westhealth™ policy center

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Secretary
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Jonathan Kanter
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Chair
Federal Trade Commission
600 Pennsylvania Ave. N.W.
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The United States Department of Justice's Antitrust Division, the Federal Trade Commission, and the Department of Health and Human Services

RE: RFI Docket No. ATR 102

Dear Secretary Becerra, Assistant Attorney General Kanter, & Chair Kahn:

West Health is a family of nonprofit, nonpartisan organizations that combines applied medical research, policy analysis, and grantmaking to improve care, lower costs, and enhance the aging experience for seniors and all Americans. In our daily work, we collaborate with researchers, patients, health care providers and health insurers to study, develop, and advance scalable, sustainable, and more affordable health care delivery models that lower care costs to enable seniors to successfully age in place.

We are pleased to submit comments to the Department of Health and Human Services, Federal Trade Commission, and United States Department of Justice ("the agencies") on the effects of health care consolidation. Increasing health care spending in recent years is primarily attributable to increases in prices for health care services and fees, rather than greater utilization.[1] Consolidation within the health care system, both horizontally, when consolidation occurs between the same types of entities (e.g. a hospital purchasing a hospital), and vertically, when consolidation occurs across different types of providers (e.g. a hospital purchases a physician practice) have greatly contributed to these price increases. Higher prices from

[1] Health Care Cost Institute, "2022 Health Care Cost and Utilization Report," April 2024. https://healthcostinstitute.org/images/pdfs/HCCI_2022_Health_Care_Cost_and_Utilization_Report.pdf

consolidation ultimately expose patients to higher health insurance premiums and out-of-pocket expenses.

We agree with the agencies that robust competition in health care markets promotes lower health care costs, while fostering high-quality patient care and driving innovation across the health care system. West Health is concerned that limited competition today generates profits for firms at the expense of patients' health, quality of care, and affordability for consumers and taxpayers.

We thank the Department of Justice, the Department of Health and Human Services, and the Federal Trade Commission for raising the issue in this Request for Information. In our comments, we plan to focus on some clear impacts that that hospital and pharmacy benefit manager consolidation has had on the cost of health care services and on pharmaceutical costs. We hope our comments will help inform the agencies' identification of enforcement priorities and future action, including new regulations and reimbursement methodologies, aimed at promoting and protecting competition in health care markets and ensuring appropriate access to quality, affordable health care goods and services.

Hospitals

Hospital mergers long ago reached a point where more than 80% of MSAs are considered highly consolidated by FTC-DOJ criteria[2]. While Medicare controls its payments which are close to the costs hospitals report they spend to provide care, private fees average around 210% of Medicare rates. Moreover, some hospitals receive fees as much as 300-400% of Medicare rates. These inflated payments not only impact private payers, but they increase federal spending. A 2021 estimate found that capping hospital prices in the commercial market to 200% of Medicare would reduce national health expenditures by over a trillion dollars, including reducing the federal deficit by $216 billion over ten years.[3] As consolidation continues, the agencies should continue to strengthen their oversight of mergers, acquisitions, and consolidation to curb the growth of hospital prices and address the harmful consequences of existing consolidation.

A more recent and very disturbing trend involves hospital purchases of physician practices. Hospitals have a significant financial incentive to purchase physician practices. In addition to increasing their leverage in bargaining with insurers, it enables them to increase their revenue by labeling those practices as outpatient facilities and charging higher prices compared to prices charged when the offices operated as independent physician practices. Information from the American Medical Association's Physician Practice Benchmark Surveys indicates that the share

[2]Cooper, Gaynor, "Addressing Hospital Concentration and Rising Consolidation in the United States," 2021. https://onepercentsteps.com/wp-content/uploads/brief-hc-210208-1700.pdf

[3]"Capping Hospital Prices", February 23, 2021. https://www.crfb.org/papers/capping-hospital-prices

of physicians who were either in practices at least partially owned by hospitals or were employees of hospitals increased from 29.0 percent in 2012 to 39.8 percent in 2020.[4]

While this significant vertical consolidation has implications for prices paid by private insurers and patients, it has also led to higher prices and greater out-of-pocket spending for outpatient services for Medicare beneficiaries.[5] The Medicare program pays different rates for equivalent or identical services depending on where the service is performed. Generally, procedures performed in hospital outpatient departments (HOPDs) are paid at a higher rate than the same procedures performed in a physician's office or an ambulatory surgical center (ASC). In some cases, the payment differentials are large. Medicare paid HOPDs an average of 125 percent more than physicians' offices for an evaluation and management visit.[6] And overall, Medicare rates for HOPDs are almost twice as high as rates for ASCs.[7] To highlight one example, in 2023, Medicare paid 194 percent more in an HOPD than in a freestanding office for a transthoracic echocardiogram with image documentation.[8]

MedPAC has estimated that paying the same amount across ambulatory settings for 66 ambulatory payment classifications (APCs) would have reduced Medicare Hospital Outpatient Prospective Payment System (OPPS) outlays in 2021 by $6.0 billion and beneficiary cost sharing by $1.5 billion, or 3.8 percent of aggregate Medicare revenue for OPPS hospitals.[9] The Committee for a Responsible Federal Budget, in partnership with West Health as part of the Health Savers Initiative[10] found that implementing such site-neutral payment policies will reduce projected national health expenditures by a range of $346 to $672 billion over a decade and projected federal budget deficits by $217 to $279 billion.[11] Moreover, without federal action, this trend is expected to continue. The Congressional Budget Office has projected fee-

[4] Kane, C. 2021. *Policy research perspectives. Recent changes in physician practice arrangements: Private practice dropped to less than 50 percent of physicians in 2020.* Chicago, IL: American Medical Association
[5] MedPAC, "Report To Congress: Medicare and the Health Care Delivery System," June 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[6] MedPAC, "Report to Congress: Medicare Payment Policy," March 2019, Chapter 4. https://www.medpac.gov/document/march-2019-report-to-the-congress-medicare-payment-policy/
[7] MedPAC, "Report to Congress: Medicare Payment Policy," March 2019, Chapter 5. service. https://www.medpac.gov/document/march-2019-report-to-the-congress-medicare-payment-policy/
[8] MedPAC, "Report To Congress: Medicare and the Health Care Delivery System," June 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[9] MedPAC, "Report To Congress: Medicare and the Health Care Delivery System," June 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[10] The Health Savers Initiative, is a project of the Committee for a Responsible Federal Budget, Arnold Ventures, and West Health working to identify bold and concrete policy options to make health care more affordable for the federal government, businesses, and households.
[11] "Equalizing Medicare Payments Regardless of Site-of-Care," February 23, 2021. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care

for-service payments to HOPDs will grow faster than any other sector's payments – doubling over the next decade.[12]

There is little reason for the significant payment differentials between HOPDs and physicians' offices when the services performed are equivalent, are safely provided in office settings, and the patient health status is similar. The adoption of a site-neutral policy option would address the payment disparity and lower Medicare spending, lower premiums and out-of-pocket costs for beneficiaries, and reduce the financial incentives for vertical consolidation. CMS has already taken action in this space by administratively adopting site-neutral payments for all evaluation and management visits at off-campus HOPDs. The agency should take additional action to more closely align Medicare payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access.

Another frequent consequence of vertical consolidation seen by the commercially insured population is the increasing prevalence of facility fees. Hospitals bill these fees, to cover their operational expenses for providing health care services. They are separate from the professional fees physicians and other health care practitioners charge to cover their time and expenses. Commercial payers may or may not provide coverage for such off-campus facility fees. If those fees are not covered by insurers they may be passed directly to patients. Despite the claim that hospitals use facility fees for overhead operational expenses, there is very little evidence that they are used for reasons other than profit maximization.

Federal lawmakers have begun discussing policies addressing facility fee reform. In 2023 the Senate Health, Education, Labor and Pensions Committee advanced the Bipartisan Primary Care and Health Workforce Act of 2023 on a bipartisan 14-to-7 vote. This legislation prohibits facility fees for telehealth and evaluation and management services provided outside hospital walls. States also are engaging in facility fee reform and are at the forefront of tackling outpatient facility fee billing in the commercial sector. West Health collaborated with Georgetown University's Center on Health Insurance Reforms to identify state action on regulating facility fees and found laws and regulations in 11 states demonstrating the range of facility-fee reforms available such as (1) prohibitions on facility fees; (2) out-of-pocket cost protections; (3) consumer disclosure requirements; (4) hospital reporting requirements; and (5) provider transparency requirements.[13]

While currently, the federal government has limited scope to influence private insurance market prices, the agencies should conduct research analyzing the effects of hospital consolidation on the cost of health care for consumers in the commercial market, particularly as they relate to extraneous costs like facility fees. This research would benefit employers, policy makers and

[12] "Equalizing Medicare Payments Regardless of Site-of-Care," February 23, 2021. Using CBO Medicare Baseline 2020. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care

[13] Monahan, Davenport, Swindle, Picher. "Regulating Outpatient Facility Fees: States are Leading the Way to Protect Consumers," July 2023. https://georgetown.app.box.com/v/statefacilityfeeissuebrief

state regulators. Additional research in this space may help to encourage congressional action to adopt site neutral payment policies in the commercial market, as well as in Medicare, which West Health and CRFB estimate would reduce the federal deficit by $117 billion.[14]

Pharmacy Benefit Managers

Pharmacy Benefit Managers (PBMs) can play a valuable role in securing lower prices for drugs. Effective negotiation with pharmaceutical companies who may have monopolies on the supply of critical drugs requires consumer representatives have sufficient purchasing power to incent pharmaceutical companies to provide discounts. PBMs can also realize administrative efficiencies in assembling easily accessible pharmacy networks for consumers and health plans and managing the large volume of pharmaceutical transactions. However, those potential benefits have been severely compromised due to both horizontal and vertical consolidation involving PBMs.[15]

Today, three Pharmacy Benefit Management organizations (PBMs) manage prescription drug claims for around 80% of the U.S. market[16], with approximately 70% of Americans covered by a health insurance plan that is vertically integrated with a PBM.[17] Vertical integration raises concerns about potential impacts n for employers providing health coverage. Nationally, large insurers under common ownership with PBMs are responsible for approximately 90% of rebate negotiations on behalf of commercial plans that cover both medical and pharmacy benefits, disadvantaging employers and individuals who must purchase health coverage in highly concentrated markets. The three largest PBMs — Express Scripts, Optum, and Caremark — serve approximately 270 million Americans and are owned by companies that also market health insurance plans as well as retail, mail order, and specialty pharmacy businesses.[18]

Vertical integration between health insurers, pharmacies, and PBMs coincides with increasing concentration in these markets. In highly competitive markets, cost efficiencies from vertical integration may be shared with consumers. For plan sponsors, like employers, and beneficiaries, this would mean lower premiums and out-of-pocket (OOP) costs because PBMs would compete by sharing more of their rebate revenues and offering lower prices at pharmacies. In fact, in a

[14] "Moving to Site Neutral Payments in Commercial Insurance Payments," February 13, 2023. https://www.crfb.org/blogs/site-neutral-payments-would-lower-private-health-costs-encourage-competition

[15] Kaltenboeck, Chen, Lash. "Pharmacy Benefits Manager Reforms: Can Congress Fix the Market Without Breaking It?" ATI Advisory & West Health Working Paper, April 2024. https://s8637.pcdn.co/wpcontent/uploads/2024/04/ATI-PBM-Paper_4.15.24.pdf

[16] Myshko, Wehrwein, "Beyond the Big Three PBMs," December 2022. https://www.formularywatch.com/view/beyond-the-big-three-pbms

[17] José R. Guardado, "Competition in Commercial PBM Markets and Vertical Integration of Health Insurers with PBMs: 2023 Update," 2023. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf

[18] National Association of Insurance Commissioners, "Pharmacy Benefit Managers," June 2023. https://content.naic.org/cipr-topics/pharmacy-benefit-managers

highly competitive market, reforms to regulate revenues and increase accountability would be redundant. But vertically integrated businesses with significant market power don't have to share their cost efficiencies. For plan sponsors and beneficiaries, this means increased health insurance premiums and OOP costs. While greater transparency is oft cited as a critical need, accountability provisions, including more disclosure and audit requirements regarding PBM operations, are unlikely to improve matters. Identified deficiencies are a result of PBMs and their corporate partners' greater market power, not non-compliance with contract terms.

Recognizing the potential benefits of PBMs along with the possible harms from the lack of competition and vertical integration, potential policy responses should be based on a thorough understanding of current realities. We applaud the FTC for starting an investigation of PBM practices such as using fees and clawbacks charged to unaffiliated pharmacies, methods to steer patients towards pharmacy benefit manager-owned pharmacies, potentially unfair audits of independent pharmacies, complicated and opaque methods to determine pharmacy reimbursement, the prevalence of prior authorizations and other administrative restrictions, the use of specialty drug lists and surrounding specialty drug policies, and the impact of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients.

It is time to go much further and determine whether the anticompetitive effects of PBM consolidation and the vertical integration among health plans, pharmacies, and PBMs outweigh any potential efficiencies. Then the appropriate policies to protect all parties within the health care system can be determined and must be pursued.

On behalf of West Health, I appreciate the opportunity to offer comments on the effects of health care consolidation on hospital and drug prices. We share the goal of the agencies to lower health care costs by improving competitive markets. West Health is concerned that health care facilities with significant market power may generate profits at the expense of patients' health, quality of care, and affordable health care for patients and taxpayers. Thank you for recognizing the need to address horizontal and vertical consolidation across the health care industry. The efforts by your agencies to improve competition and oversight will ultimately benefit patients, providers, payers, and taxpayers. Please do not hesitate to contact me, should you require additional information. I and my colleagues at West Health would be delighted to discuss ways to ensure that your efforts to address consolidation in health care markets are successful.

Sincerely,

Tim Lash
President & Chairman West Health Policy Center