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February 4, 2022

The Honorable Kevin Hern
U.S. House of Representatives
1019 Longworth House Office Building
Washington, DC 20515

The Honorable Rick Allen
U.S. House of Representatives
570 Cannon House Office Building
Washington, DC 20515

The Honorable Victoria Spartz
U.S. House of Representatives
1523 Longworth House Office Building
Washington, DC 20515

Dear Representatives Hern, Allen, and Spartz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide the following comments to questions posed by the Healthy Future Task Force Affordability Subcommittee.

I. Improving Healthcare for America's Workers and Small Business Owners

1. On June 19, 2018, the Department of Labor (DOL) finalized the Association Health Plan (AHP) rule 3, which allows small businesses, including the self-employed, to band together by geography or industry to obtain healthcare coverage as a single large employer. In addition, this Congress Rep. Walberg, Republican Leader Foxx, Rep. Allen, and Rep. Burgess introduced H.R. 4547, the Association Health Plans Act to codify association health plans.

    a. Have geographic based AHPs been successful in creating additional insurance options for small businesses?
    b. Should Congress expand upon the Trump Administration rule to increase the number of entities eligible to form AHPs, such as by expanding the "commonality of interest" necessary to form an AHP?

The AMA supports efforts to maximize health plan choices for individuals and small businesses seeking coverage in the individual and small group markets. The AHPs defined by and outlined in the previous Administration's rule, however, fell short of maintaining crucial state and federal patient and provider protections and would result in a lack of meaningful health insurance coverage. We were also concerned about questions raised by the rule regarding the preemption of state insurance laws and the potential for insolvent and fraudulent AHPs.

Expanding upon the AHP rule without the necessary clarification of state regulators' ability to regulate these insurance products would also be a mistake. Congress amended ERISA in 1983 to provide an exception to Employee Retirement Income Security Act of 1974's (ERISA) preemption provisions for the

regulation of multiple employer welfare arrangements (MEWAs) under state insurance laws. The AMA seeks clarification as to the preemption of AHPs as MEWAs. ERISA preemption is complex and can be highly confusing with the interaction of the deeming clause, savings clause, and MEWA exemptions from certain ERISA preemptions along with the different treatment between self-insured and fully insured plans. While the AMA appreciates that not every instance can be described, any further guidance regarding what state insurance laws apply to AHPs and what state insurance laws are "inconsistent with ERISA" would be beneficial. These instructions would lessen confusion among states and help prevent fraudulent AHPs from forming because of confusion around what government entity has enforcement authority. Specifically, the AMA believes the following questions need to be addressed and clarified:

- whether states can outright prohibit the formation or operation of an AHP under the final rule;
- whether states can require AHPs to cover certain state mandated benefits;
- whether states can require individual and small group ACA-like consumer protections for AHPs;
- whether there is any impact on state solvency laws; and
- whether there is any difference in preemption between fully insured and self-insured AHPs.

c. What are the key features needed to allow small businesses to successfully band together to leverage their size to lower costs? What barriers currently exist?

The AMA agrees that "AHPs have the potential to create significant efficiencies that could lower premiums across the board." However, without proper oversight to account for insolvency and fraud, AHPs also have the potential to increase already high insurance premiums and overall health care costs, while threatening patients' health and financial security and the financial stability of physician practices and other providers. Any effort to expand the availability of AHPs and prevent insolvent and fraudulent AHPS should:

- Require AHPs to receive a federal designation;
- Require AHPs to provide explicit notice to participants and beneficiaries;
- Provide clear statement on states' enforcement authority over AHPs; and
- Adequately fund DOL implementation and oversight activities. Given the history of insolvency and concerns with fraud, AHPs should be required to receive a federal designation. Such designation can include basic contact information and description on how the AHP meets the commonality of interest test. Furthermore, AHPs should be required to attest to the truth and accuracy of the information provided for the designation and subject any signature to the penalty of perjury. This provision would provide DOL with authority over the universe of AHPs that will operate under the final rule, which will greatly help oversight and coordination with state insurance commissioners.

The AMA supports the role of states in serving as the primary regulators of the business of health insurance and is frequently supportive of proposals that allow state flexibility in determining the most effective and comprehensive way to deliver care—provided that proposals maintain critical state and federal consumer protections; cover at least as many people; maintain or improve upon established levels

of quality of care; ensure and maximize patient choice of physician and private health plan; and include reforms that eliminate denials for pre-existing conditions. Additionally, the AMA would support the selling of health insurance across state lines, including multi-state compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. As stated above, these protections include not weakening any state's laws or regulations involving network adequacy and transparency; fair contracting and claims handling; prompt pay for physicians; regulation of unfair health insurance market products and activities; rating and underwriting rules; grievance and appeals procedures; and fraud. Furthermore, the AMA believes that patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

II. Promoting Employer Programs to Lower Costs and Improve Care

2. Entities who participate or are planning to participate in programs such as direct contracting, high performance networks, and centers for excellence must determine how to measure value and health care outcomes. For those who participate in these types of private value-based programs please answer the following questions:

    a. How is "value" defined?
    b. How are outcomes measured?
    c. What data is available to understand baseline expenditures, utilization, and population health?
        i. How is this data sourced?
    d. How are providers targeted for network inclusion? What criteria will be used to evaluate performance and where will you source this data?
    e. When applicable, how will an employer group operationalize the contract management, including:
        i. Contract negotiation and management
        ii. Claims payment
        iii. Issue resolution
        iv. Outcomes tracking
        v. Case management/Utilization management
    f. When recruiting providers, how is participation incentivized?
    g. For entities who participate in direct contracting
        i. If the operational aspect of contract management is outsourced, how is confidentiality of terms maintained?
        ii. Is the program regional or national?
        iii. Does it include all services or select high value specialties (oncology, orthopedics, etc.)?
        iv. Does the direct contract exist in addition to standard health plan benefits (for example, will the patient liability be less if the direct network is used, while offering the patient the option of a wider PPO option via standard coverage)?
        v. Has virtual care enhanced these programs? How so?
        vi. Please give an example of the successes and challenges of the program. Please share any additional information about these programs you believe the Healthy Future Task Force should know.

Direct Contracting holds promise as an innovative care delivery model for physicians to be paid for value over volume of care provided and to avoid reporting on legacy quality improvement and cost of care process measures in the Merit-based Incentive Payment System (MIPS) portion of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) program that are less relevant today in achieving good patient outcomes. Unfortunately, the models proposed to date, the Geographic Population Based Payment Model (PBP) and the Global and Professional Direct Contracting Model (GPDCM) need further study and refinement. With the Geographic PBP model, AMA has concerns that the proposal is not sufficiently detailed, is confusing and has numerous operational issues and complexities. We support that model being put on hold and not continued. The AMA agrees with National Association of Accountable Care Organizations (NAACOS) that while it offers some promising policy components—such as allowing utilization management and providing access to a real-time claims application programming interface (aka, API)—that these features could be incorporated into other accountable care models without creating a new model that introduces another layer of administrative complexity to Medicare. The AMA also supports the NAACOS position that certain policy goals of the Geographic Option would be better tested and evaluated in the Direct Contracting Model's Professional and Global Options and/or other ACO programs.

Physicians eagerly embrace innovation as shown by the rapid adoption of telehealth during the pandemic. Telehealth spending went from $14 million in the first two and a half months of 2020 to $1.8 billion between March 16 to June 30 of 2020. While removing barriers in the Medicare Physician Fee Schedule to provider reimbursement for telehealth has been the single biggest factor in this uptick; we are anxious to work with Congress to address administrative barriers to Medicare health care delivery reform as well with the Centers for Medicare and Medicaid Innovation (CMMI). Physician practices have introduced 30 innovative payment models of which 19 were approved by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for CMMI's consideration. To date, Centers for Medicare & Medicaid Services (CMS) has approved zero models. This has had the unfortunate effect of leaving 97 percent of physician practices reporting in the MIPS portion of the MACRA program instead of having an off-ramp into the alternative payment model portion of the program. While conversations with CMMI recently have been more encouraging, additional support from Congress to keep the pressure on for approval of new APMs would bring sorely needed modernization and innovation in care delivery to the Medicare program.

III. Increasing Transparency and Marketplace Innovation

1. Hospitals in the United States typically have more than 20,000 items in their chargemaster files, making it very difficult for patients to compare the price of individual services across hospitals. On November 27, 2019, the Department of Health and Human Services finalized price transparency requirements that make hospitals publish a list of user-friendly, standard charges for certain items and services online.

    a. Earlier this year a report found that the majority of the nation's biggest hospitals were noncompliant with the Department's chargemaster price transparency requirements. Additionally, many hospitals that are in compliance still make it difficult for consumers to access the price information by blocking information from displaying on search engines and providing the information in a non-useable format. What uniform standards

should Congress consider to ensure user-friendly, accessible chargemaster data for patients?

b. In addition to having user-friendly, accessible chargemaster prices it is critical patients have access to accurate information. Often, chargemaster prices are vastly greater than actual payments for those services. To what extent do distorted chargemaster prices affect negotiated payment rates? To what extent do Medicare outlier payments influence hospital chargemaster prices?

c. What quality measurements should hospitals incorporate on their consumer price transparency tools?

The AMA has long-supported efforts to provide price transparency to patients. The current lack of timely, standardized information about the cost of health care services prevents health care markets from operating efficiently. The recent influx of high-deductible health insurance plans, as well as challenges with provider networks adequately meeting the needs of enrollees, means that patients are assuming greater financial responsibility for care choices, thereby increasing the demand for better information about anticipated out-of-pocket costs. As the health care market evolves, patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is rendered. Achieving meaningful price transparency can help lower health care costs and help patients make informed care decisions. As stated above, the AMA believes the most valuable information to a patient is the cost information related to their financial liability.

IV. Increasing Competition and Identifying Anti- Competitive Consolidation

2a. What role should the Federal Trade Commission (FTC) Play in Preventing and Addressing Consolidation in the Hospital Market?

FTC Should Advocate for Lifting the Ban on Physician-Owned Hospitals

The U.S. healthcare system is a market-based system that is not working as well as it could; it faces issues like high and rising prices, suboptimal quality of care, and poor pricing practices.[1] This is partly the result of significant consolidation occurring in hospital markets around the country.[2] Many markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[3] Consolidation has real-life consequences, as clearly laid out in a new book by Professors David Dranove and Lawton R. Burns about health care "megaproviders." They found that in markets "where megaproviders dominate…, health care spending is higher, often much higher, and health

[1] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, 2 (May 19, 2021) (Martin Gaynor, Antitrust Applied).

[2] Martin Gaynor, *Antitrust Applied*, at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/. (last accessed July 14th, 2021), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

[3] Martin Gaynor, *Antitrust Applied*, at 2.

care quality is no better, and sometimes lower."[4] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[5] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[6] The AMA is focused on this issue because the pace of consolidation in hospital markets is accelerating.[7] This consolidation drives up health care costs and marginalizes physicians who want to remain independent.[8]

Fortunately, there is something FTC and Congress can do. The FTC through its Office of Policy Planning that guides the agency's advocacy and policy work, should encourage and support Members of Congress, working together in a bipartisan manner, to take steps to encourage new hospital market entry. Low-hanging fruit would be removing barriers to health care market entry that the government itself has erected. This includes the elimination of the restraint the Affordable Care Act ("ACA") placed on Physician Owned Hospitals ("POHs"). As explained by Joshua Perry in *An Obituary for Physician-Owned Specialty Hospitals,* 23 Health Lawyer 2, 24 (2010), prior to the enactment of the ACA, physicians enjoyed a "whole hospital exception" to the Stark law, meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital. However, provisions within section 6001 of the ACA (42 USC 1395nn) essentially eliminate the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, the POH cannot expand its treatment capacity unless certain restrictive exceptions can be met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement.

The restraint is inconsistent with the general thrust of the ACA, which is to encourage competition, as demonstrated by the creation of health insurance exchanges and the formation of new delivery systems. To increase competition, the AMA urges the removal of that ban on POHs.

An April 12 *Health Affairs* article entitled *"Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals"* explores the prospects of physician-owned hospitals in greater detail. One of the byproducts of hospital consolidation is lower hospital market competition, which translates into higher prices for patients and fewer options for patients to receive needed care. As a result, the article argues that reversing the ACA imposed ban on new construction or expansion of existing physician owned hospitals will both stimulate greater competition and provide patients with another option to receive high quality health care services.

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[4] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021). (Dranove)
[5] Martin Gaynor, *Antitrust Applied*, at 5.
[6] Dranove, *supra*, at 178.
[7] Thomas C. Tsai and Jha K. Ashish, *Hospital Consolidation, Competition, and Quality*, 312 *JAMA* 1, 29 (2014) (The number of hospital mergers in 2014, for example, was double the number of mergers that occurred five years prior.). doi:10.1001/jama.2014.4692.
[8] Dranove, *supra*, at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, Antitrust Applied at 3.

Consolidation Is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health costs.[9] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[10] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[11] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[12] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years. [13] Advocates of mergers argue that these mergers will be able to provide better care or lower costs; however larger health care systems generally have neither superior health outcomes nor lower costs.[14] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[15] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs. [16]

Increased Hospital Concentration Is Correlated with Worse Health Outcomes

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets. [17] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[18] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

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[9] Martin Gaynor and Robert Town, *supra*.

[10] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 The Quarterly Journal of Economics 1, 51 (February 2019). https://doi.org/10.1093/qje/qjy020.

[11] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, RAND Corporation, 3 (2020).

[12] Martin Gaynor, *Health Care Industry Consolidation*, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).

[13] Martin Gaynor, *Antitrust Applied*, at 4.

[14] Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 *International Journal of the Economics of Business* 1 (2011); Robert Lawton Burns, Jeffrey S. Mccullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. *Is the System Really the Solution? Operating Costs in Hospital Systems*, 72 Medical Care Research and Review 3, 247 (2015). doi:10.1177/1077558715583789.

[15] Emily Gee, *Provider Consolidation Drives Up Health Care Costs*, Center for American Progress, (last accessed July 14th, 2021), https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/.

[16] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service*, 5 American Economic Journal: Economic Policy 4, 134 (2013). doi:10.1257/pol.5.4.134.

[17] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q J Econ. 2, 577 (2000).

[18] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).

Antitrust Enforcement Has Not Been Adequate to Reinvigorate Markets

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. In their new book, Professors David Dranove and Lawton R. Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[19] The antitrust response has been inadequate notwithstanding the significant resources dedicated to restoring competition in health care. For example, between 2010 and 2018, over half of antitrust cases brough by the FTC were focused on the health care industry.[20] Yet antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision.[21] Similarly, the FTC cannot even enforce against anticompetitive conduct by not-for-profits; a problem, considering how many hospitals are run as not-for-profits.[22] Consequently, the problem of concentrated hospital markets dominated by megaproviders driving up the high cost of healthcare in America requires new remedies.

Lifting the Ban on Physician Owned Hospitals Would Encourage New Hospital Market Entry

There have been many policy solutions proposed as remedies to slow consolidation within the hospital market. A 2020 report from Alexander Acosta, Alex M. Azar II, and Steven T. Mnuchin, entitled *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020) recommends that "Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals."[23] The ban of POHs has measurable consequences; the ban prevented the development of more than 75 new hospitals.[24] Congressional action would be especially welcome because physician owned hospitals have developed an enviable track record for high quality and low-cost care.[25]

In sum, much of the U.S. hospital market lacks competition and restoring the whole hospital exception to Stark law is the right prescription.

In addition to consideration of the problems created by consolidation in hospital markets, it would be a mistake to overlook the consolidation in health insurance markets and how it contributes to less access to care for patients and higher health plan premiums. Every year, the AMA studies insurance market concentration in metropolitan statistical areas (MSAs), the 50 states and DC using the Herfindahl-Hirshman Index (HHI). Markets that exceed an HHI of 2500 points are "highly concentrated" according to federal guidelines. The AMA's 2021 Update to *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* found that, between 2014 and 2020, the share of MSA-level markets that were

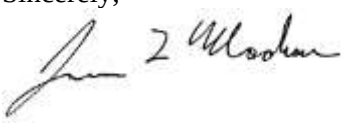
[19] Dranove, *supra*, at 178.
[20] Martin Gaynor, *Antitrust Applied*, at 17.
[21] C. Capps, David Dranove, and C. Ody, *Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene*, 36 Health Affairs 9, 1556 (2017).
[22] Martin Gaynor, *Antitrust Applied*, at 18.
[23] Alexander Acosta, Alex M. Azar II, Steven T. Mnuchin, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020).
[24] Jesse Ehrenfeld et. al., *Reversing Hospital Consolidation: The Promise of Physician Owned Hospitals*, Health Affairs (last accessed April 12, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210408.980640/full/.
[25] Acosta, *supra*.

highly concentrated increased from 71 percent to 73 percent. Plus, more than half (54 percent) of the markets that were highly concentrated in 2014 grew *even more* concentrated by 2020. Furthermore, 91 percent of the MSA-level markets had a single insurer with a market share of 30 percent or greater, while 46 percent of MSA-level markets had a single insurer with a market share of 50 percent or greater. As experience has shown us, less competition in health insurance markets over the years does not translate into efficiencies and cost savings that are passed along to patients. Instead, it facilitates the exercise of health insurer market power—lower reimbursement for providers, and higher premiums for patients. In other words, everyone loses except for the health insurer whose net profits have increased.

In short, there is little competition in both health insurance and hospital markets.

Thank you for your consideration of our comments.

Sincerely,



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