

**Testimony of the
American Hospital Association
before the
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
of the
Committee on the Judiciary
of the
U.S. House of Representatives**

**“The State of Competition in the Health Care Marketplace: The Patient Protection and
Affordable Care Act’s Impact on Competition”**

September 10, 2015

I am Rick Pollack, president and CEO of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I thank you for the opportunity to testify.

When the AHA last testified before the House Judiciary Committee in 2012, we began by noting that the health care landscape was changing. At that time, not even we appreciated how much and how fast that environment would change. Market forces continue to rapidly transform the landscape for hospitals and health systems as they work to achieve the Triple Aim – improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. To better serve their communities, hospitals and health systems are integrating with other providers in a variety of ways to ensure more coordinated and patient-centered care and improve efficiency and reduce costs. Hospitals are making progress in all of these areas despite operating in an environment that has enormous capital and regulatory demands and payments linked increasingly to achieving high performance. Meeting these demands often requires significant restructuring for hospitals, all of which has taken place during a period of historically low levels of hospital price growth. (See attached chart at the end of the testimony.)



Contrast that with the recently announced commercial insurance deals – Anthem/Cigna and Aetna/Humana. Those deals appear motivated by top-line profits. The market concentration threatened by the pending insurance deals is large and durable, and consumers and providers are at risk if the deals are allowed to move forward. The two deals promise fewer choices for consumers for commercial insurance and Medicare Advantage (MA) plans, narrower networks of providers in what few choices remain, and higher premiums and/or out-of-pocket costs, among other things. Even if these insurers make good on their promise to reduce costs if they are permitted to consolidate, insurers have a dismal track record of passing any of those benefits on to consumers, and there is no reason to think these deals will be differentⁱ.

The momentum hospitals have established to move our health care system forward also is at risk. Despite their recent claims that they are fostering innovation, these commercial insurers continue to benefit financially from letting hospitals do the hard work of reducing readmissions, improving (rigorously measured) patient quality, experimenting with accountable care organizations (ACOs) and bundling programs, instituting population health programs and numerous other efforts designed to turn a system predicated on volume to one measured by value. There is no reason to believe that allowing these insurers to become even larger and more immune from competitive forces would alter their incentive to sit mostly on the sidelines and reap the considerable financial rewards of provider innovation.

Our testimony focuses on the market forces reshaping the hospital field and how different those are from those that are at work in the proposed commercial insurance consolidations. We also discuss some of the reasons we believe the Department of Justice’s Antitrust Division (Department) is likely to find that these deals present an unacceptable risk to consumers.

HOSPITALS ADAPT TO A CHANGING LANDSCAPE TO BENEFIT PATIENTS

Hospitals’ Realignment. Hospitals have shouldered much of the heavy burden of reshaping the nation’s health care system to meet the laudable goals of improving quality and efficiency and making care more affordable for patients and families. And hospitals have made significant strides toward meeting all of those goals. A July 2015 study, reported in the *Journal of the American Medical Association*, described it as a “medical hat trick:”ⁱⁱ

In this comprehensive analysis of the hospital trends in the Medicare fee-for-service populations aged 65 years and older, there were marked reductions in all-cause mortality rates, all-cause hospitalization rates, and inpatient expenditures, as well as improvements in outcomes during and after hospitalization.

The major forces reshaping the health care system for hospitals are:

- Widespread recognition, especially among those in the hospital field, of the need to replace a “siloed” health care system with a continuum of care that improves coordination and quality and reduces costs for patients;
- Changes in reimbursement models to reward value and encourage population health;
- Increased capital requirements; and

- Competition that is rapidly changing how services are delivered.

Building a Continuum of Care. Our 2012 testimony detailed some of the pivotal events that led the hospital field to begin in earnest replacing a health care system characterized by uncoordinated silos of care with one that provided patients with a continuum of care. That work has continued unabated.

Building a continuum demands that providers be more integrated. Integration can take many forms – hospitals, physicians, acute-care providers and others in the health care chain can integrate clinically or financially, horizontally or vertically, and the relationships can range from loose affiliations to complete mergers – and it is happening across the country. For example, a large teaching hospital in Virginia is partnering with other hospitals in the state to form a regional health care system stretching into Northern Virginia; a New Orleans health system is partnering with four other hospitals across the state to launch a network to provide patients with access to 25 medical facilities and more than 3,000 physicians; and hospitals in Michigan partnered to create a regional affiliation allowing a critical access hospitals’ patients access to the full array of services offered by the larger system.

Hospitals and patients benefit when a hospital realigns. The most common benefits are improved coordination across the care continuum, increased operational efficiencies, greater access to cash and capital for smaller or financially distressed hospitals and support for innovation, including payment alternatives that entail financial risk. For financially struggling hospitals, finding a partner can make all the difference. For example, a health system in Ohio acquired a small, community hospital in bankruptcy with closure impending, which saved 250 community jobs, increased technological efficiencies and expanded access to care in the rural area. The acquisition by a nearby hospital system of a hospital that was struggling financially led to it being transformed into a much-needed regional children’s hospital, which provided improved access and services for area children.

Regulatory Barriers Persist for Integration. While innovative partnerships and integrative arrangements abound throughout the country, permanent arrangements, such as mergers, offer the most protection from a staggering array of outdated regulatory barriers that make integration risky when Medicare or Medicaid patients are involved. Despite the AHA having identified the five main barriers to clinical integration more than 10 years ago, to date, only one regulatory barrier has been addressed. The following barriers remain:

- Lack of antitrust guidance on clinical integration (current guidance applies only to arrangements that are part of the Medicare Shared Savings Program, better known as ACOs);
- Restrictions on arrangements that base payments on achievements in quality and efficiency instead of just hours worked (Stark Law);
- Restrictions on financial incentives to physicians that could be construed as influencing care provided, even if the goal of the incentive is to adopt proven protocols and procedures to improve care (Anti-kickback law); and

- Uncertainty about how the Internal Revenue Service will view payments from tax-exempt hospitals to non-tax exempt physicians working together in clinically integrated arrangements.

It is notable that all these barriers to clinical integration had to be addressed to allow the ACO program to move forward. Yet, the federal agencies responsible for administering these laws and regulations have yet to modernize them, with one limited exception, to support even more progress toward building a continuum of care through innovative arrangements like those described above.

MOVING TO A VALUE-BASED REIMBURSEMENT SYSTEM

Increasingly, reimbursement models are being recast to compensate providers based on outcomes, not the volume of services provided. The outcomes being rewarded include keeping patients well (population health) and providing high-quality services when patients are in the hospital.

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve higher quality care at lower costs. These reforms include forming ACOs, bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations. The Centers for Medicare & Medicaid Services (CMS) recently announced a goal of moving 30 percent of Medicare payments to alternative models of reimbursement that reward value by 2016 and to 50 percent of payments by 2018. In its announcement, CMS recognized that achieving these goals would require hospitals to “make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care.”

Hospitals have supported these efforts and often take the lead in testing and improving them. In addition, hospitals are collaborating with and learning from each other in order to improve the quality of care they deliver to patients. For example, the Health Research & Educational Trust (HRET), an AHA affiliate, was awarded a contract by CMS to support the Partnership for Patients campaign, a three-year, public-private partnership designed to improve the quality, safety and affordability of health care for all Americans. The AHA/HRET Hospital Engagement Network project helped hospitals adopt new practices with the goal of improving patient care and reducing readmissions by 20 percent. The project, which included a network of nearly 1,500 hospitals across 31 states, focused on several areas of impact and produced cost savings of \$988 million through improved care. Some additional highlights include: a 61 percent reduction in early elective deliveries across 800 birthing hospitals; a 48 percent reduction in Venous thromboembolism (blood clot in a vein) across 900 hospitals; and a 54 percent reduction in pressure ulcers across 1,200 hospitals.

Meanwhile, many hospitals report that it has been difficult to work with commercial insurers in moving to new payment models. We recently surveyed members of AHA’s nine regional policy boards, which represent hundreds of hospitals around the nation, about their experience working

with commercial insurers on new payment models. About 80 percent reported it was a challenge to work with insurers on new payment models, and more than 40 percent described it as a major challenge.

INCREASED CAPITAL REQUIREMENTS

The fundamental restructuring that CMS anticipates in response to its alternative reimbursement models will undoubtedly come with a high cost that will be particularly difficult to bear for small and stand-alone hospitals. Already, the field is under serious financial pressure from the need for capital expenditures, particularly those for health information technology (IT) and electronic health records (EHRs). In fact, the AHA estimates that hospitals collectively spent \$47 billion on IT, including EHRs, each and every year between 2010 and 2013.

EHRs are essential to improving care and, consequently, succeeding in value-based reimbursement models. Every hospital is expected to meet a constantly evolving set of standards for having and using EHRs for their patients. And a portion of Medicare and Medicaid reimbursement is conditioned on EHR adoption and use. Estimates are that EHRs will cost a hospital between \$20 and \$200 million depending on their size. For smaller, rural and stand-alone hospitals, these costs can be ruinous without a partner to absorb some of the cost and provide the necessary technical expertise.

For many hospitals, the credit markets are already difficult to access. The most recent FitchRating report confirms this; starting in 2011, the profitability “metrics” for the lowest rated hospitals has declined.ⁱⁱⁱ The lowest rated hospitals tend to be smaller or stand-alone. The debt burden for the lowest rated hospitals also has continued to grow, and the hospitals’ operating margins are razor thin. For these hospitals, accessing the credit markets for capital improvements, including technology, will be difficult, if possible at all. Without a partner, these hospitals will continue to decline until they are forced to close their doors, with potentially devastating repercussions for the communities they serve.

NEW COMPETITION FOR HOSPITAL SERVICES

Rapid changes in the health care market are providing consumers with an increased array of options for their health care, including services that hospitals provide.

CVS, Walgreens and Wal-Mart, among others, are changing where consumers go for their health care needs. The retailers offer an array of health care services, including primary care, immunizations, blood pressure monitoring and routine blood tests, all of which were formerly available only in a doctor’s office or hospital outpatient clinic or emergency room. Meanwhile, many of the retailers have ambitions to provide even more sophisticated care and services at their thousands of convenient locations. These developments challenge hospitals to become more integrated with physicians and other providers so that they too can offer convenient and more affordable care that is attractive to patients.

Telehealth promises to revolutionize how an incredible array of health care services are provided to consumers and to change the competitive landscape entirely. Telehealth is already delivering services as different as dermatology and mental health to patients across town and across the country. A hospital in Arlington, Va., has an arrangement with the Mayo Clinic, which is based in Rochester, Minn., that allows its patients access to Mayo's expertise without leaving the neighborhood. A hospital system in California was able to cover its needs for physician intensivists at one of its satellite facilities using mobile telehealth devices instead of hiring new doctors, with positive clinical and patient satisfaction outcomes. Increasingly patients are able to consult doctors using their computers, laptops and smartphones, and this is becoming a more common expectation of patients when they seek care. For their part, insurers too are increasingly relying on telehealth to reduce costs and meet network adequacy requirements. All of this changes the competitive landscape for hospitals. Now, competitors for even specialized services do not have to be in the same neighborhood, city or state to connect with patients that might otherwise have sought care at their local hospital.

The rapid growth of telehealth illustrates how quickly the competitive landscape can change for hospitals and the importance of having adequate financial resources and access to capital. Without those resources, hospitals cannot keep up with the demands of new technology or the opportunities they present.

SERIOUS CONCERNS ABOUT HEALTH INSURANCE CONSOLIDATION

The AHA has serious concerns about the recently announced health insurance consolidation: Anthem with Cigna and Aetna with Humana. These deals would eliminate two of the largest national health insurance companies, leaving just three dominant providers of health insurance. A recent study in *Technology Science*, highlighted why this increasing concentration should be of particular concern. It found the largest issuer in each state not only raised premiums higher, but also raised premiums on more of their plans than other issuers in the same state.

In separate letters to the Department, AHA detailed the hospital field's concerns about the deals. The two letters are available at www.aha.org/letters, and we briefly outline our concerns below.

The Anthem Deal Threatens to Reduce Competition on a Massive Scale. The Anthem/Cigna transaction threatens to reduce competition in at least 817 markets across the U.S. serving 45 million consumers. This estimate uses the same concentration index – the Herfindahl-Hirschman Index (HHI) – as the federal antitrust agencies. The high barriers to entry in the health insurance market exacerbate this massive concentration. A former Acting Assistant Attorney General described entry as “difficult,” particularly in concentrated markets like those at issue in this transaction.

Claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different. In addition, neither of the

legislated controls on excessive premium hikes – medical loss ratio (MLR) or rate review – are sufficient to prevent Anthem from raising rates to consumers above competitive levels.

The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. The MLR thresholds are set at 85 percent for large group health insurance coverage and 80 percent for small group coverage. Despite its seeming promise, the MLR will not be effective in controlling premium cost increases because: the MLR requirements apply to fewer than 50 percent of Americans under 65 with health insurance coverage; the rules for reporting MLRs may mask differences in premiums rate increases; and the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities.

Likewise, insurance rate review will not prevent rate hikes. Neither the Department of Health and Human Services nor most states have the power to prevent a rate hike. For example, an article in the August 27 *Wall Street Journal* reported that officials had “greenlighted” hikes in health insurance rates of more than 36 percent in Tennessee, 25 percent in Kentucky and 23 percent in Idaho.

Lastly, Anthem’s affiliation with the Blue Cross and Blue Shield (Blue) system raises some particular competitive concerns that we urge the Department to examine closely as part of its comprehensive investigation. An August 2015 letter from Joe R. Whatley, Jr., to the Department described the BCBSA License Agreement that prevents the individual Blues from directly competing against one another, and also prevents their non-Blue subsidiaries from competing even slightly vigorously against other Blue companies. The letter stated:

Because Anthem cannot expand its non-Blues business, an evaluation of the effects of its merger with Cigna must include not only those geographic markets in which Cigna competes with Anthem, but also those geographic markets where Cigna competes (or would compete) with any other insurers. In each of those markets ... Cigna can no longer compete for new business in any market unless it decreases its business by an offsetting amount in another market. The net effect is that Cigna’s effectiveness as a competitor ... will be impaired.

The letter may only have partially captured the extensive interconnections between Anthem and the other Blue Card members that appear likely to eliminate competition between Cigna and every Blue plan in every state. In fact, the letter may understate the coordination likely to result between Cigna and the non-Anthem Blues plans.

As a result of the folding of Cigna into the overall Blue system through Anthem Blues’ affiliation, this merger may augment the already considerable power of the Blue plan in every state. American Medical Association data report that Blues plans tend to be the most dominant plan in virtually every state in which they operate. Because of the way in which the Blue system operates, Blues plans nationwide may now be able to control Cigna lives, particularly for BlueCard members including national employer accounts, as their own when they negotiate with providers for rates, terms, and conditions under which coverage is available to consumers. If so, this would give these Blues plans even more market power to block entry into their local markets and to constrict plan

design and reimbursement rates, by, for example, further narrowing provider networks available to consumers and/or driving down rates for those in the network below competitive levels and causing some to decline to participate in any network. The Blues' control over provider reimbursement would increase their ability to put new and potentially expanding competing health plans at a competitive disadvantage by depriving providers of the flexibility and options to work effectively with those new insurance competitors.

At a time of rising health insurance premiums, the Department and state Attorneys General should take a close look at how this acquisition could increase Blue plan dominance nationwide. Blue Cross dominance has been an issue the Department has been concerned about in previous health insurance consolidations. In a speech by former Assistant Attorney General Christine Varney, she noted that local health plan dominance (i.e. Blues plan dominance) creates barriers to entry. And, the department has challenged two Blue plan mergers that would have increased that dominance. Given the size and scope of this deal and the dominance of the Blues plans nationwide, the Department should thoroughly investigate how the addition of Cigna to the Blues' arrangement could further entrench that widespread dominance and result in less competition, fewer practicing providers and higher consumer premiums.

Aetna's Deal with Humana Could Further Concentrate MA Markets Already Suffering from a Lack of Competitive Alternatives. More than 2.7 million seniors are enrolled in MA plans operated by the companies in more than 1,000 markets that would become highly concentrated if Aetna is permitted to acquire Humana (this estimate uses the HHI). The deal will not only eliminate current competition between Aetna and Humana in the MA market, it also will eliminate the possibility of future competition between them. Humana is the second largest MA insurer and Aetna the fourth.

This is particularly concerning as there is almost a complete lack of competition in MA markets, according to an August 2015 report by the Commonwealth Fund, which states that "97 percent of the [MA] markets in U.S. counties are highly concentrated." This confirms a recent report by the Kaiser Family Foundation that also describes MA markets as highly concentrated. That report also notes that while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

The Department has viewed MA as a separate product market because of its unique characteristics. Both lower out-of-pocket costs and a more extensive benefit design have distinguished it from traditional Medicare. While payments to MA plans have moderated, the financial protection and greater range of benefits offered by MA plans continue to attract seniors in large numbers, despite predictions that lowered payments would have the opposite effect. Today, almost one in three Medicare beneficiaries are enrolled in an MA plan, amounting to 16.8 million people.

The high barriers to market entry and lack of efficiencies present in the Anthem deal are present here as well. The remedy the Department has relied on in previous health insurance deals – a series of MA plan divestitures – is unlikely to be sufficient to remediate the likely competitive harm from this deal. Even if it were feasible, it would be a staggering task to develop, implement

and supervise these divestitures in a manner that did not further erode the competitive equilibrium in these markets.

CONCLUSION

Hospitals are woven into the fabric of their communities, and as such, they know what their patients need and how to deliver that care at lower costs while improving quality. At the same time, hospitals are adapting to the enormous change that is occurring in the health care landscape because they know yesterday's health care system will not meet the nation's current and future health care needs. This is why hospitals are coming together with other providers to provide patients with high-quality, well-coordinated care, and it is contributing to lower cost growth. On the other hand, the recently announced commercial insurance deals will not benefit consumers. Instead, they will lead to further consolidation of an already highly concentrated health insurance market, fewer choices for consumers for commercial insurance and MA plans, and higher premiums and/or out-of-pocket costs.

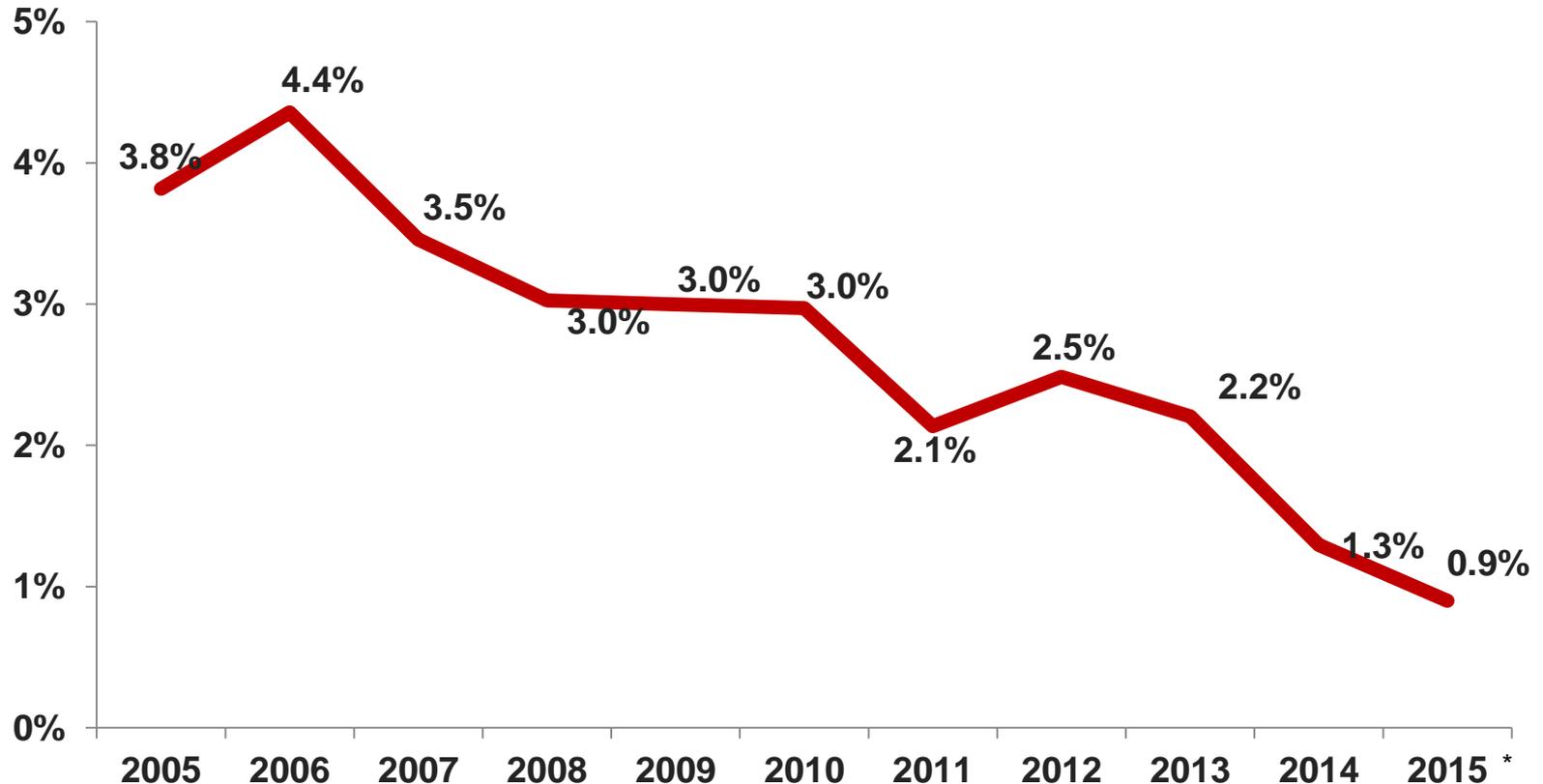
ⁱ Paying a Premium on Your Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry, Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan. *American Economic Review* 2012, Volume 102, No. 2.

ⁱⁱ 'Jaw-dropping': Medicare deaths, hospitals AND costs reduced, USA Today, July 28, 2015. Reporting on "Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Years and Older, 1999-2013", Krumholz, Nuti, Downing, Normand & Wang, *JAMA*, July 28, 2015, Vol. 312, No. 4.

ⁱⁱⁱ FitchRatings, 2015 Medium Ratios for Nonprofit Hospitals and Health Systems, Special Report, August 10, 2015.

The annual growth in hospital prices has been low and declining.

Annual Percent Change in Hospital Prices, 2005-2015*



Bureau of Labor Statistics. Producer Price Index data, 2014-2015, for Hospitals (622)
*Hospital price percent change in 2015 is from July of 2014 to July of 2015.