May 5, 2021

The Hon. Jerrold L. Nadler
Chairman
House Committee on the Judiciary
U.S. House of Representatives
2132 Rayburn House Office Building
Washington, DC 20515

The Hon. Jim D. Jordan
Ranking Member
House Committee on the Judiciary
U.S. House of Representatives
2056 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the record, "Treating the Problem: Addressing Anticompetitive Conduct and Consolidation in Health Care Markets"

Dear Chairman Nadler and Ranking Member Jordan:

Thank you for this opportunity to submit these comments regarding the Subcommittee on Antitrust, Commercial, and Administrative Law's recent hearing on healthcare competition. We are grateful for your leadership on this issue. Additionally, we applaud Chairman Cicilline and Ranking Member Buck's interest in focusing on the problem of consolidation, especially the monopolistic practices of hospitals and health insurance plans.

Action for Health[1] is a national, non-profit patient advocacy organization. In all our work, we attempt to educate policymakers like yourself, the media, and concerned citizens about critical healthcare issues. One of our main focuses currently is ensuring fair regulatory outcomes for the No Surprises Act, legislation enacted last year[2] that eliminates surprise medical bills for patients and constructs an independent dispute resolution (IDR) process for physicians and health insurers to settle out-of-network (OON) payment disputes. In fact, **equitable implementation of this law is the best way to stem the tide of consolidation in healthcare markets**. If the No Surprises Act is implemented to the advantage of health insurers, independent physicians will not be compensated fairly and will always lose their cases brought to an IDR arbitrator. These physicians will then have to become employed by hospitals, where costs are exponentially higher and administrative pressure leads to lower quality care.

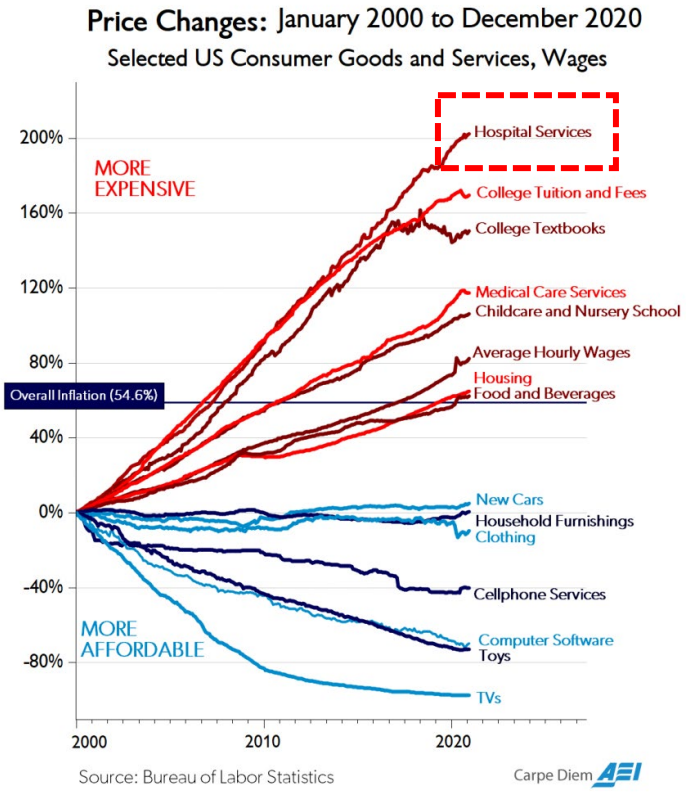
Throughout our research and advocacy efforts, we spend considerable time analyzing the anticompetitive conduct of healthcare system actors. As such, we hope these comments are helpful to you and the Committee as you pursue your timely and important work on this subject.

[1] Action for Health, www.action4health.org.
[2] H.R. 133, Consolidated Appropriations Act, 2021, (P.L. 116-260), December 27, 2020, accessed: https://www.congress.gov/bill/116th-congress/house-bill/133/text.

Introduction

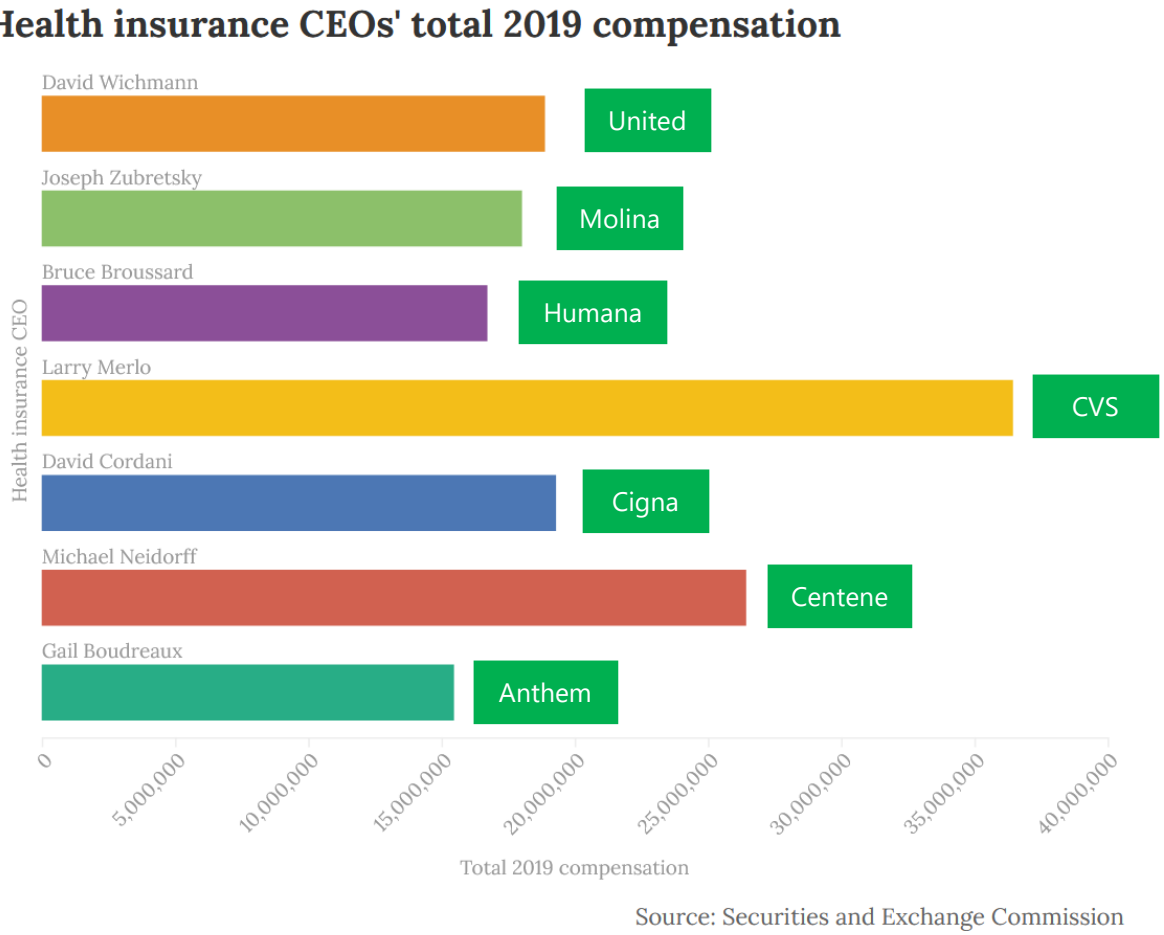
Healthcare costs in our country have soared because giant hospital systems and health insurers have exerted outsized regional and national dominance. Indeed, **the true impediment to improved quality and lower cost is hospital-insurance monopolies.** Establishing fairer rules and checking these actors' power would help everyone, especially patients. Moreover, independent doctors should be making healthcare decisions, rather than administrators and executives.

The CEOs of large hospitals and health insurance companies alike have aggressively pushed for more consolidation. This anticompetitive behavior not only drives up costs and increases their own profits and salaries, but also stifles competition, innovation, and quality improvements. This chart, often cited, captures just how extraordinarily hospital costs have risen over the past 20 years.[3]



[3] Mark J. Perry, "Chart of the day… or century?", American Enterprise Institute, January 17, 2021, accessed: https://www.aei.org/carpe-diem/chart-of-the-day-or-century-5.

Speaking of salaries, total compensation for the nation's seven largest health insurance company chief executives continues to skyrocket.[4] To be clear, we are not opposed to executives earning large sums for stellar performance, nor do we advocate setting rates for renumeration. But for these CEOs to be earning these astronomical salaries on the backs of patients who are crushed by ever-increasing premiums and fewer choices due to insurers narrowing their coverage networks is wholly unacceptable.



[4] Paige Minemyer, "CVS' Merlo was the top paid health insurance CEO in 2019. Here's a look at what other payer CEOs earned", Fierce Healthcare, April 27, 2020, accessed: https://www.fiercehealthcare.com/payer/here-s-what-top-health-plan-ceos-earned-2019.

Perhaps even more egregious is the compensation supposed non-profit hospitals pay their CEOs. As a *Forbes* column highlighted, "…These hospitals add billions of dollars annually to their bottom line, lavishly compensate their CEOs, and spend millions of dollars, which are generated by patient fees, lobbying government to defend the status quo."[5] An eye-opening oversight report of the country's 82 largest non-profit hospitals really homes in on this extravagant pay. Of these largest hospitals, 13 of them compensated their top earner between $5 million and $21.6 million per year.[6] Without a doubt, while these non-profit hospital CEOs are getting wealthier, patients "are getting healthcare poorer."[7]

Additionally, concerning profits, it is worth noting the sheer financial fortune health insurers' anticompetitive practices have produced. For example, back when the Affordable Care Act (ACA) was passed in March 2010, UnitedHealth's share price was roughly $32 per the chart below.[8] Fast forward 11 years, and, as of this writing, UnitedHealth's stock is now worth $412 per share. In such a relatively short timeframe, **UnitedHealth's stock has appreciated %1,188.**

Source: Merrill Lynch

[5] Adam Andrzejewski, "Top U.S. 'Non-Profit' Hospitals & CEOs Are Racking Up Huge Profits", Forbes, June 26, 2019, accessed: https://www.forbes.com/sites/adamandrzejewski/2019/06/26/top-u-s-non-profit-hospitals-ceos-are-racking-up-huge-profits/?sh=f45665e19dfb.
[6] Open the Books, "Top 82 U.S. Non-Profit Hospitals: Quantifying Government Payments and Financial Assets", June 2019, accessed: https://www.openthebooks.com/top-82-us-non-profit-hospitals-quantifying-government-payments-and-financial-assets--open-the-books-oversight-report.
[7] Andrzejewski, Ibid.
[8] Merrill Lynch, UnitedHealth Group Incorporated (NYSE:UNH), Security Profile, May 4, 2021.

Physicians are rightfully standing up to these anticompetitive practices, as well. As the *New York Times* reported last month, "UnitedHealthcare, one of the nation's largest health insurers, is being sued in two states by a large group of anesthesiologists who are accusing the company of stifling competition by forcing the doctors out of its network and by using its enormous clout to pressure hospitals and surgeons to stop referring patients to them."[9]

Finally, last year's skewed and inequitable disbursement of Covid-19 provider relief funds has further exacerbated these consolidation and anticompetitive challenges. Approximately three months into the pandemic, the nation's two largest hospital operators had already received a combined $7.3 billion in aid.[10] Even earlier, in May 2020, four major hospital operators – all of whom are publicly-traded companies with significant access to capital – disclosed that they had already received between $195 and $700 million in federal aid.[11] Small hospitals and independent medical groups received next to nothing.

Healthcare decisions made between the nation's approximately one million physicians and the nation's 330 million patients have essentially been taken over by the large health system CEOs and their peers at the largest health insurance companies. There can be no real healthcare reform, cost reduction, or quality improvement without real reform of non-profit hospitals and insurance companies to allow for a functioning healthcare marketplace. Therefore, we are offering three (3) sets of recommendations, covering hospital reform, insurance reform, and government reform. It is hoped that the Congress in general, and your Committee specifically, thoroughly explores these recommendations. If implemented, they would reverse the trends of anticompetition and consolidation in our healthcare markets.

Hospital Reform

Large hospital systems are the only ones with any bargaining power with the dominant health insurance plans. **Together, hospitals and insurers are acting to lower in-network rates and force independent physicians out of business.** Thousands of doctors have been forced out of business by insurers. Conversely, not a single insurance plan has been forced out of business by physicians.

[9] Reed Abelson, "Doctors Accuse UnitedHealthcare of Stifling Competition", New York Times, April 1, 2021, accessed: https://www.nytimes.com/2021/04/01/health/unitedhealthcare-lawsuit.html.
[10] Chad Terhune,, "Billions in COVID relief go to biggest hospital chains as smaller rivals await aid", Reuters, June 9, 2020, https://www.reuters.com/article/us-health-coronavirus-hospital-billions/billions-in-covid-relief-go-to-biggest-hospital-chains-as-smaller-rivals-await-aid-idUSKBN23G1GI.
[11] Ayla Ellison,, "14 health systems receiving biggest CARES Act payments", Becker's Hospital Review, May 8, 2020, https://www.beckershospitalreview.com/finance/14-health-systems-receiving-biggest-cares-act-payments.html.

Health insurance companies agree to pay hospitals exorbitant in-network rates for hospital services in return for the hospital agreeing to put all its doctors in-network and "accepting" miniscule fees for the doctors' professional services. Hospitals then "true-up" physicians by paying them a much larger fee for their services than would be warranted from their in-network contracts. Hospitals kick back a large part of the large in-network fee for hospital technical services. As a result, all hospital physicians are often in-network, and many independent physicians are OON. In effect, the only option for many independent doctors is to refuse insurers' artificially low rates and remain OON.

Recommendations

Administration

- A non-profit hospital should make at least 50% of its emergencies (through emergency call) available to voluntary physicians on staff at that hospital.

Compensation

- A non-profit hospital should pay its employed physicians based approximately on the value of the insurance contracts for which it signs its physicians. For example, a physician's compensation for clinical services should be based on that physician's collections or expected collections minus overhead expenses (e.g., malpractice insurance, health insurance, secretarial salaries, and billing, marketing, and administrative costs). Non-clinical payments should also be made at fair market value. States would routinely check random physician compensation arrangements to confirm that they follow these provisions. Importantly, an exception can be made for physicians who work in hospitals in underserved communities where patients are primarily uninsured or covered only by Medicaid.

- Compensation, including bonuses and long-term incentive plans, for hospital administrators should not be tied in to increased hospital revenue, increase hospital profits, or increased hospital volume.

- Non-profit hospital public payments – such as through tax exempt charitable donations, other tax exemptions, or other government subsidies or payments – should not be used to pay for physician or administrator compensation.

Credentialing

- A non-profit hospital should offer credentialing to any qualified voluntary provider (physician, physician's assistant, or nurse practitioner), provided the provider will pay for the cost of credentialing. Any provider who is denied prompt credentialing by a hospital may appeal to the applicable state for relief. The loser will bear the process' cost. This provision would not apply to physicians who are full-time employees of other hospitals.

- A non-profit hospital that has volume requirements for credentialing should allow for comparable case experiences to be used for such requirements.

Human Resources

- Any provider who believes that an unjust decision had been made against him or her in a hospital quality assurance committee or other care oversight committee may appeal the decision to the applicable state for relief. Any provider who has been subject to disciplinary action or termination from a hospital may appeal the decision to the applicable state for relief. The loser will bear the cost of the process.

- A non-profit hospital should be prohibited from creating or enforcing restrictive covenants against any providers or other employees. Additionally, a non-profit hospital should be prohibited from creating or enforcing gag orders against providers or employees who allege misconduct by the hospital.

- Non-profit hospitals should not be permitted to reward, pay, or pressure their employed physicians to refer to that hospital's services, or to the services of other physicians employed by that hospital. Similarly, these hospitals should not be permitted to threaten or punish physicians who choose not to refer patients to the services of that hospital or other physicians employed by that hospital.

Ownership

- It is high time that regulations from 2010 prohibiting new physician-owned hospitals (POH) from participating in Medicare or Medicaid be amended. Furthermore, anyone, including physicians, should be permitted to own a hospital.

Health Insurance Reform

Private insurance company profits are tied to overall premiums. Due to regulations embedded in the ACA, these profits are capped at 20% of premiums. The higher the premiums, the higher their profits. For those health insurers that are publicly traded companies, they have a fiduciary responsibility to their shareholders to maximize their profits. Therefore, given the ACA cap, these insurers must continually raise their premiums year-over-year.

The health insurer business model is frankly straight forward: offer as few plans and providers in a region as possible. This consolidation leads to higher costs. Physicians and hospitals rely on private insurers to make up for Medicare and Medicaid. Unfortunately, health insurers can choose to deny contracts for any physician or hospital. Put simply, there are no real negotiations between insurers and independent doctors regarding in-network rates.

Insurers sign millions of essentially phony contracts with hospitals for their physician services, which insurers know will not be the basis for those doctors' compensation. As such, in-network rates are generally not market rates.

<u>Recommendations</u>

Competition

- Health insurance companies should not be permitted to coordinate any marketing, coverage, or other business activities with other insurers.

Contracting

- Insurers should agree to sign contracts with any competent provider or hospital, at no less than 10% of the median local contracted rate.

- Removal by an insurer of any competent provider or hospital from their network should be prohibited.

- Insurers should not be able to require that all physicians of a given group sign contracts in order to sign contracts with one or more such physicians.

- Health insurance companies should not be allowed to execute contracts with hospitals for physicians or other providers that are not based on what the hospital intends to ultimately compensate that physician or provider. The insurer should confirm with the

hospital that it does not intend to kick back hospital collections or profits to offset the values of the rates agreed to with said insurer.

- The creation of "anti-assignment" provisions in insurance company contracts should be prohibited.

- Insurers should lower their payments for hospital ("technical") services and increase their payments for physician services. This way, contracted rates accurately reflect what hospitals and physicians are being paid for their services.

Ownership

- Anyone should be permitted to own or create a health insurance product. Such product should also not be unduly denied or delayed by the federal or state governments.

Payments

- Health insurers that claim a "claw back" is due to them may bring their case to an appropriate judicial proceeding. They should be prohibited, however, from withdrawing payments from those due for different patients or different services.

- At the signed request of a patient, his or her health insurer should send payments directly to the physician or hospital.

Referrals

- If a patient requires the services of a specialist and asks for an in-network specialist from their health insurer, the insurer must promptly provide the name of such a qualified and available regional provider. If that provider is determined to be unqualified or unavailable to provide such a service, the patient should be permitted to find an appropriate OON provider at no additional cost to the patient.

Reimbursement

- At the request of a patient or a treating physician (including a non-participating physician, if the patient has signed a waiver to this effect), the health insurer should promptly provide in writing exact data about its intended reimbursement benefits.

Federal Government Reform

Last week, the Centers for Medicare and Medicaid (CMS) finalized a host of regulations that will impact the price of and access to 2022 ACA exchange plans for patients. While this is a step in the right direction, robust reform of Medicare and Medicaid has eluded the Congress for many years.

Recommendations

Equity

- Any entity or provider that provides a medical service in a given area should be paid the same for Medicare or Medicaid for providing that service.

Fee Schedules

- The Medicare and Medicaid fee schedules for hospitals and physicians should be recalibrated (i.e., hospital payments lowered and physician payments increased). This will more accurately reflect what hospitals are actually paying physicians for their services.

Subsidies

- If "extra clinical payments" are being made for "medical teaching" or "medical research", then any entity (e.g., large hospital, small hospital, or independent medical group) must be equally eligible to participate and receive such funding.

- Government subsidies (state and federal) that are made available to large hospitals should be equally available to small hospitals and to independent medical groups.

Conclusion

If large hospital systems and health insurance companies continue to use their unfair negotiating position to squeeze independent physicians, quality of care will ultimately suffer. Fewer independent physicians mean hospital and insurance concerns – and notably, their profits – will govern medical care.

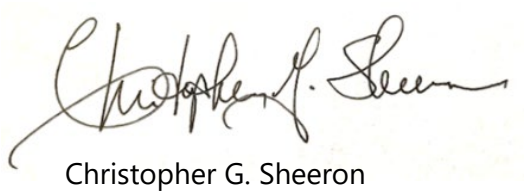
This is much more than just dollars and cents. According to a survey by the Physicians Foundation and Merritt Hawkins, only 31.4% of physicians identified as independent practice

owners or partners in 2018. In 2012, independent physicians made up 48.5% of all doctors.[12] Physicians and other providers are already under siege from insurers. The effects of the Covid-19 pandemic on physicians' ability to work only made matters much worse.

In sum, the forced consolidation of medical practices will result in fewer physicians, higher costs, and poor quality of patient care.

Thank you again for this opportunity to provide you our comments on the current state of competition and consolidation in our nation's healthcare markets. Much more work remains, but we are confident there are solutions readily available, such as the recommendations provided herein, to address these problems. If we can be of any help to you or your staffs, please do not hesitate to contact me directly at (202) 823-2333.

Sincerely,



Christopher G. Sheeron
President
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Cc: The Hon. David N. Cicilline
Chairman
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[12] Physicians Foundation, "2018 Survey of America's Physicians, Practice Patterns, and Perspectives", September 2018, p. 23, accessed: https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf.