Community Catalyst

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Dear Assistant Attorney General Kanter, Chair Khan, and Secretary Becerra,

Thank you for the opportunity to provide comments in response to the Request for Information on Consolidation in Health Care issued by the Department of Justice (DOJ), Department of Health and Human Services (HHS), and the Federal Trade Commission (FTC). We appreciate the focus on these important issues and the opportunity for public input.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses, administrations, and on Capitol Hill.

In the addition to the comments below, we have joined coalition comments that focus exclusively on private equity in health care that we co-authored with Americans for Financial Reform and Private Equity Stakeholder Project.[1] In addition, we support the comments submitted by the National Consumer Law Center, particularly the section on private equity ownership of emergency department staffing companies and access to hospital financial assistance.[2]

We write separately to highlight additional concerns and recommendations related to consolidation in health care. As you know, health care markets are increasingly concentrated, which often leads to higher prices, profit-driven care decisions, less provider network options, and less access to lower-margin services. All too frequently, this burden falls disproportionately on communities that have been historically underserved by our health system, such as Black, Latino, and low-income communities.

In Section I, we discuss the trends and impacts of consolidation by physicians, hospitals and health systems, and insurers. In Section II, we provide recommendations for HHS, FTC, and DOJ to address concerns about consolidation in the health care industry.

[1] *See* Coalition Comments Authored by Americans for Financial Reform, Community Catalyst, and Private Equity Stakeholder Project, June 4, 2024.
[2] NCLC Comments on Healthcare Consolidation to DOJ, FTC, HHS, May 30, 2024, https://www.regulations.gov/comment/FTC-2024-0022-1761.

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I. Trends and Impacts of Healthcare Consolidation

A. Physicians

Physician employment has changed significantly in the last twelve years. In 2012, 60 percent of physicians worked in practices that were wholly owned by physicians.[3] Today, about 78 percent of physicians are employed by hospitals or other corporate entities, such as insurers and private equity firms.[4]

As discussed below in Section II, one reason that physicians are leaving private practice is the increasing administrative burdens associated with reimbursement.[5] Please see our recommendations for policy solutions in Section II. Please also see the policy recommendations on additional transparency regarding private equity ownership in the Coalition Comments Authored by Americans for Financial Reform, Community Catalyst, and Private Equity Stakeholder Project.

1. Hospital Acquisition of Physician Practices Are Increasing Facility Fees

Physician employment by hospitals has increased significantly. From 2012 to 2024, the share of physicians employed by a hospital or health system increased from about 26 percent to over 55 percent.[6] When previously independent physician practices acquired by hospitals or health systems, costs increase.

Across a range of services, commercial payments are higher for ambulatory services delivered in hospital outpatient departments than for services delivered in physician offices.[7] Notably, one study found a 200 percent increase in predicted out-of-pocket expenses for procedures performed in hospital outpatient departments as compared with those performed in physician offices.[8] Facility fees appear to be an important factor in these price differences.[9]

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[3] American Medical Association, "New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment," 2013, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf.

[4] Physician Advocacy Institute, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Employment, 2019 – 2023," at 13, updated April 2024, https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d

[5] American Medical Association, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022," at 4, https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf.

[6] *Id.* at 5, 14.

[7] Gale AH. Hospitals' Opposition to Site Neutral Payments Prove They Are More Interested in Profiting from Owning Doctors than in Lowering Health Care Costs. Mo Med. 2021 Mar-Apr;118(2):94-96. PMID: 33840842; PMCID: PMC8029634.

[8] Billig JI, Lan WC, Chung KC, Kuo CF, Sears ED. The Increasing Financial Burden of Outpatient Elective Surgery for the Privately Insured. Ann Surg. 2020 Sep 1;272(3):530-536. doi: 10.1097/SLA.0000000000004201. PMID: 32740255; PMCID: PMC8015353.

[9] *Id.*

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Independent physician offices do not charge facility fees. However, when a hospital acquires a previously independent physician practice, the hospital may then impose facility fee charges for services at the physician offices – on top of the regular professional charges. For instance, when one patient received her annual steroid injection in 2021, which previously cost her about $30, she was shocked to find that her bill now included a $1,262 "facility fee."[10] The only change from previous years was that the hospital had "moved" the infusion clinic from an office-based practice to a "hospital-based setting" – even though the services were provided in the same medical office building, which was not a hospital.[11]

When facility fees are added or increased, patients often bear a significant financial burden. For uninsured patients, facility fees have a direct impact on costs. Even for insured patients, however, facility fees can impose significant costs because many insurers impose separate cost-sharing responsibilities for professional and facility fees.[12] As *Health Affairs* explained: "However a plan's cost sharing is structured, the addition of a hospital facility fee on top of a physician's fee for care that can be safely provided in a physician's office leads to higher out-of-pocket costs for patients and frequently higher costs for insurers than is necessary."[13]

We also emphasize that facility fees impose the greatest burden on historically disadvantaged communities. For instance, Hispanic, American Indian and Alaska Native, and Black individuals are most likely to be uninsured[14] and therefore bear the full cost of facility fees. Further, Black and Hispanic individuals are less likely to report having a primary care provider and more likely to report receiving routine healthcare in an emergency department,[15] where facility fees are significant and unpredictable.[16] Addressing facility fees is an important step in the direction of health equity.

2. Physician Employment by Other Corporate Entities

Physicians are also increasingly likely to be employed by other corporate entities such as insurers, private equity firms, or other business such as CVS or Amazon.[17] From 2019 to 2024, the

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[10] KFF Health News, "Her Doctor's Office Moved One Floor Up. Her Bill Was 10 Times Higher." March 6, 2021, https://kffhealthnews.org/news/article/bill-of-the-month-hospital-facility-fee-outpatient-arthritis-injections/.

[11] *Id.; see also* Consumer Reports, "The Suprise Hospital Fee You May Get Just for Seeing a Doctor," June 13, 2019, https://www.consumerreports.org/fees-billing/surprise-hospital-fee-just-for-seeing-a-doctor-facility-fee/ (describing a patient who received an X-ray and a cortisone shot at his doctor's office in less than 30 minutes - but was charged a $1,375 facility fee because - unbeknownst to the patient - the doctor was working for a hospital).

[12] Health Affairs, "Facility Fees 101: What is all the Fuss About?" Aug. 4, 2023, https://www.healthaffairs.org/content/forefront/facility-fees-101-all-fuss.

[13] *Id.*

[14] KFF, Key Facts about the Uninsured Population, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#.

[15] Parast L, Mathews M, Martino S, Lehrman WG, Stark D, Elliott MN. Racial/Ethnic Differences in Emergency Department Utilization and Experience. J Gen Intern Med. 2022 Jan;37(1):49-56. doi: 10.1007/s11606-021-06738-0. Epub 2021 Apr 5. PMID: 33821410; PMCID: PMC8021298.

[16] Vox, "Emergency rooms are monopolies. Patients pay the price." Dec. 4, 2017, https://www.vox.com/health-care/2017/12/4/16679686/emergency-room-facility-fee-monopolies.

[17] Physician Advocacy Institute, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Employment, 2019 – 2023," at 13, updated April 2024,

percentage of physicians employed by other corporate entities increased from 15 percent to 22 percent.[18] Overall, the largest employer of physicians is UnitedHealth Group – which is also the nation's largest insurer.[19]

Corporate control over physician practices can increase costs to the government and individuals. For instance, corporate owners may encourage physicians to include codes that make patients appear sicker than they are, therefore increasing payments by the government.[20] Indeed, UnitedHealth, which is the largest employer of physicians in the country and a major Medicare Advantage insurer, received over $3.7 billion in Medicare Advantage overpayments in 2017, according to the HHS Office of Inspector General.[21]

Insurer influence over physicians, either through direct ownership of physician practices or through exclusive contracts with physicians, can prevent access to necessary care with so-called "utilization management" processes. For instance, health plan Kaiser Permanente, which has exclusive contracts with physician groups, recently paid almost $3 million to settle a medical malpractice case with the family of a Ken Flach.[22] Flach, a former tennis star, died from sepsis after a Kaiser nurse and doctor only spoke to him by phone and would not send him for an in-person visit or to the emergency room, despite pleading from his wife.[23]

B. Hospitals and Health Systems

1. Hospital Consolidation

Hospitals are also becoming more consolidated. From 2005 to 2022, the percentage of hospitals affiliated with a larger health system grew from 53 percent to 68 percent.[24] By 2022, the ten largest health systems accounted for about 22 percent of generate acute care hospital beds in the country.[25] In

https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d

[18] *Id.* at 15.

[19] The Washington Post, UnitedHealth grew very big. Now, some lawmakers want to chop it down," April 30, 2024, https://www.washingtonpost.com/health/2024/04/30/unitedhealth-congress-review-cyberattack/.

[20] American Economic Liberties Project, Medicare Advantage and Vertical Consolidation in Health Care, at 4, April 2024, https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf.

[21] Senator Elizabeth Warren Press Release, ICYMI: At Hearing, Warren Warns Against Corporate Consolidation in Health Care, June 9, 2023, https://www.warren.senate.gov/newsroom/press-releases/icymi-at-hearing-warren-warns-against-corporate-consolidation-in-health-care.

[22] The New York Times, "Corporate Giants Buy Up Primary Care Practices At Rapid Pace," May 12, 2023, https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html.

[23] *Id.*

[24] KFF, "Ten Things to Know About Consolidation in U.S. Health Care Markets," April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[25] *Id.* (note that this excludes federal hospital beds).

2022, HCA Healthcare operated *over 38,000 hospital beds across 19 states*.[26] Significant evidence indicates that hospital consolidation leads to higher prices.[27]

2. Nonprofit Health Systems

Notably, seven of the ten largest health systems in the country are nonprofit.[28] For 2020, the cumulative value of these tax exemptions was estimated at over $28 billion.[29] However, some of these purportedly "not-for-profit" health systems are generating more revenue than the largest companies in the country. Nonprofit health system Kaiser Permanente – which also owns health insurance plans – had an operating revenue of *over $100 billion* in 2023.[30] For comparison, Kaiser's 2023 revenue was greater than the 2023 revenue of Bank of America ($98 billion), Tesla ($94 billion), or Johnson & Johnson ($89 billion).[31]

The extraordinary growth of nonprofit health systems is concerning because, although they are exempt from taxation as charitable institutions, many nonprofit hospitals spend proportionally *less* on charity care than their for-profit counterparts.[32] Nonprofit CommonSpirit Health, which operates hospitals in 18 states and a revenue over $33 billion in 2021,[33] spent less than 1.6 percent of its revenue on charity care.[34] Allina Health System ("Ascension") runs more than 100 hospitals and clinics and brought in nearly $5 billion in 2021,[35] but spent less than 0.4 percent of its revenue on charity care[36] – and refused to schedule appointments for patients with outstanding bills, including children and those with chronic illnesses like diabetes and depression.[37]

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[26] *Id.*
[27] Fierce Healthcare, "Hospital M&A Studies Highlight Higher Prices, Tepid Antitrust Intervention," April 26, 2024, https://www.fiercehealthcare.com/finance/hospital-ma-studies-highlight-higher-prices-tepid-antitrust-intervention.
[28] *Id.*
[29] KFF, "The Estimated Value of the Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020," March 14, 2023, https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/.
[30] KFF, "Ten Things to Know About Consolidation in U.S. Health Care Markets," April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/
[31] Companies Market Cap, "Top Publicly Traded American Companies by Revenue," https://companiesmarketcap.com/usa/largest-american-companies-by-revenue/.
[32] Ge Bai et al., "Do Nonprofit Hospitals Deserve Their Tax Exemption?" New England Journal of Medicine, July 20, 2023.
[33] KFF, "Ten Things to Know About Consolidation in U.S. Health Care Markets," April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.
[34] Senate Health, Education, Labor and Pensions Committee, Majority Staff Report at Appendix 1, Oct. 10, 2023, https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf.
[35] The New York Times, This Nonprofit Health System Cuts Off Patients With Medical Debt, June 7, 2023, https://www.nytimes.com/2023/06/01/business/allina-health-hospital-debt.html.
[36] Senate Health, Education, Labor and Pensions Committee, Majority Staff Report at Appendix 1, Oct. 10, 2023, https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf.
[37] The New York Times, "This Nonprofit Health System Cuts Off Patients With Medical Debt," June 1, 2023, https://www.nytimes.com/2023/06/01/business/allina-health-hospital-debt.html.

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Further, as nonprofit health systems grow, they tend to expand in affluent areas and divest in high-poverty communities.[38] This exacerbates the structural racism that is embedded in our health care system today. For instance, CommonSpirit Health was significantly more likely to divest from hospitals in high-poverty communities than it was to acquire hospitals in such communities.[39] Similarly, as nonprofit Ascension grew to be the third-largest health system in the country with an operating revenue of over $28 billion in 2023[40] and an investment company that manages more than $41 billion,[41] it also *closed* its hospitals in the poorest neighborhoods of Washington, D.C. and Chicago, IL.[42]

3. Case Study: Ascension

i. Closure of Providence Hospital in Washington, D.C.

Ascension's closure of Providence Hospital illustrates some of the harms when behemoth nonprofit hospital systems close their less lucrative hospitals. Half of the patients at Providence Hospital were insured through Medicaid, and thirty percent were insured through Medicare.[43] Notably, three-quarters of the patients at Providence Hospital were from Wards 5, 7 and 8[44] – areas of the city with the highest concentrations of Black residents[45] and the lowest life expectancies.[46] In 2020, the year after Providence Hospital closed, more than 579 Black residents of the District died of COVID – as compared with 82 White residents.[47]

Ascension's closure of Providence Hospital also demonstrates how the structure of large nonprofit health systems can decrease local control of hospitals. Notably, the Internal Revenue Service (IRS) recommends that nonprofit hospitals maintain a Board of Directors drawn from the community in order to ensure that the hospital is serving public, rather than private, interests.[48] At Providence

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[38] The Wall Street Journal, "Big Nonprofit Hospitals Expand in Wealthier Areas, Shun Poorer Ones," Dec. 26, 2022, https://www.wsj.com/articles/nonprofit-hospitals-deals-tax-breaks-11672068264.
[39] *Id.*
[40] KFF, "Ten Things to Know About Consolidation in U.S. Health Care Markets," April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.
[41] The New York Times, "How a Sprawling Hospital Chain Ignited Its Own Staffing Crisis," Dec. 15, 2022, https://www.nytimes.com/2022/12/15/business/hospital-staffing-ascension.html.
[42] The Wall Street Journal, "Big Nonprofit Hospitals Expand in Wealthier Areas, Shun Poorer Ones," Dec. 26, 2022, https://www.wsj.com/articles/nonprofit-hospitals-deals-tax-breaks-11672068264.
[43] DC Fiscal Policy Institute, "Testimony of Ed Lazere, Executive Director, at the Public Oversight Hearing on the Department of Health's Role in Approving Providence Hospital's Proposed Elimination of Acute Care Services and the Impact on the District's Emergency Health Care System," Oct. 10, 2018, https://www.dcfpi.org/wp-content/uploads/2018/10/10.10.18-Providence-Hopsital-Closure.pdf.
[44] *Id.*
[45] Washington Post, "Half of Black D.C. Residents Lack Easy Access to Health Care, Analysis Shows," Jan. 3, 2024, https://www.washingtonpost.com/dc-md-va/2024/01/03/dc-black-health-care-outcomes/.
[46] DC Health, "Life Expectancy," https://ourhealthydc.org/dc-chna/health-outcomes/life-expectancy/ (life expectancy by ward for 2013 – 2017).
[47] Washington Post, "Half of Black D.C. Residents Lack Easy Access to Health Care, Analysis Shows," Jan. 3, 2024, https://www.washingtonpost.com/dc-md-va/2024/01/03/dc-black-health-care-outcomes/. Note that the District is about evenly split between Black and White residents. https://www.census.gov/quickfacts/fact/table/DC/PST045222.
[48] I.R.S. Rev. Rul. 69-45, 1969-2 C.B. 117, at 3.

Hospital, the Board of Directors initially opposed the closure of the hospital.[49] In response, Ascension fired and replaced a majority of the Providence Hospital Board members.[50] In other words, Missouri-based Ascension had the power to silence community voices from the District of Columbia about the future of Providence Hospital.

Finally, the relationship between Ascension and Providence Hospital illustrates how the financial structure of giant health networks can harm community hospitals. Ascension charged Providence Hospital an extraordinary $20 million in management fees in 2017,[51] and then announced that Providence Hospital would close because it was performing "very poorly financially."[52] In 2018, after an investigation by the D.C. Attorney General indicated that the fees appeared to be excessive, Ascension agreed to forgive a total of *$130 million* that Providence Hospital owed Ascension.[53]

Such management fees are common in large nonprofit health systems, where a parent company centralizes the legal, human resources, and accounting operations and then charges a fee to the subsidiary hospital.[54] Instead of increasing efficiency, however, these fees may siphon needed funds away from hospitals in poorer communities. The large health system may then argue – as Ascension did – that the hospitals in poorer communities are not financially viable.

ii. Understaffing to Increase Profits

As Ascension has grown, so too has the focus on revenue – often at the expense of patient care. Ascension's CEO received *over $13 million* in compensation for 2021,[55] while Ascension spent less than 2 percent of its revenue on charity care that year.[56] Simply put, Ascension's executives make more money if the health system brings in more revenue.[57] Ascension sets financial targets for hospitals across its network, and hospital executives have to meet those targets to receive bonuses.[58]

One of the easiest ways to meet Ascension's targets is to keep staffing low, as labor costs comprise about half of hospital expenses.[59] Ascension has engaged in a years-long effort to cut staff

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[49] Office of the Attorney General of the District of Columbia, Investigating the Closure of Providence Hospital & Safeguarding Nonprofit Assets, Sept. 8, 2020, https://oag.dc.gov/blog/investigating-closure-providence-hospital.
[50] *Id.*
[51] National Catholic Reporter, Attorney General in DC Turns Attention to Providence Hospital Finances," Jan. 18, 2019, https://www.ncronline.org/news/attorney-general-dc-turns-attention-providence-hospital-finances.
[52] WAMU, "A 'Medical Red Line': Dozens Testify Against Closure Of Providence Hospital," Oct. 10, 2018, https://wamu.org/story/18/10/10/medical-red-line-dozens-testify-closure-providence-hospital/
[53] Office of the Attorney General of the District of Columbia, Investigating the Closure of Providence Hospital & Safeguarding Nonprofit Assets, Sept. 8, 2020, https://oag.dc.gov/blog/investigating-closure-providence-hospital.
[54] National Catholic Reporter, Attorney General in DC Turns Attention to Providence Hospital Finances," Jan. 18, 2019, https://www.ncronline.org/news/attorney-general-dc-turns-attention-providence-hospital-finances.
[55] *Id.*
[56] Senate Health, Education, Labor and Pensions Committee, Majority Staff Report at Appendix 1, Oct. 10, 2023, https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf.
[57] The New York Times, "How a Sprawling Hospital Chain Ignited Its Own Staffing Crisis," Dec. 15, 2022, https://www.nytimes.com/2022/12/15/business/hospital-staffing-ascension.html.
[58] *Id.*
[59] *Id.*

through layoffs and unfilled vacancies.[60] Not surprisingly, many Ascension hospitals were understaffed and unprepared for the COVID pandemic, and nurses continue to report chronic understaffing.[61] Nurses report that patients have: (1) lingered on gurneys with serious, time-sensitive medical issues; (2) laid in their own feces for so long that the excrement dried; and (3) developed bed sores because they were not repositioned often enough.[62] In July 2022, one nurse at Ascension-owned St. Joseph in Illinois wrote: "Someone is going to die if this continues, and there is no indication that anyone is concerned."[63]

iii. Closing Less Profitable Labor and Delivery Units

Despite its Catholic mission, Ascension has been closing labor and delivery departments at a higher rate than the national average.[64] Obstetrics and gynecology services are lower-margin services, particularly in areas where many patients have Medicaid.[65] Ascension, which had an operating revenue over $28 billion in 2023,[66] has the resources to support less profitable departments. However, Ascension has closed *more than a quarter* of its labor and delivery units that existed in 2012.[67]

Many of Ascension's labor and delivery closures occurred in predominantly Black and Latino communities.[68] For instance, in 2019, Ascension stopped providing birthing services at the Ascension Sacred Heart Bay Hospital in Bay County Florida, where 67 percent of the residents are Black.[69] In 2021, the rate of maternal deaths in Bay County spiked to 95.2 per 100,000 live births – more than twice the rate in 2018, the year prior to the closure.[70] Nationwide, Black women face maternal mortality rates that are 2.6 times higher than for White women,[71] and these labor and delivery closures exacerbate the disparity.

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[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] Religion News Service, "Catholic Bishops Silent As Ascension Hospital System Shrinks Maternity Care," Apr. 8, 2024, https://religionnews.com/2024/04/08/catholic-bishops-silent-as-ascension-hospital-system-shrinks-maternity-care/.
[65] *Id.*
[66] KFF, "Ten Things to Know About Consolidation in U.S. Health Care Markets," April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.
[67] Religion News Service, "Catholic Bishops Silent As Ascension Hospital System Shrinks Maternity Care," Apr. 8, 2024, https://religionnews.com/2024/04/08/catholic-bishops-silent-as-ascension-hospital-system-shrinks-maternity-care/.
[68] National Nurses Organizing Committee, "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies," at 14, January 2024, https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223_AscensionSeton_Obstetrics_DangerousDescent_Report.pdf.
[69] *Id.*
[70] *Id.*
[71] Centers for Disease Control and Prevention, "Maternal Mortality Rates in the United States, 2021," last reviewed March 16, 2023, https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#:.

C. Insurers

1. General Consolidation of Health Insurance Markets

Health insurance markets continue to become more concentrated. In 2022, nearly three-quarters of metropolitan statistical areas (MSAs) meet the older, more stringent DOJ/FTC definition of "highly concentrated."[72] Notably, the DOJ and FTC recently lowered the threshold for the "highly concentrated" definition.[73] Under the current DOJ/FTC guidelines, *95 percent of health insurance markets are highly concentrated*.[74]

Health insurance consolidation may harm providers, while increasing prices for patients. Specifically, horizontal consolidation among insurers is associated with lower rates paid to providers as insurers gain market power in such negotiations.[75] However, these savings are not passed onto patients.[76] To the contrary, insurance premiums generally *increase* after health insurers consolidate.[77]

2. Vertical Integration by Insurers

Vertical integration by health insurance companies may also increase prices and avoid intended protections for patients. Specifically, the Affordable Care Act required health insurance companies to spend 80 – 85 percent of premiums on medical claims, known as Medical Loss Ratio (MLR) requirements.[78] However, health insurance companies that own physician practices, pharmacies, or pharmacy benefit managers may inflate prices to meet these requirements.

Indeed, one recent investigation found significant markups of generic drug prices by insurers CVS Aetna, Cigna, and UnitedHealth.[79] These three health insurance companies own or are affiliated with the three largest pharmacy benefit managers (PBMs) in the country.[80] They also own many pharmacies.[81] Across a range of specialty generic drugs, such as those for cancer and multiple

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[72] American Medical Association, "Competition in Health Insurance," at 2, 2023 update, https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-care-research.
[73] DOJ and FTC, Merger Guidelines, (Dec. 18, 2023), https://www.ftc.gov/reports/merger-guidelines-2023.
[74] American Medical Association, "Competition in Health Insurance," at 2 n.7, 2023 update (noting that the percentage of highly concentrated health insurance markets would rise to 95 percent if the DOJ and FTC adopt the new proposed threshold of highly concentrated at an Herfindahl-Hirschman Index (HHI) of 1800); *see also* DOJ and FTC, Merger Guidelines, (Dec. 18, 2023), https://www.ftc.gov/reports/merger-guidelines-2023 (adopting a lower HHI threshold of 1800 for highly concentrated markets).
[75] HHS, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline and Framework for Analysist," at 5, July 2023, https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf.
[76] *Id.* at 5-6.
[77] *Id.*
[78] CMS, "Medical Loss Ratio," https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio, revised Sept. 6, 2023.
[79] The Wall Street Journal, "Generic Drugs Should Be Cheap, But Insurers Are Charging Thousands of Dollars for Them," Sept. 11, 2023, https://www.wsj.com/health/healthcare/generic-drugs-should-be-cheap-but-insurers-are-charging-thousands-of-dollars-for-them-ef13d055.
[80] *Id.*
[81] *Id.*

sclerosis, Cigna and CVS's prices were at least 24 times higher than what the medicines' manufacturers charge.[82] UnitedHealth Group's charges were 3.5 times higher.[83]

Senators Elizabeth Warren (D-MA) and Mike Braun (R-IN) have explained the impact of this vertical integration by insurers:

> The calculation is simple. By owning every link in the chain, a conglomerate like UnitedHealth Group – which includes an insurer, a PBM, a pharmacy, and physician practices – can send inflated medical payments to its pharmacy. Then, by realizing those payments on the pharmacy side – the side the charges for care – rather than on the insurance side, the insurance line of business appears to be in compliance with MLR requirements, while keeping more money for itself.[84]

3. Vulnerability to Cyberattacks and Other Threats

The sheer size of healthcare businesses poses threats to the health system. For instance, there was a massive February 2024 cyberattack on UnitedHealth Group subsidiary Change Healthcare, which acts as a clearing house for 40 percent of all medical claims.[85] The cyberattack caused a huge backlog of unpaid claims, and *over 60 percent of the country's hospitals lost more than $1 million in revenue per day*.[86] This type of attack causes the most harm to hospitals and medical providers that are already financially vulnerable, potentially causing them to close or sell to a large healthcare conglomerate like UnitedHealth Group.[87] It also demonstrates that due to the larger corporate entities which exist from consolidation, a single event can cause much more widespread harm.

II. Policy Recommendations

A. HHS

HHS has several avenues available to address consolidation. First, HHS should use its required annual reports on health care consolidation to highlight trends in health care market concentration and the impact on patients. Specifically, the No Surprises Act required HHS to report annually for five years about the impact of the law on horizontal and vertical consolidation, overall health care costs, and access to health care items and services.[88]

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[82] *Id.*
[83] *Id.*
[84] Letter from Senators Warren and Braun to HHS Office of Inspector General, at 3, Nov. 21, 2023, https://www.warren.senate.gov/imo/media/doc/2023.11.21%20Letter%20to%20HHS%20OIG%20regarding%20MLR%20evasion.pdf.
[85] House Energy and Commerce Committee Blog, "What We Learned: Change Healthcare Cyber Attack," May 3, 2024, https://energycommerce.house.gov/posts/what-we-learned-change-healthcare-cyber-attack.
[86] The Hill, Ashley Nowicki and Hayden Rooke-Ley, "Too big to care: Is it time for a Glass-Steagall Act for health care," May 1, 2024, https://thehill.com/opinion/healthcare/4633316-unitedhealth-group-change-cyberattack-glass-steagall-act-healthcare-too-big-to-fail/.
[87] *Id.*
[88] Pub. Law No. 116-260, Div. BB, Sec. 109.

In these reports, HHS should:

- Consult with community organizations. In the first report, HHS stated that it intended to gather feedback from interested parties and engage in other qualitative approaches.[89] We urge the agency to meet with community-based organizations and other groups that can shed light on the patient impact of consolidation in the health care system.

- Consult with the FTC and Attorneys General. The NSA requires HHS to consult with the FTC and Attorneys General for these annual reports.[90] In the first report, HHS noted that one possible response to the impact of the NSA on out-of-network billing is that providers may seek to strengthen their bargaining positions by consolidating.[91] We urge HHS to work with the FTC and Attorneys General to analyze the rise of private equity, serial ("roll-up") transactions, and other consolidation trends that may impact access and health care prices.

- Emphasize overall consolidation in health care markets. We appreciate that HHS emphasized in its first annual report that overall health care consolidation is increasing, which may have impacts on health care prices and quality that are independent of the No Surprises Act.[92] We urge HHS to continue this research and include analysis of the impacts of overall health care consolidation on health care quality, prices, and access in future reports.

Second, we encourage HHS to address insurance denials. The increasing administrative and financial burdens from insurance denials is an incentive for physicians to leave independent practices for hospital or other corporate employment.[93] Further, insurance denials can delay or prevent access to necessary care and increase medical debt.

To address insurance denials, HHS should:

- Increase transparency. HHS has statutory authority to require detailed claims data reporting from marketplace plans, non-grandfathered group plans, and health insurers offering group or

[89] HHS, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis," at 33, July 6, 2023, https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf.
[90] Pub. Law No. 116-260, Div. BB, Sec. 109.
[91] HHS, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis," at 32, July 6, 2023, https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf
[92] HHS, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis," at 5, July 6, 2023, https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf.
[93] *See, e.g.,* American Hospital Association, "Examining the real factors driving physician practice acquisition," https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf ("Physicians report that health insurer policies and practices have had a significant impact on their decision to seek employment outside their own practice.").

individual coverage.[94] However, reporting is only currently required for marketplace plans.[95] Working with the Departments of Labor and Treasury as necessary,[96] HHS should require reporting from *all* plans covered by these requirements, including employer-sponsored plans.

- Increase oversight. HHS is statutorily required to periodically review the Essential Health Benefits (EHBs) and report to Congress and the public about "whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost."[97] HHS is also required to periodically update the EHBs to address "any gaps in access to coverage" based on this review.[98] CMS should use the information on claims denials to investigate, report on, and address these key issues.

Third, we urge HHS's Office of Inspector General (OIG) to investigate whether vertically integrated health care companies are undermining MLR protections and increasing health care costs. Senators Elizabeth Warren (D-MA) and Mike Braun (R-IN) have provided research and specific recommendations for an investigation of these issues.[99] As Senators Warren and Braun noted, such an investigation is in line with OIG's mission "to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs."[100] We agree with their bipartisan request and encourage OIG to undertake this investigation.

B. FTC

The FTC should use a multi-pronged approach to address consolidation in health care. First, the FTC should address facility fees. Facility fees are charged by hospitals, ostensibly to cover operational expenses. Facility fees are not charged by independent physician practices. However, as hospitals acquire physician practices and other previously independent providers, patients are seeing facility charges more frequently for services that did not previously result in facility fees. Significantly, the opportunity to add facility fees, which range from hundreds to thousands of dollars, in an incentive for hospitals to acquire physician practices.[101]

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[94] Affordable Care Act § 1311(e)(3) (authority to require reporting from plans seeking certification as Qualified Health Plans) and § 2715A (requiring group health plans and health insurance issuers offering group or individual coverage to comply with the reporting requirements in § 1311(e)(3)); CMS, Transparency in Coverage, https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage.

[95] CMS, "Health Insurance Exchange Public Use Files (Exchange PUFs) General Information," https://www.cms.gov/files/document/exchange-pufs-geninfofacts-py24.pdf.

[96] CMS, "Affordable Care Act Implementation FAQs – Set 15," https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15#ftn9, last revised Sept. 6, 2023 (stating that the Departments of Health and Human Services, Labor, and Treasury will coordinate to issue regulatory guidance on transparency requirements for coverage offered outside the marketplace).

[97] Affordable Care Act § 1302(b)(4)(G)(i).

[98] Affordable Care Act § 1302(b)(4)(H).

[99] Letter from Senators Warren and Braun to HHS Office of Inspector General, Nov. 21, 2023, https://www.warren.senate.gov/imo/media/doc/2023.11.21%20Letter%20to%20HHS%20OIG%20regarding%20MLR%20evasion.pdf.

[100] *Id.* at 3.

[101] Health Care Cost Institute, "Facility Fees and How They Affect Health Care Prices," June 2023, https://healthcostinstitute.org/images/pdfs/HCCI_FacilityFeeExplainer.pdf.

As described more fully in our previous coalition comments on the issue,[102] we urge the FTC to promptly issue a final rule on unfair or deceptive fees. Significantly, the FTC's proposed rule on facility fees would prohibit the imposition of facility fees for telehealth services and require disclosure before imposing facility fees for other services. We encourage the FTC to move forward with this rulemaking.

Second, the FTC should investigate and issue public reports on consolidation in health care markets.[103] We applaud the FTC's ongoing investigation of PBMs, for example.[104] We encourage the FTC to investigate other health care consolidation issues, including hospital facility fees and private equity roll-up acquisitions.[105] The FTC should also submit reports to Congress with recommendations for legislation to address these issues.[106]

Third, the FTC should aggressively enforce the FTC Act against nonprofit entities that are operating like for-profit entities, such as large nonprofit health systems. As the FTC recently emphasized, both Congress and the courts have recognized that the Commission may regulate "so-called nonprofit corporations" if they are operating like profit-making enterprises.[107] The FTC should enforce prohibitions like the recent non-compete rule against behemoth nonprofit health systems that are not operating like charitable institutions. Two examples of nonprofit hospitals that are operating like profit-making enterprises are as follows:

- As described in Section 1.B.2., Allina Health brought in nearly $5 billion in revenue for 2021, but spent less than 0.4 percent of its revenue on charity care – and refused to schedule appointments for patients with outstanding bills, including children and those with chronic illnesses like diabetes and depression. The FTC previously found that charities were "shams" when less than two percent of their revenue was directed toward charitable missions.[108] It would be consistent with FTC precedent to find that Allina Health is not operating like a nonprofit institution and is subject to the FTC Act.

- As described in Section 1.B.3, Ascension Health had an operating revenue of over $28 billion in 2023 and an investment company that manages more than $41 billion. Despite these resources, Ascension closed hospitals in poor neighborhoods, eliminated over a quarter of its labor and delivery units, and consistently understaffed its hospitals to increase profits. The

[102] Comment from Community Catalyst and 32 other organizations focused on health care and consumer protection issues, FTC Regulations FTC-20230064-3191, February 2024, accessible at https://www. regulations.gov/comment/FTC-2023-0064-3191.
[103] *See* 15 U.S.C. § 46(a) and (f).
[104] FTC, "Remarks by Chair Lina M. Khan As Prepared for Delivery, White House Roundtable on PBMs," March 4, 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/2024.03.04-chair-khan-remarks-at-the-white-house-roundtable-on-pbms.pdf.
[105] 15 U.S.C. 46(a) and (f).
[106] 15 U.S.C. 46(f).
[107] FTC, "Non-Compete Clause Rule," 89 Fed. Reg. 89 at 38357 (May 7, 2024).
[108] FTC, "FTC Joins Four States in Action to Shut Down Alleged Sham Charity Funding Operation That Bilked Millions From Consumers," Sept. 16, 2020, https://www.ftc.gov/news-events/news/press-releases/2020/09/ftc-joins-four-states-action-shut-down-alleged-sham-charity-funding-operation-bilked-millions.

FTC has ample evidence that Ascension is not operating like a nonprofit institution and should be subject to the FTC Act.

C. DOJ

We applaud the DOJ's recent focus on health care consolidation, such as the new Task Force on Health Care Monopolies and Collusion[109] and the health care competition portal.[110] We strongly support the DOJ's review of UnitedHealth and the effects of vertical integration in health care markets, such as UnitedHealth's ownership of both an insurance business and health services practices.[111] We also support the DOJ's review of the proposed UnitedHealth Group acquisition of Amedisys, although are concerned that Amedisys is now reportedly considering a sale of many home health and hospice locations to a private equity company.[112]

We encourage the DOJ to continue to aggressively investigate and challenge health care consolidation from different angles.[113] First, we urge the DOJ to continue to investigate and challenge anticompetitive practices in health insurance markets. The DOJ should continue to investigate and aggressively challenge the vertical integration concerns described in Section I.C.2 of this comment. In addition, the DOJ should also investigate anticompetitive contract terms between health insurers and hospitals, including nonprofit hospitals.[114]

Second, we encourage the DOJ, along with the FTC, to investigate MultiPlan, a health data company that provides services to help insurance companies determine how much to pay for out-of-network care. Specifically, the DOJ should investigate whether MultiPlan is using algorithms to subvert competition among insurance companies, resulting in higher prices for patients. As Senator Amy Klobuchar (D-MN) has explained, this behavior may amount to price-fixing.[115]

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[109] DOJ Press Release, "Assistant Attorney General Johnathan Kanter Announces Task Force on Health Care Monopolies and Collusion," May 9, 2024, https://www.justice.gov/opa/pr/assistant-attorney-general-jonathan-kanter-announces-task-force-health-care-monopolies-and.

[110] DOJ, "Help us ensure access to fair and competitive healthcare markets for you and your family," https://www.justice.gov/atr/HealthyCompetition (last visited June 3, 2024).

[111] Healthcare Dive, "UnitedHealth under antitrust investigation by DOJ: reports," Feb. 28, 2024, https://www.healthcaredive.com/news/unitedhealth-antitrust-investigation-doj-unitedhealthcare-optum/708727/.

[112] Hospice News, "Report: Amedisys May Sell 100 Locations to Advance UnitedHealth Group Deal," May 8, 2024, https://hospicenews.com/2024/05/08/amedisys-to-sell-100-locations-to-advance-unitedhealth-group-deal/.

[113] Letter from Sen. Klobuchar to DOJ and FTC, Arp. 29, 2024, https://static01.nyt.com/newsgraphics/documenttools/1d00c48c7634f677/0d0d8490-full.pdf.

[114] *E.g.,* The Wall Street Journal, "Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition," Sept. 18, 2018, https://www.grassley.senate.gov/news/news-releases/grassley-seeks-ftc-assessment-reported-health-insurance-scheme-may-increase; *see also* DOJ Press Release, "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.

[115] Senator Klobuchar Press Release, Klobuchar Urges Department of Justice, Federal Trade Commission to Investigate Conduct in Health Care Payment Market, May 1, 2024, https://www.klobuchar.senate.gov/public/index.cfm/2024/5/klobuchar-urges-department-of-justice-federal-trade-commission-to-investigate-conduct-in-health-care-payment-market
see also The New York Times, "Collusion in Health Care Pricing? Regulators Are Asked to Investigate," May 1, 2024, https://www.nytimes.com/2024/05/01/us/multiplan-health-insurance-price-fixing.html.

Third, we urge the DOJ to use the new data collected by HHS on private equity ownership and management of institutional Medicare providers.[116] The DOJ should analyze this data for trends in serial acquisitions that result in significant market power in particular industries or geographic areas. The DOJ should also investigate patterns of substandard care or inflated billing across multiple providers owned or managed by the same private equity firm.

Thank you for the opportunity to submit comments on these important issues. If you have any questions, please contact Mona Shah at mshah@communitycatalyst.org.

Respectfully submitted,

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Community Catalyst

[116] Medicare Learning Network, New Ownership Reporting Requirements for Providers Using the Form CMS-855A, Nov. 2023, https://www.cms.gov/files/document/mln9340578-new-ownership-reporting-requirements-providers-using-form-cms-855a.pdf.