westhealth

UNITED STATES of CARE

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STATE ACTION TO ADDRESS HOSPITAL PRICING AND CONSOLIDATION:

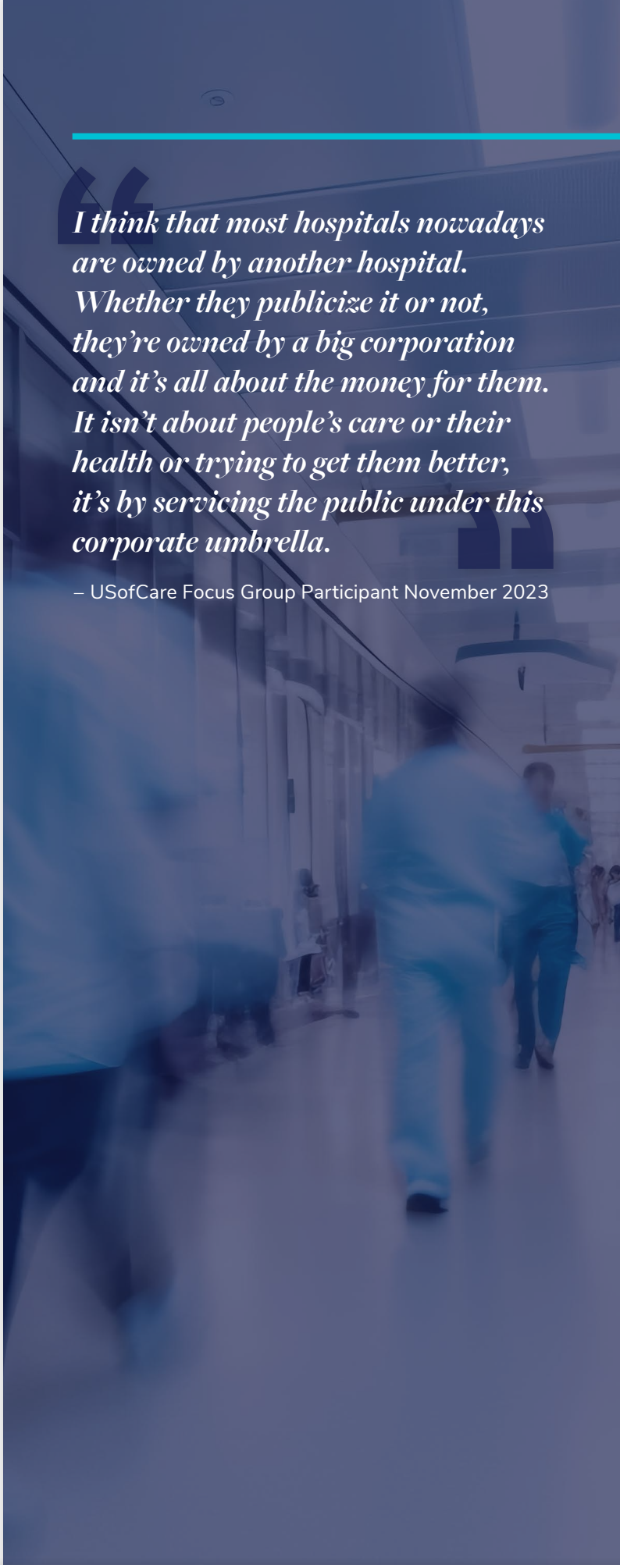
Solutions for Policymakers

Stories of soaring prices charged by hospitals, everyday people devastated by exorbitant hospital bills, and growing medical debt crisis in the United States all make for compelling and alarming headlines regularly featured in daily news and media. A recent Wall Street Journal article showcased how hospital prices have a direct and inverse relationship with wages and catalyzes layoffs. A KFF Health News series covered the arcane billing schemes patients encounter while paying hospital prices for routine doctors visits. NBC recently featured a gut-wrenching story of a patient saddled with over a decade's worth of medical debt. These accounts are widespread and ring the collective alarm bell for immediate policy solutions and protections for patients. Unfortunately, political and industry-heavy interests determined to fossilize the status quo continue to dampen progress.

There are, however, bright spots in recent years that prove the political winds are shifting and progress is, in fact, possible and meaningful. This report highlights where those advances have made a difference at leveling the playing field so that everyday people and patients seeking care are no longer beholden to the reimbursement and pricing schemes of large hospitals and health care systems.

United States of Care (USofCare) works to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people. We know the high cost of care is the biggest health care issue for people across demographic backgrounds and that hospital consolidation and high prices charged by hospitals impact people's experience with the health care system, leading to rising premiums and out-of-pocket costs, less choice and competition, and skipping care altogether. In addition, high prices and consolidation exacerbate existing barriers accessing health care for those already struggling.

Against this backdrop, we continue to lower prices, informed and driven by what we hear from people. We provide this overview of the impacts of skyrocketing prices charged by hospitals, action taken by states, and considerations for future policymaking, focusing on addressing facility fees, advancing site neutral payments, placing limits on hospital prices, and protecting patients from harmful hospital consolidation.



> *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 Problem with Hospital Prices and Consolidation

Rising health care costs limit people's health care choices and put a strain on family and government budgets. A main driver of those rising costs are the prices hospitals are charging, which only continue to increase as a consequence of consolidation. This impacts patients, employers, and state and federal governments in significant ways:

- **Patients:** In addition to having fewer provider choices and being charged increasingly unjust and high prices, patients are increasingly unable to afford care. Over half of working age adults report difficulties affording health care and approximately 14 million people hold significant amounts of medical debt. The high prices charged by hospitals are leading to increasingly unaffordable premiums too, with 42% of privately-insured individuals' premium dollars going towards hospital spending. While these sky-high prices affect everyone, certain communities are disproportionately impacted, such as those living in rural areas and those with chronic conditions and/or complex medical needs.
- **Employers and Employees:** Rising prices charged by hospitals impact employers and employees through higher premiums, lower wages, increasingly high deductibles, and benefit packages with less choice. Nearly half of employers believe rising health care costs impact their ability to compete. Employers want to continue providing health coverage, but 75% believe rising costs will lead to tradeoffs between salaries and wages. Lost wages and cuts to benefits have long-term impacts on the health and wellbeing of employees, their families, and local communities and economies.
- **State and Federal Governments:** State and federal budgets are also impacted by high prices charged by hospitals, leading to ongoing debate about how to drive savings within health programs state and federal governments oversee. For example, policies to bring more fair and just hospital pricing through site neutral payments would bring the federal government $470 billion in savings over ten years.

> *"I know people who are making $50,000 a year, that sounds like a decent amount of money, but they still can't afford to live. And then you have inflation on top of that, and you don't qualify for SNAP or any type of assistance. But at the same time, you can't afford anything. So, people don't seek health care, because they can't afford the copays or can't afford the bills yet."*
>
> – USofCare Focus Group Participant
> September 2022

Public opinion research conducted by USofCare and others consistently shows widespread support across party lines and demographics to address high hospital prices. Four-in-five voters say prices charged by hospitals are unreasonable and consistently support policies to lower them. In addition, voters in states across the country are demanding their state policymakers take action. For example, three in four Washington voters are concerned about the cost of hospital care and 87% of voters across party lines agree that state elected officials should take action to reduce health care costs.

Federal Momentum

In recent years, federal policymakers have expressed increasing interest in pursuing solutions to address high hospital prices and increasing consolidation. In 2019, the Trump Administration's Centers for Medicare & Medicaid Services (CMS) finalized its hospital price transparency rules which, despite inconsistent enforcement and low compliance, required hospitals to post their prices online for the first time. Building on these actions to address costs, the Biden Administration directed agencies responsible for overseeing competition in health care to investigate the effects of private equity and other entities on health care consolidation. Given previous action on hospital transparency, it's possible the incoming Administration may continue to pursue aggressive measures to address high hospital prices and increasing consolidation.

Federal legislative efforts have focused more on high prices charged by hospitals and billing reforms. The Bipartisan Budget Act (BBA) of 2015 was Congress' first attempt at site-neutral reform, although existing hospital outpatient department (HOPD) facilities were grandfathered in under the policy. The 118th Congress considered several bills to promote fair billing. The Lower Costs, More Transparency Act, which passed the House, would have expanded site neutrality to physician-administered drugs and reformed the billing process to ensure that HOPDs would have their own National Provider Identifier (NPI). While it didn't receive a vote in either chamber, the Site-based Invoicing and Transparency Enhancement Act, would have removed the BBA's exemptions clause altogether and showed increased appetite for more aggressive site-neutrality policy. Finally, the Transparency Telehealth Bills Act, which unanimously passed out of the House Education and Workforce Committee, would have prohibited hospitals from charging facility fees for telehealth services. While none of these bills passed, bipartisan support for these reforms suggests future action may be possible.

Policy Solutions and State Trends

As federal policymakers pursue policy options to address health care consolidation and lower high prices charged by hospitals, they should look to the states for proven solutions that can be expanded and scaled on the national level. While states are limited by the Employee Retirement and Income Security Act (ERISA) in pursuing policy changes to health benefit plans overseen by the federal government, they have wide latitude in regulating prices charged by hospitals.[1]

Below, we provide an overview of policies targeting hospital pricing and consolidation states have pursued, insights on their impact, and lessons learned to inform ongoing debate as other states and federal policymakers remain focused on finding solutions. These policy trends include:

1. **Addressing facility fees;**
2. **Advancing site neutral payment policy;**
3. **Directly placing limits on hospital prices; and**
4. **Protecting patients from harmful hospital consolidation.**

> *"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

Policy Solution 1. Addressing Facility Fees

As hospitals increasingly acquire independent physician offices, loopholes in billing requirements allow hospitals to tack on surprise charges called "facility fees" across care settings, adding hundreds or even thousands of dollars to patient bills and leaving them unable to make informed decisions about the true cost of their care. These fees, charged by hospitals and health systems in addition to the professional fees paid to providers, often result in the same service costing more simply because it was provided in a hospital-owned outpatient facility or clinic rather than an independent physician's clinic. These fees are often not completely covered by insurance, leaving many people with unexpected out-of-pocket costs, which often have a disproportionate effect on underserved communities. Nearly half of all adults report not being able to pay for a $500 unexpected medical expense, an amount not uncommonly charged by hospitals in the form of facility fees.

[1]The Employee Retirement and Income Security Act (ERISA) of 1974 restricts states' ability to make changes to employee benefits, which includes employee health benefits. While Congress has considered changes to ERISA statute, federal law continues to limit states' ability to pursue solutions directly impacting people covered by those plans.

An overwhelming majority of Americans support federal legislation to limit facility fees and state legislators have taken notice. Legislation pursued in the states has often included one or more of the following areas of focus:

- **Facility fee prohibitions:** Patients shouldn't be subject to facility fees for common, everyday care. Many states have pursued targeted facility fee prohibitions, such as placing service-based restrictions on these charges based on the type of care delivered, like primary care or telehealth services, or site-based restrictions tied to where a service is delivered, such as in an off-campus outpatient department.

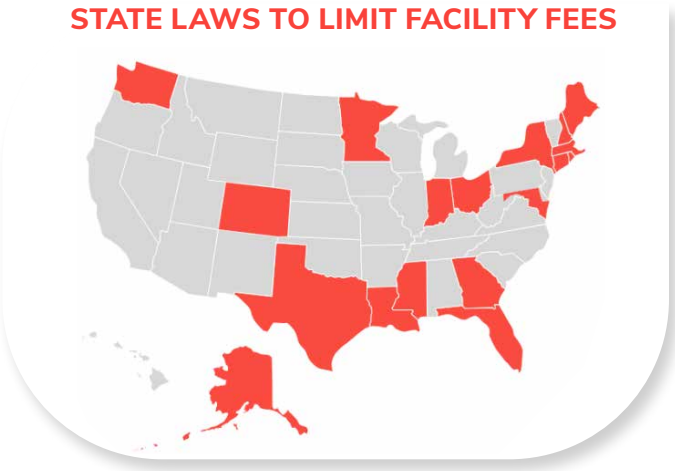
- **Patient notification and transparency:** Facility fees often come as a surprise to patients. In cases where facility fees aren't banned, some states, especially those who may be just beginning to address facility fees, have established policies to require hospitals to disclose to patients when these fees are charged and to provide general cost estimates when an appointment is scheduled.

- **Enforcement and compliance:** Patients often have few options to contest a facility fee they feel they were wrongly charged. By granting state agencies, like state attorneys general, the authority to investigate facility fee protections violations subject to civil penalties, hospitals are held accountable and patients have greater protections.

- **Collecting data:** Comprehensive, easy-to-understand data on the prevalence and impact of facility fees remains difficult to find. States that may not have this information readily available through their all-payer claims database or other means have required hospitals to provide claims information and other data points to share with the public and also inform future legislative or regulatory efforts to address facility fees. In addition, some states have also required HOPDs to obtain their own national provider identifier (NPI), independent of but related to its "parent" health system, in order to better track facility fees.

State policymakers can pursue legislation that includes any combination of the policies above, making action to address facility fees an attractive option for states looking to lower costs while also recognizing the unique needs of individual states. While it's important for states to address facility fees more broadly, many that have pursued more comprehensive restrictions on facility fees have often started with limited prohibitions or transparency measures and then expanded restrictions for other routine services. Some states, such as Ohio and Georgia, have adopted a more modest approach by prohibiting facility fees for telehealth while others, like Connecticut have enacted more comprehensive facility fee prohibitions for most doctors' visits, whether on or off a hospital's campus.

STATE LAWS TO LIMIT FACILITY FEES



Other states, such as Massachusetts and Washington, have established transparency requirements to let people know when facility fees are charged ahead of time. Maine conducted impact studies and required hospitals to report facility fee data, which can be used to guide future efforts to regulate facility fees. In 2018, Colorado required all HOPDs to obtain and use a unique NPI on claim reimbursement forms to make it easier to identify where facility fees are being charged. States have also established enforcement mechanisms to ensure compliance with new facility fee rules, although many could strengthen these requirements by enacting higher financial penalties and/or potential loss of state licensure.

Actions to address facility fees can lower health care costs for patients, but limiting them doesn't address the underlying drivers of increased hospital consolidation and higher prices overall. Facility fees are only a symptom of a system that allows hospitals to charge different prices for the same service delivered in different settings. More comprehensive reforms to lower the overall cost of care can be achieved through larger fair-billing changes to promote "site-neutrality" in hospital payments. While actions to restrict facility fees promote access to more affordable care in a more targeted way, site-neutral policy can secure even greater savings for people by ensuring that hospitals charge the same price for the same service no matter where it's delivered.

Policy Solution 2. Advancing Site-Neutral Payment Policy

Medicare has long paid hospitals higher rates for services delivered in hospital outpatient settings. This has incentivized health systems to purchase independent physician offices or ambulatory surgical centers (ASCs) and reclassify them as hospital outpatient departments (HOPDs) which are subject to higher reimbursement. For patients, this could lead to someone paying significantly more for a procedure simply because it was delivered in a HOPD compared to a physician's office. **For example, a patient in need of chemotherapy for breast cancer may spend $2,505 for one course of treatment in a physician's office before insurance kicks in. By contrast, the same course of treatment delivered in an HOPD may cost about $4,325, or nearly twice as much for the same exact service.** While banning facility fees for treatment in off-campus settings may lower the costs for patients by eliminating some add-on costs, the underlying loophole to allow hospitals to charge higher prices remains. Adopting fair-billing or "site-neutral" policies removes this incentive and lowers patients' costs by ensuring they pay the same cost for the same service regardless of site of care.

While most federal efforts to promote site neutrality have focused on Medicare payments, its policies are often adopted in full or in part by commercial payers given Medicare's market share. If extended throughout the commercial market nationwide, site neutrality could reduce national health spending by $458 billion over ten years. Estimates show that patients also stand to benefit, with $386 billion in premium savings and an additional $73 billion reduction in out-of-pocket costs back in people's pockets.

Overwhelming public support in favor of fair billing policies has driven increased interest among state and federal policymakers. Site-neutral payment policy should incorporate the following:

- **Limits on prices charged by hospitals:** Provider payments often vary widely depending on where a service is delivered, even if the service offered is no different in quality. Site-neutral reforms impose the lower, non-hospital Medicare payment rate – or some percentage of this rate, depending on state-specific circumstances – to all off-campus providers, whether or not they're owned by a hospital. This may also include specific prohibitions on facility fees.
- **Identify services affected:** The Medicare Payment Advisory Commission (MedPAC) identified 66 services best suited to adopt site-neutral payment in a June 2023 report. States have also considered including other common health care services and wellness visits subject to site-neutrality and should consider some mechanism to update this list to include additional services that are safe and appropriate to deliver in all care settings
- **Considerations for certain providers:** Given the unique operational and financial challenges facing certain providers, such as safety-net hospitals or those in rural areas, site-neutral policy for these facilities should be structured in a way that doesn't harm people's access to care. On the federal level, one site-neutral proposal has promoted reinvestment mechanisms for certain lines of service in rural or safety-net providers to offset any revenue loss associated with site-neutral payment policy.
- **Transparency and data collection:** Gaps in data exist that prevent policymakers and others from fully understanding the impacts of prices charged by hospitals and policies to reduce them. Policymakers should require providers to publicly report data on pricing and utilization to inform patients about the cost of care and guide future efforts to implement these and other fair billing practices.

> *"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

Recognizing these potential savings associated with site-neutral policy, fair billing advocates have increasingly turned their attention to the state level, especially in states that have already pursued some limits on billing practices through facility fee limits or other reforms. New York's legislation prohibits providers from charging more than 150 percent of the Medicare rate for certain services and establishes penalties for noncompliant hospitals. An analysis completed by New York's 32BJ Health Fund found that site-neutral adoption in the commercial market in the state for a core set of services would lead to $1.5 billion in savings annually. Building on previous facility fee reforms, Indiana passed legislation to adopt changes that move toward site neutrality in the commercial market to address exorbitant hospital prices.

Policy Solution 3. Directly Placing Limits on Hospital Rates

Without policy interventions, we will continue seeing hospitals charge unsustainable and increasingly high rates. Hospitals in some states charge commercial plans an average of three times what they charge Medicare and state budgets are increasingly impacted by rising hospital prices. In addition, there is high variation of prices across geographies, with prices varying significantly within states and even within the same hospital. With these unjustified prices, it is no surprise that people think prices are too high: 75% of voters think the prices that hospitals and doctors charge privately insured patients for medical services are too high relative to Medicare, and half of voters (51%) believe reimbursement rates at twice what Medicare pays is too high.

States can directly address high prices charged by hospitals in a range of ways:

- **Establishing a cost growth target:** State policymakers can also create an annual statewide target for how much health care spending can grow each year. Setting a target protects patients and other payers from rising costs while providing policymakers with more robust data to better understand cost drivers and support other strategies to lower hospital prices. Policymakers pursuing cost growth targets should ensure the policy is designed to hold hospitals and others accountable for meeting targets and that agencies are provided the resources needed for enforcing the targets.
- **Setting or capping provider rates:** This directly targets reimbursement rates by setting or capping rates at a specific level, often relying on a multiplier of Medicare as the "reference price." States can set or cap rates for certain types of providers and/or within certain markets, such as the individual market or for state employee health plans (SEHPs). Setting or capping provider rates is a good option for states looking to target high outlier costs and bring the prices charged for services more in line with what the actual cost to provide them. Specifically targeting rates paid through SEHPs has the potential to generate significant savings that can be reinvested in other areas of the state budget, including Medicaid or other state-based affordability programs.

- **Establishing in- and/or out-of-network rate caps:** States can specifically target in- and/or out-of-network provider rates by placing limits on what in- or out-of-network providers – often large health systems – can charge. Rate caps bring prices more in line with actual costs. Establishing out-of-network rate caps, specifically, help prevent large hospital systems from using their negotiating power to force plans to pay what they demand or threaten leaving the network, which raises prices overall. The impacts of this policy can "spillover" to other areas as well, because the incentive to go out-of-network and demand higher prices is reduced. Establishing these types of caps can be particularly helpful for policymakers looking to address high prices often associated with highly-concentrated markets.

These policies have advanced in states and offer insights to other policymakers looking to directly tackle and lower overall health care system costs. For example, the Colorado Option includes provisions that allow the state to set provider and hospital rates based on a statutorily established-formula if plans aren't able to lower premiums to a target level. Because of this, the program has led to nearly $493 million in savings for Coloradans, with 2025 premiums being lowered nearly 24%. Montana has also seen success since implementing rate caps within its SEHP, leading to over $48 million in savings in the first two years alone. Oregon, too, saw significant savings of over $107 million in the first two years after establishing in- and out-of-network provider rate caps within their SEHP.

Solutions to limit prices charged by hospitals through strategies like reference pricing or out-of-network caps may also provide states with the opportunity to transition away from volume-based fee-for-service payment toward "patient-first care," or value-based care models. While states may tie cost-saving solutions to existing Medicare payment rates or some multiplier of this rate, policymakers on both the federal and state levels are also increasingly using value-based purchasing arrangements and other alternative payment mechanisms to determine payment rates, or channeling savings from policies like site neutrality towards patient-first care models. USofCare's research found that, by a 4:1 margin, people favor a patient-first care model that ties provider payment to improved patient care and health outcomes instead of the current fragmented, disjointed system that prioritizes quantity over quality.

4. Protecting Patients from Harmful Hospital Consolidation

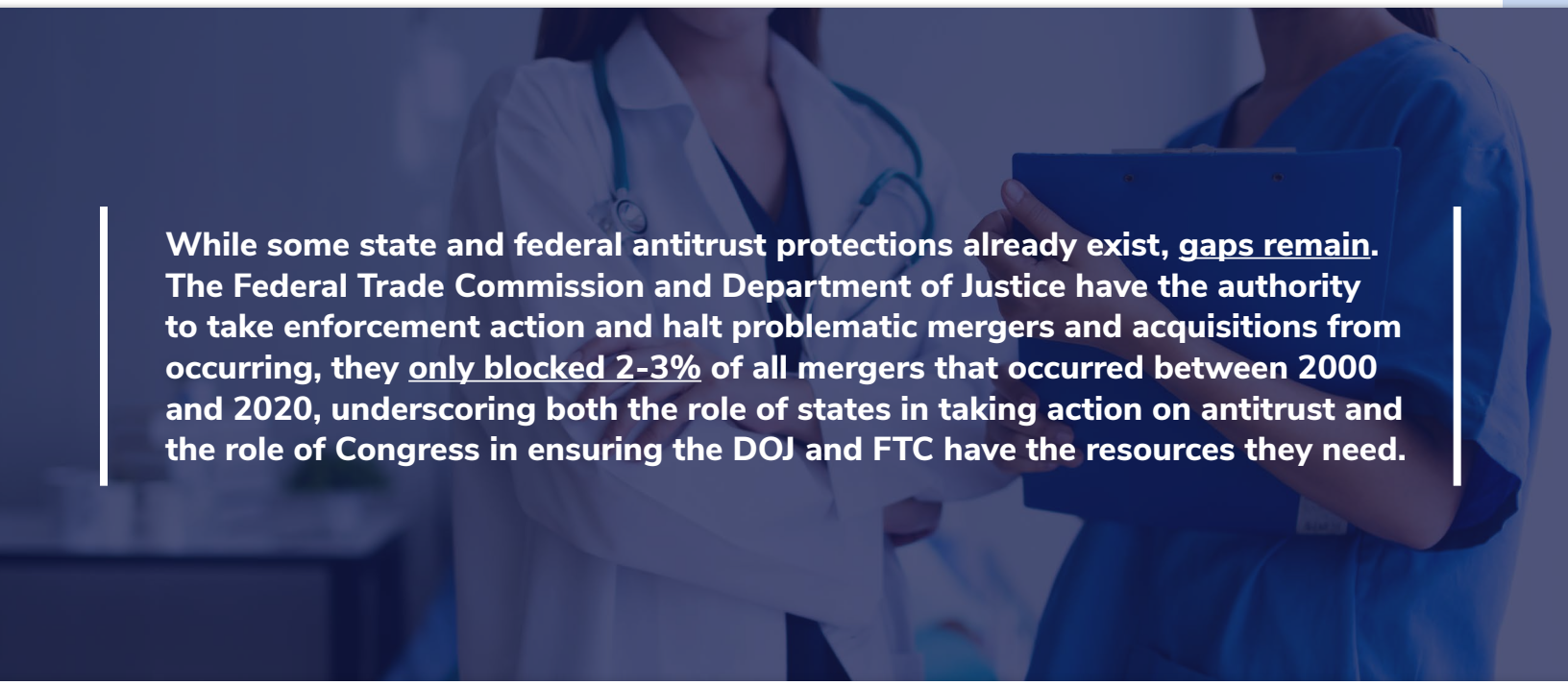
Recent analysis showed that one or two health systems controlled the entire market for inpatient hospital care in 47% of metropolitan areas in 2022 and, in more than 82% of metropolitan areas, one or two health systems controlled more than 75% of the market. Rural areas, many of which have long experienced a lack of health care competition, have also undergone health care consolidation in recent years as independent hospitals are bought out by or merge with other hospitals or health systems. Overall, 90% of hospital markets, regardless of geographic location, have been deemed "highly concentrated."

Additionally, more than half of physicians are now employed by health systems or hospitals, up from only 26% of physicians in 2012, when a majority of physicians were independent providers. What's more, an increasing number of hospitals and other providers, including physicians' offices, have come under corporate or non-physician ownership, the financial backing of which is often difficult to identify. Approximately 22% of physicians are now employed by private equity or some other corporate actor. Given high operating costs, independent providers in both urban and rural areas are often left with no choice but to be employed by large corporate hospitals or other entities that may have vested financial interests, and not quality patient care, as their chief motivator.

When hospitals consolidate through merging with or acquiring other hospitals or providers, higher prices, closures and reduction of service lines soon follow. The increasingly alarming trend is leaving patients, providers, and whole communities with less choice and access.

While mergers and acquisitions are associated with anywhere from 20% to 40% price increases, they are not associated with increases in the patient choice, satisfaction, or the quality of care received.

These impacts – paired with 75% of voters supporting preventing hospitals from engaging in business tactics that reduce competition and 74% supporting limits to mergers and acquisitions – have led to state policymaker action.



While some state and federal antitrust protections already exist, gaps remain. The Federal Trade Commission and Department of Justice have the authority to take enforcement action and halt problematic mergers and acquisitions from occurring, they only blocked 2-3% of all mergers that occurred between 2000 and 2020, underscoring both the role of states in taking action on antitrust and the role of Congress in ensuring the DOJ and FTC have the resources they need.

In response to increasing consolidation, states are advancing a range of policies that other state and federal policymakers can look to and learn from:

- **Increasing ownership transparency:** With health care entity ownership structures becoming more and more complex, state policymakers are also advancing policies that expand ownership transparency, which is an important foundational policy to address harmful consolidation. This creates more transparency and provides a clearer picture of the financial backing behind providers and provides an opportunity for the public to engage and weigh in on changes that may impact them.
- **Requiring prior notice and review before a proposed health care transaction (such as a merger or acquisition) is approved:** States can establish or increase oversight authority before health care transactions are approved. This includes requiring additional review and public notice and providing authority to review additional types of transactions, such as non-profit mergers or transactions involving private equity.
- **Allowing agencies to block or place conditions on transactions:** Policymakers can give a state agency, attorney general, or a combination of both the authority to block harmful transactions from occurring or allow them to impose consumer-protective conditions on transactions they approve. This is an effective way for states to prevent harmful transactions from occurring, and states set specific parameters around the criteria used to determine whether a transaction should be blocked or approved with conditions, such as blocking mergers that are not in the public interest or likely to raise costs, lead to reduction in services, or lead to increased health disparities.

States across the country are pursuing these actions and seeing results. Rhode Island provides both its attorney general and state Department of Health the authority to block transactions involving nonprofit and for-profit hospitals. Citing this authority, the state's attorney general, after thorough review, successfully stopped the merger of Rhode Island's two biggest health systems, citing its negative impact on health care costs, quality, and access. Louisiana and Ohio provide their attorney's general with the authority to block transactions involving nonprofit hospitals. Oregon's Health Care Market Oversight Program recently approved an acquisition on the condition that transacting entities not impose new facility fees for a set amount of time after a transaction.

> *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

Recommendations for Federal Policymakers

With people across demographics, geography, and incomes struggling, now is the time for bold federal policy solutions. While states have made tremendous strides in tackling hospital pricing and hospital consolidation, federal action is needed for these policies to have the biggest impact and alleviate financial burden and pressure on everyday people.

Based on lessons learned from state efforts, Congress should take action on:

- **Ensuring each HOPD has its own NPI:** Congress should require unique NPIs for hospital-affiliated providers. These NPIs should be structured in a way to preserve the connection between "parent" hospital and affiliated provider in the data.
- **Limiting unfair facility fees:** Congress should protect people from unfair hospital facility fees, including facility fees for telehealth visits, preventive services, and in outpatient settings.
- **Advancing site-neutral payments:** Congress should eliminate hospital payment disparities and disincentivize unfair billing practices by advancing site neutral payment, including by eliminating exemptions to the Bipartisan Budget Act of 2015 and requiring site-neutral payments in alignment with MedPAC recommendations.
- **Increasing hospital billing transparency:** Congress should ensure existing transparency measures are complied with and enforced. As noted in our Site-Neutral Out of Pocket Costs Principles, more protections need to be put in place to ensure hospitals aren't exploiting patient billing loopholes.

Just as state policymakers have done, federal policymakers should ensure the policies they advance target the right types of hospitals in the right way. As debates continue, policymakers should pay special attention to ensure that any policies avoid any unintended consequences that may negatively impact provider access or exacerbate existing health care disparities. Policymakers should not unnecessarily carve out special interests from policy interventions based solely on unverified claims by hospital industry stakeholders seeking to preserve the status quo. In designing solutions aimed at tackling hospital pricing and consolidation, lawmakers should know these policies have strong support from everyday people across party lines.

Looking Forward

With the start of this year's Congressional and state legislative sessions, policymakers have new opportunities to take meaningful action and respond to people's desires for change within the health care system. States that have long been leaders in finding solutions to lower people's health care costs have the opportunity to build on their success by advancing innovative policies like site neutrality, while others just beginning to tackle high costs should pursue proven solutions from other states, such as limits on facility fees, and adapt them to fit their own state's needs.

With states across the country already passing a range of policies aimed at specifically tackling high prices charged by hospitals and addressing an increasingly consolidated health care market, there is no shortage of bright spots to point to. These successes provide insights and lessons learned that should inform state and federal policymakers as they, too, seek to bring their constituents a health care system that truly works for them.

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