May 10, 2024

Submitted electronically via www.regulations.gov

The Honorable Lina M. Khan
Chair
U.S. Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Request for Information on Consolidation in Health Care Markets

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

The American Benefits Council ("the Council") is writing in response to the request for information (RFI), issued by the U.S. Department of Health and Human Services, U.S. Federal Trade Commission (FTC), and U.S. Department of Justice (DOJ), on consolidation in health care markets and the effects of transactions involving health care providers on various stakeholders, including patients and employers. In our comments, we take this opportunity to provide several high-level recommendations to support competition in health care, due to the necessity of increasing competition to address rising health care costs for employers, workers and their families.

The Council is a Washington, D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial wellbeing of their workers, retirees and families. Council members include more than 220 of the

world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

Employers play a critical role in the health care system, leveraging purchasing power, market efficiencies and plan design innovations to provide health coverage to over 179 million Americans. Employers have a vested interest in securing the health and well-being of their workers, and employers recognize that helping employees thrive has a measurable impact on virtually every aspect of their business. Employers have long pioneered initiatives to lower health care costs and improve quality through various value-based strategies and over the years, including during the COVID-19 pandemic, employers have shown an enduring commitment to the health and well-being of their workers.[1]

At the same time, employers have grown increasingly frustrated with rising health care costs. Top executives at nearly 87% of large employers surveyed in a 2021 poll believed the cost of providing health benefits to employees will become unsustainable in the next five-to-10 years.[2] For context, the national health expenditure grew to $4.5 trillion in 2022, representing 17.3% of the U.S. gross domestic product.[3] And the annual growth in national health spending is expected to average 5.4% over 2022-2031, reaching nearly $7.1 trillion by 2031.[4]

For employer-sponsored coverage, average annual health insurance premiums in 2023 were $8,435 for single coverage and $23,968 for family coverage (with workers contributing, on average, 17% of the premium for single coverage and 29% of the premium for family coverage).[5] Both numbers represented a 7% increase in 2023 and, notably, the average family premium has increased 22% in the last five years and 47% in the last ten years. This trajectory is unsustainable.

As a foundational matter, it is necessary to understand what is driving the increase in health care spending and to address those root causes. On this issue, research demonstrates that it is increased prices, rather than increased utilization, that primarily

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[1] Mercer and the American Benefits Council, *Leading the Way: Employer Innovation in Health Coverage* (2018) and the American Benefits Council, *The Silver Linings Pandemic Playbook* (July 2021).

[2] Kaiser Family Foundation, *Vast Majority of Large Employers Surveyed Say Broader Government Role Will Be Necessary to Control Health Costs and Provide Coverage, Survey Finds* (April 29, 2021).

3 Centers for Medicare and Medicaid Services, *2022 National Health Expenditure Fact Sheet* (NHE Fact Sheet).

[4] *Id*.

[5] Kaiser Family Foundation, *2023 Employer Health Benefits Survey* (Oct. 18, 2023).

drives spending growth.[6] And it is market consolidation that is fueling these prices increases.

Hospital spending, which is the largest health spending category in the United States (*i.e.*, $1.4 trillion in 2022), accounts for 44% of total personal health care spending for the privately insured, and hospital price increases are key drivers of recent growth in per capita spending among the privately insured.[7]

As one 2020 report on price transparency highlighted:

> One of the greatest challenges to affordable health care is the high cost of American hospitals. The most important driver of higher prices for hospital care, in turn, is the rise of regional hospital monopolies. Hospitals are merging into large hospital systems and using their market power to demand higher and higher prices from the privately insured and the uninsured.[8]

This consolidation corrodes the competitive market forces needed to align health care cost with value, resulting in higher costs for plans and patients alike. An estimated 117 million people live in a concentrated hospital market, whereas 160 million reside in a competitive hospital market.[9] And between 2010 and 2017, there were 778 hospital mergers.[10] As a result of such consolidation, many local areas are now dominated by one large, powerful health system. By 2017, two thirds (66%) of all hospitals were part of a larger system, as compared to 53% in 2005[11] and, in most markets, a single hospital system had more than a 50% market share of discharges.[12]

In concentrated markets, prices do not flow from competitive market negotiations, but from the outsized leverage that market concentration affords. Substantial evidence links hospital consolidation to higher prices. The Medicare Payment Advisory Commission (MedPAC) reviewed the published research on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation

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[6] Health Care Cost Institute, *2018 Health Care Cost and Utilization Report* (Feb. 2020).

[7] RAND Corporation, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* (Sept. 18, 2020) and NHE Fact Sheet.

[8] The Foundation for Research on Equal Opportunity, *Affordable Hospital Care Through Competition and Price Transparency* (January 31, 2020).

[9] Urban Institute, *Introducing a Public Option or Capped Provider Payment Rates into Concentrated Insurer and Hospital Markets* (March 2021).

[10] Martin Gaynor, *Examining the Impact of Health Care Consolidation*, for the Committee on Energy and Commerce Oversight and Investigations Subcommittee (Feb. 14, 2018).

[11] Kaiser Family Foundation, *What We Know About Provider Consolidation* (September 2, 2020) (KFF Report).

[12] MedPAC, *Report to Congress: Medicare Payment Policy* (March 2020).

leads to higher prices for commercially insured patients."[13] For example, one analysis looking at 25 metropolitan areas with the highest rates of hospital consolidation from 2010 through 2013 found that the price private insurance paid for the average hospital stay increased in most areas between 11% and 54% in the subsequent years.[14] Prices at monopoly hospitals are 12% higher than those in markets with four or more rivals.[15]

Moreover, consolidation has *not* come with demonstrated improvement in the quality of care.[16] Substantial economic literature has demonstrated that provider consolidation leads (on average) to "less bang for the buck" — higher prices without higher quality or access.[17]

At the same time, many private hospital systems are becoming vertically integrated with physician organizations. Hospitals and corporate entities owned almost half of America's physician practices and employed nearly 70% of physicians by the end of 2020.[18] Such integration can direct patient referrals to higher-priced hospitals within the system and away from lower-priced community providers.

As such, addressing consolidation, restoring competition and better aligning incentives with value are essential to lowering health care costs and are top priorities for the Council and its members.

With this context in mind, we take this opportunity to thank HHS, FTC and DOJ for undertaking this RFI, and we urge the administration and Congress to continue to work to restore competition and prevent further consolidation in health care markets in order to lower health care costs for American families. To this end, below we provide high-level recommendations on various related issues, relevant not just for HHS, FTC and DOJ but also Congress and the administration more generally.

- **Expand site-neutral payment reforms.** A way to decrease incentives for consolidation is for Congress and HHS to expand implementation of site-neutral

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[13] *Id.* at pp. 468

[14] KFF Report, citing Reed Abelson, *When Hospitals Merge to Save Money, Patients Often Pay More*, New York Times (November 18, 2018).

[15] Zack Cooper, Stuart V Craig, Martin Gaynor and John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, Quarterly Journal of Economics, vol. 134, no. 1 (February 2019), pp. 51–107.

[16] See RAND Corporation, *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans* (2021). See also KFF Report.

[17] The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market* (March 2020), pp 7 (The Hamilton Project Report).

[18] Physician Advocacy Institute, *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020* (June 2021).

payment reform, which aligns payment rates for certain services across the three main sites where patients receive outpatient care. Policies that reduce providers' incentives to consolidate could slow or deter market consolidation. One such incentive results from differences in payment rates for the same or similar services at different sites of outpatient care - hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices. Medicare (and private health insurance) generally pay the highest rates for services provided in HOPDs and the lowest rates for services performed in freestanding physician offices. For services provided in freestanding clinician offices, Medicare makes a single payment to the practitioner under the physician fee schedule. For services provided in HOPDs or ASCs, Medicare makes two payments: one for the clinician's professional fee and one for the HOPD or ASC facility fee under the relevant payment system.

According to MedPAC, this disparity incentivizes consolidation of physician practices with hospitals, which result in care being provided in settings with the highest payment rates.[19] This increases costs without significant improvements in patient outcomes. MedPAC's recommendations to align payment rates across the different ambulatory settings for a greater number of services would have resulted in an estimated $6.6 billion savings to Medicare in 2019 and $1.7 billion reduction in beneficiary cost-sharing.[20] Effects for the commercial market are likely even greater. Research by University of Minnesota economist Steve Parente estimates that expanding site-neutral payment reform could result in nearly $60 billion in savings annually if adopted in the commercial market.[21] We urge Congress and HHS to expand site-neutral payment reforms.

- **Restrict hospital billing practices that fuel consolidation and mask what should be the appropriate payment amounts**. After hospitals acquire physician practices, the prices for the services provided by acquired physicians increase by an average of 14.1%.[22] A contributing factor to this increase is the use by hospitals of billing practices that portray services delivered at these sites as "hospital services" as opposed to "professional services" to receive the higher facility reimbursement fee. Hospitals have leveraged the acquisition of physician practices to unfairly bill payers – including employer-sponsored group health plans – higher rates by portraying non-hospital-based professional services as if they were delivered in a hospital. This unfair and opaque billing practice serves

[19] MedPAC, *Medicare and the Health Care Delivery System* (June 2022).

[20] *Id*.

[21] Alliance to Fight for Health Care briefing presentation, *The Untapped Potential of Site-Neutral Payment Reform* (Feb. 1, 2023).

[22] Cory Capps, David Dranove and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, Journal of Health Economics (May 2018).

to incentivize vertical hospital-physician consolidation and increase costs for employers and patients. Hospitals are able to use this billing practice because they are not required to specify where services are provided when they bill. The Council strongly supports legislation requiring each off-campus outpatient department of a hospital to include a unique identification number on claims for services. This important policy will promote "honest billing" practices and help payors distinguish between sites of service to apply the appropriate payment amount.

- **Ensure that federal antitrust laws are fully applied to horizontal and vertical integration in the health care system**. The FTC should establish stricter review and enforcement of hospital and physician practice consolidation, including mergers and hospital acquisitions of physician practices, upon completion of its study under the Merger Retrospective Program. Based on the results of the study, the FTC should make recommendations to Congress to prevent consolidation and increase market competition.

- **Remove barriers to employer innovation by restricting anti-competitive contracting provisions that impede value-driven care**. The Council is aware of large hospital systems that attempt to leverage their significant market share by forcing plans and issuers to contract with all affiliated facilities and by preventing education of patients about lower-cost, higher-quality care. These anti-competitive contract terms in the form of "all-or-nothing", "anti-steering," "anti-tiering" and "most-favored-nation" contract provisions foster highly inflated costs and limit plan sponsors' flexibility in plan design to promote access to high-value care. The Council continues to urge Congress to address anti-competitive contract terms that disrupt market dynamics and raise the cost of health care services across the system.

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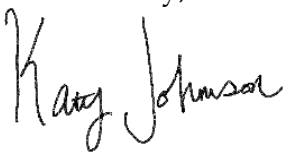
Thank you for your consideration of our comments. Please let us know how the Council can further assist in your important efforts. If you have any questions or would like to discuss further, please contact me at kjohnson@abcstaff.org.

Sincerely,



Katy Johnson
Senior Counsel, Health Policy