May 6, 2024

Chair Lina M. Khan
U.S. Federal Trade Commission

Assistant Attorney General Jonathan Kanter
Antitrust Division, U.S. Department of Justice

Secretary Xavier Becerra
U.S. Department of Health & Human Services

Submitted via regulations.gov.

RE: Request for Information on Consolidation in Health Care Markets [FTC-2024-0022]

Dear Chair Khan, Assistant Attorney General Kanter, and Secretary Becerra,

United States of Care (USofCare) is pleased to submit the following comments to the Request for Information (RFI) from the Federal Trade Commission (FTC), Department of Justice (DOJ), and Department of Health & Human Services (HHS) ("the Departments") on Consolidation in Health Care Markets.

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels. Where possible, we uplift voices of real people engaging with the health care system at the patient level whose perspectives have shaped our advocacy work.

The RFI seeks answers to a wide array of questions regarding the impact of corporate ownership of health care facilities on patients, health care workers, providers, and plan issuers. USofCare seeks to elevate consumer perspectives as the Departments account for the full spectrum of impacted stakeholders. Our response to questions the Departments raised in the RFI is organized as follows:

Trends in Market Consolidation

Our work listening to people tells us that affordability is people's top concern with the health care system. The United States spends considerably more on health care than peer nations despite no improvement in health outcomes, and people and families are increasingly saddled with high health care prices. In fact, more than half of people report having skipped or delayed care because they were unable to pay for it. Additionally, three out of four people rate the cost of health care in the United States as "only fair" or "poor," which is consistent across party lines.

Prices are rising due in large part to a decades-long industry movement toward consolidation led by corporate hospital and health care systems and often backed by private equity funding.

> *"There is a really large [corporate] health care presence in the city that I live in. So as far as I'm concerned, I don't even have the option to go to a small independent doctor's office. It is only hospitals or hospital related departments… It reminds me of going into a grocery store and getting name brand versus store brand, and just because they're slapping a new title on it they can mark up the price. I never thought of health care being similar in that way as we treat goods and groceries."*
> *~ USofCare Focus Group Participant, November 2023*

Understanding current market trends is imperative to grasping how the growing corporatization of care is leading to negative outcomes for patients. The number of hospitals across the U.S. declined from about 8,000 in 1998 to approximately 6,000 in 2021 due to the 1,887 hospital mergers announced during that time period. Despite a brief decline in hospital transactions during the COVID-19 pandemic, merger activity rebounded to pre-pandemic levels in 2023 and is expected to increase throughout 2024. Additionally, nearly 1 in 3 for-profit hospitals nationwide are owned by private equity firms as of January 2024, evidence of a growing trend. Hospitals and health systems are also acquiring independent physician practices at a remarkable pace. Between 2012 and 2018, the share of physician practices owned by hospitals rose from 14% to 31%, while private equity acquisitions of physician practices increased by 645% from 2012 to 2021, with some of these firms garnering significant shares of many local provider markets.

Many hospitals and health systems cite "financial distress" as a reason for merging with or acquiring another medical facility. However, many mergers and acquisitions take place between large, financially strong partners. In 2018, only 20% of announced merger or acquisition deals involved a partner that was "financially distressed." In 2023, this number was significantly higher than each year between 2012-2020, with a smaller transacting party average revenue of $591 million. Researchers have also highlighted a growing number of "mega mergers" taking place, which involve mergers or acquisitions where the smaller party has more than $1 billion in revenue. 12% of all hospital transactions announced in 2023 qualified as a mega merger, the third year in a row where mega mergers represented more than 10% of all hospital transactions.

Impacts to People

The RFI seeks to understand how mergers, acquisitions, and market transactions have impacted people and patients. In this section, USofCare summarizes how these actions involve corporate players of all types – including hospitals, health systems, and corporate firms – and how they affect people's access, quality, and affordability of care.

Impacts on Access to Care

Market consolidation hurts people's access to timely, quality health care services. For example, patients may have to endure longer wait times to receive the care they need as a result of consolidation. In the six years since Ballad Health became the largest state-sanctioned hospital monopoly in the country, its patients in rural Tennessee and Virginia have had to wait three times longer than they did in 2018 for emergency care.

> *"It also confuses me when you already make so much money in big corporate hospitals, it almost seems like you're trying to make it more difficult to receive*

health care for people that maybe don't have the money or have... the ability to get that health care."
~ USofCare Focus Group Participant, November 2023

After merging with or being acquired by a larger corporate actor, a facility may be subject to downsizing or closure altogether. As a result of consolidation, the availability of hospital inpatient pediatric services nationwide decreased by 9% between 2011 and 2020. Studies of rural hospitals have demonstrated fewer offerings of obstetric care, outpatient primary care, and mental health services following consolidation. This reduction creates a significant barrier to care for people, through increased travel and personal time, travel costs, and exacerbation of conditions due to delayed ability to reach a farther provider. These realities place a disproportionate burden on low-income people who are less likely to have the financial means, time off from work, or access to affordable child care to visit a farther away provider. Moreover, consolidation linked to closures creates even more barriers to care for populations we know are already marginalized by the health care system, such as those who are elderly, disabled, part of the LGBTQ+ community, in rural areas, people with limited English proficiency, and communities of color.

Market consolidation has failed entire communities by reducing operations and procedures, if not closing outright. For instance, by 2018, Prospect Medical Holdings had acquired 20 hospitals across multiple states, but by 2022, they had closed five. The Pennsylvania Health Department shut down Delaware County Memorial Hospital in 2022, citing inadequate staffing by Prospect Medical Holdings. As a result of the closure, some consumers have to travel distances up to five miles for emergency care, emergency medical services (EMS) workers are stretched thin due to covering more physical territory, and the closest nearby hospitals are experiencing an uptick in emergency room visits.

While consolidation may allow financially struggling hospitals to keep their doors open, it also means that they are now at the whim of a much larger, corporate owner. These new owners may not be based in the area or attuned to the needs of the community that it seeks to serve. For example, 55% of the 1,500 hospital merger deals from 2010 to 2019 involved hospitals or health systems in different commuting zones; between 2010 and 2018, one in eight rural hospitals merged with an out-of-market hospital or health system.

Impacts on Affordability
Increased consolidation also adds to the mounting affordability crisis impacting people and families across the country. Rising hospital prices crush people's ability to afford health care, with hospital expenditures composing almost a third of all U.S. health care spending in 2022. Data demonstrates that prices go up for patients when hospitals and health systems acquire independent hospitals and physician offices. One study from 2012 to 2018 showed that when hospitals acquire doctor's offices, it leads to an average price increase of 14% for the same service, a trend that can also be seen in private equity acquisitions of physician practices. During that same time period, average inpatient prices for commercially insured patients rose 5% after health systems acquired an independent hospital. Given this, it's no coincidence that 80% of people believe that hospital prices are unreasonable, with more than 7 in 10 supporting aggressive government action to lower them.

"I went to a clinic and they informed me that it's basically part of the hospital, so they'll charge me hospital prices. The hospital sent me an email and informed me, like, 'hey, by the way, this is part of the hospital, so the cost of things will be

a little bit different since it's not really a clinic,' even though it's literally a clinic."
~USofCare Focus Group Participant, November 2023

Increases in prices as a result of consolidation disproportionately impact access to care for communities historically marginalized by the U.S. health system, including people with chronic conditions and cancer patients. For example, cancer patients are more likely to receive care from hospital-affiliated outpatient settings rather than in independent physician offices. Furthermore, price increases correlated with health care consolidation make it more challenging for people to pay their hospital bills, often subjecting patients to aggressive medical debt collection tactics by hospitals and health systems – including suing patients, threatening credit scores, and garnishing wages. A 2023 analysis from the Urban Institute demonstrated that more than one in seven nonelderly adults live in families with past-due medical debt. Nearly two thirds of these adults had incomes below 250% of the federal poverty line, and nearly three in four of these adults owed at least some of their debt to hospitals. This is troubling, considering that people of color, particularly Black people, are disproportionately more likely to have medical debt.

Impacts on Quality of Care
Not only is the corporatization of care clearly resulting in higher prices for patients, it is not improving the quality of care patients receive, and in some instances, may actually make care worse. A Harvard University analysis of 246 hospital mergers from 2009 to 2013 indicated that consolidation did not improve hospital performance, with patient experience scores even declining after the mergers. Another study of hospital acquisitions from 2012 to 2018 found that readmission rates for cardiac care patients increased up to 12% and remained elevated for three years post-acquisition. The evidence for how private equity firm ownership of health care facilities impacts patient quality of care is slightly more mixed, with one systematic review finding 12 studies linking firm ownership and positive care quality but 21 studies connecting firm ownership and negative care quality.

Solutions for Federal Uptake
USofCare appreciates the work the Departments have done to address the drivers and downstream effects of consolidation throughout the health care market and on people's access to comprehensive, affordable care. Just last month, the Departments launched a public portal for people to submit reports of anti-competitive health care practices, such as transactions that may increase prices or limit access, that will be subject to FTC or DOJ review and investigated, if appropriate. We encourage the Departments to refer relevant complaints to the Consumer Financial Protection Bureau (CFPB) or other consumer assistance programs in the event that they do not warrant further action by the Departments.

Most notably, we applaud the FTC and DOJ on the release of their 2023 Merger Guidelines, which expand and strengthen the criteria through which both Departments review pending health care mergers and acquisitions by lowering the threshold by which a merger could be considered illegal, taking into account related factors when reviewing mergers (such as impacts on labor market dynamics), and considering the cumulative impact of a series of mergers on overall consolidation that, in isolation, may not trigger agency review.

Unfortunately, despite this promising trend in more aggressive enforcement by both the FTC and DOJ, gaps in federal authority oversight of nonprofit hospitals continue to exist. While the negative impacts of for-profit health system mergers continue to make headlines and are rightfully a priority of the Departments, nonprofit hospital ownership is common in most

provider markets. Nearly half of all Medicare-enrolled hospitals and 58% of community hospitals are nonprofit. In fact, seven of the ten largest health systems in the country are nonprofit, sprawling across multiple states as a result of their own mergers and acquisitions. Unfortunately, due to statutory limits on federal agencies and a lack of state-level regulatory authority in many states, transaction oversight of nonprofits is limited, often leading to adverse impacts on people's ability to receive health care services when they need them most. We encourage the Departments to identify where these gaps in federal oversight of nonprofits exist and employ innovative strategies, working with Congress when necessary to expand the Departments' regulatory authority to investigate these transactions.

Below, we share the following actions the Departments can take to address health care consolidation to make sure that maintaining people's access to affordable, comprehensive health care remains at the forefront of the Departments' decision making. Where possible, we highlight innovative policies pursued at the state level that the Departments can use to inform federal action.

Transaction Oversight Review Thresholds
While the 2023 Merger Guidelines allow FTC and DOJ to take into account the cumulative impact of a series of mergers when considering their impact on market consolidation, it doesn't require the proposed merging entities to report any individual mergers that fall under the $111.4 million annual acquisition value threshold for reporting under the Hart-Scott-Rodino Act. Unfortunately, many mergers that would have otherwise harmful effects on people's access to care don't trigger federal review because they simply don't meet that threshold. We encourage the Departments to work with Congress to pursue changes that lower the annual acquisition value threshold so that a larger number of mergers not subject to FTC or DOJ oversight could be opened up to federal review. Lowering this threshold – or eliminating it entirely – would grant the FTC and DOJ additional time to walk through the potential implications of a merger should they wish to take action.

States are leading the way in implementing notice requirements, which allow regulators to proactively address consolidation activities that are too small to trigger the current federal threshold. We encourage federal regulators to look at the adoption and implementation of notification requirements in states to inform federal solutions that strengthen transaction review. Currently, seven states require transacting health care entities to provide notice to state agencies for all hospital-related transactions, while an additional 26 states only require notice for transactions involving a nonprofit hospital. Only five states — Connecticut, Massachusetts, Nevada, Oregon, and Washington — require notice of transactions involving health care providers beyond just hospitals. Connecticut, Massachusetts, and Washington go the farthest, requiring notice of any transaction that would result in a "material change" to a health care entity's operations or governance structure, offering the most comprehensive approaches to ensuring regulators are able to effectively mitigate the negative impacts of consolidation.

Health Equity Assessments
We applaud the FTC's efforts over the past few years to more aggressively target mergers by citing patients' cost of care and care quality as grounds for review. Low-income individuals, who disproportionately tend to be people of color, stand to benefit from policies and agency action designed to lower health care costs. Unfortunately, the updated 2023 Mergers Guidelines did not include an explicit reference to a potential merger's impact on health equity and health care access amongst communities marginalized by the US health care system.

To address this, we encourage the Departments to incorporate a health equity framework for use in antitrust enforcement, potentially guided by CMS's Framework for Health Equity, which aligns with an Executive Order issued by President Biden on his first day in office that called on federal agencies to consider "whether new policies, regulations, or guidance documents may be necessary to advance equity in agency actions and programs." Given the disproportionate impacts of hospital consolidation on medically underserved populations – including communities of color, low-income communities, the LGBTQ+ community, and people with chronic conditions – we believe that a proposed merger's impact on these communities' access to care should be fully incorporated into the merger review process.

Many states have already incorporated health equity assessments in their Certificate of Need or transaction oversight programs. New York's Health Equity Assessment Act, signed into law in 2021, requires Certificate of Need applications for health system transactions to include an independent assessment of how the proposed health care facility changes, like reductions or elimination of services, would impact explicitly defined medically underserved communities. Similarly, Oregon's New Health Market Oversight Program, signed into law in 2021, provides the Oregon Health Authority (OHA) with jurisdiction over large merger and acquisition activity. The OHA can deny approval if the applicants cannot demonstrate that the proposed transaction would increase access to medically underserved communities, improve outcomes, or reduce patient costs. OHA has also included guidance for what metrics constitute a significant reduction in services, including a decrease of availability for culturally competent providers.

Financial/Ownership Data Collection

Despite the fact that nearly a third of all for-profit hospitals and an increasing number of physician offices are owned by private equity firms, little is publicly known about these facilities and private equity's role in health care more generally because of loose disclosure requirements. The Centers for Medicare & Medicaid Services (CMS) has already shown interest in increasing transparency in private equity ownership in health care with its final rule on nursing home ownership and management. We encourage CMS to expand its oversight of private equity ownership and financial data collection more broadly to include information on hospitals and other facilities also run by private equity firms to be used by people, states, and stakeholders alike to inform, guide decision making, and identify bad actors. The collection of this data can help to supplement the efforts of individual states in addressing health care transactions involving multi-state health care entities.

> *"I think that most hospitals nowadays are owned by another hospital. Whether they publicize it or not, they're owned by a big corporation and it's all about the money for them. It isn't about people's care or their health or trying to get them better, it's by servicing the public under this corporate umbrella."*
> *~USofCare Focus Group Participant, November 2023*

The recent financial collapse of Steward Health Care in Massachusetts highlights just how important access to this data is. The company hid financial information for years, leaving behind a trail of unpaid bills, poor working conditions, and deathly care environments for patients at the nine facilities they own in Massachusetts. Despite Massachusetts' strong hospital transaction oversight process, the extent of the problem has been unclear because Steward Health Care has refused to comply with state regulators in providing certain financial disclosures. Due to the limited information on Steward Health Care's full financial portfolio, regulators in Massachusetts were unable to foresee or step in to mitigate facility closures.

Patient Impact Reviews

We appreciate steps taken by the Departments to seek out the consumer perspective when conducting oversight of health care transactions, including the information gathered in this RFI. Still, we feel the Departments can go further in centering the patient experience when reviewing transactions to fully understand the impacts of potential health care transactions on patient costs, access, and care quality.

Massachusetts' Health Policy Commission (HPC) has led the way in incorporating various patient-centered metrics as part of the state's investigations of proposed mergers and acquisitions. In conjunction with the state's Office of the Attorney General, which has primary enforcement authority of health care transactions, HPC has engaged in Cost and Market Impact Reviews (CMIRs) that analyze a proposed transaction's impact on access to care and health equity. Agencies may even consider covening community listening sessions, patient work groups, and other consumer-focused community outreach initiatives to ensure transaction review processes reflect patient needs, especially those from underserved communities.

Other Opportunities to Address Consolidation
Moving forward, we encourage the Departments to continue to examine ways in which they can reverse the trend toward greater health care consolidation by taking action to disincentivize hospitals, health systems, and corporate actors from buying up providers. By shifting toward innovative payment structures through "patient first care" – or value-based care – arrangements that incorporate the total cost of care, models that incorporate hospital global budgets and similar prospective payment mechanisms (such as those found in CMS's upcoming AHEAD model) can provide smaller hospitals and physicians' offices with operational certainty while removing the financial pressures that may cause it to consider consolidating or integrating with a nearby health system or corporate firm. USofCare appreciates its ongoing opportunity to collaborate with the Center for Medicare and Medicaid Innovation (CMMI) to push for payment models that give smaller hospitals and physicians' offices, particularly in rural and other underserved areas the ability to remain independent and provide local, accessible, affordable care for patients where it is most accessible to them.

In addition, we are strongly supportive of additional efforts to address the underlying drivers of consolidation found in the Bipartisan Budget Act of 2015. For the first time, this law implemented so-called site neutral payment policies at newly constructed, off-campus hospital outpatient departments to ensure these providers can't charge patients more for care delivered there compared to an independent provider's office. Absent these fair billing policies, providers end up charging up to nearly three times as much for procedures, such as chemotherapy or imaging services, in a hospital outpatient department compared to if they were delivered in an independent physician's office, costing patients hundreds of millions of dollars in extra out-of-pocket costs.

Unfortunately, most care settings are exempt from the 2015 rule, and we are supportive of recommendations made by the Medicare Payment Advisory Commission (MedPAC) to expand the number of services subject to site neutrality across additional sites of delivery. Expanding "fair billing" protections that pay providers the same regardless of site of service can remove some of the incentives pushing many hospitals and health systems to purchase independent physicians offices, and we encourage HHS to work with hospitals, insurers, and others to ensure compliance with existing law and build on these protections for patients.

> *"I don't know how the federal government lets [facility fees] happen and doesn't stop them happening by law. What's the good of something like this, other than giving people such high medical costs? There are so many people out there that*

don't have insurance at all."
~ USofCare Focus Group Participant, November 2023

Absent large scale shifts toward site neutrality, we are also supportive of more targeted patient protections such as action to address the increasing prevalence of facility fees for services delivered in hospital outpatient departments and other care settings. These fees increasingly come as a surprise to patients, are often not covered by insurance, and are even billed to patients who seek care in-network. The unpredictable nature of these fees serve as yet another deterrent to care for people already putting off needed doctors' visits due to high medical costs. We encourage the Departments to take action as appropriate to help patients struggling with these fees, such as requiring patients to be notified about the costs of these fees when making an appointment, similar to the Administration's efforts on airline "junk fees," or banning these fees entirely in certain circumstances, as found in the President's proposed budget to Congress.

Conclusion

We appreciate the Departments' tireless work in promoting a competitive health care market to ensure that all people have access to affordable, comprehensive health care. Thank you for the opportunity to respond to the Request for Information on Consolidation in Health Care Markets. Please reach out to Eric Waskowicz, Senior Policy Manager, at ewaskowicz@usofcare.org with any questions.

Sincerely,

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United States of Care