

USC-BROOKINGS SCHAEFFER
INITIATIVE FOR HEALTH POLICY

Testimony of Loren Adler, MS
Associate Director and Fellow, USC-Brookings Schaeffer Initiative for Health Policy
Economic Studies, Brookings Institution

Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

*Lowering Unaffordable Costs:
Legislative Solutions to Increase Transparency and Competition in Health Care*

April 26, 2023

Chairman Guthrie, Ranking Member Eshoo, members of the Subcommittee, thank you for the opportunity to testify today on this crucial topic. My name is Loren Adler and I am a Fellow and Associate Director of the USC-Brookings Schaeffer Initiative for Health Policy. My research focuses on health care market competition, provider payments, and prescription drug policy. Prior to joining Brookings, I worked for the Committee for a Responsible Federal Budget and the Bipartisan Policy Center.

Relevant to today's hearing, much of my current research aims to decipher the effects of private equity, payer, and hospital acquisitions of physician practices, as well as develop policy responses.

I have previously written on a broad array of policy options to reduce costs by increasing transparency and competition in health care – most recently in a policy brief with Benedic Ippolito at the American Enterprise Institute.¹ This testimony focuses more narrowly on two main points:

- 1) Medicare rates are intended to reflect the costs of providing services for an efficient provider. As such, Medicare should not pay more for the same service performed in a hospital outpatient department versus a physician's office, provided that the physician's office setting is safe and clinically effective for most patients. Implementing this policy change would result in substantial savings for beneficiaries and taxpayers, while fostering greater competition in physician markets by reducing incentives for hospitals to acquire physician practices.
- 2) Increased transparency can both facilitate stronger research and oversight and, in certain circumstances, steer patient volume to lower-cost providers. Specifically, with systematic data about provider ownership arrangements and commercial market prices and volumes, researchers could better identify the effects of various forms of health care consolidation and elucidate solutions. The opacity of payment flows between specific actors in the drug supply chain similarly inhibits research. And evidence suggests that patients can make use of transparent pricing information for more "shoppable" services.

Background

In 2021, the U.S. devoted 18.3% of its economy to pay for health care, a higher share than any other country.² These high costs stem not only from a higher willingness to pay for care, but also insufficient competition in many markets and other market inefficiencies. Elevated health care costs have far-reaching consequences, straining government budgets, hindering wage growth, and affecting individual finances.³

The health care industry has experienced significant increases in consolidation, both horizontal and vertical. Horizontal consolidation, such as the merging of hospitals or physician groups within the same

¹ Adler, Loren and Benedic Ippolito. "Procompetitive Health Care Reform Options for a Divided Congress." Brookings Institution, March 2023, <https://www.brookings.edu/essay/procompetitive-health-care-reform-options-for-a-divided-congress/>.

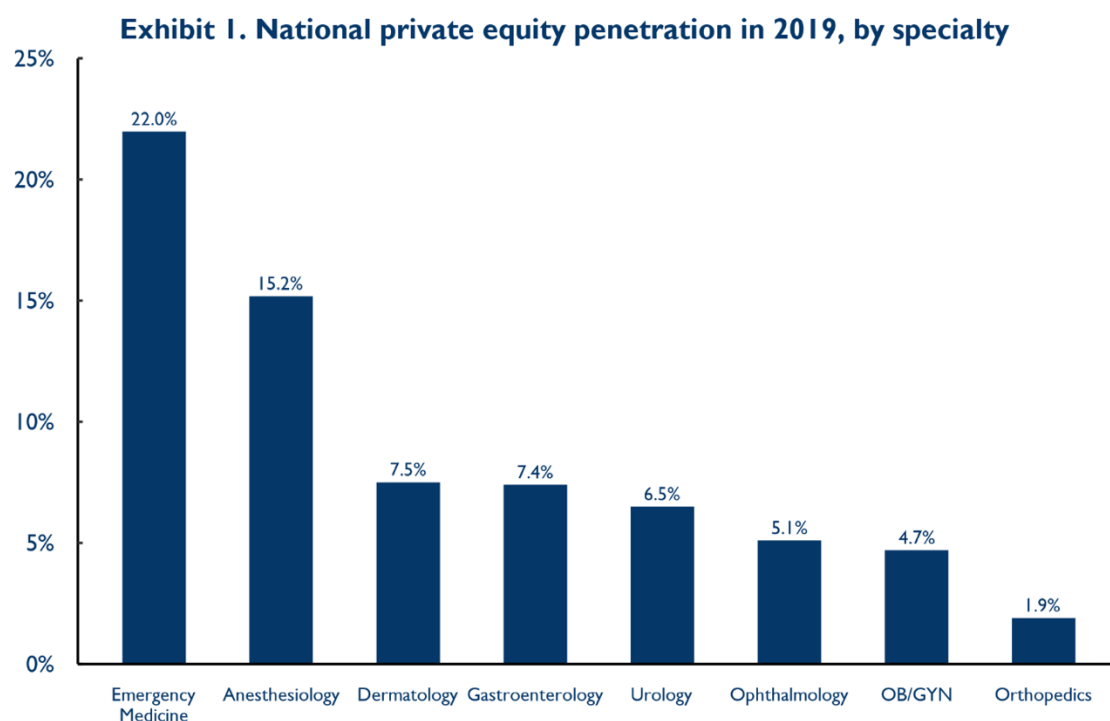
² Centers for Medicare & Medicaid Services. "National Health Expenditures - Historical and Projected Data." CMS.gov. Accessed April 24, 2023. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>.

³ Arnold, Daniel and Christopher M. Whaley. "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages." Santa Monica, CA: RAND Corporation, 2020. <https://doi.org/10.7249/WRA621-2>.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

geographic market, leads to higher prices for consumers and potentially diminished quality of care.⁴ These increased costs, in turn, appear to commensurately reduce employee wages.⁵ With greater market power as an employer locally, there is also evidence that hospital mergers reduce the wages paid to hospital staff with industry-specific skills such as nurses.⁶

Private equity firms have also driven substantial horizontal consolidation in many physician specialty markets (Exhibit 1), often focused in specialties that have seen fewer hospital acquisitions. As expected, empirical evidence suggests that these acquisitions have substantially increased health care costs.⁷



Source: Singh et al. (*JAMA Health Forum*, 2022). Adler, Milhaupt, and Valdez (*Health Affairs Scholar*, forthcoming).

USC Schaeffer

BROOKINGS

⁴ Cooper, Zack et al. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107. <https://doi.org/10.1093/qje/qjy020>; Beaulieu, Nancy D. et al. "Changes in Quality of Care after Hospital Mergers and Acquisitions." *New England Journal of Medicine* 382, no. 1 (January 2, 2020): 51–59. <https://doi.org/10.1056/NEJMSa1901383>; Koch, Thomas, Brett Wendling, and Nathan E. Wilson. "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries." *Health Services Research* 53, no. 5 (October 2018): 3549–68. <https://doi.org/10.1111/1475-6773.12825>.

⁵ Arnold and Whaley, 2020

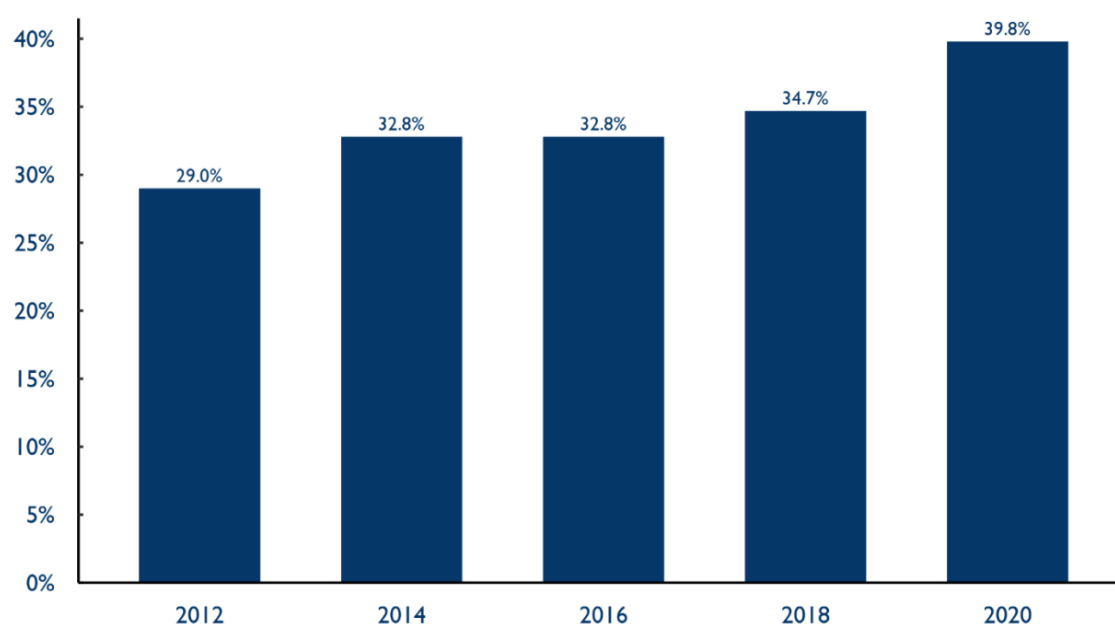
⁶ Prager, Elena, and Matt Schmitt. 2021. "Employer Consolidation and Wages: Evidence from Hospitals." *American Economic Review*, 111 (2): 397-427. DOI: 10.1257/aer.20190690.

⁷ See, e.g., Singh, Yashaswini, Zirui Song, Daniel Polsky, Joseph D. Bruch, and Jane M. Zhu. "Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization." *JAMA Health Forum* 3, no. 9 (2022): e222886. <https://doi.org/10.1001/jamahealthforum.2022.2886>; La Forgia, Ambar, Amelia M. Bond, Robert Tyler Braun, Leah Z. Yao, Klaus Kjaer, Manyao Zhang, and Lawrence P. Casalino. "Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners." *JAMA Internal Medicine* 182, no. 4 (2022): 396-404. <https://doi.org/10.1001/jamainternmed.2022.0004>.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

“Vertical” consolidation involving hospitals and physician groups (Exhibit 2) also appears to drive up costs, but the impact on the quality of care remains unclear.^{8,9} These effects likely operate through multiple channels. Hospital-physician integration directly increases Medicare spending because the program pays substantially more money for the same service when performed in a hospital outpatient department rather than an independent physician’s office. Bringing together multiple physician practices in the same specialty under a hospital can effectively increase horizontal consolidation, increasing the joint entity’s bargaining power. There is also strong evidence that hospital-owned physician practices are more likely to refer patients to their own hospitals and away from lower intensity sites of care, effectively strengthening the hospital’s bargaining power vis a vis insurers.^{10,11}

Exhibit 2. Percentage of physicians working directly for a hospital or a practice at least partially owned by a hospital or health system, 2012-2020



Source: American Medical Association's Physician Practice Benchmark Survey, 2021.

USC Schaeffer

BROOKINGS

⁸ See, e.g., Post, Brady, Tom Buchmueller, and Andrew M. Ryan. "Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality." *Medical Care Research and Review* 75, no. 4 (August 2018): 399–433. <https://doi.org/10.1177/1077558717727834>. Capps, Cory, David Dranove, and Christopher Ody. "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending." *Journal of Health Economics* 59 (2018): 139-152. <https://doi.org/10.1016/j.jhealeco.2018.04.001>.

⁹ Koch, Thomas G., Brett W. Wendling, and Nathan E. Wilson. "The Effects of Physician and Hospital Integration on Medicare Beneficiaries’ Health Outcomes." *The Review of Economics and Statistics*, August 16, 2021, 1–15. https://doi.org/10.1162/rest_a_00924.

¹⁰ See, e.g., Baker, Laurence C., M. Kate Bundorf, and Daniel P. Kessler. "The Effect of Hospital/Physician Integration on Hospital Choice." *Journal of Health Economics* 50 (December 2016): 1-8.

<https://doi.org/10.1016/j.jhealeco.2016.08.006>; Whaley, Christopher M., Xiaoxi Zhao, Michael Richards, and Cheryl L. Damberg. "Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration." *Health Affairs* 40, no. 5 (May 2021): 811-818. <https://doi.org/10.1377/hlthaff.2020.01006>.

¹¹ Richards MR, Seward JA, Whaley CM. Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. *J Health Econ.* 2022 Jan; 81:102569. doi: <https://10.1016/j.jhealeco.2021.102569>.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

Despite evidence pointing to potential antitrust concerns, glaringly so in the case of horizontal consolidation, many acquisitions proceed unchallenged due to factors including insufficient pre-merger notification requirements, data limitations, and resource constraints faced by federal antitrust agencies.¹²

Site-Neutral Payments

Many health care services can be delivered either through a physician's office, an ambulatory surgery center (ASC), or a hospital outpatient department (HOPD). For some services, such as medical emergencies or complex surgeries, there may be safety and quality benefits to receiving care at a HOPD, where there exists emergency standby capacity and other specialists in the case of complications. But for lower-complexity services such as office visits, imaging, and drug administration, it is typically safe and clinically effective to receive care at a physician's office.¹³

Yet Medicare pays substantially more – typically between two and three times more – even for low complexity services when delivered in a HOPD rather than a physician's office. Similarly, Medicare pays more for the same service in a HOPD compared to an ASC, and (to a lesser extent) in an ASC versus a physician's office. For instance, in their June 2022 report, the Medicare Payment Advisory Commission (MedPAC) notes that “Medicare pays 141 percent more in an HOPD than in a freestanding office for the first hour of chemotherapy infusion ... [and] 105 percent more in on-campus HOPDs than in freestanding offices for a midlevel office visit.”¹⁴

When Medicare pays more, Medicare beneficiaries also pay more, both because they are generally responsible for coinsurance equal to 20% of the Medicare rate and because Medicare Part B premiums and deductibles are tied to a percentage of program costs.¹⁵

Using the example presented by MedPAC in their March 2023 meeting, a Medicare patient receiving a Level 2 nerve injection at a physician's office in 2023 would owe \$51 in coinsurance on the total Medicare rate of \$256. If that same patient instead received the same service at a HOPD, they would owe nearly three times as much – \$148 in coinsurance on a total Medicare payment of \$741.¹⁶

This market distortion created by Medicare policy also incentivizes hospital acquisitions of physician practices. This financial incentive can be quite large. For an independent physician in 2016, integrating with a hospital would have increased total annual Medicare payments for their services by \$141,000, on

¹² Wollmann, Thomas. “How to Get Away with Merger: Stealth Consolidation and its Effects on Us Healthcare (May 2020).” NBER Working Paper No. w27274, Available at SSRN: <https://ssrn.com/abstract=3615470>

¹³ Medicare Payment Advisory Commission. *June 2022 Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, 2022. <https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/>

¹⁴ Ibid.

¹⁵ For beneficiaries with supplemental coverage who are shielded at least in part from the higher coinsurance, those additional costs translate to higher Medigap premiums, costs to their employer, or higher state Medicaid program costs.

¹⁶ Zabinski, Dan. “Aligning fee-for-service payment rates across ambulatory settings.” MedPAC, Mar. 2023, <https://www.medpac.gov/wp-content/uploads/2022/07/Site-neutral-March-2023-SEC.pdf>.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

average (or nearly \$180,000 in today's dollars).¹⁷ While not the only factor driving vertical consolidation between hospitals and physicians, evidence suggests that Medicare's policy of paying more for the same service when performed in a HOPD has played a substantial role.¹⁸

As discussed earlier, this vertical consolidation then also has the knock-on effect of increasing health care costs for employers and individuals in the commercial market.

Medicare has taken small steps toward site-neutral payments, first with the Bipartisan Budget Act of 2015 (BBA). That law reduced Medicare payments to off-campus HOPDs to align with physician fee schedule rates, but excepted (or grandfathered) any off-campus HOPD established before November 2, 2015 (the exception was subsequently expanded to protect any off-campus HOPD under construction by that time). The Trump Administration, through rulemaking, then expanded site-neutral payments to office visits at grandfathered off-campus HOPDs.¹⁹

The justification for paying more for the same service delivered at an off-campus HOPD is particularly weak. Often a hospital would acquire a physician practice and rebrand it as a HOPD with little to no noticeable difference to patients. For example, Dranove and Ody (2019) note how an acquired physician group assured its patients that "our diagnostic testing services will still be provided at the same office locations but will be billed as outpatient hospital procedures. Our staff members caring for you in these areas and the services rendered will remain the same."²⁰

But less than 1% of hospital outpatient spending occurs at HOPDs subject to the BBA 2015 changes, and "only one-third of the office visits provided in HOPDs occur in off-campus [HOPDs]."²¹ There are also relatively few limits on expanding grandfathered off-campus HOPDs.

Therefore, while modest improvements have been made, Medicare payment policy continues to encourage vertical consolidation by offering higher payments for the same service when performed at grandfathered off-campus HOPDs (other than office visits), on-campus HOPDs, ASCs, freestanding emergency departments, and cancer hospitals, compared to at a physician's office.

MedPAC has recommended and this Subcommittee is considering legislation that would end the exception for off-campus HOPDs established before 2015 for all services and align payments between on-campus HOPDs and independent physician offices for a set of low complexity services. These proposals would also align payments between ASCs and HOPDs for certain services that can be safely delivered in an ASC.²² Office visits, imaging, and drug administration comprise two-thirds of the services,

¹⁷ Post, Brady, Edward C. Norton, Brent Hollenbeck, Thomas Buchmueller, and Andrew M. Ryan. "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments." *Health Services Research* (2019). <https://doi.org/10.1111/1475-6773.13613>.

¹⁸ Dranove, David, and Christopher Ody. "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians." *American Economic Journal: Economic Policy* 11, no. 4 (2019): 249-271. <https://doi.org/10.1257/pol.20170020>.

¹⁹ Adler, Loren, Andrés de Loera-Brust, Matthew Fiedler, Paul B. Ginsburg, and Will Palmisano. "CMS' Positive Step on Site-Neutral Payments and the Case for Going Further." *Brookings Institution*, August 10, 2018. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-going-further/>.

²⁰ Dranove and Ody, 2019

²¹ MedPAC June 2022

²² Ibid.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

by program spending, that MedPAC identifies where it is safe and clinically effective to deliver care at a physician’s office (Exhibit 3).

Exhibit 3. Medicare spending, cost-sharing, and volume for services that MedPAC recommends alignment of OPPS and PFS payment rates, 2019

APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
Clinic visits	\$ 3,029	\$ 757	32,685
Imaging w/o contrast	\$ 2,587	\$ 647	22,694
Drug administration	\$ 2,086	\$ 521	24,094
Level 3 nuclear medicine	\$ 685	\$ 171	696
Skin procedures	\$ 673	\$ 168	2,418
Nerve injections	\$ 663	\$ 165	1,888
Diagnostic tests & related services	\$ 583	\$ 145	1,927
Urology and related services	\$ 376	\$ 94	518
Other	\$ 946	\$ 252	11,510
Total	\$ 11,628	\$ 2,920	98,430

Notes: OPPS stands for Outpatient Prospective Payment System. PFS stands for Physician Fee Schedule. Data is drawn from the MedPAC June 2022 report, Table 6-2, with Ambulatory Payment Classifications (APCs) categorized by the author.

Taken together, the Congressional Budget Office (CBO) estimated that a similar combination of policies proposed by the Trump Administration would reduce Medicare spending by \$140 billion over 10 years.²³ And MedPAC estimated that their June 2022 proposal would have reduced aggregate beneficiary cost-sharing by \$1.7 billion in just the year 2019 had it been in place.²⁴

Some hospital groups have argued that their payment rates should be higher for the same service because they treat sicker patients. While it is true that HOPD patients tend to have higher risk scores than those treated in physician offices, on average, the policy changes under consideration are focused on low complexity services where the cost of providing care does not appear to differ by patient health status. Hospital outpatient departments can also still bill for additional services for patients requiring more intensive care.²⁵

Moving toward site-neutral payments for services that can be safely delivered in a physician’s office offers an opportunity to substantially reduce costs for taxpayers and beneficiaries while removing one of

²³ Congressional Budget Office. "Proposals Affecting Medicare—CBO’s Estimate of the President’s Fiscal Year 2021 Budget." March 2020. Accessed April 27, 2023. <https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf>.

²⁴ MedPAC June2022

²⁵ Zabinski, MedPAC, 2023

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

the most glaring incentives for consolidation. Similar policies have been proposed in both Obama and Trump budgets,²⁶ and generate widespread bipartisan support from think tanks and other policy experts.²⁷

Transparency

Many of the proposals under consideration by the Subcommittee today would enhance transparency for researchers, patients, and employers.

The data necessary to best understand health care market dynamics and how new policies will affect the system are often difficult or impossible to access, in many cases controlled by private actors who benefit from opacity. Tracking and analyzing growing trends such as private equity and payer acquisitions of physician practices are hampered by a lack of systematic data on the parent companies and ownership structures of physician group owners.

Two transparency proposals, in particular, would provide better tools for research and oversight:

- 1) **Requiring entity-level reporting on the parent company name, address, and ownership structure (e.g., private equity, health plan, hospital) of physician practices and making this data publicly-available.** At present, my attempts (and those of collaborators) to compile this sort of information requires a painstaking amount of manual effort on top of purchasing access to privately-held data resources, and is inevitably subject to some level of imprecision given the manual steps involved. Instead, if such information was reported to the government, the Centers for Medicare and Medicaid Studies could make available a longitudinal dataset that identifies the parent company and ownership structure of physician groups matched to identifiers for each clinician who treats Medicare patients.
- 2) **Codifying and standardizing reporting by insurers under the Transparency in Coverage rules.** The Transparency in Coverage rules require that health insurance plans and issuers make public a treasure trove of data on contracted prices for health care services and amounts paid for out-of-network services. These data offer an opportunity to get a more complete picture of our health care system and examine heterogenous effects across payers. The size and varied reporting structures, however, limit the data's usability. The proposal under discussion by this Subcommittee would helpfully require some standardization in the way the data is reported. The most valuable addition for researchers would be to also require reporting on the volume of each service paid for by the health plan.

²⁶ The White House. "Budget of the U.S. Government: Fiscal Year 2016." February 2, 2015. Accessed April 25, 2023. <https://www.govinfo.gov/content/pkg/BUDGET-2016-BUD/pdf/BUDGET-2016-BUD.pdf>; The White House. "Budget of the U.S. Government: Fiscal Year 2021." February 10, 2020. Accessed April 25, 2023. <https://www.govinfo.gov/content/pkg/BUDGET-2021-BUD/pdf/BUDGET-2021-BUD.pdf>.

²⁷ See, e.g., Americans for Prosperity. "Bipartisan Support for Site-Neutral Payment Reform." Sign-on letter to Congress. April 2023. Accessed April 28, 2023. <https://americansforprosperity.org/wp-content/uploads/2023/04/Bipartisan-Support-For-Site-Neutral-Payment-Reform.pdf>; Van de Water, Paul N. "Strengthening Medicare Financing." *Center on Budget and Policy Priorities*, December 14, 2020. <https://www.cbpp.org/research/health/strengthening-medicare-financing>; Blase, Brian and Joe Albanese. "Turning the Tide on Red Ink: Commonsense Policies to Make Federal Health Programs More Sustainable." Paragon Institute, March 2023. https://paragoninstitute.org/wp-content/uploads/2023/03/Turning-the-Tide-on-Red-Ink_Brian-Blase_Joe-Alabanese_FINAL_202303072031.pdf.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

For consumers, evidence suggests that meaningful price transparency can place modest downward pressure on health care prices, at least for “shoppable” services such as imaging.²⁸ The proposed codification and standardization of both the hospital and insurer transparency rules, including the requirement for patient-facing tools that provide real-time information, likely offer the greatest benefits in this respect.

Lastly, there is likely value to increasing transparency into the role of pharmacy benefit managers (PBMs) and payment flows between specific actors throughout the pharmaceutical supply chain. CBO, for instance, estimates that transparency about PBM rebates and other fees can help some plan sponsors negotiate better deals, although such savings are expected to dissipate over time as private actors modify the structure of their contracts.²⁹ Transparency of drug rebates, payment flows in the drug supply chain, and ownership arrangements can also help foster research to better understand prescription drug markets. For instance, such transparency could make it easier to identify whether vertically-integrated PBMs or pharmacies give worse deals to competing insurers.

Conclusion

The Committee’s focus on bipartisan policies to improve health care competition and transparency is a welcome sight. Thank you again for the opportunity to testify.

²⁸ Brown, Zach Y. "Equilibrium Effects of Health Care Price Information." *The Review of Economics and Statistics* 101, no. 4 (2019): 699-712. https://doi.org/10.1162/rest_a_00765.

²⁹ Congressional Budget Office. "Cost Estimate: S.1895, Lower Health Care Costs Act." Washington, D.C.: Congressional Budget Office, July 16, 2019. Accessed April 29, 2023. https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

The views expressed in this testimony reflect those of the author and should not be attributed to the staff, officers, or trustees of the Brookings Institution.