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February 14, 2018

The Honorable Gregg Harper  
Chairman, Subcommittee on Oversight and  
Investigations  
Committee on Energy and Commerce  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Diana DeGette  
Ranking Member, Subcommittee on  
Oversight and Investigations  
Committee on Energy and Commerce  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Harper and Ranking Member DeGette:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments to the Energy and Commerce Subcommittee on Oversight and Investigations for its hearing on “Examining the Impact of Health Care Consolidation.”

While the AHA appreciates the committee’s continued interest in examining health care spending, we are concerned that this hearing fails to present a full and accurate picture of the forces that are reshaping the health care environment and how hospitals are responding in order to continue serving their communities. Relying on a panel of academic witnesses who are largely unaffected by this evolving environment and untethered from the challenges hospitals face every day in providing high quality, lower cost and more responsive care, provides little, if any, useful information on which to base important public policy considerations.

What is important for policymakers to understand is how the rapidly changing health care environment is challenging hospitals to adapt by realigning with other hospitals and with providers, such as physicians, particularly those providing essential services that might be unavailable to individuals in their community absent that alignment. In addition, policymakers should be skeptical of studies that fail to account for the realities of delivering care, particularly when the resulting analyses are filled with flaws that challenge their validity.

Our detailed comments follow.



## **HOSPITALS ADAPT TO A CHANGING LANDSCAPE TO BENEFIT PATIENTS**

If there was ever any doubt that the health care landscape is changing dramatically, one has to look no further than the recent announcements that CVS seeks to acquire Aetna; Amazon, Berkshire Hathaway and JP Morgan Chase & Co partnering on employee health care; and UnitedHealth Group embarking on a physician acquisition spree.

The hospital field has long anticipated this disruption and has sought to participate by replacing an outdated “siloes” health care system with a continuum of care to improve coordination and quality and reduce costs for patients. Building a continuum demands that providers are more integrated. This can take many forms, involving mergers with other hospitals, acquisition or employment of physicians and clinical integration, among other arrangements.

These various arrangements are designed to improve patient care by addressing concerns that our health care system is simply not sustainable – that is what hospital leaders told the economists who studied contemporary hospital mergers and what the data confirmed. According to the [Charles River Associates](#), hospital mergers are transforming health care by laying a foundation for the next generation of patient-centric and value-based care. They are doing so by:

- Decreasing costs due to benefits of scale, reducing costs of capital and clinical standardization;
- Improving quality from additional volume, standardization of clinical protocols and investments to upgrade facilities and services at acquired hospitals; and
- Expanding the scope of services available to patients to provide more comprehensive and efficient care.

Perhaps just as important, for the mergers studied, revenue per patient admission declined in a statistically significant manner (3.9 percent), which runs counter to the findings of some researchers, including some of the panelists testifying at this hearing, who link mergers with higher prices.

A study from [January 2017](#) of hospital mergers over a 10-year period found, “on average, acquired hospitals realize cost savings between 4 and 7 percent in the years following the acquisition.”

Moreover, during a period of significant realignment, hospital prices have been increasing at historic lows, while insurance premiums and prescription drug prices have been rising at much faster levels. According to the [Kaiser Family Foundation \(KFF\) and the Health Research & Educational Trust survey](#) of private and nonfederal public employers, in 2017 the average individual premium increased 4 percent and the average family premium increased 3 percent. Premiums for family coverage have increased 19 percent since 2012 and 55 percent since 2007. A [KFF analysis of Express Scripts Data from December 2017](#) found that while per capita retail

prescription drug spending grew at a slow rate in 2016 (0.6 percent), in 2015 pharmaceutical spending grew 8.1 percent on a per capita basis and in 2014 costs grew 11.5 percent. By contrast, hospital price increases have been trending downward for the last 10 years (see attached chart). From 2015 to 2016, hospital prices increased by only 1.2 percent.

Meanwhile it also is important to consider that unlike many drug company deals and many of the deals among commercial health insurers that predated the Anthem and Aetna challenges, hospital realignment has been subject to numerous challenges by the federal antitrust authorities, specifically, the Federal Trade Commission (FTC). The FTC has not hesitated to investigate and challenge hospitals when it believed a merger threatened competition. The FTC has been entirely unsympathetic to concerns that its outdated perspective on the evolution of the health care field is blocking progress among hospitals to participate fully in a rapidly changing landscape.

## **HOSPITAL ACQUISITION AND EMPLOYMENT OF PHYSICIAN PRACTICES**

More physicians are electing to be employed by hospitals, and new doctors are the most inclined to want to choose a salaried arrangement over private practice. Aligning fully with the physicians who make decisions about patient care is essential to building a continuum of coordinated care. Moreover, physicians increasingly are electing to practice in an environment in which hospitals absorb the costs and burden of an overextended regulatory apparatus predicated on a model of care neither hospitals nor physicians, much less patients, believe offers optimal benefit in terms of quality, cost or convenience. Moreover, affiliation with a hospital offers benefits to the entire community that might otherwise be unavailable.

Relative to patients seen in physician offices, patients at [hospital provider-based departments](#) are:

- 2.5 times more likely to be Medicaid, self-pay or charity patients;
- 1.8 times more likely to be dually eligible for Medicare and Medicaid;
- 1.8 times more likely to live in low-income areas;
- 1.7 times more likely to be Black or Hispanic; and
- 2 times more likely to receive care from a nurse in addition to a physician.

Although hospital-based physician practices have higher costs, it is because they often provide services that are not otherwise available in the community. For example, they treat more chronically ill patients requiring greater resources; face greater regulatory requirements, including stand-by-capacity-costs related to offering continuous access to emergency department and other services; and provide specialty services, such as burn units and psychiatric services.

## **PATIENT BENEFITS FROM PHYSICIAN ALIGNMENT, INCLUDING WITH ONCOLOGY CLINICS**

Contrary to speculation by certain critics of the 340B drug saving program, larger market forces have influenced independent oncology practices to merge with their community hospitals. Oncology, like other practices, benefit greatly from having hospitals absorb the costs and burdens of an overextended regulatory apparatus that makes it much more difficult to practice medicine and serve patients, particularly those who require services that are more complex. Independent oncology practices are under no obligation to provide services to the vulnerable patients who seek care.

Congress created the 340B drug savings program to allow hospitals that care for communities with vulnerable patients to obtain discounts on expensive prescription drugs in order “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” The 340B program requires drug companies participating in Medicaid to sell outpatient drugs at discounted prices to these hospitals. For 25 years, the 340B program has been critical in helping hospitals expand access to lifesaving prescription drugs and comprehensive health care services to communities across the country with a high number of vulnerable patients, at no cost to the federal government.

Not surprisingly, the value of the 340B discounts for participating hospitals has grown correspondingly with the dramatic increases in prices by the drug companies. For example, cancer pills approved in 2000 cost an average of \$1,869 per month compared to \$11,325 for those approved in 2014. The 340B program continues to provide benefits in terms of care and services to communities serving vulnerable patient that would otherwise be unavailable if the hospitals had to absorb the brunt of such staggering drug price increases.

## **NEJM STUDY’S CONCLUSIONS LACK VALIDITY**

A recent study published in the New England Journal of Medicine (NEJM) claimed that the 340B program does not expand access to care to low-income populations or improve their mortality rates, while driving hospital/physician consolidation. The study as designed and executed by its authors fails to draw meaningful, valid conclusions about the program due to constraints and flaws in the methodology used. Some of the concerns we have with the study include:

- using a limited sample set – just 20 percent of 340B hospitals – to make expansive statements about the implications of the program;
- relying on fee-for-service Medicare data only to make claims about the impact of the 340B program on low-income individuals, thereby ignoring that the vast majority of low-

income people are not enrolled in Medicare. Only 23 percent of low-income individuals are elderly or disabled and therefore potentially eligible for Medicare;

- the study authors put forward their own beliefs of how the 340B program should work, not Congress's intention for the program, which is as previously stated, to "stretch scarce Federal resources as far as possible;" and
- Failing to account for changes in coding of physician practices during the study period. Beginning in 2011, the Health Resources and Services Administration (HRSA) required that all outpatient and other community-based sites of care that intended to use 340B drugs for their patients register separately for the 340B program, along with other requirements. By ignoring this HRSA reporting change, the study authors fail to acknowledge that the increase in the registration of hospital-owned outpatient clinics and services in the 340B program may simply be a matter of changes in reporting.

A more detailed [review](#) of the study is available on our website, along with [information](#) on how 340B hospitals tailor programs to meet local community needs.

## CONCLUSION

Hospitals and health systems are there every day providing care for their patients and communities in a rapidly changing health care environment. We appreciate the committee's interest in health care consolidation and welcome the opportunity to discuss the issue in more detail.

Sincerely,

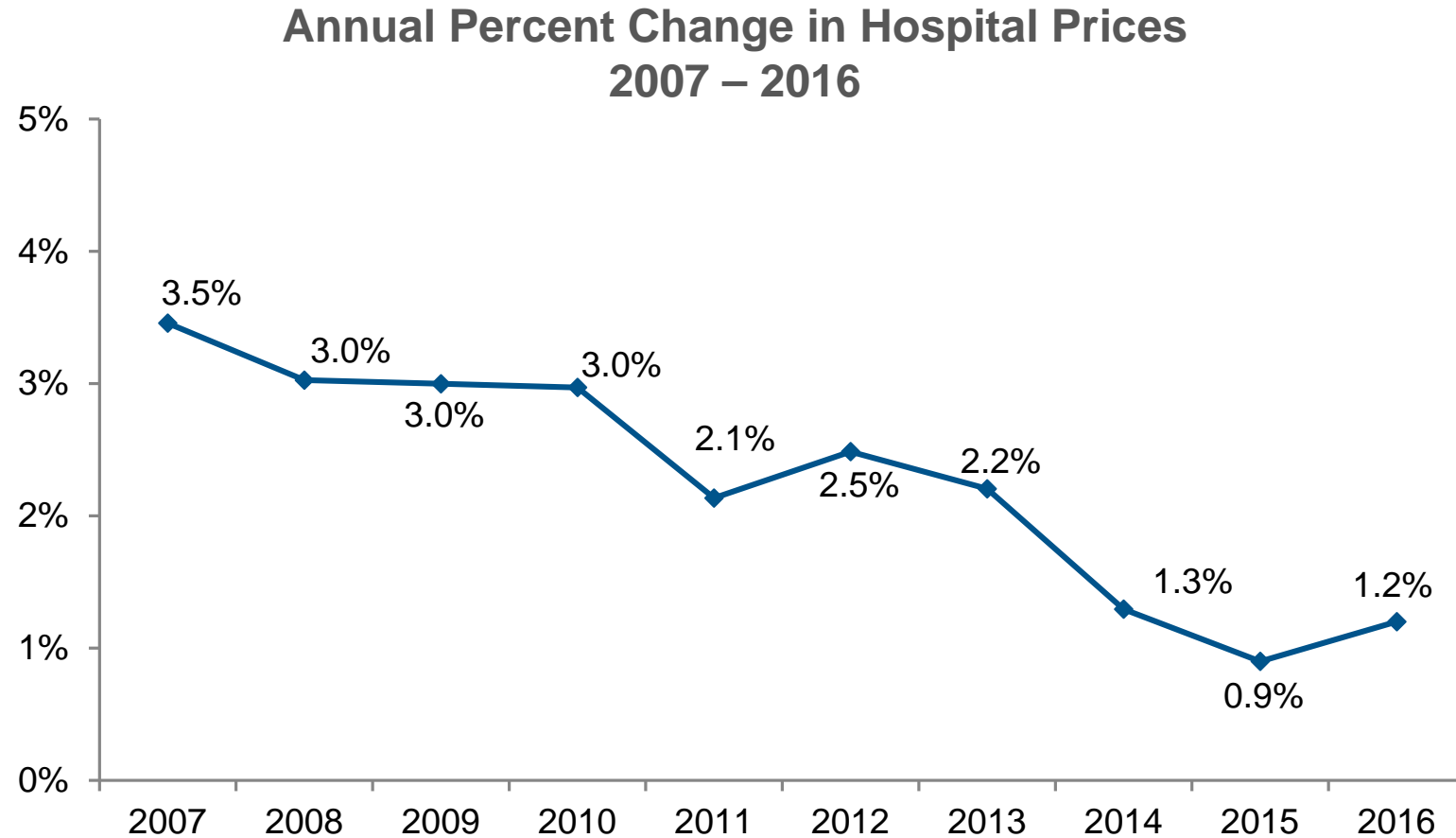
/s/

Thomas P. Nickels  
Executive Vice President

cc: Members of the Subcommittee on Oversight and Investigations

Attachment

# Hospitals continue to aggressively hold down price growth...



Source: Bureau of Labor Statistics. Producer Price Index data, 2007 - 2016, for Hospitals (NAICS Code 622)