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Advancing Health in America

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Testimony

of the

American Hospital Association

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of the

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of the

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"Antitrust Applied: Hospital Consolidation Concerns and Solutions"

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Good afternoon Chair Klobuchar, Ranking Member Lee and members of the Subcommittee. I am Dr. Rod Hochman, Chair of the American Hospital Association's (AHA) Board of Trustees, and I am pleased to be here today representing our nearly 5,000 member hospitals, health systems and other health care organizations across the country. On behalf of the AHA, I thank you for your support as our hospital and health system teams cared for the millions of patients with COVID-19 over the past year and a half. Our hospitals and health care workers are heroes, and they continue to serve on the front lines of this pandemic as we gather today.

I have served in the medical field for 42 years as an immunologist and rheumatologist, and I currently serve as president and CEO of Providence, a 52-hospital, integrated, not-for-profit health system located throughout the West – from Alaska to Texas.

I know we have a shared commitment to ensuring patients have access to the lifesaving care that caregivers in our hospitals provide. I am particularly pleased to have the opportunity to share with you how our caregivers at hospitals, and hospital systems in particular, serve patients and communities around the nation, in addition to their heroic efforts on the front lines of the COVID-19 pandemic. I've known for a long time, but

COVID-19 has underscored, that hospitals are the lifeline of our communities. We are this nation's most trusted public health safety net.

Hospitals continue to care for all the patients who walk through their doors and to meet the challenges present in the communities they serve. Whether those challenges include a surge in COVID-19 patients, treating victims of addiction, mass violence, accidents or natural disasters, or an increase in maternal deaths or cancer, hospitals are stalwarts of their communities. Serving all of these community needs – and many others – requires more integration than ever. Integration is necessary to assure that both the human and financial capital is available to stand up, reconfigure or even reimagine the services needed and how best to deliver them in a field facing increasing competition.

The hospital field is awash with new entrants, such as commercial health insurers that own physician practices and technology companies offering services that compete with those provided by integrated hospital systems. Many of those competitors do not play by the same rules as hospitals and health systems or even pretend to serve the entire community. This increases the pressure on integrated hospital systems to fill in the gaps for a ragged public health infrastructure and to serve everyone in the community, including those the technology companies would leave behind.

Hospital mergers and acquisitions also enjoy an enormous amount of scrutiny from the federal antitrust agencies and state attorneys general. The AHA has been critical of the approach and framework the Federal Trade Commission (FTC) has employed to review hospital transactions. The FTC continues to challenge any transaction it believes presents anticompetitive risks and until recently had an impressive track record in the courts. However, the transactions challenged publicly only tell part of the story as the FTC has many tools to discourage hospitals moving forward with a transaction before it gets to court.

There are many reasons for mergers and acquisitions in the hospital field. Often they are prompted by financial pressures that can limit a hospital's ability to marshal the resources needed to effectively care for its community, especially small and rural critical access hospitals. The numbers alone tell the story: 136 rural hospitals have closed since 2010,[i] inpatient admissions have been declining for years, and Medicaid and Medicare rates are perpetually below the cost of providing care. Those combined underpayments amounted to $75.8 billion in 2019, according to the AHA.

At the same time, hospitals' expenses continue to grow. Prescription drug spending per hospital admission increased 18.5% between fiscal years 2015 and 2017.[ii] Private staffing firms and agencies are leveraging workforce shortages to drive up labor costs, a trend that has been exacerbated dramatically by the COVID-19 pandemic – a topic AHA requested the FTC investigate to no avail.[iii,iv,v]

Commercial health insurer consolidation contributes substantially to increasing providers' costs in ways that do not benefit consumers. Seventy-four percent of metropolitan statistical area (MSA)-level markets were highly concentrated in 2019, up from 71% in 2014.[vi] In fact, in nearly half of all markets (48%), one insurer's share is at

least 50%. And peer-reviewed studies have found that when an insurance market is highly concentrated, insurers reduce provider payments and do not pass savings along to the consumer.[vii] In addition, some of the insurers are using leverage gained by acquisitions that went unchallenged by the federal antitrust agencies to increase costs for hospitals and health systems with myriad rules that create hurdles to care. These do not benefit patients and needlessly increase hospitals' costs.[viii]

As health insurers have grown, they have diversified their health care portfolios to provide products and services in ways that circumvent medical loss ratio limits on profit, including in technology, analytics, pharmacy and care delivery. For example, UnitedHealth Group directs a substantial amount of premium dollars to itself through its growing network of employed, affiliated and managed providers – it currently has 53,000 providers and plans to grow by at least 10,000 more by the end of this year.[ix] And insurers' acquisition of pharmaceutical benefit managers are contributing to the increase in hospital and health system drug spending. In fact, three of the largest pharmacy benefit managers are owned by health insurers: Caremark (CVS Health), Express Scripts (Cigna), and OptumRx (UnitedHealth Group).[x]

THE BENEFITS OF BEING PART OF A HEALTH SYSTEM

Being a member of a health system brings measurable benefits to patients and health system employees: lower health care costs, improved patient care, better access to health care providers, and increased investment in technology and equipment.

Lower Health Care Costs

Mergers with larger hospital systems can provide community hospitals the scale and resources needed to decrease costs.[xi] Various studies confirm that increased administrative efficiencies and reduction of redundant or duplicative services contribute to merger-related cost reductions.[xii, xiii]

For example, hospital mergers between 2009 and 2014 "were associated with a 2.5% reduction in operating expense per adjusted admission at the acquired hospitals."[xiv] And extending the analysis through 2017 finds a 2.3% reduction in annual operating expenses per admission at acquired hospitals, and an approximately 1.5% to 3.5% reduction in total expenses through consolidation of administrative and supply chain operations.[xv] Another study of hospital transactions between 2000 and 2010 found "evidence of economically and statistically significant cost reductions at acquired hospitals" averaging between 4% and 7%.[xvi]

Moreover, additional substantial savings come from improved information technology (IT) systems and advanced data analytics. Consolidated hospital systems can often better invest in IT infrastructure for both clinical and financial data that can then be used to identify best practices for more cost-effective, integrated and streamlined care.[xvii] These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals. Hospital systems can spread the costs over a larger patient population while also performing more sophisticated analyses given the larger patient database to identify patterns and improve care. In a survey of hospital

executives involved in mergers, implementing or upgrading clinical information systems was the most common use of new capital received by the acquired hospital.[xviii]

In addition, hospitals realize the cost benefits of mergers quickly, with hospitals largely reporting reduced operating expenses one year after the merger.[xix] And the benefits have a lasting impact, with studies finding cost savings still evident four years after consummation of the merger and lower cost growth rates and lower price growth rates at merging hospitals compared to non-merging hospitals over an extended period.[xx]

Unfortunately, consumers do not always benefit when hospitals are able to reduce costs because commercial insurance consolidation has allowed insurers to pocket those savings instead of passing them on to consumers. This was laid bare when the Department of Justice challenged the attempted merger of Cigna with Anthem.

Increased Ability to Make Needed Capital Investments and Effectively Deploy Other Resources

Financially distressed hospitals often cannot effectively recruit clinical staff, upgrade technology or offer specialty services, relative to their financially stable peers. Acquiring-hospitals often provide capital infusions to address these issues, as evidenced by the almost 80% of respondents in one survey who reported significant capital investments in the acquired hospital after the transaction.[xxi] These investments result in improved services.

Mergers also can help hospitals "respond to marketplace needs and can help ameliorate resource constraints," including physical space, capital and personnel.[xxii] With reduced patient volumes and financial difficulties, community hospitals often have excess capacity.[xxiii] Significant excess capacity can result in higher operating costs per patient, but reduction or elimination of excess capacity may be difficult to achieve absent mergers or consolidation.[xxiv] When a transaction involves an academic medical center it may be because those organizations often have capacity constraints that can be addressed by a merger with a community hospital.

More efficient allocations of resources also facilitate treatment of patients in less costly settings. For example, integration of community hospitals with academic medical centers or hospital systems allows the health system to admit patients to the facility best suited for their needs and decrease costs of care. Patients using the academic medical center for less complex services instead could be treated at the community hospital, easing capacity constraints at the academic medical center, potentially lowering patients' costs, and often providing a more convenient location for the patients. The academic medical center could then reutilize existing space for the specialist, tertiary and quaternary services not available at community hospitals.

Greater Ability to Participate in Payments Linked to Outcomes

Scale and capital investment also are key conditions that hospitals and health systems must meet in order to take on risk and participate in alternative payment models. Provider payment is moving away from volume-based systems in an effort to focus on patient outcomes while reducing costs. Realigning care around these incentives requires scale in order to take on financial risk. Moreover, these efforts would not be

possible without analytics and key investments in health technology. Hospital and health system mergers will help boost participation in these models, which in turn will drive down the cost of care and improve health outcomes.

More Stability and Opportunities for Hospitals' Workforce

Hospitals are often anchors for their communities and key economic contributors. Hospitals are jobs creators, and hire employees to serve in many roles, both skilled and unskilled. For example, the Saint Raphael campus added 541 employees following its 2012 merger with Yale New Haven Health. Hospitals are perpetually working to fill clinical positions, including physicians and nurses, where shortages are common and projected to get worse. That was never truer than during the pandemic when skilled nurses treating COVID-19 patients were in short supply and private nursing staffing agencies were charging double and even triple their usual fees to obtain their services.

Measuring workers' benefits on the basis of salary alone fails to account for benefits that can make hospitals the best places to work in any community. Hospitals and health systems provide many other benefits such as retirement plans, life and other insurance coverage, subsidized child care and tuition reimbursement, to name a few. Mergers and acquisitions can provide new benefits, as well as growth or promotional opportunities. For example, Yale New Haven Health reports that over 1,100 employees of Saint Raphael Hospital were able to take part in career ladders to further advance their careers as a result of their merger in 2012.

Quality Improvements Fueled by Mergers

Mergers can provide community hospitals with the necessary scale to use sophisticated data analytics, identify best practices and implement innovations such as telemedicine. Data-driven development of best practices can reduce the rates of readmission and mortality in merged hospitals.

For example, one hospital system in the Northeast was able to better deploy their surgical staff according to expertise and experience following an acquisition, which led to improved health outcomes.[xxv] Statistically significant empirical results include a decrease of 1.1% in the 30-day readmission for heart attacks and a decrease of 1.7% in the mortality rate for pneumonia.[xxvi] Other quality improvements following a hospital acquisition include increased Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, reduced readmissions, reduced physician appointment wait times and reduced mortality.[xxvii]

The Pandemic Confirmed the Value of Health Systems' Integration

The COVID-19 pandemic has highlighted many of the benefits of being part of a health system. Hospitals and health systems were faced with multiple COVID-19 surges that pushed resources to capacity. Integrated health systems were well positioned to deploy their resources to procure equipment in short supply, utilize IT systems to triage equipment and staff, reconfigure space to focus on infected patients and separate them from others, participate in large scale targeted research, and perhaps most importantly, redeploy the workforce needed to meet these rapidly changing needs in multiple locations.

As COVID-19 case surges occurred throughout the country, health systems with multiple hospitals were able to transfer patients from one facility to another depending on their respective volume levels and available hospital and intensive care unit (ICU) beds. This was especially true for health systems with smaller, rural hospitals that had fewer ICU beds and staff trained to treat infected patients. Having the ability to look across a system and identify where there was available capacity was immensely important to ensuring that patients got needed care and that resources were used efficiently.

This wasn't just limited to transfers of patients. Faced with unprecedented workforce challenges, health system leaders often were able to develop flexible staffing strategies to address patient surges in emergency departments, ICUs, and medical and surgical units. This extended beyond clinical staff. Health systems often were able to redeploy administrative staff to the front lines in roles such as unit clerks and vaccination processing teams.

Health systems also were able to deploy their resources and size to quickly mobilize dedicated supply chain teams responsible for tracking down personal protective equipment and other supplies and purchase them in bulk to avoid shortages. Often these efforts were on a global scale, as system staff looked for supply sources outside their typical chains around the world. In some cases, health systems were able to invest directly in domestic manufacturers to actually produce supplies.

In addition, health systems often were able to develop in-house testing capabilities, drastically expanding and supplementing often dangerously strained local and state public health efforts. Many systems that established testing sites were later infusion centers and more recently vaccination sites.

The ability to harness data and analytics to understand current trends, predict future needs and quite often expand care capacity also was essential during the year. Again, health systems often were able to use their existing data and IT infrastructure to meet these rapidly changing needs.

CONCLUSION

Some critics are quick to dismiss the benefits of hospital mergers and acquisitions. As a physician with over four decades of experience caring for patients, I can tell you that integration is the key to ensuring every community, whether rural, urban or suburban, has access to the same high standard of affordable, evidenced-based care. The ability of health systems to marshal financial and human resources during the pandemic to save lives and protect communities illustrates vividly their enduring value. And unlike other sectors of health care, communities can be assured that there is vigorous oversight by every level of government to assure those benefits are actually delivered to the patients hospitals and health systems serve. We look forward to discussing with you our shared goal of ensuring that hospitals remain a vital source of care for everyone in their communities, and that they can meet whatever new challenges arise as we work to advance health in America.

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