opportunities for hospital specialization. They may more quickly recognize when the benefits of optimizing facilities around their practices outweighs the costs of having to fully support those specialized facilities around a narrower set of patient needs. And indeed, POHs include a disproportionate share of specialty surgery hospitals: 45 percent.[64] By contrast, only a small fraction of the nearly 6,000 non-physician owned hospitals are built around a medical specialty.

Consider the case of surgeons who routinely perform inpatient procedures that cannot be managed in a clinic or ambulatory setting. The surgeon must obtain admitting privileges from a hospital and contract with the hospital to use its operating room and associated facilities. This may be efficient for some procedures but could lead to frustrations and inefficiencies for other procedures as operations can vary widely. For example, some operations must be scheduled on short notice, require a generalized setup, or may have wide variation in how long the operation takes. Others can be scheduled well in advance, take a consistent amount of time, but require dedicated support staff and a highly specialized setup with a unique instrument tray. It may not always be efficient to schedule different operations in the same operating room. Even for a given procedure, different surgeons may have different staffing, equipment, and setup preferences. Consequently, operating rooms may be more or less optimized based on the number of operating rooms, the way the rooms are equipped and staffed, the range of procedures, and the way the hospital handles transitions and scheduling.

For example, otolaryngologists typically operate on a patient's ear, nose, and throat, necessitating that the operating room table be rotated 180 degrees away from the anesthesia machine, ventilator, and other pieces of equipment. By contrast, orthopedic surgeons typically operate on a patient's extremities or spine, requiring an operating room setup that is functionally the opposite of what an otolaryngologist requires. Other key hospital clinical operations may impede efficiency: operating room turnover may be lengthy and key specialists like anesthesiologists may have limited availability during periods of high demand, resulting in lost opportunities to treat patients and lost revenue for a surgeon as he or she waits to complete his or her next procedure. Finally, a surgeon is frequently unable to fully control and customize the pre- and post-operative care that their patients receive because much of this may be handled by the hospital where the surgeon operates with nursing staff typically under a separate, hospital-controlled managerial structure.

Therefore, physicians may be especially attuned to when the operating rooms in local hospitals are poorly optimized for their specialty. And physician ownership may provide a

[64] Daniel M. Blumenthal et al., *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, 351 THE BMJ h4466 app. 8 (Sep. 2, 2015), https://www.bmj.com/content/bmj/351/bmj.h4466.full.pdf (main article) and https://www.bmj.com/content/bmj/suppl/2015/09/01/bmj.h4466.DC1/blud025729.ww1_default.pdf (Data Supplement).

strong incentive for physicians to act when they identify market opportunities to design and optimize their own hospital operations, as well as pre- and post-operative care.

Specialty hospitals may be most efficient when there are scale efficiencies and scope efficiencies to tailoring care towards a limited set of procedures—a "focused factory" model of care that can give rise to a quality-volume relationship. Specialty hospitals, many physician-owned, are most common for orthopedic, cardiac, and general surgical services.[65] A systematic review of over thirty years of research found improved quality at lower or comparable cost for specialty POHs as compared with non-POH competitors.[66] To illustrate, the Shouldice Hernia Hospital in Canada, a private hospital founded by Dr. Earle Shouldice in 1945, has been the subject of both management[67] and medical research into its use of specialization, and has been found to have a lower rate of recurrence for inguinal hernia repairs.[68] Other areas of orthopedic surgery also benefit from the quality-volume relationship, such as decreased complication rates in total knee arthroplasty (knee replacement)[69] and lower mortality with total hip arthroplasty (hip replacement).[70] Cardiac care shows a similar pattern, with domestic data demonstrating a positive quality-volume relationship for percutaneous coronary intervention (cardiac catheterization) with lower in-hospital mortality associated with higher volumes,[71] with a similar positive quality-volume relationship seen in cardiac surgery, best documented with mitral valve surgery.[72] The physician-ownership model lends itself naturally to these specialized care delivery settings by allowing them to apply their knowledge directly to customize and efficiently deliver care, providing an important source of additional market entrants and innovation.

As described in this part, generalization can be efficient and also can benefit from more physician-ownership and input. Physician-owners are also especially well-situated to identify

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[65] *Id.* at 4.
[66] Ted Cho, Andrew Meshnick, Jesse M. Ehrenfeld, and Brian J. Miller, *Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review*, SPECIAL STUDY, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Sep. 7, 2021), https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review.
[67] James L. Heskett & Roger H. Hallowell, *Shouldice Hospital Limited (Abridged)*, HARVARD BUSINESS SCHOOL, Case 805-002 (July 2004; rev. Jan. 2005), https://www.hbs.edu/faculty/Pages/item.aspx?num=31326.
[68] Atiqa Malik et al., *Recurrence of inguinal hernias preaired in a large hernia surgical specialty hospital and general hospitals in Ontario, Canada*, 59(1) CANADIAN JOURNAL OF SURGERY 19 (2016).
[69] Rick L. Lau et al., *The role of surgeon volume on patient outcome in total knee arthroplasty: a systematic review of the literature*, 13 BMC MUSCULOSKELETAL DISORDERS 250 (Dec. 14, 2012).
[70] Jeffrey N. Katz et al., *Association between hospital and surgeon procedure volume and outcome of total hip replacement in the United States Medicare population*, 83(11) JOURNAL OF BONE AND JOINT SURGERY 1622 (Nov. 2011).
[71] Alexander C. Fanaroff et al., *Outcomes of PCI in Relation to Procedural Characteristics and Operator Volumes in the United States*, 69(24) JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY 1913 (2017); Alexander C. Fanaroff et al., *Relationship Between Operator Volume and Long-Term Outcomes After Percutaneous Coronary Intervention: Report From the NCDR CathPCI Registry*, 139 CIRCULATION 458 (2019).
[72] Joanna Chikwe et al., *Relation of Mitral Valve Surgery Volume to Repair Rate, Durability, and Survival*, 69(19) JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY 2397 (2017); Vinay Badhwar et al., *Mitral Valve Surgery in the United States*, 5(1) JAMA CARDIOLOGY 1092 (2020).

the opportunities where greater specialization may be beneficial. Physicians may recognize when different approaches should be integrated. For example, Lincoln Surgical Hospital in Nebraska partnered with OneHealth Nebraska, an Independent Physicians Association comprised of 65 clinics with over 300 primary and specialty care physicians,[73] to serve as a network for self-insured employers[74] and as a network for a messenger model plan with BlueCross BlueShield Nebraska.[75] In short, there are many reasons to think that physician ownership can offer important benefits for entry and innovation in hospital markets.

C. The Physician-Ownership Model Provides Further Means to Attract and Retain Physicians

Physician ownership also may facilitate circumstances where more varied compensation packages for frontline physicians, such as an ownership stake, better aligns incentives for care delivery, similar to employee stock ownership plan models.[76] This may be particularly important for certain low-volume surgical practices and may enable market entry that would not otherwise be viable.

Take the case of cardiac surgery. A cardiac specialty hospital would typically only have two cardiac surgeons. The departure of any one surgeon may be very costly—the specialty hospital could potentially see a very large drop in surgical capacity and revenue until a new cardiac surgeon is found. Large hospital systems can mitigate this risk by employing a larger number of cardiac surgeons (typically anywhere from two to ten), but any individual metro area may not offer enough case volumes to support many such hospital units. Physician ownership offers a way for smaller, specialty hospitals to also mitigate the risk of losing a cardiac surgeon by making the surgeon an owner—potentially allowing for more specialty hospital competition in a given market. Because the cardiac surgeon shares ownership in the hospital, the surgeon has the potential to earn more through profit-sharing when he or she stays and the specialty hospital is succeeding and that surgeon would also share in the losses if his or her departure left the hospital in the lurch.

Specialty orthopedic hospitals face similar risks of surgeons leaving and thus may see similar benefits from physician ownership, though to a lesser degree than cardiac specialty

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[73] *Who We Are*, ONEHEALTH NEBRASKA, https://onehealthne.com/about/ (last visited Dec. 25, 2022).
[74] *Insurance Plans*, ONEHEALTH NEBRASKA, https://onehealthne.com/insurance-plans/ (last visited Dec. 25, 2022). OneHealth Nebraska's network product for self-insured employers has a $2,800 deductible and no copay or co-insurance for in-network care, whereas out of network care results in a $3,000 deductible and 20% coinsurance.
[75] *Contracting*, ONEHEALTH NEBRASKA, https://onehealthne.com/contracting/ (last visited Dec. 25, 2022).
[76] Thomas Dudley & Ethan Rouen, *The Big Benefits of Employee Ownership*, HARV. BUS. REV., THE BIG IDEA SERIES / GETTING SERIOUS ABOUT STAKEHOLDER CAPITALISM 6 (May 13, 2021), https://hbr.org/2021/05/the-big-benefits-of-employee-ownership. Of course, properly aligned incentives also means avoiding misaligned incentives that can produce adverse outcomes, which can be especially worrisome in healthcare and are discussed further below in Part III.

hospitals because health care markets can often support more practices with 10 to 20 orthopedic surgeons.[77] Evidence from other markets demonstrates associations of employee firm ownership with improvements in firm survival,[78] suggesting that this benefit is likely real and durable for physician-owned specialty hospitals, proffering opportunities for hospital market entry and competition.

POHs also provide other advantages for attracting and retaining physicians. For example, they provide employment flexibility, frequently offering an open staffing model, wherein physicians are credentialed and privileged albeit not obligated to practice at the facility. This stands in stark contrast to non-profit and investor-owned hospitals, which are aggressively transitioning to a closed-staff model with employed, salaried medical groups, frequently with mandated in-system referral.[79] These same facilities frequently require physicians—as a condition of employment—to sign non-compete agreements, which, given their market power, could further limit practice flexibility and patient access. Noncompete agreements are an area of current antitrust enforcement and policy movement.[80] Thus, POHs not only encourage market entry in payor and patient markets, they also provide an important source of competition in the market for physician labor, providing flexibility in practice modalities.

Part III explores how these important incentives of physician ownership become only more important when hospitals have market power over physicians and over payers and consumers.

III. The Beneficial Incentives of Physician-Ownership Become More Important in the Face of Market Power

This paper does not purport to rigorously define specific markets as would be necessary in antitrust litigation. Nevertheless, this paper and competition analysis generally can benefit from a discussion of the likely contours of affected markets and the implications for the likely competitive incentives of market participants in response to a policy change. As such, this part will describe why POHs are likely to find themselves as participants in three kinds of local markets: markets to provide hospital services to consumers, markets for the sale of hospital services to payors, and markets where hospitals compete for physician services. This part then

[77] *See, e.g.*, IMS HEALTH & SK&A, MARKET PROFILE OF U.S. ORTHOPEDIC SURGEONS MARKET INSIGHTS REPORT 3 (2016), http://www.coa.org/docs/SKA.pdf (noting almost 50% of orthopedic surgery practices have 3-10 physicians and an additional about 30% of practices have 11 or more).
[78] Rho Keun Park et al., *Does Employee Ownership Enhance Firm Survival?*, 8 EMPLOYEE PARTICIPATION, FIRM PERFORMANCE AND SURVIVAL, ADVANCES IN THE ECONOMIC ANALYSIS OF PARTICIPATORY AND LABOR-MANAGED FIRMS 3 (2004).
[79] Anna Wilde Mathews & Melanie Evans, *The Hidden System That Explains How Your Doctor Makes Referrals*, THE WALL STREET JOURNAL (Dec. 27, 2018), https://www.wsj.com/articles/the-hidden-system-that-explains-how-your-doctor-makes-referrals-11545926166.
[80] *See supra* p.7.

describes how market power by incumbent hospitals and health systems would accentuate the incentives of physicians identified in Part II to act on market opportunities for entry and innovation and how market power would also accentuate the importance of such entry and innovation to the welfare of consumers and physicians. Lastly, this part will describe a recent FTC investigation into an acquisition by an incumbent health system of a specialty surgical POH, and how the FTC's analysis is consistent with this paper's assessments.

A. Healthcare Markets Where Physician-Owned Hospitals Compete

The Horizontal Merger Guidelines issued jointly by the U.S. Department of Justice and the Federal Trade Commission lay out key principles of market definition.[81] A market is defined around "horizontal" competition in that it includes actual and potential competitors that offer substitute products or services but not upstream providers or downstream customers.[82] The Guidelines explain: "Market definition focuses solely on demand substitution factors, i.e., on customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service."[83]

As described below, substitution factors show that POHs may operate in at least three service markets of policy significance—patient markets for hospital services, markets for the sale of hospital services to payors, and markets where hospitals compete for physician services. This comports with recent case law that characterizes hospital markets as a "two-stage model of competition": first, "insurers and hospitals negotiate to determine whether the hospitals will be in the insurers' networks and how much the insurers will pay them," and second, "hospitals compete to attract patients, based primarily on non-price factors like convenience and reputation for quality."[84] The market for physician services is less often a relevant market in the case law, but it arises, as well, as a potential market that can be harmed and as a critical input market for entry.[85]

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[81] HMG, *supra* note 25, § 1.
[82] *Id.*
[83] *Id.* § 4.
[84] Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 168 (3d Cir. 2022) (quoting FTC v. Advocate Health Care Network, 841 F.3d 460, 465 (7th Cir. 2016)).
[85] *E.g.*, FTC v. ProMedica Health System, 2011 WL 1219281, at *31-34 (emphasizing the time new hospitals require to obtain the requisite staff and physician affiliates); Jake Satisky, *Duke agrees to pay $54.5 million to settle class action lawsuit*, THE CHRONICLE (May 25, 2019), https://www.dukechronicle.com/article/2019/05/duke-university-settles-class-action-lawsuit-for-54-5-million; Seaman v. Duke Univ., No. 1:15-CV-462, 2019 WL 13193731 (M.D.N.C. Sept. 24, 2019) (order granting approval of proposed class action settlement); United States v. Anthem, Inc., 236 F. Supp. 3d 171, 187 (D.D.C. 2017), *aff'd* United States v. Anthem, Inc., 855 F.3d 345 (D.C. Cir. 2017) (noting "plaintiffs allege that the newly formed company will use its market power to pressure doctors, hospitals, and other providers to lower their prices, so the merger will result in harm to competition in the market for the purchase of healthcare services, or a monopsony" though not reaching this claim because the court found in plaintiff's favor on other grounds).

1. Markets to provide patients hospital services

From the perspective of patients, both general acute care and specialty POHs are additional providers where patients can obtain medical treatment for certain services.

General acute care hospitals, regardless of ownership structure, must provide services across a wide range of specialties focused on inpatient care and associated diagnostic service.[86] Since such facilities offer one-for-one substitutes across a broad range of specialties with other general acute care hospitals in their geographic market, it makes sense that patients see such institutions as alternatives across a range of patient medical needs. General acute care hospitals may also provide services that partially overlap with those offered by specialty hospitals. Consider a general acute care hospital and a cardiac specialty hospital. Both hospital types could offer and compete for interventional cardiology services. A cardiac specialty hospital's interventional cardiology service would not, however, compete with primary care services offered at the general acute care hospital. The caselaw also recognizes this partial overlap in services between general acute care hospitals and specialty hospitals.[87]

Specialty POHs likewise present patients an alternative both to other specialty hospitals and to general acute care hospitals, but only for a narrower set of services and medical needs. Based upon a 2015 survey, 45% of POHs are specialty hospitals.[88] Of POHs, 30.1% are cardiac specialty hospitals, 16.8% are orthopedic surgical specialty hospitals, 35.0% are general surgical specialty hospitals, and 18.1% are some other specialty.[89] So for example, a cardiac specialty hospital might compete in the market for cardiac services in a particular geography with general acute care hospitals (which would have a cardiology unit) as well as other non-POH cardiac specialty hospitals. If a patient needed to urgently or emergently undergo a cardiac catheterization for a balloon angioplasty and coronary artery stent placement with the expectation of post-procedural inpatient care and monitoring, a patient would be limited to these options: relevant cardiac specialty hospitals (incl. physician-owned) and general acute care

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[86] Centers for Medicare and Medicaid Services, Hospitals, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals (Medicare definition of a hospital includes coverage of a wide range of services); Joint Commission, Joint Commission Standards, https://www.jointcommission.org/standards/#f0e5e9ff3315465e9d8eff40d8124f3c_47a58d7b88154128b4df17e3c94092aa (Joint Commission requirements for accreditation of hospitals likewise includes coverage of a wage range of services).

[87] *See, e.g.*, Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc., 527 F. Supp. 2d 1257, 1265 (D. Kan. 2007) ("Niche providers include . . . specialty hospitals providing a limited range of specialty procedures, often organized around a singular issue, such as surgery, cardiac care, or women's care . . . . The insureds can obtain their healthcare from any of the niche providers or the traditional general hospitals.").

[88] *See* Daniel M. Blumenthal et al., *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, 351 THE BMJ h4466 app. 6 (Sep. 2, 2015), https://www.bmj.com/content/bmj/351/bmj.h4466.full.pdf (main article) and https://www.bmj.com/content/bmj/suppl/2015/09/01/bmj.h4466.DC1/blud025729.ww1_default.pdf (Data Supplement).

[89] *Id.*

hospitals. The office of a physician practice could not fill this patient need on site because they would not have the specialized operating room and equipment, and they would not have the beds to provide inpatient care overnight (and if they did have this capacity, they would have to be licensed *as a hospital*). Likewise, an ambulatory surgical center also could not fill this patient need—even if they have an operating room with relevant specialized equipment, they would not have the beds to provide inpatient care overnight, as required. Again, if they did have those beds, they would have to be licensed *as a hospital*. Of course, outside their specialization, specialty POHs are not market participants.

The geographic market is defined from the perspective of patients by their willingness to travel. For some commonplace or routine procedures or treatments, patients may not be willing to travel much beyond their local hospital or clinic. By contrast, for complex surgical services patients may be more willing to travel.[90] Government economists,[91] academics,[92] and state regulators[93] closely study home care bias, limited willingness for travel time or distance for primary care, and general geographic consumer preferences. Managed care market regulators recognize this market reality,[94] often implementing minimum, specific "time and distance" standards by medical specialty or type of care sought, a feature seen in ACA[95] and Medicare Advantage markets,[96] amongst others.

As a result of consumer preferences, the geographic market will be narrower and hospitals outside that locality would not be in the same geographic market. For rarer and higher stakes procedures or treatments such as complex cancer care or surgery, willingness to travel may increase and so even providers in other states might be seen as serving the same geographic market. However, even where some patients may be willing to travel greater distances, most patients may not be willing to travel farther, and so a provider with market power may still be

[90] Benjamin Resio et al., *Motivators, Barriers, and Facilitators to Traveling to the Safest Hospitals in the United States for Complex Cancer Surgery*, 1(7) JAMA NETW OPEN. e184595 (Nov. 2018), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2714502.
[91] Devesh Raval & Ted Rosenbaum, *Why is Distance Important for Hospital Choice? Separating Home Bias From Transport Costs.* 69(2) J. IND. ECON. 338 (July 11, 2021).
[92] Robin Haynes et al., *Potential Accessibility, Travel Time, and Consumer Choice: Geographical Variations in General Medical Practice Registrations in Eastern England*, 35(10) ENVIRONMENT AND PLANNING A: ECONOMY AND SPACE 1733 (Oct. 2003).
[93] Wei Yen, *How Long and How Far Do Adults Travel and Will Adults Travel for Primary Care?*, WASHINGTON STATE HEALTH SERVICES RESEARCH PROJECT, Research Brief No. 70 (Apr. 2013), https://ofm.wa.gov/sites/default/files/public/legacy/researchbriefs/2013/brief070.pdf.
[94] Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022), https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.
[95] Justin Giovannelli, Kevin Lucia, & Sabrina Corlette, *Regulation of Health Plan Provider Networks*, HEALTH AFFAIRS HEALTH POLICY BRIEFS, Jul. 28, 2016, https://www.healthaffairs.org/do/10.1377/hpb20160728.898461/full/healthpolicybrief_160.pdf.
[96] *Medicare Advantage Network Adequacy Criteria Guidance*, CMS (Jan. 10, 2017), https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

able to sustain a price increase, reflecting a narrower geographic market.[97] For most patients, the combination of cost-sharing with third party payors and limited price transparency means many patients will have weaker incentives to seek out a different provider based on cost so long as their provider is in-network.[98] Similarly for quality, patients have far from perfect information about how well healthcare providers diagnose patients or perform treatments and procedures, and this can dampen how far most patients are willing to travel to see an inconveniently located provider.[99] When combining all these factors, the literature and case law generally finds that these are local markets.[100] And in these narrow geographic markets, an additional local provider such as a POH could be a competitively significant addition for meeting patient needs.

2. Markets for the sale of hospital services to payors

From the payors' perspective, POHs offer more ways to put together a network of providers they can offer to employers and other insurance customers.[101] General acute care POHs would compete to be in-network with other general acute care hospitals across the range of offered services.[102]

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[97] For antitrust market definition, the Agencies "often" look for the ability to sustain a price increase of at least five percent. HMG, *supra* note 25, § 4.1.2.

[98] *See, e.g.*, Ezekiel J. Emanuel & Amaya Diana, *Considering the Future of Price Transparency Initiatives—Information Alone Is Not Sufficient*, 4(12) JAMA NETW. OPEN, Dec. 13, 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787076; Ateev Mehrotra et al., *Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information*, 36(8) HEALTH AFFAIRS 1392, August 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1471.

[99] *C.f.* Stefanie Bühn et al., *Are patients willing to accept longer travel times to decrease their risk associated with surgical procedures? A systematic review*, 20 BMC PUBLIC HEALTH 253, Feb. 19, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7031936/ ("Older age and fewer years of formal education were associated with a higher risk tolerance in the local hospital.").

[100] *See, e.g.*, Jean Marie Abraham et al., *Entry and Competition in Local Hospital Markets*, 55(2) THE JOURNAL OF INDUSTRIAL ECONOMICS 265, 267 (2007), http://www.jstor.org/stable/4622384 ("Hospital markets are local because consumers are not generally willing to travel far to obtain care"); Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 167 (3d Cir. 2022) (affirming proposed relevant geographic market in hospital merger challenge defined as all hospitals used by commercially insured patients who reside in Bergen County, New Jersey); Fed. Trade Comm'n v. Advoc. Health Care Network, 841 F.3d 460, 470 (7th Cir. 2016) ("[B]ecause most patients prefer to go to nearby hospitals, there are often only a few hospitals in a geographic market."); United States v. Rockford Memorial Corp., 898 F.2d 1278, 1284–85 (7th Cir. 1990) (approving six-hospital market in part because "for the most part hospital services are local").

[101] *See, e.g.*, Fed. Trade Comm'n v. Advoc. Health Care Network, 841 F.3d 460, 465 (7th Cir. 2016) ("In the United States today, most hospital care is bought in two stages. In the first, which is highly price-sensitive, insurers and hospitals negotiate to determine whether the hospitals will be in the insurers' networks and how much the insurers will pay them."); *supra* Part II.B (discussing example of Lincoln Surgical Hospital in Nebraska as a provider in a plan with BlueCross BlueShield Nebraska).

[102] For example, several insurers list general acute care POH Doctors Hospital at Renaissance, discussed *supra* in Part II.B, is an in-network provider. *See, e.g.*, Table of participating (in-network) hospitals for calendar year 2021, AETNA, https://www.aetna.com/dsepublicContent/assets/pdf/en/tx_non_contracted_prvdr_rprt.pdf (last visited Dec. 26, 2022); *Provider Director 2023*, UNITEDHEALTHCARE, https://www.uhc.com/medicare/alphadog/UHTX23RP0078088_001 (last visited Dec. 26, 2022).

Even for the many POHs that do not provide payor coverage for as many services as a general acute care hospital, such POHs may still be a valuable source of competition. This competition can be important to protect because (a) consumers of those service lines benefit from the competition directly, (b) payors benefit from more fulsome choices when developing their networks through the inclusion of low cost, high quality specialized hospitals, and (c) specialized POHs could be well-positioned to enter additional service lines. For example, payors have found that specialized service providers, such as imaging centers and ambulatory surgical centers, can provide significant cost savings,[103] and there is reason to think they would likewise benefit from additional provider choices in the form of specialty hospitals.[104] Moreover, even if a POH begins as an ambulatory surgical center or specialty hospital, it may expand the range of services it offers over time and become a general acute care hospital,[105] which today account for 55 percent of POHs.[106]

Geographic markets from the payor perspective also tend to be local.[107] For market and regulatory reasons, health insurance plans need a minimum number of providers in a given geography.[108] This is true of plans sold directly to consumers like those on ACA exchanges and in Medicare Advantage markets.[109] The breadth and quality of a payor's network is part of what they compete on and sell to consumers.[110] Moreover, network adequacy regulations ensure health insurance plans never drop below a minimum number of providers in a given geography.[111] For employer-provided health insurance, even national employers need to ensure

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[103] *See, e.g.*, Morgan Haefner, *UnitedHealth: Move routine imaging out of hospital, lower spending by 62%*, BECKER'S PAYER ISSUES (Nov. 18, 2020), https://www.beckerspayer.com/payer/unitedhealth-move-routine-imaging-out-of-hospital-lower-spending-by-62.html (discussing report from UnitedHealth Group finding potential for 62 percent cost savings by shifting diagnostic imaging from hospitals to lower-cost imaging centers); UnitedHealth Group, *Shifting Common Outpatient Procedures to ASCs Can Save Consumers More than $680 per Procedure* (2021), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2021/Site-of-Service-Research-Brief.pdf (finding 59% cost reduction from use of ambulatory surgical centers).

[104] *See infra*, Part V.C (discussing evidence of lower quality-adjusted prices from POH competition).

[105] For example, as discussed *supra* in Part II.B, Doctors Hospital at Renaissance originated as a 2-room ambulatory surgery center in 1997 and has grown into a 530-bed general acute care POH.

[106] Daniel M. Blumenthal et al., *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, 351 THE BMJ h4466 app. 8 (Sep. 2, 2015), https://www.bmj.com/content/bmj/351/bmj.h4466.full.pdf (main article) and https://www.bmj.com/content/bmj/suppl/2015/09/01/bmj.h4466.DC1/blud025729.ww1_default.pdf (Data Supplement).

[107] *See, e.g.*, Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 167 & 169 (3d Cir. 2022) (affirming proposed relevant geographic market defined as all hospitals used by commercially insured patients who reside in Bergen County, New Jersey and noting that the "commercial realities here are that most Bergen County residents receive their inpatient general acute care services in Bergen County and thus insurers feel they cannot offer a plan that does not include any Bergen County hospital options.").

[108] *See, e.g.*, Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022), https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.

[109] *Id.*

[110] *See, e.g.*, United States v. Aetna Inc., 240 F. Supp. 3d 1, 45 (D.D.C. 2017) (Noting insurers Aetna and Humana "compete on multiple dimensions of Medicare Advantage plan design, including network and cost.").

[111] *See, e.g.*, Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022), https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.

networks meet *local* employee needs. And since an employer tends to want to hire employees who live across a local geography, the network must be able to serve employees on the eastside of town and the westside, in downtown and in the suburbs, or however a local labor market may be geographically divided. As a result, employer-sponsored health insurance may reinforce geographically narrow healthcare markets or enhance the market power of local providers, since employer plans are less able to exclude hospitals in parts of local geographies with fewer alternatives.[112]

Medicare Advantage similarly enforces locality of consumer health preferences. Traditional Medicare is an "any willing provider" system, and is functionally a network of all physicians[113] without network tiering or steering. Thus, traditional Medicare allows consumers to select any physician without any financial consequences (no differences in copay or coinsurance) as the fee schedule is administratively set at the national level, with minimal geographic variation. Given the costs and tradeoffs of this insurance design, an increasing share of beneficiaries are turning to Medicare Advantage and accepting greater financial protections and supplemental benefits in turn for a network (with preferred and non-preferred providers and associated cost-sharing differences) and some utilization controls. Seniors may enroll only in Medicare Advantage plans offered in the county where they live.[114] With Medicare Advantage becoming the dominant form of Medicare in many counties[115] in the US and Medicaid managed care dominating the Medicaid market,[116] network competition increasingly will help determine price and quality.

In this context, an additional local provider such as a POH could be a meaningful addition that helps payors create networks that are competitive and satisfy regulatory requirements.

3. Markets where hospitals compete for physician services

From the perspective of physicians, POHs offer additional competition to utilize their services. Depending on their specialty, physicians can interact with hospitals in one of three ways: as salaried employees, as physicians with admitting privileges who either bill as part of

[112] *See, e.g.*, Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (Sep. 2022), https://www.cbo.gov/publication/58541 (noting "providers with market power can credibly threaten to stay out of an insurer's network and still maintain their market share, which strengthens their ability to negotiate higher prices with insurers.").
[113] Traditional Medicare includes 97% of US physicians. *See* Nancy Ochieng, Karyn Schwartz, & Tricia Neuman, *How Many Physicians Have Opted-Out of the Medicare Program?*, KFF (Oct. 22, 2020), https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/
[114] United States v. Aetna, Inc., 240 F. Supp. 3d 1, 19 n.6 (D.D.C. 2017).
[115] Meredith Freed et al., *Medicare Advantage in 2022: Enrollment Update and Key Trends*, KFF (Aug. 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.
[116] Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KFF (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

their independent private practice or as part of a larger medical group (frequently owned and operated by the hospital), or in the case of POHs as employers who share in a hospital's income. Unlike in the other two kinds of markets, here POHs should be understood as the purchaser of the relevant services, not the seller. Despite that difference, the relevant principles of economics and competition policy principles still apply.[117] A POH will increase competition for a given physician's services if the physician's specialty is relevant to a specialty POH or to a department within a general acute care POH. This can promote greater supply of physician services.

Geographically, labor markets tend to be local and that includes labor markets for physician services. In some ways, physicians may be more mobile than the typical employee. For example, they tend to be higher income, they are highly educated and so can better research opportunities in other locations, and their skills are in demand across the United States. On the other hand, medical licenses are often not easy to transfer across state lines, physician practices can take a lot of time to rebuild as referral relationships must be built, and physicians may have substantial roots in a locality (e.g., a spouse with a local job, a mortgage, children in the local school, family nearby, etc.). The economic evidence finds that the costs and frictions of relocating for a physician is sufficiently high that a hypothetical monopolist could exercise market power.[118] As a result, the addition of a local POH could substantially strengthen competition for physician services.

4. Barriers to Entry in the Hospital Market

Though not the dominant view, some commentators and case law incorporate factors like barriers to entry and expansion when defining a market.[119] Otherwise, a lack of entry barriers can be a defense to a finding of market power and competitive effects.[120] Either way, barriers to hospital entry are important to whether hospitals can exercise market power in these three kinds of markets. And the evidence strongly suggests barriers to entry and expansion are high.

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[117] *See* HMG, *supra* note 25, § 12.

[118] *See, e.g.*, United States v. Aetna, Inc., No. 3-99 CV 1398-H, 1999 WL 1419046, at *15 (N.D. Tex. Dec. 7, 1999) (approving consent decree in case alleging acquisition would "consolidate . . . purchasing power over physicians' services in Houston and Dallas, enabling the merged entity to unduly reduce the rates paid for those services."); *see also* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 6, p. 16, July 2004, https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf (noting importance of evaluating switching costs in monopsony analysis and discussing reasons physicians may face high switching costs, including value of physician's time, difficulty quickly replacing lost patients, investment in specialized assets and training, and lack of geographic mobility); *cf.* United States v. Bertelsmann SE & Co. KGaA, No. CV 21-2886-FYP, 2022 WL 16949715, at *19-20 (D.D.C. Nov. 15, 2022) (applying hypothetical monopolist test to assess proposed relevant market for publishing rights to anticipated top-selling books).

[119] *E.g.*, PHILLIP E. AREEDA & HERBERT HOOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION §561(b)(2) (2022) ("Differential entry effects may identify market."); *Blue Cross Blue Chield United of Wis. V. Marshfield Clinic*, 65 F.3d 1406, 1410-11 (7th Cir. 1995) ("Definition of a market depends on substitutability on the supply side as well as on the demand side).

[120] HMG, *supra* note 25, § 9.

A new hospital generally must enter multiple service markets at once. For example, most hospitals include emergency care, procedural care, ambulatory care (primary and specialty), and habilitative services to name a few. Construction time is measured in years, with technology-driven facilities frequently requiring as long as four years.[121] Building a new hospital or expanding an existing hospital is a tremendously expensive and time-consuming[122] endeavor, as frequently both development and initial operating costs must be covered. Direct costs include land acquisition, facility construction, and the acquisition of medical equipment to name a few, along with initial staffing – clinical (nursing, pharmacy, physician), ancillary (technicians, patient transporters, unit secretaries, environmental services, facilities maintenance), and managerial. Even small micro hospitals,[123] which are typically around 10 beds, can cost $25-50 million.[124] Hospital construction costs per square foot are significant, typically running $285 to $700 per square foot in a major city.[125] Measured differently, "cost per bed" can run $1-3 million depending upon the intended use, with recent examples of facility expansion including Rush University's new $654 million, 304 bed pavilion,[126] MedStar Georgetown University Hospital's new $567 million, 477,000 square foot surgical pavilion[127] that includes 156 new beds,[128] and the Mayo Clinic's $353 million La Crosse and Mankato projects with a new 70-bed hospital and a 121-bed expansion.[129]

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[121] *How do you build a hospital that balances cutting edge technology and affordable healthcare?*, ARUP, https://www.arup.com/projects/kaiser-permanente-san-diego (last visited Dec. 25, 2022).
[122] John E. Millsap, *Understanding the Hospital Planning, Design, and Construction Process*, CALIFORNIA HEALTHCARE FOUNDATION ISSUE BRIEF (Feb. 2007), https://www.chcf.org/wp-content/uploads/2017/12/PDF-SB1953HospitalConstructionIB.pdf.
[123] Michelle E. Andrews, *Microhospitals May Help Deliver Care In Underserved Areas*, NPR (Jul. 19, 2016), https://www.npr.org/sections/health-shots/2016/07/19/486500835/microhospitals-may-help-deliver-care-in-underserved-areas.
[124] Beth Jones Sanborn, *Are micro-hospitals the answer for systems looking for low-cost expansions? They might be*, HEALTHCARE FINANCE (Jul. 12, 2017), https://www.healthcarefinancenews.com/news/are-microhospitals-answer-systems-looking-low-cost-expansions-they-might-be.
[125] Alia Paavola, *12 US Cities Ranked by Cost per Square Foot to Build a Hospital*, BECKER'S HOSPITAL REVIEW (Jul. 21, 2017), https://www.beckershospitalreview.com/capital/12-us-cities-ranked-by-cost-per-square-foot-to-build-a-hospital.html.
[126] Rush Content Hub, *Rush's New Hospital is the Largest New Construction Health Care Facility in the World to Receive LEED Gold Certification*, RUSH UNIVERSITY MEDICAL CENTER (Jun. 25, 2014), https://www.rush.edu/news/rushs-new-hospital-largest-new-construction-health-care-facility-world-receive-leed-gold.
[127] Tina Reed, *MedStar Georgetown University Hospital prepares to start construction on new tower*, WASHINGTON BUSINESS JOURNAL (Feb. 23, 2018), https://www.bizjournals.com/washington/news/2018/02/23/medstar-georgetown-university-hospital-prepares-to.html.
[128] *Building Medical Excellence: The Medical/Surgical Pavilion at MedStar Georgetown University Hospital*, MEDSTAR HEALTH, https://www.medstarhealth.org/philanthropy/get-involved/medstar-georgetown-medical-surgical-pavilion (last visited Dec. 25, 2022).
[129] Karl Oestreich, *Mayo Clinic invests in facilities at Mayo Clinic Health System locations and in Florida to expand and enhance patient care*, MAYO CLINIC (Feb. 22, 2022), https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-invests-in-facilities-at-mayo-clinic-health-system-locations-and-in-florida-to-expand-and-enhance-patient-care/.

Beyond these direct costs, new hospitals often must overcome significant regulatory hurdles such as zoning, building permits, and licensure. In many markets, hospital facilities must obtain clearance for market entry through a certificate of need ("CON") process, a regulatory barrier present in 35 states and the District of Columbia. Originating in the 1960s and intended to provide downward pressure on health care expenditures and avoid facility duplication or the "medical arms race,"[130] certificate of need laws can suppress market entry, especially when incumbents abuse the hearing, comment, and appeal processes, as documented by the U.S. Department of Justice, the Federal Trade Commission, and policy scholars.[131]

Additionally, new hospitals often must negotiate agreements with multiple public and private payor networks to be included in their insurance coverage. To participate in the Medicare and Medicaid program, hospitals must meet the conditions of participation[132] and accept public payor fee schedules. As part of this process, hospitals typically undergo a survey process, or an inspection and review by certifying agency such as the Joint Commission, Det Norske Veritas, or the Center for Improvement in Healthcare Quality. Hospitals typically also use those survey results for participation in private plan networks, with facilities facing the additional step of negotiating payment rates with each private plan or modifying pre-existing health system payor contracts to include the new or expanded facility. If a hospital is opened as a stand-alone facility rather than as part of a larger network, the hospital may lack leverage to negotiate higher rates with payers which may make it more difficult to recoup the significant investments necessary to open the new hospital, further discouraging new entry.

Thus, the barriers to hospital construction or expansion are significant, and this conclusion is echoed in the antitrust case law.[133]

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[130] Christopher J. Conover & James Bailey, *Certificate of need laws: a systematic review and cost-effectiveness analysis*, 20 BMC HEALTH SERVICES RESEARCH 748 (Aug. 14, 2020).

[131] *See, e.g.*, U.S. Dep't of Justice & Fed. Trade Comm'n, *Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform* (Sep. 15, 2008), https://www.justice.gov/atr/competition-health-care-and-certificates-need-joint-statement-antitrust-division-us-department; U.S. Dep't of Justice & Fed. Trade Comm'n, *Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission on Certificate-of-Need Laws and Alaska Senate Bill 62* (Apr. 12, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf; Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30(1) Antitrust 50 (Fall 2015), https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf; Matthew D. Mitchell et al., *CON Laws in 2020: About the Update*, MERCATUS CENTER (Feb. 19, 2021), https://www.mercatus.org/publications/healthcare/con-laws-2020-about-update.

[132] *Critical Access Hospitals (CAHs)*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals (last modified Dec. 1, 2021, 7:02 PM).

[133] *E.g.*, FTC v. ProMedica Health System, 2011 WL 1219281, at *31-34 (N.D. Oh. Mar. 29, 2011) (it "take[s] significantly longer than the two-year timeframe prescribed by the *Merger Guidelines* to plan, obtain zoning, licensing, and regulatory permits, and construct a new hospital," that it takes time to obtain the requisite staff and physician affiliates, and that hospitals require "an extraordinarily large, up-front capital investment.").

B. Market Power by Incumbent Hospitals and Health Systems—How it Affects the Incentives and Importance of Physician-Owned Hospitals

Given the three kinds of markets identified in Part III.A, we can revisit the trends and concerns for consolidation discussed in Part I. When hospitals and health systems consolidate and develop market power, we should expect effects in terms of price, quality, output, and innovation. For example, payors may have fewer ways to put together their provider networks for a given local market. That may mean payors develop lower quality networks and consumers have fewer in-network alternatives. It may mean hospitals and health systems have more leverage to demand higher prices, as some providers become increasingly "must haves" for meeting network adequacy thresholds and for offering viable, commercially attractive plans. Similarly, quality and innovation may suffer as hospitals and health systems face less pressure to earn their in-network status or earn patient loyalty. Risk-taking with innovations in hospital management and care delivery may seem unnecessary. Lastly, these institutional providers may have incentives to engage in anticompetitive conduct, like contracting practices that protect their market power.

As these hospitals and health systems exercise market power upstream in the market for physician services, we can likewise see how physicians would have fewer alternatives for their services locally, and one can see the attractiveness to hospitals of moving physicians to a salary model. As employees, physicians would not be negotiating independently with payors for compensation, so the health system can demand more from payors for the very same physician services. Additionally, physicians are no longer negotiating as independents for the terms of admitting privileges at the hospital, and they can more effectively be asked to work longer hours for less pay and less profit sharing. Moreover, physicians may be asked to engage in referral patterns that are limited to their employer health system. Lastly, health systems may be less responsive to requests to design hospital operating rooms and other aspects of the hospital setting around optimizing specific physician practice areas, as discussed above in Part II.B, especially if those physician requests do not conform to maximizing supracompetitive profits for the health system overall (for example, if a focused-factory model increases output in a way that reduces overall rents from market power).

These likely harms of market power accentuate the potential value of physician entry and innovation identified in Part II and in some respects makes POH entry more feasible. If market power increases the costs of hospital services downstream, that increases the importance of a POH to compete and defeat the price increases, and those high incumbent prices also creates the space for the entrant to win market share. The same is true on quality and innovation—it becomes more important to the local market to make up for the deficit in high quality, innovative care, and that also becomes a way for the POH entrant to earn its place in the market. Moreover,

to the extent physicians are being underpaid or overworked or their services are not being effectively utilized, the market power of incumbent hospitals in upstream labor markets gives physicians greater incentive to form a POH and greater ability to attract colleagues and affiliated physicians with enticing terms to join their new POH, including an ownership interest.

The FTC's 2012 investigation into the Reading Health System's (RHS) proposed acquisition of Surgical Institute of Reading L.P. (SIR) is illuminating, which the parties abandoned following the FTC's complaint.[134] As alleged in the complaint, RHS was the dominant incumbent health system in the Reading, Pennsylvania area.[135] RHS had 735 licensed hospital beds and is the largest local employer of physicians.[136] By contrast, SIR was a surgical specialty POH formed only in 2007 with a mere 15 licensed beds.[137] SIR provided a range of inpatient and outpatient surgical services, including ENT, orthopedic, spine, neurological, and general surgery.[138] The FTC identified only one other general acute care hospital in the local market.[139] Among the relevant markets of concern, the FTC determined that the acquisition would give RHS control of two-thirds of the local market for inpatient orthopedic services, up from 42 percent.[140]

SIR entered the market in 2007.[141] RHS was alarmed when SIR's entry was pending, projecting heavy losses on its revenue and volume on competing surgical procedures.[142] That sense of alarm appeared to be well-founded. Once in the market, RHS began internally attributing "notable losses of volume" directly to SIR, especially for orthopedics, ENT, and general surgery.[143] By 2009, RHS believed SIR had already acquired 10 percent of the inpatient orthopedic market.[144] By the time FTC reviewed the proposed acquisition in 2012, SIR's share was 24 percent of the local inpatient orthopedic market.[145] RHS executives complained of SIR as its "nemesis" and observed how "by service line" RHS was "even a harder hit."[146]

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[134] *Reading Health System, and Surgical Institute of Reading, In the Matter of*, FED. TRADE COMM'N LEGAL LIBRARY (Dec. 7, 2012), https://www.ftc.gov/legal-library/browse/cases-proceedings/1210155-reading-health-system-surgical-institute-reading-matter.
[135] Complaint ¶ 1, Reading Health System/Surgical Institute of Reading L.P., C-9353, FTC File No. 1210155 (2012).
[136] *Id.* ¶ 11.
[137] *Id.* ¶ 13.
[138] *Id.*
[139] *Id.* ¶ 9.
[140] *Id.* ¶¶ 58-59.
[141] *Id.* ¶ 1.
[142] *Id.* ¶ 2.
[143] *Id.* ¶ 24.
[144] *Id.* ¶ 25.
[145] *Id.* ¶ 59.
[146] *Id.* ¶ 25.

According to the FTC, SIR achieved this remarkable entry by outcompeting RHS. There were "wide differences" in the rates SIR charged health plans.[147] SIR also received higher patient satisfaction scores than RHS and St. Joseph (the other local general acute care hospital).[148] SIR distinguished itself by offering 24-hour visitation, quick schedule times, private rooms, and lower infection rates.[149]

Per the complaint, RHS primarily responded to SIR with exclusionary tactics. RHS offered discounts but only contingent on health plans excluding SIR.[150] These exclusionary discounts were mostly rejected by health plans because of the value of SIR to their provider networks and members.[151] Of course, both the exclusionary discounts and SIR's competitive rates would be lost had the acquisition proceeded.[152] RHS also successfully used its role in one health plan to steer patients away from SIR and to RHS.[153] And RHS-employed primary care physicians—a significant share of the local market—stopped referring patients to SIR.[154] The foreclosure of primary care referrals attempted to make SIR's entry less likely by making it harder to attract a sufficient number of patients to sustain the POH and become a meaningful competitor.[155]

Why was SIR's market entry nevertheless successful? The FTC credited SIR's "physician-driven management" and "patient-focused" approach to care that was notably "less bureaucratic" than RHS.[156] But this explanation still begs the question: why was this so difficult for others to replicate? The FTC flagged that there are significant barriers to entry or expansion in these markets, which in addition to building up surgical referrals from local primary care physicians, included access to the requisite surgical specialists, establishing contracts with payors, and building the physical infrastructure which can take several years.[157] SIR was able to overcome these barriers, and it certainly seems like the local incumbents should be well-situated to match SIR's competition. They've already overcome these market barriers on their existing orthopedic surgical services, RHS is well-capitalized with over $1 billion in unrestricted cash and investments, RHS dominates the local market for primary care physicians, and the FTC determined that RHS had "already immense bargaining leverage" over health plans.[158] And yet, despite RHS internally recognizing the cost of losing these "higher-reimbursed patients" to SIR and the importance of "improv[ing] our services so that patients will want to come," RHS

[147] *Id.* ¶ 26.
[148] *Id.*
[149] *Id.* ¶ 37.
[150] *Id.* ¶ 27.
[151] *Id.*
[152] *Id.*
[153] *Id.* ¶ 28.
[154] *Id.*
[155] *Id.* ¶ 69.
[156] *Id.* ¶ 39.
[157] *Id.* ¶¶ 68-73.
[158] *Id.* ¶ 7.

"struggle[d] to provide the same level of service and amenities" as SIR.[159] Notably, the point of failure for both RHS and St. Joseph was the inability to recruit additional orthopedic surgeons to improve their departments and compete with SIR.[160] RHS was reduced to using exclusionary tactics. When those efforts failed, RHS offered to buy out SIR at a "considerable premium" compared to other bidders.[161] Accordingly, RHS must have seen its best path to protecting its market position lay not in competition but in removing SIR from the competition.

The FTC also observed that "[b]ased on recent history, the most likely entrant into this market would be another physician-owned specialty hospital."[162] Unfortunately, the POH ban that is the subject of this article was already in place by 2012, so such entry would not be forthcoming. But why couldn't another specialty surgical hospital, not owned by physicians, follow SIR's lead and have similar success by employing "physician-driven management" and taking a "patient-focused," "less bureaucratic" approach?

The FTC's evidence here suggests physician-owned SIR had an edge in Reading, Pennsylvania, over incumbents and non-physician-owned entrants alike, for the reasons identified above in Part II and discussed in this part. The unique role of physicians in providing and directing care helps them identify opportunities for hospital market entry and innovation. Physician ownership gives them the incentives and ability to seek out and act on those opportunities. Ownership also helps overcome challenges recruiting physicians. Lastly, the combination of upstream and downstream market power supercharges these incentives. These strengths would give SIR an edge in timing its entry, in identifying ways to distinguish its services, and in recruiting surgeons. Moreover, RHS used its dominance to become "one of the most expensive healthcare providers in central Pennsylvania," while also being dominant as a healthcare employer.[163] This exercise of upstream and downstream market power by RHS gave SIR an opening to outcompete RHS in contracting with health plans, which RHS failed to prevent with its exclusionary pricing, and in recruiting orthopedic surgeons, which SIR did successfully and where RHS fell short. A non-physician-owned entrant would likely lack this competitive edge that SIR obtained from physician ownership.

With this formidable POH competition in mind, Part IV explores the history and historic growth of POHs and the halt of that growth under the ban.

IV. The Growth of Physician-Owned Hospitals and the Subsequent Ban

[159] *Id.* ¶¶ 2, 40.
[160] *Id.* ¶¶ 9, 70.
[161] *Id.* ¶ 29.
[162] *Id.* ¶ 72.
[163] *Id.* ¶ 21.

Hospitals are an important part of the story of physician entrepreneurship in the United States mentioned in Part II, and indeed hospitals were frequently owned and managed by physicians during the first half of the twentieth century.[164] Physicians began giving up ownership and control of hospitals and other large medical institutions in the 1930s and 1940s,[165] spurred on further by the Hill Burton Act of 1947, which provided federal funding for the development of community hospitals.[166]

POHs began to re-emerge in the 1980s, driven in part by a push for efficiency and specialization.[167] Physicians sought a greater ability to improve general hospital medical care and customize the entire treatment process, including operating room workflows and associated pre- and post-op care, and ancillary clinical operations such as radiology, diagnostic laboratories, etc., which all can be facilitated by physician ownership. As POHs gained steam, they emerged as a countertrend to consolidation in hospital markets discussed in Part I.

A. 2000-2010: Growth, Scrutiny, and Early Interventions

In the lead up to the ACA, the number of POHs grew rapidly throughout the 2000s. As of 2003, there were 67 POHs.[168] From 2002-2004, the number of POHs roughly doubled.[169] By the end of the decade, the number of POHs had peaked at approximately 265 in the US (in a country of just over 6,000 hospitals).[170]

Throughout this period of growth, POHs faced extensive scrutiny. Congress and various federal agencies conducted hearings and issued multiple reports examining POHs. These include:

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[164] NANCY J. NILES, BASICS OF THE U.S. HEALTH CARE SYSTEM 5 (2014 2d ed.), https://samples.jbpub.com/9781284043761/Chapter1.pdf.
[165] *Id.*
[166] *See, e.g.*, Barbra Mann Wall, *History of Hospitals*, UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/ (last visited Dec. 4, 2022); John H. Schumann, *A Bygone Era: When Bipartisanship Led To Health Care Transformation*, NPR (Oct. 2, 2016), https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation; *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316 (1979), http://digitalcommons.law.umaryland.edu/mlr/vol39/iss2/5; Julie A. Bargo, *The Hill-Burton Act of 1946: America's First Health Policy*, PA TIMES (Mar. 14, 2020), https://patimes.org/the-hill-burton-act-of-1946-americas-first-health-policy/; *The Hospital Survey And Construction Act*, 132(3) JAMA 148 (Sep. 21, 1946).
[167] Staff, *Attack on Physician-Owned Hospitals in America: History, Current Efforts and the Impact on the Future of Healthcare*, BECKER'S HOSPITAL REV. (Mar. 22, 2010), https://www.beckershospitalreview.com/news-analysis/attack-on-physician-owned-hospitals-in-america-history-current-efforts-and-the-impact-on-the-future-of-healthcare.html.
[168] CENTERS FOR MEDICARE & MEDICAID SERVICES, "STUDY OF PHYSICIAN-OWNED SPECIALTY HOSPITALS REQUIRED IN SECTION 507(C)(2) OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, at i (2005) [hereinafter 2005 CMS REPORT].
[169] MEDPAC, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, at vi (Mar. 2006) [hereinafter 2006 MEDPAC REPORT].
[170] Tanya Albert Henry, *Physician-Owned Hospitals Seize Their Moment*, 110(4) MO. MED. 282 (July/Aug. 2013).

the 2005 and 2006 MedPac reports,[171] the 2005 GAO report,[172] the 2005 CMS report,[173] the Senate Finance Committee's May 17, 2006 hearing on Physician-Owned Specialty Hospitals,[174] and the 2006 HHS report.[175] These studies examined issues such as referral patterns,[176] quality of care,[177] patient satisfaction,[178] costs,[179] patient population,[180] rationales for POHs,[181] share of uncompensated care,[182] and responses of community hospitals to increased competition.[183]

In the 2000s, there began fierce marketplace resistance to POHs by incumbent hospitals. Some of this is illustrated by antitrust litigation. We have identified at least three examples in the 2000s and at least two examples in the 2010s where local incumbent hospitals faced antitrust litigation for employing tactics, sometimes in concert, to exclude POHs from the market. The most common tactic alleged in these cases is conditioning contracts with private health plans on excluding a POH from their networks. For example, suits in Texas on behalf of the state Attorney General and private plaintiffs alleged a hospital coerced health plans to refuse to deal

[171] MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC), REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS (Mar. 2005) [hereinafter 2005 MEDPAC REPORT]; 2006 MEDPAC REPORT, *supra* note 169.
[172] UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE (GAO), SPECIALTY HOSPITALS: INFORMATION ON POTENTIAL NEW FACILITIES, GAO-05-647R (May 19, 2005) [hereinafter 2005 GAO REPORT].
[173] 2005 CMS REPORT, *supra* note 168.
[174] *Physician-Owned Specialty Hospitals, Profits Before Patients?: Hearing Before the Comm. on Finance*, U.S. Sen., 109 Cong. (May 17, 2006).
[175] United States Department of Health and Human Services (HHS), "Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005" (2006) [hereinafter 2006 HHS Report].
[176] *E.g.*, 2005 CMS REPORT, *supra* note 168, at ii-iii (concluding "the notion that specialty cardiac hospitals are transferring more severely ill patients to general hospitals was not supported by our study" and that "[t]he notion that specialty cardiac hospitals are systematically screening out more severely ill patients using the ED is not supported by our findings").
[177] *E.g.*, 2005 CMS REPORT, *supra* note 168, at iii (concluding cardiac POHs delivered quality of care good or better than competitors).
[178] *E.g.*, 2005 CMS REPORT, *supra* note 168, at iii ("Patient satisfaction was very high in both cardiac and orthopedic/surgery hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for their family members if needed, easy parking, and good food.").
[179] *E.g.*, 2005 MEDPAC REPORT, *supra* note 171, at vii ("Physician-owned specialty hospitals, thus far, do not have lower costs for Medicare patients than community hospitals, although their patients have shorter lengths of stay."); 2006 MEDPAC REPORT, *supra* note 169, at vi-vii (same).
[180] *E.g.*, 2005 MEDPAC REPORT, *supra* note 171, at vii ("[Physician-owned specialty hospitals] treat patients who are generally less severe cases (and hence expected to be relatively more profitable than the average) and concentrate on particular diagnosis-related groups (DRGs), some of which are relatively more profitable. They tend to have lower shares of Medicaid patients than community hospitals.").
[181] *E.g.*, 2005 MEDPAC REPORT, *supra* note 171, at vii ("We found that physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity, and to provide greater satisfaction for them and their patients. They may also be motivated by the financial rewards, some of which derive from inaccuracies in the Medicare payment system.").
[182] *E.g.*, 2005 CMS REPORT, *supra* note 168, at iii-iv (finding "total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care").
[183] *E.g.*, 2005 MEDPAC REPORT, *supra* note 171, at 24 (finding competitor community hospitals cut expenses, instituted "aggressive pricing strategies," and expanded profitable business lines in order to maintain profit margins in line with national averages).

with a rival POH.[184] Other suits in Arkansas challenged an incumbent hospital's alleged exclusionary conduct against a cardiac specialty POH.[185] This list also includes the 2012 FTC complaint in Pennsylvania discussed in Part III.B. More recently in Ohio, the Sixth Circuit found that two hospitals with a joint operating agreement could conspire to boycott plaintiff POH by forbidding insurers from contracting with the POH.[186]

One illustrative example is *Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc.* In 2005, Heartland Surgical Specialty Hospital, LLC ("Heartland"), a POH in the Kansas City metro area, filed suit against five traditional hospitals and six managed care organizations (MCOs) for conspiring to boycott its entry into the Kansas City market in violation of the Sherman Act, among other claims.[187] In 2007, defendants' motion for summary judgment ("MSJ") was denied regarding the Sherman Act conspiracy claim (except as to one defendant).[188]

Heartland opened in 2003 and was owned by physicians specializing in orthopedic, neurological, plastic, pain management, and general surgery disciplines.[189] Heartland claimed that it outperformed other local providers on patient recovery times and infection rates that translated into better outcomes and lower overall costs for its patients.[190] Likewise, defendant hospitals acknowledged in their own negotiations with payers that POHs were "lower cost providers" that "can schedule faster, [were more] convenient, [offered] 'better' quality etc."[191] Despite these benefits, Heartland was unable to obtain an in-network contract prior to filing the lawsuit from any of the six managed care organization defendants,[192] who collectively accounted for approximately 90 percent of the Kansas City payor market.[193] Heartland learned that five of its competitors, traditional hospitals accounting for 74 percent of patient revenues,[194] were pressuring the MCOs to reject Heartland's business while still adding new facilities from those hospitals to their networks.[195] Defendant hospitals also asked payers to help address "referral

[184] Texas v. Memorial Herman Healthcare Systems, Inc., No. 2009-04609, 281st Judicial District (Texas Attorney General sued and settled with hospital coercing health plans to refuse to deal with rival physician-owned hospital); In re Memorial Herman Healthcare Systems, Inc., 274 S.W.3d 195 (Tex. Ct. App. 14th Dist. 2008) (follow-on private litigation on behalf of plaintiff physician-owned hospital).
[185] Little Rock Cardiology Clinic PA v. Baptist Health, 591 F.3d 591 (8th Cir. 2009) (rejecting plaintiff's product and geographic market definition in a physician-owned hospital challenge against a hospital's exclusionary conduct); *but see* Baptist Health v. Murphy, 373 S.W.3d 269 (Ark. 2010) (granting state tortious interference claim by plaintiffs on overlapping facts with 8th Cir. case); FTC v. Penn State Hershey Ctr., 838 F.3d 327 (3d Cir. 2016) (rejecting legal tests on market definition in *Little Rock Cardiology Clinic*).
[186] *E.g.*, Medical Center at Elizabeth Place v. Atrium Health System, 817 F.3d 934 (6th Cir. 2016).
[187] Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc., 527 F. Supp. 2d 1257, 1263 (D. Kan. 2007).
[188] *Id.*
[189] *Id.* at 1266.
[190] *Id.* at 1267.
[191] *Id.* at 1281, 1284.
[192] *Id.* at 1277.
[193] *Id.* at 1266.
[194] *Id.*
[195] *Id.* at 1283-88.

practices" to prevent "leaking" to Heartland.[196] At the time of the motion for summary judgment, the judge found that plaintiff had provided sufficient evidence to support bringing their case to trial, noting that Heartland had shown not only that the defendants acted in parallel, but that there was a "motivation to enter an agreement to boycott and that the competing defendants cooperated with each other to effectuate the agreement."[197] The defendants ultimately settled with Heartland before trial.[198]

Antitrust violations can expose defendants to treble damages. Given these stiff penalties, hospitals would not be expected to risk such liability unless the stakes were high and alternatives like competing on the merits were less attractive. Defendant hospital HCA Midwest, the largest in the Kansas City metro area (28% market share),[199] explained it well in internal documents: it was "under attack from physician-syndicated specialty hospitals (particularly in high margin services)" and "We have high risk of losing this volume if the regulatory environment doesn't help us out. . . . if they stay so entrenched in their business model." [200] Other defendant hospitals spoke in similar terms of the need to deny Heartland access to the market.[201] The message was heard by the MCOs. For example, Humana explained, that "[the] major systems . . . view [POHs] as direct competitors" and "are placing intense pressure on carriers not to contract with these entities."[202]

Efforts to exclude competition from POHs are also reflected in the lobbying activity of the American Hospital Association and other industry groups throughout this period who regularly advocated for legislative scrutiny and restrictions curtailing POHs, describing the market as limited-service specialty hospitals, leaving unaddressed the half of the POH market comprised of general acute care hospitals. In 2005, George Lynn, then Board Chair of the American Hospital Association, called for a ban on POHs,[203] followed by both an AHA letter to CMS,[204] denoting POHs as "physician-owned, limited service hospitals," and an AHA-commissioned case study of the impact of POHs on community hospitals, denoting competitive impacts.[205] Investor-owned hospitals chimed in, with Federation of American Hospitals (FAH)

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[196] *Id.* at 1284.
[197] *Id.* at 1321.
[198] *E.g.*, Staff, *Physician-Owned Hospital Settles Landmark Antitrust Suit Against Regional Insurers and Hospitals*, BECKER'S HOSPITAL REV., August 26th, 2008, https://www.beckershospitalreview.com/news-analysis/physician-owned-hospital-settles-landmark-antitrust-suit-against-regional-insurers-and-hospitals.html.
[199] Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc., 527 F. Supp. 2d 1257, 1266 n.8 (D. Kan. 2007).
[200] *Id.* at 1281.
[201] *See id.* at 1281-83.
[202] *Id.* at 1281.
[203] Mary Ellen Schneider, *AHA: ban self-referrals to specialty hospitals*, INTERNAL MEDICINE NEWS, May 1, 2005, https://cdn.mdedge.com/files/s3fs-public/issues/articles/70724_main_3.pdf.
[204] Letter from Rick Pollack, Executive Vice President, American Hospital Ass'n to Mark McClellen, Administrator, Centers for Medicare and Medicaid Services (June 12, 2006), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/Comments_from_American_Hospital_Association.pdf.
[205] *See* McManis Consulting, *The Impact of Physician-owned Limited-service Hospitals: A Summary of Four Case Studies* (Feb. 16, 2005).

CEO Chip Kahn calling for their ban, describing POHs as an "intolerable risk, irreparable harm" in a 2006 *Health Affairs* column.[206]

In 2003, Congress passed temporary restrictions on the growth of POHs. Section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA of 2003") (passed into law on Dec. 8, 2003) effectively imposed an 18-month moratorium (through June 8, 2005) on new specialty POHs.[207] The moratorium operated by prohibiting physician referrals to new specialty hospitals in which the physician has an ownership interest, except for those specialty hospitals already in development or operation as of November 18, 2003.[208]

At the state level, there were also efforts to single out physician-owned facilities. For example, Florida banned specialty hospitals that treat a single condition, which are disproportionately physician-owned facilities, while relaxing CON requirements for general hospitals.[209]

In April of 2004, the American Medical Association Board of Trustees agreed to develop a position paper on POHs. At the time, the AMA sought to determine (1) their wide ranging impact on the provision of healthcare, (2) competitive pressures and tactics used by hospitals and others to stop the building of specialty hospitals, (3) known and potential benefits associated with specialty hospitals including quality of care improvements, patient satisfaction and cost effectiveness, (4) the financial impact on community hospitals and "safety net" institution, access to emergency and trauma care services, and the quality of physician training programs, (5) the appropriateness of physician referral patterns, and (6) any other issues relating to specialty hospitals that may impact quality of care.[210] The report, which was developed with broad stakeholder input, including input from the AMA Council on Ethical and Judicial Affairs, opposed efforts to extend the moratorium and sought to encourage competition between and among health facilities as a means of promoting high-quality, cost-effective health care.[211] Notably the report found, "Many physicians are frustrated over hospital control of management decisions and investment decisions that affect their productivity and quality of patient care. They want a greater involvement in governance and management, reinvestment of profits to maintain state-of-the art care and equipment, and greater control over scheduling and the types of cases performed in the operating room. They also have a perception that hospitals are not

[206] Charles N. Kahn, *Intolerable Risk, Irreparable Harm: The Legacy of Physician-Owned Hospitals*, 25(1) HEALTH AFFAIRS 130 (Jan./Feb. 2006).
[207] *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, sec. 507, 117 Stat. 2066 (2003) [hereinafter MMA of 2003]; *see also* 2006 HHS Report, *supra* note 175, at 3-4 (summarizing the 18-mo POH moratorium imposed by section 507 of the MMA of 2003).
[208] *See* 2006 HHS Report, *supra* note 175, at 3-4.
[209] Fla. Bill SJ 01740 (effective July 1, 2004), *amending* Fla Stat. ch. 408.036, .0361 (2003).
[210] American Medical Ass'n, *Board of Trustees Report*, 2004 PROCEEDINGS OF THE INTERIM MEETING OF THE HOUSE OF DELEGATES 88, 88 (Dec. 2004).
[211] *Id.*

working to align hospital processes or providing opportunities for joint ventures. Specialty hospitals allow physicians to increase their productivity and have more control over scheduling and purchasing of desired equipment."[212]

Congress also considered legislation during this period to make the moratorium permanent before successfully passing the ACA which effectively banned new or expanded POHs in 2010. For example, Senators Charles Grassley and Max Baucus introduced legislation in 2005 that would have made the moratorium retroactive and permanent.[213] In 2007, the House passed a bill that would have effectively banned new or expanded POHs.[214] The House passed similar legislation in 2008, with a nearly identical ban on new or expanded POHs, but with authority for the Secretary of HHS to grant exceptions to expand POH capacity by 50%.[215]

B. 2010: The Physician-Owned Hospitals Ban

The 2010 Patient Protection and Affordable Care Act (ACA), which largely focused on setting up a system of competitive market-driven insurance exchanges based upon a premium support model and reforms to other insurance markets, also contained a provision effectively banning opening new POHs and expanding existing ones.[216] Following the ban, the number of POHs has remained around 250 POHs across 33 states as of 2017.[217]

1. The Deal with Traditional Hospitals

The restrictions on POHs in the ACA are unrelated to the creation of insurance exchanges, the expansion of Medicaid coverage, and other significant provisions of the ACA. Rather, the restrictions arose as part of the legislative horse trading with hospital interest groups to reduce opposition to ACA's passage. As part of these negotiations, the Federation of American Hospitals, the Catholic Health Association, and the American Hospital Association publicly accepted $155 billion in cuts to Medicare and Medicaid reimbursements over ten years, and the administration agreed to demands of the hospital groups, most notably restrictions on

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[212] *Id.* at 90.
[213] *See* 2006 HHS Report, *supra* note 175, at 4-5 (summarizing the Hospital Fair Competition Act of 2005).
[214] Children's Health and Medicare Protection Act of 2007, H.R. 3162, 110th Cong. § 651 (as passed by House, Aug. 1, 2007) (effectively banning new or expanded POHs by eliminating the whole hospital exception for such POHs).
[215] Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, 110th Cong. § 106 (as passed by House, Mar. 5, 2008). The Senate would have increased the expansion exception to 200% of a hospital's original capacity. *See* S. Amdt. 4803 to H.R. 2642, 110th Cong. § 6002 (as passed by Senate, May 22, 2008).
[216] *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, sec. 6001, 124 Stat. 119 (2010) (amending 42 U.S.C. 1395nn).
[217] *See* Daniel M. Blumenthal et al., *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, 351 THE BMJ h4466, at 1 (Sep. 2, 2015), https://www.bmj.com/content/bmj/351/bmj.h4466.full.pdf.

POHs.[218] Indeed, in their spoken and written comments announcing the deal, the hospitals groups consistently listed the POH ban as their first and therefore presumably most important achievement from these negotiations.[219] In the final legislation, those restrictions took the form of an effective ban on the expansion of existing POHs or the opening of new POHs.

Chip Kahn, the President and CEO of the Federation of American Hospitals later admitted that the hospital industry groups, and particularly his own, were instrumental in getting Congress to pass the ban:

> [I]n 2003, we got the original moratorium placed in the Medicare Modernization Act and then the full ban—which, to be clear, was on being paid when they refer a patient—was enacted as part of the ACA in 2010.
>
> While other trade associations and the hospital community spent a lot of energy on it, I'd say the current ban on physician-owned hospitals wouldn't be there if it wasn't for the Federation. I don't think I've ever admitted this publicly, but I can remember emailing one of the staffers, literally sending in talking points to some of the senators as the process was taking place. If we hadn't been there, history might have been different.[220]

These admissions show that the ban on POHs in the ACA resulted from lobbying by incumbent hospitals.

2. How the Ban Works

The ACA effectively bans new or expanded POHs by prohibiting such POHs from accepting Medicare and Medicaid referrals from physician owners, which are important for

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[218] *U.S. Hospitals and Health Care Legislation*, C-SPAN (July 8, 2009), https://www.c-span.org/video/cc/?progid=209194; John Reichard, *Biden Announces Deal with Hospitals to Cut Medicare, Medicaid Payments by $155 Billion*, COMMONWEALTH FUND (July 8, 2009), https://www.commonwealthfund.org/publications/newsletter-article/biden-announces-deal-hospitals-cut-medicare-medicaid-payments-155; Michael D. Shear, *Biden Rolls Out Deal With Hospitals to Cut $155B in Costs*, WASH. POST (July 8, 2009); Jessica Zigmond, *Agreement threatens to strangle physician-owned hospitals*, MODERN HEALTHCARE (July 13, 2009), https://www.modernhealthcare.com/article/20090713/MODERNPHYSICIAN/307059974/agreement-threatens-to-strangle-physician-owned-hospitals.

[219] Press Release, American Hospital Association, Statement About Agreement With White House And Senate Finance Committee On Health Reform (July 8, 2009), https://www.aha.org/system/files/presscenter/pressrel/2009/090708-jointst-covreform.pdf; John Reichard, *Biden Announces Deal with Hospitals to Cut Medicare, Medicaid Payments by $155 Billion*, THE COMMONWEALTH FUND (July 8, 2009), https://www.commonwealthfund.org/publications/newsletter-article/biden-announces-deal-hospitals-cut-medicare-medicaid-payments-155.

[220] Chip Khan, *'If we hadn't been there, history might have been different': Chip Kahn on two decades helming the Federation of American Hospitals*, ADVISORY BOARD (June 1, 2021), https://www.advisory.com/blog/2021/06/two-decades.

hospitals to be commercially viable. Empirical results confirm that the POH ban worked as intended, effectively eliminating the formation of new POHs.[221]

Prior to the passage of the ACA, POHs were permitted to bill Medicare and Medicaid under the "whole hospital exception" to a collection of statutes and regulations known as the "Stark Laws." The Stark Laws prohibit physician (but not corporate) self-referral for a variety of healthcare products and services[222] in the Medicare and Medicaid programs.[223] But for the whole hospital exception, the Stark Laws would apply to POHs because POH owners refer their patients to the POH they own for surgery. The whole hospital exception was included in the initial Stark Law passed in 1989, and the whole hospital exception allowed for charges to Medicare and Medicaid for physician self-referrals when a physician's ownership interest was in a whole hospital facility like a POH as opposed to a subdivision of the hospital.[224] The ACA effectively removed the whole hospital exception for POHs and subjected them to the Stark Laws (a) if they did not have a provider agreement in place with CMS by December 31, 2010, (b) if they increased the physician ownership share in a POH beyond what existed on March 23, 2010, or (c) if they expanded the number of operating rooms, procedure rooms, or licensed beds beyond what existed on March 23, 2010.[225]

The restriction on expanding existing POH facilities includes an exemption where the expansion is approved by the Secretary of HHS.[226] However, this exemption has had little effect. First, the exemption only applies to the restriction on expanding existing POHs.[227] The

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[221] Elizabeth Plummer & William Wempe, *The Affordable Care Act's Effects On The Formation, Expansion, And Operation Of Physician-Owned Hospitals*, 35(8) HEALTH AFFAIRS 1452 (Aug. 2016) ("We found no evidence that existing physician-owned hospitals stopped accepting Medicare to avoid the ACA restrictions, although some investors adopted a seemingly unsuccessful strategy of not accepting Medicare at physician-owned hospitals formed after implementation of the ACA. We conclude that the ACA restrictions effectively eliminated the formation of new physician-owned hospitals, thus accomplishing what previous legislative efforts had failed to do.").

[222] Centers for Medicare and Medicaid Services, *Physician Self Referral*, https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index (last modified Dec. 1, 2021, 8:00 PM).

[223] Morey J. Kolber, *Stark regulation: a historical and current review of the self-referral laws*, 18(1) HEC FORUM 61 (Mar. 2006).

[224] *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, sec. 6204, 103 Stat 2106 (Dec. 19, 1989) [hereinafter Stark I] (adding Section 1877 to the Social Security Act limiting physician self-referrals for Medicare patients for clinical laboratory services and providing for a whole hospital exception at Section 1877(d)(3)); *see also* Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, sec. 13562, 107 Stat 312 (Aug. 10, 1993) [hereinafter Stark II] (amending Section 1877 of the Social Security Act to expand limitations on physician self-referrals to include certain hospital services and Medicaid patients and similarly amending the whole hospital exception provided in Section 1877(d)(3)); *see also* 42 U.S.C. § 1395nn(d)(3) (codifying whole hospital exception).

[225] Specifically, Section 6001 of the ACA effectuates this change adding additional requirements set forth in 42 U.S.C. § 1395nn(i)(1) to the whole hospital exception, codified in 42 U.S.C. § 1395nn(d)(3). *See* 42 U.S.C. § 1395nn(d)(3)(D); 42 U.S.C. § 1395nn(i)(1).

[226] 42 U.S.C. § 1395nn(i)(1)(B) ("Except as provided in paragraph (3) [which allows for approval by the Secretary of HHS], the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date").

[227] *Id.*

requirement that a POH must have already been operating prior to December 31, 2010 contains no such exception.[228] Second, the statute includes extensive restrictions on what expansion the Secretary can approve,[229] including limiting increases in the number of operating rooms, procedure rooms, and beds to no more than twice the existing number[230] and allowing such increases only on the hospital's main campus.[231] Third, as discussed in the next subpart, the Secretary has in practice allowed only limited expansion of existing POHs.

Thus, while the ACA allowed existing POHs to continue to operate, it effectively prohibited the construction of new POHs and the expansion of existing POHs.

C. 2010-Present: Frozen in Time

Since the passage of the ACA, the growth of POHs has been effectively frozen in time. Thirty-six expansion projects for existing hospitals were halted, according to the POH trade group Physician-Led Healthcare for America (PHA, previously Physician Hospitals of America).[232] PHA also identified another 29 hospitals that were under development but could not be completed before the December 31, 2010 deadline to qualify as existing POHs under the ACA.[233] PHA further identified 25 hospitals that were no longer under development following the passage of the ACA.[234] The economic impact of halted expansion projects for existing hospitals totaled an estimated $275 million.[235] Additionally, some POHs formed after implementation of the ACA attempted an unsuccessful strategy of not accepting Medicare, and all entered bankruptcy within 5 years.[236]

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[228] 42 U.S.C. § 1395nn(i)(1)(A) ("The hospital had--(i) physician ownership or investment on December 31, 2010; and (ii) a provider agreement under section 1395cc of this title in effect on such date.").
[229] 42 U.S.C. § 1395nn(i)(3) *et seq*.
[230] 42 U.S.C. § 1395nn(i)(3)(C)(ii) ("The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.").
[231] 42 U.S.C. § 1395nn(i)(3)(D) ("Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.").
[232] PHYSICIAN HOSPITALS OF AMERICA, PHYSICIAN HOSPITAL: IMPACT OF IMPLEMENTATION OF SECTION 6001, at 1-2 (Feb. 17, 2011); *see also* Debra Shute, *Is it time to lift the ban on physician-owned hospitals?*, MED. ECON., May 25, 2018, at 36, 38-39, https://www.medicaleconomics.com/view/it-time-lift-ban-physician-owned-hospitals ("According to the [Physician Hospitals of America] PHA, 37 physician-owned hospitals were not built because of the ban, 40 nearly finished, construction projects were prevented, and 20 major expansion projects were canceled.").
[233] PHYSICIAN HOSPITALS OF AMERICA, PHYSICIAN HOSPITAL: IMPACT OF IMPLEMENTATION OF SECTION 6001, at 3 (Feb. 17, 2011).
[234] *Id.* at 4.
[235] *Id.* at 1.
[236] Elizabeth Plummer & William Wempe, *The Affordable Care Act's Effects On The Formation, Expansion, And Operation Of Physician-Owned Hospitals*, 35(8) HEALTH AFFAIRS 1452 (Aug. 2016).

CMS permitted some POHs to expand during this period, but the limited nature of those allowances demonstrates how POHs largely cannot exceed the status quo of 2010. For example, in updating its regulations in 2010 following the passage of the POH ban, CMS noted that a POH would be permitted to reduce and subsequently increase the number of licensed beds, procedure rooms, and operating rooms, so long as the POH did not exceed the baselines that existed on March 23, 2010.[237] More recently, CMS has made small changes to its regulations on POHs (e.g., permitting POHs that qualify as high Medicaid facilities to apply for exemptions more frequently than once every two years), while affirming CMS "continue[s] to believe that our current regulations . . . are consistent with the Congress' intent to prohibit expansion of physician-owned hospitals."[238] CMS has also permitted limited expansion through a handful of advisory opinions. For example, in a 2016 advisory opinion, CMS permitted a POH to add "observation beds" beyond the March 23, 2010 baseline so long as they are not used for inpatient stays, operating rooms, or procedure rooms.[239] In a 2019 advisory opinion, CMS permitted POH use of operating rooms that were fully operational and accredited on March 23, 2010, and could be up and running within a few days but happened to not be in use in 2010 or in subsequent years.[240] Similarly, in a 2021 advisory opinion, CMS concluded that the addition of outpatient observation beds not subject to state licensure or registration to an existing POH would not violate the prohibition on expansion.[241] These narrow exceptions simply do not facilitate meaningful entry or expansion by POHs in the vast majority of circumstances.

In recent years, the AMA has advocated for repealing the ban on POHs.[242] The PHA has likewise sought repeal and even unsuccessfully challenged the constitutionality of the ACA restrictions on POHs.[243]

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[237] *See* 75 Fed. Reg. 71800, 72242 (Nov. 24, 2010) ("Additionally, we are clarifying that a physician-owned hospital may add or increase the number of physician owners or investors, or replace physician owners or investors, as long as the aggregate percentage of physician ownership or investment does not increase.").

[238] Centers for Medicare and Medicaid Services, *Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-FC)*, at 1163-64 (2020), https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf; *see also* Press Release, CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-FC) (Dec. 2, 2020), https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (summarizing rule changes).

[239] Advisory Opinion No. CMS-AO-2016-01 (CMS Mar. 2016), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/CMS-AO-2016-01.pdf.

[240] Advisory Opinion No. CMS-AO-2019-01 (CMS Aug. 2019), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/CMS-AO-2019-01-Redacted.pdf.

[241] Advisory Opinion No. CMS-AO-2021-2 (CMS Dec. 2021), https://www.cms.gov/files/document/cms-ao-2021-02.pdf.

[242] Letter from James L. Madara, MD, Executive Vice President, CEO, American Medical Association to Seema Verma, Administrator, Centers for Medicare & Medicaid Services, regarding File Code CMS–1736–P (Oct. 5, 2020), https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-4-Letter-to-Verma-re-2021-OPPS-FINAL.pdf (noting "The AMA also strongly supports repealing the federal ban on physician-owned hospitals.").

[243] Physician Hospitals of America v. Sebelius, 691 F.3d 649 (5th Cir. 2012).

Thus, despite these efforts to work around the ban or repeal it, the ACA's restrictions on POHs have halted the growth and expansion of POHs and thus eliminated competition from new or expanded POHs. The result deprives multiple service markets of potential competition as will be more fully explored in the next part. These losses encompass both specialty hospitals and general acute care hospitals, in addition to foreclosing new competition for vertically integrated care delivery.

V. A Competition Analysis on Curtailing the Physician-Owned Hospitals Ban

In this part we examine the competitive impact of the POH ban on competition in the three kinds of healthcare markets—markets to provide hospital services to consumers, markets for the sale of hospital services to payors, and markets where hospitals compete for physician services. We begin by outlining a competition policy approach to analyzing these issues. We then consider the purported objectives of the ban—whether the purported market failures are well-founded and can justify how the ban harms competition in these markets. Lastly, we consider whether there are more narrowly tailored policy options available to preserve the benefits of increased competition from POHs while addressing potential concerns with POHs. We conclude that concerns regarding POHs are not sufficient to justify the competitive harms of the POH ban and are better addressed through more narrowly tailored policies.

A. Analytic Approach

A competition policy approach considers the competition offered by POHs in various markets and whether particular approaches to regulating POHs may unnecessarily impede competition in those markets. It is not simply a matter of comparing the value proposition of one service provider over another, as that decision is typically left to the marketplace absent a market failure. Rather, this approach focuses on the dynamic effects on competition in particular markets. For example, even higher cost or lower quality providers can still provide useful services while putting pressure on competitors. To illustrate, even in the presence of higher-cost firms, low-cost competitors can be induced to share more of their lower costs with customers in the form of better prices to protect market share. Similarly, high-quality providers can be induced to maintain or increase investments in the quality of their services to prove their value over alternatives. Of course, when new entrants do offer lower cost or higher quality products or services, the marketplace provides them the opportunity to expand, and it induces incumbent competitors to improve their offerings or lose their market share.

This paper has identified many reasons to think POHs offer competitive services and that they may be particularly well-positioned to take advantage of market entry opportunities, and so the potential benefits offered by their competition can be especially important to protect. This is

exemplified by the five examples of antitrust litigation identified in this paper where local incumbents were alleged to address POH entry with anticompetitive conduct, rather than competition on the merits. This is likewise reflected in a systematic review of the cost and quality research of POHs, where evidence suggests that surgical specialty POHs exhibit higher quality and lower or comparable cost compared to non-POHs, while general acute care POHs were similar in terms of cost and quality performance when compared to their non-profit and investor-owned hospital counterparts.[244]

A competition policy approach is especially concerned with policies that affect barriers to entry and expansion and consequently the accumulation or exercise of market power. If barriers to entry or expansion are very low, a large incumbent likely cannot exercise market power because the moment it raises prices, reduces output or quality, or ignores innovation, new entrants will see the market opportunity and push price, output, quality, and innovation back towards a competitive equilibrium. However, when policies unnecessarily raise barriers to entry or expansion, a powerful incumbent may be able to raise prices, reduce output or quality, or ignore innovation with reduced fear of a competitive response. By contrast, when policies do not affect entry or expansion generally, they may not harm competition outcomes even if a policy harms a subset of competitors. In the case of POHs, if a loss of POH entry was easily replaced with entry by investor-owned or nonprofit hospitals, then the competitive significance would be minimal. However, this paper has found many reasons to think POH entry is not easily replaced. In general, Part I found that market trends are towards more consolidation and less new entry. Part IV shows how POHs are an exception. As discussed in Part II, physicians have a unique role in directing and delivering care that makes them potent competitors when hospital ownership gives physicians the incentives and ability to act on innovative ideas and market opportunities. Moreover, as explained in Part III, the frequent combination by hospitals of upstream market power over physicians and downstream market power over payers and customers, gives physicians added incentive and ability to affect market outcomes when they can enter these markets with their own hospitals.

Even when there are important market failures that merit a policy response (e.g., to address externalities, fraud, substandard care, etc.), a competition policy approach asks whether there are policy alternatives that can achieve the same policy objectives while preserving more of the benefits of competition. On balance, the benefits of addressing a market failure should exceed the harms to competition arising from the policy response. For example, if a policy unnecessarily raises barriers to entry or expansion and keeps firms out of the market, such a policy can produce multiple harms: (1) it would deny customers access to a potentially attractive provider, (2) it can reduce output and raise prices if other providers cannot fill the gap between

[244] Ted Cho, Andrew Meshnick, Jesse M. Ehrenfeld, and Brian J. Miller, *Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review*, SPECIAL STUDY, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Sep. 7, 2021), https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review.

supply and demand, and (3) it can reduce competitive pressure on the remaining firms (a) to lower their costs and pass those low costs onto customers, (b) to keep their quality high, and (c) to continue innovating—harms which can redound to their existing customers. By focusing on markets where a policy impinges on competition and by considering policy alternatives that preserve benefits of that competition, a competition policy approach can lead to better policies and better welfare outcomes. Here, there are strong reasons to believe a POH ban is an overly broad restriction that fails to narrowly address any of its purported justifications.

We begin this competition policy analysis by considering the purported objectives of the POH ban and whether those concerns are sufficiently well-founded to justify restricting competition.

B. Purported Objectives of Physician-Owned Hospitals Ban

Critics of POHs—especially incumbent hospital interests that benefit from excluding competition from POHs—have generally made two arguments against POHs. First, they argue that specialty POHs cherry-pick highly profitable patients. Second, they argue that the ownership structure of both specialty and general acute care POHs give their physician owners an incentive to order unnecessary medical treatments, which drives up costs. Below we lay out these arguments and responses to assess the merits of these policy concerns. The weight of the evidence suggests that to the extent there are any such perverse incentives, they are not unique to POHs.

According to the first argument, specialty POHs specialize in highly profitable procedures such as elective total hip arthroplasty or total knee arthroplasty (hip and knee replacement, respectively) and focus on healthier patients with fewer comorbidities while leaving community general acute care hospitals to treat less profitable patients seeking the same procedure.[245] For example, consider two patients seeking a total knee replacement: a healthy fifty-year-old man with no comorbidities who wishes to continue playing tennis and a fifty-year-old man suffering from severe morbid obesity (BMI 50), congestive heart failure, coronary artery disease, and insulin-dependent diabetes. The latter patient is far more likely to experience complications such as delayed or poor wound healing, post-operative venous thromboembolism, require extended recovery in-hospital, and other untoward events that—in addition to being disadvantageous to the patient—are expensive and reduce hospital profitability. In addition to cherry-picking the most profitable procedures through specialization, so the hospital industry argument goes, specialty POHs can avoid less profitable patients, for example, by having only a minimal number of Emergency Department (ED) beds. The industry argues that the patient with multiple comorbidities who falls and fractures a hip or has a heart attack would either not be

[245] Patients with fewer comorbidities are less likely to experience complications or have an extended length of stay. As hospitalization is paid as an episode bundle, complications and extended length of stay reduce profitability.

dispatched to the specialty POH due to the limited supply of ED beds or would be preferentially transferred to another hospital for treatment due to limited service scope at specialty POHs. In other words, critics allege that the owners of POHs essentially free ride off of nearby general acute care hospitals that treat the sickest and most complex patients, while profiting handsomely by taking only the healthiest ones. Any apparent decrease in the price of specialty procedures, so the argument goes, is not the result of increased efficiency, but rather, a matter of avoiding the costs associated with treating less profitable patients. This argument would not appear to extend as well to general acute care POHs.

The second argument traditionally made against POHs is that they have an incentive at the margins to refer more patients for a higher volume and intensity of care at the surgical facilities they own than they would absent that financial incentive, which drives up costs. In the healthcare economics literature this is described as "provider-induced demand,"[246] and may arise, for example, where more than one diagnostic or treatment strategy may be appropriate, and where a provider's choice tends to reflect financial incentives.[247] In support of the argument that provider-induced demand arises for POHs, critics point to evidence that POHs have been associated with a statistical increase in surgical procedures, which they argue are due to the impact of financial incentives on individual clinician decisions.[248]

Supporters of POHs have raised several arguments in response to these arguments. First, either a cherry-picking theory or a provider-induced-demand theory presumes that physician owners have perverse incentives that nonprofit and investor-owned hospitals lack. Any such incentives likely reflect vertical integration—that the referring provider and the surgical site have shared ownership, and so the referring practice profits from either (a) steering low-cost patients to the owned surgical site and complex, high-cost patients elsewhere or (b) inducing demand that otherwise would not exist. But vertical integration is not unique to physician owners. Indeed, because of the consolidation trends explored in Part I, integrated health systems increasingly dominate local markets, and those systems often encompass a meaningful share of local physician practices (along with emergency departments) that can be essential sources for referrals. These vertically integrated health systems would also profit from cherry-picking or inducing demand. Both non- and for-profit hospitals face similar incentives to encourage their

[246] Memorandum from the Volume-and-Intensity Response Team, Office of the Actuary, HCFA, CMS to Richard S. Foster, Chief Actuary, CMS (Aug. 13, 1998), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/physicianresponse.pdf.

[247] *See, e.g.*, Louis L. Nguyen et al., *Provider-Induced Demand in the Treatment of Carotid Artery Stenosis*, 152 JAMA SURGERY 565 (2017).

[248] *See* 2006 MEDPAC REPORT, *supra* note 169, at vi - vii ("Taken together these findings—an increase in overall surgeries, but no material shift in the ratio of high-severity to low-severity surgeries—are consistent with more than one hypothesis. One hypothesis is that physicians have a financial incentive to invest in cardiac hospitals, and these new speciality hospitals result in more surgical capacity and hence more surgeries per capita. Alternatively, individual physicians' clinical decision making is directly affected by financial incentives, but the change is a broad shift toward more surgeries rather than a precise shift toward the most profitable surgeries.").

doctors to perform more treatments in order to increase billings and the volume of care in the pursuit of greater revenue.[249]

Second, a cherry-picking theory or a provider-induced-demand theory presumes that physician owners have a distinct ability to act on those perverse incentives that other providers lack, perhaps by better aligning the referring physician's incentives with those perverse outcomes. But nonprofit and investor-owned hospitals also have many tools to affect the referral practices of their employed physicians, from setting policies to conditioning employment on following those policies. To the extent these incentives exist, investor-owned and nonprofit hospitals do in fact act on them. According to a 2016 Nielson Strategic Health Perspectives survey of hospital executives, 55% were actively managing, or planning to manage, referrals to keep them within their hospital systems.[250] As the FTC found in its complaint against the Reading Health System discussed in Part III.B, POHs can be victims of such conduct as health systems have used control over primary care providers in attempts to deny referrals to POHs. And health systems have been accused of cherry-picking by steering high-cost patients to other facilities. For example, a plaintiff hospital successfully alleged that two Kaiser hospitals were directing emergency personnel to steer "uninsured and indigent" (high-cost) patients from their trauma center to the plaintiff's competing facility, while steering insured patients to Kaiser-owned facilities.[251]

Third, physician referral patterns are not unconstrained. As MedPAC helpfully explained in its 2005 report, physician referrals are constrained by factors such as payors, patient preferences, specialty hospital location, and taking emergency department "call"[252] from local competitor hospitals.[253] If POHs were just cherry-picking low-cost patients or ordering unnecessary services, economic theory suggests that payors acting rationally would negotiate for lower rates and greater oversight or would remove providers from their network. In recent decades, as physicians have been pushed to provide more data and information to justify tests and treatments, payors have employed managed care networks and increasingly sophisticated

[249] Rachel O. Reid et al., *Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems*, 3(1) JAMA HEALTH FORUM e214634 (Jan. 28, 2022).

[250] Anna Wilde Mathews & Melanie Evans, *The Hidden System That Explains How Your Doctor Makes Referrals*, THE WALL ST. J. (Dec. 27, 2018), https://www.wsj.com/articles/the-hidden-system-that-explains-how-your-doctor-makes-referrals-11545926166 (describing the survey).

[251] NorthBay Healthcare Group, Inc. v. Kaiser Foundation Health Plan, Inc., 838 Fed. Appx. 231, 234 (9th Cir. 2020).

[252] Procedural specialty physicians frequently remain "on call" for a hospital. Functionally they are either on-site or frequently off-site within a pre-specified time or distance, available to return to the hospital. Physicians are responsible for responding to and addressing consults and procedures during the on-call period. For example, an interventional cardiologist may be "on call" at a local hospital for a week, remaining within a 20-minute drive of the hospital. During that week, they may be called to the hospital to perform emergent coronary catheterizations for heart attack patients.

[253] 2005 CMS REPORT, *supra* note 168, at ii-iii. The study also noted that the referral rates varied by the type of specialty POH. At Cardiac POHs, the percentage of Medicare cardiac referrals by owners ranged from 61% to 82%, at orthopedic POHs owner referrals ranged from 48% to 98%, and at the surgical POH, owner referrals were 90%.

tools to adjust payments for the risk and complexity of diagnosing and treating a particular patient. Many such payors utilize prior authorization or narrower networks. That is not say these tools are without their limitations, especially in an environment of imperfect, asymmetric information. Nevertheless, this bargaining, oversight, and network selection process by payors, who are sophisticated third parties and repeat players, should reduce excess profits from cherry-picking and deter referrals for unnecessary services, resulting in lower prices for downstream consumers.

Moreover, it is possible that POHs might be more subject to constraint by payors than integrated health systems. To the extent an integrated health system has incentives to cherry-pick or induce demand for certain services, it may be able to use its market power to shield that practice from a payor in negotiations, similar to how they might shield unreasonably high prices from competition. For example, DOJ spent several years challenging a dominant health system for imposing restrictions on payors that prevented them from steering patients towards lower cost alternative providers.[254] As POHs tend to be smaller and offer fewer service lines, they may have less leverage to shield unjustified referral patterns. Therefore, it is not obvious that a physician owner would be more effective at pursuing such a strategy with payors than a non-physician owner.

Fourth, while ban proponents may argue that POHs are structured to avoid complex patients (e.g., by having fewer ED beds), evidence suggests POH facilities are driven by the services they provide rather than their ownership structure. As one study author explained, the majority of POHs "are generally larger acute care hospitals with several hundred beds. They have big EDs. They look just like community hospitals."[255] Similarly, the 2005 CMS report found that cardiac hospitals resemble full-service hospitals with emergency departments, whereas orthopedic hospitals and general surgical specialty hospitals more closely resemble Ambulatory Surgery Centers (ASCs), [256] frequently lacking active emergency departments, and focusing on outpatient services or cases with a reasonable expectation of limited hospitalizations. That is, cardiac hospitals that make greater use of emergency departments had EDs more similar to general acute care hospitals, whereas more outpatient procedure-focused specialty POHs were more similar to other specialty hospitals or akin to ASCs with a small "hospital" component. In

[254] Press Release, U.S. Dep't of Just., Office of Public Affairs, Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions, (Nov. 15, 2018), https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering.

[255] Debra Shute, *Is it time to lift the ban on physician-owned hospitals?*, MED. ECON., May 25, 2018, at 36, 39, https://www.medicaleconomics.com/view/it-time-lift-ban-physician-owned-hospitals.

[256] 2005 CMS REPORT, *supra* note 168, at ii. Ambulatory surgical centers (ASCs) are entities that exclusively perform outpatient surgery, that is, surgeries with an expected duration of less than 24 hours that do not require hospitalization. *See* 42 C.F.R. § 416.2 (2022). Such centers generally may not mix functions and operations in a common space with another entity such as a physician's office. *See Ambulatory Surgery Centers*, CMS, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs (last modified Sep. 6, 2022).

each of these cases, the facility design is driven by the services that the facility provides rather than being a POH versus a non-POH. An important criticism of the POH research performed during the 2000s that motivated the ban is that those studies compared specialty POHs to non-physician-owned general acute care hospitals, rather than comparing apples-to-apples: the same type of hospital that differed only by physician ownership. Consequently, the differences observed reflected differences in the services provided rather than just differences in ownership.[257]

Fifth, a systematic review found that this claim of cherry-picking lacks consistent support in the research.[258] Instead, the review found that after controlling for a variety of factors, such as case mix, disease severity, and volume of procedures, research results on quality metrics was highly favorable for specialty POHs and neutral for general acute care POHs.[259] In contrast, cost evidence was neutral to favorable, suggesting that specialty POHs tended to have lower or similar costs, while general acute care POHs tended to be similar in costs.[260] Indeed, several studies looking at the effect of hospital ownership on healthcare utilization have concluded that physician ownership does not lead to an increased volume of surgeries being performed, suggesting that any evidence of increased utilization is at best mixed.[261] These limited, mixed findings show that cherry-picking by POHs is not a well-established fact in the empirical literature.

Sixth, the argument that the POH model will lead to cherry-picking or unnecessary procedures seems to assume that business ethics will somehow protect the public better than medical ethics. But why would one make that assumption? Medical specialty societies have responded to the problem of unnecessary or low value care, with the American Board of Internal

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[257] *E.g.*, Daniel M. Blumenthal et al., *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, 351 THE BMJ h4466, at 6 (Sep. 2, 2015), https://www.bmj.com/content/bmj/351/bmj.h4466.full.pdf ("[T]he populations of specialty POHs included in previous studies are not representative of POHs more broadly.").

[258] Ted Cho, Andrew Meshnick, Jesse M. Ehrenfeld, and Brian J. Miller, *Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review*, SPECIAL STUDY, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Sep. 7, 2021), https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review.

[259] *Id.*

[260] *Id.*

[261] Gregory D. Schroeder et al., *The Effect of Hospital Ownership on Health Care Utilization in Orthopedic Surgery*, 31(2) CLIN. SPINE SURG. 73 (Mar. 2018) (concluding that "[i]n a well-established large orthopedic practice, surgeon ownership of a hospital or ASC does not lead to an increase in surgical volume."); G. William Woods et al., *Orthopaedic surgeons do not increase surgical volume after investing in a specialty hospital*, 87(6) J. BONE JOINT SURG. AM. 1185 (June 2005) (concluding "The opening of an orthopaedic surgery specialty hospital did not increase the surgical volume or the surgical rate for ten orthopaedic surgeons who held a financial interest in the facility."); *but see* Jean M. Mitchell, *Effect of physician ownership of specialty hospitals and ambulatory surgery centers on frequency of use of outpatient orthopedic surgery*, 145(8) ARCH SURG. 732 (Aug. 2010) (concluding that "[t]he consistent finding of higher use rates by physician owners across time clearly suggests that financial incentives linked to ownership of either specialty hospitals or ambulatory surgery centers influence physicians' practice patterns.").

Medicine Foundation leading the development of the Choosing Wisely criteria, a list of over five hundred tests, procedures, and services that represent low value services and should be avoided.[262]

Comparing the medical profession with the legal profession suggests a way that the POH model could *mitigate* the incentive to cherry-pick or perform unnecessary procedures relative to other hospitals.

Physicians are bound by principles of medical ethics that prioritize patient needs, and they can risk their medical license when they violate medical ethics. Similarly, lawyers are bound by detailed ethical obligations, including duties of competence, diligence, loyalty, and confidentiality.[263] As such, the legal profession not only allows lawyers to own law firms, but actually prohibits non-lawyers from having an ownership stake, or even taking a share of the revenue or otherwise exercising control over legal judgment.[264] The rationale for this rule is to preserve the ability of lawyers to exercise their legal judgment on behalf of their clients.[265] This is driven at least in part by a concern that non-lawyer owners might encourage their lawyer employees to perform unnecessary work on behalf of their clients to increase revenues.[266] As a group of nine general counsel from Cisco, GE, Intel, IBM, among others, explained in a submission to the American Bar Association Center for Professional Responsibility:

> [N]on-lawyer investment cannot help but inject outside concerns into a partnership's calculations. It changes a firm from a group of like-minded attorneys zealously pursuing their clients' interests, into a group with inherently mixed motives and responsibilities, where some partners have a professional duty to the client's interests and others do not. It is not hard to imagine that non-lawyer partners might place considerations of economic gain ahead of a client's interests. That is not a criticism of those who seek profit. It is simply a

[262] *Five Things Patients and Providers Should Question*, CHOOSING WISELY (Nov. 15, 2017), https://www.choosingwisely.org/wp-content/uploads/2015/01/Choosing-Wisely-Recommendations.pdf.
[263] *E.g.*, MODEL RULES OF PRO. CONDUCT r. 11, 1.3, 1.6, and 1.7 (AM. BAR ASS'N 2020).
[264] *See, e.g.*, *id.* r. 5.4 ((a) A lawyer or law firm shall not share legal fees with a nonlawyer, except that [listing limited exceptions]; (b) A lawyer shall not form a partnership with a nonlawyer if any of the activities of the partnership consist of the practice of law. . . . (d) A lawyer shall not practice with or in the form of a professional corporation or association authorized to practice law for a profit, if: (1) a nonlawyer owns any interest therein, except that a fiduciary representative of the estate of a lawyer may hold the stock or interest of the lawyer for a reasonable time during administration; (2) a nonlawyer is a corporate director or officer thereof or occupies the position of similar responsibility in any form of association other than a corporation ; or (3) a nonlawyer has the right to direct or control the professional judgment of a lawyer.").
[265] *Id.*, r. 5.4 cmt. ("The provisions of this Rule express traditional limitations on sharing fees. These limitations are to protect the lawyer's professional independence of judgment.").
[266] *See, e.g.*, Mark Chandler et al., *Comments of Nine General Counsel on the ABA Commission on Ethics 20/20's Discussion Paper on Alternative Law Practice Structures*, at 5 (Feb., 2012), https://www.americanbar.org/content/dam/aba/administrative/ethics_2020/ethics_20_20_comments/ninegeneralcounselcomments_alpschoiceoflawinitialdraftproposal.authcheckdam.pdf.

> recognition of the reality that our profession often mandates conduct and practices that are not profit maximizing or optimizing. Investors operate under a different code.[267]

By limiting law firm ownership to lawyers, the owners are bound by the same legal ethics rules as the other attorneys at the firm, which prohibits them from performing unnecessary legal work and to act in the best interests of their clients.[268]

Doctors have similar ethical obligations to their patients.[269] The American Medical Association Code of Medical Ethics (the "Code") has a number of opinions on professional self-regulation that deal with competition, financial incentives, economic incentives tied to care levels, as well as self-referral and fee-splitting.[270] Importantly, the Code encourages competition amongst physicians because ethical medical practice thrives best under free market conditions when patients are able to choose freely between and among competing physicians and alternate systems of medical care. The Code explicitly states that "[t]reatment or hospitalization that is willfully excessive … constitutes unethical practice" and repeatedly notes that providing "unnecessary treatment" is prohibited.[271] The Code further states that "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients."[272] With respect to hospital practice, the Code indicates that physicians on a medical staff have an obligation to avoid wasteful practices and unnecessary treatment that may cause unnecessary hospital expense and furthermore that in situations where the economic interests of a hospital in conflict with patient welfare, that patient welfare always takes priority.[273] These ethical requirements present one way that the POH model could better resist incentives to perform unnecessary procedures than either non-profit or for profit hospitals (i.e. non-POHs) where the owners are not bound by the same medical ethics rules as the doctors they employ.

Cherry-picking and induced demand do appear to be legitimate concerns in the healthcare marketplace, but the evidence and arguments do not clearly establish that physician owners of

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[267] *Id.*
[268] *See, e.g.*, MODEL RULES OF PRO. CONDUCT r. 1.5 (AM. BAR ASS'N 2020) ("A lawyer shall not . . . charge . . . an unreasonable fee. The factors to be considered in determining the reasonableness of a fee include . . . the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly . . . ."); *id.* r. 1.3 ("A lawyer shall act with reasonable diligence and promptness in representing a client.").
[269] *See* AMA CODE OF MEDICAL ETHICS, https://code-medical-ethics.ama-assn.org (last visited Dec. 25, 2022).
[270] *See, e.g.*, AMA Council on Ethical and Judicial Affairs, *AMA Code of Medical Ethics' Opinions on the Physician as Businessperson*, AMA JOURNAL OF ETHICS (Feb. 2013), https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinions-physician-businessperson/2013-02.
[271] AMA CODE OF MEDICAL ETHICS, Opinion 11.2.2 Conflicts of Interest in Patient Care, https://code-medical-ethics.ama-assn.org/sites/default/files/2022-09/11.2.2%20Conflicts%20of%20interest%20in%20patient%20care%20--%20background%20reports.pdf (last visited Dec. 25, 2022).
[272] *Id.*
[273] *Id.*

hospitals should be singled out. Rather, this appears to be a more general problem that can arise with vertical relationships including vertical integration. Of course, vertical integration also may offer the opportunity for some efficiencies.[274] For example, a trend in the movement towards value-based healthcare is towards greater reliance on coordination across providers.[275]

The next subpart discusses the competitive costs of singling out POHs for a ban, while Subpart V.D discusses narrowly tailored alternatives that might better address concerns of cherry-picking and induced demand while preserving the competitive benefits of POHs and, where appropriate, of vertical integration.

C. The Competition Costs of the Physician-Owned Hospitals Ban

In setting any policy, the purported benefits should exceed the costs. Here, the sweeping POH ban would need to justify the substantial harm it causes to competition in the markets for physician services, payor markets, and consumer markets, as discussed in this subpart. Given that the literature has not established that cherry-picking and induced demand are even distinct risks of the POH model, the POH ban cannot justify these competition costs.

Evidence shows these markets have been subject to the acquisition and exercise of market power. As discussed in Part I, the general trend in healthcare markets has been towards increased consolidation, and this lack of competition is associated with higher prices for health services,[276] higher health insurance premiums,[277] lower quality, decrements in patient experience,[278] and less choice. In the patient market for healthcare services and the payor market for provider networks, patients and payers have fewer providers to choose from and those providers face less competitive pressure to keep prices low and quality high, in addition to decreased market pressure to innovate. Likewise, in the employer market for physician services,

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[274] *See, e.g.*, Brian J. Miller & George L. Wolfe, *Managed Care Marketplaces: Growing Drivers of Payer-Provider Vertical Integration*, THE ANTITRUST SOURCE (Apr. 2017), https://www.akingump.com/a/web/57128/aoiok/wolfe-article.pdf.

[275] *See generally What Is Value-Based Healthcare?*, NEJM CATALYST (Jan 1, 2017), https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558.

[276] Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134(1) QUARTERLY JOURNAL OF ECONOMICS 51 (Feb. 2019); Karyn Schwartz et al., *What We Know About Provider Consolidation*, KFF (Sep. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/; Martin Gaynor & Robert Town, *The impact of hospital consolidation — Update*, ROBERT WOOD JOHNSON FOUNDATION (June 1, 2012), https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html.

[277] Andrew Boozary et al., *The Association Between Hospital Concentration And Insurance Premiums in the ACA Marketplaces*. 38(4) HEALTH AFFAIRS 668 (Apr. 2019), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05491; Erin Trish, Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health insurance Premiums?,* 42 J. HEALTH ECON. 104 (July 2015).

[278] Nancy D. Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382(1) N. ENGL. J. MED. 51 (Jan. 2, 2020).

physicians have fewer potential employers and less bargaining power, potentially resulting not just in lower wages but also in a lower quality work environment, as reflected in the growing share of salaried physicians and in the uptick in physician burnout.[279]

As explored in Subpart III.A.4, this market power is not easily defeated by new entry. There are significant costs and other barriers to building new hospitals and expanding existing ones. A new hospital generally must enter multiple service markets at once. Construction time is measured in years, especially for technology-driven facilities. Building a new hospital or expanding an existing hospital is tremendously expensive and time-consuming. There exist many regulatory barriers in the form of zoning, permits, and licenses, and often a CON process that can be abused by incumbent rivals to impose further delay. Lastly, new hospitals must build up their staff and establish themselves in payor networks, all the while justifying their value proposition to consumers.

The POH ban exacerbates these barriers by directly restricting entry or expansion by a class of new entrants, and the ban has been unfortunately effective. As described in Parts IV.A and IV.C, POH entry was growing quickly in 2000-2010, a unique countertrend to the story of consolidation, and that entry story came to a standstill after the POH ban went into effect. The literature has not identified other providers that have filled the gap of POH entry.

Some early evidence and criticism of POHs is that they are only comparable in price,[280] but even if true, from a competition perspective, the loss of such entrants would be costly. Putting aside potential benefits that are specific to POHs, discussed below and even identified in some of that early research,[281] and instead assuming POHs are no better than non-POHs or only serve a portion of the market, the potential entry of additional providers reduces the ability of incumbents to exercise market power and applies competitive pressure on price, quality, and innovation. Even the threat of such entry can improve market outcomes as incumbent hospitals keep prices and quality more competitive to avoid inviting a new entrant. Consequently, the ban exacerbates the accumulation and exercise of market power in markets where incumbents could otherwise have faced actual or potential POH entry.

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[279] NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE ET AL., TAKING ACTION AGAINST CLINICIAN BURNOUT: A SYSTEMS APPROACH TO PROFESSIONAL WELL-BEING 334 (2019).

[280] *E.g.*, 2005 CMS REPORT, *supra* note 168, at vi-vii. ("Specialty hospitals' inpatient services are not less costly than community hospitals' services, as might be expected from a 'focused factory' hypothesis.").

[281] *E.g.*, 2005 CMS REPORT, *supra* note 168, at iii ("Patient satisfaction was very high in both cardiac and orthopedic/surgery hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for their family members if needed, easy parking, and good food"); U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. DEPARTMENT OF TREASURY, AND U.S. DEPARTMENT OF LABOR, REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION, at 73-74 (2018) [hereinafter 2018 HHS REPORT] (noting that more than 40% of POHs received a top 5-star rating, whereas only 5% of general hospitals received such a rating).

As explored in depth in Part II, POHs likely present a model with unique competitive potential, and so their continued ban is likely to have an outsized, negative effect on the marketplace. Physicians, given their operational expertise directing care, are extremely well positioned to identify opportunities for entry and innovation. They may have insights on how the science and business of their practice area can be improved, as well as what ways local markets are underserved. Ownership gives them the incentive to seek those opportunities out. Moreover, hospital market power is being exercised not just downstream against payors and consumers, but also upstream against the very physicians who might start their own hospital and become competitors. These physicians are likely to know whether wages or other local market conditions, like lack of control over patient care, might be making local physicians dissatisfied, and they may also know the identities of fellow physicians ready to join a new POH. This upstream and downstream market power provides space to attract and retain physicians—a critical labor input—by paying them more competitive rates (including by sharing in hospital profits) and granting them more control of patient care, while also creating space to offer payors and consumers more competitive rates and higher quality service.

A POH's ability to distinguish itself in the market both upstream and downstream is more important to the newly established facility that must build business quickly than it is to an established incumbent. This POH value proposition must be clear from the outset, when a POH begins to raise capital from future physician owners and outside investors. To this end, POHs may be helped because many investors prefer founders with technical backgrounds and that may extend to fellow physicians. Moreover, ownership provides physicians with more "skin in the game," better aligning the incentives of the physician-owners with outside investors, as compared with a model where the hospital is owned exclusively by non-physician outside investors.

Moreover, specialty hospitals may be a distinct and underutilized path to market entry that physician owners are particularly well-suited to identify and seize upon. This may explain why a disproportionate share of POHs (nearly half) are specialized surgical hospitals. These specialty POHs are often built around the practices of the surgeon owners who may have distinct ideas on how to better tailor their pre-operative care, operating room design and setup, clinical staffing, and post-operative care to the specific set of procedures they perform. As described in Part II, physicians may be deeply attuned to when specialization rather than generalization can more efficiently address patient needs. This pathway provides a potential avenue for entry into one or a small handful of service markets in a local geography, rather than needing to enter all the service lines of a general acute care hospital.

Then once in the market, specialty POHs are well-positioned to expand into other service lines or other locations. This is well-illustrated by DHR, a POH discussed in Part II.B, that grew from a 2-room ambulatory surgery center in 1997 to a substantial health system, all the while

treating a high-need patient population and addressing unmet local needs, such as kidney transplants and beds to treat COVID-19. Other specialty POHs have also evolved into health systems, with the Oklahoma Heart Hospital, a cardiac POH, growing into a system with two heart hospitals and 60 clinics, including other specialties such as family medicine.

Specialty POHs have also promoted competition in downstream payor markets, primarily by helping payors develop more robust, competitive networks but also occasionally by entering the markets directly. For example, Lincoln Surgical Hospital in Nebraska partnered with independent physicians to form an Independent Physicians Association (IPA), OneHealth Nebraska,[282] which sells a benefits package to self-insured employers in Nebraska.

Both statistical evidence and specific examples illustrate how POHs are potent competitors, especially specialty POHs. As mentioned in Part V.B, research results on quality metrics were highly favorable for specialty POHs and neutral for general acute care POHs, and cost metrics were neutral to favorable, suggesting that specialty POHs tended to have lower or similar costs, while general acute care POHs tended to be similar in cost .[283] Specialty POHs also demonstrated a positive volume-quality relationship,[284] supporting the thesis of the "focused factory" and the benefits of clinician-driven procedural focus and operational design. For example, cardiac POHs had lower 30-day mortality in the setting of treatment and hospitalization for congestive heart failure and acute myocardial infarction,[285] while orthopedic specialty POHs earned superior patient satisfaction,[286] were more likely to try conservative therapies before offering surgical intervention,[287] exhibited lower average length of stay[288] and lower ratios of actual to expected length of stay,[289] and demonstrated lower readmission rates in the setting of total knee and total hip arthroplasty.[290]

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[282] *Who We Are*, ONEHEALTH NEBRASKA, https://onehealthne.com/about/ (last visited Dec. 25, 2022).
[283] Ted Cho, Andrew Meshnick, Jesse M. Ehrenfeld, and Brian J. Miller, *Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review*, SPECIAL STUDY, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Sep. 7, 2021), https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review
[284] *Id.*
[285] Brahmajee K. Nallamothu et al., *Acute myocardial infarction and congestive heart failure outcomes at specialty cardiac hospitals*, 116(20) CIRCULATION 2280 (Nov. 13, 2007).
[286] As measured by recommending the hospital, communication of both doctors and nurses, staff responsiveness, overall hospital rating, and HCAHPS summary star rating. *See* P. Maxwell Courtney et al., *Reconsidering the Affordable Care Act's Restrictions on Physician-Owned Hospitals: Analysis of CMS Data on Total Hip and Knee Arthroplasty*, 99(22) J. BONE JOINT SURG. AM. 1888 (Nov. 15, 2017).
[287] Gregory D. Schroeder et al., *Are patients undergoing an anterior cervical discectomy and fusion treated differently at a physician-owned hospital?*, 31(5) CLIN. SPINE SURG. 211 (2018).
[288] Antonia F. Chen et al., *Utilization of total joint arthroplasty in physician-owned specialty hospitals vs acute care facilities*, 32(7) J. ARTHROPLASTY 2060 (July 2017).
[289] 2005 MEDPAC REPORT, *supra* note 171, at 16.
[290] Alexander J. Rondon et al., *A novel, synergistic model in total joint arthroplasty: a report of 2 specialty hospitals with joint ownership between physicians and healthcare systems*, 34(9) J. Arthroplasty 1867 (Sep. 2019).

International models also support the "focused factory" thesis in producing meaningful quality benefits for patients. For example, the famous Shouldice Hernia hospital[291] has a lower re-operation rate for hernia repair compared to general hospitals,[292] while Dr. Previ Prasad Shetty funded Nayrana Health to focus on tertiary care, particularly cardiac care.[293] Focused factories positively exploit the well-researched quality-volume relationship present in much of procedural medicine, from lower mortality in percutaneous coronary intervention (cardiac catheterization)[294] to lower complications rates in total knee arthroplasty[295] and even lower *mortality* in total hip arthroplasty.[296]

In the antitrust context, "mavericks" are competitors "that play[] a disruptive role in the market to the benefit of customers."[297] They may have a new business model or technology or they may have an ability and incentive to expand capacity or resist prevailing norms on price or other forms of competition. Such mavericks may be identifiable if they are disproportionately responsible for fluctuations in market share.[298] Removing mavericks from a market can adversely affect competition more than removing another run-of-the-mill competitor. We think it is safe to describe POHs as mavericks, given their unique role as a countertrend to consolidation, their greater use of specialty surgical hospitals, and their unique incentives for entry and innovation. Indeed, their disruptive role is very likely animating resistance from incumbents, both in the policy space and in the five antitrust cases discussed earlier in Parts III.B and IV.A-.B. Consequently, the POH ban may be distinctly harmful in preserving the market power of incumbent health systems over physicians, payors, and consumers.

D. We Should Expect Narrowly Tailored Policies to be Better Options

To the extent there are valid policy concerns related to cherry-picking patients and inducing demand by vertically linked healthcare institutions, more narrowly tailored policies are

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[291] James L. Heskett & Roger H. Hallowell, Shouldice Hospital Limited (Abridged), HARVARD BUSINESS SCHOOL, Case 805-002 (July 2004; rev. Jan. 2005), https://www.hbs.edu/faculty/Pages/item.aspx?num=31326; Atul Gawande, *No Mistake*, THE NEW YORKER, Mar 22, 1998, at 74.

[292] Atiqa Malik, *Recurrence of inguinal hernias repaired in a large hernia surgical specialty hospital and general hospitals in Ontario, Canada*, 59(1) CANADIAN JOURNAL OF SURGERY 19 (Feb. 2016).

[293] Andrea Taylor et al., *Expanding Access to Low-Cost, High-Quality Tertiary Care*, THE COMMONWEALTH FUND (Nov. 9, 2017), https://www.commonwealthfund.org/publications/case-study/2017/nov/expanding-access-low-cost-high-quality-tertiary-care.

[294] Alexander C. Fanaroff et al., *Relationship Between Operator Volume and Long-Term Outcomes After Percutaneous Coronary Intervention*, 139(4) Circulation 458 (Jan. 2019); Alexander C. Fanaroff et al., *Outcomes of PCI in Relation to Procedural Characteristics and Operator Volumes in the United States*, 26(24) J. AM. COLL. CARDIOL. 2913 (June 20, 2017).

[295] Rick L. Lau et al., *The role of surgeon volume on patient outcome in total knee arthroplasty: a systematic review of the literature*, 13 BMC MUSCULOSKELETAL DISORDERS 250 (Dec. 14, 2012).

[296] Jeffrey N. Kats et al., *Association between hospital and surgeon procedure volume and outcomes of total hip replacement in the United States Medicare population*, 83(11) J. BONE JOINT SURG. AM. 1622 (Nov. 2001).

[297] HMG, *supra* note 25, § 2.1.5.

[298] *Id.* § 5.3.

available that directly address these concerns. It is difficult to see why such alternatives are not preferable from a public welfare perspective to a POH ban, especially when it is not well-established that such concerns are unique to POHs and when banning POHs harms competition.

Indeed, a competition perspective would often be agnostic about the ownership structure of a business or the professional backgrounds of its owners or managers. First, all firms in a given market are likely responding to similar incentives to compete in that marketplace. Consumers typically select a firm based on their price and quality expectations of the service, not based on its corporate structure or the identity of its owners. And owners, can be expected to strive to meet that demand while maximizing revenue and minimizing costs. The antitrust agencies have long applied "the same analytical framework" rooted in general competition principles to healthcare markets.[299] That framework adapts to the market realities and imperfections of each industry, and applied to healthcare, the agencies analyze the competition offered by for-profit hospitals, non-profit hospitals, and university research hospitals similarly.[300]

Second, to the extent a particular ownership model is better at helping a firm meet consumer demand or enter a market, that is generally a consumer welfare benefit—one that is likely to be reflected in market outcomes. Perhaps start-ups are more often privately held companies and Fortune 500 companies are more often publicly held because of efficiency trade-offs associated with each business form. Similarly, certain small businesses are often sole proprietorships—including, many physician medical practices. And in some industries, technical expertise may be especially important for owners and managers. Indeed, given the importance of innovation, policymakers should find it perverse if specific entrepreneurs cannot pursue important innovations in an industry *because* they are the direct service providers and premier technical experts in that industry. By contrast, corporate law generally provides entrepreneurs with expansive flexibility to structure their business as they deem fit and without regard to the identities of the owners. Given that, legislators and regulators should be extremely skeptical of efforts to impose a business model on an industry, here the business model of incumbent hospitals, especially when a new business model—physician ownership—likely offers important market benefits that are hard to replicate (see Parts II and V.C) and when alternative, narrowly tailored policies are available.

Here we consider the two main policy concerns directed at POHs by their critics and address alternative policy approaches. Both concerns arise where a vertically integrated provider like a health system or a POH can exert some control or influence over whether a patient receives follow-up care at an owned facility or at a rival's facility. In such circumstances, the

[299] *See, e.g.*, U.S. DEP'T OF JUST. & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Chapter 4, at 2 (July 2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

[300] *See, e.g.*, *id.*, Executive Summary, at 27 ("Hospital merger analysis should not be affected by institutional status.").

provider may have incentives to cherry pick and direct low-cost, easy-to-treat patients to their own facility, and free-ride off of rival hospitals by directing more costly, hard-to-treat patients elsewhere. Similarly, they may have incentives to induce demand, where more than one diagnostic or treatment strategy may be appropriate, and where a provider tends to urge more follow-up care at their own facilities than they would absent the financial incentives. When the policy concerns are properly stated, one can already imagine better tailored policies.

For example, policymakers can make greater use of payment and other policy tools to address these concerns. First, by accurately adjusting payments for the complexity and cost of caring for a given patient, payors reduce a provider's incentive to cherry pick because easy-to-treat and hard-to-treat patients will have comparable profitability. For example, in 2007 in response to hospital industry complaints, CMS pursued more granular adjustments for patient acuity.[301] Of course, a payor will never have perfect visibility to adjust for a given patient's condition or the best course of treatment or the likely costs of their care. Collecting more information from providers is not costless and can exhibit diminishing returns.

Second, in risk-adjusted, capitated managed care programs such as Medicare Advantage (48% of Medicare enrollees)[302] and Medicaid managed care (72% of Medicaid enrollees),[303] health plans are functionally paid an annual global budget to care for a population. Structurally, health plans are incentivized to deploy utilization review tools to ensure appropriate use and combat induced demand for over 80 million Americans enrolled in publicly financed, privately managed health benefits markets.

Third, to directly address induced demand, policy makers also can further promote research, development, and appropriate use of oversight of a provider's referral patterns and billing practices, especially for outliers that reflect their financial incentives instead of the best evidence on clinical practice. Health plan tools such as pre-payment claims editing, neural network-driven fraud detection, and other advanced analytic tools can operationalize the products of fraud identification and prevention research. Slow, costly oversight can have its own health implications for patients. Nevertheless, these tools have often been validated by the literature in their use by managed care networks and in prospective payment systems, and their use could be further refined and expanded.

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[301] In 2007, as part of the rulemaking process, CMS added a complicating condition and case-mix index adjustment to Diagnosis Related Groups (DRGs) for the fiscal year 2008. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 Fed. Reg. 47130 (Aug. 22, 2007).
[302] Meredith Freed et al., *Medicare Advantage in 2022: Enrollment Update and Key Trends*, KFF (Aug. 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.
[303] *Total Medicaid MCO Enrollment*, KFF, https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Dec. 25, 2022).

These policies do not have to be perfect—just good enough to disincentivize cherry-picking and induced demand, by increasing the time, effort, and cost to the provider of acting on a perverse incentive.

Fourth, policymakers also can work to reduce the control or influence of vertically-integrated providers over where patients receive follow-on care by promoting information sharing and transparency of the price and quality of services. To the extent they have less control or influence, providers would be less able to act on such perverse incentives. Current policy efforts encourage patients to learn about their options for follow-up and to consider alternative, competing providers. Ongoing price transparency efforts that span administrations seek to facilitate price transparency for shoppable services,[304] including the recent increase in penalties for non-compliance.[305] Still other policy efforts focus around quality comparisons for providers, such as CMS star ratings for dialysis facilities (launched in 2001),[306] nursing homes (launched in 2008),[307] and hospitals (launched in 2016).[308] While imperfect and a source of controversy,[309] star ratings and recent early efforts at price transparency seek to advance patient choice and competition by endeavoring to reduce vertically-linked organizations' ability to capture patients. Policymakers should look to enhance and strengthen these various policy interventions by increasing price transparency, particularly in the context of quality, and encourage the provision of pricing at the clinical point of service (i.e. the exam room).[310] Policymakers also should be mindful of conduct counter to these efforts. For example, DOJ successfully challenged a dominant health system that DOJ alleged "insulate[d] itself from competition" by preventing transparency and steering of its patients to lower cost providers.[311]

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[304] Brian Miller et al., *Price Transparency: Empowering Patient Choice and Promoting Provider Competition*, 44 J. MED. SYST. 80 (Mar. 5, 2020); Nisha M. Patel et al., *What Should "Shopping" Look Like in Actual Practice?*, 24(11) AMA J. ETHICS E1099 (Nov. 2022).

[305] Press Release, Centers for Medicare & Medicaid Services, *CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care* (Nov. 2, 2021), https://www.cms.gov/newsroom/press-releases/cms-oppsasc-final-rule-increases-price-transparency-patient-safety-and-access-quality-care.

[306] Alyssa Pozniak & Jeffrey Pearson, *The Dialysis Facility Compare Five-Star Rating System at 2 Years*, 13(3) CLIN. J. AM. SOC. NEPHROL. 474 (Mar. 7, 2018).

[307] In 2002, detailed nursing home quality information was made public, followed by the implementation of star ratings in 2008. *See* R. Tamara Konetzka et al., *Two Decades of Nursing Home Compare: What Have We Learned?*, 78(4) MEDICAL CARE RESEARCH AND REV. 295 (Aug. 2021).

[308] Press Release, Centers for Medicare & Medicaid Services, First Release of the Overall Hospital Quality Star Rating on Hospital Compare (July 27, 2016), https://www.cms.gov/newsroom/fact-sheets/first-release-overall-hospital-quality-star-rating-hospital-compare.

[309] Elizabeth Whitman, *CMS releases star ratings for hospitals*, MODERN HEALTHCARE (July 27, 2016), https://www.modernhealthcare.com/article/20160727/NEWS/160729910/cms-releases-star-ratings-for-hospitals; Karl Y. Bilimoria et al., *The New CMS Hospital Quality Star Ratings: The Stars Are Not Aligned*, 316(17) JAMA 1761 (Nov. 1, 2016).

[310] Brian Miller et al., *Redefining the Physician's Role in Cost Conscious Care*, 322(8) JAMA 721 (Aug. 27, 2019).

[311] *See* Competitive Impact Statement at 9-11, United States v. The Charlotte-Mecklenburg Hospital Authority, No. 16-311 (W.D.N.C. Dec. 4, 2018), https://www.justice.gov/atr/case-document/file/1117111/download (describing how Atrium Health's anti-steering and anti-transparency provisions in its payor contracts allegedly foreclosed competition).

Finally, both public and private payers could also encourage second opinions through specific operational and regulatory actions, where a patient seeks advice from a rival provider on appropriate follow-up. For example, CMS and state insurance commissioners could audit provider directories, and health plans could increase the accuracy and transparency of and information available in these directories,[312] helping to create shopping tools for patients to obtain information about the availability of providers of specific services. This could include, for example, a list of all the local providers for a given surgery or expensive diagnostic procedure. Similarly, health plans could require disclosures of financial relationships between the referring provider and the follow-on site of care agnostic of ownership model, promoting competition between care delivery sites.

By contrast, the POH ban is very poorly targeted at these policy concerns. It is dramatically under-inclusive because investor-owned and nonprofit hospitals and health systems also have the incentive and ability to cherry pick and induce demand, and a POH ban does nothing to address any problematic conduct by such institutions. A POH ban is also dramatically over-inclusive because it bans all new or expanded POHs without any regard to whether a specific POH has engaged in such practices or is likely to do so. This poorly tailored policy is especially egregious because it is not well-established in the literature that POHs disproportionately engage in cherry picking or induced demand and because it sacrifices all the competition and consumer welfare benefits POHs offer their patients.

VI. Conclusion

Leaders across administrations have noted the importance of increasing competition in health care markets,[313] including in the recent Executive Order on promoting competition.[314] With the hospital industry demonstrating decades of flat or absent labor productivity growth,[315] the ills of consolidation are clear. With decades of research demonstrating that competition results in lower costs, improved quality, and greater innovation—and recent healthcare cost and quality research questioning the merits of the POH ban—Congress should consider the competition policy perspective provided by this paper. Ongoing hospital consolidation and high entry barriers put at risk upstream competition for physician services and downstream competition to meet the network needs of payors and the healthcare needs of patients. POH

[312] Jack S. Resneck Jr. et al., *The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks*, 150(12) JAMA DERMATOL. 1290 (Dec. 2014); Michael Adelberg et al., *Improving Provider Directory Accuracy: Can Machine-Readable Directories Help?*, 25(5) THE AMERICAN JOURNAL OF MANAGED CARE 241 (May 2019); Abigail Burman & Simon F. Haeder, *Potemkin Protections: Assessing Provider Directory Accuracy and Timely Access for Four Specialties in California*, 47(3) J. HEALTH POLIT. POLICY LAW 319 (June 1, 2022).
[313] 2018 HHS REPORT, *supra* note 281.
[314] Exec. Order No. 14036, 86 C.F.R. 36987 (July 9, 2021).
[315] *Private Community Hospital Labor Productivity*, U.S. BUREAU OF LABOR STATISTICS, https://www.bls.gov/productivity/highlights/hospitals-labor-productivity.htm (last visited Dec. 25, 2022).

market entry offers one of the few paths to challenge this trend. The literature offers many reasons to invite POH market entrants to improve healthcare competition and outcomes. Policy concerns like cherry picking and induced demand are not unique to POHs and do not justify the competitive harm of the POH ban, particularly since policymakers have better, more appropriately targeted options that can reduce any provider's incentive to engage in such conduct. Physicians are directly affected by hospital consolidation and are uniquely positioned to challenge it. By removing the POH ban, Congress would free physicians to invest and innovate in the hospitals where they apply their expertise every day. Congress should unleash their potential to inject much-needed competition into healthcare markets.

Texas Medical Association

Physicians Caring for Texans

TMA STATEMEMT – FOR IMMEDIATE RELEASE

April 24, 2023

TMA Applauds Medicare Relief

Statement by Texas Medical Association (TMA) President-Elect Rick Snyder, MD, in support of the United States House of Representatives Energy and Commerce Committee's Health Subcommittee taking up Medicare relief this week.

"The Texas Medical Association applauds the U.S. House Energy and Commerce Health Subcommittee for addressing two critical issues that have impacted patient care for decades.

"Medicare patients and people with disabilities need a physician in charge of their care but the method used to pay physicians doesn't work and hasn't for years. Every year, physicians face a payment decrease from Medicare while other health care providers realize payment increases.

"We [Texas physicians] are heartened by the subcommittee's effort to fix this broken system. It's essential that Congress take steps to pay physicians for the care they provide to vulnerable patients at the same rate as other health care providers, like hospital outpatient clinics when they are performing the exact same service. This important action would allow more physicians to treat Medicare patients today and into the future.

"TMA also is grateful for the subcommittee's action to lift the ban on physician-owned hospitals, which has crippled patient access to timely and affordable care."

TMA is the largest state medical society in the nation, representing more than 57,000 physician and medical student members. It is located in Austin and has 110 component county medical societies around the state. TMA's key objective since 1853 is to improve the health of all Texans.

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TMA contacts:
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Eligibility for Non-Citizens in Medicaid and CHIP

Center for Medicaid and CHIP Services

November 2014

Overview

- Eligibility for Non-Citizens (PRWORA)
- Lawfully Residing Option for Medicaid/CHIP
- Eligibility for Medicaid, CHIP, and Marketplace/QHPs
- Application and Enrollment Tips for Non-Citizens
- Accessibility/Language Services

Eligibility for Non-Citizens in Medicaid and CHIP
under Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)

- The following groups may be eligible for Medicaid and CHIP:
  - Qualified non-citizens who entered before 8/96
  - Qualified Immigrants who reach end of 5 year waiting period (i.e LPRs/green card holders)
  - Qualified Immigrants exempt from 5-year waiting period (e.g., Refugees, Asylees, Cuban/Haitian entrants, Trafficking Victims, Veteran families)
- No federal funding to cover undocumented immigrants, except for payment for limited emergency services

Who is a “Qualified Non-Citizen”?

- Specific list includes:
  - Lawful Permanent Residents (LPRs or green card holders)
  - Asylees and Refugees
  - Cuban/Haitian entrants
  - Parolees for more than 1 year
  - Battered non-citizens, spouses and children
  - Victims of trafficking
  - Veterans and active military, and their spouses and children
- Note: Many of these groups are exempt from the 5 year waiting period

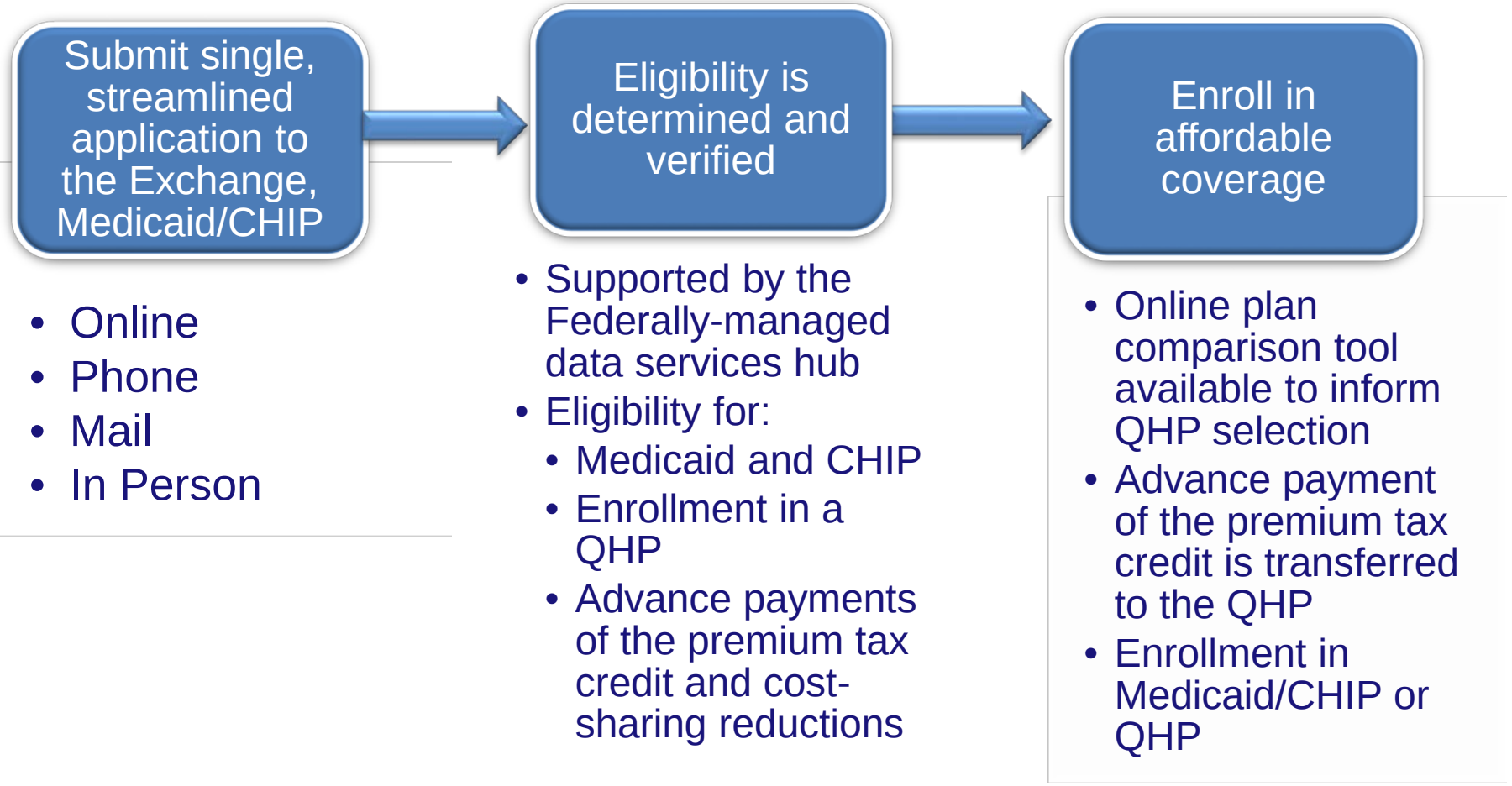
Option to Cover Lawfully Residing Children and Pregnant Women

- CHIPRA made available a state option to cover children and/or pregnant women who are:
  - Lawfully present, and otherwise eligible
  - Without a 5-year waiting period
  - Regardless of date of entry into the U.S.
- 29 states, DC and CNMI

“Lawfully Present” includes:

- Qualified non-citizen, regardless of a waiting period
- Humanitarian statuses or circumstances (Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture)
- Valid non-immigrant visa holder
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals)
- Lawfully present in American Samoa and the Northern Mariana Islands

Seamless, Streamlined System of Eligibility and Enrollment



Minimizing Burden in Application Process

- The state may only require an individual to provide the information necessary to make an eligibility determination
- Applications may ask a non-applicant for certain information necessary to determine eligibility for an applicant (i.e. income, tax filing status, relationship)

Application Process Cont.

- Request for SSN of a non-applicant is permitted if:
  - It is voluntary
  - It is used only to determine eligibility for applicant/beneficiary or for purpose directly connected to Medicaid program
  - Clear notice is provided to individual
- States should not ask for citizenship/immigration information from a non-applicant

Public Charge

- Applying for Medicaid or CHIP does not make someone a "public charge."
  - It will not affect someone's chances of becoming an LPR or US citizen.
  - The one exception is for individuals receiving long-term care in an institution at government expense. These people may face barriers getting a green card.

Accessibility and Federal Funds for Language Services

- Information must be accessible to individuals who are limited English proficient and individuals with disabilities
  - Entities receiving federal funds have a responsibility to provide these services and not to discriminate based on national origin for individuals who are limited English proficient under Title VI of Civil Rights Act of 1964
  - Based on disability under section 504 of the Rehabilitation Act of 1973
- Federal funds are available for oral interpretation and written translation provided to Medicaid and CHIP applicants and beneficiaries

Eligibility Options for Non-Citizens

Program	Summary of Eligibility Rules
Medicaid/CHIP	• Qualified non-citizens • Must apply the 5-year waiting period to certain non-citizens • State option to cover lawfully residing children and/or pregnant women (removes the 5-year waiting period)
Marketplace/QHP	• Must be lawfully present to purchase insurance in a Qualified Health Plan, or to be eligible for an Advance Payment for Premium Tax Credit or Cost-Sharing Reduction • Under 100% FPL of household income, may be eligible for APTC and CSRs, if lawfully present and ineligible for Medicaid due to immigration status

Resources

Information on non-citizen eligibility, application, and verification for Marketplace, Medicaid and CHIP eligibility
https://www.healthcare.gov/immigrants/

Information on Medicaid and CHIP eligibility for non-citizens

http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html

Statement for Hearing on
"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

House Committee on Energy and Commerce
Subcommittee on Health

April 26, 2023

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. We appreciate the subcommittee's interest in lowering health care costs for Americans by increasing transparency and competition. Medicare payment policies can have spillover benefits in private insurance and enable health insurance providers to secure better prices. The impact of new Medicare payment policy solutions on health insurance providers can be complex; to the extent that health insurance providers contract with providers in a manner that is tied or benchmarked to Medicare fee-for-service rates, improvements in Medicare methodologies could help commercial payers.

Every American deserves access to affordable, comprehensive, high-quality coverage and care. However, health care prices continue to escalate year after year, making coverage and care less accessible for everyone. This challenge can be tied directly to health care markets where there is little to no competition, and it calls for a comprehensive effort to spur the robust competition that is essential to providing Americans with more choices, better quality, and lower costs.

Hospitals Driving Costs

To better understand the distribution of growing health care costs, AHIP analyzed data from commercial health insurance plans between 2018 and 2020 to determine how enrollees' premiums are spent. During this 3-year span, the largest driver of cost was hospital care, which totaled 42.2 cents per premium dollar, including the 19 cents for in-patient hospital costs, 19.9 cents for out-patient hospital costs, and 3.3 cents for emergency room costs.[1] Of note, after accounting for medical costs and administrative costs, including premium taxes and fees, cost

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go

containment expenses, and quality improvement activities, health plan profits equated to only 3.6 cents per premium dollar.[2]

Advance Site-Neutral Payments to Defend Patients from Overpaying
Health insurance providers are Americans' bargaining power, fighting for lower prices for Americans by using free-market tactics to negotiate lower prices with care providers and other elements of the health care ecosystem. Advancing site-neutral payments is a competition-enhancing approach that would improve affordability and access for everyone.

Patients can go to a variety of care settings to receive comparable care, but their financial costs may differ dramatically depending on the setting in which their care is delivered. Most patients, however, do not know about the cost difference until after the care is provided and they receive a bill.

Historically, Medicare has paid a higher amount for comparable services that are provided in a hospital outpatient department than in a physician's office. For example, medical imaging services are typically priced significantly higher in hospital settings versus other settings, such as outpatient imaging centers. This higher payment structure has created a perverse incentive for hospitals to acquire physician practices and convert them to off-campus, provider-based hospital outpatient departments and thus allowed providers to charge patients more with no demonstrable difference in care or outcomes.

These practices increase premiums and out-of-pocket costs and make care less affordable for all patients and consumers. Solutions that permit comparable payment for comparable services encourage an efficient and competitive market that works for everyone. Additionally, a recent industry study found that if enacted site-neutral payments would save patients and taxpayers close to $500 billion over ten years.[3]

In order to create a more affordable and transparent health care system, AHIP supports the subcommittee's ongoing efforts to enact site neutral payment policies and provides the following comments on select bills that show great promise toward these goals:

1. **H.R.___, To amend title XVIII of the Social Security Act to require payment for all hospital-owned physician offices located off-campus be paid in accordance with the applicable payment system for the items and services furnished**

The discussion draft would expand upon the Bipartisan Budget Act of 2015, which required that new off-campus hospital-based outpatient departments (HOPDs) be paid by Medicare and

[2] Ibid
[3] https://www.bcbs.com/sites/default/files/file-attachments/affordability/BCBSA_Issue_Brief_Site_Neutral_Payment_Proposal_2.28.23.pdf

Medicare beneficiaries at the same rate as other outpatient providers (physician offices, ambulatory surgical centers (ASCs) for the same services performed safely at such facilities. AHIP is strongly supportive of policies that seek to reduce payment disparities that result in hospital-based locations being reimbursed at a higher rate than physician offices for the same service. Higher cost care settings can impose considerable financial burden on patients through higher out-of-pocket payments at the point of care and potentially higher health insurance premiums.

Payment differentials across sites of service create two problems for the health care system. First, it results in increased costs to patients and their health insurance providers for individual services at the point of care. Consumers often face lower co-pays for a visit to a physician's office than a visit to a hospital facility, where they may have to pay cost sharing for a facility fee, in addition to cost sharing for professional services. Second, the prospect of higher reimbursement rates paid to hospital-affiliated practices is seen as a contributing factor to consolidation, as hospitals have an economic incentive to purchase independent physician offices to receive higher rates at those locations.[4,5] In fact, as of 2020, the majority of physicians in the U.S. (50.2%) worked outside of private practice.[6]

When a hospital acquires a physician's office and converts it to an off-campus HOPD, there is often no change in either the physical location, services provided, or change in the acuity of patients seen. Furthermore, studies have shown that vertical integration is not associated with improved health outcomes,[7] but is associated with higher physician prices, including commercial rates.[8]

We agree that closing the grandfather exception would better drive affordability and improve upon the site neutral payment policies Congress has already worked to implement through the Bipartisan Budget Act. Health insurance providers often align contracts to Medicare payment policies and thus legislative improvements such as those outlined in this discussion draft can have a broad impact on the market overall. Furthermore, to the extent that they reduce incentives

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[4] Government Accountability Office (GAO); "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform" (Dec. 2015); GAO-16-189; available at: https://www.gao.gov/assets/gao-16-189.pdf.
[5] MedPAC Report to Congress, Chapter 3 (March 2015); available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-3-hospital-inpatient-and-outpatient-services-march-2015-report-.pdf; MedPAC Report to Congress, Chapter 6 (June 2022); available at: https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.
[6] American Medical Association (AMA); "Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020;" available at: https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf.
[7] See, e.g., Marah Noel Short, Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality;" Medical Care Research and Review (Feb. 2019); available at: https://journals.sagepub.com/doi/10.1177/1077558719828938; TG Koch, BW Wendling, NE Wilson; "The Effects of Physician And Hospital Integration On Medicare Beneficiaries' Health Outcomes;" Rev Econ Stat. 2020:1-38. doi:10.1162/rest_a_00924.
[8] James Godwin, et al.; "The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence;" Inquiry (Mar. 2021); available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7940736/.

for provider consolidation, they have an even larger impact on the market by promoting competition.

2. H.R. ___, To amend titles XI and XVIII of the Social Security Act to require each outpatient department of a provider to include a unique identification number on claims for services, and to require hospitals with an outpatient department of a provider to submit to the Centers for Medicare & Medicaid Services an attestation with respect to each outpatient department

The discussion draft would require off-campus HOPDs to obtain a unique identifier that is separate from the hospital that owns it. It would also require hospitals to report clearly to CMS on how they meet "provider-based" facility requirements.

Requiring off-campus HOPDs to obtain separate identifiers for payment and billing purposes would help public and private payers in identifying the locations that should be subject to site neutral provisions under existing laws as well as the site neutral payment provisions being considered by this subcommittee. Furthermore, requiring provider-based facilities to attest to their compliance with CMS regulations would help provide greater oversight into compliance as current regulations only provide for voluntary attestation.

In an audit of CMS' oversight of provider-based locations, the Department of Health and Human Services' (HHS') Office of Inspector General (OIG) reported that vulnerabilities made it difficult to implement the Bipartisan Budget Act. [9] For example, CMS' reliance on *voluntary* attestations hampered its ability to audit locations to ensure they are meeting provider-based requirements, in turn limiting the effectiveness of the Bipartisan Budget Act.[10] Before January 2016, CMS could not distinguish billing from on- and off-campus HOPDs owned by the same hospital, or among multiple off-campus HOPDs. Therefore, CMS could not create a population of off-campus HOPDs that should be grandfathered (i.e., excepted) from site neutral payments.

The OIG observed that the agency has since made changes to help identify off-campus HOPDs and implement site neutral payments, although vulnerabilities remained. Like Medicare, health insurance providers have reported difficulties identifying the off-campus locations that should be subject to site neutral payment policies. Current policies rely on a system of billing modifiers that are not always followed by providers and may be difficult to implement through private contracts. Therefore, the ability to identify HOPDs through separate billing identifiers would better enable health insurance providers to target locations that should be subject to site neutral payments in the commercial market.

3. H.R. ___, To amend title XVIII of the Social Security Act to provide for parity in Medicare payments for hospital outpatient department services

[9] "CMS is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain;" OIG (June 2016); available at: https://oig.hhs.gov/oei/reports/oei-04-12-00380.pdf.
[10] *Id.*, at page 10.

The discussion draft would equalize the amount Medicare and Medicare beneficiaries pay for the provision of physician-administered drugs across outpatient settings.

We are encouraged by the provision that would provide parity for certain drug administration, which could decrease the incentive for hospitals to purchase physician practices. MedPAC noted in its March 2023 meeting that the acquisition of physician practices has shifted the billing of services from the physician fee schedule (PFS) to the outpatient prospective payment system. By way of comparison, from 2012 to 2021, there was a 3.2 percentage point increase in the share of outpatient office visits while there was a 16.7 percentage point difference in the growth of outpatient chemotherapy administration.[11]

Furthermore, we appreciate the waiver of budget neutrality for any savings generated by this discussion draft. This would result in greater savings for the program as the savings generated would not be funneled back into the payment system to fund other services, thereby driving higher beneficiary copays and costs for other services.

4. H.R. ___, To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings

This discussion draft implements a proposal designed by MedPAC to ensure that for certain services performed safely in multiple care settings that patients and Medicare pay the same amount for the same services regardless of where they are furnished. However, the discussion draft limits Medicare revenue reductions at safety net hospitals to 4.1% annually with the Secretary having discretion to set a lower amount.

AHIP appreciates the attention MedPAC and this subcommittee are paying to addressing outpatient payment reform and the thoughtful, broad-based approach taken. However, we encourage policymakers to evaluate the operational barriers that may impede the efficacy of its potential draft.

A new payment policy that annually shifts which fee schedule is used on a service-by-service basis will be challenging from an operational and systems perspective, even with proper identifiers as outlined in the discussion draft previously noted. Given the Medicare outpatient and ASC prospective payment system rulemaking occurs before the PFS rulemaking, the outpatient and ASC rates that would be capped at the PFS rates would need to be based on the prior year's PFS rate. As another example, changing the claims algorithms to package and unpackage services depending on the particular fee schedule used for that service for that year would be resource intensive. As policy makers further discuss and refine potential policies on

[11] https://www.medpac.gov/wp-content/uploads/2022/07/Site-neutral-March-2023-SEC.pdf

site-neutral payment, we urge you to consider coding, billing, and other implementation constraints and to seek simplified policies where possible.

5. H.R. ___, To phase out certain services designated as inpatient-only services under the Medicare program

This discussion draft would phase out certain musculoskeletal services that Medicare, through a regulatory policy known as the Inpatient Only List (IPO), has required to be conducted in an inpatient care setting, rather than allowing for doctors and patients to decide if the procedure could be safely conducted in a potentially lower-cost outpatient setting. The draft would also require the Secretary of HHS to conduct a study and report on clinical outcomes and patient safety as well as patient cost-sharing and the financial impact of the inpatient-only service list on Medicare. Starting January 1, 2027, the Secretary of HHS could not refuse to designate a service as an outpatient service unless there is conclusive evidence the service may not be safely performed in an outpatient setting.

AHIP supports policies that move services from the inpatient to the outpatient setting where clinical evidence and quality data support doing so. In general, AHIP supports allowing physicians to determine the most appropriate site-of-service for patient care in consultation with the patient. We also support enabling patients to seek care in an outpatient, rather than inpatient, setting when clinical evidence demonstrates a procedure or service has a comparable safety profile when performed at an outpatient facility. AHIP supports the removal of the musculoskeletal-related services from the IPO list. Allowing flexibility in the site of service will allow providers to innovate and build capacity in lower cost, often more consumer-friendly sites of care. However, policymakers will need to ensure that Medicare beneficiaries are still receiving the high-quality services they deserve. They should monitor the impact of any changes when procedures move from inpatient-only to the outpatient department and should publicly share its findings in its annual rulemaking.

The shift between the inpatient diagnosis-based payment system to the outpatient procedure-based payment for the remaining IPO procedures may require significantly more study and preparation both in terms of safety and impact on the integrity of the APC weights. AHIP urges policymakers to continue to use the transparent rulemaking process to gather stakeholder input on which IPO-list services should be transitioned to the outpatient setting each year and provide adequate notice and provider education about resulting changes. AHIP urges a cautious approach when considering which services to remove from the IPO list or terminating the list altogether.

While the site-neutral proposals are all steps in the right direction to providing more competition and less out-of-pocket costs for patients, we have concerns that not all of the bills being considered would advance our shared goal of advancing pro-competition legislation.

H.R. ___, To amend title XVIII of the Social Security Act to promote transparency of common ownership interests under Parts C and D of the Medicare Program would subject

Medicare Advantage, Part D plans, and certain providers, pharmacies and pharmacy benefit managers with common ownership arrangements to new reporting requirements relating to claims, risk adjustment, payments, and a range of other data.

Medicare Advantage (MA) and Part D plans are already subject to numerous reporting requirements. Any legislation that imposes onerous new reporting requirements must consider the administrative costs that would ultimately limit benefits or increase costs for enrollees and taxpayers. Additionally, the legislation requires reporting of MA and Part D information that would be impractical or impossible to provide, such as the calculation of a medical loss ratio for only certain providers. AHIP would be pleased to work with the subcommittee to provide technical assistance on the bill in order to achieve its objective while not adding redundant burdens on MA and Part D plans.

Conclusion

Along with site-neutral policies such as those mentioned above, AHIP has developed detailed policy prescriptions to improve health care competition, and we are committed to working with federal and state officials as well as other health care leaders to take decisive action. We advocate for the laws, regulations, and enforcement needed to move our system forward. Prioritizing these reforms and taking concrete action toward them will benefit everyone: patients will have more choices, employer coverage will be more affordable with better benefits, and treatment programs will be more accessible and affordable for patients.

We welcome the opportunity to address this feedback in greater detail and look forward to working together to champion these solutions that would improve affordability, access, and quality of care.

careviso

April 26, 2023

Chair Cathy McMorris Rogers (R-WA)
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Frank Pallone, Jr. (D-NJ)
House Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, D.C. 20515

Subject: Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care

Dear Chair Rogers and Ranking Member Pallone:

Thank you for the committee's current focus affordability and transparency in the delivery of health care.

careviso's mission is to remove barriers and improve patient access to their health care, with a focus on diagnostic testing. For the last five years, careviso has built a technology platform that works with physicians, facilities, and payors. The platform can tell a patient what the out-of-pocket price is expected to be for a test or service, along with any medical management – such as prior authorization requirements. Our goal is to have patients and physicians focus on treating their condition or disease and having a platform available, such as careviso's, to be able to complete necessary administrative tasks associated with accessing health care and understanding the costs that will be paid by individual and their health plan.

As members of the health care technology community, and consumers of health care ourselves, we are encouraged that members of Congress are working to improve affordability and transparency so that patients and physicians have the information necessary to navigate the complexities of the current system.

careviso's health care provider-facing tool will help patients make informed decisions before receiving a treatment or service, without delaying care or creating unnecessary anxiety for an individual or family about a future surprise bill for a past treatment or service.

info@careviso.com
careviso.com

As we continue to work towards our shared goal of improving affordability and increasing transparency, please let careviso know if we can provide technological background or compliance expertise to inform the legislative process.

Sincerely,

Andrew Mignatti, President & CEO

Immigrants

Immigration status and the Marketplace

People with the following immigration statuses qualify for Marketplace coverage.

Get details about what document numbers and other information you'll need to fill out a Marketplace application.

Immigrants with the following statuses qualify to use the Marketplace:

- Lawful Permanent Resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian Entrant
- Paroled into the U.S.
- Conditional Entrant Granted before 1980
- Battered Spouse, Child and Parent
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Individual with Non-immigrant Status, includes worker visas (such as H1, H-2A, H-2B), student visas, U-visa, T-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance)
- Lawful Temporary Resident
- Administrative order staying removal issued by the Department of Homeland Security
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa

Applicants for any of these statuses qualify to use the Marketplace:

- Temporary Protected Status with Employment Authorization
- Special Immigrant Juvenile Status
- Victim of Trafficking Visa
- Adjustment to LPR Status
- Asylum (see note below)
- Withholding of Deportation, or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) (see note below)

Applicants for asylum are eligible for Marketplace coverage only if they've been granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days.

People with the following statuses and who have employment authorization qualify for the Marketplace:

- Registry Applicants
- Order of Supervision
- Applicant for Cancellation of Removal or Suspension of Deportation
- Applicant for Legalization under Immigration Reform and Control Act (IRCA)
- Legalization under the LIFE Act

Remember: Information about immigration status will be used **only** to determine eligibility for coverage and not for immigration enforcement.

Can we improve this page?

Give feedback

Wednesday, April 26, 2023

Connecticut State Medical Society Urges Congress to Support Increased Competition, Transparency in Health Care

Connecticut State Medical Society made the following statement in support of the House Energy and Commerce Committee's Health Subcommittee hearing on transparency and competition.

Connecticut's physicians commend the U.S. House of Representatives Energy & Commerce Subcommittee on Health's for its hearing today to explore legislative solutions for increased competition, transparency and choice in our health care system.

"Misguided policies have contributed to a decade-long trend of widespread consolidation throughout the health care system.

"Patient-centered healthcare demands that Connecticut's patients have choice of who directs their care and where they receive it, based on quality and cost of services. This requires a large dose of competition and transparency that does not exist today. Supporting H.R. 977 will end the misguided federal policy restricting physicians from owning and operating hospitals. Lifting this moratorium will allow physicians to invest in their communities and offer our state's patients the choice of physician-directed care.

"Medicare physician payments must be updated to adjust for inflation and to accurately reflect the cost of delivering medical services. The inadequate payment rates have made it difficult for many physicians to sustain their practices, leading to early retirements, and even further consolidation in the medical community."

Connecticut's physicians support legislation that stands up for physician-led health care, giving patients lower costs, higher quality, and more choice in their care."

# # #

About Connecticut State Medical Society
One of the nation's oldest medical societies, the Connecticut State Medical Society (CSMS) was founded in 1792 and serves thousands of physicians across the state. The mission of CSMS is to be the voice of all Connecticut physicians; to lead physicians in advocacy; to promote the profession of medicine; to improve the quality of care; and to safeguard the health of our patients. For more information visit www.csms.org.

CALIFORNIA MEDICAL ASSOCIATION

U.S. House of Representatives
Energy and Commerce Subcommittee on Health
Hearing on "*Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care*"
April 25, 2023

CMA supports Congressional Efforts to Address Health Care Consolidation

In response to the U.S. House of Representatives Energy and Commerce Health Subcommittee's upcoming hearing to discuss legislative solutions for increasing transparency and competition in health care, Donaldo Hernandez, M.D., President of the California Medical Association (CMA), representing nearly 50,000 physicians, issued the following statement:

"CMA appreciates the Subcommittee's work to address Medicare policies that have driven consolidation and higher health care costs. These policies have prevented physician-led organizations from competing with larger corporate interests.

According to a Physicians Advocacy Institute (PAI) and Avalere Health study, nearly 75% of physicians are employed by hospitals, health systems and other corporate entities compared to just 25% a decade ago.

Currently, hospitals receive significantly higher Medicare payments for physician services compared to the payments physicians receive for providing the same service in their independent offices or ambulatory sites. This Medicare "site of service" payment policy when coupled with a stagnant Medicare physician fee schedule has led to consolidation and reduced competition in health care markets.

While CMA supports efforts to reduce consolidation, including efforts to bring more parity to payment for physician services independent of the site of service, we are concerned that simply reversing current "site of service" policies could have a negative downstream impact on physicians and their ability to care for patients. **CMA urges the Subcommittee to reinvest the savings from site neutral legislation into the physician fee schedule to ensure patient access to physician care.**

The Medicare physician fee schedule has failed to keep pace with rising costs to run a medical practice. Since 2001, Medicare physician payment increased just 9% compared to a 60% payment increase for hospitals. However, the cost to run a medical practice has increased 47%. When adjusted for inflation, that means physician payments have declined 26% since 2001.The Medicare Trustee's Report recently said that without change to Medicare physician payments, patient access to care is anticipated to become a significant issue. CMA is sounding the alarm that Medicare access to care is eroding in California.

We urge Congress to address this important issue to ensure patients have equitable access to affordable health care."

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North Carolina Medical Society
Established 1849
Leadership in Medicine

Wednesday, April 26, 2023

North Carolina Medical Society Urges Congress to Support Increased Competition, Transparency in Health Care

North Carolina Medical Society issued the following statement in support of the House Energy and Commerce Committee's Health Subcommittee hearing on transparency and competition.

"The North Carolina Medical Society joins the growing federation of physician organizations advocating for H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023**,** a reasonable and responsible measure to improve our nation's health care system. The NCMS commends the U.S. House of Representatives Energy & Commerce Committee's Subcommittee on Health for its hearing on the bill today and its support of legislative initiatives to achieve increased competition, transparency and choice.

"H.R. 977 would repeal the controversial moratorium on expansion and construction of physician-owned hospitals (POHs), which have been strictly prohibited as a result of the Affordable Care Act (ACA). This restrictive policy has contributed to a decade-long trend of widespread consolidation throughout the health care system. Consolidation has resulted in higher overall cost of care and this legislation offers an excellent opportunity to help curtail that trend. Allowing physician ownership would drive innovation and improve outcomes, while also lowering costs through competition.[1]

"The NC Medical Society supports patient-centered, team-based healthcare, and patients should have the choice of who directs their care and where they receive it, based on quality and cost of services. H.R. 977 will put federal policy back on track by allowing physician ownership of hospitals and greater ability to appropriately guide patients' care. Lifting this moratorium will encourage physician investment in their communities and offer our state's patients greater choice of physician-directed care.

"Data from the Centers for Medicare & Medicaid Services (CMS) also shows that, since the enactment of the ACA, POHs outperform non-physician-owned hospitals in terms of quality, patient satisfaction and cost.[2]

"Achieving greater competition and transparency in the healthcare system also necessitates site neutral payment policies to ensure that North Carolinians receive care in the most efficient, cost-effective setting, which is often the physician's office. Medicare's payment

[1] *https://ssrn.com/abstract=4350105*

[2] *https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/xubh-q36u*

disparity favoring services delivered in a hospital-owned setting, coupled with inadequate Medicare physician payment updates to adjust for inflation, have made it difficult for many physicians to sustain their practices.

“The ban on new and expanded Physician-Owned Hospitals has negatively impacted the health care system and has penalized patients who deserve the right to receive care at the facility of their choice. POHs can inject much-needed competition into the healthcare marketplace, incentivizing improvement and innovation into the system. Further, POHs allow physicians, who know patient care best, to be more involved in the day-to-day decision-making in the facility setting as well as the out-patient setting.

The North Carolina Medical Society supports legislation that promotes physician-led health care, lowering patients’ costs, and higher quality.”

# # #

The North Carolina Medical Society is the oldest professional member organization in North Carolina, representing physicians and physician assistants who practice in the state. Founded in 1849, the Society seeks to provide leadership in medicine by uniting, serving and representing physicians and their health care teams to enhance the health of North Carolinians.”

Nebraska Medical Association

Advocating for Physicians and the Health of all Nebraskans

Tuesday, April 25, 2023

Nebraska Medical Association Urges Congress to Support Increased Competition, Transparency in Health Care

Nebraska Medical Association made the following statement in support of the House Energy and Commerce Committee's Health Subcommittee hearing on transparency and competition.

Nebraska's physicians commend the U.S. House of Representatives Energy & Commerce Subcommittee on Health's for its hearing today to explore legislative solutions for increased competition, transparency and choice in our health care system.

"Misguided policies have contributed to a decade-long trend of widespread consolidation throughout the health care system.

"Patient-centered healthcare demands that Nebraska's patients have choice of who directs their care and where they receive it, based on quality and cost of services. This requires a large dose of competition and transparency that does not exist today. Supporting H.R. 977 will end the misguided federal policy restricting physicians from owning and operating hospitals. Lifting this moratorium will allow physicians to invest in their communities and offer our state's patients the choice of physician-directed care.

"Getting to greater competition and transparency also necessitates site neutral payment policies to ensure that Nebraskans receive care in the most efficient, cost-effective setting, which is often the physician's office. Medicare's payment disparity favoring services delivered in a hospital-owned setting, coupled with inadequate Medicare physician payment updates to adjust for inflation, have made it difficult for many physicians to sustain their practices.

Nebraska's physicians support legislation that stands up for physician-led health care, giving patients lower costs, higher quality and more choice in their care."

# # #

About Nebraska Medical Association
The Nebraska Medical Association was founded in 1868, and represents nearly 3,000 active and retired physicians, residents, and medical students from across the state of Nebraska. Our mission is to serve physician members by advocation for the medical profession, for patients and the health of all Nebraskans.

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SOUTH CAROLINA MEDICAL ASSOCIATION

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Wednesday, April 26, 2023

South Carolina Medical Association Urges Congress to Support Increased Competition, Transparency in Health Care

South Carolina Medical Association made the following statement in support of the House Energy and Commerce Committee's Health Subcommittee hearing on transparency and competition.

South Carolina physicians commend the U.S. House of Representatives Energy & Commerce Subcommittee on Health for today's hearing to explore legislative solutions for increased competition, transparency, and choice in our health care system.

"Widespread consolidation of health care systems in South Carolina has been perpetuated by misguided policies that ultimately weaken access and affordability of physician-led patient care.

"Patient-centered healthcare demands that South Carolina's patients have the ability to make their own decisions – based on quality and cost of service – about who directs their care and where they receive it. Success requires both competition and transparency, neither of which exists today. Supporting H.R. 977 will end the misguided federal policy restricting physicians from owning and operating hospitals. Lifting this moratorium will allow physicians to invest in their communities and offer South Carolinians the choice and privilege of physician-directed care.

"Increasing competition and transparency also necessitates site neutral payment policies to ensure that South Carolinians receive care in the most efficient, cost-effective setting, which is often the physician's office. Medicare's payment disparity favoring services delivered in a hospital-owned setting, coupled with inadequate Medicare physician payment updates to adjust for inflation, have made it difficult for many physicians to sustain their practices.

South Carolina's physicians support legislation that stands up for physician-led health care, giving patients lower costs, higher quality and more choice in their care."

# # #

The South Carolina Medical Association is the only membership organization in South Carolina that represents physicians of all specialties and geographic locations. The SCMA is the voice for South Carolina physicians. SCMA has a constant presence at the South Carolina State House and SCMA staff works methodically to guide SCMA members though statewide issues affecting the practice of medicine.

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Wednesday, April 26, 2023

TMA Urges Congress to Support Increased Competition, Transparency in Health Care

Tennessee Medical Association made the following statement in support of the House Energy and Commerce Committee's Health Subcommittee hearing on transparency and competition.

Tennessee's physicians commend the U.S. House of Representatives Energy & Commerce Subcommittee on Health for its hearing today to explore legislative solutions for increased competition, transparency and choice in our health care system.

> Misguided policies have contributed to a decade-long trend of widespread consolidation throughout the health care system.
>
> Patient-centered healthcare demands that Tennessee's patients have actual choice of where they receive their care, based on quality and cost of services. This requires more openness and transparency than exists today. We support H.R. 977 on the premise that we may end the antiquated federal policy restricting physicians from owning and operating hospitals. Lifting this moratorium will allow physicians to invest in their communities and offer our state's patients additional choice and control of their own care delivery.
>
> By allowing for greater competition and transparency, Tennesseans can receive care in the most efficient, convenient, and cost-effective setting, which is often their physician's office. For this to be a reality requires site neutral payment policies.
>
> The inequities of current site reimbursement policy, coupled with Medicare's payment disparity that pays more for services delivered in a hospital-owned setting, on top of inadequate Medicare physician payment updates for inflation, make it very difficult for many physicians to sustain a private practice.
>
> Tennessee's physicians support legislation that stands up for physician-led health care, giving patients lower costs, higher quality and more choice in their care.

Russ Miller
Chief Executive Officer
T: 615-460-1668

# # #

About the Tennessee Medical Association

The Tennessee Medical Association is a nonprofit advocacy organization representing more than 9,800 Tennessee physicians. We advocate for public policies, laws and rules that promote healthcare safety and quality for all Tennesseans and improve the non-clinical aspects of practicing medicine. tnmed.org

GREATER NEW YORK HOSPITAL ASSOCIATION
PRESIDENT, KENNETH E. RASKE • 555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG

April
Twenty-Four
2 0 2 3

Dear Members of the New York State Congressional Delegation:

I am writing to express Greater New York Hospital Association's (GNYHA) major concerns with the Medicaid work requirements in the Limit, Save, Grow Act of 2023, which the House will likely consider in the coming days.

The Limit, Save, Grow Act of 2023 requires certain Medicaid beneficiaries to work, participate in a work program, or volunteer for at least 80 hours per month. Beneficiaries who are younger than 19 years old, disabled, pregnant, the caretaker of a dependent child, or attending school part time would be excluded from the work requirement. The Center on Budget and Policy Priorities estimates that the proposal could put over 10 million Medicaid beneficiaries at risk of losing coverage.

GNYHA is extremely concerned that mandatory Federal work requirements for Medicaid beneficiaries will imperil access to care for vulnerable New Yorkers. When Arkansas implemented Medicaid work requirements in 2019 through its Section 1115 waiver, approximately 18,000 residents lost Medicaid coverage.[1] The data from Arkansas suggests that the requirements were confusing to enrollees, and that they were disenrolled due to the burden of demonstrating compliance rather than ineligibility.[2] The Centers for Medicare & Medicaid Services halted all state-based Medicaid work requirements in 2021, reasoning that they "do not promote the objectives of the Medicaid program."[3]

Many states, including New York, are restarting their Medicaid renewals after they were paused during the COVID-19 public health emergency. This "unwinding" process creates a new administrative burden for Medicaid recipients who may not be aware that they need to take action to avoid disenrollment. Work requirements would exacerbate this already difficult process and likely cause thousands of eligible enrollees to lose their health insurance.

We are also deeply concerned that Medicaid work requirements will dramatically increase uncompensated care costs for hospitals. New York's public and voluntary hospitals care for every patient that walks through their doors, regardless of their ability to pay—but treating uninsured patients comes at an enormous financial loss. As hospitals struggle with rising costs and soaring inflation, additional uncompensated care costs will push them to the financial brink.

[1] https://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas
[2] https://www.cbo.gov/publication/58199
[3] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-cms-ltr-state-demo-02122021.pdf

Thank you for considering our concerns about the Limit, Save, Grow Act of 2023. GNYHA is committed to working with members of Congress to address the nation's—and New York's—critical health care needs.

Sincerely,

Kenneth E. Raske
President

HANYS®
Always There for Healthcare

Marie B. Grause, RN, JD • President

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202.488.1272

April 25, 2023

Dear New York Congressional Delegation:

On behalf of the Healthcare Association of New York State and our statewide membership, thank you for your support for and meaningful engagement with New York's hospitals and health systems. As negotiations to address the nation's debt limit continue, your commitment to protecting access to healthcare and coverage is crucial to hospitals and health systems and the patients they serve in your communities.

HANYS strongly opposes any policy that would create undue barriers to accessing healthcare coverage. Unfortunately, the package to address the debt limit the House is expected to consider this week, *The Limit, Save, Grow Act of 2023*, includes a proposal to establish new work requirements for certain Medicaid beneficiaries. While the intent of the policy is to control federal spending, it would have a detrimental impact on those individuals who would lose coverage, increase the uninsured rate, threaten the health of our communities and exacerbate fiscal pressures facing hospitals and health systems.

Our healthcare provider members' core mission is to provide essential services in their communities and access to care to all who walk in their doors regardless of their ability to pay. HANYS has worked with state and federal lawmakers to ensure policies are in place to help New Yorkers receive health coverage; as a result, New York has one of the lowest uninsured rates in the nation, at 5%.

The Medicaid program in New York is a critical component to maintaining low uninsured rates. More than three million[1] children and seniors across the state rely on this coverage to help them access care. While the Medicaid program significantly underpays for these services, it nonetheless helps hospitals and health systems maintain their core mission and provide needed services.

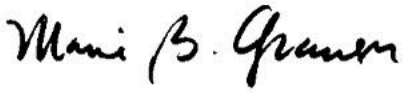
Hospitals and health systems across the state are experiencing historic financial strain, with four out to five of our hospitals operating on a thin or negative margin. This is driven by escalating costs of drugs and supplies and a national workforce labor shortage with no end in sight. Any additional fiscal burden, such as increases in uninsured patients, could destabilize an already fragile industry and undermine the work we have collectively achieved to ensure New Yorkers have access to health coverage.

[1] Kaiser Family Foundation (2023) Medicaid Enrollment by Age. https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-age

Imposing barriers such as work requirements for Medicaid eligibility would undermine the state's ability to implement innovations that leverage broad coverage to reduce costs and improve care for our most vulnerable populations. As such, **we urge the delegation to oppose this harmful proposal to establish work requirements as a condition for Medicaid eligibility.**

Thank you for your thoughtful approach to this important debate. If you have questions, contact Cristina Batt, senior vice president, federal relations, at cbatt@hanys.org or 202.488.1272 or Elyse Oveson, senior director, federal relations, at eoveson@hanys.org or 202.488.1275 in our Washington, D.C., office.

Sincerely,



Bea Grause, RN, JD
President

April 19, 2023

The Honorable Charles Schumer
Majority Leader
United State Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader Schumer, Minority Leader McConnell, Speaker McCarthy, and Minority Leader Jeffries:

As leading national, state, and local organizations dedicated to promoting the health and well-being of America's families, we are writing to underscore the critical importance of the Medicaid program and to express our united opposition to any proposals to cut Medicaid funding as part of upcoming negotiations over the federal budget, debt limit, or any other legislative priorities. We urge you to protect this vital program from cuts or harmful changes in any budget negotiations or other legislative venue this year.

Our health should not depend on our wealth in this country. Efforts to undermine Medicaid would harm millions of families whose health hangs in the balance when they cannot get the care they need otherwise. Medicaid is a lifeline to 91 million Americans, providing insurance coverage for millions of children, veterans, and people who own and work at small businesses. The program is a critical source of coverage to people who have historically been egregiously underserved by our health care system including people of color, particularly in Black, Latino, Asian American, Native Hawaiian and Pacific Islander, and Indigenous communities, and people living in rural communities. It provides health insurance to 6.9 million seniors and over 10 million people with disabilities, and covers 54 percent of long-term care services and 42 percent of all births in the country. Additionally, more than 60 percent of adults with disabilities qualified for Medicaid without supplemental security income (SSI), largely through Medicaid expansion under the Affordable Care Act (ACA).

The evidence is clear that when people have a reliable source of high-quality health coverage, they can access critical health services, including preventive care and behavioral health services; experience improved health outcomes and better overall health; and are protected against unexpected medical expenses. After the upheavals associated with the COVID-19 epidemic over the past three years, it is clearer than ever how critical Medicaid is to our country's health and financial well-being.

In recent years, proposals to cut the Medicaid program have been thinly disguised as policies such as "per capita spending caps," "block grants," "provider tax reforms," and bureaucratic "work requirements." Since the passage of the ACA thirteen years ago, there have been continued attempts to repeal or otherwise undermine Medicaid expansion, which covers 18 million people in 40 states and

Washington D.C., many of whom would otherwise go uninsured. No matter how they are framed, the reality of these policy proposals is that they destabilize state budgets and local economies, take health care away from millions of children, older adults, working parents, people with disabilities, and people of color with cascading harmful effects on small businesses, rural communities, health care providers and others.

These ideas are not new: they were resoundingly rejected by people across the country when they were proposed as part of efforts to repeal the ACA in 2017. Unsurprisingly, the American public continues to strongly oppose them – new polling shows that 71 percent of Americans say it is important to prevent Medicaid cuts. Our collective message is as clear today as it was then: cuts to the Medicaid program are unacceptable.

Sincerely,

National Organizations

ACA Consumer Advocacy
ADAP Advocacy Association
AFL-CIO
AFSCME
Academic Pediatric Association
Advocates for Community Health
Allergy & Asthma Network
Alliance for Retired Americans
Allies for Independence
American Academy of Family Physicians
American Academy of Pediatrics
American Association on Health and Disability
American College of Obstetricians and Gynecologists
American College of Physicians
American Dental Therapy Association
American Federation of Teachers
American Friends Service Committee
American Geriatrics Society
American Lung Association
American Pediatric Society
American Public Health Association
Asian and Pacific Islander American Health Forum
Association for Community Affiliated Plans
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Maternal & Child Health Programs
Association of Medical School Pediatric Department Chairs
Association of University Centers on Disabilities
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
COVID Survivors for Change
Cancer Support Community
Caring Across Generations
Center for Health Law and Policy Innovation
Center for Law and Social Policy (CLASP)
Child Neurology Foundation
Coalition on Human Needs
Community Catalyst
Congregation of Our Lady of Charity of the Good Shepherd, U.S. Provinces
Disability Rights Education and Defense Fund (DREDF)
Doctors for America
Epilepsy Foundation
Families USA
First Focus Campaign for Children
Foundation for Sarcoidosis Research
HIV + Hepatitis Policy Institute
Health Care Voices
Healthy Teen Network
Hemophilia Federation of America
Human Rights Campaign
Immune Deficiency Foundation
Justice in Aging
Lakeshore Foundation

LeadingAge
Legal Action Center
Lutheran Services in America
March of Dimes
Medicare Rights Center
MomsRising
NASTAD
National Advocacy Center of the Sisters of the Good Shepherd
National Alliance on Mental Illness
National Association of County Human Services Administrators
National Association of Free and Charitable Clinics
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Association of Social Workers
National Birth Equity Collaborative
National Center for Medical-Legal Partnership
National Community Action Partnership
National Consumers League
National Council of Jewish Women
National Council of Urban Indian Health
National Education Association
National Family Planning & Reproductive Health Association
National Health Care for the Homeless Council
National Health Council
National Health Law Program
National Hemophilia Foundation
National Hispanic Medical Association
National Immigration Law Center
National Interprofessional Initiative on Oral Health
National League for Nursing
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Partnership for Women & Families
National Patient Advocate Foundation
National Resource Center on Domestic Violence
National Viral Hepatitis Roundtable (NVHR)
Network Lobby for Catholic Social Justice
Pediatric Policy Council
Planned Parenthood Federation of America
PlusInc
Prevent Blindness
Primary Care Collaborative
Protect Our Care
SIECUS: Sex Ed for Social Change
Service Employees International Union (SEIU)
Society for Pediatric Research
Susan G. Komen
The AIDS Institute
The Arc of the United States
The Forum for Youth Investment
The Gerontological Society of America
The Kennedy Forum
The Leadership Conference on Civil and Human Rights
The National Domestic Violence Hotline
Third Way
Treatment Communities of America
UnidosUS
Union for Reform Judaism
United States of Care
WomenHeart
Young Invincibles

State Organizations

Alabama

Alabama Arise
AIDS Alabama

Arizona

Children's Action Alliance
William E. Morris Institute for Justice

California

Asian Resources, Inc.
BG Nurse Consultants
California Pan-Ethnic Health Network
California Rural Legal Assistance Foundation (CRLA Foundation)
California State Association of Counties
County of Los Angeles, California
County Welfare Directors Association of California

Solano County
SEIU2015
The Children's Partnership

Colorado
Colorado Center on Law and Policy
Colorado Consumer Health Initiative
Disability Law Colorado
Healthier Colorado

Connecticut
Connecticut Oral Health Initiative
Universal Health Care Foundation of Connecticut

District of Columbia
Public Advocacy for Kids (PAK)

Florida
American Children's Campaign
Catalyst Miami
Florida Voices for Health
Floridians for Dental Access

Illinois
AIDS Foundation Chicago
Health & Medicine Policy Research Group
Illinois Aging Together

Indiana
Covering Kids and Families of Indiana
Hoosier Action

Kansas
Alliance for a Healthy Kansas
Kansas Action for Children
Kansas Breastfeeding Coalition

Kentucky
Kentucky Equal Justice Center
Kentucky Voices for Health

Louisiana
Louisiana Democratic Party Disability Caucus
Louisiana Partnership for Children and Families

Maine
The Bingham Program
Children's Oral Health Network of Maine
Maine Consumers for Affordable Health Care
Maine Equal Justice
Kennebec Valley Family Dentistry

Maryland
AIDS Action Baltimore
Maryland Dental Action Coalition
Maryland Health Care For All! Coalition
Public Justice Center

Massachusetts
Health Care For All Massachusetts
Mass Alliance of HUD Tenants
Massachusetts Law Reform Institute

Michigan
Michigan Council for Maternal and Child Health

Minnesota
Apple Tree Dental

Mississippi
Mississippi Health Advocacy Program

Missouri
Missouri Health Care for All

Nebraska
Nebraska Appleseed

New Hampshire
ABLE NH

New Jersey
Disability Rights New Jersey
Family Voices NJ
New Jersey Citizen Action
SPAN Parent Advocacy Network

New Mexico
Aspen Copies & Office Supplies
Health Action New Mexico

New York
Black Health Commission
Center for Elder Law & Justice
The Children's Agenda
Medicaid Matters New York
Metro New York Health Care for All
Oral Health Nursing Education and Practice Program (OHNEP)

North Carolina
Healthcare for all NC
NC Child
NC Medicare 4 All
North Carolina Council of Churches
North Carolina Medicare For All Coalition
Wayne County Democratic Women
4 Positive Choices, Greensboro, NC

Oklahoma
Oklahoma Policy Institute

Pennsylvania
Achieva / Disability Healthcare Initiative
PA Coalition for Oral Health
Pennsylvania Health Law Project

Rhode Island
Protect Our Healthcare Coalition RI

South Carolina
Bleeding Disorders Association of South Carolina
Family Connection of South Carolina
Healthcare For All - South Carolina
Latino Communications CDC
NAACP South Carolina Conference
SC Christian Action Council
South Carolina Appleseed Legal Justice Center

Tennessee
SisterReach
Tennessee Health Care Campaign
Tennessee Justice Center – TJC

Texas
Every Texan
La Unión del Pueblo Entero (LUPE)
Unitarian Universalist Fellowship of Hidalgo County Texas

Utah
Utah Health Policy Project

Vermont
Vermont Office of the Health Care Advocate
Southern Vermont Area Health Education Center

Virginia
Allergy & Asthma Network
The Commonwealth Institute for Fiscal Analysis
Virginia Coalition of Latino Organizations
Virginia Health Catalyst
Virginia Poverty Law Center
Voices for Virginia's Children

Washington
Conscious Talk Radio
Northwest Health Law Advocates

West Virginia
West Virginians for Affordable Health Care

Wisconsin
IndependenceFirst
Our Lord's UMC

Wyoming
Better Wyoming

AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 26, 2023

The Honorable Brett Guthrie
Chairman
Health Subcommittee, House Committee
on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee, House Committee
on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to express our appreciation for the Subcommittee's continued interest in transparency and competition in the health care sector by holding today's legislative hearing titled "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The AAFP shares your commitment to advancing policies that promote transparency and competition, and we write to offer our policy recommendations from the family medicine perspective.

The AAFP strongly believes that all individuals have a right to access timely, high quality, and affordable essential health care services, including comprehensive primary care. Unfortunately, family physicians encounter patients who struggle to make ends meet every day, and the escalating costs of health care have led many patients to delay or forgo needed care. Rising health care costs for patients have been driven in part by increases in anticompetitive practices and consolidation, which inflate health care prices without improving quality.

Last month, the AAFP provided recommendations in advance of the Subcommittee's initial hearing on this topic. The Academy has long advocated to Congress in support of policies that will strengthen our nation's investment in primary care and improve patients' access to affordable health care. We have also supported efforts to improve the patient experience through increased transparency. Building upon our previous recommendations, we continue to urge Congress to address health care costs and consolidation by supporting payment methods that promote competition, improving administrative burden through transparency, and limiting the use of anti-competitive contracting practices that harm clinicians and patients.

Physician Payment Reform

In comments submitted to the Federal Trade Commission (FTC) this month, the AAFP highlighted the drastic increase in physician employment over the last several years, which has been propelled in part by practice and hospital consolidation. There have been at least 1,600 known hospital mergers in the United States between 1998-2017.[i] Meanwhile, a significant shift from physicians as owners of independent practice has been occurring over many years across all medical specialties. The most recent American Medical Association (AMA) Physician Practice Benchmark Survey (2020) reported that for the first time, less than half of physicians (49.1%) delivered care in independent practice (meaning organizations wholly owned by physicians) and the proportion of physicians who have an

ownership stake in their practice is shrinking as well. Just 24% of AAFP members report that they are sole or partial owners in their practice setting. The proportion of family physicians who are employed continues to grow each year with 73% of all AAFP members and 91% of new physicians (1-7 years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering that only 59% of AAFP members reported being employed in 2011.

Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates and the continuing consolidation of insurers and large health systems threatens their long-term viability. **Evidence indicates that consolidation increases health care prices and insurance premiums, as well as worsens equitable access to care for patients in rural and other medically underserved communities**.[ii,iii] Therefore, we appreciate the Committee's consideration of legislation that would require the Department of Health and Human Services (HHS) to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation. **We urge Congress to go further, however, and take tangible action to reform the current Medicare payment structure that fails to appropriately pay physicians and spurs consolidation.**

The Academy continues to recommend that Congress promote payment methods that boost competition in the marketplace and create greater choice for patients. Despite evidence indicating that additional investments in primary care would improve population health and advance health equity, primary care has been historically underfunded in the U.S. Medicare and Medicaid have historically undervalued primary care. In the short-term, inadequate payment rates mean that primary care physicians lack the resources needed to provide comprehensive, continuous care for their patients and may be forced to accept fewer Medicare or Medicaid patients, close their practices, or sell to a health system or corporation. In the long-run, payment distortions between primary and specialty care will continue to drive more physicians to go into higher paid specialties, worsening the maldistribution of the physician workforce. A recent Medicare Payment Advisory Commission (MedPAC) analysis highlighted that the median compensation remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties – underscoring concerns about the mispricing of fee schedule services and its impact on the primary care pipeline.[iv]

Medicare's current physician payment system is undermining physicians' ability to provide high quality, comprehensive care – particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. In October, the Academy submitted robust recommendations to Congress on ways to reform the Medicare Access and CHIP Reauthorization Act (MACRA) to address challenges affecting our members and their patients. Since then, both MedPAC and the Board of Trustees have raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending that Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[v]

Congress should heed these warnings. **The AAFP strongly urges Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to provide for an annual update to the Medicare Physician Fee based on the Medicare Economic Index (MEI).** This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

Additionally, the Academy strongly supports the Centers for Medicare and Medicaid Services (CMS) plan to implement a new add-on code for complex evaluation and management (E/M) visits: G2211. The G2211 code recognizes the inherent complexity of primary care office visits and provides commensurate Medicare payment. We were disappointed that Congress elected to delay implementation of that code, and **we urge Congress to support full implementation of G2211 in the CY 2024 Medicare physician fee schedule.**

The AAFP also supports site neutral payment policies that would establish payment parity across care settings and has called for an expansion of site neutrality to all on-campus and off-campus hospital-based departments, as well as other facilities. We have repeatedly urged Congress to build upon past efforts to increase site neutrality, including in our aforementioned remarks for last month's hearing. We support reducing payment differences between sites of service since it enables patients to make more informed healthcare decisions by making costs more transparent and would reduce patient cost-sharing. As such, site neutral payment encourages patient choice based on quality rather than cost. It is the AAFP's policy that patients should have reasonable freedom to select their physicians, other providers, and healthcare settings. Importantly, whenever making a choice, patients and caregivers must be well-informed on the options available and possible effects of, and responsibilities involved with, each option.

Therefore, we appreciate the Subcommittee's consideration of several discussion drafts today that would implement site neutral payment policies. The AAFP encourages Congress to continue exploring ways to advance site neutral payment policies with careful consideration so as not to further incentivize or accelerate consolidation.

Congress must also act to bolster the primary care physician pipeline by enacting Medicaid payment parity. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[vi] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Price Transparency and Administrative Burden

As acknowledged above, **the AAFP recognizes the value of transparency in health care and has long supported federal policies promoting price transparency**. These policies improve data collection and enable patients and their health care teams to compare prices across facilities and insurers. As our members seek opportunities to enter into value-based care arrangements, it is critical they have access to information on clinicians' and facilities' costs and quality performance to ensure they make informed decisions with their patients when making referrals.

The Academy appreciates and supports the Subcommittee's continued efforts to improve price transparency for patients. **However, primary care services, which are most often low-cost and high-value, are not the drivers of high, distorted health care prices.** The AAFP has repeatedly shared concerns regarding the administrative burdens imposed on primary care practices by the recently implemented good faith estimate (GFE) requirements and proposed advanced explanation of benefits (AEOB) requirements, resulting from the No Surprises Act (NSA). Congress did not intend for the NSA to impose burdensome regulatory requirements on primary care practices, which are already overwhelmed with administrative tasks. We urge Congress to ensure new price transparency reporting requirements are narrowly designed to target services and sectors that are driving price increases and do not impose burdensome new requirements on primary care practices.

One of the proposals considered during today's hearing seeks to promote transparency of common ownership interests under Parts C and D of the Medicare Program. We caution against moving forward with this legislation which may pose a similar risk once implemented.

Specifically, **the AAFP is concerned that the legislation as currently written would exacerbate already high rates of administrative burden among primary care physicians and subject them to undue reporting requirements.** Administrative burden is one of the leading causes of practice closures and physician burnout. Processes like prior authorization and step therapy already take up significant physician and staff time, with a 2022 American Medical Association survey reporting that physicians and their staff spend almost two business days each week completing prior authorizations.[vii]

The AAFP recently applauded CMS's 2024 Medicare Advantage (MA) and Part D final rule, which increases transparency of prior authorization under Medicare Advantage Plans. Instead of applying additional reporting requirements to physician practices contracting with MA plans and pharmacy benefit managers, **the AAFP strongly encourages Congress to build upon this momentum and prioritize codifying efforts to improve the transparency of and reduce overall use of prior authorization processes under Medicare Advantage plans, in addition to other insurers.** We also urge Congress to pass the Safe Step Act (H.R. 2630 / S. 652), which promotes transparency from health plans by requiring the development of a clear, transparent exception process to step therapy for patients and providers.

Finally, the AAFP supports policies such the Medical Loss Ratio (MLR) requirements on health plans offering coverage in the individual market, which requires they submit data on the proportion of premium revenues spent on clinical services and quality improvement. This helps ensure health care resources are focused on patient care rather than insurer profits or administrative expense. These federal policies have helped advance affordability and improve equitable access to comprehensive health care coverage in the individual market.

Stop Anti-Competitive Contracting Practices that Harm Clinicians and Patients

Congress should also prohibit the use of noncompete agreements in physician contracts. Noncompete agreements in health care impede patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, and stifle competition. Despite projected physician shortages, many health care employers still intentionally restrict physician mobility and workforce participation via noncompete agreements.

Currently, noncompete agreements are enforced through a patchwork of state laws. Twelve states deem noncompete agreements unenforceable and against public policy; however public awareness of these laws remains low, and employers still intimidate employees with the threat of legal action. Thirty-eight states allow noncompete agreements in some form, judging enforceability on factors including job type, legitimacy of business interests, and reasonableness of duration, scope, and distance. Family physicians from across the country have expressed deep concerns about how noncompete agreements are forcing them to remain in undesirable employment situations which harm their financial and mental health or abandon their patients and travel long-distances or uproot their families to practice in a new geographic area. **The AAFP urges Congress to pass legislation to ban noncompete clauses in physician employment contracts to ensure patients have access to their physicians and to allow physicians to freely practice medicine in their communities.**

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with the Subcommittee on policies that support primary care physicians and their patients through improved transparency and competition. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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[i] Gaynor, M. What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work, Policy Proposal No. 2020–10, The Hamilton Project.
[ii] Yerramilli P, May FP, Kerry VB. Reducing Health Disparities Requires Financing People-Centered Primary Care. JAMA Health Forum. 2021;2(2):e201573. Available at: https://jamanetwork.com/journals/jama-health-forum/articleabstract/2776056
[iii] O'Hanlon CE, et al. Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation. December 2019. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00918
[iv] Medicare Payment Advisory Commission. (2021, March). Chapter 4 -Physician and other health professional services. Retrieved February 10, 2023, from https://www.medpac.gov/wpcontent/uploads/2021/10/mar21_medpac_report_ch4_sec.pdf.
[v] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed April 6, 2023: https://www.cms.gov/oact/tr/2023
[vi] 7 Zuckerman, S., Skopec, L., & Aarons, J. (2021, February 01). Medicaid physician fees remained substantially Below fees paid by Medicare in 2019. Retrieved February 9, 2023, from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611.
[vii] American Medical Association, "2022 AMA prior authorization (PA) physician survey." Accessed April 22, 2023. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

The Disability and Aging Collaborative &

April 20, 2023

The Honorable Chuck Schumer
Majority Leader
U.S. Senate
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, DC 20515

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leaders Schumer and McConnell, Speaker McCarthy and Leader Jeffries,

The undersigned member organizations of the Consortium for Constituents with Disabilities (CCD), and the Disability and Aging Collaborative (DAC), and other state and national organizations write to urge you to exclude Medicaid cuts or changes that limit funding or eligibility from any debt ceiling and budget negotiations and legislation. People with disabilities, older adults, family caregivers and their children, direct care workers, and other low-income individuals and families need more, not less investment in this essential health care program.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance. The Disability and Aging Collaborative (DAC) is a coalition of approximately 40

national organizations that work together to advance long-term services and support policy at the federal level. Formed in 2009, the DAC was one of the first coordinated efforts to bring together disability, aging, and labor organizations. Together we have been pushing to protect and strengthen Medicaid, which is why we are deeply concerned with proposals that include Medicaid per capita caps and work requirements.

Any funding cuts, caps, or changes that limit eligibility for the Medicaid program threaten the longstanding Medicaid guarantee for people with disabilities, older adults and their families. Medicaid is already lean and efficient, with provider payment rates significantly lower than Medicare or private insurance. The pandemic only stretched those resources thinner. Any change in federal funding will force states to cut services and eligibility. People will lose care and supports that keep them healthy and independent. Cutting Medicaid would amount to negotiating against the health and wellbeing of people with disabilities, older adults, and other low-income people and families. For many people with disabilities and older adults, accessing timely needed care is a life or death matter.

Federal Funding Caps Harm People with Disabilities and Older Adults

For example, imposing per capita caps on Medicaid spending would have devastating consequences for low-income older adults and people with disabilities:

- Care for nursing facility residents - two-thirds of whom rely on Medicaid - would be jeopardized;
- Since coverage for home and community-based services is optional under Medicaid, care for the over 7 million recipients would be at particular risk;
- Future Medicaid cuts would be far easier to make, by simply dialing down or freezing federal spending growth rates from year to year;
- Perverse incentives would be created for states to cut services for people with the highest cost needs - primarily older adults and people with disabilities who need long-term services and supports;

Additionally, the cuts that would inevitably result from these arbitrary spending limits would result in significant job losses, reduced wages and lower economic growth. Federal cuts in Medicaid would strongly affect the financial viability of rural hospitals, while states with higher than average growth rates or lower spending per person would be unfairly penalized.

Work Requirements Don’t Work

The letter that Speaker McCarthy sent to President Biden laid out another troubling proposal, Medicaid work requirements. Work requirements are ineffective and unfairly punitive. Work requirements take away coverage from people who are eligible for Medicaid and often have no other insurance options, including people with disabilities, older adults, and their caregivers. Such requirements do not accommodate the needs of individual Medicaid beneficiaries, with and without disabilities, and misplace resources that could be used to provide additional services, create new job opportunities, improve access to affordable child care, or increase

funding for job training, employer accommodations, or other employment supports. It would add undue bureaucratic burdens to all beneficiaries.

We oppose any work requirements because they will result in hundreds of thousands of low income Americans, including people with disabilities and family caregivers, losing access to Medicaid services. Work requirements create barriers to Medicaid coverage and are justified by using false stereotypes about people who live in poverty lacking incentive to work. In fact, nearly four in five adults enrolled in Medicaid who are not receiving disability benefits already live in families with at least one worker.

Those adults not doing paid work are mostly either caregivers, students, or persons with chronic conditions or disabilities (who might either be temporarily unable to work or require supportive services to find and keep a job). In all, fewer than one in ten of this population of adult Medicaid beneficiaries cited some other reason for not working. This data suggests that the impact of the policy will not be to boost employment, but rather to slim the Medicaid rolls by adding more paperwork. It certainly shows that adding administrative burdens for all adult Medicaid enrollees and for states is costly and misguided.[1]

It may seem simple to assert that "people with disabilities and caregivers will be exempt," but converting such a statement into an effective policy process is complicated, expensive, and fundamentally flawed.[2] Identifying exactly what qualifies as a disability, ensuring that people know how to request an exemption, and creating an accessible pathway to receive such an exemption has proven both misguided and unworkable.

Access to health care coverage is a matter of life, death, and independence for millions of Americans with disabilities, older adults, and their families and friends.

CCD and DAC strongly oppose per capita caps, work requirements, and other cuts to the Medicaid program. We will oppose them in every form. It is never acceptable to cut services for low income individuals with disabilities, adults, older Americans, and children, including in debt ceiling or budget negotiations. If you have any questions, contact DAC and CCD LTSS co-chair Nicole Jorwic, nicole@caringacross.org.

Sincerely,

ACA Consumer Advocacy
Agency on Aging / Area 4

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[1] Jennifer Wagner & Judith Solomon, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligibile Beneficiaries*, (2018), https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible.

[2] Kali Grant et al., *Unworkable & Unwise: Conditioning Access to Programs that Ensure a Basic Foundation for Families on Work Requirements*, 43 (2019), https://www.georgetownpoverty.org/wp-content/uploads/2019/02/Unworkable-Unwise-20190201.pdf.

Allies for Independence
AltaMed Health Services
American Association of People with Disabilities
American Association on Health and Disability
American Muslim Health Professionals
American Network of Community Options and Resources (ANCOR)
American Speech-Language-Hearing Association
Andrew County Ministries, Inc RSVP
APIAHF
Area Agency on Aging District 7 (Ohio)
Assistive Technology Law Center
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Maternal & Child Health Programs
Association of People Supporting Employment First (APSE)
Autism Society of America
Autistic People of Color Fund
Autistic Self Advocacy Network
Autistic Women & Nonbinary Network
Bazelon Center for Mental Health Law
Bread for the City
Bubble Land Child Care
California Advocates for Nursing Home Reform
California Foundation for Independent Living Centers (CFILC)
Caring Across Generations
Care in Action
Care Weavers - Patient Care Advocates
Center for Medicare Advocacy
CenterLink: The Community of LGBTQ Centers
Central Arizona Shelter Services
Charlotte Center for Legal Advocacy
Choice in Aging
Christopher & Dana Reeve Foundation
City of Wauwatosa
Colorado Center on Law and Policy
Colorado Consumer Health Initiative
CommunicationFIRST
Communities Actively Living Independent & Free
Community Access and Disability Center
Community Cataylst
Consumer Directed Action of New York
Crohn's & Colitis Foundation
Detroit Disability Power
Disability Law Center
Disability Law Center (MA)

Disability Law Center of Utah
Disability Law Colorado
Disability Policy Consortium
Disability Rights & Resources
Disability Rights Education and Defense Fund (DREDF)
Disability Rights Florida
Disability Rights Michigan
Disability Rights North Carolina
Disability Rights South Carolina
Disability Rights Texas
Disability Rights Wisconsin
Disciples Center for Public Witness (Disciples of Christ)
Diverse Elders Coalition
Economic Opportunity Institute
Empowered Aging of Contra Costa County
Encuentro
Epilepsy Foundation
Equal Rights Advocates
EverThrive Illinois
Families USA
Family Voices
Georgia Equality
GO2 for Lung Cancer
Golden State Opportunity
Hand in Hand: The Domestic Employers Network
Hoosier Action
Indiana Disability Rights
Indivisible Marin
Iowa Citizens for Community Improvement
IRRC
Jewish Family Services, Inc.
Jewish Federations of North America
Justice in Aging
JusticePoint, Inc.
Lakeland Park Service Coordinator
Lakeshore Foundation
Legal Action Center
Leslie Fenninger
LifeLong Medical Care, Inc.
LifeTime Resources, Inc.
Little Lobbyists
Lutheran Services in America
Maine Equal Justice
Medicare Rights Center

Mental Health Hookup
Mercer County Senior Citizen Center
MKE MENTAL HEALTH TASK FORCE
MomsRising
Muscular Dystrophy Association
National Academy of Elder Law Attorneys
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Council on Independent Living
National Disability Rights Network(NDRN)
National Domestic Workers Alliance
National Employment Law Project
National Health Law Program
NATIONAL INDIAN COUNCIL ON AGING
National PACE Association
National Partnership for Women & Families
National Respite Coalition
National Viral Hepatitis Roundtable (NVHR)
National Women's Law Center
Network Lobby for Catholic Social Justice
New Disabled South
New Disabled South Rising
New York Legal Assistance Group (NYLAG)
New York State Association of Resident Service Coordinators
North Dakota Protection & Advocacy Project
North Seattle Progressives
Northwest Harvest
Nourish California
NYAPRS.org
Our Mother's Voice
Pathfinders Milwaukee, Inc.
People's Action
PRC
Progressive Democrats of America (PDA)
Project Guardianship
Protect Our Care
Public Citizen
Public Justice Center
Senior Advocacy Network
Senior Advocates of the Desert

Senior Citizens' Law Office
Senior Staff Attorney, Greater Boston Legal Services
Service Employees International Union (SEIU)
SHIP
Sirona Recovery, Inc.
Sojourners
South Carolina Appleseed Legal Justice Center
Special Needs Alliance
Sunny Cal ADHC
TASH
Tasha Yorey Enterprises
Tennessee Justice Center
The Arc of New Mexico
The Arc of the United States
The Arc of Washington State
The Center for Disability Empowerment
The Children's Partnership
The Commonwealth Institute for Fiscal Analysis
The Difference Principle, Inc.
The Kelsey
The Myalgic Encephalomyelitis Action Network
Union for Reform Judaism
United Church of Christ Justice and Local Church Ministries
Virginia Poverty Law Center
VOYCE
Washington Anti-Hunger & Nutrition Coalition
Washtenaw Association for Community Advocacy (ACA)
Well Spouse Association
WI Department of Corrections

30 Patient Organizations Oppose Legislation Threatening Healthcare for Millions of Patients

WASHINGTON, D.C. (April 24, 2023) – This week, the House of Representatives is expected to consider legislation that would add so-called "work requirements" to the Medicaid program. Due to the disastrous impact this would have on access to Medicaid, which provides coverage for almost a hundred million individuals, 30 patient advocacy organizations released the following statement, urging lawmakers to vote no:

"Our organizations strongly oppose legislation adding a work, or community engagement, requirement policy to the Medicaid program. This legislation is a clear attack on access to quality and affordable healthcare with particularly devastating consequences for patients with serious, acute and chronic illnesses. We urge Congress to reject this bill.

"To be clear: these requirements are not about work, they are about paperwork, and otherwise-eligible patients will lose coverage when they get caught up in this bureaucratic red tape. In 2018, Arkansas imposed this paperwork requirement on people enrolled in Medicaid. Before a federal court halted the state's efforts, more than 18,000 individuals who were otherwise eligible for Medicaid lost their healthcare in just seven months due to onerous paperwork requirements and additional bureaucracy. The coverage losses would be even more severe on a national scale, applying to individuals enrolled in both traditional Medicaid and Medicaid expansion.

“The ‘exemptions’ in this legislation are wholly insufficient to protect patients. The criteria in the House legislation are even narrower and more extreme than those used in Arkansas: more older adults are included and people who are medically frail would need a medical professional to verify an exemption. The intricacies of deciding who is and is not able to work is outside of the scope of most medical providers and can be very complex decisions. Additionally, exemption processes inherently create opportunities for administrative errors that jeopardize patients’ access to care. No exemption criteria can circumvent this problem and the serious risk to the coverage and health of the people we represent.

“The House legislation impacts all Medicaid eligibility groups and places an enormous administrative burden on state Medicaid programs at a time when they are already restarting redeterminations for the first time since 2020. By eliminating the federal match for individuals not in compliance, the legislation leaves no doubt that states would take away coverage from millions of individuals and result in significantly worsened health outcomes.

“Our organizations strongly oppose this bill due to the devastating impact it would have on health coverage and urge members to vote no on this and any other legislation that jeopardizes access to Medicaid.”

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American Cancer Society Cancer Action Network
American Kidney Fund
American Lung Association
ALS Association
Asthma and Allergy Foundation of America
Cancer Support Community
CancerCare
Chronic Disease Coalition
Crohn's & Colitis Foundation
Epilepsy Foundation
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Lupus Foundation of America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association`
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart

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American College of Obstetricians and Gynecologists: Kate Connors | kconnors@acog.org

American College of Physicians: Jackie Blaser | jblaser@acponline.org

American Osteopathic Association: Brooke Johnson | pr@osteopathic.org

American Psychiatric Association: Erin Connors | econnors@psych.org

America's Leading Physician Groups Oppose Medicaid Work Requirements

Washington, D.C. (April 24, 2023) – Our organizations, representing nearly 600,000 physicians and medical students, firmly oppose any legislation seeking to implement Medicaid work requirements. Mandating work requirements for Medicaid beneficiaries does not promote the objectives of the Medicaid program. The experiences of states that have previously implemented work requirements have demonstrated that work requirements do not improve employment rates, but can lead to higher program administrative costs for states, increased medical debt for patients, and barriers to care.

Our organizations have a long history of supporting evidence-based policies that promote access to affordable health care and standing against those that impose burdensome, unsubstantiated Medicaid eligibility restrictions and would likely result in massive coverage losses for beneficiaries. Any proposals to impose punitive requirements run counter to the core tenets of Medicaid and our responsibility as physicians: improving equitable access to high-quality health care.

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About the American Academy of Family Physicians
Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical

specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine, the AAFP's positions on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit www.aafp.org/media. For information about health care, health conditions and wellness, please visit the AAFP's award-winning consumer website, www.familydoctor.org.

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds.

About the American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary, nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing patients and their families and communities. www.acog.org.

About the American College of Physicians

The American College of Physicians is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. ACP membership includes 160,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Follow ACP on Twitter, Instagram, and Facebook.

About the American Osteopathic Association

The American Osteopathic Association (AOA) represents more than 178,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; and is the accrediting agency for osteopathic medical schools. To learn more about DOs and the osteopathic philosophy of medicine, visit www.osteopathic.org.

About the American Psychiatric Association

The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 38,000 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.

NEWS

Statement of ACAP CEO Margaret A. Murray on Work Requirements and Medicaid

FOR IMMEDIATE RELEASE: April 19, 2023

FOR MORE INFORMATION: Jeff Van Ness, 202-204-7515; **jvanness@communityplans.net**

STATEMENT OF ACAP CEO MARGARET A. MURRAY ON WORK REQUIREMENTS AND MEDICAID

WASHINGTON—Margaret A. Murray, CEO of the Association for Community Affiliated Plans (ACAP), issued the following statement shortly after release of the *Limit Save Grow Act of 2023,* which proposes to make Medicaid coverage for some adults conditional on the fulfillment of work requirements:

"Nearly two-thirds of adults enrolled in Medicaid already work. Medicaid helps people who work stay on the job. In fact, a **survey of people covered by Medicaid in Michigan** found that people who had Medicaid coverage were better able to get a job—and keep it.

"States will be hard-pressed to implement extensive new requirements on beneficiaries at a time when Medicaid agencies are striving to redetermine eligibility and preserve coverage for millions of people as pandemic-era Medicaid eligibility protections come to an end.

"We are also concerned that work requirements will exacerbate 'churn,' where people who meet the eligibility requirements for Medicaid are disenrolled owing to paperwork and administrative burdens. Reducing or eliminating health care coverage would impose financial stress on families, limit access to the care they need, and run the risk of denying coverage to people who are Medicaid-eligible."

About ACAP:

ACAP represents 79 health plans, which collectively provide health coverage to more than 25 million people. Safety Net Health Plans serve their members through Medicaid, Medicare, the Children's Health Insurance Program (CHIP), the Marketplace and other publicly sponsored health programs. For more information, visit **www.communityplans.net**.

# # #

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April 21, 2023

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Hybrid Workforce

April 20, 2023

Charles N. Kahn III
President and CEO

April 25, 2023

The Honorable Brett Guthrie
Chair
Health Subcommittee
House Energy and Commerce Committee
2434 Rayburn House Office Building
Washington, DC 20215

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee
House Energy and Commerce Committee
272 Cannon House Office Building
Washington, DC 20215

Dear Chairman Guthrie and Ranking Member Eshoo,

The Federation of American Hospitals (FAH) submits the following Statement for the Record in advance of the House Energy and Commerce Health Subcommittee's hearing on "*Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care.*" The FAH is deeply concerned with several legislative proposals being considered and how their enactment would ultimately amount to significant cuts to Medicare and thereby patient access to care.

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.

We welcome the opportunity to work with the Energy and Commerce Committee to find solutions that will reduce health care costs without compromising access to care for patients, and we appreciate the opportunity to provide input on these key issues. This statement reflects our initial reactions to the legislative proposals and discussion drafts as released. We look forward to a continued dialogue with the Committee after the hearing.

Legislative Proposals Under Consideration by the E&C Health Subcommittee:

Eliminating the Current Ban on Self-Referral to Physician-Owned Hospitals (POH): *The FAH Strongly Opposes H.R. 977, The Patient Access to Higher Quality Health Care Act of 2023*

To help achieve the important goal of lowering health care costs, it is important that Congress continue to reject efforts by those who seek to weaken the Stark Law ban on self-referral to POHs. Such arrangements are mired in conflicts of interest, and years of independent data show such arrangements result in over-utilization of Medicare services at significant cost to patients and the Medicare program.

There is a substantial history of Congressional policy development and underlying research on the impact of self-referral to POHs. 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, excessive utilization of care, and patient safety concerns. The standing policy includes more than a decade of work by Congress, involving numerous hearings, as well as analyses by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC).

In 2010, Congress acted to protect the Medicare and Medicaid programs and the taxpayers that fund them by imposing a prospective ban on self-referral to new POHs. The FAH strongly believes that the foundation for the current law must not be weakened. It is noteworthy that Congressional Budget Office scoring of proposals to modify existing law consistently demonstrates that self-referral to POHs increases utilization, which increases Medicare costs and health care costs generally.

The law helps ensure that full-service community hospitals can continue to meet their mission to provide quality care to all the patients in their communities. Data from the health care consulting firm Dobson | DaVanzo, released last month[1], shows that POHs, when compared to other hospitals, treat less medically complex and more financially lucrative patients, provide fewer emergency services, and treat fewer COVID-19 cases. Specifically, the new study shows that:

- POHs cherry-pick patients by avoiding Medicaid beneficiaries and uninsured patients;
- POHs treat fewer medically complex cases;
- POHs enjoy patient care margins 15 times those of community hospitals;
- POHs provide fewer emergency services—an essential community benefit; and
- POHs, despite their claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.

[1] Dobson | DaVanzo Study: https://www.fah.org/wp-content/uploads/2023/03/2023-Fact-Sheet_20230323_wAppendixandCharts_POH-vs.-NonPOH-Only.pdf

The new data reinforces many of the findings of earlier studies by the HHS OIG, GAO, and MedPAC, among others, documenting the conflicts of interest inherent with POHs that led to the Congressional ban in 2010.

CMS itself recently proposed to reimpose "program integrity restrictions" on POH expansion criteria to guard against "a significant risk of program or patient abuse," and to "protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking."[2]

Thus, maintaining current law is key to 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 expanding the very behaviors that Congress successfully has deterred for more than a decade.[3]

Cutting Medicare Through Site-Neutral Payment Cuts: ***The FAH Strongly Opposes Site-Neutral Payment Cut Legislative Proposals***

The FAH strongly opposes the three Site-Neutral Payment Policy proposals that would reduce hospital-based outpatient department (HOPD) payments in a non-budget-neutral manner.

Site-neutral payments do not consider one simple fact: hospitals and doctors' offices are not the same. Hospitals provide critical services to entire communities, including 24/7 access to emergency care and disaster relief. They need to maintain the ability to treat high acuity patients who require more intense care, and therefore require a different payment structure. Hospital-affiliated sites offer patients more integrated care across health care settings, services for which hospitals need to be properly reimbursed to maintain coordinated, high-quality care for patients.[4]

Increasingly, care is shifting from the inpatient to outpatient settings, meaning that patients now seen in HOPDs may require a higher level of care than traditionally offered – or even available – in a physician's office.

A recently released study from the American Hospital Association (AHA) backs up this fact. [5] Researchers found that HOPDs treat more underserved populations and sicker, more complex patients than other ambulatory care sites. The study indicates that relative to patients seen in independent physician offices and ambulatory surgical centers, Medicare patients seen in hospital outpatient departments tend to be:

- Lower-income;
- Non-white;

[2] FAH Blog on POH. April 24, 2023: https://www.fah.org/blog/physician-owned-hospitals-are-bad-for-patients-and-communities/
[3] FAH Blog on POH: March 28, 2023. https://www.fah.org/blog/new-analysis-reaffirms-need-to-maintain-current-law-banning-self-referral-to-physician-owned-hospitals/?swcfpc=1
[4] FAH Blog on Site Neutral: April 23, 2023. https://www.fah.org/blog/stronguwhats-in-a-name-because-there-is-nothing-neutral-about-site-neutral-policyustrong/
[5] AHA Report: https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristics-report

- Eligible for Medicare based on disability and/or end-stage renal disease;
- More severe comorbidities or complications;
- Dually-eligible for Medicare and Medicaid; and
- Previously seen in an emergency department or hospital setting.

It is vital that reimbursement for outpatient services provided in a HOPD reflects the higher overhead costs associated with providing care in that setting.

Additionally, regulatory requirements such as the Emergency Medical Treatment and Labor Act (EMTALA), hospital Conditions of Participation, hospital state licensure, and complex cost reports impose substantial resource and cost burdens that physician offices and ambulatory surgical centers do not have and therefore are not reflected in their payments.

Eliminating Medicaid DSH Cuts: ***The FAH Strongly Supports H.R. 2665, The Supporting Safety Net Hospitals Act***

The FAH appreciates the inclusion of *H.R. 2665, The Supporting Safety Net Hospitals Act*, which eliminates the scheduled Medicaid DSH cuts for 2024 and 2025. Medicaid patients need to know hospitals will be there when they need care. This legislation is vital for ensuring access to quality care for our most vulnerable patients and safeguarding the essential hospitals that serve them.

Increasing Transparency of Medicare Part C and D Plans: ***The FAH Supports Proposals to Increase Transparency of Health Plan Prior Authorization Practices that Delay and Deny Needed Patient Care***

The FAH appreciates the Committee's efforts to highlight the importance of transparency in Medicare Advantage (MA) plan practices that can limit and deny patient care. We have raised serious concerns about prior authorization practices of MA plans and how they systemically apply problematic operating policies, procedures and protocols that limit care to Medicare beneficiaries and prevent them from receiving the same services they would under traditional Medicare fee-for-service.

MA practices can become a health risk for patients if inefficiencies in the process cause care to be delayed, create significant burdens and costs on hospitals and providers, and can be a major source of burnout for health caregivers. In particular, our members experience difficulty determining payer-specific requirements for items and services that require prior authorization; inefficient use of provider and staff time processing prior authorization requests and information (sending and receiving) through fax, telephone, and web portals; and unpredictable wait times to receive payer decisions. In short, prior authorization is a burdensome process that diverts provider resources away from patient care, increases health care costs, and, at worst, may prompt patients to delay or forego needed care.

We believe that publicly available data reported to CMS would aid interested providers and patients to generally understand payer performance with respect to prior authorization processes for decisions, approvals, denials, and appeals. This data could be used to create

understandable quality metrics, as proposed by the FAH, and help Medicare beneficiaries select MA plans not just based on cost, but on whether MA plan practices delay or even deny needed patient care.

Hospital Price Transparency Compliance: ***The FAH Appreciates the Committee's Efforts in Highlighting the Importance of Price Transparency***

The FAH appreciates the Committee's efforts in highlighting the importance of price transparency, especially focusing on all stakeholders in the health care industry. The FAH believes that all individuals deserve transparent, meaningful and easy to understand information, especially about their cost sharing responsibility, so they can make more informed decisions regarding their health care.

Our hospitals are committed to being compliant with the CMS Hospital Price Transparency Rule and are supportive of the Committee's efforts to highlight the importance of patients knowing how much their care will cost before they receive it.

It has been falsely reported by some based on questionable reviews that hospitals are avoiding complying, sometimes intentionally, with the Hospital Price Transparency Rule. The truth is that in early 2023, CMS released a report that found that 70% of hospitals complied with both components of the regulation, including the consumer-friendly display of shoppable services information, as well as the machine-readable file requirements in 2022.[6] 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). With this significant increase in compliance in just one year, significant progress has been, and will continue to be made, in complying with the important but challenging requirements.

Turquoise Health – whose Co-Founder & Chief Executive Officer Chris Severn provided testimony at the Subcommittee's March 28th hearing – recently released a new state-of-the-industry report outlining major strides in price transparency in the health care sector.

Nearly 5,400 hospitals, or 84% of the roughly 6,400 applicable hospitals, have posted a machine-readable file with pricing data as of the end of Q1 2023, according to Turquoise Health.[7] Those numbers are up from the company's fall numbers, which listed about 4,900 (76%) hospitals with a machine-readable file, nearly 4,200 (65%) with negotiated rates and almost 4,100 (63%) with cash rates.

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[6] "Hospital Price Transparency: Progress And Commitment To Achieving Its Potential", Health Affairs Forefront, February 14, 2023. https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential

[7] Turquoise Health: Price Transparency Impact Report Q1 of 2023: https://s3.amazonaws.com/turquoise-app.user-uploads/impact_reports/Turquoise_Health_Impact_Report_Q1_2023.pdf?AWSAccessKeyId=AKIAQZAEKZBJGIFVBXVJ&Signature=ChpNNgBt07xjECtH%2F2YksOKg15U%3D&Expires=1682194899

Thus, hospitals and health systems remain committed to working with CMS to implement these policies and deliver reliable and usable pricing information to patients.

Phase-out of the Medicare Inpatient-Only (IPO) List: ***The FAH Supports Current Approach by CMS to Evaluate Services to Include on Medicare's IPO List to Ensure Medicare Beneficiary Care is Safe and Effective***

The FAH opposes proposals to arbitrarily eliminate the IPO list or procedures on the IPO list, which designates those procedures that are not payable under the OPPS because they can only be appropriately provided on an inpatient basis. The assignment of procedures to the IPO list considers key clinical considerations that preclude the procedure from being provided to Medicare beneficiaries on an outpatient basis: (1) the invasive nature of the procedure, (2) the need for postoperative care, and (3) the underlying physical condition of the patient who would require the surgery. The IPO list serves as an important programmatic safeguard, ensuring that Medicare beneficiaries undergoing any of the 1,740 procedures on the IPO list receive inpatient care and monitoring, and its proposed elimination without any supporting clinical analysis arbitrarily removes an important patient safety mechanism. In addition, eliminating the list imposes administrative burdens on physicians and hospitals, increases beneficiaries' financial burden, and erodes the value of Part A coverage.

Instead, the FAH strongly supports the case-by-case evaluation by CMS of procedures against longstanding clinical criteria for removal.

****

The FAH is committed to working with Congress to ensure the availability of affordable, accessible health care for all Americans. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR THE RECORD

U.S. HOUSE OF REPRESENTATIVES

ENERGY AND COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH

HEARING ON:

"LOWERING UNAFFORDABLE COSTS: LEGISLATIVE SOLUTIONS TO INCREASE TRANSPARENCY AND COMPETITION IN HEALTH CARE"

The Partnership for Employer-Sponsored Coverage (P4ESC) commends the Subcommittee on Health for holding this hearing on lowering health care costs for working Americans and their families by increasing transparency and competition. Helping make coverage more affordable is at the core of P4ESC's mission.

P4ESC is a nonpartisan advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and sectors, and the millions of Americans and their families who rely on employer-sponsored coverage every day. Employer-sponsored health coverage is the single largest source of coverage in our nation.

P4ESC and employers strongly support greater transparency in health care. Not only do health care consumers need more comparative health care information (and the means to easily understand and put that information to good use) but employers are frequently tasked with producing benefits information not within our actual control. Greater transparency can help serve both needs. However, we caution that transparency alone is not enough.

P4ESC and businesses of all sizes long have been concerned by health sector consolidation and limited access to certain provider groups. The growth of private equity involvement in health care has helped to fuel consolidation. Increased consolidation dampens competition to the detriment of health care consumers. Consolidation in health care is increasing medical costs for employees and employers. Congress should encourage the FTC to examine consolidation of hospitals and physician practices by private equity more closely and continue oversight on its progress.

Employer-based coverage has been stressed by cost pressures and crises such as the COVID-19 pandemic, which tested the link between work and health care benefits. However, the number of Americans with employer-provided coverage fell only 1-2 percent despite the unemployment rate peaking at over 14 percent in 2020, according to the Commonwealth Fund. Employer-based insurance can and should continue to be the foundation of our nation's coverage.

Partnership for Employer-Sponsored Coverage | 999 E Street, NW, Washington, DC 20004
neil@trautweinstrategies.com | 703.517.3692 | www.p4esc.org | @P4ESC

The fiscal viability and rising cost of our nation's health care system have long been debated, even before the COVID pandemic. Though many proposals have sought to address the ***demand side*** of health care spending by discouraging utilization, the better approach would be to address the ***supply side*** of health care spending. The rising cost of hospitalizations and prescription drugs are unsustainable in the long-run, and are a major factor driving the increase in cost of employer plans. We urge Congress to address the supply side of health care spending.

Rising health care costs are the greatest challenge in employer-sponsored health coverage. Small business owners have cited this as a leading challenge for more than 30 years.[1] Medical care from doctors, hospitals, and other medical providers is too expensive as are prescription drugs and biologics. P4ESC strongly supports greater congressional oversight of the Federal Trade Commission (FTC) review of hospital and physician practice consolidation with emphasis on the growth of private equity acquisition of hospitals and physician practices. P4ESC also supports building on site-neutral rules to deter location-based gaming of coverage (e.g., the *Transparency of Hospital Billing Act*). Greater oversight of the high cost of medical care is long overdue.

The present and growing cost of pharmaceutical and biological therapies is as much a threat to employer-sponsored coverage as it is essential to modern health care. Pharmaceutical manufacturers, Pharmacy Benefit Managers (PBMs), and others are wrapped up in a convoluted and mutually dependent web that adds needless cost to coverage. Greater transparency of the pharmaceutical supply chain has helped to a degree, but the market has ultimately proven to be an insufficient governor of supply and cost. Additional steps to improve transparency and greater oversight and regulation of the pharmaceutical supply chain are needed. We also urge Congress to investigate the current patent approval process and the apparent gaming of patents by incremental changes to extend patent exclusivity.

Conclusion

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage appreciates the opportunity to provide these comments to members of the Subcommittee. P4ESC represents employers across the spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a significant stake in developing and implementing health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout the 118th Congress. If you or your staff would like to meet to discuss the issues raised in our statement, please have your staff contact P4ESC's Executive Director Neil Trautwein at neil@trautweinstrategies.com.

[1] National Federation of Independent Business, www.nfib.org

April 25, 2023

The Honorable Charles E. Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem S. Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leader Schumer, Leader McConnell, Speaker McCarthy, and Leader Jeffries,

For decades, skyrocketing health care costs have put a squeeze on families' budgets and created a downward pressure on wages and income. Rising prices for health care are putting a larger than ever burden on consumers, employers, and state and federal taxpayers.

A new national survey shows an overwhelming majority of voters (94%) across the political spectrum believe it's important for Congress to take action to address high health care prices in the next two years. Similarly, voters on both sides of the aisle broadly support a wide range of policies to lower hospital prices. The findings show a large majority of voters (74%) are more concerned that Congress won't do enough to limit high prices—not that policymakers will go too far. This research underscores the frustrations voters have with health care affordability and highlights the bipartisan demand for more aggressive federal action to lower prices.

We are a non-partisan group of organizations that represent consumers, businesses, purchasers, and physicians who are working together to make high-quality health care more affordable. We promote action to protect consumers and employers from predatory pricing, and advance policies that prevent powerful health systems from engaging in business tactics that stifle competition and lead to higher prices. We believe that making health care more affordable for consumers, employers, and taxpayers is an economic and societal imperative.

Our work is centered around the following four principles:

1. **Making health care more affordable for consumers, employers, and taxpayers is an economic and societal imperative.** To do this, we must address the central driver of high health care costs for the privately insured—the high prices being charged for care—by increasing choices for consumers and purchasers, and limiting anti-competitive behavior to lower prices.

2. **Market failures must be directly addressed.** There is insufficient competition on price and quality in many health care markets where provider markets are highly consolidated. Dominant providers and health systems have the ability to demand high prices, and there is an imbalance in the information available to consumers. It is essential that action is taken where markets have failed to restore and increase competition and to lower prices.

3. **We need more complete and transparent information on pricing.** In order for families, purchasers, and policymakers to understand and fix the problem of high health care prices with common-sense solutions that work, we need more complete and transparent information on price, quality, and other aspects of our health care system.

4. **We must address high health care prices in a way that directs resources where they are most needed across the health care system.** A comprehensive solution to address high health care costs must ultimately create a more accessible, equitable, and sustainable system that provides high-quality affordable care.

While there are several drivers that contribute to high prices, we hope to continue to shine a light on some of the most egregious behaviors and practices that are increasing costs for patients, purchasers, and taxpayers. We know that policymakers and consumers need more complete and transparent information on prices, quality, and other aspects of our health care system to better understand and fix the pricing problem with solutions that work. We welcome the opportunity to share future related research and stand ready to partner with you to put affordable, equitable, and high-quality health care at the center of your legislative efforts.

Sincerely,

American Academy of Family Physicians

American Benefits Council

Arnold Ventures

Blue Cross Blue Shield Association

The ERISA Industry Committee

Families USA

Purchaser Business Group on Health

Small Business Majority

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Comments for the record from U.S. PIRG
House Energy & Commerce Committee, Subcommittee on Health hearing
"Lowering Unaffordable Costs: Legislative Solutions To Increase Transparency And Competition In Health Care"

Submitted by
Patricia Kelmar, U.S. PIRG Senior Director, Health Care Campaigns
April 26, 2023

Chairman Guthrie, Ranking member Eshoo and members of the subcommittee,

U.S. PIRG is pleased to offer these comments for the record on the issue of affordability in health care and how high prices of health services impact families ability to use and access high value health care.

U.S. PIRG, the Public Interest Research Group, with our state PIRG affiliates, works to promote policies that advance high value health care. Our health care dollars should be spent effectively to achieve high quality outcomes. We are aligned in a common mission today to identify the best solutions to the high prices that we are paying in today's health markets. We know we can do better to bring costs down while achieving better individual care and improving population health.

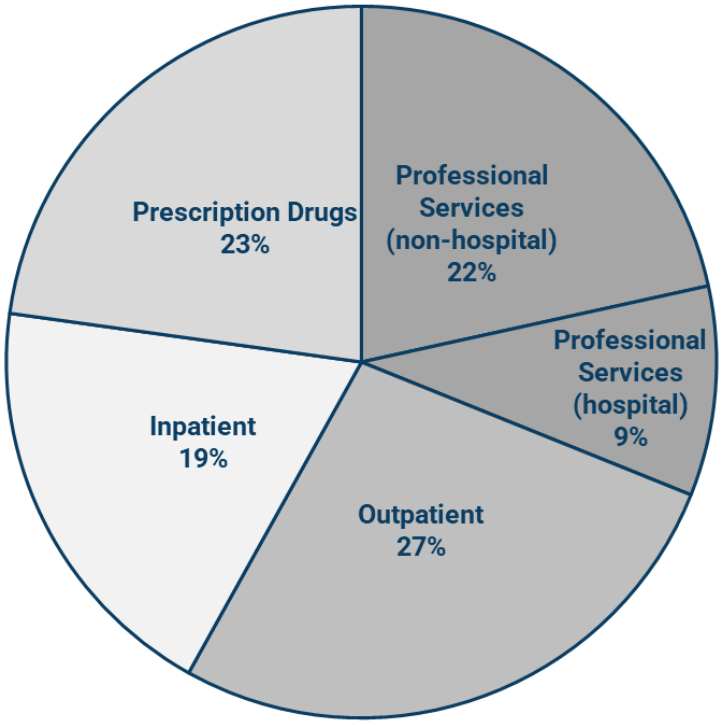
Every week I interact with members of the public who contact us, usually in their attempt to solve a difficult medical billing problem. For example, David, an engineer, and Christy, an IT analyst, reached out to share their experience with the birth of their first child last fall. Little Theo arrived early and was having difficulty breathing. The doctors at their local hospital recommended specialist care at a nearby children's hospital to properly diagnose and treat their baby. Theo was transferred by ambulance to that hospital 16 miles away. There he was diagnosed with multiple heart and lung diseases and in his two week stay he received the care that allowed him to go home with his family. Weeks later, David and Christy received a 7,000 bill from the ambulance company. Their insurance company covered $1,000 of it. The couple was shocked to learn it was their responsibility to pay the

remaining $6,000. They didn't understand why they still owed this amount, when they had already paid their deductible and their out of pocket maximum. The problem arose because it was an out-of-network ambulance that transported Theo to the specialists. Dave and Christy had received the "balance bill" for the amount not covered by the health plan. Over the following weeks, they tried negotiating with the health plan and the ambulance company to lower the surprise billing amount. Unsuccessful, they set up a 30 month payment plan to pay off the $6,000. Theo will be nearly three by the time that debt is paid off.

Circumstances just like this can set families back for years, struggling to pay for expensive medical bills that they can't control or negotiate.

Health care prices are driving our national health care spending.

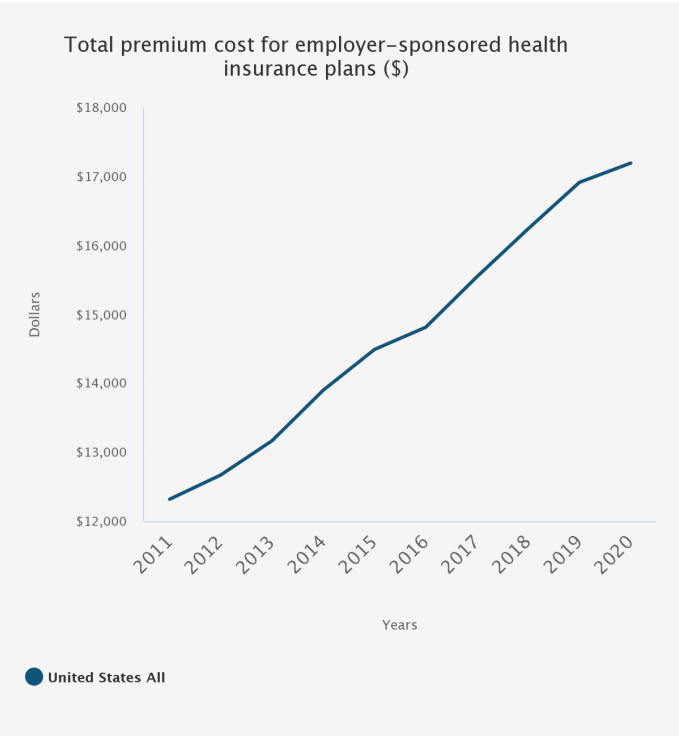
Per capita spending on health care is double the average of other wealthy countries.[1] And the major reason is because of U.S. prices for health care. Our prices have been rising every year for decades. The two highest drivers of our national health care expenditure are the prices of prescription drugs, and the prices of inpatient and outpatient hospital services as seen clearly in this example of 2020 data. Hospital services and prescription drugs make up almost three-quarters of the per-person health care spend for employer sponsored insurance. (See chart)[2]

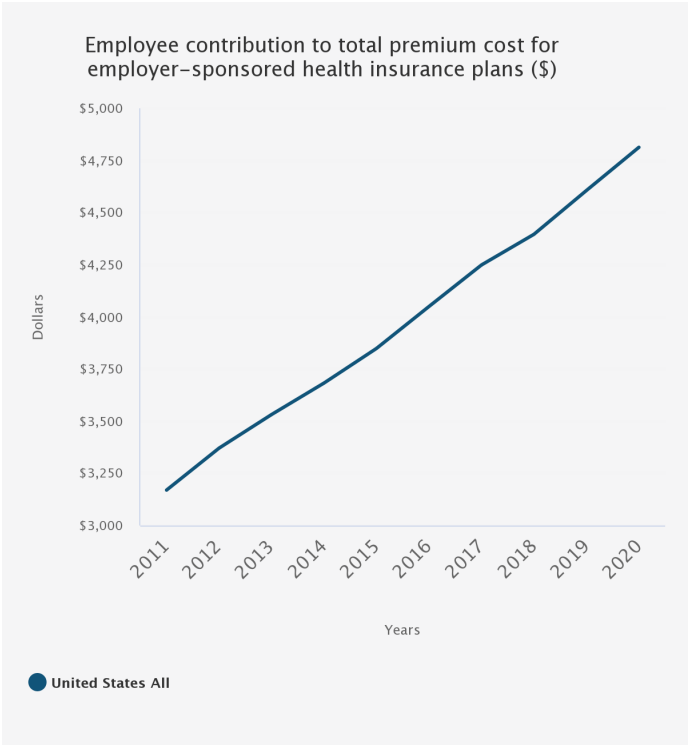


[1] Peter G. Peterson Foundation, *Key Drivers of the National Debt*, https://www.pgpf.org/the-fiscal-and-economic-challenge/drivers

[2] Health Care Cost Institute, 2020, Per person spend is $5,607. https://healthcostinstitute.org/hcci-research/hccur-data-point-use-and-spending-on-clinician-services-in-hospital-and-non-hospital-settings

Employers and businesses find it difficult to pay for ever increasing costs of employee health care coverage and feel the pressure to offer or design plans that push more of the costs onto their workers, in an effort to keep down premium costs. That results in employees paying more in deductibles, co-payments and co-insurance. The price burden is real and has been growing every year since at least 2011. (See chart.)[3]





So even with a good insurance plan by a well-meaning employer, many families still struggle to pay their out-of-pocket share for their health care. And for those with high deductible, minimal coverage plans, the out-of-pocket burden is even higher, and with no ability of the consumer to negotiate a lower price.

But why are prices for medications and hospital services so high? Lack of competition.

[3] The Commonwealth Fund: https://www.commonwealthfund.org/datacenter/total-premium-cost-employer-sponsored-health-insurance-plans?performance_area=9356 and https://www.commonwealthfund.org/datacenter/employee-contribution-total-premium-cost-employer-sponsored-health-insurance-plans?performance_area=9356

The lack of competition in prescription drugs.

U.S. prescription drug spending increased 60% over the last decade[4] and prices continue to rise, sometimes multiple times in a year. Two-thirds of U.S. adults rely on prescription drugs.[5] And yet 1 in 4 people struggle to pay for them.[6] When people can't fit the cost of their medications into their monthly budgets, they make decisions that negatively impact their health such as not filling prescriptions or skipping doses.[7] High drug prices impact all insured people, not just those taking medications. Because drug expenses make up 20% of our insurance costs, when drug prices go up[8], employers find it more difficult to keep insurance premiums affordable. High prescription drug prices are also a huge burden on our important taxpayer-funded health programs like Medicare and Medicaid.

What should be done to address prescription drug prices?

What's missing in the drug marketplace is competition. The FDA demonstrated that with the introduction of even one generic competitor, the price for that medication drops by almost 40%, and if we get four competitors, generic prices are almost 80% less than the brand name drug before competition was introduced.[9] Savings from new generic drug approvals are dramatic - $10-20 billion annually.[10] That's the power of a competitive marketplace.

In the charts below, you can see rising prices of just some of our most important classes of medications.[11] However, note that in the cardiovascular area, where there are more competitors, prices are trending downwards.

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[4] I-MAK, *"Overpatented, Overpriced Curbing patent abuse: Tackling the root of the drug pricing crisis*", September, 2022. https://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report.pdf

[5] Emily Ihara, "*Prescription Drugs*", Georgetown University Health Policy Institute, accessed at https://hpi.georgetown.edu/rxdrugs/#:~:text=More%20than%20131%20million%20people,United%20States%20%E2%80%94%20use%20prescription%20drugs

[6] Ashley Kirzinger et al., "*Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say it's Difficult To Afford Their Medicines, Including Larger Shares Among Those With Health Issues, With Low Incomes and Nearing Medicare Ages*", KFF, March 1, 2019, https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/

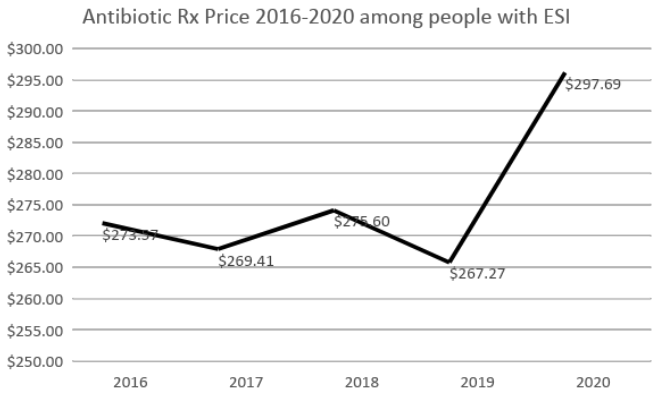
[7] See note 6.

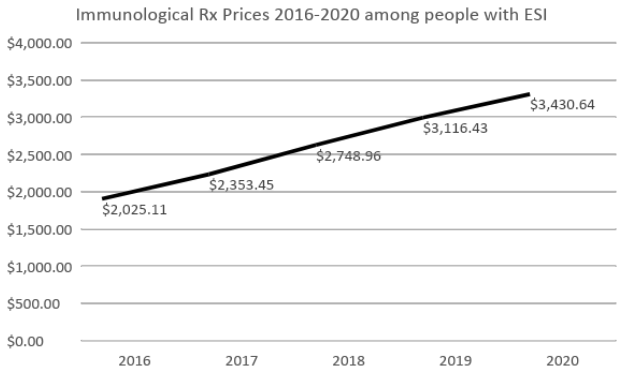
[8] AHIP, "*Your Health Care Dollar: Vast Majority of Premium Pays for Prescription Drugs and Medical Care*", Americas Health Insurance Plans, September 6, 2022, https://www.ahip.org/news/press-releases/your-health-care-dollar-vast-majority-of-premium-pays-for-prescription-drugs-and-medical-care

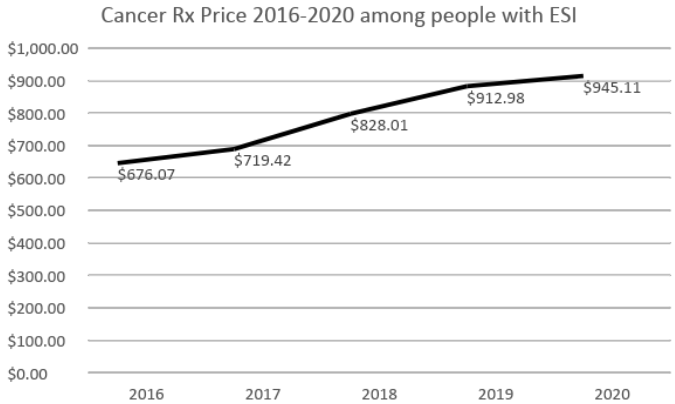
[9] FDA, "*New Evidence Linking Greater Generic Competition and Lower Generic Drug Prices*", 2019 https://www.fda.gov/media/133509/download

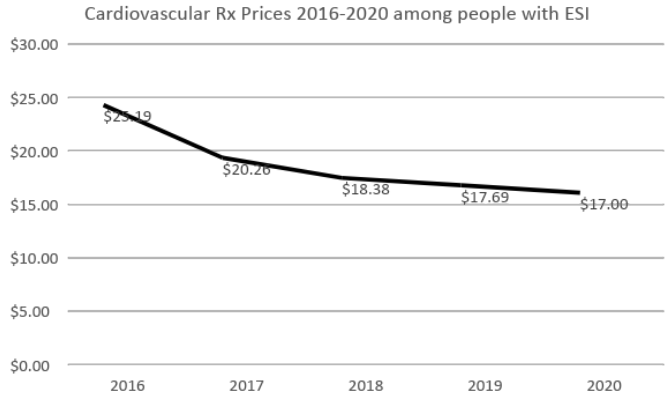
[10] Ryan Conrad PhD et al., "*Estimating Cost Savings from New Generic Drug Approvals in 2018, 2019, and 2020*", US Food and Drug Administration, August 2022, https://www.fda.gov/media/161540/download

[11] Health Care Cost Institute, *Health Care Cost and Utilization Report,* 2020 Downloadable Data, https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports









Note: Price is price per 30 days supplied

Americans love the cost savings of generics. Congress, the Patent and Trademark Office and the FDA should break down the barriers that prevent generics and biosimilars from coming to the market to compete.[12] Pharmaceutical companies are abusing patent law through tactics like product hopping, patent thickets and pay-for-delay.

While brand-name drugs make up only 8% of prescriptions, they account for 84% of all U.S. drug spending.[13] Imagine the kind of savings we could achieve if we made drugs compete in an active market. Without competition from generic drugs, brand-name companies can keep their prices high for decades. It's not just a huge financial hit impacting our insurance premiums and public health programs, but it's a budget buster for our out-of-pocket costs as well.

It's important to focus on all drugs, not just prescription drugs that folks take at home. Data shows even higher price increases for drugs administered in doctor's offices and hospitals, prices

[12] PIRG, *The Cost of Prescription Drug Patent Abuse*, April 2023, https://pirg.org/resources/the-cost-of-prescription-drug-patent-abuse/
[13] IQVIA Institute for Human Data Science, *The Use of Medicines in the U.S. 2022*, April, 2022, 39. https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2022

increased over 40% for those drugs between 2016-202.[14] Greater oversight of billing practices for these drugs should be conducted. Is this a competition issue, a site-payment issue, or is something else happening with these drugs?

High in- and outpatient hospital prices are rising in the wake of extensive market consolidation.

Prices for hospital services are also driving our national health care expenditures. And there is one significant reason: consolidation. Health markets are becoming increasingly concentrated with recent unchecked merger activity, including both horizontal and vertical consolidation among hospitals and physicians.[15] Between 1998 and 2021, there were more than 1800 hospital mergers reducing the number of hospitals in the country from 8,000 to 6,000.[16] In many metropolitan areas, just one health system has the majority of market power.[17] Insurers with only one hospital system in a region have no leverage to negotiate lower market-based prices.

One study found that prices at monopoly hospitals are about 12 percent higher than at hospitals that have 4 or more competitors.[18] Another study found that hospitals that are part of a health system charge 31 percent more for services than hospitals that are not part of a larger system.[19] To be clear, these higher prices do not even result in an improvement in quality outcomes.[20]

Although horizontal consolidation does not impact Medicare prices for physicians or hospitals that are generally paid based on the prospective payment systems, vertical mergers can result in higher Medicare charges. That's because physician offices purchased by a hospital can bill higher Medicare rates by coding the service as a hospital outpatient department, even though it is actually provided in that same physician's office location.[21]

But we know that prices don't have to be high for hospitals to keep their doors open. For example, in 2018 the average price for a knee or hip replacement at an in-network facility in the

[14] HCCUR *Data Point: Trends in Total (Administered and Prescription) Drug Spending in ESI*, https://healthcostinstitute.org/hcci-research/hccur-data-point-trends-in-total-administered-and-prescription-drug-spending-in-esi
[15] Michael Furukawa et al., "*Consolidation of Providers into Health Systems Increased Substantially, 2011-2016*" https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00017
[16] Hoag Levins, "*Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality"*, Jan. 19, 2023 https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/
[17] Health Care Cost Institute, HMI Interactive Report, https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index
[18] Zack Cooper et al. "*The Price Ain't Right?*" Sept. 2018, https://pubmed.ncbi.nlm.nih.gov/32981974/
[19] Nancy Beaulieu et al. "Organization and Performance of U.S. Health Systems," JAMA, January 2023, https://jamanetwork.com/journals/jama/article-abstract/2800656
[20] Lovisa Gustafsson et al., "*The Pandemic Will Fuel Consolidation in Health Care*" Harvard Business Review, March 9, 2021, https://hbr.org/2021/03/the-pandemic-will-fuel-consolidation-in-u-s-health-care
[21] Karyn Schwartz, KFF, "*What we know about provider consolidation*", Sept 2020, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation

Baltimore area ($23,000) was half the average price in the New York City Metro area ($58,000).[22] These price differentials are seen across the country and with new transparency laws, we'll soon have a clearer understanding of which hospitals are better at controlling prices, which will make it even more obvious that the competitive market for hospital care is broken.

With no cost constraints and almost no competition, employer and private insurers are paying 247 percent of what Medicare would have paid for the same in- and outpatient services services.[23]

Private equity investments in health care are pushing the business of health care toward maximum profits.

Private equity investment is further challenging our health markets, driving prices higher in even more sectors. The impact of a change in ownership to private equity is dramatic and swift. Private equity-controlled practices in the areas of dermatology, gastroenterology, and ophthalmology charged an average of 20 percent more per claim and increased the amount per claim allowed by payers by 11 percent shortly after the acquisition.[24]

There is no doubt that private equity invests in the health care services in which they can charge whatever they want. But when we step in to address their anticompetitive practices, things are better for consumers. When the No Surprises Act banned balance billing by out-of-network air ambulances, private-equity backed air ambulance providers, notorious for staying out-of-network and charging higher prices, quickly started closing helicopter sites, allowing community-based air ambulance providers to serve the area with lower prices. Those same private-equity backed companies however do continue to run their ground ambulances, a service where the surprise billing prohibition does not apply and they can profit off of balance billing.

What can be done to address high prices in hospital-owned settings?

For geographic areas where markets haven't already undergone dramatic consolidation, greater oversight should be given to pending mergers. Regulators should carefully consider past behaviors of health systems and evaluate the potential impact of even "small" mergers on health markets. It is only a temporary fix when regulators approve mergers after gaining promises from the consolidating parties to hold costs down or keep service lines open. Three or five years pass and the promises expire. Regulators should also actively audit and monitor hospital and insurance contracts to ferret out anti-competitive agreements, such as all-or-nothing clauses that

[22] Nisha Kurani et al., "*Price Transparency and Variation in U.S. Health Services*", Jan 2021 https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/
[23] Christopher Whaley, Rand Corp., "*Nationwide Evaluation of Health Care Prices Paid by Private Health Plans*", 2021, https://www.rand.org/pubs/research_reports/RR4394.html
[24] Yashaswini Singh et al. JAMA,"*Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization*" Sept 2022, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946

force health plans to include higher priced health systems in networks, driving up prices for everyone.

States are innovating their own solutions - creating cost containment structures for both prescription drugs (Prescription Drug Affordability Boards) and for overall health care costs, such as the Massachusetts Health Policy Commission and Rhode Island's use of an Affordability Standard. These forays into cost containment can offer some new solutions which Congress should build upon and improve.

Congress should put an end to add-on charges simply because the service is offered in hospital-owned buildings. Consumers can't possibly be expected to figure out whether their physician's office is now owned by a hospital. Prohibit facility fees and establish site-neutral payments to start paying for the actual service, rather than the location of the service.

Additional Congress and regulators could better support employers by translating the new hospital price and health plan transparency data points into a format that can help plans create high value networks with reasonable prices and outstanding quality.

High-priced health care burdens families with medical debt.

In conclusion, it's important to remember that these high prices result in higher medical bills that hurt families in the near term and can have lasting negative financial consequences. One study shows almost 20% of individuals have medical debt with a mean amount of $429.[25] But the patients I'm talking to have bills that are so much higher - and they are desperately trying to figure out how to pay them, knowing they are just one more illness away from losing their car or worse, their home.

Medical debt can carry a long tail. According to the Consumer Financial Protection Bureau, as of mid-2021, 58% of bills in collections and on credit reports were medical bills.[26] Bad credit scores follow people for years, impacting their ability to rent or buy a home. These lasting financial impacts shouldn't be the result when someone finally gets through chemo or survives a car crash.

While we work to get health care prices under control, we need to provide immediate relief to patients who need care.

- Every day I celebrate the millions of surprise out-of-network bills already prevented by the No Surprises Act. But of the 3 million insured patients who ride in an ambulance in the next year, half will be exposed to a potential out-of-network surprise bill. It's time to close that gap, and impose a ban on ground ambulance surprise billing.

[25] Raymond Kluender et al, JAMA, "*Medical Debt in the U.S. 2009-2020*" https://jamanetwork.com/journals/jama/fullarticle/2782187

[26] Consumer Financial Protection Bureau, *CFPB Estimates $88 Billion in Medical Bills on Credit Reports*, news release, March 1, 2022, https://www.consumerfinance.gov/about-us/newsroom/cfpb-estimates-88-billion-in-medical-bills-on-credit-reports/

- Congress should require reviews of nonprofit hospitals' financial statements and penalize hospitals which fail to fulfill their mandated nonprofit obligation to offer financial support for vulnerable patients. And hospitals must do a better job notifying patients about their financial assistance policies and help them use it.
- Patients deserve to know what their costs will be before they receive care. Regulations requiring Advanced Explanation of Benefits from insurers should not be delayed (No Surprises Act).
- And because medical debt is unlike other consumer debt, we need new rules against abusive medical debt collection actions. Patients need more time to heal and more time to fight inaccurate bills, up-coding, claim denials, or illegal balance billing. We should prohibit suing patients, garnishing wages or placing liens on homes for debts for medically necessary care.

I look forward to working with members of the subcommittee to work on these and other recommendations to achieve a high value health system that gives us the quality care we desire, without the high price tags we have today. Thank you for your commitment to solving this issue.

ALLIANCE of SAFETY-NET HOSPITALS

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April 25, 2023

Please Oppose the Proposal to Limit Access to Medicaid in the House Debt Ceiling Bill

Dear Representative:

I am writing on behalf of the Alliance of Safety-Net Hospitals (ASH) to ask you to reject a provision in the House debt ceiling bill – the Limit, Save, Grow Act of 2023 – that would impose work requirements on Medicaid beneficiaries.

ASH supports and appreciates the effort to raise the federal debt limit but we strongly oppose any attempt to reduce access to health care for low-income, uninsured, and unemployed individuals and their families. There could not be a worse time for such a new requirement: the current unwinding of continuous Medicaid eligibility established in response to the soon-to-end public health emergency will result in as many as 14 million Americans losing their Medicaid coverage and access to health care, according to the Kaiser Family Foundation. Now is not a time to increase further the number of Americans who lack access to care.

In addition, Kaiser notes that the majority of adult Medicaid beneficiaries already work and that most of those who do not work face serious barriers to employment, such as poor health and functional disabilities. We should not make the challenges such individuals already face even worse by eliminating their access to much-needed health care.

We speak from experience when we express concern about the effect such a policy would have on low-income Americans: ASH hospitals work tirelessly to ensure equitable access to care for the medically vulnerable residents of the generally low-income communities they serve. A Medicaid work requirement would make our work harder, but more important, it would make the lives of the residents of our communities immeasurably worse.

Again, we support your efforts to address the debt ceiling but believe reducing access to health care by imposing Medicaid work requirements should not be part of any plan to do so. For this reason we urge you to oppose inclusion of a Medicaid work requirement in the House debt ceiling bill.

Sincerely,

Kate Finkelstein
Director, Government Affairs

NATIONAL DOWN SYNDROME CONGRESS

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April 25, 2023

The Honorable Chuck Schumer
Majority Leader
U.S. Senate
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, DC 20515

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leader Schumer, Minority Leader McConnell, Speaker McCarthy, and Minority Leader Jeffries:

The National Down Syndrome Congress (NDSC) writes to express our concerns with the "Limit, Save, Grow" Act which was recently introduced. Specifically, we have concerns with "Sec. 321. Community engagement requirement for applicable individuals." NDSC is the country's oldest national organization for people with Down syndrome, their families, and the professionals who work with them. We provide information, advocacy, and support concerning all aspects of life for individuals with Down syndrome and work to create a national climate in which all people will recognize and embrace the value and dignity of people with Down syndrome.

Broadly speaking, our analysis of "Sec 321. Community engagement requirement for applicable individuals" is that it imposes a work requirement for Medicaid recipients ages 19-55. NDSC believes strongly that employment should be an expected life activity for individuals with Down syndrome, and that individuals with Down syndrome should have the individual and systemic supports necessary to enable them to find, keep and succeed in careers in the community based on their preferences, interests, and strengths. We have long advocated for empowering individuals with Down syndrome to work in careers of their choosing while also pushing for an infrastructure of supports for individuals to be successful in the workforce. However, given that Medicaid is the single largest funding source of both acute health care and long term services and supports (LTSS) for people with Down syndrome and other disabilities, any attempt to curtail Medicaid benefits, such as through work requirements, gives us tremendous pause.

From our perspective, Sec. 321 would result in billions of dollars of cuts and loss of coverage for millions on Medicaid[1]. Additionally, we believe this section would impose additional administrative burdens on individuals with disabilities in order to remain on Medicaid. Furthermore, while the proposal does include a work requirement exemption for certain recipients, they are confusing and vague. The exemption category most relevant to people with disabilities is the provision that states an individual is exempt from the work requirement if they are "physically or mentally unfit for employment, as determined by a physician or other medical professional;". We are unaware of this standard appearing anywhere else in federal statute and in fact we believe this would create a new and stricter standard for people with disabilities to meet to retain Medicaid coverage. People with disabilities already go through an extensive administrative process to obtain Medicaid and we believe adding yet another burdensome eligibility layer could result in people losing coverage as a result of administrative error or inability to obtain the appropriate documentation from a provider. From our perspective, crafting a work requirement exemption is one thing and operationalizing it is another. We are extremely skeptical that this work requirement exemption would function correctly in practice and in fact we believe that instead it would create additional barriers for people with disabilities to retain Medicaid.

In fall 2022, House Energy and Commerce Committee Republicans released their report Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion and asked for public input. The report includes a robust discussion about Medicaid and specifically Medicaid LTSS and potential improvements that could be made. NDSC welcomed this report and vision set by the new majority party on the Energy and Commerce Committee. Our reading of this report at the time and today does not include proposals around Medicaid work requirements. We raise this as a point of inconsistency between the Medicaid provisions in the "Limit, Save, Grow" Act and the vision set forth for Medicaid by the Energy and Commerce Committee which has jurisdiction over the Medicaid program. It is unfortunate that the Energy and Commerce Committee report and vision has in many ways been undermined by Sec. 321 of the "Limit, Save, Grow Act" and we are concerned about this inconsistency in policy proposals becoming a trend.

Given the concerns raised in this letter, we respectfully request that Congress not proceed with this bill as we believe it could be detrimental to people with Down syndrome and other disabilities who utilize Medicaid. As stated before, we share your goal of increasing employment, but it cannot come at the expense of Medicaid eligibility for people with disabilities. We thank you for your consideration of these comments. If you have any questions, please contact Cyrus Huncharek, Director of Policy and Advocacy at cyrus@ndsccenter.org.

Sincerely,

[1] See: https://www.cbo.gov/system/files/2022-06/57702-Work-Requirements.pdf

Jordan Kough
Executive Director
National Down Syndrome Congress

CC: Senate Finance Committee
House Energy and Commerce Committee

CONSUMERS F1RST

The Alliance to Make the Health Care System Work for Everyone

Statement for the Record

House Committee on Energy and Commerce

Subcommittee on Health

Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

Prepared by *Consumers First: The Alliance to Make the Health Care System Work for Everyone*

April 26, 2023

Chairs McMorris Rodgers and Guthrie and Ranking Members Pallone and Eshoo, on behalf *of Consumers First* and our undersigned allies we want to thank you for holding this important and timely hearing on legislative solutions to increase transparency and competition in health care.

As an alliance that brings together the interests of consumers, employers, labor unions, and primary care clinicians working to realign and improve the fundamental economic incentives and design of the health care system, *Consumers First* thanks you for building off of the robust discussion of last month's Health Subcommittee hearing to pursue meaningful policy solutions to address our nation's affordability crisis and rein in irrational and abusive health care prices driven overwhelmingly by industry - and principally hospital - consolidation. We stand ready to support you as you continue this critical work.

As we wrote in our March 28, 2023 Statement for the Record[i], consumers, employers, workers, and clinicians are struggling in a health care system whose payment and delivery structure incentivizes high cost, low quality care. Rising consolidation, particularly among hospitals, has eliminated healthy competition and led to irrational health care prices and anticompetitive behavior.[ii]

A number of the solutions being considered today would make important strides towards addressing some of the most obvious health system failings that have enabled anticompetitive behaviors, prevented healthy competition, and resulted in monopolies that set outrageous and unjustifiable prices. We are particularly interested in today's discussion around codifying and strengthening price transparency rules and expanding site neutral payments, which track recommendations from our March 28 statement.

Price transparency pulls back the curtain so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses. Moving towards achieving full transparency of health care prices is a critical step towards driving value in the U.S. health care system and ensuring our nation's families receive affordable, high-quality health care.

We are also encouraged by the Committee's consideration of legislation to implement site-neutral payment policies across the board, and legislation to eliminate site-dependent reimbursement distortions that incentivize acquisition of non-hospital patient access points. This flaw in Medicare's current payment structure unnecessarily promotes care in more expensive settings while failing to appropriately pay some clinicians and other health care workers in non-hospital settings. Advancing comprehensive site-neutral payment reforms would be a welcome first step to crack down on industry gaming that uses misaligned payment incentives to drive up costs without investing in quality, and these policies are estimated to result in billions of dollars of savings for Medicare beneficiaries and the Medicare program.[iii]

These policies and others under consideration by Energy and Commerce would set critical groundwork to reduce inflated spending throughout the system and make health care more affordable and value-driven for consumers.[iv] We encourage you to work with your colleagues on this committee and the other committees of jurisdiction to advance these solutions without delay.

Consumers First and our undersigned allies look forward the discussion today and to working with you to enact bipartisan and commonsense improvements to our nation's health care payment and delivery system. Please contact Jane Sheehan, Director of Federal Relations at Families USA,

JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

Sincerely,

Consumers First Steering Committee

American Academy of Family Physicians
American Benefits Council
American Federation of State, County & Municipal Employees
Families USA
Purchaser Business Group on Health

Supporting Organizations

ACA Consumer Advocacy
Alabama Arise
Allergy and Asthma Network
American Medical Student Association
American Muslim Health Professionals
Asian Pacific Islanders American Health Forum
Colorado Consumer Health Initiative
Connecticut Oral Health Initiative
Consumers for Quality Care
ERISA Industry Committee (ERIC)
Florida Voices for Health
Georgians for a Healthy Future
Health Care Voices
International Association of Firefighters
Medicare Rights Center
Moms Rising
National Partnerships for Women and Families
NJ Citizen Action
Northwest Health Law Advocates
Pennsylvania Health Action Network
PIRG
Small Business Majority
Swope Health Services: Minority Women and Children
Tennessee Health Care Campaign
Tennessee Justice Center
Third Way
Utah Health Policy Project
Virginia Organizing

[i] Consumers First Statement for the Record, House Energy and Commerce Subcommittee on Health Hearing on "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care" March 28, 2023 https://familiesusa.org/wp-content/uploads/2023/03/Final-CF-Statement-for-the-Record-for-EC-Transparency-and-Competition-32823.pdf.

[ii] Jaime S. King et al., Preventing Anticompetitive Healthcare Consolidation: Lessons From Five States (Source on Healthcare Price and Competition and Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California Berkeley School of Public Health, June 2020), https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/; Martin Gaynor, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," Journal of Economic Literature 53, no. 2 (June 2015): 235–284.

[iii] Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System Chapter 6, Aligning fee-for-service payment rates across ambulatory settings (June 2022), https://www.medpac.gov/wpcontent/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf.

[iv] *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services.* Congressional Budget Office. 2022. https://www.cbo.gov/publication/58222

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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AAP Statement on Harmful Policies for Children and Families in House Debt Limit Proposal

By: Sandy Chung, MD, FAAP, President, American Academy of Pediatrics

"The bill proposed in the U.S. House of Representatives to address the debt limit includes numerous polices that are harmful to the health of children and families. At a time when families need to be supported, this proposal does the opposite – jeopardizing key programs and policies that young people and their families rely on.

"Pediatricians know first-hand the importance of programs like Medicaid and the Supplemental Nutrition Assistance Program (SNAP) to the health of children and families across the country. It is critical that they can access these vital health care coverage and nutrition programs without added, unnecessary administrative barriers or paperwork. Policies like work requirements make it harder for families to access the health care services and nutrition assistance they need to be healthy.

"The legislation also proposes dangerous cuts to federal programs that support the health and well-being of children and families. These include programs that aim to improve mental health services for children, fund special education, improve immunization rates, advance medical research, provide services for foster children, reduce child abuse, address the child health impact of climate change, and more. These funding cuts would have a devastating impact on real families, resulting in fewer children getting the health care, support and services that are vital to their lifelong health and development.

"Children deserve policies that are most supportive of their overall health. The Academy urges lawmakers to prioritize children's health in their policymaking and spending decisions and reject any harmful proposals that put it at risk."

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The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds